THE CANCER LETTER INTERACTIVE

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Von Eschenbach Takes NCI's Helm As Bush Proposes Budget Increase

Andrew von Eschenbach was formally sworn in as the NCI director on Feb. 4, just hours after Bush Administration officials proposed a 16 percent budget increase for NIH and a 12.2 percent increase for NCI.

Von Eschenbach, a urologic surgeon from M.D. Anderson Cancer Center in Houston, said he would work to enhance NCI's commitment to investigator-initiated grants, support the research of young investigators, and improve collaboration among scientific disciplines.

"Today, the world now knows real hope for a solution to cancer,"

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In Brief:

Jerome Yates Named VP For Research At ACS; MSKCC Wins Zoning Request For New Labs

JEROME YATES was named national vice president for research at the American Cancer Society. Yates will supervise worldwide scientific investigation and advances in oncology, coordinate research initiatives with the other ACS strategic programs, and play an active role in research fundraising initiatives. He was senior vice president for population sciences and senior vice president for clinical affairs at Roswell Park Cancer Institute. Yates served as the associate director for Centers and Community Oncology at NCI, where he was part of the group responsible for the generation and subsequent evaluation of the Community Clinical Oncology Program. He was also a participant in the NCI-funded research on aspects of supportive care and cancer in the elderly. . . . **MEMORIAL SLOAN-KETTERING** Cancer Center received approval from the New York City Council for its application and partial rezoning request to construct a laboratory research building. Construction could begin as early as this spring and take as long as six years, giving MSKCC its first building since the Rockefeller Research Laboratories building opened in 1989. "The rezoning will allow MSKCC to develop much needed laboratory space; but the greatest benefit of the zoning change will be felt in the decades ahead, since MSKCC will have the ability to plan for the replacement of Memorial Hospital, now 28 years old," said **Douglas Warner III**, chairman of the boards of overseers and managers. . . . **W. J. PLEDGER** was named deputy director at H. Lee Moffitt Cancer Center & Research Institute. Pledger holds the Cortner-Couch Endowed Chair in Cancer Research at the center. He joined Moffitt in 1994 and is known for his research in cancer susceptibility and genetic

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New NCI Director's Mission: "Promote Cancer Research"

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von Eschenbach said at the ceremony, held at the NIH Clinical Center. "Research has led us to fundamental understanding of the genetic, molecular and cellular processes that are responsible for the development and progression of a malignant tumor…. My mission as Director of NCI will be dedicated to continuing to promote and enhance cancer research."

Von Eschenbach has been working at NCI for the past two weeks (**The Cancer Letter**, Jan. 25).

HHS Secretary Tommy Thompson read the oath of office for von Eschenbach, whose wife Madelyn held the von Eschenbach family bible.

"Andy, you're getting a big [budget] increase," Thompson said. "So it's not for lack of money if you don't find an answer."

Also attending were Acting NIH Director Ruth Kirschstein, President's Cancer Panel Chairman Harold Freeman, and Bert Vogelstein, Clayton Professor of Oncology, Johns Hopkins Oncology Center.

"One hundred years from now, cancer will not be as much of a problem as it is today because of better early detection," Vogelstein said. "I know Andy von Eschenbach is absolutely committed to applying knowledge from the lab to patients. I look forward to an exciting time for NCI."

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World Wide Web: http://www.cancerletter.com

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-318-4030
PO Box 9905, Washington DC 20016
E-mail: news@cancerletter.com

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724
E-mail: info@cancerletter.com

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In the audience were von Eschenbach's four children and numerous family members, former Rep. Paul Rogers, and former NCI Directors J. Carl Barrett, Samuel Broder, and Richard Klausner.

Following is the text of von Eschenbach's remarks:

What an incredible privilege to be a public servant and to join the ranks of so many talented and dedicated individuals who have sacrificed in order to serve others. What an incredible privilege to have all of you gathered here today, to recognize and celebrate my becoming the Director of the National Cancer Institute. What an incredible privilege to have the trust of the President of the United States of America and the support of Secretary Thompson. And what an incredible privilege to be a part of the National Cancer Institute with its great history of achievement.

But today, while I stand before you as a man of great privilege, a child born with a genetic defect that causes a malignant tumor of the eyes underwent surgery—and while his parents were told he was cured, the child said, 'mommy, I can't see.'

Today, while I stand before you as a man of great privilege, a young mother raising her family was told she has breast cancer and will begin a life-long struggle marked by successful remissions and tragic recurrences.

And today, while I stand before you as a man of great privilege, a grandfather who worked and sacrificed all of his life now will spend years anguishing over whether he made the right decision for his prostate cancer or will be told death is certain to result from his metastatic lung cancer.

Today, Mr. Secretary and distinguished guests, is not about my privilege but rather about the mission I humbly accept. A mission to join with each of you to eliminate the burden and suffering of cancer.

This is my moment, but it is our time.

It is our time to realize the fulfillment of our hope to eliminate the burden of cancer—for ourselves, for future generations, and for our world. This is a hope that in large part was created because of the National Cancer Institute and now, by working together, it is a hope we will translate into freedom from suffering and into saved lives.

When I arrived on this campus a few short weeks ago, I was keenly aware of the privilege of being the Director of the National Cancer Institute, but I was even more overwhelmed by the enormous weight of the responsibility. I took a walk down to the pavilion

in front of Building One, and I looked up at the title *The National Institutes of Health.* And then I looked down at the plaque honoring my dear friend from our days on the Board of the American Cancer Society, the Honorable Paul Rogers, and I read the inscription of his quote made 30 years ago at the creation of the National Cancer Act '*…without research there is no hope…*'

Because of that vision 30 years ago, the commitment of our nation and the effort of so many and the leadership of this NCI, today the world now knows real hope for a solution to cancer. Research has led us to fundamental understanding of the genetic, molecular and cellular processes that are responsible for the development and progression of a malignant tumor.

Today, we are beginning to exploit this knowledge and to develop novel interventions to detect, halt and even prevent this malignant process. We are realizing that the cancer cell is much like a participant in a bizarre decathlon, and in order to succeed it must successfully compete in a variety of events. To overcome our defenses, a cancer must be able to grow or proliferate; it must be able to invade surrounding tissues; and it must be able to spread and metastasize, grow again and become resistant to therapy.

Today, because of research, there is real hope that tomorrow we can intervene in a variety of ways at a variety of places along this malignant decathlon and defeat the cancer. Already we are seeing actual novel therapies—such as STI 571 that interfere with the cancer's metabolic machinery—being delivered to patients with far advanced cancers with astonishing results. Dr. Vogelstein has told us of being able to use this sophisticated understanding of abnormal cancer genes to devise innovative ways to detect early cancers.

These great achievements, however, are only proof of principle; they are not the complete fulfillment of the hope. The malignant process is very complex and there is so much more we need to learn. Basic research must continue. And my mission as Director of NCI will be dedicated to continuing to promote and enhance cancer research.

That means enhancing our commitment to the R01 grant mechanism, to ensure that investigators have the opportunity and resources to pursue promising research ideas. It means developing and nurturing the work of young investigators with intriguing research ideas. And it means strengthening our commitment to collaboration and communication—especially with other institutes at NIH. This is especially important because breakthroughs in cancer research may be dependant upon progress in other disciplines. And because progress in our understanding of cancer may be applied to other diseases, such as diabetes, AIDS, and Alzheimer's.

But though the study of the biology of cancers in a test tube and under the microscope and in an animal model is essential, we must always remember that cancers exist in a person and the person is as important as the tumor. Research must be done to evaluate the "real-world" story of cancer's behavior in human populations and in the individual person.

In addition to understanding the tumor, we must also understand the human host. There are great horizons we must explore in this dynamic interaction. And so it will be important to always go beyond the laboratory, to the clinic and bedside. As we apply these interventions we must also use the clinical experience to inform our next laboratory investigation.

But even when all the studies are complete, when our understanding of the complex disease we call cancer is complete, hope will not have been fulfilled. Without research there is no hope, but when hope exists—as it does today and tomorrow—it must be translated to saved lives and reduced suffering.

Dr. Freeman has reminded us of the toll and burden that cancer places upon our citizens—most especially upon those who are underserved or underprivileged. We must do what we can to help deliver what we have achieved through discovery. To do this, we must look for new, creative ways to work together. As Director, I will work to foster the cooperation, collaborations, and consortia that are the key to a comprehensive solution to the cancer problem.

Our hope for the elimination of cancer is our nation's agenda, and it is the mission of the National Cancer Institute to lead and assure that agenda is fulfilled. But no matter how great the Institute, the goals of the National Cancer Agenda will only be achieved when we work together as a society. Federal agencies outside the NCI and NIH—state and local agencies, and importantly private institutions, organizations and advocates—must forge creative partnerships. My mission will be to work with you to go beyond individual agendas to seek the synergy we require. Our differences in perspective and expertise are eclipsed by our identity of purpose.

Today, the Secretary has commissioned me with a great mission. Today, the President has renewed

his commitment to provide the support we require to carry out this mission. And today, I stand before you having been granted the greatest privilege of my life. It will be my mission to serve each of you in assuring that the hope that has been created by those who have gone before me at the National Cancer Institute will be a hope that is realized.

A hope that will be translated into the realization of a little boy with retinoblastoma who can be cured without being blind. A hope that will be translated into the realization of a mother prone to breast cancer who will raise her family without fear. And a hope that will be realized by a grandfather who will enjoy the fruits of his long labor with assurances of life rather than death.

Today, this is my privilege; for every day, this will be my mission.

Let me close with a message to my families—both personal and professional—who make possible this privilege and this mission. To my mom and dad and brother—thank you for creating the life in me; and to Madelyn and our children—thank you for breathing life into me every single day. If there is honor and privilege in this day it belongs to you.

To my professional families—first to all the faculty, staff and patients at M.D. Anderson Cancer Center, where I spent the last 25 years learning the possibility of hope through research and the purpose for that hope to save lives. If there is purpose for my mission, it is a purpose I learned with you.

And to my new professional family at the National Cancer Institute—in just a brief period, you have made me feel welcomed and accepted, and I have been inspired by your talent and dedication. If there is a success in store for my mission, it will come from serving you.

Mr. Secretary, Dr. Kirschstein, distinguished ladies and gentlemen, our President and our nation have placed great trust in us and, as he said last week in his State of the Union address: "We are reminded that we are citizens with obligations to each other, to our country, and to history."

Today, he reaffirmed his pledge to provide us with the resources we require. We are a nation blessed with the privilege of serving each other and the world. We have been offered a unique mission to rid the world of cancer, and we must not let this moment pass.

I ask that you please pray that God will guide me and I will pray that God will continue to bless you, the NCI, and America.

President's Budget Request:
NCI Would Get $4.725 Billion, 12% Increase, In Bush Budget

The Bush Administration's budget proposal for fiscal year 2003 would provide $4.725 billion to NCI, an increase of $515 million, or 12.2 percent, over the current year's appropriation of $4.2 billion.

The President's budget request, released Feb. 4, includes a total of $5.5 billion for cancer research at NIH, out of a proposed $27.3 billion request for the Institutes. Under the proposal, NIH would receive nearly a 16 percent increase, or $3.7 billion in new funds, completing the five-year doubling for NIH begun in 1998.

Neither NIH or NCI spokesmen were able to provide specific information on how the amount for cancer research provided to the other institutes—$775 million—would be spent.

"With focused efforts and increased resources, NIH will build on past successes and technological breakthroughs to stimulate progress in addressing some of our most difficult questions about cancer," according to an NIH statement. "Our increased investments in all areas of cancer research will accelerate the pace of cancer research and improve our ability to find better ways to care for those whose lives are touched by cancer."

According to the NIH statement, funding will support "large-scale studies on critical cancer control, prevention, and screening questions," including the SELECT trial to determine if vitamin E and selenium can protect against prostate cancer, and a study to compare digital mammography to standard mammography for the detection of breast cancer. Both trials are being funded by NCI.

"Furthermore, investigators who are part of an NIH Cohort Consortium will be working to uncover potential interactions of genetics and environmental exposure by combining data from prospective cohort studies involving 7,490 cases of breast cancer and 7,130 cases of prostate cancer," the statement said. "Interactions between established risk factors and a set of genetic variants associated with these cancers will be studied. The collaborative effort will serve as a model for future efforts that can take full advantage of investments in large population studies and increase our understanding of what is needed to better control, prevent, and treat cancer."

The NIH statement on the President's budget proposal is available at http://www.nih.gov.

A table comparing funding by disease is available at http://www.nih.gov/news/specialareas.htm.

The HHS portion of the President's budget proposal is available at http://www.hhs.gov/budget/docbudget.htm.

Other highlights of the budget proposal:

—**Breast and Cervical Cancer Screening**: The budget includes $203 million for the National Breast and Cervical Cancer Early Screening Detection Program, an increase of $9 million above FY 2002.

—**Women's Health**: $4 billion, a 21.5 percent increase, for NIH for research on women's health, and a $2.1 million increase for the HHS Office on Women's Health, bringing the office's total budget request to $29.1 million.

—**HIV/AIDS**: $12.9 billion for HHS, an increase of $906 million, or 8 percent, over the current year's appropriation. The budget allocates $2.8 billion to NIH for research on HIV and AIDS, a $255 million, or 10 percent increase, above the current year's funding level. The NIH budget includes $422 million for AIDS vaccine research, a 24 percent increase over the previous year. The HHS budget includes $939 million for the Centers for Disease Control and Prevention for HIV prevention, about the same as provided for in the fiscal year 2002 budget. The budget also would allocate $1.9 billion—the same as the current year—to fund Ryan White treatment programs. About $639 million of this funding would be available for the AIDS Drug Assistance Program, which provides medications to about 85,000 people. HHS' portion of the President's budget includes $100 million for the Global Fund to fight HIV/AIDS, Maleria and Tuberculosis.

The budget would allocate $410 million for efforts targeted specifically at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities. This includes $105 million to expand treatment and services at the Substance Abuse and Mental Health Services Administration and $50 million for the Minorities Community Fund support infrastructure development, technical assistance, prevention and treatment strategies and education in affected communities, as well as $124 million under the Ryan White program, $116 million for community-based prevention activities at the CDC, and other resources at the NIH and other HHS offices and agencies.

—**Patient Safety**: The Administration proposes $10 million in new funding for an initiative to improve patient safety and reduce medical errors, bringing the HHS budget for improving patient safety to $84 million. The funds will support efforts to put known safety technologies into wider use, develop new approaches and support a stronger system for rapid reporting of adverse medical events.Under the initiative, the Agency for Healthcare Research and Quality will receive $60 million, an increase of $5 million, for patient safety. A portion of the increased funds will provide "challenge grants" to states to encourage the adoption of proven but underused technologies by health care organizations to reduce medical errors. The new funding will also be used to train on-site patient safety experts to provide technical assistance and support to states to encourage a culture of patient safety.

FDA would receive $5 million in new funding for patient safety, bringing its total funding for this issue to $22 million. The new funds would allow the agency to improve its ability to assess and follow-up on reports of adverse events that occur after the use of FDA-regulated products. Specific initiatives include partnering with the private sector to develop technologies, such as bar coding medications, so that electronic prescription programs can be introduced widely and thus diminish the number of medication errors.

The proposed budget requests $2 million for the Centers for Disease Control and Prevention for developing a Web-based system for providers to report data on infections that patients acquire in hospitals.

—**Health Credits**: The budget proposes $89 billion in new health credits for those not covered by employer-subsidized insurance. Eligible families with two or more children and incomes under $25,000 could receive up to $3,000 in credits to cover as much as 90 percent of the costs of purchasing health insurance. The credit phases out at $60,000 for families. Eligible individuals earning up to $15,000 annually would receive up to a $1,000 tax credit. For individuals, the credit phases out at $30,000.

—**Community Health Centers**: The budget includes $1.5 billion for community-based health centers, a $114 million increase, to support 170 new and expanded health centers and provide services to a million additional patients. About half the patients treated at health centers have no insurance coverage, and many others have inadequate coverage.

—**Extended Transitional Medical Assistance**: The budget will provide $350 million to continue funding Medicaid for families in transition from welfare to work.

—**National Health Service Corps**: The budget

will include $191.5 million, a $44 million increase, for the National Health Service Corps, which supports doctors, dentists and clinicians who serve in rural and inner-city areas that lack adequate access to care. With the increased funds, the corps will provide scholarships or loan assistance to about 1,800 professionals practicing in underserved areas, an increase of about 560 participants.

Drug Development:

BMS Demands Resignation Of Two ImClone Executives

In an extraordinary ultimatum, Bristol-Myers Squibb Co. (NYSE: BMY) demanded resignation of two top executives of ImClone Systems Inc. (NASDAQ: IMCL).

According to a press release dated Feb. 5, "Peter R. Dolan, [BMS] chairman and chief executive officer, said today that he has proposed steps to fundamentally restructure the company's relationship with ImClone."

Though the press release didn't list Bristol's demands, The Wall Street Journal cited Bristol sources stating that the pharmaceutical company is seeking removal of ImClone president and CEO Samuel Waksal and his brother, Executive Vice President Harlan Waksal.

Moreover, Bristol wants to take control over development of the monoclonal antibody Erbitux, also known as C225.

Last September, Bristol spent $1 billion to purchase a 19.9 percent stake in Imclone and another $200 million in a first payment for a 40 percent stake in C225. The pharmaceutical company promised to pay another $800 million if the agent is approved.

The transaction, hailed as the biggest in the history of biotechnology, quickly turned sour. FDA declined to accept the C-225 application, issuing a "refuse to file" letter to ImClone, a rare piece of correspondence that states that the data supporting the application cannot be evaluated, and is not good enough to be presented to the agency's extramural advisors (**The Cancer Letter**, Jan. 4, Jan. 11, Jan. 25).

As a result of the RTF letter and its subsequent publication in **The Cancer Letter**, ImClone's stock tumbled, and Bristol's stake in the company lost over 70 percent of its value. Recently, Bristol took a $780 million write-off on its investment in ImClone.

The ImClone debacle has become something of the biotech industry's equivalent of Enron. There is no shortage of parallels between the two business disasters. For one thing, preclinical development of C225 was spearheaded by John Mendelsohn, president of M.D. Anderson Cancer Center, and a member of the boards of directors of both ImClone and Enron.

On the Enron board, Mendelsohn serves on the audit committee. The ImClone board also includes former NCI Director Vincent DeVita, and Arnold Levine, president of the Rockefeller University.

The inside players at ImClone profited handsomely from the transaction with Bristol. The Waksal brothers sold over $150 million in stock when the price was high. A summary of trading activity by ImClone insiders can be found on http://biz.yahoo.com/t/i/imcl.html. A history of trading shows that from Dec. 5 through Dec. 28, 2001, the day the company received the RTF letter, the volume of sale of company stock increased, driving down the price of the shares.

In a press release dated Feb. 5, Bristol said its demands from ImClone included restructuring "certain economic, financial and other terms of the agreement." These included ceding greater control over driving the agent through the FDA approval process and "changes in ImClone senior management effective until FDA approval of Erbitux."

Also Bristol demanded "expanded rights to ImClone's intellectual property related to Erbitux and fewer restrictions on the company's ability to resell ImClone shares."

The Wall Street Journal on Feb. 5 reported that Bristol wanted the ImClone Board Chairman Robert Goldhammer to run the company, at least in the interim. Bristol officials didn't dispute the article.

"If these conditions are accepted, Bristol-Myers Squibb will take the lead in the FDA approval process and other clinical and regulatory matters related to Erbitux," Bristol CEO Peter Dolan said in the press release. "We are taking this action because we believe Erbitux has great potential to treat cancer patients, and we want to move the process forward as quickly as possible."

ImClone responded with a terse statement:

"We have received the proposal from Bristol-Myers Squibb outlining the terms of a proposed restructuring of their relationship with ImClone Systems. We will review their proposal and respond appropriately in due course."

Bristol has powerful incentives to start a public brawl with the Waksals, observers said.

To begin with, a fight would differentiate Bristol from ImClone at a time when the C225 debacle is being investigated by the same entities who are probing the undoing of Enron: the Securities and Exchange Commission, the U.S. Department of Justice, and the House Committee on Energy and Commerce and its subcommittee on Oversight and Investigations. Also, ImClone is facing about two dozen suits by disgruntled shareholders.

Also, there is a difference in styles. BMS officials surely cringed on Dec. 31, as Samuel Waksal, addressing investors, claimed to be "surprised" to receive the RTF letter, when in fact the text of the letter states that the agency repeatedly criticized the structure of the company's clinical trials.

In a subsequent statement, Waksal announced to Wall Street that his company "screwed up" the pivotal clinical trial testing C225 and CPT-11 in colorectal cancer patients whose disease progressed on other regimens containing CPT-11.

Under last year's deal, ImClone was in charge of the trials and the FDA submissions, but following the RTF letter, Bristol scientists started to work side-by-side with ImClone to reconstruct the files of patients who took part in the pivotal trial, to determine whether they met the eligibility criteria.

Soon after that process began, Bristol took a $735-million write-off on the ImClone investment, and acknowledged that additional write-offs may follow.

Bristol officials have good reasons to regret the unusual structure of their investment deal with ImClone. In a departure from standard practice in corporate acquisitions, the pharmaceutical company purchased the ImClone stock at a premium price directly from the shareholders, and not from the company, said David Hines, president of Avalon Research Group Inc.

Had the stock been purchased from ImClone, most of the proceeds would have been sitting safely in a money market account. As it stands, Bristol's money has gone to all four winds.

"Bristol struck a historically bad deal when it agreed to buy $1 billion of ImClone stock at $70 from ImClone shareholders, and not directly from ImClone, the company," Hines said to **The Cancer Letter**.

By going on the war path, Bristol may ease the questioning of its scrutiny of ImClone's data before concluding the deal, observers say.

"It seems that Bristol performed shoddy due diligence, failing to pick up faulty and incomplete data," Hines said. "It only makes sense that Bristol will seek to remedy this embarrassing and costly mistake."

Merrill Lynch analyst Eric Hecht said ImClone officials have no reason to cave to Bristol's ultimatum.

"We do not see any reason why ImClone would succumb to these demands since they are outside the terms of the contract," Hecht wrote. "BMS has also not stated on what basis they believe they are entitled to these changes.

"While the stock is not likely to react well to the public display of discontent between the parties, the dispute is in our view a 'sideshow.' In our view, ImClone stock will recover or wane depending upon which way the regulatory process goes for Erbitux.

"We continue to believe that Erbitux is an effective cancer drug, and will ultimately win FDA approval. What is unclear is the timing of this event. Our prior notes state that we believe this could happen by mid-2003.

"The dispute between BMS and ImClone does not currently change this view," Hecht wrote.

The acquisition agreement signed by the two companies last September contains a termination clause, which states, among other things, that Bristol has a right to end its relationship with ImClone if "any of the representations or warranties [by ImClone]… fail to be true and correct."

Health Statistics:

HHS Reports Some Gains In Reducing Health Disparities

HHS released a new report that shows significant improvements in the health of racial and ethnic minorities, but also indicates that disparities in health persist among different populations.

The report presents national trends in racial- and ethnic-specific rates for 17 health status indicators during the 1990s.

The report is part of Healthy People 2000, an HHS-led effort to set health goals for each decade and then measure progress toward achieving them.

All racial and ethnic groups experienced improvement in rates for 10 of the indicators: prenatal care; infant mortality; teen births; death rates for heart disease, homicide, motor vehicle crashes, and work-related injuries; the tuberculosis case rate; syphilis case rate; and poor air quality.

For five more indicators—total death rate and death rates for stroke, lung cancer, breast cancer, and

suicide—there was improvement in rates for all groups except American Indians or Alaska Natives.

The report, "Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990-1998," can be viewed or downloaded at http://www.cdc.gov/nchs.

CDC also issued a related study, "Recent Trends in Mortality Rates for Four Major Cancers, by Sex and Race/Ethnicity, United States, 1990 - 1998." That study is available at http://www.cdc.gov/mmwr/.

HHS Seeks Health Care Safety, Quality Ideas

Council on Private Sector Initiatives to Improve Security, Safety, and Quality of Health Care has been formed in HHS to consider ideas from the private sector. The council will review ideas and products, and triage them to the appropriate federal agencies.

AHRQ Director John Eisenberg serves as chairman of the council. The council has established a Web site: http://www.cpsi.ahrq.gov.

Funding Opportunities:

Program Announcements

PA-02-054: Short-Term Courses in Human Embryonic Stem Cell Culture Techniques

Application Receipt Dates: April 23 and Oct. 23

NIH invites applications for grants to develop, conduct, evaluate, and disseminate short-term courses that should include hands-on experience to improve the knowledge and skills of biomedical researchers to maintain, characterize, and utilize human embryonic stem cells in basic research studies and be made available to investigators in research areas of interest to all of the institutes and centers of the NIH. In both developing and teaching the courses, applicants are encouraged to take an interdisciplinary approach and involve a wide array of perspectives of the biological sciences including genetics, reproductive biology, physiology, cell biology, oral biology, neurobiology, biochemistry, microbiology, immunology, and toxicology.

The 12 sponsoring Institutes and Centers have committed $1 million for total costs for the first year of support in FY 2002. Four to five grants may be awarded. Direct costs are limited to $150,000 for each of the three years of support. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-02-054.html.

Inquiries: For NCI—John Sogn, deputy director, Division of Cancer Biology, NCI, Executive Plaza North, Room 5050, 6130 Executive Blvd., Rockville, MD 20892, phone 301-594-8782; e-mail js150x@nih.gov

PAR-02-052: Competing Supplements for Organotypic Models of Cancer

Application Receipt Date: March 28, 2002

The PA encourages the design and use of organotypic cell cultures. These systems may be used to delineate the roles of the different cell types in a tissue or organ, define their interactions, and study the contribution of normal or mutated phenotype of each to tumors that arise in that organ. The cells themselves may be normal, tumor-derived, or genetically engineered, and used in various combinations. Organotypic models may provide alternatives to cell culture models that are currently used for a variety of research applications, for example, to screen molecularly targeted therapy or test delivery strategies for new agents. The PA will use the NIH competing supplement mechanism to ongoing NCI R01, P01, or U01 grants. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PAR-02-052.html.

Inquiries: Suresh Mohla, Division of Cancer Biology, NCI, Executive Plaza North, Suite 5000, Bethesda, MD 20892, phone 301-435-1878; fax 301-480-0864; e-mail sm82e@nih.gov

Notice For Grant Applicants

Addendum—Early Clinical Trials of New Anti-Cancer Agents with Phase I Emphasis

NCI informs of a change in the application procedure for RFA-CA-02-011. For a detailed list of the changes, see at http://grants.nih.gov/grants/guide/notice-files/NOT-CA-02-016.html.

Inquiries: Louise Grochow, chief, Investigational Drug Branch, CTEP, DCTD, NCI, Executive Plaza North, Rm 7131, 6130 Executive Blvd MSC 7426, Bethesda, MD 20892-7432, phone 301-496-1196; fax 301-402-0428; e-mail grochowl@ctep.nci.nih.gov

In Brief:

O'Leary Leads RPCI's OR; Brooks Wins ACS Award

(Continued from page 1)

immunotherapy. . . . **KATHLEEN O'LEARY** was appointed director of the operating room at Roswell Park Cancer Institute. She has been vice chairman of the Department of Anesthesiology and Pain Medicine since 2000. In her new position, O'Leary will coordinate the scheduling, staffing and day-to-day administration of the seven operating rooms at RPCI. . . . **SALLY BROOKS**, an long-time American Cancer Society board member and chairman of the California Department of Health Services Breast and Cervical Cancer Advisory Council and its Cancer Research Advisory Council, received the ACS Ted Marrs Award for her volunteer work in public policy and advocacy.

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