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Senators Call Mammography Debate Confusing, Say Screening "Saves Lives"

U.S. senators told scientists last week that the debate over mammographic screening for breast cancer has confused women, but the decision by the Department of Health and Human Services to reaffirm its support of screening for women 40 and older may help clarify the matter.

"I understand the dissent in the scientific community and difference of opinion about particular studies, but this conflict is exacerbating," said Sen. Barbara Mikulski (D-MD), chairman of the Feb. 28 hearing of two Senate committees that oversee health issues. "Women don't know who

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In Brief:

Bush May Nominate Zerhouni For NIH Director; Duke Promised $11.5M For Eye, Lung Research

ELIAS ZERHOUNI, executive vice dean of the Johns Hopkins University School of Medicine in Baltimore, is reported to be President Bush's choice for NIH director. Zerhouni, a radiologist by training, has served on the NCI Board of Scientific Advisors. . . . **DUKE UNIVERSITY MEDICAL CENTER** will receive a gift of $11.5 million from **Herman and Ruth Albert** of Purchase, NY, and Palm Beach, FL, for an eye research institute and for lung cancer genetics research, said **Ralph Snyderman**, chancellor for health affairs and president and CEO of the Duke University Health System. The gift includes $8 million to build the Ruth and Herman Albert Eye Research Institute and $3.5 million to support the Herman and Ruth Albert Lung Cancer Genomics Fund. In October, the Alberts gave $1.5 million to the Thoracic Oncology Program at the Duke Cancer Center and in 1997 the couple established the Ruth Albert Endowment for Eye Research at Duke. **Thomas D'Amico** heads the lung cancer genomics research effort. "The science of genomics opens new doors in our search for treatments and cures for myriad diseases," said **David Epstein**, director of the Eye Center. "Advances in molecular biology and new technology will lead to major innovations in both cancer and eye research." . . . **NATIONAL CANCER ADVISORY BOARD** members whose six-year terms end this month were recognized for their service at the board's meeting Feb. 20. They are: **Richard Boxer**, of Medical College of Wisconsin; **Howard Koh**, commissioner of the Massachusetts Department of Public Health; **Frederick Li**, of Dana-Farber Cancer Institute; **Sandra Millon-Underwood**, of University of Wisconsin; **Ivor Royston**, of Forward Ventures; **Ellen Stovall**, president and CEO of the

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Senators Seek Clear Answer On Screening Mammograms

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to believe or what they should do."

Mikulski and other senators said they also endorsed mammographic screening. "I do believe that mammograms do save lives, and we need to know when is the best time to get them," Mikulski said. "In the absence of clarity, I'm concerned that conflicting studies will give women pause."

The senators called on NCI Director Andrew von Eschenbach to explain the controversy over the study by Danish researchers that concluded that clinical trials of mammography were so flawed that no screening recommendation could be made.

"If I'm asked by a constituent after this hearing, 'Well, what did Dr. von Eschenbach say should be done?' what's my short answer?" asked Sen. Hillary Clinton (D-NY).

In his first formal appearance on Capitol Hill as NCI director, von Eschenbach offered the unambiguous answer the Senator sought. "Beginning at age 40, you ought to have a mammogram every one to two years," he replied.

"OK. Great. I just wanted to be absolutely clear about that," Clinton said.

Von Eschenbach said breast cancer mortality rates are declining at a rate of 3.2 percent per year, due to both early detection and better therapies.

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"Abstract Statistical Data Confuse The Issues"

The joint hearing of the Senate Subcommittee on Public Health, of the Health, Education, Labor and Pension Committee, and the Senate Appropriations Subcommittee on Labor, Health and Human Services, offered a clear lesson to biostatisticians: ambiguous results don't play well in politics.

"I think the bottom line is women need to know what they can do to fight breast cancer," said Sen. Patty Murray (D-WA). "Unfortunately, this debate too often comes down to a debate between numbers versus women, and we've allowed abstract statistical data to confuse and distort the issues."

Sen. Tom Harkin (D-IA) said Iowa physicians, nurses, and breast cancer survivors he spoke to in a conference call told him that "the consensus was clear …that a mammogram can be the key to early detection."

During previous controversies over mammograms, members of Congress "upbraided" NCI for sending a "mixed message," said Sen. Kay Bailey Hutchison (R-TX), who was one of the foremost upbraiders.

"Dr. von Eschenbach, I'm so glad that you have clarified very quickly that 40 is the recommendation, because I know that we have saved lives," Hutchison said. "Everyone in this room knows that by early detection we have saved lives. We also have put hundreds of millions of dollars into the research to try to find the cure. And you will be in a pivotal position to help us find that cure so that we won't have to talk about mammograms anymore."

Von Eschenbach characterized the recent discussion of the Nordic Cochrane Centre study by Ole Olson and Peter Gotzche, published last October in The Lancet, as a debate among biostatisticians, with no clinical consequence.

"In summary, the investigators … looked at the seven randomized trials, made decisions about certain aspects of those trials in terms of how much they would weigh them or include them in a combined analysis of the information, called the meta-analysis," von Eschenbach said. "Based on their judgments and their decisions about the relative value of some of those studies, they eliminated some of them … and then when they applied their meta-analysis, concluded that the information was not significant enough to warrant continued support of mammography.

"Other statisticians have looked at their analysis and have raised concerns about many of the judgments that they made on a statistical basis," von Eschenbach

said. "So there is a difference of opinion as to how one should evaluate those seven combined trials. Other experts have looked at that information and have concluded, as the U.S. Preventative Services Task Force has, that the data still supports the value of mammography….

"So the issue here, Senator, is a difference in statistical interpretation and methodology. From the scientific perspective, there is value in that argument. From the clinical perspective, however, one must conclude that there is no indication that mammography should not be in that equation based on that analysis."

MIKULSKI: Essentially, what you're saying is one group of biostatisticians came to one set of conclusions, and another have come to another, both competent people?

VON ESCHENBACH: Correct.

MIKULSKI: There have only been seven studies over 40 years in terms of the efficacy of mammograms in early detection. Do you think it's time to do another study?

VON ESCHENBACH: No, I do not.

MIKULSKI: Could you comment on that, because it would seem like we need a study to settle the disputes about the other studies.

VON ESCHENBACH: Those studies over that period of time enrolled over 400,000 patients, and over that period of time much has changed with regard to the state-of-the-art of mammography and our state-of-the art with regard to breast cancer care. To attempt to repeat that kind of study in which there would be a randomization that women, by the flip of a coin or by chance, would be assigned to either mammography or no mammography would not, at this point in time, be a viable or rational study, in my opinion…. In the meantime, we believe we should be focusing our efforts on even better methods of detection than mammography….

Fear That Women Will Avoid Screening

Also testifying in support of the HHS and NCI guideline were Harmon Eyre, chief medical officer of the American Cancer Society; Carolyn Runowicz, vice chairman of obstetrics and gynecology at St. Luke's-Roosevelt Hospital, representing the American College of Obstetricians and Gynecologists; and LaSalle Leffall, chairman-elect of the Susan G. Komen Breast Cancer Foundation.

"We may have to live with certain amounts of uncertainty when it comes to the results of mammographic screening trials," Runowicz said. "Over the years, we have made significant strides in educating women about mammography by breaking down financial, physical, and psychological barriers to women seeking mammographic screening. I fear that these barriers might be reinforced by this negative attention and uncertainty generated by the media hype."

ACOG and other groups are concerned that the controversy might discourage health insurers from covering screening mammograms, Runowicz said.

"The assault on mammography has created a cloud of confusion and an atmosphere of suspicion," Leffall said. "It's also done a true injustice to American women who understand that screening is not prevention."

"We Want To Know What To Do"

In contrast to NCI's more certain position, Donald Berry, biostatistics chairman at M.D. Anderson Cancer Center and a member of the PDQ Screening and Prevention Editorial Board, said the board's current statement "indicates that the benefits of screening are uncertain, based in part on the [Nordic Cochrane] study."

The board, which decides what screening and prevention information to post in NCI's Physician Data Query database, plans to "modify the statement to add that the existence of a benefit is itself uncertain," Berry said.

Currently, the PDQ breast cancer screening statement says that mammography "reduces breast cancer mortality, an effect that can be identified within several years after the start of screening" for women 50-69 years old. "Screening initiated in the 40s reduces breast cancer mortality, an effect that can be identified about 10 to 12 years after the start of screening. A portion of this benefit may be due to screening performed after age 49," the statement says.

According to the PDQ statement, the randomized trials "show that cancer-related survival is better in screened compared to nonscreened women. The question remains whether these findings reflect a true improvement in population level survival due to early detection, or whether the apparent benefit may be explained by" several biases, including the "healthy volunteer" effect, lead time bias, length bias, and overdiagnosis. PDQ is available at http://www.cancer.gov/cancer_information/pdq/.

Berry said several of the mammographic screening trials had flaws that biased the results in favor of screening. The most recent data from the

Swedish studies show a 21 percent reduction in breast cancer mortality as a result of screening in terms of relative risk. However, the corresponding increase in life expectancy is only four extra days of life, he said.

"What should we tell women? The answer is the truth," Berry said. "The benefits of screening are uncertain and women should know this. They should be informed of the possible benefits and risks along with the associated uncertainties and decide about screening for themselves."

Harkin grilled Berry on the mortality benefit.

"It would seem to me logical that if a woman could find a cancer earlier, not knowing whether it's indolent or aggressive, and it could be removed with the least invasive procedure, it would seem to me it would be far ahead rather than waiting until later on," Harkin said.

BERRY: If you could find the first cell that mutated, there's no question. The issue is when between that time…does it have a metastatic potential, and there we don't know. It may be already doing its dastardly deeds when it's only a few million cells, when it cannot be detected mammographically.

HARKIN: I don't know how to respond to that. I've always been told—am I wrong on this—the earlier you can detect the cancer, the better your prognosis is going to be.

BERRY: There's no question about that. The question is does it translate into a benefit from mortality.

HARKIN: Well, I guess we're playing some kind of an odds game here…. It just seems to me again that if I have breast cancer and if I know that I wait, I know that it's going to metastasize at some point.

BERRY: Not necessarily.

HARKIN: More often than not?

BERRY: No, not—well, actually, it depends whether it's detected mammographically or otherwise. If it's detected mammographically, fewer than 50 percent will ever metastasize. If it's detected otherwise, something possibly greater than 50 percent...

HARKIN: If it's detected mammographically and less than 50 percent metastasize, that's because something's been done, right?

BERRY: Yes. But the question is, Senator Harkin, what has been done? Several things have been done. One is that you found more cancer. And some of the cancer that you found may be incredibly important to find. I'm not saying that mammography is not good. It may be incredibly important to find. But some of what you find is not important to have found. The problem is, of course, we can't distinguish which.

HARKIN: Well, again, I know what you're saying you would advise them. You'd tell them all the odds and let them make up their own mind.

BERRY: Yes.

HARKIN: But we're lay people; hell, we're not scientists. And we want to know what odds on, what's the best thing to do. I mean, we look to the medical community for this kind of advice and guidance and direction. What I'm hearing from most of the medical people I talked to yesterday was that … mammography is not the sole thing, but in concert with other things, it is a useful tool for early detection, and the earlier detected, the better your prognosis is going to be.

BERRY: If a woman says, "OK, you've told me all this stuff, and it doesn't make any sense to me. Just tell me whether to get a mammogram," and she says it to a doctor who has her best interest at heart, and the doctor says, "I think you should get a mammogram," and she does, that's fine. I very much encourage that. But I want that woman to be exposed to, if she wants, all of the information that she can digest.

SEN. BILL FRIST (R-TN): Dr. Berry, do you counsel patients at all?

BERRY: No, I do not.

FRIST: You're trained as a Ph.D. in biostatistics.

BERRY: That is correct.

FRIST: And you're being asked questions really that center on a doctor-patient relationship, and you're answering from the statistical data in your analysis.…

I think, just for the audience, it is very important, because if you hear a biostatistician looking at statistics and looking at the lead time bias in your explanation, which is very clear, and in your presentation and in your writing. I think we need to be very careful in posing hypothetical questions to you… You shouldn't be in that position, in terms of clinical advice to a particular patient.

BERRY: That is correct.

FRIST: With that, if someone comes to a clinician, and a clinician calls you on the phone, you'll basically tell the clinician what you've written here. Once again, you're not going to say whether or not that patient should get a mammogram or not.

Would you ever feel comfortable being in a position of answering whether or not someone should get a mammogram, based on the data out there? Again, I recognize you're not a clinician. As a patient, or as

a woman who comes to you, or a man, that questions, "Should I get a mammogram," are you comfortable advising them or counseling them at all, even given what you know?

BERRY: If somebody were to come to me and say, "I'm putting myself in your hands. You are to decide whether I get a mammogram?"

FRIST: That's correct.

BERRY: I would run away.

FRIST: I think that's the correct answer. But it is the position that physicians are in, because they're looking at the biostatistical data, and it's clearly confusing to the American people or people around the world, where the statistics are limited. They don't give the full answer. In your written statement, you do make the statement, "When it comes to inferring the benefits of screening, clinical observation is fundamentally subject to flawed interpretation." The implication of that, to me, is that one should not rely on clinical observation.

BERRY: In the context of screening. It's very important in the context of treatment. If a doctor gives Ms. Smith a treatment, and Ms. Smith does well, he or she learns from that, and that's very important. Those things you can't learn in screening.

FRIST: And the biostatistician from screening looks at large populations in order to—which I think is potentially dangerous—infer how you should treat a particular patient. And that's the implication in your testimony and your written testimony, and I think, to me, it's very dangerous, as a physician, to make that inference, because what people are doing—they're listening to you interpreting the biostatistics, and they're taking it down to what you should advise the individual woman, and I think that's dangerous, as a clinician. And I ask your response to help me understand it, and I think that's what Senator Harkin is struggling with as well.

It's a hypothetical question, and you answered it, and I don't think you should. You answered it appropriately, but I don't think it leaves the correct image of what we really need to answer. And that is, an individual woman coming in, should you get a mammogram or not.

BERRY: I think there's a distinction between talking about the individual as an abstract and the individual as a particular one.

FRIST: Yes, I agree.

BERRY: If the individual is a particular one, I completely agree. If the individual is an abstract—I mean, I am interested in communicating with particular women, but not with women as individuals. These are not policy statements that I'm interested in. Other members of the PDQ may differ from that. I'm interested in a particular woman's decisions and what kinds of things she should consider. When it comes to an individual, that's a whole different story.

FRIST: And I think that's really important for us to understand in the hearings…. I think we have to be very careful in taking biostatistics and say that, basically, the observations which are applied to a screening and the statement on policy of screening, when it comes to the individual patient may not apply. Correct me if I'm wrong.

BERRY: I agree.

A Simple Message Isn't The Goal

Fran Visco, president of the National Breast Cancer Coalition, supported Berry's position.

"Biostatisticians are experts in this debate," Visco said. "They are experts in looking at clinical trials, designing them, and interpreting data on which clinical decisions must be made.

"Women need to know the truth," she said. "Our goal should not be to provide a clear, simple message. Our goal here should be: Let's find the truth about what will save women's lives, and let's get that information and those interventions for women.

"A clear, simple message, while comforting, is not necessarily correct," Visco said.

"Too many organizations, individuals, policy makers focus their breast cancer work on how to get screening mammograms to healthy women," Visco said. "There is much work to be done that will take billions of dollars and much attention. Yet we continue to spend billions of dollars on mammography."

Visco recommended an independent review of the Swedish screening data. "Let's get the best possible answer we can for women under the circumstances, and let's move on," she said. "Let's find out how to prevent this disease, how to detect it truly early, how to get non-toxic therapies, how to get quality care to all women. Finally, let's reauthorize the Mammography Quality Standards Act, because diagnostic mammography will continue, as will screening mammography, and we need to make certain that it's done well."

Mikulski, in a concluding statement, summarized the hearing's findings: "First of all, what we see is that the biostatisticians disagree. They will be continuing to look at data and analyzing it and so on. Clinicians, those who have the lives of the patients in

their hands, do not disagree. The clinicians agree and recommend in the most enthusiastic, unabashed, and unqualified way that we follow the existing guidelines that have been established by the National Cancer Institute, recently reaffirmed by the Preventive [Services] Task Force at HHS, and have been longstanding recommendations also of the American Cancer Society….

"There's also agreement that, first of all, we need access to health care…. We agree we need research on new tools and on new treatments….We've got to be really careful that while we scientifically disagree, we do not end up discouraging health insurance plans from covering this important screening tool….

"We say most of all to the American women, if you're over 40, get that mammogram."

Drug Development:

Waksals Keep ImClone Jobs, BMS Pumps $200M Into C225

Bristol-Myers Squibb Co. has abandoned its effort to jettison two top executives of ImClone Systems Inc. and watered down its demand to lower the payments for C225, a monoclonal antibody for late-stage colorectal cancer.

A new agreement between the two companies gives Bristol greater control over the development of C225, trade name Erbitux, and cuts at least $100 million from the total $2 billion price of the agent. In exchange for winning concessions in future earnings, Bristol agreed to pump $200 million in cash into the New York-based biotechnology firm over the next year.

The deal, announced March 5, concludes two months of scuffling between Bristol and ImClone executives. While Bristol didn't walk away from the deal, as it threatened to do, the pharmaceutical company has committed more cash to a risky, poorly run venture. Should the C225 program fail now, Bristol will have lost $1.4 billion.

"We are confident that we will now be able to move forward in our partnership with ImClone Systems for the development of Erbitux," Peter Dolan, Bristol chairman and CEO, said in a joint statement with ImClone. "As the world leader in oncology, we are looking forward to playing an expanded clinical and strategic role related to the Erbitux development program, working in close collaboration with the ImClone Systems team."

The revised deal leaves ImClone President and CEO Samuel Waksal and his brother, Executive Vice President Harlan Waksal, in their jobs. However, a long-time Bristol executive Andrew Bodnar will be put in charge of a joint team running clinical and regulatory development of Erbitux. Bodnar is a senior vice president of medical and external affairs at Bristol and a member of the ImClone board of directors.

If the drug is approved, ImClone's share of North American sales will be capped at 39 percent, regardless of sales volume. Under the original deal, the ImClone share went up as volume increased.

In another change, Bristol will no longer be obligated to pay ImClone $500 million on approval of C225 by FDA. Instead, the pharmaceutical company will pay $250 million for approval of the first indication and $250 million for approval of the second.

In exchange for these concessions, ImClone will immediately receive $140 million in cash and another $60 million a year after signing the revised agreement. Under the original agreement that was announced last September, ImClone stood to receive $300 million for submitting an acceptable application to FDA.

The deal follows a meeting between FDA and officials of the pharmaceutical companies involved in developing the monoclonal antibody. At the Feb. 26 meeting, the companies sought FDA guidance on salvaging ImClone's botched clinical development program that resulted in a Refusal to File letter from the agency (**The Cancer Letter**, Jan. 4).

Issues related to development of C225 have triggered investigations by the Department of Justice, Securities and Exchange Commission, and the House Committee on Energy and Commerce (**The Cancer Letter**, Jan 25).

Discussions between FDA and drug sponsors slammed with RTF letters are rarely bird-dogged by the press. However, the case of the much-hyped C225 was different. A television news team and print reporters were staking out the FDA Parklawn building for the Feb. 26 meeting.

The two-hour meeting between FDA and pharmaceutical company officials was cordial and low-key, sources said. Agency officials agreed to review the protocol from a randomized phase II study of C225 being conducted in Europe by Merck KgaA. That study is enrolling 225 patients refractory to CPT-11 in the two-arm trial comparing single agent C225 or C225 plus CPT-11.

Merck, based in Darmstadt, Germany, has an agreement with ImClone to develop the agent in Europe. Under the 1998 licensing agreement, the

German company has to provide its clinical data to ImClone.

The Merck protocol was not discussed in detail at the meeting with FDA, sources said. Experts in clinical trials say the study appears to have low power for a randomized trial. Still, at least on the surface, the study appears to be roughly what the agency described as appropriate for this indication.

According to the FDA Refusal to File letter dated Dec. 28, 2001, ImClone would be expected to conduct additional studies. The agency suggested a "randomized, controlled trial directly comparing the efficacy of single agent [C225] to [C225] plus [CPT-11] in patients who can be documented to be refractory to [CPT-11] therapy." Alternatively, FDA suggested a three-arm trial comparing C225 and CPT-11 as single agents with a combination of the two agents in patients not refractory to CPT-11.

ImClone sought accelerated approval based on a single-arm phase II trial that was originally designed as a hypothesis-generating study measuring tumor shrinkage in CPT-11-refractory colorectal cancer patients receiving a combination of C225 and CPT-11.

An independent review of the ImClone protocol demonstrated, among other things, a lack of detailed inclusion criteria (**The Cancer Letter**, Feb. 15). Also, ImClone officials acknowledged that the BLA didn't contain patient files that could allow the agency to analyze the data for every patient.

After receiving the RTF letter, Bristol and ImClone have reconstructed the files for almost all patients, sources said. Though the conclusions of this audit were not discussed at the meeting, such retrospective analysis can be useful in generating hypotheses, but can't be used as a substitute for prospective clinical trials, experts say.

Now, it appears that ImClone and Bristol will ask FDA to consider Merck's data in conjunction with whatever information can be salvaged from the U.S. trial.

"Based on concerns raised by the FDA regarding its U.S. phase II clinical study, ImClone Systems discussed an approach to provide the FDA with data from a European clinical trial currently being enrolled by Merck KGaA in conjunction with reanalyzed clinical data from ImClone Systems' U.S. phase II clinical trials," the Bristol and ImClone said in a joint statement issued after the meeting.

Merck is aiming to complete the colorectal cancer trial within a year. Participants in the meeting didn't discuss the potential for filing a Biological License Application with FDA in any indication beyond colorectal cancer, sources said. C225 is in phase II trials for head-and-neck cancer in the U.S. and in Merck-sponsored phase III European trials for this indication.

Though the Feb. 26 meeting can be described as inconclusive, it has produced at least an appearance of an approval strategy. This was enough for investors to bid up the price of ImClone stock from $15.52 per share on Feb. 26 to $28.25 per share on March 4. Following the news of a peace treaty with Bristol, ImClone stock was traded at about $28.45 on March 7.

ImClone has to clear many a hurdle to prove that Erbitux works. However, the company has obtained the next best thing to FDA approval: an endorsement of its data on the editorial page of The Wall Street Journal.

The Feb. 27 editorial said that despite compelling anecdotal accounts of patient benefit, and notwithstanding involvement of cancer luminaries in the company trial, "FDA declined even to review ImClone's application, leading to allegations that ImClone executives had misled investors about the status of the drug.

"Well, we've had a good look at the leaked letter detailing the FDA's reasons for rejecting ImClone's study, and we'd say it says more damning things about the agency than it does about ImClone," the editorial continued. "To be sure, it goes into detail about patient data it wishes ImClone had provided. But the bottom line is a demand for additional studies 'directly comparing the efficacy of single agent [Erbitux] to the combination of [Erbitux] plus irinotecan.'

"In other words, although the FDA granted fast-track approval review to Erbitux last year, it apparently never had any intention of approving the drug based on the kind of study it knew ImClone was doing. Moreover, the FDA now wants critically ill patients to endure a study to test Erbitux alone, even though ImClone has good reasons to believe the drug is twice as effective when used in combination with a traditional chemotherapy agent. Isn't there some famous medical oath about doing no harm?"

The FDA letter said ImClone was repeatedly warned that the data from its trial would not support approval.

The text of the FDA Refusal to File letter to ImClone is posted on **The Cancer Letter** Web site at http://www.cancerletter.com.

In Brief:

NCI To Study Whether It Gets The Most From Advisors

(Continued from page 1)

National Coalition for Cancer Survivorship; and NCAB Chairman **Phillip Sharp**, of Massachusetts Institute of Technology. They can remain on the board for up to 180 days until their replacements are appointed by the President. NCI Director **Andrew von Eschenbach** said he plans to study the Institute's use of advisory boards "to make sure we're getting the most effective use of [board members'] time and talents." . . . **NCI** Office of Policy Analysis and Response is the new name of the former Office of Legislation and Congressional Activities. Office director **Dorothy Foellmer** said the change was made to more accurately reflect the full range of the office's activities, which include responding to requests from Capitol Hill, tracking legislation, coordinating Freedom of Information and Privacy Act for NCI, managing the State Cancer Legislative Database, and serving as NCI liaison to the HHS Office of Inspector General and to the General Accounting Office. . . . **MARVIN CASSMAN**, director of the National Institute of General Medical Sciences at NIH since 1996, plans to leave the institute in May to direct the Institute for Quantitative Biomedical Research at the University of California, San Francisco. . . . **ELIZABETH JAMES DUKE** was appointed administrator of the Health Resources and Services Administration in HHS. She has been acting administrator since March 2001. HRSA works with states, local governments, and other grantees to fund health services. Its fiscal year 2002 budget is $6.5 billion, second largest among the eight agencies of the U.S. Public Health Service. . . **NATIONAL HEALTH SERVICE CORPS** will give $89.4 million in scholarships and loan repayments to doctors and other health professions who serve in rural and inner-city areas that lack adequate access to care, said HHS Secretary **Tommy Thompson**. "We are looking for the best and brightest to work where they can turn people's lives around and provide health care to people not used to getting it," Thompson said. The increased resources—almost $19 million more than last year—will support 900 new and continuing loan repayment awards and 400 new and continuing scholarship awards. Awardees must agree to provide health care services for a minimum of two to four years in areas with the greatest shortage of medical professionals. Applications must be postmarked by March 29. "The NHSC is one of the best tools the federal government has to extend quality health care to Americans who need it most," said **Elizabeth Duke**, acting administrator of Health Resources and Services Administration. Information on the award application process is available at the NHSC Web site: http://www.bhpr.hrsa.gov/nhsc/. . . . **AMERICAN CANCER SOCIETY** released its Nutrition and Physical Activity Guidelines for Cancer Prevention, which stress the importance of physical activity for both youth and adults, and provide a first-time recommendation for communities to play a role in improving the health of residents. "These healthier behaviors are made easier if governments, worksites, schools and neighborhoods help facilitate them and provide access to the resources people need," said **Colleen Doyle**, director of nutrition and physical activity for ACS. One-third of the more than 500,000 annual U.S. cancer deaths are attributable to diet and physical activity habits, ACS said. The guidelines emphasize a diet with a wide variety of healthy foods that are primarily plant-based. . . . **THE GROUP ROOM**, the nationally syndicated radio call-in talk show about cancer, will feature a live interactive broadcast on colorectal cancer from the German Cancer Congress in Berlin on March 10, from 4-6 pm ET (1-3 pm PT; 9-11 pm GMT; 10 pm-midnight CET) during National Colorectal Cancer Awareness Month. . . . **PATRICIA HARSCHE**, vice president of planning, business development and regulatory affairs at Fox Chase Cancer Center, has been named president-elect of the Association of University Technology Managers. In her new position, Harsche will oversee the annual meeting committee and planning activities for the organization. . . . **CHRISTOPHER PLASS**, cancer geneticist at Ohio State University Comprehensive Cancer Center and a member of its Molecular Biology and Cancer Genetics Program, received the Leukemia & Lymphoma Society Scholar Award. The award is designed to support young scientists who have attracted funding from national sources and whose research is in blood-related cancers. The designation carries a $100,000 in salary support for five years.

NCI Contract Award

Title: A-In Vivo Efficacy in Disease Related Models.

Contractor: Tumor Biology Center, University of Greiburg, Freiburg, Germany; amount: $74,436.

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