THE CANCER LETTER INTERACTIVE

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Another HHS Recommendation: Screen 50 And Older For Colorectal Cancer

Three weeks after recommending mammographic screening for breast cancer, HHS Secretary Tommy Thompson this week encouraged colorectal cancer screening for Americans age 50 or older.

"Colorectal cancer is the second leading cancer killer in the United States and screening can save lives," Thompson said at a March 13 event marking March as National Colorectal Cancer Awareness Month. "If Americans age 50 or older had regular screening tests, our nation would see a substantial reduction in colorectal cancer deaths."

Thompson said HHS and the American Cancer Society will establish

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In Brief:

UCSF Wins $500,000 Cancer Research Grant From Bristol-Myers Squibb Foundation

UNIVERSITY OF CALIFORNIA, San Francisco has received a five-year $500,000 Unrestricted Cancer Research Grant from the Bristol-Myers Squibb Foundation for signal transduction pathways that are altered in cancer cells. **Frank McCormick**, director of the Cancer Research Institute at UCSF and director of the UCSF Comprehensive Cancer Center, will supervise the grant. McCormick is known for his work in molecular cancer biology and his contributions to the understanding of oncogene signal transduction pathways. "Our aim is to integrate the growing database of genetic changes that occur in cancer cells, with our knowledge of signaling pathways and cancer biology, so that we can identify new relationships between pathways that could lead to new approaches to cancer therapy," said McCormick. "This holistic approach can only be achieved with state-of-the-art informatics that can cope with the tremendous complexity of genetic and biological changes that are typical of cancer cells. From this complexity, we expect to extract new insights that will help guide our efforts towards new therapies and better use of existing ones.". . . **AMERICAN SOCIETY for Blood and Marrow Transplantation** elected the following officers at its annual meeting in Orlando: **John Wingard**, director of the Bone Marrow Transplant Program at the University of Florida, was named president; **Armand Keating**, professor of medicine and director of the Division of Hematology at the University of Toronto, was named vice president, to become president in 2004. **Joseph Antin**, chief of the Bone Marrow Transplant Team at Dana-Farber Cancer Institute, was named president-elect and will assume the presidency in

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HHS, ACS To Coordinate Colorectal Cancer Awareness

(Continued from page 1)

a task force to improve coordination and increase public awareness on the causes, symptoms, treatment and prevention of colorectal cancer. He also announced the release of four new public service announcements as part of the HHS "Screen for Life" campaign designed to educate people over age 50 about the importance of screening for colorectal cancer.

HHS recommended one or more of the following screening tests for colorectal cancer: fecal occult blood test, sigmoidoscopy, colonoscopy, and double contrast barium enema.

Compared to screening for cervical or breast cancers, rates for colorectal cancer screening remain low. Recent findings from the Centers for Disease Control and Prevention state-based Behavioral Risk Factor Surveillance System indicates that only 44 percent of adults aged 50 years and older had at least one of three recommended screening tests (FOBT, colonoscopy or flexible sigmoidoscopy) within the appropriate time interval.

"We encourage Americans, particularly those 50 and older, to talk to their physicians about colorectal cancer screenings," Thompson said. "Physicians can also encourage their patients to eat at least five fruits and vegetables a day and to exercise as part of a plan to help reduce colorectal and other cancers."

CDC has developed materials for physicians and other health professionals to emphasize the importance of prevention and early detection, available at http://www.cdc.gov/cancer/colorctl/calltoaction/index.htm.

Medicare covers all four types of colorectal screening tests for beneficiaries, including a fecal occult blood test once a year. Medicare also covers a screening colonoscopy as often as every 24 months for beneficiaries at high risk for colorectal cancer. Since July 2001, Medicare has covered screening colonoscopy once every 10 years for beneficiaries who are not at high risk.

Further information about Medicare coverage for colorectal screening tests is available by calling 1-800-MEDICARE or visiting http://www.medicare.gov.

Risk factors for colorectal cancer include age over 50, a diet low in fruits and vegetables and high in animal fat, a family or personal history of colorectal polyps or cancer, obesity, alcohol consumption, tobacco use, and inflammatory bowel disease.

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Capitol Hill:

Sen. Feinstein Introduces New National Cancer Act

Sen. Dianne Feinstein (D-CA) last week introduced the National Cancer Act of 2002, a bill intended to replace the 1971 document that began the federal government's War on Cancer.

"This important legislation will form our new battle plan to fight cancer and help us find a cure," Feinstein said. "The measure will: improve basic cancer research; create incentives for the transformation of that research into new, effective treatments; and prevent cancer when possible and improve the quality of care to patients."

The bill, S. 1976, is a compendium of measures that include a restructuring of the cancer centers program, changes in coverage of cancer care, and FDA regulation of tobacco (**The Cancer Letter**, Feb. 22).

The legislation also authorizes a nearly 50 percent increase in the NCI budget over five years, starting at $4.8 billion in fiscal 2003, and ending with $7.1 billion in fiscal 2007. The measure was cosponsored by 29 other Senate members.

"The battle plan takes into account the advances that have been made in understanding the human genome, making it possible to move forward with a whole new series of drugs—such as Gleevec—that could stop cancer as the devastating disease that it is

today," said Feinstein. "I believe the promise of these drugs is now so bright that we might well be able to find a cure for cancer in my lifetime."

The writing of a white paper that frames the foundations of the bill was funded by the American Cancer Society as an offshoot of another ACS-funded program, the National Dialogue on Cancer. The panel that wrote the white paper was headed by ACS chief executive John Seffrin and former NCI director and Yale Cancer Center Director Vincent DeVita.

Since the funding for the committee didn't come from the government, the panel was exempt from the Senate's open meetings rules and was able to meet behind closed doors throughout its existence. Feinstein is the vice chairman of the Dialogue, an ACS-funded effort to develop an overarching cancer agenda, and co-chairman of the Senate Cancer Coalition.

Feinstein said the goal of her legislation is to transform cancer into a fully treatable disease. "It is my hope that this legislation will become the rallying cry for the entire cancer community. In order for this bill to pass Congress, we need a united front," Feinstein said. "I urge all Americans to rally behind this measure so that we can soon find a cure."

The legislation would:

—Establish a network of at least 20 "translational cancer research centers" that would be distributed evenly throughout the US. The centers would be operated by "public or nonprofit private entities." Their mission would combine basic and clinical research, and transfer technologies to private companies that would assume development and commercialization of discoveries made at the centers. Also, the centers would "develop and implement a plan expanding and disseminating the efficacious products of translational research to providers of cancer care in the region of the translational research center."

According to the document, the program would require $100 million a year. It is unclear how the translational centers would affect the NCI-designated cancer centers, cooperative groups, and other programs.

—Private insurers would be required to reimburse patient care costs associated with clinical trials.

—The application of Orphan Drug Act would be broadened in the case of cancer drugs. Now, the act applies to cancer types defined by primary site. Instead, the incentives should be extended based on targets and mechanisms of pathogenesis of diseases, the bill states. This provision of the bill is unlikely to have significant impact since many cancers meet eligibility of the current law: 200,000 patients per year.

—Authorize a $100-million-a-year Health Resources and Services Administration program to pay the tuition of health care professionals, primarily nurses, who commit to providing cancer care to the underserved.

—Require private and government insurers to pay for cancer screening, smoking cessation, genetic testing and nutritional counseling. The screening would be based on ACS guidelines.

—Direct the Institute of Medicine to conduct a study of the costs and benefits of providing Medicare coverage to cancer patients who lack other insurance.

—Develop standards of quality of cancer care, Under this provision, AHRQ would convene a panel of experts who would develop and disseminate consensus protocols and practice guidelines for optimal cancer treatments.

—Authorize Medicare and Medicaid to pay a bonus to physicians who manage the care of cancer patients. These physicians would act as "cancer quarterbacks," the bill states.

—Authorize $65 million for the Centers for Disease Control and Prevention to provide grants to the states to prepare cancer plan. Altogether, 24 states have such plans. States would be able to use the CDC grants for linking cancer registries to environmental data bases, studying disparities in the access to appropriate care; and promoting cancer education and prevention.

—Give FDA the authority to regulate tobacco products. The bill doesn't call for creation of an oncology center at FDA. The center, which was recommended in the white paper, would consolidate the agency's handling of all oncology-related products.

The bill doesn't include a plan for oversight of the new cancer program. Last year, the legislation committee apparently rejected a proposal to create a White House Office of the Cancer Czar (**The Cancer Letter**, June 1). That recommendation was not included in the white paper (**The Cancer Letter**, Sept. 28).

Cosponsors of the Feinstein bill include: Sen. Gordon Smith (R-OR), and Senate Majority Leader Tom Daschle (D-SD), Jim Jeffords (I-VT), Kay Bailey Hutchison (R-TX), Hillary Clinton (D-NY), Olympia Snowe (R-ME), Barbara Mikulski (D-MD), Barbara Boxer (D-CA), Susan Collins (R-ME), Mary Landrieu (D-LA), Blanche Lincoln (D-AR), Patty Murray (D-WA), Lincoln Chafee (R-RI), Debbie Stabenow (D-

MI), Maria Cantwell (D-WA), Jean Carnahan (D-MO), Robert Torricelli (D-NJ), Charles Schumer (D-NY), Ben Nelson (D-NE), Tim Johnson (D-SD), Jack Reed (D-RI), John Breaux (D-LA), Jon Corzine (D-NJ), Patrick Leahy (D-VT), Harry Reid (D-NV), John Kerry (D-MA), Bob Graham (D-FL) and Bill Nelson (D-FL) Christopher Dodd (D-CT).

Groups Say Bill Is Flawed

Several patient groups that belong to the patient-led Cancer Leadership Council said the legislation is flawed.

The letter was signed by the American Society of Clinical Oncology, the American Society for Therapeutic Radiology and Oncology, Cancer Care Inc., The Children's Cause, Foundation for the Children's Oncology Group, National Coalition for Cancer Survivorship, National Prostate Cancer Coalition and North American Brain Tumor Coalition.

The text of their letter to Feinstein follows:

The undersigned cancer patient, provider and research organizations believe the time is right to review and possibly revise the National Cancer Act as it moves into its fourth decade. After more than 30 years of qualified success in the effort against cancer, the national cancer program has reached a new crossroads characterized by certain developments, including (1) many new basic science discoveries that require translation into clinical applications if patient care is to benefit; (2) a proliferation of government programs sited in different agencies, all of them related to cancer but not appropriately coordinated, and (3) increased demands for cancer investment in a time of relatively constrained government resources.

These new opportunities and challenges call for a new National Cancer Act designed specifically to address those matters. We believe that legislation should be guided by the following general principles: first, the government should be able and willing to provide new mechanisms to facilitate translational research or other needs as they arise; second, the focus of cancer policy should remain squarely with the National Cancer Institute, eliminating confusing duplication or overlap of responsibilities; and third, every effort should be made to make the national cancer program more efficient and cost-effective, including incentives to the use of public-private collaborations where appropriate. Aside from these general principles, we have the following specific concerns and comments regarding certain elements of the proposed National Cancer Act of 2002:

—**NCI Appropriations Authorization.** The draft Act authorizes specific levels of appropriations through fiscal year 2007, the amounts roughly tracking anticipated increases in the Bypass Budget of ten percent annually. Such limits on NCI appropriations are at least theoretically inconsistent with the concept of a professional judgment budget. It would seem to us that we should encourage the NCI to use its Bypass Budget authority to indicate to the President and the Congress the amounts which its experts believe could reasonably be invested in the national cancer program, even if appropriations in those amounts are extremely unlikely. Utilization of "such sums as may be necessary" authorization levels would allow the Bypass Budget process to continue without restraint.

—**Translational Research.** As indicated above, translational research is one of the priority goals of the national cancer program, and we endorse the draft Act's attention to this issue. However, it is important to note that the cancer program already includes comprehensive cancer centers and extensive nationwide clinical trials networks in the form of the NCI cooperative groups. Every effort should be made to incorporate translational research into the existing infrastructure to minimize expense and avoid duplication. Specifically, we note that, while geographical diversity is critical for cancer centers, we do not necessarily believe that translational research centers need to be geographically dispersed so long as the technology developed in such centers is readily available nationwide through the cooperative groups.

—**IOM Study of Expanded Cancer Coverage.** We endorse the concept of an Institute of Medicine study of insurance coverage for the uninsured with cancer, but believe it should not be limited to Medicare. Recent experience with such extended coverage-i.e., in the case of uninsured women identified as possible breast and cervical cancer patients through the screening program of the Centers for Disease Control and Prevention has focused on Medicaid, not Medicare.

—**Role of AHRQ and Other Non-NCI Agencies.** The development of outcome measures for quality cancer care is already well underway by private provider-based organizations and by NCI itself. We do not believe it is necessary to replicate these ongoing efforts with a new quality assessment program at the Agency for Healthcare Research and Quality (AHRQ). Moreover, AHRQ is no longer involved in

the development of practice guidelines but instead has developed a clearinghouse for those guidelines published in the private sector; this division of responsibility between the public and private sectors related to practice guidelines strikes us as appropriate.

We also have concerns which can be fleshed out later about potential for duplication and lack of coordination as a result of involvement of CDC and other agencies in the national cancer program. In our view, the program will operate most efficiently and most in accordance with strong scientific principles if NCI remains the lead agency on cancer matters, with others involved where there is a specific unmet need for their expertise.

—**Clinical Trials Coverage.** We have some specific concerns about the provisions of the Act relating to coverage of routine patient care costs in clinical trials. For example, the coverage provisions that would be mandated for Medicare are less liberal than those already put into place voluntarily by the Medicare program, and coverage in the private sector is addressed by provisions in the pending Patients' Bill of Rights.

—**"Cancer Quarterback."** This is another provision that requires additional discussion. We are concerned that reimbursement for coordination activities as contemplated by the provision will be so insignificant as to have no impact on cancer care. An IOM study has been proposed in order to evaluate a broad range of physician reimbursement issues for cancer care, and a requirement for such a study might be an appropriate addition to the draft Act.

—**Tobacco Regulation.** We strongly support legislative and regulatory measure that will help to eradicate the scourge of tobacco use. It is unclear whether regulation by the Food and Drug Administration, as previously proposed, is the best mechanism, but we look forward to working with you to arrive at an approach that will achieve the common goal of tobacco elimination as expeditiously as possible.

—**Orphan Drug Incentives.** The draft Act proposed to extend orphan drug coverage to "targets and mechanisms of pathogenesis of diseases," rather than just the traditional disease classifications. This is yet another area that bears further thought, but we are not yet clear how effective the current orphan drug incentives can be in accomplishing the desired research results. We note, for instance, that most cancers already meet the statutory definition of "orphan" as having no more than 200,000 patients. The suggested changes would thus have relatively limited impact. We would be interested in exploring with you and your colleagues additional ways in which to enhance the incentives available under the Orphan Drug Act or otherwise.

—**FDA Review of Oncology Drugs.** One frequently mentioned initiative that we were disappointed not to see in the draft Act was a provision establishing an Oncology Center at FDA. Given the multidisciplinary nature of modern cancer care, we find the current organization of the review divisions at FDA to be inefficient and unscientific. We would urge you to consider a legislative requirement that all review of oncology products be consolidated in one Center, including not just drugs but also biologicals, devices and diagnostics. We appreciate your consideration of this proposal in any later draft of the Act.

Thank you for the obvious effort and thought that have gone into the drafting of the National Cancer Act of 2002. We hope you will welcome the involvement of patient, provider and research advocates in the further development of provisions for inclusion in this important legislation.

Obituaries:

Paul Carbone, Former Director, U. of Wisconsin Cancer Center

Paul Carbone, former director of the University of Wisconsin Comprehensive Cancer Center, died Feb. 22 in Singapore of an apparent heart attack.

Carbone, 70, had been in Singapore since December, where he had been asked by the National University of Singapore to assist in the development of a comprehensive cancer program.

Born May 2, 1931, in White Plains, N.Y., Carbone received his medical degree from Albany Medical College in 1956 and served at the National Cancer Institute as associate director of medical oncology from 1960 until 1976. He went to the University of Wisconsin-Madison in 1976, where he served as head of clinical oncology at the University of Wisconsin Medical School.

He served as chairman of the Department of Human Oncology from 1977 until 1987 and as the second director of the University of Wisconsin Comprehensive Cancer Center from 1978 until 1997.

Since his retirement, Carbone served as emeritus director of the center and as associate dean for the UW Medical School's HealthStar campaign to raise

funds for the new UW Medical School Health Sciences Learning Center and Interdisciplinary Research Complex.

Under Carbone's leadership, the cancer center helped develop the state's tumor registry, the Wisconsin Cancer Council, and the Tobacco Coalition. He was instrumental in the establishment of the university's Center for Tobacco Research and Intervention and the designation of UW-Madison as a site for the federally-funded Women's Health Initiative.

Carbone achieved national recognition for his work in the treatment and cure of Hodgkin's disease, development of new chemotherapy drugs, and adjuvant treatment of breast cancer. For this achievement, Carbone shared the Lasker Prize for Medicine in 1972. Other awards he received included the American Cancer Society Medal of Honor (1987); Mastership, American College of Physicians (1993); Distinguished Service Award for Scientific Achievement, American Society of Clinical Oncology (1994) and the Folkert O. Belzer Lifetime Achievement Award, recognizing outstanding contributions in academic medicine at the University of Wisconsin Medical School (2000).

"Dr. Paul Carbone was one of the most thoughtful, attentive and caring cancer physicians I have known," said John Niederhuber, director of the UW Comprehensive Cancer Center. "Above all else he was the ultimate husband, father and grandfather. In his long and distinguished career as UWCCC Director and Chairman of the Eastern Cooperative Oncology Group, he touched the lives of many students, faculty colleagues and patients—not only here at the University of Wisconsin but around the world. I will personally miss his wise counsel and the privilege of working with him each Wednesday afternoon in clinic."

Carbone was chairman of the Eastern Cooperative Oncology Group for 20 years and served as president of the American Society of Clinical Oncology and the American Association for Cancer Research. He was also instrumental in the development of the Don and Marilyn Anderson HospiceCare Center in Fitchburg, Wis.

He is survived by his wife, the former Mary Iamurri, whom he married in 1954; three sons, David, of Franklin, Tenn., Paul John, of Chicago, and Matthew, of San Rafael, Calif.; four daughters, Kathryn Carbone of Adamstown, Md., Karen Traber of Wayne, Pa., Kimberly Carbone of Naperville, Ill., and Mary Beth Catanzaro of Signal Mountain, Tenn.; and 16 grandchildren.

John Eisenberg, AHRQ Director

John Eisenberg, director of the Agency for Healthcare Research and Quality, died March 11 after a yearlong illness caused by a brain tumor. He was 55.

Born in Atlanta in 1946, he was a 1968 graduate of Princeton University and the Washington University School of Medicine in St. Louis, in 1972. After his residency in Internal Medicine at the University of Pennsylvania, he was a Robert Wood Johnson Foundation Clinical Scholar and earned a Master of Business Administration degree at the Wharton School with distinction.

From 1986 through 1995, Eisenberg was a founding commissioner of the Congressional Physician Payment Review Commission, serving as its Chairman from 1993 to 1995. He was chief of the Division of General Internal Medicine at the University of Pennsylvania, and then moved to Georgetown University to become chairman of the Department of Medicine and physician-in-chief.

He joined AHRQ in 1997.

"John's enthusiasm and has inspired colleagues within the Department of Health and Human Services and across the federal government," said HHS Secretary Tommy Thompson. "Largely through his efforts, improving patient safety and health care quality are top national priorities."

Survivors include his wife of 32 years, DD Rudner Eisenberg; his mother Roslyn Eisenberg Karesh of Charleston, SC; sons William, of Philadelphia, and Michael, of Potomac, MD; and three brothers, Richard, of Arlington, IL; William, of Memphis TN; and Jeff, of Bedford NH.

Paul Grotzinger, Surgeon, Fox Chase Cancer Center

Paul Grotzinger, chief of surgery at the Hospital of Fox Chase Cancer Center from 1960 until his retirement in 1986, died Feb. 26 after an apparent stroke. He was 83.

Grotzinger was one of the early leaders of what became Fox Chase Cancer Center, which became an NCI-designated comprehensive cancer center in 1974. He served as medical director at Fox Chase until 1982 and as vice president for medical affairs starting in 1975. He also was chief of surgery at the adjacent Jeanes Hospital from 1963 to 1977, and was president of the Jeanes medical staff from 1976 to 1980.

Born in Philadelphia Oct. 18, 1918, Grotzinger

earned a bachelor's degree at Muhlenberg College in 1939 and his medical degree at Hahnemann Medical College in 1943. He served his internship and residency in general surgery at Hahnemann Hospital. He was a member of the U.S. Naval Reverve from 1943 to 1954 and was on active duty with the Navy in Japan in 1945-46. He joined the Hahnemann staff in 1949.

He is survived by his wife of 31 years, the former Mary Rita Rush. His first wife, Dorothy Cloud Grotzinger, died of cancer in 1965 after 19 years of marriage. Also surviving are their children, George, of North Wales, Pa.; John, of Dover, Mass.; and Jean Bridgers, of Horsham, Pa., and seven grandchildren.

Funding Opportunities:

RFA Available

RFA-OD-02-003: Human Subjects Research Enhancements Program

Application Receipt Date: May 7

NCI and other centers and institutes invite applications for short-term interim support for institutional activities that will strengthen oversight of human subjects research at institutions that receive significant NIH support for clinical research. This is a one-time solicitation; it is not anticipated that this RFA will be reissued. While all NIH components supporting clinical research are providing support for this program, it will be administered by the National Center for Research Resources. The RFA will use the NIH S07 award mechanism. The RFA is available at http://grants1.nih.gov/grants/guide/rfa-files/RFA-OD-02-003.htm.

Inquiries: Anthony Demsey, senior advisor for policy, Office of Extramural Research, Bldg. 1, Rm 154, Bethesda, MD 20892, phone 301-496-5127; fax 301-402-3469; e-mail demseya@od.nih.gov

RFA-OD-02-003: Human Subjects Research Enhancements Program

Letter of Intent Receipt Dates: July 26; March 26 and Nov. 25, 2003

Application Receipt Date: May 7

NCI and other Centers and Institutes invite applications for short-term interim support to strengthen oversight of human subjects research at institutions that receive significant NIH support for clinical research. While there is considerable flexibility in the types of activities that could be supported under this program, it is important that these enhance the protection of research subjects by means that will be sustained by the institution after the award period ends. While all NIH components supporting clinical research are providing support for this program, it will be administered by the National Center for Research Resources. The PA will use the NIH R21, R33, and the combined R21/R33 Phased-Innovation Award mechanisms. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-02-003.html.

Inquiries: For application submission: Center for Scientific Review, NIH, 6701 Rockledge Dr., Rm 1040 - MSC 7710, Bethesda, MD 20892-7710, Bethesda, MD 20817 (for express/courier service). To expedite the review process, at the time of submission, send two additional copies of the application to: Referral Officer, NCI, 6116 Executive Blvd., Rm 8041, MSC 8329 Bethesda, MD 20892-8329, Rockville, MD 20852 (for overnight/courier service.)

RFP Available

NOT-CA-02-014: Research-Grade Cranberry Product Development

NCI and the National Center for Complementary and Alternative Medicine seek a contractor to develop standardized products for cranberry (Vaccinium macrocarpon) (1) juice cocktail, (2) concentrate, and (3) encapsulated powders, and their matching placebos, which will be used in NIH-supported research grants. The

NCCAM's plans for research on cranberry include award of (1) this contract for development and production of research-grade cranberry products and placebos and (2) subsequent grants for basic and clinical research on the role of cranberry in the prevention and treatment of urinary tract infections, other infections, and other conditions for which there is credible evidence of efficacy. Award of the contract for cranberry product development is the first step in the overall program. The contractor shall support the preparation, characterization, standardization, and maintenance of a supply of research-grade cranberry products and matching placebos with concomitant quality control and quality assurance.

The RFP N01-AT-21011-64 is available at: http://rcb.nci.nih.gov/appl/rfp/published_rfps.jsp with instructions for submission of proposals and evaluation criteria.

Inquiries: James Carder, phone 301-435-3776; fax 301-480-0241; e-mail carderj@mail.nih.gov

Program Announcements:

PA-02-075: Innovative Toxicology Models: SBIR/STTR

Letter of Intent Receipt Dates: July 26; March 26, Nov. 25, 2003

Application Receipt Dates; Aug. 23; April 23, Dec. 23, 2003

NCI and others Institutes and Centers encourage the development, standardization, and validation of new and innovative assays that determine or predict specific organ toxicities (e.g., hematotoxicity, cardiotoxicity, gastrointestinal toxicity, hepatotoxicity, nephrotoxicity,

ototoxicity, bladder toxicity, neurotoxicity, pulmonary toxicity, and endocrine toxicity, including pancreatic beta cell toxicity) as well as new methodology for high throughput toxicity screening that involves the use of molecular endpoints, computer modeling, proteomics and genomics. The development of these toxicity assays and their incorporation early in the development process would assist in the evaluation and prediction of human sensitivity and allow for more cost efficient evaluations of numerous analogs prior to the selection of the ultimate drug development candidate. Support for this PA is through the SBIR and STTR mechanisms that are set-aside programs. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-02-075.html.

Inquiries: For NCI: Adaline Smith, Division of Cancer Treatment and Diagnosis, Toxicology and Pharmacology Branch, 6130 Executive Blvd, Rm 8036 MSC 7451, Bethesda, MD 20892-7451, phone 301-496-8777; fax 301-480-4836; e-mail smithad@mail.nih.gov or James Crowell, NCI, Division of Cancer Prevention, Chemopreventive Agent Development Research Group, 6130 Executive Blvd., Rm 2118 MSC 7322, Bethesda, MD 20892-7322, phone 301-594-0459; fax 301-594-2943; e-mail jcrowell@exchange.nih.gov

In Brief:

ASBMT Honors Dupont, Hansen, For Stem Cell Work

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2003. New officers and directors were also elected: **James Ferrara**, University of Michigan Cancer Center at Ann Arbor; **Robert Negrin**, Stanford University Hospital; and **Robert Rifkin**, Rocky Mountain Blood and Marrow Transplant Team, Denver. ASBMT also presented the ASBMT Lifetime Achievement Award to **Bo Dupont**, of Memorial Sloan-Kettering Cancer Center and professor of Immunology at Cornell University, Weill Graduate School of Medical Science, and to **John Hansen**, professor of medicine at the University of Washington and of the Fred Hutchinson Cancer Research Center in Seattle. For the past 30 years, they have collaborated on the genetics of stem cell transplantation and compatibility between patients and donors. "Together, they have made major contributions to the HLA system and the role of allo-antigen disparities to transplant outcome," said **Richard O'Reilly**, past president of ASBMT. . . . **EDEN STOTSKY-BLUM**, human resources program coordinator for the Office of Faculty, Staff and Retiree Programs at Johns Hopkins University and a four-year colorectal cancer survivor, has been appointed the first education director of the Johns Hopkins Colon Cancer Center, said **Michael Choti**, director of the JHCCC. She will coordinate education and screening efforts in the East Baltimore community and support groups for Hopkins patients and their families. Stotsky-Blum will develop a buddy system with volunteer groups of colorectal cancer survivors matched to newly diagnosed patients modeled after a program in the Johns Hopkins Breast Center. . . . **CANCER LEGAL RESOURCE CENTER, LOYOLA LAW SCHOOL** of Los Angeles, is offering its services to cancer patients and their families, said **Barbara Schwerin**, director of the center. CLRC provides specialized seminars, workshops, and one-on-one counseling. . . . **JOHNS HOPKINS** ovarian cancer Web site received the Editor's Choice Award from HealingWell.com. The International Association of Web Masters and Designers awarded the Hopkins site a Golden Web Award for excellence in design. The site is available at http://ovariancancer.jhmi.edu. . . . **DEANNA MENESSES**, executive director for the Louisiana Academy of Family Physicians, was named executive director of the Alliance for Lung Cancer Advocacy Support and Education of Vancouver, WA.

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