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Samuel Waksal Resigns From ImClone Following Unimpressive ASCO Presentation

Samuel Waksal resigned from his jobs as president and CEO of ImClone Systems Inc., making way for his younger brother, Harlan Waksal, to rise to the top at the troubled New York-based biotechnology company.

Dynastic succession at ImClone comes days after presentation of unimpressive data on the company's lead agent, C225, at the annual meeting of the American Society for Clinical Oncology, and in the midst of investigations by the U.S. Department of Justice, Securities and Exchange Commission, and the House Committee on Energy and Commerce.

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In Brief:

Elias Zerhouni Starts Work As NIH Director; ASCO Honors Eight With Special Awards

ELIAS ZERHOUNI began work as the new NIH director on May 20. He was confirmed for the position by the Senate on May 2. Zerhouni, 51, was most recently executive vice dean of Johns Hopkins University School of Medicine, chair of the Russell H. Morgan department of radiology and radiological science, and Martin Donner professor of radiology and professor of biomedical engineering. Before that, he was vice dean for research at Johns Hopkins. Since 2000, he has been a member of the National Academy of Sciences' Institute of Medicine. He has served on the NCI Board of Scientific Advisors since 1998. In 1985 he was a consultant to the White House under President **Ronald Reagan**. "It is an honor to be asked to lead the NIH," Zerhouni said. "Its leadership has resulted in profound knowledge about our biological systems and has enhanced our ability to explore health and disease. I look forward to meeting with Institute and Center staff in the next several weeks to determine how we might best work towards furthering medical research and improving health for everyone." . . . **AMERICAN SOCIETY** for Clinical Oncology presented its 2002 Special Awards at the 38th annual meeting in Orlando this week to eight individuals who have made contributions to both ASCO and the practice of clinical oncology. **Peter Greenwald,** director of the NCI Division of Cancer Prevention, was awarded the American Cancer Society Award Lecture, recognizing contributions to cancer prevention and control, research, or practice. Greenwald's contributions include implementation of preclinical and clinical research programs in chemoprevention, nutrition, early detection, biomarker

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ECOG Trial Of C225 Finds No Survival Advantage

(Continued from page 1)

In a prepared statement announcing his resignation as president, CEO and a member of the board of directors, Samuel Waksal said this action was caused by "recent events and the distractions they have caused."

"I am withdrawing myself from the daily operation of the company in the confidence that ImClone Systems will be able to maintain its focus on the advancement of our clinical development and research programs," Waksal said in a statement.

Waksal's resignation was announced May 22. A few days earlier, at the ASCO annual meeting in Orlando, Waksal showed no signs of emotional distress. He chatted with scientists, financial analysts, and reporters, and appeared at several parties, including a reception held by M.D. Anderson Cancer Center for its president John Mendelsohn, who had delivered the prestigious Karnofsky lecture on agents like C225, which target EGF receptors.

In addition to having conducted preclinical development of C225, Mendelsohn is an ImClone shareholder and a member of the board of directors and the scientific advisory board.

In the Karnofsky lecture, Mendelsohn made no mention of the controversy surrounding the clinical development of C225, and acknowledged Harlan Waksal's contributions to development of the agent.

Samuel Waksal, 54, is widely known to seek out the company of the rich, famous, and the glamorous, occasionally finding himself in litigation over unpaid debts and failed business ventures. His ImClone successor Harlan, 49-year-old former executive vice president and chief operating officer, also has a colorful history.

On Feb. 14, 1981, he was apprehended by undercover sheriff's deputies at the Fort Lauderdale International Airport. A search uncovered a kilogram of cocaine in his underwear, pockets, and carry-on bag. Harlan Waksal was convicted for possession of cocaine with intent to distribute and sentenced to nine years in prison, but the conviction was overturned on appeal, after a higher court found that the search that uncovered the cocaine was illegal.

This incident has been described in detail in the press, first appearing in a 1993 article in Barron's, and, most recently, in the June issue of Vanity Fair. Several major players on Wall Street and in the pharmaceutical industry said they have avoided involvement with ImClone as a result.

"ImClone Systems is at a critical phase in the clinical and regulatory development of Erbitux [C225]," Harlan Waksal said in the statement announcing his promotion. "With the board and the support of the company's management and hundreds of dedicated employees, I will work to see that this important biologic reaches the market as soon as possible and that our pipeline of other promising new drugs continues to move forward, with the goal of building long-term value for ImClone Systems' shareholders."

As two top executives, the Waksals assembled some of the most prominent oncologists and oncopoliticians for the company boards of directors and scientific advisors, and ultimately made a record-setting $2 billion deal with Bristol-Myers Squibb. The pharmaceutical company bought a stake in ImClone and a share of U.S. and Japanese rights to C225.

Last December, the Waksals' efforts to obtain FDA approval for the agent resulted in a "refusal to file" letter, in which FDA said the company's Biologics License Application was so poorly put together that it could not be evaluated (**The Cancer Letter**, Jan. 4).

The Cancer Letter obtained a copy of the RTF letter, and, subsequently, a copy of the company's proprietary phase II study of C225 and CPT-11 as a second-line therapy for advanced colorectal cancer.

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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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According to three experts in clinical trials who were asked to review the protocol, the study was fundamentally flawed and inappropriate for a registration trial (**The Cancer Letter**, Feb. 15).

Leonard Saltz, a gastrointestinal oncologist at Memorial Sloan-Kettering Cancer Center, served as the lead investigator on ImClone's pivotal trial. However, the protocol was generated within ImClone, and Saltz joined the trial long after accrual began.

Following these setbacks for C225, Bristol attempted to oust both Samuel and Harlan Waksal. Ultimately, Bristol signed off on a compromise deal that left the Waksals in their jobs, but gave the pharmaceutical company greater control over clinical and regulatory development of the agent.

Setbacks for C225 continued. Days before the ASCO meeting, ImClone's European partner Merck KgaA declined to increase enrollment in its colorectal cancer study to a level suggested by FDA.

The data from Merck's randomized phase II study of C-225 in patients whose disease progressed on regimens containing CPT-11 represented ImClone's only chance for approval of C225 without beginning new trials. Last February, in a meeting discussing the refusal-to-file letter with ImClone and Bristol, FDA agreed to review the Merck protocol as well as data gleaned from the U.S. trials (**The Cancer Letter**, March 8).

Following the meeting with FDA, Merck boosted the enrollment from 225 to about 330, the company said. This increase was insufficient to satisfy FDA, which suggested a larger trial as well as several changes in the structure of the trial underway.

Still, Merck said it plans to submit its own application to the European regulatory submission in the first half of 2003.

Another blow to the company was dealt at the ASCO meeting, when the Eastern Cooperative Oncology Group presented data from a small phase III trial comparing cisplatin and C225 with cisplatin and placebo in recurrent head-and-neck cancer. The trial found a marginally statistically significant improvement in response rate in the cisplatin plus C225 arm, but no significant difference in progression-free survival or overall survival.

According to an ImClone press release, ImClone and Bristol are planning a series of additional phase II and phase III clinical trials.

Meanwhile, ImClone's losses mounted. On May 16, the company reported a first-quarter loss of $30 million (41 cents per share), compared to $1.2 million (2 cents per share) at the same time last year. Revenue fell to from $28 million to $18.6 million, a 34-percent drop. The company reported an increase in marketing and administrative costs, which included $2.25 million in fees related to renegotiation of its deal with Bristol.

In addition to announcing changes in the executive offices earlier this week, the company's board decided to delay the annual shareholders meeting from May 23 to June 11.

For the most part, ImClone's shareholders are not a happy bunch. As a result of a barrage of bad news, the company's stock was trading at a little over $10 per share, more than an 85-percent drop from last December, when shares traded at about $75.

Company insiders were selling stock while the prices were high. On Oct. 29, 2001, as the Bristol deal went into effect, eight officers of the company sold $149.8 million worth of shares at $70 per share. The transaction with Bristol was structured to put the money in the hands of the selling shareholders, rather than to the company.

On that day, Samuel Waksal sold $57 million worth of stock, and Harlan Waksal sold $54.3 million. Over the course of several weeks, the brothers sold more than $150 million in stock.

Did ImClone insiders have reasons to expect that the C225 application was in trouble? As SEC, Justice, and Congress launched their probes of potential violations of security laws, shareholders were filing suits against the company.

Recently, about two dozen class action suits against the company were consolidated in the U.S. District Court for the Southern District of New York in Stuart Krosser vs. ImClone. The class is represented by the law firm of Scott & Scott of Colchester, CT. Additional shareholder suits related to C225 have been filed against BMS.

ASCO Annual Meeting:
Tamoxifen Remains Standard For Preventing Breast Cancer

ORLANDO, FL— Available data on the use of aromatase inhibitors for the prevention of breast cancer recurrence following surgery do not support routine use for this indication outside of clinical trials, according to report by a panel of the American Society of Clinical Oncology.

"While recent findings on the use of aromatase inhibitors for the prevention of breast cancer

recurrence are encouraging, data on long-term use of the drugs are needed before a change in the standard of care is justified," Eric Winer, director of the Breast Oncology Center at the Dana-Farber Cancer Institute and chairman of the panel, said at the ASCO annual meeting this week. "Patients and physicians can rest assured that tamoxifen remains the best option for use outside of clinical trials, and that it reduces the risk of recurrence and improves overall survival with manageable side effects for most women."

The panel of breast cancer experts was formed to conduct an assessment of available data on aromatase inhibitors, following the release of preliminary data from the ATAC (Arimidex (anastrazole), Tamoxifen Alone or in Combination) study at the San Antonio Breast Cancer Symposium at the end of 2001. The preliminary findings suggested that the aromatase inhibitor anastrazole (Arimidex) may be more effective than tamoxifen at preventing recurrence in post-menopausal early stage breast cancer patients who have undergone surgery. ASCO examined the ATAC trial, as well as the medical literature.

The ATAC study is designed to compare the benefits of anastrazole and tamoxifen over five years, and includes over 9,000 patients with early stage breast cancer who previously completed primary surgery and were candidates to receive adjuvant hormonal therapy. In a preliminary analysis conducted after a median follow-up of 33 months, 317 of the 3,125 women taking anastrazole had a relapse of their breast cancer or died, compared to 379 of the 3,116 women on tamoxifen. This represents a 17 percent reduction in the risk of disease recurrence with anastrazole treatment compared to tamoxifen. No formal analysis of the impact of anastrazole on patient survival has yet been conducted.

Although the reduction in breast cancer recurrence seen in the ATAC trial is promising, the ASCO panel determined that the lack of data on the long-term efficacy and tolerability of anastrazole makes it premature to recommend the drug for routine use. Because a five-year course of therapy is required in order for tamoxifen to provide its greatest clinical benefit, the data is not sufficiently long-term to appropriately compare the two drugs.

While incidence of serious side effects in the ATAC trial was low for both anastrazole and tamoxifen, it is possible that long-term use of anastrazole may lead to unexpected side effects. In contrast, there is extensive, long-term follow-up data on patients treated with tamoxifen and a clearer understanding of its associated risks. The expert panel also found no evidence to suggest that women who have started a standard course of tamoxifen should consider switching to anastrazole or other aromatase inhibitors. However, for women with specific contraindications or adverse reactions to tamoxifen, the use of anastrazole may be an option. Healthcare providers and patients should make this decision on individual basis, with careful consideration of all the available data, the ASCO panel said.

ASCO also updated its recommendations on the use of hormonal therapies for the reduction of breast cancer risk in pre-menopausal women at elevated risk for the disease. The results of a new technological assessment support the recommendation that women age 35 and over with a five-year projected breast cancer risk of greater than 1.66 percent be considered candidates for tamoxifen.

The assessment, which confirms a similar ASCO recommendation from 1999, also found insufficient evidence to suggest that raloxifene be used for breast cancer risk reduction. Also, the assessment found no evidence to support the use of aromatase inhibitors for reduction of breast cancer risk.

An abstract of the panel assessment is available at: http://www.asco.org/prof/pp/html/guidelines/ai.htm.

ASCO Strategic Plan: Increase Value To Members, Public

ORLANDO—A new strategic plan developed by leaders of the American Society of Clinical Oncology emphasizes improving the society's effort to meet the professional needs of its membership of 18,000 multidisciplinary cancer specialists.

The society, which has a $33.4 million budget for its current fiscal year, spent the past year formulating a new strategic plan to guide its work through 2005. The society's board and 11 task forces reviewed the society's governance infrastructure, programs, products, services, and policies.

The second phase of the project will be to establish new programs to better meet the needs of the membership, said Larry Norton, who passed on the ASCO presidency to Paul Bunn at the society's annual meeting on May 20. The primary goals of ASCO under the new plan are to "increase the value

of ASCO to its members and increase the value of ASCO to people," Norton said at the plenary session of the annual meeting.

Previous strategic plans have led to the establishment of the ASCO Public Policy office in the early 1990s, the hiring of an executive vice president in the mid-1990s, and the expansion of ASCO programs over the last few years. The most recent ASCO Strategic Plan was formulated in 1998-1999, during the presidencies of Robert Mayer and Allen Lichter.

Following is the text of the new strategic plan:

Goal 1: Multidisciplinary Member Needs. ASCO will understand and provide for the professional needs of a multidisciplinary membership, both domestic and international. Objectives:

1.1 Promote multidisciplinary cancer prevention, management, and research at all levels of training and continuing medical education.

1.2 Position ASCO as the organization serving and coordinating the multidisciplinary and disease-oriented needs of all clinical oncology specialties.

1.3 Maximize oncology specialty-based information to the leadership and committees that reflect the multidisciplinary composition of its membership.

1.4 Increase support for and collaboration with State Affiliates.

1.5 Collaborate with the NCI, other government agencies, and other specialty societies as appropriate to promote multidisciplinary cancer prevention, management, research, and education.

1.6 Ensure responsiveness to special needs of international members.

Goal 2: Education. ASCO will provide education designed to meet the needs of its diverse membership. Objectives:

2.1 Strengthen the value of the annual meeting and reinforce its position as the premier educational venue in clinical oncology, especially with increased emphasis on the science of oncology and multidisciplinary and disease-oriented cancer care and prevention.

2.2 Maximize the value of the Journal of Clinical Oncology and reinforce its position as the premier clinical cancer journal, including an increased coverage of the science of oncology and multidisciplinary and disease-oriented cancer care and prevention.

2.3 Increase ASCO's capacity to effectively use print, broadcast, and electronic media as vehicles for delivering education and provide ways to enhance members' understanding of their value.

2.4 Expand educational programs and enduring materials with different themes and venues throughout the year, especially disease-oriented programs.

Goal 3: Research. ASCO will actively promote high quality clinical and translational research in oncology, with a focus on increased accrual to clinical trials. Objectives:

3.1 Increase understanding of the scientific foundations of oncology as a priority area of core competency.

3.2 Enhance advocacy efforts undertaken in support of greater funding for cancer research, including prevention.

3.3 Facilitate clinical and translational research at the community and academic level by developing and advocating for tools, resources, methods, and cooperative activities.

3.4 Provide meeting and other program content that will keep ASCO at the leading edge of communicating advances in oncology research.

3.5 Increase scientific training and education about clinical and translational research, in collaboration with other national societies and organizations as appropriate.

3.6 Strengthen the distribution of information about the importance and benefits of clinical trials to key audiences.

Goal 4: Cancer Care. ASCO will improve the quality of and access to the full spectrum of cancer care services, including prevention and palliation. Objectives:

4.1 Define ASCO's role in quality and access issues involving cancer care.

4.2 Provide expert opinion, including guidelines where appropriate, that establish or clarify standards of evidence-based cancer care.

4.3 Increase the society's collaboration with other state, national, and international societies and organizations, including patient advocacy/support groups.

4.4 Strengthen relationships with State Affiliates to improve quality and access to care at the local level.

4.5 Advocate appropriate reimbursement for the full range of cancer care services.

4.6 Define ASCO's role in health services research.

4.7 Work more closely with regulatory and government agencies, including the NCI, FDA, and CDC.

Goal 5: Early Career Development. ASCO will help new oncology specialists and trainees establish productive careers and practices. Objectives:

5.1 Facilitate the development of core curricula involving oncology training for all specialties.

5.2 Promote activities that enable new oncology specialists to establish productive community practices and successful academic careers.

5.3 Provide educational materials tailored to the needs of oncology fellows and new practitioners.

5.4 Facilitate and support the activities of oncology training directors.

5.5 Promote the recruitment and retention of minority group members in oncology careers.

Goal 6: Authoritative Resource. ASCO will be the authoritative resource on cancer in the U.S. Objectives:

6.1 Develop credible, reliable, and valuable information about cancer care, research, and prevention.

6.2 Enhance efforts to position ASCO as the leading source of expert commentary to the media and other key audiences.

6.3 Strengthen relations and increase collaborative work with patient organizations and state, national, and international oncology societies.

6.4 Expand patient educational materials online and in print.

6.5 Build public support for ASCO's policy positions.

Goal 7: Governance and Operations. ASCO will ensure its effectiveness in governance, its organizational vitality, its operational excellence, its economic soundness, and its technological capacity. Objectives:

7.1 Improve effectiveness and role clarity of the governing bodies within ASCO.

7.2 Fully integrate the process of planning strategically with the operational planning and budgeting cycles of ASCO.

7.3 Increase alignment of organizational and staffing structure with the new ASCO Strategic Plan to promote operational excellence.

7.4 Continue to diversity and expand ASCO's revenue streams in both ASCO and the ASCO Foundation.

7.5 Continue to build a modern technological infrastructure to support the full range of ASCO's programs.

7.6 Expand ASCO's role as a publisher of oncology information.

Goal 8: Internet-based Services. ASCO will expand its Internet-based services and other information technologies, in support of its mission. Objectives:

8.1 Improve usage, navigability, and sophistication of ASCO Web sites.

8.2 Increase ASCO's electronic and digital communications capacity.

8.3 Fully utilize Internet technology and Web applications, including ability to customize content to individual practitioner needs.

8.4 Strengthen member participation in the society's Internet-based services, including ASCO's Web Communities.

8.5 Explore the feasibility of an oncology Web network.

The text of ASCO's previous strategic plan from 1999 is available at: http://www.asco.org/prof/ps/html/m_strategicplan99.htm.

Funding Opportunities:

Program Announcements

PA-02-108: Structural Biology of Membrane Proteins: SBIR/STTR

Application Receipt Dates: April 1, Aug. 1, Dec 1

Expiration Date: April 10, 2005 unless reissued

The purpose of the PA is to encourage researchers to solve the structures of membrane proteins at atomic resolution and to develop the tools needed to solve these structures. NIH has undertaken the Protein Structure Initiative to accelerate the rate of solving protein structures. (See: http://www.nigms.nih.gov/funding/psi.html).

Membrane proteins and membrane complexes associated with the biology, diagnosis and treatment of cancer. These include membrane proteins whose alterations have been linked to the development and progression of cancer or that are part of cancer-related signaling pathways; proteins associated with the extracellular matrix (for example, laminins and fibronectin); and proteins with potential as diagnostic markers and/or therapeutic targets. NCI is also soliciting applications focused on the development of new approaches and technologies for the isolation, purification, and structure determination of these proteins. Applicants strictly focused on technology may wish to consider applying under the NCI Innovative Molecular Applications of Technology Program (see http://otir.nci.nih.gov/tech/funding.html).

The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-02-108.html.

Inquiries: Daniel Gallahan, chief, Structural Biology and Molecular Applications Branch, Program Director, Cancer Cell Biology Branch, Division of Cancer Biology, NCI, Rm 5000, EPN, 6130 Executive Blvd., Rockville, MD 20892-7385, phone 301-435-5226; fax 301-480-2854; e-mail dg13w@nih.gov.

PA-02-109: NIH National Research Service Award Institutional Research Training Grants T32

NIH will award National Research Service Award Institutional Training Grants T32 to develop or enhance research training opportunities for individuals, who are training for careers in specified areas of biomedical, behavioral, and clinical research. The NRSA program supports predoctoral, postdoctoral, and short-term research training experiences. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-02-109.html.

Inquiries: For NCI— Lester Gorelic and Cynthia Pond, phone 301-496-8580; e-mail lg2h@nih.gov and cp32z@nih.gov. Note: NCI has special policies and requirements for T32 grants. Refer to the following URL for this information: http://deainfo.nci.nih.gov/awards/supt32guideline.htm

Other Funding Notices

NOT-CA-02-017: Notice of Limited Competition Exploratory/Developmental Grants: Overcoming Carriers to Early Phase Clinical Trials

Cancer Centers Branch of the NCI Office of Centers, Training, and Resources invites grant applications from NCI-designated Clinical and Comprehensive Cancer Centers for participation in a pilot program focused on identifying and overcoming barriers to early phase cancer clinical trials.

The purpose of the initiative is to enhance national capability to test agents by developing a spectrum of exportable models that NCI Cancer Centers and other organizations can use for increasing and sustaining accrual rates of patients to such trials. NCI Cancer Centers are particularly suited for participation in this pilot program as they have the infrastructure available for conduct of early phase clinical trials, are located in a variety of geographic settings with access to diverse populations, have strong linkages to the communities they serve, and are recognized by industry and the NCI as the best organizations for testing new therapeutic agents. Applicants that are selected for funding must agree to share all information and models that are developed through the initiative with the broader cancer research community and with the NCI.

This is a collaborative initiative of the NCI and the Foundation of the National Institutes of Health Inc., which is in partnership with the following pharmaceutical firms: Aventis, Bristol-Myers Squibb, GlaxoSmithKline, Eli Lilly, and Novartis. Support will be through the NIH exploratory/developmental grant R21 award mechanism. Approximately $3 million in total costs will be made available for each of two years. Half of this amount is to provided by the NCI and half provided through the industrial partners as represented by the Foundation for the National Institutes of Health Inc. The maximum total cost requested in each cancer center application for support cannot exceed $600,000 per year. NCI expects to make five to eight awards. The notice is available at http://grants.nih.gov/grants/guide/notice-files/NOT-CA-02-017.html.

Inquiries: Linda Weiss, chief, Cancer Centers Branch, Office of Centers, Training, and Resources, NCI, 6116 Executive Blvd., Suite 700, Bethesda, MD 20892-8345, phone 301-496-8531; fax 301-402-0181; e-mail lw187q@nih.gov.

NOT-CA-02-018: NCI Cancer Center Supplements for High School and Undergraduate Student Research Experiences P30

The annual salaries for high school and undergraduate students participating in the Continuing Umbrella of Research Experiences program at cancer centers will receive the equivalent of the State or Institutional minimum wage. The salaries as stated in the Guidelines are no longer effective. All other allowable direct costs within the maximum allowable direct cost level of $60,000 will remain the same. The full text of the Guidelines for NCI Cancer Center Supplements for High School and Undergraduate Student Research Experiences P30 may be found at http://minorityopportunities.nci.nih.gov/.

Inquiries: Bobby Rosenfeld, senior program analyst, Comprehensive Minority Biomedical Branch, OCTR, 6116 Executive Blvd., Suite 7028, MSC 8350, Bethesda, MD 20892; e-mail rr63v@nih.gov; voice 301-496-7344; fax 301-402-4551.

In Brief:

ASCO Honors 8 For Service; Opens Web Site For Patients

(Continued from page 1)

development and validation, as well as preventive oncology training. **Richard Klausner,** executive director for global health at the Bill & Melinda Gates Foundation, received the Distinguished Service Award for Scientific Leadership for his leadership during a six-year tenure as NCI director. **Alfred Knudson Jr.**, senior advisor to the president of Fox Chase Cancer Center, was awarded the Pediatric Oncology Lectureship for his research in cancer genetics with emphasis on the pathogenesis of cancer in children and adults. From studies of children with retinoblastoma and their families, he theorized that the development of the cancer was the result of two distinct events; this became known as the two-hit hypothesis, which became the basis for a field of study in cancer genetics. **John Mendelsohn,** president of the University of Texas M.D. Anderson Cancer Center, received the David A. Karnofsky Award for his clinical research and for his role in changing the way oncologists think about the general practice of oncology. He is known for his work in targeted therapy with epidermal growth factor receptor inhibition. **Rep. Deborah Pryce** (R-OH) received the Public Service Award. Pryce serves as co-chairman of the House Cancer Caucus and has sponsored legislation that would require health plans to provide coverage for the routine patient care costs of clinical trials and extend Medicare coverage for additional oral anti-cancer drugs. Pryce and Randy Walker founded Hope Street Kids in memory of their daughter, Caroline Pryce Walker, who died at age nine of neuroblastoma. **Gen. Norman Schwarzkopf**, retired U.S. Army general and member of the board of Friends of Cancer Research, received the Special Recognition Award for his work with FOCR and his involvement in raising public awareness about prostate cancer. **Ellen Sigal,** chairman of the board of Friends of Cancer Research, received the Special Recognition Award for role in establishing FOCR in 1996. **Joseph Simone** received the Distinguished Service Award for Scientific Achievement for his role in finding cures for childhood leukemia during his career as a pediatric hematologist–oncologist. He is the clinical director emeritus of the Huntsman Cancer Institute and professor emeritus of pediatrics and medicine at University of Utah School of Medicine.

He served as physician-in-chief at Memorial Sloan-Kettering Cancer Center and was director for almost 10 years at St. Jude Children's Research Hospital in Memphis. He has served ASCO in a variety of capacities, including as a member of the Board of Directors and as an associate editor for the Journal of Clinical Oncology for 17 years. . . . **PRESIDENT GEORGE W. BUSH** greeted the ASCO annual meeting participants in a video shown at the opening ceremony. . . . **ASCO AWARDED** its 41 Career Development Awards, Young Investigator Awards and Merit Awards for a total of nearly $3 million for clinical and laboratory cancer research. CDAs were presented to 11 physicians in their first, second, or third year as full-time faculty members. They each receive a three-year grant totaling $170,100 for research or to test a hypothesis. YIAs were presented to 30 physicians who are entering their first year of an oncology training program and intend to pursue careers in clinical oncology. Each recipient will receive a one-year grant of $35,000. The Merit Award was given to 100 physicians in training who presented their abstracts at the annual meeting. They received awards of $1,500 each to assist with travel expenses. . . . **NEW WEB SITE:** ASCO has begun a Web site, People Living with Cancer, to help cancer patients and their families make informed health decisions. The site provides information on more than 25 types of cancer, including symptoms, risk factors, prevention, statistics, diagnosis, staging, types of treatments, and symptom management. The site materials are reviewed by oncologists and patient advocates. Patients have access to ASCO resources including its physician database, treatment guidelines, and research abstracts from the society's annual meeting. The site is available at http://PeopleLivingWithCancer.org or http://www.plwc.org. . . . **JOHN RUCKDESCHEL**, CEO and director of the H. Lee Moffitt Cancer Center and Research Institute since January 1992, said he will step down from his senior management responsibilities when his contract expires on June 30. Ruckdeschel said he plans to remain at Moffitt as a researcher while returning to his patient practice. He will continue to serve as professor of oncology and medicine at the University of South Florida College of Medicine. Ruckdeschel also serves as president of the Florida division of the American Cancer Society. . . . **NATIONAL COMPREHENSIVE** Cancer Network has begun The Journal of the National Comprehensive Cancer Network. The quarterly journal will publish original research and discussion of issues in cancer care. "The creation of the JNCCN is in response to a need for improving communication and enhancing collaboration among the oncology community," said **Rodger Winn**, editor-in-chief of JNCCN. "JNCCN will serve as an essential forum for medical professionals to publish and review issues related to oncology standards of practice, use of the NCCN Practice Guidelines in Oncology and related evidence-based clinical outcomes. The guidelines and the journal are part of the NCCN effort to enhance the effectiveness and efficacy of care delivery by ensuring that practitioners have access to the best scientific information to guide treatment decisions." The first issue is scheduled for publication in January 2003. . . . **LARGEST ONCOLOGY SOCIETY:** Oncology Nursing Society announced it reached a membership high when **Laura Jackson**, a recent oncology nursing graduate and a chemotherapy nurse from Huntsville, AL, became its 30,000th member earlier this year. Jackson was recognized during opening remarks by ONS President **Paula Trahan Rieger** at the society's annual congress in April.

DIRECTOR

DUKE COMPREHENSIVE CANCER CENTER

The Duke Comprehensive Cancer Center (DCCC) is seeking a dynamic physician-scientist with strong leadership, research and clinical skills to direct all aspects encompassed in its mission. The DCCC is a major component of this academic health center and has 285 members. The Director is responsible for the Cancer Center's 11 investigative programs, 15 shared resources and leads programs in cancer education for patients, students, health professionals and scientists. The Director will oversee and manage the major Cancer Center operations, including: planning, control and periodic review of appointments; collaboration with departments in the recruitment of gifted faculty; assignment of space; management of shared resources and development of new programs. The Director reports directly to the Dean of the School of Medicine.

Duke University Medical Center is one of the nation's leading academic medical centers. Located in a culturally diverse and dynamic region, the Triangle area of North Carolina is one of the fastest growing regions in the country and is often cited as being among the best places to live.

Applicants should submit a copy of their curriculum vitae electronically to **schre003@surgerytrials.duke.edu to the attention of the Director, DCCC Search Committee. A secondary original copy may be mailed to the Director, DCCC Search Committee, c/o Ms. Monica Schreiner, Box 3627, Duke University Medical Center, Durham, North Carolina, 27710.**

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