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Preventive Services Task Force Urges Colorectal Cancer Screening For 50 And Up

The U.S. Preventive Services Task Force, in its strongest ever recommendation for colorectal cancer screening, urged that all adults age 50 and over get screened for the disease, the nation's second leading cause of cancer deaths.

Various screening tests are available, making it possible for patients and their clinicians to decide which test is most appropriate for each individual, the task force said in a July 15 statement.

"When it comes to colon cancer, screening saves lives," HHS Secretary Tommy Thompson said in announcing the task force

(Continued to page 2)

In Brief:

Okunieff To Lead SWOG Radiation Committee; Marshall Heads Cancer Prevention At Roswell

PAUL OKUNIEFF, chairman of radiation oncology and director of the Robert J. Flavin Shaped Beam Surgery Center at the University of Rochester Medical Center James P. Wilmot Cancer Center, was named chairman of the Southwest Oncology Group Radiation Oncology Committee. Okunieff will lead the clinical and basic science research of all radiation therapy studies through SWOG, an NCI-funded cooperative research group. The appointment places Okunieff on the SWOG Steering Committee, joining **Richard Fisher**, director of the Wilmot Cancer Center. Fisher serves as chairman of the Lymphoma Committee. Okunieff is also chairman of the Translational Research Committee of the Radiation Therapy Oncology Group. . . . **JAMES MARSHALL**, associate director of cancer control and prevention at the Arizona Cancer Center and professor of public health and medicine at the University of Arizona College of Medicine, has been appointed senior vice president for population sciences and cancer prevention at Roswell Park Cancer Institute. He will be responsible for the overall direction of the Cancer Prevention Program of the RPCI Cancer Center Support Grant and expansion and oversight of prevention and populations sciences programs. . . . **JUDY LUNDGREN**, an oncology nurse at the Texas Oncology, P.A., office, was named president of the Oncology Nursing Society. Her term extends from 2002-2004. She succeeds **Paula Rieger**, director of international affairs at the American Society of Clinical Oncology in Alexandria, VA. Also elected were ONS board members **Linda Abbott**,

(Continued to page 8)

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New Studies Strengthen Screening Recommendation

(Continued from page 1)

recommendations. “Less than half of all Americans over the age of 50 are currently being screened for colorectal cancer. This new recommendation—based on the best medical evidence available—should encourage more Americans to get one of the key screening tests to identify colon cancer early when people are more likely to recover.”

An estimated 143,300 U.S. adults will be diagnosed with colorectal cancer in 2002, and nearly 57,000 will die from it. Of cancer deaths, only lung cancer kills more Americans.

This recommendation strengthens the task force’s previous position in 1996, when it “simply recommended” screening. It now “strongly recommends” screening for colorectal cancer because new studies show even more clearly that various screening methods are effective in diagnosing cancer and preventing deaths. The task force is an independent panel of experts sponsored by the Agency for Healthcare Research and Quality. The recommendation was published in the July 16 Annals of Internal Medicine.

Although several screening tests are effective in diagnosing colorectal cancer at an early stage when it is treatable, the task force noted that current information is insufficient to recommend one method over another. Options include at-home fecal occult blood test; flexible sigmoidoscopy; a combination of home FOBT and flexible sigmoidoscopy; colonoscopy; and double-contrast barium enema. Screening can also lead to early detection of adenomatous polyps—pre-cancerous growths that can be removed to prevent them from progressing to cancer.

The task force found good evidence that annual FOBT reduces deaths from colorectal cancer and fair evidence that sigmoidoscopy alone, or in combination with FOBT, reduces deaths. It noted that colonoscopy or barium enema were also likely to be effective screening tools, although the Task Force did not find direct evidence that colonoscopy or barium enema are effective in reducing colorectal cancer deaths. The Task Force could not determine whether the increased accuracy of colonoscopy, which allows doctors to examine the entire colon, offsets the procedure’s inconvenience, costs, and potential complications, such as a small risk for bleeding and perforation of the colon.

“There is no single best test for all patients and clinical practice settings—each test has advantages and disadvantages,” said Alfred Berg, chairman of the task force. “Clinicians should talk to patients about the benefits and potential harms with each option. The decision to screen should be based on patient preferences and available resources for testing and follow up.”

Most cases of colorectal cancer occur in people at average risk for the disease, a category that includes people 50 and over. About 20 percent of colorectal cancers occur in those at high risk for the disease, including people with a personal history of ulcerative colitis or a family history of colorectal cancer in a first-degree relative; that is, a mother, father, sister, or brother who received a diagnosis before age 60.

For those at high risk, the task force indicated that screening could begin at a younger age but didn’t recommend a specific time schedule.

The task force based its conclusion on a report published in the July 16 Annals of Internal Medicine from a research team led by Michael Pignone, at AHRQ’s Evidence-based Practice Center at RTI International—the University of North Carolina.

The task force grades the strength of evidence from “A” (strongly recommends) to “D” (recommends against).

The recommendation for colorectal cancer

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screening is an "A" recommendation.

The colorectal cancer recommendation and materials for clinicians are available on the AHRQ Web site at www.ahrq.gov/clinic/3rduspstf/colorectal.

Advisory On Breast Cancer Chemoprevention

In another recommendation earlier this month, the task force said clinicians should discuss the potential benefits and risks of taking prescription medicines such as tamoxifen to reduce the risk of breast cancer with their female patients who are at high risk for the disease.

The task force recommended against the use of these drugs by women at low or average risk for breast cancer.

The task force reviewed three randomized controlled trials that studied the use of the drug tamoxifen and one study on the off-label use of the drug raloxifene to reduce the risk of breast cancer. The recommendations were published in the July 2 Annals of Internal Medicine.

"The Task Force found fair evidence that tamoxifen can significantly reduce the risk for invasive estrogen-receptor-positive breast cancer by approximately 50 percent in women at high risk for the disease," said Janet Allan, vice chairman of the task force.

"We found consistent evidence for raloxifene, but it was limited to one study that focused on use of the drug to prevent fractures," Allan said.

Tamoxifen is the only medication approved by FDA to reduce the incidence of breast cancer in women at high risk for breast cancer. FDA and AstraZeneca added a boxed warning and strengthened the Warnings section of the Novaldex (tamoxifen citrate) label earlier this month to inform healthcare professionals about the increased risk of uterine sarcoma from taking Novaldex.

Raloxifene currently is approved by FDA for the prevention and treatment of osteoporosis, but some clinicians prescribe it off-label to reduce the risk of breast cancer.

The Study of Tamoxifen and Raloxifene, a trial funded by NCI, is recruiting post-menopausal women at increased risk for breast cancer to compare the safety and efficacy of the two drugs in reducing the risk of the disease. Information about the trial can be found at www.cancer.gov/star .

Women are considered at high risk for breast cancer if they are over 40 and have a family history of breast cancer in a mother, sister, or daughter, or have a history of atypical cells on a breast biopsy. A risk assessment instrument developed by NCI can help estimate cancer risk based on age, family history, and other risk factors. The tool is available at www.cancer.gov/bcrisktool.

For women who are not at high risk for developing breast cancer, the task force recommended against the routine use of tamoxifen or raloxifene to reduce the risk of breast cancer, because the potential harmful side effects may outweigh the potential benefits.

Side effects can include hot flashes and increased risk for blood clots in the legs or lungs. Tamoxifen also has been found to increase the risk for endometrial cancer.

The task force found that the balance of benefits and harms of chemoprevention is more favorable for women in their 40s who are at high risk for breast cancer and have no predisposition toward blood clots, and for women in their 50s who are at high risk for breast cancer who have no predisposition to blood clots and who do not have a uterus.

However, each woman needs to talk with her clinician about whether the potential benefits of reducing her risk for breast cancer are worth the potential risks of the medications, the task force said.

The Task Force based its conclusion on a report from a team led by Linda Kinsinger and Russell Harris, from AHRQ's Evidence-based Practice Center at RTI International-the University of North Carolina.

For women at low or average risk, the task force recommends against the use of drugs to reduce the risk of breast cancer (D recommendation).

For women at high risk, the Task Force recommends that clinicians and patients discuss the potential risks and benefits of taking drugs to reduce the risk of breast cancer (B recommendation).

The task force recommendations on breast cancer chemoprevention are available at www.ahrq.gov/clinic/3rduspstf/breastchemo/ .

Previous recommendations, summaries of the evidence, fact sheets, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending an email to ahrqpubs@ahrq.gov. Clinical information also is available from the National Guideline Clearinghouse at www.guideline.gov.

To help clinicians apply task force recommendations in practice, AHRQ sponsors the Put Prevention Into Practice program. Information is available at www.preventiveservices.ahrq.gov.

Cancer Prevention:

More Bad News For HRT: Increased Ovarian Cancer Risk

NCI researchers have found that women in a large study who used estrogen replacement therapy after menopause were at increased risk for ovarian cancer.

The scientists followed 44,241 women for approximately 20 years. Compared to postmenopausal women not using hormone replacement therapy, users of estrogen-only therapy had a 60 percent greater risk of developing ovarian cancer. The risk increased with length of estrogen use.

The women, who were followed from 1979 to 1998, were former participants in the Breast Cancer Detection Demonstration Project, a mammography screening program conducted between 1973 and 1980.

"The main finding of our study was that postmenopausal women who used estrogen replacement therapy for 10 or more years were at significantly higher risk of developing ovarian cancer than women who never used hormone replacement therapy," said James Lacey Jr., lead author of the study from NCI's Division of Cancer Epidemiology and Genetics.

The relative risk for 10 to 19 years of use was 1.8, which translates to an 80 percent higher risk than non-users, and increased to 3.2 (a 220 percent higher risk than non-users) for women who took estrogen for 20 or more years.

The report was published in the July 17 issue of the Journal of the American Medial Association.

In addition to studying the effect of estrogen use alone, Lacey and his colleagues looked at whether women using estrogen-progestin therapy were more likely to develop ovarian cancer. No increased risk was found.

"Even though our data showed that women who took estrogen combined with progestin were not at increased risk for ovarian cancer, only a few women in our study who developed ovarian cancer had used estrogen-progestin therapy for more than four years," Lacey said. "At this point, there simply aren't enough data to say whether taking the combined therapy has any effect on ovarian cancer."

Results from a large multi-center clinical trial, also published in the July 17 issue of JAMA, showed increases in breast cancer, coronary heart disease, stroke, and blood clots in the lungs and legs for women on estrogen-progestin therapy for an average of 5.2 years.

The trial, part of the Women's Health Initiative, also found fewer cases of hip fractures and colon cancer among women taking the combined therapy. However, because overall the harm was greater than the benefit, the trial was stopped last week, three years ahead of schedule (**The Cancer Letter**, July 12).

The WHI randomized trial for estrogen alone in women who have had their uterus removed is continuing.

"Because hormone therapy may influence so many conditions that affect women after menopause—cardiovascular disease, osteoporosis, breast cancer, uterine cancer, gallbladder disease, blood clots, and now potentially ovarian cancer—we should no longer think of a woman basing her decision to use hormones on the potential risk of just one condition," Lacey said. "Women should continue to talk to their health care providers about whether hormones might be right for them."

Previous studies looking at the effect of postmenopausal hormones on ovarian cancer risk have been inconsistent. Some reported increased risk with estrogen use while others reported either no effect or a protective one. Most of these earlier studies were relatively small and limited by incomplete information about ovarian cancer risk factors.

Two recent large studies found a link between hormone use and ovarian cancer. A large prospective study published last year (JAMA 2001;285:1460-1465) showed that postmenopausal estrogen use for 10 or more years was associated with increased risk of ovarian cancer mortality, and a recent Swedish study (J. Natl. Cancer Inst. 2002;94:497-504) reported that estrogen use alone and estrogen-progestin used sequentially (progestin used on average 10 days/month) may be associated with an increased risk for ovarian cancer. In contrast, estrogen-progestin used continuously (progestin used on average 28 days/month) seemed to confer no increased ovarian cancer risk.

Lacey said some of the unknowns concerning hormone use and ovarian cancer include the following:

—Duration vs. dose of estrogen therapy. It is not clear from this study whether the increased risk with estrogen use is due to higher doses of estrogen, longer duration of estrogen use, or both dose and duration. It is also not clear whether long-term use of lower-dose estrogen is associated with ovarian

cancer.

—Duration of estrogen-progestin therapy. Most women in this study were on the combined therapy for less than four years, so more data will be needed to determine whether estrogen-progestin use increases risk. The effect of long-term use of estrogen-progestin therapy is not known.

—The type of estrogen-progestin regimen. The continuous regimen involves taking both hormones simultaneously throughout the month. The sequential regimen involves taking estrogen every day, and progestin for 10 to 14 days each month.

—Use of more than one type of hormone replacement therapy. For instance, after taking estrogen alone, some women changed to a combined regimen after reports of increased endometrial cancer risk with estrogen alone. More data are needed to analyze the effect of switching from one regimen to another.

—The form of estrogen administration. Most studies have analyzed the use of estrogens in pill form, but it can also be administered by patches, shots, and creams.

Every year, about 23,000 U.S. women are diagnosed with ovarian cancer and 14,000 women die from the disease. A woman's lifetime risk of developing ovarian cancer is 1.7 percent. This means that in a group of 100 women followed from birth to age 85, fewer than two would get ovarian cancer. In comparison, about 13 women would get breast cancer (lifetime risk is 13.3 percent), fewer than three women would develop uterine cancer (lifetime risk is 2.7 percent), and between 16 and 32 women would develop osteoporosis.

Anywhere from 20 percent to 45 percent of U.S. women take some form of hormone therapy between the ages of 50 and 75. According to industry estimates, about 8 million U.S. women use estrogen alone and about 6 million U.S. women use estrogen-progestin therapy. About 20 percent of hormone users continue for more than five years.

For more information on recent studies on hormone therapy, see http://cancer.gov/clinicaltrials/digest-page-menopausal-hormone-use.

Cancer Centers:

UC Davis Cancer Center Achieves NCI Designation

The University of California, Davis, Cancer Center has been awarded an NCI Cancer Center Support Grant.

The cancer center becomes one of 20 NCI-designated centers west of the Mississippi and the only one between San Francisco and Portland, Ore.

"As the only NCI-designated cancer center in this region, UC Davis Cancer Center will have an impact that extends far beyond its own walls, across Northern and Central California," Sen. Barbara Boxer (D-CA) said in announcing the award. "UC Davis Cancer Center will serve as a valuable local, regional and national resource in our battle against this disease."

The grant will provide $1.2 million in each of the next three years. NCI supports nearly $9 million a year in cancer research at UC Davis. The center receives about $62 million a year in funding from other sources.

"California leads the nation in cancer control and prevention efforts, and it now has the nation's newest NCI-designated cancer center," California Gov. Gray Davis said. "Designation recognizes that UC Davis Cancer Center, a program of the nation's finest public university system, has built itself into one of the nation's top cancer centers. It's an accomplishment we can all take pride in."

The center's year-old research partnership with Lawrence Livermore National Laboratory, the first of its kind in the nation, was a key factor in winning designation, center officials said. In that partnership, physicians and scientists work to turn technology developed for the defense industry into new cancer therapies, detection methods, and prevention strategies.

"UC Davis Cancer Center represents an enormous asset and resource," said NCI Director Andrew von Eschenbach. "At UC Davis Cancer Center, discovery converges and, through center-based clinical trials, a seamless transfer of improved detection, diagnosis and treatment will reach patients in their local communities."

UC Davis Health System invested $70 million in the cancer program over the past decade, recruiting 35 new research scientists and building the 52,000-square-foot cancer center and 50,000-square-foot cancer research facility. The Lawrence Livermore

partnership contributed 40 additional scientists.

"Our 12-year effort to achieve NCI designation has been an investment in resources that didn't exist in this region before, and that people in our area will be benefiting from for years to come," said Ralph deVere White, director of the cancer center.

To become eligible for designation, cancer center officials said they had to organize widely dispersed cancer-research efforts into an efficient machine for bringing new ideas into the clinic. A cooperative cancer research effort was created by integrating cancer investigators from the university's programs in veterinary medicine, comparative medicine, biological sciences, and agriculture and engineering, and linking this talent with the resources at Lawrence Livermore.

The center coordinates the work of more than 200 scientists at the UC Davis Medical Center campus in Sacramento, on the main campus in Davis, and at Lawrence Livermore in Livermore, Calif.

"This is a great opportunity for Lawrence Livermore," said Dennis Matthews, leader of the Medical Technology Program at Lawrence Livermore National Laboratory and associate director for technology development for the UC Davis Integrated Cancer Research Program. "It means that we physical scientists and engineers will have clinical scientists to guide us both in developing research instrumentation and in translating our findings into medical care. Because of this partnership, patients will get the latest technology."

Joint projects with Lawrence Livermore include:

—Proton-beam radiation therapy. Originally designed to determine whether bombs are still active, proton-beam accelerators can deliver a more potent and focused beam of radiation than that emitted by radiotherapy machines. Size and cost are preventing its widespread use: A proton-beam machine costs more than $100 million to build, and takes up as much space as a basketball court. Two are in use nationwide for treating cancer. UC Davis Cancer Center and Lawrence Livermore scientists expect to build a proton-beam accelerator that will cost less than $10 million and fit in a typical radiation oncology clinic.

—Photonic probes. Scientists are testing a slender probe that uses light to determine whether a breast lump is cancerous. Also in development is a miniature photonic device that can detect cancer inside the bladder or other internal organs. This device promises to diagnose cancer instantly, sparing patients the need for surgical biopsy.

—Accelerator mass spectrometry investigations. Livermore scientists were the first to use accelerator mass spectrometer technology for biological and cancer studies. Originally employed to detect the fission products of atomic tests, Livermore's giant AMS is used for studying the effects of carcinogens on humans and animals. Researchers hope the technology also will prove useful for individualizing chemotherapy regimens.

With the addition of UC Davis, NCI funds 61 cancer centers. Nine are in California, seven of them between San Diego and Los Angeles. The other NCI-designated cancer center in Northern California is at UC San Francisco. UC Davis Cancer Center serves a population of five million in Northern and Central California, Nevada, and Oregon, and cares for more than 3,000 new cancer patients annually. Through collaborations with community hospitals, the center also operates outpatient centers in Yuba City and Merced.

H. Lee Moffitt Cancer Center Reads The Cancer Letter

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Moffitt is the seventh institution to sign a site license agreement for **The Cancer Letter Interactive**. Moffitt was established by the Florida Legislature in 1981 and named for H. Lee Moffitt, the former Florida Speaker of the House who spearheaded the effort to build and fund a cancer center. Construction of the original $70-million, 380,000-square-foot hospital was funded by proceeds of the state's cigarette tax. The center opened in 1986

and won recognition and funding as an NCI-designated comprehensive cancer center in 2001.

Under construction at the center is a new research tower that will add 331,000 square feet and contain labs and facilities to provide outpatient care for more than 1,200 patients a day.

The center has more than 280 physicians and 600 researchers, and logs more than 5,000 inpatient admissions and 135,000 outpatient visits a year. The center receives more than $27 million in federal and corporate research grants annually, and has access to the academic and scientific resources of the University of South Florida.

Other current site license holders are: Dana-Farber Cancer Institute and the Dana-Farber/Harvard Cancer Center, Boston; Barbara Ann Karmanos Cancer Institute, Detroit; University of Pittsburgh Cancer Institute, Pittsburgh, Pa.; the University of Kentucky Medical Center Library (for the Markey Cancer Center), Lexington, Ky; Roswell Park Cancer Institute, Buffalo, NY; and the National Cancer Institute, Bethesda, Md.

Funding Opportunities:
Program Announcements

PA-02-124: Basic and Preclinical Research on Complementary and Alternative Medicine

National Center for Complementary and Alternative Medicine invites research grant applications to help stimulate the amount and elevate the quality of basic, mechanistic, and preclinical research in all domains of CAM in order to provide a stronger foundation for ongoing and planned clinical studies. NCCAM desires to encourage the most rigorous CAM and conventional researchers to focus on the opportunities in CAM research, and to employ the most current and emerging technologies to strengthen the biomedical research knowledge bases needed to elevate clinical practice. NCI, the National Institute of General Medical Sciences, and the National Institute of Mental Health share programmatic interests in some areas of CAM research with NCCAM. The PA will use the NIH R01, R21 and R15 award mechanisms. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PA-02-124.

Inquiries: Wendy Smith, program director, Office of Cancer Complementary and Alternative Medicine, NCI, 6130 Executive Blvd, EPN, Suite #102, MSC 7302 Bethesda, Maryland 20892-7302, phone 301-435-7980; fax 301-480-0075; e-mail smithwe@mail.nih.gov

PA-02-125: Bioengineering Nanotechnology Initiative

The PA, issued as an initiative of the trans-NIH Bioengineering Consortium, invites grant applications for Small Business Innovation Research projects on nanotechnologies useful to biomedicine. The PA encourages team approaches to research in the belief that a synergistic blend of expertise and resources may be needed to allow for strong partnerships between the small businesses and other entities in Phase I.

Applications are encouraged from teams of investigators from commercial, academic and other sectors of the research community. Partners to the small businesses may play important roles in these projects and may receive appropriate support for their efforts. In addition to requiring collaboration from various sectors, it is expected that this initiative will require expertise from a variety of disciplines, including engineering, chemistry, physics, material science, engineering, and biology. Phase I applications will be funded as phase I SBIR Grants R43. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PA-02-125.html.

Inquiries: For NCI—Ed Monachino, NCI, Bldg. 31, Rm 10A49, MSC 2580, Bethesda, MD 20892-2580; phone 301-496-1550; fax 301-496-7807; e-mail monachie@mail.nih.gov

PA-02-127: Mentored Quantitative Research Career Development Award

Participating NIH institutes and centers invite applications to investigators whose quantitative science and engineering research has thus far not been focused primarily on questions of health and disease. Examples of quantitative scientific and technical backgrounds considered appropriate for this award include, but are not limited to: mathematics, statistics, economics, computer science, imaging science, informatics, physics, chemistry, and engineering. The K25 award mechanism provides support for a period of supervised study and research for productive professionals with quantitative backgrounds who have the potential to integrate their expertise with NIH-relevant research and develop into productive investigators. It is intended for research-oriented investigators from the postdoctoral level to the level of senior faculty.

NIH is especially interested in increasing the number of scientists trained to conduct high-quality research that combines insights derived from, and cuts across, different scientific, technical, and biomedical areas. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-02-127.html.

Inquiries (for NCI): Maria Agelli, Cancer Training Branch, NCI, 6116 Executive Blvd., MSC 8346; Bethesda, MD 20892-8346; phone 301-496-8085; fax 301-402-4472; e-mail ma215e@nih.gov

In Brief:

FDA External Relations Office Headed By Linda Skladany

(Continued from page 1)

clinical nurse specialist at the Holden Comprehensive Cancer Center, and **Ruth Van Gerpen**, clinical nurse specialist for oncology at BryantLGH Medical Center in Lincoln, NE. . . . **LINDA SKLADANY**, vice president for Congressional relations for the Washington, DC, law firm of Parry, Romani, DeConcini and Symms, has been appointed senior associate commissioner in charge of FDA's new Office of External Relations, said FDA Deputy Commissioner **Lester Crawford**. . . . **ERIC LARSON** has been named director of the **Group Health Cooperative** Center for Health Studies effective Nov. 1. The center supports more than 150 public-domain research studies. Larson, an internal medicine specialist known for his research in aging, dementia, and technology assessment, is director of the University of Washington Medical Center. As director of CHS, Larson will be responsible for the scientific and administrative leadership of the center, which conducts epidemiologic, health services, behavioral, and clinical research to benefit Group Health members and the general public. His duties will include recruiting and developing scientific and professional staff; assuring the financial stability of the center; formulating and implementing CHS policy; and assuring that research activities contribute to the mission of the center. . . . Skladany will oversee the FDA Advisory Committee Oversight and Management Staff, Office of Executive Secretariat, Office of the Ombudsman, Office of Public Affairs, and Office of Special Health Issues. . . . **Pro-NAD**, a patented derivative of niacin developed by two University of Arizona College of Pharmacy professors, will undergo testing supported by NCI to evaluate its potential as an agent to prevent skin cancer. NCI has awarded a Rapid Access to Preventive Intervention Development Award to support the proposal submitted by **Elaine Jacobson** and **Myron Jacobson**. The RAPID program uses the pre-clinical and clinical drug development resources of the NCI's Division of Cancer Prevention to aid in the development of novel compounds for cancer prevention. Pro-NAD is designed to allow the topical delivery of niacin on a sustained basis to skin cells, to limit the onset of pre-cancerous lesions and to halt the progression of these lesions to skin cancers. The NCI award will include studies to assess pre-clinical pharmacology and toxicology issues, leading to a clinical phase I pharmacokinetic study and safety evaluation in humans. The Jacobsons are co-founders of Niadyne Inc., a biopharmaceutical company based in Tucson.. . . **COALITION OF NATIONAL CANCER COOPERATIVE GROUPS** hosted more than 50 patient advocates at the first annual Cooperative Group Patient Advocate Training Program recently in Dallas. Representatives of NCI and FDA also participated. The purpose of the training program was to inform the advocates about clinical research to help them become more effective participants in the cooperative group process. The coalition plans to conduct the workshop annually for patient advocates. Next year's workshop is being planned for March 2003. For further information, see www.cancertrialshelp.org.

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DEATHS: SIMON KRAMER, radiation oncologist and former chairman of the Radiation Therapy Oncology Group and the Patterns of Care Study and Distinguished Professor Emeritus in the Thomas Jefferson University Department of Radiation Oncology, died June 17. He was 83. In 1971, Kramer became the principal founder and first chairman of the RTOG, a multi-institutional national cooperative clinical trials group funded by NCI. In 1974 he became the first chairman of the landmark Patterns of Care Study, also funded by NCI. The PCS examined the quality and accessibility of radiation therapy care in the U.S. . . . **HARVEY PREISLER**, director of Rush Cancer Institute and the Samuel G. Taylor III Professor of Medicine at Rush Presbyterian St. Luke's Medical Center in Chicago, died on May 19 of lymphoma. He was 61. Preisler was principal investigator of a $10 million grant from NCI to study and treat secondary hematologic diseases as well as running an independent laboratory devoted to basic and molecular research in acute myeloid leukemias.

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