THE CANCER LETTER INTERACTIVE

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Vol. 28 No. 34
Sept. 20, 2002

Faulty Estimates Led NCI To Overstate Black-White Cancer Disparity In Atlanta

The U.S. Census Bureau underestimated the number of blacks and overestimated the number of whites living in the Atlanta metropolitan area in the late1990s, an Emory University professor has found.

The total population of blacks in five counties in the Atlanta area was underestimated by 18 percent, while the white population was overestimated by about 10 percent.

These differences have led to significant overestimation of cancer incidence rates for blacks and underestimates of cancer incidence rates

(Continued to page 2)

In Brief:

Childhood Cancer Foundation Names New President; TJU, Christiana In Alliance

PAUL BURKE has been named president of the National Childhood Cancer Foundation. The grantee and fundraising organization supports the cooperative research programs of the Children's Oncology Group. Burke has served as the national director of marketing and communications for UCP in Washington, DC, representing individuals with disabilities. He plans to bring his extensive development, marketing, and communication experience to the challenge of increasing public awareness and fundraising for the foundation. Burke has also served with Special Olympics International and Young Astronauts International. He will be located at new offices recently opened by the foundation in Bethesda, Md. The foundation has scheduled several public education events in Washington Sept. 25-27 for childhood cancer patients, survivors, parents, and healthcare professionals, including a rally at the U.S. Capitol, a workshop on legislative issues, and visits with members of Congress. Further information is available at: www.childhoodcancerawareness.org. . . . **THOMAS JEFFERSON UNIVERSITY** in Philadelphia and Christiana Care Health System in Delaware have entered into a research alliance. The alliance will strengthen cancer research and patient care in each organization, said **Walter Curran Jr.**, professor and chairman of radiation oncology at Jefferson Medical College of TJU and clinical director of Jefferson's Kimmel Cancer Center. For Christiana Care, the alliance will allow access to the latest translational research, said **Nicholas Petrelli**, medical director of the of the Christiana Care Helen F. Graham Cancer Center. For Jefferson, the alliance offers participation in a wider

(Continued to page 7)

Click Here for Photocopying Guidelines

Bureau Underestimated Atlanta Black Population

(Continued from page 1)

for whites, said John Young, the epidemiology professor at Emory who discovered the problem.

The data in question were paid for by NCI and generated by the Census Bureau under an interagency agreement. If the Atlanta statistics are an indication, studies of other health disparities such as rates of heart disease, diabetes, and stroke also may have been affected, and the problem may be repeated in other metropolitan areas with large black populations.

"What we've been saying about disparities between blacks and whites in cancer rates has been overestimated," said Young, who serves as principal investigator of the NCI Surveillance, Epidemiology and End Results registry for the Atlanta region. "We hope it will mean things are not as bad as we have thought in Atlanta."

The Institute pays the Census Bureau about $40,000 to $100,000 a year to provide population estimates by county, age, and race.

NCI officials said Young's findings probably are accurate, though they have not been published or subjected to formal peer review. The Institute is taking the finding seriously, and for the first time, will include its own population estimates in next spring's annual cancer statistics "report card," said Brenda Edwards, director of the Surveillance Research Program in the Division of Cancer Control and Population Sciences. In the past, the Institute relied solely on Census estimates, Edwards said.

A Census Bureau spokeswoman said the bureau's population estimates, which are based on the national Census performed every 10 years, tend to become more inaccurate toward the end of the decade.

"Estimates are just estimates, and the further away from the base, the worse it gets," said Bea Piddock, information services specialist for the bureau's Atlanta regional office.

Other experts said population migration is particularly difficult to track, and all data accuracy suffers when examined in small pieces, such as at the county level. But the inaccuracies Young found in Atlanta are wider than generally expected, NCI's Edwards said.

"Probably everything I've published in past five years in the SEER program, we'll have to revise," Edwards said. "We've been living in the more uncertain half of the decade."

The cancer incidence rates in blacks in the 1990s have been based primarily on data from four SEER registries: Atlanta, Connecticut, Detroit, and San Francisco-Oakland. More recently, NCI added new registries that will provide further data on blacks.

In Georgia, disparity in cancer incidence and mortality between blacks and whites was regarded as the worst in the U.S. According to NCI data, which are now being questioned, blacks in the Atlanta metropolitan area were significantly more likely to develop cancer and die from it than blacks nationwide.

The mortality from prostate cancer among Atlanta blacks was believed to be 40 percent higher than for blacks nationwide. Mortality from breast cancer in Atlanta blacks was 19 percent above breast cancer mortality among blacks nationwide. Colon cancer mortality rates in Atlanta blacks were 16 percent above the U.S. average for blacks.

The problem appeared to be so severe that Gov. Roy Barnes started the Georgia Cancer Coalition, a statewide cancer control research program to combat the disparities. The coalition also addresses disparities in the quality of care.

"The new estimates would make us believe that cancer mortality rates among blacks in Georgia are consistent with the national numbers," said Otis Brawley, professor of oncology and associate director of cancer control at the Winship Cancer Institute at

THE CANCER LETTER

Member, Newsletter and Electronic Publishers Association

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

Subscription $305 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc. Founded Dec. 21, 1973, by Jerry D. Boyd

Emory. "That said, black/white disparities still exist and need to be addressed."

"Wild Rates of Cancer"

Young, no stranger to cancer statistics, worked in the SEER program at NCI for 23 years before moving to Emory five years ago. He discovered the problem with the Census estimates while preparing an application for renewal of Emory's SEER contract.

At first, Young thought he found a major health disparity. It appeared that in 1999, the incidence of breast cancer for black women in the Atlanta area was 144 per 100,000 women, compared to 140 per 100,000 for white women.

This would have been "an amazing phenomenon," Young said. "We generally know the breast cancer incidence rates among black women are lower than for white women, but all of a sudden, our black female rates were higher," he said.

On further examination, Young found other anomalies in the 1999 data for the five counties—Clayton, Cobb, Dekalb, Fulton, and Gwinnett. The incidence rate of prostate cancer in black men appeared to be more than twice that of white men—300 per 100,000 black men, compared to 142 per 100,000 white men.

"That seemed much too high," Young said.

Gradually, Young began to wonder whether the problem was in the denominator—the population estimates.

"When you put all five counties together and you put all the denominators together for blacks, you get wild rates of cancer," he said.

Young then looked at data from the 2000 Census compared to the 1999 population estimates. The bureau estimated that 144,522 whites and 58,164 blacks lived in Clayton County in 1999.

However, the 2000 Census counted 89,741 whites and 121,921 blacks in the county. Had the county shifted dramatically from majority white to majority black in one year?

In fact, Young said, the population change probably took place over the decade. The 1999 estimates were simply projected upward from the 1990 Census, maintaining the racial proportions. Similar population shifts took place in Cobb, Dekalb, and Gwinnett counties.

In Fulton County, the Census estimates missed the fact that more whites were moving back into the city in the 1990s, and thus underestimated the white population, Young said.

"I'm incredulous that you can have that shift in population and not have anyone notice it," Young said. "How could you not have noticed the shift from black to white and white to black? We need to call into question how the Census Bureau makes these estimates."

The bureau relies on state and county information to develop the race and age estimates by county for NCI, Edwards said. "I don't think anyone made mistakes," she said. "The further away from the Census, the worse it's going to be. They look at some measures of population growth they use, and they get information from the state. It could be they didn't have as good information on where there was growth and where people were moving."

State population estimates are more accurate than county estimates, said Barry Miller, of the NCI SEER program. "Part of the problem is that the databases available to the Census Bureau aren't in sufficient detail or geographic level to develop as accurate a county-level estimate," Miller said.

While inaccuracy of population projections is not a new problem, the magnitude of the gap between projection and the Census in Atlanta is unusual, experts said.

"We have known that the denominators will change for most recent period and will have impact on last five years, and we've known that we will be revising denominators," Edwards said.

The problem and its implications for upcoming statistical publications "makes me lose sleep at night," Edwards said.

"Error of Closure" Problem

Jennifer Madans, associate director for science at the National Center for Health Statistics in the Centers for Disease Control and Prevention, said the differences Young noticed are not new.

"It happens every 10 years," she said. "It's the 'error of closure' problem, the difference between post-censal estimates and the Census. You don't know that difference until you do another Census."

In 1990, for the U.S. overall, the error of closure from 1989 was small, Madans said. Between 1999 and 2000, the error is expected to be larger, due to a variety of demographic reasons including migration and changes in the way the Census asks people about their race.

"The more you cut the data down to age, race, or smaller geographic areas, your estimates are going

to be less accurate," Madans said. "If [Young] is looking at a set of counties, he is more likely to see some kind of error. He probably is overestimating, but I don't know by how much. We know the errors in the total population, but down to smaller populations, we don't know that yet. The change in national data won't be that dramatic, but down to the county level, it might be dramatic. It's hard to get a handle on migration. County stuff is very hard 10 years after a census."

The Census Bureau, NCHS, and NCI will use the current Census data to revise earlier estimates for population and health statistics, each of the agencies said.

"I would caution anyone who is interested in any disparity, whether it's cancer or heart disease, to make sure their denominators are correct," Young said. "I think Atlanta was particularly hit because of the way the population has been changing. We had a lot of growth."

Focusing On The Wrong Factors?

For Emory professor Brawley, the numbers of blacks and whites in Atlanta—and, consequently, the rates of cancer incidence and mortality—are not esoteric issues to be debated in statistical journals.

"This is a very serious problem, because decisions and agendas for cancer research are based on these numbers," said Brawley, who is also medical director of the Georgia Cancer Center at Grady Memorial Hospital, a downtown Atlanta hospital that serves a predominantly poor, black population.

"I've been running around the country saying black men in Atlanta have a 40 percent excess death rate for prostate cancer," he said. "Now we see the mortality differential is clearly not a 40 percent excess, and for black women with breast cancer, there is not a 19 percent excess death rate in Atlanta."

"We are starting to learn that we have been focusing on some of the wrong factors," Brawley said.

Clearing up confusion surrounding incidence and mortality is a prerequisite for addressing the problems of disparity in efficacy of cancer care in the state, Brawley said. About half of all black men in Atlanta diagnosed with localized prostate cancer get no treatment, Brawley said. In the U.S., about 70 percent of blacks with localized prostate cancer receive treatment for the disease.

"Since I have a higher proportion of black men in Atlanta who get diagnosed and not treated, and mortality in Atlanta is higher than the U.S. overall, I started to conclude that treatment actually saves lives," Brawley said.

"The fact is, the mortality rates for Atlanta and the rest of country for prostate cancer are much closer than I thought they were," he said. "The true data suggest that prostate cancer treatment may not be as efficacious as the former data would have suggested."

CDC Publication To Include Warnings

The "denominator problem," as Young's finding has come to be called among NCI officials, cannot be verified and fixed instantly, experts said.

While NCI accepts Young's estimates as valid, the Census Bureau does not. The bureau plans to review its county population estimates sometime next year, NCI's Edwards said.

Young's finding created a last-minute problem for a joint NCI-CDC report scheduled for publication in November, a 500-page review of 1999 cancer incidence data by Census region.

Young submitted his revised estimates of cancer incidence in Atlanta for the publication, but because the rates are not based on official population estimates sanctioned by the Census Bureau, they could not be included in the report, Edwards said.

Instead, the report will include warnings that the cancer incidence rates in some metropolitan areas may be misleading.

"The Atlanta rates we know are misleading," Edwards said. "I was concerned that we will have a fair amount of data in this report that are going to be impacted in an important way by this denominator problem. We tried to write a few caveats in the tables to warn the readers."

Phyllis Wingo, chief of the cancer surveillance branch in the CDC Division of Cancer Prevention and Control, said Young's findings were not cause for making major revisions to the publication. "We do have some cautions in the technical notes about the denominator data," Wingo said. "This will affect any statistics that are generated using population data anywhere, not just health statistics. This always occurs at the end of the decade."

Another report, Cancer Incidence In Five Continents, published every five years by the International Union Against Cancer, will include Young's corrected data for the Atlanta SEER registry, Edwards said.

For the cancer statistics report card to be

released next spring, NCI plans to examine data for all metropolitan areas and will work with CDC and NCHS "to come up with our best estimate of what the denominators should be," Edwards said.

"We have a demographer, a geographer, and an epidemiologist, and their chore for the next few months is to work on a better denominator," Edwards said. "We will do the best we can to come up with the best estimates for the denominators of the population that we can. But these will not be numbers reported by the Census Bureau."

NCI also plans to study how changes in the reporting of racial categories in the Census will affect the denominators. In 2000, the Census allowed people to select more than one racial category.

The net effect on health disparities can't be determined at this point, but will require much more research, Edwards said. "There are so many ways to look at a health disparity," she said. "Many of the racial groups have lower incidence or mortality, but it may be that they don't do enough screening."

"You have to look beyond the actual rate," Edwards said. "I want to get people to look at whether the rate is going in the right direction. That is where our challenge will be, to find out what is driving those trends. I think we have plenty of work to do."

Young said he was pleased that NCI will continue to study the population estimates.

"I don't want to create a big storm over all of this," he said. "I just want to make sure people have the correct denominators, since we have spent so much money to get the numerators."

NCI Programs:

Screening Trial Seeks 50,000 Current And Former Smokers

NCI this week began the National Lung Screening Trial to determine if spiral computerized tomography or chest X-ray screening can reduce deaths from lung cancer.

The trial, expected to cost $200 million over eight years, will seek to enroll 50,000 current or former smokers and will take place at 30 sites in the U.S.

Two research networks funded by the Institute will enroll and screen participants. One network has been conducting the Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial, and the other is the American College of Radiology Imaging Network.

"NLST is important because there are an estimated 90 million current and former smokers in the U.S. at high risk for lung cancer, and death rates for this disease, unlike many other cancers, have not declined," said NLST co-director John Gohagan, of the NCI Division of Cancer Prevention. "Lung cancer kills more people than cancers of the breast, prostate, colon, and pancreas combined and will claim nearly 155,000 lives this year. Our hope is that this study will lead to saving lives."

The American Cancer Society said it will commit $5 million to help promote the study and recruit participants. The society plans to work with local NLST investigators to develop tailored promotional methods at each the sites.

"Reducing lung cancer deaths is a high priority of the American Cancer Society," said Harmon Eyre, ACS chief medical officer and executive vice president for research and cancer control. "With a recognized commitment to saving lives from cancer, and a trusted local presence near each of the NLST sites, the society is uniquely positioned to communicate the benefits of the trial, build trust in eligible participants, and help NCI reach full enrollment as soon as possible."

Study participants will be randomly assigned to receive either a chest X-ray or a spiral CT once a year for three years. Researchers will continue to contact participants annually to monitor their health until 2009.

When detected, lung cancer has usually spread outside the lung in 15 percent to 30 percent of cases. Spiral CT can pick up tumors well under 1 cm, while chest X-rays detect tumors about 1 to 2 cm in size.

"Conventional wisdom suggests that the smaller the tumor when it is found, the more likely the chance of survival—but that remains to be proven," said ACRIN researcher and NLST co-director Denise Aberle, professor and chief of Thoracic Imaging, at the University of California, Los Angeles. "Because of the number of individuals participating and because it is a randomized, controlled trial, NLST will be able to provide the evidence needed to determine whether spiral CT scans are better than chest X-rays at reducing a person's chances of dying from lung cancer."

Spiral CT, a technology introduced in the 1990s, uses X-rays to scan the entire chest in about 15 to 25 seconds, during a single breath hold. A computer creates images from the scan, assembling them into a 3-dimensional model of the lungs. More than half of the hospitals in the U.S. own a spiral CT machine

and routinely use them for staging lung and other cancers. Recently some hospitals have begun performing spiral CT scans as a new way to find early lung cancer in smokers and former smokers. However, no scientific evidence to date has shown that screening or early detection of lung cancer with either spiral CT or chest X-rays actually saves lives.

Some NLST centers also will collect blood, urine, and sputum. The samples will be used for future research to test for biomarkers that may someday aid in lung cancer diagnosis.

Participants in NLST will receive lung cancer screenings free of charge. Men and women can participate in NLST if they meet the following requirements:

—Are current or former smokers ages 55 to 74

—Have never had lung cancer and have not had any cancer within the last five years (except some skin cancers or in situ cancers)

—Are not currently enrolled in any other cancer screening or cancer prevention trial

—Have not had a CT scan of the chest or lungs within the last 18 months.

Participants can receive referrals to smoking cessation programs if they are interested in quitting smoking.

For further information about NLST, contact the NCI Cancer Information Service, 800-4-CANCER (800-422-6237), or see www.cancer.gov/NLST.

NIH News:

NIH Awards $32M Contract To Computer Sciences Corp.

The first major contract for developing the Clinical Research Information System at NIH has been awarded to the Computer Sciences Corp., of El Segundo, Calif.

CSC will serve as systems integrator for the NIH project, which will ultimately be a collection of information systems that tie together and support patient care and clinical research at NIH.

Under the six-year, $32 million contract, CSC's task is to ensure that all segments of the CRIS project are developed and implemented effectively.

"CRIS will serve as the nerve center of the Mark O. Hatfield Clinical Research Center now under construction at NIH, and will be an innovative resource for clinical researchers who translate laboratory discoveries into better health care," said John Gallin, director of the Warren Grant Magnuson Clinical Center and NIH associate director for clinical research. The Clinical Center is NIH's research hospital; the Hatfield Center will house new hospital and lab facilities.

The Clinical Center developed and has used an electronic medical information system for more than a quarter century. The system was one of the nation's first. Further information about the CRIS project is available at http://cris.cc.nih.gov.

Funding Opportunities:

Program Announcement

PA-02-147: Novel Approaches To Enhance Animal Stem Cell Research

The purpose of this program announcement is to encourage the submission of applications for research to enhance animal stem cells as model biological systems. Research to isolate, characterize and identify totipotent and multipotent stem cells from nonhuman biomedical research animal models, as well as to generate reagents and techniques to characterize and separate those stem cells from other cell types is encouraged. Innovative approaches to the problems of making multipotent stem cells available from a variety of nonhuman sources, and to creating reagents that will identify those stem cells across species and allow for separation of multipotent stem cells from differentiated cell types, will be stressed. Studies involving human subjects are not allowed under this PA.

Projects supported by the National Center for Research Resources under this PA are intended to generate research tools, reagents or multipotential stem cells of utility to research on a broad range of tissue or cell types and of interest to more than one categorical or disease-oriented Institute or Center of NIH. Projects that will focus on research on tissues or disease processes specific to the mission of an Institute or Center should be directed to the respective Institute or Center.

The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PA-02-147.html.

Inquiries: John Harding, Division of Comparative Medicine, National Center for Research Resources, tel: 301-435-0744, fax: 301-480-3819; email: hardingj@ncrr.nih.gov; or (for NCI) Colette Freeman, Cancer Cell Biology Branch, Division of Cancer Biology, NCI, tel: 301-496-7028, fax: 301-402-1037; email: cf33a@nih.gov.

NCI RFP Available

RFP N02-CP-31004-50: Procurement of DNA, RNA, Transformed Lymphocytes and Lymphoblastoid Lines For Genetic Studies

Responses Due: Nov. 18, 2002

The NCI Division of Cancer Epidemiology and Genetics is recompeting a project performed by the

American Type Culture Collection under Contract No. N02-CP-81019. The DCEG is seeking a contractor who will support the various on-going case-control and cohort studies with molecular biology components being conducted by DCEG Investigators.

There are four laboratory procedures, or assays to be provided by a single contractor for the acquisition. One or more of the tasks shall be performed on each sample provided by the NCI project officer. These include: 1) Extraction of DNA from fresh whole blood specimens, transformed lymphoblastoid lines, cultured fibroblasts, tumor specimens, buccal cells, paraffin-embedded tissue, Guthrie cards, cytology preparations, or other biological specimens, as possible from advances in technology; 2) Extraction of RNA from fresh whole blood specimens, transformed lymphoblastoid lines, cultured fibroblasts, tumor specimens, or other biological specimens, as possible from advances in technology; 3) Isolation of lymphocytes, and transformation of lymphocytes and/or cryopreserved whole blood to lymphoblastoid cells using the Epstein-Barr virus , and 4) Expansion of lymphoblastoid or other types of cell lines up to gram quantities. Approximately 11,000 samples will be submitted to the Contractor for processing during a one year period. Note that some procedures to be performed on these samples are overlapping, resulting in 12,000 procedures estimated to be performed each year.

It is anticipated that one incrementally funded, cost reimbursement, completion type contract will be awarded for a base period of three years, and two one year options. The RFP may be accessed via the NCI Research Contracts Branch Web site: under "Current Requests For Proposals."

Inquiries: Karen McFarlane, Contracting Officer, tel: 301-435-3782, fax: 301-480-0241.

Pancreatic Cancer Network Offers Research Grants

The Pancreatic Cancer Action Network is joining with the American Association for Cancer Research and the American Society of Clinical Oncology to sponsor two Career Development Awards in 2003.

The PanCAN-AACR award is a two-year grant of $50,000 per year for direct research expenses and support for travel to the 2003 and 2004 AACR annual meetings. Applications are due Oct. 15, 2002.

The PanCAN-ASCO award is a three-year grant worth $59,400 per year for establishment of an independent clinical cancer program competitive for national funding. The deadline for applications is Nov. 13, 2002.

For further information, see www.pancan.org/1hcp/index.html. Questions may be directed to Michelle Muething, director of Patient and Liaison Services and Scientific Affairs, PanCAN, 2221 Rosecrans Avenue, Suite 131, El Segundo, CA 90245, tel: 877-272-6226 or 310-725-0025, fax: 310-725-0029, mmuething@pancan.org.

In Brief:

Moffitt Awarded DOD Grant For Functional Genomics

(Continued from page 1)

array of clinical trials, in addition to expanding its own trial patient base. Christiana Care is an NCI Community Clinical Oncology Program with more than 80 available studies for cancer prevention and control. . . . **EDWARD GELMANN**, professor of medicine and oncology at Lombardi Cancer Center at Georgetown University, was appointed the Dr. William M. Scholl Chair in Medical Oncology. The endowed chair was established by the Dr. Scholl Foundation for a nationally recognized scholar in medicine. Gelmann directs the Lombardi Cancer Center Program in Growth Regulation of Cancer, and the Clinical Research Management Office. He is also principal investigator at Georgetown of the Prostate, Lung, Colon, and Ovarian Cancer Screening trial and the National Lung Screening Trial. . . . **MOFFITT CANCER CENTER** & Research Institute was awarded $3.2 million to establish the National Functional Genomics Project by the Department of Defense. The NFGP will be an integrated research program on gene expression analysis, genetics, proteomics and translational research, with a bioinformatics program to support data analysis and interpretation. Moffitt will integrate data generated from NFGP with that from other institutes working on functional genomics, said **William Dalton**, director and CEO of Moffitt. . . . **G. PETER VOOIJS** has been appointed dean of the University of Sint Eustatius Medical School, the Netherlands, and principal of the University. He is vice-chairman of the National Cancer Society Board and member of the Board of Trustees for the National Cancer Institute in the Netherlands. He was director of Cytopathology, Department of Pathology, chairman of the Department of Pathology, Dean of Faculty of Medical Sciences, Pro-Rector of the University of Nijmegen, and vice chairman of the Board of the Academic Medical Center. The University of Sint Eustatius Medical School offers a traditional U.S. format medical program taught in English leading to a Doctor of Medicine degree. . . . **ANDRE KONSKI** was named medical director of the Prostate Cancer Risk-Assessment Program at Fox Chase Cancer Center. He was a clinical associate professor in the Department of Radiation Therapy at the Medical College of Ohio. . . . **FOX CHASE**

CANCER CENTER has appointed a physician to its staff and promoted another. **Neil Topham,** of the University of Texas M.D. Anderson Cancer Center, was appointed chief of plastic and reconstructive surgery in the Department of Surgical Oncology. **Jonathan Chernoff** was promoted to senior member in the Division of Basic Science. Chernoff, a molecular oncologist, is program leader for the tumor-cell biology working group of the medical and population science divisions. . . . **ALAN GUTTMACHER**, senior clinical advisor to the director of the National Human Genome Institute, has been named second deputy director, said NHGRI Director **Francis Collins**. . . . **NATIONAL CENTER** for Complementary and Alternative Medicine appointed six members to its National Advisory Council. The new members are: **Zang-Hee Cho**, professor, Department of Radiological Sciences, Psychiatry and Human Behavior, and Ophthalmology, University of California, Irvine; **Kristina Collins**, chiropractor, Old Dominion Chiropractic Inc. McLean, Virginia; **Murray Goldstein**, medical director, United Cerebral Palsy Research and Educational Foundation, Washington, DC; **Michael Irwin**, professor and director, Norman Cousins Center for Psychoneuroimmunology, University of California, Los Angeles; **Barbara Timmermann**, Regents Professor, Department of Pharmacology/ Toxicology, University of Arizona; and **Benjamin Chi-Kuo Yang**, commissioner, State of California Industrial Medical Council. . . . **ALFRED BIGGS Jr.,** former president and CEO of Health Midwest Comprehensive Care, was appointed interim chief medical officer of The Cancer Institute, a position he has held since July 2002. . . . **AVON FOUNDATION** has launched Avon Walk for Breast Cancer fundraising events. The 2003 events will be held from April to September in eight cities: Boston, Chicago, Cincinnati, Los Angeles, New York, Portland Ore., San Francisco, and Washington, DC. For further information, see www.avonwalk.org. . . . **TWO NEW NCI PUBLICATIONS** are available: "Life After Cancer Treatment" and "You Can Make a Difference in Cancer." The publications are available at www.cancer.gov/publications. . . . **ORTHO BIOTECH PRODUCTS** said it will open a comprehensive resource directory of cancer links on the World Wide Web at www.cancer.com on Sept. 24, with links to more than 200 cancer Web sites operated by organizations and companies.

Copying Policy for The Cancer Letter Interactive

The software that comes with your issue allows you to make a printout, intended for your own personal use. Because we cannot control what you do with the printout, we would like to remind you that routine cover-to-cover photocopying of The Cancer Letter Interactive is theft of intellectual property and is a crime under U.S. and international law.

Here are guidelines we advise our subscribers to follow regarding photocopying or distribution of the copyrighted material in The Cancer Letter Inc. publications in compliance with the U.S. Copyright Act:

What you can do:

--Route the printout of the newsletter to anyone in your office.

--Copy, on an occasional basis, a single story or article and send it to colleagues.

--Consider purchasing multiple subscriptions. Contact us for information on multiple subscription discounts.

What you can't do without prior permission:

--Make copies of an entire issue of the newsletter. The law forbids cover-to-cover photocopying.

--Routinely copy and distribute portions of the newsletter.

--Republish or repackage the contents of the newsletter.

We can provide reprints for nominal fees. If you have any questions or comments regarding photocopying, please contact Publisher Kirsten Boyd Goldberg, phone: 202-362-1809, email: kirsten@cancerletter.com

We welcome the opportunity to speak to you regarding your information needs.

Click Here for
Photocopying Guidelines