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Cancer Incidence Rates For Recent Years Too Optimistic, NCI Researchers Find

NCI's reports on cancer incidence rates for recent years may have been more optimistic than warranted, researchers said last week.

Using a new statistical modeling technique, NCI found that the reporting of cancer cases to the Institute can be delayed by many years, and these delays have significantly skewed incidence rates.

Incidence rates for breast, colorectal, lung, and prostate cancers, as well as melanoma, were thought to have been leveling off or decreasing.

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In Brief:

Senate Confirms McClellan For FDA; UCLA Wins Prostate Cancer SPORE Grant

MARK McCLELLAN was confirmed by the Senate as the FDA Commissioner. McClellan, 39, is an internist and an economist, who serves on the White House Council of Economic Advisors. McClellan is a former associate professor of economics, associate professor of medicine, and director of the Program on Health Outcomes Research at Stanford University. He is also a former member of the National Cancer Policy Board of the National Academy of Sciences. In the Clinton administration, McClellan was a deputy assistant secretary of the Treasury for economic policy. . . . **UCLA'S JONSSON CANCER CENTER** was awarded an NCI Specialized Programs of Research Excellence grant in prostate cancer. The five-year, $11.5 million grant is the second SPORE grant for the center. In April 2001, the lung cancer program was awarded a SPORE grant. "This prostate cancer SPORE gives us the resources and the opportunity to pull together multiple investigators to work toward the goal of improving the way we diagnose and treat prostate cancer," said **Jean deKernion**, chairman of the UCLA Department of Urology and the Clark Urology Center and director of the new prostate cancer SPORE. "We've been building an outstanding prostate cancer program for the last five to seven years, and that program will provide an excellent foundation for this center of research excellence." DeKernion was recently appointed to the National Cancer Advisory Board. The SPORE will focus on identifying new molecular targets and investigating nutritional strategies to prevent disease and impede tumor growth. . . . **FOOD FIGHT**: HHS Secretary **Tommy Thompson** and Department of Agriculture Secretary **Ann Veneman** met Oct. 15 with officials from the National Restaurant Association and the National Council of Chain Restaurants to talk about

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Some Cancer Incidence Rates Higher Than Previously Stated

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After adjusting for reporting delays and errors, the NCI statisticians found that incidence rates for these cancers are increasing.

"Our results suggest that ignoring reporting delay and reporting error may result in the false impression of a recent decline in cancer incidence when the apparent decline is, in fact, caused by delayed reporting of the most recently diagnosed cases," the researchers said in a study published in the Oct. 16 issue of the Journal of the National Cancer Institute.

The study is the first known research on the impact of reporting delays and errors on cancer incidence rates, the authors wrote.

In the study, NCI researchers looked at case counts that cancer registries reported to the Surveillance, Epidemiology and End Results program from 1981 to 1998. SEER allows its contract registries up to 19 months to report cancer cases.

The study found that the cases reported within two years accounted for only 88 percent to 97 percent of the final data. It takes four to 17 years for the registries to report 99 percent of the cases to SEER, the study found.

The NCI researchers developed a statistical model to estimate the impact of delays and errors on the incidence data. The computer program, called joinpoint regression software, is available and can be adopted by cancer registries, the authors said.

Rates For Five Cancers Higher

After adjusting for reporting delays and errors, the study found that:

—Breast cancer incidence in white women increased by 0.6 percent a year since 1987, contrary to earlier reports that breast cancer incidence in whites had leveled off. Breast cancer incidence in black women has increased by 1.2 percent a year, compared to 0.9 percent increase previously reported. "Research efforts to explain the cause for the recent rise in breast cancer incidence rates are warranted," the study said.

—Colorectal cancer incidence in white women increased by 2.8 percent a year since 1996, compared to 0.9 percent previously reported. For white men, the increase was 0.7 percent a year, compared to 0.07 percent. These increases, after about a decade of 2 percent per year decreases in colorectal cancer incidence in whites, may be related to a rise in the rate of polypectomies since 1995, the study said.

—Colorectal cancer incidence in blacks is level or decreasing, but at rates slightly higher than previously reported.

—Prostate cancer incidence in white men increased by 2.2 percent a year since 1995, compared to the previously reported decrease of 0.1 percent per year. For blacks, the incidence increased by 0.4 percent a year, compared to the decrease of 2.1 percent previously reported.

—Lung cancer incidence in white women, which had been reported as leveling off, has increased by 1.2 percent per year since 1988.

—Melanoma incidence in white men increased by 4.1 percent per year since 1980, as opposed to the flat or downward trend reported since 1997.

A New Tool Provides Earlier Insight

Brenda Edwards, associate director of the NCI Surveillance Research Program, said incidence rates can be influenced by many factors, including changes in screening or medical practice.

"Incidence has always been much more volatile and more difficult to explain than mortality," said Edwards, who is not one of the study authors.

"The advantage of this study is that now in SEER we can come up with these adjusted rates," Edwards said. "I would like to see us move more toward

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adjusting for reporting delays."

The annual SEER Cancer Statistics Review now includes the reporting-adjusted incidence rates for the five cancer sites examined in the study. The review is available at http://seer.cancer.gov.

The reporting delays for cancer incidence do not affect the cancer mortality rates reported by the National Center for Health Statistics, Edwards said.

Incidence data from 1998 were publicly reported by SEER in 2001, Edwards said. "If we had had this information at that time, we wouldn't have said incidence was going down for these cancers," Edwards said. "This is a new tool that gives us earlier insight."

In recent years, NCI directors and other officials who claimed decreases in cancer incidence rarely discussed the limitations of the data.

"We are always told to present a simple message to the media and the pubic, and there has been less interest in the methodology and the limitations," Edwards said. "This study reminds us that when we are presenting data, whether it's for cancer control at the local level or for the SEER annual report, there needs to be healthy respect for the limitations of the data."

Other cancer registries may not have enough years of data to be able to adjust for reporting delays, Edwards said. "It would be difficult to call for using this method for a national database," she said. SEER began in 1973.

The software the NCI researchers developed is available at http://srab.cancer.gov/joinpoint.

The JNCI paper, titled "Impact of Reporting Delay and Reporting Error on Cancer Incidence Rates and Trends," was written by Limin Clegg, Eric Feuer, Douglas Midthune, Michael Fay, and Benjamin Hankey, all of NCI. The article is available at http://jncicancerspectrum.oupjournals.org/cgi/content/full/jnci;94/20/1537.

Regulatory Policy:

Bush Bars Drug Companies From Blocking Competitors

President George W. Bush earlier this week signed an executive order that will restrict the ability of innovator pharmaceutical companies to block generics from entering the market.

Under the executive order, which was signed Oct. 21, innovators will be allowed to claim no more than one 30-month extension of market exclusivity, during which companies are expected to resolve patent disputes.

Though the 1984 Hatch-Waxman Act doesn't explicitly permit more than one extension, since 1998, several innovators have succeeded at obtaining additional extensions.

The new federal rule, which is based on the executive order, is expected to be published later this week and to become final after a 60-day comment period. The rule will prohibit extensions to resolve disputes involving patents for packaging methods, intermediate forms of drugs, and the drugs' metabolites. Requirements for disclosure will also be tightened.

The text of the new rule will be posted on the FDA Web site: www.fda.gov/ohrms/dockets.

"These steps we take today will not undermine patent protection," Bush said as he signed the order in the Rose Garden. "Instead, we are enforcing the original intent of a good law. Our message to brand-name manufacturers is clear: you deserve the fair rewards of your research and development; you do not have the right to keep generic drugs off the market for frivolous reasons."

The President's action is likely to help Republicans in next month's elections, observers said.

The rule largely follows the recommendations of the Federal Trade Commission, which last summer published a report on loopholes in Hatch-Waxman. The report is posted on the FTC Web site: www.ftc.gov/os/2002/07/genericdrugstudy.pdf.

The rule does not implement the FTC recommendation that authorities monitor potential agreements between innovators and first-to-file generics to slow down progress of the generic. An arrangement of this sort can, potentially, extend the innovator's exclusivity.

The rule is also not as broad as the McCain-Schumer bill, Greater Access to Affordable Pharmaceuticals Act (S. 812), which was passed by the Senate earlier in this session. The bill has the support of Generic Pharmaceutical Association, a lobbying group for the generics, which characterized the President's action as an incremental step.

The President's action will stop the most aggressive tactics used by innovator companies to extend exclusivity, observers said. One important dispute, cited as a case study in the FTC report, involved maneuvers by Bristol-Myers Squibb to extend market exclusivity of the anti-anxiety drug BuSpar.

In November 2000, the day before BusSpar's exclusivity was scheduled to expire, Bristol claimed a dispute involving a newly-issued patent covering a metabolite of the drug. Bristol's listing of the patent in the FDA Orange Book was challenged by generics, who succeeded at having the patent "delisted" in March 2001. A federal district court that threw out the claim held that "no objective person could reasonably have believed that the listing was proper."

"The audacity of Bristol's inappropriate behavior is what finally pushed the FTC to recommend these proposed regulations—and to this executive order," said Steven Lieberman, an attorney with the Washington law firm of Rothwell, Figg, Ernst and Manbeck, who led the BuSpar litigation.

In another case, Bristol sought additional exclusivity to resolve a Taxol-related dispute with American BioScience Inc. of Santa Monica, CA. The disputed patent involved the vial size for Taxol (**The Cancer Letter**, Oct. 1, 2000).

Antitrust suits by generics and state attorneys general over Taxol and BuSpar are pending (**The Cancer Letter**, June 7).

Judge: FDA Lacks Authority To Enforce Pediatric Rule

A federal judge last week invalidated an FDA regulation that allows the agency to demand that sponsors conduct drug studies in children.

Judge Henry Kennedy Jr., of the U.S. District Court for the District of Columbia, ruled that FDA lacked authority to enforce the 1999 Pediatric Rule, which required sponsors to conduct pediatric studies for drugs and biologics treating diseases that occur in adults and children.

Kennedy's injunction Oct. 17 was a victory for the Association of American Physicians and Surgeons, the Competitive Enterprise Institute, and Consumer Alert, who challenged the agency's rule.

The 31-page ruling compares the Pediatric Rule and the pediatric incentive program initiated in the 1997 FDA Modernization Act and renewed in the 2002 Best Pharmaceuticals for Children Act.

Under the incentive program, sponsors who conduct pediatric studies in response to a written request from FDA receive up to six months of additional market exclusivity. Under the Pediatric Rule, sponsors are expected to conduct pediatric studies if an application under review is for a disease or condition that exists in both adults and children, represents a significant therapeutic advance, or is anticipated to be widely used off-label by pediatricians. The requirement can be waived or deferred to avoid delay in reviewing products for use in adults.

"Congress adopted an incentive scheme, while the FDA adopted a command-and-control approach," Kennedy wrote. "The two schemes differ in almost every possible regard. Far from complementing Congress's voluntary incentive scheme, the Pediatric Rule usurps it by superimposing an often-incompatible regime."

Initially, the AAPS effort to nullify the Pediatric Rule was led by attorney Dan Troy, who has since been appointed by President Bush to the post of the FDA chief counsel. Troy has recused himself from the case, FDA sources said.

Over the years, pharmaceutical companies have been reluctant to test cancer therapies in children, in part because pediatric cancer is rare, and the markets small. Also, companies fear that adverse events in children could trigger publicity and derail development of drugs for adults. Though this has never happened, drug companies often cite this fear.

The Pediatric Rule is predicated on the agency's belief that incentives are insufficient to overcome the sponsors' resistance to study drugs in children. Pediatric oncology activists say the Pediatric Rule and the pediatric provision of FDAMA are complementary and address different aspects of pediatric drug development. Supporters of the rule include the American Academy of Pediatrics, the Children's Oncology Group, and the Alliance for Childhood Cancer.

Generally, pediatric investigators don't gain access to a new therapy for about seven years after conclusion of phase I studies in adults. No pediatric cancer drug therapies have been approved by the FDA since 1990, and there have been no submissions for claims since that time. Only one therapy for children has been approved by the agency's Center for Biologics, uricozyme, for decreasing uric acid levels following tumor lysis.

Kennedy's ruling states that companies have the right to determine the indications for which their drugs are developed.

"If [the Pediatric Rule] truly gave the FDA the authority that it claims, the door would be open to the FDA's regulation of all off-label uses, based solely on the manufacturer's knowledge that those uses are

common-place," Kennedy wrote. "This authority would surely conflict with Congress's will, and would eviscerate the long-established foundation of food and drug law, which allows, not the FDA, but the manufacturer of the article, through his representations in connection with its sale, to determine the use to which the article is to be put."

Several members of Congress have been working to give FDA clear-cut authority to enforce the Pediatric Rule. The Senate measure (S2394) was co-sponsored by Sen. Hillary Rodham Clinton (D-NY), Michael DeWine (R-OH) and Christopher Dodd (D-CT). In the House, two bills attempt to accomplish the same goal: HR4730, sponsored by Rep. Henry Waxman (D-CA), and HR5594, sponsored by Deborah Pryce (R-OH) and Connie Morella (R-MD).

The Senate measure was reported out of committee, but has not gone to a floor vote. Capitol Hill sources said four Republican Senators have put holds on the measure.

A report, which accompanies the Senate bill, argues that incentives alone are insufficient to ensure that sponsors conduct pediatric studies. The document states:

"FDA reports that, between April 1, 1999, when the rule first became effective, and March 31, 2002, 404 new drug applications and supplements fell within the scope of the rule. For approximately 266 of these drugs, manufacturers have submitted, or will be required to submit, studies in one or more pediatric age groups (the remaining drugs received complete waivers, typically for safety reasons in children or because the drug's approved indication is not for a childhood disease). As of March 31, 2002, 94 submitted applications contained complete or partial pediatric use information. FDA attributes 48 of these submissions to the Pediatric Rule alone. By comparison, FDA reports that 57 drugs have been granted exclusivity and 8 have been denied exclusivity, with 35 of these drugs currently labeled for use in the pediatric population. It is therefore clear that the Pediatric Rule has made a substantial contribution to the slow but steady improvement in the pediatric labeling of drugs and biological products that has occurred since 1997, when Congress first provided for pediatric exclusivity and FDA first proposed the Pediatric Rule."

Having prevailed in court, AAPS attacked Clinton's Senate bill.

"Children are not guineas pigs in a regulatory grab for power," Jane Orient, executive director of Tucson, AZ, based AAPS, said in a statement. "It's senseless for the FDA to require pediatric testing for drugs that expressly disclaim any use on children. We are gratified that the court agreed with us. We don't want the government requiring drug companies and doctors to expose children to unnecessary risks. Would you volunteer your child for experimental trials?

"No tears will be shed for curtailing the FDA's power to delay new drugs. The FDA has withheld innovative drugs from needy patients for too long, and interferes with new treatments for terminal illnesses. Doctors, not the FDA, should be recommending prescription drugs for patients. There needs to be a housecleaning at the FDA before it seizes any more power for itself.

"Hillary Clinton's 'for the children' rationale for expanding government power has run out of steam. We're thrilled that a court has limited the FDA's power to delay new drugs, and children will ultimately benefit," Orient said.

Clinton said Kennedy's ruling represents "a troubling step backward" for pediatrics.

"I want to make clear that strong FDA enforcement of the pediatric rule is exactly what we intended," Clinton said. "Without adequate information about how a drug works in children of different ages and sizes, they are more likely to be under- or overdosed, or to experience dangerous side effects. The FDA has previously defended the rule vigorously, and I urge them to continue to do their utmost to protect the health and safety of children. In the meantime, however, the protections that we have relied on since 1998 to assure the safety and efficacy of our children's medicine have been taken away."

Kennedy's ruling is posted on the court's Web site: www.dcd.uscourts.gov/00-02898.pdf.

IOM Report:

Evidence Insufficient To Link Polio Vaccine And Cancer

Scientific evidence is insufficient to prove or disprove the theory that exposure to polio vaccine contaminated with a monkey virus between 1955 and 1963 has triggered cancer in humans, according to a report Oct. 22 from the Institute of Medicine of the National Academies.

The vast majority of population studies, which carry the most weight in establishing causal

relationships, have found no increased rates of cancer in people who received the vaccine contaminated with simian virus-40 (SV40). However, a possible link cannot be completely ruled out because of limitations in the available data and in the way the studies were conducted.

Moreover, while there is a strong body of biological evidence that SV40 is capable of causing cancer, it is not clear that exposure to the virus through the tainted polio vaccine could cause certain cancers suspected of being associated with SV40—mesothelioma, osteosarcoma, ependymoma, and non-Hodgkin's lymphoma—said the committee that wrote the report.

"Biological data can help shape research directions, but cannot prove causality on their own," said committee chairman Marie McCormick, professor and chairman, department of maternal and child health, Harvard School of Public Health, Boston. "Given the uncertainties raised by all the studies, our report offers a research strategy and suggests a process for handling contamination of vaccines should it ever occur again."

In the early years of polio vaccine production, the tissue cultures that were used to grow poliovirus for the vaccine came from the kidneys of rhesus and cynomolgus monkeys. Researchers discovered in 1960 that these tissues could be infected with SV40, a previously unknown virus that commonly causes a harmless infection in certain species of Asian macaques, particularly the rhesus monkey. When SV40 was detected in polio vaccine, health officials began taking steps to remove the virus. Following the implementation of altered production techniques and more stringent screening, the polio vaccine has been free of SV40 since 1963. Through large-scale vaccination efforts, polio was eliminated from the Western Hemisphere by 1994.

Researchers estimate that 10 percent to 30 percent of the polio vaccine given to adults and children in the U.S. between 1955 and 1963 was contaminated with SV40, potentially exposing between 10 million and 30 million Americans to the virus. However, as with all viruses, not everyone who comes into contact with SV40 will become infected; and those who are infected may never suffer symptoms or adverse health consequences. In the absence of sensitive and specific blood tests for SV40, it is impossible to determine how many people actually became infected with the virus.

The committee does not recommend a review of polio vaccination policy on the basis of concerns over cancer risks from SV40 contamination, since the polio vaccine is no longer contaminated. However, it does recommend that the Department of Health and Human Services coordinate efforts to develop a comprehensive plan for addressing vaccine contamination.

The bulk of studies to date that have examined the potential link between the vaccine and cancer in human populations indicate no increased risk of cancer in vaccine recipients. However, the committee found substantial statistical and design limitations in the 13 population studies. In many cases, year of birth was used instead of individual vaccination records to determine who received the polio vaccine during the period of contamination. Furthermore, there is no way for researchers to know now which individuals received the contaminated polio vaccine decades ago. The rarity of most of the tumors thought to be associated with exposure to SV40 makes it difficult to do statistically sound studies.

In laboratory studies, rodents that were exposed to SV40 developed the same type of tumors as those human cancers suspected of being associated with the virus. The incidence of some of these cancers has risen, but this could be attributable to better detection techniques and other possible causes. Studies also show that the DNA of SV40, like that of other viruses, has been detected in human tumors. However, the committee noted that not all the tumors studied contained the viral genetic material, and some studies have detected SV40 in normal tissues from healthy subjects. The presence of viral material in a human tumor does not by itself demonstrate a causal link.

Future research efforts should focus on developing sensitive blood tests and standardized techniques to more definitively detect SV40 in people who may have been infected, the committee said. Once the best detection methods and protocols are determined, they should be used to assess the incidence of infection in humans prior to the introduction of polio vaccine in 1955 and after the elimination of the contaminated supplies in 1963. These analyses would help to reveal how much of the existing SV40 infection in humans can be attributed to contaminated polio vaccine as opposed to other potential sources. The committee advised against conducting more epidemiological studies of people potentially exposed to the contaminated vaccine until the technical issues of detection and

study design have been resolved.

The report, "Immunization Safety Review: SV40 Contamination of Polio Vaccine and Cancer," is available at www.nap.edu.

Funding Opportunities:
Program Announcements

PAR-03-009: Improving Diet and Physical Activity Assessment

Letter of Intent dates: Jan. 1, Sept. 1, 2003; May 1, 2004; Jan. 1, Sept. 1, 2005

Application receipt dates: Feb. 1, Oct. 1, 2003; June 1, 2004; Feb. 1, Oct. 1, 2005

Revised application dates: Nov. 1, 2003; July 1, 2004; March 1, Nov. 1, 2005

The objective of this PA is to support research to improve diet and physical activity measurement through improved instruments, technologies, or statistical/analytic techniques. Proposals should explore the combination of objective and self-report measures of physical activity or dietary intake that can capture these behaviors in both general and diverse populations. The focus is on the assessment of the behaviors, and not on the determinants of these behaviors. Support will be through the NIH R01 or an exploratory/developmental grant R21. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PAR-03-009.html.

Inquiries: Amy Subar, or Richard Troiano, Division of Cancer Control and Population Sciences, NCI, Bldg., EPN Rm 4005, Bethesda, MD 20892, phone 301-594-0831 or 301-435-6822; fax 301-435-3710; e-mail subara@mail.nih.gov or troianor@mail.nih.gov.

PA-03-008: Bone Anabolic Hormones, Their Receptors and Signal Transduction Pathways

The objective is to elicit grant submissions that focus on systemic hormones, local growth factors and bone-active cytokines with potential bone anabolic effects. The signal transduction pathways recruited by the receptors of these hormones and growth factors are of particular interest. Although the primary focus is on basic research, the long-term objective is to identify potential targets of therapeutic value in the treatment of diseases that adversely affect bone including, but not limited to, osteoporosis due to loss of gonadal steroids, aging, use of glucocorticoids and immunosuppressive drugs, hyperparathyroidism, excessive thyroid hormone replacement, or tumor metastasis to bone. The PA will use the NIH R01 and R21 award mechanism(s). The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PA-03-008.html.

Inquiries: Suresh Mohla, Division of Cancer Biology, NCI, 6130 Executive Blvd, EPN 5038, Rockville, MD 20892, phone 301-435-1878; fax 301-480-0864; e-mail mohals@mail.nih.gov

In Brief:
Group Questions Corporate Cancer Awareness Campaigns

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how the food and beverage industries can help Americans combat obesity. The meeting, the first in what HHS officials said will be a series of talks, comes one week after HHS released new data indicating that nearly one-third of all adults in the U.S. classify as obese, and that 15 percent of children aged 6 to 19—close to 9 million children—are overweight. The Cabinet officials urged the fast-food industry to offer lighter, healthier food selections. . . . **AMERICAN CANCER SOCIETY** announced 96 research and training grants, totaling $47,752,824, to begin Jan. 1. Of these grants, 82 were new awards and 14 were renewals. The awards include three research professorships, 28 postdoctoral fellowships, and seven clinical research training grants. The remainder are research scholar grants in the basic, clinical, and behavioral research areas. . . **"THINK BEFORE YOU PINK"** is the new slogan devised by the San Francisco-based group Breast Cancer Action to call attention to corporate breast cancer awareness campaigns. "More and more companies are using breast cancer as a marketing ploy to sell products and promote their brand while donating very little to the cause," said **Barbara Brenner**, executive director of Breast Cancer Action. "We are urging consumers to 'think before they pink' because as long as we believe we're doing something meaningful about breast cancer by buying into these corporate marketing schemes, the real work that needs to be done around treatment, prevention, and access to care will continue to be under-funded and ignored." The group placed ads in the New York Times in October to draw attention to the "troubling trend of corporate pinkwashing." The ad is available at www.thinkbeforeyoupink.org. . . . **INSTITUTE OF MEDICINE** will lead a study of the scientific and policy implications of the use of complementary and alternative medicine in the U.S. The $1 million, two-year study, is sponsored by the National Center for Complementary and Alternative Medicine at NIH, and 16 other NIH Institutes and offices. IOM will assemble a panel of about 16 experts from a range of CAM and conventional disciplines. . . . **IOM ELECTED** 65 new members earlier this month. The list may be viewed at www.nas.edu. . . . **DONALD FREDRICKSON**, the former NIH director from

1975 to 1981 who died last June 7, was remembered by colleagues at a memorial at NIH on Oct. 18. Fredrickson's papers have been added to "Profiles in Science," at www.profiles.nlm.nih.gov. Fredrickson discovered the relationship between heart disease and cholesterol. . . . **NATIONAL HUMAN GENOME** Research Institute awarded a three-year, $15-million grant to combine three protein sequence databases. The United Protein Database, or UniProt, will combine SWISS-PROT, TrEMBL and the Protein Information Resource. SWISS-PROT, a hand-curated database, was established in 1986 by **Amos Bairoch** at the Swiss Institute of Bioinformatics in Geneva. TrEMBL, a computer-annotated supplement to SWISS-PROT, was created by SIB and the European Bioinformatics Institute. PIR is a joint effort between Georgetown University Medical Center and the National Biomedical Research Foundation in Washington, DC. **Rolf Apweiler**, who has led SWISS-PROT since 1994, will be principal investigator of the project. UniProt data will be accessible at www.uniprot.org. . . . **AMERICAN SOCIETY FOR THERAPEUTIC RADIOLOGY AND ONCOLOGY** named officials to its board of directors: **Nora Janjan** is chairman and **Joel Tepper** is president. Janjan is professor of radiation oncology at the University of Texas M.D. Anderson Cancer Center. Tepper is professor and chairman of radiation oncology at the University of North Carolina School of Medicine in Chapel Hill. Other board members: president-elect, **Ted Lawrence**, University of Michigan, Ann Arbor; community practice member-at-large, **Peter Blitzer**, radiation therapy associates, Cape Coral, Fla.; academic clinician member-at-large, **Colleen Lawton**, Medical College of Wisconsin, Milwaukee. . . . . **NATIONAL COLORECTAL CANCER ROUNDTABLE**, a coalition of groups led by the American Cancer Society and the Centers for Disease Control and Prevention, released "Promoting Early Detection Tests for Colorectal Cancer and Adenomatous Polyps: A Framework for Action, " published in the Oct. 15 issue of the journal Cancer, and available at www.cancer.org. . . . **LLOYD LAW**, a geneticist with NIH since 1947, died Oct. 20 at his home in Gaithersburg, Md. He was 91. Law was credited with the discovery of a combination chemotherapy to treat childhood leukemia. He was scientist emeritus and chief of the cell biology laboratory at NCI until he retired in the 1990s.

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