THE CANCER LETTER INTERACTIVE

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# B.J. Kennedy, "Father of Medical Oncology," Dead At 81, Pioneer In Cancer Education

B.J. Kennedy, leader of the effort to establish medical oncology as a subspecialty of internal medicine, died April 6 at his home in Minneapolis of multiple myeloma. He was 81.

Kennedy, a medical professor at the University of Minnesota, invented the term "medical oncology" in the mid-1960s to describe the emerging role of internists in treating people with cancer. At that time, surgeons treated solid tumors, while hematologists treated leukemia, lymphoma,

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*In Brief:*

## Kenneth Foon Moves To UPCI To Direct Biological Therapeutics Program

**KENNETH FOON** has joined the University of Pittsburgh Cancer Institute as co-director of the Biological Therapeutics Program and as co-director of the Hematologic Malignancies Program. Foon, whose recruitment was supported by part of a $3.6 million gift from the Mario Lemieux Foundation, also has been appointed professor, Division of Hematology/Oncology, UP School of Medicine. At UPCI, his research will focus on lymphomas and chronic lymphocytic leukemia, said **Ronald Herberman**, director, UPCI and UPMC Cancer Centers. Foon was clinical professor, Department of Internal Medicine, Stanford University and director of clinical development at Abgenix Inc. . . . **RICHARD PAYNE** has assumed the presidency of the America Pain Society. Payne is chief, pain and palliative care service and attending neurologist, Sloan-Kettering Cancer Institute. **Dennis Turk** will serve as president-elect of the society for 2003-4. Turk is John and Emma Bonica professor of anesthesiology and pain research, University of Washington School of Medicine. **Patricia McGrath**, Hospital for Sick Children, Toronto, is treasurer. Directors at Large are: **Robert Jamison**, Harvard Medical School; **Christine Sang**, Massachusetts General Hospital and Harvard Medical School; **George Wilcox**, University of Minnesota Medical School. . . . **WESTERN NEW YORK Neuro-Oncology Center** has been formed through a collaboration between Roswell Park Cancer Institute and the Dent Neurologic Institute in association with the Department of Neurosurgery at the University at Buffalo. The WNY,

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# Kennedy Advocated Research, Education In Geriatric Oncology

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and other blood cancers.

"B.J. early on recognized the need for establishing a real subspecialty, and pushed for the American Board of Internal Medicine to establish a subspecialty exam," said John Durant, former executive vice president of the American Society of Clinical Oncology, now retired. "That played an enormous role in helping to define oncology and overcome the resistance of hematologists."

Kennedy retired from the university in 1991, retaining the titles of Regents Professor of Medicine Emeritus and Masonic Professor of Oncology Emeritus.

He served as ASCO president in 1988, and remained active in the organization, serving as chairman of its Geriatric Oncology Task Force. He edited the ASCO curriculum on cancer in the elderly, published last fall.

"He came up to me one time at one of these increasingly large meetings of ASCO and said, 'John Durant, what have you done?' " Durant said. "He either gave me credit or blamed me for it, but there's no going back.

"Everybody revered B.J.," Durant said. "He was a very nice man, and he treated patients well. They loved him and that's why he was so successful."

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**Medical Oncology: A New Subspecialty**

Kennedy was born in Plainview, Minn., grew up in Rochester, and graduated with B.A. and B.S. degrees from the University of Minnesota in 1943, He received his M.D. from the University of Minnesota Medical School in 1946. He did his internship, residency, and fellowship at Massachusetts General Hospital, where he met his wife Margaret. He went to McGill Medical School for training in experimental medicine, and then joined the Minnesota faculty in 1952.

Trained as an endocrinologist, Kennedy became interested in treating breast cancer with hormones.

"He was not exactly considered one of the stars of the Department of Medicine, because cancer wasn't interesting to internists," said Raymond Weiss, clinical professor of medicine at Lombardi Cancer Center, who was a fellow in Kennedy's medical oncology training program in 1970-72.

"In the 1950s and early '60s all you could say to patients was, 'You have cancer and you're going to die.' That's about it," Weiss said. "Treating cancer patients with medical manipulations was in its infancy."

As an assistant professor studying a field his department considered relatively unexciting, Kennedy had no access to funding to build a research program. Kennedy convinced the Masons to raise funds for cancer research. The fraternal organization began a fund drive in 1955 to build a two-story cancer hospital, the Masonic Memorial Hospital, now known as the Masonic Cancer Center. In 1957, Kennedy was promoted to associate professor of medicine.

"He started a little empire and built it from there," Weiss said. "As more drugs came along in the early '60s, he got into treating leukemia."

Kennedy was one of the first to recognize that physicians needed to treat the whole patient with cancer, from the onset of the disease to the end of life. However, hematologists saw Kennedy's work as an attempt to take away their patients.

"The hematology community wasn't entirely accepting of the development of medical oncology," said George Canellos, medical director for network development, Dana-Farber/Partners CancerCare. "B.J. was one of the—if not the only—outspoken proponent of medical oncology as a discipline."

In 1965, two more floors were added to the cancer hospital as a result of Mason fundraising. In 1967, Kennedy was appointed a full professor of medicine and director of the new Division of

Oncology, which he led until his retirement in 1991.

Kennedy developed the first academic program of training in medical oncology, a two-year program.

"One learned about all forms of cancer and focused on cancer as a general disease," Weiss said. "You were capable of managing the disease in formulating treatment and doing what is too often the situation of the internist, the handholding when a patient is dying of the disease."

Kennedy accepted only one fellow a year in the 1960s and early 1970s. Fellows who completed the program were not recognized as having any official designation by the medical establishment. So Kennedy lobbied the American Board of Internal Medicine to recognize medical oncology as a new subspecialty, which the board finally did in 1971.

The first board exams were held in October 1973.

"He was so elated," recalled Weiss. "When the official recognition was given, then you knew that you had arrived. You weren't just calling yourself an oncologist. Now you were an official subspecialist, just like cardiologists."

Kennedy's training program during the early 1970s gave its fellows the feeling of "being in on the ground floor of a new subspecialty," Weiss said.

"It was very exciting. In 1971, when I went to my first ASCO meeting, there was a drug each year that dominated the meeting," he said. "That year it was bleomycin. In '72, it was Adriamycin. In '73, CCNU and BCNU."

**Advocate for Geriatric Oncology**

Kennedy is credited with helping to develop therapies for genitourinary tract cancers and testicular cancer, and advanced breast cancer. He was active in the Cancer and Leukemia Group B clinical trials cooperative group.

"B.J. was a guiding spirit for me in my early days in the CALGB and an invaluable source of information about the history of medical oncology, CALGB, and ASCO," said Larry Norton, head of the Solid Tumor Division, Memorial Sloan-Kettering Cancer Center.

"In addition to his extraordinary intellect and medical skill, he was a great humanist, friend, and educator of both colleagues and patients," Norton said. "B.J taught me much about the importance of growth rates in understanding cancer."

Kennedy also was one of the first to become interested in the specific problems of providing cancer care to older people, because of his connection with the Masons. He served for 29 years on the board of directors of the Presbyterian Homes of Minnesota.

Kennedy often took his fellows to homes for the elderly so they would become accustomed to being around older people, Weiss said.

As ASCO president in 1988, Kennedy advocated for more research and education on cancer treatment in the elderly. He predicted that cancer incidence would rise as life expectancy continued to improve.

"Cancer in the elderly has been under-screened, under-detected, under-staged, and under-treated," Kennedy said in an interview last year (**The Cancer Letter**, May 17, 2002, Vol. 28 No. 20).

"People over age 75 haven't been included in many clinical trials," he said. "Only now are the cooperative groups beginning to look at this problem."

Last year, ASCO honored Kennedy for his work in geriatric oncology.

"His leadership of ASCO was a role model for all who followed, particularly in his advocacy for geriatric oncology, which has since become a major focus of both ASCO and the oncology community," Norton said.

"He was also a passionate advocate of what has since been termed 'translational oncology,' recognizing the critical importance of laboratory science in the development of clinical oncology," Norton said.

"He will be deeply missed, but his influence and vision will live on."

Kennedy received many awards, including the 1996 Medal of Honor in Clinical Research from the American Cancer Society.

The University of Minnesota Medical Foundation established a lectureship, scholarships, and endowed chair in medical oncology in his name.

He served as president of the American Association of Cancer Education.

Survivors include his wife Margaret; daughter Sharon, of Minneapolis; sons Bradford and Grant, of Minneapolis, and Scott, of Rochester, NY; and four grandchildren.

A memorial service is scheduled for April 26, at 2 p.m., at Westminster Presbyterian Church, 1200 Marquette Ave., Minneapolis.

Memorials may be sent to the B.J. Kennedy Oncology Scholarship Fund, Minnesota Medical Foundation, 200 Oak St. SE Suite 300, Minneapolis, MN 55455.

*NCI Programs:*

## NCI Says Cancer Rate In Marin Matches W. Coast Counties

Breast cancer incidence rates in Marin County, Calif., are "substantially lower" than previously calculated, NCI officials said.

"Our preliminary results show that revised rates for Marin County based on Census 2000 numbers are much lower than rates calculated using the 1990 numbers," said Brenda Edwards, associate director of the Surveillance Research Program at NCI. "Rates for Marin county remain high in these preliminary results, but in line with other counties on the West Coast, and do not differ from some other California regions."

The discrepancy was due to "projected population growth differing considerably from actual population growth," according to an NCI statement. Edwards said more analyses are underway to confirm these findings.

At the request of Rep. Lynn Woolsey (D-Calif.), NCI and other federal health agencies formed a task force last November to address breast cancer rates in the county. Besides NCI, the task force consists of representatives from the National Institute of Environmental Health Sciences, the Center for Disease Control and Prevention, and the Environmental Protection Agency (**The Cancer Letter**, Nov. 15, 2002, Vol. 28 No. 42).

NCI and NIEHS have committed $1.9 million over a three-year period to the study of Geographic Information Systems in Northern California. The institutes are working with GIS experts to discuss ways to enhance the systems to address geographic differences in breast cancer occurrence.

GIS is a research tool that can correlate information from multiple sources, including demographic, environmental, and epidemiologic databases, in order to study causes of disease in geographic areas.

With encouragement from NCI, the Northern California Cancer Center in Union City, Calif., submitted an application for funding to examine the prevalence of established breast cancer risk factors such as late childbearing and other reproductive events, personal history of breast cancer, and hormone replacement therapy, NCI said. The proposal was submitted through NCI's Rapid Response Surveillance Studies mechanism, which allows researchers to conduct innovative population-based surveillance and outcome studies on scientific inquiries deemed to be of high priority to NCI, Congress, and advocacy groups.

Also through NCI's RRSS mechanism, investigators at the Northern California Cancer Center proposed to develop statistical models to predict attributable risk (the amount of disease that could be due to specific risk factors) based on the breast cancer risk factors of alcohol use, hormone replacement therapy, and breastfeeding. The results of this analysis can be used to measure the benefits of interventions that were designed to modify these risk factors.

At the task force's meeting last November, von Eschenbach encouraged Bay Area investigators to submit a proposal for funding as a Breast Cancer and Environment Center, NCI said. Breast Cancer and the Environment Research Centers, jointly funded by NIEHS and NCI, are a network of centers in which multidisciplinary teams of scientists, clinicians, epidemiologists, breast cancer advocates, and others work collaboratively on scientific questions that focus on how chemical, physical, biological, and social factors in the environment work alone or in combination with genetic factors to cause breast cancer.

In February, NCI convened a meeting with representatives from NIEHS, CDC, and EPA to develop guiding principles for addressing high cancer incidences throughout the country, including Marin County. This is one in a series of meetings focused on a science-based approach for assessing the contribution of environmental exposure to breast cancer risk. The task force is assessing available technologies and processes that may be valuable in answering questions about the impact of the environment on breast cancer risk and discussing how better approaches might be developed, NCI said.

"Even though the preliminary results of the incidence of breast cancer in Marin County may not be higher than other areas on the West Coast, I will continue to fight for Marin based cancer studies and research," Woolsey said in a statement earlier this month. "Women and their families continue to suffer in the North Bay and if we can find out what is happening in Marin, we can help women fight breast cancer throughout the nation."

On April 8, Woolsey introduced legislation requesting $45 million to fight breast cancer among young women throughout the country. The legislation is named after Annie Fox, a breast cancer activist

from Marin County who died of the disease at age of 35; she was diagnosed with breast cancer when she was 29.

"We must continue to move forward in finding the cause of the high rate of breast cancer in the North Bay," Woolsey said. "An important part of this effort is making sure that younger women have proper diagnosis and treatment to prevent and cure this dreaded disease."

*International:*

## Cancer Rates Could Increase By 50% Worldwide, IARC Says

Cancer rates could further increase by 50 percent to 15 million new cases in the year 2020, according to the World Cancer Report, a publication of the International Agency for Research on Cancer, of the World Health Organization.

However, public health action by governments and health practitioners could stem this trend, and prevent as many as one-third of cancers worldwide, the report said.

In 2000, malignant tumors were responsible for 12 percent of the nearly 56 million deaths worldwide from all causes. In many countries, more than a quarter of deaths are attributable to cancer. In 2000, 5.3 million men and 4.7 million women developed a malignant tumor and 6.2 million died from the disease. Cancer has emerged as a major public health problem in developing countries, matching its effect in industrialized nations, the report said.

"The World Cancer Report tells us that cancer rates are set to increase at an alarming rate globally," said Paul Kleihues, IARC director and co-editor of the World Cancer Report. "This report calls on governments, health practitioners, and the general public to take urgent action. Action now can prevent one-third of cancers, cure another third, and provide good, palliative care to the remaining third who need it."

The 351-page World Cancer Report describes the global burden, the causes of cancer, major types of malignancies, early detection, and treatment.

"The report provides a basis for public health action and assists us in our goal to reduce the morbidity and mortality from cancer, and to improve the quality of life of cancer patients and their families, everywhere in the world," WHO Director-General Gro Harlem Brundtland said.

The report said stemming the increase of cancer rates would require:

—Reduction of tobacco consumption. In the 20th century, approximately 100 million people died worldwide from tobacco-associated diseases.

—A healthy lifestyle and diet including frequent consumption of fruit and vegetables.

—Early detection through screening, particularly for cervical and breast cancers.

The predicted sharp increase in new cases from 10 million new cases globally in 2000, to 15 million in 2020, will mainly be due to steadily aging populations in both developed and developing countries, and to current trends in smoking prevalence and the growing adoption of unhealthy lifestyles, the report said.

"Governments, physicians, and health educators at all levels could do much more to help people change their behavior to avoid preventable cancers," said Bernard Stewart, co-editor of the report, director of cancer services and professor of medicine at University of New South Wales, Australia. "If the knowledge, technology, and control strategies outlined in the World Cancer Report were applied globally, we would make major advances in preventing and treating cancers over the next 20 years and beyond."

"From a global perspective, there is strong justification for focusing cancer prevention activities particularly on two main cancer-causing factors: tobacco and diet," said Rafael Bengoa, director, management of non-communicable disease, at WHO.

"We also need to continue efforts to curb infections which cause cancers," Bengoa said. "These factors were responsible for 43 percent of all cancer deaths in 2000—that is 2.7 million fatalities—and 40 percent of all new cases, or four million new cancer cases."

The report reviews and recommends a number of strategies to reduce global tobacco consumption, requiring the coordinated involvement of government and community health organizations, health care professionals, and individuals.

The Framework Convention on Tobacco Control, which the member states of WHO have agreed to submit to the World Health Assembly in May, represents a powerful tool to ensure that such strategies are implemented, the report said.

WHO is also preparing a Global Strategy on Diet, Physical Activity and Health, which will be presented to the World Health Assembly in May 2004.

To obtain copies of the World Cancer Report, see www.who.int/.

## UK Research Groups To Fund National Virtual Tumor Bank

A UK organization plans to create a national system in that country to collect and analyze cancer tissue through a virtual tumor bank.

The National Cancer Research Institute, the coordinating body established in 2001 between the UK government, the Medical Research Council, Cancer Research UK, and other cancer charities, said it will form the National Cancer Tissue Resource.

The proposal for the tumor bank has been drawn up by the National Translational Cancer Research Network, which includes 10 cancer centers.

A number of hospitals and research centers run their own tissue collection banks, but there is no national infrastructure for standardization of tumor sample, data collection, and storage.

"Advances in genomics and proteomics give us a real opportunity to make progress in cancer research," said Liam O'Toole, NCRI director. "If we don't do something now, lack of tissue samples could severely slow down the rate of progress. Up until now we have had a fragmented approach to collecting and using tumor samples for research. This initiative from the NCRI partnership now gives us an opportunity to do things properly on a much bigger scale for the benefit of cancer patients."

Funding for the first phase of the tumor bank will come from the Department of Health (£500,000 per year), Cancer Research UK (£250,000 per year) and the Medical Research Council (£250,000 per year).

The Welsh Assembly Government has also provided funding for a Welsh Tumor Bank that will be developed in partnership with NCTR.

The long-term aim is to establish a network of tissue acquisition centers linked to a range of processing centers that will extract DNA, RNA and related bioproducts. Tissue microarrays will be produced for samples associated with key clinical trials.

The networks will be linked and managed through a coordinating center that will work with the research community to develop standard protocols for collection and storage of tumor samples. A central information system will track samples through the system and provide a bioinformatics hub to link histopathological data with clinical/outcome data and research results.

The Department of Health and patient representatives will be involved in the oversight of the National Cancer Tissue Resource.

"The establishment of the National Cancer Tissue Resource is a major step forward for cancer research in the UK," said National Cancer Director Mike Richards. "This initiative has been made possible because of the effective partnership between government and the cancer research charities which has developed within the National Cancer Research Institute."

Sir Paul Nurse, Cancer Research UK's Nobel Prize winner said, "This initiative is key to restoring public confidence in the research community and rebuilding bridges between doctors and their patients. It sets out clear boundaries for the collection of tumor samples which are essential for us to better understand cancer and help us improve treatments for people with the disease."

NTRAC studied different models of tumor banks nationally and internationally before drawing up the proposal.

"This is a very important development for cancer research in this country," said NTRAC Director David Kerr. "A lot of hard work has gone into getting us this far and NTRAC staff look forward to working with the cancer community to make the NCRI National Cancer Tissue Resource available to front-line researchers."

A chief operating officer will be appointed, reporting to Kerr. Cancer Research UK will manage this process on behalf of the other NCRI funders and will also be responsible for establishing systems to oversee access to the resource.

Full NTRAC Network Center status and funding has been awarded to 10 centers: Birmingham; Cambridge; Imperial College London; Leeds/ Bradford; Manchester; Oxford; Newcastle; Royal Marsden; Southampton; and University College London. Each center will receive around £1m funding over five years to help build the research infrastructure.

Information about NCRI is available at www.ncri.org.uk.

*Funding Opportunities:*

## NCI RFPs Available

**RFP: N01-CP-31006-50: Pre-solicitation Notice: Agricultural Health Study (Field Stations)**

NCI Occupational Epidemiology Branch is

seeking contractors maintain field stations for the prospective cohort study in North Carolina and/or Iowa. A cohort of 59,000 has been established in Iowa and 30,000 in N.C., that can be followed for 10 years or more to obtain information on agricultural exposures, diet, cooking practices, and other factors of etiologic interest for cancer and other diseases.

The RFP may be accessed via the Research Contracts Branch Web site: http://rcb.nci.nih.gov/ under Current Requests For Proposals.

Inquiries: Karen McFarlane, contracting officer, Department of Health and Human Services, NIH, NCI, Research Contracts Br., 6120 Executive Blvd. EPS Suite 600, Rockville, MD, 20852, phone 301-435-3782; fax 301-480-0241, e-mail km63k@nih.gov or Sharon Miller, contracting officer, phone 301-435-3783; fax 301-480-0241; e-mail sm103r@nih.gov.

**RFP: N02-CP-31007-50: Presolicitation Notice: Agricultural Health Study (Coordinating Center)**

NCI Occupational Epidemiology Branch is seeking a contractor to perform the above named project. The contract will maintain a Coordinating Center to assist the NCI Project Officer in the monitoring and coordination of the work of the two state-wide Field Stations. One of stations is in North Carolina and the other in Iowa. An existing cohort of approximately 89,000 study subjects was created in the first five years of the study (1993-1997) and will need to be followed for 10 years or more to obtain detailed information on agricultural exposures, diet, cooking practices, and other factors of etiologic interest for cancer and other diseases. The contract will be a cost-reimbursement, completion type for a 60-month period.

Inquiries: See preceding RFP.

## RFA Available

**RFA CA-04-003: Long Term Cancer Survivors: Research Initiatives**

Letter of Intent Receipt Date: May 12

Application Receipt Date: June 16

The RFA, a re-issuance of the NCI FY 2004 Extraordinary Opportunity in Cancer Survivorship initiative, reflects the NCI recognition for research that addresses the impact of cancer and its treatment especially among cancer survivors diagnosed as adults. Applications are expected to cover the full range of domains affected by long-term survival from cancer (physiologic, psychologic, social, behavioral, economic) and emphasize understudied areas and gaps in current research.

The purpose is to build upon the established research base with respect to: a) specific survivor groups: such as those treated for previously understudied cancer sites (e.g. colorectal, gynecologic, hematologic, head and neck), and those belonging to underserved populations (elderly, rural, low education/income, diverse racial and ethnic groups); and b) questions addressing specific gaps in our knowledge: such as the incidence of and risk factors for late and long-term (chronic or persistent) effects of cancer and its treatment, the role of socio-cultural and behavioral factors in modulating treatment outcomes, the impact of survivorship on health care utilization, the role of co-morbidity in outcomes, appropriate follow up care and surveillance for survivors, and the effect on families of living with a cancer history in a loved one. The RFA will use three grant mechanisms: R0, R21, and R03. The RFA is available at http://grants1.nih.gov/grants/guide/rfa-files/RFA-CA-04-003.html.

Inquiries: Noreen Aziz, Office of Cancer Survivorship, Division of Cancer Control and Population Sciences, NCI, 6130 Executive Blvd. North, Rm 4090, Bethesda, MD 20892 (For express / courier service only: Rockville, MD 20852), phone 301-496-0598; fax 301-594-5070; e-mail na45f@nih.gov.

## NCI Small Business PAs

**NCI Program Announcements for Small Business Innovative Research and Small Business Technology Transfer Research Program Opportunities:** The program is designed to stimulate technological innovation and encourage partnerships between research institutions and small businesses.

NCI has several PAs available for FY2004, in addition to the Omnibus Solicitation for SBIR and STTR applications available at http://grants.nih.gov/grants/funding/sbirsttr1/index.pdf. Applicants are encouraged to use this mechanism as it may apply to cancer research projects.

PAR-01-105: Innovative Technologies for the Molecular Analysis of Cancer.

PAR-01-107: Applications of Innovative Technologies for Molecular Analysis of Cancer.

PA-02-075: Innovative Toxicology Models.

PA-02-108: Structural Biology of Membrane Proteins.

PA-02-125: Bioengineering Nanotechnology Initiative.

PA-03-013: Small Business Grants for Identifying Molecular Signatures of Cancer.

PAR-03-074: Flexible System to Advance Innovative Research for Cancer Drug Discovery by Small Businesses (FLAIR)–SBIR/STTR.

The PAs are available at http://grants.nih.gov/grants/guide/index.html.

*In Brief:*

## Cohen Heads New Program At M.D. Anderson Center

(Continued from page 1)

located at RPCI, is a brain tumor treatment center and a center of excellence in neuro-oncology. The co-directors of the center are **Robert Fenstermaker**, Department of Neurosurgery, RPCI, and associate professor UB, and **Laszlo Mechtler**, clinical associate professor of Neurology, UB. The center will provide diagnostic, consultative and treatment services for primary and metastatic tumor of the brain, spine, and cancer related neuromuscular complications and pain. The center will also develop and participate in clinical trials for nervous system cancers. . . **LORENZO COHEN** has been named director of the newly formed integrative medicine program, Division of Cancer Medicine, and chief of the Section of Integrative Medicine, Department of Palliative Care and Rehabilitation Medicine, M.D. Anderson Cancer Center. Cohen is associate professor, Department of Behavioral Science. He joined the M.D. Anderson faculty in 1997 and has held a joint appointment as an assistant professor of behavioral sciences at The University of Texas-Houston Health Science Center, School of Public Health, since 1998. The program will provide direction, support and resources for research of complementary therapies being conducted throughout the institution and as it expands, the program will begin research projects including mind-body based trials, natural products research and acupuncture trials. The M. D. Anderson Complementary and Integrative Medicine Education Resources Web site is available at (www.mdanderson.org/departments/cimer/). The site contains evidence-based information and scientific reviews for patients and health care staff on complementary therapies for cancer and links to other authoritative resources. . . . **PRISCILLA INGEBRIGTSEN** received the Neuro-Oncology Social Worker of the Year Award from the Association of Oncology Social Work in recognition for her work with patients with brain tumors and their families. The award, sponsored by the National Brain Tumor Foundation, was presented at the AOSW 19th Annual Conference in Salt Lake City in April. Ingebrigtsen has worked at the University of Colorado Cancer Center and in outpatient oncology services at the Anschutz Cancer Pavilion at Fitzsimons for 12 years. . . . **MERRILL EGORIN**, co-director, molecular therapeutics/drug discovery program, University of Pittsburgh Cancer Institute, has received the Elliott Osserman Award for Distinguished Service in Support of Cancer Research from the Israel Cancer Research Fund in recognition of his three years of service on the ICRF scientific review panel. The 26-member panel of scientists and researchers from the U.S. and Canada volunteer to review grant applications submitted by Israeli cancer researchers. ICRF has awarded 1,366 grants totaling more than $26 million to Israeli scientists, said **Yashar Hirshaut**, president of ICRF. . . . **RONDA JOHNSON** has been appointed senior vice president of the Karmanos Cancer Foundation, the fundraising arm of the Karmanos Cancer Institute, said **John Ruckdeschel**, president and CEO of the Barbara Ann Karmanos Cancer Institute. She was a consultant with Ketchum Inc., of Dallas, a fundraising consulting firm for large non-profit organizations. . . . **NEW JERSEY CANCER Trial Connect,** operated by the Cancer Institute of New Jersey, is an Internet-based resource that allows users to search for clinical trials by entering a diagnosis and treatment history. They are then given a clinical trial that matches their need and are electronically updated as trials arise. The initiative was launched by **Gov. James McGreevey**, **William Hait**, director of The Cancer Institute of New Jersey, and **Clifton Lacy**, commissioner of the Department of Health. The NJCTC can be accessed at electronically at www.njct.org or by phone at 866-788-3929. The Cancer Institute of N.J. has also established the first cooperative network of clinical trials, known as CINJ Oncology Group. The program not only provides access to the new and developing information about cancer therapies, it also allows physicians and researchers to pose questions, share information and develop the most current treatment options. The trials are developed from tumor-specific committees made up of physicians from CINJ and communities throughout the state.

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