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# Finasteride Cut Risk Of Prostate Cancer In Large Trial, But Value In Clinic Unclear

The Prostate Cancer Prevention Trial detected a 24.8 percent reduction in incidence of prostate cancer in asymptomatic men who were randomized to take Proscar (finasteride).

"This trial proves that prostate cancer—at least in part—is preventable," Peter Greenwald, director of the NCI Division of Cancer Prevention and a participant in the trial, said at a press conference June 24. "With this trial, NCI, the physicians and other health professionals, and the over 18,000 participants put cancer research to its most important test."

The placebo-controlled trial also evaluated the capability of digital

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*In Brief:*

## NCI Provides $40 Million To Four Centers For Cancer Communications Research

**NCI** said it will provide $40 million to fund four Centers of Excellence in Cancer Communications Research. The specialized center grants (P50s) are intended to produce information about communicating health information to the public. The funded centers and their principal investigators are: University of Michigan, **Victor Strecher**; University of Pennsylvania, **Robert Hornik**; St. Louis University, **Matthew Kreuter**; and University of Wisconsin, Madison, **David Gustafson**. . . . **TULANE UNIVERSITY** received a five-year, $4.3 million grant from the National Center for Research Resources to establish a center for the preparation, quality testing, and distribution of adult stem cells. The center will prepare and distribute a continuous supply of marrow stromal cells derived from adult human and rat bone marrow using standardized protocols. "While the potential for adult stem cell research is great, the technical requirements and the expense of producing high-quality cells limit the capacity of investigators to proceed with their research," said NCRR Director **Judith Vaitukaitis**. "This center, with the emphasis on quality control and standardized methods, will move this promising research forward." Researchers may contact the center at http://cgt@tulane.edu. . . . **MAUREEN HATCH,** chief of the Chornobyl Research Unit in the NCI Division of Cancer Epidemiology and Genetics, was elected president-elect of the Society for Epidemiologic Research. . . . **STEPHEN TAPLIN,** associate director of preventive care research at Group Health Cooperative of Puget Sound, will join NCI this fall as a senior

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## Trial Demonstrated Limitations Of Prostate Cancer Screening

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rectal examination and the Prostate Specific Antigen test to detect prostate cancer, and the results raise questions about the value of screening.

PCPT is a political landmark, too. Its results were announced at a time when NCI is operating under a plan to end "suffering and death due to cancer" by the year 2015, based in part on development of chemopreventive agents that would attack surrogate endpoints for the development of cancer, such as elevated levels of PSA.

The study was conducted by the Southwest Oncology Group.

**Higher-Grade Tumors On Finasteride Arm**

The trial began in October 1993, and was expected to continue through May 2004. It was stopped early, after the Data and Safety Monitoring Committee found a clear reduction of risk on the finasteride arm.

A paper on PCPT will be published in the July 17 issue of the New England Journal of Medicine. Because of the trial's importance to public health, the materials are posted on the journal's Web site, www.nejm.org.

According to the paper, 803 of the 4,368 men who received finasteride developed prostate cancer, and 1,147 of 4,692 men on placebo developed the disease. The reduction in prevalence over seven years was 24.8 percent, (95 percent confidence interval, 18.6 to 30.6 percent; P<0.001).

On the finasteride arm, higher-grade tumors of Gleason grades 7 through 10 were more prevalent than on the placebo arm. High-grade tumors accounted for 37 percent of the disease found on the finasteride arm, compared to 22.2 percent on the placebo group.

It is unclear whether the high-grade disease on the finasteride arm will behave as aggressively as high-grade disease not treated with finasteride, experts say. The trial's principal pathologist, Scott Lucia, of the University of Colorado Health Sciences Center, said there are three possible explanations for higher Gleason scores on the finasteride arm.

"It could be that finasteride favors the growth of high-grade cancers," Lucia said at the press conference.

Alternatively, finasteride may interfere with the appearance of prostate cancer, and the tumors that seem to be high-grade may actually be less aggressive, Lucia said.

"We know that more aggressive anti-androgen therapy does alter the appearance of prostate cancer, making the tumors look high-grade, when they actually are not," he said. "Could this be occurring with finasteride, too?"

A third possibility is more mechanical: tumors that are not responsive to finasteride become easier to detect as the agent shrinks the prostate.

"If you have a tumor that is no longer responsive to finasteride, and if your gland is shrinking, then relative proportion of tumor size unaffected by finasteride to gland size increases, and therefore, it would be easier to detect when you put a needle in," Lucia said.

**Next: "An Explosion of Scientific Knowledge"**

The 24.4 percent incidence of prostate cancer on the placebo arm was more than fourfold the 6-percent incidence that researchers expected to encounter.

PSA and DRE screening led to the diagnosis of 571 tumors found on the PCPT placebo arm, but failed to detect another 576 tumors that were found through end-of-study biopsies.

"This is the first study that carefully followed men over a prolonged period of time with annual PSA and rectal examinations," said Ian Thompson,

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chairman of the urology division at the University of Texas Health Sciences Center at San Antonio and principal investigator on the study.

"One of the advantages of PCPT is that it sets a foundation for an explosion of scientific knowledge," Thompson said at the press conference. "What are the cancers like in men with normal PSAs? Historically, about a third of all prostate cancers detected in the US are in men with normal PSAs."

Presumably, the explosion of scientific knowledge would result in new approaches to evaluating clinical significance of prostate cancers found through screening.

The finding that an arbitrary needle biopsy has a one-in-four chance of leading to a prostate cancer diagnosis became fodder for humor among the *cognoscenti*.

"On the way to Washington, on the airplane, Ian announced to me that on Monday he has an open slot for my prostate cancer biopsy," quipped Charles Coltman, SWOG chairman, responding to a reporter's question. "Not PSA, but a biopsy."

**Questions About Screening**

The PCPT results demonstrate the limitations of screening for prostate cancer, said Otis Brawley, an oncologist at Emory University, who took part in designing PCPT 10 years ago.

"If you take a low-risk group of men in their early 60s, and you rigorously screen them for seven years with PSA and DRE, you will diagnose over 12 percent of them with prostate cancer, and then you will miss half the prostate cancer," Brawley said to **The Cancer Letter**.

"It says that the sensitivity of PSA and DRE is at best 50 percent, and that the specificity is even worse," Brawley said. "In the UK, where there is no screening, 3 percent of all men die of prostate cancer. If you diagnose 24 percent of men with prostate cancer, yet only 3 percent of men die from prostate cancer, that means that there is a hell of a lot of prostate cancer that we are diagnosing that does not need to be treated."

Unlike Brawley, Thompson is not ready to condemn screening.

"PSA screening has revolutionized the management of prostate cancer in the U.S.," he said at the press conference. "When I first began in this process, men walked in with bone pain, who have lost 30 pounds. It has dramatically changed the diagnosis, but there are many questions that remain unanswered. The potential to answer the question of how we can use PSA to identify cancers that are biologically significant is an additional effect of this trial."

The trial included the end-of-study biopsies primarily to make sure that finasteride didn't obscure cancers by lowering the PSA. The analysis of PSA in the placebo arm was a secondary endpoint.

Finasteride is approved for the treatment of benign prostatic hyperplasia and male pattern baldness, and can be prescribed off-label.

**Relevance in the Clinic**

Physicians express a range of opinions on finasteride's usefulness in the clinic.

"If I were sitting with a man who is at risk, as a physician, as a urologist, there are several important things that need to be done," Thompson said at the press conference. "No. 1 is to assess his risk. Second step is to assess the potential side effects or benefits that are not related to prostate cancer prevention.

"As we demonstrated in this study, urinary complications were less in men receiving finasteride, whereas sexual complications were more common," Thompson said. "So, a man who has significant urinary symptoms and who is sexually inactive stands to benefit more than a man who has no urinary symptoms and is sexually active."

Peter Scardino, chief of urology at Memorial Sloan-Kettering Cancer Center, said the agent should not be used for lowering the risk of the disease.

"On the balance, finasteride does not seem to be an attractive agent for the chemoprevention of prostate cancer," Scardino wrote in an editorial in the New England Journal of Medicine.

"Although it reduced the cumulative incidence of cancer in the PCPT trial, the reduction was relative to the incidence in a control group in which biopsy was recommended for all men regardless of risk factors—an approach that is destined to lead to the overdetection of histologically identified cancers of little clinical significance," Scardino's editorial continued.

"We do not know the malignant potential of such cancers and have no evidence that any benefit would be worth the risk associated with the treatment," Scardino wrote. "Furthermore, the study results suggest that finasteride may accelerate the growth of high-grade cancers, which may pose a thereat to life and health if they are not treated successfully.

"Finally, the effects of finasteride on sexual

function lessen the attractiveness of the drug as a preventive agent," Scardino wrote.

**SWOG Proposes Follow-Up Studies**

Limitations notwithstanding, PCPT has compiled pathology samples that can be correlated with the outcomes.

"The men who participated in PCPT have left behind an incredible legacy of blood samples, prostate tissue, and tumor samples, and we have assembled a world-class group of scientists to use these materials and explore on a molecular level who is at risk for prostate cancer, and how does finasteride modify this risk, and in which men," said Leslie Ford, associate director for clinical research at the NCI Division of Cancer Prevention.

The trial has produced a serum bank from the longitudinal series of blood samples. The tissue samples taken at the time of biopsy are fixed in formalin and stored at the University of Colorado.

"In the beginning, the question was, can we prevent the onset of prostate cancer?" said pathologist Lucia. "The answer is yes. Now, we have raised some questions about the grades of tumors, who can respond, and when, and why. Those questions could take many more years to answer."

SWOG investigators are applying for an NCI program project grant to analyze the pathology and to follow the patients.

The technology for evaluation of small tissue samples obtained through needle biopsy is emerging rapidly, said Steven Shak, chief medical officer of Genomic Health Inc., a Redwood City, Calif., company that specializes in individualized genomic analysis of tumor biopsies.

"We have successfully examined expression profiles in formalin-fixed cancers of other tissues, including breast, lung, colon and head and neck, and I am confident that this can be applied to prostate cancer as well," Shak said to **The Cancer Letter**.

Genomic Health was able to analyze tissues going back to the 1970s, Shak said.

"We are excited and confident that this can be applied to small amounts of tissue in prostate cancer," he said. "Even if we can't do it today, it's not going to be a long time from now."

The trial's informed consent documents permit the analysis of pathology samples.

"This is a $60-million trial," said Brawley, who was involved in designing the trial when he was a program director at the NCI Division of Cancer Prevention and Control. "From the start, we decided that if we don't show that finasteride prevents prostate cancer, let's learn something anyway."

Finasteride's sponsor, Merck, appears to be preparing a filing to FDA, Coltman said.

"I hold the IND for finasteride, and I sent a copy of an early draft and the subsequent manuscript to FDA, so they could be prepared to address the question for expedited review, and we have Merck people in the audience who are planning that adventure," Coltman said.

The study is emblematic of the contribution of the cooperative groups, said Brawley.

"The PCPT findings are the work of and tribute to the NCI-supported cooperative groups," he said. "This is the kind of important work that cannot be accomplished without them. All of us are in debt to the men who volunteered and participated and the hard work of the members of SWOG, the Eastern Cooperative Oncology Group and the Cancer and Leukemia Group B."

NCI Director Andrew von Eschenbach did not attend the press conference. According to a spokesman, the Institute director, who is both a urologist and a cancer survivor, had a previous commitment.

"He had a long-standing speaking engagement for that morning at the Hispanic/Latino Genetics Community Consultation Network summit meeting," Caroline McNeil, an NCI spokesman, said to **The Cancer Letter**. "This was the first nationwide conference to address genetics issues significant to Hispanic/Latino populations."

According to the agenda of the three-day conference, von Eschenbach was part of a panel discussion that began at 10:45 a.m., June 24, at the Hyatt Regency Washington on Capitol Hill.

The PCPT press conference began at 10 a.m., at the National Press Building, about a five-minute cab ride from the Capitol Hill Hyatt.

Both events were sponsored by NCI.

*In Congress:*

## Cancer Groups Criticize Prescription Drug Bills

A dozen cancer organizations this week criticized provisions in the House and Senate Medicare prescription drug bills that would reduce coverage for chemotherapy drugs and other cancer care.

"Instead of expanding access to live-saving

drugs, these bills would severely limit access to cancer treatments for some of the most seriously ill Medicare beneficiaries," said Ellen Stovall, president and CEO of the National Coalition for Cancer Survivorship.

The provisions in the bills would dramatically cut Medicare reimbursement for chemotherapy, without adequately increasing reimbursement for patient care services, such as for oncology nurses, pharmacists, equipment, counseling, and patient support. If these provisions were to be enacted, most private oncologists and many hospitals would not be able to afford to provide outpatient chemotherapy to Medicare beneficiaries, the Cancer Leadership Council said. More than 80 percent of people with cancer receive their care in an outpatient setting, the council said.

"The millions of cancer patients in this country who rely on Medicare need to know that their access to care will be severely disrupted if these bills go through," said Susan Braun, president and CEO of the Susan G. Komen Breast Cancer Foundation.

While cancer drugs are reimbursed at rates higher than their actual cost to physicians, Medicare under-reimburses for necessary patient services. Cancer organizations have been advocating for years to fix the system.

"The system is broken and in need of repair," said Margaret Tempero, president of the American Society of Clinical Oncology. "But to address one side of the equation and not the other is a losing formula for cancer patients."

The CLC and ASCO support Senate bill S. 1303, the Quality Cancer Care Preservation Act, introduced last week, and a companion bill in the House, H.R. 1622, which would provide "appropriate and balanced reform of Medicare reimbursement for outpatient cancer services," ASCO said.

ASCO has urged its U.S. members to contact their representatives. Further information is available at http://capwiz.com/asco/home/.

* * *

**NIH Appropriations:** The Senate Appropriations Committee's Subcommittee on Labor, Health and Human Services, Education and Related Agencies approved a fiscal 2004 increase for NIH of $1 billion, or 3.7 percent, over the current $26.98 billion budget.

The proposal was scheduled for markup at the full committee on June 26.

The House Appropriations Committee earlier this week approved $27.66 billion for NIH.

*Pharmaceutical Industry:*

## AstraZeneca To Pay $355M In Illegal Pricing Penalties

AstraZeneca Pharmaceuticals LP agreed to pay $355 million as part of criminal charges and civil liabilities in an alleged scheme involving illegal pricing and marketing of the prostate cancer drug Zoladex.

Under an agreement announced June 20:

—AstraZeneca pleaded guilty to criminal conspiracy to violate the Prescription Drug Marketing Act by causing Medicare, Medicaid and other federal providers to be overcharged for Zoladex that had been provided as free samples to urologists. As part of the plea agreement, the company agreed to pay a $63,872,156 criminal fine.

—AstraZeneca also agreed to settle its civil liabilities and to resolve allegations that its fraudulent drug pricing schemes and sales and marketing misconduct had caused false and fraudulent claims to be filed with federal and state health care programs.

The agreed payments are $266,127,844 to the federal government for claims filed with the Medicare, TriCare, Department of Defense and Railroad Retirement Board Medicare programs, and $24.9 million to the federal and state governments for claims involving state Medicaid programs.

The federal investigation found that AstraZeneca employees were using several illegal methods to stimulate the demand for Zoladex. The company provided thousands of free samples of Zoladex to physicians, knowing they would charge their patients and insurance programs for the samples, the government said. The company also inflated the price of Zoladex reported to Medicare as the basis for reimbursement, while deeply discounting the actual price charged to the physicians, the government said.

The investigation, which is continuing, also resulted in charges against three physicians of conspiring with AstraZeneca to bill patients and third-party payers for free Zoladex samples. Two of the prescribers have pleaded guilty.

* * *

The merger of the FDA's drug center with certain biologic product review functions is on track to be completed by June 30, FDA Commissioner Mark McClellan said.

Further information is available at www.fda.gov/bbs/topics/ANSWERS/2003/ANS01231.html.

*GAO Report:*

## Taxol CRADA "Successful," But Not Great Financial Deal

NCI's 1991 Cooperative Research and Development Agreement with Bristol-Myers Squibb Co. for Taxol, one of the first such agreements to result in a "breakthrough" drug, did not result in large financial benefits for NIH compared to the company's revenues from the drug, but the agreement serves as "an example of a successful collaboration between the public and private sectors in pharmaceutical technology transfer," a report by the General Accounting Office concludes.

The CRADA provided BMS with "unlimited access to NIH research results that were critical to BMS' ability to quickly receive FDA approval to market Taxol," the report said. FDA approved Taxol for ovarian cancer treatment in 1992. It has been approved for breast and lung cancer, and AIDS-related Kapoci's sarcoma.

Also, the company supplied Taxol to NCI, allowing the Institute "to dramatically expand its paclitaxel research," the report said.

Tallying up the expenditures and payments, GAO found that:

—NIH spent $183 million on all Taxol research from 1977 through the end of the CRADA in 1997, and $301 million from 1998 to 2002.

—NIH spent $96 million for clinical trials supporting the CRADA, offset by a $16 million payment from BMS.

—The value of the Taxol that BMS supplied to NIH was about $92 million, allowing NCI to provide the drug to 28,882 patients in clinical trials over the course of the CRADA.

—The company's Taxol sales totaled more than $9 billion from 1993 to 2002.

—Royalty payments to NIH, at a rate of 0.5 percent, have come to $35 million.

—Medicare payments for Taxol totaled $687 million from 1994 to 1999.

The report noted that several factors affected NIH negotiations with BMS. "First, NIH did not have a patent on Taxol and thus could not grant an exclusive patent license to a CRADA partner," the report said. "Second, in NIH's evaluation, it was limited by a shortage of available, qualified alternative CRADA partners."

The report was done at the request of Sen. Ron Wyden (D-OR). In a June 6 statement, Wyden said NIH "dropped the ball" in negotiations with BMS. "Because NIH didn't use its power to get a better deal for taxpayers and patients, Medicare has paid more than a half-billion taxpayer dollars to buy a taxpayer-funded drug for the taxpayers who funded it," he said.

The report, "Technology Transfer: NIH-Private Sector Partnerships in the Development of Taxol," is available at www.gao.gov/cgi-bin/getrpt?GAO-03-829. A one-page summary is available at www.gao.gov/highlights/d03829high.pdf.

Wyden's statement is available at http://wyden.senate.gov/media/speeches/2003/06062003_taxol_statement.html.

*Letter to the Editors:*

## AACR Defends Policy Paper And Work Of Barker, Sigal

To the Editors:

We read with great concern your May 30 cover article, "NCI Deputy Barker Hits FDA, Calls for New Incentives for Pharmaceutical Industry," in which you criticize the AACR Task Force Report, "Treatment and Prevention of Intraepithelial Neoplasia–An Important Target for Accelerated New Agent Development," published in the February 2002 issue of Clinical Cancer Research, as well as the members of the cancer community who are advocates for the evaluation of surrogate endpoints in cancer prevention. The article you published contains many inaccuracies and lacks objectivity.

Cancer remains a major public health problem. Clearly, we are in great need of new strategies to prevent and cure cancer. One such strategy was spelled out in the above-cited AACR Task Force Report. This peer-reviewed paper recommended "focusing on established precancers as the target for new agent development because of the close association between dysplasia and invasive cancer and because a convincing reduction in IEN burden provides patient benefit by reducing cancer risk and/or by decreasing the need for invasive interventions."

The use of surrogate endpoints for drug approval is open to legitimate differences of opinion among scientists. This expert Task Force proposed several clinical trial designs that "provide practical and feasible approaches to the rapid development of new agents to treat and prevent precancer." The report was written to open a dialogue among scientists, government officials, members of the pharmaceutical

industry, and cancer survivors on what many cancer researchers believe to be a new and highly promising area of investigation.

Your article misrepresented the content of the position paper by stating: "For those who worry about 'the risks of giving medicine to seemingly healthy people—including those with precancers,' AACR has a prescription: look at cardiovascular disease and don't worry."

Although our experts believe the history of drugs approved to treat cholesterol and hypertension, which lower the incidence of heart disease, offers some lessons for how we might begin to prevent lethal cancers, in no statement or report does the AACR or the Task Force recommend a policy of "don't worry," as you paraphrased. Nor is there any suggestion by the AACR that physicians violate their primary commandment, "First, do no harm," when it comes to the development and administration of any new chemopreventive agents. The Task Force Report states: "Clearly, the IEN treatment studies must monitor patient safety and efficacy long enough to ensure that risks associated with the agent do not exceed its benefit. Alternatively, the agent's long-term safety must have been evaluated in other patient populations."

The authors of the AACR Task Force Report are in the mainstream of high-quality science; they are over 50 of the world's leading experts from all sectors and in all fields of cancer prevention, from basic to clinical. They have spent their careers studying the biology of cancer and its progression, and they keenly understand the complexities of molecular targets, along with drug discovery and development. All of the relevant scientific issues you raised in your article have been taken into consideration in their deliberations.

A newly formed AACR Task Force on Cancer Prevention, chaired by Dr. Waun Ki Hong, with more than 25 leading experts in a variety of disciplines, will continue to focus on chemoprevention as an effective way of reducing cancer incidence and mortality. This Task Force will delineate a comprehensive cancer prevention strategy that includes consideration of promising scientific work in the treatment and prevention of intraepithelial neoplasia. The science on this subject is progressing rapidly, and we expect that more articles will be published in the near future to support such new strategies in cancer prevention.

Regarding the NCI Director's "Vision for 2015," ambitious goals are often at first viewed with skepticism. Certainly the elimination of death and suffering due to cancer by the year 2015 is a huge challenge to the cancer community. But which is worse: the disappointment of failure, or the failure to try? The AACR applauds Dr. von Eschenbach's vision and his commitment to accelerating progress against cancer. Exploring new paradigms in chemoprevention based on excellent science is critical to reaching this goal.

Dr. Anna Barker, who recently assumed the post of Deputy Director for Strategic Scientific Initiatives at the NCI, has a unique background encompassing basic science, knowledge of the corporate sector and public-private partnerships, and remarkable achievements in her work with cancer survivors. She also served admirably for over 15 years as the Chairperson of the AACR Science Policy and Legislative Affairs Committee. In this role, she competently and selflessly gave of her personal time and energies to public education, survivor relations, and science policy, and was consistently lauded by the AACR Board of Directors, and also by numerous other cancer organizations, for her passion to conquer cancer. To label her extraordinary work that has greatly benefited cancer research and cancer patients around the world as "oncopolitics" is an injustice.

Dr. Ellen Sigal, who served with distinction on the National Cancer Advisory Board and numerous other important bodies, was also treated unfairly in your article. For decades she has been one of the most dedicated leaders in advocacy for cancer research, and her work has been pivotal to increased funding for cancer research.

The AACR will continue to collaborate with all sectors in the cancer community—academia, NCI, FDA, the pharmaceutical and biotech industries, survivor advocates, and other cancer research and clinical oncology organizations—to make advances in cancer prevention so that we can dramatically reduce cancer incidence and save lives.

**Susan Band Horwitz**, President
**Karen Antman**, President-Elect
**Waun Ki Hong**, Past President
**Margaret Foti**, Chief Executive Officer

*The Cancer Letter responds:*

*Our story distinguished the AACR position statement on "precancers" from the IEN paper on which it was based. We demonstrated that the AACR recommendation to change the criteria for*

*drug approval reaches beyond the scope of the IEN paper on which it was based.*

*According to the position statement, in the past, "many worried about the risks of giving medicine to seemingly healthy people—including those with precancers—to prevent them from getting sick.... However, this attitude clearly has changed with the treatment of other life-threatening conditions such as cardiovascular disease.... The AACR now believes that reducing precancers lowers cancer risk.... AACR believes the link between some precancers and invasive cancers—particularly in certain high-risk populations—is so clear that drug developers should only be required to prove their proposed medicines are safe and effective in treating or preventing the evolution of precancer to cancer."*

*As the above letter suggests, this is a complicated area of inquiry that requires rigorous study. That was the point of our story.*

*The story traced in detail Barker's and Sigal's work in cancer policy, using the term "oncopolitics" to refer not only to their work, but generally to activities related to the politics of cancer research, including advocating for funding or policy change. We don't agree that using the term demonstrated unfairness.*

*Finally, we take this opportunity to point out that science policy, especially when it involves public health and expenditure of public funds, is not above public scrutiny.*

*We stand by the story.*

*In Brief:*

## Talpin To Join NCI; Pat Barr, Early NBCC Activist, Dead

(Continued from page 1)

multidisciplinary scientist for cancer screening evaluation and implementation in the Applied Research Program of the Division of Cancer Control and Population Sciences. Talpin is an affiliate investigator at the Fred Hutchinson Cancer Research Center and serves as principal investigator for the Group Health Cooperative site in the National Breast Cancer Surveillance Consortium, an NCI initiative to evaluate the performance of mammography in clinical practice. He is PI of the Detecting Early Tumors Enables Cancer Therapy study, a component of the NCI Cancer Research Network. Talpin also is chairman of the Health Disparities Collaborative on Cancer Screening Promotion and Follow-Up Management, sponsored by NCI and the Health Resources and Services Administration. . . . **PATRICIA BARR**, one of the original directors of the National Breast Cancer Coalition, who was instrumental in obtaining Congressional approval for increases in government funding for breast cancer research, died June 19. She was 52 and had metastatic breast cancer. Barr, a lawyer and resident of Shaftsbury, Vt., was a member of the NCI Informed Consent Working Group that established national standards for participants in cancer clinical trials and served as a member of the Commission on Genetic Testing Task Force under HHS Secretary Donna Shalala. At the time of her death, she was the co-chairman of Americans for Peace Now and a board member of the Reconstruction Rabbinical College in Philadelphia. She co-founded the law firm now known as Barr, Sternberg, Moss, Lawrence, Silver & Saltonstall, in Bennington, and served on the State Board of Bar Examiners for six years. She was appointed to the State Board of Education for two terms, and served on the Vermont Task Force on Gender Bias in the Legal System. . . . **GILBERT BEEBE**, an NCI epidemiologist and statistician known for his studies of populations exposed to ionizing radiation, died March 3 at age 90. He had retired last year as head of the Chornobyl Research Unit. Beebe began his research career after World War II, working with **Michael DeBakey** to create the Medical Follow-up Agency at the National Academy of Sciences, which Beebe directed until 1977. He also worked on the Atomic Bomb Casualty Commission, documenting the effects from the 1945 atomic bombings of Hiroshima and Nagasaki. Beebe spent seven years in Japan as the ABCC's statistics chief. In 1977, Beebe joined NCI. After the Chornobyl accident in 1986, he led an international study of thyroid cancer and leukemia risk among radiation-exposed populations in Belarus and Ukraine. Last year, the Department of Energy, NCI, and the NAS Board on Radiation Effects Research established the Gilbert W. Beebe Fellowship in Radiation Sciences. The fellowship provides support for recipients to work at NCI and NAS. The NAS commemorated the occasion last summer by sponsoring the first annual Gilbert Beebe Scientific Symposium; the second symposium will be held in July. The REB started a memorial fund in Beebe's name, which will be used for travel awards for young investigators attending the Radiation Research Society Annual Meeting.

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