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Study Tests A "Truth" In Radiation Oncology, Raises Questions About Anemia Treatment

Michael Henke, a radiation oncologist at the University of Freiburg, Germany, set out to demonstrate that correction of anemia improves outcomes in cancer therapy.

In 1997, Henke launched a randomized, placebo-controlled trial to test one of the truths taught in medical school: that increasing the level of oxygen in the blood makes tumors more sensitive to radiation, which likely translates into greater efficacy. A similar belief, albeit not so clearly articulated, lurks in the background in medical oncology.

The trial called for giving erythropoietin to head and neck cancer

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In Brief:

MSKCC Picks David Kissane To Succeed Jimmie Holland As Psychiatry Chairman

DAVID KISSANE was named chairman of the Department of Psychiatry and Behavioral Sciences at Memorial Sloan-Kettering Cancer Center. He replaces **Jimmie Holland**, founder of the field of psycho-oncology, who decided to step down after 26 years.

Kissane will be responsible for a broad program of services, research, and training in the diagnosis and treatment of psychiatric problems related to cancer and its care. He plans to expand the department's psychological assessment and intervention services across MSKCC's 17 multidisciplinary Disease Management Teams.

"Since Dr. Holland expressed a desire, about three years ago, to step down from her administrative responsibilities, Memorial Sloan-Kettering has been seeking a successor," said **Robert Wittes**, MSKCC physician-in-chief. "We sought an individual whose leadership, academic achievements, and clinical skills would insure the department's status in the front rank of psycho-oncology units worldwide, as well as advance its programs in the behavioral sciences relating to cancer. At the conclusion of the process, Dr. Kissane was the search committee's unanimous choice. His breadth of interests in the full range of issues in psycho-oncology will serve our patients and the institution well."

Kissane received his medical degree from the University of Melbourne and completed his residency and fellowship at St. Vincent's Hospital in Melbourne. In 1987, after several years of family medicine practice, he joined the faculty at St. Vincent's as clinical instructor in psychiatry and then joined the Department of Psychological Medicine at

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Agent Corrected Anemia, But Didn't Improve Survival

(Continued from page 1)

patients who were mildly anemic in order to maintain their hemoglobin level in the normal physiologic range (14 g/dL for women, and 15 g/dL for men) and test whether their outcomes would improve. Generally, erythropoietin can be given to cancer patients after their hemoglobin dips below 11.7 g/dL, but many physicians wait till hemoglobin drops below 10 g/dL, or even 9 g/dL.

The stakes were high for the agent's sponsor, F. Hoffmann LaRoche. Henke's data had the potential to find another reason for administering erythropoietin, improving efficacy of radiation, and expanding what is now an $8.1 billion global market for the agents. The standard rationale for giving erythropoietin to cancer chemotherapy patients is to reduce the need for blood transfusions and improve the quality of life.

"I was a strong believer, but sometimes you see different things," Henke reflected in an interview with **The Cancer Letter**.

Instead of strengthening Henke's faith in erythropoietin, the results shook it. The randomized, placebo-controlled trial which enrolled 351 patients receiving radiation showed that erythropoietin corrected anemia, but didn't improve survival or tumor control.

"Despite a reliable rise in hemoglobin concentrations, we saw no benefit for locoregional progression-free survival, locoregional progression, or survival," according to Henke's paper, published in The Lancet on Oct. 18. "On the contrary, patients given placebo fared significantly better…" The patients received epoetin beta, marketed by Roche under the trade name NeoRecormon.

Now, Henke is hypothesizing that he may have encountered a biological phenomenon that may have implications far beyond his cohort of patients. "I think it's time for the laboratory now," he said. "It's not time for the clinics."

Meanwhile, as a clinician, Henke said he would no longer prescribe erythropoietin in a potentially curative setting, but would consider using it for palliation.

"If you have a young lady with localized breast cancer, in a so-called neo-adjuvant setting, I wouldn't give her erythropoietin," he said. "If you have a patient with metastatic breast cancer, and she is feeling bad because she is anemic, you might as well go ahead and give her erythropoietin, so she is feeling better. If this shortens her life by a couple of weeks, I don't have a problem with discussing it with her. She would feel better for a shorter period of life; why not? That's a deal, and if the patient is okay with that deal, that's okay."

Henke's study is significant because it asks a fundamental question in radiation oncology, experts say. The results appear to be particularly interesting because they appear at a time when several trials examining the consequences of using a Johnson & Johnson erythropoietin to keep hemoglobin in the normal range were suspended after detecting an increased level of thrombotic events.

At the same time, the Centers for Medicare and Medicaid Services is trying to pinpoint a proper level of reimbursement for Aranesp, the Amgen version of erythropoietin, while also adjusting reimbursement for all cancer drugs infused by oncologists in their offices. Considering that erythropoietin generates greater revenues than any other product in oncology, any examination of its efficacy is certain to get attention.

Spokesmen for Amgen and J&J, two major rivals in the battle of erythropoietin products, point out that Henke's trial was performed with a Roche agent, which differs from theirs. Indeed, comparisons between these agents may not be straightforward. Also, the patients received care that wouldn't be

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considered state-of-the art in the U.S. today, several critics said.

Still, clinical scientists are intrigued. "This trial is interesting, it's worth noting," said Charles Loprinzi, chairman of medical oncology and principal investigator of the Community Oncology Program research base of the North Central Cancer Treatment Group. Though the results show no improved efficacy of radiation in patients whose anemia is kept in the normal range, the hypothesis has not been laid to rest, Loprinzi said.

"Maybe the hypothesis is wrong, and oxygenation does not help," Loprinzi said. "Or maybe the hypothesis is true, and erythropoietin does something otherwise that's bad. You can't put that hypothesis to rest, because you don't know the mechanism by which the erythropoietin arm seems to be doing worse. It might be that there is something intrinsic about erythropoietin that's counteracting the increased oxygenation that might be doing good."

Walter Curran Jr., chairman of the Radiation Therapy Oncology Group, said the Henke study doesn't address the approved uses of erythropoietin. "It doesn't make us rethink any of the appropriate uses of this agent," Curran said. "It just tells us that an attempt to gain a further advantage with therapy of head and neck cancer has clearly been demonstrated in this trial to be non-advantageous."

Erythropoietin agents aren't indicated for use in conjunction with radiotherapy for enhancing tumor control. "That's a very different setting than someone who becomes anemic as a result of cancer therapy, and you salvage them with an agent like erythropoietin from a very low hemoglobin in single digits to a normal range," said Curran, professor and chairman of radiation oncology at Thomas Jefferson University, and clinical director of the Kimmel Cancer Center of Jefferson Medical College. "That's different from this study, which was bringing people who typically would not be corrected up into the high normal range."

Standard rationale for using erythropoietin remains intact, Curran said. "Clearly, there is well documented evidence that quality of life of patients is improved when they are receiving palliative cancer therapy of any kind if their anemia is corrected, and there is certainly nothing about this study that should discourage that FDA-approved use," he said.

Henke predicts that his study would likely support the quality of life benefit, when those results are analyzed. However, he is surprised to see the oncology profession move beyond the fundamental questions about erythropoietin to refining administration regimens for its various versions.

"Nobody really has ever studied survival and tumor control," Henke said. "When we prescribe a drug to cancer patients, we have to look at the so-called hard endpoints. We are just obliged. Thousands of people have been treated, and no one has seriously looked at those hard endpoints."

The results in Henke's study differ from population to population. The subgroups receiving postoperative radiation for incompletely resected disease and primary definitive radiotherapy fared better on placebo than on epoetin beta. "Furthermore, epoetin beta had a particular negative impact on outcome of patient with cancer of the hypopharynx," the paper states.

This is puzzling, experts say. "I am, personally, at a total loss to explain that," Curran said. "In those patients with the lower tumor burden—those are the patients that had a complete resection and postoperative therapy—there really was no adverse therapeutic effect. But in the patients with greater tumor bulk—the incompletely resected and the unresected—there clearly was an adverse effect of therapy.

"I can think of a couple of theories. No. 1, that head and neck cancer patients are a very heterogeneous group in terms of prognosis and staging, and maybe there is an unequal distribution, despite the investigator's best efforts or prognostic factors, and No. 2, that there was something about the agent that contributed to the adverse effect," Curran said.

Henke attributes his findings to a biological phenomenon rather than a methodological flaw.

"I don't think our results will be explained by methodological pitfalls," he said. "We controlled almost for everything. It was randomized. It was placebo-controlled. It was blinded. What else do you want? We even had a decent number of patients. We had 351. We are left with the hypothesis that we might have encountered a biological phenomenon."

Hence, Henke's next question: Why did correction of anemia fail to produce greater efficacy? What is the real mechanism of the hemoglobin effect?

"The hemoglobin effect is like Cinderella," Henke said. "It's sitting in the corner, and nobody really looks at it, but it's a very potent prognostic factor, and very easy to determine. You just draw a blood sample, and if the patient has hemoglobin of 10 d/gL, you know he has poor prognosis. In addition to

that, I don't know why there is a correlation between low hemoglobin and poor prognosis."

Henke offers a hypothesis:

"Originally, the hemoglobin effect was thought to directly alter cancer treatment, particularly radiotherapy. Low hemoglobin concentrations reduce tumor oxygenation, amplify tumor hypoxia, and might decrease, via the oxygen effect, radiosensitivity.

"Conversely, erythropoietin activates potent antiapoptotic pathways that promote erythropoiesis and protect from damage in non-hemapoietic cells. Furthermore, breast cancer cells express erythropoietin receptors that are functional, and therefore there is increasing evidence that tumor cells use the erythropoietin system for growth and angiogenesis. Thus, antiapoptotic mechanisms activated by endogenous anemia-released erythropoietin could also explain the hemoglobin effect.

"This scenario clearly is not restricted to radiotherapy and may account for unfavorable clinical results in anemic patients after surgery or chemotherapy, and eventually correspond with the observations of this study."

This engenders a maybe/maybe-not reaction from clinical researchers. "I am just not in a position to know whether this is just speculation by Dr. Henke," said Curran, who nonetheless enthusiastically agrees that the controversy could benefit from bench research. "Clearly, translational research involves not just bench-to-bed, but bench-after-bed," Curran said. "When we get a discordant result with our hypotheses, going back and testing it in the laboratory is a terrific idea."

At least one other publication, a letter that appeared in the August issue of The Lancet Oncology, reported an adverse effect on survival in a study that sought to maintain a normal level of hemoglobin among 939 patients with metastatic breast cancer.

The trial, which sought to assess the effect of 12 months of treatment on survival, was terminated early, after the data and safety monitoring board found a statistically significant increase in mortality in a group treated with Eprex, an erythropoietin marketed by J&J, wrote Brian Leyland-Jones, of McGill University.

Leyland-Jones reported that there were 41 deaths in the Eprex group, compared to 16 in the placebo group. "The observed difference in the number of early deaths was mainly due to an increase in incidence of disease progression in the Eprex group, compared with the placebo (6% vs. 3%) as well as an increase in the incidence of thrombotic and vascular events in the Eprex group (1% vs. 0.2%)," Leyland-Jones wrote.

Robert DeLap, vice president, global regulatory affairs, at J&J Pharmaceutical Research & Development, L.L.C., said the company encouraged publication of this negative result.

"This publication as a letter to the editor was deemed important to quickly make this information publicly available," DeLap said. "A more complete publication of these results is in preparation, to make additional details available to the medical-scientific community."

Another paper, by T.J. Littlewood, published in the June 1, 2001, Journal of Clinical Oncology, concluded that epoetin alpha "safely and effectively ameliorates anemia and significantly improves quality of life in cancer patients receiving non-platinum chemotherapy." The study wasn't powered to detect survival, but secondary analysis suggested a survival advantage.

"If the reports in literature went exactly the opposite way, and erythropoietin was on top, would people be claiming that erythropoietin prolongs survival? I hope not," said Loprinzi. "I don't think the data we have are enough for us to say that erythropoietin improves survival or inhibits survival."

It's also possible that Henke may have pinpointed the pitfall of using erythropoietin to raise hemoglobin to the normal range.

In recent weeks, several U.S. cooperative groups suspended clinical trials or made dose adjustments of the J&J epoetin alpha after finding an increased risk of thrombosis among patients receiving erythropoietin intended to increase hemoglobin to the normal range.

The problem first surfaced in August, when a trial of erythropoietin in patients who were not anemic was closed by a data and safety monitoring board because of increased vascular thrombotic events in patients on the active therapy arm, sources said.

Subsequently, J&J found a similar problem in a study by the Gynecologic Oncology Group (GOG-0191), a phase III trial evaluating "the efficacy of maintaining hemoglobin levels above 12 g/dL with erythropoietin versus above 10 g/dL without erythropoietin in anemic patients receiving concurrent radiation and Cisplatin for cervical cancer."

"Preliminary analyses of recent data, from GOG-0191 and other investigational oncology

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studies, suggest that there is an increased risk of thrombotic vascular events when epoetin alpha is administered to patients with cancer treated with chemotherapy with or without radiation therapy with hemoglobin levels that are higher than the levels specified in current product labeling," stated a Sept. 29 letter that announced suspension of the GOG trial. "In these studies, the frequency of TVEs was higher than expected in patients being treated with epoetin alfa, compared to patients not receiving epoetin alfa."

Similar problems were found in a Canadian trial in small cell lung cancer, sources said.

On Oct. 1, RTOG temporarily closed its trial 99-03, "a randomized phase III trial to assess the effect of erythropoietin on local-regional control in anemic patients treated with radiotherapy for carcinoma of the head and neck."

The notice said that "no… excess adverse events have been observed in RTOG 99-03." However, "epoietin alpha should be discontinued for all patients enrolled in RTOG 99-03 who are currently receiving it."

Curran said the RTOG review of the study didn't demonstrate excessive toxicity, but the trial was suspended and administration of the agent stopped. "FDA has asked for an update of our trial—perhaps along with other trials—and we are preparing that information this week," Curran said.

After learning about the toxicity, the North Central Cancer Treatment Group altered its protocol NO2C2, which compares administration regimens of erythropoietin alpha.

The protocol called for stopping erythropoietin after the hemoglobin level reached 15 g/dL, and resumed after it dropped to 13 g/dL.

"Because of this new information coming out, and concerns that as you get to hemoglobin levels greater than 13 g/dL, you are getting into clotting troubles, the new recommendation was for us to change our protocol, so now the patient stops at the hemoglobin level of 13 g/dL, not 15 g/dL, and cannot restart until their hemoglobin drops below 12 g/dL," Loprinzi said.

DeLap confirmed that the company is no longer sponsoring studies that elevate hemoglobin into the normal range.

"We have observed that treatment of cancer patients with hemoglobin levels above the range specified in approved labeling may be associated with an increased frequency of side effects," DeLap said. "For this reason, we are not currently sponsoring clinical research trials in this area. We are very interested in learning more details of findings from studies of other erythropoietic agents, including the study of Henke *et al.*, so that we can better understand and learn from the experiences of other companies with agents in this class."

It's not clear who, if anyone, would be willing to ask the fundamental questions about the role of erythropoietins in the treatment of cancer.

Henke is not optimistic about finding a pharmaceutical company to sponsor the current phase of his research. "In order to disprove this trial, you have to conduct another one," Henke said. "Our expectation would be that you would get negative results. Who is going to pay for that, with a negative result?"

NCI was recently pulled into the fight between J&J and Amgen, and by HHS to conduct a trial that would help set the reimbursement for Amgen's agent Aranesp. Sources said that NCI and the cooperative group investigators decided to answer the question posed by HHS in the context of more fundamental questions (**The Cancer Letter**, Dec. 13, 2002).

However, planning for the NCI study appears to have stopped soon after it began, sources said. "I know of no indication that that's moving forward at this time," said one academic oncologist who was involved in designing the trial. On Nov. 1, CMS is expected to publish ruling on prospective payment for drugs, including Aranesp.

Ultimately, NCI cooperative groups or public agencies outside the U.S. would have to sort out the evidence on erythropoietin, observers say.

"Cooperative groups can and do take on studies that a pharmaceutical company might not choose to do—for whatever reason," said David Johnson, deputy director of the Vanderbilt-Ingram Cancer Center, director of the Vanderbilt Division of Hematology-Oncology, and president-elect of the American Society of Clinical Oncology. "Why would a company continue to study an area that makes their product look 'bad'?

"From a business perspective, the company's desire to understand the 'why' of a failure is not as strong as their desire to 'move on' into other areas of potential success," Johnson said. "By contrast, an independent investigator may wish to explore the 'why' of a 'failure.'

"Understanding why something doesn't work can sometimes lead to better understanding of the

basis of the failure and in turn lead to better study design and possibly a 'positive' outcome. This takes time, and often it is the cooperative groups that carry out such trials.

"Cooperative groups are often more willing to take on 'risky' trials (risky from the drug company's perspective). Furthermore, cooperative groups represent the only entities large enough and well enough organized to conduct the important trials companies themselves may eschew," Johnson said.

Henke said his study appears to have generated interest outside academic oncology. "I got an enormous echo on this article," he said. "There are even a couple of lawyers that have been phoning me from the U.S.

"They are asking, 'What happens if a patient is getting one of these drugs, and he is dying earlier?'"

Funding Opportunities:

Broad Agency Announcement

N01-CO-47010-16: Novel Technologies for Noninvasive Detection, Diagnosis and Treatment of Cancer

Due Date: Jan. 21

The Unconventional Innovations Program of NCI is soliciting proposals for the development of multifunctional technology platforms to support minimally intrusive approaches that integrate: a) sensing of the fundamental signatures of precancers, or early, metastatic, or recurring cancers in the living body, b) transmission of signature information to an external monitor, c) controlled, specific, treatment, d) monitoring of the effects of treatment. The UIP particularly seeks technology platforms that integrate approaches to signature recognition, signal generation, signal amplification, signal transmission, intervention delivery, intervention feedback, and data interpretation. Proposals are encouraged from investigators from a variety of disciplines including, but not limited to, biomedical research, chemistry, physics, engineering, and computational sciences; particularly as multidisciplinary teams.

NCI anticipates awarding 8-12 contracts based on technical merit, available funds, and programmatic balance. Program staff estimates the average total annual cost (direct and indirect costs) for these contracts to be $500,000 per contract. However, it is anticipated that the total costs for each award may vary substantially depending upon the scope and capacity of the technical objectives of the award.

Text of the announcement is available at http://rcb.cancer.gov/rcb-internet/appl/rfp/published_rfps.jsp with instructions for submission of proposal and evaluation criteria. Investigators are encouraged to visit the UIP websites; http://otir.cancer.gov/tech/uip.html for a program overview, and http://otir.cancer.gov/tech/uip_awards.html for abstracts of currently funded UIP contractors.

Inquiries: Annmarie Keane, phone 301-435-3814; fax 301-402-6699; e-mail ak155a@nih.gov.

RFP Available

RFP N02-CM-37029-23: Clinical Trials and Information Management Support

Response Due: Dec. 16

The Cancer Therapy Evaluation Program of the NCI Division of Cancer Treatment and Diagnosis is seeking a contractor to provide direct organizational and data management support for specific clinical trials programs and to provide support to the CTEP Professional Staff in the acquisition, review and analysis of data and information which result from extramural clinical research and to assist in the development, planning and conduct of scientific studies and clinical trials. NCI staff may require frequent analyses and reports from the data files maintained at the Contractor's facilities, and frequent, often face to face contact (several times per week) with the Program Manager or designee(s) to discuss technical problems and to review data. The Contractor will need to access information as often as daily, that is either maintained in various files and libraries of CTEP or provided to the contractor for action at the contractor's site.

The proposed acquisition is a recompetition of contract N02-CM-97032 awarded to the EMMES Corp. It is anticipated that the effort required for this will be 93.1 productive FTEs over a period of seven years (four years with three years award term incentives) under NAICS Code 541990. The RFP is available at http://rcb.nci.nih.gov/.

Contracting officer: Doris Rosenblatt, e-mail: dr220a@nih.gov, fax 301-402-6699; tel: 301-435-3824.

Program Announcements

PA-04-012: Cancer Surveillance Using Health Claims-Based Data System

NCI and Agency for Health Research and Quality invite investigator-initiated grant applications using health claims data for cancer surveillance. This may include assessment of patterns of care, quality and outcomes of care, and health disparities across the continuum of treatment. Projects may focus on treatment and outcomes at the patient-specific level or include influences from the provider or broader health-system level. In addition, the Pa may initiate analyses to expand understanding of and methods needed to use claims data for cancer surveillance. The PA will use the NIH investigator-initiated research project grant R01 and the exploratory/developmental grant R21) award mechanism. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PA-04-012.html.

Inquiries: Joan Warren, NCI Division of Cancer

Control and Population Sciences, Executive Plaza North, Rm 4004, Bethesda, MD 20892, phone 301-496-5184; fax 301-435-3710; e-mail joan_warren@nih.gov.

PAR-04-011: Cohort Studies in Cancer Epidemiology

Letter of Intent Receipt Date: May 1, 2004; Jan. 2, 2005; Sept. 1, 2005.

Application Receipt Dates for New Applications: June 1, 2004; Feb. 2005; Oct. 1, 2005.

Application Receipt Dates for Competing Continuations Type 2, Competitive Supplements, and Revised Applications: July 1, 2004; March 1, 2005; Nov. 1, 2005

NCI Division of Cancer Control and Population Sciences announces special receipt dates for R01 grant applications from investigators intending to initiate, competitively supplement, or competitively renew population-based epidemiologic or survivorship cohort studies of human cancers. The PA would coordinate submission, review, and funding of population-based epidemiologic or survivorship cohort studies, and covers applications characterized by their cohort design and direct costs of $500,000 or more in any one study year. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PAR-04-011.html.

Inquiries: Sandra Melnick, NCI DCCPS, phone 301-435-4914; fax 301-402-4279; e-mail melnicks@mail.nih.gov.

PAR-04-009: National Cooperative Drug Discovery Groups for the Treatment of Mood Disorders or Nicotine Addiction

Letter of Intend Receipt Date: Jan. 15, 2004; Sept. 23, 2005, 2006

Application Receipt Date: Feb. 12, 2004; Oct. 21, 2005, 2006

The solicitation invites applications from academic and pharmaceutical industry investigators interested in participating with National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and NCI in a cooperative group to accelerate innovative drug discovery, the development of pharmacologic tools for basic and clinical research in mood disorders or nicotine addiction, and, in the case of mood disorders, the development and validation of models for evaluating novel therapeutics.

The particular interest of NCI Division of Cancer Prevention is discovery and development of pharmacological agents for cessation of tobacco use. The incidences of cancers of the lung, oral cavity, bladder, pancreas, and other organs are highly associated with tobacco use both in current and in former smokers. Second hand exposure to tobacco smoke may also increase the risk of developing cancers.

The PAR is available at http://grants1.nih.gov/grants/guide/pa-files/PAR-04-009.html.

Inquiries: James Crowell, Division of Cancer Prevention, NCI, 6130 Executive Blvd., Rm 2117, MSC 7322, Rockville, MD 20852-7322, phone 301-594-0459; fax 301-402-0553; e-mail jcrowell@mail.nih.gov.

Leukemia & Lymphoma Society Offers Translational Grants

Preliminary Application Deadline (submitted via Web site): March 1.

Full Application Deadline: March 15.

Leukemia & Lymphoma Society Translational Research Program provides early-stage support for clinical research intended to promote collaboration between basic and clinical scientists for work that has clinical application as a near-term goal.

Proposals should be based on epidemiological, molecular, cellular or integrated systems findings and be conceptually innovative. The application should have a clear plan for the clinical exploitation of the studies proposed.

Principal investigators may request that the society be a partner for an application to the NCI Academic Public/Private Partnership Program AP4. The application must indicate that the applicant will apply for a Translational Research Program grant through the Society's standard procedure, which, if awarded, may be used for the A4 program matching requirements.

Individuals working in domestic or foreign non-profit organizations, such as universities, colleges, hospitals, and laboratories, may submit applications. Applications from Society Scholars, investigators who are in an underrepresented minority, and women investigators are encouraged to apply.

Awards will be limited to a maximum of $130,000, which include direct costs and 8 percent overhead per year for three years. Renewal of funding for two additional years may be available from the Society. Requests for renewal of support require a competitive renewal application and must include an IRB-approved clinical trial as the centerpiece of the research plan.

Inquiries: Director of Research Administration, The Leukemia & Lymphoma Society, 1311 Mamaroneck Avenue, White Plains, NY 10605, phone 914) 821-8859; e-mail: researchprograms@tlls.org; Web site: www.leukemia-lymphoma.org.

NCI Contract Awards

Title: Radiation Dose-Response and Second Primary Cancers of Stomach, Esophagus and Pancreas: A Study of Cancer Survivors.

Contractors: Danish Cancer Society, $282,418; Finnish Cancer Registry, $132,391; University of Iowa, $83,870; Karolinska Institute, $539,927; Cancer Care Ontario, $260,735.

In Brief:

Kissane Succeeds Holland; SEER Celebrates Its 30th Year

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Monash University and Monash Medical Centre in Victoria. In 1996, he became the Foundation Professor of Palliative Medicine at the University of Melbourne, a position he held until his move to MSKCC.

He is known particularly for his work characterizing demoralization of late-stage cancer patients and distinguishing between this syndrome and depression. From 2000-2003, he served as president of the International Psycho-Oncology Society.

Kissane has a particular interest in physician-patient communication and will establish a formal instructional program at MSKCC. He also plans to expand clinical supportive care trials, neurocognitive studies of patients receiving chemotherapy, and behavioral research.

"In addition to promoting patient adaptation to illness, developing a model of family-centered care has proved challenging to clinical services, yet so needed in oncology," Kissane said. "Our family therapy trials have paved the way to achieve this through the coordinated use of the psychosocial multidisciplinary team. We plan to further develop this teamwork at Memorial Sloan-Kettering so that our psychiatrists, psychologists, social workers, chaplains, and all other healthcare workers collaborate to achieve an integrated and expanded program of supportive care services. We aim to optimize the quality of life of all affected by cancer, including those graduating as survivors, as well as those receiving palliative care or becoming bereaved."

* * *

NCI celebrated the 30th anniversary of its Surveillance, Epidemiology, and End Results Program on Oct. 16 with a scientific conference in Bethesda. The program collects and publishes cancer incidence and survival data from population-based cancer registries and supplemental registries that cover 26 percent of the U.S. population. It is the only comprehensive source of population-based information in the U.S. that includes stage of cancer at the time of diagnosis and survival rates within each stage. The conference included presentations on cancer trends and the role of the program in health care research, policy, and practice. Seminar speakers included **Martin Brown**, chief, Health Services and Economics Branch, Applied Research Program, NCI; **Colin Begg**, professor of Biostatistics and Public Health, Cornell University Medical School; **John Ayanian**, associate professor of Medicine and Health Care Policy at Harvard Medical School; **Ellen Stovall**, executive director, National Coalition for Cancer Survivorship; and **Dee West**, executive director, Northern California Cancer Center. . . . **WOMEN AGAINST LUNG CANCER**, a non-profit professional organization with the goal of educating the public and health professionals about the magnitude of the lung cancer problem in women, has been started by a group of women oncologists. Few women understand that lung cancer is a major women's health issue, accounting for more deaths per year than breast and ovarian cancer combined, said WALC President **Joan Schiller**, professor of medicine, University of Wisconsin. **Kathy Albain**, professor of medicine and director of the Thoracic Oncology Program at Cardinal Bernardin Cancer Center, Loyola University, is vice president, **Kathy Pisters**, of M.D. Anderson Cancer Center, is secretary/treasurer, and the executive director is **Cynthia Rittenberg**. The Board of Directors includes: **Julie Brahmer, Carolyn Dresler, Jennifer Garst, Laurie Gaspar, Heidi Gillenwater, Bonnie Glisson, Ellen Gritz, Janet Healy, Karen Kelly, Ritsuko Komaki, Linda Sama, Frances Shepherd, Jill Siegfried, Deb Smith-Fuderer, Carleen Wild Southwood**, and **Antoinette Wozniak**. WALC held its first scientific symposium at the World Lung meetings in Vancouver (www.2003worldlungcancer.org/). The group's first lay outreach program is scheduled for Nov. 1, in Chicago. Further information is available from the organization's office at 504-828-2184. A Web site will be established early next year. . . . **ALICE HAMM**, 90, died Oct. 8 in Washington, D.C. She was a technical writer at NCI for 17 years before retiring in 1988. Among her professional positions prior to NCI, she worked for Fortune Magazine, the Library of Congress, as a congressional reporter, and as a speechwriter for financier Bernard Baruch, and for the League of Women Voters. . . . **CORRECTIONS: THOMAS SELLERS** is the correct name of the new associate director for cancer control at H. Lee Moffitt Cancer Center. His name was incorrectly reported in the Sept. 26 issue of **The Cancer Letter**. In the Oct. 10 issue, **Michael Lairmore's** new position with Ohio State University Comprehensive Cancer Center should have been noted as associate director for basic research.

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