

THE

CANCER LETTER

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Three Centers Win \$9M Core Grants, 11 of 13 Competitors Cut Due To Shortfall

Three cancer centers last year received over \$9 million each in NCI Cancer Center Support Grants.

Five-year grants for each of these centers—Fred Hutchinson Cancer Research Center, Memorial Sloan-Kettering Cancer Institute, and M.D. Anderson Cancer Center—grew by an average of about \$3 million a year.

The gap between last year's Big Three and the rest of the competing field was dramatic. The University of California, Los Angeles, came in fourth and received \$4.4 million. Altogether, 11 centers that competed for NCI core grants in fiscal 2003 saw their peer-review recommended budgets cut, based
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In Brief:

“C-Change” New Name for Dialogue; Comment Period For NBN Extended

THE NATIONAL DIALOGUE ON CANCER was renamed **C-Change**. “This name reflects our hope that a coordinated effort from the public, private and not-for-profit sectors leaders will result in significant advances in the way that cancer is prevented, treated and managed in our lifetime,” the organization explained on its Web site. . . . **INTERBRAND**, a consulting company, developed the new name as “an in-kind donation,” and the renaming was announced at a meeting Dec. 12. Lapel pins with an aqua-blue logo that depicts a turning page were handed out to C-Change members. . . . **CONNIE CURRAN** was named executive director of C-Change. A former health industry consultant, Curran replaces **Allan Erickson**, a retired American Cancer Society official who ran the group since its inception five years ago. The Dialogue was launched by the American Cancer Society in order to build an overarching cancer agenda, and is funded primarily by ACS and the pharmaceutical companies. Another major donor is the American Legacy Foundation. C-Change officers include NCI Director **Andrew von Eschenbach**, who serves as vice chairman of the board, and NCI Deputy Director **Anna Barker**, a board member. . . . **C-CHANGE** has extended to Jan. 31 the comment period on the controversial multibillion-dollar tissue bank called the **National Biospecimen Network**. The plan was developed for NCI, using NCI funds. As a non-profit organization, C-Change operates behind closed doors. The NBN plan is posted at www.ndoc.org. . . . **MAURIE MARKMAN** was named vice president of clinical research at M.D. Anderson Cancer Center. Markman leaves the job of director of the Cleveland Clinic Taussig Cancer Center, and chairman of the
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Centers Program Facing Leadership, Budget Issues

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on a sliding scale tied to their priority score.

As the Cancer Centers Program entered its 30th year, it dispensed \$223 million to the 61 NCI-designated cancer centers. This was \$9 million below the funding levels recommended by peer reviewers.

During the five-year near-doubling of the NCI budget, the steady diet of research funding increases, supplemental grants, and cancer center planning grants seemed to calm the anxieties of directors of the cancer centers. Now, with the tightening of the NCI budget, the program's constituents are asking fundamental questions about the program.

Do "freestanding" all-in-one cancer centers have an advantage over the "matrix" centers that are pulled together within universities? Can a smaller or newer center grow up to compete with the big, long-established centers? Can a university without a center grant win one, or has the system become a closed, exclusive club?

The leadership of the program is about to change. For the past 15 years, the centers were overseen by Brian Kimes, a resilient manager, who took heat from center directors for NCI requirements as often as he worked to implement their suggestions for greater flexibility.

On Jan. 30, Kimes will retire from his post as director of the Office of Centers, Training, and Resources.

Tasked with finding a replacement for Kimes is Karen Antman, an oncologist who is on assignment to NCI from Columbia University, where she served as director of the Herbert Irving Comprehensive Cancer Center. Antman replaces Robert Wittes, who left NCI in 2002 to join Memorial Sloan-Kettering.

Last year, Antman's center fared poorly in peer review of its Cancer Center Support Grant after failing to secure a strong "institutional commitment" from university officials, sources said. NCI essentially put the center on probation by renewing its grant for only two years instead of the full five.

Antman also has the task of developing NCI's response to a report on the Cancer Centers Program delivered to von Eschenbach 11 months ago by a working group he appointed.

Last October, von Eschenbach acknowledged that the Institute had not begun implementation of the P30-P50 Working Group's recommendations. Speaking at the annual meeting of the Association of American Cancer Institutes, von Eschenbach said he was waiting to recruit "appropriate leadership with which to manage the process." He promised some action within six months (**The Cancer Letter**, Oct. 31, 2003).

"Nothing has been done with the report yet, because, as Dr. von Eschenbach indicated, it was waiting for the Bob Wittes replacement with Karen Antman coming in," Ronald Herberman, director of the University of Pittsburgh Cancer Institute, said to **The Cancer Letter**. "Hopefully, there will be some response to the report, and implementation of the recommendations."

CCSGs, or cancer center "core" grants, pay for shared resources designed to provide administrative or technical support to existing NCI-funded research at institutions around the country. The grants allow centers to call themselves an "NCI-designated cancer center." The designation can be parlayed into millions of dollars of philanthropy.

The center grants were formally established in June 1973, with the publication of NCI's first official guidelines for the CCSG.

And The Winners Are...

In fiscal 2003, peer reviewers scored Fred Hutchinson and MSKCC in the "outstanding" range. Under the funding plan that NCI decided to use, the two received the full recommended funding, Centers Branch Chief Linda Weiss said to **The Cancer Letter**. The other competing centers were funded on a sliding scale based on priority score.



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Editor & Publisher: Kirsten Boyd Goldberg

Editor: Paul Goldberg

Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 **Fax:** 202-318-4030

PO Box 9905, Washington DC 20016

E-mail: news@cancerletter.com

Customer Service: 800-513-7042

PO Box 40724, Nashville TN 37204-0724

E-mail: info@cancerletter.com

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The list of centers that competed last year follows.

Center	FY03 Award	Total Award
Fred Hutchinson	\$9,549,526	\$50,939,085
Sloan-Kettering	\$9,166,572	\$50,078,030
M.D. Anderson	\$9,000,000	\$47,406,781
UCLA	\$4,487,365	\$23,093,002
Univ. of Arizona	\$3,750,000	\$19,763,543
Roswell Park	\$3,276,134	\$18,641,983
Univ. of Minnesota	\$3,252,575	\$17,175,244
Georgetown Univ.	\$2,908,354	\$12,094,984(4 yrs)
New York Univ.	\$2,501,624	\$13,232,880
City of Hope	\$2,258,337	\$11,805,422
Columbia Univ.	\$1,768,473	\$3,610,030 (2 yrs)
Wistar Institute	\$1,666,681	\$12,229,841
Purdue Univ.	\$1,139,423	\$6,034,086

M.D. Anderson now ranks No. 1 for the total amount of NCI grant funding for fiscal 2003, a total of 208 grants worth \$98.37 million, according to a chart released at the AACI meeting. Hutchinson ranks fifth, with 122 grants worth \$81 million, and Sloan-Kettering ranks eighth, with 118 grants worth \$59.7 million.

History Is Funding Destiny?

Historically, the freestanding cancer centers have received larger core grants from NCI, because they entered the program at the outset, in 1973 or 1974, and had built a large base of research prior to the official start of the CCSGs, said Joseph Simone, a consultant and former director of the Huntsman Cancer Institute at the University of Utah, who served as co-chairman of the P30-P50 Working Group.

“Years ago, everyone worried about Anderson and Fox Chase,” Simone said. “The worry always has been that the big centers are going to squeeze out new centers. My own opinion is that there aren’t a whole lot of candidates out there who have the requisite NCI support [\$4 million in NCI grants] to apply. I am not sure that those few large grants are preventing new centers from coming on board.”

The center that receives the largest NCI core grant is the consortium formed in 2000 by Dana-Farber Cancer Institute, Harvard University, and the Massachusetts General Hospital. The consortium received \$10.2 million for its core grant in fiscal 2003. The consortium is scheduled for its first competitive renewal in fiscal 2005.

NCI and cancer center directors debated for years whether to place a cap on funding for the largest centers.

In 1992, the Institute established a “ratio” cap tied to each center’s amount of NCI research funding. The ratio of core grant to NCI funding should be no higher than 20 percent. For example, a center with \$25 million in NCI research grants should get a core grant of no more than \$5 million. Also, no center should receive more than 5 percent of NCI’s budget for the centers program (**The Cancer Letter**, Feb. 14, 1992).

The ratio model was designed by the centers program staff under the assumption that the Institute’s budget would grow by no more than about 3 percent a year. At that time, no one imagined that Congress would double the NIH budget over five years, from fiscal 1999 to fiscal 2003. NCI’s budget increased 80 percent over that time.

Centers were poised to win more research grants, and did. Now centers that are up for core grant renewal are seeking their 20 percent on a much greater denominator, just at the time when NCI budget growth has come back to about 3 percent.

“We simply didn’t have the funds to fund everyone at the level they might have been funded at times when the budget was growing at a greater rate,” Weiss said to **The Cancer Letter**. “We couldn’t apply [the ratio] and come up with a figure we could afford.”

NCI decided to fund the grants using a sliding scale, Weiss said.

The centers that scored in the outstanding range received the full funding as recommended by the CCSG “parent committee.” Then, each percentage point in the score over outstanding resulted in a budget cut of half a percent. In NIH grant scoring, a low number is a better, more meritorious score than a higher number. The funding plan was approved by von Eschenbach, sources said.

“Without a formal policy, [von Eschenbach] used a sliding scale,” Herberman said. “I actually think that’s a pretty fair way to do it. It essentially leaves it up to peer review, to a large extent.

“Why some of the ones that have the mega-grants stay as high as they are relative to their funding base, I find a little puzzling,” Herberman said.

With the five-year funding cycle for most of the centers, it would seem that during the near-doubling, every center had a shot at getting an increase. However, that wasn’t the case, Herberman said.

Some centers, including UPCI, missed out on the good times.

“Our last renewal was in the first year of the doubling, so we were not able to hit the crest of the wave as some others were able to,” Herberman said. The UPCI

core grant will come up for renewal this year.

"It's not a perfect system," Herberman said.

Counting The Base

The core grant funding method should be re-examined in light of the NCI budget outlook, observers said.

The calculation of the funding base is a controversial topic among center directors. The P30-P50 report recommended that NCI develop "quantifiable metrics for determining the size of the P30 award that reflects the broad spectrum of involvement of individual cancer centers in scientific discovery, dissemination of information, and delivery of care."

According to the report, "using NCI funding (in particular, R01s) as a measure against which to award funds is likely to penalize centers conducting more clinical and translational research. The working group concludes that the NCI-funded research base as a parameter on which to base budgetary calculations for individual centers is too restricted and that methods should be found within the guidelines to recognize and reward outstanding efforts of individual cancer centers across a broad spectrum of effort, including dissemination and outreach."

Matrix cancer centers in particular are affected by the NCI policy of counting only the research dollars awarded to a single institution. An investigator at a hospital, who is also a center member, might win an R01, but because the award notice names the hospital rather than the center, the award doesn't count in the funding base.

"Even though the center views everyone as one big, happy family, the grants go through a separate organization, so the dollars don't count," Herberman said. "That is applicable to our center."

Peer reviewers have an affinity for freestanding cancer centers, long-time observers of the program said.

Those centers have an advantage, because they don't have to convince reviewers of an institutional commitment. However, the center grant should fund the "value added" by the core resources. "There is no evidence that the 'value added' is done better in a freestanding cancer center," the source said.

The P30-P50 report noted that a 1996 review of the centers program concluded that "centers should be primarily reviewed for the quality of science, and such review should be based on the 'value added by the center grant to the advancement of excellence in all appropriate areas of cancer research. This working group reiterates

the importance of that recommendation and encourages NCI to explore ways to implement it."

Reviews "should focus on the difference the funds have made in promoting research, enhancing cooperative interactions, and developing new initiatives," the working group wrote.

Aspiring Centers: Go Directly To P30

The one action NCI has taken in response to the P30-P50 report is to suspend the P20 cancer center planning grants program.

No new applications are being accepted "until further notice," according to an announcement on the centers program Web site. "It is possible that the planning grant program will be reinstated under different guidelines at a later date," the announcement said.

Since 1992, NCI funded 25 planning grants. Six are still active. Of the 19 remaining, seven competed successfully for a P30 core grant, the working group report said. The report recommended a moratorium on planning grants "because there are few institutions remaining with a sufficient NCI research award base that have expressed interest in becoming NCI-designated cancer centers, but that lack the resources to submit directly a P30 application."

In an interview, working group chairman Simone said some institutions were "trying to use the P20 as the sole lever on institutions and that often failed. The good programs go directly for the P30," he said.

Howard Ozer, director of the University of Oklahoma Health Cancer Center and winner of one of the last planning grants prior to the program's suspension, said he disagreed with the working group's recommendation.

Eliminating the planning grants will make it harder for small institutions to become centers, he said. "Getting something started at a university is hard and getting harder in the face of a shrinking budget," Ozer said.

"What it really comes down to is, what is the fundamental concept of the NCI Cancer Centers Program? To simply match high-quality science on a dollar-for-dollar basis, or to advance cancer research across a variety of institutions and geographic areas?" Ozer said. "The big guys say, 'We are special. Look at our science,' but I don't think all the best ideas come from New York and Houston. When you go to review, the reviewers go nuts for the science, and it's much easier to review science than to say, well, Oklahoma needs a cancer center, but it only has \$4.2 million in NCI

(Continued to page 6)

Cancer Centers by State (P30 Core Grants) Fiscal Year 2003

The table below released at the AACI annual meeting last October includes all core grants funded last fiscal year. The amounts for the competing grants listed here differ slightly from the amounts noted by NCI Cancer Centers Program staff on page 3.

State	Grantee Institution	Type	Amount
Alabama	Univ. of Alabama at Birmingham	Comprehensive	\$5,124,250
Arizona	Univ. of Arizona	Comprehensive	\$3,750,000
California	Beckman Research Institute	Comprehensive	\$2,371,212
	Burnham Institute	Lab/Basic	\$3,043,791
	Salk Institute	Lab/Basic	\$2,689,041
	Univ. of California Davis	Clinical	\$1,295,530
	Univ. of California Irvine	Comprehensive	\$2,617,401
	Univ. of California Los Angeles	Comprehensive	\$5,275,687
	Univ. of California San Diego	Clinical	\$3,978,437
	Univ. of California San Francisco	Comprehensive	\$7,770,540
	Univ. of Southern California	Comprehensive	\$5,915,633
Colorado	Univ. of Colo. Health Sciences Ctr	Comprehensive	\$3,658,965
Connecticut	Yale University	Comprehensive	\$1,039,412
D.C.	Georgetown University	Comprehensive	\$2,908,354
Florida	Univ. of South Florida	Clinical	\$2,284,528
Hawaii	Univ. of Hawaii at Manoa	Clinical	\$1,963,561
Illinois	Northwestern University	Comprehensive	\$4,689,612
	Univ. of Chicago	Comprehensive	\$4,116,017
Indiana	Indiana U.-Purdue U./Indianapolis	Comprehensive	\$1,361,756
	Purdue U. West Lafayette	Lab/Basic	\$1,139,423
Iowa	Univ. of Iowa	Comprehensive	\$1,558,668
Maine	Jackson Laboratory	Lab/Basic	\$2,572,089
Maryland	Johns Hopkins University	Comprehensive	\$5,924,366
Massachusetts	Dana-Farber Cancer Institute	Comprehensive	\$10,286,547
	Mass. Institute of Technology	Lab/Basic	\$2,482,124
Michigan	Univ. of Michigan at Ann Arbor	Comprehensive	\$5,055,037
	Wayne State University	Comprehensive	\$730,469
Minnesota	Mayo Clinic Rochester	Clinical	\$3,112,358
	Univ. of Minnesota Twin Cities	Comprehensive	\$3,252,575
Missouri	Washington University	Comprehensive	\$1,384,782
Nebraska	Univ. of Nebraska Medical Ctr	Lab/Basic	\$1,532,091
New Hampshire	Dartmouth College	Comprehensive	\$1,870,792
New Jersey	Univ. of Med/Dent NJ-RW Johnson	Clinical	\$2,678,981
New York	Cold Spring Harbor Laboratory	Lab/Basic	\$3,742,281
	Columbia Univ. Health Sciences	Comprehensive	\$1,768,473
	Institute for Cancer Prevention		\$3,299,047
	NYU School of Medicine		\$2,501,624
	Roswell Park Cancer Institute	Comprehensive	\$3,582,573
	Sloan-Kettering Institute	Comprehensive	\$9,232,739
	Yeshiva University	Comprehensive	\$3,755,651
North Carolina	Duke University	Comprehensive	\$5,839,815
	U. of North Carolina at Chapel Hill	Comprehensive	\$5,296,422
	Wake Forest Univ. Health Sciences	Comprehensive	\$1,483,272
Ohio	Case Western Reserve Univ.	Comprehensive	\$3,948,518
	Ohio State University	Comprehensive	\$2,760,556
Oregon	Oregon Health & Science Univ.	Clinical	\$1,228,141
Pennsylvania	Fox Chase Cancer Center	Comprehensive	\$7,730,174
	Thomas Jefferson University	Clinical	\$4,909,066
	Univ. of Pennsylvania	Comprehensive	\$5,393,962
	Univ. of Pittsburgh	Comprehensive	\$4,062,870
	Wistar Institute	Lab/Basic	\$2,465,700
Tennessee	St. Jude Children's Research Hosp.	Clinical	\$4,848,536
	Vanderbilt University	Clinical	\$3,264,263
Texas	CTRRC Research Foundation	Comprehensive	\$1,753,666
	U. of Texas M.D. Anderson Can Ctr	Comprehensive	\$9,026,321
Utah	Univ. of Utah	Clinical	\$1,497,387
Vermont	Univ. of Vermont & St. Agric Coll	Comprehensive	\$1,304,012
Virginia	Univ. of Virginia Charlottesville	Clinical	\$2,056,121
	Virginia Commonwealth Univ.	Clinical	\$2,262,131
Washington	Fred Hutchinson Cancer Res. Ctr	Comprehensive	\$9,653,326
Wisconsin	Univ. of Wisconsin Madison	Comprehensive	\$5,378,150
		Total P30s	\$223,478,826

Centers Await NCI Action On P30-P50 Report

(Continued from page 4)

funding. That's softer and more political, but potentially more creative in the long run."

The issue of funding established centers versus new centers arose briefly last November, at a meeting of the NCI Board of Scientific Advisors.

At the meeting, von Eschenbach said the Institute has little flexibility in its budget, given the commitments to non-competing grants as well as the "long and ongoing commitment" to established centers that came in for recompetition.

After von Eschenbach's remarks, BSA member Susan Horwitz, of Albert Einstein College of Medicine, put in a word for new centers.

"There are new places that would like to have a cancer center and are deserving," she said. "Things change. One of the great things about the NCI and NIH has been the peer review system. New places should be encouraged to apply, even though it may be not at the best time" (**The Cancer Letter**, Nov. 28, 2003).

NCI should develop a new model for institutions that can't compete for center designation, Simone said in an interview.

"There has been a lot of pressure from Congress over the years to spread the centers around," he said. "We took that into account in the working group report. We recommended that there should be a new model for those who can't become cancer centers."

Under the working group's proposal, smaller programs should be able to link with NCI-designated cancer centers to apply for infrastructure support, similar to the U54 awards that NCI uses to support cancer centers at minority-serving medical schools, or through supplements to the P30s.

"It wouldn't cost a lot of money, and NCI could support some good programs," Simone said. "You might get \$600,000 a year to support a good epidemiology program, for example."

Center directors have been invited to meet with von Eschenbach on March 8 for discussion of the NCI budget.

In 1996, when the Cancer Centers Program Review Group submitted its report to NCI, the Institute formed an implementation committee within two months. "About half the recommendations were implemented; substantial changes were made," said Simone, who served as chairman of that review group.

For now, center directors and those vying for

designation can only wait for the Institute to act on the latest report.

"It's been 11 months," Simone said.

Cancer Prevention: HHS Plans "Comprehensive" New Report On Tobacco

HHS Secretary Tommy Thompson and Surgeon General Richard Carmona last week said they will issue a comprehensive report on tobacco and health this year.

Also, the department plans to develop a database of information on diseases caused by tobacco use, and proven approaches for helping people avoid tobacco use.

The new report and database were announced on the 40th anniversary of the first Surgeon General's Report on Smoking, by then-Surgeon General Luther Terry, which for the first time linked smoking with lung cancer. The 28th report, to be issued this year, "The Health Consequences of Smoking," will examine the effects of tobacco on every system of the human body.

The new database would include medical research, treatment and prevention information, to make the most recent findings continually available to professionals and the public.

Thompson said the new report and database "will provide a new level of support and comprehensiveness in helping us understand the health effects of tobacco and helping Americans avoid this single most significant preventable cause of death and disease."

In a statement, Thompson said, "Forty years after the first Surgeon General's report on smoking, the fact remains the same: Smoking remains the single leading preventable cause of death in this country, costing us too many lives, too many dollars, and too many tears."

Funding Opportunities: RFAs Available

RFA-CA-05-005: The Early Detection Research Network: Clinical Epidemiology and Validation Centers

Letter of Intent Receipt Date: May 14, 2004

Application Receipt Date: June 14, 2004

Division of Cancer Prevention, NCI, invites new and competing renewal cooperative agreement applications to continue the EDRN for the development, evaluation, and validation of biomarkers for earlier cancer detection and risk assessment. Biomarkers

are defined as cellular, biochemical, and molecular (genetic and epigenetic) alterations by which a normal, abnormal, or simply biologic process can be recognized or monitored. Biomarkers are measurable in biological media, such as in tissues, cells, or fluids. The Network has four main components : Biomarker Developmental Laboratories, Biomarker Reference Laboratories (formerly known as Biomarker Validation Laboratories), Clinical Epidemiology and Validation Centers (formerly known as Clinical and Epidemiologic Centers), and a Data Management and Coordinating Center. The RFA will use the NIH Cooperative Agreement U01 and U24 award mechanisms. The RFA is available at <http://grants2.nih.gov/grants/guide/rfa-files/RFA-CA-05-005.html>.

Inquiries: Sudhir Srivastava, program coordinator, Division of Cancer Prevention, NCI, 6130 Executive Blvd., EPN Rm 3142, Bethesda, MD 20892, phone 301-435-1594; fax 301-402-8990; e-mail srivasts@mail.nih.gov Or Paul Wagner, Division of Cancer Prevention, Phone 301-496-9424; fax 301-402-8990; e-mail wagnerp@mail.nih.gov.

RFA-CA-05-006: Innovative Technologies for Molecular Analysis of Cancer

Letter of Intent Receipt Dates: Feb. 10, 2004; May 17, 2004; Sept. 17, 2004

Application Receipt Dates: March 10, 2004; June 17, 2004; Oct. 18, 2004

NCI invites applications for research projects proposing the development of highly innovative cancer-relevant technologies, which encompasses methods and tools that enable research, including, but not limited to, instrumentation, techniques, and devices. Technologies solicited include, but are not necessarily limited to, those that are suitable for the detection of alterations and instabilities of genomic DNA; measurement of the expression of genes and gene products, including proteins; analysis and detection of gene and/or cellular products, including post-translational modifications and functions of proteins; identification and characterization of exogenous infectious agents in cancer; and assaying the functions of major signal transduction networks involved in cancer. Developing technologies would include those that will support molecular analysis in vitro, in situ, or in vivo in discovery processes as well as in pre-clinical models and clinical research. The RFA uses the SBIR and STTR mechanisms, which are set-aside programs. The RFA is available at <http://grants2.nih.gov/grants/guide/rfa-files/RFA-CA-05-006.html>.

Inquiries: Gregory Downing, Office of Technology

and Industrial Relations, NCI, Bldg., 31, Rm 10A52, Bethesda, MD 20892, Rockville, MD 20652 (or express/courier service), phone 301-496-1550; fax 301-496-7807; e-mail downingg@mail.nih.gov.

RFA-CA-05-007: Application of Emerging Technologies for Cancer Research (SBIR/STTR)

Letter of Intent Receipt Dates: Feb. 10, 2004; May 17, 2004; Sept. 17, 2004

Application Receipt Dates: March 10, 2004; June 17, 2004; Oct. 18, 2004

NCI invites applications for research projects to evaluate the usefulness of emerging technologies for initial application to clinical or biological questions in cancer research. Projects should demonstrate that the technology is robust and yields reproducible measurements. Projects should also be designed to gather preliminary data to support the use of the technology in a future project(s) with a clinical or biological focus. In addition, applications that propose the use of commercially available technology under standard conditions, or any technology that is already commonly accepted for the proposed use, are not appropriate. The RFA uses the SBIR and STTR mechanisms, which are set-aside programs. The RFA is available at <http://grants2.nih.gov/grants/guide/rfa-files/RFA-CA-05-007.html>.

Inquiries: See preceding RFA.

RFA-CA-05-008: Innovations in Cancer Sample Preparation (SBIR/STTR)

Letter of Intent Receipt Dates: Feb. 10, 2004; May 17, 2004; Sept. 17, 2004.

Application Receipt Dates: March 10, 2004; June 17, 2004; Oct. 18, 2004.

NCI invites applications for research projects involving the development and significant enhancement or adaptation of sample preparation methodologies and technologies, the development of assays to assess sample quality, and criteria studies designed to judge sample quality. The outcome will be products and methods designed to optimize sample utility. Samples may originate from residual material not necessary for patient care or from cell lines, model organisms, or other sources relevant to cancer research. The RFA will allow the submission of applications involving phase I, phase II, and Fast-Track mechanisms. The RFA uses the SBIR and STTR mechanisms, which are set-aside programs. The RFA is available at <http://grants2.nih.gov/grants/guide/rfa-files/RFA-CA-05-008.html>.

Inquiries: See preceding RFA.

In Brief:

Raghaven Replaces Markman As Center Director In Cleveland

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Department of Hematology/Oncology at The Cleveland Clinic Foundation. . . **DEREK RAGHAVAN** replaces Markman as the center director and takes a more senior post of division chief at CCF. He will report directly to the chief of staff and will have equivalent status to the chairman of medicine and the chairman of surgery. Raghavan leaves the post of professor of medicine and chief of the division of oncology at University of Southern California and associate director for Clinical Research at USC-Norris Cancer Center. . . .

RAGHAVAN and **James Willson**, chairman of the Case Comprehensive Cancer Center, are working on a plan to integrate the Cleveland Clinic Cancer Center into a matrix incorporating Case and the University Hospitals. . . . **NICHOLAS VOGELZANG** was named director of the **Nevada Cancer Institute**, a freestanding cancer center that will be affiliated with the University of Nevada at Reno and Las Vegas. The 140,000 square foot building will be located on a five-acre site on the western edge of Las Vegas, and surrounded by a 60-acre biotechnology park. Vogelzang is the former director of the University of Chicago Cancer Center. **Everett Vokes**, chief of hematology and oncology, was named acting director, and a search committee has been organized to find Vogelzang's successor. . . .

JEFFREY HUMPHREY was named site head for early cancer drug development at the **Pfizer Inc.** global research & development unit. He directs phase I and phase II development of all cancer compounds at the Groton/New London, Conn., site. Humphrey is the former biotechnology analyst at Durus Capital Management and former director of clinical development of oncology drugs at Bristol-Myers Squibb. . . . **ANDRZEJ KUDELKA** joined **Pfizer Oncology** as medical director and regional medical and research specialist for the Northeast region. He will work in the metropolitan New York City area. Kudelka is a former associate professor of medicine specializing in gynecologic and endocrine oncology at M.D. Anderson Cancer Center. . . .

WILLIAM TODD was selected president of the Georgia Cancer Coalition by the organization's board of directors. Todd has served as executive director of the Commission for a New Georgia since last May. The GCC is in the process of implementing a strategic plan based on a report commissioned by **Gov. Sonny Perdue** and developed under the leadership of committee co-

chairmen **Louis Sullivan**, former Morehouse School of Medicine president, and **Hamilton Jordan**, cancer survivor and chief of staff to former President **Jimmy Carter**. The report recommended supplementing state funds through a campaign to raise foundation and private contributions. Other recommendations included strengthening GCC leadership through the appointment of a president and adding to the board of directors. The GCC board of directors elected **Robert Jepson Jr.**, CEO, Jepson Associates Inc., as board chairman and appointed several new members. Appointees include **Jenny Pruitt**, CEO, Jenny Pruitt & Associates Realtors of Atlanta; **John Kane**, former president and CEO of Cardinal Health; **Felker Ward**, chairman, Pinnacle Investment Advisors Inc., as well as senior representatives of the four medical schools in Georgia: **Daniel Rahn**, Medical College of Georgia; **Michael Johns**, Emory Healthcare; **William Gavin**, Morehouse School of Medicine; and **Douglas Skelton**, Mercer University. Continuing directors include **Doug Hertz**, president, United Distributors Inc.; **Kathelen Spencer**, executive vice president and director of corporate communications and deputy counsel, AFLAC Inc.; and **Michael Cassidy**, president, Georgia Research Alliance. . . . **K. VISH VISWANATH**, acting associate director of the Behavioral Research Program in the NCI Division of Cancer Control and Population Sciences, has moved to the Harvard School of Public Health and Dana-Farber Cancer Institute. **Scott Leischow**, chief of the NCI Tobacco Control Research Branch since 2000, was appointed acting associate director of the BRP. **Cathy Backinger** moves into the job of acting chief of the TCRB. . . . **MANUEL VALDIVIESO**, director of the Cancer Institute at Southern Illinois University in Springfield, was appointed associate director of clinical affairs and chief medical officer for Barbara Ann Karmanos Cancer Institute, effective Feb. 2. He will be responsible for medical staff development, the oversight of clinical care activities and leadership of multidisciplinary teams. Valdivieso will also oversee business services, clinical operations, networking, contracting, hospice, screening operations and clinical affiliations. Valdivieso was with the institute from 1986 to 1996 as a member of its Thoracic Oncology Program. . . . **CLIFFORD SCHOLD Jr.** was named chairman of the Department of Interdisciplinary Oncology and associate center director for clinical affairs at H. Lee Moffitt Cancer Center & Research Institute, effective in March. He is associate vice chancellor for clinical research, director of neuro-oncology, and professor of neurology at the University of Pittsburgh.

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