THE CANCER LETTER

Vol. 30 No. 43
Nov. 12, 2004

Price $335 Per Year

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Clinical Biomarker Discovery Initiative Would Speed Progress, Hartwell Tells NCI

By Kirsten Boyd Goldberg

NCI should establish a large-scale program to discover biomarkers to accelerate progress in the early detection of cancer and measurement of response to therapy, Leland Hartwell, president and director of the Fred Hutchinson Cancer Research Center, said to the Institute's Board of Scientific Advisors earlier this week.

Hartwell, a 2001 Nobel laureate, presented a proposal for a "Clinical Biomarker Discovery Initiative" to provide a platform to develop technology and research in molecular diagnostics.

"The discovery progress should discover biomarkers for all aspects of

(Continued to page 2)

In Brief:

NCI Appoints Robert Young BSA Chairman; Sigal Reappointed, 11 New Members Named

ROBERT YOUNG was named chairman of the NCI Board of Scientific Advisors and reappointed to the board for a term expiring in 2007. Young, president of Fox Chase Cancer Center, has served on the BSA since its inception in 1996. As chairman, he succeeds **Frederick Appelbaum**, of Fred Hutchinson Cancer Research Center. NCI Director **Andrew von Eschenbach** also reappointed **Ellen Sigal** to the board for a second, consecutive term, through 2009. Sigal, chairman of Friends of Cancer Research, served on the National Cancer Advisory Board from 1992 to 1998, and was appointed to the BSA in 1999. . . . **NEW APPOINTMENTS** to the BSA include: **Kirby Bland**, deputy director, University of Alabama at Birmingham Comprehensive Cancer Center; **Kathleen Foley**, neurologist, Memorial Sloan-Kettering Cancer Center; **Sanjiv Sam Gambhir**, professor of radiology medicine, Stanford University School of Medicine; **Joe Gray**, director, Division of Life Sciences, Lawrence Berkeley National Laboratory; **Mary Hendrix**, president and scientific director, Children's Memorial Research Center; **Leroy Hood**, president, Institute for Systems Biology; **Stanley Korsmeyer**, professor of pathology, Dana-Farber Cancer Institute; **Christopher Logothetis**, chairman, Department of Genitourinary Medical Oncology, M.D. Anderson Cancer Center; **Edith Perez**, director of clinical investigations and director of the Breast Cancer Program, Mayo Clinic, Jacksonville; **John Potter**, senior vice president and director, Division of Public Health Sciences, Fred Hutchinson Cancer Research Center; and **Jane Weeks**, chief, Division of Population Sciences, Dana-Farber Cancer Institute. . . . **YOUNG OUTLINED**, in

(Continued to page 7)

Hartwell: Biomarker Program Has Low Cost, High Potential

(Continued from page 1)

cancer: therapeutic response or recurrence of disease, for prognosis as well as early detection," Hartwell said to the BSA at its meeting Nov. 8. "Is it possible to do better with a more systematic and organized approach than we are currently using? I think the answer to that question is Yes."

Hartwell's proposal follows his lectures at the American Association for Cancer Research and American Society of Clinical Oncology annual meetings earlier this year, where he advocated a publicly-funded program in molecular diagnostics (**The Cancer Letter**, April 9).

NCI officials asked Hartwell to further develop the idea by holding conferences with experts and writing a "white paper." The draft of the paper outlining the components of the research program was distributed at the BSA meeting.

The program would cost about $20 million to establish and take through validation for the first cancer site, Hartwell said. Research in subsequent cancer sites would cost about $4 million to $6 million, he said.

Discovery of biomarkers would include three core components, Hartwell said. An informatics core would develop standards for efficient communication, data formats, and house a central database. A reagents core would organize the tools for clinical biomarker discovery. A technology assessment core would provide "best" techniques and protocols.

"Satellite" components would include teams of investigators working on discovery of biomarkers at a particular cancer site, as well as investigators working to optimize methods for discovery in a particular class of biomarkers. The program would fund pilot projects to test technology for discovery of biomarkers.

Hartwell said the initiative would have the following goals:

—Establish criteria and centers for testing biomarker discovery technologies in order to define an effective pipeline for discovery.

—Develop a publicly available informatics platform that permits data storage, analysis, searching, and comparison.

—Establish consortia of collaborating laboratories to discover biomarkers in particular cancer sites and for particular classes of biological molecules.

—Establish repositories of reagents for clinical biomarker discovery.

—Promote the translation of new imaging agents to clinical trials.

"We know that screening can work," Hartwell said. "For colon and cervical cancer, colonoscopy and Pap smears have been demonstrated to reduce mortality from cancer. That is the gold standard. It isn't good enough to screen and find more cancer. You must show that the screening procedure reduces mortality."

Compared to the cost of drug development, research in biomarkers has the potential for a tremendous payoff, Hartwell said. "The price tag for early detection is really modest, and this is one of the arguments for putting a lot more effort into this area," Hartwell said.

"The problem with the current state-of-the-art is that we are constricted right at the beginning," he said. "The discovery phase is failing, because we haven't learned how to discover biomarkers very effectively, and now I'm talking about protein biomarkers, not DNA or RNA, where things are much more advanced than they are in proteomics.

"I think we all believe that protein markers likely exist, that there is probably an enormous amount of untapped information in our blood," Hartwell said. "We have only scratched the surface. We believe that because a lot of good biomarkers exist for various diseases, and because we know that cancer is prone to release proteins into the blood….

"In spite of the fact that there is not a huge success in this area yet, I think there is good reason to be hopeful," he said.

THE CANCER LETTER

Member, Newsletter and Electronic Publishers Association

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Letters to the Editor may be sent to the above address.

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724
Customer service FAQ: www.cancerletter.com

Subscription $335 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc.
Founded Dec. 21, 1973, by Jerry D. Boyd.

Moving the field forward will require funding of pilot grants, academic-industry collaboration, and development of new technologies to increase throughput, Hartwell said.

NCI officials said they would develop Hartwell's proposal and discuss detailed plans with the BSA next year. "This is an area whose time has come," said Anna Barker, NCI deputy director for advanced technologies and strategic partnerships. "We hope to do something substantive in this area and bring NCI into a key leadership role."

Could "Piggyback" On Clinical Trials

Several BSA members noted that the program could be more costly and complicated than Hartwell suggested. .

"One of the things we have to start thinking about right now, is at what point would biomarker development lead to the same costs and constrictions," as with therapeutics development, said Richard Schilsky, associate dean for clinical research, Biological Sciences Division, University of Chicago. "Although the cost of the reagent development is modest, most of the cost of drug development is in clinical trials to demonstrate the value of the drugs. Ultimately, any biomarker that gets developed is going to have to be subjected to the same sort of rigorous clinical evaluation. We know that biomarker studies frequently require even more numbers of patients than therapeutic clinical trials to demonstrate the real utility of the marker. So we are going to have to be planning right now how those trials are going to be organized, and if your initiative is successful, as the biomarker pipeline then begins to get flooded with potential markers, we are going to have the same constriction point we have in beginning to evaluate all those markers as we do in evaluating all the new chemical entities."

HARTWELL: "Actually, I think the scenario that we will develop a trial to validate each marker is wrong. It's too expensive to do that. When we have thousands of markers, we will use samples already collected in the Women's Health Initiative and other studies to look at thousands. There will be very little added cost on the validation side. I think the same thing will happen on the clinical trial side. We will not do a clinical trial to validate a biomarker. We will piggyback on therapeutic trials where samples are being taken. I really don't see the validation adding a great deal of expense, once markers have been validated as indicative of cancer."

SCHILSKY: "I would just quibble with you on one point. At least with respect to validating markers of therapeutic response, it takes probably a sample size of three to four times what it takes to do a therapeutic clinical trial. We can't simply piggyback. We are going to have to design clinical trials somewhat differently to have adequate statistical power to answer the biomarker question."

SUSAN HORWITZ, the Falkenstein Professor of Cancer Research, Albert Einstein College of Medicine: "Although I'm very optimistic, I do think we have to realize this is much more complicated than perhaps it has been presented. For example, we are looking at tubulin in a variety of tumors, and what we find out is that tubulin has at least 14 isoforms. Each of those isoforms is post-translationally modified in a different way. So, I think that this is a very important project, but we have to enter it with open eyes and realize this is really a much more complicated thing than looking for a single protein."

HARTWELL: "I agree entirely, and that's one of the strong arguments for using proteins as biomarkers, because those post-translational modifications may be very unique and informative. Of course, that does increase the complexity of the analysis. With current technology, we are limited in our ability to do that."

BSA member Jane Weeks, chief of the Division of Population Sciences, Dana-Farber Cancer Institute, suggested careful targeting of biomarker development to cancers for which early detection can make a difference in outcome.

"The key attribute for the use of a screening test is that early detection allows you to do something that you otherwise wouldn't be able to do and it changes the outcome," Weeks said. "For these tests to be useful, it would really have to shift us from being aware of disease in a way that we can locally intervene with therapy to cure a tumor. The funny thing about a serum test is that it doesn't tell you where a lesion is, so it doesn't tell you what you can do about it. You need to follow up with some sort of radiographic procedure that gets you there. It seems to be that that is possible variably across tumors.

"For something like breast cancer, where we are screening annually or every other year with mammography anyway, the incremental benefit of a serum test would be rather limited," Weeks said. "In contrast, for something like pancreatic cancer, where the disease is sufficiently rare that population screening radiographically doesn't make sense, there a serum test could make a huge difference. So, I would urge us to think through some of these real-life issues that could grow out of a program like this and make sure we target

our investment in areas where we are most likely to get early clinical benefit."

Without better technologies, biomarker discovery is going to be "prohibitively slow and very expensive," said Leroy Hood, president of the Institute for Systems Biology. "Do you see technology being part of this, or do you see it being funded in other ways by NCI?"

"New technology development is critical for this area, but the only point I'm trying to make is that with existing technology, I think we can do a lot more than we are doing right now," Hartwell responded. "Every effort should be made to integrate the technology development programs at NCI with this effort, and also to identify new technologies that are being developed to exploit them as soon as possible."

Hood said the Human Genome Project started by developing "criteria for metrics of assessment," and while those early meetings to establish standards were contentious, they were crucial to the project's success. "I think the field of proteomics needs that even more," he said.

Hartwell said a research group is developing open-source software for a standard database for the field, at a time when every lab working in proteomics is using different software. "I think the field is ready to coalesce around a standard software," he said. "It's important that software be publicly available."

Pharmaceutical Industry:
Justice, Congress To Examine Merck, FDA Actions On Vioxx

By Paul Goldberg

It took a rigorously monitored cancer prevention trial to determine that the drug Vioxx , a $2.55 billion a year COX-2 inhibitor approved for arthritis pain, was causing strokes and heart attacks.

The finding prompted Merck & Co. to withdraw Vioxx from the market in late September, but the controversy didn't end there. Pointing to the enormity of risks of developing drugs for the prevention of cancer, the Vioxx fiasco has affected sponsors of other COX-2 inhibitors, FDA, and, likely, the entire field of chemoprevention.

Earlier this week, Merck disclosed that it has received a subpoena from the U.S. Department of Justice "requesting information related to the Company's research, marketing and selling activities with respect to Vioxx in a federal healthcare investigation under criminal statutes."

Also, the company said the staff of the Securities and Exchange Commission has launched and informal inquiry. On another front, the company is facing personal injury class action suits and two Congressional investigations, by the Senate Committee on Finance and the House Committee on Government Reform.

Since the mechanism of action of COX-2 inhibitors in cancer prevention is unknown, scientists, regulators and plaintiff's attorneys are likely to have a difficult time determining whether the toxicities observed with Vioxx (rofecoxib) also affect other COX–2 inhibitors.

The situation is all the more uncertain because a reanalysis of clinical data on another COX-2 inhibitor, the Pfizer Inc. $1.7-billion a year drug Bextra (valdecoxib), found an elevated risk of strokes and heart attacks, compared to nonselective non-steroidal anti-inflammatory drugs or placebo. Separately, Bextra was recently found to increase the risk of Stevens-Johnson Syndrome, a severe drug reaction, and FDA would likely give it "black box" warning on its label.

The COX-2 controversy is getting perilously close to Pfizer's Celebrex (celecoxib), an arthritis drug that is also one of the most important agents tested for chemoprevention of cancer (**The Cancer Letter**, Oct. 15, Oct. 22).

Last week, the National Post, a Toronto newspaper, reported that the adverse events reporting system of Health Canada registered 111 cardiovascular reactions, including 14 deaths among patients who took Celebrex over the past five years. During that time, 18 million prescriptions of the drug have been filled, the National Post said. After obtaining files from,

Jirina Vlk, a Health Canada spokesman, said to **The Cancer Letter** that following the National Post report, the agency reviewed the cases of the 14 patients who died while taking Celebrex and determined that only six of those deaths could have been connected to the drug.

Even before National Post's report, the Merchant Law Group, a Saskatchewan-based firm, filed a product liability suit naming the Canadian health authorities as well as pharmaceutical companies that make COX-2 inhibitors.

The firm has been inviting calls from patients who took Vioxx and Celebrex, said attorney Evatt Merchant. "Certainly, people who took Celebrex have contacted us since the news of the Celebrex suit, and we are finding that there are similar symptoms complained of by Celebrex users as we had already found with Vioxx users," Merchant said to **The Cancer Letter**. "We have had people who have had strokes and heart attacks who have used both Celebrex and Vioxx, but we can't isolate

it to one or the other."

Arguing that the safety profile of Celebrex is well established, Pfizer is planning to launch a study to demonstrate that the drug is actually beneficial to patients with heart disease.

Also, Pfizer and NCI are scrutinizing the adverse events in the Celebrex cancer prevention studies. Like Vioxx, Celebrex was studied for its ability to prevent recurrence of benign polyps, which would establish the agent as an alternative to colonoscopy and surgical removal of polyps.

Celebrex is approved for reduction in the number and size of polyps in patients with familial adenomatous polyposis, based on a surrogate endpoint. FDA is yet to decide whether reduction of recurrence of benign polyps would constitute a surrogate endpoint for prevention of colon cancer in patients who don't have FAP. Considering that patients receiving the agent for cancer prevention are technically healthy, an elevation of risk of side effects would be difficult to justify, cancer prevention experts say.

Two years ago, NCI floated the idea of loosening standards for FDA approval of chemoprevention agents based on surrogate endpoints and reliance on the agency's adverse events monitoring system to keep track of toxicity (**The Cancer Letter**, May 30, 2003).

In the course of the Vioxx controversy, FDA's ability to monitor adverse events came under attack from Congress.

Last week, FDA commissioned the Institute of Medicine to evaluate the agency's monitoring system for approved drugs. The IOM would "assess what additional steps could be taken to learn more about the side effects of drugs as they are actually used," the agency said.

Moreover, FDA promised to conduct a national search to fill the position of director of the Office of Drug Safety at the Center for Drugs Evaluation and Research and institute a procedure for adjudicating "differing professional opinions."

"CDER will formalize a program to provide an improved process to ensure that the opinions of scientific reviewers are incorporated into its decision-making process," FDA Acting Commissioner Lester Crawford said in a statement Nov. 5. "In most cases, free and open discussion of scientific issues among review teams, and with supervisors, managers and external advisors, leads to an agreed course of action. Sometimes, however, a consensus decision cannot be reached, and an employee may feel that his or her opinion was not adequately considered.

"Such disagreements can have a potentially significant public health impact, so CDER's program provides for a review of the involved differing professional opinions by FDA and outside experts," Crawford said. "An ad hoc panel, whose members were not directly involved in disputed decisions, will have 30 days to review all relevant materials and recommend to the Center Director an appropriate course of action."

A detailed proposal for resolution of differing professional opinions—dubbed DPOs by the agency—is posted at www.fda.gov/bbs/topics/news/2004/NEW01131.html.

The Vioxx controversy appears to have brought FDA face-to-face with a differing opinion expressed in a memorandum and a scientific presentation by FDA scientist David Graham.

In documents that ended up at the Senate Committee on Finance, the House Committee on Government Reform, and The Washington Post, Graham argued that patients taking Vioxx had four times the risk of acute myocardial infarction or sudden cardiac death, compared to patients taking naproxen.

According to Graham's analysis, this excess risk accounts for 27,785 heart attacks and sudden deaths among Vioxx users between 1999 and 2003. Apparently bowing to pressure from Congress, FDA last week posted the Graham memo, with a caveat that the document "has not been fully evaluated… and may not reflect the official views of the agency." The memo is posted at www.fda.gov/cder/drug/infopage/vioxx/default.htm.

"The public must be able to have faith in FDA," said committee Senate Finance Committee Chairman Chuck Grassley (R-Iowa). "It's obvious that the leadership of the agency must take on what look like deep-rooted problems when it comes to putting public health and safety first and public relations second," Grassley said in a statement. "Today's announcement is welcome, albeit late in coming. These initiatives need to take hold in a meaningful way and be more than an attempt to inoculate the agency in the face of alarming revelations."

NCI Programs:

Ernest Hawk Named Director Of NCI Centers, Training Office

Ernest Hawk was appointed director of NCI's Office of Centers, Training and Resources, effective Nov. 14.

Hawk, chief of the NCI Gastrointestinal and Other Cancers Research Group in the Division of Cancer

Prevention since 1999, came to NCI in 1993 as a cancer prevention fellow. As OCTR director, he will oversee the Cancer Centers Branch, the Cancer Training Branch, the Comprehensive Minority Biomedical Branch, and the Organ Systems Branch, with a combined total grant portfolio of more than $500 million.

Linda Weiss served as acting director of the office since the retirement of Brian Kimes last January. Weiss will remain chief of the Cancer Centers Branch. Jaye Viner will serve as acting chief of the Gastrointestinal and Other Cancers Research Group.

Hawk received his medical degree from Wayne State University School of Medicine, and trained in internal medicine at Emory University and in oncology at the University of California, San Francisco. He received a Masters of Public Health in 1994 from Johns Hopkins School of Public Health.

"I am extremely pleased that Dr. Hawk has accepted this position," said NCI Director Andrew von Eschenbach. "He brings with him a wealth of experience as both a manager and a researcher, and he will be a strong member of NCI's senior leadership team."

St. Jude Wins NCI Contract For Pediatric Preclinical Tests

NCI has established the Pediatric Preclinical Testing Program to systematically test 10 to 15 agents or combinations of agents annually in preclinical models of common childhood cancers.

The PPTP will develop procedures for generating sufficient preclinical information to allow pediatric oncology researchers to reliably prioritize new agents for study in children with specific cancers.

NCI funds the program through a contract to St. Jude Children's Research Hospital, with Peter Houghton as the principal investigator. Testing will take place at St. Jude and at subcontract sites that have expertise in specific childhood cancers. The institutions and PIs are: Children's Hospital of Philadelphia (John Maris), Albert Einstein Medical Center (Richard Gorlick), Duke University (Henry Friedman), Children's Hospital of Los Angeles (Patrick Reynolds), and Children's Cancer Institute Australia (Richard Lock).

The PPTP builds on Houghton's research demonstrating the ability of preclinical testing using rhabdomyosarcoma and neuroblastoma xenografts to predict activity of new agents in children with these cancers. The program will attempt to extend these observations to other childhood cancer types and to a broader spectrum of anticancer agents.

The PPTP will test anticancer agents against panels of preclinical models of the most common childhood cancers. The in vivo testing panels primarily will use childhood cancer xenograft lines, with genetically engineered models utilized when these are available and relevant to the agent being tested. The PPTP will use in vivo test panels for neuroblastoma, rhabdomyosarcoma, Ewing's sarcoma, osteosarcoma, acute lymphoblastic leukemia, renal tumors (Wilms and rhabdoid), embryonal brain tumors, and glial brain tumors. Each in vivo panel will consist of four to eight xenograft lines.

The in vitro panel will represent a similar range of children cancers and will include 20 to 25 cell lines.

Each of the xenograft and cell lines used in the PPTP will undergo extensive molecular characterization. Gene expression profiles for the lines will be available using both cDNA arrays (performed by Javed Khan, of NCI) and Affymetrix arrays (performed at St. Jude). Tissue arrays are being prepared that include each of the program's xenograft lines, and these will allow immunohistochemical determination of the expression of proteins relevant to molecularly targeted new agent testing.

New agents will be tested, when feasible, near the time that they are entering evaluation in adults with cancer and prior to their possible initial evaluation in children, NCI said. Several standard chemotherapy agents also will be tested in parallel, to calibrate the "PedPreclin" tumor panels using agents of known clinical activity for specific tumor types.

For both new agents and standard agents tested, pharmacokinetic studies will be performed in the animal models to determine the serum drug levels and systemic drug exposures associated with antitumor activity.

For selected molecularly targeted agents, the PPTP will evaluate whether target inhibition/modulation is achieved by the agent under the test conditions and whether this modulation is associated with antitumor activity.

Results from the preclinical testing program will be correlated with the clinical activity and the pharmacokinetic profile of the tested agents in children to assess the predictive capabilities of the PPTP's childhood cancer panels and the animal models.

NCI said the PPTP is responsive to the Best Pharmaceuticals for Children Act, which states that the NCI director "shall expand, intensify, and coordinate the activities of the institute with respect to research on the development of preclinical models to evaluate which therapies are likely to be effective for treating pediatric cancer."

Funding Opportunities:

RFAs Available

RFA-CA-05-021: Comprehensive Minority Institution/Cancer Center Partnership

Letters Of Intent Receipt Date: Jan. 22

Application Receipt Date: Feb. 22

NCI invites applications for partnerships between Minority-Serving Institutions and NCI-designated Cancer Centers (or groups of centers). The grant provides for collaborations among MSIs and cancer centers to develop stronger national cancer programs to understanding cancer disparities and impact on minority populations. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-05-021.html.

Inquiries: Sanya Springfield, NCI Office of Center, Training, and Resources, phone 301-496-7344; fax 30- 402-4551; email springfs@mail.nih.gov.

RFA-CA-05-022: Cooperative Planning Grant for Comprehensive Minority Institution/Cancer Center Partnership

Letters Of Intent Receipt Date: Jan. 22

Application Receipt Dates: Feb. 22

NCI invites cooperative agreement applications for a U56 Cooperative Planning Grant for Comprehensive MI/CCP to be used for institutions that are in the initial stages of planning for a comprehensive partnership. The CMICCP U54 (see preceding RFA) is to be used by institutions, which have already conducted considerable prior planning, and evaluation and are ready to begin implementing a partnership that involves inter-institutional cancer research projects, cancer training, and/or education or outreach programs. This U56 initiative promotes the development of plans and initiatives that will enable institutions to become competitive for a U54 cooperative agreement. The RFA is available at http://grants1.nih.gov/grants/guide/rfa-files/rfa-ca-05-022.html.

Inquiries: See preceding RFA.

Program Announcement

PAR-05-011: NCI Transition Career Development Award to Promote Diversity

NCI Comprehensive Minority Biomedical Branch invites applications from recipients of the NCI Mentored Career Development Award for Underrepresented Minorities or from advanced postdoctoral and/or newly independent research scientists representative of groups underrepresented in biomedical, behavioral, clinical, or social sciences. Awards will be made through the K22 mechanism for a total project period not to exceed 3 years. The PAR is available at http://grants.nih.gov/grants/guide/pa-files/PAR-05-011.html.

Inquiries: For Scientific/Research Contacts at NCI--Belinda Locke, Comprehensive Minority Biomedical Branch, phone 301-496-7344; fax 301-402-4551; e-Mail lockeb@mail.nih.gov.

In Brief:

Young: "We All Have A Stake In The Success Of NCI"

(Continued from page 1)

opening remarks at the BSA meeting on Nov. 8, his view of the board's role: "I have come to believe that this is one of the most influential and successful of all advisory boards that the NCI has. Our domain, broadly described, is about 85 percent of the NCI budget, that's roughly all of the funds that go extramurally. We influence only very indirectly certain large parts of that extramural budget, the R01 and P01 grant pools, but even there, the voice of this body is very important in letting the leadership of NCI understand the feeling of the community about the environment in which they work.

"We are the extramural funding community's voice," Young said. "We are the people who run into grant mechanisms on the ground. While there are many other bodies that provide input, we are charged with making sure that the NCI understands what it's like out there when one tries to utilize the grant mechanisms....

"We are advisors, not managers," Young said. "Their job is to listen. I can tell you, based upon my years of experience, they listen very carefully. It is very uncommon to see the NCI leadership go against the strongly expressed wishes of this board with regard to the construct of grants and mechanisms for stimulating cancer-related research.

"We will, from time to time, disagree in a spectrum of intensity with the proposals from the NCI. If you go back and look at the votes on the last four or five RFAs, you will see that unanimous opinions are not routine in this group. I believe that that's good. We fail if we don't speak out about the things we both like and dislike about the things we see in front of us.

"I personally believe that we all have a very big stake in the success of the National Cancer Institute and of its leadership," Young said. "We need this institution, this organization, and this leadership to be successful. We will be more successful if they are more successful. That's the spirit in which I agreed to take this over. Those of you who know me know that I frequently speak my mind, and I think that's what we all have to do if we are doing our job right in this capacity."

* * *

SUSAN GOTTESMAN of the NCI Center for Cancer Research, Laboratory of Molecular Biology, is the first recipient of the newly created **Alan Rabson** Award for NCI Intramural Cancer Research. The award

was initiated in recognition of Rabson's dedication and enthusiasm for NCI and its intramural program during his 50-year tenure at NCI, the Institute said. Rabson selected the award recipient with assistance from the Intramural Advisory Board. Gottesman will present the first Rabson Award Lecture at the NCI Combined Intramural Retreat, Jan. 12–13. . . . **JO ANNE ZUJEWSKI** was named senior investigator in the Clinical Trials Evaluation Program, NCI Division of Cancer Treatment and Diagnosis, where she will oversee breast cancer trials. Zujewski joined NCI in 1993. She founded the Breast Cancer Faculty Steering Committee and served on the planning committee for the NIH Consensus Conference for the adjuvant treatment of breast cancer. She also served as an expert medical consultant to several international initiatives in breast cancer. . . . **ELAINE OSTRANDER** was named chief of the Cancer Genetics Branch, one of seven branches in the Division of Intramural Research, National Human Genome Research Institute. Ostrander has held joint appointments at the Human Biology Division and Clinical Research Division at the Fred Hutchinson Cancer Research Center, and is an affiliate professor at the University of Washington, Seattle, in both the Department of Genome Sciences at the School of Medicine and the Department of Biology at the College of Arts and Sciences. For more than a decade, her laboratory has been mapping genes responsible for cancer susceptibility in dogs and humans, as well as studying prostate and breast cancer susceptibility genes in humans. . . **AMERICAN SOCIETY for Therapeutic Radiology and Oncology** awarded its 2004 Gold Medals to **Eli Glatstein**, **Luka Milas**, and **Paul Wallner**. Glatstein, professor and vice chairman, Department of Radiation Oncology, University of Pennsylvania Medical Center, is known for his work in staging cancer, particularly Hodgkin's disease. As chief of the Radiation Oncology Branch, Clinical Oncology Program, NCI Division of Cancer Treatment, he combined radiation oncology with medical oncology. Milas is professor of experimental radiation oncology, deputy head for translational research, Division of Radiation Oncology at M.D. Anderson Cancer Center. He was recognized for his work in the basic biology of tumors and clinical applications. Wallner is chief of the Clinical Radiation Oncology Branch, Radiation Research Program, NCI Division of Cancer Treatment and Diagnosis. He is known for his work in health policy. The awards were presented at the annual meeting in Atlanta on Oct. 4.

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