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NCI Tells CCOPs To Slow Patient Accrual To Clinical Trials, Prepare For Budget Cuts

By Kirsten Boyd Goldberg

Preparing for budget cuts, NCI officials told the principal investigators of its Community Clinical Oncology Program to slow the accrual of patients to cancer clinical trials.

Impending cuts are the latest of the calamities that have hit the community oncology program that accrues about a third of the patients who enroll in NCI treatment trials.

At the same time, Medicare has cut reimbursement for drugs, making some practices less eager to route patients to government trials, which pay far less than trials funded by industry. Also, NCI-funded cooperative groups are cutting the number of clinical trials they conduct, narrowing opportunities for enrollment by CCOP investigators.

"Right now, the incentive is not to put a patient on a trial," said Shaker Dakhil, PI of the Wichita, Kan., CCOP. "Unless something is done to

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In the Cancer Centers:

MSKCC Receives $100-Million Commitment From Zuckerman For New Research Center

MEMORIAL SLOAN-KETTERING Cancer Center received a commitment from publisher, real estate developer, and MSK Board member **Mortimer Zuckerman** of $100 million from his charitable trust toward the center's new cancer research facility scheduled to open this month.

The donation is the largest single commitment by an individual in MSK history. The MSK Boards of Overseers and Managers plan to name the building The Mortimer B. Zuckerman Research Center. Zuckerman is chairman and editor-in-chief of U.S. News and World Report, publisher of the New York Daily News, and the founder of Boston Properties Inc.

When completed, the 693,000 square-foot complex will nearly double the size of MSK's research enterprise.

"The Mortimer B. Zuckerman Research Center gives vivid physical expression to this institution's role as a leader in cancer research," said MSKCC President **Harold Varmus**. "The configuration of its laboratories and other spaces will encourage interactions that are critical to productive collaborations among basic scientists and clinical investigators. We are fortunate to have someone like Mort who recognizes the essential connection between scientific discoveries and advances in patient care."

The new building, which includes 16 laboratory floors, is located on

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Medicare And NCI Put Squeeze On CCOP Ability To Accrue

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encourage NCI research, all research is going to be done by industry. Maybe that's the goal."

Reviewers, PIs, and NCI officials often hail the program as the institute's most successful endeavor to bring state-of-the-art cancer care to patients in their communities. But the Bush administration has proposed a $40-million cut in NCI's $4.8 billion budget next year, which seems to have caught NCI officials in a bind between previous grant commitments and rising research costs.

In March, the NCI official who oversees the CCOP told the PIs to watch their numbers.

"I informed everyone that our program was not immune to the budget cuts affecting all the NCI programs and that it was our expectation that the FY06 funding would be less than FY05," Lori Minasian, chief of the NCI Community Oncology and Prevention Trials Research Group, said to The Cancer Letter. "Faced with decreasing funding through the CCOP grant, it would only be prudent for the CCOP investigators to slow down their accrual."

Those were discouraging words to many CCOP PIs, since many of the programs had been able to increase accrual over the past several years.

"It was not a good message to hear," said one CCOP PI who did not want to be identified by name.

"The message was to be prepared for flat funding or a 10 percent downturn," said another CCOP PI. "At the time we are being asked to push accrual, if you put 100 patients on trials and you get X amount of dollars, and if you put 150 people on trials and you still get X amount of dollars. It strains your resources."

An administrator of a CCOP research base, which develops and implements prevention and control trials, said CCOPs could be in for a rough time. "We were told that the overall program would be taking a cut this year, and that next year would be worse," the administrator said. "Under those circumstances, it just might be prudent for the CCOPs to reduce accrual, since they may have to reduce staffing.

"We need a really good 'tooth fairy.'"

The institute established the CCOP in 1983 to help community oncologists offer patients the option of enrollment on NCI-supported cancer treatment and prevention trials without having to travel to distant cancer centers.

Currently, NCI funds 50 CCOPs and 13 Minority-Based CCOPs, a program established in 1989 to improve minority accrual. The grants pay the salaries of research support staff to handle paperwork and data collection. About 4,000 community oncologists are involved with CCOPs, providing access to trials at over 400 community hospitals, according to an NCI publication written for the program's 20th anniversary in 2003. The book is available at www.cancer.gov/prevention/ccop20th/.

"NCI strongly supports the CCOP and MB-CCOP," NCI Division of Cancer Prevention Director Peter Greenwald said in an email to The Cancer Letter. "Together, they have been a pillar of strength and excellence. CCOPs lead our landmark cancer prevention trials, contribute one-third of accrual to cancer treatment trials, provide crucial studies of optimal symptom management, and boost minority participation in NCI-sponsored trials. I have tremendous respect and admiration for the participants; the CCOP physicians, nurses, clinical research associates and their co-workers; and the superb management by the CCOP research bases.

"Accrual is tied to budget," Greenwald said. "We will aim for a good and dependable budget, but must recognize that nearly everyone in the cancer research community is hit by the current squeeze. We may not know our FY07 budget until September, or possibly even later."

"We Shut Down For Two Months"

If Congress doesn't provide NCI with additional funding, more CCOP PIs could be faced with the kind

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Founded Dec. 21, 1973, by Jerry D. Boyd.

of administrative toothache that confronted Wichita's Dakhil.

Last year, the CCOP exceeded its target accrual in 10 months. NCI encouraged Dakhil to continue accrual, but couldn't offer funds to hire additional staff, he said. "If we continued, with the same number of nurses, we would overwork our nurses and we will have lousy data," he said.

"We were 100 credits above our target, so we told our physicians to stop accruing," Dakhil said. "We just shut down for two months."

The research staff of 18 spent the two months "catching up on paperwork, 95 percent of which has little value," Dakhil said.

The Wichita CCOP, an NCI grantee since 1983, normally budgets for 900 accrual credits—a number that Dakhil said represents about 1,200 patients, since some trials provide only partial credits.

The Wichita CCOP was one of 12 community practices recently recognized by the American Society of Clinical Oncology for its commitment to clinical research. Dakhil said that commitment is increasingly strained by the financial squeeze resulting from changes in Medicare reimbursement.

"[In a trial] a drug is provided for free to the patient," Dakhil said. "Therefore, I lose revenue on that drug. But also, if you can't bill for the drug, you can't bill for chemotherapy administration. If I didn't put the patient on a trial, I can bill for the drug and the administration."

At the satellite office of Dakhil's practice in Dodge City, 160 miles from Wichita, nurses not paid by the CCOP grant register patients on NCI trials. "For the CCOP, I don't charge any rent, and when I use my own nurses, I don't charge the CCOP," he said. "If I put so many patients on trial and many are from the satellite, I'm paying for it."

Recently, Dakhil figured out how much he pays for the honor of being a CCOP PI. "We subsidize the research by at least $200,000 a year," he said. "We did it for years, because money was less tight, but now, Medicare said you can't make money on this, and we looked at the expenses and found out that all these years, we have been subsidizing the research."

The Kansas oncologists also enroll patients on trials funded by the pharmaceutical industry, which pay $6,000 to $8,000 per patient, compared to NCI's $2,000. "Now, we have less than 10 percent involvement in pharmaceutical trials, but over time, we will be shifting to more of these," Dakhil said.

Dakhil also hopes to secure additional support for the CCOP through the state legislature. "We are committed to this program, because what we get is much better care," he said. "We have been able to tell our patients in the state of Kansas that being on a clinical trial is really in the upper echelon of care. This has been a major asset to our practice."

CCOPs are "probably the best concept NCI ever came up with for research," Dakhil said. "CCOPs are major accruers on all of these major national trials, and the quality of research is as good as anybody else's. It's an extremely valuable program, but the support has been dwindling. If the effect has not been shown yet, it's because people are subsidizing it."

Dakhil said he worries about recruiting the next generation of community oncologists to clinical research. "You see all these gray-haired people who go to the CCOP meetings," he said. "How do we get people to commit to the program?"

The trials require "paperwork that is just humongous," with extensive reporting to the local IRB, Dakhil said. "You have sick people on chemotherapy, and anything that happens has to be reported."

The incentives for taking part in CCOPs have suddenly vanished, Dakhil said. "Why put yourself through such a hassle—and it costs the practice money?"

"Funding Is Never Adequate"

In Marshfield, Wisc., CCOP PI Tarit Banerjee said he wouldn't stop accruing patients to trials.

"The funding is never adequate," Banerjee said. "We have to support it with institutional funds, and they try to restrict the funding to hire people to run the program. It's a big struggle.

"On the other hand, the physicians like the program, because they can get the state-of-the-art clinical trials that they can offer to their patients," he said.

In addition to the treatment trials, CCOPs are required to accrue patients to prevention and control studies, sometimes in healthy people who might not normally visit an oncologist's office. "The insurance programs often do not cover this, so we have to find a way to recruit them outside the clinic pool. That's hard work."

But for Banerjee, of the Marshfield Medical Research and Education Foundation CCOP, stopping accrual wouldn't be an option.

"We have not stopped it, because it would be discouraging to the oncologists not to put patients on the studies," Banerjee said. "In the cancer control studies, we are achieving the accrual goals. We would have

received additional funding if we could have exceeded our accrual goals. We won't be able to do it this time. The problem is, we don't have any new prevention protocols this year. We are just following up on the prevention studies from previous years. There is one new breast cancer prevention study coming this fall, so that will help next year."

Having the CCOP grant and access to trials "helps improve the institution, especially in the quality of surgery, radiation, and chemotherapy, since everything has to be carried out under protocol guidelines," Banerjee said.

"We have to struggle through," he said. "This program will improve cancer treatment and survival. The more people who go on studies, the better it is for everyone."

Martin Wiesenfeld, PI of the Cedar Rapids Oncology Project CCOP, said revenue from industry-funded trials and foundations helps support accrual to NCI trials.

"We have enough foundation money that funding is not a barrier to accrual," Wiesenfeld said. "Each CCOP is going to have to look at their situation. Some say, 'when we get to 100 credits, we are going to have to close the door.' I don't know how much of that is posturing or is a real problem. It's probably a combination of both.

"You can always get a few more people on [trials] just by economies of scale," Wiesenfeld said. "Many CCOPs do a mix of NCI and industry trials.

"Industry studies may help you generate revenue to do government studies, but many people have concerns that it's a bad precedent to have publicly-funded research paid from another direction," Wiesenfeld said. "If federal funding drops too low, it's not a good thing."

The lack of a permanent NCI director also "is not making anyone comfortable," Wiesenfeld said. "No one is saying we're going to shut down, but there is worry that CCOP accrual is not open-ended. Everyone is very confused, because for the last couple of years, the emphasis at NCI has been on 'big science.'

"CCOP participation has brought investigators and their communities together for a common purpose," Wiesenfeld said. "It is too successful a program to jeopardize with budget cuts."

In Phoenix, Susan Colvin, research director for Western Regional CCOP, said she finds herself trying to restructure the program at a time of budget constraints.

"We struggle more with meeting our accrual than exceeding it," Colvin said. "Our concerns with funding are what's going to be there for a CCOP that struggles to meet its goals?"

The Western Regional CCOP was established 23 years ago with all staff in one location. Nurses and data managers travel to meet patients at physician offices and hospitals. But often, the CCOP doesn't get the opportunity to present the option of a clinical trial to a patient, because the physician has already discussed treatment. The CCOP staff may have to travel 40 miles through heavy traffic to see the patient, and by that time, the patient has already decided on a course of treatment.

"This year, we are moving toward getting space at the hospitals we deal with and trying to staff them to be closer to the physicians," Colvin said. "It's being there to remind the physician that, hey, there is a protocol. And not having that be an afterthought."

Waiting For The RFA

PIs are waiting for NCI to release the FY07 Requests for Applications for the CCOP and Minority-Based CCOP.

The institute didn't release RFAs last year, but provided CCOPs with one-year funding extensions while the Clinical Trials Working Group reviewed the institute's programs.

Minasian said the FY07 RFAs are "actively planned for release." In its review, the CTWG praised the CCOPs and recommended expanding the Minority-Based CCOPs, she said.

"The CTWG also established a Clinical Trials Operation Committee that has been working on standard language across all funding mechanisms for clinical trials, and some delay in this year's release stems from the need for their input," she said.

Since the CCOP grant year is June 1 to May 31, FY05 funding supports accrual from June 1, 2005, until May 31, 2006, Minasian said. "For FY05, the nine-month treatment data suggested that the total treatment accrual would be closer to 8,000 if the CCOPs continued to accrue at the current rate," she said.

"During the years of the NIH budget doubling, we had the ability to increase the grant funding based upon accrual productivity," Minasian said. "Thus, many CCOPs were able to demonstrate their capacity for accrual and there was a steady increase over time, as each year's increase in accrual resulted in some increased funding.

"In FY03, the CCOPs and Minority-Based CCOPs accrued about 7,400 cancer patients to treatment trials and another 5,500 participants on cancer prevention/

control trials," she said.

For calendar year 2005, the total accrual to NCI phase III treatment trials was 22,320, including CCOP accrual, Minasian said.

In 2001 through 2003, when there were two large prevention trials open, STAR and SELECT, the CCOPs alone accrued between 7,000 and 8,000 participants to prevention trials, she said.

"When there are open large prevention trials, we have high accrual, and when there are only small trials open for accrual, we have smaller numbers," she said.

Under NCI's projections for FY07, if the administration's budget proposal is enacted, funding would drop for the cooperative groups and cancer centers as well, institute officials said.

Advocacy:

NBCC Seeks To "Award" Those Who Exploit Cancer

By Paul Goldberg

Late next month, the National Breast Cancer Coalition will announce the winner of what may be one of the more competitive, yet least sought-after prizes in oncology: the Golden Boob.

"In the fight to stop breast cancer, we're out to find and highlight the biggest boobs of all: Those who are exploiting breast cancer for their own business or political ends," the coalition said, announcing this award. "And we need your help.

"It's time to expose these boobs for what they are."

How can one help? By visiting www.GoldenBoob.org and either voting for one of the nominees or nominating someone more worthy of the honor.

"The nominations are open, and we hope people will give us their best ideas," said Sandra Adams, NBCC senior vice president for external affairs.

Adams said a trophy would be awarded. "Yes, there will be a real award, which will be unveiled in June, when we announce the winner," she said.

It's less certain that the laureate would appear to accept the honor.

The coalition's initial picks are:

—The Abortion/Breast Cancer Coalition. According to NBCC, "ABC asserts abortion leads to an increased risk of breast cancer. There is no credible evidence to back up this claim, and the largest and most reliable research studies have found that no such link exists, a truth accepted by the National Cancer Institute and all credible groups and researchers. This group is using breast cancer as a scare tactic, pure and simple. By spreading false medical information, ABC misleads the public and creates needless anxiety for women who may have had abortions. Their attacks on the work of national organizations and research institutions dangerously undermine efforts to find the true causes, prevention, and cures for breast cancer."

—Mark For Life, an organization that sells a "Breast Self Examination Kit," which includes an "examination shirt," a marking pen, and an instruction card for $24.99.

"This group suggests that performing a breast self examination could save your life," the NBCC nomination states. "This organization is twisting the facts to make a buck. In reality, BSE is not a reliable and sure way to detect breast cancer. On the contrary, there is solid evidence that BSEs lead to an increased number of unnecessary breast biopsies due to the detection of non-cancerous lumps."

Now, with the nomination process open, the field of contenders has widened—and running for cover has ceased to be an option.

Capitol Hill:

House Committee Adds $4.1 Billion To HHS Budget

The House Appropriations Committee earlier this week passed a budget resolution that added $4.1 billion to the President's budget proposal for the departments of Labor, HHS and Education.

However, these funds aren't expected to make their way to NIH.

The allocation by House Appropriations Committee Chairman Jerry Lewis (R-Calif.) was approved by the committee on a 35-27 vote May 9.

The House allocation for the spending bill now stands almost $3 billion below the Senate allocation, which seeks to boost the Labor, HHS bill by $7 billion over the President's proposal.

A $7 billion increase would make it possible to increase NIH funding, and would match the Senate allocation.

The allocation is slightly below the President's cap on discretionary spending.

Lewis said his goal is to pass all the spending bills before July 4, thereby avoiding appropriating funds through an enormous omnibus bill.

"That type of legislating breeds fiscal mischief and should be avoided at all costs," Lewis said in a statement.

In Brief:

Zuckerman Commits $100M To MSKCC For New Building

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East 68th Street between First and York Avenues in Manhattan, across the street from Memorial Hospital. After the building opens, work will begin on a connecting seven-story structure scheduled for completion in 2009. It will add a conference center with a 350-seat auditorium and a number of "dry" laboratories.

"As a member of the board, I have been impressed and inspired by the vision that led to the creation of this beautiful and functional research building," Zuckerman said in a statement. "And, as someone who has seen both the suffering cancer causes and the hope each new advance brings, I am determined to do what I can to accelerate the pace of progress and to help the center's extraordinary scientists and physicians achieve their crucial goals."

* * *

VIRGINIA COMMONWEALTH University Massey Cancer Center May 6 dedicated the Goodwin Research Laboratory, an 80,000-square-foot cancer research laboratory. Named in honor of **William and Alice Goodwin**, the laboratory provides space for up to 250 researchers. The Goodwins have donated $25 million to Massey for the new building and for the center's translational research program. . . . **EMIL FREI III**, physician-in-chief emeritus of Dana-Farber Cancer Institute, was honored at the Friends of Dana-Farber Cancer Institute 30th Anniversary Gala April 29 in Boston. With two others, Frei is credited with developing a novel approach to chemotherapy that led to complete cures for some childhood leukemia patients in the early 1960s and has been used successfully on other cancers as well. The event raised more than $440,000. **Edward Kennedy Jr**., a former patient of Frei's, spoke at the gala, along with a number of physicians who worked with Frei. . . . **MILTON BROWN,** an expert in the design, synthesis, and evaluation of new therapeutic agents and a faculty member at the University of Virginia, will join Georgetown University on June 1. He will have a double appointment as associate professor in oncology and neuroscience. Over the past five years, Brown's laboratory tested nearly a thousand compounds for possible use as therapeutics to treat prostate cancer, acute myeloid leukemia, pain, and epilepsy. Human clinical trials are expected to be conducted on a number of these compounds. Brown will bring 10 members of his research team from UVA with him.

Obituary:

David K. King, Original PI, Western Regional CCOP

DAVID K. KING, principal investigator of the Western Regional Community Clinical Oncology Program for 23 years, died March 21 of pancreatic cancer at his home in Phoenix, Ariz. He was 64.

King was chief of staff of the Banner Good Samaritan Medical Center. He was one of the original CCOP PIs when NCI began the program in 1983. King and his practice partners, with four other private oncology practices, organized what was then known as the Greater Phoenix CCOP.

King was active in the Association of Community Cancer Centers, serving as its president in 1988-89. He represented ACCC on the American College of Surgeons Commission on Cancer from 1994 through 2003. Under his leadership, the commission's 151 standards for cancer programs were revised, culminating in the Cancer Program Standards 2004.

Locally, he served in the Arizona Division of the American Cancer Society and was a board member and medical advisor for the Hospice of the Valley. He was instrumental in developing the City of Hope Samaritan Bone Marrow Transplant Program in 1997.

"Dr. King was one of those rare individuals who can positively influence at the local, regional and national levels," the medical center statement said. "He touched the lives of tens of thousands of Arizonans through his 30-plus years in medical practice and through the many hours he devoted to developing educational, outreach, research, and cancer care programs. A bright light has gone out for many—we will miss his humor, wisdom, compassion, and love."

Born in Logan, W.Va., King received his undergraduate degree from Yale University and his medical degree from the West Virginia University School of Medicine. After completing a fellowship at the M.D. Anderson Hospital and Tumor Institute, King relocated to Phoenix.

King is survived by his wife Vicki; a daughter; a son and daughter-in-law; his mother and a brother.

Funding Opportunities:

RFPs Available

RFQ-NCI-60062-NV: Drafting of Clinical Trials Agreements, Cooperative Research and Development Agreements and Materials Transfer Agreements. Response Due Date: May 23. NCI Cancer Therapy Evaluation Program seeks a contractor with a Ph.D. in a biomedical scientific

field, and experience in the drafting of the agreements used by the NIH to facilitate collaborations with pharmaceutical companies and academic institutions. Full text: http://www.fbodaily.com/archive/2006/05-May/07-May-2006/FBO-01041909.htm. Deborah Moore, 301-402-4509; dm170b@nih.gov.

RFP: N02-CB-57037-19 Management of NCI Chemical Resource Repository. Response Due Date: Oct. 24. NCI Chemical and Physical Carcinogenesis Branch seeks a contractor to perform chemical characterizations and develop analytical protocols to ensure chemicals of uniform, high quality and maintain a computerized chemical inventory system. Full text: http://www.fbodaily.com/archive/2006/05-May/03-May-2006/FBO-01038767.htm. Inquiries: Diane Stalder, 301-435-3822, MaryAnne Golling, 301-435-3819, ds88b@nih.gov, mg345x@nih.gov.

RFAs Available

RFA-CA-07-022: Innovations in Cancer Sample Preparation. R21. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-022.html.Inquiries: Gregory Downing, 301-496-1550; downingg@mail.nih.gov.

RFA-CA-07-023: Innovations in Cancer Sample Preparation. R33. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-023.html.

RFA-CA-07-024: Innovations in Cancer Sample Preparation. R21/R33. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-024.html.

RFA-CA-07-017: Application of Emerging Technologies for Cancer Research. R21. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-017.html. Inquiries: Gregory Downing, 301-496-1550; downingg@mail.nih.gov.

RFA-CA-07-018: Application of Emerging Technologies for Cancer Research. R33. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-018.html.

RFA-CA-07-019: Application of Emerging Technologies for Cancer Research. R21/R33. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-019.html.

RFA-CA-07-015: Innovative Technologies for Molecular Analysis of Cancer. Letters of Intent Receipt Date: Aug. 21, Application Receipt Date: Sept. 21. R21. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-015.html. Inquiries: Gregory Downing, 301-496-1550; downingg@mail.nih.gov.

RFA-CA-07-016: Innovative Technologies for Molecular Analysis of Cancer. R33. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-016.html.

Program Announcements

PA 06-380: Basic Translational Research in Emotion. R01. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-380.html. Inquiries: Kevin Quinn, 301-443 1576; kquinn@mail.nih.gov.

PAR-06-406: In Vivo Cellular and Molecular Imaging Centers. P50. Letters of Intent Receipt Date: July 16; July 16, 2007. Application Receipt Date: Aug. 16, Aug. 16, 2007. Full text: http://grants.nih.gov/grants/guide/pa-files/PAR-06-406.html. Inquiries: Anne Menkens, 301-496-9531; menkensa@mail.nih.gov.

PA-06-404: Studies of Energy Balance and Cancer in Humans R01. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-404.html. Inquiries: Virginia Hartmuller, 301-594-3402; hartmulv@mail.nih.gov.

PA-06-405: Studies of Energy Balance and Cancer in Humans R21. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-405.html.

PA-06-400: Developmental Projects in Complementary Approaches to Cancer Care.R21. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-400.html. Inquiries: Wendy Smith, 301-435-7980; smithwe@mail.nih.gov.

PA-06-398: Novel Technologies For In Vivo Imaging. R21/R33. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-398.html**.** Inquiries: Guoying Liu, Keyvan Farahani, James Deye, or Houston Baker, 301-496-9531 for GL, KF, HB; 301-496-6111 for JAD; guoyingl@mail.nih.gov, farahank@mail.nih.gov, deyej@mail.nih.gov, bakerhou@mail.nih.gov.

PA-06-399: Novel Technologies For In Vivo Imaging. R33. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-399.html**.**

PAR-06-381: Cancer Prevention, Control, Behavioral, and Population Sciences Career Development Award. K07. Full text: http://grants.nih.gov/grants/guide/pa-files/PAR-06-381.html. Inquiries: Lester Gorelic, 301-496-8580; gorelicl@mail.nih.gov.

PA-06-396: New Technologies for Liver Disease. STTR. R41/R42. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-396.html. Inquiries: Asad Umar, 301-594-7671; au9q@nih.gov.

PA-06-397: New Technologies for Liver Disease. STTR. R43/R44. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-397.html.

PA-06-385Cancer Surveillance Using Health Claims-Based Data. R01. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-385.html. Inquiries: Joan Warren, 301-496-5184; warrenj@mail.nih.gov.

PA-06-386Cancer Surveillance Using Health Claims-Based Data. R21. Full text: http://grants.nih.gov/grants/guide/pa-files/PA-06-386.html.

PAR-06-394: Global Research Initiative Program, Basic/Biomedical Sciences. R01. Full text: http://grants.nih.gov/grants/guide/pa-files/PAR-06-394.html.

NOT-CA-06-025: Selection of Appropriate Funding Opportunity Announcements for the Innovative Technologies for Molecular Analysis of Cancer Program. Full text: http://grants.nih.gov/grants/guide/notice-files/NOT-CA-06-025.html. Inquiries: Gregory Downing, 301-496-1550; downingg@mail.nih.gov.

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The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

Mohammad Jahanzeb, MD
St. Jude Children's Research Hospital/ University of Tennessee Cancer Institute

Coming Soon

Highlights from the NCCN 11th Annual Conference: Clinical Practice Guidelines & Quality Cancer Care™

- 2006 CMS Oncology Demonstration Program With NCCN Guidelines
- A Multidisciplinary Approach to Staging: Issues for Colon and Rectal Cancer
- Adjuvant Chemotherapy in High-Risk Stage II Colon Cancer Patients
- Advances in Vaccines for Cancer Prevention
- Clinical Data Evaluating Use of Erythropoietin in Solid Tumors and Hematologic Malignancies
- Multidisciplinary Approaches to the Treatment of Head & Neck Cancer
- New Therapies for Renal Cancer
- New Therapies in Breast Cancer
- New Trends in the Treatment of Chronic Myelogenous Leukemia
- New Trends in the Treatment of Mantle Cell Lymphoma
- Update: Breast Cancer Guidelines
- Update: Soft Tissue Sarcoma Guidelines

Highlights from the NCCN 11th Annual Conference are approved for AMA PRA Category 1 Credit and are also approved for Nursing CE credit.

Available Now

NCCN Regional Guidelines Symposia

- NCCN Cancer- and Treatment-Related Fatigue and Anemia*
- NCCN Clinical Practice Guidelines in Oncology™ Breast Cancer
- NCCN Clinical Practice Guidelines in Oncology™ Colorectal Cancers
- NCCN Clinical Practice Guidelines in Oncology™ Non-Small Cell Lung Cancer
- NCCN Clinical Practice Guidelines in Oncology™ Supportive Care*
- NCCN Task Force Report: Adjuvant Therapy in Breast Cancer

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