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FDA Approves Gemzar For Ovarian Cancer, Contradicting ODAC Recommendation

By Paul Goldberg

FDA earlier this week contradicted the recommendation of the Oncologic Drugs Advisory Committee and approved the Eli Lilly & Co. drug Gemzar (gemcitabine HCl) in combination with carboplatin for recurrent ovarian cancer that has relapsed at least six months after initial therapy.

At a meeting last March, the committee voted 9-2 against approval because the Gemzar-carboplatin combination failed to extend survival in this indication (The Cancer Letter, March 24).

The decision to approve the therapy amounts to a declaration by

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In Brief:

Cancer Society Presents Luther Terry Awards To Anti-Tobacco Advocates At D.C. Meeting

AMERICAN CANCER SOCIETY honored anti-tobacco advocates with its 2006 Luther L. Terry Awards, presented at the World Conference on Tobacco OR Health last week in Washington, D.C. The award winners were: **Margaretha Haglund**, co-founder and president of the International Network of Women Against Tobacco; **Witold Zatonski**, activist and researcher in Poland and Eastern Europe; **Luk Joossens**, tobacco control advocate whose work led to Belgium's tobacco advertising ban; **Bungon Ritthiphakdee**, coordinator of the Southeast Asian Tobacco Control Alliance; **Sir Richard Peto**, professor of medical statistics and epidemiology and co-founder and co-director of the clinical trial service unit at the University of Oxford; the Ministry of Health and Family Welfare, Government of India, headed by **Anbumani Ramadoss**, for health promotion and tobacco control; Department of Health and Children, Republic of Ireland, headed by **Tánaiste Mary Harney**, for its national tobacco control legislation; **Campaign for Tobacco-Free Kids**, for its work as a counter force to the tobacco industry; and **Framework Convention Alliance**, a global coalition of non-governmental organizations. . . . **LUSTGARTEN** Foundation for Pancreatic Cancer Research announced the awardees for two grants of $500,000. **Marcia Canto**, associate professor of medicine and oncology at Johns Hopkins University, will lead a screening study on inherited predisposition for pancreatic cancer. With matching funds from NCI, over $1 million has been committed to the project. **Georg Halder**, of M.D. Anderson Cancer Center, will study genetic screens to identify drug targets for pancreatic cancer. . . . **RICHARD BLEICHER** joined the Department of Surgical Oncology at Fox Chase Cancer Center. Bleicher was

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Approval Continues FDA Trend To Recognize PFS As Endpoint

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the agency that a delay in the progression of disease represents a compelling justification for regular approval. Previously, the agency's standard for regular approval in many indications was prolongation of survival.

The apparent change is the outcome of a series of meetings held by the agency's oncology drug division in collaboration with the American Society of Clinical Oncology and the American Association for Cancer Research.

The change is not related to the Critical Path initiative, which is used by the agency to encourage validation of surrogate endpoints and development of methodology for adaptive clinical trials (The Cancer Letter, July 14).

The Gemzar approval for ovarian cancer is part of a trend in agency actions that favor approving oncology drugs based on progression-free survival, and a similar metric, time to progression. In recent months, the agency approved the drugs Nexavar, Sutent, and Revlimid based on their ability to slow progression of disease (The Cancer Letter, Feb. 24).

In the case of Gemzar, the agency's action is particularly telling because it involved contradicting the recommendation of an advisory committee that determined explicitly that an increase in progression-free survival in recurrent advanced ovarian cancer was insufficient to support an approval of a supplemental New Drug Application. PFS—defined as time from randomization to progressive disease or death—is a soft endpoint that doesn't eliminate the potential of investigator bias, the committee decided.

The agency's top oncology official, Richard Pazdur, justified the decision in a letter to ODAC members and in an interview with The Cancer Letter.

"Although an improvement in overall survival remains the gold standard, alternative endpoints, especially PFS and time-to-progression (TTP) in advanced disease and disease-free survival (DFS) in the adjuvant setting, have been advocated for approval endpoints in malignant diseases," Pazdur wrote in a letter to ODAC members. "The analysis of overall survival may be confounded by cross-over and/or subsequent therapies. PFS, measured prior to the introduction of other therapies, may more accurately depict a treatment's therapeutic effect."

The text of the letter appears on page 3.

In an interview, Pazdur said the Gemzar approval points to advantages of randomization:

"We really want to emphasize the role of doing randomized trials in drug approval. I think we have demonstrated through this action a willingness to accept a delay in progression as clinical benefit, and we definitely would like to see trials done which examine progression-free survival rather than doing single-arm trials looking solely at response rates in very refractory disease populations," Pazdur said.

"I think on multiple occasions we've discussed the advantages of randomized trials not only providing greater efficacy information regarding time-to-event endpoint, such as survival and time-to-progression and progression-free survival, but also giving a more accurate picture of safety."

The text of the interview appears on page 5.

Gemzar has been on the market for a decade and is approved for pancreatic cancer, non-small cell lung cancer, and metastatic breast cancer.

The Gemzar-carboplatin combination has been widely used off-label to treat ovarian cancer patients who had relapsed after treatment with taxane and platinum, because it has a compelling toxicity profile.

Patients treated with paclitaxel-carboplatin have residual neuropathy and cannot continue to receive that regimen. Oncologists have been offering Gem-carbo as an alternative for these patients.

In the company's phase III pivotal trial, the Gemzar-carboplatin regimen was compared with carboplatin alone, producing a median increase in progression-free survival of about three months, but no

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

overall survival advantage.

The study was conducted by AGO-OVAR, a European cooperative group that specializes in gynecological malignancies.

The study, which was conducted entirely outside the U.S., enrolled 356 patients with advanced ovarian cancer that had relapsed after six months. Patients were randomized to receive either Gemzar with carboplatin or carboplatin alone. The study was powered for PFS as a primary endpoint. Overall survival was a secondary endpoint.

According to an FDA analysis presented at the ODAC meeting, the Gemzar-carboplatin combination improved PFS (HR 0.72, p=0.0038, median 8.6 months for Gemzar-carboplatin vs. 5.8 months for carboplatin alone).

There was no apparent effect on survival (HR 0.98, p=0.898). However, this finding could have been confounded by crossover from the carboplatin to Gemzar-carboplatin.

The combination regimen was associated with higher anemia, neutropenia, and thrombocytopenia. However, the Gemzar combination produced less neurotoxicity than the taxane-platinum combinations that patients in the U.S. would likely have received as first-line therapy.

Independently assessed response rates were 46.3 percent for Gemzar-carboplatin and 35.6 percent for carboplatin alone.

Last April, a month after the ODAC meeting, FDA held a workshop on endpoints for approval of drugs for ovarian cancer. The meeting was co-sponsored by ASCO, AACR, and FDA.

Also, following ODAC, the company presented additional followup safety and efficacy data as well quality of life data on the drug.

"I think it was the aggregate of the data that swayed the FDA," said Richard Gaynor, vice president of cancer research and global oncology platform leader at Eli Lilly.

Though the agency is moving away from the survival endpoint, it's not clear that the measurements of slowing disease progression should be applied across the board, he said. "I think what you are going to have to do is look at it in each clinical situation," Gaynor said. "It would be very challenging to look at overall survival in trials where multiple treatment options are available to patients after they fail experimental therapy. It will have to be on a tumor-by-tumor basis that you evaluate the significance PFS. However, with more and more agents coming up that have efficacy in different tumors, at least it seems that there will be more use of PFS in evaluating agents that come forward in the future."

Two years ago, the Third Ovarian Cancer Consensus Conference recognized PFS as an acceptable endpoint for studies in first-line and second-line ovarian cancer. The statement of the consensus conference, which represented the views of 13 leading ovarian cancer treatment groups, reads:

—"Although OS is an important end point, progression-free survival may be the preferred primary end point for trials assessing the impact of first-line therapy because of the confounding effect of the post-recurrence/progression therapy on OS. When PFS is the primary end point, measures should be taken to protect the validity of analysis of OS."

—"Post-recurrence/progression trials: The choice of the primary end point needs to be fully justified with appropriate power calculations. Symptom control/quality of life (for early relapse) and OS (for late relapse) may be the preferred primary end points, although PFS should still be used in the assessment of new treatments. Whatever the primary end point, the ability of the study design to detect important differences in survival should be formally addressed."

The results of the consensus conference are posted at http://ctep.cancer.gov/resources/gcig/bibliography.html.

FDA doesn't always follow the recommendations of its advisory committees. In oncology, the agency chose not to take the committee's unanimous recommendation to approve the colon cancer drug UFT (The Cancer Letter, July 21, 2000).

FDA Says Gemzar Approval Consistent With Recent Action On Nexavar, Sutent, Revlimid

In a letter to members of the Oncologic Drugs Advisory Committee, Richard Pazdur, director of the FDA Office of Oncology Drug Products, described the agency's rationale for disregarding the committee recommendation and approving the Eli Lilly & Co. drug Gencitabine for ovarian cancer.

The text of the July 17 letter follows:

On July 14, 2006, the FDA approved the supplemental NDA (sNDA) for Gemzar gemcitabine HCl, Eli Lilly & Co.) in combination with carboplatin for the treatment of patients with advanced ovarian cancer whose disease had relapsed at least 6 months after completion of platinum-based therapy. This sNDA was discussed at the March 13, 2006, ODAC meeting. The

committee recommended not to approve this sNDA. The FDA generally follows the recommendation of advisory committees; however, these recommendations provide advice to the Agency and are not binding. The Agency carefully considered the ODAC's deliberations in our review process. We are writing to provide you with the rationale for our current regulatory decision.

Gemcitabine has been marketed for over a decade in the United States and has indications in advanced pancreatic cancer (initial approval), advanced non-small lung cancer, and advanced breast cancer. From a safety perspective, the previous NDA, sNDAs, and extensive post-marketing experience have provided a comprehensive safety profile consistent with other approved cytotoxic drugs prescribed in the treatment of advanced cancers. The safety data base contained in the current sNDA is consistent with this extensive prior experience with gemcitabine. We considered the totality of the past information, both safety and efficacy, in our regulatory decision-making.

The primary basis for approval of the current sNDA was a multicenter, international, randomized trial allocating patients to either carboplatin or a carboplatin plus gemcitabine combination. The study's primary endpoint was progression-free survival (PFS). The trial achieved its primary endpoint demonstrating a statistically significant improvement in the PFS endpoint for the combination arm (HR 0.72 (0.57, 0.90), p=0.0038) representing a 28% improvement in PFS in patients treated with the combination compared to those treated with single-agent carboplatin. Several exploratory sensitivity analyses examining PFS corroborated gemcitabine's effect on this endpoint.

A statistically significant improvement in investigator reviewed response rate (including complete response rate) was associated with the addition of gemcitabine to carboplatin. Overall survival was a secondary endpoint and was not statistically improved by the addition of gemcitabine to carboplatin. Approximately 75% of patients in each arm received post-study chemotherapy, including 13 of 120 patients on the carboplatin arm for whom post-progression chemotherapy drugs were known and who received gemcitabine after progression. Following the ODAC meeting, the applicant submitted additional analyses (event-free interval and treatment-free interval). Both event-free interval and treatment-free interval analyses demonstrated statistically significant improvements with the addition of gemcitabine to carboplatin.

Considerable discussions within the Agency, at the ODAC meetings (including the March 13 meeting), with international regulatory agencies, and in workshops conducted with oncology professional societies have focused on appropriate endpoints for drug approval in malignant diseases. These workshops have included endpoint discussions in lung, colorectal, and prostate cancers as well as hematological malignancies. In April, 2006 a workshop was held discussing endpoints for drug approval in advanced ovarian cancer.

Although an improvement in overall survival remains the gold standard, alternative endpoints, especially PFS and time-to-progression (TTP) in advanced disease and disease-free survival (DFS) in the adjuvant setting, have been advocated for approval endpoints in malignant diseases. The analysis of overall survival may be confounded by cross-over and/or subsequent therapies. PFS, measured prior to the introduction of other therapies, may more accurately depict a treatment's therapeutic effect. PFS and DFS have been suggested either as "surrogates" for clinical benefit (survival improvement) or as clinical benefit per se indicating that the delay in disease progression is of direct benefit to patients.

The Agency has demonstrated flexibility in accepting PFS, TTP and DFS in recent regulatory actions, including recent drug approvals for renal cell cancer (Nexavar), multiple myeloma (Revlimid), and GIST (Sutent) indications. Our approval of this gemcitabine sNDA is consistent with these recent actions indicating our willingness to accept a delay in disease progression as clinical benefit.

We encourage sponsors to interact early with our oncology divisions in the selection of endpoints and other design issues prior to initiation of trials. Claimed improvements in endpoints, such as PFS, must be carefully documented and methodologically sound. Results must be clinically significant in a risk/benefit analysis. Time-to-event endpoints can only be accurately assessed in randomized trials, and we continue to emphasize to sponsors the value derived from adequately powered randomized trials rather than single-arm registration trials in refractory patients.

As stated above, we sincerely appreciate your viewpoints on this application during the ODAC deliberations and hope this short communication provides you with our perspective on this application.

We remain in dialog with the oncology community regarding endpoint selection for registration trials. Regulatory decisions must consider the totality of information on a drug and be consistent with recent regulatory decisions in similar clinical settings. Effects on endpoints must be both clinically and statistical

significant. Please feel free to contact either Robert Justice, Karen Weiss, or myself if you have questions or desire further discussion.

Review Of Standards Began With Nixing Oxaliplatin In 2000

Pazdur discussed the FDA decision in an interview with Paul Goldberg, editor of The Cancer Letter.

Paul Goldberg: Why did you feel you needed not to follow ODAC's advice this time?

Richard Pazdur: We did take their advice under consideration. However, we came to a different decision. This was a careful deliberation by the agency.

We felt that there were several factors here. Gemcitabine had been marketed for over a decade in the US. There was extensive experience both with the safety and efficacy of the drug in different disease settings: pancreatic carcinoma, lung cancer, and breast cancer.

The agency looks at the totality of evidence both from the safety and efficacy perspective. It's important to understand that this was a positive randomized trial. It achieved its primary endpoint, demonstrating an improvement in progression-free survival.

We did several sensitivity analyses and requested additional analyses other secondary endpoints, which did corroborate gemcitabine's impact on this endpoint.

This brings us to the question: should progression-free survival be an approval endpoint? We have had significant discussions with the ODAC, workshops, [and meetings] with foreign regulators. There is a great deal of positive sentiment toward using progression-free survival as a regulatory endpoint in a variety of diseases.

PG: This is really unusual. I think it might be the first time in oncology. Is it?

RP: The UFT application is another example. The ultimate opinion of the agency was different from ODAC's opinion. In that case, the opinion was to approve the drug, but the agency took a non-approval action on the application; a kind of a reverse situation.

PG: Do you think ODAC was mistaken? Or missed some points? I didn't see you at the meeting. I don't believe you were at the table.

RP: I had a medical emergency, so I was unable to attend. We took ODAC discussion under consideration as we made our decision. We discussed internally whether progression-free survival should be an endpoint for drug approval.

PG: Did the company submit any additional data?

RP: The company submitted additional analysis, including event-free interval, and treatment-free interval. These analyses showed significant improvements with the addition of gemcitabine to carboplatin also.

PG: But they had a positive trial anyway…

RP: Correct. This was a positive trial, and it was corroborated by the investigator-assessed endpoint of response rate and complete response rate. So there was internal corroboration of this endpoint as well as sensitivity analyses were performed on PFS, corroborating the effect of gemcitabine on this endpoint.

PG: And then, of course, you held the endpoints meeting on ovarian cancer after [the ODAC meeting on Gemzar.]

RP: Several of the members of that committee advocated the use of progression-free survival in this disease setting. One important point is that over 75 percent of patients in that trial had post-progression chemotherapy off-trial. This sort of thing can confound survival analysis. It's frequently hard to obtain accurate data on post-progression chemotherapy.

PG: So perhaps [PFS] is the best that can be done…

RP: Progression-free survival, because it occurs before the introduction of other therapies, might more accurately depict what's going on with the drug.

PG: If you are sending a message to the industry here, what is this message?

RP: We generally don't send messages. But I think people can take a look at the action. We want to emphasize the role of randomized trials in drug approval. We have demonstrated through this action a willingness to accept a delay in disease progression as clinical benefit. We definitely would like to see trials examining progression-free survival rather than single-arm trials looking solely at response rates in very refractory disease populations.

On multiple occasions we've discussed the advantages of randomized trials not only providing greater efficacy information regarding time-to-event endpoints: survival and time-to-progression, progression-free survival. Randomized trials also give a more accurate picture of safety.

PG: So the message is: Randomize.

RP: As I said before, we are not trying to send a message. We would like to emphasize the role of randomized trials. I would rather have a randomized study—such as this trial—than a single-arm trial looking at response rates in a very refractory disease population.

PG: If this is a precedent, what would be the boundaries here? Where would somebody taking this too far? Is it just one disease that we are dealing with? Really, not, as you look at Nexavar and Sutent…

RP: This action is consistent with a move toward looking at progression-free survival in a variety of diseases as a primary endpoint. With an increasing number of available therapies, there is a tendency to treat patients more extensively after disease progression. Hence, survival analysis may be confounded..

PG: You are kind of teaching the industry to walk a little bit differently. In this situation, should they check in with you, is this a case where Special Protocol Assessment is something that pays off?

RP: I think one of the issues is how accurately progression-free survival is documented. It has to be a methodologically sound endpoint. Recent ODAC discussions have focused on potential problems in measuring PFS. It is incumbent that sponsors meet with the agency and discuss the expected drug impact on this endpoint and how this will be measured. It has to be methodologically sound.

PG: What about oxaliplatin? That would have been where the issues came up, in the original ODAC meeting [in 2000], when the drug was not approved. Was that a case where the methodology was not sound, or was there a learning curve for the agency as well? This, of course, predates the whole process of assessment of endpoints.

RP: I was recused for the evaluation of the 2000 application. I was one of the investigators during that initial trial. The drug had an impact on a progression endpoint. However, it did not demonstrate a statistically significant impact on overall survival.

Perhaps this could have been due to insufficient power or crossover to oxaliplatin after progression.

Oxaliplatin is clearly an active drug in colorectal carcinoma. It has been shown to have a significant role in the treatment of this disease.

This demonstrates that the agency needs to have flexibility in considering endpoints. Rather than being dogmatic and saying that we are only going to take survival as an endpoint, we need to evaluate alternative endpoints, cognizant that there can be confounding effects in their interpretation.

PG: The oxaliplatin example predates the process that we are talking about…

RP: Correct…

PG: Did it in any way inspire this process? I am trying to put this in historical perspective.

RP: We always look at past experiences in drug approvals. And that experience provided us with a case study for examination.

PG: I am trying to be an instant historian here. But looking at this from the point of view of this current decision with Gemzar, does this stem from the series of workshops that you held? This is not the Critical Path initiative…

RP: No, this is not a Critical Path initiative. These workshops were instituted when I was in my former job as a division director of oncology drug products, and was instituted before Critical Path.

PG: Looking at this from the global perspective, for companies that are developing drugs internationally—which I guess is most of them—what does the gemcitabine story say? Clearly, one message might be: Randomize.

RP: An acceptance of progression-free survival brings us in line with our European colleagues. They have used time to progression and progression-free survival as primary regulatory endpoints and have approved therapies in many diseases. Reliance on PFS represents a more common, unified endpoint in drug development for both regulatory agencies.

PG: So oxaliplatin pops up again...

RP: Could be. Obviously, it was approved in Europe before it was approved in the US, based on the initial trial, which we reviewed in 2000.

PG: And as far as randomization?

RP: As far as randomization, our European colleagues have made it quite clear in their public presentations their desire to have randomized, controlled trials be the basis of their regulatory decisions.

NCI Programs:

NCI-Sponsored Meetings Must Find Smoke-Free Locales

By Kirsten Boyd Goldberg

NCI announced a new policy requiring that meetings and conferences organized or primarily sponsored by the institute be held in a state, county, city, or town that has adopted a comprehensive smoke-free policy, unless specific circumstances justify an exemption.

Institute officials said the policy is based on extensive scientific data, summarized in the U.S. Surgeon General's recent report indicating that secondhand smoke, also known as environmental tobacco smoke (ETS), causes premature death and disease in nonsmokers. In the report, Surgeon General Richard Carmona declared that exposure to secondhand

smoke remains "a serious public health hazard," and that there is no safe level of exposure.

"NCI seeks to recognize the contribution of states, counties, cities, and towns that have chosen to protect the public, including employees, from secondhand smoke exposure," Robert Croyle, director of the NCI Division of Cancer Control and Population Sciences, said in a press release. "We hope this policy will encourage other states and cities to do likewise."

NCI's meeting policy will take effect Jan. 1, and will apply to NCI-sponsored or organized meetings of 20 or more attendees.

"Today, the term 'smoke free' is generally reserved for a law that provides complete protection for the general public and employees, by completely prohibiting smoking indoors within one or more types of facilities," according to a new NCI Web site to help meeting planners find smoke-free jurisdictions: http://dccps/tcrb/smokefreemeetingpolicy.html.

According to a document listing acceptable locations: "For purposes of meeting planning, NCI considers a jurisdiction (state, city, town, or county) smoke-free if it provides employees and the general public complete or near complete protection from ETS in enclosed workplaces, including restaurants. Inclusion of bars is not required at this time. Additionally, the list includes states with laws that allow minor exemptions to a smoke-free workplace, such as: employers with five or fewer employees may allow smoking if all employees consent; private workplaces that are open to the public by appointment only are exempt; and others."

The policy does not apply to meetings or conferences for which NCI is not the sole or primary organizer or sponsor and where location arrangements have already been made, the institute said in a statement. It would not apply to conference grants, which are awarded by NIH.

Also, circumstances may require exemptions from this policy, the institute said. "These circumstances include the need to hold a meeting in coordination with one that is not sponsored by NCI yet takes place in a location that is not yet smoke-free, and the need to conduct site visits to institutions located in places that are not yet smoke free, among other reasons," the statement said.

Fifteen states and the District of Columbia (effective 2007) qualify or soon will qualify as smoke-free. The states are: California, Connecticut, Delaware, Florida, Hawaii (effective Nov. 16), Idaho, Maine, Massachusetts, Montana, New Jersey, New York, Rhode Island, Utah, Vermont, and Washington.

In addition, 22 states contain one or more municipalities that qualify under the new policy: Alabama, Alaska, Arizona, Arkansas, Colorado, Georgia, Illinois, Indiana, Kansas, Louisiana (effective 2007), Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Ohio, Oregon, Texas, West Virginia, Wisconsin, and Wyoming.

NCI employees will be able to continue to hold meetings at the NIH campus in Bethesda, Md., and rented buildings in nearly Rockville, since Montgomery County qualifies with a smoke-free law.

Thirteen states have inadequate or no smoke-free laws, according to NCI: Iowa, Kentucky, Michigan, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, and Virginia.

In Brief:

Norway King Honors Fodstad; Lester Rosen To Lead ASCRS

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with the Palo Alto Medical Foundation, where he had a clinical appointment at Stanford University Medical Center. He also served as primary investigator for the American College of Surgeons Oncology Group trials at Palo Alto. . . . **OYSTEIN FODSTAD** received the King Olav V Cancer Research award along with $125,000 for lifetime achievements in cancer research. Oystein, scientific director of the Mitchell Cancer Institute at the University of South Alabama, was given the award by **King Harald V** of Norway, son of King Olav V. Before coming to MCI, Oystein was director of the Institute for Cancer Research at the Norwegian Radium Hospital. . . . **LESTER ROSEN** was elected president of the American Society of Colon and Rectal Surgeons. He succeeds **Ann Lowry**. The society also elected members to the executive council. **W. Douglas Wong**, of New York, is president-elect. The vice president is **John Roe**, of Sacramento. **Tracy Hull**, of Cleveland, and **Theodore Saclarides**, of Chicago, were elected council members. Rosen is professor of clinical surgery, Pennsylvania State University/Hershey Medical Center. Wong is chief of the colorectal surgical service at Memorial Sloan-Kettering Cancer Center. Roe is associate clinical professor of surgery at the University of California, Davis. Hull is a staff member of the Department of Colorectal Surgery, Cleveland Clinic Foundation. Saclarides is head, section of colon and rectal surgery, Department of General Surgery, at Rush University Medical Center. . . . **CITY OF HOPE** received a $2

million gift from **Morrie Darnov** and his daughter, Sharon, in memory of Natalie Darnov, wife and mother. The second floor lobby of Helford Clinical Research Hospital at City of Hope will be named The Natalie and Morris Darnov Inpatient Surgery Lobby. Darnov also donated a handicap-equipped van to City of Hope. Also, the center has joined the Multiple Myeloma Research Consortium to accelerate therapies for the disease, said **George Somlo**, director of the Multiple Myeloma Program at City of Hope. . . . **NIH IS RECRUITING** a new head for the National Institute of Diabetes and Digestive and Kidney Diseases. NIDDK has a staff of 650 and an annual budget in FY06 of $1.854 billion. Information is available at http://www.jobs.nih.gov under the Senior Jobs Openings section. . . . **FDA** celebrated the centennial of the Pure Food and Drugs Act of 1906 on June 30, with a ceremony at Harvey W. Wiley federal building—named for the scientist who served as the first director of the Bureau of Chemistry of the Department of Agriculture, which later became the FDA. Health and Human Services Secretary **Michael Leavitt**, Acting FDA Commissioner **Andrew von Eschenbach**, and former FDA commissioners spoke at the event. The modern FDA dates its origin to June 1906, when President **Theodore Roosevelt** signed the Food and Drugs Act. . . . **ROSWELL PARK** Cancer Institute announced three additions to the faculty. **Dan Iancu** joins the Department of Pathology and Laboratory Medicine; **Prasanna Kumar** is on staff in the Department of Diagnostic Imaging; and **Johnny Yap** is part of the Department of Radiation Medicine. Iancu was research scientist in the Department of Laboratory Medicine at M.D. Anderson Cancer Center; Kumar recently completed his fellowship at Jackson Memorial Hospital in Miami; and Yap was attending radiation oncologist at Cedars-Sinai Comprehensive Cancer Center.

Obituary:

Robert Dickson, Georgetown

ROBERT DICKSON, vice chairman of the Department of Oncology at Georgetown University and co-director of the Breast Cancer Program at Lombardi Comprehensive Cancer Center since 2001, died of a ruptured aorta June 24 at his home in Kensington, Md. He was 54.

Since 1993, he also was director of an interdisciplinary tumor biology program at Georgetown, where he supervised doctoral students. Dickson specialized in pharmacology, biochemistry and cell biology. He is credited with discovering that properties contained in chocolate might combat breast cancer. He was a post-doctoral fellow at NCI, then a staff fellow, and finally a senior investigator until he was named to the Georgetown faculty in 1988.

Funding Opportunities:

NBCC Offers Advocacy Awards

National Breast Cancer Coalition Fund Awards for Best Practices in Breast Cancer Advocacy. Application Deadline: Aug. 15

Nominations are being accepted for up to six awards, ranging from $25,000 to $50,000, for breast cancer quality care, access and/or research. Organizations serving diverse populations and the medically underserved are encouraged to apply.

Inquiries: NBCCF www.stopbreastcancer.org.

RFAs, PAs Available

RFA-CA-07-020 Alliance of Glycobiologists for Detection of Cancer and Cancer Risk. U01. Application Receipt Date: Aug. 23. Full text: http://grants2.nih.gov/grants/guide/rfa-files/RFA-CA-07-020.html. Inquiries: Sudhir Srivastava, 301-435-1594; srivasts@mail.nih.gov.

RFA-NR-07-001: Research on Research Integrity. R01. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-NR-07-001.html. Letters of Intent Receipt Date: Aug. 14. Application Receipt Date: Sept. 14. Inquiries: Mary Scheetz, 240-453-8438; MScheetz@osophs.dhhs.gov.

RFA-RM-06-010: Using Metabolomics to Investigate Biological Pathways and Networks. R01. Letters of Intent Receipt Date: Sept. 22. Application Submission Date: Oct. 20. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-06-010.html. Inquiries: Young Kim, 301-496-0126; yk47s@nih.gov.

RFA-AT-06-004: **Mechanisms of Immune Modulation**. R01. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-AT-06-004.html. Application Receipt Date: Dec. 12. Inquiries: Young Kim, 301-496-0126; yk47s@nih.gov.

RFA-AT-06-005: **Mechanisms of Immune Modulation**. R21. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-AT-06-005.html.

PAS-06-466: The Role of Nuclear Receptors in Tissue and Organismal Aging. R21. Full text: http://grants.nih.gov/grants/guide/pa-files/PAS-06-466.html. Inquiries: Neeraja Sathyamoorthy, 301-435-1878; ns61r@nih.gov.

PAR-06-475: Nanoscience and Nanotechnology in Biology and Medicine. R21. Application Submission Date: Aug. 18. Full text: http://grants.nih.gov/grants/guide/pa-files/PAR-06-475.html. Inquiries: Jeff Schloss, 301-435-5538; schlossj@exchange.nih.gov.

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