THE CANCER LETTER

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Community Cancer Centers RFP Issued; NCI Advisors Criticize Project Structure

By Kirsten Boyd Goldberg

NCI, through its contractor SAIC-Frederick Inc., released a Request for Proposals for the NCI Community Cancer Centers Program, a $9-million, three-year pilot project proposed by Institute Director John Niederhuber.

Under the new program, SAIC-Frederick would award about six subcontracts to community hospitals to establish ties with academic research centers to provide access to NCI-sponsored clinical trials, develop outreach programs, and start using electronic medical records and NCI's biorepository guidelines.

The decision to fund the NCCCP pilot project as a subcontract enabled Niederhuber to bypass review by outside advisory groups. Instead, the institute

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In the Cancer Centers:

Abeloff Plans To Step Down At Hopkins, Recruitment For Center Director Begins

MARTIN ABELOFF plans to step down as director of the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins. The center began a search for a new director; the target date for recruitment is next fall. Abeloff will remain as head of the center until the new director is hired.

Abeloff, 64, will have served as cancer center director for 15 years. He joined Hopkins in 1972 with a focus on research in the therapy of lung and breast cancer. When he was named the director in 1992, the center had 142 faculty members and research funding totaled $24.2 million. Currently, the center includes 220 members from 26 departments with research funds totaling $145.7 million. Under his leadership, the center has been awarded seven NCI Specialized Programs of Research Excellence grants in breast, lung, prostate, cervical cancer, GI, lymphoma, and head and neck cancer.

Abeloff served as president of the American Society of Clinical Oncology and chairman of the FDA Oncologic Drugs Advisory Committee. He also served as chairman of the NCI Board of Scientific Counselors.

Also during his tenure, the center received the largest single gift to Hopkins and was renamed after Sidney Kimmel. Abeloff oversaw the building of three new facilities that expanded the cancer complex to include nearly one million square feet of space dedicated to cancer care and research.

Abeloff received his medical degree from the Johns Hopkins University School of Medicine. He was a resident in internal medicine at the University of Chicago and the Beth Israel Hospital in Boston. He completed his subspecialty

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Advisors Call New $9 Million Pilot Project Duplicative

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director presented the program to the Board of Scientific Advisors and the National Cancer Advisory Board as a point of information, without seeking review.

"When I came to NCI over a year ago, I was interested in developing what I've often referred to as another rim of cancer center activity around the comprehensive cancer centers program," Niederhuber, former director of the University of Wisconsin Comprehensive Cancer Center, said to the BSA at its Nov. 2 meeting. "Part of that came from my experience as a center director, trying to work in a rural state, in a rural community, and part of it from personal experience about the difficulty of a patient with cancer getting access to the latest in early-phase clinical trials."

Niederhuber made a similar presentation to the NCAB on Sept. 6 (The Cancer Letter, Sept. 8).

Judging from the comments of BSA members, Niederhuber would have had a difficult time convincing the board to approve the program. BSA members expressed concerns about the program's structure, its feasibility, and duplication of existing programs at NCI-designated cancer centers and Community Clinical Oncology Programs.

"Let me just say on behalf of the BSA, John, how much we appreciate your being willing to stand up and go into this in great detail," said BSA Chairman Robert Young, president of Fox Chase Cancer Center. "I would emphasize to this group that that is not at all necessary. He doesn't need anything from us to go ahead and do what he's already decided to do, and I suspect that he knows that there is some level of concern about this program."

NCI recently announced its intention to renew the operations and technical support contract for the NCI-Frederick research center with SAIC-Frederick on a sole-source basis for up to 10 years. In 2001, SAIC-Frederick won the five-year, $1.2 billion contract, which was awarded on a competitive basis, although there was no other bidder.

SAIC-Frederck, a subsidiary of Science Applications International Corp., has held the Frederick contract since 1995. It is the largest single research contract awarded by the Department of Health and Human Services. The sole source notice is posted at http://www.fbodaily.com/archive/2006/10-October/04-Oct-2006/FBO-01159641.htm.

Niederhuber is launching his pilot project at a time of tight budgets for NCI research prgrams. Though NCI increased funding for the Cancer Centers Program by 3.9 percent in FY 2006, other programs have taken cuts, and the R01 payline is at the 12th percentile. For FY 2007, NCI officials specifically told the CCOPs and cooperative groups to slow the accrual of patients to clinical trials and to plan for budget cuts of up to 10 percent (The Cancer Letter, May 12 and Oct. 27).

NCI released the RFP for the new project on Nov. 1, the day before the BSA meeting.

The pilot project appears to have been developed entirely within NCI, and everyone but the institute insiders first learned about the plan from the House Appropriations Committee report on the fiscal 2007 NCI budget. In his presentation to BSA, Niederhuber cited the committee report, which "commends NCI for its foresight in developing the community cancer centers program, which is a direct mechanism to translate the most promising advances in cancer treatment… to community hospitals around the country."

To be eligible to apply for the subcontracts, hospitals must have a cancer program that includes medical, surgical, and radiation oncology. The hospital must have treated a minimum of 1,000 new cancer cases a year, and be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the College of American Pathologists or JCAHO for laboratory services, and the Commission on Cancer of the American College of Surgeons. The pilot sites also must have accrued at least 25 patients to clinical trials during each of the past three years.

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Responses to the RFP are due Jan. 9., and NCI expects to make selections in March. The RFP is posted at http://web.ncifcrf.gov/bizopps/rfps.asp. Also on the same page are several attachments, including a five-page "Questions and Answers" document (RFP Attachment 6) which provides further information.

"Are We Reinventing The Wheel?"

Starting the discussion, BSA member Raymond DuBois, director of the Vanderbilt Ingram Cancer Center, said the program might help cancer centers link to non-profit hospitals outside their immediate area.

"This concept has a lot of potential to reach out into the community in a very positive way, but I guess some of that really depends on what the ground rules are for establishing these community centers," DuBois said. "We've had some experience in our community dealing with for-profit hospital groups that don't tend to see anybody that's not covered by insurance. They send those people our way. I wonder if the ground rules could be put together in such a way that we could reach out into the community, like Knoxville or Chattanooga, and bring some of those non-profit people on board with these kinds of concepts?"

"I think you and I are thinking exactly the same way," Niederhuber replied.

But BSA member Patricia Ganz wondered whether the project would duplicate existing NCI programs.

"I happen to work in a cancer center where we have extensive outreach for early-phase trials in our community, as do several of the cancer centers," said Ganz, director, Division of Cancer Prevention and Control Research, Jonsson Comprehensive Cancer Center, University of California, Los Angeles. "Accessing state-of-the-art trials is not necessarily always a problem in the community practices. Secondly, for most of those who do population science work, the laboratory is the community, and we are looking at these issues scientifically. Is this a demonstration project or is this science? I have concerns that there is research that is going on in various institutions where helping leverage some resources might do as much and create more infrastructure. Many of our community hospitals already have multidisciplinary tumor boards and so forth. Are we reinventing the wheel, or do you think you are going to reach people who are not interested in the Commission on Cancer?"

NIEDERHUBER: "I think this will incentivize places to do that. Hopefully, we will be able to reach into communities where these programs don't, and in as robust a manner as we would like. I think there are many areas in this country where individuals are at great distances, four or five hours away, from major cancer hospitals, lots of rural areas in this country, in the Southeast and Southwest. Even in the city of Washington, there are some major issues of access where a program like this might address."

JAMES WILLSON, director, Simmons Comprehensive Cancer Center, University of Texas Southwestern Medical Center: "I, too, agree that dissemination of discovery is very laudable and this is a great time to be doing this, because of where science and treatment and control is. I've been impressed over the last five years in looking at cancer centers, how well many cancer centers are beginning to do dissemination, and I want to second Patty's comments and to raise a concern. That concern is that as you talk about the science of this initiative, you truly have set a very high bar in areas of dissemination, in areas of tissue procurement, and early-phase clinical trials that are challenging the very best of our cancer centers to do this well, and I think there are some models out there that are doing quite well, but they are still striving to improve….

"Maybe this is turned around. Maybe the initiative of dissemination really belongs with the NCI-designated cancer centers looking out into the community with opportunities which you recognize and cancer centers recognize. It should be focused."

NIEDERHUBER: "As I tried to stress at the beginning, I know that many of our cancer centers are doing this and working very hard at it. This isn't in competition with that. This is, hopefully, in addition to and in parallel with. What we are doing is creating another program, another rim, if you will, that I hope will add to what is going on in the cancer centers program."

HEDVIG HRICAK, chairman, Department of Radiology, Memorial Sloan-Kettering Cancer Center: "I'm worried about the quality control… specifically for pathology and radiology. We know how often the diagnosis is changed, the stage is changed, as we receive outside films and outside pathology. So, you may have the best new drug that's given for a disease. Are you going to have some ground rules?... Before you put those places on site, there has to be some kind of quality control that they do have dedicated radiology related to cancer care."

NIEDERHUBER: "I think we can ignore that and leave it as it is, or we can get our feet on the ground and our hands dirty and get into the community and see if we can change that. I don't know how to change that unless

we get involved in the community. We can't solve those problems—we're not going to change that unless we get there are work with them. When we bring clinical research into a setting, whether it's in this country or some of the underdeveloped countries, we change the quality of care."

HRICAK: "That's exactly what I meant. Can we build in some ground rules for competence that they have to demonstrate, for example, that they have radiology that specialize in oncology, that reads certain number of cases?"

NIEDERHUBER: "I don't know that we want to be that specific on ground rules for entering into this system, but we certainly have built into this metrics and are continuing to evolve the metrics for how we are going to gauge the success."

LELAND HARTWELL, president, Fred Hutchinson Cancer Research Center: "We've heard a lot of comments around the table about programs that are going on at various cancer centers and community involvement, and a lot of comments about the problems associated with them. I would think that one of the most useful things that NCI could do would be to collect that information and disseminate it to us at cancer centers—case studies of what works and what doesn't."

"A Challenging Model, To Be Sure"

The cooperative groups also view the project as duplicative, Young said. He summarized a statement sent to him by BSA member Richard Schilsky, chairman of Cancer and Leukemia Group B.

"Rich Schilsky had to leave early, but he sent me some comments, and I think it expresses a concern that certainly would be present throughout the whole cooperative group structure," Young said. "He emphasizes, as others have, that the project is very diffuse, and the infrastructure required to accomplish the goals is, therefore, hard to delineate. He points out that the goals call for doing early-phase clinical trials in community settings, and for improving accrual of minority patients to clinical trials—and the strategies for accomplishing those are very different and would be challenging in any setting, let alone a community setting…. He mentions that it's likely that the only community sites that would qualify for this initiative are likely to be CCOPs or large hospitals already participating in cooperative groups, and he said, 'I think it's surprising to commit $9 million to this program at a time when the cooperative group budget is being cut by 10 percent.' In his mind, this is money to create an infrastructure to duplicate something that already exists."

Young continued, speaking for himself:

"I would second the comments that Jim Willson made. I was very interested in this, because we've had an extensive program and we've put probably 600 patients a year on clinical trials through a very extensive network that's taken 20 years to build…. The description [of the project] is that the principal investigator must be in a hospital that has at least 1,000 cancer patients, but less than $2 million in peer-reviewed funding. So, that defines large community hospitals with no historical involvement/interest in research or clinical trial activities. It then requires that group, which has historically been somewhat estranged from the rest of us, to link up closely with cancer centers, to presumably provide that clinical trial infrastructure, research infrastructure, to make this thing work.

"It seemed to me that that's a challenging model, to be sure," Young said. "Maybe Jim's right. Maybe the driver ought to be thrown back into the cancer centers environment, and tell them, if they haven't already done it, 'show me how you're going to do it.'"

Niederhuber didn't respond to Young's statement.

Kathleen Foley, a neurologist at Memorial Sloan-Kettering Cancer Center, asked how the project's success would be measured. "Would it be 1,000 more patients enrolled by these institutions in clinical trials, or the program is just up and running?" she asked.

"I think it's much more than that," Niederhuber said. "It's how effective they've been in getting electronic medical records into this environment. How effectively they have been in creating a cohort across sites. It's about how effective they have been in education among populations which would benefit from education about cancer prevention and screening. It's about how effective we have been in bringing new advances, targeted therapies as an example, biomarkers research as an example—how effective they have been in bringing that to a community setting."

Foley also asked whether centers would have any incentive to work with the hospitals. "There is a level of technology transfer that you are attempting to create in this system," she said. "What would be the incentive for the cancer center to help them with this technology transfer? Usually, it will require time, energy, money—and that's been a problem in the CCOP program. All of us trying to do research in the community know how hard this is to do. There need to be some incentives for the cancer centers to help this technology transfer, so is there money built in to this pilot project to do this?"

Niederhuber said the pilot didn't include incentive money for cancer centers.

Susan Curry, director, Institute for Health Research and Policy at University of Illinois at Chicago, asked whether the pilot sites would be representative of the hospitals where most cancer patients are treated. "Sometimes, for any study we are doing, you kind of recruit the best you can get, and you wind up really not learning a whole lot about what you're doing in general care," she said. "There are a lot of national organizations involved in the quality of care and have a lot of influence on how health care is delivered. If this is a serious initiative, you want to somehow be bringing them in."

"We actually did," Niederhuber said. "A number of those large groups came to visit with us and spent the day discussing this program with us. A lot of them have innovative programs to change the way things are done in their system…

"There is a lot of opportunity for us for a very small amount of money to leverage for a very big impact," Niederhuber said. "That's a little hard to stand up here and explain to you, unless you've kind of been out there talking and seeing how just the opportunity to say, 'We are connected to the National Cancer Institute,' how much that means in a community setting, and how much they are willing to put resources into programs. I happen to think that's important."

The "Third D," But Wrong Mechanism

Referring to former NCI Director Andrew von Eschenbach's use of the phrase "discovery, development, and delivery" to describe the phases of cancer research, BSA member Jane Weeks, chief of the Division of Population Sciences, Dana-Farber Cancer Institute, said she favored research on health care delivery, but had concerns about this project.

"I'm delighted to see that the third 'D' is getting some attention, and nobody's more enthusiastic about that than I am," Weeks said. "But, I share the concern expressed by essentially everybody that this may not be the right mechanism with which to do that.

"I think about the history on the cancer treatment side, and we really learned the hard way that it's better to understand the mechanisms first and then develop therapies and interventions to target those mechanisms," Weeks said. "On the delivery side, I'm not sure we understand well enough what the structures are that lead to poor quality versus good quality. The little bit of literature that does exist on this I don't think would necessarily support the components of this plan as the ideal way to get optimal cancer care into the community. Some pieces, yes. Some pieces, probably no.

"Nine million dollars is not a lot of money, but, boy, would it be a lot of money to begin to answer that question, and it's really painful to see funds that could be used to answer those questions really being used to replicate what I think many of the cancer centers, my own included, are already doing."

Niederhuber didn't respond to her comment.

BSA member Shelton Earp III, director of the Lineberger Comprehensive Cancer Center at University of North Carolina, Chapel Hill, said he favored a program that would focus on a specific area, such as "six inner-city hospitals that concentrate on African-Americans" or filling in parts of the U.S. far from NCI-designated cancer centers. "You talk about how the hospital systems are interested in putting resources into this so they will have an NCI designation," Earp said. "That's, of course, nothing, compared to what our institutions are putting into the NCI. So, I worry about the structure."

Niederhuber didn't respond to his comment.

Young asked whether the project would emphasize accrual to phase I or phase II trials. Many cancer centers that have outreach programs are accruing patients to phase II trials, he said. "Phase I trials, however, are a very different breed of cat," he said. "We, for instance, in 20 years, have not done it, nor are our community hospitals interested in doing it when they find out what is involved with having to deal with it."

Niederhuber said he developed a program at Wisconsin that brought rural patients in for phase II studies. "At that time, in watching that program and learning from it as we were doing phase II, there were certainly elements of phase I—especially as we are moving into this new era—where I bet we could do some phase of that in community settings…. Not everything, certainly not our first-in-man study that we do in the Clinical Center, for example.

"I'm not sure that sometime over the next five or six years, that phase I, phase II, phase III will be [outmoded as terms] of clinical trial nomenclature," Niederhuber said. "We are moving into a different era. Most of us recognize that our major cancer centers grew up in order to manage toxicity. We had very toxic therapies, and we needed those big centers and all those resources, and all the ancillary divisions within the medical center—infectious disease, cardiology, and all of those programs that actually helped us manage. This is changing, and I think it's going to change even more dramatically over the next four years, five years, to a decade."

Capitol Hill:

Change May Improve Outlook For NIH Budget In 2008-09

By Paul Goldberg

Democrats won control of Congress in the midterm elections Nov. 7, changing the political alignments in cancer research, drug development, and cancer care.

Though the appropriations prospects for science in the current cycle were unpredictable, most observers see the President's flat budget as the best-case scenario for NIH.

"I am optimistic from the standpoint that the status quo wasn't working for us, and I guess I take my chances with change at this point," said Jon Retzlaff, director of legislative relations for the Federation of American Societies of Experimental Biology. "Democrats aren't going to increase the deficit, Bush isn't going to increase funding any more than he has, but we are getting a Speaker of the House who served on the Labor HHS subcommittee, is familiar with NIH, and was extremely supportive of NIH," said Retzlaff. "I think there are opportunities there."

Some insiders predict that the appropriations picture for NIH would brighten next year, as former critics of the administration's funding priorities take over Congress.

With former Labor HHS appropriations subcommittee member Rep. Nancy Pelosi (D-Calif.) becoming the first woman Speaker of the House, the funding prospects for NIH could well improve. Some observers were hopeful to see Rep. David Obey (D-Wisc.) take over as chairman of the House Appropriations Committee.

"Obey has been very critical of the Bush Administration and the Republican leadership for the very small increases and in some cases decreases that they have been proposing for NIH," said a Washington lobbyist who represents several cancer clients. "This will mean some significant increases down the road."

In the Senate, the reins for appropriations would pass to Sen. Tom Harkin (D-Iowa), who has worked so closely with his Republican counterpart Sen. Arlen Specter (R-Penn.) that no measurable change would be expected.

In the House, oversight on health matters will likely be carried out by Rep. Henry Waxman (D-Calif.) the likely chairman of the Committee on Government Reform, Rep. John Dingell (D-Mich.), the likely chairman of the House Committee on Energy and Commerce, and Rep. Pete Stark (D-Calif.) the likely chairman of the Ways and Means Health Subcommittee.

Medicare is likely to be the centerpiece of the oversight agenda, observers said. Congress is likely to try to give the Center for Medicare and Medicaid Services the authority to negotiate drug prices paid under Part D.

Also, importation of drugs from outside the U.S. is likely to get new attention. The 2007 Homeland Security law allows individuals to transport a 90-day supply of drugs from Canada. Direct-to-consumer advertising, too, is likely to get new scrutiny, insiders said.

Waxman is advocating allowing multiple companies to market comparable biologics. Earlier this year, he introduced a bill, cosponsored with Sen. Hillary Clinton (D-NY) and Sen. Charles Schumer (D-NY), to allow newcomer companies to compete with innovators. A summary of that bill, which is widely seen as a work in progress and which has no Republican co-sponsors, is posted at http://www.house.gov/waxman/issues/health/generic_biologics.htm

Biologics are a big-ticket item for Medicare. The top five products—two versions of EPO, Rituxan, Remicade, and Enbrel—added up to about 20 percent of Part B spending in 2005.

Few observers expect much activity when Congress returns for a lame duck session next week. The legislators would likely pass whatever laws are absolutely necessary and politically feasible, and depart as promptly as possible.

Most likely, this means that the Senate wouldn't consider the NIH reauthorization bill that passed the House earlier this year.

In other highlights of the elections:

—Republicans lost Rep. Nancy Johnson, a moderate legislator who cultivated her independence from the White House, and who frequently served as an honest broker on cancer-related issues.

—Rep. Clay Shaw (R-Fla.), a founder of "the 2015 Coalition" of legislators who support the goal to "eliminate suffering and death due to cancer" within the next nine years, was defeated as well.

—Missouri voters approved a constitutional amendment known as the "Stem Cell Research and Cures Initiative." The measure would specifically legalize all stem cell research and therapies consistent with federal law.

—Tobacco control initiatives were passed in Arizona, Florida, Nevada, Ohio, and South Dakota. Similar measures in California and Missouri were defeated. ACS estimates that the tobacco industry spent over $100 million to fight these measures.

In the Cancer Centers:

Roswell Park To Use $2M Gift For Clinical Research Center

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training in oncology and hematology at NCI, the Tufts-New England Medical Center, and Hopkins.

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ROSWELL PARK CANCER INSTITUTE received an anonymous $2 million gift to establish a Clinical Research Center to increase participation in clinical trials.

RPCI currently enrolls 550 patients in 156 different phase I and phase II clinical studies, said **Donald Trump**, associate director of RPCI. The new center will allow two to three times more enrollment, he said.

Two physicians were appointed to lead the new center. **Alex Adjei** was appointed senior vice president of clinical research and chairman of the Department of Medicine. He was professor of oncology at Mayo College of Medicine. He is vice-chairman of the North Central Cancer Treatment Group and chairman of the NCCTG Lung Cancer Committee.

Kelvin Lee was appointed chairman of the Department of Immunology and vice chairman of the Department of Medicine. Lee was professor of microbiology, immunology, and medicine, at University of Miami Medical School/Sylvester Comprehensive Cancer Center.

* * *

MAYO CLINIC Cancer Center's Specialized Programs of Research Excellence grant from NCI for prostate cancer research was renewed for an additional five years. Mayo's original five-year prostate SPORE grant of $12 million was awarded in 2001. The current grant brings an additional $11.2 million. **Donald Tindall** is the principal investigator. . . . **OHIO STATE UNIVERSITY Medical Center** received a five-year, $11.8 million NCI grant to study chronic lymphocytic leukemia and to translate basic research findings into clinical trials. The program project grant was awarded to a team led by **Samson Jacob,** program director and principal investigator. **Michael Grever**, chairman of the department of internal medicine and co-leader of the experimental therapeutics program, is co-director of the grant. The grant includes five projects led by OSU Comprehensive Cancer Center researchers **John Byrd**, **Jacob**, **Mark Parthun**, **Christoph Plass** and **Saïd Sif**. . . . **GRAHAM COLDITZ** was named the Niess-Gain Professor and associate director of prevention and control at the Siteman Cancer Center at Washington University School of Medicine and Barnes-Jewish Hospital in St. Louis. Colditz, a newly elected member of the Institute of Medicine, was director of the Harvard Center for Cancer Prevention and leader of the Cancer Epidemiology Program at Dana Farber/Harvard Cancer Center. Colditz plans to recruit faculty who will work on the link between physical activity, obesity, and cancer, and on cancer markers and premalignant conditions. He also plans to expand the Program to Eliminate Cancer Disparities, headed by **Dione Farria**, assistant professor of radiology. . . . **ROBERT BAST**, vice president for translational research at M. D. Anderson Cancer Center, received the Award for Excellence in Gynecologic Oncology from the International Gynecologic Cancer Society for his contributions to ovarian cancer research and treatment, and for leadership in training academic gynecologic oncologists. Bast developed the CA-125 blood test for ovarian cancer. Bast also is principal investigator on the NCI Specialized Program of Research Excellence grant for ovarian cancer research. . . . **STEPHEN HECHT** was selected to receive the fifth annual American Association for Cancer Research-Cancer Research and Prevention Foundation Award for Excellence in Cancer Prevention Research. Hecht, the Wallin Professor of Cancer Prevention and the American Cancer Society Research Professor at The Cancer Center at the University of Minnesota, is being honored for more than three decades of research on tobacco and its link to cancer formation and growth. His work showing that exposure to second-hand tobacco smoke resulted in the presence of tobacco-specific carcinogens in nonsmokers has had a profound impact on clean indoor air laws critical for tobacco control. Hecht will give an award lecture Nov. 14, at the AACR International Conference on Frontiers in Cancer Prevention Research, in Boston. . . . **MARCIN CHWISTEK** joined the pain management and supportive oncology care section of the Fox Chase Cancer Center medical oncology department. Chwistek was an assistant professor in the Department of Medicine at University of Pittsburgh's Medical Center. . . . **JACQUELINE JERUSS** joined the Lynn Sage Comprehensive Breast Center at Northwestern Memorial Hospital, as well as Northwestern University's Feinberg School of Medicine as an assistant professor in the Department of Surgery. She is a member of the Robert H. Lurie Comprehensive Cancer Center of Northwestern University. She came to Northwestern from M.D. Anderson Cancer Center. . . . **LESLIE SMETZER** was promoted from nurse manager to director research nursing and manager phase I clinic and infusion center at the Cancer Therapy & Research

Center. Smetzer joined CTRC in 1993 as a research nurse in the division of clinical investigations. . . . **CORRECTION**: An item in the In Brief section Oct. 27 incorrectly identified the winner of a $10.7 million grant from the Department of Defense Breast Cancer Research Program. The grant was awarded to Fox Chase Cancer Center for breast cancer research to be led by principal investigator **V. Craig Jordan**. Translational Genomics Research Institute is a collaborator in the project.

Obituaries:

Arthur Holleb, 85, ACS Officer

ARTHUR HOLLEB, former chief medical officer of the American Cancer Society, died Oct. 19, in Stamford, Conn, of complications of diabetes He was 85.

Holleb joined the ACS national staff in 1948 and helped build public awareness of the Pap test for cervical cancer. From 1968 to 1988, he was the ACS senior vice president for medical affairs and national chief medical staff officer. In the 1970s, he led a campaign to promote mammography for the early detection of breast cancer. In the 1980s, he helped introduce guidelines calling for mammograms for women in their 40s, a recommendation that was controversial at that time.

Holleb wrote a book with New York Times columnist Jane Brody, "You Can Fight Cancer and Win" (1977).

Holleb graduated from Brown University and New York University College of Medicine and received surgical training at Memorial Sloan-Kettering Cancer Center. He was associate director of the M.D. Anderson Hospital and Tumor Institute, and professor of surgery at University of Texas.

John Venditti, NCI Scientist

JOHN VENDITTI, 79, who served 26 years as chief of the NCI Drug Evaluation Branch, died Oct. 21 at his home in Bethesda, Md.

During the early 1950s, Venditti's laboratory work was instrumental in developing a number of anticancer drugs. He was considered one of the world's leading experts on drug interactions and for many years was a member of NCI's Acute Leukemia Task Force. From 1966 to 1986, he directed the NCI anticancer drug screening program. In 1983, he established National Cooperative Drug Discovery Groups, and directed the program until his retirement in 1987.

Venditti graduated from the University of Maryland and George Washington University.

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