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I-ELCAP "Soundbites" For Investigators Were A Protocol For Spin, Critics Say

By Paul Goldberg

Proponents of spiral CT screening for lung cancer launched a public relations campaign that critics say was aimed at maximizing exposure in the media and obscuring the limitations of findings published in the Oct. 26 issue of the New England Journal of Medicine.

In talking points intended for use in media interviews, physicians who put patients on the study were urged to repeatedly use the word "compelling" to describe the results, refrain from mentioning ongoing randomized trials, and advise people to get screened.

The documents, which were obtained by The Cancer Letter, state: "AVOID USE OF THE FOLLOWING TERMS FOR THE I-ELCAP DESIGN: Observational, noncomparative."

One of the documents, "I-ELCAP soundbites" appears on page 3. I-ELCAP is an acronym for the International Early Lung Cancer Action Program, the organization that conducted the study.

The "soundbites" were distributed with another document, titled

(Continued to page 2)

Assessing The Claims:

Questions From The Press? I-ELCAP Responses Offered Unfounded Claims, Evidence Experts Say

The Cancer Letter obtained a document in which I-ELCAP investigators were given suggestions for answers to likely questions from the press.

Health services researchers Steven Woloshin and Lisa Schwartz of Veterans Affairs Outcomes Group at White River Junction, Vt., and Dartmouth Medical School, were asked to assess the suggested responses. Their critiques don't represent the view of the VA.

Too many "false positives"

I-ELCAP Response:

In our research program we found that the number of people undergoing additional testing in the first year was less than 15% and after that, it was about 6%. This is comparable to mammography. The goal is to continue to reduce this number, and we have experts from around the world working on refining the protocol. We expect this number requiring additional tests to continue to decrease.

One should not delay screening because of the potential of a "false

(Continued to page 6)

Talking Points Were Based On Findings, Henschke Says

(Continued from page 1)

"Issues and Responses." The Cancer Letter asked experts in medical evidence to assess the accuracy of that document. The story appears on page 1.

The choice of the word "compelling" is evidence of spin, said Sheldon Rampton, research director at the Center for Media and Democracy and author of books about the public relations industry. "The word 'compelling' by itself doesn't mean anything other than 'you should feel compelled to believe me,'" Rampton said. "It sounds more impressive somehow to say that our data are compelling than to say, 'You should believe me, really, dude.' But the message is the same."

Claudia Henschke, I-ELCAP principal investigator and lead author of the study, said the documents were put together on Oct. 22, at a conference of her group investigators. "It's pretty compelling to me, and that's what other people said," said Henschke, professor of radiology at the Weill Medical College and chief of the division of chest imaging at New York Hospital-Cornell Medical Center

"I am kind of horrified at the thought that somebody would take it as a spin document," Henschke said. "It's what we stand behind in terms of what our study is, how our study is described, and what we feel we can legitimately say about it. We are investigators, we are not press people, so we hear that there are soundbites that the press wants, so we called it 'soundbites.' It's not something that we would ever normally say."

The word "compelling" was introduced in a press release by New York-Presbyterian Hospital/Weill Cornell Medical Center. "We believe this study provides compelling evidence that CT screening… offers hope for millions of people," Henschke was quoted as saying in the press release issued Oct. 20.

As the story hit, Henschke repeated the word "compelling" in numerous interviews, including one with The Cancer Letter. At least two other investigators used the word as well. They were Daniel Ray of Evanston Northwestern Healthcare and Barry Sheppard of Mills-Peninsula Health Services of Burlingame, Calif.

The study reported the results of screening 31,567 asymptomatic smokers and former smokers, who were given spiral CT scans in a single-arm study. This resulted in diagnosing lung cancer in 484 participants, or whom 85 percent had stage I disease, the paper states.

The documents are evidence of an effort to make the public think that the data are more reliable than they are, thereby limiting the individuals' ability to make an informed decision, said Heidi Malm, associate professor of philosophy at Loyola University and the outside ethicist of the NCI-funded Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial.

"The thing I found most troubling was the instruction not to use the word 'observational,'" said Malm after reviewing the documents supplied to her by a reporter. "It's a rather standard term that people could understand, but it might lead people to question the term 'compelling' when they find out that it's just an observational study. That suggests some effort to spin the results."

This departure from the standard language of science appears to be part of an effort to deceive the public, Malm said.

"Why instruct other researchers not to state factual claims?" she said. "This limits informed consent by suggesting that this kind of study has the same merit as other studies. [I-ELCAP] is blocking the terms that would make it clear that it isn't the same kind of study, so people might just assume that it has the same evidentiary quality as a randomized clinical trial.

"It feeds into the misassumption by the public that finding more cancers is the same as saving more lives, and that's what we need the randomized trial to show," Malm said.

Henschke said I-ELCAP investigators don't view their study as observational.

"We are not an observational study," she said. "We've always objected to that description, because

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I-ELCAP soundbites

REPORTS ARE EMBARGOED UNTIL
WEDNESDAY, OCTOBER 25 AT 5 PM

REMEMBER WE MUST STAY ON MESSAGE.

In the 1999 Lancet publication, we demonstrated that using our regimen of screening we can detect the majority of lung cancers in Stage I, the earliest and most curable stage of lung cancer.

Our current work studied the effectiveness of treatment of our screen-detected lung cancers. We have now shown that treatment is curative in most cases.

Using the I-ELCAP regimen of screening, we have shown that lung cancer can be detected in its earliest stage in 85% of patients. When found in this early stage and when it is surgically removed in a timely fashion, the 10-year survival rate is 92%.

IF ASKED ABOUT ONGOING STUDIES, RCTS , ETC. STAY ON THE HIGH GROUND

Emphasize our results in the publication. We have shown that CT screening saves lives and if those same cancers are left untreated, the person dies of lung cancer.

AVOID USE OF THE FOLLOWING TERMS FOR THE I-ELCAP DESIGN: Observational, noncomparative

We refer to our design as the I-ELCAP design which assesses how well lung cancer is diagnosed using low-dose CT and then how effective early treatment is when compared to no treatment or delayed treatment.

REFRAIN FROM COMMENTING ABOUT OTHER STUDIES

When asked about our study as compared to others you can say that we are reporting on our study results which are compelling and there are no other current studies being reported.

DO NOT BE LED INTO COMPARATIVE EXCHANGES OF OUR RESEARCH PROGRAM TO OTHERS - STAY ON THE HIGH GROUND

Our message is that the data are compelling. You can emphasize this repeatedly.

I-ELCAP investigators received this primer on what to say—and what not to say—to the press.

we have two components in our studies. We evaluate the diagnostic question and the optimal way that it can be evaluated, and then we go to the treatment component once the cancer is diagnosed, where we say randomization can be done. So, it is not an observational trial. It has a comparison group in the treatment arm."

The word "compelling" caught on in part because reporters covering the story were unable to detect a deviation from scientific terminology, said Shannon Brownlee, Schwartz senior fellow at the New America Foundation.

"Compelling in whose eyes?" Brownlee said. "There is something Orwellian about this. If you say that this study is compelling enough times, people will start printing that, and everyone will start thinking that it must be right, that it is compelling evidence. Next comes the question: Why do we need a randomized trial?"

The soundbites document is a "shocking"

protocol for spin, said Gary Schwitzer, director of the health journalism graduate program at the University of Minnesota School of Journalism and Mass Communication and publisher of a health journalism website, http://www.HealthNewsReview.org.

"I consider myself well-informed on the latest methods of 'managing the media' by different sources in the dissemination of health, medical, and science information," Schwitzer said. "Yet, I am shocked by what is written in these I-ELCAP 'soundbites.' The advice is to avoid discussing the trial design. Here are scientists urging each other to mislead journalists into doing an inferior job. The observational nature of the trial is critical to consumer understanding. But the I-ELCAP PR machine advises spokespersons to run from the truth."

The Eight Who Died

The talking points instruct investigators to make claims that are usually made based on randomized trials or historical comparisons.

"We have shown that CT screening saves lives and if those same cancers are left untreated, the person dies of lung cancer," the soundbites document states.

This statement is based on what skeptics describe as an unsupported tidbit of information that appeared in the New England Journal paper: "The 8 participants with clinical stage I cancers who did not receive treatment died within 5 years after diagnosis." A similar statement appeared in the Weill Cornell press release: "Of stage I patients who chose not to be treated, all died within five years."

From these sources, the informal comparison got into the Associated Press story and was carried worldwide.

Patients who decline treatment are usually sicker than patients who choose to be aggressive, doctors say. Moreover, patients who do not undergo surgical resection often have more advanced stage cancers that cannot be appreciated until surgery; they are not really stage I cancers.

"What did they die of?" said Brownlee. "Did they die of their cancers? Did they die of walking in front of a bus? That was something that the press should have figured out. Why would 8 patients out of 484 (a) be compelling, and (b) do we know why these people die?"

In an interview, Henschke said she doesn't believe that randomization has a place in the detection phase of her study. "Treatment trials is where randomization should take place," she said. "There are many options of how those randomized treatment trials are set up. They don't necessarily have in one arm treatment in the other arm no treatment. They may have varying levels of treatment. That's left to the discretion of investigators. But what we are saying here is technically correct."

NCI Randomized Trial Criticized

The soundbites document states:

"IF ASKED ABOUT ONGOING STUDIES, RCTS, ETC. STAY ON THE HIGH GROUND."

Some proponents of screening failed to "stay on high ground," launching a series of verbal attacks on the National Lung Screening Trial, an ongoing $200 million randomized trial comparing CT screening with a standard chest x-ray.

A patient group, the Lung Cancer Alliance, described the NLST as "outdated" and "a failed trial" (The Cancer Letter, Nov. 3). In media interviews, Henschke said that randomization couldn't be done at her institution because CT scans pick up more nodules than standard x-rays.

Former NIH Director Bernadine Healy attacked the skeptics who "worry that small cancers, even those growing before a doctor's eyes, may not be dangerous."

"This ignores what we know," Healy wrote in a column in U.S. News & World Report Nov. 5. "The smaller the size of the cancer, the better the patient survival. It also supposes that informed patients would join an early-detection study that offers a 50-percent chance of being screened. Or that it's A-OK to bill a study as a cancer action program when the game plan for half its subjects is 'don't look, don't find.'"

Rampton sees this as a PR strategy. "I find it striking that you have this thing about staying on message at the same time that you see this aggressive tone, and I wonder if there is a division of labor here, where some players get to be more aggressive rhetorically and the others try to stay on high ground and sound like the voice of reason," Rampton said.

About 50,000 people have enrolled in NLST. In cancer, similar studies have put an end to bone marrow transplantation and high dose chemotherapy for breast cancer, despite enthusiasm of patients and some physicians.

"I respectfully disagree with Dr. Healy—we don't know the answer yet," said Fadlo Khuri, professor and Blomeyer chair in translational cancer research at Winship Cancer Institute at Emory University. "We should await the results of the definitive phase III trial which has involved thousands of patient-hours

and considerable resources on the part of the NCI to address the question definitively. I am concerned we may invalidate this large phase III trial by saying that we know the answer prematurely." Khuri, who is a lung cancer expert, isn't involved in NLST.

Skeptics say that Henschke's data fall short of providing a justification for CT screening.

"They've spun it a certain way and have not provided all of the requisite data," said Ned Patz, a professor of radiology, pharmacology and cancer biology at Duke University and a co-investigator of the NLST. "I have not seen all the data. I don't know whether they would help or hurt, but I would like to see more results from this study."

Patz said the campaign looks like an effort to short-circuit the scientific process.

"Not all of the conclusions follow the study design, and their recommendations do not follow the data presented," he said. "You design the appropriate study, you state the hypothesis, you validate the results, and then you can make recommendations. You don't have a theory and suggest that it's going to work based on preliminary data or unproved assumptions. We should be doing the right rigorous science, and the public deserves to know all of the risks and benefits."

"You Are Completely Fine"

Bioethicist Malm said that the coverage may well have started "an availability cascade" for CT screening.

"People start perceiving the risk by how much they see it around them," Malm said. "So if all of a sudden we start seeing ads for CT screening, people will start worrying about whether they need it more. And the more they worry about it, the more companies will come up to solve those worries. Once the availability cascade gets going, it's extremely difficult to stop. I don't know if it can really be stopped."

Media coverage fuels such cascades, Brownlee said. "The reporting of science is not done by people who understand science, and in some cases it's done by people who aren't the least bit skeptical," she said. "Any medical reporter who knows any history knows we have been down this path before. We were down it with lung cancer 25 years ago."

The press craves hope, Brownlee said. "People are interested in medicine because they are interested in life and death," she said. "But they are interested in having good news, and it seems like medicine is one of the few places besides the food page where you can actually get some good news."

The NBC Nightly News coverage of CT screening illustrates how these forces align in favor of unquestioning coverage of cancer screening.

The network's two-part series on Henschke's study was framed as a personal story of correspondent Mike Taibbi's fear of lung cancer. A 40-year smoker, Taibbi gets a CT scan in a gleaming white machine manufactured by NBC's parent company General Electric.

Henschke, wearing a white coat, looks over his scan on camera and states definitively: "Your lungs look quite good. You are completely fine."

After hearing the good news, Taibbi goes across the street to see a skeptic, Peter Bach, a health systems researcher at Memorial Sloan-Kettering Cancer Center. While Henschke gives hope, Bach tries to take it away.

"It's hard to say this, because it seems sort of unbelievable, but I don't think you should feel that much better, actually," Bach says, failing to convince Taibbi, who concludes his report by affirming that he is "committed to future scans." Henschke gets to repeat a message of hope: "Clearly, when you find lung cancer early, you can cure it."

Schwitzer said that "Taibbi commits the sin of reporter-involvement and editorializing by tilting the balance of the story toward pro-screening, giving his own perspective about 'my reason for getting tested... why I feel good about the results...and why I am committed to future scans.'

"Where is the balancing perspective of one who gave reasons for *not* being tested, or for *not* feeling good about the results (such as a false positive), or for *not* being committed to future scans?" Schwitzer said. "Why are those perspectives any less legitimate and newsworthy than Taibbi's?"

Schwitzer said the story violates two tenets of the Society of Professional Journalists' Code of Ethics, which state that journalists should:

"—Examine their own cultural values and avoid imposing those values on others.

"—Distinguish between advocacy and news reporting. Analysis and commentary should be labeled and not misrepresent fact or context."

NBC anchor Brian Williams similarly doesn't get high marks from Schwitzer. In a chat with Taibbi following the Nov. 16 broadcast of the story, Williams plainly endorsed screening:

"Well, Mike… If you've changed the mind of just one viewer tonight by doing this, we should thank you for that and for your honesty."

False Positives? Cost? Dose? Answers Called Misleading

(Continued from page 1)

positive." We are practicing the best science available at this time and a much worse outcome would be not to screen.

Woloshin and Schwartz Evaluation: The I-ELCAP investigators deserve credit for developing a protocol that tries to minimize the burden of false positive CT scans; nevertheless, the false positive rate is still substantial. For example, the false positive rate for the baseline screen was 12%, meaning that nearly 3,800 people who subsequently turned out not to have cancer underwent either a repeat CT scan after 3 months, a PET scan, antibiotics and a repeat CT scan after one month, and/or a fine needle biopsy.

Because screening would be recommended annually, this rate will accrue over time. While the data are not provided to calculate the cumulative chance of a false positive over 10 years of screening, we used data from the "annual screenings" in Figure 1 of the NEJM article (where the false positive rate is 5%) and estimate the chance to be approximate 40% (45% if the initial 12% false positive rate is used for the 1st year). False positives have important consequences: living in a state of uncertainty/anxiety for 3-6 months, and, for a minority, lung biopsy with its attendant risks of infection and collapsed lungs.

Until a randomized trial shows that CT screening for lung cancer really reduces mortality, the investigator's claim—"a much worse outcome would be not to screen"—is unfounded.

Cost to society

I-ELCAP Response:

We would expect that this type of screening would cost no more than other types of accepted screening, such as mammography, and far less than others such as colonoscopy. In addition, the cost of treatment of early stage lung cancer is far lower than that of late stage; the cost of late stage treatment is more than double that of early stage treatment. Therefore, finding cancers early saves money in addition to saving lives.

Woloshin and Schwartz Evaluation: The claim that mammography reduces breast cancer mortality is supported by evidence from multiple randomized trials. At present there is no similar evidence to support claims about the benefit of lung cancer screening. Whether lung cancer screening is more or less expensive than proven screening interventions is besides the point. There is no evidence yet that lung cancer screening saves lives.

Nonetheless, in their NEJM paper, the I-ELCAP investigators selectively reference the literature to support their assertion that CT screening for lung cancer is "highly cost effective," an assertion contradicted by Mahadevia, *et. al.* in a 2003 paper in JAMA that is conspicuously uncited. But until the effectiveness of lung cancer screening is demonstrated, it is of course impossible to establish cost-effectiveness.

In their talking points, the I-ELCAP investigators actually assert that screening would save money because "the cost of treatment of early stage lung cancer is far lower than that of late stage." But this argument is specious. While it is true that early stage disease is cheaper to treat than later stage disease on per-case basis, there are many other costs to consider. Many people need to be screened to find the relatively few with lung cancer. The costs of testing and working up abnormal scans for the majority who are not destined to get cancer will be large. Large costs will also come from greatly increasing the amount of early stage cancer diagnosed and treated (some of which would represent overdiagnosis). Unless CT screening results in an extremely dramatic stage shift (i.e., substituting early cases for late), it will increase rather than decrease spending.

Most importantly, the public, media, physicians, and policy makers should not be distracted by questions of cost. I-ELCAP does not and *cannot* prove that screening does more good than harm. Debating cost now is premature and may lead people to think that the controversy is about saving money when in fact it is about whether it works.

Radiation dose

I-ELCAP Response:

The estimated dose from a low-dose CT scan used for screening is less than the average background radiation a person living in the United States receives on a yearly basis. The radiation dose of a low-dose CT is about that of a mammogram.

Woloshin and Schwartz Evaluation: Radiation is a known carcinogen. So it makes sense to limit one's exposure to x-rays unless they are clearly needed. While it is widely accepted that the dangers of radiation from *diagnostic* CT scans (i.e., done to evaluate a problem) are less than the risks of not scanning, the same cannot be said for lung cancer screening. We simply do not know if such screening has a benefit that outweighs the

potential harms. That said, radiation is probably the least important potential harm of screening. We think the most important harm is the potential for overdiagnosis and overtreatment of "cancers" that would never have affected a person's health in the absence of screening.

NCI Programs:

NCI Articles Highlight Work On Molecular Profiling

NCI introduced a new series of research articles, "Spotlight on Molecular Profiling," in the Nov. 7 issue of Molecular Cancer Therapeutics.

The series will highlight molecular profiling studies that provide broad-spectrum genomic and proteomic data that could prove useful for the discovery of new drugs and biomarkers. The first article shows how such profiles can be used to discover a new biomarker that might someday help to personalize treatment of ovarian cancer.

"Rather than forming a hypothesis about a specific gene or protein and designing experiments to test it, molecular profiling takes a more global approach to cancer research," said NCI Director John Niederhuber. "This technique surveys the expression of thousands of genes in a single experiment to map the changes in the human genetic blueprint associated with cancer. The molecular profiling approach will accelerate our understanding of the molecular basis of cancer and will lead to new insights for the treatment, detection, and prevention of these diseases."

"The real value of molecular profiling will be realized when biomedical scientists with a particular expertise are able to integrate and use the data fluently for hypothesis generation, hypothesis-testing, and what I would term 'hypothesis-enrichment,'" said John Weinstein, head of the Genomics and Bioinformatics Group at NCI.

In one of the articles, Weinstein and his colleagues used a panel of 60 human cancer cell lines, known as the NCI-60 panel, to analyze the actions of L-asparaginase (L-ASP), a bacterial enzyme that has been used since the 1970s to treat acute lymphoblastic leukemia. L-ASP scavenges the blood, chewing up molecules of free asparagine, one of 20 amino acids needed to build proteins in a cell. Normal cells can use the enzyme asparagine synthetase (ASNS) to make their own asparagine, but L-ASP starves cancer cells that cannot produce enough of the amino acid.

Since recent studies have suggested a link between L-ASP activity and ASNS, the NCI research team analyzed activation of the ASNS gene in the NCI-60 cancer cell lines. The NCI-60 panel of cells has been used by NCI's Developmental Therapeutics Program to screen more than 100,000 compounds for anti-cancer activity since 1990.

Five different microarray platforms used in the molecular profiling of the NCI-60 revealed a strong correlation between the anticancer activity of L-ASP and reduced activation of the ASNS gene in ovarian cell lines. Subsequently, the researchers used RNA interference, to reduce the activation level of ASNS five-fold in one of those cell lines. L-ASP became over 500 times more effective at killing the cancer cells, suggesting that ASNS levels are the principal determinant of L-ASP activity. This increased activity was maintained in ovarian cancer cells that had developed classical multi-drug resistance to other forms of treatment.

"We are hopeful that the level of ASNS expression may one day be useful as a tool for selecting ovarian cancer patients who will most benefit from the use of L-ASP," said Philip Lorenzi, lead author of the study. "This study provides an example of what the NCI-60 cell line panel can do that is complementary to a different NCI-sponsored study, The Cancer Genome Atlas, which is profiling clinical tumors."

For further information on the NCI research and a set of computer resources that include the databases and tools for integrating the data, go to http://ccr.cancer.gov/staff/staff.asp?profileid=5816.

In Brief:

ACS Honors Four Individuals

AMERICAN CANCER SOCIETY honored four individuals for their work. **Barrie Cassileth** and **Kathleen Horsch** received the Distinguished Service Award. Cassileth is chief, integrative medicine service, Memorial Sloan Kettering Cancer Center and founding president, International Society of Integrative Oncology. Horsch is an independent management consultant. **David McClusky**, medical director, Department of Biological Services, Idaho State University, was awarded the National Volunteer Leadership Award. **Stuart Finch,** professor of medicine emeritus, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, received the Humanitarian Award. . . . **NEVADA CANCER INSTITUTE** fundraising event "Bond for the Cure" brought in more than $5.3 million for the institute. The event featured celebrity emcees and a screening of the new James Bond movie, "Casino Royale," said **Heather Murren**, CEO and cofounder.

Funding Opportunities:

Program Announcements

PA-07-007: Basic and Preclinical Research on Complementary and Alternative Medicine. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-007.html. Inquiries: Wendy Smith. 301-435-7980; smithwe@mail.nih.gov.

PA-07-013: Research on Improving Health Care for Obese Patients. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-013.html. Inquiries: Stephen Taplin, 301-402-1483; st256s@nih.gov.

PA-07-021: Development, Application, and Evaluation of Prediction Models for Cancer Risk and Prognosis. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-021.html. Inquiries: Andrew Freedman, 301-435-6819; freedmaa@mail.nih.gov.

PA-07-023: Basic Research in the Bladder and Lower Urinary Tract. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-023.html. Suresh Mohla, 301-435-1878; sm82e@nih.gov.

PA-07-026: Developmental Biology and Regeneration of the Liver. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-026.html. Inquiries: John Cole III; 301)-496-2025; jc121b@nih.gov.

PA-07-045: Social and Cultural Dimensions of Health. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-045.html. Inquiries: Sabra Woolley, 301-435-4589; woolleys@mail.nih.gov.

PA-07-046: Research on Mind-Body Interactions and Health. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-046.html. Inquiries: Paige McDonald, 301-496-8776; pm252v@nih.gov.

PA-07-060: Methodology and Measurement in the Behavioral and Social Sciences. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-060.html. Inquiries: Bryce Reeve, 301-594-6574; reeveb@mail.nih.gov.

PA-07-062: Research on Clinical Decision Makingin Life-Threatening Illness. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-062.html. Inquiries: Martha Hare, 301-451-3874; Martha.hare@nih.gov.

PA-07-069: Mechanisms of Alcohol-Associated Cancers. R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-069.html. Inquiries: Sharon Ross, 301-594-7547; rosssha@mail.nih.gov.

PA-07-070: Research Project Grant. Parent R01. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PA-07-070.html. Inquiries: http://www.cancer.gov/researchandfunding/contacts.

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