THE CANCER LETTER

Vol. 33 No. 33
Sept. 14, 2007

CT Screening For Lung Cancer Unproven; Limit Use To Trials, Chest Physicians Urge

By Paul Goldberg

A guideline about to be published by the American College of Chest Physicians states that low-dose spiral computed tomography screening of smokers and former smokers is unproven and should be offered only in "well-designed clinical trials with appropriate human subjects protections."

The guideline cautions against current proliferation of the technology by pointing out that CT screening hasn't been shown to decrease mortality and may cause harm through overdiagnosis and overtreatment.

"Even in high-risk populations, current research does not show that lung cancer screening alters mortality outcomes," W. Michael Alberts, co-chairman of the ACCP lung cancer guidelines and chief medical officer of H.

(Continued to page 2)

Election 2008:

Presidential Candidates Promise Increases In Funding For Cancer Research, Prevention

By Kirsten Boyd Goldberg

In a forum sponsored by the Lance Armstrong Foundation, four Democratic presidential candidates committed to significantly increase funding for cancer research and to develop other policies to improve cancer prevention, control, and treatment.

Democratic candidates Sen. Hillary Clinton, John Edwards, Congressman Dennis Kucinich and Gov. Bill Richardson outlined their plans to support anti-tobacco efforts, universal health insurance, reimbursement for clinical trial participation, and increased funding for FDA.

Only two of the eight Republican candidates attended: Sen. Sam Brownback and former Arkansas Gov. Mike Huckabee. Both pledged to increase research funding.

The Livestrong Presidential Cancer Forum was held Aug. 27 for Democratic presidential candidates and Aug. 28 for Republicans in Cedar Rapids, Iowa. Livestrong founder Lance Armstrong and MSNBC anchor Chris Matthews moderated the sessions.

"It is my belief, like a lot of other Americans, that the next occupant of the Oval Office must discuss this critical issue with voters," Armstrong said. "We want to know how the next president is going to fight for us and our loved ones against this dreaded disease. And throughout this campaign, I promise to make it my mission to keep cancer at the forefront."

Video and transcripts are posted at www.livestrong.org/forum.

(Continued to page 5)

Guidelines Boost NCI Trial Of Lung Cancer Screening

(Continued from page 1)

Lee Moffitt Cancer Center and Research Institute, said in a statement. "We hope that one day, we can find a useful and accurate tool for general lung cancer screening, but, at this time, the evidence does not support the use of LDCT screening."

The screening recommendation is part of a compendium of evidence-based guidelines on lung cancer detection and treatment that will be published in conjunction with the September issue of the ACCP journal CHEST and is expected to be available on its web site sometime next week, sources said.

While an earlier ACCP guideline, published in 2003, didn't recommend screening, the latest document takes a stronger stance, urging that the procedure now widely promoted by academic institutions and community doctors should be regarded as experimental.

According to the guideline, which was made available to The Cancer Letter, some proportion of cancers found through CT screening are likely pose no threat. Relying on published literature, the guideline asserts that nodules most likely to be detected by CT appear to have slower growth rates than early-stage tumors seen in the clinic.

The guideline constitutes an endorsement of the NCI-funded National Lung Screening Trial, a randomized study that has been attacked by proponents of screening. By the same token, the document states implicitly that physicians who provide CT screening off-protocol, sometimes relying on roadside billboards to drum up demand, are operating outside the mainstream and may be harming patients.

Proponents of CT screening argue that the controversy has been resolved in their favor last fall, when a group of researchers published the results of its 31,567-patient single-arm study of CT screening. The paper, by the International Early Lung Cancer Action Program, was published in the Oct. 26, 2006, issue of the New England Journal of Medicine.

I-ELCAP claims to have demonstrated a 92-percent survival rate for the procedure (The Cancer Letter, Nov. 3 and Nov. 22, 2006).

The I-ELCAP Principal Investigator Claudia Henschke, of New York Presbyterian Hospital and Weill Cornell Medical Center, has said repeatedly that the NCI-funded NLST is unethical, because the ability of CT to detect early lesions has been demonstrated in her group's trials (The Cancer Letter, Jan. 12).

Laurie Fenton-Ambrose, president of the Lung Cancer Alliance, a pro-screening group, described the ACCP guideline as "shocking" and "difficult to take seriously."

"Recommending against CT screening for lung cancer, as ACCP does, is an extreme position that is out of step with current realities,"she said in a statement. "The fact is that hundreds of thousands of Americans have already discussed lung cancer screening options with their physicians. Many of those individuals have exercised their choice and consumed their personal resources in an informed decision to undergo spiral CT evaluation for the presence of an early lung cancer."

I-ELCAP investigator Harvey Pass, chief of thoracic surgery and thoracic oncology at NYU School of Medicine, urged patients to disregard the ACCP guidelines.

The guidelines "simply dismiss the mounting evidence which continues to mature from the largest international, protocol-driven screening effort (I-ELCAP) showing that CT screening in a high-risk population has the potential to reverse the current 15% five-year survival rate," he said in a statement issued by LCA.

Pass, who is also an LCA board member and chairman of the group's medical and scientific advisory board, said that patients shouldn't be limited in their selection of trials.

"Despite these guidelines, individuals at high risk for lung cancer should make it a personal choice after conferring with their doctors as to whether they want to

THE CANCER LETTER

® The Cancer Letter is a registered trademark.

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-318-4030
PO Box 9905, Washington DC 20016
Letters to the Editor may be sent to the above address.

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

Subscription $365 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc.
Founded Dec. 21, 1973, by Jerry D. Boyd.

participate in ongoing protocol-driven programs for the early detection of lung cancer using whatever means is being studied," Pass said in the LCA statement.

The ACCP guideline recommends that patients, regardless of their lung cancer risk, should be enrolled in trials that have a "reasonable possibility of generating new knowledge about harms and benefits of screening and should have appropriate human subjects protections in place, including informed consent procedures" and screening should not be administered "in the absence of an experimental protocol that has been approved by and is being overseen by an institutional review board."

The I-ELCAP structure relies on oversight by local IRBs, but doesn't have a data and safety monitoring board. Also, the group's studies have been focused on the ability of CT to detect nodules, and haven't studied the potential risks of screening.

Is CT Finding Slower Growing Tumors?

The ACCP guidelines point to the following methodological flaws in the I-ELCAP data:

"In the I-ELCAP analysis, there is no information on the outcomes of the 98.7% of subjects who did not have screening-detected stage I lung cancer, so the reader cannot determine whether a large or small number of lung cancer deaths occurred among the subjects.

"Second, the comparators in these studies are intrinsically biased, because screening improves survival through lead-time and length-time biases, even in the absence of an impact on natural history; therefore, these studies provide limited information regarding the potential benefit or harm of LDCT screening."

The paper states that cancers detected by CT screening could be of a slower-growing variety than those seen in clinical practice. Relying on published literature, the authors compared the most probable doubling rates associated with aggressive lung cancer with the doubling rates of CT-detected lung cancer.

The researchers calculated that lung cancers responsible for the majority of cancer deaths usually double in size every 40 to 70 days. Cancers detected through CT appeared to have much slower doubling intervals, they found. For example, in one Japanese study, doubling times were reported at 149 to 813 days.

"If doubling times are indicative of clinical behavior, then most lung cancers that are detected through screening are quite a bit more indolent than lung cancers that account for most clinical disease," the guideline states.

The CT screening guideline was written by Peter Bach of Memorial Sloan-Kettering Cancer Center, Gerald Silvestri of the Medical University of South Carolina, Morgan Hanger of MSKCC, and James Jett of the Mayo Clinic. Bach and Jett were co-authors of an analysis of three single-arm trials that pointed to a result that contradicted the I-ELCAP finding. The paper was published in the March 7 issue of the Journal of American Medical Association (The Cancer Letter, March 9).

Bill Would Use CDC To Broaden I-ELCAP Reach

The guidelines could provide a counterweight to the lobbying push by LCA and other boosters of CT screening.

On Capitol Hill, a lung cancer screening provision was recently inserted into the current iteration of the National Cancer Act, a piece of legislation that has become something of a Capitol Hill repository for scientifically controversial and spectacularly expensive plans.

The first version of this bill was introduced in the Senate as part of the American Cancer Society's push to create a single cancer constituency led by the National Dialogue on Cancer in 2002, and after that bill failed to become law, others versions followed (The Cancer Letter, Feb. 22, 2002).

The latest bill, S.1056, would require Centers for Disease Control and Prevention to award at least 10 grants to establish CT scanning programs "utilizing the comprehensive protocol that encompasses pre-diagnosis and post-diagnosis, that was developed under the best published clinical practices, and that was established by the multi-institutional, multi-disciplinary research program initiated in the year 1993."

This language limits consideration to I-ELCAP without naming the group.

Also, the bill would require CDC-funded investigators to send their data to I-ELCAP.

"To be eligible for a grant under this section, an entity shall agree to collect, transmit, and preserve imaging data as required under the protocol," the bill states.

The measure was introduced by Sens. Dianne Feinstein (D-Calif.) and Sam Brownback (R-Kan.) last March. A similar bills is pending in New York's state legislature.

Other Guidelines

Altogether, the ACCP guidelines, titles "Diagnosis and Management of Lung Cancer: ACCP Evidence-Based Clinical Practice Guidelines," provide 260

recommendations related to lung cancer prevention, screening, diagnosis, staging, and medical and surgical treatments.

The guidelines include new recommendations related to bronchioloalveolar carcinoma and updated recommendations related to adjuvant chemotherapy after surgical resection and the diagnosis and treatment of solitary pulmonary nodules.

Recommendations include:

—**Bronchioloalveolar Carcinoma**. For the first time, the ACCP lung cancer guidelines include recommendations on the diagnosis, prognosis, and treatment of bronchioalveolar carcinoma (BAC), a type of lung cancer often seen in nonsmokers or those with minimal smoking history.

Recommendations suggest that although staging, diagnosis, and treatment are the same for BAC as for other histologic subtypes of non-small cell lung cancer, additional treatment options exist that may prove to be equivalent, if not more effective, for patients with BAC, including sublobar resection and the use of epidermal growth factor receptor targeted agents. Also, the recommendations note that a diagnosis of BAC should be reserved for those tumors meeting the 1999 World Health Organization revised classification system for lung tumors.

—**Adjuvant Chemotherapy**. Previous ACCP recommendations did not support postoperative chemotherapy for either Stage I or Stage II NSCLC. However, the new guidelines now support the use of platinum-based adjuvant chemotherapy for patients with completely resected Stage II NSCLC who have good performance status. The change in the recommendation was prompted by new research showing adjuvant therapy significantly reduced the risk of death in patients with Stage II NSCLC.

—**Solitary Pulmonary Nodules**. The guidelines also include recommendations on the management of solitary pulmonary nodules (SPN), rounded opacities commonly noted on chest radiographs or CT scans. The new recommendations outline a specific algorithm for the evaluation and management of SPNs and also stress the value of risk factor assessment, the utility of imaging tests, the need to weigh the risks and benefits of different management strategies, and the importance of obtaining patient preferences.

The recommendations were developed and reviewed by 100 multidisciplinary panel members, including pulmonologists, medical oncologists, radiation oncologists, thoracic surgeons, integrative medicine specialists, oncology nurses, pathologists, health-care researchers, and epidemiologists. The guidelines were further reviewed and approved by the ACCP Thoracic Oncology NetWork, the Health and Science Policy Committee, the Board of Regents, and external reviewers from the journal CHEST.

The guidelines have been endorsed by the American Association for Bronchology, American Association for Thoracic Surgery, American College of Surgeons Oncology Group, American Society for Therapeutic Radiology and Oncology, Asian Pacific Society of Respirology, Oncology Nurses Society, Society of Thoracic Surgeons, and the World Association of Bronchology.

The guidelines will be posted at www.chestjournal.org. The document will be available at no charge to ACCP members and journal subscribers. According to a spokesman, the size of the document is making it difficult to post, and the technical problems are likely to be worked out next week.

Cancer Prevention:

FDA Approves Lilly's Evista To Reduce Breast Cancer Risk

FDA approved the osteoporosis drug Evista (raloxifene HCl), made by Eli Lilly and Co., for a new use to reduce the risk of invasive breast cancer in two populations: postmenopausal women with osteoporosis and postmenopausal women at high risk for invasive breast cancer.

Evista, a selective estrogen receptor modulator, is approved for the prevention and treatment of osteoporosis in postmenopausal women. In July, the FDA Oncologic Drugs Advisory Committee voted to recommend approval for the new uses (The Cancer Letter, July 27).

The FDA approval was based on data submitted in November 2006, evaluating clinical results from about 37,000 postmenopausal women that spanned nearly 10 years.

"Thousands of women each year are diagnosed with invasive breast cancer," said Lawrence Wickerham, associate chairman of the National Surgical Adjuvant Breast and Bowel Project, and associate professor of human oncology at Drexel University School of Medicine. "Today's approval of Evista for these new uses gives postmenopausal women at risk for this disease an important new treatment option that allows them to take a proactive approach to reducing their risk."

The FDA evaluated a data package that included multiple trials assessing three different populations of

postmenopausal women:

—The Study of Tamoxifen and Raloxifene (STAR) trial, sponsored by NCI and coordinated by NSABP, involved postmenopausal women at increased risk for invasive breast cancer. The observed incidence rates of invasive breast cancer were Evista 4.4 and tamoxifen 4.3, per 1000 women per year.

—The Raloxifene Use for The Heart (RUTH) trial looked at postmenopausal women with known or at increased risk for coronary disease. The study demonstrated that Evista significantly reduced the risk of invasive breast cancer in postmenopausal women by 44 percent with an absolute risk reduction of 0.6 percent.

—The Multiple Outcomes of Raloxifene Evaluation (MORE) and Continuing Outcomes Relevant to Evista (CORE) trials evaluated postmenopausal women with osteoporosis. Both four-year trials showed that Evista reduced the risk of invasive breast cancer in women by 71 percent with an absolute risk reduction of 1.1 percent, and 56 percent with an absolute risk reduction of 1.0 percent, respectively.

"The FDA's decision marks a major milestone. For the first time, postmenopausal women with osteoporosis will have one treatment option that can help address two leading health concerns—osteoporosis and invasive breast cancer," said Gwen Krivi, vice president of Lilly Research Laboratories. "Further, postmenopausal women at high risk for invasive breast cancer will have an alternative therapy for invasive breast cancer risk reduction."

Earlier this year, the osteoporosis label for Evista was updated to include safety information from the RUTH trial, which evaluated postmenopausal women with known or at increased risk for coronary disease taking Evista. This trial found no increase in the incidence of stroke, but an increase in the incidence of death due to stroke.

Since the new label for Evista includes new uses and an expanded patient population, Lilly worked with the FDA to revise the package insert, which will now include a boxed warning. The warning highlights information already included in the Contraindications and Warnings & Precautions sections of the prior label. It emphasizes that women with an active or past history of venous thromboembolism should not take Evista, and that women at risk for stroke should receive Evista only after evaluating the risk-benefit balance with their healthcare providers.

The most commonly reported side effects are hot flashes, leg cramps, peripheral edema, arthralgia, flu syndrome and sweating.

Election 2008:

Candidates Discuss Cancer, Healthcare Plans, At Forum

(Continued from page 1)

Following are highlights of the candidates' remarks.

Clinton: Double NIH And NCI Budgets

Research funding: "We need to bring the same attention, and focus, and resources to the War against Cancer as we have in other parts of the world. That money needs to come home to help us prevent, detect, and treat cancer…. I want to double both the National Institutes of Health and the National Cancer Institute budgets. We've had a flat NIH budget over the last four years and a decreasing NCI budget.

"Between 1993 and 2001, we doubled the budget to the National Institutes of Health and increased dramatically the funding going to the National Cancer Institute. Now we're kind of in a stalemate. We need to get back to unleash the genius of our researchers, our physicians. We need to get more people into clinical trials."

Insurance discrimination: "As President, I want to end insurance discrimination against those who suffer from cancer. It has been the cause of so many families going into bankruptcy, totally exhausting their insurance, finding themselves without resources. We also need to end genetic discrimination against people who have a preexisting condition because of their genetic make up."

Prevention: "We need a smarter approach to prevention and early detection. Every insurer should be required to pay for mammograms, and PSAs, and colorectal screenings; things that will save lives."

Universal healthcare: "One of my other big goals is quality, affordable healthcare for every single American because that goes hand-in-hand with the War Against Cancer. If people can't get access to the preventive services they need, if they can't get the incredible advances in medical care that we're pioneering in our country, it won't matter. We will still be losing people unnecessarily to cancer. So the big goal of the War Against Cancer has to be fit in to the absolute essential big goal of quality, affordable healthcare; universal healthcare for every single American. You cannot do one without the other and we need to do both. And I intend to."

Anti-tobacco policy: "In my healthcare plan, I would also help pay to have smokers quit by paying for

the programs that work, because that is a lot cheaper than paying for end-stage lung cancer. And I think the more we can do to prevent it in the first place the better off we'll be.

"I favor the FDA being able to regulate advertising about nicotine and tobacco products, and we're going to push through, I hope, a bill to get that done."

Stem cell research: "We need to stay ahead of the rest of the world and investing in healthcare research is an edge we have over everybody. Let's not lose it. That's why I favor stem cell research. That's why I think we need to be pushing a lot of the boundaries of what we're going to be investing in when it comes to healthcare because we never know what we might discover."

Ideal NCI director: "Ideally I'd want somebody who does have a background and an understanding of the science, either as a researcher or a clinician. And I'd want somebody who has good management and advocacy skills, because I would like that person to really take a very public role. You know, Tony Fauci, who is our infectious disease specialist at the National Institutes of Health. When people see him on TV, they know he's going to talk about AIDS, he's going to talk about SARS, he's going to talk about infectious diseases. I want somebody at the National Cancer Institute who can be that public face but who has the background and the knowledge of how to explain what it is we're trying to do. I think we've got to get people, the best qualified people. I mean, I have this old fashioned idea that we should start appointing qualified people to take the positions in our government again."

Edwards: "Dramatic Increase" For Research

Universal healthcare: "We have to have a universal healthcare system so that every man, every woman in this country, when they're diagnosed with cancer, gets absolutely all of the treatment that they need, state-of-the-art treatment. And so that we can make sure that they're getting ongoing screenings, we ensure that when they have any sign of cancer that it's detected at the earliest possible stage so that we can intervene and intervene quickly. We need a universal healthcare system so that we start literally from birth until death in every single stage of the process of life. People are being monitored, they're being taught wellness, nutrition, wellbeing. They're getting the preventive care that they need to make sure that they avoid getting sick, getting catastrophically sick. And at the first sign of any kind of illness, including cancer, they get the treatment that they need.

"I believe that the insurance companies, the drug companies, and their lobbyists killed the healthcare reform that was attempted in the 1990s by Sen. Clinton and we applaud her for her work. But I think they're the people who killed it and I think the lesson from that, my lesson is not the same as hers. Her lesson is: give them a seat at the table. At least, that's what I heard her say a few minutes ago. I think if you give drug companies, insurance companies, and their lobbyists a seat at the table, they'll eat all the food. I think you have to take their power away from them."

Research funding: "Alarm bells also should be going off in America because we are not doing what needs to be done to fund the research to find a cure for cancer in this country. It used to be, about five out of every 10 NIH grant requests were granted, were funded; now we're down to about two. I mean, what are the chances that out of those 10, one of the other eight will actually find the cure for cancer? And not only that, it's even worse than that particularly for the young researchers. The young researchers who, in many cases, are doing the most creative, most innovative work in this area. For the young researchers, the number is much lower than that. So the net result is you get your most talented and most creative researchers that are available, the people who could actually find a cure for cancer in this country and they're not being funded. And the result of that is they go to work for industry. So instead of doing work for the public good, instead of doing the research either at a university medical center or with the NIH, instead they end up in industry. We cannot lose our most talented and most creative researchers in America to that area…. I can't give you an exact number [for the cancer research budget] but I would dramatically increase what we're doing today."

On his wife, Elizabeth Edwards: "Obviously this is personal to me. You know many people say to both Elizabeth and myself, they say, 'Well, you know, we're proud of you. We're proud of what you've done. You've shown great courage.' Here's the truth. The truth is millions of women have been diagnosed with exactly what Elizabeth's been diagnosed with and we've been blessed. I mean, we have the best healthcare that you could possibly have. But here's what we know. What we know is that every single woman who's ever diagnosed with breast cancer should get exactly the same kind of a treatment that Elizabeth has gotten. And I am committed as President of the United States to being the president that leads America to do the work, to be creative, and to be aggressive, and this is very personal for me, to be aggressive in finding a cure."

Anti-tobacco policy: "I would push for anything

that will reduce smoking in the United States of America including, beyond that, including a significant increase in the funding for smoking cessation programs."

Kucinich: Prevention, Diet, FDA

FDA: "Under a Kucinich Administration, the Food and Drug Administration is going to be looking at not only food safety with respect to the products that are out there in the market, but also the drugs that are brought to market to make sure that the FDA isn't working in service to the pharmaceutical companies, which is generally the case. You know, we need to make sure that people have access to drugs that are effective and that can help them deal with their conditions.

"A Kucinich presidency will be focused on prevention, we'll be talking about diet, nutrition, the personal choices that we make, how we can make better choices. We'll be talking about environmental causes, about the role of the FDA and the EPA and these other federal agencies."

Food policy: "We need a major health education program here so that it's not just about advertising where so many Americans have been Super Sized. It's only fairly recently that we've had the full disclosure of what's inside what we're eating. So as President, I would lead the way to make sure not only that people know what they're eating but also to help people learn the variety of choices they have. And actually, there's a direct connection not only between diet and health, but diet and the environment, diet and the economy. And so as President, I'm going to be singularly positioned to be able to lead that discussion because I've taken my own journey towards health based on my dietary choices."

His diet: "I happen to be a vegan…. I changed my diet in 1995 and I had a pretty conventional diet until then. I changed my diet to a diet that I don't eat meat, I don't do dairy, I don't do any chicken or fish. So it's basically a diet that is free of animal products."

Anti-tobacco policy: "If we know that...tobacco causes cancer and cancer kills people, then we need to see the connection there and I think that it's important for the FDA to become actively involved."

Universal healthcare: "My proposal, HR676 Medicare For All, is the only one that [filmmaker] Michael Moore says meets the requirement for providing a not-for-profit system and a national healthcare plan."

Richardson: 206 Percent Budget Increase

Research funding: "Richard Nixon in 1971 declared a war on cancer and we're not doing too well in that war. This president wants a surge in the war in Iraq. I want a surge on the War on Cancer. We spend in America $6 billion a year on cancer research; that's two weeks in the war in Iraq. That is pathetic.

"I would increase over a 10-year period cancer research by 206 percent. I would more than double the research for cancer in America. It would be an increase of 7.5 percent per year in the next 10 years. I have a specific plan.

"Why is it that only 5 percent of research grants are approved on cancer research and 95 are rejected? Why is it that the budgets for the National Institute of Health have been flat or declining in the last four years? Why is the National Cancer Institute budget in the last four years gone down when we are losing this battle?"

Prevention: "We need to focus on prevention. We need to start early. Two-thirds of cancer deaths are preventable. And we need to start early. We need to start with getting rid of junk food in schools. I did that in New Mexico and we need to do that. We need to have healthy breakfast for every child. We need also to have mandatory physical education in our schools. I've done that in New Mexico. We need also in this country to enact smoking bans. I did that in New Mexico. A comprehensive ban.

"We need to make screening available to every American. We need to improve that access. That has to happen with universal healthcare. Access to every American and we especially have to improve access to those with ovarian cancer."

Cancer Czar: "I would name as the cancer czar Lance Armstrong, whether he says yes or no. You cannot say no to a president."

Brownback: Access To "Tier 1" Drugs

War on Cancer: "As president, I will not only declare war on cancer, I will declare war on cancer before it kills us. We've got to get after this disease. Sen. Diane Feinstein, a Democrat from California, and I have the National Cancer Act of 2007, a comprehensive cancer bill."

Research funding: "I think the answer here is not just to say, 'Okay, I'm going to double this,' because it may require tripling of research funding. I think the answer here is to set a clear objective that the American people want to see you achieve. Ending deaths by cancer in 10 years, but a lot of researchers don't want to take that one, because what if we don't make it?

"This is how you move the American public is by setting a very high objective. And even if we didn't get there totally, because this is not one disease, it's

200 diseases. What if we got 50 of them knocked out in that 10-year time period? Wouldn't the American public cheer that you got 50 of these even if you have 150 left? But the way to move the budget numbers forward is to set an objective that the American public really wants to see."

FDA: "We have to give access earlier to people who are in terminal cancer position and they and their physician agree to use experimental drugs at a Tier 1 phase. The Abigail Alliance is a group that's pushing this. I put forward a bill called the Access Act in 2005. We will reintroduce it after the break here and try to get a bipartisan group on board, because if people don't have a choice, we need to provide some options and this is a way that we can get out and in front of this and dealing with this by giving more treatments.

"There's a great Wall Street Journal editorial about two weeks ago by the Abigail Alliance people talking about the hundreds of thousands of Americans that have died waiting on key drugs to be approved by the FDA. This is, to me, this is a no-brainer that we should do. If you're in a terminal position and you and your physician agree to do this, then you really should.

"We lost the court case of the DC Circuit; it's gone to the Supreme Court."

Healthcare coverage: "I think you've got a different viewpoint of how we ought to address the question of healthcare coverage in the United States. A number of Democrat candidates are saying we need more government involved in this, and the Republican candidates, including myself, say we need more markets involved in this."

Anti-tobacco policy: "Now you have many places that are a smoke-free environments. I want to see it continue to progress the way it has been. It's been on state by state, local basis."

Huckabee: Healthy Lifestyles, Prevention

War on Cancer: "I would want to expand it to a War on Chronic Disease as well as just cancer, not just cancer, but on all chronic disease, which now represents 80 percent of the $2 trillion dollars a year that we spend on healthcare. It's where we are spending our money."

Anti-tobacco policy: "As a governor, I led our state to become the first state in the South to have a statewide ban on smoking anywhere indoors, and I'm proud of that, and it wasn't the easiest thing in the world to get done. You can imagine in a state in the South where smoking rates are higher than the national average to even propose that is not exactly the most politically advantageous thing in the world.

"For both our Medicaid population and all state employees, if they would be willing to get off smoking, we would pay for the total cost of a smoking cessation program which included patches, the gum, 24-hour-a-day access to telephonic counseling, whatever it took. Because whatever we spent to get a person off of smoking, we got back multiples from the cost of what smoking was going to take from them."

Screening: "In our state, we eliminated co-pays and deductibles on colonoscopy, mammograms, and prostate cancer exams for all of our employees for the simple reason that it costs a lot less money to provide screenings than it does to wait until people are diagnosed in Stage 4."

Health insurance: "We need to make it so that we have insurance availability for people who have had cancer for the simple reason that just because a person has had cancer does not automatically mean they're going to be less healthy. Our whole insurance system is upside-down, because we don't necessarily insure just against risk. The reality is that having a broader level of coverage, but including in that healthy lifestyles as a part of reducing the premiums is a much more sane way of getting to that goal of universal coverage.

"One thing we know is that just having coverage, universal, unlimited, is not tantamount to good health. If it were, the healthiest people in America would be those in the Medicaid program, because they have an access that very best healthcare plan in the country: unlimited access, unlimited capacity, yet they're also the unhealthiest population we have in the nation.

"It's a combination of coverage that also combines incentives for personal steps of good healthy behavior for nutrition, for exercise, for screenings and eliminating the impediments to the screenings.

"The reality is, we save money in the long term by spending it on the front end, screening and preventing, as opposed to waiting until a person has significant symptoms and then it may be too late. And the cost of intervention is simply prohibitive versus the cost of prevention."

Nutrition: "For the people who are on Food Stamps, why don't we leverage the purchases of Food Stamps so that if your dollar of Food Stamps is used toward a fresh fruit, a vegetable, or some type of produce or a healthy food, that dollar could be worth a dollar and a quarter. If you wanted to use your Food Stamp on junk food—you know, by law you couldn't prohibit because then you'd get into the whole issue of discrimination—but make it only worth 75 cents. Create the incentive so people are willing to try the fruits and vegetables."

Distribution Policy for The Cancer Letter

Thank you for your purchase of this issue of The Cancer Letter! Because issue and subscription sales are our major source of revenue, we wouldn't be able to provide you with the information contained in this newsletter without your support. If you have any questions or comments about the articles, please contact the editors (see page 2 of your issue for contact information).

We welcome your use of the newsletter and encourage you to send articles once in a while to colleagues. But please don't engage in routine distribution of The Cancer Letter to the same people week after week, unless your organization has purchased a site license or group subscription. If you aren't sure, ask the person who is paying for this subscription. If you are sending the newsletter to an unauthorized list, please stop; your actions are against Federal law. If you received this newsletter under an unauthorized arrangement, know that you are in receipt of stolen goods. Please do the right thing and purchase your own subscription.

If you would like to report illegal distribution within your company or institution, please collect specific evidence from emails or photocopies and contact us. Your identity will be protected. Our goal would be to seek a fair arrangement with your organization to prevent future illegal distribution.

Please review the following guidelines on distribution of the material in The Cancer Letter to remain in compliance with the U.S. Copyright Act:

What you can do:

- Route a print subscription of the newsletter (original only) or one printout of the PDF version around the office.
- Copy, on an occasional basis, a single article and send it to a colleague.
- Consider purchasing multiple subscriptions. We offer group rates on email subscriptions for two to 20 people.
- For institution-wide distribution or for groups larger than 20, consider purchasing a site license. Contact your librarian or information specialist who can work with us to establish a site license agreement.

What you can't do without prior permission from us:

- Routinely copy and distribute the entire newsletter or even a few pages.
- Republish or repackage the contents of the newsletter in any form.

If you have any questions regarding distribution, please contact us. We welcome the opportunity to speak with you regarding your information needs.

The Cancer Letter
PO Box 9905
Washington DC 20016
Tel: 202-362-1809
www.cancerletter.com