THE CANCER LETTER

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PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Facing Congressional Criticism, NIH Starts Review of Extramural Conflict Policies

By Paul Goldberg

In a letter to a House investigative committee, top NIH officials said they are considering strengthening the oversight of ethics regulations that apply to extramural researchers.

"We share your belief that the results of NIH-funded research should be based on objective scientific evidence," NIH Director Elias Zerhouni and NCI Director John Niderhuber wrote in a the June 6 letter to Reps. John Dingell (D-Mich.) and Bart Stupak (D-Mich.).

"In fact, NIH is currently conducting a review of applicable extramural conflict of interest policies to determine whether there are areas where

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NCI News:

With A Flat Budget, Niederhuber Outlines NCI Priorities In Speech To ASCO Meeting

By Kirsten Boyd Goldberg

NCI Director John Niederhuber used a speech to the opening session of the American Society of Clinical Oncology annual meeting May 31 in Chicago to lay out his vision of the institute's priorities in an era of flat federal funding for cancer research.

From NCI's tumor sequencing program, The Cancer Genome Atlas, to support for clinical research, to a role in developing drugs for rare cancers, Niederhuber's priorities reflect a core of clinical, translational, and basic research that have been NCI's traditional strength over the past 35 years.

Yet, only two years ago, under its previous director, Andrew von Eschenbach, the institute was branding itself with the bombastic goal to "eliminate suffering and death due to cancer by 2015." Niederhuber's decidedly low-key speech to ASCO contrasted with that recent history.

"Among our many challenges, there is none, I believe, greater than the necessity that we more rapidly translate our discoveries, our new interventions, to patients," said Niederhuber, who became NCI director in October 2006. The surgeon and scientist came to NCI in September 2005 to serve as deputy director for translational and clinical sciences, and was selected as acting director when von Eschenbach was appointed FDA commissioner.

Over the past year and a half, Niederhuber abandoned several of von Eschenbach's managerial experiments, returned the institute to it traditional management structure, taking a decidedly hands-on approach (The Cancer

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NCI Finds No Conflicts Among NLST Investigators

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oversight of extramural conflicts could be enhanced," the letter states

Capitol Hill sources said this is the first public acknowledgement by NIH that it is reviewing the conflict of interest rules in the extramural program, which channels $24 billion a year to academic institutions. The letter doesn't specify how the review is being conducted.

The NIH letter was obtained by The Cancer Letter under the Freedom of Information Act and is posted at http://www.cancerletter.com/publications/special-reports/special-reports.

NIH has been under pressure from many directions to strengthen its oversight of conflicts of extramural researchers, who operate under less stringent ethical constraints than their intramural counterparts. Oversight of ethics on the part of these investigators is delegated to the institutions that employ them.

Last week, Sen. Chuck Grassley (R-Iowa) wrote a letter to NIH, citing multiple examples of apparent conflicts in the extramural program and what he describes as inadequacy of the existing system. A copy of Grassley's letter is posted at http://www.cancerletter.com/publications/special-reports/special-reports. A story stemming from the letter appeared on the front page on The New York Times June 8.

The Dingell and Stupak inquiry, which stemmed from allegations of conflicts of interest on the part of investigators involved in the National Lung Screening Trial, has not produced any information that could harm that trial. Dingell is the chairman of the House Committee on Energy and Commerce, and Stupak heads its Subcommittee on Oversight and Investigations.

The letter states that the NIH review of ethics disclosures on the part of all investigators involved in that $200 million study showed that no conflicts existed. "Respondents indicated that none of the investigators involved with the NLST had reported any Significant Financial Interests relevant to the NLST trial," the letter states.

Dingell and Stupak started the investigation on behalf of the Lung Cancer Alliance, a Washington group that advocates an immediate change of healthcare policy to include computed tomography screening of current and former smokers.

This proposed change would be based on the findings of the International Early Lung Cancer Screening Program, a group of researchers based at Weill Cornell Medical College.

In a paper in the Oct. 26, 2006, issue of the New England Journal of Medicine, I-ELCAP claimed that their screening regimen could prevent 80 percent of deaths from lung cancer. Skeptics say that screening could find a lot of clinically irrelevant disease and lead to overtreatment, and a randomized trial powered to detect mortality, as opposed to survival, would resolve the question.

Dingell and Stupak wrote to NIH last October (The Cancer Letter. Oct. 26, 2007).

Soon thereafter, this publication reported that the I-ELCAP leaders, who promote screening and oppose NLST, had failed to make proper disclosure of intellectual property rights and commercial ties manufacturers of screening equipment, as well as having received research funding from a tobacco company.

Medical journals, including the New England Journal of Medicine, the Journal of American Medical Association, Cancer, Cytopathology, The Oncologist, and Nature Clinical Practice Oncology, have published corrections, clarifications and editorials stemming from these conflicts. Also, the Accreditation Council for Continuing Medical Education is investigating the allegations that I-ELCAP Principal Investigator Claudia Henschke, a radiologist at Weill Cornell, had failed to disclose her conflicts of interest in CME presentations.

Last week, Grassley and the Republican side of the House Committee on Energy and Commerce and

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

Editorial: 202-362-1809 Fax: 202-379-1787
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its Subcommittee on Oversight and Investigations asked NIH to provide additional information on I-ELCAP's conflicts and tobacco ties (The Cancer Letter, June 6).

Preparing the response to the letter on NLST, NIH obtained information from all of the study's 46 sites.

To receive federal funds, these institutions had to adopt conflict of interest policies and were required to manage the researchers' adherence to these policies.

Under federal rules, investigators have to disclose "significant financial interests," which includes patent rights as well as financial interests valued at $10,000 or more that could reasonably appear to be affected by NIH funding.

Last December, NCI asked the institutions to provide disclosures of significant financial interests on the part of investigators, copies of the institutions' conflict of interest policies and documents related to management of conflicts.

No relevant financial interests were reported.

In April, NCI sent out a second letter, asking for a more detailed reporting of conflicts that don't meet the bar of significant financial interest. Institutions were asked to provide disclosures of "funds or financial interests" that the investigators had "received or held related to the NLST research or objectives of the NLST study since its initiation."

Again, the institutions responded that no investigator held any financial interest related to the study.

While no conflicts were found, the institutions' conflict of interest policies apparently required some scrutiny. NIH is "in the process of following up with the institutions to clarify portions of their policies," the letter states. "As is standard practice, we will work with institutions to ensure that any identified policy deficiencies are corrected."

The House investigation was triggered by a report that two of the NLST investigators had helped tobacco companies defend product liability suits that sought "medical monitoring" with CT.

One of the two—William Black, a radiologist at Dartmouth Hitchcock Cancer Center—never submitted testimony and returned a $700 check as soon as the controversy surfaced. The other—Denise Aberle, NLST co-principal investigator and professor at the University of California, Los Angeles—did testify, receiving $11,576 between 2000 and 2003. (UCLA collected $30,000 for Aberle's testimony, keeping nearly two-thirds of this sum.)

Aberle's money was placed in a professional academic account and was not used to finance research.

Aberle and Black were investigated by their institutions, which found no wrongdoing. Both contend that their testimony, stating that the change in healthcare policy to include CT screening was premature, was in the mainstream of science and in the public interest.

Four I-ELCAP principal investigators did testify as expert witnesses for the plaintiffs in one of the suits.

The House letter asked NIH whether, in what amounts to a hypothetical situation, an intramural researcher would be allowed to act as an expert witness in a tobacco suit.

NIH response:

"Under the applicable ethical standards, NIH employees may not engage in outside activities that conflict with their official duties and cannot use their public office for private gain. A conflict would arise if engaging in the outside activity would require an employee to disqualify from matters so central or critical to the performance of his or her official duties that the employee's ability to perform the duties of his or her position would be materially impaired. Under the hypothetical situation you posed, the NIH would prohibit the expert witness service on one or both of these grounds, regardless of whether the tobacco industry is designated a [substantially affected organization]."

NCI News:

Niederhuber Sets Priorities In Time Of Flat NCI Budget

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Letter, Sept. 22, 2006.) He eliminated the 2015 goal (The Cancer Letter, Dec. 8, 2006). He stopped an effort to phase out the Specialized Programs of Research Excellence grants and announced his continued support for the program. He began a process to reduce the program bloat in his own office, which he called "a large garbage can" where programs were "dumped" for lack of thought to where they should actually fit (The Cancer Letter, Dec. 8, 2006).

He also led the painful process to scale down or eliminate programs. The most public and contentious of these was his decision not to fund the P-4 tamoxifen vs. raloxifene breast cancer prevention trial proposed by the National Surgical Adjuvant Breast & Bowel Project. Privately, some NCI-watchers criticize Niederhuber for a "top-down" management style. However, others praise his leadership.

"As a nation, I believe we must confront the fact that a rapidly aging population and its cancer burden

will weigh heavily, not only on healthcare, but on the workforce and our economy," Niederhuber said. "As cancer researchers and cancer physicians, we face an inescapable question: Can we sustain our momentum and continue to lessen the all-too devastating impact of cancer? I believe that we are all here in Chicago this week, thousands strong, to resoundingly answer: 'Yes.' "

Niederhuber acknowledged the limitations placed on the institute by the flat budget. "I stand here this morning to recommit the NCI to make every effort toward the healthy tomorrows we all envision. I extend this promise fully aware of the challenges of funding that is now, for four years straight, consistently below the rate of medical inflation," he said.

"I also know that our cancer patients don't want to hear explanations about flat budgets. They want prevention options. They want effective, novel therapies. The NCI has an obligation, to our patients and to our country, to set the agenda for, and facilitate cancer research in, the decades ahead. I believe, as well, that NCI is uniquely poised to bring together industry, academia, and government in the search for solutions none could provide by itself."

Niederhuber listed several areas of priority:

—"The Cancer Genome Atlas, often called TCGA for short, to denote the four DNA bases. Co-sponsored by the NCI and our sister NIH institute, the National Human Genome Research Institute, this three-year pilot project is an effort to test the feasibility of large-scale characterization and sequencing of patient's tumors. We have sequencing centers up and running, along with tissue characterization centers making sure samples archived for sequencing (up to 500 samples of both tumor and matched normal tissue) are of sufficient quality.

"The first cancers being studied in this pilot program are lung, ovarian, and glioblastoma multiforme. In part, because high-quality tumor tissue has been available, glioblastoma has led the way in this effort. To date, more than 234 tumors have undergone comprehensive characterization and 1,300 genes have been sequenced, and some fascinating associations have been revealed—specifically, two genes that are highly associated with glioblastoma: NF1 and Erbb2. Neither of these genes was previously known to have an association with this disease. In addition, previously unknown changes in the EGFR receptor and the p53 tumor suppressor gene are now known to be part of glioblastoma's course. Based on this new, very preliminary analysis, at least four general subtypes of glioblastoma are emerging.

"Tumor sequencing of this sort, along with the rapidly advancing field of whole genome scanning, are, without a doubt, at the forefront of cancer science. Yet, for now, this is just information: a collection of T's, C's, G's, and A's. Our challenge is to convert this powerful information into knowledge of how gene expression is transcriptionally regulated; how that expression is translated into proteins affecting signal pathways; and how these changes eventually alter tissue function and disease phenotype. These determinations will not be easy.

"Ultimately, the power of the genome will be to push forward the development of new strategies in prevention, of new opportunities for early detection, of essential biomarkers of disease, and, of course, novel drugs and new treatment approaches. We must be focused on enabling translation.

"This need was made clear in a report in 2007 of NCI's Translational Research Working Group, which spent two years conducting a detailed analysis of how to realize the power of a bench-to-bedside approach. The report called on NCI to tailor both new and existing programs to facilitate early translational research progress. NCI is working hard to answer the report's call in five key ways:

—"The first area is clinical research. We are fortunate to have, on the NIH campus in Bethesda, the world's largest hospital principally devoted to clinical studies. It is the home to a dedicated cadre of NCI's intramural science programs and scientists. But we have also come to believe that, in order to facilitate the best translational efforts, this outstanding facility should become a resource for the extramural community. For the first time, we have a trial open with an extramural co-principal investigator, and there are several more such trials pending.

"Additionally, we are reaching out to both the new Walter Reed Medical Center, which is due to begin construction right across the street from the NIH this summer, and Suburban Hospital, which is just across the street on the other side of campus. These two facilities have the potential to give us an opportunity to work on prevention and to see more early-stage patients.

—"Our second goal is drug development. NCI often works with orphan opportunities: small molecules and biologics that are not being developed by industry because they lack a significant market share or they are too risky to pursue. We must enable that work. We see drug development as a platform that encompasses a new chemical biology consortium and extends NCI's Developmental Therapeutics Program. We have a duty, I

believe, to develop new agents and to carry them forward to first-in-human studies.

—"Drug development will make our third goal essential: reaching out to work with both the Food and Drug Administration and the Centers for Medicare and Medicaid Services, connecting regulators and those responsible for reimbursement. Just one example is our Interagency Oncology Drug Task Force that, among other functions, sponsors NCI-FDA fellowships to train young scientists in research and in research-related review, policies, and regulations.

—"Public-private partnerships will also be increasingly necessary. As we move to a more personalized era of oncology, it is clear that we will require multiple agents to target multiple pathways in the same patient. Facilitating that future will challenge how we think of competition, of intellectual property, and even the language of contracts. I believe NCI must step into those areas and become the facilitator between the public, private, and academic sectors. I believe it is a fair question to ask: If not NCI, then who will lead this absolutely vital effort?

—"Fifth and finally, if NCI is to appropriately facilitate translation, we must make every attempt to provide stable funding for some of the most important programs at the heart of translational research. Specifically, I am referring to clinical trials, the Specialized Programs of Research Excellence (SPOREs), the Community Clinical Oncology Program (CCOPs), and the Cooperative Groups.

"Although it is entirely possible that NCI's below-inflation funding may continue for several more years, we will do, and must do, all we can to keep these crucial programs vigorous.

"NCI has a duty to make every effort to reduce the disparities that affect cancer prevention and treatment. I am convinced that access to our latest science will be the greatest determinant of cancer mortality in the years to come. To address this, we are now beginning the second year of our NCI Community Cancer Centers pilot program: a research effort to study how we can best bring state-of-the-art, multi-specialty care and earliest phase clinical research—phase I and phase II studies—to patients in the communities where they live. It gives me great pride to hear the 16 community hospital sites report on their enthusiastic efforts, and how much they have been able to leverage the modest funding provided by NCI. It is also extremely gratifying to know that these pilot sites, seven of which have links to the CCOP program, are participating in ASCO's Quality Oncology Practice Initiative."

Bush Names 8 To National Cancer Advisory Board

President George W. Bush made eight appointments to the National Cancer Advisory Board on June 12.

Bush designated Carolyn Runowicz as chairman of the NCAB for a two-year term. Runowicz, who currently serves as NCAB chairman, is director of the Carole And Ray Neag Comprehensive Cancer Center and the Northeast Utilities Chair In Experimental Oncology at University of Connecticut Health Center.

Also appointed were:

Victoria Lee Champion, associate dean for research, the Mary Margaret Walther Distinguished Professor of Nursing, and director of cancer control, Indiana University.

William Goodwin Jr., chairman and president of CCA Industries Inc., a diversified holding company in Richmond, Va.

Waun Ki Hong, professor and head of the Division of Cancer Medicine at University of Texas M. D. Anderson Cancer Center.

Judith Salmon Kaur, medical director for the Native American programs of the Mayo Comprehensive Cancer Center and medical director for the Mayo Clinic Hospice and chairman of the Palliative Care Task Force.

Mary Vaughan Lester, of the Lester Family Foundation, a member of the UCSF Foundation, and a member of the M.D. Anderson Board of Visitors.

H. Kim Lyerly, the George Barth Geller Professor of Cancer Research and director of the Duke Comprehensive Cancer Center.

Jennifer Pietenpol, director of the Vanderbilt-Ingram Cancer Center, the B.F. Byrd Jr. Professor of Oncology and professor of biochemistry at Vanderbilt University.

The function of the NCAB is to advise, assist and make recommendations to the HHS secretary and Human Services and the NCI director. The NCAB may make recommendations regarding support grants and cooperative agreements, technical and scientific peer review, and functions pertaining to the NCI.

FDA News:

Administration Seeks $275M Increase In FY09 For FDA

The Administration has amended its budget request for 2009 to ask for an additional $275 million for FDA.

However, the announcement June 9 triggered an outraged letter from Sen. Arlen Specter (R-Penn.), who

is working to add $275 million to the agency's budget during the current year.

"Currently, negotiations are underway to reduce the domestic portions of the supplemental bill," Specter, the ranking member of the appropriations subcommittee on Labor, HHS and Education, wrote in a June 10 letter to HHS Secretary Michael Leavitt. "The FDA funding is among the items being discussed for elimination."

The letter continues:

"The submission of your budget amendment at this time undermines the work we have been doing to obtain these additional dollars on an expedited basis. The facts are that if these funds are not provided in this supplemental, no additional dollars will be available until March or April of 2009—at the earliest. Supporting additional dollars in FY '09 sends a signal that there is no urgency in providing these funds.

"The 81 deaths due to contaminated heparin and the one suspected death in the ongoing salmonella outbreak show that we cannot wait nine months to give FDA the resources needed to protect the public."

Professional Societies:

ASCO Ad In USA Today Urges Increase In Research Funding

The American Society of Clinical Oncology placed an advertisement in USA Today on June 2 to draw attention to the need for increased federal funding for cancer research.

ASCO also is asking its members and others to sign a petition to support increased funding for NIH and NCI: http://www.asco.org/portal/site/asco/template.FEEDBACK_FORM.

The U.S. is in the midst of the longest sustained period of flat funding for cancer research. The budgets for NIH and NCI have been flat for five years. Adjusted for inflation (using the Biomedical Research and Development Price Index), the NIH budget has fallen 13 percent since 2003, and the NCI budget has fallen 12 percent since 2004.

From 1998 to 2003, funding for NCI increased by 80 percent. Since that period, NCI's budget has grown by an average of less than 1 percent annually. In FY 2006, NCI experienced a cut of almost 1 percent.

"These declines in the value of NIH and NCI funding threaten to erode the extraordinary recent progress made in biomedical research over the past decade, at a time when scientific potential has never been greater," the society said in a position statement.

ASCO and others in the biomedical research community are calling for Congress to increase funding for NIH by $1.9 billion, or 6.6 percent, in FY 2009, to keep pace with medical research inflation, to reverse the effects of flat funding and to sustain momentum in biomedical research.

ASCO said it respects the professional judgment of the NCI in requesting a total of $5.26 billion (a $455 million increase over FY 2008 funding levels).

"ASCO will work to ensure that Congress approves the largest possible total funding increase to support NIH and cancer research," the society said. "ASCO is also calling for funding increases over the next several years that at least keep pace with inflation to ensure that progress in cancer research continues."

In Congress:

House Authorizes $30 Million For Pediatric Cancer Research

The House earlier this week passed a bill authorizing an increase of $30 million a year over five years to enhance funding for research in pediatric cancer.

The bill, H.R. 1553, the Caroline Pryce Walker Conquer Childhood Cancer Act, was named in memory of the daughter of Rep. Deborah Pryce (R-Ohio), who died of neuroblastoma in 1999 at age nine.

The bill authorizes funding for collaborative pediatric cancer clinical trials research, to create a population-based national childhood cancer database, and to further improve public awareness and communication regarding available treatments and research for children with cancer and their families.

"For far too long, children suffering from pediatric cancer have gotten short shrift on federal resources," said Pryce, original author of the legislation. "The bill we passed today dramatically expands federal investment into childhood cancer research and education, and will make an historic difference in the lives of the more than 12,000 children who will be diagnosed with cancer each year. A nation with our resources, our scientists, our committed doctors and oncologists, and our inherent and insuppressible fighting spirit can and should do more to put an end to so much suffering."

"The Caroline Pryce Walker Conquer Childhood Cancer Act allows for translation of the very best research discoveries into clinical evaluation and practice, in order to improve the cure rates for all children with cancer," said Gregory Reaman, chairman of the Children's Oncology Group. "Only research cures childhood cancer. On behalf of my colleagues in

the Children's Oncology Group and the children with cancer and their families who are our partners in clinical research, we thank our Congressional leaders."

Companion legislation in the Senate (S.911), sponsored by Sen. Jack Reed (D-RI), cleared the Senate Health, Education, Labor and Pensions Committee unanimously last November. The Senate version of the Conquer Childhood Cancer Act currently has 63 co-sponsors; a full Senate floor vote on the bill is expected this summer.

In the Cancer Centers:

Bradley Directs Proton Center At Washington University

JEFFREY BRADLEY was named the first director of the Kling Center for Proton Therapy at Siteman Cancer Center at Washington University School of Medicine in St. Louis and Barnes-Jewish Hospital. He is associate professor of radiation oncology and has been a faculty member since 1998. The Kling Center is the first single-vault proton therapy facility in the country, with a cost of one-fifth the $100 million of the older type of proton therapy center and can fit in a much smaller area. "Getting the proton beam radiation center here has been a team effort," said Bradley. The center is scheduled to open in summer 2009. . . . **CITY OF HOPE** named **Joseph Alvarnas** director of quality systems for cellular therapeutics, Division of Hematology and Hematopoietic Cell Transplantation. A bone marrow transplantation researcher working in T cells as an anticancer therapy, Alvarnas was director of cell processing at the City of Hope-Banner Bone Marrow Transplant program in Phoenix. . . . **NEVADA CANCER INSTITUTE** Diagnostic Imaging Department received approval by the American College of Radiology Imaging Network to participate in clinical imaging trials. "Participation in ACRIN should help strengthen the NVCI position to become a corresponding member of the National Cancer Institute/Association of American Cancer Institute's Imaging Response Assessment Teams," said **Michael Gach**, director of the NVCI research imaging facility. ACRIN is part of a grant awarded to the American College of Radiation from NCI. The NVCI diagnostic imaging facility is accredited by ACR. . . . **HOPE FUNDS** for Cancer Research announced the recipients of Hope Funds Postdoctoral Fellowships. The new charity supports research on difficult or under-studied cancers. The 2008 Hope Funds Fellows are **Pedro Medina**, of Yale University, and **Nathan Robison**, of Children's Hospital at University of Southern California. Medina, in the laboratory of **Frank Slack**, is researching microRNA as it relates to lung cancer. Robinson, in the laboratory of **Shahab Asgharzadeh**, is looking at outcomes of non-radiation therapy on children with brain cancer. Each will receive $87,000 over two years, with the possibility for a third year of additional research funding, said **Leah Cann**, chairman of the board of trustees.

Obituary:

George Moore, Roswell Park Director From 1952-67

George Moore, director of Roswell Park Cancer Institute from 1952-67, died May 19 in Conifer, Co., at age 88.

Born in 1920 in Minneapolis, Moore held six degrees from the University of Minnesota, including a doctor of medicine and a doctor of philosophy in surgery.

Known as the "Father of the Modern Roswell Park," Moore's tenure was marked by attracting prominent physicians and scientists to the staff, initiating innovative cancer programs and expanding physical facilities.

Though only 32 years old when he arrived in Buffalo, Moore had served as associate professor of surgery, director of the Tumor Clinic and cancer coordinator at the University of Minnesota Medical School, where he discovered the use of fluorescent and radioactive materials in the diagnosis and localization of brain tumors as a 26-year-old intern.

Moore also was known for his long fight to reduce the health hazards of cigarettes, for establishing collaborative studies of surgical procedures and anticancer agents, and for developing special facilities for growing human white blood cells in the laboratory.

Moore believed that bright young people interested in science should be given an opportunity to develop their interests in a scientific environment. He established the Roswell Park Graduate Division of the University at Buffalo and supported the initiation of a research participation in science program at the Institute for outstanding high school and college students and teachers. Both still exist today after 56 years.

Moore placed a high premium on developing the careers of deserving junior colleagues. He was widely known for his uncanny ability to evaluate people and to mediate complex interpersonal and institutional problems.

Moore left Roswell Park in 1967 when he was

appointed director of Public Health Research in New York. He continued in that role until 1973 when he moved to Denver as professor of surgery and microbiology at the University of Colorado School of Medicine and chief of the Oncology Section at Denver General Hospital.

Moore received wide public recognition for his scientific and community activities. Several organizations named him their "Man of the Year," and he was awarded the Bronfman Award in 1964 for developing the use of radioactive isotopes to diagnose and localize brain tumors.

"He was a role model for oncologists and a highly successful administrator of the oldest comprehensive cancer center," said Donald L. Trump, MD, FACP, President & CEO, Roswell Park Cancer Institute.

NIH News:

Three Firms Join International 1000 Genomes Project

Three firms that pioneered development of new sequencing technologies have joined the 1000 Genomes Project, the international effort to build the most detailed map of human genetic variation as a tool for medical research.

The new participants are 454 Life Sciences, a Roche company, of Branford, Conn.; Applied Biosystems, an Applera Corp. business, of Foster City, Calif.; and Illumina Inc., of San Diego.

The 1000 Genomes Project, which was announced last January, is an international research consortium that is creating a new map of the human genome that will provide a view of biomedically relevant DNA variations at a resolution unmatched by current resources.

Organizations that support to the project are: the Beijing Genomics Institute, Shenzhen, China; the Wellcome Trust Sanger Institute, Hinxton, Cambridge, U.K.; and the National Human Genome Research Institute.

The NHGRI-supported work is being done by the institute's Large-Scale Sequencing Network, which includes the Human Genome Sequencing Center at Baylor College of Medicine; the Broad Institute of MIT and Harvard; and the Washington University Genome Sequencing Center at Washington University School of Medicine.

Each of the three companies agreed to sequence the equivalent of 75 billion DNA bases as part of the pilot phase. Each company will contribute the equivalent of 25 human genomes over the next year.

The Cancer Letter Recognized For Reporting on ESAs

Paul Goldberg, editor of The Cancer Letter, received a journalism award for his coverage of the controversy surrounding use of erythropoiesis stimulating agents in the treatment of cancer.

Goldberg received a 2008 Dateline Award for Excellence from the Society of Professional Journalists, Washington, D.C., Chapter, for his series of stories in 2007 on ESAs.

Goldberg was the first to report the results of a Danish study that demonstrated that use of Aranesp caused tumor progression in head-and-neck cancer (The Cancer Letter, Feb. 16, 2007). Amgen later acknowledged the study.

Goldberg stayed on top of the story as concerns about ESAs launched Congressional investigations, an inquiry from the Securities and Exchange Commission, shareholder suits, special meetings of the FDA Oncologic Drugs Advisory Committee, re-examination of and changes to private and public insurance coverage, a series of papers in the New England Journal of Medicine, and changes to the prescribing label for ESAs.

In 2007, Goldberg wrote over 20 stories on these news events.

ESAs have been the single costliest—and some say overused—contributor to the price of cancer treatment in the U.S. Utilization of ESAs has dropped by about half over the past year, according to industry figures.

Funding Opportunities:

RFA-CA-08-026: Pediatric Brain Tumor Consortium. U01. Letters of Intent Receipt Date: July 15. Application Receipt Date: Aug. 15. Full text: http://www.grants.nih.gov/grants/guide/rfa-files/RFA-CA-08-026.html. Inquiries: Malcolm Smith, 301-496-2522; smithm@ctep.nci.nih.gov.

PAR-08-175: Millennium Promise Awards: Non-communicable Chronic Diseases Research Training Program. D43. Letters of Intent Receipt Date: Aug. 31; Aug. 31, 2009; Aug. 31, 2010. Application Receipt Dates: Sept. 29; Sept. 29, 2009; Sept. 28, 2010. Full text: http://www.grants.nih.gov/grants/guide/pa-files/PAR-08-175.html. Inquiries: Aron Primack, 301-496-4596; aron_primack@nih.gov.

NOT-CA-08-024: Rapid Access to Intervention Development. Full text: http://www.grants.nih.gov/grants/guide/notice-files/NOT-CA-08-024.html. Inquiries: RAID Office of associate director, 301-496-8720; raid@dtpax2.ncifcrf.gov.

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