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Research vs. Delivery? Advisors Debate NCI Role In Review of Community Program

By Kirsten Boyd Goldberg

The NCI Board of Scientific Advisors was forced to confront a fundamental question as it reviewed the institute's pilot project slated to provide $15 million for community hospitals:

Should the institute focus exclusively on research, or should it be spending its dwindling resources on improving the delivery of cancer care to rural and underserved populations?

"That is not research; it's quality improvement," BSA member Jane Weeks, chief of the Division of Population Sciences at Dana-Farber Cancer Institute, said of the signature project of Institute Director John Niederhuber at a board meeting Nov. 6

The board was never asked to vote yea or nay on the NCI Community Cancer Centers Program. However, at its most recent meeting, BSA heard

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Washington Roundup:

Senate Democrats Include $1 Billion Boost To NIH In Economic Stimulus Package

The Senate Democrats' version of the economic stimulus package proposed earlier this week includes a $1 billion boost to NIH during the current year.

The version of the bill passed by the House (HR 7110) didn't include an increase for NIH.

The Senate bill (S 3689), a $100.3 billion measure introduced by Senate Majority Leader Harry Reid and Senate Appropriations Committee Chairman Robert Byrd, seeks to create jobs, support the auto industry, and provide other forms of economic relief, will be taken up by Congress during its planned lame duck session. The bill was introduced on Nov. 17.

Lobbying for the Senate bill, the Federation of American Societies for Experimental Biology sent letters to every senator. "Studies have shown that every dollar invested in NIH generates more than twice that amount in state economic output, a tremendous return on investment," FASEB President Richard Marchase said. "The money for NIH included in the proposed stimulus will provide jobs all over the United States, and forestall delaying progress on treatments and cures for diseases like Alzheimer's, diabetes, and other pressing health challenges. If this bill passes, money could immediately start flowing to local universities, who are often the largest employers in their communities."

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The Cancer Letter will not be published next week in observance of Thanksgiving. The next issue is scheduled for publication Dec. 5.

Community Cancer Centers Pilot Grew From $9M To $15M

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a status update on the year-old program that gives $500,000 a year for three years to each of the 10 community hospitals selected to take part.

"If you took $500,000 and pumped it into any center in the U.S., my God, I would hope the quality of care would get better," said Weeks. "But that is not a sustainable model."

The program hasn't gone through the standard peer review process, and is instead funded as a subcontract under NCI's $5.2 billion, 10-year contract with SAIC-Frederick Inc., the firm that runs the institute's intramural research campus in Frederick, Md. The NCI sole-source contract with the company is now the subject of a Congressional investigation (The Cancer Letter, Nov. 14).

When it was originally presented to the National Cancer Advisory Board, the project was slated to distribute $9 million (The Cancer Letter, Sept. 8, 2006). However, when contracts were awarded, NCI committed $15 million (The Cancer Letter, June 22, 2007).

"If we are really to do the kinds of science we need to do, we absolutely must take NCI to where all the cancer patients live, work, and get their care," Niederhuber said to the board that was never asked to formally review it. "I'm very excited about this."

Niederhuber said the hospitals that won the NCI contracts last year have been able to supplement the funding from other sources. As a result, the hospitals are engaging in activities that weren't previously possible, including enrolling cancer patients in clinical trials, collecting biospecimens, and conducting community education and outreach.

"One of the more impressive things to me is the enthusiasm, the leveraging, and the integration and interaction across the sites," Niederhuber said. "This is a very integrated, help-each-other project. It's exactly what we need."

"I think we need to be careful about our enthusiasm," said BSA Chairman Robert Young, chancellor of Fox Chase Cancer Center. "This program contains three things: it contains a research arm; a hope, promise and dream of further research; and a demonstration project. And they are all mixed up. But in my view, they are very different. I think there is a huge danger in the NCI evolving into an entity that embraces demonstration projects."

The purpose of the centers is unclear, said Ellen Sigal, chairman of Friends of Cancer Research. "It feels like mission creep to me of what our charter is at NCI and NIH, and it feels like other agencies should be a part of this," Sigal said at the meeting. "We do need to get out to the community, we do need to get people on clinical trials, and we do need to understand research, but our entire budget, the entire $4.8 billion [NCI budget] could be consumed with this and it wouldn't be enough."

The outreach program duplicates the NCI Community Clinical Oncology Program, begun more than 20 years ago, said Richard Schilsky, associate dean for clinical research at University of Chicago Medical Center.

"All of the CCOP PIs that I know would say that their mission is not only to put patients on clinical trials, but to do cancer control activities, patient education, to address disparities, and to collect high-quality biospecimens," he said. "This is a wonderful new network, but it is really difficult to see how, as it matures, it's going to in any way be different from the CCOP network."

However, BSA member William Dalton, CEO of H. Lee Moffitt Cancer Center, said he strongly supported the program.

"This may be one of the most important experiments that we are doing," Dalton said. "It's hard to say what's more important than the other when you are talking about cancer research and care. My impression is that what you have designed here is an experiment in delivery and access.

"If we desire to improve accrual to clinical trials

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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
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: www.cancerletter.com

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

to get over that 10 to 15 percent, to continue to try to do it at academic centers isn't gong to do it, especially when 85 percent of the patients are in the community," Dalton said. "The only way we can do it is to somehow partner with our colleagues in the community. It's a huge experiment in delivery and access. But it's also about integrating cultures. You've got a culture of academic research and you've got a culture of delivering the best care. That's a challenge.

"My question and concern is that it's a three-year experiment," Dalton said. "If you plan for success, and I think you should, how are you going to sustain this? I think your initial investment of $500,000 a year is good for building infrastructure, but if this is successful, the cost is going to go up. So how are we going to be able to sustain this effort? I don't think it can be done by the NCI alone."

NIEDERHUBER: "I've said right from the beginning of this program that I thought we as an institute absolutely had to address the issue of access. I wasn't worried about our ability to progress in science. I am really concerned that for cancer patients, a greater determinant of cancer mortality in years to come will be the inability of these patients to get access to our science. That's why I feel so strongly about this program.

"When I talk on [Capitol] Hill about what we're doing in genomics, proteomics, stem cells— their eyes are a little bit glazed and they aren't on the edge of the chair. But when I talk about this program, they move forward in their chair, and then they become engaged. So, clearly, we have also to recognize that our legislative leadership is searching for how we as institutes of science can help in the questions of delivery and access. We have to recognize that that's our responsibility as well."

"We have already begun discussions of how we are going to transition this pilot, because already we are feeling very positive about the pilot. We are going to need your support and your endorsement to help us. We are moving down the road rapidly, not only to collect the evidence, but to be able to disseminate the evidence, especially on [Capitol] Hill, and to begin a next phase of this program."

The View From Billings, Mont.

Tom Purcell, director of the Billings Clinic Cancer Center in Billings, Mont., one of the NCCCP sites, told the board that the existing Montana CCOP and the new program are "synergistic."

While the CCOP funding provides the foundation for putting patients on clinical trials, the NCCCP funding supports outreach to rural and underserved populations, he said.

"If we just practiced in Billings, then I'm not sure how much [the NCCCP] would add," Purcell said. "About two-thirds of our patients are from rural areas—at least half are over 200 miles away."

Without the NCCCP funding, the clinic wouldn't be able to enroll a patient from a remote location onto a clinical trial, Purcell said. "The infrastructure isn't there, the regional navigator who coordinates the care and coordinates the flow sheets, it just wouldn't be done," he said. "There is overlap, but I think it is synergistic."

Mark Krasna, an NCCCP principal investigator and advisor to Catholic Health Initiatives Cancer Care, which operates 45 community cancer centers at hospitals around the country, said 40 percent of the NCCCP funding must be used to address healthcare disparities.

"It's used for disparities research, but it's also used for very practical outreach," Krasna said. "We actually applied for an received a supplement that's helping us look at disparities research for increasing accrual to clinical trials. That's in addition to the funds we have from NCI to go out and provide care. The applied care component, there is nothing I know of in CCOP that mandates a certain level of quality care in the community. What we are doing is voluntarily committing to get to that certain level of care in the community setting."

NIEDERHUBER: "The NCCCP is designed to be more than clinical trials. Education, screening, navigation of the underserved population—all of these things are important. We believe if we are going to collect high-quality biospecimens, we are going to need that kind of a resource network to obtain the kind of specimens and especially in rare tumors, that we can't get other ways. We believe this is a place where we can perhaps make inroads into electronic medical records. Maybe in this kind of environment, we can set up models that will allow us to create for clinical research a network of well documented patients and health records."

SCHILSKY: "I think the CCOP PIs would probably say there is complete overlap in their mission and the NCCCP mission. While I understand what you said, Dr. Purcell, about the CCOP not having sufficient resources to enable outreach to far-flung communities, the real question is, could you have accomplished that simply by supplementing CCOP funding, and perhaps accomplished it somewhat less expensively than by creating a whole parallel network infrastructure? Could you address the question of, if the Billings CCOP had

been given an X percent increase in its budget, could many of the same things have been accomplished?"

PURCELL: "Personally, from a clinical trials standpoint, that's only 20 percent of what we are doing, like Dr. Niederhuber said. We do a pretty significant focus on multidisciplinary care, which does not have anything really to do with the CCOP, necessarily, although we talk about it a lot at our meetings. The outreach to disparities—we are talking about a rural population, which, literally the education of cancer care and knowing what is best practice, is so foreign to what we would think in a major metropolitan area. Clinical trials is a portion of what we are doing. If you were to tell me to increase accrual for clinical trials, the only thing we would need to do is bump up the CCOP funding. That may be possible, but to get the demographics to enroll more American Indian patients or more rural patients, that wouldn't happen."

SCHILSKY: "I appreciate everything that you are doing, but at least one NCCCP member is a CCOP. All of those CCOP PIs that I know would say that their mission is not only to put patients on clinical trials, but to do cancer control activities, patient education, to address disparities, to collect high-quality biospecimens. This is a wonderful new network, but it is really difficult to see how, as it matures, it's going to in any way be difference from the CCOP network."

"How Much It Means To Them"

Besides the funding, the communities involved in NCCCP appreciate the connection to NCI, Niederhuber said to the board.

"I've had opportunities to be in communities outside the academic umbrella, and in talking to people in communities, I hear how much it means to them—not patients, but people who are the community leaders, individuals who serve on foundations and local boards, people who lead their communities in social ways—how much it means to them to have a connection to the National Cancer Institute," he said.

"It's not about money," Niederhuber said. "It's about feeling that they are part of the National Cancer Program. One of the things that we have missed over the years, our focus has been, which it rightly should be, on our academic institutions, our great universities, our science, but in that process, we forgot that there are other people to which the work we do has a lot of meaning.

"Feeling connected to us in some way is much more important than I ever realized," he said. "They are anxious to work in their local communities to bring us to people who have cancer."

Under the program, the Billings Clinic can put more Native American patients on trials, Purcell said. The Indian Health Service uses the same guidelines for covering clinical trials as Medicare. For patients in remote locations, radiologic scans are uploaded to a website for access by Billings physicians. All biospecimen collection will be compliant with NCI's Cancer Genome Atlas program.

"I'm from Great Falls [Mont.]," said BSA member Irving Weissman, director of the Stanford University Comprehensive Cancer Center. The ability to access closely bred populations such as Native American populations "opens up the possibility of family analysis for some cancers," he said.

WEISSMAN: "The biospecimen program you have is great for staining and for DNA and RNA analysis, but a problem some of us have when we try to understand if certain cancers have cancer stem cells in them, is that you need to have viable cell suspensions, frozen down and alloquated into many tubes, so that you can later sort the cells and investigate them. At a place like Stanford, many of the tumors we get are miniscule. So it has to go to pathologists. But I imagine in the underserved areas, until you get a really good education program in place, some of the tumors probably come in pretty big. That at least represents for us the possibility to do something we can't do now, to obtain large tumors and make cell suspensions from that, and use the cell suspensions to investigate back at Stanford the tumorigenicity."

PURCELL: "We're ready when you are."

"This Is Not T2 Research"

BSA member Weeks said NCI shouldn't be in the business of improving access to care, but should be involved in research on ways to improve access to care.

WEEKS: "I'm going to be much more negative than others who have spoken. When this concept was presented to us, many board members expressed concern. I was one of them. I agree the presentations were clear, it's very helpful to see what's going on here, but I have to say it increases, not decreases, my concern.

"Here is the issue. This is not T2 research. I think we need to be clear about what this is and what it isn't. T2 research is about taking established knowledge with a firm evidence base and studying how to get it out to the world. I couldn't agree more with John [Niederhuber] that access should be absolutely a top priority of NCI, but research on how to achieve access. That's not what this is.

"There is no part of T2 research that is putting

patients on clinical trials, which is doing experiments using drugs that are not yet proven. I couldn't believe more in clinical trials and I would like to see us put much more money to clinical trials, but I think we have to recognize that the benefits of clinical trials accrue to future patients, not the patients who are on the trials. The dominance of the therapeutic misconception in our field is really kind of frightening. There is no high-quality evidence that outcomes are better when you put patients on trials. Putting patients on trials is not a way to improve quality of care, it's a way to move the science forward and to improve the care for the next round of patients. Incredibly important, we need to do it, but if our goal is to help people in under-resourced settings, offering them experimental therapies and taking pieces of them back to Stanford, which would be wonderful research, doesn't help them. It helps other patients.

"You worked incredibly hard to put together an evaluation plan that is impeccable and lovely, but it's layered on evaluation on top of something that is not research. It's quality improvement. If you took $500,000 and pumped it into any center in the U.S., my God, I would hope the quality of care would get better. But that is not a sustainable model.

"So the question is, how can we alter the way we deliver care, how can we alter systems of care, in a way that is sustainable economically and that also leads to improvement? Those are research questions. That's what access research looks like.

"I think it's almost inevitable that under new administration, there's going to be a lot more interest in that kind of research. If you have a commitment to improving health care of the whole population, oh my God, there's never been a time when we needed more of that kind of research.

"I hope the NCI will say, 'you know what, we're getting into the business of access, we want to improve access,' and run with it, but recognize that it needs to be framed as research, rather than public health delivery, which is not what the NCI does. That belongs to other groups. What the NCI does do is to really lead the field in doing the research, establishing what works at a price that we can afford, what works better than something else to achieve that goal.

"I'm afraid this program is not that."

"You're Wrong"

BSA member James Omel, a volunteer with three myeloma advocacy organizations, disagreed with Weeks.

OMEL: "I live in one of those three Nebraska towns that is part of the CHI network. I really think this is a great program, and I thank Dr. Niederhuber for his insight and foresight in starting it. Clinical trial accrual in Grand Island, where I live, is now up to 8.3 percent, which of course you know the national average is 3 percent, and it's part of the pride factor that John mentioned. We are having two new oncologists coming to Grand Island in July next year. I'm sure the NCCCP association was a big factor in their decision.

"I totally disagree with Dr. Weeks regarding phase II or III trials not helpful to current patients. They are extremely helpful. In myeloma, it's been so helpful, with patients clamoring to get into certain myeloma trials. You're wrong. It's very helpful not only for future patients, but for current patients.

"About sustainability, this is a pilot program, and remember, in three years, this is going to spread to many, many communities, we'll find what's good and bad about this program. I think it's going to spread and move out from this pilot. And this great access to the NCI, which is not just pride, it's tremendous for cancer patients."

BSA member Edith Perez, director of the Breast Cancer Program at Mayo Clinic, Jacksonville, also said she supported the program. "One of the goals of NCI is to increase access and improve participation in clinical trials, so I think this is in the realm of what we should be supporting," she said. "We probably could have put more money into CCOPs, but this is a new program, it seems to be working well together. The future will depend on our ability to learn from this system and expand it to many more places."

BSA members Sigal and Young made the final comments in the discussion:

SIGAL: "Clearly, this is an extremely important project, however, it feels like mission creep to me of what our charter is at NCI and NIH, and it feel like other agencies should be a part of this, CDC, CMS, and others should be a part of this, which they seem not to be.

"The biospecimen part of this particularly troubles me, because I think the collection and access is incredibly important, but it seems to me that we are reinventing the wheel yet again. That is very troubling to me. I don't know what the answers are, because I think we do need to get out to the community, we do need to get people on clinical trials and we do need to understand research, but our entire budget, the entire $4.8 billion could be consumed with this and it wouldn't be enough. We have to be very careful, particularly with other agencies that frankly have the same mission, so we have to think about what we are doing."

YOUNG: "As I think about the fundamental measurements of this program, we're going to need to look at productivity; that is, we've got a whole list of things that are measurable output—numbers of patients on clinical trials, biospecimens created, and so forth. Several people have touched on the issue of sustainability, which is a fundamental issue that we are going to have to think about sooner rather than later. The third is what I would call exportability. One of the things you'd like to do is succeed in creating a matrix or a blueprint for other people in other parts of the country to pick this up other than those who initially participated.

"The fourth issue, and I think the thing that everyone wondered about at first, was leverage. Could you get other people to buy into it? I'd like to start with that one, because it seems pretty clear that there is already a lot of leverage in this. I wonder about whether or not you could use that as a way of ultimately ending up with exportability and sustainability, by doing something like the NCI seal of approval and defining what constituted a community oncology program, these are the things you have to put in place, and if you do, we'll give you a big gold star. A gold star doesn't seem like much, but John said, it is what it is. So that may be one of the things we could do.

"Let me come back to the point that Jane and Ellen made. I think we need to be careful about our enthusiasm. This program contains three things: it contains a research arm; a hope, promise and dream of further research; and a demonstration project. And they are all mixed up. But in my view, they are very different. I think there is a huge danger in the NCI evolving into an entity that embraces demonstration projects. As Ellen said, there is no end to worthwhile, beneficial, meaningful, appropriate demonstration projects to address the illnesses of this country. There are other groups set up to deal with that, who are charged with that responsibility. We are the only ones who are charged with the research piece of it.

"We need to make sure that as we evolve these things, we are focused primarily on our central area of responsibility, which is the research."

Washington Roundup:

Waxman Ousts Dingell; Obama Picks Daschle For HHS

(Continued from page 1)

REP. JOHN DINGELL (D-Mich.) was voted out of his position as chairman of the House Committee on Energy & Commerce. Dingell, the 82-year-old crusader against fraud, abuse, and scientific misconduct, who held the Energy & Commerce job, will be replaced by **Rep. Henry Waxman** (D-Calif.)

While Dingell has been aggressive on health issues, he has been more restrained on the environment and oversight of the automobile industry, which is headquartered in his state. Waxman, 69, is equally aggressive on health and environmental issues.

Dingell fought hard to retain chairmanship of the committee that will be crucially important in Obama's agenda in healthcare, the environment and economic recovery. Breaking with the seniority system, Democrats Nov. 20 voted by secret ballot 137-122 in favor of Waxman.

TOM DASCHLE has been offered the position of HHS Secretary in the Obama administration. Daschle is a former Democratic Senator from South Dakota and a former Senate Majority Leader. After losing his Senate seat in 2004, Daschle joined a lobbying firm that represented health care clients and co-wrote a book, which includes an analysis of failure by the Clinton administration to enact comprehensive healthcare reform.

NCI Cooperative Groups:

SWOG Wins $2.5 Million Grant For Trial Of H. Pylori Therapies

The Southwest Oncology Group received a $2.5 million grant from the Bill & Melinda Gates Foundation to find the most effective way to eradicate Helicobacter pylori, the principal known cause of stomach cancer.

The grant was given to to the University of Michigan, the institution where SWOG is based.

The cooperative group will conduct a clinical trial involving 1,400 people infected with H. pylori at seven clinical centers in Chile, Colombia, Costa Rica, Honduras, Mexico and Nicaragua.

The trial will compare the effectiveness of two different combinations of antibiotics known to effectively treat H. pylori, one given for five days and the other for 14 days.

"A shorter regimen, if effective, would make a future public health effort to eradicate H. pylori cheaper and more feasible," said principal investigator Laurence Baker, professor of internal medicine and pharmacology at the University of Michigan and chairman of SWOG.

The long-range goal of the trial and larger trials in the future is to establish simple, low-cost ways to

eliminate H. pylori infections and thereby prevent stomach cancer, one of the world's two leading causes of cancer deaths.

"This study will be the first step in a comprehensive plan to determine whether curing H. pylori can reduce the incidence of gastric cancer, one of the leading causes of cancer-related mortality worldwide," says E. Robert Greenberg, senior epidemiologist, Cancer Research and Biostatistics and affiliate member of the Fred Hutchinson Cancer Research Center in Seattle.

Chronic infection with H. pylori is associated with two-thirds of all cases of stomach cancer, diagnosed in nearly a million people worldwide each year. Stomach cancer, though not a leading form of cancer in the U.S., is the main cause of cancer death in much of East Asia and Latin America.

Antibiotics can effectively rid people of H. pylori, but most countries with high rates of stomach cancer have not implemented large-scale efforts to treat the infections. That could change, if this initial trial and a much larger one planned in the future are able to show that such an effort could prevent stomach cancer and not prove too costly. Previous studies have shown that programs to eradicate H. pylori could save lives and reduce health care expenditures.

"Our study will establish the effectiveness of different treatment regimens to cure H. pylori infection in Central and South America and will help to establish a network of researchers for the next phase of the study and make a far-reaching difference in health worldwide," Baker said in a statement.

MONICA BERTAGNOLLI was elected chairman of Cancer and Leukemia Group B, to succeed Richard Schilsky, who earlier this year announced his plan to step down.

Bertagnoli, professor of surgery at Harvard Medical School, chief of the Division of Surgical Oncology at Brigham and Women's Hospital, and the current CALGB vice chairman, will serve a five-year term, which will begin April 1, 2010.

Bertagnolli has been a member of CALGB since 1996, chairman of GI Correlative Sciences since 1996, vice chairman of the GI Committee since 2005 and a member of the Board of Directors since 2007.

She is also a member of the board of directors of the American Society of Clinical Oncology and as a member of the Biomarkers Consortium of the Foundation for NIH.

A native of Rock Springs, Wyo., Bertagnolli received her M.D. from the University of Utah and completed her residency at the Brigham and Women's Hospital. She completed a research fellowship in Immunology at the Dana-Farber Cancer Institute and subsequently joined the faculty at Cornell University Medical College before returning to Harvard and Brigham and Women's in 2000.

Tobacco Control:

States Spent Only 3.2 Percent Of Windfall On Cessation

Ten years ago, the states received a windfall of $246 billion in legal settlements against the tobacco industry, but failed to deliver on their promise to spend a significant portion of the money on smoking cessation programs and preventing smoking in children, a report by a coalition of health organizations found.

The report found that over the past 10 years, the states have received $203.5 billion in tobacco-generated revenue—$79.2 billion from the tobacco settlement and $124.3 billion from tobacco taxes. But they have spent only 3.2 percent of their tobacco money—$6.5 billion—on tobacco prevention and cessation programs.

Also, this year, no state is funding tobacco prevention programs at the levels recommended by the U.S. Centers for Disease Control and Prevention. Only nine states are funding tobacco prevention at even half the CDC-recommended amount, and 27 states are providing less than a quarter of the recommended funding. (Beginning in fiscal 2010, North Dakota will fund its prevention program at the CDC-recommended level as a result of a state ballot initiative approved on Nov. 4.)

The limited restrictions on tobacco marketing imposed by the tobacco settlement have failed to curtail the tobacco industry's ability to aggressively market its products. Annual tobacco marketing expenditures have increased by 94 percent, from $6.9 billion in 1998 to $13.4 billion in 2005, the most recent year for which the Federal Trade Commission has reported such data. The tobacco companies spend nearly $19 to market tobacco products for every $1 the states spend to prevent kids from smoking and help smokers quit.

Recent surveys have shown that from 1997 to 2007, smoking rates declined by 45 percent among high school students and by 20 percent among adults. However, the decreases have slowed down in recent years, and tobacco use remains the nation's leading cause of preventable death, killing more than 400,000 people and costing nearly $100 billion in health care expenditures each year.

The report, titled "A Decade of Broken Promises: The 1998 State Tobacco Settlement Ten Years Later," was released by the Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society Cancer Action Network, American Lung Association and Robert Wood Johnson Foundation.

The document is posted at www.tobaccofreekids.org/reports/settlements/.

In the Cancer Centers:

Davidson To Direct UPCI, Succeeding Herberman

NANCY DAVIDSON was named director of the University of Pittsburgh Cancer Institute effective March 1, succeeding **Ronald Herberman**. She also will serve as associate vice chancellor for cancer research and as chief of the Division of Hematology-Oncology in the University of Pittsburgh Department of Medicine.

Davidson is director of the Johns Hopkins Kimmel Cancer Center's Breast Cancer Program and professor of oncology at Johns Hopkins School of Medicine, where she also holds the Breast Cancer Research Chair in Oncology.

In September 2007, founding center director Herberman announced his intention to step down. "I am delighted that Dr. Davidson has accepted the directorship of UPCI," Herberman said. "Dr. Davidson is an outstanding physician-scientist whose research has made a tremendous impact in the cancer field."

UPCI receives a total of $174 million in research grants and is ranked 10th in funding from NCI.

Davidson received her B.A. from Wellesley College and M.D. from Harvard Medical School, after which she conducted her residency in internal medicine at Johns Hopkins Hospital and a fellowship at NCI. She recently served as president of the American Society of Clinical Oncology.

WALTER CURRAN Jr., was awarded the inaugural Lawrence W. Davis Chair of Radiation Oncology in the Emory University School of Medicine. Curran is chairman of the Department of Radiation Oncology, Emory School of Medicine, and medical director of the Emory Winship Cancer Institute. Curran is group chairman and principal investigator of the Radiation Therapy Oncology Group. . . . **OHIO STATE** James Cancer Hospital and Solove Research Institute outpatient oncology programs will be housed in the new JamesCare Comprehensive Breast Health Center as of 2011. The Ohio State University Board of Trustees authorized negotiation of final terms and enter into a lease/purchase agreement for property less than a mile from The James. Construction of the JamesCare Comprehensive Breast Health Center will more than double the space currently in use at JamesCare in Dublin and allow for future expansion. The facility will satisfy the growing demand for outpatient breast oncology care and increase patient access to therapeutic clinical trials, said **Michael Caligiuri**, CEO of The James and director of the Ohio State University Comprehensive Cancer Center. Costs for the new facility will come from operating revenue generated at the center. . . . **E. ANTONIO CHIOCCA**, chairman of neurosurgery at the James Cancer Hospital and Solove Research Institute, received a $5.5 million NIH grant over five years to develop an oncolytic virus to treat brain cancer. . . . **FOX CHASE CANCER CENTER** announced the election of **David Marshall** to chairman of its board of directors. Marshall, chairman and CEO of Amerimar Realty Co., has been a member of the Fox Chase board since 1994. He replaces **William Avery**, retired chairman and CEO of Crown Cork and Seal Co., who has served since 2003. **Louis Della Penna Sr**., was elected vice chairman, replacing Marshall. Della Penna is founder and former chairman of LDP Consulting Group Inc., an employee-benefits consulting company. . . . **ALBERT EINSTEIN COLLEGE OF MEDICINE** of Yeshiva University received a five-year, $10-million grant renewal from NCI for metastases research. The study would look at the role of macrophages in how cancer is spread. **John Condeelis**, co-chairman and professor of anatomy and structural biology, is principal investigator. The program project grant is part of activities in the Tumor Microenvironment and Metastasis Program, one of seven interdisciplinary programs of the Albert Einstein Cancer Center. Project investigators include **Jeffrey Pollard**, **E. Richard Stanley**, **Dianne Cox**, **Jeffrey Segall**, **Jonathan Backer**, and **Anne Bresnick**. . . . **MARY BABB RANDOLPH** Cancer Center at West Virginia University recruited two cancer scientists: **J. Michael Ruppert** and **Michael Schaller**, said **Scot Remick**, center director. Ruppert will be the first Jo and Ben Statler Eminent Scholar and Chair in Breast Cancer Research, made possible as part of a $5 million gift to the center in 2007. Ruppert was associate professor of medicine at University of Alabama at Birmingham and co-director of the Program in Cancer Cell Biology of the UAB Comprehensive Cancer Center. Schaller was named chairman of the Department of Biochemistry at WVU. He was professor of cell and developmental biology at University of North Carolina.

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The Cancer Letter
PO Box 9905
Washington DC 20016
Tel: 202-362-1809
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