THE CANCER LETTER

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House Plan Promises $3.5 Billion For NIH; Cooperative Groups May Get AHRQ Funds

By Paul Goldberg

The House version of a bill designed to jump-start the economy proposes a $3.5 billion increase for NIH.

Of this sum, $1.5 billion would pay for research projects over two years: $750 million during the current fiscal year, and $750 million in fiscal 2010.

The rest of the new funds proposed for NIH would pay for construction on the NIH campus and at grantee institutions. All of this money would be spent this year.

The bill cleared the House Appropriations Committee Jan. 21 by a 35-22 vote split along party lines. The bill is expected to reach the House floor sometime next week. Titled the American Recovery and Reinvestment Bill of 2009, the measure seeks to create or save up to four million jobs and

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In the Cancer Centers:

Cummings Receives ACS Award For Research On Tobacco Control; Mihich Named AAAS Fellow

K. MICHAEL CUMMINGS, chairman of the Department of Health Behavior, Roswell Park Cancer Institute, will receive the American Cancer Society's 2009 Luther L. Terry Award for Outstanding Research Contribution during the 14th World Conference on Tobacco OR Health, in Mumbai, India, in March. The award recognizes Cummings' contributions to tobacco science research which have significantly impacted tobacco control policy and advocacy. Cummings' research contributed to the scientific basis for the policies and programs recommended in the Framework Convention on Tobacco Control adopted in 2003. . . . **ENRICO MIHICH**, Distinguished Member of the Department of Pharmacology and Therapeutics at Roswell Park Cancer Institute, was named a Fellow of the American Association for Advancement of Science. He was chosen for his contributions to the fields of immunopharmacology, immunotherapy, and cancer therapeutics, particularly for recognizing the potential importance of molecular targets on immune cells. Mihich has been affiliated with Roswell Park since 1957. . . . **LEUKEMIA & LYMPHOMA SOCIETY** and University of Kansas Cancer Center announced a partnership to translate discoveries by LLS-funded researchers into phase I clinical trials. Through the partnership, LLS will initially provide up to $1.5 million to the university's Office of Therapeutics,

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Stimulus To Fund Construction At NIH, Grantee Institutions

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combines $275 billion in tax cuts with $550 billion in investments.

Next week, the Senate is expected to release the details of its version of the bill, which may include a much larger increase for NIH.

Insiders say that Senate supporters of NIH have set a target of $10 billion, which would increase the NIH budget by more than a third.

On top of this, NIH would benefit from an increase in the budget of the Agency for Healthcare Research and Quality, which under the House bill would receive an astounding $1.1 billion raise on top of its $271.6 million budget. The money would establish a program of "comparative effectiveness" research.

AHRQ relies on the NIH peer review system when it awards grants, and in this case, the bill requires the agency to pass through $400 million to NIH specifically for comparative effectiveness studies.

This could provide a new revenue stream to the cancer clinical trials cooperative groups, which have decades of experience in comparing treatment regimens. While group leaders say they are ready and willing to focus systematically on these issues, pharmaceutical companies and some clinical researchers warned against erecting barriers that would prevent patients from obtaining drugs because of cost considerations.

In recent weeks, aides to Sen. Arlen Specter (R-Penn.), ranking member of the Subcommittee on Labor, HHS and Education of the House Appropriations Committee, have been telling advocacy groups that they intended to seek a $10 billion increase for NIH, either in the Senate bill or in a subsequent amendment, Capitol Hill sources said. Insiders surmise that Sen. Tom Harkin (D-Iowa), chairman of the subcommittee who usually works with Specter, supports this plan.

With one substantial increase proposal in hand and a much larger increase promised by friends in the Senate, cancer advocacy groups are facing an unusual dilemma:

—They can applaud the windfall in the House bill, thereby risking undercutting efforts of their Senate supporters.

—Alternatively, they can hold out for the bigger prize, thereby risking appearing ungrateful to Rep. Dave Obey (D-Wisc.), chairman of the House Appropriations Committee, who provided them with $3.5 billion more than they would otherwise get.

The Federation of American Societies for Experimental Biology chose Door No. 1. The American Association for Cancer Research chose Door No. 2.

"We are very pleased that the House proposal for economic recovery reflects Congress' commitment to investing in science and medical research," Richard Marchase, FASEB president, said in a statement. "We look forward to continuing to work with leaders in the Senate, such as Senators Tom Harkin and Arlen Specter, to ensure that the jobs and business activities generated by federal investment in research remain an integral part of the plan for economic recovery."

In an email blast, AACR urged its members to call their legislators and "ask them to support a $10 billion investment for the NIH in the final economic stimulus package."

AACR also criticized the House bill. "Let your House Member know that you are disappointed that the social and economic benefit of biomedical research was undervalued in the recently released plan and ask him or her to contact Speaker Nancy Pelosi to increase the amount allocated to the NIH and the NCI," the e-mail read. "Ask your Senators to contact leadership on the Senate Appropriations Committee and ask them to ensure that the Senate plan includes the $10 billion for NIH research championed by Senators Specter and Harkin."

Report Language on NIH and AHRQ

The report language that applies to NIH reads:

National Center for Research Resources

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University Research Facilities Recovery funding: $1.5 billion

This program, authorized in section 481A of the Public Health Service Act, supports renovation and construction of university research facilities. These institutions need adequate infrastructure to compete for the biomedical research grants supported by the National Institutes of Health to advance the nation's scientific enterprise and maintain its international standing. Funding has not been provided for the past three years. The National Science Foundation estimates that academic institutions have about $3.9 billion in deferred projects to repair and renovate biomedical science research space. (FY 2005 Survey of Science and Engineering Research Facilities) Funds are awarded competitively through a request for applications with a statutory board to conduct the peer review. Bill language for the $1.5 billion has been tailored to limit awards to renovation and repair rather than new construction to ensure that funds can be spent quickly and to permit the purchase of instrumentation.

Office of the Director NIH, Including Transfer of Funds

Research Recovery funding: $1.5 billion

Economic recovery funding will support 21st century science and engineering research to bring the nation needed health breakthroughs. Funding for biomedical research supported by the National Institutes of Health has almost flat-lined after the doubling period at the beginning of the decade, imperiling high risk, high return research that was sparked during the doubling. This funding will help return NIH to a predictable investment stream and secure the earlier investments Congress has made. Funds will be allocated by competitive peer review to universities nationwide, as is current NIH funding, and to NIH intramural research. Since NIH is currently able to support less than 20 percent of approved applications, it will be able to disburse this funding without delay through its regular grant cycles. Funds provided in FY 2010 will provide the second year of support for the new research generated by FY 2009 funding.

Buildings and Facilities

NIH Campus Modernization Recovery funding: $500 million

With more than 300 owned or leased facilities (some more than 50 years old) occupying more than 17 million square feet of space, NIH has very substantial facilities needs. Excluding new construction priorities identified in the NIH Master Plan, NIH estimates its FY 2009-2010 renovation and improvement (R and I) needs at nearly $1 billion. These funds would bring the buildings' condition index to an acceptable level by the end of 2010. Funds will be spent according to the R and I strategic plan developed by the NIH Office of Research Facilities for the most urgent campus safety and functional repair needs.

The report language on comparative effectiveness research by AHRQ reads:

Recovery funding: $1.1 billion

The Agency for Healthcare Research and Quality began a Comparative Effectiveness Research program after passage of the Medicare Modernization Act of 2003 to conduct, support, or synthesize unbiased research about the comparative effectiveness of different healthcare interventions. By knowing what works best and presenting this information more broadly to patients and healthcare professionals, those items, procedures, and interventions that are most effective to prevent, control, and treat health conditions will be utilized, while those that are found to be less effective and in some cases, more expensive, will no longer be prescribed. Substantially increasing the Federal investment in comparative effectiveness research has the potential to yield significant payoffs in reducing health care expenditures and improving quality.

New Money For Cooperative Groups?

According to the bill, $400 million of AHRQ's new money would be passed through to the Office of the NIH Director, and another $400 million would be spent by the HHS secretary on comparative effectiveness research. All of these funds would be spent during the current fiscal year.

NIH would use the money "to conduct or support comparative effectiveness research," and could be transferred to institutes and the NIH Common Fund at the director's discretion.

The HHS secretary's $400 million would be spent to "accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies, including through efforts that: (1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data."

The bill mandates the HHS secretary to commission a $1.5 million report by the Institute of Medicine. The

report, due by June 30, would contain "recommendations on the national priorities for comparative effectiveness research to be conducted or supported with the funds provided."

Also, the bill establishes the Federal Coordinating Council for Comparative Effectiveness Research.

NCI's cooperative groups are well suited for conducting comparative effectiveness studies, group leaders say.

"The cooperative groups are ideally suited to conduct comparative effectiveness research and, to a large extent, have been doing so for decades," said Richard Schilsky, chairman of Cancer and Leukemia Group B. "As publicly funded research organizations that conduct investigator-initiated clinical trials, the cooperative groups have the expertise to conduct such studies independently and with the goal of establishing the best possible treatment approach for each individual patient.

"The limited resources available from NCI have hampered the groups in collecting the comprehensive cost and outcome data that might be necessary to assess comparative effectiveness, but with additional funding, the groups are fully capable of doing such studies," Schilsky said.

Robert Comis, chairman of Eastern Cooperative Oncology Group and president and chairman of the Coalition of Cancer Cooperative Groups, agrees.

"Indeed, the cooperative group system is the major driver of developing the standards of care for cancer patients on the publicly funded side of the system—obviously it is under-funded and could benefit from and play a major role in this effort," Comis said in an email. "The most important thing for each cancer patient is to get the right treatment from the beginning, based on evidence, no matter what the stage of disease. This could be done now by establishing an IT-driven system available to payers/providers/patients so that all would know what the right evidence-based treatment is for a given patient and stage of disease—as we develop newer and better treatments for cancer in the clinical trials system that data base would expand appropriately."

However, Comis said he is concerned about the report language stating that "less effective and, in some cases, more expensive will no longer be prescribed."

"We can't have a system, such as in the U.K., where patients have to beg for newer, more effective expensive, treatments (i.e. the TK inhibitors; various antibodies etc)—or only the rich can get them," he said. "The decision should be based upon effectiveness established in rigorous clinical trials such as those performed by the cooperative groups—or by groups of experts who reach a consensus—not bureaucrats driven by cost alone."

This concern was echoed by the Pharmaceutical Research and Manufacturers of America.

"We would like to work with Congress and the Obama Administration to get this right," PhRMA spokesman Ken Johnson said in a statement. "If this is done right, it could lead to better outcomes and will support patient access to beneficial medical services, rather than leading to the restrictions on beneficial care that have so concerned members of Congress in the past."

NCI News:

Niederhuber Asked To Stay While Obama Makes NIH Plans

By Kirsten Boyd Goldberg

NCI Director John Niederhuber said he has been asked to remain in his job for the time being. He announced his status in an email to institute staff on Jan. 16.

Niederhuber had submitted a resignation to the Bush White House, required of all presidential appointees, that was to have been effective at noon on Jan. 20. Niederhuber has said he would be willing to continue to serve in the Obama administration (The Cancer Letter, Dec. 19, 2008).

Following is the text of Niederhuber's email:

As we eagerly anticipate events of the coming week, I am pleased to tell you that I have been asked to continue as NCI director, to provide stability and continuity while the new administration develops its vision and plans for the NIH and the National Cancer Program.

Indeed, Tuesday, January 20 will be a milestone day for our country, as we formally welcome the Obama administration—and we celebrate, once again, the peaceful transition of presidential power. I look forward to watching the day's events, and I admire those of you who are hardy enough to brave the weather and crowds, to watch in person.

The weeks and months ahead will be an exciting time for all of us at the National Cancer Institute. We will closely track the development of an economic stimulus plan and the potential for funds directed to biomedical research—particularly the possibility of an inflationary increase to NCI for 2009. We will also eagerly anticipate the naming of a new NIH director.

At NCI, the new administration will give us a fresh

chance to shine, to continue our vital basic, clinical, translational, population, and behavioral research, even as we strive to implement new ideas and develop new lifesaving technologies and therapies.

I believe 2009 will be an exciting year. Thank you for everything you will do to make it a successful one as well.

Professional Societies:

ASCO Urges Funding Increase, Support For Clinical Trials

The American Society of Clinical Oncology released its annual report on clinical cancer advances and urged policymakers to accelerate progress against cancer by increasing cancer research funding and improving access to clinical trials.

The report, developed by a 21-member editorial board of oncologists, identifies 12 major advances and 19 other notable advances in cancer prevention, screening, treatment and survivorship over the past year.

"This report shows we are making important progress in preventing, detecting and treating cancer," said Richard Schilsky, ASCO president. "Each of the studies highlighted in the report represents new hope for people with cancer and those who care for them.

"Scientifically, we've never been in a better position to advance cancer treatment. But five years of flat federal funding for cancer research puts future success at risk," Schilsky said. "We're seeing signs of slowdown already. Tighter budgets mean less funding for high-risk research that could have big payoffs, the most significant clinical cancer research is increasingly conducted overseas, and talented young physicians are seeing less opportunity in the field of oncology and are opting instead for other specialties."

In the report, ASCO makes two recommendations to accelerate progress against cancer:

—Renew the Nation's Investment in Cancer Research: The U.S. is in the midst of the longest sustained period of flat funding for cancer research in the country's history—the budgets for NIH and NCI have remained unchanged for five years. ASCO called for an increase in annual NIH funding by at least $2 billion to keep pace with inflation, fund studies of cancer's molecular mechanisms, and accelerate progress against difficult-to-treat cancers.

"This year's report illustrates that investment in cancer research pays off. But unless we reverse the effects of flat federal funding, the great potential we currently have to advance cancer treatment will go to waste," said the report's executive editor Eric Winer, chairman of ASCO's Cancer Communications Committee and director of the Breast Oncology Center at Dana-Farber Cancer Institute. "We hope the new administration will renew the nation's investment in cancer research so researchers can take full advantage of the scientific discoveries waiting to be translated into treatments for patients."

—Remove Barriers to Clinical Trial Participation: Clinical trials are the engines that drive cancer research and lead to improved patient care. Yet just 5 percent of cancer patients currently participate. To encourage and increase participation in cancer clinical trials, ASCO recommends nationwide public and private insurance coverage of clinical trials; full reimbursement to oncology practices for the cost of participating in clinical trials; and measures to increase diversity in clinical trial participation and in the oncology workforce to reduce disparities in care.

"Clinical trials offer patients promising, new therapies and high-quality care. But without greater participation, the pace of progress will slow," said CCA executive editor Julie Gralow, associate professor of medicine/oncology at the University of Washington and director of Breast Medical Oncology at the University of Washington. "We need to reduce unnecessary barriers so that doctors can enroll patients and patients have the information and coverage they need to participate."

ASCO identified 12 advances in six key areas: hard to treat cancers, new drug approvals, reducing cancer recurrence, personalized cancer medicine, reducing cancer risk, and improving access to care.

1. New Treatment Options for Hard-to-Treat Cancers: Lung and pancreatic cancers are among the most lethal: lung cancer is the top cancer killer in the United States, and just five percent of pancreatic cancer patients survive five years or more following diagnosis.

Two studies over the past year identified ways to improve outcomes for people with both diseases—one found that the targeted therapy cetuximab (Erbitux) improves survival for advanced non-small cell lung cancer patients; another found that the chemotherapy drug gemcitabine (Gemzar) improves survival after surgery for patients with early-stage pancreatic cancer.

2. New Cancer Drug Approvals: Identifying and expanding treatment options for people with cancer is critical to improving patient outcomes. This year, FDA approved new treatments that will have a significant impact on patient care—the targeted therapy bevacizumab (Avastin) for women with advanced breast cancer that does not express the HER2 protein (the majority of breast cancers), and bendamustine (Treanda) for people with chronic lymphocytic leukemia, a cancer with few treatment options.

3. Reducing Cancer Recurrence: Cancer recurrence after successful initial therapy is a major cause of cancer death, and finding ways to reduce the risk of recurrence is a top research priority. Researchers reported two significant advances in preventing recurrence of breast cancer (the most common women's cancer) and melanoma (the deadliest form of skin cancer).

For early-stage breast cancer, several studies over the past year found that additional years of hormonal therapy (with aromatase inhibitors or tamoxifen) after the standard five years of tamoxifen significantly reduced the risk that cancer would return, as did use of a bone-building drug called zoledronic acid (Zometa). For melanoma, a large randomized study found that pegylated interferon helps stop the disease from returning in patients whose disease has spread from the original site.

4. Personalizing Cancer Medicine: Cancer treatments are increasingly being tailored to the unique genetic characteristics of patients and tumors, increasing efficacy while eliminating unnecessary side effects and cost for those patients who will not benefit from treatment.

Researchers reported a significant advance in personalized medicine for colorectal cancer patients this year, finding that only patients whose tumors have a normal (wild-type) form of the KRAS gene benefit from the addition of cetuximab (Erbitux) to standard chemotherapy.

5. Reducing Cancer Risk: Identifying cancer risk factors is key to prevention and early detection, and two studies over the past year delivered promising news for preventing ovarian cancer and head and neck oral cancers.

A large analysis of epidemiologic studies found that oral contraceptives were strongly correlated with reduced ovarian cancer risk, and may have prevented some 200,000 ovarian cancers and 100,000 deaths to date worldwide. Another epidemiologic review found that the incidence of HPV-related head and neck oral cancers has increased over time, perhaps due to increases in oral sex, suggesting a potential new role for the HPV vaccine, which is currently approved only for cervical cancer.

6. Improving Access to Care: Research advances are critical, but they are only half the equation - new treatments must reach those who need them. Two studies this year shed new light on the long-term health needs of cancer patients.

One study predicted that the number of cancer patients will grow by 55 percent by 2020, significantly outpacing the availability of cancer doctors, and necessitating enhanced recruitment for oncology and new models for delivering cancer care. Another showed that childhood cancer survivors are five to10 times more likely to develop heart disease later in life than their healthy siblings, emphasizing the need to monitor for delayed health effects of cancer treatments throughout the lives of cancer survivors.

The report, "Clinical Cancer Advances 2008: Major Research Advances in Cancer Treatment, Prevention and Screening," was published online in the Journal of Clinical Oncology and will be available on Cancer.Net.

AMERICAN SOCIETY FOR THERAPEUTIC RADIOLOGY AND ONCOLOGY is changing its name to the American Society for Radiation Oncology. With its new name, ASTRO has also unveiled a new logo that will keep the acronym ASTRO by having the "T" represent ASTRO's tagline, "Targeting Cancer Care."

"Today, most departments and practices use the term 'radiation oncology' to represent the hard work they do using radiation therapy to treat and cure patients with cancer," said Laura Thevenot, ASTRO's chief executive officer. "Over the past few decades the term 'therapeutic radiology' has become outdated and confusing as radiation oncology has evolved into a specialty very separate from its origins in diagnostic radiology. ASTRO's new name will better correlate with the term that our members are using in their own practices to communicate with patients and better reflect who we are as a specialty."

This is the fourth time the society has changed its name since it was established as the American Club of Therapeutic Radiologists in 1958.

In the Cancer Centers:

Vanderbilt's Sosman Receives ACS Melanoma Professorship

(Continued from page 1)

Discovery and Development for the funded projects. The cancer center and its partner, Beckloff Associates Inc., are supporting two early stage projects of LLS-funded researchers at University of Virginia and University of Toronto. The number of projects is expected to expand over the year. Beckloff Associates Inc., based in Overland Park, Kan., provides development and regulatory support on the projects. The University of Kansas Cancer Center holds a development contract with NCI and has helped formulate seven out of the 19 drugs developed through NCI's Developmental Therapeutics Program. . . . **JEFFREY SOSMAN**, professor of medicine at Vanderbilt-Ingram Cancer Center, received the first American Cancer Society Mary Hendrickson-Johnson Melanoma Professorship. The $400,000 award is given to an outstanding investigator who over their career has made a seminal contribution that has changed the direction of cancer research and who continues to provide leadership in the field of melanoma research. Sosman will continue his work in the development of new drugs and targets in the therapy of melanoma. . . . **JONATHAN FRIEDBERG**, was appointed chief of the Division of Hematology/ Oncology of the Department of Medicine and the James

P. Wilmot Cancer Center at the University of Rochester Medical Center. Friedberg, associate professor of medicine and director of hematological malignancies clinical research, has been on the faculty since 2002. . . . **DONALD ROSENSTEIN** joined the University of North Carolina's Lineberger Comprehensive Cancer Center as director of the new UNC Comprehensive Cancer Support Program. Rosenstein, who will be a professor in the UNC School of Medicine department of psychiatry, directed the clinical program at the National Institute of Mental Health and served as chief of the NIH psychiatry consultation-liaison service. . . . **WILLIAM PAO** accepted a new post as associate professor of Medicine in the Division of Hematology/Oncology at Vanderbilt-Ingram Cancer Center, with secondary appointments in the Departments of Cancer Biology and Pathology. He also has been named assistant director of Personalized Cancer Medicine and an Ingram Associate Professor of Cancer Research. Pao's research focus will include defining clinically relevant molecular subsets of lung cancer. Pao comes to Vanderbilt-Ingram from Memorial Sloan-Kettering Cancer Center, where he is an assistant member of the Human Oncology and Pathogenesis Program and assistant attending physician in the Thoracic Oncology Service. He also serves as assistant professor of medicine at Weill Medical College of Cornell University. . . . **WILLIAM TANSEY** joins Vanderbilt-Ingram as professor of cell and developmental biology and co-leader of the Genome Maintenance Program. He also has been named an Ingram Professor of Cancer Research. His research at Vanderbilt-Ingram will focus on the regulation of gene activity in normal and cancer cells. Tansey is a professor at Cold Spring Harbor Laboratory.

Advocacy Organizations:

ACS Awards Medal Of Honor To Sen. Edward Kennedy

AMERICAN CANCER SOCIETY presented its Medal of Honor to **Sen. Edward Kennedy** (D-Mass.) for cancer control, **Mina Bissell** for basic research, **Susan Band Horwitz** for clinical research, and **Jon Huntsman** for cancer philanthropy. As chairman of the Senate health subcommittee in 1971, Kennedy led in the passage of the National Cancer Act. Bissel, known for her research into the role of the microenvironment in cancer, is a scientist at the Lawrence Berkeley National Laboratory and the University of California, Berkeley. Horwitz is Distinguished Professor at Albert Einstein College of Medicine of Yeshiva University and the Rose C. Falkenstein Professor of Cancer Research and co-chairman of the Department of Molecular Pharmacology. Her work led to the identification of the mechanism of action of Taxol. Huntsman, founder and chairman of Huntsman Corp., has raised or contributed over $600 million for cancer research. . . . **FOUNDATION** for the National Institutes of Health added five directors to its board. They are: **Joseph Feczko**, senior vice president, chief medical officer, Pfizer Inc.; **Peter Neupert**, corporate vice president, Health Solutions Group, Microsoft Corp.; **Kurt Schmoke**, dean, Howard University School of Law; **Samuel Thier**, professor emeritus, medicine and health care policy at Harvard Medical School, Massachusetts General Hospital; and **Anne Wojcicki**, co-founder of 23andMe. . . . **LANCE ARMSTRONG FOUNDATION** awarded nearly $2 million with 11 grants to research institutions in the U.S. and Australia. The 2008 research grantees represent City of Hope; University of California, Los Angeles; University of Connecticut; Georgetown University; Veterans Affairs Medical Center and Indiana University; Montana State University; Massachusetts General Hospital; Columbia University; Ohio State University; and the University of Sydney. The 2008 grantees are addressing key recommendations from the National Action Plan on Cancer Survivorship and the reports of the Adolescent and Young Adult Oncology Progress Review Group. Also, through co-sponsorship with the National Lung Cancer Partnership, new knowledge will be gained in the area of lung cancer survivorship. . . . **NATIONAL COALITION FOR CANCER SURVIVORSHIP** appointed **Jane Barton Griffith** as senior director of development. She was the director of principal gifts at the Washington Hospital Center Foundation. . . . **COLON CANCER ALLIANCE** appointed **Andrew Spiegel** as chief executive officer. Spiegel, an attorney, was a founder and board member of the Alliance. According to **Michael Zahaby**, chairman of CCA's Board of Directors, "Mr Spiegel was appointed to re-focus the association's efforts in raising awareness of colorectal cancer and increasing services for those affected by the disease." He plans to rapidly expand the UNDY 5000 5K walk/runs and the local chapters program. . . . **MELANOMA RESEARCH FOUNDATION** appointed **Timothy Turnham** as its executive director. He held positions at several non-profit organizations, including the United Cerebral Palsy Associations, Whitman-Walker Clinic, and the Children's Research Institute at the Children's National Medical Center.

Obituaries:

SYLVAN GREEN, 62, director of biometry at the Arizona Cancer Center, died Dec. 13, in Tucson, of pancreatic cancer.

Green held the inaugural Linda McCartney Breast Cancer Endowed Chair in Biometry at the cancer center and was a professor of epidemiology and biostatistics in the College of Public Health at University of Arizona.

Green joined the Arizona Cancer Center in 2002, where he led the center's methodological and applied research activities. He played a major role in the center's translational research by participating in several major grants in study design, project development, and biostatistical analyses. His research interests were in design and analysis of clinical trials, prevention trials, and epidemiologic studies, and applying biostatistical and computer methodologies to medical and public health problems.

Green was born in Philadelphia. He received a B.A. in natural science and his M.D. from University of Pennsylvania. He served a medical internship at the State University of New York Upstate Medical Center in Syracuse in 1972-1973.

Green spent 24 years at NCI, where he was lead research investigator in the Clinical and Diagnostic Trials Section, Biometry Branch. In 1997, Green joined the faculty of the Case Western Reserve University School of Medicine as professor of epidemiology and biostatistics, professor of biomedical ethics, professor of oncology, and cancer center associate director.

Green was elected a Fellow of the American College of Epidemiology in 1983. He served as president of the Society for Clinical Trials in 1994-1995 and was elected a Fellow in 2007.

Green is survived by his wife, Angela Lyn Redlingshafer Green.

DONALD GLEASON, 88, who invented the Gleason score to determine the aggressiveness of prostate cancer, died Dec. 28 in Edina, MN, of aheart attack.

He was former chief of pathology at the Minneapolis VA Medical Center and taught at the University of Minnesota.

Gleason devised the scoring system in the 1960s from his observations of the cellular architecture of the prostate. The score is based on a pathologist's microscopic examination of prostate tissue that has been chemically stained after a biopsy.

Gleason was born in Spencer, Iowa, and grew up in Litchfield, Minn. He earned his undergraduate, medical and Ph.D. degrees from the University of Minnesota. After an internship at the University of Maryland, Baltimore, as a lieutenant in the Army Medical Corps, he trained as a pathologist at the Minneapolis VA hospital. He became the hospital's chief of anatomic pathology and laboratories and retired in 1986.

Gleason is survived by his wife, Nancy; three daughters, Donna O'Neill of Annandale, Va., Sue Anderson of Burnsville, Minn., and Ginger Venable of Eden Prairie, Minn.; a sister, Barbara Jarl of St. Paul; and nine grandchildren.

Funding Opportunities:

RFA-CA-09-501: Comprehensive Minority Institution/Cancer Center Partnership (Limited Competition U54). Letters of Intent Receipt Date: Feb. 17. Application Receipt Date: March 17. http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-501.html.

RFA-CA-09-010: Genome Characterization Centers and Genome Data Analysis Centers for The Cancer Genome Atlas Research Network. Letters of Intent Receipt Date: Feb. 13. Application Receipt Date: March 13. http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-010.html. Pre-application meeting Jan. 29, 9 a.m.-noon, Conference Room C at 6001 Executive Boulevard, Rockville, MD.

NOT-OD-09-037: This notice provides updated information regarding the salary limitation for NIH grant and cooperative agreement awards and extramural research and development contract awards. The Consolidated Appropriations Act, 2008, Public Law 110-161, restricts the amount of direct salary of an individual under an NIH grant to Executive Level I of the Federal Executive Pay scale. NIH continues to operate on a continuing resolution through March 6. The CR applies the terms of the FY 2008 appropriations into the period covered by the CR. The Executive Level I annual salary rate was $191,300 for the period Jan. 1 through Dec. 31, 2008. Effective Jan. 1, 2009, the Executive Level I salary level increased to $196,700.

RFA-CA-09-002: Transdisciplinary Cancer Genomics Research: Post-Genome Wide Association (Post-GWA) Initiative (U19). Letters of Intent Receipt Date: April 29. Application Receipt Date: May 29. http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-002.html.

PAR-09-078: Cancer Prevention, Control, Behavioral, and Population Sciences Career Development Award (K07). http://grants.nih.gov/grants/guide/pa-files/PAR-09-078.html.

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