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With $10.4 Billion To Spend In 18 Months, NIH Says Money Will Be Spent Rationally

By Kirsten Boyd Goldberg

The $787 billion economic stimulus measure President Barack Obama signed on Feb. 17 includes $10.4 billion for NIH, with $8.2 billion to fund biomedical research, $1.8 billion to upgrade research facilities, and $400 million specifically for "comparative effectiveness research."

The new money comes on top of the NIH's current funding of about $29 billion and must be spent by the end of September 2010. With this sudden, unprecedented windfall, NIH is facing the unusual challenge of having to reassure anxious NIH constituencies that the money wouldn't be simply dumped, but instead would be spent rationally.

"We have been working literally around the clock to develop a range

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In the Cancer Centers:

Roswell Park Recruits William Cance For Surgery Chairman, Pili For GU Chief

WILLIAM CANCE was appointed chairman of the Department of Surgical Oncology and surgeon-in-chief at Roswell Park Cancer Institute. Cance will lead the Department of Surgical Oncology and provide administrative oversight for the operating room and surgical services. He also will serve as RPCI's principal investigator of a training grant in surgical oncology. Cance was professor and chairman of the Department of Surgery at University of Florida. His scientific interests focus on the biology of focal adhesion kinase. He currently serves as president of the Society of Surgical Oncology. . . . **ROBERTO PILI** was appointed professor of oncology, chief of the Genitourinary Section and co-leader of the Genitourinary Program at Roswell Park Cancer Institute. Pili was associate professor of oncology and urology at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins University. . . . **JEAN GREM**, professor of hematology/oncology at the University of Nebraska Medical Center, has been appointed to the FDA Oncologic Drugs Advisory Committee for a three-year term. The committee is responsible for evaluating new cancer drugs for safety and effectiveness, and recommending approval for drugs to treat cancer. Grem is co-leader of the Cancer Genes and Molecular Regulation Program at the UNMC Eppley Cancer Center and co-director of the Cancer Center's recently secured GI/pancreatic cancer SPORE grant. . . . **ELECTRA PASKETT**, associate director of population sciences at Ohio State University

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Kington Says Stimulus Funds Aren't Meant To "Restore Cuts"

(Continued from page 1)

of options for discussion with the administration and Congress about how we can use the funds wisely," Acting NIH Director Raynard Kington said Feb. 18 at a briefing for medical organizations.

"Obviously, we are extremely grateful to President Obama and Congress," Kington said at the briefing, held at the American Association for the Advancement of Science headquarters in Washington. "Thank you again for recognizing both the economic impact and the health impact of the investment in biomedical and behavioral research. There are vexing public health challenges and many scientific opportunities that are available. We are going to focus hard on making sure that these resources are used to address those problems."

Although Kington described the funds provided through the American Recovery and Reinvestment Act of 2009 as "two-year" money, NIH actually has only 18 months to spend it. "The goal here is to give you a broad outline and go over the key principles of the bill and reassure you that we are working and we are thinking," Kington said at the meeting.

Congress applied two criteria for including NIH in the Recovery Act, Kington said. "One is that you actually have a short-term economic impact, that funding in your organization would stimulate the economy, and two, that it would make sense as a long term investment for the nation," he said.

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"We think that we meet both of these criteria, and we think that investing in the scientific apparatus of this country is a smart thing for the government to do, but also there is a compelling amount of evidence that there is a direct economic impact on the communities where the 3,000 institutions that we support are located.

"They are often the largest employers and major economic engines of their communities, and we believe that there will prove to be, as predicted, a short-term stimulus effect as well as a long-term effect, because there is increasing evidence that support from NIH gets multiplied in the communities as services are purchased and people are hired, but also attracts other funding from non-federal sources to stimulate the research apparatus in communities," he said.

Kington said he was unable to provide a target for how much of the funds could be spent by the end of the current fiscal year.

"We plan to use every opportunity we can to spend as much as feasible and as much as we can do prudently in '09 to support the goals of the Act and to advance science, but obviously, we will somewhat be restricted by the mechanisms that we use and how quickly we can activate," he said.

Distribution of Funds

Of the $8.2 billion for research, $7.4 billion will immediately be distributed among the institutes and centers and the NIH Common Fund, proportional to their budgets, Kington said. The Common Fund is used to support the NIH Roadmap Initiatives and other trans-NIH activities.

Another $800 million—in addition to the money for the Common Fund—will go to the Office of the Director and will be used to support "a range of scientific efforts," Kington said. "The allocation of those dollars will be by scientific priority-setting and will depend upon what opportunities there are that are identified by the institutes and centers and the Office of the Director," he said.

Of the remaining $2.2 billion out of the $10.4 billion total, the legislation outlines the following distribution:

—$1 billion for extramural construction, repairs, and alterations. These funds are allocated to the National Center for Research Resources in support of NIH-funded research institutions.

—$300 million, also to NCRR, for shared instrumentation and other capital equipment for extramural institutions.

—$500 million for repair, construction, and

improvement of NIH buildings.

—$400 million comes to NIH after a brief stopover at the Agency for Healthcare Research and Quality, to fund comparative effectiveness research.

The new money isn't added to the budgetary base of NIH, and recipients shouldn't assume that any funds they receive through the Act will be renewed by NIH beyond September 2010, Kington said.

Also, the new money will come with additional reporting requirements, Kington said.

"It's important that the constituencies recognize that these are not usual dollars," he said. "These are dollars with a very short-term focus and that's on stimulating the economy. As a result, there will probably be an unprecedented level of reporting requirements that are above and beyond our usual requirements for reporting for NIH grants. There will be pretty regular reports about factors, such as the number of jobs created or preserved."

NIH and HHS are developing guidance for grantees about the reporting requirements, he said.

"The expectation is that we will be able to demonstrate in a transparent way to the American public exactly what the dollars are used for and all of the evidence of its impact on the local economy," Kington said.

Three "Big Buckets" for Research Funding

For beginning the process of identifying projects to receive the stimulus funds set aside for research, NIH has devised three categories.

Kington described these as three "big buckets."

—R01 grants and related research. NIH had 14,000 R01 applications that had been peer reviewed approved for funding but missed the payline by the end of fiscal 2008. Although these are four-year projects, institutes and centers could begin to identify those projects that could make "a compelling case" that two-year funding "would result in significant scientific advances," Kington said. These would likely be in areas that are high priorities for the institutes and centers and there would be no implied commitment to renewal of the funding after two years.

—Supplemental funding to existing grants. NIH has procedures in place for adding funds to grants, to expand the research. "Some of these may be done in a competitive way, some may be done administratively, which the programmatic staff identify likely candidates and request investigators to request supplements," Kington said. "There also may be opportunities for 'themed' supplements, such as those targeted toward training slots, or toward equipment purchases, or other themes that might cut across the missions of the various institutes and centers and across various scientific areas."

—NIH Challenge Grant Program, a new program, will provide grants of $500,000 a year for two years in areas identified by the institutes and centers. NIH will develop a Request for Applications for these grants, and would establish a shortened application and peer review process, Kington said. NIH may commit "in the range of $100-$200 million" for this program, but that will depend upon "what opportunities the institutes and centers identify in these other two buckets, and what types of applications we receive for the new RFA," he said.

"We aren't able to give anything even close to broad outline about the number of awards or the amount of money in each of these categories, but we are setting up a deliberative, thoughtful process that will give us an opportunity to set priorities based on the usual measures that we use to set priorities: scientific merit, scientific opportunity, compelling public health need, and opportunity to have the biggest impact," Kington said.

NIH grantees shouldn't view the stimulus funding as a means of "restoring cuts," Kington said. "There will not be any restoration," he said. "This is about looking to the future."

Kington declined to provide details about how the funding for comparative effectiveness research would be distributed. He said NIH is meeting with AHRQ to "set priorities."

The Recovery Act doesn't require NIH to set aside any portion of the funding for the small business research programs. "The institutes and centers might choose to, but I don't think that will be a priority," Kington said.

Kington said some types of research might be more suited to two-year funding, while other types of research, such as clinical trials, might not be. Investigators and institutes will have to "make a compelling case" that two years of funding would help move forward the science.

Also, institutes and centers will have to be careful where they choose to put the new money so as not to cause problems when the money's gone, Kington said. The new money is likely to spur an increase in the number of grant applications. "We don't want a really disruptive year in '11," he said.

Kington urged research institutions not to apply for the stimulus funds if they can't finish a project in

18 months and don't have means of further support for the work. That, he said, "would be the height of embarrassment."

Congress has not yet acted on fiscal 2009 appropriations for NIH, and the institutes are operating under a continuing resolution that provides the same level of funding as last fiscal year.

A recording of Kington's remarks and question-and-answer session is posted at www.cancerletter.com/publications/special-reports.

Cancer Policy:

M.D. Anderson President Outlines Plan For Research

John Mendelsohn came to Washington earlier this week to present his thoughts about the future directions for cancer research and health care reform.

Mendelsohn, president of the University of Texas M.D. Anderson Cancer Center, described his 10-point policy recommendations to Congress in remarks at the National Press Club on Feb. 17.

"We have experience that I hope I can share with those who, over the next three or four years, are going to be making policies that I hope will improve heath care, improve research, and improve access for all Americans to health care," Mendelsohn said at the press conference. "I wrote out some ideas in a little pamphlet."

Mendelsohn's essay, which he said he wrote primarily as an "exercise for myself, to carry around and talk about," was published in the Houston Chronicle's Outlook section on Jan. 25.

Following is the text:

Cancer In 2009—What Needs To Be Done

An American diagnosed with cancer today is very likely to join the growing ranks of survivors, who are estimated to total 12 million and will reach 18 million by 2020. The five-year survival rate for all forms of cancer combined has risen to 66%, more than double what it was 50 years ago.

Along with the improving five-year survival rates, the cancer death rate has been falling by 1% to 2% annually since 1990.

According to the World Health Organization, cancer will be the leading world-wide cause of death in 2010. Over 40% of Americans will develop cancer during their lifetime.

While survival rates improve and death rates fall, cancer still accounts for one in every five deaths in the U.S.A., and cost this nation $89.0 billion in direct medical costs and another $18.2 billion in lost productivity during the illness in 2007, according to the National Institutes of Health.

Here are 10 steps we can take to ensure that deaths decrease more rapidly, the ranks of survivors swell, and an even greater number of cancers are prevented in the first place.

1. Therapeutic cancer research should focus on human genetics and the regulation of gene expression.

Cancer is a disease of cells that have either inherited or acquired abnormalities in the activities of critical genes and the proteins for which they code. Most cancers involve several abnormally functioning genes — not just one — which makes understanding and treating cancer terribly complex. The good news is that screening for genes and their products can be done with new techniques that accomplish in days what once took years.

Knowledge of the human genome and mechanisms regulating gene expression, advances in technology, experience from clinical trials, and a greater understanding of the impact of environmental factors have led to exciting new research approaches to cancer treatment, all of which are being pursued at M. D. Anderson Cancer Center:

* Targeted therapies. These therapies are designed to counteract the growth and survival of cancer cells by modifying, replacing or correcting abnormally functioning genes or their RNA and protein products, and by attacking abnormal biochemical pathways within these cells.

* Molecular markers. Identifying the presence of particular abnormal genes and proteins in a patient's cancer cells, or in the blood, will enable physicians to select the treatments most likely to be effective for that individual patient.

* Molecular imaging. New diagnostic imaging technologies that detect genetic and molecular abnormalities in cancers in individual patients can help select optimal therapy and determine the effectiveness of treatment within hours.

* Angiogenesis. Anti-angiogenesis agents and inhibitors of other normal tissues that surround cancers can starve the cancer cells of their blood supply and deprive them of essential growth-promoting factors which must come from the tumor's environment.

* Immunotherapy. Discovering ways to elicit or boost immune responses in cancer patients may target destruction of cancer cells and lead to the development of cancer vaccines.

2. Better tests to predict cancer risk and enable earlier detection must be developed.

New predictive tests, based on abnormalities in blood, other body fluids, or tissue samples, will be able to detect abnormalities in the structure or expression of cancer-related genes and proteins. Such tests may predict the risk of cancer in individuals and could detect early cancer years before any symptoms are present.

The prostate-specific antigen test for prostate cancer currently is the best known marker test to detect the possible presence of early cancer before it has spread. Abnormalities in the BRCA 1 and 2 genes predict a high risk for breast cancer, which can guide the decisions of physicians and patients on preventive measures. Many more gene-based predictors are needed to further our progress in risk assessment and early detection.

3. More cancers can and must be prevented.

In an ideal world, cancer "care" would begin with risk assessment and counseling of a person when no malignant disease is present. Risk factors include both inherited or acquired genetic abnormalities and those related to lifestyle and the environment.

The largest risk factor for cancer is tobacco smoking, which accounts for nearly one-third of all cancer deaths. Tobacco use should be discouraged with cost disincentives, and medical management of discontinuing tobacco use must be reimbursed by government and private sector payors.

Cancer risk assessment should be followed by appropriate interventions (either behavioral or medical) at a pre-malignant stage, before a cancer develops. Diagnosis and treatment of a confirmed cancer would occur only when these preventive measures fail.

A full understanding of cancer requires research to identify more completely the genetic, environmental, lifestyle and social factors that contribute to the varying types and rates of cancer in different groups in this country and around the world. A common cancer in Japan or India, for example, often is not a common cancer in the U.S. When prostate cancer occurs in African-Americans it is more severe than in Caucasians. A better understanding of the factors that influence differences in cancer incidence and deaths will provide important clues to preventing cancer in diverse populations world-wide.

4. The needs of cancer survivors must become a priority.

Surviving cancer means many things: reducing pain, disability and stress related to the cancer or the side effects of therapy; helping patients and their loved ones lead a full life from diagnosis forward; preventing a second primary cancer or recurrence of the original cancer; treating a difficult cancer optimally to ensure achieving the most healthy years possible; and more. Since many more patients are surviving their cancers—or living much longer with cancer—helping them manage all the consequences of their disease and its treatment is critically important. It is an area ripe for innovative research and for improvement in delivery of care.

5. We must train future researchers and providers of cancer care.

Shortages are predicted in the supply of physicians, nurses and technically trained support staff needed to provide expert care for patients with cancer. On top of this, patient numbers are projected to increase. We are heading toward a "perfect storm" unless we ramp up our training programs for cancer professionals at all levels. The pipeline for academic researchers in cancer also is threatened due to the increasing difficulty in obtaining peer-reviewed research funding. We must designate more funding from the NIH and other sources specifically for promising young investigators, to enable them to initiate their careers.

6. Federal funding for research should be increased.

After growing by nearly 100% from 1998-2002, the National Cancer Institute budget has been in decline for the past four years. Through budget cuts and the effects of inflation, the NCI budget has lost approximately 12% of its purchasing power. Important programs in tobacco control, cancer survivorship and support for interdisciplinary research have had significant cuts. The average age at which a biomedical researcher receives his or her first R01grant (the gold standard) now stands at 42, hardly an inducement to pursue this field. This shrinks the pipeline of talented young Americans who are interested in careers in science, but can find easier paths to more promising careers elsewhere. Lack of adequate funding also discourages seasoned scientists with outstanding track records of contributions from undertaking innovative, but risky research projects. The U.S. leadership in biomedical research could be lost.

Biomedical research in academic institutions needs steady funding that at least keeps up with inflation and enables continued growth.

7. The pace of clinical research must accelerate.

As research ideas move from the laboratory to patients, they must be assessed in clinical trials to test their safety and efficacy. Clinical trials are complicated, lengthy and expensive, and they often require large numbers of patients. Further steps must be taken to

ensure that efficient and cost-effective clinical trials are designed to measure, in addition to outcomes, the effects of new agents on the intended molecular targets. Innovative therapies should move forward more rapidly from the laboratory into clinical trials.

The public needs to be better educated about clinical trials, which in many cases may provide them with access to the best care available. Greater participation in trials will speed up drug development, in addition to providing patients with the best options if standard treatments fail. The potential risks and benefits of clinical trials must continue to be fully disclosed to the patients involved, and the trials must continue to be carefully monitored.

The issue of how to pay for clinical trials must be addressed. The non-experimental portion of the costs of care in clinical trials currently are borne in part by Medicare, and should be covered fully by all payors. The experimental portion of costs of care should be covered by the owner of the new drug, who stands to benefit from a new indication for therapeutic use.

8. New partnerships will encourage drug and device development.

One way to shorten the time for drug and device development is to encourage and reward collaboration among research institutions, and collaboration between academia and industry. Increasingly, partnerships are required to bring together sufficient expertise and resources needed to confront the complex challenges of treating cancer. There is enormous opportunity here, but many challenges, as well.

Academic institutions already do collaborate, but we need new ways to stimulate increased participation in cooperative enterprises.

Traditionally, academic institutions have worked with biotech and pharmaceutical companies by conducting sponsored research and participating in clinical trials. By forming more collaborative alliances during the preclinical and translational phases prior to entering the clinic, industry and academia can build on each other's strengths to safely speed drug development to the bedside. The challenge is that this must be done with agreements that involve sharing, but also protect the property rights and independence of both parties.

The results of all clinical trials must be reported completely and accurately, without any influence from conflicts of interest and with full disclosure of potential conflicts of interest.

9. We must provide access to cancer care for everyone who lives in the U.S.A.

More than 47 million Americans are uninsured, and many others are underinsured for major illnesses like cancer. Others are uninsurable because of a prior illness such as cancer. And many are indigent, so that payment for care is totally impossible.

Depending on where they live and what they can afford, Americans have unequal access to quality cancer care. Treatment options vary significantly nationwide. We must find better ways to disseminate the best standards of high quality care from leading medical centers to widespread community practice throughout the country.

Cancer incidence and deaths vary tremendously among ethnic and economic groups in this country. We need to address the causes of disparities in health outcomes and move to eliminate them.

We are unique among western countries in not providing direct access to medical care for all who live here. There is consensus today among most Americans and both political parties that this is unacceptable. Especially for catastrophic illnesses like cancer, we must create an insurance system that guarantees access to care.

A number of proposals involving income tax rebates, vouchers, insurance mandates, and expanded government insurance programs address this issue. Whatever system is selected should ensure access and include mechanisms for caring for underserved Americans. The solution will require give-and-take among major stakeholders, many of which benefit from the status quo. However, the social and economic costs have risen to the point that we have no choice.

10. Greater attention must be paid to enhancing the quality of cancer care and reducing costs.

New therapies and medical instruments are expensive to develop and are a major contributor to the rising cost of medical care in the U.S. The current payment system rewards procedures, tests and treatments rather than outcomes. At the same time, cancer prevention measures and services are not widely covered. A new system of payment must be designed to reward outcomes, as well as the use of prevention services.

Quality of care can be improved and costs can be reduced by increasing our efforts to reduce medical errors and to prescribe diagnostic tests and treatments only on the basis of objective evidence of efficacy.

A standardized electronic medical record, accessible nationwide, is essential to ensuring quality care for patients who see multiple providers at multiple sites, and we are far behind many other nations. Beyond that, a national electronic medical record could provide

enormous opportunities for reducing overhead costs, identifying factors contributing to many illnesses (including cancer), determining optimal treatment and detecting uncommon side effects of treatment.

What the future holds in store.

I am optimistic. I see a future in which more cancers are prevented, more are cured and, when not curable, more are managed as effectively as other chronic, life-long diseases. I see a future in which deaths due to cancer continue to decrease.

Achieving that vision will require greater collaboration among academic institutions, government, industry and the public. Barriers to quality care must be removed. Tobacco use must be eradicated. Research must have increased funding. Mindful that our priority focus is on the patient, we must continue to speed the pace of bringing scientific breakthroughs from the laboratory to the bedside.

NCI News:

NCI, CDC, Release State-Level Cancer Incidence And Mortality

NCI and the Centers for Disease Control and Prevention released state-specific cancer statistics earlier this week.

The 1999-2005 United States Cancer Statistics: Incidence and Mortality web-based report, includes information on more than one million cases of cancer diagnosed in 2005 among residents of 48 states, 6 metropolitan areas, and the District of Columbia—geographic areas in which about 96 percent of the U.S. population reside.

Incidence data are from CDC's National Program of Cancer Registries and NCI's Surveillance, Epidemiology, and End Results Program. Data from population-based central cancer registries in these states and metropolitan areas meet the selected criteria for inclusion in this report.

The report also provides cancer mortality data collected and processed by CDC's National Center for Health Statistics. Mortality statistics, based on records of deaths that occurred during 2005, are available for all 50 states and the District of Columbia.

The report is produced in collaboration with the North American Association of Central Cancer Registries.

The publication, as well as companion materials based on the report data, is available at http://www.cdc.gov/uscs.

Obituary:

ACS Epidemiologist Calle, 57, Found Dead In Atlanta Home

By Paul Goldberg

Eugenia Calle, 57, former vice president of epidemiology at the American Cancer Society, was found dead in her Atlanta apartment Tuesday Feb. 17.

A 22-year-old man was arrested Thursday and charged with her murder, police said.

Calle had retired from ACS two weeks earlier and was consulting for the society as well as other clients.

Police said there were signs of struggle in Calle's apartment, and she died of blunt force trauma to the head.

Calle's apartment in a high-rise in midtown Atlanta was on the market. Police said Jamal Thompson, the man charged with her murder, had posed as a potential buyer to gain entry.

"The suspect was identified from surveillance video in the building and he was tracked and eventually captured after he used the victim's credit card," said Eric Schwartz, a spokesman for the Atlanta Police Department. Thompson was arrested in southwest Atlanta.

Calle joined ACS in 1989, and was the principal investigator on the society's Cancer Prevention Study, one of the largest cohort studies in history. Her recent work focused on the links between obesity and cancer.

"Jeanne was one of the world's most respected epidemiologists in the field of causes of cancer," said Otis Brawley, ACS chief medical officer. "Up to now, her greatest work has been the link between obesity and cancer.

"Another thing which can't be underestimated is her work in overseeing Cancer Prevention Study II," Brawley said. "And another of her great contributions is in press at the NEJM, scheduled to be public in early March."

Calle received a doctorate in epidemiology from Ohio State University and worked as an epidemiologist at the Oak Ridge National Laboratory in the area of cancer risk assessment and at the Centers for Disease Control on the Agent Orange Projects before joining ACS.

Calle was an adjunct professor of epidemiology at Emory University. Her husband, Richard Letz, a professor at Emory University's Department of Behavioral Sciences and Health Education, died of cancer three years ago.

In the Cancer Centers:

Hope Funds Recognizes Work Of Scientists, Advocates

(Continued from page 1)

Comprehensive Cancer Center-James Cancer Hospital and Solove Research Institute, was elected chairman of the American Public Health Association's newly formed Cancer Forum. Its mission is to create a focus on cancer as a public health issue within the organization. . . . **HOPE FUNDS** for Cancer Research announced its 2009 Awards of Excellence for outstanding contributions to basic, clinical, and medical cancer research, as well as prominent advocacy and philanthropy on behalf of cancer research. The honorees are: **Robert Weinberg**, founding member of the Whitehead Institute; **Brian Druker**, director of the Oregon Heath & Science University Knight Cancer Institute; **John Cameron**, the Alfred Blalock Distinguished Service Professor of Surgery at The Johns Hopkins University School of Medicine; **Amy Dockser Marcus**, a Boston-based staff reporter for The Wall Street Journal, for advocacy; and the **Virginia and D.K. Ludwig Fund for Cancer Research**, for its work in philanthropy.

In Brief:

Zerhouni At Gates Foundation To Advise On Global Health

ELIAS ZERHOUNI, who resigned as NIH director last fall, joined the Bill and Melinda Gates Foundation as senior fellow in the global health program. In the part-time position, he will advise the foundation's Global Challenges initiative and other projects. . . . **CANCER RESEARCH PRIZES** given every other year by the Charles Rodolphe Brupbacher Foundation, this year recognize scientists whose work has had strong implications for public health: **Nubia Muñoz**, of Colombia, for her contributions to the epidemiology of cancer causation by chronic infections, in particular the etiology of cervical cancer; and **Sir Richard Peto**, professor of medical statistics and epidemiology at the University of Oxford, for his contributions to cancer epidemiology, in particular the establishment of the causation of premature death by tobacco smoking. . . . **ASSOCIATION OF RESIDENTS** in Radiation Oncology elected three members to its Executive Committee. **Karen De Amorim Bernstein**, of Albert Einstein College; **Luqman Dad**, of Roswell Park Cancer Institute; and **Vinai Gondi**, of the University of Wisconsin-Madison. ARRO is the resident organization within the American Society for Radiation Oncology, representing nearly 600 radiation oncology residents in the U.S. . . . **RALPH NEAS**, former president and CEO for People For the American Way, and former executive director of the Leadership Conference on Civil Rights, was named CEO of the National Coalition on Health Care, a non-partisan alliance working for comprehensive health care reform. . . . **DALE BIRKLE DREER** was appointed chief of the Office of Scientific Review at the National Center for Complementary and Alternative Medicine, at NIH. The office is responsible for the peer review of all grant applications assigned to NCCAM. Dreer began her NIH career in NCCAM's OSR in 2001 as a scientific review officer. Prior to joining NIH, she was a professor in the Department of Pharmacology and Toxicology at West Virginia University.

Funding Opportunities:

Revision: Notice of Re-issuance of Kirschstein-NRSA T32 (PA-08-226) and T35 (PA-08-227) Funding Opportunity Announcements. http://grants.nih.gov/grants/guide/notice-files/NOT-OD-09-049.html.

Update to PAR-09-091 Pre-Application for Dietary Supplement Research Centers: Botanicals (X02) and RFA-OD-09-001, Dietary Supplement Research Centers: Botanicals (P50): Informational Webinar for Applicants. http://grants.nih.gov/grants/guide/notice-files/NOT-OD-09-050.html.

Allowable Salary Levels on Career Awards Supported by NCI. http://grants.nih.gov/grants/guide/notice-files/NOT-CA-09-013.html.

Correction to Review Criteria for RFA-CA-09-004, RFA-CA-09-006, and RFA-CA-09-008, the Innovative Molecular Analysis Technologies (IMAT) for Cancer Program. http://grants.nih.gov/grants/guide/notice-files/NOT-CA-09-015.html.

Clarification of Page Limitations for Research Plan in PAR-09-026 Collaborative Research in Integrative Cancer Biology and the Tumor Microenvironment (U01). http://grants.nih.gov/grants/guide/notice-files/NOT-CA-09-017.html.

PA-09-094: New Technologies for Liver Disease STTR (R41/R42). http://grants.nih.gov/grants/guide/pa-files/PA-09-094.html.

PA-09-095: New Technologies for Liver Disease SBIR (R43/R44). http://grants.nih.gov/grants/guide/pa-files/PA-09-095.html.

PAR-09-103: Centers for AIDS Research: D-CFAR, CFAR (P30). http://grants.nih.gov/grants/guide/pa-files/PAR-09-103.html.

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