THE CANCER LETTER

Vol. 35 No. 33
Sept. 11, 2009

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

Rejecting Data, Believers In PSA Screening Strengthen Guidelines, Launch Outreach

By Paul Goldberg

Earlier this year, two large randomized studies of prostate cancer screening pointed to overdiagnosis and overtreatment of the disease.

Even though one study showed no benefit from the procedure and another pointed to a slight benefit at a substantial cost, the procedure hasn't been abandoned.

Two major U.S. guideline-making organizations strengthened recommendations for screening, patient groups continued to dispute the implications of the trials, and a major pharmaceutical company started an outreach effort aimed at getting men screened.

This response doesn't seem to bode well for medicine being guided

(Continued to page 2)

In the Cancer Centers:

Bookman Joins Arizona Cancer Center As Chief Of Hematology/Oncology

MICHAEL BOOKMAN joined the Arizona Cancer Center as chief of the hematology/oncology section. He has been appointed professor of Medicine at the University of Arizona and will head the Department of Medicine's Hematology/Oncology section. Bookman will lead the 28 clinical and research faculty within the section and will join the leadership team of the Arizona Cancer Center. Bookman was vice president for ambulatory care and clinical research at Fox Chase Cancer Center, where he has served since 1988. He is an expert in gynecological medical oncology. His interests include developmental therapeutics, medical informatics and international outreach in gynecologic cancer management and collaborative research. "As a close friend and long-term research colleague, I have come to know Michael as a brilliant clinical and translational researcher, especially in women's cancers. He brings to the Arizona Cancer Center well-honed, in-depth clinical and informatics operation skills," said **David Alberts**, director of the Arizona Cancer Center. . . . **UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES** nanotechnology researcher **Vladimir Zharov** has been awarded $2.3 million in three grants in the field of prevention of cancer metastasis. Zharov, director of the Phillips Classic Laser and Nanomedicine Laboratories at UAMS, received $1.2 million from the National Institute of Biomedical Imaging and Bioengineering to support comprehensive preclinical studies and a first-of-its-kind clinical trial using nanoparticles at the UAMS

(Continued to page 6)

U.S. Groups Promote PSA; EU Group: Data Insufficient

(Continued from page 1)

by studies in comparative effectiveness, the approach to cutting medical costs proposed by the Obama administration.

"At times we appear to be a society that worships science and disregards the scientific process," said Barnett Kramer, NIH associate director for disease prevention, editor-in-chief of JNCI, and one of the the investigators on the NCI-sponsored Prostate, Lung, Colorectal and Ovarian Cancer Screening trial, which found no benefit to screening with prostate-specific antigen and digital rectal exam. "If we are only willing to accept the results of trials when they reinforce what we already believe, that calls into questions the need for doing trials."

Data do not support either more aggressive guidelines or screening promotion campaigns, Kramer said. "I think that unvarnished sound bite-driven campaigns are out of synch with the evidence that emerged over then last 10 years or so," he said.

While PLCO found no benefit, the European Randomized Study of Screening for Prostate Cancer found that PSA testing reduced death rate from prostate cancer by 20 percent, but at an enormous cost of overdiagnosis and overtreatent. That study found that 1,410 men had to be screened over nine years to detect 48 cases and prevent one death (The Cancer Letter, Mar. 20).

THE CANCER LETTER

® The Cancer Letter is a registered trademark.

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg

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

In a statement, the European Association of Urology said that "current published data are insufficient to recommend the adoption of population screening for prostate cancer as a public health policy because of the significant overtreatment that would result."

By contrast, in the U.S., enthusiasm for screening remains undiminished:

—The American Urological Association issued a "best practice statement" that recommended that screening begin at a younger age—40. Previous guidelines recommended the age of 50 as the threshold (The Cancer Letter, May 1).

—Last month, the National Comprehensive Cancer Network issued a guideline stating that "PSA testing is effective and needs to be more rigorous in high-risk populations." In a statement accompanying the new guideline, Mark Kawachi, chair of the NCCN Guidelines for Prostate Early Detection and Associate Professor of Surgery, Urology and Urologic Oncology at City of Hope Comprehensive Cancer Center, said that "PSA testing has saved thousands of lives and continues to be an important tool in the fight against prostate cancer. We are most likely to produce further declines in prostate cancer mortality if we focus on younger men who are more likely to die of prostate cancer than other causes and the diagnosing of aggressive prostate cancer in all men."

NCCN argues that the European study didn't include any information about family history or specify the racial composition of its patients and PLCO included a very small number of patients with a family history of prostate cancer or African-American men.

"Some of the controversy with the recent trials assessing the benefits of PSA testing stems from people confusing early detection with screening," Kawachi said in a statement. "It is imperative to distinguish the two terms from each other and understand that screening implies testing a random group of participants where as early detection targets a select group of patients whose need is greatest."

An additional update to the NCCN Guidelines is a higher PSA (1.0 ng/mL) that would prompt high-risk men to receive more frequent screenings. Therefore, the current NCCN Guidelines recommend that at age 40, high-risk men be offered a baseline PSA and DRE and if their PSA is 1.0 ng/mL or greater, that they receive annual follow-ups. If their PSA is less than 1.0, the NCCN Guidelines recommend that these men be screened again at age 45.

—AUA and other groups have recruited tennis player John McEnroe, whose father was diagnosed with

prostate cancer in 2006, to promote the more aggressive screening guideline.

The campaign, which includes print advertisement that debuts in September, is led by AUA, Stand Up To Cancer, a program of the Entertainment Industry Foundation, as well as the American Urological Association, GlaxoSmithKline (NYSE:GSK), Men's Health Network, Prostate Cancer Foundation and the Prostate Conditions Education Council. More information is available at www.ProstateCancerWatch.com. GlaxoSmithKline is a sponsor of dutasteride, a drug focused against benign prostate hyperplasia.

The science to justify earlier screening is not solid, said Len Lichtenfeld, deputy chief medical officer of the American Cancer Society. The recommendation is reminiscent of the time when experts recommended that breast cancer screening begin at 35, with a baseline mammogram.

"It took us years to figure out that baseline screening did not help us reduce deaths from breast cancer and didn't add anything material to early the diagnosis of he disease," Lichtenfeld said. "If you look at prostate cancer, we see that science is sending us a message that maybe we shouldn't be as certain as we have been about the value of PSA in prostate cancer screening. Before we start making statements of opinion about how and when PSA should be used, we should let the lessons of the past teach us something about present and the future, and mammogram at 35 is such a lesson. We need to develop the science before we go out and start subjecting even more men to potential overdiagnosis and needless treatment."

The European Guidelines

The following is the excerpted text of the European guideline on prostate cancer screening:

—Prostate cancer is a major health problem and one of the main causes of male cancer death. Before screening is considered by national health authorities, the level of current opportunistic screening as well as issues of overdiagnosis, overtreatment, quality of life, cost, and cost-effectiveness should be taken into account.

—Overdiagnosis of prostate cancer potentially leads to significant overtreatment of prostate cancer. Health professionals, especially urologists, should avoid over- treatment by developing safe methods of cancer surveil- lance and monitoring without resorting to invasive therapy. Invasive therapies should be tailored to patients' needs and the prognosis of cancers diagnosed.

—Current screening algorithms are insufficient because of their lack of specificity and lack of selectivity for aggressive cancers that require treatment. The develop- ment of novel diagnostic and prognostic markers and imaging modalities is urgently needed to enhance the predictive value of screening tools.

—In the absence of population screening, the EAU advises men who consider screening by PSA testing and prostate biopsy to obtain information on the risks and benefits of screening and make an individual risk assessment..

—The EAU and the ERSPC study group represent essential European stakeholders who will further develop health strategies for prostate cancer screening.

—The EAU promotes the quality of care for prostate cancer patients in Europe in collaboration with the patient support organisation Europa Uomo through the development of information support and guidelines.

—The EAU wishes to support and foster research needed to develop reliable active-surveillance protocols for low-risk prostate cancers, prognostic markers, and targeted therapies to deliver optimal patient care.

One-Million Man Overdiagnosis

The overdiagnosis of men that occurred between 1986 and 2005 exceeded one million, a paper published in the Aug. 31 issue of JNCI estimates. The growth is particularly dramatic for younger men, researchers said.

Researchers H. Gilbert Welch of Dartmouth and Peter Albertsen of the Department of Surgery, University of Connecticut School of Medicine, obtained data on age-specific incidence and initial course of therapy from the NCI Surveillance, Epidemiology, and End Results Program and used age-specific male population estimates from the U.S. Census to determine the excess (or deficit) in the number of men diagnosed and treated in each year after 1986, the year before PSA screening was introduced.

Incidence of prostate cancer rose rapidly after 1986, peaked in 1992, and then declined, but is still at a level considerably higher than 1986. Overall incidence, however, obscured distinct age-specific patterns: The relative incidence rate (2005 relative to 1986) was 0.56 in men aged 80 years and older, 1.09 in men aged 70–79 years, 1.91 in men aged 60-69 years, 3.64 in men aged 50– 59 years, and 7.23 in men younger than 50 years. Since 1986, an estimated additional 1,305,600 men were diagnosed with prostate cancer, 1,004,800 of whom were treated.

Making the most optimistic assumption—that the decline in prostate cancer mortality observed during this period is attributable to this additional diagnosis—researchers estimate that, for each man who experienced the presumed benefit, more than 20 had to be diagnosed with prostate cancer.

In an editorial accompanying the Welch and Albertsen paper, Otis Brawley, chief medical officer of the American Cancer Society, said that the experience with prostate cancer screening is an example of perils faced by evidence-based medicine.

"The current political rhetoric supports comparative effectiveness research," Brawley wrote. "In principle, this is good. The strongest scientific supports for an intervention are findings from a prospective randomized controlled trial. In the case of prostate cancer screening, many screening advocates actually discouraged such trials even while the trials were under way.

"The rational use of medicine, not the rationing of medicine. An important element of health-care reform is a reform of how we consume health care. The irrational tendency to adopt treatments and technologies without adequate assessment is a form of 'medical gluttony' and a major reason that US per capita healthcare costs are the highest in the world. We do not get what we pay for; our life expectancy is 29th among developed countries.

"Medical costs are approaching one-fifth of our gross domestic product. The economy cannot afford the continued growth of health-care costs seen over the past 30 years. Economic realities have already led to some restrictions or rationing. More will occur unless we begin the rational practice of medicine."

FDA News:

FDA Issues Final Rules On Patient Access To Investigational Drugs

FDA published two rules that seek to clarify the methods available to seriously ill patients interested in gaining access to investigational drugs and biologics when they are not eligible to participate in a clinical trial and don't have other satisfactory treatment options.

To support the effort to help these patients, the agency also opened a new Web site where patients and their health care professionals can learn about options for investigational drugs. In general, these options include being treated with a drug that has been approved by FDA, being given an investigational drug as part of a clinical trial, or obtaining access to an investigational drug outside of a clinical trial.

The new rule, "Expanded Access to Investigational Drugs for Treatment Use," makes investigational drugs more widely available to patients by clarifying procedures and standards. The other rule, "Charging for Investigational Drugs Under an Investigational New Drug Application," clarifies the specific circumstances and the types of costs for which a manufacturer can charge patients for an investigational drug when used as part of a clinical trial or when used outside the scope of a clinical trial.

"With these initiatives, patients will have the information they need to help them decide whether to seek investigational products," said FDA Commissioner Margaret Hamburg. "For patients seeking expanded access to investigational drugs and biologics, the new rules make the process easier to understand."

Obtaining a drug or biologic under an expanded access program may be an option for some patients who are not able to enroll in clinical trials.

The FDA has allowed expanded access to experimental drugs and biologics since the 1970s. That access has allowed tens of thousands of patients with HIV/AIDS, cancer, and other conditions to receive promising therapies when no approved alternative is available.

"The final rules balance access to promising new therapies against the need to protect patient safety and seek to ensure that expanded access does not discourage participation in clinical trials or otherwise interfere with the drug development process," said Janet Woodcock, director of the FDA's Center for Drug Evaluation and Research. "Clinical trials are the most important part of the drug development process in determining whether new drugs are safe and effective, and how to best use them."

FDA's new web site on options for investigational drugs: http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/AccesstoInvestigationalDrugs/default.htm.

The final rules for expanded access are posted at http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/InvestigationalNewDrugINDApplication/ucm172492.htm.

Center For Tobacco Products Formed, Director Named

FDA opened its new Center for Tobacco Products to oversee the implementation of the Family Smoking

Prevention and Tobacco Control Act signed by President Obama in June.

FDA's responsibilities under the law include setting performance standards, reviewing premarket applications for new and modified risk tobacco products, and establishing and enforcing advertising and promotion restrictions.

Lawrence Deyton, an expert on veterans' health issues, public health, tobacco use, and a clinical professor of medicine and health policy at George Washington University School of Medicine and Health Sciences, will serve as the center's first director.

"We are thrilled to announce Dr. Deyton's appointment as director of the Center for Tobacco Products and look forward to him joining the agency," said FDA Commissioner Margaret Hamburg. "He is the rare combination of public health expert, administrative leader, scientist, and clinician."

Before coming to the FDA, Deyton was chief public health and environmental hazards officer for the U.S. Department of Veterans Affairs. His responsibilities there included oversight of the VA's public health programs including tobacco use, the health of women veterans, the long-term health consequences of military service, and the VA's emergency preparation and response. He was selected after a national search.

The FDA's Center for Tobacco Products, located on the FDA's White Oak Campus in Silver Spring, Md., will use the best available science to guide the development and implementation of effective public health strategies to reduce the burden of illness and death caused by tobacco products.

To implement the program, the FDA will start with $5 million from the fiscal year 2009 budget to establish the necessary administrative functions for the Center. As set forth in the Family Smoking Prevention and Tobacco Control Act, funding for the Center and other activities related to the regulation of tobacco will come from user fees paid by manufacturers and importers of tobacco products.

One of Deyton's priorities had been revitalization of the VA's smoking and tobacco use cessation programs. Under his leadership, current smoking among veterans enrolled in the cessation program fell from 33 percent in 1999 to 22 percent in 2007.

"I am eager for the challenge of leading the tobacco team at FDA," said Deyton. "This is a tremendous opportunity for us at FDA to work hand-in-hand with the CDC, researchers at the National Institutes of Health, and public health leaders in the states to make progress in combating tobacco use—the leading cause of preventable death in the United States."

In 2002, Deyton established the VA's Public Health Strategic Health Care Group, which encompassed responsibilities for HIV, hepatitis C, tobacco use cessation, bioterrorism, and issues such as SARS, pandemic influenza, and other emerging public health threats. He became chief officer in January 2006.

Deyton has served for 11 years in leadership positions in the National Institute of Allergy and Infectious Diseases at NIH, six years in the Office of the Assistant Secretary for Health at HHS, and as a legislative aide with the House of Representatives Subcommittee on Health and the Environment in the 1970s.

He was a founder in 1978 of the Whitman Walker Clinic, a community based AIDS service organization in Washington, D.C. He is a graduate of Kansas University, the Harvard School of Public Health and the George Washington University School of Medicine. Deyton's post-doctorate medical training was at the University of Southern California/Los Angeles County Medical Center. He is board certified in internal medicine and continues to care for patients on a regular basis.

Tobacco Products Scientific Advisory Committee

FDA also has officially established the Tobacco Products Scientific Advisory Committee (TPSAC).

The Tobacco Products Scientific Advisory Committee is tasked with providing advice, information, and recommendations to the Commissioner of Food and Drugs on health and other issues relating to tobacco products. The committee will be asked to consider a variety of topics including:

—Identifying the effects of the alteration of the nicotine yields from tobacco products.

—Reporting on the impact of the use of menthol in cigarettes on the public health.

—Advising on an application for modified risk (use of descriptors such as "light") tobacco product.

The TPSAC will consist of 12 members, including the chair to be selected by the FDA Commissioner, from among experts knowledgeable in the fields of medicine, medical ethics, science, or technology involving the manufacture, evaluation or use of tobacco products. There will be nine voting and three non-voting members. Of the nine voting members, seven will be health care professionals practicing in the area of oncology, pulmonology, cardiology, toxicology, pharmacology, addiction, or any other relevant specialty. One member will be an officer or employee of a state or local government or the federal government, and the final

member will be a representative of the general public.

The three non-voting members will be identified with industry interests. These members will include one representative of the tobacco manufacturing industry, one representative of the tobacco growers, and one representative of the small business manufacturing industry.

Further information on FDA's implementation of the Act is available at http://www.fda.gov/TobaccoProducts/default.htm.

In Brief:

UICC Names Banking Exec As Chief Executive Officer

INTERNATIONAL UNION AGAINST CANCER (UICC) appointed **Cary Adams** as chief executive officer. He succeeds **Isabel Mortara**, who stepped down from the position after eight years. Adams served as chief operating officer of Lloyds TSB Group International Banking in London and will start his new position at the UICC in Geneva on Sept. 21.

The UICC executive search committee, comprising members from the board and senior staff, chose Adams over other finalists with NGO experience, because he has a track record of taking on businesses where he at first had little familiarity with operational detail and leading them to success quickly.

"The final choice was a unanimous one," said UICC President **David Hill**. "We are very confident that we have chosen a leader with outstanding capacity to build the organization, commensurate with the challenge of the global cancer crisis. Cary already has an impressive knowledge of current issues, activity and challenges in our field."

In the Cancer Centers:

Ohio State's Zharov Wins Three Nanotech Grants

(Continued from page 1)

Winthrop P. Rockefeller Cancer Institute. It will explore a way to diagnose breast cancer metastasis in its earliest stages. Zharov and his team have developed hybrid multicolor gold and magnetic nanoparticles that can target metastatic cells within the body once they have spread through the blood and lymph system. A laser is used to heat the nanoparticles attached to metastatic cells. Rapid expansion of nanoparticles in metastatic cells causes ultrasound waves, which travel through the tissue and are captured by a small ultrasound transducer held near the skin. In a preliminary study the technique was able to detect and count rare metastatic cells before they form distant metastases. **Laura Hutchins**, professor and director of the Division of Hematology/Oncology in the UAMS College of Medicine will be participating in the trial. The second grant, a nearly $400,000 over two years from NCI, will focus on the role of stem cells in cancer development. The third grant is for $700,000 over four years from the National Science Foundation to develop high resolution laser nano-imaging of tiny structures in live single cells that can be used for both basic and clinical studies with a focus on the early diagnosis of abnormal processes responsible for cancer and aging. Collaborating with Zharov in the latter two grants are **Robert Reis**, professor in the UAMS Departments of Geriatrics; **Thomas Kelly**, associate professor in the UAMS Department of Pathology; and **Evgeny Shashkov**, a visiting scholar. . . . **OHIO STATE UNIVERSITY** Comprehensive Cancer Center – James Cancer Hospital and Solove Research Institute appointed **Tanios Bekaii-Saab** as medical director of the division of gastrointestinal oncology. The division also recruited **Kyle Perry** and **Jeffrey Rose** as assistant professors. Bekaii-Saab was an assistant professor in Ohio State's College of Medicine and served as the chairman of gastrointestinal cancer disease specific committee at OSUCCC-James since 2003. . . . **VIRGINIA COMMONWEALTH UNIVERSITY** Massey Cancer Center received a five-year, $1.5 million grant from NCI to study the impact of teaching family health history as a tool to prevent breast and colon cancer. In the study, a research assistant will meet one-on-one with 245 participants from VCU Women's Health Clinics and teach them how to draw a family tree, identify biological kin, and to ask for and document information about family members who have had breast cancer or colon cancer. Another 245 women in a control arm will receive standard care. Researchers will measure for differences between these two groups on the primary outcome of family communication about cancer. **Joann Bodurtha**, professor in VCU School of Medicine's Department of Human and Molecular genetics and co-director of Massey's Familial Cancer Center, is principal investigator. . . . **CHARLES BALCH** will receive the Association of Community Cancer Centers' 2009 Outstanding Achievement in Clinical Research Award at ACCC's 26th National Oncology Economics Conference, Sept. 22-25, in Minneapolis, Minn. He will be honored for his extensive research, leadership, and commitment to individuals with cancer. Balch is professor of surgery and oncology and dermatology and

deputy director at the Johns Hopkins Institute for Clinical and Translational Research. Over the past 30 years he has authored more than 600 publications on clinical investigations involving the natural history of melanoma, prognostic factors predicting clinical outcomes, standards of surgical treatment, and the conduct and methodology of clinical research and immunology. He is the editor of "Cutaneous Melanoma," a textbook on melanoma, and founding editor-in-chief of the Annals of Surgical Oncology and is chair of the Melanoma Staging Committee of the American Joint Committee on Cancer. He has been a principal investigator or co-PI of numerous clinical trials, including 10 phase III trials, most of which were NCI-funded national phase III trials. Balch's leadership roles have involved the Society of Surgical Oncology (president), the American Board of Surgery (Board of Directors), the Association of Academic Surgeons (president) and the Commission on Cancer (chair, Board of Directors) and the American Joint Committee on Cancer (Executive Committee). He also has more than 30 years of experience in breast cancer management and research. His clinical trials leadership in breast cancer in the 1980s and 1990s included the only randomized surgical trial comparing radial vs. modified radical mastectomy, as well as the early development of skin-sparing mastectomy and immediate breast construction; two major advances at the time. He was also one of the early pioneers on developing the sentinel lymph node biopsy in the staging of breast cancer, especially in breast cancer patients who had received pre-operative chemotherapy. Balch was the founding editor of Breast Diseases. . . . **UNIVERSITY OF SOUTHERN CALIFORNIA** named **Stephen Sener** professor of clinical surgery at the Keck School of Medicine and chief of the Division of Surgical Oncology at the USC Norris Comprehensive Cancer Center and Hospital. Sener comes to USC from Northwestern University, where he served as professor of surgery at Northwestern University Feinberg School of Medicine and vice-chairman of the Department of Surgery at NorthShore University HealthSystem. He also served as national president of the American Cancer Society in 2004-2005. . . . **EMORY UNIVERSITY** named **Xingming Deng** as associate professor in the Department of Radiation Oncology. He has also joined the Emory Winship Cancer Institute as a member of the Discovery and Developmental Therapeutics Program. Deng joins Emory from the University of Florida Shands Cancer Center where he was an assistant professor in the Division of Hematology/Oncology, Department of Medicine. His areas of research interest are focused on three major cancer-related fields: the mechanism of apoptosis and development of new anti-cancer drugs by targeting apoptotic mechanisms; DNA repair and genetic instability; and tumor invasion and metastasis. . . . **ARGONNE NATIONAL LABORATORY** received an additional $29.1 million in DOE Office of Science funding under the American Recovery and Reinvestment Act for a range of improvements and upgrades to major scientific facilities and other projects. The new funds come in addition to an earlier $15.1 million in Recovery Act funds provided for laboratory infrastructure modernization and $99 million in Recovery Act money provided by DOE's Office of Environmental Management for clean-up and remediation of legacy nuclear waste and facilities. The new funds bring Argonne's total Recovery Act funding to date to more than $140 million. . . . **NEVADA CANCER INSTITUTE** has made five appointments of faculty and executives, said **John Ruckdeschel**, director and CEO. **William Bennett**, chief financial officer was the senior vice president for new business development at the Barbara Ann Karmanos Cancer Institute. **Karen Fields, chief medical officer,** worked at the M.D. Anderson Cancer Center in Houston, serving as the vice president for Global Academic Programs. She also served as the president and chief executive officer for the Cancer Therapy & Research Center in San Antonio. **Rebecca Garrett**, will serve in the Cancer Pain, Rehabilitation and Symptom Management section, Medical Oncology Department. She was director of Cancer Rehabilitation and Noninterventional Pain & Symptom Management at the University of Pittsburgh. **Meredith Mullins** was named associate center director and senior vice president of research operations. She was a senior vice president for research administration and government affairs at Barbara Ann Karmanos Cancer Institute. **Gavin Pepper** was named director of hospitality and volunteer services. Pepper was general manager of the Westin's Element Hotel, located next to the institute. . . . **ROSWELL PARK CANCER INSTITUTE** appointed three new faculty members to the Department of Medicine. **Foluso Olabisi (Bisi) Ademuyiwa** will see patients in the RPCI Breast Clinic. Ademuyiwa comes to RPCI from Indiana University School of Medicine, where she completed a fellowship in hematology/oncology. **Hongbin Chen** will treat patients diagnosed with lung cancer. Chen comes to RPCI from The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins University where he completed a fellowship in medical oncology. **Hong Liu** will treat patients diagnosed with multiple myeloma and

leukemia. Liu completed residency training in internal medicine and a fellowship in hematology/oncology at University of Florida, Gainesville. . . . **YALE CANCER CENTER** Director **Thomas Lynch Jr**. named **Kevin Vest** deputy director for clinical affairs and administration. Vest joins Yale from Massachusetts General Hospital Cancer Center, where he served as administrative director for hematology/oncology and finance. Vest will oversee the management of the clinical operations, finance and administration, research management, clinical trials management, marketing, and strategic planning.

Funding Opportunities:

NCI Offers Fellowships In Cancer Prevention

The Cancer Prevention Fellowship Program at NCI is a postdoctoral training opportunity that provides training in public health and mentored research with investigators at NCI.

The overarching goal of the CPFP is to provide a strong foundation for clinicians and scientists to train in the field of cancer prevention and control. The program offers training toward an M.P.H. degree at an accredited university during the first year, followed by mentored research with investigators at the NCI. Opportunities for research cut across a wide range of methodologies: basic science laboratory studies, clinical studies, epidemiologic studies, community intervention trials, studies of the biological and social aspects of behavior, policy studies, and research on the ethics of prevention.

The CPFP provides competitive stipends, paid health insurance, reimbursement for moving expenses, and a travel allowance to attend scholarly meetings or training. The typical duration in the CPFP is four years. To be eligible, applicants must possess an M.D., Ph.D., J.D., or other doctoral degree in a related discipline (e.g., epidemiology, biostatistics, ethics, philosophy, or the biomedical, nutritional, public health, social, or behavioral sciences) or must be enrolled in an accredited doctoral degree program and fulfill all degree requirements by June 21, 2010. Foreign education must be comparable to that received in the United States. Applicants must also be US citizens or permanent residents and have no more than five years relevant postdoctoral experience.

For further information: http://cancer.gov/prevention/pob or contact cpfpcoordinator@mail.nih.gov.

NIH Announcements

The Biology of Estrogen Receptor-Negative Breast Cancer in Various Racial and Ethnic Groups (U01) (RFA-CA-09-026) http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-026.html

Image-guided Drug Delivery in Cancer (R01) (PA-09-253) http://grants.nih.gov/grants/guide/pa-files/PA-09-253.html

Small Business Innovation Research (SBIR) Program Contract Solicitation (PHS 2010-1) http://grants.nih.gov/grants/guide/notice-files/NOT-OD-09-137.html

Recovery Act of 2009: FederalReporting.gov Opens for Registration http://grants.nih.gov/grants/guide/notice-files/NOT-OD-09-138.html

Pre-application Meeting for Requests-for-Applications for the Early Detection Research Network (Sept. 29) http://grants.nih.gov/grants/guide/notice-files/NOT-CA-09-033.html

Notice of Availability of Serum Samples and Research Support for Validation of Hepatocellular Carcinoma Biomarkers http://grants.nih.gov/grants/guide/notice-files/NOT-DK-09-016.html

Clarification: NHLBI Does Not Accept R21 Applications Primarily Related to Cancer Research http://grants.nih.gov/grants/guide/notice-files/NOT-HL-09-124.html

2010 NIH Directors Pioneer Award Program (DP1) (RFA-RM-09-010) http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-09-010.html

Exploratory Innovations in Biomedical Computational Science and Technology (R21) http://grants.nih.gov/grants/guide/pa-files/PAR-09-219.html

Extension of Expiration Date for PAR-06-511: NCI Cancer Education and Career Development Program (R25) http://grants.nih.gov/grants/guide/notice-files/NOT-CA-09-034.html

2010 NIH Directors New Innovator Award Program (DP2) (RFA-RM-09-011) http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-09-011.html

Institutional Clinical and Translational Science Award (U54) (RFA-RM-09-019) http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-09-019.html

Distribution Policy for The Cancer Letter

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

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

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

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

What you can do:

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

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

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

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

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