THE CANCER LETTER

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NCI Grant Funding Payline To Begin At 16th Percentile For Fiscal Year 2010

By Kirsten Boyd Goldberg

NCI's grant funding payline will start at the 16th percentile for fiscal 2010, NCI Director John Niederhuber said earlier this week.

Eventually over the course of the fiscal year, through exceptions funding, Niederhuber said he hopes to be able to reach a 20 percent success rate overall for research project grants. This would be similar to the FY2009 level, without counting the 543 research project grants funded through the economic stimulus dollars the institute received under the American Recovery & Reinvestment Act.

Congress hasn't passed an FY2010 appropriations bill for NIH, despite the fact that the fiscal year began Oct. 1. The delay in receiving

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Capitol Hill:

House Passes 2.8 Percent Increase For NCI, Pushes Institute Apropriation Over $5 Billion

By Paul Goldberg

The House Dec. 10 passed a massive appropriations bill that gives a 2.8 percent increase to NCI in fiscal 2010. This translates into a $139 million raise and pushes the appropriation to $5.1 billion.

The institute's increase is higher than the overall NIH increase of 2.3 percent, $691 million, which raises the appropriation to $31.008 billion.

While changes in appropriations for NIH are relatively modest, the cancer programs of Centers for Disease Control and Prevention are seeing substantial increases. Overall, CDC's cancer programs are getting an 8.8 percent increase over their $340.3 million budget.

This boost comes entirely from Congress, which disregarded the administration's proposal to keep the agency's budget at last year's level.

The omnibus measure has been through the House-Senate conference, and the Senate is expected to approve it as early as Saturday.

"The House of Representatives today showed a renewed commitment to defeat cancer, passing an FY 2010 domestic appropriations bill that includes long overdue increases for cancer prevention services and helps to sustain critical research funding levels," said John Seffrin, CEO of the American Cancer Society, which has traditionally lobbied for increased CDC funding. The increases come on the heels of seven years of cuts and flat budget, Seffrin said in a statement.

The following CDC programs are slated for substantial increases:

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NCI's ARRA Funds Obligated; No New Stimulus Projects

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an appropriation until about mid-March has become the rule rather than the exception, although that could change this year as a result of the House passage of an ombnibus appropriations bill earlier this week (see story, page 1).

The House Labor-HHS-Education appropriations bill originally gave NCI $5.15 billion, a 3.7 percent increase over the FY2009 appropriation. "That would be fantastic," Niederhuber said to the National Cancer Advisory Board at its Dec. 1 meeting.

However, the increase appears to be lower in an omnibus appropriations bill passed Dec. 10.

The Senate bill would provide $5.04 billion, a 1.7 percent increase. For planning purposes, NCI is using the lower Senate figure, Niederhuber said.

At the beginning of the year, NCI will fund the grants that "clearly are going to be awarded"—the top scoring grants—and then the institute will "restore" funding for more grants when it gets an appropriation, Niederhuber said.

NIH expected a large increase in grant applications due to last year's stimulus funding, but so far that hasn't materialized in the first round of FY2010 grant applications, Niederhuber said. However, the stimulus funding is likely to cause an increase in grant applications in 2011 and 2012, when the two-year grants run out. Generally about 90 percent of successful NIH grant applicants apply to renew their grants.

NCI obligated or committed $845.5 million of its ARRA funds prior to last Sept. 30. The remaining balance of about $400 million will be used to cover FY09 commitments and a "limited number" of FY10 projects. The institute will not solicit competitive revisions or general administrative grant supplements this fiscal year.

NCI maintains a web page for ARRA funding information: http://www.cancer.gov/recovery.

On a different note, Niederhuber said one program that keeps him awake at nights is the NCI Cancer Centers Program. "I've got cancer centers lined up around the block that want to apply," he said. "I don't know how to manage that. I don't know where we are going to get the new resources to continue to grow the appetite of that program. I share that with you because it's one of those things that I wake up in the middle of the night thinking about."

Whatever Happened To…?

Joe Torre, manager of the Los Angeles Dodgers and former manager of the New York Yankees, was selected by President George W. Bush for the President's Cancer Panel toward the end of the Bush presidency. But Torre, who was to replace Lance Armstrong on the panel, never officially joined the advisory group.

"It just didn't work out," Niederhuber said at the NCAB meeting, in response to a board member's question about Torre's selection for the panel. Panel members are considered "special governmental employees" during their days of service on the panel, and subject to various requirements that may have been an issue, he said.

Niederhuber said he met with an Obama administration official in charge of presidential committees "some months ago" to discuss the President's Cancer Panel. "We had a good discussion," including the pros and cons of naming a celebrity to the panel, he said. "I have not heard anything further."

Current panel members are panel chairman LaSalle Leffall Jr., the Charles R. Drew Professor of Surgery at Howard University College of Medicine, and Margaret Kripke, executive vice president and chief academic officer, University of Texas M.D. Anderson Cancer Center.

NCI Awards Cancer Information Service Contract

NCI awarded a $55.4 million, seven-year contract to Fred Hutchinson Cancer Research Center to operate

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

its Cancer Information Service Contact Center.

The CIS is a free public telephone (1-800-4CANCER) and Internet-based resource for personalized information about cancer prevention, screening and treatment. The Hutchinson Center has operated a CIS contact center since 1981.

Over the years, the number of CIS contact centers has dwindled from 26 to three. In addition to Seattle, centers currently operate at Memorial Sloan-Kettering Cancer Center in New York City and at the University of Miami Sylvester Comprehensive Cancer Center. The Miami and New York centers will cease operations March 15.

The award will create 60 new jobs at the Hutchinson Center, nearly tripling the size of its current CIS workforce, once the consolidated center is fully operational, scheduled for March 15. The Seattle CIS center will remain in its existing location on the Hutchinson Center campus.

The consolidation will allow operating hours to expand significantly, from 5 a.m. to 5 p.m. Pacific Time weekdays for phone calls (previously 9 a.m. to 4:30 p.m.) and from 5 a.m. to 8 p.m. Pacific Time weekdays for the popular "live help" chat service via the Internet (previously 6 a.m. to 8 p.m.).

New to the Seattle office will be the ability to provide bilingual service to callers in Spanish. Three oncology-certified nurses will be among the new hires to train information specialists and act as mentors to supervisors.

"We love the service we provide to the public and we're happy to have the opportunity to continue to provide this service on a broader scale," said Nancy Zbaren, project director.

NCI established the CIS in 1975 to educate people about cancer prevention, risk factors, early detection, symptoms, diagnosis, treatment, and research.

"We are the voice of the National Cancer Institute," said Dawn Sittauer, Seattle CIS contact center manager.

The CIS currently handles up to about 470 inquiries per day, including a growing amount of "live help" inquiries from the NCI web site at www.cancer.gov, and emails. Calls come from throughout the U.S. and its territories, but about 12 percent of the chat and email inquiries come from outside the country, according to Sittauer.

"When the public calls with any question or concerns, we are able to provide evidence-based information," Zbaren said. "We answer questions about cancer from patients, family members, physicians and the general public seeking clinical trials, treatment options, any question you an imagine. Our job is to provide information, not advice, in a compassionate and tailored manner."

The contract also provides for smoking cessation counseling via NCI's Smoking Quitline (1-877-44U-QUIT). The Contact Center handles over 100,000 inquiries annually and has responded to over 10 million callers since its inception in 1976.

Capitol Hill:

Several CDC Cancer Programs Receive Boost In House Bill

(Continued from page 1)

• National Breast and Cervical Cancer Early Detection Program is getting $215 million, a 4.4 percent increase over fiscal 2009.

• Comprehensive Cancer Control Initiative will get $21 million, a 26.6 percent increase.

• Colorectal Cancer Screening, Education and Outreach is getting $45 million, a 14.3 percent increase.

• Prostate Cancer Awareness campaign is getting $14 million, a 3 percent increase.

• National Cancer Registries Program will get $4 million, a 10.5 percent increase.

• Skin Cancer Prevention Programs are getting $2 million, a 16.7 percent increase.

Congress has also created a $5 million program for Breast Cancer Awareness for Young Women. The program is a an outgrowth of a controversial measure introduced by Rep. Debbie Wasserman Schultz (D-Fla.), a breast cancer survivor and an appropriations committee member (The Cancer Letter, July 24).

In a related development, Congress is providing $5 million to the Health Resources and Services Administration to launch the Patient Navigator Program, designed to help patients receiving cancer care. The administration didn't seek to establish this program.

The bill also gives FDA additional $310 million, a 15.2 percent increase, which boosts the agency's appropriation to $2.35 billion.

The text of the bill is posted on the Rules Committee website: http://rules.house.gov/bills_details.aspx?NewsID=4520.

* * *

In another development, Sens. Sherrod Brown (D-Ohio) and Senator Kay Bailey Hutchison (R-Tex.) introduced an amendment to the healthcare bill to require health plans to cover routine patient care costs

for patients enrolled in clinical trials. The measure would cover patients with cancer or other life-threatening diseases or conditions.

Annual Report Finds Continued Declines in Overall Cancer Rates

Rates of new diagnoses and rates of death from all cancers combined declined significantly in the most recent time period for men and women overall and for most racial and ethnic populations in the U.S., according to a report from NCI and other health organizations.

The drops are driven largely by declines in rates of new cases and rates of death for the three most common cancers in men (lung, prostate, and colorectal cancers) and for two of the three leading cancers in women (breast and colorectal cancer). New diagnoses for all types of cancer combined in the U.S. decreased, on average, almost 1 percent per year from 1999 to 2006. Cancer deaths decreased 1.6 percent per year from 2001 to 2006.

These findings are from a report authored by researchers from NCI, the Centers for Disease Control and Prevention, the American Cancer Society, and the North American Association of Central Cancer Registries. The report was published online Dec. 7, in the journal Cancer.

diagnosed cancer in both men and women, and the second leading cause of cancer deaths in the U.S., overall rates are declining, but increasing incidence in men and women under 50 years of age is of concern, the report said.

In the Special Feature section, the authors used modeling projections of colorectal cancer rates to find that, with accelerated cancer control efforts to get more Americans to adopt more favorable health behaviors (such as quitting smoking) and higher use of screening (such as colonoscopy), as well as optimal treatment outcomes for colorectal cancer (such as more effective chemotherapy), there could be an overall colorectal cancer mortality reduction of 50 percent by 2020.

Other highlights from the report show that in men, incidence rates have declined for cancers of the prostate, lung, oral cavity, stomach, brain, colon and rectum, but continue to rise for kidney/renal, liver, and esophageal cancer, as well as for leukemia, myeloma and melanoma.

In women, incidence rates decreased for breast, colorectal, uterine, ovarian, cervical and oral cavity cancers, but increased for lung, thyroid, pancreatic, bladder, and kidney cancers, as well as for non-Hodgkin lymphoma, melanoma and leukemia.

"The continued decline in overall cancer rates documents the success we have had with our aggressive

Top 15 Cancer Sites for Men and Women

Cancer Type	Men: New Cases	Men: Deaths	Women: New Cases	Women: Deaths
Bladder			+0.2%	+0.4%
Brain	+0.5%	-1.0%		-1.1%
Breast			-2.0%	-1.9%
Cervix			-3.5%	
Colon/rectum	-3.0%	-3.9%	-2.2%	-3.4%
Esophagus	+0.7%	+0.4%		
Kidney	+1.8%	-1.5%	+2.4%	-0.6%
Leukemia	+0.1%	-0.8%	+0.3%	-1.6%
Liver	+3.6%	+2.4%		+1.8%
Lung	-1.8%	-2.0%	+0.4%	—
Melanoma	+3.1%	+2.0%	+3.0%	
Myeloma	+0.7%	-1.1%		-2.4%
Non-Hodgkin Lymphoma		-3.0%	+1.1%	-3.7%
Oral	-1.2%	-2.2%	-0.9%	
Ovary			-2.1%	-1.4%
Pancreas			+1.7%	+0.1%
Prostate	-2.4%	-4.1%		
Stomach	-2.0%	-3.7%		-2.7%
Thyroid			+6.3%	
Uterus			-0.5%	

Trends data are based on the most recent trends in rates and variable time periods. The "—" symbol indicates neither a statistically significant rise nor fall in the rates during the time period studies. Blank spaces indicate cancers that were not in the top 15 for that gender/category.

Overall cancer rates continue to be higher for men than for women, but men experienced the greatest declines in incidence (new cases) and mortality (death) rates. For colorectal cancer, the third most frequently

efforts to reduce risk in large populations, to provide for early detection, and to develop new therapies that have been successfully applied in this past decade," said NCI Director John Niederhuber. "Yet we cannot be content

with this steady reduction in incidence and mortality. We must, in fact, accelerate our efforts to get individualized diagnoses and treatments to all Americans and our belief is that our research efforts and our vision are moving us rapidly in that direction."

Among racial/ethnic groups, cancer death rates were highest in black men and women and lowest in Asian/Pacific Islander men and women. Although trends in death rates by race/ ethnicity were similar for most cancer sites, death rates from pancreatic cancer, the fourth most common cause of cancer death in the United States, increased among white men and women but decreased among black men and women.

The three leading causes of cancer death for all men, with the exception of Asian/Pacific Islanders, were lung, prostate and colorectal cancer. Lung, liver and colorectal cancers were the top three causes of cancer death in Asian/Pacific Islander men.

For women, the three leading causes of cancer death were lung, breast and colorectal cancer for all racial/ethnic groups except Hispanic women, for whom breast cancer ranked first. The differences and fluctuations in death rates by racial/ethnic group, sex, and cancer site may reflect differences in risk behaviors, socioeconomic status, and access to and use of screening and treatment.

"The continued decline in incidence and death rates for all cancers combined is extremely encouraging, but progress has been more limited for certain types of cancer, including many cancers that are currently less amenable to screening, such as cancer of esophagus, liver and pancreas," said Betsy Kohler, executive director of NAACCR.

The special section on colorectal cancer rates says that long-term incidence trends for colorectal cancer have been fairly consistent for men and women, with major declines from 1985 to 1995, minor increases from 1995 to1998, and significant declines from 1998 to 2006. Since 1984, death rates have also declined for men and women with accelerated rates of decline since 2002 for men and 2001 for women.

In the most recent decade for which there are data (1997-2006), rates of newly diagnosed colorectal cancer have decreased for men and women in all racial/ethnic groups examined except American Indian/Alaskan Native women. Incidence rates declined most rapidly among men and women over 65 years of age and increased most rapidly in people under age 50 in most population groups.

"This report shows that we have begun to make progress reducing colorectal cancer. Yet, colorectal cancer still kills more people than any other cancer except lung cancer," said CDC Director Thomas Frieden. "Reducing smoking further can bring lung and other cancer rates down, and improved colorectal cancer screening can prevent colorectal cancer. Through CDC's Colorectal Cancer Control Program, we have tremendous potential to reduce the disparities that exist in colorectal cancer screening and to save lives."

The CDC program supports population-based screening efforts and provides colorectal cancer screening services to low-income men and women ages 50 to 64 years who are underinsured or uninsured for screening, when no other insurance is available.

Researchers used microsimulation modeling to analyze the historical impact of changes in risk factors, screening and treatment practices, and to project future mortality trends for colorectal cancer.

The model, named MISCAN-Colon, which was developed by NCI's Cancer Intervention and Surveillance Modeling Network consortium, simulates the U.S. population from 1975 through 2020. The model includes factors that could increase risk for colorectal cancer (i.e., smoking, obesity, and red meat consumption), as well as factors that could decrease colorectal cancer risk (i.e., aspirin use, consumption of supplements such as folate and calcium, and physical activity).

To calculate screening use, researchers used national data on the use of fecal occult blood testing (which looks for blood in stool samples), and endoscopy (including flexible sigmoidoscopy and colonoscopy, which allows doctors to examine the lower part of the colon or the entire large intestine, respectively). To assess the effects of treatment, researchers assessed data on use of, and disease-free survival rates associated with, four chemotherapy regimens used for advanced colorectal cancer during different historical time periods.

Using the model, the researchers were able to estimate the impact of historical changes in risk factors, screening practices, and treatment advances on past changes in incidence and mortality, as well as predict future trends through 2020.

From 1975 to 2000, colorectal cancer incidence fell 22 percent, half of which was most likely due to changes in risk factors, and half due to screening. Similarly, colorectal cancer deaths fell by 26 percent during that time period, with a 9 percent drop resulting from a change in risk factors, a 14 percent drop from screening, and a 3 percent drop from improved treatment.

The researchers created projections to look at how colorectal cancer mortality trends could change

with varying levels of cancer control interventions. If there were no changes in risk factors, screening or treatment (stable since 2000), Americans could expect a 17 percent decline in colorectal cancer mortality from 2000 to 2020.

However, if current trends persist, Americans could see a 36 percent decline in colorectal cancer mortality. With accelerated cancer control efforts, there could be an overall colorectal cancer mortality reduction of 50 percent by 2020.

"The extraordinary progress on colorectal cancer shows what can be achieved by coordinated and targeted efforts to apply existing knowledge to cancer control at the state and federal level," said John Seffrin, chief executive officer of the American Cancer Society. "Increases in colorectal cancer screening have been achieved through a variety of efforts, including education of the public and medical community and advocacy for health insurance coverage of the full range of colorectal cancer screening tests. The American Cancer Society is committed to continuing these efforts to get as close as we can to the potential 50 percent colorectal cancer mortality reduction that this report says is possible."

To view the full report, go to: www.interscience.wiley.com/cancer/report2009.

In the Cooperative Groups:

Adamson Elected Chairman Of Children's Oncology Group

PETER ADAMSON, a pediatric oncologist at the Children's Hospital of Philadelphia Research Institute, has been selected to lead the Children's Oncology Group, effective Jan. 1.

Adamson was elected by principal investigators of more than 200 COG sites. COG unites more than 5,000 experts in childhood cancer at leading children's hospitals, universities, and cancer centers across North America, Australia, New Zealand, and Europe, to conduct research in childhood cancer.

"Dr. Adamson's broad experience working with many investigators and industry partners, his own extensive research efforts, and his participation in key scientific committees of the National Cancer Institute give him a unique perspective on the challenges facing the cancer clinical trial system," said Steven Altschuler, president and CEO, the Children's Hospital of Philadelphia. "As chair of the Children's Oncology Group, he will play a crucial role in advancing treatment for childhood cancer."

Adamson, who came to the Children's Hospital of Philadelphia in 1999 from NCI, is the director of Clinical and Translational Research and chief of the Division of Clinical Pharmacology and Therapeutics at Children's Hospital. He also is a professor of pediatrics and pharmacology at the University of Pennsylvania School of Medicine. He will remain on the staff of Children's Hospital and on the Penn faculty while serving as COG chair.

Adamson's previous roles at COG have included leading a 21-site phase 1 consortium that conducted initial evaluations of drugs being developed to treat cancer in children. During the eight years that Adamson led this effort, the collaborating sites conducted more than 25 studies designed to test the safety of novel anticancer drugs.

"Scientific discovery today is occurring at an unprecedented pace, but the clinical trial system that historically worked so well is showing a diminishing rate of return in our ability to cure children," said Adamson. "This system was not designed to rapidly bring findings from the bench to the bedside, and a transformation of the system's approach is needed to propel translational efforts on an international scale. I hope to fully leverage the emerging discoveries being made at a rapid pace by transforming how research moves from the bench to the bedside in a very large collaboration."

COG was the first group to recognize the importance of collaboration in pediatric research, as even common childhood cancers are rare enough that no one center treats the number of children required for large-scale clinical trials. Today, more than 90 percent of the 12,500 children diagnosed with cancer each year in the U.S. are treated at COG institutions, with the Children's Hospital of Philadelphia being one of the largest such centers in the world.

"We are looking forward to working with Dr. Adamson in his new leadership role with the Children's Oncology Group," said John Lehr, president and CEO of CureSearch National Childhood Cancer Foundation. "Dr. Adamson's life-long dedication to children with cancer is remarkable and we remain committed to supporting the efforts of the Children's Oncology Group to conquer childhood cancer."

Adamson received his M.D. from Cornell University Medical College and performed his pediatric residency at the Children's Hospital of Philadelphia from 1984 to 1987. He then became a fellow in pediatric hematology/oncology at NCI, where he also served as a biotechnology fellow, a Children's Cancer Foundation Research Scholar, an investigator and an attending physician over 12 years.

In the Cancer Centers:

Hopkins, UAB, Colorado Collaborate In NCI SPORE

JOHNS HOPKINS UNIVERSITY was awarded an NCI Specialized Program of Research Excellence grant in cervical cancer in collaboration with researchers at University of Alabama at Birmingham Comprehensive Cancer Center and the University of Colorado at Boulder. The $11.5 million grant will focus on next-generation human papillomavirus vaccines for the prevention of cervical cancer and test more therapeutic agents that have shown promise in preventing, slowing, or effectively treating the disease.

The partnership grant will fund these four primary projects:

—L1 capsomere HPV vaccine. A Phase I clinical trial in humans will examine the use of an experimental vaccine that potentially can be produced at low cost and stored at room temperature to see if it is as effective as HPV vaccines that must be refrigerated, such as Gardasil. The experimental vaccine is based on HPV cell structures called L1 capsomeres. Worldwide HPV-vaccine programs are hampered by the limited availability of refrigeration in under-developed regions. Principal investigators are **Warner Huh**, of UAB; **Richard Roden**, of Hopkins; and Robert Garcea, of Colorado.

—L2 prophylactic HPV vaccine. Testing continues for an agent that targets an HPV protein called L2 and is designed to generate antibodies capable of preventing infection by a diverse number of HPV strains. Principal investigators are Roden and Huh.

—Genetic HPV vaccine. Testing continues for a vaccine that triggers an immune response against HPV through delivery of genetic information contained in the cell. Principal investigators are **Cornelia Trimble**, **Drew Pardoll**, and **T. C. Wu**, all of Hopkins.

—Genetic HPV vaccine delivered by gene gun. A phase I clinical trial will examine using an experimental injector gun to administer the genetic HPV vaccine under review in this project. The gene-gun method is a needle-free alternative to vaccine shots. Delivering vaccine to the dermal layer has shown increased immune responses; it could boost the vaccine's anti-HPV effect. Principal investigators are Trimble, Wu and **Ronald Alvarez**, director of the UAB Division of Gynecologic Oncology.

FRED HUTCHINSON CANCER RESEARCH CENTER received a pledge of $10 million from the Bezos family for the center's Program in Immunotherapy. "Thanks to the generosity of the Bezos family, we will be able to recruit and retain top immunotherapy researchers, create resources for the development of new immunological drugs and strengthen our clinical trials program to make these novel therapies more widely available to patients," said **Lee Hartwell**, president and director of the Hutchinson Center. The Bezos family chose to structure the gift as a challenge in the hope that it will unite others in the community to join the cause.

MOORES UCSD CANCER CENTER has named **Donald Durden** as vice chair for research in the Department of Pediatrics and Research Director, Division of Hematology/Oncology. A professor of pediatrics, Durden will head efforts to apply targeted therapeutics into other pediatric diseases at UC San Diego Medical Center and Rady Children's Hospital-San Diego. He comes to UCSD from Emory University, where he was the Aflac Endowed Chair and professor of Pediatrics at the Emory University School of Medicine and scientific director of Basic and Translational Research at Emory's Aflac Center for Cancer and Blood Disorders since 2003.

CITY OF HOPE childhood cancer survivorship expert **Smita Bhatia** was selected by the American Society of Pediatric Hematology/Oncology to receive its prestigious 2010 Frank A. Oski Lectureship Award. Bhatia is director of the Center for Cancer Survivorship, and chair and professor of population sciences.

ROSWELL PARK CANCER INSTITUTE researcher **Clement Ip**, professor emeritus in oncology, is the principal investigator of a $5.4M P01 grant from NIH to study the role of finasteride and selenium in preventing prostate cancer. The grant will fund three related projects. **James Mohler**, vice president of translational research and chair of the Urology Department, and **James Marshall**, senior vice president in the Cancer Prevention and Control department will collaborate on the projects.

RPCI researchers received a two-year, $650,000 NIH grant to study a novel approach to treating breast cancer with tamoxifen. **Gokul Das** and **Swati Kulkarni** are co-lead investigators. The study should provide screening guidelines to identify patients who are likely to be responsive to tamoxifen therapy, and avoid unnecessary exposure of patients with tumors unresponsive to tamoxifen.

Also, RPCI physician **Roberto Pili** was awarded a two-year R01 grant for $675,000 to study the role of histone deacetylase inhibitors in treating renal cell carcinoma. Pili is c**hief of the Genitourinary Section** in the Department of Medicine and **co-leader of the**

Genitourinary Program.

VIRGINIA COMMONWEALTH UNIVERSITY Massey Cancer Center investigator **Steven Grant** received a $1.2 million Grand Opportunities grant from NCI to partially fund a phase I clinical trial for patients with acute forms of leukemia. The study will use two novel, targeted agents, belinostat and bortezomib, in combination. The goal is to develop a new therapeutic approach for treating acute myeloid and lymphoid leukemias; blast crisis of chronic myelogenous leukemia; and myelodysplastic syndrome. The funding will also support correlative laboratory studies. The trial will be led by Grant and will be carried out in collaboration with M.D. Anderson Cancer Center and H. Lee Moffitt Cancer Center.

COMPREHENSIVE CANCER CENTER at Wake Forest University Baptist Medical Center has been awarded an NCI grant to partner with community cancer centers across the country to improve cancer-related health care disparities in underserved, disadvantaged and uninsured populations. The $300,000 grant will be used to initiate cancer patient navigator programs and evaluate the role of patient navigators in clinical trials. **John Stewart IV**, a surgical oncologist, is project leader for the grant. The first two community cancer centers participating are Gibbs Regional Cancer Center in Spartanburg, S.C., and St. Joseph Medical Center in Towson, Md. The program will be expanded to other community cancer centers over the next two years.

WINSHIP CANCER INSTITUTE of Emory University has opened a Phase I Clinical Trials Unit dedicated to advancing cancer research through a singular focus on caring for patients enrolled in phase I clinical trials. Establishment of a facility focused on the earliest stage of new treatments is an important development for Winship, said executive director **Walter Curran**. Also, Winship has recruited **Bassel El-Rayes** as associate professor in hematology and medical oncology and director of Winship's Gastrointestinal Oncology Program. El-Rayes joins Winship from the Karmanos Cancer Center. His primary area of clinical and research interest is in pancreatic cancer.

Advocacy:

Komen Board Names Brinker As CEO, Williams As President

The board of directors of Susan G. Komen for the Cure announced the appointment of **Nancy Brinker** as chief executive officer.

Brinker, a breast cancer survivor, founded the organization nearly 30 years ago in memory of her sister, Susan Komen, who died from the disease at 36.

The board also appointed **Mike Williams** as interim president. Williams served as the organization's interim CFO before the position was filled in early 2009. With these appointments, the board separated the roles of CEO and president, which had previously been one position.

Brinker founded the organization in 1982, and a year later founded the Susan G. Komen Race for the Cure. In 2009, Brinker was awarded the Presidential Medal of Freedom. She served as U.S. Ambassador to the Republic of Hungary from 2001-2003 and U.S. Chief of Protocol from 2007-2009. She is currently Goodwill Ambassador for Cancer Control for the United Nations' World Health Organization.

NIH News:

Collins Appoints Eric Green As Genome Institute Director

NIH Director Francis Collins announced the appointment of Eric Green to succeed him as director of the National Human Genome Research Institute.

Green, the NHGRI scientific director and director of the NHGRI Division of Intramural Research, became director of the institute on Dec. 1. Collins led NHGRI from April 1993 until August 2008. Alan Guttmacher, NHGRI's deputy director, has served as acting NHGRI director since Collins's departure.

"Dr. Green is the perfect choice to be NHGRI director. He grew up professionally with the genome era and has been on the cutting edge of genomics research for more than two decades," Collins said. "As NHGRI scientific director, Dr. Green has overseen spectacular growth and diversification of the institute's intramural research program. Some of his notable contributions include founding and ably directing for over a decade the NIH Intramural Sequencing Center, establishing the Social and Behavioral Research Branch and the NIH Center for Research on Genomics and Global Health, and helping to launch innovative programs such as the Undiagnosed Diseases Program."

Green also served as chief of the Genome Technology Branch and head of the Physical Mapping Section. His work included involvement in the Human Genome Project. He established a program in comparative genomics that involves the generation and analyses of sequences from targeted genomic regions in evolutionarily diverse species. The data provided insights about vertebrate genome organization.

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