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FDA Issues MedWatch Warning, Begins Safety Review Of Prostate Cancer Drugs

By Paul Goldberg

FDA has started a review of safety of gonadotropin-releasing hormone agonists and issued a MedWatch warning about these widely used agents.

GnRH agonists have been associated with an increased risk of diabetes, heart attack, sudden cardiac death and stroke in men undergoing treatment for prostate cancer.

The agency's action May 3 follows a "science advisory" issued by the American Cancer Society, the American Urological Association, the

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Environment & Cancer:

Cancer Caused By Environmental Exposure "Grossly Underestimated," Cancer Panel Says

By Kirsten Boyd Goldberg

The President's Cancer Panel concluded in a report to the White House on May 6 that "the true burden of environmentally induced cancers has been grossly underestimated" and urged action to reduce widespread exposure to carcinogens.

The panel advised President Obama "to use the power of your office to remove the carcinogens and other toxins from our food, water, and air that needlessly increase health care costs, cripple our nation's productivity, and devastate American lives."

Environmental exposures "do not represent a new front in the ongoing war on cancer. However, the grievous harm from this group of carcinogens has not been addressed adequately by the National Cancer Program," the panel said in a letter to Obama that precedes the report. "The American people—even before they are born—are bombarded continually with myriad combinations of these dangerous exposures."

"There remains a great deal to be done to identify the many existing but unrecognized environmental carcinogens and eliminate those that are known from our daily lives—our workplaces, schools and homes," said LaSalle Leffall Jr., chairman of the panel. "The increasing number of known or suspected environmental carcinogens compels us to action, even though we may currently lack irrefutable proof of harm."

In a statement on its website, the American Cancer Society said it took issue with aspects of the panel's report, although some elements of the panel's report are consistent with a recent report by the society on environmental

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Risk May Be Unacceptable For PSA-Detected Early Cancer

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American Heart Association, and the American Society for Radiation Oncology (The Cancer Letter, Feb. 5).

GnRH agonists are approved for palliative care of advanced prostate cancer, and randomized trial data show that they slightly improve survival for clinically advanced localized disease when combined with radiation therapy. There are no randomized trials that would point to improvement in survival in any other setting.

Pattern of care studies show that now about one in three men treated for prostate cancer receives GnRH agonists at least at one point in their disease. This adds up to 60,000 to 70,000 new patients per year. Altogether, at least 250,000 men are receiving GnRH agonists drugs, paying about $800 a month, often for the rest of their lives, epidemiologists estimate.

Frequently, GnRH agonists are prescribed to men with asymptomatic early disease after it is detected via prostate-specific antigen assays. No one knows exactly how many of these men receive GnRH agonists for early disease, but epidemiologists say that the proportion of such use is likely to be substantial.

"Healthcare professionals and patients should be aware of these potential safety issues and carefully weigh the benefits and risks of GnRH agonists when determining treatment choices," the agency said in the MedWatch alert. "FDA recommends that patients receiving GnRH agonists should be monitored for development of diabetes and cardiovascular disease. Patients should not stop their treatment with GnRH agonists unless told to do so by their healthcare professional."

The alert is posted at http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm210576.htm

"Most of the studies reviewed by FDA reported small, but statistically significant increased risks of diabetes and/or cardiovascular events in patients receiving GnRH agonists," the agency said. "FDA's review is ongoing and the agency has not made any conclusions about GnRH agonists and whether they increase the risk of diabetes and cardiovascular disease in patients receiving these medications for prostate cancer."

The review of GnRH agonists involves the agency's Office of Oncology Drug Products and the Office of Surveillance and Epidemiology, said FDA spokesman Crystal Rice. "The agency will continue to review information relating to this safety concern as more information becomes available," Rice said in an email. "We do not have a set timeframe."

In principle, FDA's ongoing review of the data could result in a "black box" warning against off-label use. Safety concerns can also lead the agency to make sponsors institute Risk Evaluation and Mitigation Strategies.

For example, in the case of erythropoiesis-stimulating agents, the requirements of REMS include forcing doctors to administer informed consent each time they give ESAs.

With ESAs, the agency made it known in 2004 that it was consistently monitoring the emerging safety data, repeatedly summoning the sponsors and skeptics to present data before the Oncologic Drugs Advisory Committee, consistently updating the label to reflect safety concerns, strengthening the black box warnings, and finally instituting REMS (The Cancer Letter, Feb. 19).

In the case of GnRH agonists, the agency may have to confront several interesting questions, which begin with the definition of approved indications for this class of drugs. All 10 GnRH agonists on the market are approved for "palliative treatment of advanced prostatic cancer."

"The question is, how do you define, advanced prostate cancer, and that's a gray zone," Albertsen said. "If the label is for treatment of widespread metastases, the question is, is a rising serum PSA or an elevated

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serum PSA evidence of widespread metastases, and that's a gray zone. In the absence of a positive bone scan or a positive CAT scan, I would say that you don't have obvious evidence of metastases. But I think everybody has begun to accept that a rising PSA reflects that you are about to get metastases."

Addressing a related problem in the past, FDA has not accepted the reduction in PSA score as evidence of efficacy of prostate cancer drugs.

The value of PSA in detection of prostrate cancer is even more controversial. Last year, the NCI-sponsored Prostate, Lung, Colorectal and Ovarian Cancer Screening trial found no benefit to screening with PSA and digital rectal exam. At the same time, the European Randomized Study of Screening for Prostate Cancer found that PSA testing reduced the rate of death from prostate cancer by 20 percent, but this benefit came at a very high cost of overdiagnosis and overtreatment.

The European study found that 1,410 men had to be screened over nine years to treat 48 additional cases of prostate cancer, preventing one death. By way of comparison, in breast cancer, about 1,400 women between 50 and 69 need to be screened for 10 years to diagnose five to 12 additional cancers and save one life, according to an analysis of published studies by the American Cancer Society (The Cancer Letter, March 20, 2009).

For now, FDA recommends the following:

• Healthcare professionals should be aware of these potential safety issues and carefully weigh the benefits and risks of GnRH agonists when determining treatment.

• Patients receiving GnRH agonists should be monitored for development of diabetes and cardiovascular disease.

• Health care professionals should manage cardiovascular risk factors for patients, such as smoking and increases in blood pressure, cholesterol, blood sugar, and weight, according to current clinical practice.

• Patients should not stop their treatment with GnRH agonists unless told to do so by their healthcare professional.

"Not a Great Success"

Under the worst-case public health scenario, widespread use of these agents is causing men to die of cardiovascular disease and diabetes before they would ordinarily die of prostate cancer, some epidemiologist warn.

"It's very appropriate for FDA to get involved," said Peter Albertsen, chief of the Division of Urology at the University of Connecticut Health Center. "The reason is, when androgen-deprivation therapy originally came into use, it was used in men with widespread metastatic prostate cancer, and most of these men had life expectancies of one, two, three, four, five years at most.

"People were not living long enough to appreciate any of the side effects that the FDA is now starting to focus on. What has changed is, as a consequence of PSA testing, we are finding many, many, many more men with localized prostate cancer, and despite the lack of evidence, many of these men are being placed on hormonal therapy as primary treatment for their localized disease," Albertsen said.

"As a consequence, these men are no longer being placed on these drugs for just three or four years. They are on these drugs for eight to twelve years, and now all of a sudden, the side effect we previously thought were infrequent are becoming more severe. And as a consequence, the disparity between what you gain vs. what prices you are paying in terms of metabolic consequences is becoming very real."

The studies that prompted FDA review started appearing after 2005, as the wide-ranging consequences of PSA testing have become more pronounced.

"As we screen, we have created a pseudo-epidemic; that's pretty well established," said Barnett Kramer, NIH associate director for disease prevention. "The men who have prostate cancer are much healthier and asymptomatic, compared to pre-PSA era. And now that we follow men so carefully with PSA, there is a tendency to treat earlier and earlier in the natural history, even of advanced disease."

Proliferation of treatments before they are thoroughly tested is a common problem in medicine, Kramer said.

"Sometimes we become aware of the benefits of a therapy in some subgroups first, and then we start to extend the indications to other subgroups just by inference or by the use of logic before we have randomized trials to directly test the balance of risks and benefits," Kramer said. "And then, with time, we sometimes become aware of harms that weren't studied carefully. The same thing happened with the ESAs."

Peter Boyle, president of the International Prevention Research Institute in Lyon, it's "appropriate at this juncture that the FDA lead an investigation into this issue and examine in great detail the risks and benefits of using hormonal therapies on life expectancy.

"There is evidence that hormonal therapies for prostate cancer increase risk of cardiovascular disease

and stroke and this has raised concern that there could be an increase of non-prostate cancer deaths in patients treated for prostate cancer," Boyle said. "There is some randomized trial evidence to support this increased non-prostate cancer death rate."

"With many more prostate cancer survivors in the population, it is necessary to pay a lot more attention to survivorship issues. To attempt to cure someone of their cancer and only succeed in increasing the risk of death from another chronic condition is not a great success."

Papers That Triggered Review

There is no ongoing trial that would answer the scientific questions of toxicity of these drugs.

"It's expensive, and it's a big study, but it could be done," Albertsen said.

To address these questions, researchers would need to compare the consequences of using these drugs early after diagnosis with using them after disease progression.

"You would take men with localized disease, you would randomize them to receiving the drug now or only receiving it after they develop early metastases," Albertsen said. "And what you would find is, a good number of men would never get to that stage of metastases, so in the early treatment arm, you would have lots of men experiencing the side effects, and then you would look at the survival benefit in the two arms, to see if there is any increased survival."

However, clinical trialists say that a study of this sort would likely run into opposition from urologists and would have problems accruing patients.

The sponsors of GnRH agonsists cannot be expected to be excited about getting results because of their potential effect on sales.

By contrast, ESA studies that led FDA to clamp down on the use of that class of drugs were undertaken because the sponsors saw the potential for substantial expansion of the franchise.

ESAs were approved as an alternative to blood transfusion for correction of anemia in patients receiving chemotherapy for solid tumors. However, the sponsors wanted to push the hemoglobin targets beyond correction of anemia and into the normal level. Some of the most negative data were obtained from a study of correction of anemia in cancer patients who were not receiving chemo.

In the absence of efforts to expand the GnRH agonists franchise, the negative data are being generated in observational studies. Three papers that triggered the FDA review and the earlier joint statement by ACS, AUA and ADA include:

• Nancy L. Keating, A. James O'Malley, Stephen J. Freedland, and Matthew R. Smith. Diabetes and Cardiovascular Disease During Androgen Deprivation Therapy: Observational Study of Veterans With Prostate Cancer. J Natl Cancer Inst, 6 January 2010; 102: 39 - 46.

The paper is based on an observational study of 37 443 population-based men who were diagnosed with local or regional prostate cancer in the Veterans Healthcare Administration from January 1, 2001, through December 31, 2004, with follow-up through December 31, 2005. Cox proportional hazards models were used to assess whether androgen deprivation therapy with gonadotropin-releasing hormone (GnRH) agonists, oral antiandrogens, the combination of the two (ie, combined androgen blockade), or orchiectomy was associated with diabetes, coronary heart disease, myocardial infarction, sudden cardiac death, or stroke, after adjustment for patient and tumor characteristics. All statistical tests were two-sided.

RESULTS: Overall, 14 597 (39%) of the 37 443 patients were treated with androgen deprivation therapy. Treatment with GnRH agonists was associated with statistically significantly increased risks of incident diabetes (for GnRH agonist therapy, 159.4 events per 1000 person-years vs 87.5 events for no androgen deprivation therapy, difference = 71.9, 95% confidence interval [CI] = 71.6 to 72.2; adjusted hazard ratio [aHR] = 1.28, 95% CI = 1.19 to 1.38), incident coronary heart disease (aHR = 1.19, 95% CI = 1.10 to 1.28), myocardial infarction (12.8 events per 1000 person-years for GnRH agonist therapy vs 7.3 for no androgen deprivation therapy, difference = 5.5, 95% CI = 5.4 to 5.6; aHR = 1.28, 95% CI = 1.08 to 1.52), sudden cardiac death (aHR = 1.35, 95% CI = 1.18 to 1.54), and stroke (aHR = 1.22, 95% CI = 1.10 to 1.36). Combined androgen blockade was statistically significantly associated with an increased risk of incident coronary heart disease (aHR = 1.27, 95% CI = 1.05 to 1.53), and orchiectomy was associated with coronary heart disease (aHR = 1.40, 95% CI = 1.04 to 1.87) and myocardial infarction (aHR = 2.11, 95% CI = 1.27 to 3.50). Oral antiandrogen monotherapy was not associated with any outcome studied.

CONCLUSION: Androgen deprivation therapy with GnRH agonists was associated with an increased risk of diabetes and cardiovascular disease.

• Tsai HK, D'Amico AV, Sadetsky N, Chen M-H, Carroll PR. Androgen deprivation therapy for localized

prostate cancer and the risk of cardiovascular mortality. J Natl Cancer Inst 2007;99:1516-1524.

The paper investigated whether androgen deprivation therapy use is associated with an increased risk of death from cardiovascular causes in patients treated for localized prostate cancer.

METHODS: From the Cancer of the Prostate Strategic Urologic Research Endeavor database, data on 3262 patients treated with radical prostatectomy and 1630 patients treated with external beam radiation therapy, brachytherapy, or cryotherapy for localized prostate cancer were included in this analysis. Competing risks regression analyses were performed to assess whether use of ADT was associated with a shorter time to death from cardiovascular causes after controlling for age (as a continuous variable) and the presence of baseline cardiovascular disease risk factors. All tests for statistical significance were two-sided.

RESULTS: The median follow-up time was 3.8 years (range = 0.1–11.3 years). Among the 1015 patients who received ADT, the median duration of ADT use was 4.1 months (range = 1.0–32.9 months). In a competing risks regression analysis that controlled for age and risk factors for cardiovascular disease, both ADT use (adjusted hazard ratio [HR] = 2.6; 95% confidence interval [CI] = 1.4 to 4.7; $P = .002$) and age (adjusted HR = 1.07; 95% CI = 1.02 to 1.1; $P = .003$) were associated with statistically significantly increased risks of death from cardiovascular causes in patients treated with radical prostatectomy. Among patients 65 years or older treated with radical prostatectomy, the 5-year cumulative incidence of cardiovascular death was 5.5% (95% CI = 1.2% to 9.8%) in those who received ADT and 2.0% (95% CI = 1.1% to 3.0%) in those who did not. Among patients 65 years or older treated with external beam radiation therapy, brachytherapy, or cryotherapy, ADT use was associated with a higher cumulative incidence of death from cardiovascular causes, but the difference did not reach statistical significance.

CONCLUSION: The use of ADT appears to be associated with an increased risk of death from cardiovascular causes in patients undergoing radical prostatectomy for localized prostate cancer.

• Keating NL , O'Malley AJ , Smith MR. Diabetes and cardiovascular disease during androgen deprivation therapy for prostate cancer. J Clin Oncol. 2006 ; 24 (27): 4448 – 4456.

Androgen deprivation therapy with a gonadotropin-releasing hormone (GnRH) agonist is associated with increased fat mass and insulin resistance in men with prostate cancer, but the risk of obesity-related disease during treatment has not been well studied. We assessed whether androgen deprivation therapy is associated with an increased incidence of diabetes and cardiovascular disease.

PATIENTS AND METHODS: Observational study of a population-based cohort of 73,196 fee-for-service Medicare enrollees age 66 years or older who were diagnosed with locoregional prostate cancer during 1992 to 1999 and observed through 2001. We used Cox proportional hazards models to assess whether treatment with GnRH agonists or orchiectomy was associated with diabetes, coronary heart disease, myocardial infarction, and sudden cardiac death.

RESULTS: More than one third of men received a GnRH agonist during follow-up. GnRH agonist use was associated with increased risk of incident diabetes (adjusted hazard ratio [HR], 1.44; $P < .001$), coronary heart disease (adjusted HR, 1.16; $P < .001$), myocardial infarction (adjusted HR, 1.11; $P = .03$), and sudden cardiac death (adjusted HR, 1.16; $P = .004$). Men treated with orchiectomy were more likely to develop diabetes (adjusted HR, 1.34; $P < .001$) but not coronary heart disease, myocardial infarction, or sudden cardiac death (all $P > .20$).

CONCLUSION: GnRH agonist treatment for men with locoregional prostate cancer may be associated with an increased risk of incident diabetes and cardiovascular disease. The benefits of GnRH agonist treatment should be weighed against these potential risks. Additional research is needed to identify populations of men at highest risk of treatment-related complications and to develop strategies to prevent treatment-related diabetes and cardiovascular disease.

Environment & Cancer:

Cancer Society Says Panel Overstates Role Of Pollution

(Continued from page 1)

factors of cancer.

"Issues highlighted in both reports include the accumulation of certain synthetic chemicals in humans and in the food chain; the large number of industrial chemicals that have not been adequately tested; the potentially greater susceptibility of children; the possibility that some chemicals or combinations of chemicals may have effects at low doses; and the potential risks from widely used medical imaging procedures that involve ionizing radiation," said the statement, attributed to Michael Thun, vice president

emeritus, Epidemiology & Surveillance Research.

"Unfortunately, the perspective of the report is unbalanced by its implication that pollution is the major cause of cancer, and by its dismissal of cancer prevention efforts aimed at the major known causes of cancer (tobacco, obesity, alcohol, infections, hormones, sunlight) as 'focused narrowly,'" Thun said in the statement.

"The report is most provocative when it restates hypotheses as if they were established facts," Thun continued. "For example, its conclusion that 'the true burden of environmentally (i.e. pollution) induced cancer has been grossly underestimated' does not represent scientific consensus. Rather, it reflects one side of a scientific debate that has continued for almost 30 years.

"There is no doubt that environmental pollution is critically important to the health of humans and the planet," Thun said. "However, it would be unfortunate if the effect of this report were to trivialize the importance of other modifiable risk factors that, at present, offer the greatest opportunity in preventing cancer."

According to a statement by the President's Cancer Panel, the report's key findings include:

• "With nearly 80,000 chemicals on the market in the US, many of which are used by millions of Americans in their daily lives and are un- or under-studied and largely unregulated, the report finds that exposure to potential environmental carcinogens is widespread. Yet, the public remains unaware of many of these carcinogens as well as their own level of exposure, especially to many common environmental carcinogens such as radon, formaldehyde and benzene.

• "In addition to environmental carcinogens, the report found that while improved imaging technologies have facilitated great strides in diagnosing and treating diseases, including cancer, some of these technologies also carry risks from increased radiation exposures. Many health care professionals, as well as the public, are unaware of the radiation dose associated with various tests or the total radiation dose and related increased cancer risk individuals may accumulate over a lifetime.

• "In addition, the report found that health care providers often fail to consider occupational and environmental factors when diagnosing patient illness. Physicians and other medical professionals ask infrequently about patient workplace and home environments when taking a medical history, thereby missing out on information that could be invaluable in discovering underlying causes of disease.

• "The report also recognizes the United States military as a major source of toxic occupational and environmental exposures that can increase cancer risk. Information is available about some military activities that have directly or indirectly exposed military and civilian personnel to carcinogens and contaminated soil and water in numerous locations in the United States and abroad, such as radiation exposure due to nuclear weapons testing. Nearly 900 Superfund sites are abandoned military facilities or facilities that produced materials and products for, or otherwise supported, military needs. In some cases, these contaminants have spread far beyond their points of origin because they have been transported by wind currents or have leached into drinking water supplies.

• "The panel concluded that Federal responses to the plight of affected individuals have been unsatisfactory, and that those affected lack knowledge about the extent of their exposure or potential health problems they may face."

The panel's recommendations include:

• Increase, broaden and improve research regarding environmental contaminants and human health.

• Raise consumer awareness of environmental cancer risks and improve understanding and reporting of known exposures.

• Increase awareness of environmental cancer risks and effects of exposure among health care providers.

• Enhance efforts to eliminate unnecessary radiation-emitting medical tests, and to ensure that radiation doses are as low as reasonably achievable without sacrificing quality.

• Aggressively address the toxic environmental exposures the U.S. military has caused, and improve response to associated health problems among both military personnel and civilians.

The panel, established by the National Cancer Act of 1971, is charged with monitoring the National Cancer Program and reporting annually to the President on any barriers to its execution. Besides Leffall, the other panel member is Margaret Kripke, of University of Texas M.D. Anderson Cancer Center. Both were appointed by President George W. Bush. A third seat on the panel is vacant.

The 240-page report, "Reducing Environmental Cancer Risk: What We Can Do Now," is available at http://pcp.cancer.gov.

[Disclosure: Paul Goldberg, editor of The Cancer Letter, and Otis Brawley, chief medical officer of the American Cancer Society, are under contract with St. Martin's Press to complete a book about oncology.]

NCI News:

NCI Funds 14 More Hospitals For Community Program

NCI is using $80 million from the American Recovery and Reinvestment Act to expand research at the 16 member hospitals of the NCI Community Cancer Centers Program and to add 14 new hospitals to the network.

The expansion uses about $40 million of ARRA funds to support additional research within the original network of 16 NCCCP sites and another $40 million of ARRA funds to expand the network to include 14 new community cancer centers, for a total of 30 sites in 22 states.

The NCCCP began as a pilot program in 2007 as a network of community hospital cancer centers that is working to provide research-based cancer care from prevention through end-of-life care, with an emphasis on minority and underserved populations. The program is designed as a community-based platform to support basic, clinical, and population-based initiatives.

NCCCP centers are studying ways to reduce healthcare disparities, improve access to clinical trials, improve overall quality of care, promote an infrastructure to collect high-quality biospecimens such as blood and tissue samples for research, and to link with national computer networks that support research. The centers also work to improve survivorship, palliative care services, and patient advocacy.

The newly funded centers are:

Northside Hospital, Atlanta, Georgia (Northside Hospital Cancer Care Program)

The Queen's Medical Center, Honolulu, Hawaii (The Queen's Cancer Center)

St. Luke's Regional Medical Center, Boise, Idaho (Mountain State Tumor Institute)

Mercy Medical Center, Des Moines, Iowa (Mercy Cancer Center)

Norton Suburban Hospital, Louisville, Kentucky (Norton Cancer Institute)

Maine Medical Center, Portland, Maine (Maine Medical Center Cancer Institute)

St. Joseph Mercy Hospital, Ann Arbor, Michigan (St. Joseph Mercy Cancer Care Center)

Saint Mary's Health Care, Grand Rapids, Michigan (The Lacks Cancer Center)

Providence Portland Medical Center, Portland, Oregon (Providence Cancer Center)

Lehigh Valley Hospital, Allentown, Pennsylvania (John and Dorothy Morgan Cancer Center)

Geisinger Medical Center, Danville, Pennsylvania (Geisinger Medical Center Cancer Institute)

Albert Einstein Medical Center, Philadelphia, Pennsylvania (Einstein Cancer Center and Einstein Center One)

Gundersen Lutheran Medical Center, La Crosse, Wisconsin (Gundersen Lutheran Center for Cancer & Blood Disorders)

Waukesha Memorial Hospital, Waukesha, Wisconsin (Waukesha Care Regional Cancer Center)

NIH News:

Ten Awards For Population Health And Disparities

NIH has awarded 10 new Centers for Population Health and Health Disparities, designed to better understand and address inequities associated with the two leading causes of death in the U.S., cancer and heart disease.

The program is supported by NCI, the National Heart, Lung, and Blood Institute, and the Office of Behavioral and Social Sciences Research. NCI and NHLBI will each contribute $10 million per year in grant funding over the next five years for $100 million in total funding, and OBSSR will provide support for annual meetings.

The 10 centers will support transdisciplinary collaborations among biological, medical, behavioral, social, and public health scientists. In addition, each center will each play a major role in the training of a new generation of transdisciplinary researchers in collaborative team science. The goals are to increase the rigor and impact of science that addresses the many factors associated with health disparities.

The centers and investigators are:

Fred Hutchison Cancer Research Center, Beti Thompson.

Harvard University School of Public Health, David Williams.

Johns Hopkins University, Lisa Cooper.

Northeastern University, Katherine Tucker.

Ohio State University, Electra Paskett.

Rush University Medical Center, Lynda Powell.

University of California, Los Angeles, Alexander Ortega.

University of Illinois at Chicago, Richard Warnecke.

University of North Carolina, Chapel Hill, Alice Ammerman.

University of Washington, Dedra Buchwald.

In the Cancer Centers:

Johnson Named Chairman Of Medicine, UT Southwestern

DAVID JOHNSON, deputy director of the Vanderbilt-Ingram Cancer Center and director of the Division of Hematology and Oncology at Vanderbilt, will become chairman of medicine at the University of Texas Southwestern in Dallas and will hold the Donald W. Seldin Distinguished Chair in Internal Medicine.

Johnson came to Vanderbilt in 1981 for a medical oncology fellowship and joined the faculty two years later. When the cancer center was formed in 1993, Johnson was one of the leaders who joined with Harold Moses, now director emeritus, to focus on making Vanderbilt a leader in research and patient care. "David contributed enormously to the development of the cancer center," Moses said. "Without his enthusiastic involvement we certainly would not have been as successful as we were in building what has become an internationally recognized cancer center," said Moses. Johnson also served as president of American Society of Clinical Oncology in 2004-2005.

Carlos Arteaga, head of the VICC Breast Cancer Program and its Specialized Program of Research Excellence in Breast Cancer, will serve as interim director of the Division of Hematology and Oncology. A search committee will be named to lead a national search for Johnson's successor.

"As an internationally acclaimed oncologist, David has been recruited many times by other institutions," said **Jennifer Pietenpol**, director of Vanderbilt-Ingram. "This position at UT Southwestern is a tremendous leadership opportunity for David and we are thrilled for him."

In another development, Vanderbilt-Ingram Cancer Center said its Radiation Oncology Clinic in the basement of its main campus was flooded earlier this week due to the weekend rainstorms that caused flooding in Nashville and other parts of Tennessee. Patients scheduled for treatment were being shuttled to other centers in the area.

THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER, for only the fourth time in its 69-year history, has updated its logo, with a new look that symbolizes its mission: to eradicate cancer. The logo integrates M.D. Anderson's tagline, "Making Cancer History," and the long-running cancer strike-through campaign, in which survivors tell their cancer stories and draw a red line through their cancer type to mark their triumph over the disease.

"We are proud that we've created tremendous momentum in cancer research and care. Every patient and research finding teaches us more about how we can eliminate cancer," said John Mendelsohn, president of M.D. Anderson. "This logo tells who we are and signifies that our efforts have a steadfast focus on the ultimate goal: Making Cancer History."

M.D. Anderson is steeped in traditions that provide patients with important milestones of hope during treatment and recovery, be it ringing a bell to signify the end of radiation therapy or collecting a bead of courage for each treatment completed.

"The red cancer strikethrough has proven to be one of the most powerful symbols of hope and inspiration to patients and their families and many have shared stories of how they dreamed of the day when they would star in an M.D. Anderson ad and strike out their disease with a red line for the world to see," said Mendelsohn.

The updated logo is appearing in many venues, including on the center's website, campus signs, institutional vehicles, print and online publications and advertising campaigns. M.D. Anderson Children's Cancer Hospital and the Children's Art Project also have new logos reflecting the strike through. The logo was created for MD Anderson by The Richards Group of Dallas, which has been its advertising agency since 1996.

BARBARA ANN KARMANOS CANCER INSTITUTE received a $2.5 million donation from **Joseph Dresner** to construct the Joseph Dresner Family Bone Marrow Transplant and Hematologic Malignancies Center at its main campus in Detroit. Dresner has supported the institute in the past, with gifts now totaling $5 million. His latest donation will improve patient care and enhance communication among caregivers in this new center. Project details are yet to be determined. The new center will expand Karmanos' ability to conduct future cancer research and clinical trials focusing on leukemia, multiple myeloma, lymphoma and MDS, said Karmanos President and CEO **Gerold Bepler**.

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute has recruited **Christopher Pelloski** as the first director of pediatric radiation oncology. He also serves as director of the radiation oncology residency program and medical student education.

Pelloski received his medical degree from Northwestern University Medical School and completed his residency at M.D. Anderson Cancer Center.