THE CANCER LETTER

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Niederhuber: Clinical Trials System Must Refocus To Emphasize Translational Studies

NCI Director John Niederhuber sat down with editors of The Cancer Letter for an interview on June 29. Niederhuber, who has described himself as the "accidental director," having taken over management of the institute in October 2005 after NCI Director Andrew von Eschenbach became FDA commissioner, will step down when President Obama's appointee, Harold Varmus, arrives on July 12. He plans to remain at NCI working in the laboratory he established when he arrived at NCI as deputy director for clinical and translational sciences.

THE CANCER LETTER: What have you learned on the job and what advice would you have for your successor?

NIEDERHUBER: I've certainly learned that this is not an easy job. It has a lot of complexity to it in terms of being a government job. I've learned a lot about managing a very complex budget. It's a big budget, but yet, it's a budget that is committed to a great extent each year, because as an agency we are in the business of awarding grants to our scientists. Those are long-term commitments of two, three, four, five years. So there are very few flexible

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In the Cancer Centers:

Center For Health Policy And Outcomes Established At Memorial Sloan Kettering

MEMORIAL SLOAN KETTERING CANCER CENTER has started a Center for Health Policy and Outcomes. The center will be headed by **Peter Bach**, a pulmonologist and a member of Memorial's Health Outcomes Group.

In addition to conducting research in health services delivery in cancer, the new center will tie this research to the development and evaluation of policy proposals and programs.

The objective would be to conduct such work outside politics. "Work on policy should be fundamentally academic work," Bach said. "It involves the development and testing of hypotheses, and its dissemination should include rigorous academic channels. That differs from some policy work, which can tend to be ideologically anchored or driven by advocacy of a particular view regardless of contravening data."

In a memo to Memorial's staff, Physician-in-Chief **Robert Wittes** said the center will address "an eclectic menu of issues." These will include "the quality and efficiency of health care along the illness trajectory from diagnosis

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Niederhuber Regrets Inability To Increase Per-Case Payment

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resources from year to year, and programs are pretty established, so you don't have an opportunity to move nimbly or easily money from one program or project over to something new. As you know from watching over the past five years, when you try to stop something, you can get a great deal of criticism for that.

TCL: But you have been able to make cuts, you had to tighten down a lot.

N: I have, we have done quite a bit of cutting down, and despite a flat budget, we have been able to start some really innovative programs—the investments in nanobiology, investments in proteomics—I call these the trans-NCI activities that cut across all of our divisions and centers at NCI. One that I've had the most to do with and enjoyed getting started the most on the science side was the series of workshops involving physicists and physical chemists, and people from mathematics—individuals that had not been funded by the NCI. They were very willing to come together for three workshops. They were probably the most exciting dialogues. Out of that came the opportunity for them to put together virtual center-type applications, and we had some outstanding applications, over 30 applications. We had a stellar review group that came in to review those applications, and ended up being able to award an exciting group. I think that brings another set of eyes and technology expertise to work on cancer. I was pleased to see them come together annually now to talk about what they are doing and share ideas.

TCL: What was the hardest thing to cut?

N: I'm not sure off the top of my head I could say what was the hardest thing to cut. I think the most difficult thing has been not to be able to put more resources into the clinical trials operation. One of the disappointments to me is that we know how much sacrifice is made by the physicians who are out there in the trenches putting patients on clinical trials, and how inadequate our per-case compensation is for the very vital work that they do. I think the disappointment I've had is not having enough extra resources to be able to increase the per-case reimbursement and make some of the changes that would help us move the clinical trials activities of the National Cancer Institute closer to where we need to be in the new era of highly targeted, highly personalized cancer therapy, the direction in which our science is taking us.

TCL: In your remarks to the National Cancer Advisory Board (The Cancer Letter, June 25, 2010), you advocated a completely new system for clinical trials, run by the cancer centers. Can you expand on that?

N: I was really exercising the prerogative of someone leaving the office, in trying to be a bit provocative to my colleagues to say, 'You need to think seriously about where we are in our clinical trials structure today and where we know we need to go and need to be.' I was trying to stimulate them to think about options and alternatives to the current structure that we have and to get them to think about where the strength or the majority of our science occurs in cancer research, and to think about how we need to work harder as a cancer research community to bring our laboratory science closer together with our clinical translational science. It's not something that's new or revolutionary at all. Throughout my career, we have always been working in our academic institutions to try to do that as best we could.

TCL: So you weren't making a specific suggestion to move things to the cancer centers?

N: I was throwing out an option to think about it. I don't know what the right answer is. We have some very talented people with a lot of experience in leading the cooperative groups. The point that I tried to make is that more and more of our work is going to be in that early phase of translation, from our laboratory research to our first-in-human studies. That's certainly going to be driven by where that work is taking place. We are also going to need to invest more in the correlative

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science than ever before. We can't put new agents into trial without some biomarker or some assay system that will allow us to follow what's happening, whether we are getting to the target. Whether that's an imaging or chemical biomarker or assay that allows us to determine what's taking place, we are going to be doing this, not one drug at a time. We are going to be doing this in terms of recipes of drugs that will target multiple targets. Everybody knows that, so I'm not saying anything new.

TCL: Would you concur that the cooperative groups' biorepositories are as valuable as the groups say they are? Are they valuable, are they useful?

N: I think all of our biorepositories are valuable, and we have worked hard to increase the standards to which we acquire specimens. Under Carolyn Compton's leadership, we put a lot of effort into defining those standards, getting those standards out, so that we are doing everything we can at the National Cancer Institute to lead the cancer research community, to make sure that we have the best specimens we can have today with the knowledge we currently have about how those specimens should be collected and stored. Do I think it's perfect today? No, I think we will continue to learn more as our technology and our science progress, and we will be able to do an even better job in years ahead in understanding the best practices, the best methods to collect and store our specimens and to make the specimens available to the research community.

TCL: There have been so many reports on the clinical trials system over the years, and when you came in you had the report from the Clinical Trials Working Group. But after that, you asked the Institute of Medicine for another study. What did you see as the problem?

N: When Dr. [James] Doroshow [director of the NCI Division of Cancer Treatment and Diagnosis] arrived about six years ago, and I arrived about five years ago, the Clinical Trials Working Group was meeting, and Jim was leading that and I attended a significant number of those meetings in my role as chair of the National Cancer Advisory Board at that time. A large number of our colleagues across the country participated in generating that report. When I arrived here, [then-NCI Director] Dr. [Andrew] von Eschenbach had asked for a study of the translational phase [the Translational Research Working Group], and I wanted to be sure that, as that group worked on a subset of the clinical trials operation, we didn't create two siloed reports, that we did our best to integrate those reports. I think we did that. The two reports were really quite complementary.

Jim and I have worked hard, as well as our colleagues at NCI and in the cancer community, to implement the recommendations of both of those reports, and we are well on track. We have found resources and applied resources that were needed to accomplish those recommendations.

TCL: But was there a sense that [those two reports] didn't go far enough?

N: I think the real question that we have struggled with is what really are inadequate resources to do clinical research, and we have all known that, both outside NCI and inside the NCI. We haven't had enough resources to adequately fund clinical research. We have looked at the number of cooperative groups and whether, as we moved into this new era of highly personalized, highly targeted drug development, do we need a different structure, do we need some consolidation? So, recognizing that we had a system that was over 50 years old, a system that has accomplished a tremendous amount over the years, is it time to look at that to see if there should be changes that would make it an even better system in the future?

I had been sitting on the [IOM] Cancer Policy Forum since I arrived here, and we meet regularly as part of that board's activities. We talk about what are questions or areas that the Institute of Medicine could investigate or address through conducting these workshops, that would enhance the National Cancer Program. In those discussions, I suggested that maybe it would be a good idea for the IOM to spend some time thinking about the current cooperative group structure that we had. I attended a couple of those sessions, too. I think the report is a good solid report that certainly says that we need to see, in a collegial and cooperative way, what changes we can make that would strengthen this program.

TCL: Does it go far enough?

N: Does the IOM report go far enough? That depends on who you ask. If you ask me, my bias is that we need some consolidation. That's just a personal feeling, that we need some consolidation of this structure to make it more cost-effective, to make it more nimble and capable of doing the work that I think needs to be done in drug development.

TCL: Does it give your successor the political mandate to increase the budget for the program?

N: It underscores what we have been saying over the years, that the work in translating novel agents into approved, efficacious drugs needs more resources than what we are putting into it.

TCL: Your signature program, what you have called your pet program, the NCI Community Cancer

Centers Program (NCCCP)—how is that going?

N: One of the things I wanted to do when I came here was to see if there was a way the National Cancer Institute could build another rim of research activities out in the community. It doesn't mean that the NCI hasn't been out working in the community. We have had many different kinds of projects—patient navigation, working with ethnically diverse populations, to understand better how to educate, how to do screening, tobacco cessation. But I felt that one of the most significant determinants of patient outcome and survival in the future will not be whether our science is creating new therapies and ways to prevent the disease. Our challenge is going to be getting the vast populations of patients with cancer access to our new technology and therapy. As I have said many times, 85 percent or so of patients who develop cancer are diagnosed and get their care in the communities where they live. So we need to keep that in mind as we develop programs at NCI. It has been rewarding to see the reaction of these sites. One individual said to me at a meeting of the leaders of the initial pilot sites, 'We had never dreamed that we could work with the National Cancer Institute.' I know it's good for patients, but I think it's also good for the National Cancer Institute. If you asked somebody on the street what is the National Cancer Institute, you would get more blank stares than you would get people who know what their National Cancer Institute was and what it did. And that's despite a lot of money and a lot of effort that we have put into communicating. I think if you went into these communities where we have a presence now, I bet you more people know what the National Cancer Institute is and how it's making a difference in their lives.

TCL: Does the NCI Community Clinical Oncology Program [a much older NCI program] do the same?

N: I think the CCOPs program was primarily built around giving people access to clinical trials. So I think this program was not meant to replace the CCOPs program. It was meant to try something else. Whenever you are out working in the community in that way, it should have an impact on how patients see and view clinical research and understand clinical research. A goal and a measurement of your success ought to be more patients on clinical trials. But I have from the beginning said this is not a program simply designed to increase the number of patients on clinical trials or to be another CCOP program. Our intention was, could we bring the physicians, medical oncologists, in their offices, radiation oncologists in other offices, surgeons in other offices—could we bring these people together around their specific cancers of interest, GI cancer or breast cancer or lung cancer? And if we brought them together, say on a weekly basis, to review their cases, without question, that will raise the quality of care for those patients.

TCL: Getting them to act more like a cancer center?

N: Getting them to act more like a cancer center, giving the patients more opportunities for one-stop consultation on their cancer. The quality of care rises to the brightest and most knowledgeable people who assemble around that table, getting them to think and look at the CT scans and MRIs together always increases the quality of interpretation. Having the pathologist in the room at the same time, again, it's an educational process for the physicians involved, and it's a raising of the level and quality of care. Along with that, certainly comes the increased opportunity to say, 'There is a good trial that this patient is well suited for.' It brings in the hospital, too, because in the rural setting, the hospital is really the glue of the physician community.

So, it gets the hospitals involved, it leverages hospital resources. Every one of those programs now has a robust navigation program to help with the disparities issues. About 40 percent of the budget is directed to be used to solving and dealing with disparities issues in the community—education, screening. Every site is a little different, and we tried to recognize that. I would have to say it has been much more successful than my wildest dreams.

Can we use that as a model to create a cohort of highly characterized patients that are in our database? In the future we can't simply wait for the individual to walk through the door and say, you're a candidate for this study. I believe that the major pharmaceutical companies recognize that the current system that we have in place for doing drug discovery and development isn't well suited to doing the kind of work that we are going to need to do. I think that the major contract research organizations that work in this arena also recognize that the model that they are using probably has to be changed down the road to work well in this new era of genomic characterization and sequencing of disease. I think that means we need to be building that cohort of patients, and maybe cancer is the model that we start with that then can be transported to other chronic diseases. It's not just the electronic medical record. That's one component. It's really adding into this database: what's the social history of this patient, what's the behavioral history of this individual over their lifetime? Where

have they worked? What have they been exposed to in the environment? What do we know about their family history? In terms of genomic characterization and sequencing information, what does that tell us about how they will react to pharmacogenetics? How will they react to a particular drug? Do they have the right enzymes to metabolize that drug?

So it's bringing all of that kind of data into a comprehensive database for each individual patient, and then building on top of that the experience with large numbers of patients, in terms of, say, pancreatic cancer and how they respond to different treatments. So you have that kind of a knowledge base as well. And then being able to rapidly integrate that kind of information, clinical information, pathology, sequencing, proteomics—all of that biology of the disease. Being able to not just store it, but rapidly integrate it, building the analytical tools that will empower the point of care with the maximum amount of knowledge in a usable format. The goal then is to make that point of care as intelligent as our technology and our information system can make it. That's where we are trying to head. If that's where we are trying to head, then to me, that changes how we will do drug discovery and drug development. Clearly, our science will change how we find the targets.

TCL: How does this compare with the biorepositories held by the cooperative groups, where you have patients with the same sets of characteristics receiving treatment in a protocol-based manner, correlated with the outcomes?

N: Those are very unique and very special resources, and they will be very valuable as we continue to do this kind of individual patient analysis as well. All of that information is eventually going to come together. It's extremely valuable.

TCL: Looking at the suggestion that the cancer centers take over the work of the groups, how do you get at this information? This is all grant supported, not contract supported. The [cooperative group biorepositories] are not yours.

N: I think the community of cancer researchers will find ways to work together to make sure we maximally utilize what we have all put our hearts and souls into in terms of the clinical trials we have developed, the specimens we have collected over the years, and the information. We will figure out ways to make this as meaningful as we can make it. It won't go wasted. I think this is a work in progress.

TCL: You have been talking about what NCI should be doing and moving into. Then there is the reality of the budget. What does NCI *not* do? Is there anything NCI does now, in your opinion, that it should stop doing?

N: On my way out the door, I think it would be very foolish to say, especially in print.

TCL: NIH Director Francis Collins has said that NCI's special authorities [granted in the National Cancer Act of 1971] are "more of a negative than a positive." Where do you stand on that?

N: My appointment is a presidential appointment, and I think that has been controversial for years. I don't get into that. I think there are some positives to that and probably some negatives.

TCL: What about President's Cancer Panel and it's recent report?

N: I think I'll pass on that. I just don't want to go out making statements about my position or the NCAB. There is a working group in place. We should let the working group deliberate these issues. There are some very influential people who agreed to serve on that working group, people of true stature. I think one of the good things about the working group is that it's not just all individuals with a vested interest in the chicken house. There are people with a wide range of backgrounds and expertise, so it's not the cancer community reviewing the cancer community.

The bypass budget is an exercise. We are required by statute to put this together. It's really a progress report. We are really not influencing the president's 2012 budget for cancer. If we were designing the optimal program for cancer patients, you and I might see these things as a positive, because we feel passionate about cancer and we want to try to make a difference. So we might sit down and say we need better access to the president, to tell the president what he needs to put in the budget. Or we might need a seat at the table when OMB plans the next budget. If you are passionate about cancer, that's where you would be as a cancer community.

TCL: I think what Dr. Collins was saying mostly was that this should be just another NIH institute without any special authorities, because that leads to politicization of science.

N: I think if you go back and look at the history, our work in oncology has contributed tremendously to our understanding of the basic biology of many diseases. I don't see the harm that has occurred by some of the special authorities that came about as a result of the National Cancer Act. I think maybe that's why we have made as much progress as we have made. I think Dr. Varmus feels differently, and Dr. Collins feels differently.

I think that this has been an institute that has led

over many years. Without special authorities, could we have stepped into the AIDS epidemic as quickly as we did? The NCI was able to step in and figure out what these patients were presenting with, an immunodeficiency disease. The work at NCI not only helped identify the virus, but as a surgeon, I can tell you how panicked all of us were in our work in the operating room, and the risk we had in managing patients and transfusions of large amounts of blood. We forget what a panic that was in our country. So the work to develop the testing for blood so the blood banking system in our country was safe was a huge accomplishment. Work led by Sam Broder and others here that created the first drugs to attack the disease. Now patients die not of AIDS as much as they die of cancer. So, the NCI really has contributed over the years. Also, NCI led the development of the HPV vaccine. We won't see the immediate impact of that, but gosh, if we can immunize against the development of cervical cancer around the world, what an impact that is. So the NCI isn't such a bad place.

TCL: That brings us to the intramural program. Now that you will be going into the intramural program full-time, where do things stand with the program now?

N: I think that under Joe Fraumeni, Bob Wiltrout and Lee Helman's leadership, there has been tremendous progress made in terms of quality of science in the intramural program, and centers of excellence that have been created under Bob's leadership. I have interacted with the Board of Scientific Counselors that come here to do site visits of our laboratories and hear their reviews. These are people that we select for their expertise. Again, really solid reviews and a lot of enthusiasm for the work that is done here in the intramural program. Our chromatin biology group is recognized as the third best group in the country. We have a number of members elected to the National Academy of Sciences. This is an outstanding group.

TCL: The reviews are having an impact?

N: The reviews are having an impact on the quality of the work being done here, making sure that we recruit the best and most talented people.

TCL: Are you ready to be reviewed?

N: I have been partially reviewed. Our big lab, of which my lab is part, has been reviewed.

TCL: What are you going to be working on?

N: I have had a lab since I've been here. We work mostly in the microenvironment, specifically on cancer-activated fibroblasts, that is, the fibroblasts that are in association with the cancer and how those cells are genetically reprogrammed. We have been working on looking at some of the regulatory RNAs and how they control gene expression in those cancer-activated fibroblasts and how they may relate to different pathways of activity within those cells and the relationship of those cells to the tumor, the origin of those cells—are they recruited from bone marrow, for example. The idea being eventually that this host tissue that interacts with the tumor and supports the tumor, many of us think could be a significant target for therapy, in terms of stabilizing or keeping this disease a chronic process, blocking the metastatic process. Being able to target both the host and the tumor, in the future could be a great advance.

TCL: What's your advice to Dr. Varmus?

N: Work hard. It's a great job.

[For a previous interview with Niederhuber, see The Cancer Letter, Dec. 19, 2008.]

In the Cancer Centers:

MSKCC Opens New Facility For Image-Guided Intervention

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to the end of life; the assessment, approval, and clinical use of cancer drugs and treatments; and the effective and rapid implementation of health information technology in a manner that also satisfies the complexities of caring for cancer patients," Wittes wrote.

The center includes a number of Memorial Sloan-Kettering faculty and will be doing some recruiting. "There are more opportunities in the study of cancer health policy than we can handle, so I guess I'd say that the phones are open," Bach said.

Bach served as an advisor to **Mark McClellan** when he directed the Centers for Medicare and Medicaid Services.

MEMORIAL SLOAN-KETTERING CANCER CENTER has opened its Center for Image-Guided Intervention. The facility includes an expansion of the Surgical Day Hospital and a new endoscopy suite. The proximity of these three entities will allow interventional radiologists, surgeons, and endoscopists to collaborate in developing new procedures and treatments. The new 40,000-square-foot facility cost more than $100 million in construction and equipment. About 120 patients a day are expected to be seen in the facility.

"Seven years in the making, this magnificent facility is a result of shared vision and collaboration," said **Hedvig Hricak**, chair of the Department of Radiology, who, along with **Peter Scardino**, chair of the Department of Surgery, was instrumental in

conceptualizing and planning the new facility.

MSKCC has one of the first combined "angio-CT" suites in the U.S. The CIGI contains two additional angio-CT units. These combination rooms have enabled procedures that have never been performed before. Traditionally, interventional procedures were done using conventional two-dimensional x-ray equipment. Three-dimensional CT, MRI, and PET display anatomy in much greater detail and provide additional information about metabolism and physiology that improves cancer detection and characterization.

Scardino said the new facility makes it possible to consolidate several procedures performed by different specialists into a single patient visit. "A patient with an unspecified mass in the chest could typically require a CT scan by an interventional radiologist to biopsy it, an ultrasound by an endoscopist to stage it and determine its size, and a surgical procedure called a mediastinoscopy to take out a lymph node," he said. "In the past, getting all three procedures would require three separate trips to the hospital over several weeks. Now we can do them consecutively in the same day and move promptly to therapy."

The CIGI includes a laboratory research facility devoted to developing and testing phantoms and animal models techniques that can eventually be evaluated in clinical trials.

FRED HUTCHINSON CANCER RESEARCH CENTER said its three-year-old Vaccine and Infectious Disease Institute has become the center's fifth scientific research division and has been renamed the Vaccine and Infectious Disease Division. The other four divisions are Clinical Research, Public Health Sciences, Basic Sciences and Human Biology.

"Divisions serve many purposes but their primary function within the institution is to provide an environment for the career development of faculty," said **Lee Hartwell**, Hutchinson president and director. "With 20 primary faculty and 25 affiliate investigators and grant revenue of more than $130 million, VIDD is a substantial component of the center's research activities."

The original institute was formed in 2007 to encompass the cancer center's infectious disease, population science, immunology and vaccine development programs. It also is the core of the center's global health efforts, which include the HIV Vaccine Trials Network and a partnership with the Uganda Cancer Institute to research infections that cause cancer. About 20 percent of all cancers arise from infections, with developing nations bearing the biggest burden of such cancers.

VIDD will have three co-directors: **Larry Corey**, head of the infectious disease sciences program; **Julie McElrath**, head of the immunology and vaccine development program; and **Steve Self**, head of the populations sciences program. Corey will represent the division as its senior vice president.

The Hutchinson Center also said two researchers who study immunotherapy have received awards from the Damon Runyon Cancer Research Foundation. **Brian Till,** a research associate in the Hutchinson Center's Clinical Research Division, was awarded a three-year, $450,000 clinical investigator award to help fund his work on a new immunotherapy-based treatment for patients with lymphoma. **Colleen Delaney,** who leads the Hutchinson Center's research and clinical program in cord blood stem cell transplantation, received a two-year, $300,000 continuation grant from Damon Runyon.

CITY OF HOPE said it received a $2.5 million gift from Morgan and Helen Chu to establish the Morgan and Helen Chu Dean's Chair for the Irell & Manella Graduate School of Biological Sciences. **John Rossi**, a leader in the field of RNA technology and dean of the graduate school, will be the first holder of the chair. Morgan Chu is a partner in the Los Angeles-based law firm of Irella & Manella LLP.

SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER at Johns Hopkins said **Elizabeth Platz** was selected as the first Abeloff Scholar. Platz is nationally recognized for her work in cancer prevention and specifically for her research of the role of statins in preventing prostate cancer. She is the co-director of the center's Cancer Prevention and Control Program and directs the Training Program in Cancer Epidemiology, Prevention, and Control.

The Abeloff Scholars Program in Cancer Prevention and Control was established in 2007 to combine the study of basic, clinical, and population science. The program honors former Kimmel Cancer Center director Martin Abeloff.

UNIVERSITY OF COLORADO CANCER CENTER member **Paul Jedlicka** received two grants totaling $280,000 to support his work in understanding the function of microRNAs in Ewing's

sarcoma. Jedlicka, assistant professor of pathology at the University of Colorado School of Medicine, is one of three University of Colorado scientists to be named inaugural Boettcher Investigators, an award that shares a $700,000 pool of grant money. The program supports early-career biomedical investigators. Jedlicka also received a two-year, $80,000 Young Investigator Award from the Alex's Lemonade Stand Foundation for Childhood Cancer to continue work on microRNAs identified by his laboratory that may suppress Ewing's sarcoma tumors.

Professional Societies:

Oncology Nursing Society Celebrates 35th Anniversary

The Oncology Nursing Society is celebrating its 35th anniversary as a professional association providing membership benefits to more than 36,000 registered nurses who specialize in caring for patients with cancer.

Incorporated in July 1975, ONS was the brainchild of a small group of nurses who attended the First National Cancer Nursing Conference held in Chicago, sponsored by the American Cancer Society. The early goals of ONS were to identify other oncology nurses across the country and encourage the development of educational programs and meetings appropriate to nurses who specialize in treating patients with cancer.

"When we planned it—dreamed it would be more accurate—not one of us dared imagine it would become the professional home for so many of our colleagues for so many years," said **Connie Henke Yarbro**, a charter member of ONS and served as the society's first treasurer and second president. "We have moved from a few isolated oncology nurses scattered across the country to over 36,000 well-organized, interacting professionals with formal educational and research programs linked by journals, regional and national meetings, and a unity of purpose to improve the quality and quantity of life of those afflicted with cancer."

"We are very proud of what we've accomplished in the past 35 years," said **Carlton Brown**, president of ONS. "We look forward to the challenges of preparing oncology nurses for the rapid advancements in cancer treatment and care."

Today, ONS provides nurses and healthcare professionals with access to educational programs, cancer care resources, and research opportunities. More than 220 local chapters and 27 special interest groups provide a network for education and peer support.

Funding Opportunities:

NCI Prevention Fellowship Program Accepting Applications By Sept. 1

The NCI Cancer Prevention Fellowship Program is accepting applications for Cancer Prevention Fellows through Sept. 1.

The program provides the opportunity to obtain an MPH degree at an accredited university during the first year, followed by mentored research with investigators at NCI. Research opportunities exist across the spectrum of cancer prevention research, including: epidemiology, biostatistics, clinical services, laboratory, nutritional, and social and behavioral sciences. The program 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 (year 1: master's degree; years 2-4: NCI Summer Curriculum in Cancer Prevention and mentored research).

Applicants should meet the following eligibility criteria: Possess an MD, PhD, JD, or other doctoral degree in a related discipline or must be enrolled in an accredited doctoral degree program and fulfill all degree requirements by June 2011; be a citizen or permanent resident in the U.S. at the time of application; and have no more than five years relevant postdoctoral experience.

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

Other NIH Announcements

Listed below are some NCI opportunities and other items of potential interest to cancer researchers.

Clinical Proteomic Technologies for Cancer Initiative: Proteome Characterization Centers (U24) (RFA-CA-10-016) Application Receipt Date: Sept. 29. http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-10-016.html

Advancing Novel Science in Womens Health Research (R21) (PAS-10-226) Application Receipt/Submission Dates: Oct. 16 and Nov. 16. http://grants.nih.gov/grants/guide/pa-files/PAS-10-226.html

Request for Information: Clinical and Translational Research Infrastructure in Institutional Development Award (IDeA) Program Institutions (NOT-RR-10-010) http://grants.nih.gov/grants/guide/notice-files/NOT-RR-10-010.html.

Notice to Highlight Current NIH Funding Opportunities that Promote Research on the Human Health Effects of Climate Change (NOT-TW-10-008) http://grants.nih.gov/grants/guide/notice-files/NOT-TW-10-008.html

For a complete weekly list of NIH funding opportunities, see http://grants.nih.gov/grants/guide/index.html.