THE CANCER LETTER

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First Round of Cooperative Group Mergers Falls Short of Meeting NCI's Stated Goal

By Paul Goldberg

As NCI prepares to shrink the number of cooperative groups, the leaders of several groups are negotiating consolidations.

• Three groups—the Cancer and Leukemia Group B, the North Central Cancer Treatment Group and the American College of Surgeons Oncology Group—are discussing a merger.

• The National Surgical Adjuvant Breast & Bowel Project and the Radiation Therapy Oncology Group are similarly negotiating combining their operations.

NCI's goal is to consolidate its nine cooperative groups studying adult cancer to four (The Cancer Letter, Dec. 17, 2010). If these consolidations

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Cancer Centers vs. Community Care:

Fox Chase Publishes Its Cancer Survival Data; The Move is Partly Science, Partly Marketing

By Paul Goldberg

Fox Chase Cancer Center earlier this week published data that showed that the center produced better survival outcomes than community-based hospitals.

The decision to publish these data makes Fox Chase a newcomer in a small group of academic centers as they make the case for patients to choose them over community oncology clinics.

Some data show that specialized centers can produce better outcomes although there are some limitations in comparing outcomes in academic and community settings.

"In these charts, people will see that patients receiving care at Fox Chase Cancer Center have superior outcomes compared to individuals treated for the major cancers in community hospitals," said Michael Seiden, president and CEO of Fox Chase Cancer Center. "We have always believed that our singular focus on understanding, preventing, and treating cancer leads to a higher overall standard of care, and the figures, on the whole, bear that out."

The cancer center's data are posted at www.foxchase.org/outcomes

Institutions involved in cancer care are increasingly publishing varying amounts of outcomes data, with varying degrees of interpretation. The centers that publish such data include:

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The Place of GOG, ACRIN Uncertain in Consolidation

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take place, the number of groups would stand at six, two more than the institute's maximum.

The chairs of two of the largest groups—Southwest Oncology Group and Eastern Cooperative Oncology Group—said they have no active plans to merge with any other groups.

If NCI sticks to its goal, another round of mergers or elimination of groups will be required. The candidates for mergers are the American College of Radiology Imaging Network and the Gynecologic Oncology Group.

GOG Argues Against Merger

GOG recently it asked the institute to spare it from being absorbed.

"The dismantling of the current structure of the GOG will produce a dramatic down-turn in the scientific study of gynecologic cancers," the group said in a "white paper" addressed to NCI officials and signed by chairman Philip DiSaia. "The make up and function of the GOG is unique (as is the Children's Group), and it will not merge easily with other groups.

"The structure in any reorganization must preserve its current operational integrity," the document states. "If in fact the purpose of the reorganization is to improve operational efficiency, it makes far more sense to retain the GOG as one of the adult groups because of its unique features, its ability to conduct trials that have not been successfully conducted in settings such as the broad medical oncology groups.... To do otherwise is to risk having no active effort to study effectively gynecologic cancers that affect substantial numbers of women in the United States and elsewhere."

"CALGB, NCCTG and ACOSOG are discussing an alliance of the three groups that is responsive to the recommendations of the Institute of Medicine," Monica Bertagnolli, chair of CALGB, said to The Cancer Letter. "This is a challenging but exciting process that is resulting in promising new collaborations."

The proposed reorganization is NCI's response to the Institute of Medicine report earlier this year recommending wide-ranging changes in the cooperative groups and NCI's interaction with the groups (The Cancer Letter, April 16, 2010).

The NSABP-RTOG talks were described in a brief letter to NSABP members, signed by group chairman Norman Wolmark.

"I would like to make you aware that we have been in discussion with Dr. Wally Curran, chair of RTOG, to explore an alliance between our two organizations," Wolmark wrote in the letter dated Jan. 3. "As the year closed, we had a teleconference with our full board of directors to secure their agreement to go forward with these discussions.

"The board unanimously (with one abstention) endorsed this course of action. Accordingly, we will arrange a series of meetings to develop a plan to formalize a cooperative structure that can be approved by the board.

"Dr. Curran and I agree on the general principles related to the future organization of the groups, and we will work closely with his staff and members of the NCI to develop a strong scientific and administrative platform on which the two groups can build for the future.

"We will keep you informed of our progress and look forward to our Annual Meeting at the end of March when I will have the opportunity to talk with you directly.

SWOG, ECOG Not Seeking Mergers

Meanwhile, the leaders of two of the larger groups—Southwest Oncology Group and Eastern Cooperative Oncology Groups—say they aren't contemplating mergers.

"If you are asking me whether SWOG is merging with anyone, the answer is no," group chairman

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Laurence Baker said to The Cancer Letter.

Robert Comis, chairman of ECOG, said his group isn't engaged in merger talks.

"We aren't really contemplating any sort of a merger at this point, but we are talking with others about how we can strengthen some of our positions," Comis said. ECOG intends to focus on developing studies based on biomarkers, Comis said.

"We know from the experience of Children's Oncology Group that any type of merger or consolidation takes a tremendous amount of time and effort," Comis said. "We can't spend the next five years in chaos."

Late last year, GOG explored a merger with ECOG. "My people didn't like that idea, because they felt they would become just another committee in a large structure and kind of be swallowed up," DiSaia said to The Cancer Letter.

DiSaia said he doesn't agree with the rationale for limiting the number of adult groups to four. The prospect of what DiSaia calls "an open marriage of three" with NSABP and RTOG doesn't sound terribly enticing either.

"I see the future being best with us not being married to people who don't want us," he said. "We are as different as apples, oranges and cumquats. If you were to have a merger, you should merge ECOG and SWOG. They do the same things. CALGB does the same things. NCCTG does the same things.

"We are like the children's group. We don't do what everybody else does." The document is posted at http://cancerletter.com/categories/documents.

ACRIN's place in the new structure is unclear as well.

"From the ACRIN perspective we have been struggling to see where we might best fit in," group chairman Mitchell Schnall said to The Cancer Letter. "We are very different than most of the other groups in many respects including scientific focus, structure and funding source."

The group is funded through the NCI Cancer Imaging Program, as opposed to the Cancer Therapy Evaluation Program, which funds the rest of the cooperative groups.

"We have been in exploratory talks with at least two other groups and will be discussing strategy at a meeting of our leadership next week," Schnall said.

"Our goal is to find an opportunity to strengthen our program through better engagement to the broader clinical cancer research community, while protecting what we think is an important and unique research agenda."

Centers Post Survival Data To Claim Better Outcomes

(Continued from page 1)

• The Cleveland Clinic Taussig Cancer Institute: http://my.clevelandclinic.org/Documents/outcomes/2009/taussig-2009-outcomes.pdf.

• Roswell Park Cancer Institute: http://www.roswellpark.org/search/apachesolr_search/cancer%20Quality%20Outcomes.

• Northwestern Memorial http://www.nmh.org/nm/quality+view+report+card.

• MD Anderson Cancer Center: http://www.mdanderson.org/patient-and-cancer-information/cancer-information/cancer-types/lung-cancer/outcomes-data.html.

• Vanderbilt-Ingram Cancer Center used to publish survival data on its website, but the information was removed because it had become outdated, said Dagny Stuart, a spokesman. "We intend to post the data again at some point in the future," Stuart said. "We are currently engaged in a redesign of our overall online strategy and the patient outcomes data will be included in that process."

• Cancer Treatment Centers of America, a for-profit group, publishes its data, posted at: www.cancercenter.com/cancer-statistics.cfm.

Epidemiologists have long ago noted that patients who receive care in the context of clinical trials may do better than patients treated off-protocol, perhaps because their doctors follow treatment regimen with greater rigor.

Also, patients who seek care at cancer centers and are willing to travel may be insured, better educated and more motivated to discover their disease early, and early diagnosis can increase survival even when mortality remains unchanged.

The figures released by Fox Chase reflect five-year survival rates for patients diagnosed at the different stages of breast, colorectal, lung, and prostate cancers. Only patients who received care at Fox Chase are included in the statistics.

These numbers are compared with survival data from both small and large community hospitals across the country, using statistics from the National Cancer Data Base, maintained by the American College of Surgeons.

Seiden attributes better outcomes to Fox Chase's patient volume and its exclusive focus on cancer. Fox Chase, an NCI-designated Comprehensive Cancer Center, treats more than 32,000 oncology patients a

year, including 7,600 new patients.

The Cancer Letter *asked Seiden to discuss the outcome data and the decision to publish them. The interview was conducted by editor Paul Goldberg:*

TCL: When did you decide to do this study?

MICHAEL SEIDEN: We are part of a couple of different groups. We are obviously an NCI-designated comprehensive cancer center.

We are also part of the NCCN and we're also part of the Alliance of Dedicated Cancer Centers. All three of those groups collect aggregate data on patient outcomes, particularly in the more common cancers, and we look for things like best practices.

We've been aware for years that our data compares favorably to these other groups that I mentioned, but in general compares very favorably to a variety of national databases, such as the Surveillance, Epidemiology and End Results database and community cancer databases.

And that began a discussion over a year ago about whether we should make these data publicly available.

We were aware of a few other centers that had begun to put their data out, initially just to referring physicians.

So that began essentially a one-year dialogue at Fox Chase, with a variety of opinions about the advantages and disadvantages of doing this.

About four or five months ago, we were interested in learning more about how patients made cancer care decisions, and we engaged an independent firm to ask some questions—not of cancer patients but of citizens—in southeast Pennsylvania, northern Delaware and central New Jersey.

They were asked, "If you or a loved one had cancer, how would you make decisions about seeking care?

"What's most important? Location, private rooms, good nurses, reputation of the doctors, outcomes, price?"

In this survey the number one answer was "Clinical outcomes." As the world becomes more information-seeking, and as the national dialogue about paying for quality intensifies, as people think that, "Gee, if I had cancer, this is the most important thing I'd want to know." We realized we've been collecting these data for decades. We made a decision that we should begin posting them.

TCL: Do you view this as epidemiology or do you view this as marketing?

MS: It fits in the middle.

I think the hard-core statisticians will tell you the comparisons are not perfect. First of all, it's data collected between 1998-2002.

And that's partly because we wanted to compare them honestly to the exact same data in a national database, and that data takes a while to get collected from all the community hospitals and get deposited in the national databases. So the data are somewhat dated. And this isn't a randomized trial. Some people would argue that it's a little like comparing an apple to an orange.

TCL: Also, you are measuring survival, as opposed to mortality.

MS: Right.

TCL: You are also running into selection bias.

MS: Of course, right.

People who are healthy enough to come to comprehensive cancer centers probably are a little younger; probably have a little less co-morbid disease. So it's not a perfect comparison.

TCL: But there's still something there?

MS: We believe there's something there. I think the data—each disease, each stage—potentially has a sub-story.

But there are plenty of examples in the literature that suggest if you take care of very high volumes of patients with complex diseases, and bring in nurses and physicians who spend a very high percentage of their time doing just that one thing, whether it's replacing hips, or taking out prostates—there probably is a measurable difference in outcomes compared to someone for whom that's one of 32 things they do.

So we find it completely believable that the outcomes are better.

But you can make arguments about [the data], that it isn't perfectly an apple compared to an apple.

TCL: How do you separate selection bias from what might be actually there?

MS: That was part of the one-year discussion. Should we adjust our curves? Should we age match them, should we co-morbidity match them, things like that.

There were two things we considered. First of all, we felt that if we adjusted our curves, we felt we would be accused of monkey business—we threw out this, we threw out that. So we decided to not adjust our curves.

The second thing is, when you come up with a list of everything you might possibly want to adjust for, a lot of that is not in the community databases.

So we said we'll essentially download their curves and we'll download our curves and we won't adjust them.

We'll just accept the fact that they are the not the exact same populations, maybe the ages are slightly

different, maybe the co-morbidities are slightly different. Wealth, gender, education—all those things might be different. It's hard to correct for them perfectly.

And you know, we tried not to over-editorialize. We tried to say: here is how our patients with stage II breast cancer did over this time period compared to nationally available cancer database curves.

TCL: Has anyone done this before? Any of the cancer centers?

MS: There are a few centers that are beginning to do this. We also know, because of our participation in a variety of groups, that a number of the other cancer centers are discussing this.

I think this might be viewed by some as marketing to consumers, but I think other people might argue it's being responsible:

The centers have these data, shouldn't patients have access to it?

In fact, the only email I've gotten from a patient has been, "Well, what about my cancer?" because it wasn't one of the four most common cancers. "I want to see those curves."

TCL: So it's working, whatever it is?

MS: I guess the other consideration is whether coming to a comprehensive cancer center potentially has a higher economic cost and whether that's justified.

More gas to get there, more time away from work—perhaps because you participated in the clinical trials—perhaps different co-pays, different out of pocket costs. We don't know what exactly what our charges are compared to our competitors, because that's illegal.

But the government, the payers, the patients are allowed to say, if it's more of a hassle for me to drive to get to participate in the care at this comprehensive cancer center, which is considerably farther than the community hospital that's 10 seconds away, that's a cost. Do I get something for that cost?

TCL: And you kind of do; don't you?

MS: I believe you do. But a critic or a skeptic might say, "Well, prove it."

And we can respond: "Well, we have our survival data, and we can compare that to national survival data."

TCL: And then you can have the conversation we just had.

MS: Right. So that's why we felt people would say the curves aren't perfect.

But we do have these data—they are imperfect data, but they are our data.

We aren't going to compare ourselves to any particular hospital, but we can say, "Here is data from a national database, and here's our data—that's it."

The Duke Scandal:

Lancet Oncology Yanks Paper; NEJM Says "No Retraction"

By Paul Goldberg

The February issue of The Lancet Oncology this month published a retraction of a paper by the Duke genomic researchers.

The journal had earlier published an expression of concern about the paper, by Bonnefoi H, Potti A, Delorenzi M, et al., "Validation of gene signatures that predict the response of breast cancer to neoadjuvant chemotherapy: substudy of the EORTC 10994/BIG 00-01 clinical trial," Lancet Oncol 2007.

Early in the controversy, Joseph Nevins, the mentor of the disgraced Duke genomic researcher Anil Potti, described that paper—incorrectly—as blinded validation of the group's work.

The retraction, published in the February issue of the journal reads:

The Lancet Oncology and the European co-authors of the article mentioned above, recently expressed concern over the validity of the results. The chemotherapy sensitivity predictions reported in the Article were based on an approach described by Anil Potti and colleagues in Nature Medicine.

Re-examination of the validation datasets used for the Nature Medicine study has uncovered errors in the labeling of the clinical response in some of the datasets. Reanalysis of the predictive accuracy with correctly labeled data has shown that in two instances the reported signatures do not predict the response of the validation samples to chemotherapy.

The authors of the Nature Medicine paper have therefore decided to retract that paper. Because the Article published in The Lancet Oncology was based on the approach reported in the Nature Medicine paper, we have decided to retract The Lancet Oncology paper. We apologise to readers for any inconvenience caused by the publication of our paper in the Lancet Oncology."

Duke Seeks Closure on Publications

In a letter to Potti's co-authors, top Duke officials are seeking to establish the names of persons responsible for data management, statistical analysis and interpretation of the results.

The letter, dated Jan. 27, was signed by Robert Califf, vice chancellor for clinical research and director of the Duke Translational Medicine Institute, and Huntington Willard, director of the Duke Institute for Genome Science and Policy.

Until this piece of correspondence, Potti's mentor Nevins took the lead in dealing with correcting the academic medical record. However, two weeks ago, Duke officials announced that the IGSP center, which was headed by Nevins and which employed Potti, had been abolished.

Also, FDA officials were on the Duke campus auditing the data from clinical trials that used genomic technology to determine treatment for patients enrolled in phase II trials. Duke hadn't obtained an Investigational Device Exemption—an equivalent of an Investigational New Drug—license to conduct the trials (The Cancer Letter, Jan. 28).

The text of the letter to co-authors follows:

In keeping with our institutional commitment and mandate to maintain public trust, and to be prepared to respond to any future inquiries, we request that you confer with your fellow coauthors on each manuscript and assure that you can identify the person or persons responsible for the data management, statistical analysis, and interpretation of the results.

Based on the requirements for authorship, we ask you to attest that you are confident that these elements of the manuscript are appropriate, accurate, and free of improper manipulation.

If you cannot do so, we will work with you to reach the point of either assuring that the paper and its results are reasonable or retracting the article. We have attached the publicly available International Committee of Medical Journal Editors rules of authorship, which do not require that you are able to attest to the details of data management and analysis, but do require that you are able to identify who is responsible for these aspects of the publication.

We therefore ask that you review the article or articles in question, identify the responsible individuals, and obtain assurances regarding the quality of the data and the analysis. In order ensure that we as an institution as well as others in the scientific community can have confidence in the integrity of these papers, we will select a small number at random for a detailed review.

We apologize for any inconvenience this may cause. However, it is critical that we quickly determine and, if necessary, resolve any additional issues related to Dr. Potti's work.

We are committed to the restoration of the organization's focus to the important, high-quality science that is the reason you joined Duke.

We know that this request may come as a bit of a surprise, but we pledge to do what it takes to support you through this.

Papers in Question

An attachment to the letter asks co-authors to identify persons responsible for data management, statistical analysis and interpretation of statistical analysis.

The co-authors are asked to sign the following statement: "I attest that the rules of authorship have been met and I have confidence that data management, statistical analysis and interpretation are appropriate, accurate and free of inappropriate manipulation."

According to the PubMed database, Potti and Nevins together are listed as authors on 30 scientific papers. In addition to The Lancet Oncology paper, two other papers have been retracted.

• Hsu DS et al., "Pharmacogenomic strategies provide a rational approach to the treatment of cisplatin-resistant patients with advanced cancer," J Clin Oncol. 2007 Oct 1;25(28):4350. This paper was retracted. The retraction is posted at http://jco.ascopubs.org/content/25/28/4350/suppl/DC2

• Potti A et al. "Genomic signatures to guide the use of chemotherapeutics," *Nature Medicine* 17, 135 (2011) doi:10.1038/nm0111-135. The retraction is posted at http://www.nature.com/nm/journal/v17/n1/full/nm0111-135.html

However, one key Duke paper—published by the New England Journal of Medicine in 2006—still stands.

"There have been no developments here since you last asked," Karen Buckley, an NEJM spokesman, said to The Cancer Letter. "We still have no plans to retract the paper."

FDA News:

FDA Clears Sodium Fluoride F18; Tracer to Be Used in Bone Scans

FDA has approved a New Drug Application from NCI for a new strength of a previously approved drug, Sodium Fluoride F18, for use in bone scans.

In contrast to Technetium-99m (Tc-99m), which has been the only approved radioactive tracer for bone scans, Sodium Fluoride F18 is not subject to the supply problems that have led to recent nationwide shortages of Tc-99m.

Many diagnostic imaging tests, including bone scans that utilize Single Photon Emission Computed Tomography, require the use of Tc-99m.

Sodium Fluoride F18 was approved in 1972 but withdrawn in 1975, when the less expensive tracer Tc-99m became available. Tc-99m is derived from molybdenum-99 (Mo-99), which is made mostly in

highly enriched uranium nuclear reactors.

Since both Mo-99 and Tc-99m have fairly short half-lives (66 hours and six hours, respectively), these drugs cannot be stockpiled.

Seven nuclear reactors worldwide currently produce Mo-99 for medical use, with much of the U.S. supply coming from a nuclear reactor in Canada that has had frequent outages, the latest one lasting more than a year.

Although Sodium Fluoride F18 is more expensive than Tc-99, it can be produced in medical cyclotrons, which are available at many academic universities and commercial suppliers in the U.S.

This drug also provides better images because it uses Position Emission Tomography instead of SPECT imaging, allowing for improved, earlier detection.

The previous strength of Sodium Fluoride F18 was discontinued for market reasons, not for reasons of safety or efficacy.

NCI officials said they hope that multiple companies and institutions will submit Abbreviated New Drug Applications so that generic versions of the drug can be produced, allowing for a reduction in cost.

A decision by the Centers for Medicare & Medicaid Services regarding coverage for the agent was posted on Feb. 26, 2010, https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

The agency allowed Coverage with Evidence Development, and a formal registry is being established by the National Oncologic PET Registry.

In the Cancer Centers:

UCSF Receives $20 Million Gift For Stem Cell Research Building

THE UNIVERSITY OF CALIFORNIA, San Francisco, received a $20 million donation from **Ray and Dagmar Dolby** to build a stem cell research building on the Parnassus campus. It will be named the Ray and Dagmar Dolby Regeneration Medicine Building.

The facility will be the headquarters of the Eli and Edythe Broad Center of Regeneration Medicine and Stem Cell Research at UCSF. At full capacity, the building will house 25 laboratories. The Dolbys previously donated $16 million for the construction of the $123.3 million center in 2006.

CITY OF HOPE received a $2.5 million gift from the **Conrad N. Hilton Foundation** to establish the Barron Hilton Chair in Pediatrics**.**

City of Hope will recruit a department chair to lead pediatric cancer research and treatment programs.

The foundation most recently donated $2 million to support the institution's transfusion medicine center. The foundation also gave $1 million to establish the Conrad Hilton Research Building, which opened in 1986.

THE OHIO STATE UNIVERSITY Comprehensive Cancer Center was awarded the highest rating—"exceptional"—from **NCI.**

The center includes the James Cancer Hospital and the Solove Research Institute. NCI has renewed the university's designation as one of 40 comprehensive cancer centers in the U.S. for another five years.

MD ANDERSON CANCER CENTER received the Bill Aston Award for Quality from the **Texas Hospital Association.**

The center was recognized for lowering its rate of intensive care unit ventilator-associated pneumonia to zero, for the past two years. In 2002, the rate of ICU pneumonia cases was 34.2 per 1,000 ventilator days, almost double the national average. VAP can increase ICU stay by over three weeks, and it has the highest mortality rate of healthcare-related infections.

MEMORIAL SLOAN-KETTERING Cancer Center plans to open an outpatient facility in Westchester County. The center has filed an application with the NYS Department of Health for an 114,000-square-foot treatment center in Harrison, NY.

The center would provide services to detect, diagnose, treat and support cancer patients—with medical, neurologic and radiation oncology; diagnostic radiology; surgical consultations; dermatology; high-risk cancer screening; and survivorship programs. The facility is scheduled to open in early 2015, with a staff of 140. Memorial Sloan-Kettering has regional care centers in Long Island, Westchester County, and northern New Jersey.

TGen DRUG DEVELOPMENT (TD2) of Scottsdale, Ariz., and **Oncoholdings Inc.** of Syracuse, NY., announced a partnership to develop anti-cancer agents.

Under the agreement, TD2—a subsidiary of the Phoenix-based Translational Genomics Research Institute—will be the exclusive development partner for Oncoholdings' oncology portfolio. The company said it

plans to develop as many as 15 early-stage drugs over the next three years.

ROSWELL PARK CANCER INSTITUTE and **KING FAHAD SPECIALIST HOSPITAL** of Dammam, Saudi Arabia, signed a formal agreement under which RPCI will train KFSH clinicians, scientists, nurses and support staff.

Trainees will stay at RPCI for periods ranging from three weeks to three years, and RPCI's Office of International Collaboration will coordinate the implementation and monitoring of the program. KFSH has identified more than 55 faculty and staff who are candidates for training at RPCI over the next two years.

NIH News:

NIH Gives $6.7 Mil. Grant To Chicago Health Network

ACCESS COMMUNITY HEALTH NETWORK of Chicago received a $6.7 million Clinical and Translational Science Award grant from NIH. The goal of the center's research will be to engage the community and reduce racial and ethnic disparities in health care.

Through its Roadmap Initiative, NIH intends to transform how research is conducted by encouraging researchers to connect with communities. ACCESS, the largest network of federally-qualified health centers in the U.S., is one of only three non-academic organizations to receive one of NIH's community-based research grants.

ACCESS' research center—the first-ever for a federally-qualified health center network—will be located in Chicago's Englewood neighborhood, where residents have high rates of diabetes, heart disease and cancer, and will directly benefit from the research conducted at the center.

ACCESS said it plans to break ground on the 17,000-square-foot research center in early 2011 and complete construction a year later.

Advocacy Groups:

Ex-CNN Anchor Judy Fortin Moves To ACS Media Job

JUDY FORTIN, former CNN medical correspondent and anchor has joined the **American Cancer Society** as national director of media relations.

Fortin worked as a reporter for CNN's Medical Unit and Headline News for 16 years, winning awards for her reporting from medical organizations such as the National Marrow Donor Program and the American Academy of Orthopaedic Surgeons, as well as an Emmy Award for CNN's coverage of the Oklahoma City bombing. Fortin will be responsible for developing and implementing news media relations strategies in Atlanta.

JOHN SEFFRIN, CEO of the American Cancer Society, was appointed by the White House to the advisory group for the **National Prevention, Health Promotion and Public Health Council.**

THE NATIONAL LUNG CANCER PARTNERSHIP has announced the winners of its **2011 Young Investigator Research Grant** competition. Grant recipients will receive $100,000 towards their research.

They are: **Peter Hammerman** of Dana Farber Cancer Insititute; **James Kim** of Stanford University; **Claire Simpson** of NIH; **Puneeth Iyengar** of UT Southwestern Medical Center; **Celine Mascaux** of the University of Colorado-Denver; and **Sunil Singhal** of the University of Pennsylvania.

THE HOPE FUNDS FOR CANCER RESEARCH announced its 2011 Award of Excellence honorees.

They are: **Joan Massagué**, for basic science; **Kenneth C. Anderson**, for clinical development; **Larry Norton**, for medicine; **Ellen Stovall** for advocacy; and **Donald J. Listwin**, for philanthropy.

Massagué holds the Alfred P. Sloan Chair in the Cancer Biology and Genetics Program at Memorial Sloan-Kettering Cancer Center, and is also a professor at the Weill Cornell Graduate School of Medical Sciences.

Anderson is the Kraft Family Professor of Medicine at Harvard Medical School and director of both the LeBow Institute for Myeloma Therapeutics, and the Jerome Lipper Center for Multiple Myeloma at the Dana-Farber Cancer Institute.

Norton is deputy physician-in-chief for breast cancer programs at Memorial Sloan-Kettering Cancer Center, medical director of the Evelyn H. Lauder Breast Center, and the Norma S. Sarofim chair in clinical oncology.

Stovall is the senior health policy advisor at the National Coalition for Cancer Survivorship, and a three-time survivor of Hodgkins disease.

Listwin is founder and chairman of The Canary Foundation, a non-profit organization focused on funding early cancer detection research.

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COMPREHENSIVE CANCER CENTER
UNIVERSITY *of* CALIFORNIA · IRVINE
A National Cancer Institute-Designated Comprehensive Cancer Center

DEPUTY DIRECTOR POSITION AVAILABLE

The University of California, Irvine is recruiting a physician scientist for a tenured position at the associate or full professor level who will also be the Deputy Director of the Cancer Center. We are seeking an experienced translational scientist with an established research program focused on either basic/translational investigations or clinical/translational science. This is a senior leadership position within a National Cancer Institute designated Comprehensive Cancer Center. Responsibilities of the selected individual would include:

(1) Conducting a translational research program with external peer-reviewed funding.
(2) Bridging basic, clinical and cancer control research among the 6 research programs with the goal of facilitating translational programs, P0-1s, SPOREs and similar multi-investigator grants and contracts.
(3) Providing senior leadership for the physician-scientists and clinical investigators in the Center.
(4) Managing the clinical research infrastructure within the center.
(5) Representing the Cancer Center throughout the campus and greater community.

As the current long-term Director has announced his departure from this role following the next CCSG review, responsibilities of the Deputy Director will expand in the near future to include transitioning the Center with new leadership.

Applicants must hold an MD or equivalent degree, be board certified in their cancer related sub-specialty, and be eligible to obtain an active license to practice medicine in the state of California.

For more information, contact Krista Hollinger, MPH at kholling@uci.edu.

Application Procedure: Interested candidates must submit a cover letter, curriculum vitae, statement of research, statement of teaching, and contact information for 3-5 references via the University of California's Academic Personnel RECRUIT system at http://recruit.ap.uci.edu. Please reference OEOD# 5012.

The University of California, Irvine has an active career partner program and an NSF ADVANCE Program for Gender Equity and is an Equal Opportunity Employer committed to excellence through diversity.