THE CANCER LETTER

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

Vol. 37 No. 22
June 3, 2011

Physicians Accept Plans by City of Hope To Pay for Services Through New Foundation

By Paul Goldberg

After nearly two years of wrangling, City of Hope has purchased the assets of the California Cancer Specialists Medical Group.

The deal that concluded May 31 terminates a long-standing arrangement under which an off-campus, for-profit group managed over $100 million worth of patient care, research and teaching functions at the NCI-designated comprehensive cancer center.

As a result of concluding the deal, these activities will be conducted through a non-profit called the City of Hope Medical Foundation.

"This will enable us to have a single, coordinated, integrated operation," Michael Friedman, president and CEO of the institution and director of its cancer center, said to The Cancer Letter. "We want to create a seamless alignment for the future, not to have different parties with different agendas, but to have a group of physician leaders deeply involved in the organization."

(Continued to page 2)

In the Cancer Centers:

Reaman Named Associate Director of OODP; Potti Joins Myrtle Beach, S.C., Private Practice

GREGORY REAMAN was named associate director of the **FDA Office of Oncology Drug Products**.

Reaman served two five-year terms as the first elected chair of Children's Oncology Group and is a former member of the FDA Oncologic Drugs Advisory Committee. He retains his academic appointment as professor of pediatrics and medicine at George Washington University and his clinical appointment at Children's National Medical Center.

At FDA, he reports to office director Richard Pazdur.

ANIL POTTI joined the **Coastal Cancer Center**, a private practice with offices in Myrtle Beach and Conway, S.C.

Potti was a genomic researcher at Duke University whose papers have been retracted by several journals, including The New England Journal of Medicine, Nature Medicine, The Journal of Clinical Oncology and The Lancet Oncology. His career suffered a setback after this publication reported that he had claimed incorrectly to have been a Rhodes Scholar.

He subsequently resigned from Duke, and recently he hired an online reputation management firm, which posted positive news items about him (The Cancer Letter, April 15).

(Continued to page 7)

Parties Ironed Out Differences After Judge Denied Injunction

(Continued from page 1)

"What sort of things are we going to need to do in the future to be successful? We are going to have to have greater efficiency. We are going to have to have greater coordination. There will be expected outcomes measures," said Friedman. "This is an opportunity to work together to create a new shared future was so attractive that the majority of physicians in medical group realized that this was a great opportunity."

The foundation would be able to compensate faculty members for different "baskets" of achievements and activities. For example, doctors and scientists who publish in higher-profile journals could receive higher pay, as could doctors who produce better outcomes or make better use of evidence-based medicine.

Nearly the entire medical staff—182 of about 200 physicians—chose to renew their employment contracts.

"People are here because they want to make a difference, and I was reassured as the vote came in that they chose to do that," said Stephen Forman, chair of hematology and hematopoietic cell transplantation at City of Hope, who was one of the five negotiators who hammered out the agreement that was ultimately accepted by the administration and the practice group.

"They saw that the model we put together and the way it was structured would allow them to make a difference."

Forman—who is also the Francis and Kathleen McNamara Distinguished Chair in Hematology and Hematopoietic Cell Transplantation, co-leader of the Hematologic Malignancies Program, and clinical director of cancer immunotherapeutics and tumor immunology—represented the practice group in the negotiations.

The former arrangement between the center and the Monrovia-based independent practice group was created by a California law that bars "corporate practice of medicine," by prohibiting hospitals from hiring physicians directly.

The law—intended to protect the doctor-patient relationship—also makes it harder for hospitals to integrate their information systems and coordinate services.

Hospitals that have medical schools are exempt from this provision of the law and are allowed to employ doctors directly. However, Duarte-based City of Hope has no medical school, and its strategy for asserting greater control over its activities was to create a foundation that would contract with a physician group.

Many major medical centers in California—including Cedars-Sinai, Scripps, Catholic Healthcare West and Sutter Health—have established successful medical foundations. The terms of this week's transaction were not disclosed.

The for-profit group previously controlled considerable business.

In 2009, $35 million in teaching, administration, and research funds went from City of Hope to the medical group, which then cut the checks to the doctors. The group generated another $70 million from standard practice management work.

Under the just-concluded deal, City of Hope will purchase an outpatient facility in South Pasadena and practices in Antelope Valley, Glendale and Santa Clarita.

City of Hope administrators said that having to deal with an independent for-profit entity made it difficult to recruit academic oncologists.

The California Cancer Specialists Medical Group often prevented the administration from offering anything more than two-year contracts, and sometimes prevented hiring specialists who practiced in less profitable areas of medicine, such as psychology, psychiatry and palliative care, administration officials said.

The institution was unable to compensate its physicians directly, even under NIH grants.

Also, the practice group and the medical center maintained separate human resource departments, separate IT infrastructures, separate quality committees.

THE CANCER LETTER

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Editorial, Subscriptions and Customer Service:
202-362-1809 Fax: 202-379-1787
PO Box 9905, Washington DC 20016
General Information: www.cancerletter.com

Subscription $395 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc. Founded Dec. 21, 1973, by Jerry D. Boyd.

Controversy Began in September 2009

To streamline operations, starting in September 2009, the City of Hope administration took a series of gutsy moves. At that time, City of Hope informed the medical group that its contract with CCSMG would not be renewed when it expires on Jan. 31, 2011, court documents show.

First, the administration attempted unsuccessfully to buy out the group's shares and rehire all the CCSMG physicians as well as its administrative staff. The group's resistance to moving to the hospital is rooted in history: it had operated on-campus before, but in the late 1990s, the group became truly independent, moving off-campus—and prospered.

Negotiations between the practice group and City of Hope broke down last spring, and on May 3, 2010, the group filed a lawsuit against the center.

The group claimed that the foundation schema envisioned by the City of Hope would not be sufficiently independent to comply with state law and, therefore, physicians who join the planned foundation may be practicing without proper licenses.

In a countersuit, City of Hope pointed out that the foundation had not been formed, and thus was not ripe to be declared illegal. Besides, other hospitals in the state similarly rely on foundations, the suit contends.

When efforts by City of Hope to buy out the group failed, the administration started work on creating another, separate practice group, called Oncology Specialists of COH. This new group, known as OSCOH, was headed by Alexandra Levine, chief medical officer at City of Hope.

The battle between the administration and CCSMG grew so intense that at one point the practice group sent a mass mailing to 10,000 patients, claiming that the institution's actions would place "clinical and research programs at risk."

Doctors employed by CCSMG, too, were warned that any discussion of career opportunities with OSCOH would trigger breach of contract actions that would be brought against them by the practice group. (The standard contract between the doctors and the practice group contains a non-compete clause.)

For doctors, this created a serious problem, as many of them were less interested in maximizing compensation than in maintaining their COH appointments and continuing research.

On Oct. 28, 2010, California Superior Court Judge Mary Strobel, denied the CCSMG motion for a preliminary injunction. The ruling stated that City of Hope's relationship with OSCOH would be unlikely to violate the California law that prohibits corporate practice of medicine.

After the injunction was denied, the medical group held a meeting.

"They were discussing what to do next, and somebody suggested that we should have a group that would get together with the COH administration and see what can be done, given the facts on the ground," Forman recalled.

The prevailing feeling was to nominate a group of practice members to try to come up with a negotiated solution with the City of Hope administration.

Ruling Brings Parties to the Table

The practice group nominated Forman and two people who had not been involved in previous negotiations. None of the three doctors had been involved in negotiations before.

Besides Forman, the group included Jeffrey Wong, chair of radiation oncology, and David Josephson, assistant professor of surgery, urology and urologic oncology.

"We are not either contaminated by or would be perceived as contaminated," Forman said. "We said that we would do this, and I had certain conditions."

First, Forman made it clear that he would go into discussion on the presumption that the negotiators would be developing a structure based on the foundation model.

"We wanted to develop it in terms of how it was governed, how people were compensated, how people were promoted, how they were supported in their work," he said. "Those were the details that I had my sleeves rolled up trying to resolve."

Forman's second condition was that there would be no lawyers in the room.

"I felt that if we brought lawyers into it too early, that would contaminate the very hard discussions," he said.

Forman realized that the future of City of Hope was at stake.

"My impression is that anybody who had any real academic fire in their belly was trying to stay, and my job was to help create an atmosphere in which they could continue to work, hopefully being treated in a respectful way, both in terms of compensation and for the work they do."

On the administration's side, the negotiations were handled by Alexandra Levine and Chief Strategy and Administrative Officer Robert Stone.

"We knew we would be talking to Robert and Alexandra, so we spent a lot of time deciding how we

are going to even talk to each other," Forman said.

"One of my fears was that people were so emotionally overwrought, we didn't know whether it was possible to have discussions. We could have quit on the first night."

The five negotiators met regularly for about two months, sometimes starting at 3 p.m. and hammering out the details till 3 a.m.

"We began to meet, long, hard, day after day, going through every issue and making no assumptions about what had to be the case or not based on any prior commitments, discussions, biases, hurt, pain, emotional travail or anything that was going to contaminate the discussion," Forman said.

"We basically only stopped when we couldn't go any further from energy perspective. When we were moving along, I just kept us in the room so as not to lose any momentum. Sometimes we didn't get to the seesence of the issue, without any posturing or performance till midnight or 1 a.m., and if we were there, it made no sense to leave."

The deal was to keep the negotiations confidential, with neither the practice group nor the administration receiving briefings.

"We didn't discuss what was going on in these meetings with anybody," Forman said. "We created a certain mystique: what are those people doing in there? But we thought we had to do it that way or people would pick and nip at it."

Some issues the group tackled were practical, some were psychological.

For example, the negotiators had to decide which of the practice groups would survive. The question was, who would join whom?

"My solution to that was, neither," Forman said. "Dissolve both and start a new one, and you will invite physicians from both groups into the new group. What we did was allow the new group to retain the name of City of Hope Medical Group, which is what it should be."

Now that the deal has been completed, both practice groups have ceased to exist, and a new entity—City of Hope Medical Group—has been formed. The new group will contract with the medical foundation to provide patient care, teaching, administrative and research services.

The medical group board will consist of the 11 department chairs, the chief medical officer and three elected at-large physicians (one from the former Oncology Specialists Medical Group, one from one of the community practice sites, and one junior faculty member).

Levine will continue in her role as chief medical officer and will be a member of the new medical group's board.

The board will elect their officers at their first official meeting in mid-June.

The foundation's board will be made up by three people from the medical group, three people from the administration, one community person chosen by the administration and one community person chosen by the medical group.

This board will be charged with overseeing the entire operation, including long-term planning, adjudication of difficult issues. Stone will serve as chair of the foundation.

A full transition will take 12 to 18 months to complete, City of Hope officials said.

"There was a pattern of how we addressed questions during negotiations that I hope will be the method by which we work through questions and problems as we go forward," Forman said. "I don't think this is too farfetched to say that at the same time that we were helping to put together a solution we were practicing behavior that would be better than what was being done before.

"There is a lot of work to do over the next year."

FDA News:

Agency Takes ODAC Advice, Approves Second pNET Drug

By Paul Goldberg

FDA approved the Pfizer drug Sutent (sunitinib malate), as the first anti-VEGF therapy to treat progressive, well-differentiated pancreatic neuroendocrine tumors in patients with unresectable locally advanced or metastatic disease.

pNET is a miniscule indication. The disease occurs in two to four people per million annually.

This is the second new approval by the FDA to treat patients with this disease; on May 5, the agency approved the Novartis drug Afinitor (everolimus).

"FDA believes it is important to provide cancer patients with as many treatment options as possible," Richard Pazdur, director of the Office of Oncology Drug Products, said in a statement. "The agency is committed to working with companies to bring innovative new therapies to the market and encourages companies

to continue exploring additional uses for approved products."

The studies of both Afinitor and Sutent presented interesting methodological problems, and by approving the two drugs, the agency followed advice from the Oncologic Drugs Advisory Committee. On April 12, the committee voted unanimously 10-0 to recommend approval for Afinitor, and 8-2 to recommend approval for Sutent (The Cancer Letter, April 15).

The FDA approval of Sutent is based on data from the SUN 1111 phase III trial that demonstrated the drug provided a clinically significant improvement in progression-free survival, compared to placebo (10.2 versus 5.4 months, p=0.000146) in this patient population.

Treatment with Sutent also yielded a statistically significant improvement in tumor response, with an objective response rate of 9.3 percent (95% CI: 3.2, 15.4, p=0.0066). No objective responses were observed with placebo. In addition, while overall survival was not mature at the time of final analysis, nine deaths were observed in patients enrolled in the SUTENT arm versus 21 deaths in patients enrolled in the placebo arm.

In patients treated with Sutent for neuroendocrine pancreatic tumors, the most commonly reported side effects included diarrhea, nausea, vomiting, fatigue, anorexia, high blood pressure, asthenia, abdominal pain, changes in hair color, stomatitis, and neutropenia.

Sutent is also FDA-approved for metastatic renal cell carcinoma and gastrointestinal stromal tumor.

"This approval is good news for the physicians, patients and caregivers who have had limited treatment options for this rare and difficult-to-treat tumor," Mace Rothenberg, senior vice president of Clinical Development and Medical Affairs, Pfizer Oncology Business Unit, said in a statement.

FDA's decision to approve the drug was difficult because the registration trial was stopped early.

The trial was designed to enroll 340 patients. The first interim analysis was to be conducted at 130 PFS events, to assess safety.

Originally, the experiment was monitored by an internal "pharmaco-vigilance group" comprised of Pfizer employees who were independent of the study team.

However in 2008, while the trial was in progress, the company followed a guidance published by FDA and changed its standard procedures for monitoring trials.

It formed an independent data monitoring committee comprised entirely of outside experts, none of whom were Pfizer employees.

Such groups are charged solely with protecting the interests of patient, as opposed to the interests of sponsors.

The independent committee took a succession of looks, spaced at six-month intervals. The earlier reviews were conducted primarily for safety purposes, but looked at parameters of efficacy as well, in order to get a better sense of the overall risk/benefit basis for recommending that the study continue or be terminated. Following the second DMC meeting, the group requested to reconvene in three months, rather than six.

When the group met for the third time, it encountered a result that it viewed as stunning. It found what looked like an overwhelming benefit-to-risk relationship in favor of Sutent and recommended that the trial be stopped—and that the control group cross over to the treatment arm.

The board made this recommendation after assessing 73 PFS events and reviewing safety and efficacy data on 154 patients. The board found that there were 15 deaths on placebo and only five on Sutent.

There were 24 PFS events on Sutent and 49 events on placebo. The hazard ratio for PFS was 0.397 (95% CI: 0.243-0.0.649). There were 28 serious adverse events on placebo and 20 such events on Sutent.

The unusual event in the Afinitor application involved the differences in assessment of response. The Sutent trial was unusual because it was stopped early, resulting in a higher degree of uncertainty regarding the balance of benefit and risk.

In the beginning, Novartis sought two indications for Afinitor, conducting a randomized study in each. The second trial of Afinitor ran in neuroendocrine tumors of gastrointestinal or lung origin, also known as carcinoid tumors.

In a protocol-specified analysis in the carcinoid indication, investigator review determined that the trial should be stopped because the drug had crossed the threshold of demonstrating efficacy. However, central review came to the opposite conclusion: the trial should be stopped because there is no chance that it would ever demonstrate efficacy.

Novartis ended up with two diametrically opposed conclusions based on the same scans. This was an unprecedented in the history of the FDA oncology office, the agency's medical reviewer said at the ODAC meeting.

Days before the meeting, after release of the briefing documents, Novartis notified the agency that it wouldn't seek the carcinoid tumor indication. Prior to that, the company amended the protocol on the pNET

indication.

In the Afinitor application, PFS was based primarily on investigator determination, and PFS determined by central review became a secondary endpoint. As a result of making that change in the pNET protocol, the company's Special Protocol Assessment agreement with the agency became invalid. The pNET indication remained viable because the PFS metrics went in the same direction.

EU News:

CHMP Recommends Approval For Skeletal Events Treatment

The Committee for Medicinal Products for Human Use of the European Medicines Agency recommended a positive opinion for the marketing authorization of Xgeva (denosumab) for the prevention of skeletal-related events (pathological fracture, radiation to bone, spinal cord compression or surgery to bone) in adults with bone metastases from solid tumors.

If approved by the European Commission, Amgen would receive marketing authorization for Xgeva in all European Union member states.

The CHMP also recommended to grant Xgeva an additional year of data and market exclusivity in the EU, since the indication was considered significantly new for Xgeva, and based on the significant clinical benefit of the product in comparison with existing therapies."Xgeva provides patients with superior efficacy over Zometa in preventing skeletal-related events in patients with solid tumors and prolonging the time until pain worsens," Amgen Senior Vice President and International Chief Medical Officer Willard Dere said in a statement.

"Xgeva also offers the ease of every four weeks subcutaneous injection and no requirement for dose adjustment for changes in renal function. Xgeva has the potential to make a meaningful difference for patients with advanced cancer and their healthcare providers."

The CHMP positive opinion is based on three phase III head-to-head trials that evaluated the effectiveness of Xgeva versus Zometa (zoledronic acid) in delaying SREs.

The clinical program for Xgeva spanned more than 50 tumor types in over 5,700 patients. In the SRE trials, Xgeva demonstrated a clinically meaningful improvement in preventing SREs compared to Zometa.

In patients with breast or prostate cancer and bone metastases, Xgeva was superior to Zometa in reducing the risk of SREs.

In patients with bone metastases due to other solid tumors or multiple myeloma, Xgeva was non-inferior to Zometa in reducing the risk of SREs.

In an integrated analysis of all three studies Xgeva was superior to Zometa in delaying time to first on-study SRE by 17 percent or 8.2 months (median time to first skeletal related event of 27.6 months for Xgeva and 19.4 months for Zometa, $p < 0.0001$).

In this analysis, Xgeva was also superior to Zometa in delaying time to first-and-subsequent on-study SRE by 18 percent ($p<0.0001$).

In patients with mild or no pain at baseline, time to worsening pain was delayed for Xgeva compared to Zometa (198 versus 143 days) ($p=0.0002$). The time to pain improvement was similar for Xgeva and Zometa.

In these double-blind trials, Xgeva was administered every four weeks as a 120 mg subcutaneous injection, versus Zometa delivered every four weeks via a 15-minute intravenous infusion, with adjustments for kidney function per the requirements of the Zometa prescribing information.

Xgeva was not associated with renal toxicity or acute phase reactions, both well known side effects of Zometa treatment.

Overall rates of adverse events and serious adverse events were generally similar between Xgeva and Zometa. Osteonecrosis of the jaw was infrequent, with no statistically significant difference between treatment arms. Hypocalcemia was more frequent in the Xgeva treatment group. Overall survival and progression-free survival were similar between arms in all three trials.

Xgeva is currently approved in the U.S. for the prevention of SREs in patients with bone metastases from solid tumors. In the U.S., Xgeva is not indicated for the prevention of SREs in patients with multiple myeloma.

The most common adverse reactions in patients receiving Xgeva were fatigue/asthenia, hypophosphatemia, and nausea. The most common serious adverse reaction in patients receiving Xgeva was dyspnea. The most common adverse reactions resulting in discontinuation of Xgeva were osteonecrosis and hypocalcemia.

Survival Data

Roswell Park Publishes Survival, Quality Data

Roswell Park Cancer Institute released a report on its clinical trends and outcomes, as well as quality indicators that the center said contribute to a positive experience for RPCI patients.

The report, titled *Quality 2011,* is available *at www.roswellpark.org/quality.*

Several other cancer centers have published their survival data. These reports are controversial since statisticians point out that database comparisons of survival outcomes are biased (The Cancer Letter, Feb. 4, March 18).

"As both healthcare consumers and providers, we believe that the best, most direct way of engendering the confidence of our cancer patients—and the physicians, payers and employers who entrust them to our care—is by applying current best practices and continually reviewing, measuring and sharing outcomes," Donald Trump, president and CEO, said in a statement.

"Unsupported claims of bigger, better and safer no longer sway today's educated healthcare consumers, who are now choosing their care based on measurable indicators of a facility's quality."

The 122-page RPCI report takes a broad provides data on general and disease-site-specific trends and outcomes as well as patient quality-of-life services and programs.

The report primarily uses national benchmarking data collected by the NCI Surveillance, Epidemiology, and End Results program and the National Cancer Data Base of the American Cancer Society and the American College of Surgeons Commission on Cancer.

Data on patient demographics, best-practice treatments and survival are presented on five major cancers: breast, colorectal, prostate, lung and adult leukemia.

In the section titled "Centers of Excellence," outcomes data are also provided on robot-assisted surgeries for bladder, kidney and prostate cancers; blood and marrow transplants; and the use of radiation therapy for head and neck tumors.

Quality 2011 also includes data on such quality indicators as patient and employee satisfaction, community outreach and education, clinical genetics, palliative care, clinical research studies, rehabilitation, advocacy, pain management and psychosocial and nursing care.

In addition, informational sidebars, which contain patient testimonials, easy-to-understand definitions and historical facts, enhance the RPCI quality story.

The Institute will update the report annually and, as more data become available, expand its coverage of disease sites.

"We knew going into this project the many challenges to interpreting survival data at face value, and agree that such comparisons do not necessarily reflect superiority of one cancer center over another," Trump said. "We caution the reader not to use the survival data as 'stand-alone' evidence of a center's quality."

In the Cancer Centers:

Wattenberg Receives AACR Lifetime Achievement Award

(Continued from page 1)

The website of the South Carolina practice recently published the following brief biography of Potti:

Dr. Potti joined Coastal Cancer Center in March 2011. He received his medical school training from Christian Medical College in Vellore, India. Dr. Potti completed internal medicine residency training at the University of North Dakota, subsequently serving on staff at that institution. After finishing a 3-year fellowship in Hematology and Medical Oncology at Duke University in Durham, NC, he then served on faculty at Duke University in the Division of Oncology. He received Certifications from the American Board for Internal Medicine in 1999 and Medical Oncology in 2007.

In addition to patient care, Dr. Potti is passionate about teaching and research. Over the past ten years including his time at Duke University, he has received several recognitions for mentoring, teaching and research efforts, including the ASCO IDEA Mentor, the Joseph Greenfield Mentoring Award (given annually to one faculty member in the Department of Medicine at Duke) and the Leonard B. Tow Humanism in Medicine Award. He is also actively associated with a large number of reputed organizations like Alpha-Omega-Alpha Honor Society, American Society of Clinical Oncology and American Association of Cancer Research.

During his free time Dr. Potti likes to spend time with his wife and three children.

LEE WATTENBERG received the 2011 **AACR Award for Lifetime Achievement in Cancer Prevention Research** for his role in launching the field of chemoprevention and his work to understand the

potential mechanisms of action of chemopreventive compounds.

Wattenberg is a professor at the Masonic Cancer Center at the University of Minnesota and past president of the American Association for Cancer Research.

Wattenberg first recognized that some groups of compounds could be effective in chemoprophylaxis of carcinogenesis in experimental animals in 1965. He introduced the term "chemoprophylaxis" in a 1966 review that was published in Cancer Research, a journal of the AACR. In this publication, he laid the groundwork for the experimental inhibition of chemically induced animal carcinogenesis.

The concepts he developed led to the framework for understanding the potential mechanisms of action for chemopreventive compounds, which still guides preventive agent development today.

Wattenberg's studies have covered a wide range of chemopreventive agents, including dietary preventive substances and most recently synthetic compounds that might prevent carcinogen-induced lung cancer. He pioneered the use of aerosols to deliver drugs in lung cancer. His laboratory is currently studying processes that cause irreversibility in carcinogenesis and whether these processes could be targets for intervention.

Wattenberg earned an undergraduate degree from The City College of New York in 1941 and his medical degree from the University of Minnesota in 1950. He has spent most of his career at the University of Minnesota, where he now holds the position of professor at the Masonic Cancer Center.

The 2011 AACR Award for Lifetime Achievement in Cancer Prevention Research was presented at the Lee W. Wattenberg Symposium - Cancer Chemoprevention: Past Achievements, Future Strategies May 26, in the McNamara Alumni Center at the University of Minnesota.

AL BENSON III, professor of medicine at Northwestern University Feinberg School of Medicine and associate director of clinical investigations at the Robert H. Lurie Comprehensive Cancer Center of Northwestern University, received the 2011 **Rodger Winn Award.**

Presented at the National Comprehensive Cancer Network Annual Meeting in March, the award is given to one NCCN Guidelines panel member each year who exemplifies Winn's leadership, drive, and commitment to the development of evidence-based guidelines tempered by expert judgment.

The recipient provides a voice for the core mission of the NCCN, improving the quality of care for patients.

Specifically, the award recognizes service in the development of clinical practice guidelines, promotion of collegiality in NCCN activities, commitment to excellence, and dedication to multidisciplinary care.

STEVEN ROSEN, director of the Robert H. Lurie Comprehensive Cancer Center of Northwestern University, was elected to the national board of directors of the **Leukemia & Lymphoma Society**.

Rosen is the Genevieve Teuton Professor of Medicine at the Feinberg School of Medicine at Northwestern and Director of Cancer Programs at Northwestern Memorial Hospital.

JEFFREY TRENT was appointed **Foreign Trade Counselor of Luxembourg** in the U.S.

Trent is president and research director of the Translational Genomics Research Institute in Phoenix, and the Van Andel Research Institute in Grand Rapids, Mich..

He was also involved in building the Luxembourg personalized medicine infrastructure (see www.tgen.org/news/index.cfm?newsid=1167 and www.biomedicine.lu), including the Integrated Biobank of Luxembourg and the lung cancer research and development projects with the Luxembourg National Health Research Center.

GISELLE SHOLLER joined the Van Andel Research Institute, which announced the creation of the **VARI Pediatric Cancer Translational Research Program**.

The program will be co-directed by Sholler and **Craig Webb**, director of VARI's Program of Translational Medicine.

Sholler also received joint clinical and academic appointments from Helen DeVos Children's Hospital and the Michigan State University College of Human Medicine.

Sholler also continues her role as chair of the Neuroblastoma and Medulloblastoma Translational Research Consortium, a group of 11 universities and children's hospitals that will now be headquartered at VARI, which offers a nationwide network of childhood

cancer clinical trials. Sholler has chaired the research consortium since its founding in 2008.

SCRIPPS HEALTH broke ground for a $43.9 million **Scripps Radiation Therapy Center**, located on the Torrey Pines Mesa in La Jolla, Calif.In August 2010, construction began on the Scripps Proton Therapy Center in Mira Mesa, in San Diego County. The $200 million proton treatment center is expected to be open for patient care by spring 2013.

The 41,000-square-foot therapy center will include three new, state-of-the art linear accelerators: one TrueBeam STx linear accelerator–which will be the first of its kind in San Diego–and two Clinac linear accelerators, each manufactured by Varian Medical Systems of Palo Alto.

TrueBeam STx technology choreographs various high-tech systems—3D tumor imaging, beam delivery and motion management—to deliver external beam radiation therapy to the patient with unprecedented safety and accuracy. This holds true even if the tumor is on the lung and moving as the patient breathes.

The Scripps Radiation Therapy Center will also include a 16-slice CT simulator with 4D imaging capability. When complete, the center will have the capacity to treat approximately 1,200 patients annually. Costs to build and equip the radiation therapy center will be funded through a combination of income from operations, debt financing and philanthropy.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA received a $2 million gift from **Alex's Lemonade Stand Foundation.**

The four-year $2 million gift will be matched by the Children's Hospital of Philadelphia for a total of $4 million, providing $1 million of funding annually to the Center for Childhood Cancer Research.

The gift will fund three new initiatives:

• Funding for investigators with creative research hypotheses to pursue projects unlikely to be funded by traditional sources. Through an annual evaluation process led by the Cancer Leadership Group, the CCCR will have the ability to rapidly support innovative research ideas that have the potential to ultimately achieve NIH funding.

• A new Alexandra Scott Annual Research Symposium that will be held yearly at the Children's Hospital of Philadelphia in partnership with Alex's Lemonade Stand Foundation. The first symposium is scheduled for this fall.

• The Experimental Therapeutics Program at Children's Hospital will be enhanced to help continue its efforts in identifying new treatments in the lab and translating them for patients in need of innovative therapies for their relapsed cancer. This gift will enhance opportunities for research in neuroblastoma as well as in other difficult-to-treat childhood cancers, such as relapsed acute leukemia and medulloblastoma.

The Children's Hospital of Philadelphia has developed a relationship with Alex's parents, Liz and Jay Scott, founders of Alex's Lemonade Stand Foundation. In 2001, the Scotts moved to Philadelphia to seek treatment for their daughter Alex at the Children's Hospital of Philadelphia from John Maris, an expert in neuroblastoma.

That same year, Alex set up her first lemonade stand in Philadelphia to raise money for pediatric cancer research. Alex died of neuroblastoma in 2004. Through her idea of a front-yard lemonade stand fund-raiser, Alex's Lemonade Stand Foundation has raised more than $40 million for pediatric cancer, funding over 150 research projects.

DANA-FARBER CANCER INSTITUTE has launched a **redesigned website** that makes it easier for users to access the latest information on adult and pediatric cancer care, research and clinical trials.

The more functional and user-friendly site welcomes visitors with images that depict Dana-Farber's 63-year-old mission of research and clinical practice.

With more than 4,000 pages of cancer-related content, the site uses a new navigation system to make it easier for users—from patients to survivors to referring physicians—to quickly access the information they seek.

Using a special "Get Started" feature, a user searching for information on breast cancer, for example, would select an age group (adult or pediatric), a cancer type (breast cancer) and a treatment phase (before treatment, in treatment, after treatment). The user is then presented with a "diagnosis dashboard" that pulls relevant content from across the website into one convenient page.

The site also offers similar gateway pages for adult and childhood cancer survivors and for referring physicians.

"Our patients and their families told us that they often felt overwhelmed when they searched health websites, and that they only wanted to see information that was immediately relevant to their type of cancer and their treatment stage," said Caren Cummings Adams, director of interactive communications at Dana-Farber. "This feedback helped drive our site's redesign and

organizational structure."

The site also offers an extensive Health Library, which includes:

• "How-to" and news videos;

• "Meet This Doctor" physician video interviews;

• Teaching Sheets with instructional care information; and

• Recipes from Dana-Farber nutritionists.

In addition to a database of all clinical trials available at Dana-Farber, the site provides direct access to the NCI comprehensive cancer information database, PDQ.

The website was designed and developed in partnership with iFactory, a Boston-based interactive agency, and EKTRON, of Nashua, N.H. iFactory oversaw the site's overall design, information architecture and navigational structure. EKTRON provided the content management system.

Funding Opportunities

SU2C Creates "Dream Team" To Focus on Melanoma Studies

STAND UP TO CANCER and the Melanoma Research Alliance, along with the American Association for Cancer Research are inviting letters of intent for a new **Dream Team dedicated to melanoma research**.

The SU2C-MRA Melanoma Dream Team Translational Cancer Research Grant will provide funding of a minimum of $6 million over a three-year period for a cancer research project that will accelerate the application of new preventive, diagnostic or therapeutic agents to the clinic. Proposals for Melanoma Dream Team projects must present plans indicating how the work will be translated into the clinic.

The team must include laboratory and clinical researchers, senior and young investigators and senior scientists who have not worked together in the past, as well as patient advocates.

The team will span multiple disciplines and utilize the new tools of modern biology to attack research questions in a coordinated way. Mechanisms to foster collaboration within and among the Dream Teams should be employed—an approach that promotes the sharing of information and a goal-oriented focus on measurable milestones of progress.

A SU2C-MRA Joint Scientific Advisory Committee will conduct an evaluation of the applications. The committee is chaired by Nobel Laureate Phillip Sharp, the Institute Professor, David H. Koch Institute for Integrative Cancer Research at the Massachusetts Institute of Technology.

Additional information is posted at: www.aacr.org/SU2CMRA. Inquiries may be directed to the SU2C Grants Office at: (267) 765-1049 or su2c@aacr.org. Those interested should submit Letters of Intent detailing their ideas to su2c@aacr.org by 12 p.m. ET, June 20, 2011.

The SU2C-MRA Melanoma Translational Dream Team will be announced in November.

Professional Societies

New ASCO Site Marks Anniversary Of the National Cancer Act of 1971

The American Society of Clinical Oncology launched **CancerProgress.Net**, a website intended to provide an easily accessible, visual history of advances against major types of cancer in every area of patient care, from molecularly targeted therapies to quality of life.

The site offers an interactive journey through 40 years of major advances in treatment, prevention, and diagnosis, as well as expert perspective on remaining challenges, and other useful tools designed for anyone interested in progress against cancer. ASCO created www.cancerprogress.net to mark the 40th anniversary of the National Cancer Act of 1971. The timeline was developed under the guidance of 17 of the nation's leading oncologists.

"Thanks to steady advances in prevention, detection and treatment, people with cancer are living longer, with a better quality of life, than ever before," said ASCO President George Sledge said in a statement. "Our nation's investments in cancer research have been the engine of progress, and they remain essential to our future."

Key features of www.cancerprogress.net include:

• An interactive timeline of cancer research advances.

• Data visualization tools to bring cancer statistics to life.

• Video interviews with top experts.

• Historical commentary from nationally renowned leaders in oncology.

• Downloadable slides and links to other resources.

• Information on priorities for the future of clinical cancer research

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