THE CANCER LETTER

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Cancer Centers: Permanent Reinvention

The Philadelphia Story: How Surprise Filing By Abramson Spurred Penn to Follow Suit

By Paul Goldberg

Public run-ins, private vitriol and cease-and-desist letters are on the list of harbingers of lawsuits.

However, none of the above-mentioned expressions of dissatisfaction are known to have preceded the exploding dispute between Craig Thompson and his former place of employment—the Leonard and Madlyn Abramson Family Cancer Research Institute and the University of Pennsylvania.

Even though Thompson had been an unsuccessful candidate for dean of the medical school, his departure was amicable. After taking the top job at Memorial Sloan-Kettering Cancer Center in October 2011, Thompson was seen returning to Penn to attend university-related social events.

Things were cordial until—suddenly—they weren't.

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Guest Editorial

Cancer From Fukushima? Is Sushi-Eating Over?

By Robert Gale

The ongoing accident at the Fukushima Daiichi nuclear power facility in Japan, now one year old, has re-ignited the debate regarding cancer risks to the public from released radionuclides, like iodine-131 and cesium-137.

The Japanese are on the front line for potential adverse effects, but people as far away as the U.S. and Europe remain concerned. Many people—including, remarkably, some scientists, physicians and cancer experts—have canceled and continue to cancel travel to Japan.

Does this make sense?

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In Brief

UC Davis Becomes 41st Cancer Center To Earn NCI Comprehensive Designation

UC DAVIS CANCER CENTER earned "Comprehensive" status from NCI, making it the 41st U.S. cancer center to receive the designation. The center will be renamed the **UC Davis Comprehensive Cancer Center**.

NCI's "comprehensive" designation signifies that the center meets stringent criteria in the areas of laboratory, clinical and population-based research, professional and public education, and in the dissemination of clinical and public advances to the communities it serves.

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Lawyer: "It's a Fair Surmise" That Complaint Was Unexpected

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The Rubicon-crossing occurred Dec. 13, 2011, when the Abramson institute, a separate non-profit affiliated with the University of Pennsylvania Abramson Cancer Center, filed a suit alleging that Thompson had "absconded" with intellectual property he had developed while at the university and the institute.

Sources say that the filing came as a surprise to officials at both Penn and Memorial.

Also, officials at Agios Pharmaceuticals, the company Thompson co-founded while at Penn, apparently had no warning. Celgene, a firm that heavily invested in Agios, is said to be similarly surprised.

The Abramson institute's attorney, David Burger, confirmed that the action came with no warning.

"I think it's a fair surmise," Burger, an attorney with the firm of Robinson, Brog, Leinwand, Greene, Genovese & Gluck, said to The Cancer Letter. "Because, frankly, the university had not pursued anything after a certain point, and then, suddenly, the institute did what it did."

Thompson's current position as the figure between the crosshairs has been the talk of the top echelons in oncology.

"I would not like to find myself opposed to Mr. A. in court," an official at a cancer center not involved in the controversy said in an email. "He doesn't give an inch."

The philanthropist who started US Healthcare and took home an estimated $1 billion after selling the company to Aetna, is now claiming the rights to intellectual property Thompson may have produced between 1999 and 2010, the years he worked at Penn. Abramson wants the rights to discoveries his donations—$100 million worth—may have funded.

On March 16, attorneys for Thompson and Agios were scheduled to file responses to the Abramson complaint. These filings were not available by press deadline.

Abramson's action has prompted the University of Pennsylvania to file a separate complaint against Thompson.

Penn's complaint has been referred to the same judge at the U.S. District Court for the Southern District of New York (The Cancer Letter, March 9).

"I think it's fair to say that the action that I filed brought this matter to the forefront of the university's attention, and when it did so, they re-examined the situation, and they decided that, in fact, a claim should be filed," Abramson Institute attorney Burger said in an interview.

Abramson appeared to have made the decision to attack sometime in the fall of 2011, observers and insiders said.

"I cannot get into Mr. Abramson's mind to tell you exactly what he was thinking when," said Burger. "I do know that the Abramson institute's in-house counsel interviewed a number of different attorneys before they decided to hire me, and that procedure took some period of time."

What Penn Knew When

In late January 2012, more than a month after the Abramson suit was filed, the university seemed determined to stay out.

Responding to questions from this reporter on Jan. 24, Susan Phillips, senior vice president and secretary of the board at Penn Medicine, said that the university planned to "cooperate with fact-finding."

"The AFCRI is a separate organization developed to fund cancer research and has generously supported science at Penn for the last 15 years," Phillips said in an email at the time. "Neither the University nor Penn Medicine is a party to the lawsuit. We will, of course, cooperate fully in any fact-finding, and we are hopeful for a fair and expeditious resolution."

The university filed its complaint against Thompson and Agios less than a month later, on Feb. 22.

At least for now, the anatomy of that about-face remains hidden from public view.

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NCCN National Comprehensive Cancer Network®

NCCN Employment Opportunity

Chief Executive Officer

The National Comprehensive Cancer Network® (NCCN®) is seeking a full-time physician executive based in Fort Washington, Pennsylvania who is dynamic, entrepreneurial, and visionary to lead the organization and build upon the tremendous success achieved since its establishment in 1995.

About the Organization

The National Comprehensive Cancer Network® (NCCN®), a not-for-profit alliance of 21 of the world's leading cancer centers, is dedicated to improving the quality and effectiveness of care provided to patients with cancer. Through the leadership and expertise of clinical professionals at NCCN Member Institutions, NCCN develops resources that present valuable information to the numerous stakeholders in the health care delivery system. As the arbiter of high-quality cancer care, NCCN promotes the importance of continuous quality improvement and recognizes the significance of creating clinical practice guidelines appropriate for use by patients, clinicians, and other health care decision-makers. The primary goal of all NCCN initiatives is to improve the quality, effectiveness, and efficiency of oncology practice so patients can live better lives.

For more information about NCCN, visit NCCN.org

About the Position

The NCCN Board of Directors and the senior leadership team have begun a strategic planning process aimed at charting the direction for the organization. The CEO will play a significant role in the implementation of the strategic plan to shape and guide the organization's future direction. The CEO will be responsible to:

- Seek opportunities for the development of new programs and initiatives to advance the NCCN mission, increase influence, enhance value to member institutions, and improve the quality, effectiveness, and efficiency of cancer care.
- Maintain and build on positive relationships that have been established with an extensive array of constituents including member institutions, physicians, pharma/biotech industry, employers, payers, government representatives, advocacy groups, professional societies, technology partners, and other cancer organizations.
- Increase and diversify the revenue base.
- Identify opportunities to leverage existing and expand new collaborations with supporters and national organizations aligned with NCCN's mission and vision.
- Maintain strong, positive, collaborative, and transparent working relationships with the Board, member institutions, center directors, external stakeholders, and staff.

Qualifications/Expectations

- MD or DO with oncology background required.
- MBA, MPH or DPH preferred.
- Significant executive leadership experience required.
- Success working with a diverse board of directors including the ability to cultivate and maintain strong board member relationships.
- Highly developed understanding of academic values and culture.
- Knowledge of health policy issues and trends.
- Demonstrated strength in directing a complex organization with multiple stakeholders and driving long-term strategy.
- Ability to lead and manage change and to foster innovation both internally and externally.
- Proven excellence in organizational management with the ability to manage and develop high-performance teams, set and achieve strategic objectives, and empower a talented group of senior leaders.
- Persuasive and charismatic communicator with excellent interpersonal and presentation skills.
- Passion, idealism, integrity, positive attitude, and commitment to the organizational mission.
- Demonstrated success in motivating and mentoring staff at all levels and appreciation of the critical contributions of staff in charting future direction and achieving future success.
- Willingness to travel nationally and internationally.

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A 2010 photograph of Thompson, Madlyn and Leonard Abramson, and Penn President Amy Gutmann (left to right).

Some observers say that it's likely that the university decided to move from "cooperating" to taking a legal action in order to appease the donor who had given the institution over $100 million. However, it's also possible that internal politics within Penn were in play.

The university filed a separate complaint for procedural reasons, Burger said. It was easier to do so than to intervene as a party to the Abramson litigation.

"They would have had to have filed the motion to intervene in the existing case, and that would be a more involved and delayed procedure than just filing a separate case, which was referred to the same judge," he said. "They have focused on certain issues, which I have not focused on, but I think the gist of it is very similar."

After filing the complaint, the university declined to speak with The Cancer Letter.

Real Products? Real Money?

How did the Abramson institute officials get the idea that Thompson's inventions could be worth real money?

This is anything but a mystery.

In the fall of 2011, Agios generated a steady drumbeat of triumphant press releases.

Consider this quote by Kevin Starr, a partner at Third Rock Ventures, which helped found Agios in 2008, by providing a part of its $33-million Series A funding:

The company's three founders, including Thompson, "had a collective 'ah-hah' moment," Starr said to Xconomy, a biotech website. "They discovered that targeting certain metabolic enzymes could fundamentally alter cancer pathways."

Starr said that at that time, funding from Celgene made Agios into "the largest partnership we have among any of our portfolio companies by a wide margin."

The story is posted at http://www.xconomy.com/boston/2011/10/11/agios-and-celgene-anatomy-of-an-ultra-valuable-biotech-marriage/.

On Nov. 17, 2011, Agios reported having raised $261 million, most of it from Celgene. The company was also positioned to earn milestone payments and royalties under the Celgene deal.

"With this financing, we have achieved the financial strength necessary to move several programs into the clinic in genetically defined patient populations, taking us closer to the goal of bringing fundamentally new medicines to patients in need," CEO David Schenkein said in a statement.

"We appreciate the support and confidence demonstrated by our new investors and existing investors in this round and look forward to expanding our efforts while continuing to create novel first-in-class targeted therapies against key cancer metabolism targets."

The press release is still posted at http://www.agios.com/news-detail.php?id=33#top.

Some observers speculated that Thompson's "Rock Star" status and the Agios war chest made them targets for litigation.

These events raise a hypothetical question:

Would this fight be raging had Agios been an ordinary $2-million, or even a $20-million biotech startup?

Besides Thompson, Agios's co-founders are Lewis Cantley, of Harvard Medical School, and Tak Mak, of the University of Toronto. Whatever his actual role in developing the company's scientific portfolio, Thompson's name seemed to help the company's PR.

The scientist was by then running Memorial Sloan-Kettering Cancer Center, and he was a leader of one of the Stand Up to Cancer "dream teams," funded primarily through televised fundraising events.

Thompson is also featured on a poster of "Rock Stars of Science," a fundraising program of the Geoffrey Beene foundation and fashion brand.

Abramson Goes Straight to Court

Abramson, or his institute officials, appear to have decided to go directly to court to determine whether the purported "collective ah-hah moment" produced commercially viable products to which they were entitled.

While the company's patents don't list Thompson as an inventor, both the Abramson suit and the University of Pennsylvania suit focus on intellectual property before it becomes patentable.

"The rights that the university and the institute have under their agreements are with respect to intellectual property, which includes things much short of patentability," Burger said to The Cancer Letter. "Remember, Thompson was at the institute for more than 10 years, and the institute was formed only to explore new and different approaches to cancer treatment, and one would think that over the course of 10 years, someone of his stature could probably come up with some interesting ideas, and whatever that was, the institute and the university had interest in it."

The question of how far one goes to find scientists affiliated with Agios is a sensitive matter for the plaintiffs, in part because Thompson's successor as director of the Penn cancer center, Chi Van Dang, joined the Agios scientific advisory board in November 2008 (http://www.agios.com/news-detail.php?id=22#top).

He is no longer listed on the advisory board roster on the Agios website.

"Dr. Dang left in the fourth quarter of 2011, both to coincide with their respective appointments at M.D. Anderson Cancer Center and the Abramson Cancer Center of the University of Pennsylvania," said Dan Budwick, a spokesman for Agios.

Cancer Screening

USPSTF and ACS Recommend Less Frequent Cervical Screenings

By Paul Goldberg

Acting together, the U.S. Preventive Services Task Force and medical specialty groups, including the American Cancer Society, updated their screening guidelines for cervical cancer.

Both sets of guidelines recommend a reduction in the number of screening tests a woman receives. The documents also suggest using the Pap test and human papillomavirus test jointly for women ages 30 to 65.

The USPSTF guidelines are posted at: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm.

The joint guidelines from ACS, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology are posted at: http://onlinelibrary.wiley.com/doi/10.3322/caac.21139/pdf.

The groups were working separately, and the simultaneous release of the two screening guidelines was not coordinated far in advance.

The highlights of the USPSTF guidelines follow:

• Screening for cervical cancer should be done in women age 21 to 65 with cytology (Pap smear) every three years or, for women age 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and HPV testing every five years. This received an "A" recommendation from the USPSTF, which means that there is high certainty that the net benefit is substantial.

• Screening shouldn't be done in women younger than 21. This received a "D," which means that there is at least fair evidence that the service is ineffective or that harms outweigh benefits.

• Screening for cervical cancer in women older than 65 who have had adequate prior screening and are not otherwise at high risk for cervical cancer should be avoided. This received a "D" recommendation.

• Similarly, there should be no screening in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. (This received a "D.")

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• Screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than age 30 should be avoided (This also received a "D").

The highlights of the ACS, ASCCP and ASCP guidelines follows:

• Women should not be screened before age 21.

• Women 21 to 29 should be screened with the Pap test alone (conventional or liquid-based) every three years. HPV testing should NOT be used for screening in this age group.

• For women 30 and over, the preferred approach is the Pap test plus HPV testing ("co-testing") every five years. Continued screening with the Pap test alone (without HPV testing) every three years is an acceptable alternative. While screening with HPV testing alone is promising, at this time it is not recommended for most clinical settings.

• Screening is not recommended for women over age 65 that have had at least three consecutive negative Pap tests or at least two negative HPV tests the last 10 years, with the most recent test in the last five years. Women in this age group who have a history of pre-cancer (CIN2 or a more severe diagnosis) should continue routine screening for at least 20 years.

• Women who have undergone a hysterectomy (with removal of the cervix) for reasons not related to cervical cancer or pre-cancer should not be screened.

• Women who have been vaccinated against HPV should follow the age-specific recommendations in these guidelines (for unvaccinated women).

"Pap tests have been done yearly in the past, but we now know that annual screening is not needed, and in fact can lead to harm from treatment of cell changes that would never go on to cause cancer," said Debbie Saslow, director of breast and gynecologic cancer at ACS.

"Since 1980, organizations including the ACS have recommended less frequent screening. With the addition of the HPV test, we can test even less frequently, as the risk of pre-cancer and cancer when both tests are negative is so low. With these recommendations, our groups are helping to make sure women get the full lifesaving benefits of screening while minimizing its known harms."

The USPSTF recommendation updates the 2003 document.

The new guideline differs from the previous recommendation in that it recommends cytology screening every three years among women age 21 to 65 years.

The new recommendation includes more guidance on the appropriate age ranges and frequency of screening, including a new recommendation that women younger than age 21 years not be screened because the evidence shows no net benefit.

The 2003 recommendation suggested that most of the benefit of screening could be obtained by beginning screening within three years of onset of sexual activity or age 21 years (whichever comes first) and screening at least every three years.

The current recommendation includes new evidence on the comparative test performance of liquid-based versus conventional cytology that indicates no substantial difference in test performance (that is, relative detection or absolute sensitivity or specificity) for detection of CIN2+/CIN3+.

It also includes more guidance on the appropriate use of HPV testing in cervical cancer screening, including a new recommendation that women younger than age 30 years not be screened with HPV testing.

The USPSTF found new evidence that addressed the gaps identified in the previous recommendation and allowed the USPSTF to recommend HPV testing combined with cytology as an acceptable screening strategy for women age 30 to 65 years who prefer to lengthen their screening interval beyond three years.

The ACS guidelines on cervical cancer screening were last updated in 2002. The updated guidelines were first released in draft form in late 2011.

The working groups that created the draft guidelines then met with delegates from 25 organizations to further discuss and finalize the recommendations, which were then adapted into this final guideline.

"Our process resulted in guidelines that are focused on collectively presenting the best patient-centered cervical cancer screening strategies," said Mark Stoler, past-president of the American Society for Clinical Pathology. "These final recommendations are based on a broad and emerging body of literature, and meld the very latest knowledge on the interplay between new molecular tests and traditional cytology."

"While these new guidelines reflect relatively small changes over previous screening recommendations, they are important," said Alan Waxman, incoming president of the American Society for Colposcopy and Cervical Pathology. "The addition of HPV testing to the Pap test in women 30 and over has been shown in recent studies to provide better protection for longer intervals from cancer and pre-cancerous changes than the use of the Pap test alone."

The process used to develop the ACS recommendations represents a transitional stage in

guidelines development, the paper stated.

Earlier guidelines used a consensus process involving experts in the field and key stakeholders, not using a formalized process for evaluating evidence. The group that developed these guidelines also consisted of experts and stakeholders; the key difference was in the use of the principles of the Grading Recommendations Assessment, Development, and Evaluation guideline development process.

Starting this year, ACS will use a new guidelines process, which utilizes a standing group of non-specialists and a formal, pre-specified review process.

Guest Editorial

Comparing Fukushima Aftermath To Ordinary Radiation Exposures

(Continued from page 1)

Is the risk of radiation-induced cancer from Fukushima substantial enough, compared to the levels of radiation we are normally exposed to? And do exposures from Fukushima, or even Chernobyl for that matter, meaningfully increase our lifetime cancer-risk?

What other sources of radiation are we exposed to everyday, and how do doses from those sources compare to doses from Fukushima?

As a physician and scientist involved in mitigation consequences of the Chernobyl accident and who deals with nuclear workers at Fukushima and the Japanese public, there seems a need to clarify these important issues.

We are each exposed to radiation every day. About 50 percent of this (about 3 millisieverts) comes from natural sources, including the universe, the sun and our planet—all of which are radioactive.

For example, there are substantial amounts of radionuclides in the earth's crust, including uranium, thorium, radium, radon gas and many others. Other radionuclides are manmade, and never existed before the first atomic bomb explosion; cesium-137 for example.

Each of us, because we contain these radionuclides, is radioactive—men more so than women because of their larger muscle mass which contains radioactive potassium. We irradiate people who are close to us, especially if we sleep with them. Our food and water are also naturally radioactive.

And if you are considering getting porcelain caps to improve your smile—stop smiling, because you will be exposing yourself to a small radiation dose from the radionuclides that porcelain contains.

The other 50 percent of our normal radiation dose is from manmade sources. Physicians contribute about four-fifths of that by ordering X-rays, CT-scans, radioisotope studies and the like. Other sources include smoke detectors, exit signs and thousands of other products we think little about—such as active or passive cigarette smoking.

The point is that we are normally exposed to radiation—and that the dose we receive every second, minute, hour, day, and year over our lifetimes varies considerably between different people.

If your doctor sends you for a heart CT scan, you will get a radiation dose about seven times greater than you would normally get in a year from natural and manmade sources. However, few people think of declining a CT scan because of the risk of radiation-induced cancer.

Another issue we need to consider is the extent exposure to radiation might increase our risk of developing cancer above baseline.

We all, rather unfortunately, have a rather substantial risk of developing cancer in our lifetime. For example, a 50-year-old male has about a 42 percent risk of developing cancer during his remaining life. Now, naturally, one does not want to increase this risk further—but we start from a pretty high baseline risk.

There is no doubt radiation can cause cancer and can increase our cancer risk. This is evident from studies of the Japanese atomic bomb survivors and others in the medical and occupational setting. And although unproved, it is wise to assume any excess radiation exposure can increase this risk. Recent data from the A-bomb survivors support this notion, as do biological observations. But what is the relative magnitude of this increased risk compared to our baseline cancer-risk? As we will see it is quite small.

Finally, before turning at last to Fukushima, it's reasonable to ask what we have learned about cancers from the Chernobyl accident, for which we now have 25-year follow-up.

The bad news from Chernobyl is several thousand excess cases of thyroid cancer, almost all in children who drank iodine-131 contaminated milk in the three months following the accident. These children also received no potassium iodide tablets to block uptake of iodine-131. Many lived in areas of endemic iodine-deficiency, and were therefore primed to absorb iodine-124 and iodine-131.

But the good news is that despite intensive studies of thousands of people, there is no convincing evidence of an increase in leukemia or other cancers 25 years after the accident. It may be too soon for a final call, or

a very small increase may have been missed, but so far the situation looks favorable.

Assuming there will be no further large releases of radiation, it is unlikely there will be a detectable increase in cancers in Japan. This includes the workers decommissioning the facility and the approximately 100,000 evacuees.

A rough estimate is that for a 50-year-old male working at the facility and receiving 50 mSv, the lifetime risk of cancer might increase from 42 percent to 42.2 percent. The magnitude of this increased risk is comparable to the difference in background radiation difference between living in Denver versus New York for 10-15 years, smoking one pack of cigarettes a day for one-to-two years, or living with someone who smokes for about 10 years.

Radiation is dangerous. But it also saves lives. Deaths from accidents at nuclear power facilities are about 10-fold less common than from coal-fired power stations, and deaths from air pollution are about 500-fold less common with nuclear energy than coal when adjusted for comparable energy output. We also use radiation to diagnose and treat cancer, often with favorable outcomes.

Like any complex technology, caution is needed when using nuclear energy. We need inherently safer reactors (some are now being built) and we need to non-politicize the debate over storage of spent nuclear fuels, so that the problem can be solved.

But no one should cancel a trip to Japan because of the Fukushima accident, nor should they pass on sushi. Pass the unagi please.

Robert Gale is a visiting professor of hematology at the Imperial College in London, and has been involved in the response to the Chernobyl and Fukushima nuclear power facility accidents. He is executive director of hematology/oncology clinical research at Celgene Corp.

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In Brief

NCI Designates UC Davis As Comprehensive Center

(Continued from page 1)

"In practical terms, this means that the people of the Sacramento region and all of inland Northern California have a world-class cancer center at their doorstep and access to a wide array of clinical trials and new drug therapies," said Ralph deVere White, cancer center director.

"This tremendous achievement reflects the extraordinary expertise and dedication of our entire cancer center team," said Claire Pomeroy, vice chancellor of human health sciences and dean of the School of Medicine at UC Davis.

The cancer center was reviewed by an NCI review committee last summer. The evaluation was based on a 1,500-page grant proposal that detailed the accomplishments and work underway within each of the cancer center's multidisciplinary research programs, as well as a day-long visit by the entire NCI 25-member committee.

"NCI is responsible for making sure that research dollars are flowing into cancer centers that bring the most robust science and technology to the battle against cancer, so that patients here and everywhere can have the best hope for a cure," said Rep. Doris Matsui (D-Calif.). "UC Davis has proven that it is up to the task, an achievement that will surely benefit everyone in the Sacramento region."

Established in 1991, the center has received more than $108 million in federal research funding. NCI first designated the center in 2002 and renewed its five-year grant in 2006.

LYNDSAY HARRIS was appointed co-leader of the **Case Comprehensive Cancer Center** Breast Cancer Research Program in Development and medical director of the Breast Cancer Program at University Hospitals Case Medical Center Seidman Cancer Center.

She is proposed for primary appointment as a professor of medicine in the division of hematology and oncology at UH Case Medical Center and Case Western Reserve University School of Medicine.

As co-leader, she will expand the breast cancer clinical research base using genomic and other biomarkers of high-risk disease, and she will expand the number of studies in breast cancer metastasis.

Harris has served on scientific review committees for the Department of Defense, the Komen Breast

Cancer Foundation, NCI and the American Society of Clinical Oncology. She also serves as an editor for BMC Genomics and Breast Cancer Research and Treatment.

EMMANUEL KATSANIS was named program director of the **University of Arizona Cancer Center**'s Blood and Marrow Transplantation program. The center's adult and pediatric programs will be consolidated under a single leadership position which spans the UA Departments of Medicine and Pediatrics, as well as the Sections of Hematology-Oncology and Pediatric Hematology-Oncology.

Katsanis plans to integrate the adult and pediatric BMT programs while maintaining separate clinical services for adult and pediatric patients.

Katsanis has been a member of the cancer center since 1997. He is the Louise Thomas Chair in Pediatric Cancer Research and the director of the MD-PhD Program for the UA College of Medicine. He is also a professor of Pediatrics, Pathology and Immunobiology and an associate chair for research in the Department of Pediatrics. He provides clinical care and conducts research at the UA Steele Children's Research Center.

MARGARET FOTI, chief executive officer of the American Association for Cancer Research, received **Research!America**'s 2012 Raymond and Beverly Sackler Award for Sustained National Leadership.

The award was presented at the Advocacy Awards March 14 in Washington, D.C.

Foti became CEO of the AACR in 1982. In the fall of 2007, the AACR opened a Washington, D.C. office to educate members of Congress about cancer research and public health.

Recently, AACR released its Cancer Progress Report 2011, which highlighted the advances made in cancer research over the past 40 years. This report illustrated the large returns on investment in cancer research supported by NIH and NCI.

In 2009, Foti received the first Margaret Kripke Legend Award from MD Anderson Cancer Center, the European CanCer Organization lifetime achievement award and a citation from Philadelphia Mayor Michael Nutter for her dedication to increasing awareness of the importance of cancer research.

Other 2012 Research!America Advocacy Award winners include **Sen. Barbara Mikulski** (D-Md.); **Sanjay Gupta**, CNN chief medical correspondent; **Scott Johnson**, president and founder of the Myelin Repair Foundation; **Donald Lindberg**, director of the National Library of Medicine; and the **Food Allergy Initiative**.

FREDERICK BECKER will receive the **American Society for Investigative Pathology**'s Gold-Headed Cane Award, during the organization's annual meeting in San Diego April 23.

Becker is professor of molecular pathology at MD Anderson Cancer Center.

The award—a mahogany cane with a 14-carat gold head and engraved band—will recognize Becker's contributions to pathology, teaching and leadership in academic medicine.

While at the National Naval Research Institute, Becker collaborated with Judah Folkman to make the seminal observation that while viable tumors implanted in perfused thyroid lobes failed to grow beyond 2 mm, they also failed to vascularize. Those findings led to Folkman's landmark contributions that advanced the understanding of angiogenesis.

Becker's research as an New York University faculty member investigated the regulation of cell growth and proliferation as related to regeneration and carcinogenesis, helping to define the stochastic nature of the cancers which subsequently developed.

In 1976, Becker joined MD Anderson as professor and chair of the Department of Pathology. Becker was named MD Anderson's first vice president for research in 1979 and served in that post for 19 years.

THE HOLLINGS CANCER CENTER at the Medical University of South Carolina recently welcomed three researchers to the center. They are:

K. Michael Cummings, who will lead research on tobacco control, public policy and smoking cessation in Hollings' Cancer Prevention and Control program. He plans to launch a large study using spiral CT scanning to screening heavy current and former smokers for lung cancer.

Stephen Ethier, who will co-lead the Cancer Genetics and Molecular Regulation program. Ethier holds an endowed chair in breast cancer diagnosis, treatment and research. He plans to accelerate the university's programs in cancer genomics and bring the latest genome-based technology to the campus.

And **Chanita Hughes-Halbert**, who will advance Hollings' statewide initiatives in cancer disparities within the center's Cancer Prevention and Control program. She holds two endowed chairs in disparities research.