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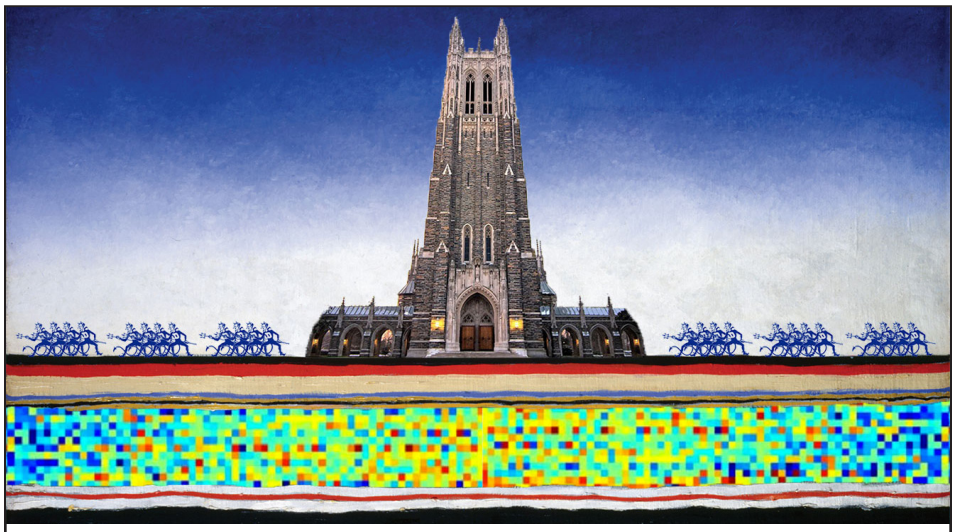

Duke Scientist: I Hope NCI Doesn't Get Original Data

By Paul Goldberg

In May 2008, the Blue Devils of genomic medicine were facing a mortal threat.

An NCI biostatistician was demanding the data Duke University scientists used to derive the predictors of response in ovarian cancer.

This inquiry had the potential to sink Duke's technology that was purported to analyze tumors and use genomic insight to identify the optimal treatment for each patient. According to Duke's projections, cancer treatment decisions are made 700,000 times a year in the U.S. alone.

Multiply that by $3,000—the going rate for advanced tests at that time—and you have $2.1 billion.

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How the "Bad Luck" Cancer Paper Was Misread by the Press

By Matthew Bin Han Ong

How much of the potential to develop cancer is due to plain "bad luck"?

A paper published Jan. 1 in Science titled, "Variation in cancer risk among tissues can be explained by the number of cell divisions," generated a mild controversy when the authors' use of the term "bad luck" caught on in the press.

(Continued to page 5)

In Brief

MD Anderson's Lee Named Medical Director Of Texas Center for Proton Therapy

ANDREW LEE was named medical director of the **Texas Center for Proton Therapy**, a collaboration of Texas Oncology, Baylor Health, McKesson Specialty Health, and The US Oncology Network, effective Feb. 1.

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Dressman Email a Microcosm Of What Went Wrong at Duke

(Continued from page 1)

Had NCI's statisticians been able to get the code and the data they sought, they would have been able to perform basic forensic bioinformatics that would have enabled them to spot unsubstantiated claims, and worse.

In an email dated May 6, 2008, Holly Dressman, a co-author on the Duke group's key papers, shot an email to team captain Joseph Nevins, and mentor and protector of its star scientist Anil Potti.

Dressman's email, now cited in a lawsuit against Duke, may cause a double-take:

"I am working on the [topotecan] signature in OVC and it's a big mess. NCI wants us to resubmit the revisions again and now asking for correct Topo info… and they may want the data for their stat folks to try out like what was done with plat stuff… I am beginning to wonder if the Topo signature is real. I guess for the review, I can just hope they don't ask for original data and just report what is in the NatMed paper."

Here, a government-funded researcher who—despite losing faith in the predictor used to decide which treatment an ovarian cancer patient would receive—expresses hope that NCI would relent before getting the "original" data and would settle for data published in one of the world's premier scientific journals.

Dressman's email, which has never intended to see the light of day, is as close as a single brief document can get to putting the entire Duke case in a nutshell. For starters, Dressman bemoans being unable to pin down Potti and find out how he got his predictors to work, because she can't. The entire email is posted here.

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The email, along with other documents supporting the case scheduled to go to trial at the Durham County Superior Court Jan. 26, demonstrates that the Duke scandal reached beyond Potti, the rogue researcher who cooked data and claimed falsely to have been a Rhodes Scholar.

Filings in the case focus on Potti's ecosystem: the protective luminary Nevins, the appeasing Duke deans, the worried Dressman—and, in the case of topotecan, collaborators at another institution.

Notably, a filing by the plaintiff's attorneys states that Duke didn't provide Dressman's email as part of discovery. The document was emailed to the plaintiff's counsel by an attorney for Potti, one of the defendants in the civil case.

Dressman, a key member of the Duke genomics team, is an associate research professor at the Duke Center for Genomic and Computational Biology and director of the Duke Microarray Core Facility. She banged out this email less than a month after a dream team of Duke University deans executed a full-court press to silence Bradford Perez, a medical student who had the misfortune to find problems in the lab of star scientist Anil Potti (The Cancer Letter, Jan. 9).

Topotecan played a crucial role in the Duke scandal. Its signature was cited in the paper the Duke group had published in Nature Medicine in 2006. In that paper, validation of signatures was reported for a set of ovarian tumors. These samples were part of a larger cohort—some from Duke and others from the H. Lee Moffitt Cancer Center.

The Duke group also used this larger cohort in a 2007 paper, published in the Journal of Clinical Oncology, which proposed using a genomically-based approach to selecting treatment for patients with ovarian cancer.

Dressman was a coauthor of the Nature Medicine paper, the first author of the JCO paper, and an author of the 2006 lung cancer predictor model paper published in the New England Journal of Medicine.

All of these papers have been retracted.

Ovarian cancer, and using the chemotherapeutic agent topotecan to treat it, were clearly an area of emphasis for the Duke researchers and their colleagues at Moffitt. Ultimately, their failure to validate the topotecan signature would be cited as a key reason for retraction of the Nature Medicine paper.

Dressman didn't respond to an email from The Cancer Letter. Duke and NCI officials declined to comment.

"The Potti case points to a strength in the clinician/researcher role that is not often noted," said Rebecca Pentz, professor of research ethics at Emory University

School of Medicine. "Most discussions of the dual role of clinician and researcher, which many oncologists have, point out the possible conflicts of interest that having a dual role entails. But the Potti case points out a potential strength. If you are directly involved in the basic research supporting clinical trials, and you discover something suspicious or doubtful in the research, as Holly Dressman did, then the research/clinician with integrity, the overwhelming majority in my decades of experience, will immediately put on her/his clinician hat and rethink any clinical trial that includes patients.

"Being involved in the research allows you to better protect patients, since you are involved in the research underpinnings of the clinical trial."

Dressman and Nevins have PhDs. Potti is a clinician.

What NCI Wanted

Dressman's email merits further unpacking.

NCI wasn't running a dragnet operation to detect questionable science. Institute officials stumbled across problems at Duke while doing what they usually do: reviewing grant applications.

The grant that led them to look at Duke was at the H. Lee Moffitt Cancer Center.

According to materials released in the course of the IOM investigation triggered by the Duke scandal, NCI stumbled across problems at Duke in July 2007.

This is four months before Nature Medicine published a letter from MD Anderson Cancer Center biostatisticians Keith Baggerly and Kevin Coombes, who would devote thousands of hours to subjecting the Duke data to what they called "forensic bioinformatics" analysis.

NCI officials were reviewing the Moffitt application to advance a R-21 grant, which covers discovery of therapies, to the next phase, called R-33, which covers their development. The grant focused on using predictor models to select therapy for ovarian cancer, and it cited papers published by the Duke group.

The NCI official Dressman dreads is Lisa McShane, a statistician in the Biometric Research Branch of the Division of Cancer Treatment and Diagnosis.

Likely because of this experience, McShane would later emerge as the point person in setting NCI's standards for moving omics advances to the clinic (The Cancer Letter, Feb. 8, 2013).

Even in the early phase of her experience with the Duke case, McShane believed that validation of predictors, if they are any good, shouldn't be overly complicated.

"I think that one of the things that made this so difficult for people to get their arms around is that the Duke investigators were often steering things towards 'Well, we've used this highly sophisticated statistical algorithm and you're trying to reproduce it, but you're not doing it exactly the way we did it,' and in fact the problems ended up being much more simple than that," McShane said in testimony to the IOM committee in March 2011.

"As I had said to Duke officials early on in our discussions over the last year: 'This is not rocket science.' There is computer code that evaluates the algorithm. There is data. And when you plug the data into that code, you should be able to get the answers back that you have reported.

"And to the extent that you can't do that, there is a problem in one or both of those items. But it is amazing how throughout this process people still kept thinking that it was just debates about statistical issues. It really wasn't debates about statistical issues. It was just problems with data and changing models."

Indeed, Dressman and her colleagues had good reasons to worry.

NCI's Circuitous Route

Moffitt's project was directed by Jonathan Lancaster, formerly a Nevins collaborator at Duke.

Lancaster's name appears on Duke's original patents and on the Nature Medicine and NEJM papers, and he was the senior author on the Dressman et al. paper focused on ovarian cancer.

Lancaster's goal was to apply the topotecan signature at Moffitt. His program was sharing personnel with the Duke group. Dressman and Nevins were assisting from Durham.

More than reputations and prestige were at stake.

At the time, Duke was running two clinical trials of the technology coming from the Nevins and Potti group. The two trials that were underway were focused on lung cancer. A third trial, in neo-adjuvant breast cancer, was getting started.

Though Dressman's email doesn't mention McShane by name, it does refer to NCI's evaluation of the "plat stuff." This is a reference to the chemotherapeutic agent cisplatin—and a specific case involving McShane.

Only one interpretation is possible here:

While reviewing the Moffitt grant, McShane was

given the code for one of the five predictors that were mentioned in the Moffitt grant progress report.

"The reason that NCI initially made the request for Moffitt to send data and computer code is that information about the validation data and predictor accuracy estimates had been observed by NCI transition team reviewers to change during the course of the review," McShane wrote in a 2011 letter to the IOM committee chair Gilbert Omenn, director of the University of Michigan Center for Computational Medicine and Bioinformatics.

In the letter to Omenn, attention-averse McShane wrote about herself in the third person.

"It took several weeks for Moffitt and Duke to produce this operational and stable version of code for the platinum/taxane sensitivity predictor, which was the only one evaluated by Dr. McShane," she wrote. "Dr. McShane did not receive data or computer code that would have allowed her to 'reproduce' findings for the topotecan and liposomal doxorubicin predictors being used in the trial, nor even to establish that those predictors were locked down."

In a nutshell: McShane is tossing questions at the folks in Tampa, who are forwarding them to folks in Durham.

The NCI review team considered the Moffitt R-33 grant to allow retrospective validation of predictors.

According to McShane's letter to Omenn, NCI expected that in the Moffitt study the tumor samples would be collected prospectively. The calculation of the predictions and correlations of the predictions with clinical response were expected to take place after patients had been treated and follow-up for clinical response was complete.

Patients were not to be assigned to treatment based on the predictors.

The IOM correspondence related to the Moffitt case is posted here.

While NCI officials believed that the predictors at Moffitt would only be retrospectively evaluated, the investigators applied for funding from the Department of Defense and started to accrue patients to a study in which the predictor models were used to prospectively assign patients to treatment.

Lancaster was listed as a sub-principal investigator on the study. Robert Wenham, a gynecologic oncologist and the principal investigator on the Moffitt study, had trained at Duke and is also listed among authors on that group's publications.

"NCI was not informed that a trial had already been initiated while NCI was funding the R-33 grant to validate the predictors," McShane wrote. "NCI believed that the predictors would be evaluated retrospectively for their validity in the R-33 portion of the grant, and would not be used to direct patient therapy."

People familiar with the situation say that at the time Duke's Dressman wrote her email to Nevins, the Moffitt researchers were in a bind.

Presumably, the Duke predictors in ovarian cancer that were published in the Nature Medicine paper were built by Potti on the basis of data from Moffitt.

However, as Moffitt scientists prepared to launch their DOD-funded trial, they were finding—as the Dressman email indicates in detail—that their predictors didn't work.

Dressman's email refers to her inability to pin down Potti.

It appears that after Dressman's failed efforts to get Potti to provide a thorough accounting of his predictors, Moffitt officials developed their own predictors. It's not publicly known how those predictors were built.

NCI officials learned about Moffitt's DOD-sponsored trial in early October 2009.

"NCI program staff called Dr. Lancaster to voice concerns about using the predictors in an ongoing trial to guide patient care," McShane wrote to IOM. "The following day, October 9, 2009, NCI was informed that the trial was closed."

The Moffitt trial was stopped two days after Duke officials suspended two of their single-institution trials. While those trials were resumed after a cursory review, the Moffitt trial was stopped for good.

At the time, Moffitt officials told The Cancer Letter that the study was stopped because "funds for this project have been spent."

"The trial was closed during extension of funding for low accrual," Patricia Kim, a Moffitt spokesman, said in an email at the time (The Cancer Letter, Oct. 23, 2009).

The Moffitt trial had accrued only four patients.

"I do not recall ever seeing Dr. Dressman's email previously," Lancaster, president of the Moffitt Medical Group and director of the Moffitt Center for Women's Oncology, said to The Cancer Letter.

"Importantly, the topotecan signature referenced in Dr. Dressman's email is NOT the topotecan signature used in the Moffitt clinical trials," Lancaster said. "In her email, Dr. Dressman references the Nature Medicine paper, which was the publication reporting the Potti topotecan signatures. This publication had nothing to do with Moffitt-developed signatures. The signatures used in the Moffitt clinical trial were developed at Moffitt."

This is consistent with what is publicly known about the Duke-Moffitt collaboration.

Herein lies the difference between Moffitt and Duke. Moffitt officials saw the bullet coming and got out of its way. Duke officials apparently thought they were bulletproof.

What Nevins Knew

The Dressman email raises new questions about what Nevins and other officials knew—and what they should have been expected to recognize.

Nevins had just played a key role in hushing Perez, the bright young man who had turned his back on seven months of work, and, placing his career in jeopardy, instructed the Nevins and Potti team to take his name off all manuscripts.

The Perez incident is important, because it establishes that top Duke officials, who had known about it, had said falsely to the IOM committee that no whistleblower had come forward in the Duke case.

In an interview with the CBS news show 60 Minutes, Nevins contended that his faith in his protégé and friend Potti was intact even after this publication reported that Potti had misstated his credentials, claiming to have been a Rhodes Scholar.

In a deposition cited by the plaintiffs, Nevins acknowledged that he didn't check Potti's data until October 2010, three months after Potti was banned from Duke campus.

The plaintiffs' attorney asks: "Once you started digging, how long did it take you to find the manipulations that had been done?"

Replies Nevins: "It would take you maybe an hour."

It's not rocket science after all.

2/3 of Variation in Cancer Risk, Not All Cancers, is Bad Luck

(Continued from page 1)

News publications focused on a specific number—65 percent—and reported that two-thirds of cancers are due to random mutations.

This was not what the authors Cristian Tomasetti and Bert Vogelstein, of Johns Hopkins University School of Medicine, were saying, cancer experts said.

"I am not at all criticizing the authors, except they wrote a very complicated paper that is hard for a lot of people to understand," said Otis Brawley, chief medical officer of the American Cancer Society. "The joke, in many respects, is on us, because the way they wrote it is correct."

Tomasetti and Vogelstein set out to determine, based on established literature and well-accepted concepts, the variation in cancer risk across tumor types and classes.

They plotted the existing literature and results along a regression line, and found a tight 65 percent correlation—not a cause-effect relationship—between the number of stem cell divisions and the risk of cancer.

"Two-thirds of the difference in risk of cancer between the different cancers is due to bad-luck mutations," Brawley said to The Cancer Letter. "That is, if you look at stem cells that are dividing quickly versus stem cells that are not dividing as quickly, two thirds of the difference in risk is due to bad luck.

"If you read his paper without knowing what I just said, it's two-thirds of all cancers.

"We are concerned that people will read headlines about this paper, and develop the attitude to become

How the Dressman Email Fits Into the Duke Scandal Timeline

2000

Joseph Nevins, Mike West founds Computational and Applied Genomics Program (CAGP) at Duke University.

2003

Duke Institute for Genome Sciences and Policy is created. CAGP becomes the new IGSP Center for Applied Genomics and Technology (CAGT).

2003

Anil Potti begins fellowship at Duke. He joins Nevins's laboratory in 2004.

2006

CAGT hires Potti to establish an independent lab focused on gene expression–based research.

October 2006

Nature Medicine publishes Potti et al. paper, "Genomic signatures to guide the use of chemotherapeutics."

November 2006

MD Anderson biostatisticians, Keith Baggerly, Kevin Coombes and colleagues, begin correspondence with Potti and colleagues about the Nature Medicine paper and subsequent publications.

2007

Duke establishes Clinical Genomics Studies Unit.

June 2007

A Phase II trial (NCT00509366) using cisplatin chemosensitivity test to direct therapy for advanced-stage lung cancer patients, began enrolling patients.

July 2007

Cancer and Leukemia Group B submits "Study Using a Genomic Predictor of Platinum Resistance to Guide Therapy in Stage IIIB/IV Non-Small Cell Lung Cancer" to ClinicalTrials.gov

July 2007

NCI officials review Moffitt application to advance a R-21 grant to R-33 grant, to cover development of predictors to be used in an ovarian cancer study.

October 2007

"Adjuvant Cisplatin With Either Genomic-Guided Vinorelbine or Pemetrexed for Early Stage Non -Small Cell Lung Cancer" (NCT00545948) is entered on ClinicalTrials.gov.

October 2007

Journal of Clinical Oncology publishes "Pharmacogenomic strategies provide a rational approach to the treatment of cisplatin-resistant patients with advanced cancer" by Hsu et al.

November - December 2007

November: Nature Medicine publishes Coombes et al. letter critiquing the Potti et al. paper, together with a rebuttal.
December: Lancet Oncology publishes "Validation of gene signatures that predict the response of breast cancer to neoadjuvant chemotherapy: A substudy of the EORTC 10994/BIG 00-01 clinical trial."

March 2008

"Trial to Evaluate Genomic Expression Profiles to Direct Preoperative Chemotherapy in Early Stage Breast Cancer" (NCT00636441) entered on ClinicalTrials.gov.

April 2008

Bradford Perez, a third-year medical student working in Potti's lab, resigns, withdraws his name from publications, and writes a memorandum titled "Research Concerns." Duke officials convince Perez to not make a detailed report to the Howard Hughes Medical Institute, which is funding his research through Duke.

April - May 2008

April: Potti and Nevins promise Perez to fix errors in studies.

***May 6:* Holly Dressman, a co-author on the Duke group's key papers emails Nevins that she is unable to verify the topotecan signature and hopes NCI doesn't ask for original data.**

October 2008 - June 2009

October 2008: Duke academic administrators meet to discuss Potti. The meeting appears to have been triggered by Perez's memo.

June 2009: Baggerly and Coombes learn that the three Duke clinical trials are underway.

July 2009

CALGB submits revised protocol (Genome-Guided Chemotherapy for Untreated and Treated Advanced Stage Non-Small Cell Lung Cancer: A Limited Institution, Randomized Phase II Study). Current Oncology Reports publishes "Translating genomics into clinical practice: Applications in lung cancer."

September 2009

Annals of Applied Statistics publishes "Deriving chemosensitivity from cell lines: Forensic bioinformatics and reproducible research in high-throughput biology" by Baggerly and Coombes. NCI contacts Duke to ask that the university carefully consider the validity of the work and its extrapolation to the clinic.

October 2009

The Cancer Letter first covers the story; Nevins asserts that the approach has been shown to work in a blinded validation by Bonnefoi et al. (2007). Enrollment in the three Duke trials is suspended. Patients already enrolled in the trials are informed of the controversy and reconsented. The Cancer Letter reports statements from coauthors of the Lancet Oncology study that the validation was never blinded.

Oct. 9, 2009

Moffitt stops its ovarian cancer trial, two days after Duke officials suspended two of their single-institution trials. While those trials were resumed after a cursory review, the Moffitt trial was stopped for good.

Nov. 9, 2009

Baggerly sends a report highlighting problems with data posted on a webpage on the cisplatin and pemetrexed tests to Kornbluth at Duke. This report was shared with Nevins, who asked that it be withheld from the external reviewers; Duke leadership decided to honor Nevins' request.

Nov. 9, 2009

Claudio Dansky Ullmann of NCI submits the review of revised CALGB-30702 protocol (Genome-Guided Chemotherapy for Untreated and Treated Advanced Stage Non-Small Cell Lung Cancer: A Limited Institution, Randomized Phase II Study) to NCI's Cancer Therapy Evaluation Program (CTEP) Protocol and Information Office and forwards the review and disapproval letter to CALGB.

Nov. 16, 2009

Lisa McShane and Jeffrey Abrams of NCI contact CALGB requesting re-evaluation of the Lung Metagene Score test for CALGB-30506.

December 2009

External reviewers find that, "In summary, we believe the predictors are scientifically valid and with a few additions can be fully responsive to the comments of Baggerly and Coombes."

January 2010

Duke restarts the three trials (NCT00545948, NCT00509366, and NCT00636441).

February 2010

NCI completes reevaluation of supporting data for the CALGB-30506 trial.

March 2010

Nevins et al. send a letter to McShane in response to some of her concerns about the LMS used in CALGB-30506. McShane and Abrams reply with the conclusions of their analysis of the LMS in the clinical trial: The test should not remain as a stratification factor, and the coprimary aim to evaluate its performance should be removed from the study.

April 2010

The Cancer Letter obtains a copy of Duke University's external review report from NCI via a Freedom of Information Act request and publishes the document.

June 2010

NCI completes reevaluation of the cisplatin chemosensitivity test. NCI hosts Duke researchers to discuss the gene expression–based tests developed at Duke. NCI states that it is not satisfied, and directs Potti and Nevins to conduct a search of their labs to supply the data and code reproducing the results in Hsu et al. (2007) and justifying the trials under way.

July 16, 2010

The Cancer Letter reports that Anil Potti incorrectly stated his credentials. Duke places Potti on administrative leave while the University investigates allegations of inaccuracies in his CV and in the research.

July 19, 2010

Thirty-one biostatisticians and bioinformatics experts from around the world send a letter, "Concerns about prediction models used in Duke clinical trials," to NCI director Harold Varmus.

July 23, 2010

Lancet Oncology issues an expression of concern for "Validation of gene signatures that predict the response of breast cancer to neoadjuvant chemotherapy." Duke suspends trials for a second time.

July 30, 2010

NCI and Duke request assistance from the Institute of Medicine in assessing the scientific foundation of the three clinical trials and identifying appropriate evaluation criteria for future tests based on omics technologies.

Aug. 27, 2010

Duke completes its review of Potti's credentials; identifies issues of substantial concern resulting in corresponding sanctions. Potti remains on administrative leave.

Oct. 5, 2010

Duke administrators—Victor Dzau, Wesley Byerly, Sally Kornbluth, Nancy Andrews and Ed Buckley—discuss the Perez matter in the context of the misconduct investigation.

Oct. 22, 2010

Duke officials inform NCI that they have determined that several datasets reported to have been used to validate the cisplatin test were found to be flawed. The Hsu et al. (2007) paper would be retracted. Investigation into other datasets was ongoing.

November 2010

NCT00545948, NCT00509366, and NCT00636441 trials terminated in ClinicalTrials.gov.

Nov. 16, 2010

Journal of Clinical Oncology retracts "Pharmacogenomic strategies provide a rational approach to the treatment of cisplatin- resistant patients with advanced cancer."

Nov. 19, 2010

Anil Potti resigns from his position at Duke, later taking a position as an oncologist in South Carolina with strong endorsement from some Duke faculty members.

December 2010

McShane describes to the IOM committee the NCI interactions with the Duke investigators pertaining to the gene expression–based tests, and supplies documentation to the committee. She reveals that NCI had discovered that it had been providing partial funding to the trial NCT00509366 through an R01 grant awarded to Anil Potti. She describes her unsuccessful attempts to reproduce the results reported in the Hsu et al. (2007) paper for the cisplatin test and how that eventually led to discovery of several corrupted datasets.

January 2011

Potti et al. Nature Medicine paper retracted. IGSP Center for Applied Genomics and Technology is dissolved. FDA conducts an inspection at Duke University to detemine the rationale for the IRB's initial non-significant risk decision regarding an investigational device exemption.

February 2011

Lancet Oncology retraction (Bonnefoi et al., 2011).

March 2011

NEJM retraction (Potti et al., 2011b). Draft document, A framework for the quality of translational medicine with a focus on human genomic studies: Principles from the Duke Medicine Translational Medicine Quality Framework committee, released. Final draft is released in May 2011.

March 30: Nevins presents at IOM, acknowledges "nonrandom data corruption" in research.

July 2011

Duke sends the IOM committee a list of identified problems, missed signals, and proposed solutions based on the work of the TMQF committee.

August 2011

Duke representatives meet with the IOM committee: Robert Califf, Sally Kornbluth, Michael Cuffe, Ross McKinney, John Falletta, Geoff Ginsburg, Michael Kelley, and William Barry. Dzau does not attend the session, citing prior commitments. Duke representatives do not turn over Perez memo and emails to IOM. Officials state that Duke has a "culture of openness" and that there are no whistleblowers.

January 2012

FDA posts documents on its website indicating that it informed Duke in 2009 that an IDE should have been obtained for the three trials. Journal of Clinical Oncology retracts "An integrated genomic-based approach to individualized treatment of patients with advanced-stage ovarian cancer."

February 2012

CBS's 60 Minutes airs "Deception at Duke: Fraud in cancer care?"

March 2012

IOM issues report, "Evolution of Translation Omics: Lessons Learned and the Path Forward."

February 2013

NCI publishes a checklist for advancing omics studies to the clinic.

August 31, 2013

Nevins leaves Duke. It is not publicly known whether an internal misconduct investigation stemming from the scandal is related to his retirement.

This timeline is adapted from The Cancer Letter archives and the 2012 Institute of Medicine report, "Evolution of Translational Omics: Lessons Learned and the Path Forward."

convinced that there is nothing that can be done to prevent cancer. Therefore, they don't have to worry about a healthy lifestyle. We're concerned that some lawmakers may read this and become less supportive of programs to support a healthy lifestyle."

The stochastic process of stem cell divisions should not be equated with bad luck, said Barnett Kramer, director of the NCI Division of Cancer Prevention.

"I wouldn't have predicted that the correlation would be quite that high, and so I found it intriguing that it was. That's the good part," Kramer said to The Cancer Letter. "The paper itself says something that appears to equate that stochastic process with bad luck. I personally think that the use of the phrase 'bad luck' can be easily misinterpreted.

"Stochastic processes have a crisp scientific definition, but 'bad luck' doesn't. The lay public may interpret incorrectly in this case, in my opinion, that 'bad luck' simply means, 'It's in the stars, it's your fate, there's nothing you can do about it.' And bad luck is not equivalent to random mutations in a stochastic process."

A conversation with Kramer appears on page 10.

According to the American Cancer Society, about a third of all cancers are currently due to tobacco usage, and another 30 percent are due to bad nutrition and lack of physical activity.

"It is inappropriate to combine the two and say 30 plus 33 equals over 60 percent," Brawley said. "We do believe it's about half, because there are a bunch of smokers who are overweight, with bad nutrition and lacking physical activity. We believe about half of all cancers are due to lifestyle issues.

"I don't know that he would agree that 50 percent of all cancers are due to lifestyle, as I said, he does agree that a large proportion are due to lifestyle, and he told me, point blank, 'You can't make that estimate from the data in my paper.'"

Johns Hopkins posted an addendum to the initial press release, clarifying that that two-thirds of the variation in adult cancer risk can by explained primarily by "bad luck."

"All cancers are caused by a combination of bad luck, the environment and heredity, and we've created a model that may help quantify how much of these three factors contribute to cancer development," said Bert Vogelstein, the Clayton Professor of Oncology at the Johns Hopkins University School of Medicine, co-director of the Ludwig Center at Johns Hopkins and an investigator at the Howard Hughes Medical Institute.

"Cancer-free longevity in people exposed to cancer-causing agents, such as tobacco, is often attributed to their 'good genes,' but the truth is that most of them simply had good luck," Vogelstein said in a statement, cautioning that poor lifestyles can add to the bad luck factor in the development of cancer.

The "bad luck" factor spread quickly because of an understandable desire to feel that cancer is beyond one's control, said Kenneth Offit, chief of the Clinical Genetics Service at the Memorial Sloan Kettering Cancer Center. Offit had opined in a Jan. 5 New York Times story on the Science paper.

"The response to this article was fascinating," Offit said to The Cancer Letter. "The NY Times story was on the top three list (stories that are emailed or posted on Facebook) and I think the reason for this is because there's an understandable desire for many of our patients to feel that their diagnosis was due to bad luck beyond their control, when we know that epidemiologic evidence shows that at least half of cancers are preventable or amenable to early detection.

"The Hopkins group wrote what I described as a elegant mathematical paper showing that two-thirds of the variation in cancer rates in different tissues was explainable by characteristics of stem cells. I pointed out that they did not include two very common human cancers—prostate or breast—where stem cell data is sparse, and so the notion that most cancer is due to random causes was not the scientific conclusion of this study.

"In fact, some of the predictions of this model are correct and some are not, as I pointed out in my commentary to the NY Times. I cited the example of medullary thyroid cancer—which is often a hereditary cancer—and in addition the cancer spectrum of Li-Fraumeni syndrome is not as would be anticipated by the model. But this model is a first approximation, and an innovative approach to an age-old question first identified by Armitage and Doll a generation ago.

"The lay and media response to the report I think conveyed more about the public's fears and misunderstanding of the causes of cancer than the intriguing hypothesis-generating content of the scholarly article published in Science."

The bad luck issue has attracted attention beyond its value and importance to cancer research and prevention, said Peter Boyle, president of the International Prevention Research Institute, professor of global public health at Strathclyde University, and lead author of the institute's 2013 State of Oncology report.

"Indeed, the media attention may have a negative influence of on-going preventive programs," Boyle said to The Cancer Letter. "There are questions raised about the overall approach taken in the paper and the nature of the sample of tumor types employed makes any overall finding of questionable value.

"Time will tell how these findings will play out. In comparison, since the middle of the last century, knowledge of cancer risk factors has grown and we are now sure that alteration of certain lifestyle factors will lead to reductions in cancer risk and, thereby, contribute to cancer prevention.

"This has already been seen with changes in lung cancer in response to changes in smoking prevalence, the reduction in upper gastrointestinal tract cancer with reductions in tobacco and alcohol and with a variety of other identified cancer causes.

"Many populations in high-resource countries have experienced a doubling or more of cancer incidence over past decades. It is difficult to believe that 'bad luck' has doubled in these populations while there have been very substantial changes in preventable risk factors such as smoking. Cancer prevention programs are now having a positive effect on reducing individual risk and to lowering population rates.

"It is essential that these advances are not put in jeopardy by science where the jury is still out on its value and importance."

Conversation with The Cancer Letter

Kramer: Our Cancer Risk Is Not Written in the Stars

The stochastic process of stem cell divisions should not be equated with bad luck, said Barnett Kramer, director of the NCI Division of Cancer Prevention, focusing on misinterpretations of the "Bad Luck" paper by Cristian Tomasetti and Bert Vogelstein, of Johns Hopkins University School of Medicine.

Kramer spoke with Matthew Ong, a reporter with The Cancer Letter.

Matthew Ong: *What was your overall impression of the Tomasetti and Vogelstein paper?*

Barnett Kramer: I found the paper interesting. What they did was they didn't generate any new experimental evidence, obviously. They searched the literature for reports on numbers of stem cells and number of divisions of the stem cells.

They used well-accepted concepts that the risk of mutations or number of mutations are relatively constant for a given cell division—in statistical terms, a stochastic process—that is, any given division, you don't know which gene is going to mutate, but for every given division, you can predict, relatively accurately, how many mutations are going to occur in the division.

You just don't know which cell it's going to happen to. But if you have enough cells, then a statistical analysis of this stochastic process gives you, generally, a pretty good idea of how many mutations there are, and the number of mutations to be a risk factor for cancer.

MO: *What were the authors trying to achieve in their analysis?*

MK: They took well-known concepts, went to the literature, looked for the number of stem cells in any given class of tumors or tissue type, and looked for reports of the number of divisions.

The innovation they added—actually directly plotting the number of anticipated mutations or divisions with the cancer risk—and what I found interesting was that, relative to most biological processes, they got a pretty tight correlation between the number of stem cell divisions and the risk of cancer.

The variation in cancer risk across the tumor types for which they had any data was about 65 percent, and that pretty tight correlation, in biological terms. So it fits with the existing notions of the association between mutations and cancer. I found that interesting. I think they took existing literature and results and, for the first time to my knowledge, plotted them looking for variation across cancers using that information and got a tight correlation.

So it's not conceptually different from what was, in essence, accepted, in terms of the association, but what they did was plot it graphically, and as it often happens, you get some biological input by taking existing data and graphing them.

That's what I took as particularly interesting in the paper. I wouldn't have predicted that the correlation would be quite that high, and so I found it intriguing that it was. That's the good part.

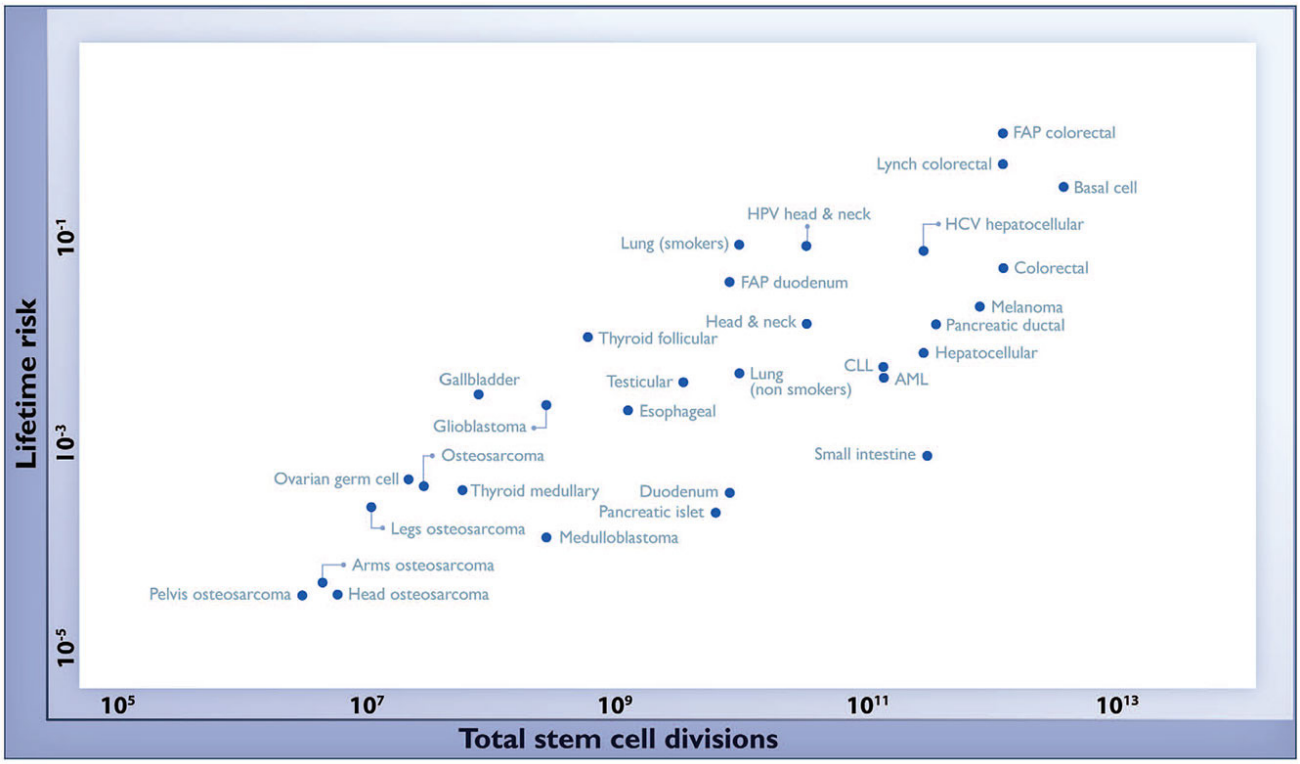
MO: *What have news reports missed in their coverage of the paper's findings?*

BK: On the parts that I think may have either been misinterpreted or picked up in the press and took an extra step too far, was going beyond the actual data to some of the implications. I don't think that, given those observations, you can conclude with any confidence what would be the best strategy to decrease mortality for a given cancer.

I don't think that tells you a priori whether the best strategy will be screening; or the best strategy will be primary prevention; or the best strategy will be treatment. Unfortunately, you're left with the hard grunt work of testing various strategies to see which is the most effective amongst the three for decreasing mortality.

A case in point would be that they unfortunately didn't have reported evidence on stem cells or stem cell divisions from two very common cancers—prostate

Source: AAAS/Science



FAP = Familial Adenomatous Polyposis ◆ HCV = Hepatitis C virus ◆ HPV = Human papillomavirus ◆ CLL = Chronic lymphocytic leukemia ◆ AML = Acute myeloid leukemia

Fig. 1. The relationship between the number of stem cell divisions in the lifetime of a given tissue and the lifetime risk of cancer in that tissue. Values are from table S1, the derivation of which is discussed in the supplementary materials.

cancer and breast cancer—and for both of those cancers we at least have some evidence about whether or not screening works, or how effective it is, and it would have added to the paper if they had some stem cell division data on those. There have been randomized trials at least to test the inference that screening would or wouldn't work.

The next important thing, which I think was sort of missed in the press—even the paper itself says something that appears to equate that stochastic process with bad luck. I personally think that the use of the phrase "bad luck" can be easily misinterpreted. Stochastic processes have a crisp scientific definition, but bad luck doesn't. The lay public may interpret incorrectly in this case, in my opinion, that bad luck simply means "it's in the stars, it's your fate, there's nothing you can do about it." And bad luck is not equivalent to random mutations in a stochastic process.

MO: *What would be a good analogy?*

BK: Let's say you're dealing with traffic patterns. The heavier the traffic, the more accidents there are going to be. There is a tight correlation between the number of cars on the roads and the number of accidents, but that doesn't mean that it's pure bad luck if you have an accident.

Statisticians can predict that, for a given road at a given time and given road conditions, that there's going to be a certain risk and a certain number of accidents. And the correlation almost certainly is going to be very tight, but that doesn't mean that the individual car driver has no control, and might as well give up because whether they have an accident is purely bad luck. They can choose to drive differently.

So aggressive drivers are at a higher risk than slower or safer drivers. And the same is true for speed limits. It's well known and it has been well described that for every mile per hour that you raise the speed limit, or every five or 10 miles per hour, the rate of mortalities or fatalities can go up.

But that doesn't mean for an individual driver, it's just pure bad luck. Because individual drivers and individual cars have a different risk of traffic fatality depending on how they drive, even if they're driving at the same speed in the same speed zone.

The other thing which was not picked up by most of the press was that the correlation they were even looking at, leaving aside the issue of cause and effect, because this isn't even designed to determine cause and effect—they were looking at classes of tumors.

They lined up 31 classes of tumors, and they found out that the correlation was surprisingly high, and I found that interesting. But they were not looking at risk

of individual tumors. Even if it were true that two-thirds of the variability among tumor types is associated with the number of stem cell divisions, it doesn't mean that two-thirds of all cancers are predetermined.

Let's say you have an extremely common tumor and ten extremely rare tumors, and you plot the number of stem cell divisions for those 11 tumors. The 11 tumors may line up very nicely along that diagonal line, that is, they fit a pattern that, across tumor types, there is a pretty tight association between stem cell divisions and cancer risk.

But remember, the most common tumor accounts for most of the cancers. And if that most common tumor is attributable in large measure to a known environmental carcinogen, then the overwhelming majority of cancers, individual cancers, will be preventable. And so a clear case in point would be lung cancer, which we know that 90 percent of lung cancers are probably attributable to smoking and preventable if people don't smoke at all.

And yet there are many, many rare tumors for which we don't have any known environmental cause, and even in the aggregate, if you add them all up, they don't come anywhere close to the number of lung cancers.

So just one simple preventive intervention would prevent the overwhelming majority of all those cancers even if the association tells you that, across cancer types, two-thirds are due to stochastic process of mutation.

Let's say there were only five cases of every other cancer type there is, and they added up to a total of 200 cases a year, and there were 150,000 cases a year of lung cancer, 90 percent of which were attributable to smoking, then the overwhelming majority of individual cancers would be preventable, even if a regression curve tells you that across cancer classes, there is a pretty tight correlation with stochastic processes.

And in this case, let's take lung cancer, which we know 90 percent are preventable by no smoking, and skin cancer, especially non-melanoma skin cancer—which is more common than all the other cancers combined, including lung cancer—and we know that non-melanoma skin cancers are largely preventable by avoiding intensive sun overexposure, the biggest risk factor for non-melanoma skin cancer.

The number of non-melanoma skin cancers just completely outweighs all other cancers combined. And so, even though skin cancer fits on that regression line, and is part of the pattern of cancer types, sun avoidance would still prevent an inordinately large number of total cancers in the country.

Unfortunately, the term "bad luck" got picked in a number of news outlets. Just the term bad luck can be misleading. Bad luck just means, to most people, "nothing you can do about it, you are meant to have cancer." And since the term was—for the sake of simplicity or I would say, over-simplicity—equated with a more precise statistical phenomenon, stochastic risk.

That led to the sense that, "Gee, there's not much you can do about cancer, it's just all in the stars." That has an unfortunate connotation, and I think that was the biggest error of translation of the results.

Lawmakers, and physicians, by the way, and health professionals and the lay public often respond to news articles, and if they are misinterpreted, then it can lead to policy decisions, which are obviously made on behalf of the lay public.

MO: *Do you have any other observations that you'd like to highlight?*

BK: Another thing I wanted to point out that I found interesting in Figure 1 of the paper—the correlation seems good relative to many biological phenomenon. One thing I took from it, and it wasn't emphasized in the article, is that you can sort of visually look at the vertical distance between any given individual cancers on that regression line.

The further it is away from the regression line, the more that one could suspect that there is something going on, if it is cause and effect, there's something additional going on that explains the higher incidences for the curves that are well above the line. And sure enough, that fits the pattern very nicely, so it's interesting to look at.

The best example is lung cancer. When you look at lung cancer (smokers) and lung cancer (nonsmokers), there is a very large vertical difference between those. So lung cancer (smokers) and you'd expect, the point is way above that regression line.

And the same is true, for example, for HPV head and neck cancer and other cancers, and hepatitis B liver cancer is way above the line relative to the rest of liver cancer. It fits that one would say, "Gee, the further vertically the point is from the line, especially if it's north of the line, the more may be going on, over and above the stochastic random process."

That is one indicator that something else might be going on, is how far above, vertically, the regression line, a given point is. That's not pure, it's very rough, but nevertheless, if you look at some of the points, they fit that pattern.

General colorectal cancer is right on the regression line, but those with a genetic predisposition (FAP) for

colorectal cancer are way above that regression line vertically. Each of those points that are very far away from the line seems to fit that pattern.

Now, always, an environmental carcinogen, you have to be very cautious before you say, it must be an environmental carcinogen. A case in point is thyroid follicular cancer—the incidence may be driven by screening for thyroid cancer and screening tests are much better at picking up thyroid follicular than other forms of thyroid cancer. So all it means is that the incidence is considerably higher than you have expected simply based on the formula of stem cells and number of divisions.

I think that we can be pretty confident that there are some causative reasons for the vertical difference. Certainly, we can be confident in the case of smoking and lung cancer. That's a well-established causative factor. I think we can be confident in the case of HPV infections for head and neck cancer. We're pretty confident that that's causative.

In the case of thyroid follicular cancer, I think the weight of evidence is that screening increases the risk of thyroid cancer even if there are no known new carcinogens. And I think there is a large body of evidence that some of the incidence, and sometimes a large measure of incidence in some cancers, is attributable to screening and overdiagnosis, such as picking up very indolent, non-life threatening cancers just by simply dipping into a reservoir of silent, non-progressive tumors with a screening test.

AVEO Cuts Workforce by 66%, Ending Research Functions

By Conor Hale

AVEO Oncology announced plans to cut its workforce by two-thirds, end its internal research functions, and vacate up to 80 percent of its facilities, including laboratory and vivarium locations. The biotechnology company was co-founded by Ronald DePinho, president of MD Anderson Cancer Center.

The restructuring would leave about 20 full-time positions.

The company also announced several changes in its leadership and board of directors, in a move to focus on the clinical setting, including the departure of Jeno Gyuris, AVEO's chief scientific officer.

Michael Bailey was named the company's president and CEO, after previously serving as chief business officer. He replaces Tuan Ha Ngoc, who will become chairman of the board of directors. The current chair, Henri Termeer, will become lead outside director. Additionally, Michael Needle was appointed chief medical officer.

"Since its founding, AVEO has benefited significantly from research, making the decision to eliminate this function particularly difficult," Bailey said in a statement Jan. 7. "This change provides us with an opportunity to evaluate biomarker-driven clinical strategies and partnerships to advance our pipeline without continuing to incur internal research expense."

DePinho, who at the time served as an AVEO board member, recommended the company's stock in a May 18, 2013, appearance on the CNBC program "Closing Bell with Maria Bartiromo."

Announcing the latest round of cuts, the company said it expects the restructuring and layoffs to cost approximately $4.5 million in severance and outplacement charges. The staff reduction is expected to save approximately $6 million annually.

Bailey joined AVEO in 2010 as chief commercial officer. Previously, he served as senior vice president and chief commercial officer of Synta Pharmaceuticals. He also held leadership positions at ImClone Systems, and worked on the development of Erbitux (cetuximab) and Cyramza (ramucirumab).

Needle, a hematologist/oncologist, most recently served as chief medical officer of Array BioPharma. Before that, he served as chief medical officer for the Multiple Myeloma Research Foundation. Needle also served as vice president of clinical affairs at ImClone.

In May 2013, an application for tivozanib in renal cell carcinoma, co-developed by AVEO and Astellas Pharma Inc., was considered by the FDA Oncologic Drugs Advisory Committee—which recommended against approval, and the drug was subsequently rejected by the FDA itself. In the submitted trial, survival was worse in the tivozanib arm than the control arm containing sorafenib (The Cancer Letter, May 3, 2013).

In the days following that vote from ODAC, AVEO's stock dropped from over $7.50 to about $2.50 a share, and never fully recovered. At this time, AVEO's stock price sits at $0.81, down from $2.01 a year ago.

Recently, the European Medicine Agency confirmed that tivozanib is eligible to be submitted for a marketing authorization in renal cell carcinoma, an indication in which tivozanib has previously been granted an orphan drug designation. AVEO said it is also exploring the use of tivozanib in non-oncologic diseases of the eye, in collaboration with Ophthotech.

FASEB Offers Recommendations To Improve Research Funding

The Federation of American Societies for Experimental Biology called for a re-examination of the way research is funded in the U.S., in a report detailing the challenges facing researchers and the threats to continued progress in the field.

The report, Sustaining Discovery in Biological and Medical Science: A Framework for Discussion, presents a series of recommendations to alleviate them.

Shortfalls in federal funding and rising regulatory costs have constrained research budgets, while at the same time, scientific opportunities have expanded and more individuals are seeking funding, the report says. These opposing trends have resulted in an increasingly unstable research enterprise, delaying scientific discovery.

FASEB's recommendations fall into three categories:

• Increased advocacy for predictable, sustainable growth in research budgets while striving to make optimal use of existing resources

• Re-examination of the way research is funded, making certain that we provide incentives to encourage the best science and reduce the amount of time spent seeking funding, and

• Improved preparation and utilization of the workforce.

"After adjusting for inflation, the federal investment in the life science has declined by more than 20 percent since 2003," the report says. "Insufficient funding—along with increased regulatory burden and budgetary uncertainty—is a growing obstacle to future advancement." FASEB recommends that, due to this budget uncertainty, federal research agencies should be able to carry over their budgets into the following fiscal year.

The organization also called for a reduction of the time spent preparing and reviewing grant applications, and that sponsors should consider extending the duration of investigator-initiated awards to decrease the amount of effort spent on competing for funding.

The report is available on FASEB's website.

Obituary

Dorothy "Dottie" Thomas, 92, "Mother of Bone Marrow Transplantation"

Dorothy "Dottie" Thomas, wife and research partner to 1990 Nobel laureate E. Donnall Thomas, died Jan. 9, at her home near Seattle. She was 92.

Don Thomas, pioneer of the bone marrow transplant and former director of the Clinical Research Division at Fred Hutchinson Cancer Research Center, preceded her in death on Oct. 20, 2012, also at age 92.

The Thomases formed the core of a team that proved bone marrow transplantation could cure leukemias and other blood cancers, work that spanned several decades.

"Dottie's life had a profound impact, not just on those who knew her personally, but also countless patients," said Fred Hutch President and Director Gary Gilliland, who became friends with the Thomases when he and Don served on the advisory board of the José Carreras Leukaemia Foundation.

Dottie Thomas, known as "the mother of bone marrow transplantation," may have gotten the name from the late George Santos, a bone marrow transplantation expert at Johns Hopkins University and a professional colleague. "If Dr. Thomas is the father of bone-marrow transplantation, then Dottie Thomas is the mother," he once said

Dottie was a journalism major in college when, in March 1943, Don was admitted to Harvard University Medical School under a U.S. Army program. Dottie got a job as a secretary with the Navy while Don attended medical school.

"Dottie and I talked it over, and we decided that if we were going to spend time together, which it turned out we liked to do, that she probably ought to change her profession," Don told The Seattle Times. "She'd taken a lot of science in her time in school, much more than most journalists. She liked science."

Dottie left her Navy job and enrolled in the medical technology training program at New England Deaconess Hospital. "Because Dottie was a hematology technician, we used to look at smears and bone marrow together when we were students," Don said.

She worked as a medical technician for some doctors in Boston until eventually Don had his own laboratory, and then she began to work with him. She worked half-time when their children were small, but otherwise was in the lab full time with her husband.

"Dottie was there at Don's side through every part

of developing marrow transplantation as a science," said Fred Appelbaum, executive vice president and deputy director of Fred Hutchinson Cancer Research Center. "Besides raising three children together, Dottie was Don's partner in every aspect of his professional life, from working in the laboratory to editing manuscripts and administering his research program."

Dottie's journalism training was a big asset to the team, her husband recalled. "In the laboratory days, my friends pointed out that Dottie, who had the library experience, would go to the library and look up all the background information for a study that we were going to do, and then she would go into the laboratory and do the work and get the data, and then with her writing skills, she'd write the paper and complete the bibliography," Don recalled. "All I would do is sign the letter to the editor."

The couple moved to Seattle in 1963. Don joined Fred Hutch in 1975, the year its doors opened in Seattle. For the next 15 years, Dottie served as the chief administrator for the Clinical Research Division. Don stepped down from the clinical leadership position in 1990 and retired from Fred Hutch in 2002.

The Thomases are survived by two sons and a daughter, eight grandchildren and two great-grandchildren.

The family requests that people who wish to honor her do so by contributing to Dottie's Bridge, an endowment for young researchers.

In Brief

MD Anderson's Lee Moves to Texas Center for Proton Therapy

(Continued from page 1)

Lee was a professor in the Department of Radiation Oncology at MD Anderson Cancer Center, working there for over 13 years. He was medical director of MD Anderson's Proton Therapy Center, and served as director of advanced technologies. He was recognized as a recipient of The University Cancer Foundation Faculty Achievement Award in Patient Care.

A. EUGENE WASHINGTON was named chancellor for health affairs at **Duke University**, as well as president and chief executive officer of the Duke University Health System, effective April 1.

Washington currently serves as vice chancellor for health sciences and dean of the UCLA David Geffen School of Medicine, as well as CEO of the UCLA Health System, where he is also a distinguished professor of gynecology and health policy and holds the Gerald S. Levey, M.D. Endowed Chair.

At Duke, he will succeed Victor Dzau, who stepped down as the university's senior medical officer to become president of the Institute of Medicine.

Washington helped spearhead efforts to change clinical practice and policy guidelines for prenatal genetics, cervical cancer screening and prevention, and reproduction-related infections. In November, he received the David E. Rogers Award from the Association of American Medical Colleges and the Robert Wood Johnson Foundation for his "major contributions to improving the health and health care of the American people." His work also has been recognized with the Outstanding Service Medal from the U.S. Public Health Service and election to the IOM and the American Academy of Arts and Sciences.

Prior to joining UCLA in February 2010, Washington served as executive vice chancellor and provost at the University of California, San Francisco, where he oversaw the research enterprise and steered strategic planning. He co-founded a research center that studied medical effectiveness for diverse populations and co-founded the UCSF-Stanford Evidence-based Practice Center.

Earlier at UCSF, he chaired the Department of Obstetrics, Gynecology and Reproductive Sciences for eight years. Prior to joining the UCSF faculty, Washington worked at the Centers for Disease Control and Prevention.

He is the founding chair of the board of governors of the Patient-Centered Outcomes Research Institute, which established the Eugene Washington Engagement Award, which supports active integration of patient, stakeholder and research communities during the research process.

JULIE BRAHMER was named director of the Thoracic Oncology Program at the **Johns Hopkins Kimmel Cancer Center**.

Brahmer will oversee a $35 million investment in the program and the opening of the new Thoracic Center of Excellence at Johns Hopkins Bayview Medical Center, as well as clinical trials and research focused on lung and esophageal cancer and mesothelioma.

Brahmer has been a faculty member at Johns Hopkins since 2001. She is a member of the American Society of Clinical Oncology and the Eastern Cooperative Oncology Group's Thoracic Committee and Cancer Prevention Steering Committee. A

founding board member of the National Lung Cancer Partnership, now known as Free to Breathe, she currently serves as a member of its Scientific Executive Committee.

She also sits on the Lung Cancer Research Foundation's Medical Advisory Board, Uniting Against Lung Cancer's Medical Committee and LUNGevity's Scientific Advisory Board.

NAIYER RIZVI was named director of thoracic oncology and immunotherapeutics in medical oncology at **NewYork-Presbyterian/Columbia University Medical Center.**

Rizvi comes from Memorial Sloan Kettering Cancer Center, where he was an attending physician and focused on thoracic immunotherapy.

He has authored or co-authored more than 60 peer-reviewed papers, books and book chapters, and currently sits on the editorial board of OncoImmunology.

SETON HALL UNIVERSITY and **Hackensack University Health Network** announced plans to form a new, four-year school of medicine. The partnership will establish the only private school of medicine in New Jersey.

The school is planned to be located on the campus of the former Hoffmann-La Roche Inc. biomedical facility, in Nutley and Clifton, N.J. The first class is expected to begin within the next three years.

Seton Hall plans to integrate their nursing and allied health programs with the new school of medicine. HackensackUHN's hospitals will serve as the primary clinical teaching sites for SHU and SHU-affiliated graduate education programs.

The plan is subject to approval by the New Jersey Economic Development Authority, and an agreement is expected to be finalized early this year.

ROCHE acquired **Bina Technologies Inc**., a privately held company that provides a big data platform for centralized management and processing of next generation sequencing data for the academic and translational research markets.

Bina will be integrated into the Roche Sequencing Unit, and will continue to focus on development of their innovative genomic analysis solution.

Bina recently announced selection of their platform by the US Department of Veterans Affairs to provide whole genome, whole exome, and SNP Chip DNA data analysis as part of the VA's Million Veteran Program, which aims to enroll 1 million veterans.

THE BARBARA ANN KARMANOS CANCER INSTITUTE received a grant of $5,375,000 from the **Dresner Foundation**. The grant, focused on hematologic malignancies research, will be distributed over the next five years.

The grant will create an endowed chair position, help recruit scientists and fellowship positions, and establish a patient registry and tissue bank for blood-related cancers.

It will also establish a Patient Assistance Fund to help low-income cancer patients with financial challenges during their cancer care. This grant, combined with the personal giving from the Dresner family, brings their total giving to Karmanos to over $10.4 million since 1998.

Charles Schiffer, multidisciplinary team leader of Malignant Hematology at Karmanos and professor of medicine and oncology at Wayne State University School of Medicine, will serve as the first endowed Joseph Dresner Chair for Hematologic Malignancies.

The Dresner Foundation was established by the late Joseph and Vera Dresner to support health researchers and those dedicated to improving the quality and length of life for patients. Joseph Dresner was diagnosed with MDS in 2002 and was treated by Schiffer at Karmanos.

THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY and the **College of American Pathologists** announced a partnership to further inter-professional education, advocacy, quality improvement, international outreach, and practice guideline development. The two organizations signed a memorandum of understanding.

ASCO and CAP will focus on the development, application, interpretation, and dissemination of pathology tests, including tumor markers and molecular diagnostics, in cancer care.

According to the two organizations, the collaboration will involve: continuing medical education on the use, interpretation, and application of molecular diagnostic tests; joint evidence-based practice guidelines for oncologists and pathologists; international workshops; and advocacy and patient information about cancer diagnostics.

MOUNT SINAI HEALTH SYSTEM and **Valley Health System** announced plans to collaborate on clinical programs, research and educational initiatives. Mount Sinai comprises seven hospitals and the Icahn School of Medicine at Mount Sinai. Valley

Health System, headquartered in Ridgewood, N.J., includes The Valley Hospital, Valley Home Care and Valley Medical Group.

The collaboration includes: establishing new clinical programs and services; participating in research initiatives; establishing clinical information system linkages; identifying opportunities for Valley physicians to obtain academic appointments at Mount Sinai's Icahn School of Medicine; and developing a clinically integrated physician network.

To oversee the development of joint initiatives for clinical services, research initiatives and educational programs, a Mount Sinai associate dean will be appointed, according to the health system.

PELOTONIA awarded six, two-year grants to projects at **The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital & Richard J. Solove Research Institute.**

Pelotonia is a fundraising bicycle tour established in 2009 to raise money for cancer research at Ohio State. In the past four years, 67 OSUCCC – James research teams have received Pelotonia Idea Grants. A total of $650,000 will be awarded in this latest round of grants, with $6.6 million in funding awarded since the program's inception.

The 2014 Pelotonia Idea Grants funded the following projects: Identifying and Developing New Immunoagents for Cancer Diagnosis and Therapy; Proteasomal Pathway Regulates PTEN Protein Degradation and Promotes Carcinogenesis; A Mass-Spectrometry Approach to Mapping Histone Modification Crosstalk; Develop IL-27 Based Combinational Immunotherapy of Cancer; Ceragenin-based Therapy for Multiple Myeloma; and Defining the Role of Autophagy in Anoikis Resistance and in Peritoneal Carcinomatosis/Sarcomatosis.

GENENTECH and **Human Longevity Inc**. signed a multi-year agreement to conduct whole genome sequencing of tens of thousands of de-identified samples provided by Genentech, a member of the Roche Group.

HLI will sequence genomes to 30x coverage and analyze the data. Financial details of the agreement were not disclosed.

HLI is building a comprehensive integrated human genotype and phenotype database, the HLI Knowledgebase, using Illumina's HiSeq X Ten and HiSeq 2500 sequencing machines and Pac Bio RS II instruments.

MD ANDERSON CANCER CENTER, **Intrexon Corporation** and **Ziopharm Oncology** announced a sublicensing agreement for intellectual property developed at the **University of Minnesota** for the development of non-viral adoptive cellular cancer immunotherapies.

Researchers at the University of Minnesota have explored the design and clinical investigation of novel chimeric antigen receptor T cell therapies using non-viral gene integration platforms. MD Anderson has built on this technology to deliver patient-derived T cells, as well as innovative approaches to generating products for universal off-the-shelf applications. The agreement will also use Intrexon's technology suite and Ziopharm's RheoSwitch Therapeutic System interleukin-12 modules.

The work continues in conjunction with MD Anderson's Moon Shots Program. Clinical trials using non-viral adoptive cellular therapies are either under way or planned for the specific cancers in the program.

Under the terms of the agreement, MD Anderson will receive consideration of $100 million; $50 million from each Intrexon and Ziopharm, payable in shares of their respective common stock, as well as a commitment of $15 to $20 million annually over three years for researching and developing the technologies.

The parties will enter into additional collaboration and technology transfer agreements to accelerate technology and clinical development.

AMGEN and **MD Anderson Cancer Center** announced a research collaborative agreement focusing on Amgen's bispecific T cell engager antibody constructs, an immunotherapy that serves as a bridge between T cells and cancer cells.

The research agreement will identify targets for this therapy in myelodysplastic syndrome patients, and provides for joint development of new agents under pre-determined terms. Amgen retains all commercial rights, while MD Anderson is eligible to receive milestones and royalties upon successful achievement of key objectives.

BiTE antibody constructs are recombinant proteins consisting of two separate antibodies held together by a flexible peptide linker or bands of amino acids. The antibodies are designed to function as a link between T cells and cancer cells. One antibody or protein domain binds to the cancer cell's surface, while the other binds to the CD3 on the T cell, resulting in the malignant cell's death.