THE CANCER LETTER

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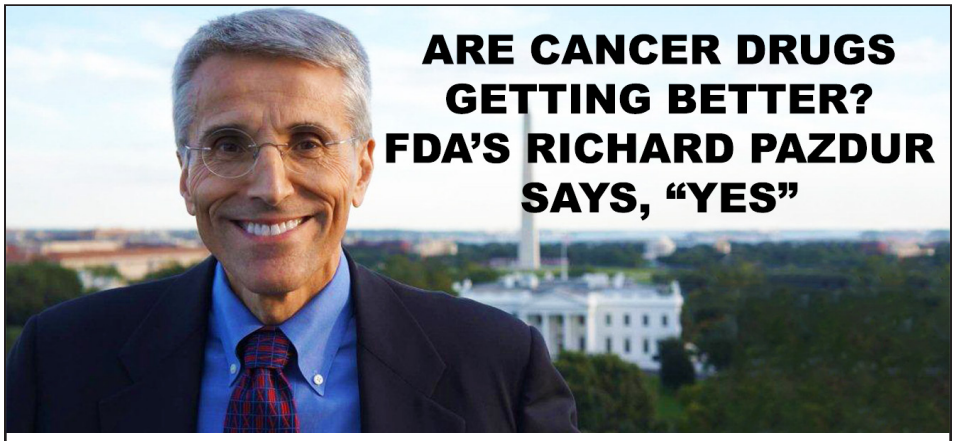

A meeting of the FDA Oncologic Drugs Advisory Committee has become a rare occurrence.

Why?

Because cancer drugs are getting better, as are applications for their approval, said Richard Pazdur, director of the FDA Office of Hematology and Oncology Products.

"Drug development is much more focused, and decisions are being made on the basis of understanding the molecular basis of the disease rather than the number of responses observed in an early phase study," Pazdur said.

Many drugs are vying for expedited approval, and preparations for ODAC would slow down the approval.

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Guest Editorial

Once Again, Hype Overshadows Data In Breast Cancer Screening Debate

By Otis W. Brawley

Studies assessing the merits of cancer screening tend to get a lot of play in the news media. It seems every six months or so a new study makes a big splash.

I can see why the press would want to interview experts who hold a variety of opinions, yet I worry that that he-said/she-said coverage of these stories often creates a situation where the press and we in medicine misinform the public.

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In Brief

Hong to Retire after 30 Years at MD Anderson

WAUN KI HONG announced his plans to retire as head of the MD Anderson Center Division of Cancer Medicine effective this summer after 30 years at that institution. Hong is 71.

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Pazdur: Drug Development More Focused, Targeted

(Continued from page 1)

"In making a decision regarding whether an ODAC is necessary, we must also balance the timing of the meeting versus an expedited approval," Pazdur said. "Our office has commonly approved important applications prior to their Prescription Drug User Fee Act goal date.

"This is relatively unique to the oncology office. These approvals have occurred as soon as 2.5 months after receipt of the application.

"ODAC scheduling and preparation can be complicated and takes many months. We must balance the potential information that may be obtained from an ODAC against a delay in approving an important drug for which we have adequate information on safety and efficacy. This is of particular concern when we have a drug that addresses an unmet medical need."

FDA approvals in oncology and hematology reflect development activity in these therapeutic areas, Pazdur said.

For example, in 2011, FDA approved 30 new molecular entities, of which 11 went through Pazdur's office. In 2012, the agency approved 39 NMEs, of which 14 went through OHOP. And in 2013, the total NMEs were at 27, of which eight were OHOP's.

Last year, only three drugs went to ODAC, and only one of them was approved. The committee nixed tivozanib and Melbez kit and voted for approval of Perjeta, and the agency followed these recommendations.

Pazdur responded to questions from Paul Goldberg, editor and publisher of The Cancer Letter.

Paul Goldberg: *There hasn't been an ODAC in a long time. Why not?*

Richard Pazdur: The main reason is simple: the drugs are better, and the applications are better. When I first came to FDA in 1999, our major internal discussions focused on whether the drug should be approved.

Now, these discussions have frequently focused on how we can expedite the approval. The major obstacle in cancer drug approval has always been the demonstration of efficacy. With a move away from general cytotoxic chemotherapy drugs with marginal efficacy findings to targeted drugs having unprecedented response rates, the review question is not whether we should approve the drug, but how quickly we can approve the drug.

We often start discussing whether an application will need to go an ODAC prior to the application's submission, but generally notify sponsors shortly after the filing the application.

These types of applications do not need to go to ODAC.

We take a careful look at whether or not to have an ODAC meeting depending on the quality of the application, the results of the clinical trials, and whether similar issues, such as endpoints or trial designs, have been previously discussed at these meetings. If the review divisions and the sponsor are aligned in a regulatory decision, there may be little information gained from holding an ODAC.

Even when applications do not go to ODAC, the review divisions have individually consulted ODAC members, disease experts, and patient representatives to discuss a pending application.

This ensures outside expertise and advice is presented to the review division but without having to undertake the extensive preparation and resources—both on the part of the FDA and sponsor—needed for an ODAC meeting. When these discussions occur, the individuals are special government employees (SGEs) cleared for conflicts of interest by FDA. Discussions with the SGEs are documented in the reviews posted after approval.

We have generally taken more problematic or

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complicated applications to ODAC, which allows for a presentation of our findings and a public discussion of the issues at hand. In the event that the application is not approved, our reviews would not be publically available; however, our preliminary review of the application can at least be discussed in a public forum during ODAC.

This is important, since sponsors may not clearly present all issues in their subsequent public disclosures after a negative regulatory action. However, it should not be assumed that if an application is presented at ODAC that a negative decision is pending.

For example, at the recent ODAC discussing Perjeta for neoadjuvant breast cancer treatment, we wanted the public to clearly understand our viewpoint on the particular application and its supporting evidence.

Also, since this was the first time a drug for neoadjuvant breast cancer was to be approved, we thought an ODAC meeting was needed to hear the viewpoints of other stakeholders such as oncologists, statisticians, and patients.

PG: *Haven't there been any review questions worth airing? Why not?*

RP: There are always questions that come up. Some questions can be handled by consulting individual disease experts, while other discussions may be better addressed by workshops like the ones conducted on minimal residual disease in pediatric leukemia and CLL, neoadjuvant breast cancer, and CNS malignancies.

These workshops are meant to provide a dialog with FDA and allow the greatest degree of participation by all stakeholders. Many times these workshops are co-sponsored by professional societies or advocacy groups.

As a disclaimer, I should note that these workshops are neither meant to provide formal advice to the agency nor are they meant to replace ODAC meetings.

In making a decision regarding whether an ODAC is necessary, we must also balance the timing of the meeting versus an expedited approval. Our office has commonly approved important applications prior to their Prescription Drug User Fee Act (PDUFA) goal date.

This is relatively unique to the oncology office. These approvals have occurred as soon as 2.5 months after receipt of the application.

ODAC scheduling and preparation can be complicated and takes many months. We must balance the potential information that may be obtained from an ODAC against a delay in approving an important drug for which we have adequate information on safety and efficacy. This is of particular concern when we have a drug that addresses an unmet medical need.

PG: *What goes on in the agency and with the sponsor in preparation for an ODAC?*

RP: Holding an ODAC is a complex procedure both for the FDA and the sponsor.

We often start discussing whether an application will need to go an ODAC prior to the application's submission, but generally notify sponsors shortly after the filing the application.

Many sponsors spend months in preparation. They hold meetings with key opinion leaders, hold mock ODACs, and try to anticipate possible questions that may arise. It seems that sponsors have hundreds of potential slides prepared in anticipation of questions. Sponsors generally have multiple consultants and technical advisors to assist them.

With a move away from general cytotoxic chemotherapy drugs with marginal efficacy findings to targeted drugs having unprecedented response rates, the review question is not whether we should approve the drug, but how quickly we can approve the drug.

Some of the same procedures occur at the FDA. One important difference is that we do not have the same resources available to us. Our reviewers must be PowerPoint "gurus" and must make all of their own slides.

The reviewer, team leader, and division director must prepare all briefing documents. We do not have any outside help for these activities, nor do we have any administrative staff to perform these activities. This all rests with the FDA oncology staff.

We have internal practice sessions prior to the ODAC that are critiqued by the entire oncology staff, now numbering approximately 50 medical oncologists or pediatric oncologists. These internal practice sessions can become quite spirited with differing viewpoints passionately presented. Interestingly, I rarely hear something at the public ODAC that has not been already internally voiced.

We have a bright and articulate staff with diverse and firmly held viewpoints that they feel free to express. At the end of the day, we have to address these issues and come to a common decision.

Preparation for an ODAC meeting is a tremendous undertaking. This time commitment has become

increasingly challenging in oncology during the last several years. Compared to other therapeutic areas, oncology has had 30-40 percent of all FDA new drug approvals. In addition, the oncology office has been heavily involved in several regulatory initiatives.

These include breakthrough therapy designation requests and meetings to discuss biosimilar registration strategies. Of the 40 breakthrough designations granted so far, 16 (or 40 percent) have been in oncology. In addition, of the 62 biosimilar programs currently in FDA/CDER, 36 (or 58 percent) of the biosimilar programs are in our office.

PG: ***Any other issues with preparation for ODAC?***

RP: One of the most difficult issues arises with screening for conflicts of interest.

This has been increasingly burdensome on FDA review staff and frequently prevents us from recruiting some of the top talent to serve on the committee. Several issues have arisen.

ODAC members may frequently be in administrative positions (division or department heads) in academic institutions. The conflicts of interest of their subordinates (research funding, consultancies) may be imputed to the ODAC member because of their presumed supervisory capacity. In addition, key disease leaders who FDA may want to serve on ODAC may have participated in either the drug's development or in the development of a competitor drug.

ODAC members are screened both for conflicts of interest attributed to the drug under review as well as competing products. When necessary and appropriate, FDA staff must engage in writing waivers for these individuals. This can be a long process and usually occurs in close proximity to the ODAC meeting when we are trying to finalize various aspects of the meeting.

PG: *Let me give you a scenario I've seen played out at ODAC time and time again: a trial shows improvement in PFS, but no improvement in OS. The finding is statistically significant. ODAC is asked whether this finding is clinically significant. How can this question go away?*

RP: This situation involves a risk-benefit decision, and each of these decisions is unique. Some factors that come into consideration are the adverse events associated with the drug, other available therapies, the magnitude of the observed PFS, and potential reasons that an OS benefit has not been observed.

We have clearly had applications that have demonstrated a statistically significant improvement in PFS that was not clinically meaningful when examined in a risk-benefit analysis.

The purpose of conducting a clinical trial is not to achieve a "p" value, but to demonstrate a clinically meaningful outcome for patients.

PG: *The reason I love ODAC—and I do love ODAC—there is no substitute for bringing together a group of smart, verbal people and giving them a go at unscripted discussions of science. Anything can happen. Is the FDA taking away a valuable teaching tool by holding fewer ODACs?*

RP: There are many venues available for medical education, particularly for the practicing oncologist. As I discussed, given the resources required for an ODAC meeting, we have generally used these meetings where we want advice from experts and where a public discussion and disclosure of information regarding an application is needed.

ODAC meetings are generally closely attended and scrutinized by regulated industry, thought leaders in a particular disease, advocacy groups, the financial industry covering pharma and biotech, and reporters.

I suspect few practicing medical oncologists in the heartland attend ODAC meetings or review ODAC transcripts.

These meetings are not intended to be educational seminars on how to use the drug. The FDA has collaborated with ASCO to provide a new drug seminar prior to the annual meeting each year where drugs and their basis for approval are reviewed. This year, the seminar will be held May 29-30 in Chicago.

PG: *Are you seeing an improvement in applications*

At the recent ODAC discussing Perjeta for neoadjuvant breast cancer treatment, we wanted the public to clearly understand our viewpoint on the particular application and its supporting evidence.

Also, since this was the first time a drug for neoadjuvant breast cancer was to be approved, we thought an ODAC meeting was needed to hear the viewpoints of other stakeholders such as oncologists, statisticians, and patients.

across all cancers, or just some cancers. If I am not mistaken, there are some diseases where there are lots of therapies where for others there isn't much. What does the chessboard look like? What impact is this having on approvability?

RP: Nothing breeds success like success.

During the first two decades of my career, there were diseases where there was little progress—renal cell carcinoma, prostate cancer, CML, lung cancer, and melanoma. Things have changed in these diseases.

During the first two decades of my career, there were diseases where there was little progress—renal cell carcinoma, prostate cancer, CML, lung cancer, and melanoma. Things have changed in these diseases.

We saw this beginning in 2005 in renal cell cancer with the rapid approval of seven drugs: sorafenib (2005), sunitinib (2006), temsirolimus (2007), pazopanib (2009), bevacizumab plus interferon (2009), everolimus (2009), and axitinib (2012). Since 2010, five drugs have been approved in metastatic prostate cancer, all with survival advantages.

These drugs for prostate cancer have diverse mechanisms, including immunotherapy, hormonal therapy, cytotoxic chemotherapy, and radiotherapy. This diversity provides a unique opportunity to examine therapeutic combinations that may provide additive anti-tumor activity and lower risks of overlapping toxicity.

We saw this success in CML after the initial development of imatinib (2001) with the subsequent approvals of dasatinib (2006), nilotinib (2007), bosutinib (2012), omacetaxine (2012), and ponatinib (2012). With the development and approval of the targeted lung cancer drug crizotinib (2011), commercial sponsors have rapidly developed drugs aimed at patients with alk-positive lung cancer who are refractory or resistant to crizotinib.

Perhaps no area is more representative of these changes than melanoma, with approaches aimed both at an enhanced immunological understanding and appreciation of molecular pathways and attempts to modulate them.

We are redefining the traditional diseases by this science. Drug development is much more focused, and decisions are being made on the basis of understanding the molecular basis of the disease rather than the number of responses observed in an early phase study.

The demonstration of efficacy has always been the challenge of oncology approval.

Because of the life-threatening nature of the disease and the historical perspective of the oncology field, we and, more importantly, our patients have accepted a high degree of toxicity.

Drugs in the recent years have had exceptional response rates that we have not observed before, frequently with greater tolerability than conventional chemotherapy agents.

Guest Editorial

Brawley: Hype Overshadows Data In Breast Cancer Screening

(Continued from page 1)

All too often, our conflicts of interest—emotional more than financial—get in the way of the truth and overshadow reason.

Earlier this week, the British Medical Journal published a 25-year update from the Canadian National Breast Screening Study. This study was really two clinical trials that enrolled nearly 90,000 women in their 40s and 50s beginning in 1980.

The report received front-page headlines in major newspapers and was the lead story on several television news programs.

Most journalists and experts simply got the finding wrong. It was widely stated that the study showed that screening didn't save lives. In reality, the study had a subtle, but important and very different finding: it found no benefit for routine mammography and clinical breast examination, compared to standard care for women in their 40s, and no benefit for mammography for women in their 50s.

All women in their 50s in the both intervention and control arms received CBE.

The fact that this study did screen the control group of women in their 50s with clinical breast examination was lost in virtually every news story. Unfortunately, even physicians tend to discount the power of physical examination, as we prefer high tech imaging.

Spokespersons for the American College of Radiology pounced on the finding with harsh criticisms bordering on an *ad hominem* attack of the authors of this paper. One said that the study is "fundamentally flawed and totally useless." They criticized the quality of the mammography equipment and the randomization scheme.

I, too, am concerned about the randomization in these trials, but I and other experts are also concerned about the randomization in several of the other mammography trials that *support* screening. This concern does not mean these trials are without merit.

Interestingly, the studies that support the inclination that screening works have gotten less scrutiny. Indeed, most have never been audited for accuracy.

Medical science is not an exact science. Indeed, there is even debate as to how many breast cancer screening clinical trials have been done. Some say eight, other say as many 12. Some consider the Canadian study to be two trials, one of women in their 40s at the start, and one of women in their 50s.

All large screening trials are imperfect. All have flaws. Several of the studies most cited as supporting breast screening have reported different numbers of women enrolled. This inconsistency is observed in different journal articles published at different times. These studies are long-term logistical challenges, run by physicians and epidemiologists. Engineers and accountants might have done a better job.

It is the job of the screening expert to objectively look at each study and assess its strengths and weaknesses, and, ultimately, try to glean a view of reality. The expert then looks at all the available clinical trials in an attempt to further distill the truth.

The authors of the study and the editorialist at BMJ called for a change in policy based on this study. That, too, might be considered an overreach. Policy should be based on an accumulation of evidence, and not just one study.

This study adds to the body of evidence, but that body of evidence still suggests that there is some benefit to mammography screening among women aged 40 and above.

Even the US Preventive Services Task Force assessed the total body of literature, including earlier reports from the Canadian trial, and said screening of women 40 to 59 likely produces a 15 percent relative reduction in the risk of death.

The tendency of Americans to believe in screening—and the fact there is passionate disagreement among experts—produced an opportunity for the press to pounce on the story.

The press has conflicts of interest, too. Indeed, a finding not supportive of the commonly accepted view creates controversy. In the old days, we used to say controversy sells newspapers. If anything, the hype has been exacerbated in the digital age.

Due to exaggeration in the past, many doctors and lay people have come to believe that mammography is better than it is. Recently, I told an educated audience that the best breast screening study to date suggested mammography caused a 35 percent decrease in the risk of death, which means that 65 percent of the women destined to die of breast cancer still died if screened regularly.

Most of the audience was shocked that women who get regular mammography can still die of breast cancer—and that this is not the due to bad mammography.

While it is my concern that the benefits of mammography screening have been exaggerated, this does not mean that it does not save lives, or that women

should not get it. It means we need to use it with caution, explain its limitations, and realize we need to develop a better test.

Such moderate views don't play well in the news media. This week, I was scheduled for an interview on a national TV news show.

However, my appearance was called off just as I was getting in a cab to go to the studio.

The producer was honest: I was being upstaged by a spokesperson from the American College of Radiology, who was angry at the finding. Hotter controversy makes for better television.

So much for doing a story that would educate the public on how to assess and apply scientific findings.

The author is the chief medical and scientific officer of the American Cancer Society.

Disclosure: Brawley and Paul Goldberg, editor and publisher of The Cancer Letter, are co-authors of How We Do Harm: A Doctor Breaks Ranks About Being Sick in America (St. Martin's Press, 2012).

Drasga and Einhorn Respond To Single Payer Proposal Critique

By Conor Hale

In a recent article published in the Journal of Oncology Practice, oncologists Ray Drasga and Lawrence Einhorn called on their colleagues to support "an improved Medicare for all" program.

The provisions of the Affordable Care Act are insufficient to solve the crises facing American cancer patients, they wrote in the journal published by the American Society for Clinical Oncology.

They authors proposed a comprehensive system run by a public agency and funded by a mix of payroll and income taxes (The Cancer Letter, Jan. 31).

In response, Gary Jones, an assistant professor of anesthesiology and perioperative medicine at Case Western Reserve University and director of the university's MS in Anesthesia Program in Houston, published a critique of the proposal on MedPage Today.

"Anyone in medicine who values evidence-based practice, one of our core competencies, needs only look at the evidence to see that an expansion of government controlled healthcare will hurt the healthcare system, the physician, and, ultimately, the patient," Jones wrote.

In a list of eight points, he covers administrative costs, personal bankruptcies related to healthcare bills, and patient outcomes.

Drasga and Einhorn then delivered their own response to the critique, also published as a guest blog on MedPage Today.

"We read the rebuttal by Mr. Jones and appreciate his time and effort to comment upon our article in Journal of Oncology Practice (JOP). Medical oncologists are particularly data-driven and make clinical decisions based upon evidence-based medicine," they wrote. "Initially, data becomes information which can then lead to a change in standard practice. However, sometimes data simply permits us to form opinions and write commentaries."

"H.L. Mencken once opined, 'For every complex problem there is an answer that is clear, simple, and wrong.' However, that does not mean we should avoid solutions for difficult issues, nor accept that the current status quo in healthcare is immutable."

In one back-and-forth, regarding the comparable overhead costs between Medicare and Medicaid and that of private insurance, Jones wrote:

"Medicare and Medicaid do not calculate administrative costs in the same manner that private insurers do, so the comparison confuses an honest assessment. When administrative costs are compared on a per-person basis, the picture changes. Medicare's administrative costs were $509 per primary beneficiary, compared with private-sector administrative costs of $453. In the years from 2000 to 2005, Medicare's administrative costs per beneficiary were consistently higher than that for private insurance, ranging from 5% to 48% higher, depending on the year."

In response, Drasga and Einhorn argued:

"Calculating the overhead costs based on the Medicare trustees' report rather than using Zycher's methodology dramatically changes per-capita spending. For example in 2005, Medicare's per-capita spending was $144 compared with $680 in the private sector. Medicare's overhead of 1.4% includes all types of nonmedical spending by the Centers for Medicare and Medicaid Services, as well as other federal agencies, such as the IRS, and is based on data contained in the latest report of the Medicare trustees. Alternative estimates aren't credible and have been refuted elsewhere. Under the Affordable Care Act, insurers are allowed overhead and profits of 15% of premiums, or 10-fold Medicare's."

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In Brief

Hong to Retire as Head Of MD Anderson Division Of Cancer Medicine

(Continued from page 1)

Hong's retirement was announced Feb. 11 in an email sent out by Ethan Dmitrovsky, provost and executive vice president.

The text of the email follows:

Dear Colleagues:

We want to inform you that Waun Ki Hong, M.D., Head, Cancer Medicine division, has decided to retire this summer. We are fortunate that he will continue his important work with us in a post-retirement position within our Sheikh Khalifa Bin Zayed Al Nahyan Institute for Personalized Cancer Therapy (IPCT) and also the Advanced Scholar Program within Cancer Medicine. A search will be launched soon to identify our next leader of Cancer Medicine.

Dr. Hong joined MD Anderson in 1984 and has served as Head of Cancer Medicine since 2001. He is a giant in the field of cancer and a legend at MD Anderson. He is truly one of our greats and is recognized internationally for his exceptional contributions to cancer medicine.

Dr. Hong's groundbreaking contributions are too lengthy to list in detail here, but we will highlight some of the most significant ones. Dr. Hong's seminal work in the fields of chemoprevention and methodology for cancer prevention trials helped to define a new discipline in oncology. He led the landmark Veterans Administration Cooperative induction chemotherapy and radiotherapy trial for laryngeal preservation, which changed the way the disease is managed and served as a model for organ preservation for many other cancers. His more recent research program in chemoprevention and treatment includes trail-blazing multidisciplinary clinical trials. The goals of these molecularly targeted approaches are to reduce morbidity and mortality for patients with lung cancer and head and neck cancer. Dr. Hong has authored more than 696 scientific publications and edited 11 books, including the 7th and 8th editions of Holland-Frei Cancer Medicine, and has served on the editorial boards of 19 scientific journals.

Preparation for his landmark career began in Korea. Dr. Hong received his medical degree from the Yonsei University School of Medicine before moving to the United States in 1970. He completed a medical residency at the Boston Veterans Affairs (VA) Medical Center, followed by a fellowship at Memorial Sloan-Kettering Cancer Center. He served as Chief of Medical Oncology at the Boston VA Medical Center and was a faculty member at both the Boston University School of Medicine and the Tufts University School of Medicine before joining MD Anderson in 1984.

From 1984 to 1992, Dr. Hong served as Chief, Head and Neck and Thoracic Medical Oncology section. From 1993 to 2005, he served as Chair, Thoracic/Head and Neck Medical Oncology department. In 2001, he was named Head, Cancer Medicine division. From August 2012 to August 2013, he served as Vice Provost for Clinical Research. He has held three endowed positions here since 1988. Since 2002, he has held MD Anderson's Samsung Distinguished University Chair in Cancer Medicine. He also is an American Cancer Society Professor.

Dr. Hong has received numerous honors, most recently election to the Institute of Medicine. Other prestigious awards include the Medal of Honor for Clinical Research from the American Cancer Society, the Raymond Bourgine Award and the Claude Jacquillat Award from the International Congress on Anti-Cancer Treatment (ICAT) in France and the Ho-Am Prize from the Samsung Foundation in Korea. He has been active in several national and international cancer research organizations, including serving as president of the American Association for Cancer Research (AACR) in 2001. He has received major AACR awards, including the Joseph A. Burchenal and Rosenthal Foundation Awards and the AACR/Cancer Research and Prevention Foundation Award for Excellence in Cancer Prevention Research. He also was an inaugural AACR Fellow. He has received some of the highest honors from the American Society of Clinical Oncology (ASCO), including the David Karnofsky Award and the ASCO-American Cancer Society Award. He also served as a member of the ASCO Board of Directors.

In addition to his research and clinical work, Dr. Hong has trained and mentored hundreds of young physicians and scientists from around the world and has worked to increase international collaboration in cancer research. He has played a leadership role in shaping public policy through his service as chair of the Prevention, Clinical and Therapeutic Subcommittee for the National Cancer Institute (NCI) External Board of Scientific Advisors (BSA); the NCI Translational Research Working Group (TRWG); the U.S. FDA Oncologic Drug Advisory Committee (ODAC); and

the Subcommittee of Clinical Investigations for the National Cancer Advisory Board (NCAB).

There will be an institutional event to recognize Dr. Hong for his exceptional service on Friday, Aug. 15, 2014. Join us to honor and congratulate him at this celebration. In the meantime, please join us in thanking Dr. Hong for his visionary leadership and service. His contributions have touched the lives of cancer patients at MD Anderson and far beyond.

Ethan Dmitrovsky, M.D.
Provost and Executive Vice President
Thomas Buchholz, M.D.
Executive Vice President and Physician-in-Chief
Thomas Burke, M.D.
Executive VP, MD Anderson Cancer Network

FRASER SYMMANS was named director of the **CALGB Alliance Translational Research Program**. He will oversee the activities of all scientific and administrative committees.

Symmans has served as a member of the Breast Committee and the Clinical Trials Concept Review Committee. He is professor and director of research operations in the Department of Pathology at MD Anderson Cancer Center.

He co-developed a method to increase the prognostic information from pathologic assessment of response from neoadjuvant chemotherapy. He also adapted genomic technologies to clinical needle biopsies of breast cancer in order to use gene expression profiling to identify important genes for response to chemotherapy and, independently, to endocrine therapy; to validate gene expression tests with clinical potential; and to establish their performance in the context of clinical testing.

Symmans has served as principal investigator for numerous NIH- and DOD-funded awards to develop and validate predictive and prognostic biomarkers, including identifying estrogen reporter genes to predict response to endocrine therapy, validating transcriptional profile data to predict response to adjuvant paclitaxel therapy and integrating pathologic findings with clinical-radiologic tumor measurements to quantify response to neoadjuvant chemotherapy.

He is also an active member within multicenter research collaborations, is a Komen Scholar, and participates within the NCI's North American Breast Group and the Breast International Group where he co-chairs the Residual Disease Working Group and is a member of the Biomarkers Working Group and the Breast Oncology Local Regional Task Force.

JOHN WALTER, president and CEO of **The Leukemia & Lymphoma Society** since 2008, has stepped down.

Louis DeGennaro was named interim president and CEO while the board of directors considers a permanent replacement. DeGennaro has been serving as LLS executive vice president and chief mission officer. Walter will consult with LLS during the transition process.

Walter joined LLS in 1995 as a senior vice president, later becoming chief operating officer. He designed and implemented LLS's co-pay assistance program, which to date has provided more than $160 million to help cover insurance premiums and drug co-pays to people with blood cancers. He also oversaw the launch of a branding platform to raise awareness about how LLS is helping to save the lives of patients with blood cancers.

As chief mission officer, he has been responsible for the society's research, patient access, public policy and advocacy, and education activities. He is recognized as a key architect of the LLS Therapy Acceleration Program and its cures and access agenda.

THE AMERICAN CANCER SOCIETY added five new officers to its 2014 national volunteer board of directors. **Pamela Meyerhoffer**, a 40-year volunteer with the society, will chair the new board.

Other officers include **Robert Youle**, vice chair; **Douglas Kelsey**, board scientific officer; **Daniel Heist**, secretary/treasurer; and **Gary Reedy**, immediate past chair.

The officers are the first to join the newly streamlined board after a reorganization of the 100-year-old society. The board was reduced from 43 members to 21 after a volunteer task force analyzed the previous structure and made recommendations to bring it more in line with industry best practices.

The board is responsible for setting policy for the society as well as establishing long-term goals, monitoring general operations and approving organizational outcomes and allocation of resources.

Meyerhoffer, is the executive director for Wickenburg Community Hospital Foundation in Arizona and serves on the society's Great West Division board of directors. She was awarded the society's St. George National Award in 1985, the highest award given to a volunteer.

Youle is a 26-year volunteer and has served on the board of directors for the past six. He is an attorney in the Denver office of Sherman & Howard, LLC, specializing in commercial litigation. He served on the American Cancer Society's Great West Division board of directors and was awarded the St. George National Award in 1998.

Kelsey is a medical fellow at Lilly Research Laboratories and is currently the lead physician for clinical ADHD studies in U.S Medical Operations Neuroscience Division in Indianapolis, Ind. Kelsey has volunteered for 20 years and has been a member of the board of directors since 2005. He received the St. George National Award in 2003.

Heist has been a volunteer for more than 20 years and has served on the board of directors since 2008. He is the director of internal audit at the Pennsylvania State University with more than 25 years of accounting, auditing, and management experience. He served on the East Central Division board of directors and was awarded the St. George National Award in 2013.

Reedy is the worldwide vice president of government affairs and policy at Johnson & Johnson. He received the Cure for Lymphoma Foundation's Trailblazer Award for cancer research excellence in 2000 and served as a charter member of the CEO Roundtable on Cancer. Reedy served as the American Cancer Society Foundation liaison from 2004 until 2007 and has been on the board of directors since 2007.

JIM ALLISON has been awarded the **2014 Szent-Györgyi Prize for Progress in Cancer Research** from the National Foundation for Cancer Research.

Allison, professor and chair of Immunology at MD Anderson Cancer Center and director of the Moon Shots Program immunotherapy platform, was recruited to MD Anderson in 2012 to build a program that supports immunotherapy research across multiple cancer types.

He is also deputy director of the David H. Koch Center for Applied Research of Genitourinary Cancers and holds the Vivian L. Smith Distinguished Chair in Immunology at MD Anderson.

Allison's research solved a crucial part of a puzzle that thwarted immunotherapy development for decades. Tumors spark an immune response, but cancer cells somehow evaded or thwarted a lethal attack. At the University of California, Berkeley, he identified an immune checkpoint molecule CTLA-4 that turns off T cells before they can attack and destroy tumors.

Allison developed an antibody that blocks the CTLA-4 immune checkpoint, Ipilimumab (Yervoy), which became the first drug to extend survival for patients with late-stage melanoma. Researchers recently reported that 21 percent of patients with advanced melanoma survived to three years after taking the drug, with some living 10 years or longer.

Allison will be honored at an award ceremony April 30 at The National Press Club in Washington, D.C.

AVEO ONCOLOGY and **Astellas Pharma Inc**. will end an agreement to develop the investigational cancer drug **tivozanib** by Aug. 11.

The companies signed a worldwide agreement to develop and market the drug outside Asia in 2011.

"Astellas has exercised its right to terminate the agreement signed in 2011 for strategic reasons, based on the clinical status of the three indications studied," the companies announced Feb. 14. "Additionally, the companies agreed to discontinue the ongoing phase II BATON (Biomarker Assessment of Tivozanib in Oncology) study in patients with colorectal cancer."

The companies last month discontinued a phase II study of tivozanib in locally recurrent or metastatic triple-negative breast cancer due to insufficient enrollment (The Cancer Letter, Feb. 7).

In December 2013, AVEO announced that a phase II study in metastatic colorectal cancer would be unlikely to reach its primary endpoint in the intent-to-treat population, following an interim analysis.

The rights to tivozanib will be returned to AVEO upon termination of the collaboration.

AVEO's co-founders include Ronald DePinho, president of MD Anderson Cancer Center, and his wife Lynda Chin, a senior scientist at the center. In 2012, DePinho recommended investing in AVEO stock during an appearance on CNBC.

Over the past year, AVEO's stock price has fallen 80 percent from its highest point. DePinho has stepped down from AVEO's board of directors, but Chin remains on its scientific advisory board. DePinho has apologized for offering investment advice.