NATIONAL CANCER INSTITUTE

# NCI Cancer Bulletin

*Celebrating Excellence in Cancer Research*

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**In this issue:**



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## MRI Detects Nearly All Contralateral Breast Cancers

A new study has demonstrated a significant benefit of adding a magnetic resonance imaging (MRI) study to the standard diagnostic workup following a new diagnosis of breast cancer in one breast.

By using MRI to examine the opposite breast in a population of 969 women with newly diagnosed breast cancer, researchers from the NCI-funded American College of Radiology Imaging Network (ACRIN) discovered 3.1 percent of the patients had cancers in the contralateral breast that were missed by standard practice mammography and clinical breast exam. A negative result on the MRI exam of the contralateral breast nearly eliminated the likelihood (0.3 percent) of cancer being found in that breast over the next year, they reported in the March 29 *New England Journal of Medicine*.

MRI demonstrated a 91-percent sensitivity (percentage of true cancers detected) and 88-percent specificity (percentage of true negatives), and MRI efficacy was not affected by patients' cancer type, age, or breast density.

*(continued on page 2)*

See page 3 for a Special Report on prostate cancer. ◆

*Director's Update*

*Nelvis Castro, Deputy Director, Office of Communications and Education*

Guest Director's Update from Nelvis Castro

## *Cancer Information for Hispanics and Latinos*

More and more Americans are surviving cancer and are continuing to live productive lives. However, many Hispanics and Latinos in the United States have not heard this message, and they have not benefited from advances in early detection and treatment. NCI's new Spanish-language Web site, launched yesterday, strongly communicates the message that cancer can be prevented and treated, in addition to offering information on all aspects of the disease.

From the very beginning, our goal was to create a site tailored to meet the needs of Latinos who seek cancer information online. Rather than simply translating the English version of the site—which would be no small task in itself—we developed a site designed specifically for this audience. The pages are organized around the issues of greatest concern to Latinos, based on surveys and focus groups.

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*(MRI continued from page 1)*

"We can now identify the vast majority of contralateral cancers at the time of a woman's initial breast cancer diagnosis," said the study's principal investigator, Dr. Constance Lehman, professor of radiology and director of breast imaging at the University of Washington and Seattle Cancer Care Alliance.

Finding cancer in the opposite breast at this juncture will help avoid the cost, morbidity, and stress of multiple or delayed treatments, Dr. Lehman said. And a negative result on the opposite breast with mammography, clinical exam, and MRI also may allow women to forego prophylactic bilateral mastectomies, "a potential outcome that we would be delighted to see," she added.

The NCI-funded trial is the first of this size on the topic, with more than 1,000 patients enrolled, including those being treated at academic medical centers, community hospitals, and private practices. Adding a contemporaneous MRI to the diagnostic workup effectively doubled the number of contralateral cancers typically found. In 121 cases, MRI findings led to biopsies, 30 of which resulted in cancer diagnoses. Of these, 60 percent were invasive cancers, while the remainder were ductal carcinoma *in situ* (DCIS), abnormal cell clusters in the lining of the breast duct that have not invaded other tissue but that can progress to full-blown invasive tumors.

Three additional tumors—all DCIS less than 5 mm in size—were diagnosed upon analyses of mastectomy tissue samples.

That one of every four cases referred for biopsy based on the MRI turned out to be cancerous is an important finding, according to Dr. Carl Jaffe,

*(continued on page 6)*

*(Director's Update continued from page 1)*

Latinos are the fastest growing online audience in the United States, and those who look for cancer information online tend to be "intermediaries" for patients, such as family members and health professionals. Many are bilingual and are comfortable reading something in one language and talking about it in another. The site allows users to toggle back and forth between pages in English and in Spanish.

The most important questions to all users in our surveys were, "What is cancer?" followed by, "Where can I go for screening and treatment?" Cancer.gov en español is organized to allow users to easily find answers to these questions and to find information about different types of cancer and about support and resources available to cancer patients and their families. The site also addresses common myths and beliefs about cancer, including the view that cancer, in general, cannot be treated successfully. These myths and beliefs are barriers to screening and treatment, and we hope the information on the site will help overcome them. In addition, the site features testimonials from Latinos about the entire cancer continuum, from prevention to survivorship.


By 2050, it's estimated that Latinos will make up a quarter of the U.S. population. National efforts to control cancer must include interventions and information directed at this group, as the authors of last year's *Annual Report to the Nation on the Status of Cancer* noted in a special section on the U.S. Latino population. They emphasized that this population is diverse and it may not be possible to compare research on groups that do not share the same origins, cultural traditions, and immigration status.

Cancer.gov en español currently contains 23 Web pages on different types of cancer, more than 100 peer-reviewed cancer treatment summaries for health professionals and patients, and a dictionary that includes 5,000 terms and definitions in both Spanish and English. In the coming year, NCI will continue to test the site to ensure that it meets the information needs of U.S. Latinos.

*(continued on page 4)*

# Special Report

## More Evidence Ties Chromosome Region to Prostate Cancer

Five new studies are reporting that a region of chromosome 8 contains genetic variations that may increase a man's risk of developing prostate cancer.

The specific variants responsible for the risk have not yet been found, and the biological mechanism underlying the effect is not yet known. But researchers have identified genetic markers that are strongly associated with the disease, and they have a flood of data demonstrating the association in different populations.

"This region has a lot of variation that differs within and among men of different ethnic backgrounds, and these changes may have important effects on prostate cancer risk," says Dr. Stephen Chanock, director of the NCI Core Genotyping Facility and co-leader of an NCI study.

"With so many new studies, we can clearly see that this region may be an opportunity to learn which variations are important to different groups," Dr. Chanock adds.

His team scanned the genomes of more than 1,100 individuals with prostate cancer and 1,100 matched controls from the Cancer Genetic Markers of Susceptibility (CGEMS) study. In the region, the researchers identified a risk variant first reported last year and a second variant nearby that acts as an independent risk factor in men of European descent.

The new variant (called rs6983267) may account for 20 percent of prostate cancers among white men in the United States, the researchers estimate. Their study was one of three published together online in *Nature Genetics* on April 1.

Dr. Kari Stefansson of deCODE Genetics in Iceland, whose team discovered the first variant (rs1447295) in the region last year, led the second study. They have now identified a second variant that contributes significantly to the risk of prostate cancer in four populations of men of European descent.

The third study, funded in part by NCI and led by Drs. David Reich of the Broad Institute at Harvard and MIT and Christopher Haiman of the University of Southern California (USC), identifies seven genetic variants associated with prostate cancer risk in three distinct parts of the region, called 8q24.

Nearly all of the variants were most commonly found in African Americans and may contribute to the higher rate of prostate cancer among this group compared with other U.S. populations. Certain combinations of the variants were associated with a fivefold increase in risk for African Americans.

Age, ethnicity, and family history are known to play a role in prostate cancer. But for more than a decade, efforts to find susceptibility genes have largely been unsuccessful.

"These are really the first bona fide genetic risk factors for prostate cancer," says Dr. Haiman, the lead author of the USC-Broad Institute report. "There is now an overwhelming amount of support for genetic variation in the region contributing to this disease."

The April 1 issue of *Cancer Research* has two additional reports on 8q24. One study estimates that white men who carry two copies of the rs1447295 variant have a 90-percent increased risk of prostate cancer compared to men without the variant. The study included 6,600 cases of prostate cancer and 7,300 controls from the NCI Breast & Prostate Cancer Cohort Consortium.

"We have never observed such consistency for prostate cancer genetics, not among linkage studies, not among association studies, and certainly not when combining all these approaches together," writes Dr. Elizabeth Platz of the Johns Hopkins Bloomberg School of Public Health in an accompanying commentary.

Quite unexpectedly, the research community has found multiple regions in the same part of the chromosome that influence prostate cancer, notes Dr. Gilles Thomas, senior author of the NCI study and co-leader of CGEMS. "And what is striking is that we don't have any good candidate genes there."

The region contains very few genes. The variants, which are single nucleotide polymorphisms (SNPs)—places in the genome where a single unit of DNA may vary from one person to the next—do not fall within or near genes, so the mechanism responsible for the risk remains a puzzle.

*(continued on page 8)*

# Cancer Research Highlights

## Rapamycin Prevents Tobacco-Induced Lung Cancer in Mice

New findings from researchers in NCI's Center for Cancer Research (CCR) have shown that rapamycin, an immunosuppressant normally used to prevent the body from rejecting organ and bone marrow transplants and also used to coat cardiac stents, was highly effective in preventing the development of tobacco-related lung tumors in mice.

The study results, published in the April 1 *Clinical Cancer Research,* showed that rapamycin (also known as sirolimus) succeeded by inhibiting mTOR, a protein known to play a critical role in the development of certain lung tumors. This study tested rapamycin for treatment as well as prevention of lung cancer.

The researchers exposed the mice to NNK, a procarcinogen found in tobacco. Those given rapamycin beginning 1 week later, on alternate days, had a 90-percent drop in the number of tumors and a 74-percent drop in tumor size. Mice given rapamycin 26 weeks after exposure to NNK continued to develop tumors at the same rate as controls; however, the tumors were smaller and did not progress as quickly.

"Our studies provide an exciting link between exposure to an important tobacco carcinogen, NNK, and mTOR," said Dr. Phillip A. Dennis, head of the Signal Transduction Section in CCR's Medical Oncology Branch. "The critical question is whether this approach would be safe and effective in smokers at high risk for developing lung cancer. Given that rapamycin is relatively inexpensive and FDA-approved for other indications, we are designing clinical trials in humans to address these questions and hope to have the answers in the near future."

Further research is needed to determine whether doses of rapamycin that achieve an antitumor effect in mice are achievable in humans, and whether giving a dose that would be sufficient for an antitumor effect would cause unacceptable levels of immune suppression or toxicity.

## New Prostate Cancer Guidelines Weigh Early Therapy, Watchful Waiting

Updated guidelines from the American Society of Clinical Oncology (ASCO) on the use of androgen deprivation therapy (ADT) to treat prostate cancer state that early ADT does not appear to offer a survival advantage over so-called watchful waiting for men with metastatic or progressive disease and, as a result, do not strongly recommend this treatment approach.

The guidelines were published in the April 2 issue of the *Journal of Clinical Oncology* and are available on the ASCO Web site. Among the materials reviewed by an expert advisory panel to develop the updated guidelines were results from recent randomized, controlled clinical trials, a meta-analysis, a systematic review, and data from several ongoing trials.

Based on its review, the panel concluded that, although early initiation of ADT did decrease the risk of prostate cancer-specific death by 17 percent, it increased the risk of overall mortality by 15 percent and, as a result, could not be endorsed as a favored option over watchful waiting.

"Doctors should discuss with patients the risks and benefits of early ADT versus deferred therapy," the guidelines' lead author, Dr. Andrew Loblaw from Toronto Sunnybrook Regional Cancer Centre, advised in a statement. "If the patient prefers to defer therapy, he should have regular visits with his doctor every 3 to 6 months to monitor the disease."

The guidelines also state that the available evidence suggests that when ADT therapy is initiated, bilateral orchiectomy or luteinizing hormone-releasing hormones (LHRH) are the recommended options. In addition, the panel found strong evidence to back the option of so-called combined androgen blockade, in which a nonsteroidal anti-androgen therapy is combined with an orchiectomy or LHRH. ◆

*(Director's Update continued from page 2)*

The development of Cancer.gov en español was a major effort that included many people across NCI and from the Latino community. I have been inspired by the creativity and hard work of the team behind the new Web site. The project could not have succeeded without the expertise of cancer physicians, researchers, health educators, translators, Web designers, and, most importantly, the Hispanic and Latino communities.

I want to thank everyone for their many contributions. It is a great privilege to be able to provide knowledge and messages of hope to Hispanics and Latinos concerned about cancer. ◆

# Spotlight

## Charting the Course for Preoperative Breast Cancer Therapy

On March 26 and 27, NCI hosted the conference "Preoperative Therapy in Invasive Breast Cancer: Reviewing the State of the Science and Exploring New Research Directions."

Preoperative systemic chemotherapy has become firmly established as part of the standard of care for locally advanced invasive breast cancer and inflammatory breast cancer. In many patients, a full course of systemic therapy before surgery allows for removal of what would otherwise be an inoperable tumor, or downstaging of the required operation from mastectomy to breast-conserving surgery.

There is also considerable interest in the community in using preoperative therapy—also known as neoadjuvant therapy—in a wider population of women with earlier stages of breast cancer. Randomized controlled clinical trials have demonstrated preoperative chemotherapy increases the rate of breast conservation without a decrease in survival. However, additional research is needed to address questions that arise when applying the principles of preoperative therapy to women whose tumors have a diverse set of biological properties and prognostic factors.

"What we've all seen is that over the past years, there has been more and more preoperative therapy given in clinical practice…and the rules by which we take care of patients when we use preoperative therapy are far less well worked out than in the setting of the standard [postoperative] approach," said Dr. Eric Winer from Dana-Farber Cancer Institute, co-chair of the conference. "Much of what we're trying to do [at this conference] is to come to some agreement about what we know, what we don't know, and then, perhaps most importantly, what we need to know and how we're going to use the setting of preoperative therapy to answer important clinical and biological questions about breast cancer."

*"It's vital that we work together... in every step of care for women receiving preoperative therapy for breast cancer."*

Conference presenters reviewed the existing data on preoperative therapy in operable breast cancer and the most pressing questions impeding the wider adoption of preoperative therapy for breast cancer. Issues addressed included incorporating endocrine and biologic therapy into preoperative treatment regimens; how to best use imaging methods—both established and experimental—to measure the response to preoperative therapy; how to determine the optimal local treatment after preoperative therapy; the role and timing of sentinel lymph node biopsy; how to best select patients who will benefit from preoperative systemic therapy; and whether or not the response of a tumor to preoperative therapy can be used to guide further treatment.

After a panel discussion to address questions collected over the 2 days of presentations and question-and-answer sessions, the conference culminated in a "statement of the science" prepared by the conference chairs, which identified the key unresolved clinical issues that need to be addressed in the next generation of clinical trials.

The statement, which focused on issues such as the timing of surgery, the potential for alteration of treatment mid-regimen, and the need for additional therapy in patients at high risk of recurrence, also highlighted an issue that came up repeatedly during the conference—the need for multidisciplinary participation in this area from medical oncologists, surgeons, radiation oncologists, plastic surgeons, and other specialists.

"It's vital that we work together, not only in the development and analysis of clinical trials but in the clinic, in every step of care for women receiving preoperative therapy for breast cancer," said Dr. Jo Anne Zujewski, a breast cancer specialist with NCI's Division of Cancer Treatment and Diagnosis and organizer of the conference.

The conference videocast, including the statement of the science, is available to the public at http://videocast.nih.gov. ◆

*By Sharon Reynolds*

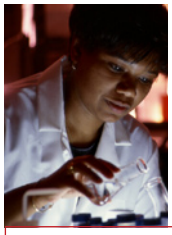
(MRI continued from page 2)
chief of the NCI Cancer Imaging Program's Diagnostic Imaging Branch. With conventional mammography, that ratio is generally closer to one in six.

"So, relative to mammography, MRI was far more specific," Dr. Jaffe said. "These contralateral breasts would have been considered negative based on mammography and a clinical exam. This is important because treatment planning for these women would have been based on incomplete information on the full extent of the disease. That's why these results are so striking."

Dr. Christy A. Russell, co-director of the University of Southern California/Norris Comprehensive Cancer Center's Lee Breast Center, suggested that this study and others should be considered in the development of consensus guidelines related to the diagnostic evaluation of a woman with newly diagnosed breast cancer.

"What we're seeing in this study and our new ACS guidelines is that the use of MRI is evolving to better meet the needs of subgroups of women, either women at very high risk and for whom mammography may be less effective, or in women with a newly diagnosed breast cancer, where MRI can identify cancers in the same breast or contralateral breast that were missed by mammography," continued Dr. Russell, who chaired the American Cancer Society panel that released new recommendations last week on breast screening in high risk individuals using MRI (see sidebar).

Because the use and practice of breast MRI is still evolving in the United States and is not available in all clinical settings, Drs. Jaffe and Russell
(continued on page 7)



# Featured Clinical Trial

## Preventing Chemotherapy-Induced Neuropathy

**Name of the Trial**
Phase III Randomized Study of Alpha-Lipoic Acid in Preventing Platinum-Induced Peripheral Neuropathy in Cancer Patients Receiving a Cisplatin- or Oxaliplatin-Containing Chemotherapy Regimen (MDA-CCC-0327). See the protocol summary at http://cancer.gov/clinicaltrials/MDA-CCC-0327.

**Principal Investigator**
Dr. Ying Guo, University of Texas M.D. Anderson Cancer Center

*Dr. Ying Guo*

**Why This Trial Is Important**
Peripheral neuropathy is characterized by sensations of pain, tingling, burning, numbness, or weakness that usually begin in the hands or feet. It can be caused by certain illnesses, for example, diabetes. It can also be a side effect of treatment with platinum-based chemotherapy drugs.

Chemotherapy-induced peripheral neuropathy can be either acute or chronic. Acute peripheral neuropathy may begin during or shortly after administration of a platinum-containing drug and usually goes away on its own after several days. Chronic peripheral neuropathy may arise weeks or months after chemotherapy treatment and may be very difficult to treat; in some patients, it may be irreversible.

In this trial, researchers are testing the ability of alpha-lipoic acid to prevent peripheral neuropathy caused by the platinum-containing drugs cisplatin and oxaliplatin. Alpha-lipoic acid is an antioxidant produced naturally by the body; it can also be found in some foods and as a nutritional supplement. In diabetes patients, it has been shown to relieve symptoms of neuropathy.

"Peripheral neuropathy is a potentially disabling condition that affects many cancer patients treated with platinum-based chemotherapy," said Dr. Guo. "We hope that alpha-lipoic acid will help prevent this condition in patients being treated with cisplatin or oxaliplatin."

Patients will be randomly assigned to receive oral alpha-lipoic acid or a placebo three times a day for at least 24 weeks.

**Who Can Join This Trial**
Researchers will enroll 224 patients scheduled to receive cisplatin- or oxaliplatin-based chemotherapy for cancer and who have not experienced previous peripheral neuropathy. See the list of eligibility criteria at http://cancer.gov/clinicaltrials/MDA-CCC-0327.

**Study Sites and Contact Information**
Study sites in the United States are recruiting patients for this trial. See the list of study contacts at http://www.cancer.gov/clinicaltrials/MDA-CCC-0327or call NCI's Cancer Information Service at 1-800-4-CANCER (1-800-422-6237) for more information. The toll-free call is confidential. ◆

An archive of "Featured Clinical Trial" columns is available at http://cancer.gov/clinicaltrials/ft-all-featured-trials.

*(MRI continued from page 6)*

indicated that some obstacles still remain to its wider adoption.

Although its use for breast screening has increased—e.g., as a follow-up to an abnormal mammogram—insurers generally do not cover MRI for screening the opposite breast. That could change, however, based on these study results.

And, as Dr. Jaffe pointed out, MRI machines specifically set up to do breast screenings—those that have a breast "coil" and in settings with the ability to perform biopsy—need to become more widely available.

To ensure the highest quality scan, Dr. Russell advised that women undergoing a diagnostic MRI go to a center that has an MRI machine appropriately equipped for breast imaging. She also advised having the screening procedure done at a facility with biopsy capability and experience.

If a suspicious lesion is found on the MRI, but the center is not equipped to do a biopsy, she explained, then the woman will have to be referred to another center and repeat the entire imaging procedure to guide the biopsy. ◆

*By Carmen Phillips*

**Related Links**

***NCI Cancer Imaging Program***
http://imaging.cancer.gov/

***NCI Research on Cancers in Women: Breast Cancer***
http://women.cancer.gov/research/breast.shtml

***NCI Cancer Topics: Breast Cancer***
http://www.cancer.gov/cancertopics/types/breast

## Guidelines Recommend Annual MRI Breast Screening for High-Risk Women

New guidelines from the American Cancer Society (ACS) released last week recommend that some women at high risk of developing breast cancer should undergo annual screenings with both mammography and magnetic resonance imaging (MRI). In certain groups of women, the recommendations explain, conducting both tests annually increases the likelihood of early detection. The guidelines were published in the March issue of *CA: A Cancer Journal for Clinicians*.

To minimize the risk of avoidable biopsies, fear, anxiety, and adverse health effects, explained Dr. Christy Russell, who chaired the ACS expert advisory group that developed the recommendations, it is "imperative to carefully select those women who should be screened using this technology."

The guidelines advise that women should receive an annual MRI screening and mammogram if they have or have had: a *BRCA1* or *BRCA2* mutation or a first-degree relative with a *BRCA1* or *BRCA2* mutation; a lifetime breast cancer risk of 20 to 25 percent or greater based on one of several accepted risk assessment tools; radiation to the chest between the ages of 10 and 30; or Li-Fraumeni syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome, or a history of these syndromes in a first-degree relative.

The recommendations state that MRI breast screenings should be conducted on machines equipped with a breast coil and that meet certain performance parameters. They also state that "the ability to perform MRI-guided biopsy is absolutely essential to offering screening MRI." ◆

## CCR Grand Rounds

**April 10:** Dr. Joan Brugge, Chair, Department of Cell Biology, Harvard Medical School. "Modeling Cancer in 3 Dimensions."

**April 17: Oncology Nursing Lecture—**Dr. Jean K. Brown, Interim Dean and Professor in Nursing, Nutrition, and Rehabilitation Science, University at Buffalo School of Nursing. "Symptom Management of Cancer-Related Nutritional Problems."

CCR Grand Rounds are held 8:30 to 9:30 a.m. at the NIH campus in Bethesda, MD, in the Clinical Center's Lipsett Amphitheater. ◆

## Funding Opportunities

*Following is a newly released NCI research funding opportunity:*

### Institutional Clinical and Translational Science Award

Announcement Number: RFA-RM-07-007
Letter of Intent Receipt Date: Sept. 24, 2007
Application Receipt Date: Oct. 24, 2007

This is a renewal of RFA-RM-07-002 and will use the U54, T32, and K12 award mechanisms. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3700. Inquiries: Dr. Anthony Hayward—haywarda@mail.nih.gov.

*For comprehensive information about NCI funding priorities and opportunities, go to http://www.cancer.gov/researchandfunding.* ◆

# Notes

### NCI Hosts Chromosome Biology Symposium

On April 26 and 27, NCI will host "The Current Status of Chromosome and Chromatin Biology Research" in the Natcher Conference Center on the NIH campus.

Leading researchers from NCI and around the world will present highlights of recent advances, define novel directions of basic chromosome research, and discuss the use and implications of these advances for clinical applications. Topics will also include transcriptional regulation, chromatin structure, epigenetics, the architecture of the nucleus, and DNA replication and repair. The agenda and registration information can be found at https://cms.palladianpartners.com/cms/1162932206/home.htm.

Attendees are strongly encouraged to use the Metro. The NIH campus can be easily accessed via the Medical Center stop on the Metro's Red Line. More information is available at http://www.nih.gov/about/visitor/index.htm. ◆

70 YEARS OF EXCELLENCE IN CANCER RESEARCH

### *If Memory Serves…*

In 1927—a decade before NCI was established to stimulate cancer research—Senator M. M. Neely of West Virginia proposed a bill that would offer a $5 million reward for the discovery of a cure for cancer. Senator Neely's "reward" bill did not pass, but it was among the first in a series of proposed legislation that laid the groundwork for the 1937 National Cancer Institute Act. (Read more) ◆

For more information about the birth of NCI, go to http://www.cancer.gov/aboutnci/ncia.

*(Prostate Cancer continued from page 3)*

"We suspect that the region may contain genetic elements such as microRNAs, which can regulate the activity of key genes," says Dr. Chanock.

"It's an exciting time," adds Dr. Brian Henderson, dean of the school of medicine at USC. "We need our basic science colleagues to help us understand what this signal is all about."

Whatever the answer turns out to be, he says, it will be brand new information that could revolutionize the treatment and prevention of prostate cancer and have implications beyond this disease.

"The answer will probably be a surprise, and that's why it will be so fascinating and important—because we didn't expect it," says Dr. Henderson, a senior author of the USC-Broad Institute study. ◆

*By Edward R. Winstead*

# A Reminder to Our Readers

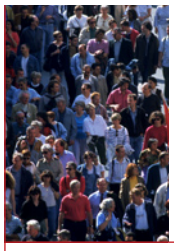
Dear *NCI Cancer Bulletin* Subscribers:

Beginning with today's issue, the *NCI Cancer Bulletin* will reduce its publication frequency to once every other week (or 24 issues per calendar year). This decision was reached following lengthy deliberations by the recently formed *NCI Cancer Bulletin* Executive Editorial Committee (EEC), which is composed of senior NCI scientists and leaders. The EEC is responsible for providing scientific advice and guidance on the newsletter's content.

This new schedule will give us the chance to create more in-depth articles and provide more perspective about the latest developments in cancer research. We on the *NCI Cancer Bulletin* staff are confident that readers will continue to find the same straightforward, high-quality science writing they have come to expect, as well as the latest cancer research news and information from NCI and other research organizations.

In just 3 years, our circulation has increased to nearly 30,000 subscriptions—with more than 500 new readers signing up each month. We appreciate this growing interest in the *NCI Cancer Bulletin* and will continue to strive to meet the needs of old and new readers alike. ◆

*—The Editors*



# Community Update

## NCI@AACR

### Meet the Experts

Learn about NCI's programs and Web sites at NCI's exhibit during the American Association for Cancer Research annual meeting, April 14–18.

**Monday, April 16**

*9:00 a.m. – 10:00 a.m.*
Small Business Grants

*11:00 a.m. – 12:00 p.m.*
NCI Peer Review: Processes for Grants and Contracts

*1:00 p.m. – 2:00 p.m.*
Epidemiology of Prostate Cancer

*3:00 p.m. – 4:00 p.m.*
Registry Data to Study the Epidemiology of HIV-Related Cancers

**Tuesday, April 17**

*10:00 a.m. – 12:00 p.m.*
Cancer Epigenetics and Epidemiology

*2:00 p.m. – 3:00 p.m.*
Bringing Biomarkers to Clinical Practice


## Featured at the NCI Exhibit

Get detailed information about these programs and offices at the NCI exhibit:

- Cancer Biomedical Informatics Grid (caBIG)
- Cancer Training Branch
- Center for Cancer Research
- Comprehensive Minority Biomedical Branch
- Division of Cancer Epidemiology and Genetics
- Division of Cancer Prevention
- Office of Technology and Industrial Relations

The *NCI Cancer Bulletin* is produced by the National Cancer Institute (NCI). NCI, which was established in 1937, leads the national effort to eliminate the suffering and death due to cancer. Through basic, clinical, and population-based biomedical research and training, NCI conducts and supports research that will lead to a future in which we can identify the environmental and genetic causes of cancer, prevent cancer before it starts, identify cancers that do develop at the earliest stage, eliminate cancers through innovative treatment interventions, and biologically control those cancers that we cannot eliminate so they become manageable, chronic diseases.

For more information on cancer, call 1-800-4-CANCER or visit http://www.cancer.gov.

*NCI Cancer Bulletin* staff can be reached at ncicancerbulletin@mail.nih.gov.

### Featured Meetings and Events

A calendar of scientific meetings and events sponsored by the National Institutes of Health is available at http://calendar.nih.gov/app/MCalWelcome.aspx ◆