CRN Connection

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CONGRATULATIONS!!

Sarah Greene and Chad Hoerner were married on Friday, August 4th!

(See Personal Story on Page 3)

The HMO CRN Cancer Research Network

The Cancer Research Network (CRN) is a collaboration of 11 non-profit HMOs plus three CRN-affiliated HMOs committed to the conduct of high-quality, public domain research in cancer control. The CRN is a project of NCI and AHRQ.

News from NCI

The Annual Report to the Nation, which reports the latest findings from cancer registries of the NCI SEER program and the CDC National Program of Cancer Registries will be published in the October 15, 2006 issue of the journal Cancer*.

The report includes comprehensive data on trends over the past several decades for all major cancers. It shows that the long-term decline in overall cancer death rates continued through 2003 for all races and both sexes combined. The declines were greater among men (1.6 percent per year from 1993 through 2003) than women (0.8 percent per year from 1992 through 2003).

Death rates decreased for 11 of the 15 most common cancers in men and for 10 of the 15 most common cancers in women. The authors attribute the decrease in death rates, in part, to successful efforts to reduce exposure to tobacco, earlier detection through screening, and more effective treatment. Incidence rates for female breast cancer stabilized from 2001 through 2003, ending increases that began in the 1980s. Whether this first indication of a

-Continued on page 4

Ed's Corner of the World

News from the CRN PI

Thanks to many of you, the NCI received a 14 lb,. 1347 page CRN renewal proposal on August 16. NCI is assembling a review group, but it will be a while before we hear the results. Thirty million dollars sounds like a lot of money, but with 13 sites, 4 projects, high indirect rates, and the money spread over 5 years, the funding to enhance capacity in each member organization is marginal.

Given this, we should view the proposed Infrastructure budget as a platform from which to generate new funds. Our track record in getting new funding is pretty good, and with better data infrastructure and investigator support we should do even better in the future.

My personal thanks go to all the project managers, financial staff, Project PI's, site PIs and Project Leaders across the CRN for all your help and support in the hard work of meeting budget guidelines and producing a competitive proposal.

Ed

What's New in the Proposed CRN3 Infrastructure?

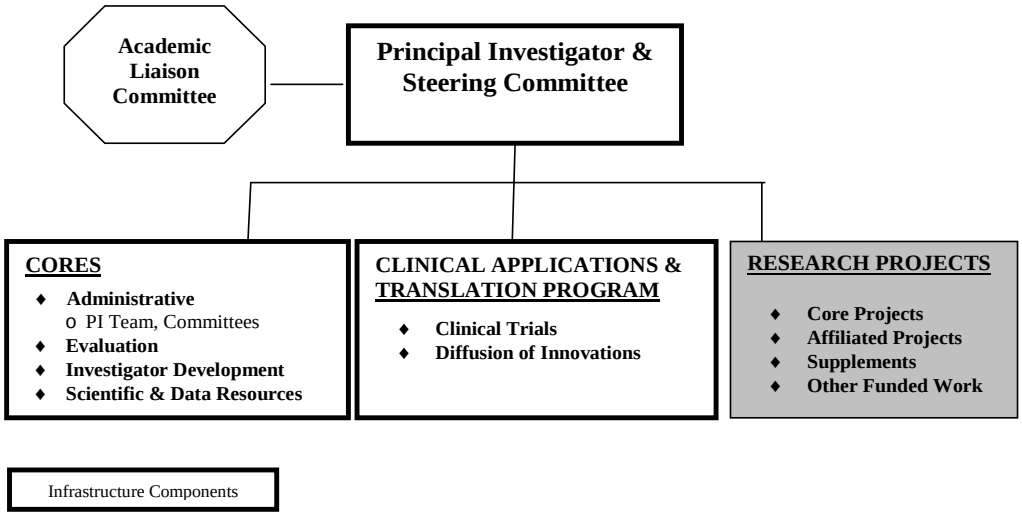
CRN3 will, if funded, retain the things that have been working well, change or enhance things that need fixing, and add some new dimensions and direction to our research activities. The Infrastructure consists of four Cores, and a Clinical Applications and Translation Program as shown in the figure. We want the Infrastructure to do four things better than we have done:

1. provide stronger support to projects in data collection, data management, and analysis,
2. further develop research capacity (human and data resources) at each CRN site,
3. serve as the nexus for new research in informatics, clinical trials, diffusion and cost/outcomes, and
4. work with HMO leaders to increase the relevance and impact of CRN research.

The leadership of the CRN will remain with the Steering Committee, which sets scientific direction, and makes all major policy decisions including those related to budget. The PI's Office provides day to day administration and budget management. The Steering Committee will continue to draw on the advice of the distinguished members of an expanded Academic Liaison Committee. Our three current Cores–Administration, Scientific and Data Resources Core (SDRC), and Evaluation–will continue on into CRN3. The New Proposals, Publications, and Communications Committees and Evaluation Core will continue their critical activities. One important proposed CRN3 change is the formation of an Organizational Advisory Committee in each CRN member organization. This group, consisting of an Oncology clinical leader, senior HMO manager, and IT leader will provide ongoing input into new CRN activities. They will also help disseminate CRN research findings within the HMO.

The SDRC's role will expand in CRN3. Much of its work in CRN2 was devoted to developing the Virtual Data Warehouse (VDW) and providing occasional data collection and management advice to projects. There is no question that the NCI's Board of Scientific Advisors based its enthusiastic endorsement of the RFA for CRN3 in part because of the availability of the VDW with its standardized databases in each site and efficient analytic strategies for using them to produce multi-site project analysis files. In CRN3, we will expand the depth and breadth of the VDW, and work more closely with projects to increase data quality and the efficiency of using the VDW.

The SDRC has proposed two new activities. In the CRN, we have chosen not to centralize data analysis preferring to support and use the rich biostatistical resources across our member organizations. But, our projects often generate very complex data with many variables and potential causal pathways. Dave Nerenz at Henry Ford will lead a new function within the SDRC that serves as a repository of information and source of advice



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What's New in the Proposed CRN3 Infrasturcture?

on newer analytic methods, many drawn from non-health disciplines. He will be assisted by Carolyn Rutter, a Group Health biostatistician, who is the PI of the colorectal screening component of the NCI's Cancer Intervention and Surveillance Modeling Network (CISNET). The second new SDRC focus will be working with caBIG. This work is described more fully in this issue.

A new Investigator Development Core, led by Suzanne and Bob Fletcher at Harvard Pilgrim, is an important investment in our future, which depends upon our ability to increase the size and productivity of our cadre of investigators. The proposed Core will offer structured education, support and mentoring for junior CRN investigators to help them to submit fundable grant proposals and acceptable manuscripts.

The other new element of the CRN3 Infrastructure is the Clinical Applications and Translation Program (CAT). The proposed CAT program has two components: 1. Clinical Trials and 2. Diffusion of Innovations in Cancer Prevention and Care. The CAT Program will coordinated by Diana Buist at Group Health. Since CRN1 a specific aim of the CRN has been to increase the participation of our cancer patients in clinical trials. But, other than surveying oncologists about possible barriers to recruitment, we have not tried to intervene. With leadership from Carol Somkin at Kaiser Permanente Northern California, we propose to develop, test and disseminate early identification strategies and other tools to help clinicians engage their patients in high priority clinical trials.

We began a Diffusion research program in CRN2 to study the spread of innovations in cancer prevention and care over time. To date, we have published papers on the impact of the negatve findings of the Women's Health Initiative on the use of Hormone Replacement Therapy (HRT), and more recently have studied the diffusion of a group of drugs, aromatase inhibitors, that block the effects of estrogen in women with estrogen responsive breast cancer. For CRN3, we propose to expand this program to include the assessment of the health impacts and financial costs of innovations beginning with other new treatments for breast cancer.

-Ed Wagner

Enjoy the Journey!

The CRN has been a journey for many of us–we've worked together for nearly 10 years, if you look back to the 1997 original RFA. In that time, we've all experienced a number of life events. I was humbled to learn that the CRN Communications Committee suggested a recent event in my own life as the focus of the CRN Connection "personal story section." On a sunny August day at a Seattle beach, I married a wonderful man named Chad Hoerner. We were surrounded by our family, including Chad's two beautiful kids, (son Zarek, age 8, and daughter Riley, age 6). I couldn't be happier as both a newlywed and a stepmom. I'm struck by the fact that I've known many of my CRN friends even longer than I've known Chad, and couldn't imagine a more enriching group of colleagues, professionally and personally. Cheers to enjoying the journey!

-Sarah Greene, GHC

CRN3 Grant Proposal Statistics

5,872,423 Bytes in pdf
1347 Page proposal
600+ Minutes spent on conference calls
120 Hours of lost sleep in late night sessions
14 Pounds in the Fed Ex box (x multiple copies)
13 Sites proposed for CRN3, plus one affiliated site
0 Minutes left on deadline at shipping time

New Diffusion Results from the Aromatase Inhibitors Team

What do you get when you take VDW data, a shoe-string budget, and dedicated volunteers? These three things added up to an award-winning abstract presented at the American Society of Preventive Oncology (ASPO) 2006 annual meeting and the development of a publishable manuscript for the CRN Anti-Estrogen Adjuvant Therapy Interest Group. Also known as the Aromatase Inhibitors (AI) team, this group of dedicated scientists, project managers, and programmers used aggregate VDW data to evaluate the diffusion of aromatase inhibitors in the CRN following the presentation and publication of clinical trial results.

The AI team took two approaches to studying diffusion. First, we asked each CRN site to survey their chief oncologist(s) regarding current cancer treatment guidelines. We used this information to determine whether sites had formal treatment protocols. Second, we collected automated pharmacy data from seven CRN sites with tumor registries (GH, HFHS, KPCO, KPH, KPNC, KPNW, and KPSC). Each site collected aggregate data on AI and tamoxifen use among women aged >55 diagnosed with invasive, estrogen receptor positive breast cancer between 1996-2003. The first clinical trial results weren't presented until December 2001 and we saw AI dispensings increase right along with those results. AI dispensings within two years of diagnosis increased from 4.1% among women diagnosed in 2000, to 13% in 2001, 24% in 2002, and 40% in 2003. Simultaneously, tamoxifen use declined after 2000 at all systems. There were no major differences among sites with or without formal treatment guidelines. Although this study had limitations (including limits on the analyses because we used aggregate data), the results still clearly show that the diffusion of aromatase inhibitors in the CRN followed evidence-based medicine practices. In addition, the lessons learned in this study will be invaluable to the team working on new diffusion projects as part of CRN3.

-Erin Aiello, GHC

Continued... News from NCI

changing trend is real or a random fluctuation cannot be determined until data reporting in the next few years is complete.

The report includes a special section on cancer among US. Latino/Hispanic populations. It is the most comprehensive coverage of cancer information for this large and rapidly growing ethnic group and is based on 90 percent of the US. Latino population. The report finds that for 1999 to 2003, Latinos had lower incidence rates than non-Hispanic whites (NHW) for most cancers, but were less likely than the NHW population to be diagnosed with localized stage disease for cancers of the lung, colon and rectum, prostate, female breast, and cervix. However, Latino children have higher incidence rates of leukemia, retinoblastoma, osteosarcoma, and germ cell tumors than do non-Latino white children.

Several cancer sites with higher incidence rates in Latinos often have infectious origins: human papilloma virus (HPV) in cervical cancer; Heliocbacter pylori (H. pylori) in stomach cancer; and Hepatitis B (HBV) and Hepatitis C (HCV) in liver cancer. Relative to the NHW population, the proportion of cases for specific cancers, in relation to all cancer sites combined, varied among four Latino groups (Mexican, Puerto Rican, Cuban, and South/ or Central American).

*Howe HL, Wu X, Ries LA, Cokkinides V, Ahmed F, Jemal A, Miller B, Williams M, Ward E, Wingo PA, Ramirez A, Edwards BK. Annual Report to the Nation on the Status of Cancer, 1975-2003, Featuring Cancer among US. Hispanic/Latino Populations. Cancer. October 15, 2006. Vol. 107, Issue 7.

-Martin Brown, NCI

So What's the big deal about caBIG?

The NCI web site describes the cancer Biomedical Informatics Grid (caBIG™) as:

"a voluntary network or grid connecting individuals and institutions to enable sharing of data and tools, creating a World Wide Web of cancer research....to speed the delivery of innovative approaches for the prevention and treatment of cancer…"

Lofty? Yes. Beneficial? We hope so. But what does this really mean for CRN researchers?

A recent Google search of "caBIG" turned up 149,000 hits. Over 100,000 of these were from the NCI web site itself. Many of the remaining, presumably, were web sites in which people described their interactions with caBIG. Indeed, random checks of other caBIG™ hits were web sites describing different universities' experiences with the caBIG™ initiative.

We should feel encouraged that some very talented IT experts around the country are engaged in this effort, and that discussions in a given caBIG™ calendar week range from "data sharing and intellectual capital" to a common adverse event reporting system for cancer trials. Yet caBIG™ still has an intangible quality for many of us as we wonder, "what will caBIG really do?" "Is this some type of magic bullet for translational research?" Moreover, from the CRN perspective, translating from the sub-cellular level to mouse models doesn't play to our greatest strengths. Does caBIG™ recognize the need to translate from bench to bedside to population?

In the CRN3 application we called out several intersections between caBIG™ and CRN. In particular, we are proposing three specific activities:

1) **Test the cancer Text Information Extraction System (caTIES)** as a means of identifying people from free text pathology data who are potentially eligible for cancer trials.

2) **Continue participating in caBIG's™ Population Sciences Special Interest Group**, a forum for identifying and exchanging possible tools to aid health services and population-based cancer research

3) **Bi-directional exchange with the cancer Data Standards Repository (caDSR)**, meaning that CRN could contribute standard data elements to a common repository, and refine the Virtual Data Warehouse (VDW) in accord with emerging national data standards.

Our hope is that through these concrete applications, caBIG™ concepts will become increasingly real in the CRN setting. For example, the caTIES application has already been used by University of Pittsburgh researchers to de-identify, code, index and store information from 30,000 pathology reports. Such a tool on the population of true eligibles for a given clinical trial, and flag these individuals as an aid to oncologists as they broach trials with their patients.

The potential of caBIG™ lies in its participants. One NCI caBIG™ leader noted recently, "we have taken on all the major organization and social challenges of getting a fairly large community of geographically separated people and institutions to work together." (This probably sounds more than a little familiar to long-term CRN participant!) If the resulting "grid" can stimulate knowledge transfer and translation on a large scale, surmounting geographic, interpersonal and technical barriers, then we will all benefit

-Sarah Greene, GHC

CRN Connection

The CRN Connection is a publication of the CRN developed to inform and occasionally entertain CRN collaborators. It is produced with oversight from the CRN Communications Committee.

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Center for Health Research

13th Annual HMO Research Network Conference

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The Center for Health Research,
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Conference will be held at the Red Lion Hotel on the River, located in Jantzen Beach along the beautiful Columbia River. Plan to arrive early and enjoy Portland's spectacular scenery.

www.HMOResearchNetwork.org

Abstracts due by November 1, 2006

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