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## Studies Suggest More Flexibility in Treating Advanced Colorectal Cancer

The results of two new large European clinical trials challenge the conventional thinking on the initial treatment of patients with advanced colorectal cancer, particularly those undergoing treatment almost strictly for palliative purposes, the studies' leaders say.

Published in the July 14 *Lancet*, the trials' results suggest that using either [fluorouracil](#) or [capecitabine](#) as single agents for first-line treatment in this patient population is no less effective and potentially less toxic than using a combination of two chemotherapy drugs, as is commonly recommended in the United States and Europe.

However, several leading experts on the treatment of colorectal cancer in the U.S. and abroad cautioned against overinterpreting the trials' results, arguing that combination chemotherapy should still be the standard of care for the first-line treatment of most patients with advanced disease.

In both trials, there was no statistically significant difference in overall survival between patients treated with regimens in which either single agent was used as a first-line treatment before moving on to other chemotherapy drugs or combinations that have shown activity in this *(continued on page 2)*

### Director's Update

## Tackling Cancer Care Disparities in the Community

The theme of this issue of the *NCI Cancer Bulletin* is cancer health disparities, in conjunction with NCI's Cancer Health Disparities Summit 2007 held last week.

The [summit](#) convened a transdisciplinary cadre of more than 700 cancer health disparities investigators, health care providers, community partners, program managers, project staff, and civic leaders from across the country. NCI grantees from such programs as the [Community Networks Program](#) and the [Patient Navigation Research Program](#) were at the forefront of the 3-day event,

discussing collaborations and partnerships, communications and bioinformatics, community engagement, managing and sustaining programs, and training and education.

Cancer health disparities continue to be a tremendous public health challenge. A recent study, led by the American Cancer Society, found that people who are without health insurance or on Medicaid are far more likely to be diagnosed with advanced cancer than those with private insurance. [Another study](#), which docu- *(continued on page 2)*

*(Colorectal Cancer continued from page 1)*  
patient population, which they called a sequential or staged approach.

For patients who are undergoing treatment without curative intent, wrote Dr. Matthew T. Seymour, from Cookridge Hospital in Leeds, United Kingdom, and colleagues who led the larger of the two trials, dubbed FOCUS, the results provide “an important choice, informed by the knowledge that a decision to opt for a staged treatment approach, starting with less toxic therapy and keeping active agents in reserve, entails minimal, if any, compromise in survival.”

The trials took somewhat different approaches in the staged-therapy arms, but both had one arm in which patients were randomized to combination chemotherapy for first-line treatment. FOCUS was the larger of the two, with more than 2,100 patients. The other trial, CAIRO, which used capecitabine as its single agent first-line therapy, had 820 patients.

In a commentary accompanying the trial results, Drs. Hans-Joachim Schmoll from Martin Luther University in Germany and Daniel Sargent from the Mayo Clinic cited several factors that support the limited use of a single-agent, first-line approach.

Several other clinical trials have shown that combination chemotherapy is superior to single-agent fluorouracil in improving overall survival, they wrote.

In addition, the first-line combination chemotherapy regimens used in FOCUS and CAIRO were not accepted standard regimens, which they argued was essential for any “trial designed to test a reduction in therapy.”

Even in the context of palliative treatment, combination chemotherapy is most often the wisest choice, says Dr. Heinz-Josef Lenz, associ-

ate director of the Gastrointestinal Oncology Program at USC/Norris Comprehensive Cancer Center.

“The data are clear: Response rates are higher with first-line combination treatment, and progression-free survival is higher,” Dr. Lenz says. That often translates into better palliation, he adds.

Use of a single agent as first-line therapy may be appropriate in some patients, advises Dr. Wasif Saif, director of the Gastrointestinal Cancers Program at Yale Cancer Center, such as those with a poor performance status and less aggressive disease in whom the intent is clearly palliation.

The trials’ results “present very important options for certain patients, but,” he cautions, “I still *(continued on page 6)*

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*(Director’s Update continued from page 1)*  
mented the underuse of surgery to treat early-stage pancreatic cancer, found that African American patients were far less likely to be offered surgery and more likely to refuse surgery.

Both studies highlight the complex economic, social, educational, and cultural factors that contribute to cancer care disparities—and reinforce the importance of identifying the most effective ways to address this unacceptable deficit in cancer care and outcomes.

A key part of the mission of the recently launched [NCI Community Cancer Centers Program](#) (NCCCP) is to research new and enhanced ways to assist, educate, and better treat the needs of underserved populations. The 16 [participating sites](#)—community hospital-based cancer centers that already offer a combination of medical, surgical, and radiation oncology care—must use 40 percent of the NCCCP funds they receive from NCI for disparities-related activities.

The cornerstones of these activities are expanded outreach and patient navigation, with the aim of allowing us to better study how to improve access to care and bring the latest scientific advances to *all* patients.

Expanded outreach will focus on improving primary and secondary prevention, including programs for smoking cessation, mammography, and colorectal cancer screening. Partnerships between NCCCP sites and community-based health and civic organizations will ensure the widest possible reach to at-risk populations.

Expanded prevention and screening programs can only be effective if there is a process in place to get care to those who need it. That is why NCCCP sites must ensure that people who are screened through their programs will receive necessary treatment. This reinforces the need for strong [patient navigator systems](#), so that those who have abnormal findings during a screening and are diagnosed with cancer have the tools available to ensure they gain timely access to quality oncology care. This pilot program will improve our ability to identify barriers to treatment and follow-up and lead to the best models for effectively moving patients from diagnosis to treatment to posttreatment care.

One of the NCCCP pilot’s most important goals is to seek broad-based and sustainable models that include public/private partnerships to address the unmet health care needs of their communities. If we are going to make significant progress toward reducing cancer care disparities, public institutions, private industry, and community-based organizations must work together to bring state-of-the-art cancer care to all patients, not just a privileged few. ♦

*Dr. John E. Niederhuber  
Director, National Cancer Institute*



# Cancer Research Highlights

## New Metastatic Breast Cancer Treatments Improved Survival Over Time

A Canadian population-based study, published online July 23 in *Cancer*, found that survival among women diagnosed with metastatic breast cancer (MBC) in British Columbia has improved over the past decade, and that this appeared to be related to the introduction of several new therapeutic agents for MBC during the 1990s.

Researchers from the British Columbia Cancer Agency (BCCA) analyzed data from 2,150 women in the Canadian province who were diagnosed and treated in 1 of 4 “time cohorts” spanning the 1990s. The earliest cohort (1991–1992) was the baseline, while subsequent cohorts were matched against the introduction of new agents for MBC: (1994–1995) [paclitaxel](#) and [vinorelbine](#); (1997–1998) [aromatase inhibitors](#) and [docetaxel](#); and (1999–2001) [trastuzumab](#) and [capecitabine](#).

“There was a significant improvement in survival for women with MBC over time,” the scientists reported. “Although there was no difference between the first two cohorts, the later two cohorts had significant improvements in overall survival.” The median survival for patients in cohorts 1 through 4 was 436 days, 450 days, 564 days, and 661 days, respectively. “Survival of women who were diagnosed with MBC in [British Columbia] in the later part of the 1990s improved by approximately 30 percent compared with a similar

cohort of women who were diagnosed in the early and middle parts of the 1990s,” they added.

“Although MBC still is an incurable disease, this study provides optimism for those women who are diagnosed with MBC today and should provide enthusiasm and evidence that continued research to discover better therapies may translate into further improvements in outcome in the future,” they concluded.

## “Tumor Paint” May Improve Excision of Multiple Tumor Types

Researchers from Fred Hutchinson Cancer Research Center and collaborators in Seattle have developed a fluorescent bioconjugate that targets numerous tumor types with high resolution. The details of their study appeared July 15 in *Cancer Research*.

The researchers called their molecule “tumor paint,” building it from chlorotoxin, a scorpion venom protein that is nontoxic in mammals and has been shown to target glioma cells, and Cy5.5, a molecule that emits fluorescent light without requiring enzymatic cleavage within the cell and with minimal light absorption by water or hemoglobin.

After administering an early version of tumor paint to mice, the researchers found that adding Cy5.5 to chlorotoxin improved its tumor-targeting ability. “The resolution of cancer foci from normal tissue under simulated operating conditions was exquisite,” down to the level of a few hundred cells, they wrote.

The team tested this conjugate in mouse models of medulloblastoma, sarcoma, and prostate and intestinal cancer, and found that it worked well in elucidating each of these tumors for as long as 15 days after administration.

The researchers suspect the specific target of the chlorotoxin on the cell membrane may be matrix metalloproteinase-2 (MMP-2). They transfected cells that failed to bind to tumor paint with plasmids containing MMP-2 and found that this facilitated attraction. Microscopy showed that the tumor paint and the MMP-2 clustered within the transfected cells. However, pull-down assays were unable to show a direct bond between MMP-2 and tumor paint, and other experiments were unable to show an enzymatic relationship between them.

## Algorithm Predicts Response to Anticancer Drugs

A team led by researchers from the University of Virginia at Charlottesville has developed an algorithm that uses comparative microarray data and responses of a panel of 60 human cancer cell lines maintained by NCI (NCI-60 panel) to anticancer drugs to predict responses in other cell lines and in human tumors. The study, published in the July 24 *Proceedings of the National Academy of Sciences*, then used the algorithm to identify experimental compounds with potential activity against bladder cancer.

The algorithm, called COXEN, consists of several steps: determining a drug’s molecular activity in a first set of cells (in this case, the NCI-60 panel); measuring the normal molecular characteristics of those cells; iden-

*(continued on page 4)*

(Highlights continued from page 3)

tifying which molecular characteristics most accurately predict the drug's activity; measuring those characteristics in a second set of cells; identifying a subset of molecular characteristics that shows a pattern of coexpression between the two cell sets; then predicting the drug's activity in the second set based on its activity in the first set and the molecular characteristics shared between the two.

When tested using a panel of 40 human bladder cancer cell lines (BLA-40) as the second set of cells, COXEN significantly predicted response of BLA-40 to the drugs [cisplatin](#) and [paclitaxel](#). The researchers then modified the algorithm to test whether it could predict *in vivo* response in human tumors from the NCI-60 *in vitro* data. When comparing NCI-60 molecular characteristics with microarray data from two breast cancer clinical trials, one of [docetaxel](#) and one of [tamoxifen](#), COXEN significantly predicted clinical response to both drugs.

Finally, the investigators used COXEN to predict chemosensitivity patterns of BLA-40 cells to 45,545 experimental compounds screened using the NCI-60 panel. They identified eight compounds to which more than 50 percent of BLA-40 cells were predicted to be sensitive, thereby finding possible candidates for early clinical trials.

The investigators, which include John N. Weinstein of NCI's [Center for Cancer Research](#), caution that "our COXEN approach needs to be further validated before it is applied in clinical practice." They will make the algorithm available to the scientific community at <http://www.coxen.org> in September, 2007. The NCI-60 microarray data are at <http://discover.nci.nih.gov>.

## SPORE Investigators' Meeting Highlights Upcoming Program Changes

On July 7–10, NCI hosted the 15th Annual Investigators' Workshop for the [Specialized Programs of Research Excellence](#) (SPOREs) translational research grants designed to help participating cancer centers move basic research findings from the laboratory to clinical settings as rapidly as possible. NCI currently funds 57 SPORE grants covering 14 cancer types.

The 2007 investigators' workshop gave SPORE researchers working on the same cancer type a chance to share results and pursue opportunities for collaboration. A special session on Saturday focused on the challenges found in using biomarker evidence in translational research, including tissue acquisition and sample size requirements for clinical trials, methods for quality assurance, and validation of the clinical utility of a potential biomarker.

The theme of collaboration grew in importance this year, as the SPORE program readies itself for a major programmatic shift. Instead of keeping the focus of the SPOREs on the 14 current cancer types, explained Dr. Jorge Gomez, chief of NCI's Organ Systems Branch, beginning in 2008 competition for the grants will be open to any type of cancer.

"The program has been and remains very popular," said Dr. Gomez. "Many groups want to compete and participate." He hopes that the increased competition will encourage collaborators from different institutions to apply together for a single SPORE grant, instead of the majority of applications coming from single institutions as they do now.

## Breast Cancer Survivors Test Diet High in Fruits, Veggies

Women who adopted a low-fat diet that was very rich in vegetables, fruit, and fiber after treatment for breast cancer did not reduce their risk of recurrence compared with similar women who consumed 5 or more servings of fruits and vegetables a day. After 7 years, both groups of women had essentially the same risk of recurrence, incidence of new primary breast cancers, and risk of overall mortality.

Even women whose diets at baseline were low in fruits, vegetables, or fiber or high in fat did not appear to benefit from the intervention, according to findings in the July 18 *Journal of the American Medical Association* (JAMA). The results are from the [Women's Healthy Eating and Living](#) (WHEL) study, a randomized controlled trial that included 3,088 women who were treated for early-stage breast cancer.

The researchers caution against applying their findings to populations beyond those in the study, which included women who had completed their initial therapy and excluded women diagnosed after age 70. The findings appear to be at odds with interim [results](#) from the [Women's Intervention Nutrition Study](#) (WINS), which suggest that a low-fat diet may help prevent breast cancer recurrence in some women.

Different patterns of weight gain and loss between the trials may account for some of the varying results, according to an editorial in JAMA. Women in both arms of the WHEL trial on average gained weight, whereas women in the intervention arm of WINS lost weight. New studies that assess interventions based on physical activity and energy intake for breast cancer survivors are warranted, the editorial concludes. ♦

# A Conversation With ... Dr. Sanya Springfield

*Dr. Springfield is director of NCI's [Center to Reduce Cancer Health Disparities \(CRCHD\)](#).*

## Why is the Cancer Health Disparities Summit important?



One of the core aspects of our work to address cancer disparities is collaboration—exchanging information and ideas and sharing research outcomes. It really is important that we foster a collaborative approach to attacking cancer health disparities because that type of strategy gives us the best opportunity to succeed. The Disparities Summit helps keep us all accountable. By coming together once a year, we are able to better assess our progress and identify and prioritize the challenges that remain. It is also a time to review and assess the strategies we are employing—a time to take stock and consider what is working and what is not.

## What did this year's summit achieve?

I believe the summit helped reiterate the need for greater collaboration, drew attention to the need to develop partnerships within regions, and helped researchers think about their work in a broader context that may encompass working with other disciplines. As a result, we have a better handle on where we need to go and what we need to do to take this agenda forward.

## Why do you think cancer health disparities are getting greater attention these days in the research community?

I think there is a realization that we all need to know more about cancer health disparities as part of our ongoing quest to learn more about cancer and its impact on society. I believe a growing number of researchers understand that with all the promise and progress in cancer over the years, especially in cancer prevention and cancer treatment, we cannot be satisfied with that progress unless everyone benefits from these advances.

## What are some of the key initiatives of CRCHD?

Our principal initiatives include the [Community Networks Program \(CNP\)](#) and the [Patient Navigation Research Program \(PNRP\)](#). But these are part of a much larger portfolio that is divided into four key areas: Disparity Research, Diversity Training, Program Evaluation/Databases, and Communications and Dissemination.

For example, in our Disparity Research program, we have the Minority Institution/Cancer Center Partnership Program, in addition to the CNP and PNRP initiatives. The objectives of the Minority Institution/Cancer Center Partnership program are to increase the participation of Minority Serving Institutions in the nation's cancer research and research training enterprise; to increase the involvement and effectiveness of the Cancer Centers in research, research training, and career development related to minorities; and to develop more effective research, education, and outreach programs that will have an impact on minority populations.

Our Diversity Training portfolio houses the [Continuing Umbrella of Research Experiences \(CURE\)](#). Through this program, we strategically address each level of the biomedical research and educational pipeline to increase the pool of underrepresented minority candidates, emphasize scientific areas of greatest need, and expand and extend the period of training and career development. Given the increased emphasis of cancer health disparities, we need to attract more minority biomedical scientists into the cancer research field. In that regard, CURE has shown great promise and results over the years. ♦



# Special Report

## Cancer Prevention Starts at Home (with a Party)

In Washington State, researchers are sponsoring “home health parties” to raise awareness about cancer and encourage people to take advantage of free screenings. The goal is to reduce health disparities among underserved populations.

“We think of these as Tupperware parties without the sale,” says Dr. Beti Thompson of the Fred Hutchinson Cancer Research Center. Her team is testing the experimental strategy in Hispanic communities in the Lower Yakima Valley.

The researchers recruit families to host the gatherings in their homes and then send a trained health educator to lead a discussion on a specific cancer topic. Parties last about an hour and may include 5 to 8 family members and friends (sometimes more). The events are informal with lots of time for questions.

“We talk about how cancer develops and the importance of screening,” says Ilda Islas, also of Fred Hutchinson. The information is usually new to the families, and many do not know that they can take steps to prevent cancer, she adds.

The cancer topic changes every 6 months. The researchers plan to cover cervical, colon, prostate, breast, lung, and skin cancers. Six months after a party, the health educators, or *promotoras*, follow up to see if a family has questions or would like a refresher course.

Preliminary data from the study are encouraging. Nearly a quarter of the 70 individuals who attended recent parties on colon cancer (and were eligible for screening) subsequently underwent screening.

“We think those are pretty good odds,” says Dr. Thompson, who is supported by NCI’s [Community Networks Program](#). “This is a unique strategy, and it appears to work well.”

It works well for some of the same reasons that Tupperware parties do. People learn about cancer among friends, often without having to leave their homes. Parties can occur in the evenings after work, and no babysitters are needed because the whole family is involved.

Children often hear the same discussions as their parents. The family is central in Hispanic culture, and family members can provide social support for individuals who are considering cancer screening, notes Dr. Thompson.

Another important element is the *promotoras*. These individuals are recruited from the communities they serve. They know the culture and understand how to reach their audiences, which may include friends and acquaintances.

“The parties are a great experience,” says Ms. Islas. “People receive us with open arms, and they express their gratitude for the information we have shared with them.”

The researchers first experienced this welcoming response several years ago as they went door to door, telling families about the dangers of pesticides. Many families invited them inside to talk, and this led to the current strategy.

Once the home health parties began, the news spread by word of mouth. Ms. Islas initially went to community events and churches to recruit families, but she now handles requests from people wanting to host parties.

The researchers plan to publish their results and lessons learned. If the pilot program is a success, they say, the strategy could be adapted for other Hispanic and Latino populations. The primary materials are large flip charts that can be carried from home to home.

“We’ve been absolutely amazed by how many families have opened their doors to us,” says Dr. Thompson. “Most people are very happy to have someone talk to them about health issues.” ♦

*By Edward R. Winstead*

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*(Colorectal Cancer continued from page 2)*  
believe a lot needs to be done before we change the standard of care.”

Dr. Saif stressed that identifying molecular biomarkers indicative of response to certain agents or treatments must be the highest research priority.

Dr. Lenz agreed, but explained that the pursuit of such biomarkers has been hampered by rapidly changing treatment patterns. He is hopeful, however, that there may now be a “window of opportunity” to develop and validate biomarkers for response to chemotherapy and targeted agents, primarily [bevacizumab](#) (Avastin) and [cetuximab](#) (Erbix), which have shown a [benefit](#) in some patients with advanced colorectal cancer. ♦

*By Carmen Phillips*



# Spotlight

## Triple-Negative Breast Cancer Disproportionately Affects African American and Hispanic Women

A form of breast cancer shown to disproportionately affect young African American women has also recently been found to have an increased incidence in Hispanic women. Called “triple-negative” breast cancer because its cells lack the receptors for estrogen, progesterone, and human epidermal growth factor receptor 2 (HER2), it cannot be controlled with drugs such as tamoxifen or trastuzumab that target these receptors, limiting the effective treatment options for patients.

Triple-negative breast cancer primarily consists of a molecular subtype called the basal-like subtype. Different molecular subtypes of breast cancer can now be identified in patients by gene-expression profiling.

The first hints that molecular subtypes of breast cancer may not be distributed equally among populations in the United States emerged several years ago, and in 2006, results from the [Carolina Breast Cancer Study](#) (CBCS) showed that 39 percent of premenopausal African American women diagnosed with breast cancer had basal-like disease, compared with 14 percent of postmenopausal African American women and 16 percent of non-African American women of any age. In early 2007, a study from the California Cancer Registry confirmed the higher incidence of triple-negative breast cancer in young African

American women and also identified a smaller but significant increased prevalence in Hispanic women.

Researchers are now attempting to answer the complex question of why this unequal distribution among various racial and ethnic groups exists. “The obvious question, if you recognize that there are subtypes of breast cancer,” said Dr. Lisa Carey, medical director of the University of North Carolina Breast Center and lead author of the CBCS paper, “is to stop saying ‘what causes breast cancer?’ and say ‘what causes different subtypes?’”

Intriguing data from the [Nurses Health Study](#), the [Women’s Health Initiative](#), and smaller studies suggest that risk factors might be different for different subtypes of breast cancer. Follow-up results from the CBCS and from a large, population-based breast cancer case-control study conducted in Poland identified elevated waist-to-height ratio, excess weight gain since childhood, lack of breast-feeding after pregnancy and use of lactation suppressants, and several other variables as potential risk factors for basal-like breast cancer.

Now researchers led by Dr. Sarah Gehlert, director of the Center for Interdisciplinary Health Disparities Research (CIHDR) at the University of Chicago, have begun a unique, multidisciplinary study looking at

the social environment (including crime) and other community factors that contribute to social isolation, reported perceptions of stress, and levels of salivary cortisol—a hormone involved in the response to stress—in a group of African American women in Chicago to determine if stress and social isolation contribute to breast carcinogenesis. “It’s a completely integrated model,” explained Dr. Gehlert.

“We realized from our animal work that social isolation was a very significant feature” in tumor development, said Dr. Gehlert. Their study hypothesis, she explained, is that “women who live in areas with...a lot of violent crime, and who live in unsafe housing, without a lot of community support to make it easier to deal with that stress, will be more likely to have sporadic mutations and will have [worse outcomes] with breast cancer.”

An important part of this integrated model is the collection of tumor tissue from participants. Interim results from the study have already found glucocorticoid receptors in tumors of women who reported high stress levels, indicating that an altered stress response may contribute to failure of apoptosis and lead to tumor growth.

The tissue collected will be analyzed by Dr. Olufunmilayo Olopade, professor of medicine and human genetics at the University of Chicago and one of four project leaders in CIHDR. Dr. Olopade’s previous work with African women in Nigeria and Senegal has shown an even higher incidence of estrogen-negative breast cancer than that found in African American women. Her laboratory is now deeply involved in determining if genetic mutations similar to *BRCA1* and *BRCA2* may contribute to the disparity in triple-negative disease under study by CIHDR.

*(continued on page 8)*

(Spotlight continued from page 7)

Work is also now beginning across the U.S. to better understand the impact of triple-negative breast cancer in the Hispanic population. “We’re concerned about this triple-negative phenomenon and whether Mexican Americans are also facing a similar [disparity],” explained Dr. Melissa Bondy, professor of epidemiology at the University of Texas M.D. Anderson Cancer Center. Dr. Bondy and her colleagues are starting a study to examine risk factors for triple-negative breast cancer in Mexican American women living in Texas and Arizona, and Mexican women from Northern Mexico and from the city of Guadalajara.

The next steps for researchers will be to figure out ways to help these populations reduce their risk and to develop new treatment options for triple-negative breast cancer, which are limited to traditional surgery, radiation therapy, and chemotherapy.

“The whole point [of the Carolina Breast Cancer Study] was...to figure out what the population frequencies were of these different subtypes and what some of the clinical associations were so that we could design trials for them,” said Dr. Carey.

Dr. Carey’s group and others around the country are now involved in large, multi-institution clinical trials testing therapies for triple-negative breast cancer. Drug regimens being examined in these trials include the antiangiogenesis agent **bevacizumab** given before surgery; new, targeted drugs that interfere with cell-signaling pathways other than those triggered by the estrogen, progesterone, and HER2 receptors; and platinum-based chemotherapy drugs, which may be effective in triple-negative disease. ♦

By Sharon Reynolds



# Featured Clinical Trial

## Education and Exercise to Prevent Lymphedema

### Name of the Trial

Randomized Study of Education with or without Exercise and Counseling in Preventing Lymphedema in Women with Stage I-III Breast Cancer Who Are Undergoing Axillary Lymph Node Dissection (CALGB-70305). See the protocol summary at <http://cancer.gov/clinicaltrials/CALGB-70305>.

### Principal Investigator

Dr. Electra Paskett, Cancer and Leukemia Group B

### Why This Trial Is Important

Surgery for breast cancer may include the removal and examination of lymph nodes in the underarm area near the affected breast (called axillary node dissection). This procedure allows doctors to determine whether cancer has spread to the lymphatic system. A common side effect of axillary node dissection is **lymphedema**, a swelling of the arm and/or hand on the same side as surgery caused by the buildup of lymphatic fluid. Lymphedema is often debilitating.

There is no known cure for lymphedema, but some measures can make it easier to live with or possibly prevent it. Women who undergo axillary node dissection should receive education about how to recognize and possibly prevent lymphedema.

This study compares a lymphedema-prevention education program to the same education program supple-

mented with an exercise regimen and counseling in women who have been newly diagnosed with breast cancer and who will undergo axillary node dissection. Researchers want to see if education, exercise, and counseling will help prevent lymphedema or limit its severity if it develops.

“As many as one third of women who undergo full axillary node dissection will experience lymphedema,” said Dr. Paskett. “These women may suffer

serious physical, social, and psychological effects because of this condition. We hope these interventions will help breast cancer survivors enjoy a better quality of life.”

### Who Can Join This Trial

Researchers will enroll 560 women aged 18 and over newly diagnosed with stage I-III breast cancer who will undergo an axillary node dissection with 10 or more lymph nodes removed. See the list of eligibility criteria at <http://cancer.gov/clinicaltrials/CALGB-70305>.

### Study Sites and Contact Information

Study sites in the United States are recruiting patients for this study. See the list of study contacts at <http://cancer.gov/clinicaltrials/CALGB-70305> or call the NCI’s Cancer Information Service at 1-800-4-CANCER (1-800-422-6237) for more information. The toll-free call is confidential. ♦



Dr. Electra Paskett

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



## Russian Federation Holds Nation's First Meeting on Tobacco Control

NCI's [Office of International Affairs](#) (OIA) participated in the first Russian Forum on Health or Tobacco in Moscow on May 28–29. The forum was sponsored by the State Duma of the Russian Federation and OIA and was the first of several meetings Russia hopes to hold in 2007 to address its growing tobacco burden. Russia has one of the highest prevalences of tobacco use in the world.

The idea for this conference came from Dr. Nikolay Gerasimenko, deputy chairman of the Health Care Committee of the State Duma of the Russian Federation, who attended the 13th World Conference on Tobacco OR Health in Washington, DC, in 2006. NCI, through the [American-Russian Cancer Alliance](#) (ARCA), and in partnership with the American Cancer Society (ACS), had hosted Dr. Gerasimenko's visit.

Rep. Steny Hoyer (D-MD) conveyed greetings and praised NCI, ACS, and ARCA for their participation in the forum. The forum was followed by a number of related activities including a congress of Russian physicians against tobacco, conferences, and public campaigns devoted to World No Tobacco Day on May 31 in all regions of the Russian Federation.

The forum also issued what was termed the "Moscow Statement on Tobacco Control." In response to the forum, the Russian Anti-Tobacco League has been formed to serve as the combined voice of anti-tobacco forces in the Russian Federation. During the forum, the Duma gave tentative approval to legislation that would restrict smoking in restaurants and several other public places, and in July the foreign ministry announced that Russia will join the [Framework Convention on Tobacco Control](#).

The forum is likely to be repeated in 2009 and become a regular event in Russia. More information about the forum can be found at <http://www.antitabak.ru/eng/index.php>.

## NCI Develops Cancer Risk Prediction Resources Web Site

The [Risk Factor Monitoring and Methods Branch](#) in NCI's [Division of Cancer Control and Population Sciences](#) has developed a new [Cancer Risk Prediction Resources](#) Web site.

The Web site was designed for investigators developing, evaluating, and applying risk prediction models for cancer risk and susceptibility. It includes citations and links for all the risk prediction models published to date, categorized by cancer site. It

also includes links to the 2004 NCI workshop on Cancer Risk Prediction Models, funding opportunities, other relevant publications, and Web sites related to risk prediction.

When used by scientific experts who understand the strengths and limitations of the various models available, risk prediction models provide an important approach to assessing risk and susceptibility by identifying individuals at high risk, facilitating the design and planning of intervention trials, and enabling the development of benefit-risk indices and estimates of population burden and cost of cancer.

## Health Behavior Constructs Web Site Launched

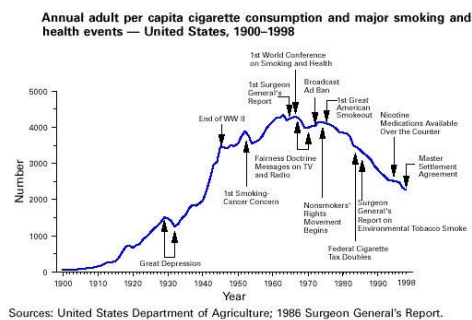
NCI's [Division of Cancer Control and Population Sciences](#) has developed an authoritative Web-based compilation of major theoretical constructs used in behavioral medicine research. This is the first resource to establish a common understanding of theoretical constructs intended to facilitate transdisciplinary collaboration. The open-access, dynamic site includes construct definitions, historical background, references, and state-of-the-art measures and can be accessed at [www.cancercontrol.cancer.gov/constructs](http://www.cancercontrol.cancer.gov/constructs). ♦

**70**  
YEARS  
OF EXCELLENCE  
IN CANCER  
RESEARCH

## If Memory Serves...

The link between smoking and cancer was first noted in scientific literature in the 1930s, at a time when the smoking prevalence in the United States was rising, particularly among soldiers who received cigarette rations during World War I. The first large epidemiological study proving this link, however, wasn't published until 1950. ♦

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





# Community Update

## Media Panel Invites Summit Researchers to Get to Know Them

What did journalists have to offer a gathering of cancer researchers and advocates at NCI's Cancer Health Disparities Summit? Plenty. That's what summit participants found out on July 18 during the plenary session, "Health Disparities in the News: Getting the Word Out."

About 700 summit participants attended a panel discussion about how and why the media is now covering cancer and health disparities. Stories about health disparities—including those related to cancer—are more prominent than ever, especially in the ethnic media, which serves many of the same special populations and communities as those attending the summit.

Providing insight into how they work, the journalists left a clear and direct message with summit attendees: The ethnic media needs to be taken more seriously; they deserve to be viewed as a legitimate "go-to" source for audiences interested in health disparities and other news. In addition, the journalists encouraged researchers and community-based advocates to learn more about the ethnic media in their own communities and establish relationships with those media outlets.

"You really can call reporters. It's okay," said George Strait, former chief medical correspondent for ABC

News and more recently the communications director for NIH's National Center on Minority Health and Health Disparities. Mr. Strait, who covered NIH as a reporter, moderated the panel, which included Sandra Basu, American Indian health beat writer for *U.S. Medicine*; Stella Choi, writer for the monthly *Asian Fortune* magazine; Hazel Edney, editor-in-chief of the National Newspaper Publishers Association/Black Press USA; Dr. Elmer Huerta, radio and TV host and founder of the Cancer Preventorium in Washington, DC, for the Hispanic community; and Viji Sundaram, health editor of the country's only major nationwide news service for ethnic media, New America Media.

"What best gets the attention of our editors and readers is when we give them the 'what to do.' Not just the statistics, but what can you do?" said Ms. Edney. "You've done a great job telling us the wheres and the whys and the statistics."

Ms. Sundaram talked about how her calls to other federal agencies and corporations are often met with dismissive attitudes, simply because she is not calling from a major media outlet. She cautioned that this is a mistake.

Many people will remember Dr. Huerta's presentation. He began with

a series of graphic displays of the ravages of breast cancer. He used that as his prop to discuss what drives him in his work, both as a member of the media and as a practicing oncologist. Dr. Huerta said that too many Hispanics have more access to the latest soccer scores and happenings on soap operas than to reliable cancer information. As a result, he works to get the word out through five radio shows and three television programs. "I'm always asking myself, 'What can we do?'"

That seemed to be the prominent question on everyone's mind during the summit: "What can we do?" It appears that the panel of journalists may have helped open up some new avenues in answering that question. ♦

*By James Alexander*

### Funding Opportunities

For a complete listing of current NCI funding opportunities, please go to the HTML version of today's *NCI Cancer Bulletin* at [http://www.cancer.gov/nci-cancerbulletin/NCI\\_Cancer\\_Bulletin\\_072407/page11](http://www.cancer.gov/nci-cancerbulletin/NCI_Cancer_Bulletin_072407/page11). ♦

### Resources on Cancer Health Disparities

NCI Center to Reduce Cancer Health Disparities  
<http://crchd.cancer.gov/>

Cancer Topics: Cancer Health Disparities  
<http://www.cancer.gov/cancertopics/types/disparities>

Cancer.gov en español  
<http://www.cancer.gov/espanol?ref=tile>

Medline Plus: Información de Salud para Usted  
<http://medlineplus.gov/spanish/> ♦