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Drug Improves Induction Chemo for Head and Neck Cancers

For patients with advanced head and neck cancers who receive an initial treatment of chemotherapy prior to other therapies, three drugs appear to be better than two. Patients who received **docetaxel** (Taxotere) in addition to the standard combination of **cisplatin** and **fluorouracil** had better outcomes than those taking cisplatin and fluorouracil alone, according to findings in the October 25 *New England Journal of Medicine*.

The results are from two randomized clinical trials that evaluated the

addition of docetaxel to standard chemotherapy for patients receiving induction (or neoadjuvant) treatment. This treatment is given before radiation-based therapy, as was the case in the two reported clinical trials, and/or surgery.

Although the trials differed in their designs, drug doses, and patient populations, each found that the addition of docetaxel improved survival and reduced mortality without adding significant toxicity (*continued on page 2*)

Director's Update

HIV/AIDS Research at NCI: A Record of Sustained Excellence

The human immunodeficiency virus (HIV) and the disease it causes, Acquired Immune Deficiency Syndrome (AIDS), announced itself in the United States in 1981, in the form of a small, sudden uptick in reports of a rare cancer, Kaposi sarcoma (KS), and a rare form of pneumonia among young gay men in New York and San Francisco. That same year, in the NIH Clinical Center, NCI physicians treated the first patient with this deadly, yet-to-be-named disease.

NCI's history will forever be intertwined with that of HIV and AIDS. NCI scientists were at the forefront of the effort to identify HIV as the cause of AIDS, characterize how it hijacked cellular machinery, and, in turn, develop the first treatments for it.



Drs. Mitch Mitsuya, Samuel Broder, and Robert Yarchoan were honored at last week's symposium for their work on HIV/AIDS. Also recognized was Dr. Robert Gallo (not pictured).

Last week, NCI and its **Center for Cancer Research** (CCR) hosted a symposium on NCI's role in HIV/AIDS research, during which four current and former NCI scientists—Drs. Robert Gallo, Samuel Broder, Robert Yarchoan, and Hiroaki (*continued on page 2*)



(Docetaxel continued from page 1)

compared with the treatment arm that used the standard induction chemotherapy regimen.

“The take-home message of these studies is that despite the grim prognosis associated with head and neck cancer, we are making significant progress in treating the disease,” said Dr. Marshall Posner of the Dana-Farber Cancer Institute, who led one of the trials, called [TAX 324](#).

The major surprise of the studies was that a third chemotherapy drug seemed to make treatment more tolerable for patients rather than less, noted Dr. Posner. Survival in the docetaxel group was 71 months on average versus 30 months in the other group.

The [second study](#) was conducted by the European Organization for Research and Treatment of Cancer. After 32 months, median survival in the docetaxel group was 18.8 months, compared with 14.5 months in the other group. Fewer patients treated with docetaxel suffered side effects such as nausea, vomiting, and mouth sores.

Previous studies have suggested that for patients with advanced head and neck cancers, chemotherapy is most effective when administered at the same time as radiation therapy. The two new trials were not designed to address the question of whether induction chemotherapy prior to concurrent chemotherapy and radiation offers advantages over concurrent chemotherapy and radiation alone, and if so, for which patients.

Answers may come soon because at least five randomized trials are testing induction chemotherapy followed by radiation and chemotherapy for these cancers. ♦

By Edward R. Winstead

(Director's Update continued from page 1)

“Mitch” Mitsuya—were honored for their pioneering work in response to this threat to global public health.

Dr. Gallo was chief of the NCI Laboratory of Tumor Cell Biology when it became apparent that the disease we would soon call AIDS was a grave public health issue. The research on human retroviruses by Dr. Gallo and his team—they discovered the first two such viruses, HTLV-1 and -2—laid the groundwork for the co-discovery of HIV in 1984.

Dr. Gallo’s lab also led the development of a blood test for HIV, meaning donated blood could be effectively screened for the virus. With others at NCI, Dr. Gallo was instrumental in developing the first treatments for HIV.

Dr. Broder, who later served as NCI director for 6 years; Dr. Mitsuya; and Dr. Yarchoan led the initial development and clinical trials of the first effective treatments for HIV. That includes AZT, a drug originally developed to treat cancer that they found could inhibit HIV replication.

The trio also led the development of two other anti-HIV drugs, didanosine (ddI) and zalcitabine (ddC), which, with AZT, were the first FDA-approved treatments for AIDS and which continue to be the cornerstone of the HAART regimen that has transformed HIV infection into a chronic disease.

What these four scientists helped to launch 26 years ago is now one of the most well-respected HIV/AIDS research programs in the world. Indeed, NCI researchers in CCR’s [HIV and AIDS Malignancy Branch](#), the [HIV DRP Host Virus Interaction Branch](#), and [Vaccine Branch](#) are building on their historic achievements.

Among these are the identification of genetic mutations that appear to protect against HIV infection or slow its progression, new insights into HIV viral diversity that contributes to drug resistance, and the development of new treatments for AIDS-related cancers, including KS and lymphoma. NCI researchers also are at the forefront of efforts to develop both preventive and therapeutic HIV vaccines and new treatments derived from natural products.

These efforts at NCI continue now in partnership with others. Our efforts today are becoming even more important to our cancer agenda, as we can now refer to this virus as yet another cancer-causing infectious agent—not just regarding the AIDS virus-associated cancers, but now in terms of the striking increase in the incidence of all epithelial malignancies in chronically infected patients.

To ensure NCI’s efforts are integrated and to foster collaboration with other NIH institutes and external partners in academia and industry, a new [Center of Excellence in HIV/AIDS & Cancer Virology](#) has been established.

The cancer community should be proud that NCI continues to expand upon the legacy of early HIV/AIDS research led by Drs. Gallo, Broder, Yarchoan, and Mitsuya. AIDS has killed more than 25 million people worldwide. Many more would have died without the efforts of these scientists and their colleagues. If their history has demonstrated anything, it’s that progress can be made even in the face of the most severe challenges. ♦

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



Cancer Research Highlights

Vitamin D May Affect Colorectal Cancer Mortality

Recent *in vitro*, animal, and human research has suggested a possible role for vitamin D in decreasing cancer incidence, mortality, or both. A new study that used data collected prospectively during the third [National Health and Nutrition Examination Survey](#) (NHANES) showed no association between levels of vitamin D in the blood and total cancer mortality, but did find a significant association between higher levels of circulating vitamin D and reduced risk of colorectal cancer mortality.

“Most of the previous studies on cancer mortality [and vitamin D] have been ecologic studies or have been based on surrogates for vitamin D levels. This is the first to look at actual measured levels and total cancer mortality,” says Dr. Michal Freedman from NCI’s [Division of Cancer Epidemiology and Genetics](#), lead author of the study, which was published online October 30 in the *Journal of the National Cancer Institute*.

Between 1988 and 1994, the investigators from NCI and the Centers for Disease Control and Prevention collected data from 16,818 NHANES participants aged 17 or older, including demographic and lifestyle factors that may contribute to increased cancer risk. Each participant contributed a blood sample that was measured for vitamin D levels.

“We found no association between [vitamin D] and total cancer mortal-

ity in the...NHANES III study population,” state the authors. However, participants with serum vitamin D levels at or above 80 nmol/L had a significantly lower risk of colorectal cancer mortality than participants with levels lower than 50 nmol/L.

The investigators cite several strengths of their study, including use of a study population that was derived from a representative sample of the U.S. population, and inclusion of many variables known to influence cancer risk. They also acknowledge limitations such as a low number of total cancer deaths to analyze and a single point of measurement for vitamin D, which may not represent blood levels over time.

“The relationship between nutritional factors and colorectal as well as other cancers is complicated...Randomized clinical trials of the effects of vitamin D on the incidence of colonic polyps and invasive cancer are needed,” state Drs. Cindy Davis of NCI’s [Division of Cancer Prevention](#) and Johanna Dwyer of the NIH Office of Dietary Supplements in an accompanying editorial.

Brain Cancer Trial Finds Longer Survival with Temozolomide Regimen

Two years ago, researchers [reported](#) that the drug temozolomide could improve the survival of patients with glioblastoma brain cancer when given along with and following radiation therapy. The survival benefit was about 2.5 months, which was significant for the disease. Now,

additional follow-up shows that some patients have survived for several years beyond the 6 to 12 months that is typical for this deadly disease.

The results, from a [phase III clinical trial](#) involving more than 500 European and Canadian patients, were presented last week at the annual meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO) in Los Angeles.

The updated results show that 12.9 percent of patients who received temozolomide during and after radiation treatment lived for 4 years compared with 3.8 percent of those who received radiation alone and also lived for 4 years. Patients who survived for 4 years after diagnosis were mostly younger than 50 and in otherwise good health without any prior major medical condition. Approximately 28 percent of these patients who were treated with temozolomide and radiation lived for 4 years, versus only 7 percent of patients who received only radiation therapy.

“The survival advantage conferred by the addition of temozolomide to radiation therapy in glioblastoma multiforme remains highly significant with a longer follow-up, and we expect a modest but significant proportion of patients to be long-term survivors,” the researchers concluded in an abstract. The study was performed by the EORTC Brain Tumor Group, the Radiation Oncology Group, and the NCIC Clinical Trials Group.

Patient Navigators Tailor Interventions in Minority, Low-Income Populations

Ethnic and racial minorities and low-income patients often encounter barriers to cancer treatment and care, and one proven strategy to

(continued on page 4)

(Highlights continued from page 3)

reduce such health disparities is to provide ethnically and linguistically appropriate lay patient navigators (LPNs). A new study by researchers at the Centinela Freeman Medical Research Center in Inglewood, CA, identified the most problematic barriers experienced by a group of 493 African American and Latino cancer patients. Strategic intervention by LPNs reduced the average time to overcoming them from 42 days to a single day.

Dr. David Khan and colleagues from the Urban Latino African American Cancer Disparities Project (ULAAC) developed a program tailored to low-income populations using the continuous quality improvement (CQI) approach. Volunteer LPNs were trained and then monitored as they counseled patients in the cohort. Tracking of these interventions and focus groups with LPNs led to the evolution of solutions for the specific barriers faced by this patient group, 60 percent of whom accepted help.

A half dozen barriers recurred among these 300-some patients: transportation was cited most often, with 167 patients needing help; followed by psychosocial issues, financial issues, a fear of cancer, issues related to caregivers, and language issues.

Another goal of the project was to increase participation by these target populations in clinical trials. Using the CQI process, ULAAC found that the navigators possessed biases against clinical trials similar to those in the target population. LPNs were retrained and again intervened with patients, 29 of whom eventually joined clinical trials.

“These patient navigator programs should become an essential part of our health care delivery system,” concludes Dr. Khan. The research,

funded by NCI’s [Cancer Disparities Research Partnership Program](#), was presented last week at the ASTRO annual meeting.

“Boost” Radiation Offers Benefits for Women with Early-Stage Breast Cancer

Women ages 40 and younger with early-stage breast cancer had a reduced risk of cancer returning in the same breast by undergoing an extra dose of radiation after surgery to conserve the breast, followed by standard radiation treatment, researchers said last week at the ASTRO annual meeting in Los Angeles. The additional “boost” dose of radiation reduced the risk of recurrence in the same breast during a 10-year period from nearly 24 percent to 13.5 percent. The effect was seen in women of all ages, though the statistical evidence was strongest among younger women.

The study included 5,500 women who underwent breast-conserving surgeries (lumpectomies) and radiation treatment for stage I and stage II breast cancer. Findings from the study, led by Dr. Harry Bartelink of the Netherlands Cancer Institute, appeared in the August 1 *Journal of Clinical Oncology*.

The treatment did not appear to help the women live longer. Nonetheless, boost radiation offers some important benefits for these women, according to Dr. Deborah C. Citrin of NCI’s [Radiation Oncology Branch](#), who [commented](#) on the study. Preventing a recurrence is an important goal after breast-conserving surgery, she said. The boost radiation meant that fewer patients needed a mastectomy because of a recurrence in the same breast, and this helped them avoid the physical and psychological effects of losing a breast. ♦

Funding Opportunities

Following is a newly released NCI research funding opportunity:

Ethical, Legal, and Social Implications Regular Research Program

Announcement Numbers: PA-08-012 and PA-08-013

Application Receipt Dates:

PA-08-012: *Non-AIDS Applications (new)*: Feb. 5, June 5, and Oct. 5, 2008; Feb. 5, June 5, and Oct. 5, 2009; Feb. 5, June 5, and Oct. 5, 2010.

Non-AIDS Applications (renewal, resubmission, or revision): March 5, July 5, and Nov. 5, 2008; March 5, July 5, and Nov. 5, 2009; March 5, July 5, and Nov. 5, 2010.

PA-08-013: *Non-AIDS Applications (new)*: Feb. 16, June 16, and Oct. 16, 2008; Feb. 16, June 16, and Oct. 16, 2009; Feb. 16, June 16, and Oct. 16, 2010.

Non-AIDS Applications (renewal, resubmission, or revision): March 16, July 16, and Nov. 16, 2008; March 16, July 16, and Nov. 16, 2009; March 16, July 16, and Nov. 16, 2010.

PA-08-012 and PA-08-013: *AIDS and AIDS-related Applications (new, renewal, resubmission, or revision)*: Jan. 7, May 7, and Sept. 7, 2008; Jan. 7, May 7, and Sept. 7, 2009; Jan. 7, May 7, and Sept. 7, 2010; Jan. 7, 2011.

This is a renewal of PA-04-050 and will use the R01 (PA-08-012) and R03 (PA-08-013) award mechanisms. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3784. Inquiries: Dr. Carol Kasten—kastentca@mail.nih.gov ♦

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/ncicancerbulletin/NCI_Cancer_Bulletin_110607/page5.



Special Report

New Guidelines Favor Chemo as Adjuvant Therapy for NSCLC

New guidelines on the use of adjuvant therapy for patients with non-small cell lung cancer (NSCLC) recommend the use of cisplatin-based chemotherapy in patients with tumors that have been successfully removed via surgery. The guidelines advise against the use of postoperative radiotherapy in stage I and II patients because its use has decreased survival compared to surgery alone.

Developed by expert panels convened by the American Society of Clinical Oncology (ASCO) and Cancer Care Ontario, the [guidelines](#) recommend the use of adjuvant chemotherapy in patients with stages IIA, IIB, or IIIA NSCLC in which the tumors have been completely resected. In most of these cases, disease has spread to nearby lymph nodes.

Until the current decade, explains guidelines panel co-chair Dr. Katherine M.W. Pisters of M.D. Anderson Cancer Center, randomized clinical trials of adjuvant therapy for NSCLC had reported negative or inconclusive results.

“It’s really only been in the last 5 to 6 years that we’ve had positive data,” she says. “These more modern trials have had better designs with larger numbers of patients studied and more homogeneous patient populations enrolled. And the chemotherapy regimens used in these trials are more effective against NSCLC than the regimens employed in older trials.”

Oncologists are urged in the guidelines to embrace adjuvant chemotherapy for the appropriate patients with NSCLC.

“The guideline panel concludes that the therapeutic nihilism toward adjuvant chemotherapy for stage II-III NSCLC should now be abandoned,” the panel wrote. “The findings and recommendations contained in this guideline provide clinicians with the evidentiary basis for a firm commitment to treat these patients.”

Part of oncologists’ reluctance to use adjuvant chemotherapy, explains Dr. Giuseppe Giaccone, chief of the Medical Oncology Branch in NCI’s Center for Cancer Research, is based on patients’ poor tolerance of chemotherapy after having undergone a thoracotomy—opening up the chest wall to access the lungs and remove the tumors.

“That is a major issue,” Dr. Giaccone says. “In only about 70 percent or less of patients can full-dose chemo be delivered after that operation.” But now, with several trials having demonstrated a clear survival benefit of adjuvant chemotherapy, he continues, that reticence “has to change.”

In two cases, the guidelines note some positive, but inconclusive, data on adjuvant treatment options: adjuvant chemotherapy for stage IB patients and adjuvant radiotherapy for stage IIIA patients.

For patients with stage IB disease (a localized, larger tumor with a strong likelihood of spreading to nearby lymph nodes), says Dr. Pisters, “the trends are there,” but the data are not strong enough at the moment to recommend routine use of adjuvant chemotherapy. At the 2006 ASCO annual meeting, longer-term data presented from a randomized clinical trial of only stage IB patients, the CALGB 9633 trial, showed no statistically significant overall survival benefit, although the data still trended in favor of adjuvant chemotherapy. An unplanned subset analysis, however, revealed a statistically significant benefit in patients with tumors 4 cm or larger.

“It’s very complicated,” Dr. Pisters admits. Oncologists “have got to sit down and talk to their [IB] patients about whether adjuvant therapy is right for them.”

As for adjuvant radiotherapy, two studies have suggested it may be beneficial in stage IIIA patients. But *(continued on page 6)*

Lung Cancer Awareness in November

November is Lung Cancer Awareness Month. For information from NCI on lung cancer, go to <http://www.cancer.gov/cancer-topics/types/lung>.

The Great American Smokeout will take place on November 15. Take this opportunity to quit smoking or learn how to help smokers quit. Information on the Smokeout can be found at <http://acsf2f.com/gaso/>. For information from NCI on smoking and cancer, go to <http://www.cancer.gov/cancer-topics/smoking>. ♦



Featured Clinical Trial

Targeted Combinations for Metastatic Kidney Cancer

Name of the Trial

Phase II Randomized Study of Bevacizumab, Sorafenib Tosylate, and Temozolomide in Patients with Metastatic Renal Cell Carcinoma (ECOG-E2804). See the protocol summary at <http://cancer.gov/clinicaltrials/ECOG-E2804>.

Principal Investigators

Dr. Keith Flaherty and Dr. David McDermott, Eastern Cooperative Oncology Group

Why This Trial Is Important

Treatment of metastatic renal cell carcinoma (kidney cancer) has changed significantly over the past several years due to better understanding of the biology of the disease coupled with the development of several targeted therapies.

Two drugs that target multiple tyrosine kinase proteins—sorafenib and sunitinib—and the drug temsirolimus, which inhibits a protein called mTOR, have been approved by the FDA for advanced kidney cancer. Additionally, treatment with a biological agent called bevacizumab, which inhibits the growth of new blood vessels (angiogenesis) to tumors by targeting a protein called VEGF, has shown promising results in a phase III trial. While all of these agents are effective in delaying the progression of kidney cancer, none are yet curative for advanced disease, and the relative importance of the molecular targets of these drugs in the biology

of kidney tumors is not yet known.

In this trial, doctors are testing different combinations of bevacizumab, sorafenib, and temsirolimus in patients with metastatic kidney cancer. Like bevacizumab, sorafenib and temsirolimus inhibit angiogenesis, but they also inhibit other processes thought to be important in kidney cancer progression.



Dr. Keith Flaherty

“In this trial, we’re testing three different combinations of these agents against each other and against single-agent therapy with bevacizumab,” said Dr. Flaherty. “We’re trying to determine which combination looks most promising, so we can advance it to a phase III clinical trial that might establish the standard of care for this disease.”

Who Can Join This Trial

Researchers seek to enroll 360 patients aged 18 and over with metastatic “clear cell” kidney cancer that is not curable by standard radiotherapy or surgery. See the list of eligibility criteria at <http://cancer.gov/clinicaltrials/ECOG-E2804>.

Study Sites and Contact Information

Study sites in the U.S. are recruiting patients for this trial. See the list of study contacts at <http://cancer.gov/clinicaltrials/ECOG-E2804> 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. ♦

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

(Special Report continued from page 5)

without data from prospective, randomized clinical trials that directly addressed this issue, the panel believed the current evidence was insufficient to recommend adjuvant radiation in all stage IIIA patients.

Oncologists generally eschew adjuvant radiotherapy in their NSCLC patients, Dr. Giaccone notes, but stage IIIA is an exception. “The chance of local relapse is high in these patients,” he says. “So having something that could prevent local relapse is an attractive option.”

Also included in the guidelines are recommendations—which the panel acknowledged were not necessarily “evidence-based”—for communicating with patients about adjuvant therapy.

Among the recommendations is dedicating a single office session to a discussion about adjuvant therapy. The discussion, the panel suggested, should cover factors beyond survival, such as the side effects of adjuvant therapy and its potential effect on quality of life. The guidelines also provide a sample chart that allows patients to more clearly see the absolute survival benefit adjuvant therapy conferred in recent clinical trials. ♦

By Carmen Phillips

Special Issue on NCI-Frederick

Don’t miss our upcoming special issue of the *NCI Cancer Bulletin*, which will focus on cancer research at NCI-Frederick. The issue will feature articles about natural products research, clinical proteomics activities, as well as a conversation with Dr. Craig Reynolds, associate director of NCI-Frederick. ♦

Portrait of Former NCI Director Unveiled

The official portrait of former NCI Director Dr. Andrew C. von Eschenbach was unveiled in a November 5 ceremony at the National Institutes of Health. Dr. von Eschenbach was joined by members of his family, a host of government dignitaries, NCI staff, and representatives of the cancer research community. Among those in attendance was the Honorable Paul G. Rogers, one of the principal Congressional sponsors of the National Cancer Act of 1971.



Official portrait of Dr. Andrew C. von Eschenbach by James Tennison.

NCI Director Dr. John E. Niederhuber honored his predecessor for his dynamic leadership of the Institute from 2002–2006. “As NCI director, Andy spoke often of the transformation of medicine and cancer care in the new molecular era,” Dr. Niederhuber said. “He embodied that vision in his enthusiastic support and development of a number of major initiatives that sought to build upon and expand NCI’s leading role in the cancer research enterprise.

Those include the launching of the [Cancer Biomedical Informatics Grid](#), re-engineering of the clinical trials enterprise through the [Clinical Trials Working Group](#), NCI’s [Alliance for Nanotechnology in Cancer](#), the [Integrative Cancer Biology Program](#), and [The Cancer Genome Atlas](#), to name just a few.”

“He also recognized the importance of science that rapidly and safely translates basic research into patient treatments—science that then takes information gleaned from the patient’s bedside back to the laboratory,” Dr. Niederhuber added. “Throughout these programs runs the thread of Andy’s firm belief that we will increasingly be able to preempt the cancer process: preempt it with improvements in prevention, early detection, and targeted treatment for cure or modulation of aggressiveness to allow patients to live longer lives with higher quality.”

The plaudits were seconded by NIH Director Dr. Elias Zerhouni, who noted Dr. von Eschenbach’s keen interest in nanotechnology, bioinformatics, and the need for greater emphasis on translational research at NCI and other NIH institutes. The NIH director also honored Dr. von Eschenbach’s “very difficult decision” to heed President Bush’s request for him to leave NCI in 2006 to assume his current role as [Commissioner of the U.S. Food and Drug Administration](#).



Madelyn von Eschenbach and NIH Director Dr. Elias Zerhouni unveil the official portrait.

Dr. S. Ward Casscells, U.S. Assistant Secretary of Defense for Health Affairs, commented upon Dr. von Eschenbach’s strong and sincere empathy for cancer patients and survivors, among whose ranks he proudly belongs. A noted cardiologist and researcher, Dr. Casscells was a former prostate cancer patient of Dr. von Eschenbach when he was a urologic surgeon at the University of Texas M.D. Anderson Cancer Center.

Dr. von Eschenbach thanked his colleagues and friends for their comments and support, particularly those among the NCI staff during his tenure. “When I arrived at NCI, I was enormously blessed by the incredibly talented and dedicated people I found here,” he said. “Each and every day I served as NCI Director was an unbelievable privilege and honor.”

He offered special thanks to his wife Madelyn, “who from the very first moment of our lives together was willing to pay any price so that we could together make a difference.” His wife, four children, six grandchildren, and other family members were present at the unveiling of the oil paint portrait by noted artist James Tennison. The painting will hang in the NCI Office of the Director gallery beside the other 11 official portraits of all former NCI directors. ♦

Director Named for Advocacy Relations

Shannon Bell has been named as the new director of the [Office of Advocacy Relations](#) (OAR), formerly the Office of Liaison Activities. Ms. Bell, whose appointment was effective October 29, previously served as deputy director of NCI's Office of Workforce Development. NCI Director Dr. John E. Niederhuber has relocated OAR in the immediate Office of the Director and appointed Special Assistant Anne Lubenow as his immediate liaison with individuals and organizations who advocate on behalf of cancer research. More information about OAR can be found at <http://advocacy.cancer.gov>.

Lowy, Schiffman Receive ACS Medals of Honor

NCI's Drs. Douglas R. Lowy and Mark Schiffman recently received the American Cancer Society's (ACS) highest honor, the Medal of Honor. The researchers were recognized for their outstanding contributions to the fight against cancer at a ceremony during the 2007 ACS annual meeting last month.

Dr. Lowy, chief of the [Laboratory of Cellular Oncology](#) in NCI's [CCR](#), received the Medal of Honor for Basic Research for his contributions to basic science and research leading to the development of the human papillomavirus (HPV) vaccine, which was carried out in close collaboration with his NCI colleague Dr. John Schiller. Dr. Schiffman, of the [Hormonal and Reproductive](#)



Shannon Bell, new director of the Office of Advocacy Relations

[Epidemiology Branch](#) in [DCEG](#), received the Medal of Honor for Clinical Research for his work in molecular epidemiology relating to HPV.

Niederhuber, Udey Named 2007 AAAS Fellows

Two NCI researchers were elected as AAAS Fellows for outstanding contributions under the Section on Medical Sciences. NCI Director Dr. John E. Niederhuber was elected for his pioneering research on MHC immunology and cancer stem cells, and outstanding leadership of the University of Wisconsin Cancer Center and NCI.

Dr. Mark C. Udey, director of the [Dermatology Branch](#) in [CCR](#), was elected for seminal research on the biology of Langerhans cells and the role of E-Cadherin and TGF-beta in their development and localization.

NCI Hosts Public Forums on Biospecimen Resources

NCI is holding a series of public forums about the NCI Best Practices for Biospecimen Resources, which outlines technical, operational, ethical, legal, and policy principles for

biospecimen resources. The purpose is to educate and obtain feedback about the NCI Best Practices from a range of perspectives, including those of investigators, physicians, industry representatives, hospital administrators, cancer survivors, patient advocates, and the public. The first forum was held on November 5 in Boston; two more forums will take place on December 3 in Chicago and on January 28, 2008, in Seattle. Attendance is free and open to the public. For more information, go to <http://www.nci-bestpractices-forum.com>.

Teleconference Focuses on NCI-Frederick

The third fall "Understanding NCI" teleconference will take place on November 8 from 1:00–2:00 p.m., ET, and highlight research conducted at NCI-Frederick. Dr. Craig Reynolds, associate director of NCI-Frederick, will be among those who discuss how their research helps bring new cancer treatments to patients.

Within the U.S., the teleconference can be accessed toll free at 1-800-857-6584; the passcode is FREDERICK. Toll-free playback will be available through December 8 at 1-866-379-4229. To view the series schedule, go to <http://advocacy.cancer.gov/activities/teleconferences>. ♦

70
YEARS
OF EXCELLENCE
IN CANCER
RESEARCH

If Memory Serves...

The earliest NCI cancer epidemiology studies in the late 1930s and early 1940s focused on two activities: a survey of radiation protection in hospitals and an evaluation of breast cancer therapy based on records from nine large cancer hospitals. ([Read more](#)) ♦

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



Community Update

Treating the Whole Person

Meeting the Emotional and Social Needs of Cancer Patients and Their Families

All too often the emotional, social, and practical problems that accompany a diagnosis of cancer are not discussed or addressed during treatment, and this may prevent patients and their families from getting the care they need, according to a [report](#) by the Institute of Medicine (IOM).

Cancer Care for the Whole Patient—Meeting Psychosocial Health Needs calls for a new standard of cancer care in which physicians screen patients for psychological and social issues as early as at the time of diagnosis. Regular follow-up would be required to ensure that recommended care was received and that new needs are being identified and addressed.

Many studies have suggested that unmet psychosocial needs can affect treatment and put patients at risk of illness later in life. Yet the report found that these needs are often not acknowledged or addressed in cancer care.

“We’re so focused on biomedical aspects of care that a patient’s psychosocial needs are not being met,” says Dr. Julia Rowland, who directs NCI’s [Office of Cancer Survivorship](#). The good news is that many community resources as well as Internet and telephone support services are available to help patients with needs.

The report includes recommenda-

tions for how to implement the new standard of care. Interest in psychosocial issues is high because many individuals are experiencing cancer as a chronic disease, and decisions made at the time of treatment can have long-term consequences.

“This report touches a nerve for people who have experienced cancer in terms of the extent to which psychosocial factors are not attended to during treatment,” says Dr. Nancy E. Adler of the University of California, San Francisco, who chaired the IOM committee.

She notes that the IOM recently received an e-mail that read simply: “Thank goodness this is finally acknowledged because it is so important.”

The report describes three models for delivering psychosocial care, which vary depending on the size of a practice. For instance, comprehensive cancer centers may have the support services on site, while providers in rural areas could use remote services, such as [CancerCare](#) and NCI’s [Cancer Information Service](#).

Though it focuses on cancer, the IOM report could be adapted for delivering quality care to patients with any chronic disease. The basic strategy requires a foundation of good com-

munication between health care providers and patients.

“This is absolutely critical,” notes Dr. Adler. “A health care provider has to ask what the patient’s psychosocial needs are in order to help, and the patient has to articulate those needs.”



The elements of effective communication are the subject of a new monograph published by NCI, [Patient-Centered Communication in Cancer Care](#). The report shows how better communication can improve clinical outcomes and psychosocial health and lays out the research agenda for the future. The focus is on teams because cancer patients communicate with a variety of health care providers.

“We need to look at the entire journey of cancer patients and their families to understand how the health care system is meeting their needs,” says Dr. Neeraj Arora of NCI’s [Division of Cancer Control and Population Sciences](#), which produced the report. ♦

By Edward R. Winstead