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Eliminating the Suffering and Death Due to Cancer

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NCI Assists in Hurricane Relief Efforts

In the wake of Hurricane Katrina, the National Cancer Institute (NCI) is working closely with the National Institutes of Health (NIH), the Department of Health and Human Services (HHS), and other government and civilian agencies to bring relief to displaced cancer patients and others. As an immediate response, NCI has posted key federal assistance information and phone numbers on its Web site at *http://www.cancer.gov/katrina* with specific information in support of cancer patients.

"This disaster has touched the entire nation," said NCI Director Dr. Andrew C. von Eschenbach. "NCI is engaged in a number of opportunities, working within the framework of lead federal agencies and with civilian organizations and relief agencies, to assist cancer patients and medical professionals in the region who have been significantly affected."

Coordinating NCI efforts is Dr. Mark Clanton, deputy director for Cancer

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Cancer patients and their families needing specific information should call:

1-800-4-CANCER (1-800-422-6237) or go to **http://www.cancer.gov/katrina**

Patients who are participating in NCI-sponsored clinical trials can also call 301-496-5725 ◆

Director's Update

CRCHD: Building on a Solid Foundation for Success

As we enter the final stretch of 2005, a glance back at the past 8 months offers a powerful reminder that NCI is an organization of constant innovation and change. Whether it's the proteomics and nanotechnology initiatives, or early efforts to characterize the human cancer genome, the NCI machinery is always pulsing at near breakneck pace.

An integral part of this machinery is the Center to Reduce Cancer Health Disparities (CRCHD), which has been under the superb leadership of Dr. Harold Freeman since its establishment in 2001. Dr. Freeman's role at NCI is about to change. He will no longer serve as CRCHD Director, but instead will serve as a senior advisor to the NCI Director on strategies to achieve the 2015 goal in minority and underserved communities.

Dr. Freeman also will be involved in other areas, including serving as a conduit between NCI and federal health agencies such as the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration. For example, he will collaborate with CDC to create a joint NCI-CDC task force on patient navigation.

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Care Delivery Systems. "Our first and foremost concern is the safety and well-being of medical personnel and patients in the area," Dr. Clanton said. "We are marshalling all available communication and information resources to accomplish this, and are also working to help NIH address the needs of displaced researchers and others."

NCI's Cancer Information Service (CIS) is providing staff and its 1-800-4-CANCER toll-free number toward relief efforts. CIS has also partnered with the American Society of Clinical Oncology (ASCO) to establish a contact point for oncologists. The NCI-ASCO collaboration serves several purposes:

- It allows displaced cancer patients to call a central, cancer-specific, toll-free number to find out where they can receive care. ASCO has already compiled a list of practices in Louisiana, Mississippi, Alabama, Arkansas, and Texas that are open and available to accept patients.
- It serves as a way for displaced oncologists to connect with oncologists accepting patients from the area. Many patients are arriving in clinics without any records or knowledge about their treatment. Displaced oncologists can provide contact information where they can be reached, thus enabling the treating physician to better reconstruct the patient's history and help coordinate any emergency treatment with other health care providers.
- It allows displaced cancer patients and their families to speak to a trained cancer information specialist who can provide basic cancer information and referrals to possible support services.

NCI is also establishing a phone number for patients and physicians searching for alternative sites for NCI clinical trials. Patients participating in an NCI-sponsored clinical trial in a hospital or oncology practice located in the hurricane-affected region should call 301-496-5725.

Other plans are underway to support displaced NCI grantees and extramural researchers from the region who may need temporary placement elsewhere to continue their research. NIH has taken a lead role in such placements for the entire biomedical community, and has created the following Web pages to help manage requests and offers of assistance: (http://www.nih.gov/about/director/hurricanekatrina/index.htm and http://grants.nih.gov/grants/katrina/index.htm).

Other major NIH efforts include:

- Creation and activation of a national coordination and referral center for specialty medical consultation (1-866-887-2842);
- Deployment of an advance team and a medical team to a field hospital in Meridian, Miss.; and
- Provision of more than 100 beds at the NIH Clinical Center for specialized, acute referrals, if needed. ◆

By Barbara Cire

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Dr. Freeman will also continue his pioneering work with patient navigator programs. Dr. Freeman's passion for and contributions toward ensuring the continued growth and evolution of these programs are enormous.

I would like to thank Dr. Freeman for his guidance and mentorship. We are fortunate that he will still be part of the NCI team. He has shared his unique vision, exceptional leadership, and unswerving commitment to improve the delivery of cancer services to populations in need of them.

CRCHD will continue to be a vital part of NCI, maintaining its direct reporting relationship to the NCI Director. Dr. Sanya Springfield, head of the NCI Comprehensive Minority Medical Branch, will serve as acting director, working closely with Dr. Mark Clanton, deputy director for Cancer Care Delivery Systems. A national search for a director will be launched in the near future.

Our commitment to addressing cancer health disparities is strong and will grow stronger, thanks in large part to initiatives such as the recently announced Community Networks Program (CNP). With $95 million in funding for 25 projects, the CNP will focus on addressing disparities instead of identifying and raising awareness about them.

Unfortunately, there is still much to do. Studies continue to highlight discrepancies in care. As reported on page 4 of this week's *Bulletin*, for instance, a new study reports that older black patients were less likely to receive chemotherapy after surgery to treat colon cancer—the standard of care—than white patients. This was influenced by several factors, including social support and environmental factors—an apt demonstration that tackling disparities is a tall task that requires immediate and lasting attention.

Addressing disparities in cancer care—and all health care—must remain one of our country's top priorities. NCI is committed to supporting the research and delivering effective interventions, something that, thanks to the efforts of people like Dr. Harold Freeman, we are well positioned to do. ◆

Dr. Andrew C. von Eschenbach
Director, National Cancer Institute

Spotlight

A New Window of Opportunity into Metastasis?

When a tumor cell begins the metastatic cascade by escaping from its primary site in an attempt to begin growing in another part of the body, success is far from assured. After slipping into the blood stream (often via the lymphatic system), the cell, either on its own or as part of a multitumor cell cluster, must maneuver past immune system cells hunting for easy prey. If it survives, the cell must then find a potentially vulnerable body part and gather the wherewithal to attach itself, invade, and set up shop to begin anew the process of uncontrolled cell division. In laboratory models, less than 1 in 1,000 tumor cells released into circulation form a new tumor.

Nevertheless, most cancer deaths are the result of metastatic disease. A relatively new field of research is attempting to find novel ways to attack metastasis, primarily by identifying new players in the metastatic cascade. The research is focused on a class of genes called metastasis suppressors.

By definition, metastasis suppressors affect only metastases, not the size or lethality of primary tumors, says Dr. Patricia Steeg, chief of the Women's Cancers Section in the NCI Center for Cancer Research (CCR). Dr. Steeg discovered the first metastasis suppressor gene, *Nm23*, in 1988.

Metastasis suppressors don't appear to have been mutated, as is the case, for example, with a number of oncogenes and tumor suppressor genes. Instead, they have been turned off, reducing their expression and, as a result, hampering their ability to keep escaped tumor cells in check. Reduced *Nm23* expression, for instance, has been associated with metastasis in several cancers, including melanoma and breast cancer.

According to Dr. Dan Welch, director of the Metastasis Program at the University of Alabama at Birmingham Comprehensive Cancer Center, who discovered the metastasis suppressor gene dubbed *KiSS1*, 14 metastasis suppressor genes have been confirmed, the large majority since 2000. Even though the field is in its infancy, he notes, it has already produced important information.

Perhaps the most important finding has been that metastasis suppressors seem to work by blocking tumor cell growth at the secondary site.

"Suppression at the secondary site does not happen in exactly the same way [with each gene], but the net effect is that the tumor cells can do everything except grow when they get to the secondary site," Dr. Welch explains.

This is a critical fact, adds Dr. Steeg, because a great deal of metastasis research has focused on how primary tumor cells escape. But in many cancer patients "that has already happened by the time they find out they have a tumor and go to surgery," she explains. "So invasion's not something you can tackle therapeutically."

But because metastasis suppressors—and the genes they influence downstream in the intracellular signaling pathway—do their most important work at the secondary site, Dr. Steeg continues, "I think they are therapeutically tractable targets."

Some recent studies indicate she may be right. In a study published last month in *Cancer Research*, researchers from the University of Virginia, led by Dr. Dan Theodorescu, Paul Mellon Professor of Urology and Molecular Physiology, identified a potential new target and drug for disrupting metastasis. The results are an extension of their work in previous studies in which they identified *RhoGDI2*, a gene that suppresses lung metastases of bladder cancer.

In the new study, the researchers identified a gene, *endothelin-1 ligand (ET-1)*, the increased expression of which directly correlates with *RhoGDI2's* decreased expression. Subsequently, in a mouse model of metastatic bladder cancer (the same one used to discover *RhoGDI2*), they found that atrasentan—an agent that specifically inhibits *ET-1*—dramatically decreased lung metastases compared with untreated mice.

Results from Dr. Theodorescu's lab have also provided evidence that loss of *RhoGDI2* in primary tumors of bladder cancer patients is associated with more frequent and faster development of metastatic disease.

Overall, the available evidence indicates that in some patients there "is a window where the cancer in the distant organ is at its most sensitive," Dr. Theodorescu says. "It has not established itself. It's a new colonist

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Cancer Research Highlights

Studies Highlight Colon Cancer Disparities

Two new studies of colon cancer treatment add to a growing body of knowledge regarding racial disparities in cancer care. The first report found that 11 percent fewer black than white patients received adjuvant chemotherapy after surgery. The second concluded that non-English-speaking patients were less satisfied with their care than English-speaking patients.

The first study, published in the August 17 *Journal of the National Cancer Institute (JNCI)*, examined Medicare records from 5,294 people diagnosed with stage III colon cancer between 1992 and 1996. By studying diagnosis and treatment codes, the researchers found that 70 percent of white patients received adjuvant chemotherapy, compared with 59 percent of black patients. The disparity was highest among patients aged 66 to 70. The authors, from the University of Washington, write that the trend is "worrisome because these 'young' elderly are most likely to derive a survival benefit from chemotherapy."

By integrating Medicare data with information from NCI's Surveillance, Epidemiology, and End Results database, the researchers were able to calculate the impact of many factors, including physician experience, hospital environment, and the sociodemographics of each patient's neighborhood. However, the study "showed no single or simple explanation."

The second report was published online August 22 in the *Journal of Clinical Oncology* by investigators at the Harvard Medical School, California Cancer Registry, and Northern California Cancer Center. The survey of 1,067 colorectal cancer patients found that non-white and non-English-speaking patients reported significantly more problems with cancer care than white and English-speaking patients. Only 52 percent of non-English speaking patients rated overall quality of cancer care as very good or excellent, compared with 81 percent of English-speaking patients. Much of the dissatisfaction among non-English-speaking patients appeared to stem from concerns about coordination of care among the nurses, physicians, and other health care providers encountered. An accompanying editorial suggests that communication and coordination of care present the greatest opportunity to raise the bar on overall cancer care quality.

Mantle Cell Lymphoma Patients Benefit from Vaccine and Immune-Depleting Therapy

A phase II clinical trial has found that some lymphoma patients may have benefited from an experimental cancer vaccine and the novel dose-adjusted EPOCH chemotherapy regimen with the drug rituximab. Although 80 percent of the patients eventually relapsed after the treatments, they lived longer on average than others with mantle cell lymphoma. After nearly 4 years, 89 percent of the patients were alive; typically, half the patients with this disease die within 3 years.

It is not clear whether the vaccine or some combination of the treatments were responsible for the prolonged survival. But the study, which included 26 patients, demonstrates that a vaccine can stimulate the body's T cells to attack the mutant B cells responsible for the lymphoma. This was true despite the fact that rituximab had eradicated the healthy B cells in these patients along with the mutant B cells.

"This study shows that healthy B cells were not necessary for generating a T-cell response, and the role of these cells in generating a T-cell response has not been known in humans," says Dr. Wyndham Wilson of NCI's CCR. He co-led the study along with Dr. Larry Kwak of the University of Texas M. D. Anderson Cancer Center.

The researchers made "personalized" vaccines for each patient based on a unique protein found on the surfaces of a patient's mutant B cells. The results, published in the August 21 *Nature Medicine*, suggest that additional doses of the vaccine should be administered for longer periods of time to achieve an optimal immune response.

"We're now trying to make the vaccine formulation more potent, and we're also investigating a universal vaccine that might be effective in every lymphoma patient," says Dr. Sattva Neelapu of M.D. Anderson and the first author of the study.

Men with Klinefelter Syndrome at Higher Risk for Some Cancers

A British cohort study has found that men with Klinefelter syndrome suffer higher rates of lung cancer, breast cancer, and non-Hodgkin's lympho-

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ma. Klinefelter syndrome is a genetic disorder caused by an excess number of X chromosomes in men.

The study examined the medical histories of 3,518 men diagnosed with Klinefelter syndrome and followed each for an average of 15.1 years; the longest follow-up was 44 years. When compared with the general population, the men's overall mortality from cancer was not significantly elevated. However, mortality from lung cancer, breast cancer, and non-Hodgkin's lymphoma was significantly higher (absolute excess risks were 23.7, 9.3, and 12.1, respectively). However, mortality from prostate cancer among the participants was significantly decreased. As found in similar studies, there was a modest association between Klinefelter syndrome and leukemia.

The report, published in the August 17 *JNCI*, warns that several limitations should be considered when interpreting the data. The vast majority of Klinefelter syndrome cases go undiagnosed, the research team noted, and many were only detected after a diagnosis of breast cancer. Nonetheless, they concluded, the statistically significant differences in risks for certain cancer types "do not appear to be due to bias or confounding."

Study Indicates Genetic Variation May Influence Metastasis

Scientists have identified a genetic variation in mice that may influence whether a tumor metastasizes to other tissues. The specific variant has not been found in the human version of the gene, called *Sipa1*, but the researchers have preliminary evidence that the human gene may be associated with some prostate cancers. They are investigating whether *Sipa1* may be involved in other types of tumors.

The new research demonstrates that an inherited gene variant—a polymorphism—can have a significant impact on tumor metastasis, according to findings published online September 4 in *Nature Genetics*. Dr. Kent Hunter of NCI's CCR, who led the study, and his team have published evidence that inherited genetic factors may influence whether tumors are successful in colonizing other parts of the body.

If the findings in mice are borne out in humans, they may have implications for cancer patients. "The research suggests that a person's genetic background may play an important role in whether a tumor will spread," says Dr. Hunter. "And this means in theory you could identify patients at risk for metastases and plan their treatments accordingly."

Most cancer deaths are associated not with primary tumors but with their spread. Dr. Hunter predicts that multiple genes will eventually be found to play a role in the efficiency of tumor metastasis. His team identifies potential factors in mice using a strategy they call "transomics," which includes a combination of research techniques such as gene expression profiling, functional genomics, and proteomics. ◆

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in a new land, and it has yet to get its footing. It could be wiped out or, if it isn't wiped out, we can at least keep it at bay."

Dr. Theodorescu is in discussion with pharmaceutical companies and NCI cooperative groups to conduct an adjuvant clinical trial to test whether blocking *ET-1* activity can reduce the risk of lung metastases in patients with advanced bladder cancer at high risk of developing metastases, as well as validate a test that correlates *RhoGDI2* expression with risk of metastatic bladder cancer.

Meanwhile, in May, Dr. Steeg's lab published a study in the *Journal of the National Cancer Institute* with an intriguing finding: in the case of *Nm23*, at least, it may be possible to turn the metastasis suppressor back on instead of focusing on other targets in its signaling pathway. In a metastatic breast cancer mouse model, administration of MPA, a hormone traditionally used in a common female contraceptive, increased *Nm23* expression and decreased the formation of metastases in breast cancer cells that expressed the glucocorticoid receptor but not the progesterone receptor—an unexpected result because MPA is known clinically as a progestin. And in cell-line studies, MPA administration significantly reduced the formation of tumor colonies.

A phase I clinical trial is being planned to test the use of MPA in patients at increased risk for metastatic breast cancer to see if *Nm23* expression can be increased, Dr. Steeg reports. ◆

By Carmen Phillips

In the Next Issue…

Next week's *NCI Cancer Bulletin* will be a Special Issue on NCI's Community Clinical Oncology Program, with information about where and how the program is bringing clinical trials to communities throughout the United States, as well as how the program is benefiting clinicians, researchers, and patients. Don't miss this special issue. ◆

Funding Opportunities

PAR-05-156 | **Specialized Programs of Research Excellence (SPOREs) in Human Cancer for Year 2006**

Letter of Intent Receipt Dates: Breast Cancer SPORE: Dec. 1, 2005; Gastrointestinal (GI) Cancer, Brain Cancer, and Lymphoma SPOREs: April 1, 2006; Head & Neck Cancer and Prostate Cancer SPOREs: Aug. 1, 2006

Application Receipt Dates: Breast Cancer SPORE: Feb. 1, 2006; GI Cancer, Brain Cancer, and Lymphoma SPOREs: June 1, 2006; Head & Neck Cancer and Prostate Cancer SPOREs: Oct. 1, 2006

This funding opportunity will use the P50 award mechanism: http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3110.

Inquiries: Dr. Rashmi Gopal-Srivastava, Breast Cancer SPORE: gopalr@mail.nih.gov; Dr. Ivan Ding, GI and Head & Neck Cancer SPOREs: dingi@mail.nih.gov; Dr. Jane Fountain, Brain Cancer SPORE: fountai@mail.nih.gov; Dr. Peter Ujhazy, Lymphoma SPOREs: ujhazyp@mail.nih.gov; Dr. Andrew Hruszkewycz, Prostate Cancer SPOREs: hruszkea@mail.nih.gov

PA-05-155 | **The Secretory Pattern of Senescent Cells**

Application Receipt Dates: Oct. 1, 2005; Feb. 1, June 1, and Oct. 1, 2006; Feb. 1, June 1, and Oct. 1, 2007; Feb. 1 and June 1, 2008

This funding opportunity will use the R01 and R21 award mechanisms: http://grants.nih.gov/grants/guide/pa-files/PA-05-155.html.

Inquiries: Dr. Felipe Sierra: sierraf@nia.nih.gov; Dr. Suresh Mohla: mohlas@mail.nih.gov ◆

Featured Clinical Trial

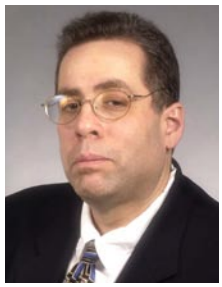
Targeted Monoclonal Antibody Therapy for a Rare T-Cell Leukemia

Name of the Trial

Phase I Study of Humanized Monoclonal Antibody MiK-beta-1 in Patients with T-Cell Large Granular Lymphocyte Leukemia (NCI-04-C0089). See the protocol summary at http://cancer.gov/clinicaltrials/NCI-04-C-0089.

Principal Investigator

Dr. John C. Morris, NCI CCR



Dr. John C. Morris

Why Is This Trial Important?

T-cell large granular lymphocyte leukemia (T-LGLL) is a rare form of chronic leukemia characterized by the abnormal proliferation of white blood cells that contain packets (granules) of toxic enzymes and can destroy cells they recognize as foreign. T-LGLL usually develops in older adults and often follows a slowly progressive (indolent) course that may not require treatment if patients remain symptom free.

However, approximately one half of patients develop complications from T-LGLL that can be life-threatening. Some complications, such as increased susceptibility to infection, anemia, and impaired blood clotting, result from abnormally low numbers of normal white or red blood cells or platelets. Other complications, such as rheumatoid arthritis, result from disturbances in the immune system that cause autoimmune disorders.

Researchers have created a humanized monoclonal antibody, MiK-beta-1, that targets a protein located on the surface of malignant T lymphocytes that is crucial to their continued proliferation. This protein acts as a receptor molecule for interleukin 15, a cytokine that stimulates T-LGLL cell growth. Treatment with MiK-beta-1 may slow or interrupt the abnormal proliferation of T-LGLL cells by blocking the binding of IL-15 to its receptor, perhaps inhibiting disease progression and reducing the severity of some complications.

"This study is designed principally to assess the safety of a single dose of this monoclonal antibody," said Dr. Morris. "If the treatment is tolerated, we hope eventually to use repeated doses of MiK-beta-1 to treat not only T-LGLL, but also certain autoimmune disorders such as rheumatoid arthritis and multiple sclerosis."

Who Can Join This Trial?

Researchers plan to recruit up to 18 patients aged 18 and over with T-LGLL. See the complete list of eligibility criteria at http://www.cancer.gov/clinicaltrials/NCI-04-C-0089.

Where Is This Trial Taking Place?

The study is taking place at the NIH Clinical Center in Bethesda, Md.

Contact Information

For more information, contact the NCI Clinical Studies Support Center at 1-888-NCI-1937. The toll-free call is confidential. ◆

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

Notes

Former NCAB Chair Joins NCI as Senior Advisor for Translational Research

Dr. John Niederhuber, who recently stepped down as chair of the National Cancer Advisory Board (NCAB), has joined NCI as a special advisor to the director for Translational and Clinical Sciences. Dr. Niederhuber is a surgical oncologist and past director of the University of Wisconsin Comprehensive Cancer Center. During his distinguished career, he pioneered a totally implanted drug delivery system to provide continuous hepatic arterial infusion for patients with liver metastases from colorectal cancer. He also was the first to implant venous access devices, which proved to be an exceptional benefit for cancer patients receiving chemotherapy.

Dr. Daniel Von Hoff will serve as interim chair for the NCAB.

President's Cancer Panel Meets to Discuss Recommendations

The President's Cancer Panel held two meetings in Washington, D.C., on August 25 and 26 to follow up on specific recommendations made in its 2003-2004 annual report, *Living Beyond Cancer: Finding a New Balance,* which identified and addressed critical challenges faced by cancer survivors across their life spans. The Panel considered the adoption of several of the recommendations vital to the National Cancer Program, prompting them to convene these meetings to assess progress. Key stakeholders and decision makers gathered to identify the steps needed to advance the Panel's recommendations.

The Panel will hold two additional meetings on October 24 and 25 to discuss recommendations from the 2004-2005 report, *Translating Research into Cancer Care: Delivering on the Promise*. For additional information, visit http://pcp.cancer.gov, or call 301-451-9399.

Collins Named DCTD Associate Director

Dr. Jerry Collins was recently named associate director of NCI's Division of Cancer Treatment and Diagnosis and will assume leadership of the division's Developmental Therapeutics Program. Dr. Collins is an internationally recognized pharmacologist who has been closely associated with NCI's new drug development effort for more than 25 years, first as an NCI intramural senior investigator and, for the past 17 years, as the director of the FDA's Laboratory of Clinical Pharmacology.

Dr. Collins received his bachelor's degree from Drexel University, and his masters and doctorate from the University of Pennsylvania. He is the author or co-author of more than 170 articles, and currently holds 8 patents.

NCI Launches Advocacy Teleconference Series

NCI's Office of Liaison Activities is offering an Advocacy Teleconference Series on crosscutting issues in cancer research. Members of cancer advocacy organizations, as well as cancer survivors, their families, and friends, are encouraged to participate in the teleconferences to gain information about NCI's research programs and how advocates are involved. Participation is free, and callers will be able to ask questions of panel members. On September 19, NCI Director Dr. Andrew C. von Eschenbach and other speakers will discuss "Eliminating Suffering and Death Due to Cancer by 2015: The Future of Cancer Research." For more information, go to http://la.cancer.gov/index.html.

HMC Holds Biannual Meeting

On August 22-23, approximately 50 grantees of the Health Maintenance Consortium (HMC) gathered in Washington, D.C., for their biannual meeting. HMC is an NIH research grant program in which NCI is one of the participating institutes. HMC's goal is to understand the long-term maintenance of behavior change, as well as to advance effective strategies for achieving sustainable health promotion and disease prevention activities. In collaboration with NIH administrators and investigators, HMC brings together behavioral health experts to help identify and discuss theories and methodologies related to the processes of behavior change.

The meeting included a panel on environmental influences on health behaviors. Grantees also agreed to work toward implementing cross-site projects that will involve identifying and sharing common data. For more information on HMC, go to http://hmcrc.srph.tamhsc.edu.

Presidential Proclamations for Cancer Awareness in September

Presidential proclamations for National Ovarian Cancer Awareness Month and National Prostate Cancer Awareness Month for September have been issued. For information on these cancers, go to the following NCI Web sites:

Ovarian Cancer: http://www.cancer.gov/cancertopics/types/ovarian

Prostate Cancer: http://www.cancer.gov/cancertopics/types/prostate ◆

Community Update

Tackling Obesity Before It Starts

A study published in the July 23 *The Lancet* revealed some startling news: after following nearly 2,400 girls under age 10 for 9 years, it found that as many girls got older, their physical activity levels dropped significantly. By the time many inactive girls reached their late teens, they had become overweight. This was especially true for African American girls, who were consistently heavier, exercised less, and had higher caloric intake than their white counterparts.

The available data suggest that this weight gain should not be dismissed. Research published last year in the *American Journal of Clinical Nutrition* showed that adolescents who were overweight or obese very often remained so as adults.

As the evidence continues to mount that obesity is an important risk factor for many cancers, including colon, breast, esophageal, and kidney, NCI is increasingly focused on understanding obesity's relation to cancer and ways to change behaviors to potentially reduce cancer risk. This is why NCI is participating in a new program called *We Can!* that is focused on preventing overweight and obesity among youths aged 8 to 13 through improved diet and increased exercise. The initiative—led by the National Heart, Lung, and Blood Institute—provides resources and community-based programs for parents, caregivers, and youths.

The evidence so far, says Dr. Louise Masse, acting chief of the Health Promotion Research Branch in the NCI Division of Cancer Control and Population Sciences (DCCPS), suggests behavioral interventions such as tailored nutrition and exercise programs, combined with counseling, have a greater impact on changing behavior compared with educational programs that focus only on changing awareness.

"Starting young is very critical," adds Dr. Linda Nebeling, acting associate director of the DCCPS Behavioral Research Program at NCI. "And the kids have to be engaged so they make healthy eating and exercise an integral, routine part of their lives, just like brushing their teeth or combing their hair every morning."

We Can!, which will be facilitated through local public health agencies, will help parents teach their children to get moderate exercise on most days of the week, eat diets richer in fruits and vegetables, consume smaller portions, and eat fewer high-fat foods that are low in nutrients.

"Parents are very eager to know what is good to eat for their kids," says Tina Shubert, with the Montgomery County (Maryland) Department of Recreation, one of the 14 communities that has agreed to be an "intensive" *We Can!* site. "A lot of them just don't know what to buy."

Reaching children "really starts with the parents," Shubert adds. "They are the ones buying the snacks and taking their children to fast food places." ◆

CCR Grand Rounds

September 13: Dr. Carlo M. Croce, Professor and Chairman, Department of Molecular Virology, Immunology and Medical Genetics; Director, Institute of Genetics; Director, Human Cancer Genetics Program; Ohio State University Comprehensive Cancer Center "MicroRNA Genes and Cancer."

September 20: Dr. James O. Armitage, Joe Shapiro Professor of Medicine, University of Nebraska College of Medicine "Is Follicular Lymphoma a Curable Disease?"

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

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

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

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