NATIONAL CANCER INSTITUTE

NCI Cancer Bulletin

Eliminating the Suffering and Death Due to Cancer

March 21, 2006
Volume 3 | Number 12

In this issue:

A Publication of the
National Cancer Institute
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
National Institutes of Health
NIH Publication No. 05-5498

http://www.cancer.gov

NCI Director von Eschenbach Nominated to Head FDA

Last week President Bush nominated current NCI Director Dr. Andrew C. von Eschenbach to be the next commissioner of the Food and Drug Administration (FDA). Dr. von Eschenbach has served as the interim FDA commissioner since late last September, after Dr. Lester Crawford resigned from the position.

"I am deeply honored to be nominated to head the FDA, and I look forward to continuing to serve our great nation in this capacity," Dr. von Eschenbach said. "As a result of this nomination, I intend to resign my position as NCI director.

"I cannot overstate how much I've enjoyed working at NCI," he said. "The staff at NCI, from the senior leadership on down, are among the most highly talented and dedicated group of people I've ever worked with. NCI is a very special organization, and I will miss my interactions with staff and the committed members of the research and advocacy communities very much."

Dr. von Eschenbach was named NCI Director in 2002, after a 25-year career at M.D. Anderson Cancer Center in Houston. At the time of his departure from

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Director's Update

Progress and Opportunity

Last week, President Bush nominated me to be the commissioner of the Food and Drug Administration (FDA). I have enjoyed serving as interim FDA commissioner, a post I have held since last September, and am honored by the President's decision to nominate me for this important public health leadership position.

I look forward to sharing with members of Congress and the medical community my aspirations for this critical agency, and how I believe we can take advantage of the numerous opportunities afforded by advances in science and technology to protect and improve our nation's health.

As a result of this nomination, I intend to resign as NCI director. I have enjoyed my time at NCI more than I could have possibly imagined. The opportunity to fly at 40,000 feet, so to speak, and witness the remarkable breadth of work done at NCI and in the entire cancer community, but, more importantly, the unmatched dedication to saving lives, has been truly gratifying.

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(von Eschenbach continued from page 1)
M.D. Anderson, he was Executive Vice President and Chief Academic Officer. He was the founding director of M.D. Anderson's Prostate Cancer Research Program and directed the Genitourinary Cancer Center.

Less than a year after Dr. von Eschenbach's arrival at NCI, the institute announced a challenge goal: to eliminate the suffering and death due to cancer by 2015.

In addition to the recently released NCI strategic plan, Dr. von Eschenbach noted that NCI has launched a number of key initiatives that will play an integral role in achieving the 2015 goal, including the NCI Alliance for Nanotechnology in Cancer, the cancer Biomedical Informatics Grid, the $95 million Community Networks Program to reduce disparities in cancer care and outcomes, and The Cancer Genome Atlas.

"Andy is an inspired choice to provide permanent leadership at this critical agency," Health and Human Services Secretary Mike Leavitt said of the nomination. "His career has been defined by his vision for progress in research and passion for the care of patients—two qualities which will serve the agency and the American public well."

Dr. John Niederhuber, NCI deputy director for clinical and translational sciences, has been overseeing the institute's day-to-day operations since Dr. von Eschenbach assumed the interim commissioner role at FDA last fall. He will continue in this role until an acting director of NCI is named. ◆

(Director's Update continued from page 1)
Dr. John Niederhuber, NCI deputy director for clinical and translational sciences, has been serving as NCI chief operating officer since late September, and will continue in this role until an acting director for NCI is named. John has done an outstanding job of overseeing the day-to-day operations at NCI over the past 6 months. I am supremely confident that he, along with the other members of NCI senior leadership, will ensure that NCI continues to play the important leadership role in guiding the country's cancer research enterprise.

I came to NCI just over 4 years ago. Not long afterward, the institute announced an important goal: to eliminate the suffering and death due to cancer by 2015. The concept behind this goal—one strongly supported by the exploding portfolio of solutions emanating from cancer research—is that we will increasingly be able to *preempt* the cancer process: preempt it with improvements in prevention, early detection, elimination, or modulating the diseases' virulence.

It was a bold goal then, and it is a bold goal now. But "bold" is not synonymous with "unlikely" or "impossible." On the contrary, it's a goal that I, and now many others in the cancer community, believe is within our grasp.

My confidence in our ability to achieve the 2015 goal goes beyond the remarkable advances in science and technology seen over the past decade. My confidence is rooted in an absolute trust that the cancer community would take up this challenge with vigor and optimism, that it would view no barrier as insurmountable, no challenge as too great.

As the recent release of the NCI strategic plan demonstrates, we now have before us a world-changing opportunity. Every day we are identifying susceptibility points in the cancer development process, and we are simultaneously studying and developing new interventions that can exploit those susceptibilities. That work is being aided by advances in areas like nanotechnology, imaging, proteomics, and information technology. But without the unprecedented intellectual capacity of the cancer research community and the unrelenting commitment of our advocacy community, these technologies would mean nothing. In the end, it's all about the people who are making this progress a reality.

We established a bold goal 4 years ago. But we are defined not by goals, but by accomplishments. And I have no doubt that we can accomplish a great many things as a community committed to a vision of a world where there no longer is suffering and death due to cancer. ◆

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

Cancer Research Highlights

Gene Profiling Reveals Novel Subtype of Liver Cancer

Researchers have used gene expression profiling to identify a subtype of liver cancer that had not been recognized previously by conventional diagnostic methods. The team adopted an experimental strategy that involved comparing gene activity across three species. The newly identified tumor subtype has patterns of activity in common with liver stem cells, and the tumors may arise from this population of cells, called adult hepatic progenitor cells.

The subtype, hepatoblast B (HB), is associated with a poor prognosis. It is distinguished from other types of liver cancer by the differential expression of hundreds of genes. The researchers compared gene activity in liver tumors from humans and mice, and validated the HB subtype gene expression signature using an independent cohort of liver cancer patients, according to an article published early online in *Nature Medicine*.

The variability of liver cancer suggests that the disease may comprise biologically distinct subtypes, including different cells of origin. Both adult hepatocytes and liver stem cells can be a source of tumors, and the new findings indicate that gene expression profiling can provide information about a tumor's cellular origins. Previous studies suggested that cancer cells retain some of the gene expression of the cellular lineage from which the cancer originated.

The study included 61 cases of liver cancer from Chinese individuals, and 14 were classified in the HB subgroup. An analysis of activated pathways in the tumors suggests that the AP-1 complex of transcription factors may be "the driving force in tumorigenesis" of the HB subtype.

"This subtype could not be distinguished from other liver tumors by pathologists, and this further demonstrates the usefulness of gene expression profiling in classifying tumors," notes lead researcher Dr. Snorri Thorgeirsson of NCI's Center for Cancer Research. "As we move toward more precise classification of liver tumors into homogeneous subtypes, we hope to translate these data into useful clinical applications."

Gene-Expression Signature Predictive in Node-Negative Breast Cancer

An international group of investigators has validated a 76-gene prognostic signature for lymph node-negative (LNN) primary breast cancer that showed promising results in an initial single-center study in the Netherlands. The results of the validation study appear online on the *Journal of Clinical Oncology* Web site.

The investigators used frozen tissue samples from 180 women with LNN breast cancer who had been followed for more than 5 years after diagnosis or who developed distant relapse within 5 years. RNA isolated from the samples was hybridized to custom-made gene chips containing the 76 genes whose expression was hypothesized to predict relapse and survival. Differences in distant metastasis-free survival and overall survival between groups of women predicted as high risk or low risk by the signature were calculated.

The gene signature accurately predicted 27 of 30 relapses that occurred within the first 5 years of follow-up, and correctly identified approximately 50 percent of patients who did not relapse. Results from the predictive gene profile were compared with risk classifications using the St. Gallen and NIH criteria. Using either set of criteria, 29 of the 30 metastatic relapses would have been predicted correctly, but 94 to 98 percent of patients who did not relapse would also have been recommended adjuvant systemic therapy. "Therefore," state the investigators, "application of this gene signature could result in a substantial reduction of the number of LNN patients who would otherwise be recommended for unnecessary adjuvant systemic therapy, in particular avoiding overtreatment by chemotherapy."

Folate in Food Cuts Pancreatic Cancer Risk

Pancreatic cancer is often asymptomatic while it develops; once diagnosed, overall survival is poor, making effective chemoprevention especially important. Researchers in Sweden have found population-based evidence that dietary folate reduces the risk of pancreatic cancer by up to 75 percent, according to a study published in the March 15 *Journal of the National Cancer Institute (JNCI).*

Folate—also known as folic acid and vitamin B-9—is found naturally in some leafy green vegetables and fruits, especially citrus. Since 1998, FDA requirements have prompted

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the addition of synthetic folic acid to many prepared foods. Folic acid affects DNA methylation, which has broad implications for human health.

Information on diet came from a 1997 questionnaire given to nearly 82,000 women and men who took part in two large prospective population studies in Sweden. Results after 6.8 years compared those who consumed the most folate from any source with those who consumed the least, and found a protective effect of 67 percent, but this did not extend to folic acid from dietary supplements and multivitamins. "Although our results suggest that increased consumption of foods naturally rich in folate may be beneficial, they do not encourage increased use of supplements for the prevention of pancreatic cancer," said Dr. Susanna C. Larsson of the Karolinska Institutet in Stockholm.

The dose-response findings suggest the more dietary folate, the better the protection against the disease. Alcohol consumption and smoking have been linked to pancreatic cancer risk in other studies, but neither showed any interaction with dietary folate in these data.

Lung Cancer Screening Trial Tests Silenced Genes as Biomarkers

A clinical trial reports that testing the sputum of individuals at high risk of lung cancer for silenced genes shows promise as a potential screening tool for detecting early signs of the disease. The experimental test, which is not yet ready for clinical use, screens 14 genes that are inactivated at different stages of lung cancer for the presence of chemicals called methyl groups that can attach to genes and silence them. The process is called hypermethylation; previous studies have suggested that hypermethylated genes could be biological markers for cancer.

Six of the 14 genes—*p16*, *PAX5-ß*, *MGMT*, *DAPK*, *GATA5*, and *RASSF1A*—were associated with a 50 percent increased risk of lung cancer. Participants who had three or more of these methylated, silenced genes in sputum that was collected within 18 months of diagnosis had a 6.5-fold increased risk for lung cancer. The test identified 65 percent of individuals who later developed symptoms of lung cancer, but it also identified 35 percent of cancer-free control participants, according to findings in the March 15 *Cancer Research*.

Dr. Steven Belinsky, who directs the Lung Cancer Program at the Lovelace Respiratory Research Institute in Albuquerque, led the research. Participants came from the University of Colorado Cancer Center Sputum Screening Cohort Study, an ongoing prospective study initiated in 1993 to determine whether mucus that coats all parts of the lung might contain genetic evidence of cancer cells when expelled in sputum.

The test performed poorly when the sputum was collected more than 18 months before lung cancer was diagnosed. A person who tests positive would receive a follow-up diagnostic bronchoscopy or x-ray to determine if tumors exist, according to Dr. Belinsky. If tumors are not evident, patients could be retested in several months.

Childhood Leukemia Incidence and Influenza in Great Britain

Researchers from the University of Oxford in England have identified small peaks in the incidence of childhood acute lymphoblastic leukemia (ALL) in Great Britain in 1976 and 1990 that immediately followed winter influenza epidemics. While their time-trends analysis was not designed to measure causation, the observed association supports the hypothesis that some types of childhood leukemia may be triggered by a challenge to the immune system. The results were published in the March 15 *JNCI*.

The investigators collected ALL incidence data from the National Registry of Childhood Tumours (NRCT) for children younger than 15 in England, Scotland, and Wales between 1974 and 2000. Cases were categorized as either CD10-positive precursor B-cell ALL (cALL) or non-cALL.

An increasing trend in the incidence of ALL between 1974 and 2000 was identified. Between 1980 and 1996, this trend was apparently due to a specific increase in the cALL subtype, suggesting that the cause of cALL differs from that of other childhood leukemias. The peaks in the incidence of ALL in 1976 and 1990, observed after winter influenza outbreaks, were also caused by a specific increase in cALL.

Their results, state the investigators, "are consistent with hypotheses suggesting that some childhood leukemia may be triggered by infection occurring close to the time of diagnosis of leukemia…and they raise the possibility that influenza may sometimes be involved." ◆

Missed Something?

The *NCI Cancer Bulletin* Archive allows you to search every issue of this online publication since January 2004. That's over 100 weeks' worth of articles on a variety of cancer research topics and updates. ◆

Funding Opportunities

Cancer Genome Characterization Centers

Announcement Number: RFA-CA-07-014
Letter of Intent Receipt Date: April 12, 2006.
Application Receipt Date: May 12, 2006.

This funding opportunity will use the U24 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3377. Inquiries: Dr. Daniela Gerhard—gerhardd@mail.nih.gov

Ubiquitin and Ubiquitin-Like Modifications Regulating Disease Processes

Announcement Number: PA-06-167
New Application Receipt Dates: June 1 and Oct. 1, 2006; Feb. 1, June 1, and Oct. 1, 2007; Feb. 1, June 1, and Oct. 1, 2008; Feb. 1, 2009.

This is a renewal of PA-03-145 and will use the R01 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3349. Inquiries: Dr. Mary Perry—mp372j@nih.gov

Ubiquitin and Ubiquitin-Like Modifications Regulating Disease Processes

Announcement Number: PA-06-168
New Application Receipt Dates: June 1 and Oct. 1, 2006; Feb. 1, June 1, and Oct. 1, 2007; Feb. 1, June 1, and Oct. 1, 2008; Feb. 1, 2009.

This is a renewal of PA-03-145 and will use the R21 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3350. Inquiries: Dr. Mary Perry—mp372j@nih.gov

Pilot Studies: Oral Complications of Cancer Therapies

Announcement Number: PA-06-212
New Application Receipt Dates: June 1 and Oct. 1, 2006; Feb. 1, June 1, and Oct. 1, 2007; Feb. 1, June 1, and Oct. 1, 2008; Feb. 1, 2009.

This is a renewal of PA-04-134 and will use the R21 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3356. Inquiries: Dr. Roy S. Wu—rw51j@nih.gov

Clinical Trials: Oral Complications of Cancer Therapy

Announcement Number: PAR-06-213
New Application Receipt Dates: June 1 and Oct. 1, 2006; Feb. 1, June 1, and Oct. 1, 2007; Feb. 1, June 1, and Oct. 1, 2008; Feb. 1, 2009.

This is a renewal of PAR-04-133 and will use the R21 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3358. Inquiries: Dr. Bruce Pihlstrom—pihlstrb@mail.nih.gov ◆

NCI Funding Update

The National Cancer Advisory Board recently approved some important changes to the Specialized Programs of Research Excellence (SPORE) application receipt and review schedules. These changes arose in response to suggestions from SPORE grant applicants and investigators seeking to resubmit revised applications in a timely manner, as is customary with most National Institute of Health (NIH) grant mechanisms.

The new receipt and review schedule has been developed to promote the highest caliber and most timely translational research. Specifically, NCI will open all future SPORE receipt dates for the submission and receipt of new, competing continuations, and amended/revised applications for all 14 organ sites and disease groups starting on September 20, 2006 (formerly October 1, 2006 receipt date). On September 20, 2006, the program will welcome applications from the following organ sites/disease groups: brain, breast, head & neck, gastrointestinal, genitourinary (excluding prostate), gynecological (excluding ovarian), leukemia, lung, lymphoma, myeloma, ovarian, pancreatic, prostate, and skin. Applications will still be received three times yearly, and NCI anticipates that all future receipt dates will be open to all 14 organ sites and disease groups.

As a result, investigators with unfunded applications following peer review will be allowed to revise and resubmit their applications at the next available opportunity and will no longer have to wait for a specific receipt date for each of the organ sites.

These changes will be re-evaluated after a year to determine whether they are achieving the intended goals. The changes were announced in the NIH Guide on March 21. NCI also directly notified current SPORE investigators, recent applicants, and Cancer Center directors of this change. Additional information is available online at http://grants.nih.gov/grants/guide/notice-files/NOT-CA-06-021.html. ◆

Meet NCI Experts at AACR

Be sure to visit NCI in Booth #901 in the exhibit hall during the American Association of Cancer Research Annual Meeting. Learn about NCI's programs and Web sites and talk with experts on a wide range of topics. NCI experts will be available according to the schedule below.

SUNDAY, APRIL 2

12:00 – 1:00: Risk Factor Monitoring and Methods Branch

1:00 – 2:00: Molecular Epidemiology of HPV Infection and Cervical Carcinogenesis

2:00 – 3:00: GenePattern

3:00 – 4:00: Translational Research Working Group

MONDAY, APRIL 3

10:00 – 11:00: NCI Center for Bioinformatics

11:00 – 12:00: Patient Navigation Research Program

12:00 – 1:00: Viral Epidemiology

1:00 – 3:00: Cancer Research Portfolio and International Cancer Research Portfolio

3:00 – 4:00: Epidemiology and Genetics Research Program

4:00 – 5:00: Transcript Annotation Prioritization and Screening System

TUESDAY, APRIL 4

9:00 – 10:00: Translational Research Working Group

10:00 – 11:00: Early Detection Research Network's Biomarkers Knowledge Base: Opportunities for Collaboration

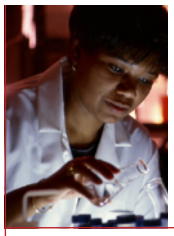
11:00 – 12:00: Cancer Training Branch

12:00 – 1:00: Translational Research Working Group

1:00 – 2:00: Vocabulary/Common Data Elements Semantic Interoperability

2:00 – 3:00: Translational Research Working Group

3:00 – 4:00: Epidemiology and Genetics Research Program ◆



Featured Clinical Trial

Combination Therapy for Peritoneal Carcinomatosis

Name of the Trial
Phase III Randomized Study of Operative Debulking and Systemic Chemotherapy with or without Intra- and Peri-Operative Intraperitoneal Chemotherapy in Patients with Peritoneal Carcinomatosis from Low-Grade Gastrointestinal Adenocarcinoma (NCI-03-C-0085). See the protocol summary at http://cancer.gov/clinicaltrials/NCI-03-C-0085.

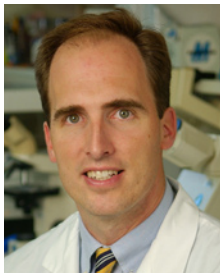
Principal Investigator
Dr. James Pingpank, NCI Center for Cancer Research

Why This Trial Is Important
Peritoneal carcinomatosis is a rare type of metastatic cancer in which tumors form throughout the peritoneum, the membrane that lines the abdominal cavity. Several types of cancer may cause peritoneal carcinomatosis, but it is often associated with gastrointestinal cancers. Without aggressive treatment, peritoneal carcinomatosis is almost always fatal.

In this clinical trial, patients with peritoneal carcinomatosis from low-grade gastrointestinal cancers will be treated with surgery to remove all visible tumors (operative debulking). During surgery, half of the patients will also be treated with hyperthermic chemotherapy administered directly into the peritoneal cavity (continuous hyperthermic peritoneal perfusion). These patients will receive additional intraperitoneal chemotherapy within 2 weeks after surgery. All patients will receive systemic chemotherapy 4 to 6 weeks after surgery.

Researchers hope to determine whether adding continuous hyperthermic peritoneal perfusion to operative debulking will help delay the progression of peritoneal carcinomatosis and result in longer survival.

"Many patients with low-grade gastrointestinal carcinomas develop peritoneal carcinomatosis rather than distant metastases," said Dr. Pingpank. "We know the most important aspect of treatment for these patients is complete resection of the tumors. What we hope to determine is whether adding the intraperitoneal perfusion will provide an added benefit that would justify the potential toxicity of the procedure."



Dr. James Pingpank

Who Can Join This Trial
Researchers will recruit 82 patients aged 18 and over with peritoneal carcinomatosis arising from low-grade gastrointestinal adenocarcinoma. See the list of eligibility criteria at http://www.cancer.gov/clinicaltrials/NCI-03-C-0085.

Study Site and Contact Information
The study is taking place at the NIH Clinical Center in Bethesda, Md. For more information, call the NCI Clinical Studies Support Center at 1-888-NCI-1937. The toll-free call is completely confidential. ◆

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

Notes

Science Writers' Seminar to Focus on Cancer Survivorship

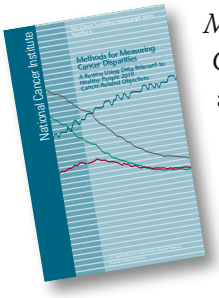
The next NCI Science Writers' Seminar will present the latest research on enhancing the quality of life of cancer survivors. It will take place at the Robert H. Lurie Comprehensive Cancer Center of Northwestern University on April 11 from 11:00 a.m. to 1:30 p.m, CDT (Noon to 2:30 p.m. EDT).

Scientists from NCI and the Lurie Center will discuss cancer survivorship research and support programs at their respective organizations. Presenters include Dr. Noreen Aziz (NCI); Drs. Charles Bennett, Kim Dilley, Lynne Wagner, and Teresa Woodruff (all from Lurie); and a cancer survivor. The seminar will take place at Northwestern University, 340 East Superior Street, 3rd Floor, Chicago. Directions and maps are online at http://www.cancer.northwestern.edu/Directions/Index.cfm. To register for the seminar, please contact Dorie Hightower or Ann Benner in the NCI Media Relations Branch at 301-496-6641 or at ncipressofficers@mail.nih.gov.

DCEG Newsletter Wins Award

Linkage, the triannual newsletter of NCI's Division of Cancer Epidemiology and Genetics, received the highest category of recognition as a Distinguished Technical Communication in the 2005 competition sponsored by the Washington, D.C., chapter of the Society for Technical Communication. The judges cited *Linkage*'s organization and visual appeal, noting that it does an excellent job of presenting complex information in a way that is both understandable and interesting to a wide and diverse scientific and lay audience.

Measurement of Cancer Disparities Monograph Available



Methods for Measuring Cancer Disparities, a monograph by Drs. John Lynch and Sam Harper of the University of Michigan, supported by NCI's Division of Cancer Control and Population Sciences, addresses the measurement of health disparities, a primary goal of the Healthy People 2010 national health promotion and disease prevention initiative. This monograph provides insights into how health disparities may be measured to shed light on the current status of cancer-related health disparities and most accurately capture trends.

The monograph also provides tools for anyone conducting health disparities research and interested in better understanding issues related to population-based analysis of health disparities. The monograph is available online at http://seer.cancer.gov/publications/disparities/.

caBIG™ Annual Meeting Slated for April

NCI's caBIG™ program will hold its third annual meeting April 9–11 at the Hyatt Regency Crystal City in Arlington, Va. Patients, clinicians, clinical and bench researchers, and industry representatives will speak in plenary and breakout sessions. The meeting will also feature poster sessions, exhibits, and technology demonstrations and a hackathon. For more information, go to https://cabig.nci.nih.gov/2006_Annual_Meeting.

TCGA Cancer Genome Pre-Application Meeting Scheduled

As part of The Cancer Genome Atlas Pilot Project, NCI will establish up to four Cancer Genome Characterization Centers (CGCCs) to analyze biomolecules obtained from a centralized Human Cancer Biospecimen Core Resource. CGCCs will use multiple high-throughput genomic analysis technologies to generate a comprehensive collection of data, which will provide the basis for selecting genomic regions of interest for sequencing.

NCI is soliciting applications from eligible investigators (http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-014.html) and will be holding a pre-application conference for potential applicants on March 31 from 9:00 a.m. to 1:00 p.m. Please contact Dr. Daniela Gerhard at gerhardd@mail.nih.gov for additional information. ◆

CCR Grand Rounds

March 28: Dr. Philip Beachy, Professor, Johns Hopkins University School of Medicine; Investigator, Howard Hughes Medical Institute, Baltimore, Md. "Hedgehog Signaling in Development and Disease."

April 4: No lecture. American Association of Cancer Research Meeting April 1–5, Washington, D.C.

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. ◆

Community Update

NIH Establishes Office to Manage and Fund Transdisplinary Research Initiatives

The National Institutes of Health (NIH) Office of Portfolio Analysis and Strategic Initiatives (OPASI) is being established to coordinate the assessment and management of the overall NIH research portfolio, including creation of a "Common Fund" for scientific initiatives in areas of interest across multiple NIH institutes and centers (ICs).

NIH Deputy Director Dr. Raynard Kington presented the background and mission of OPASI at the March 13 joint meeting of NCI's Board of Scientific Advisors (BSA) and Board of Scientific Counselors (BSC). He noted that the new office was in response to concerns raised by Congress and others that NIH was not doing a satisfactory job of strategic planning and investing to address transdisciplinary research opportunities and emerging public health needs.

"A case in point is NIH's obesity initiative," Dr. Kington commented. "The public health warnings on obesity began over 10 years ago with more and more data indicating an impending health problem for the country. Yet NIH didn't develop a comprehensive strategic plan for obesity until 2004." There was a lot of research into obesity at NCI and other ICs "but what was missing was a comprehensive integration across NIH to make sure we were making the right investments in this critical area," he added.

OPASI will "institutionalize the NIH Roadmap process" of identifying and selecting areas of research with crosscutting implications, Dr. Kington continued. OPASI's director (Dr. Kington is currently acting director) will report directly to the NIH director. The office, which will be overseen by a working group of the NIH Steering Committee, will consist of three components: Division of Resource Development and Analysis (DRDA), Division of Evaluation and Systematic Assessments, and Division of Strategic Coordination.

For example, Dr. Kington noted, DRDA will be the home for developing and using new analytic tools and information to do a better job of managing and analyzing NIH's entire portfolio of more than 40,000 grants. In addition, "we will have a systematic, transparent process for scanning the horizon for both scientific opportunities and for emerging public health needs," he explained.

OPASI's Common Fund will be a set-aside, where an agreed-upon percentage of the budget of each IC will allocated for trans-NIH initiatives selected by OPASI. This will initially be set at 1.6 percent of the ICs' appropriations for FY 2007. There will be no increase in the percentage contribution in future years until the annual NIH budget increase exceeds the Biomedical Research and Development Price Index. "And the rate of growth will be determined annually by the NIH director and the IC directors" up to a maximum of 5 percent, Dr. Kington said.

The identification and selection of trans-NIH research programs will begin with submission of proposals by stakeholders in the scientific and advocacy communities. OPASI staff will initially review the proposals and then the ICs and NIH directors will winnow the list further. They will do that in consultation with a new Council of Councils consisting of 30 members drawn from nominations from the ICs and the NIH director. Initiatives will be funded for an initial 5 years, with an option for either a 5-year renewal, transfer to one or more ICs, or termination.

"We see OPASI as a novel approach to functionally address a problem that some in Congress and others have suggested should be dealt with by structurally changing NIH," Dr. Kington commented. ◆

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.