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Decline in Cancer Death Rate Accelerating

Cancer death rates are continuing their decline, researchers announced last week, and the downswing is actually picking up steam.

The new data—published in the *Annual Report to the Nation* produced by NCI, the Centers for Disease Control and Prevention, the American Cancer Society (ACS), and the North American Association of Central Cancer Registries—show a 2.1-percent decrease in cancer mortality rates between 2002 and 2004, an approximate doubling of the 1.1-percent decline seen each year from 1993 to 2002.

The downturn was driven by lower death rates for many of the most common cancers, including breast cancer in women, lung and prostate cancer in men, and colorectal cancer in men and women. The report's authors singled out colorectal cancer as a primary contributor to the mortality rate downturn, which they attributed to improvements in early detection and removal of polyps, while noting that improved treatments also likely played a role.

The decline, explains report co-author Dr. Brenda Edwards, who directs NCI's Surveillance Epidemiology and End Results (SEER) program from which much of the data for the *Report to the Nation* are drawn, "represents a convergence of a lot of factors," such as improved tobacco

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Director's Update

Guest Update by Dr. Ken Buetow

With caBIG, the Cancer Community Goes "Interoperable"

The ability to connect people, organizations, and data through information technology is critical to fulfilling NCI's mission and to taking advantage of the research opportunities offered by 21st century science. Launched in 2004, the cancer Biomedical Informatics Grid (caBIG) was designed to be an information network that would allow the cancer research community to share data and knowledge and, in so doing, accelerate the discovery of new approaches to prevention, diagnosis, and treatment.

Dr. Ken Buetow, NCI Associate Director for Bioinformatics and Information Technology

Earlier this year, the 3-year pilot phase of caBIG was successfully completed.

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control policies and screening programs that have been in place for years, and incremental improvements in treatment.

"You have to orchestrate a lot of different interventions over many years to generate this type of mortality benefit," Dr. Edwards continues. "It's strong, evidence-based cancer control science and it's paying off."

Overall, the mortality rate declines from 2002 through 2004 were 2.6 percent per year among men and 1.8 percent per year among women.

The report has good news about other cancers as well, including a leveling of the incidence of lung cancer among women, which had been steadily increasing. This stabilization "is directly related to historical patterns in smoking," explains Dr. Elizabeth Ward, director of Surveillance Research at ACS. "The smoking prevalence in U.S. women declined from 33.9 percent in 1965 to 19.2 percent in 2003."

The decline in prostate cancer death rates also has been maintained, the study found, although it's unclear exactly what's driving the reduction. Although it's tempting to attribute the decline to widespread use of prostate-specific antigen (PSA) screening, the impact of screening on prostate cancer mortality is unknown, explains Dr. Howard L. Parnes, chief of the Prostate and Urologic Cancer Research Group in NCI's Division of Cancer Prevention.

"We do know that prostate cancer treatments have improved," Dr. Parnes notes, including surgery and radiation therapy for localized disease, adjuvant hormone therapy for high-risk patients undergoing radiotherapy, and taxane chemotherapy for metastatic disease, all of which have contributed to better outcomes. "We're awaiting the results of randomized clinical trials to determine the contribution of screening to the mortality statistics."

In a special section of this year's *Report*, the authors identified some concerning trends among American Indian and Alaska Native populations. For example, incidence rates for cancers with poor prognosis such as liver and gallbladder

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That success was marked by the achievement of several important goals, most notably the participation of more than 1,000 individuals from over 190 organizations, and its use in several potentially high-impact research projects.

During the pilot phase, we delivered more than 300 software components, including over 40 end-user applications, such as caArray and caTissue, and a wide range of infrastructure components, such as data standards and toolkits, like caCORE. We also launched caGrid, the data transmission network through which research organizations can connect and share their data.

Now caBIG is embarking on an "enterprise phase," during which the broader cancer research community can connect through a variety of technical, product, service, and training programs. All organizations in the cancer research community are invited to adopt caBIG, and the *Getting Connected with caBIG* program is open for enrollment at any time.

To expedite the adoption process, key caBIG resources are being packaged into "bundles" designed to support and streamline clinical trials, imaging, tissue banking, and integrative cancer research, and to provide the materials needed to join the secure caBIG data-sharing framework.

More than 40 NCI-designated Cancer Centers across the country have already enrolled. They will be making their trials, data, and legacy information technology systems compatible with caBIG. Their systems will be "interoperable" with caBIG, so they can provide information and data in a standardized format that can be shared and exchanged with other researchers and research centers.

This interoperability is made possible by caGrid, the underlying software infrastructure that will allow for the shared use of caBIG applications, tools, information standards, and data and analytical resources.

All told, NCI-designated Cancer Centers offer more than 400 cancer research programs, 800 shared resources, and employ approximately 14,000 independent cancer research investigators. As more Cancer Centers come on board, their successful deployment of caBIG compatibility will establish the firm, broad foundation for connectivity across the wider cancer research community.

As noted above, there is already a generation of early adopters using caBIG, leading the way to a new research paradigm. This includes the Inter-SPORE Prostate Biomarker Study, which is using caBIG to manage biospecimens for multi-institutional collaborative research activities, and The Cancer Genome Atlas, which is using the caBIG data management and distribution infrastructure.

More case studies are emerging each day, as U.S. and international organizations seek to leverage the power of caBIG and get connected. ◆

Cancer Research Highlights

Trials Demonstrate Potential Role of HPV Screening Test

Results from two large, randomized clinical trials confirm findings from earlier studies that DNA tests for human papillomavirus (HPV) are more sensitive than Pap tests and can play an important role in screening for cervical cancer. However, cautioned several researchers, the trials' results still leave unanswered many important questions about optimal cervical cancer screening practices.

Both published in the October 18 *New England Journal of Medicine (NEJM)*, the trials had different designs. The first trial, conducted in Canada, included more than 10,000 women 30 or older who received both the HPV DNA test and a Pap test in a randomly assigned sequence. Each test was evaluated as a stand-alone screening test. As has been seen in previous studies, the HPV DNA test had a far greater sensitivity for grade 2 or 3 cervical lesions compared with the Pap test, 94.6 percent vs. 55.4 percent. Also consistent with earlier research, the HPV DNA test had a slightly lower specificity than the Pap test, 94.1 percent vs. 96.8 percent.

The second trial, conducted in Sweden, included more than 12,500 women aged 32 to 38 who were randomly assigned to an HPV DNA test in combination with a Pap test or a Pap test alone. Participants were followed for approximately 4 years. For the initial screening, detection of cervical cancer or grade 2 or 3 cervical lesions was 51 percent higher in the combination screening group compared with those screened with a Pap test alone. At the follow-up screening, however, participants in the combined testing group were approximately 40 percent less likely to have grade 2 or 3 lesions or cancer compared with those in the Pap test alone group, which the study authors argued "could allow extended screening intervals, requiring fewer Pap smears and possibly lowering the costs of initial screening."

A third major trial with similar conclusions was announced earlier this month in *The Lancet* based on 5-year follow-up of more than 17,000 women. Results from the three trials are expected to accelerate the shift toward new procedures for cervical cancer screening. The question is not whether molecular assays will be incorporated, but rather how, says Dr. Diane Solomon from NCI's Division of Cancer Prevention. "We need to develop screening algorithms that capitalize on the sensitivity of molecular assays and also avoid overreferral, by use of a second 'triage' test that might include repeated HPV testing, and/or increasing the screening interval."

More Genetic Markers Found for Prostate Cancer Risk

Evidence that prostate cancer risk can be inherited has increased dramatically in 2007, with several major studies locating markers in the q24 band of chromosome 8. New results from researchers at Wake Forest University School of Medicine identified 2 regions in this area of the chromosome where genetic variants occurred more frequently in a case-control study of 1,563 European American men with prostate cancer. The study was published in the October 17 *Journal of the National Cancer Institute*.

Led by Drs. S. Lilly Zheng and Jielin Sung and funded in part by NCI, the researchers genotyped 18 single nucleotide polymorphisms (SNPs) in the 8q24 region, and looked for the presence of these SNPs in gene panels of prostate tumor tissue taken from the patients, as well as samples from 576 control subjects without cancer. One SNP, called rs6983267, had recently been identified in NCI's Cancer Genetic Markers of Susceptibility (CGEMS) study. A second set of SNPs found close to rs1447295, was previously identified as a risk marker for more aggressive disease.

What is important and novel, say the authors, is that the risk associated with each of these SNPs is additive. Because their occurrence was not linked, "the risk alleles at each are common, [and] these loci together may account for substantially more prostate cancer than previously appreciated," they note. More than a third of patients had SNPs at one or both locations. If the SNPs were found at one location, risk was increased 70 percent; if found at both locations, 168 percent.

In an editorial, Drs. Sharon A. Savage and Mark H. Greene of NCI's Division of Cancer Epidemiology and Genetics note that this study was bolstered by access to publicly available prepublication data from CGEMS, exemplifying the value of innovative data sharing policies. "We hope that

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a policy of more liberal early access to datasets of this kind will soon become the accepted standard worldwide," they wrote.

Paclitaxel Benefit May Depend on HER2 Status

Data from the Cancer and Leukemia Group B (CALGB) clinical trial CALGB 9344, first reported in 1998, showed a significant increase in disease-free and overall survival with the addition of paclitaxel to chemotherapy with doxorubicin and cyclophosphamide for women with lymph node-positive breast cancer. However, a new retrospective analysis of the data, published in the October 11 *NEJM,* indicates that only the subset of women with HER2-positive disease actually benefited from the addition of paclitaxel.

The CALGB investigators randomly selected 1,500 of the 3,121 women who originally participated in the trial, and examined tissue samples from 1,322 of them. They tested the samples for HER2 and estrogen-receptor (ER) status, and compared disease-free survival between women whose cancer was HER2-positive/ER-negative, HER2-positive/ER-positive, and HER2-negative/ER-positive.

While the addition of paclitaxel improved disease-free survival or women with HER2-positive tumors regardless of ER status, "paclitaxel did not benefit patients with estrogen-receptor-positive, HER2-negative cancers," state the authors. The group of women with HER2-negative/ER-positive cancers accounted for more than half the participants in CALGB 9344.

"Our studies suggest that [patients with HER2-negative/ER-positive cancer] could avoid the toxic effects associated with adjuvant paclitaxel when given after doxorubicin plus cyclophosphamide," conclude the authors. However, they explain, because these results are based on a retrospective analysis not planned for in the original design of the trial, "our results require validation before adoption into clinical practice."

"This is not a call to abandon taxanes for this group of patients," says Dr. Anne Moore from Weill Cornell Medical College in an accompanying editorial. Other taxane drugs or treatment schedules may still benefit patients with HER2-negative/ER-positive cancer, she explains, and analysis of other trial results based on HER2 and ER status will be important.

Batracylin Blocks DNA Replication in Cancer Cells

Batracylin, an experimental anticancer drug developed by NCI's Developmental Therapeutics Program, has been found to block two enzymes that assist in the DNA replication process—topoisomerase I and topoisomerase II. Investigators in NCI's Center for Cancer Research (CCR) report that this drug targets DNA replication and can help limit cancer's uncontrolled growth. The findings appear in the October 15 *Cancer Research.*

Other chemotherapy drugs, such as etoposide and camptothecin, can block either topoisomerase I or topoisomerase II, but not both enzymes. Since cancer cells can use either enzyme to replicate, transcribe, or repair DNA, resistance develops to drugs that only target one topoisomerase.

Earlier experiments showed batracylin's activity against topoisomerase II, indicated by an increase in double-strand DNA breaks in treated cells. The new *in vitro* experiments using colorectal cancer cells also showed the drug's activity against topoisomerase I, indicated by an increase in single-strand DNA breaks. Batracylin's interference with DNA replication lasted significantly longer in cell culture than interference caused by either etoposide or camptothecin. Subsequent *in vivo* studies will be conducted to determine whether a shorter treatment schedule might be possible with batracylin.

"Only a few dual topoisomerase inhibitors have been identified and are being developed as anticancer treatments," state the authors, led by Dr. Yves Pommier, chief of CCR's Laboratory of Molecular Pharmacology.

Dr. William Bonner, an investigator in the same laboratory, patented a biomarker that allowed the Pommier team to measure the DNA damage caused by batracylin treatment. The biomarker is a protein, called γ-H2AX, which forms a complex with stretches of bases that flank the region of DNA strand breaks. When cells were treated with very small doses of batracylin, γ-H2AX/DNA aggregates could be detected after the first hour, and increased up to 15 hours after treatment.

Batracylin and the molecular test are now being evaluated in an NCI clinical trial at the NIH Clinical Center in patients with solid tumors or lymphoma. ◆

Special Report

Preventive Double Mastectomies Increasing Despite Some Concerns

Rates of surgical removal of both breasts as a preventive measure in women diagnosed with cancer in only one breast have more than doubled in the United States within a recent 6-year period, according to a study published online October 22 in the *Journal of Clinical Oncology*. This trend has occurred even though in many cases the aggressive treatment may be unnecessary and other, less invasive preventive options are available, the scientists cautioned.

The annual incidence of contralateral breast cancer is about 0.5 percent to 0.75 percent and does not change with time. Some patients with cancer in a single breast (unilateral breast cancer) choose to have the other (contralateral) breast removed to prevent cancer in the opposite breast. The procedure is called a contralateral prophylactic mastectomy (CPM). In the first national study of trends in CPM use in the United States, researchers from the University of Minnesota analyzed data from NCI's Surveillance, Epidemiology and End Results (SEER) database to review the treatment of patients with unilateral breast cancer diagnosed from 1998 through 2003. They determined the rate of CPM as a proportion of all surgically treated patients and as a proportion of all mastectomies.

The investigators identified 152,755 patients, of whom 4,969 chose CPM. The rate for CPM was 3.3 percent for all surgically treated patients and 7.7 percent for those undergoing mastectomy. The overall rate significantly increased from 1.8 percent in 1998 to 4.5 percent in 2003. Likewise, the CPM rate for patients undergoing mastectomy significantly increased from 4.2 percent in 1998 to 11.0 percent in 2003. These increased rates applied to all cancer stages and continued to the end of the study period.

CPM significantly reduces the risk of contralateral breast cancer, the scientists acknowledged, but the procedure is more aggressive and irreversible and "it is also unnecessary for preventing contralateral breast cancer in most patients." In addition, since the risk of systemic metastases from unilateral disease often exceeds the risk of contralateral breast cancer, most patients will not experience any survival benefit from CPM.

"Although breast cancer is now often diagnosed at earlier stages, we're seeing more women having CPM, even though there are very little data showing that this irreversible procedure improves overall survival," explained lead author Dr. Todd M. Tuttle. "We need to determine why this is occurring and use this information to help counsel women about the potential for less invasive options."

Dr. Larissa Korde, staff clinician with NCI's Division of Cancer Epidemiology and Genetics (DCEG) noted of the study's findings, "Interestingly, during this same time period the rate of breast-conserving lumpectomies also increased, leading the authors to conclude that patients are either choosing less aggressive (lumpectomy) or more aggressive (CPM) surgical treatment rather than unilateral mastectomy."

Dr. Tuttle proposed several potential reasons for the increase in the rate of CPM. There is more public awareness of the genetics of breast cancer and more frequent testing for mutations in *BRCA* genes, which increase contralateral breast cancer risk (this study, though, did not examine patients' *BRCA* status). Less invasive mastectomy approaches and improved breast reconstruction techniques may also persuade more women to have both breasts removed at the same time, he suggested.

Dr. Korde pointed out the study also found that patients diagnosed at a young age and those diagnosed with lobular carcinoma were more likely to opt for CPM. "This is not surprising, since both these factors have been shown to be associated with an increased risk of contralateral breast cancer," she said. "It would have been very helpful to have some information on family history in this study, since women with a strong family history and particularly those with known *BRCA1* and *BRCA2* mutations have a very significant risk of contralateral breast cancer. However,

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Presidential Proclamation for Breast Cancer Awareness

The White House has issued a presidential proclamation designating October as National Breast Cancer Awareness Month. For information from NCI on breast cancer, go to http://www.cancer.gov/cancertopics/types/breast. ◆

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cancer, and common cancers such as lung, colorectal, and cervical cancer were higher in American Indian and Alaska Native populations than in non-Hispanic whites. There were substantial differences in cancer rates among American Indian and Alaska Native populations by region, with particularly high rates in Alaska and the Plains.

"The fact that lung and colorectal cancers rates were higher in some American Indian and Alaska Native populations points to the work we still have to do," said NCI Director Dr. John E. Niederhuber.

American Indians and Alaska Natives, the report found, were also much more likely to live in poverty and be obese, and less likely to have health insurance and have undergone routine cancer screenings. ◆

By Carmen Phillips

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this information is not available in the SEER database."

Patients with unilateral breast cancer have options that are "less extreme" than CPM, the researchers contended. Those include surveillance with clinical breast examination, mammography, and newer imaging modalities such as breast magnetic resonance imaging that may detect cancers at earlier stages.

Dr. Korde noted that research done in women who undergo genetic risk assessment suggests that those with more cancer-related distress are more likely to choose CPM. Additional research will be necessary to fully understand this decision making process. ◆

By Bill Robinson

FDA Update

New Chemotherapy Drug for Advanced Breast Cancer

The Food and Drug Administration (FDA) has approved a new chemotherapy drug for the treatment of some cases of metastatic and locally advanced breast cancer.

Ixabepilone (Ixempra) was approved for women with advanced breast cancers that fail to respond to standard chemotherapy agents such as anthracyclines, taxanes, or capecitabine (Xeloda). Ixabepilone was also approved for use in combination with capecitabine for the treatment of advanced breast cancer in certain women, including those whose cancers have become resistant to treatment with an anthracycline and a taxane.

The drug, manufactured by Bristol-Myers Squibb, belongs to a new class of chemotherapy agents known as epothilone analogs. These medicines target proteins involved in cell division. Epothilones work in a similar manner as taxanes, but unlike the taxanes they do not require patients to be premedicated to prevent possible allergic reactions.

Approval was granted based on two multicenter trials that tested ixabepilone either as a single therapy or in combination with capecitabine in patients with metastatic or locally advanced breast cancer. One of the trials was a randomized phase III study involving 752 women. Among the combination group, the median time the disease took to progress was 5.8 months compared with 4.2 months in the capecitabine alone group.

Side effects from ixabepilone were similar in both studies and included tingling or numbness in the hands and feet, fatigue, nausea, vomiting, and muscle pain.

Ixabepilone is also being studied as a treatment for other cancers, including prostate, endometrial, kidney, and non-Hodgkin lymphoma. ◆

NCI at APHA

Be sure to visit the NCI Exhibit Booth during the American Public Health Association (APHA) Annual Meeting November 3–7 in Washington, DC. The NCI exhibit will be located in booth #1128. ◆

POLITICS & PUBLIC POLICY & HEALTH

APHA 135TH ANNUAL MEETING AND EXPO
NOVEMBER 3-7, 2007 WASHINGTON, DC

American Public Health Association

Guest Commentary by Dr. Edward J. Benz, Jr.

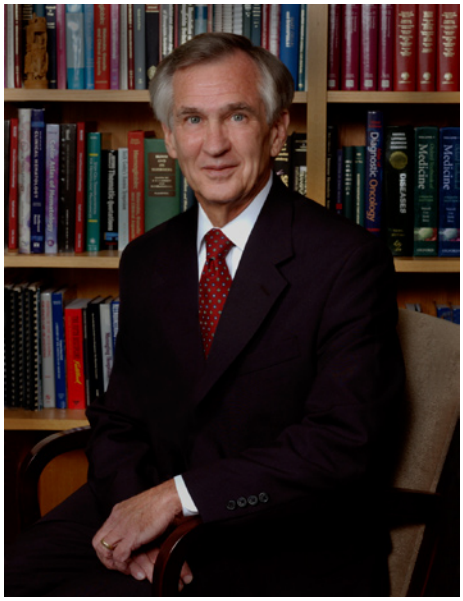
Strengthening the Nation's Oncology Workforce

At next week's annual meeting of the Association of American Cancer Institutes (AACI), I look forward to being installed as the Association's president. Living up to the standard set by my predecessors—including outgoing president, Dr. Shelley Earp of the UNC Lineberger Comprehensive Cancer Center—will be difficult, but I look forward to the challenges and opportunities of this position.

AACI is unique among cancer organizations in that it is the only association dedicated solely to representing the interests of the nation's cancer centers, including both NCI-designated cancer centers and emerging centers. The nation's cancer centers are the nexus of cancer research and patient care, with a unique perspective not only on discovering the next generations of cancer interventions, but also on delivering these interventions to patients.

Many do not realize, however, that in addition to setting the standard for state-of-the-science patient care, cancer centers also serve as the training ground for the next generation of cancer researchers, physicians, oncology nurses, social workers, and other professionals dedicated to addressing the increasing burden of cancer in the United States.

As the cancer burden in this country grows, so does a crisis in the oncology workforce. In an eye-opening study published in March of this year, the American Society of Clinical Oncology with the Association of American Medical Colleges' Center for Workforce Studies found that



demand for oncology services in the U.S. is projected to increase 48 percent by 2020. However, the supply of oncologists is expected to increase only 20 percent by 2020. An aging and growing population, increasing numbers of cancer survivors, and slower growth in the supply of oncologists will result in a shortage of 2,550 to 4,080 oncologists, according to the report.

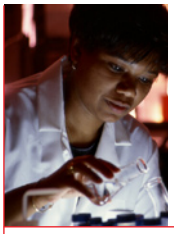
One solution to this problem is to increase reliance on other oncology professionals, such as oncology nurses, physician assistants, and others. However, shortages are anticipated in these fields as well. For instance, the Health Resources and Services Administration has predicted that by 2020, more than 1 million nursing positions will go unfilled. Additionally, a 2002 survey by the Southern Regional Board of Education projected a 12-percent shortage of nurse educators by this year.

These statistics—coupled with an anticipated 48-percent increase in the demand for oncology services by 2020—are sobering, and certainly cause for alarm. However, with forethought and careful planning, we in the cancer center community can work to prevent these grim predictions from becoming reality.

All stakeholders in the fields of cancer treatment, research, and advocacy must develop innovative programs to attract the best and the brightest to careers in cancer research and treatment. Moreover, we must ensure that measures are in place to encourage these individuals to build long careers in the fields of academic research and clinical medicine. Loan repayment programs, flexible work schedules, programs to encourage women to pursue careers in academic medicine and people of color to enter the oncology workforce, and incentives for delayed retirement may help slow the tide, but the cancer community must continue to implement innovative programs that will rebuild the most well-trained oncology workforce in the world.

I look forward to working with AACI and all of its members and partners to ensure that the same spirit of innovation that has led to the incredible strides in cancer treatment, screening, and prevention we have witnessed over the past two decades can be directed to ensuring the sustainability of the oncology workforce. ◆

Dr. Edward J. Benz, Jr.
President, AACI
President and CEO, Dana-Farber Cancer Institute



Featured Clinical Trial

Preventing Delayed Nausea in Breast Cancer Patients

Name of the Trial
Phase III Randomized Study of Different Combinations of Granisetron Hydrochloride, Dexamethasone, Prochlorperazine, Aprepitant, and Palonosetron Hydrochloride in Preventing Delayed Nausea in Women Undergoing Chemotherapy for Chemotherapy-Naive Breast Cancer (URCC-04-02). See the protocol summary at http://cancer.gov/clinicaltrials/URCC-04-02.

Dr. Joseph Roscoe

Principal Investigator
Dr. Joseph Roscoe, University of Rochester Cancer Center

Why This Trial Is Important
Nausea is a common side effect of cancer chemotherapy. Severe nausea may keep patients from consuming enough food and liquids to maintain their energy and prevent dehydration, and it can lead to disruptions in cancer treatment.

A number of drugs are available to treat and prevent chemotherapy-induced nausea, but it is unclear which drug or combination of drugs is most effective for patients experiencing delayed nausea. Delayed nausea is nausea that occurs more than 24 hours after chemotherapy is administered. It is often more severe than the acute nausea that may occur during chemotherapy, and it may have a different underlying cause.

In this trial, different combinations of drugs will be tested to see which is most effective in preventing delayed nausea in women undergoing chemotherapy for breast cancer.

"Because of the types of drugs they receive, as many as 70 percent of breast cancer patients undergoing chemotherapy experience nausea," said Dr. Roscoe, "so we're very interested in finding more effective ways of preventing and treating nausea in this population.

"This study is part of a line of research our cooperative group has been conducting into nausea and vomiting," he added, "and, although vomiting is becoming less of a problem thanks to advances in antiemetic drugs, delayed nausea continues to be a very prevalent side effect for women with breast cancer who undergo chemotherapy."

Who Can Join This Trial
Researchers will enroll 890 women diagnosed with breast cancer that has not yet been treated with chemotherapy. See the list of eligibility criteria at http://cancer.gov/clinicaltrials/URCC-04-02.

Study Site and Contact Information
Study sites in the United States are recruiting patients for this trial. See the list of study contacts at http://cancer.gov/clinicaltrials/URCC-04-02 or call 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.

Funding Opportunities

Following are newly released NCI research funding opportunities:

Continued Development and Maintenance of Software

Announcement Number: PAR-08-010
Letter of Intent Receipt Date: Nov. 17, 2007
Application Receipt Dates: Jan. 17, May 21, and Sept. 22, 2008; Jan. 22, May 22, and Sept. 22, 2009; Jan. 22, May 21, and Sept. 22, 2010.

This is a renewal of PAR-07-235 and will use the R01 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3783. Inquiries: Dr. Jennifer A. Couch—couchj@mail.nih.gov.

Limited Competition: Cooperative Family Registry for Epidemiologic Studies in Colon Cancer

Announcement Number: RFA-CA-08-052
Letter of Intent Receipt Date: Dec. 10, 2007
Application Receipt Date: January 10, 2008.

This is a renewal of RFA-CA-02-501 and will use the U24 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3782. Inquiries: Dr. Daniela Seminara—seminard@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_102307/page9. ◆

Notes

DCLG to Meet October 24–25

The NCI Director's Consumer Liaison Group (DCLG) will meet on October 24–25 in Room 6C10 in Building 31 on the NIH campus in Bethesda, MD. The meeting is open to the public and public comments will be accepted at 3:15 p.m. on October 25. The meeting will be webcast at http://videocast.nih.gov; the agenda is available at http://deainfo.nci.nih.gov/advisory/dclg/24oct07adg.pdf.

PLCO Etiology Study Seeks Applicants

The Etiology and Early Marker Studies (EEMS) is a component of the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial. By collecting biologic materials and risk factor information from trial participants before the diagnosis of disease, PLCO EEMS provides a resource for cancer research, focused on cancer etiology and early markers. Etiologic studies investigate the environmental, biochemical, and genetic risk factors for cancer. Early detection studies aim to develop reproducible, diagnostics-ready biomarkers of early disease.

PLCO data and biospecimens are available to qualified researchers through a peer review process. The EEMS program accepts proposals for access to PLCO biospecimens twice a year in June and December. Proposals will be accepted for the PLCO EEMS winter review cycle starting December 1, 2007. Applications will be accepted until December 28, 2007 at 5:00 p.m., ET. Details of the review process and application materials are available at http://www.parplco.org.

YMCA and Armstrong Foundation Partner to Promote Wellness for Cancer Survivors

The YMCA of the USA and the Lance Armstrong Foundation recently announced a partnership to develop physical activity and well-being initiatives to address the specific needs, wants, and interests of cancer survivors. During the pilot and implementation phases of the project, a panel of cancer survivorship researchers, including NCI representatives, will contribute their knowledge and perspective on best practices.

NCI Liaison Office Launches Web site

The NCI Liaison Office in Brussels, Belgium, recently launched a new Web site, making it easier for European cancer researchers to register clinical trials in PDQ, NCI's clinical trials registry.

The Liaison Office acts as a European link to NCI's cancer research and treatment programs. The mission of the office is to facilitate the interchange of information, ideas, experimental drugs, scientists, and scientific expertise between the NCI and its European partners and collaborating institutions. Activities include organization of joint symposia, initiation and coordination of exchange programs, launching of a joint clinical monitoring program, and an agreement with the European Organization for Research and Treatment of Cancer to coordinate submission of clinical trials to PDQ.

New Patient Education Materials Available

Six new or revised patient education publications are now available from NCI. They can be accessed, downloaded, or ordered at https://cissecure.nci.nih.gov/ncipubs/ or 1-800-4-CANCER. The new publications include: *Chemotherapy and You*; *Radiation Therapy and You*; *Radiation Therapy Fact Sheet Series*; *Helping Providers Help Their Patients: Using the Radiation Therapy Fact Sheets*; *Caring for the Caregiver: Support for Cancer Caregivers*; and *Facing Forward: Life After Cancer Treatment*. All of the materials are free; a shipping charge will be applied to orders of more than 20 total items.

Disparities Summit Report Available

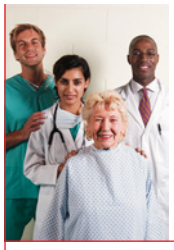
NCI's Center to Reduce Cancer Health Disparities and the National Center on Minority Health and Health Disparities recently released the report on the Cancer Health Disparities Summit 2006, *Strengthening Our Culture of Collaborations for Reducing Cancer Health Disparities.* The report evolved from a 3-day workshop held July 17–19, 2006 and can be accessed and downloaded at http://www.cancermeetings.org/CHDSummit06/CHDStrengtheningReport.pdf. ◆

70 YEARS OF EXCELLENCE IN CANCER RESEARCH

If Memory Serves…

After NCI began funding research proposals in 1937, there was a strict policy of separation between intramural and extramural projects. This was, in part, to avoid criticism that intramural personnel could benefit from knowledge of extramural grant requests. (Read more) ◆

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



Cancer Center Profile

Case Comprehensive Cancer Center

Director: Dr. Stanton L. Gerson • 11100 Euclid Avenue, Cleveland, OH 44106 •
Phone: 216-844-8797 • Web site: http://cancer.case.edu

Background

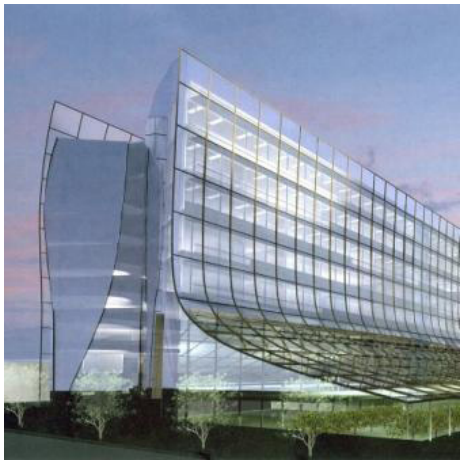
The Case Comprehensive Cancer Center, on the shore of Lake Erie, was established with NCI funding 19 years ago as a collaboration between the Ireland Cancer Center of University Hospitals Case Medical Center and Case Western Reserve University. It was designated by NCI as a Comprehensive Cancer Center in 1997, and in 2004, the partnership was expanded to include the Cleveland Clinic. Together, they serve the cancer research and clinical needs of an urban manufacturing and rural agricultural region containing 3.8 million people in northern Ohio, where the mortality rate from cancer is higher than average.

Research Activities

The Case Comprehensive Cancer Center has more than 300 collaborating scientists and physicians who have successfully competed for more than $160 million in annual funding. These investigators are organized into 9 scientific programs and have access to 17 scientific core facilities and related support services. Clinical research at the Case Comprehensive Cancer Center comprises 11 Clinical Trials Disease Teams that develop and prioritize clinical trials between the partner institutions, and a single Protocol Review and Monitoring System, Data Safety and Monitoring Plan, and Institutional Review Board. These components serve to integrate cancer research, cancer therapeutics, and prevention services at the partner institutions and throughout the region. More than 300 clinical trials are offered through the Case Comprehensive Cancer Center, providing patients with the latest treatments. The Center is also heavily involved in nonembryonic stem cell research and was instrumental in the development of umbilical cord blood stem cells to treat leukemia in adults.

Patient Care Specialties

In 2005–2006, more than 7,300 new cancer patients were treated at the Case Comprehensive Cancer Center clinical facilities—Ireland Cancer Center and Taussig Cancer Center; about 17 percent of these patients participated in therapeutic clinical trials sponsored by the Case Comprehensive Cancer Center, compared with an average national participation rate of 3 to 4 percent. Patients seeking treatment have access to a range of services, from basic research information to advanced treatments and psychosocial and supportive care. Professionals from the fields of medicine, surgery, pediatrics, pathology, and radiology work with specialized oncology nurses, psychiatrists, dieticians, social workers, and music and art therapists to create individualized patient care plans.



University Hospitals Cancer Hospital, completion expected by 2010.

Other Notable Programs

The Case Comprehensive Cancer Center hosts several major NCI-sponsored research and outreach programs. It operates an NCI-supported Cancer Information Service serving the northern half of Ohio as part of the CIS Midwest regional consortium and has an active outreach program for clinical practice-based prevention and screening initiatives, educational programs, minority recruitment, and facilitation of patient referrals. It is also a member of NCI's Cancer Biomedical Informatics Grid initiative and is pursuing electronic databases for clinical trials, tissue repositories, and related bioinformatics. In 2005, it was among four institutions selected by NCI to participate in the Transdisciplinary Research on Energetics and Cancer initiative to better understand the link between physical activity, obesity, and cancer. In addition, University Hospitals Case Medical Center has embarked upon a $1.2 billion strategic plan, called Vision 2010, that includes a number of new facilities, among them a free-standing cancer hospital—the first ever for the region—that will triple the currently available patient space and consolidate the cancer services under one roof. The new cancer hospital is scheduled for completion in 2010. ◆