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Community Hospitals Focus on Advanced Cancer Care

NCI has launched the pilot phase of its Community Cancer Centers Program (NCCCP), an initiative that aims to bring the latest advances in cancer care to patients where they live. The project will focus on underserved communities and groups that are disproportionately affected by the disease.

Over the next 3 years, 16 community hospitals will work together and with NCI to identify the best strategies for delivering state-of-the-art cancer care in community hospitals. A successful pilot could lead to a national network of community cancer centers that would benefit patients and researchers alike.

Yesterday, NCI Director Dr. John Niederhuber welcomed the leadership of the geographically diverse hospitals for 2 days of talks at NIH. The initiative is broad in scope, ranging from prevention and diagnosis to treatment and care for survivors.

The pilot study is intended to define the critical factors that will allow community cancer centers to provide patients with advanced care. "In the next few years, we hopefully will learn what we can accomplish and what is realistic," said Dr. Niederhuber.

(continued on page 2)

Director's Update

Challenges in Cancer Prevention

Despite many decades of investigation and progress that's been made in early diagnosis and treatment, the exact causes of most cancers remain unknown. For most of the cancers we treat, there exists a heterogeneous mix of genetic changes and numerous potential environmental influences that challenge the development of simple prevention strategies.

This has resulted in a level of frustration by the public regarding the primary prevention of cancer, including scientifically based recommendations for diet and lifestyle interventions. In recent years this public frustration has included the development and testing of targeted preventive oral agents that have often carried significant risk of causing a shift to other diseases or compromising daily quality of life. Our patients have clearly told us they are unwilling to trade healthy lives for these risks, even in the face of a risk of cancer.

As was discussed in detail in a recent special issue of the *NCI Cancer Bulletin*, we are beginning to view our approach to prevention research differently, and it's an approach that NCI hopes will lead to more dramatic advances. This approach is defined by the use of advanced tools and technologies—such as those employed in genomics, proteomics, and metabolo-

(continued on page 2)

(Community Hospitals continued from page 1)
NCCCP could extend the reach of NCI programs into local communities. At the same time, a national network of physicians and cancer patients could be a valuable resource for developing and testing experimental therapies.

The goals of NCCCP are to reduce cancer health disparities, increase enrollment in clinical trials, develop biospecimen resources, and evaluate electronic medical records. The project complements current NCI efforts in community cancer care, while establishing a framework for studying the topics together and in community settings.

The topics often go hand in hand. For instance, more studies are needed to learn why certain groups have an increased incidence of cancer. But it can be difficult to recruit patients for such studies if the individuals lack access to care. Expanding access in community settings could help both patients and researchers.

The 16 sites represent a cross section of the country's population, including rural and urban, and its health care systems. Each offers multidisciplinary care (medical, surgical, and radiation oncology); manages 1,000 new cancer cases each year; enrolls patients in clinical trials; and takes part in outreach to underserved populations.

Collaboration is central to the project. The sites will work with each other and with the 63 NCI-designated Cancer Centers, which are mostly based at major research universities. The Cancer Centers are the source of many innovations in cancer care, but the vast majority of patients in the U.S. are diagnosed and treated in community hospitals.

The pilot program may help researchers learn how best to conduct clinical research in the community setting and whether early-phase clinical trials can be done in community hospitals. The sites will also explore ways of sharing medical information electronically as a way to improve patient care.

The pilot study will evaluate the feasibility of implementing the "NCI Best Practices for Biospecimen Resources" guidelines in the community setting. A network of community cancer centers could potentially provide essential high-quality biospecimens for genomics and proteomics studies.

The NCI Cancer Centers program has put cancer on the leading edge of medical research and care in the United States, said Dr. Niederhuber. The challenge now is to use NCCCP to make this care available to patients wherever they live.

"The community's response to this project has been tremendous," he noted. ◆

By Edward R. Winstead

(Director's Update continued from page 1)
mics—to pursue the molecular events associated with the mechanisms and early signs of cancer development.

Cancer prevention is complex. It will require our understanding of germline abnormalities, compounded by somatic mutations throughout our lifetime, defined by protein expression patterns and cellular function. These events will be further impacted by the need to understand pharmacogenomics, environmental exposures, and lifestyle factors. All of these layers point to the difficulty of finding effective, nontoxic preventive agents.

Part of the solution involves identifying biomarkers of risk, such as ongoing efforts to identify epigenetic changes like hypermethylation that are linked to cancer risk, as well as genome-wide association studies, such as the recent studies, including those led by NCI's CGEMS program, that identified new genetic variants significantly associated with breast and prostate cancer risk.

Prevention also is about detecting disease in its earliest stages, and NCI's Early Detection Research Network is supporting researchers who are making important inroads in this area, including, for example, promising preliminary work on an early detection assay for pancreatic cancer.

NCI's cancer prevention research program has generated some remarkable success stories, including the dramatic drop in smoking rates over the past two decades, as well as the approval of tamoxifen as the first and still only drug approved by the FDA for the prevention of breast cancer.

And even as our interest in molecular prevention grows, we continue to support research into lifestyle and environmental factors that influence cancer risk. That includes anti-obesity programs aimed at minorities conducted under the auspices of the Transdisciplinary Research on Energetics in Cancer program, as well as the development of new chemopreventive agents, including a novel class of chemopreventive agents called triterpenoids being led by Dr. Michael Sporn and colleagues at Dartmouth University.

Clearly what is being presented here represents a new paradigm for cancer prevention. It will also ensure that we can achieve the greatest risk reduction at the lowest possible safety risk, something that must and will always be our guiding principle.

Prevention is and will continue to be an integral part of reducing cancer's burden, and it's something to which NCI is deeply committed. ◆

Dr. John E. Niederhuber
Director, National Cancer Institute

Cancer Research Highlights

Groups Say Common Symptoms May Indicate Ovarian Cancer

A new consensus statement recommends that women who experience any of several common symptoms for at least several weeks see a physician, preferably a gynecologist, because these might be indicative of ovarian cancer.

Released by the Gynecologic Cancer Foundation, the Society of Gynecologic Oncologists (SGO), and the American Cancer Society, the statement lists four symptoms, 1) bloating, 2) pelvic or abdominal pain, 3) difficulty eating or feeling full quickly, and 4) the sudden urge to urinate or frequent urination, that studies indicate "are much more likely to occur in women with ovarian cancer than women in the general population." Research also indicates, the statement continues, "that even early-stage ovarian cancer can produce these symptoms."

A recent case-control study, published in January in *Cancer*, found that this "symptom index"—based on retrospective symptom surveys—had a sensitivity of approximately 57 percent for detecting early-stage disease and approximately 80 percent for advanced-stage disease, with slightly better specificity for women under 50—90 percent vs. 86.7 percent for women over 50.

"Although proof that earlier recognition of symptoms improves outcomes does not yet exist, there is little to be lost and much to be potentially gained by increasing awareness of ovarian cancer symptoms that might lead to earlier medical evaluation and intervention," SGO President Dr. Andrew Berchuck explained in a statement.

Ovarian cancer patients who report having these symptoms prior to diagnosis often say they experienced long delays in getting doctors to evaluate them "or even think about ovarian cancer as a possibility," says Dr. Ted Trimble from NCI's Division of Cancer Treatment and Diagnosis. "From that perspective, this statement is part of an educational process that is timely and appropriate."

Dr. Robert F. Ozols, senior vice president at Fox Chase Cancer Center, said he would like to see a stronger evidence base, including prospectively collected data, before making such a recommendation. He also had concerns about just what the symptoms really mean.

"The big question, given the natural history of this disease, is do we expect earlier stage diagnosis based on these symptoms?" he asks. Most of the symptoms, he says, "are sort of mass effects, which would suggest late-stage disease."

The consensus statement, notes Dr. Trimble, reflects the frustration that "all too often, when this disease presents, it's already advanced." A number of ongoing studies hold promise for identifying ways to improve the early detection of ovarian cancer, he continues, including the NCI-funded PLCO Screening Trial and the UK Collaborative Clinical Trial of Ovarian Cancer Screening, as well as other NCI-supported research programs.

Early-Stage Pancreatic Cancer Patients Not Offered Surgery

The first comprehensive, nationwide review of treatment of patients with stage I pancreatic cancer who are candidates for surgery has found that nearly 4 in 10 are not offered the option, even though it has a demonstrable survival benefit.

To conduct the study, the research team analyzed data on all patients with pancreatic cancer listed in the American College of Surgeons' National Cancer Data Base between 1995 and 2004. The database captures 76 percent of all pancreatic cancers diagnosed in the United States. They identified 9,559 patients with stage I disease.

Overall, only 28.6 percent of patients with stage I disease underwent surgery, Dr. Mark S. Talamonti and colleagues from Northwestern University's Feinberg School of Medicine reported in a June 14 early online release from the *Annals of Surgery*. But after excluding patients who did not receive surgery because of factors such as comorbidities, age, or procedure refusal, they found that 38.2 percent of patients were not offered surgery.

Several factors were associated with not being offered surgery, such as being older than 65, African American, on Medicare or Medicaid, and being treated at lower volume or community hospitals.

Also, patients whose tumor was located in the head of the pancreas—

(continued on page 4)

(Highlights continued from page 3)

a location that requires a surgical procedure commonly called the Whipple procedure—were less likely to be offered surgery. This has historically been considered a challenging surgery with high mortality rates, says study co-author Dr. David Bentrem. But over the past two decades, he continues, the safety of the procedure has improved dramatically.

Remedying the problem of underutilized surgery is a difficult task, admits Dr. Bentrem.

"Some groups have advocated regionalizing care," he adds, arguing that it could be beneficial for more complicated cancer surgeries, such as those for pancreatic and esophageal cancers. "But even for those, if we can get bigger and smaller centers working more closely together, that would help to ensure patients are getting the best care."

Unrelated Cord Blood Matches Bone Marrow Transplants for Children

The first-ever study in children with acute leukemia directly comparing unrelated cord blood transplants with bone marrow transplants has found that cord blood can be just as good, and maybe better under some circumstances. The results were published June 9 in *The Lancet*.

Researchers used data from the Center for International Blood and Marrow Transplant Research and the National Cord Blood Program of the New York Blood Center, representing 503 children under the age of 16 who received cord blood transplants and 282 children who received bone marrow transplants.

Relapse rates were similar between cord blood and bone marrow recipients, except that patients who received cord blood that was mismatched at two antigens actually had a lower rate of relapse, which is consistent with a more potent graft-versus-leukemia effect.

Cord blood patients also had similar mortality rates to bone marrow patients when the cord blood was matched or the cell dose was high. The rates of 5-year leukemia-free survival were 38 percent with matched bone marrow, 37 percent with mismatched bone marrow, 60 percent with matched cord blood, 36 percent with low-cell-dose cord blood that was mismatched at one antigen, 45 percent after high-cell-dose cord blood mismatched at one antigen, and 33 percent after cord blood mismatched at two antigens.

Recurrent leukemia was the most common cause of death in both the cord blood and bone marrow groups, but it was proportionally lower among two-antigen mismatched cord blood recipients. Other causes of death included graft-versus-host disease, interstitial pneumonitis, infection, and organ failure.

Noting that the retrospective, nonrandomized nature of this study is a weakness, the authors pointed out that a clear association between cell dose, antigen match, and time to marrow recovery and survival can be used to determine the best transplant source for children with malignant disease when donors are limited. "Our findings support the need for even greater investment in cord blood because of the importance of HLA matching and cell dose on survival," they wrote.

Annual Mammography Reduces Mortality in Older Breast Cancer Survivors

Annual mammography screening for breast cancer survivors older than 65 dramatically lowers their risk of death from breast cancer, whether by recurrence or another primary tumor. Results published early online June 4 in the *Journal of Clinical Oncology* show that each successive annual mammogram reduces a woman's breast cancer mortality risk by about 31 percent; by the fourth year of compounding that reduction, their cumulative risk has been cut by 88 percent.

Dr. Timothy L. Lash of Boston University was the lead author of the cohort study, which identified 1,846 breast cancer patients from 6 Cancer Research Network (CRN) sites chosen to maximize ethnic and geographic diversity. All women were diagnosed with stage I or II breast cancer between 1990 and 1994, and were designated as "survivors" for the purposes of the study 90 days after finishing their initial breast cancer treatment. The 178 women who died within 5 years were closely matched to 634 controls. Protective effects of annual mammography were found to be the strongest among women with stage I disease, those who had received mastectomy, and those older than 79.

In an editorial, Dr. Jeanne Mandelblatt from the Lombardi Comprehensive Cancer Center in Washington, DC, commended "this high-quality observational research" that emerged from CRN, an NCI-funded collaboration between 12 large managed care systems. The large cohort study provides the best data likely to be developed on this question, because a clinical trial that randomized women to "no mammography" would disregard current guidelines, which recommend survivors receive annual surveillance mammograms. ◆

A Closer Look

Frontiers in Preoperative Chemotherapy

Preoperative chemotherapy for breast cancer first emerged as a method to shrink advanced, inoperable tumors enough to allow for successful mastectomy. The effectiveness of this technique led researchers to test preoperative chemotherapy in women whose tumors could be removed by surgery.

Today, after several large-scale clinical trials have demonstrated the safety and efficacy of preoperative chemotherapy for breast cancer, "anyone who will require [a] therapy in question" is a candidate to receive that therapy before surgery, stated Drs. Julie Gralow, from Fred Hutchinson Cancer Center, and Eric Winer, from the Dana-Farber Cancer Institute, at the NCI-sponsored conference "Preoperative Therapy in Invasive Breast Cancer: Reviewing the State of the Science and Exploring New Research Directions," held March 26 and 27 on the NIH campus.

Now, as discussed at the conference, clinical trials hold the promise of personalizing breast cancer treatment in the future. "When a drug is given preoperatively, you have access to the tumor as it's being perturbed," explained Dr. Jo Anne Zujewski, a breast cancer specialist with NCI's Division of Cancer Treatment and Diagnosis. In the preoperative setting, researchers can measure the immediate response of individual tumors to new therapies, and correlate that response with the molecular characteristics and genetic mutations found in those tumors. The ultimate goal is to improve outcomes for patients by targeting the therapy to the specific tumor type. In addition, because smaller tumors often require less extensive surgery, cosmetic outcome may be improved with a potential for decreased surgical morbidity.

The understanding that breast cancer is not a single entity, but a diverse set of diseases driven by different mutations that respond differently to therapy, revolutionized both the treatment of breast cancer and the research into new, targeted drugs. Doctors routinely administer estrogen-blocking drugs such as tamoxifen or aromatase inhibitors to women whose tumors overexpress receptors for estrogen, and the drug trastuzumab to women whose tumors overexpress the tumor marker HER2. By testing new drugs before surgery, where there is an opportunity to correlate response to treatment with common tumor characteristics, "we may be able to individualize the care of future patients off trials to an even greater extent. The hope is that we can subdivide tumors and patients to maximize effectiveness and minimize toxicity from therapy," said Dr. Winer.

In addition to using preoperative therapy to better define subgroups of breast cancer that might respond to new treatments, researchers hope that a new generation of trials can better define how to treat patients whose tumors do not respond to traditional chemotherapy. Currently, when chemotherapy is given preoperatively, investigators can see whether the drugs have an effect on the tumor. However, if a tumor does not respond, switching to another chemotherapy regimen mid-treatment hasn't been shown to make a difference.

"It seems that with chemotherapy, tumors either respond or not. You either have a chemosensitive tumor or a chemoresistant tumor," said Dr. Gralow. New trials will look at whether targeted biological drugs such as antiangiogenesis agents can help women whose tumors are resistant to preoperative chemotherapy.

One caveat stressed by participants at the conference was that "there is an incredible need for multidisciplinary care of patients and multidisciplinary involvement in research," due to the complexities that arise from using therapy that can cause a tumor to shrink or disappear even before surgery, explained Dr. Winer. "You can't provide optimal clinical care unless you have medical oncologists, surgeons, pathologists, radiation oncologists, breast imagers, and oncology nurses all working very closely together. And you can't pull off the research unless you have all of these clinicians plus a dedicated group of basic and translational scientists, and we should never forget the critical role played by our colleagues in biostatistics."

The conference videocast, including the statement of the science, is available at http://videocast.nih.gov. To download podcasts from the conference or PDFs of the slide presentations, visit the conference Web site at http://ctep.cancer.gov/bcmeeting. ◆

By Sharon Reynolds

Funding Opportunities

Following are newly released NCI research funding opportunities:

Advancing Novel Science in Women's Health Research

Announcement Numbers: PAS-07-381 and PAS-07-382

Application Receipt Dates: *New Applications:* Oct. 16, 2007; Oct. 16, 2008; and Oct. 16, 2009. *Resubmission Applications:* Nov. 16, 2007; Nov. 16, 2008; and Nov. 16, 2009. *AIDS Applications:* Jan. 7, 2008; Jan. 7, 2009; and Jan. 7, 2010.

This funding opportunity will use the R03 (PAS-07-382) and R21 (PAS-07-381) award mechanisms. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3737. Inquiries: Crystal Wolfrey—wolfreyc@mail.nih.gov.

NINR Nursing Science Research on Interventions in Chronic Illness

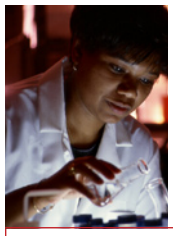
Announcement Number: RFA-NR-08-001

Letter of Intent Receipt Date: Oct. 29, 2007.

Application Receipt Date: Nov. 26, 2007.

This funding opportunity will use the P01 award mechanism. For more information, see http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=3739. Inquiries: Dr. Ann M. O'Mara—omaraa@mail.nih.gov

For comprehensive information about NCI funding priorities and opportunities, go to http://www.cancer.gov/researchandfunding. ◆



Featured Clinical Trial

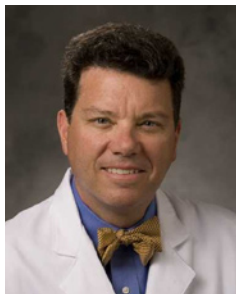
Comparing Radiation Therapies for Prostate Cancer

Name of the Trial

Phase III Randomized Study of Hypofractionated Versus Conventionally Fractionated Three-Dimensional Conformal or Intensity-Modulated Radiotherapy in Patients with Favorable-Risk Stage II Prostate Cancer (RTOG-0415). See the protocol summary at http://cancer.gov/clinicaltrials/RTOG-0415.

Principal Investigator

Dr. W. Robert Lee, Radiation Therapy Oncology Group



Dr. W. Robert Lee

Why This Trial Is Important

Radiotherapy is a standard treatment for prostate cancer. Typically, men with localized prostate cancer who undergo external-beam radiotherapy (as opposed to radioactive seed implants) are treated 5 days a week for 8 to 10 weeks, with only a fraction of the total prescribed radiation dose administered each day of treatment.

Some studies suggest that a conventional 8–10-week course of radiotherapy may not be the most effective or economical way of treating these patients. Consequently, researchers are studying whether increasing the dose of radiation during each day of treatment and delivering the total radiation dose over a shorter period of time (called hypofractionated radiotherapy) may be an equally effective approach to treating prostate cancer.

In this trial, men with favorable-risk, localized prostate cancer will be randomly assigned to receive conventionally fractionated radiation therapy over the course of about 8 weeks (41 daily treatments) or hypofractionated radiotherapy over a 5-and-a-half-week period (28 daily treatments).

"Previous studies of hypofractionated radiotherapy were not designed to tell us if the technique works as well as conventional regimens in terms of helping patients live longer without recurrence of their cancer," said Dr. Lee. "This trial is designed to answer that question."

"If we determine that we can deliver radiation over a shorter period of time with similar efficacy, we may realize benefits in terms of cost and convenience for patients as well."

Who Can Join This Trial

Researchers will recruit 1,067 men aged 18 or over with favorable-risk stage II prostate cancer. See the list of eligibility criteria at http://cancer.gov/clinicaltrials/RTOG-0415.

Study Site and Contact Information

Multiple study sites in the United States are recruiting patients for this trial. See the list of study sites at http://www.cancer.gov/clinicaltrials/RTOG-0415 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.

Notes

NCAB Meeting Held

The National Cancer Advisory Board met on June 14 and 15. To view a videocast of the public portions of the meeting, go to http://videocast.nih.gov/PastEvents.asp

Milner Receives Career Achievement Award

Dr. John A. Milner, chief of the Nutritional Science Research Group in NCI's Division of Cancer Prevention, recently received the David Kritchevsky Career Achievement Award in Nutrition from the American Society for Nutrition. This award recognizes researchers who devote their careers to promoting interaction among and support for nutrition researchers in government, private, and academic sectors. Dr. Milner was chosen for his research on bioactive substances in garlic and cancer prevention and his studies on the nutritional biochemical aspects of selenium metabolism and carcinogenesis, as well as his professionalism in promoting nutritional science research and training.

Two DCTD Staff Retire

Dr. Michaele Christian, associate director of the Cancer Therapy Evaluation Program (CTEP), will retire at the end of June after more than 20 years at NCI. CTEP is responsible for a major program in early drug development and collaborates with over 50 pharmaceutical companies to develop new agents for cancer. CTEP also oversees NCI's extramural cancer treatment clinical trials, coordinating 10 clinical trials cooperative groups and managing a large portfolio of cancer research grants. Her leadership brought the program through a critical period of development. Dr. Christian played a critical role in the development of molecularly targeted agents, particularly in combinations of agents from more than one company. New initiatives during her tenure included the creation of the Cancer Trials Support Unit and the Central Institutional Review Board.

Dr. Daniel Sullivan, associate director of NCI's Cancer Imaging Program (CIP) in the Division of Cancer Treatment and Diagnosis, will also retire from NCI at the end of this month. Under Dr. Sullivan's leadership over the past 10 years, CIP has been responsible for developing the field of molecular imaging into an important component of cancer diagnosis and therapy. These achievements include initiating a collaborative national network for cancer imaging clinical trials, developing novel imaging technologies, and creating image-guided interventional therapies.

Dr. Sullivan will leave NCI to serve as a senior science advisor for the Radiological Society of North America, where he will oversee efforts to develop imaging as a quantitative biomarker. He will also serve as a senior strategic advisor for imaging to the dean of Duke University School of Medicine, where he will help the university plan for a major reshaping of imaging facilities across the campus.

Standard Specimen Reference Sets Available

NCI's Early Detection Research Network (EDRN) has created standard specimen reference sets (SSRS), collections of high-quality, well-characterized sera that can be used for discovery and early validation of potential cancer biomarkers. EDRN has developed SSRS for prostate, ovarian, breast, and lung cancer, in the context of screening high-risk individuals. EDRN is developing another SSRS for prostate cancer, as well as sets for breast, pancreatic, gastrointestinal, bladder, and lung cancers in other screening contexts.

SSRS are deposited at NCI Frederick and advertised in appropriate journals. Details on all SSRS are available on the EDRN Web site at http://edrn.nci.nih.gov/resources/sample-reference-sets.

NCI Divisions Update Web Sites

The following three NCI divisions recently updated their Web sites: the Division of Cancer Epidemiology and Genetics, the Division of Cancer Prevention, and the Division of Cancer Treatment and Diagnosis.

Meeting on Cancer and Inflammation Set for October

The Center of Excellence in Immunology in NCI's CCR is sponsoring a meeting October 9 and 10 on cancer and inflammation in the Masur Auditorium on the NIH campus. The conference will feature international leaders in the field and provide a forum for discussion and debate on recent developments. Topics will include innate resistance and cancer, colon and prostate cancers, skin cancers, cancers with an infectious pathogenesis, and the inflammatory tumor microenvironment. Registration is free and can be completed online at http://web.ncifcrf.gov/events/cancerandinflammation/. For more information, contact Karen Kochersberger at kkochersberger@ncifcrf.gov or 301-228-4027. ◆

Community Update

New Community Partnership Increases Clinical Trials Enrollment

In 2006, NCI's Center for Cancer Research (CCR) was approached by a local clinical practice to increase communication about early-phase clinical trials for which their patients might be eligible at the NIH Clinical Center. The Clinical Center only admits and treats patients enrolled in clinical trials, distinguishing it from other hospitals in the United States. While this specialization allows an absolute dedication to clinical research within the Center, it lacks a built-in base of patients receiving standard treatments who might be interested in participating in clinical trials.

Physicians at Associates in Oncology/Hematology (AOH), a private practice in Rockville, MD, were seeking to expand the clinical trial options available to their patients. "We've been committed to clinical trials in our practice, and we participate in cooperative group trials and pharmaceutical trials," explained Dr. John Wallmark, one of AOH's seven oncologists, "but we felt that there was a need to continue to expand the options for our patients. As our patients got further along in their illnesses, a lot of times innovative clinical trials weren't available, and clinical trials in oncology are extremely important to incorporate into your treatment options."

Three AOH physicians had received training at NCI. This experience and the group's close proximity to the NIH campus led AOH to propose a pilot partnership: CCR would identify an onsite research nurse with experience in early-phase trials to screen patients in the community receiving primary cancer care at AOH, and AOH would refer eligible patients to CCR trials by the end of 12 months.

By May 2007, the pilot project had met its accrual goal, almost half a year ahead of schedule. Out of 109 patients referred to CCR by AOH, 20 have started treatment on clinical trials, with 26 additional enrollments pending. Importantly, patients enrolled through the partnership retain the patient/caregiver bond with their primary oncologist, and NCI physicians supply the AOH oncologist with regular updates on the enrolled patient.

The success of the pilot program has led to plans for expansion. The partners hope to begin several early-phase CCR trials based at AOH and the Clinical Center. "Patients want to remain in the community, and doctors like them to remain in the community," said Dr. Wallmark. "A big barrier to enrollment in these studies is the fact that most patients don't want to leave the setting in which they are comfortable—it's very daunting."

"I think this partnership is exciting," said Caryn Steakley, deputy clinical director of CCR. "It's something new and different for CCR to be doing, and I think it has a lot of promise for other groups or institutions interested in this kind of partnership." ◆

Featured Meetings and Events

A calendar of scientific meetings and events sponsored by the National Institutes of Health is available at http://calendar.nih.gov ◆

70 YEARS OF EXCELLENCE IN CANCER RESEARCH

If Memory Serves…

An important part of the National Cancer Institute Act was the authorization to design a program that would increase physicians' abilities to diagnose and treat cancer. It provided "traineeships" to young doctors who had graduated from medical school and completed 1-year internships, and who pledged to devote themselves to the specialty of diagnosing and treating cancer. (Read more) ◆

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