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## NIH Halts Use of COX-2 Inhibitor in Large Cancer Prevention Trial

On December 17, the National Institutes of Health (NIH) announced that it suspended the use of the COX-2 inhibitor celecoxib (Celebrex) for all participants in a large colorectal cancer prevention clinical trial conducted by the National Cancer Institute (NCI). The study—the Adenoma Prevention with Celecoxib (APC) trial—was stopped because analysis by an independent Data Safety and Monitoring Board showed a 2.5-fold increased risk of major fatal and non-fatal cardiovascular events for participants taking the drug compared with those on a placebo.

Additional cardiovascular expertise was added to the safety monitoring committee at the request of the steering committee for this trial after a September 2004 report that the COX-2 inhibitor rofecoxib (Vioxx) caused a two-fold increased risk of cardiovascular toxicities in a trial to prevent adenomas. The APC trial is a study of more than 2,000 people who have had a precancerous growth (adenomatous polyp) removed. They were randomized to take either 200 mg of celecoxib twice a day, 400 mg of celecoxib twice a day, or a placebo for 3 years. The trial began in early

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*Director's Update*

## NCI Leadership: Building Upward, Moving Forward

When I arrived here in January 2002, I was privileged to join an organization with a long and distinguished history of achievement and a reputation for innovative leadership. What I have experienced during my first 3 years as Director has only increased my deep respect for all of the talented and dedicated staff at NCI and in the broader cancer community who are committed to the challenge of eliminating the suffering and death due to cancer. Each of us contributes in our own way to achieving this goal, and all of our efforts are necessary to ensure success.

In the coming year, we will face a number of critical challenges and opportunities; the decisions we make in 2005 could affect cancer research for decades to come. Perhaps more than ever before, innovative and dynamic leadership will prove to be the difference. That's why I've implemented steps that will ensure the NCI leadership structure is best positioned to meet every success and exploit every opportunity. Over the next two issues of the *NCI Cancer Bulletin*, I will provide you with a glimpse of how

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(COX-2 Inhibitor continued from page 1)  
2000 and is scheduled to be completed by spring 2005.

Investigators at the 100 sites in the APC trial located primarily in the United States, with a few sites in the United Kingdom, Australia, and Canada, have been instructed to immediately suspend study drug use for all participants in the trial, although the participants will remain under observation for the planned remainder of the study.

“Data from the report on rofecoxib informed us of the need to focus on specific cardiovascular issues, and our institutes brought in the experts to do so,” said NIH Director Dr. Elias A. Zerhouni. “Our overwhelming commitment is to advance the health and to protect the safety of participants in clinical trials. We are examining the use of these agents in all NIH-sponsored clinical studies. In addition, we are working closely with our colleagues at FDA to ensure that the public has the information they need to make informed decisions about the use of this class of drug.”

“The rigor of our clinical trials system has allowed us to find this problem,” said NCI Director Dr. Andrew C. von Eschenbach. “We have a strong system that provides us with the opportunity to both find ways to effectively treat and prevent disease and to do so in a way that protects the lives and safety of the participants.”

NIH sponsors more than 40 studies using celecoxib for the prevention and treatment of cancer, dementia, and other diseases. In light of these new findings, Dr. Zerhouni requested:

- A full review of all NIH-supported studies involving this class of drug
- That all NIH institutes inform the principal investigators for all

of these studies, asking the PIs, in turn, to communicate directly with their study participants and explain the risks and benefits

- That NIH asks each investigator to inform NIH of their plan to analyze their data in light of the information
- That the Institutional Review Boards for all related trials assess the new information and conduct a safety review

Questions and answers about the APC trial are available at: <http://www.nih.gov/news/pr/dec2004/od-17Q&A.htm>. More information about regulation of COX-2 inhibitors is available from the FDA at <http://www.fda.gov/cder/drug/default.htm>. ♦

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(Director's Update continued from page 1)  
the NCI Office of the Director will evolve to more effectively meet future challenges.

Early in my tenure, I made the decision not to undertake a major reorganization of NCI. Instead, I have engaged NCI's senior leadership in a series of strategic discussions and decisions to address the institute's mission, strategy, functions, and structure. We adopted as our mission, expressed in NCI's challenge goal: eliminating suffering and death due to cancer by 2015. We have since defined a pathway to achieving the challenge goal, expressed through the functions of the discovery-development-delivery continuum (the three Ds). Now we must focus on structure, with the goal of aligning the organization with function.

My first step in this alignment was to recruit deputies to drive the implementation of our strategic priorities along the three Ds. **Four new deputy positions** were created to span the

discovery-development-delivery continuum. In addition to serving as a focal point for research along the three Ds, a key component of the deputies' function is to move NCI from an organization characterized by isolated compartments to one that is fully integrated across all divisions, centers, and offices. Our goal is to develop and nurture the talent throughout NCI and create opportunities for staff to participate in a broad range of activities, from strategic planning to implementation of new initiatives to effective portfolio management and efficient resource allocation.

This shift toward a matrix structure requires us to think in different ways about how we staff and fund various initiatives. This is a challenge, because rather than dismantling our existing organizational structure we are realigning it. It is also a challenge to undertake such an effort during a time of fiscal constraint, and this is where NCI's senior leadership plays a key role.

With the recruitment of the four new deputies, we created a new decision-making group known as the Senior Management Team (SMT). This group meets regularly and serves many functions, among them: design and implementation of trans-NCI initiatives, long range financial planning, and policy development. Of course, this decision-making group could not hope to succeed without the full complement of key leaders across NCI's many divisions and centers. In next week's Update, I will address how the current NCI leadership structure will advise and work with the SMT to ensure continued and future success. ♦

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



# Spotlight

## Palliative Care—Improving the Quality of Life Through the End of Life

A special report in the September 21 *NCI Cancer Bulletin* delineated recent advances in providing palliative care to patients undergoing cancer treatment. With advances in cancer care, some cancers have come to be viewed as chronic illnesses, with patients surviving for years and sometimes decades.

Still, many patients will die from their illnesses, notes Dr. James Tulsky, director of the Center for Palliative Care at Duke University. “There is a pressing need for end-of-life care, from symptoms management to provider care management to psychological and spiritual support,” he says. NCI’s Palliative Care Working Group is addressing that need by coordinating widespread efforts in research, education, and training and by collaborating with many government and nongovernment groups to improve care and reduce suffering for people living with advanced cancer.

“We need more evidence-based research to give better end-of-life care,” says Andrea Denicoff, the NCI coordinator for palliative care initiatives. She notes that even though the science is strong on treating cancer pain, misunderstandings about and barriers to effective pain management are still common among caregivers, patients, and physicians.

Research has shown that many physicians need education about discussing and delivering evidence-based palliative care early in the treatment continuum. Dr. Tulsky and his colleagues have been conducting a study called SCOPE: Studying Communication in

### For more information on NCI’s palliative care initiatives, visit these Web sites:

- Important advances in supportive care research: <http://www.cancer.gov/clinicaltrials/results/supportive-care-trial-results>
- Funding opportunities in palliative care and symptom management: <http://www.cancer.gov/researchandfunding/announcements/symptommanagement>
- PDQ supportive care treatment summaries: <http://www.cancer.gov/cancertopics/pdq/supportivecare>
- Patient, family, and caregiver information about palliative care, including the booklets *Advanced Cancer* and *When Cancer Recurs* are being revised to better integrate updated information and will then be added to the cancer topics section of the NCI Web site, at <http://www.nci.nih.gov/cancertopics/>
- NIH sponsored a state-of-the-science conference on end-of-life care on December 6-8; the draft NIH consensus statement can be found at <http://consensus.nih.gov/ta/024/024EndOfLifepostconfINTRO.htm>

Oncologist Patient Encounters. After attending a lecture on patient communication, 50 oncologists had their regular conversations with advanced cancer patients recorded. Half of the oncologists received CD-ROMs containing their conversations, along with comments by SCOPE staff on how well the physician communicated.

“This method allows oncologists to enhance their communication skills through feedback,” Dr. Tulsky says. “We also ask the patients for their feedback on their anxiety levels and satisfaction with their doctors; this gives us qualitative results.”

Integrating palliative care early, Ms. Denicoff points out, improves symptom management and avoids a situation in which patients feel they are being given the either/or choice of being made comfortable or aggressively treating the disease. Instead, patients should have both treatment and symptom management along the disease trajectory. At the end of life, when the symptoms may be more frequent and intense, there should be a transition to more palliative care, according to Ms. Denicoff. “Doctors can help terminally ill patients die without suffering. That is a medical success—dying with unnecessary treatment or pain is not,” she says.

To train more health professionals in palliative cancer care, the Education on Palliative and End-of-Life Care (EPEC) program is being modified to enable oncology professionals to teach colleagues about such aspects of cancer care as managing pain and symptoms, combining antineoplastic therapy and palliative care, and preventing professional burnout. The American Society of Clinical Oncology will deliver the first train-the-trainer workshop of this new EPEC-O (Oncology) program June 13-15, 2005, in Reston, Va. More information about the workshop is available at [www.asco.org/epeco](http://www.asco.org/epeco).

(continued on page 4)



(Palliative Care continued from page 3)

Barriers to communication among those most involved in end-of-life care—patients, caregivers, and clinicians—are another focus for the palliative care group. One of NCI's Centers of Excellence in Cancer Communications Research (<http://dccps.nci.nih.gov/hcirb/ceccr/>) is funding a program to test whether use of a system called CHES—Comprehensive Health Enhancement Support Systems—can improve patients' quality of life and reduce stress, improve negative partner affect, and ease bereavement. In the study, by Dr. David Gustafson of the University of Wisconsin, a group of family members caring for partners or spouses with terminal lung cancer are given a computer with Internet access while the patient is ill and until 13 months after the patient dies. One-third of the group receives their regular oncology care and access to the Internet, one-third is asked to fill out online weekly forms on the patient's symptoms and the caregiver's well-being, and one-third completes the CHES online forms to be provided to their primary oncologist. The groups filling out forms also have access to an online bulletin board where they can share feelings, suggestions, and information with other caregivers. The researchers believe that giving caregivers access to CHES and feedback from clinicians through the system will decrease use of emergency health services and benefit the patients and caregivers.

"We need to continue to provide terminally ill cancer patients with excellent care until their death," says Dr. Tulsky. "Patients' needs may change as they transition from one stage to another, but their need for care does not." ♦



# Funding Opportunities

The following are newly-released NCI research funding opportunities:

## **Innovative Technologies for Molecular Analysis of Cancer**

(SBIR/STTR)  
RFA-CA-06-005  
Letter of Intent Receipt Dates:  
Jan. 17, May 17, Sep. 18, 2005  
Application Receipt Dates:  
Feb. 17, Jun. 17, Oct. 18, 2005

This funding opportunity will use the STTR (R41/R42) and SBIR (R43/R44) grant mechanism(s).

For more information see [http://cri.nci.nih.gov/4abst.cfm?initiativeparfa\\_id=2500](http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=2500). Inquiries: Dr. Gregory J. Downing—downingg@mail.nih.gov.

## **Application of Emerging Technologies for Cancer Research**

(SBIR/STTR)  
RFA-CA-06-006  
Letter of Intent Receipt Dates:  
Jan. 17, May 17, Sep. 18, 2005  
Application Receipt Dates:  
Feb. 17, Jun. 17, Oct. 18, 2005

This funding opportunity will use the STTR (R41/R42) and SBIR (R43/R44) grant mechanism(s).

For more information see [http://cri.nci.nih.gov/4abst.cfm?initiativeparfa\\_id=2501](http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=2501). Inquiries: Dr. Gregory J. Downing—downingg@mail.nih.gov.

## **Innovations in Cancer Sample Preparation (SBIR/STTR)**

RFA-CA-06-007  
Letter of Intent Receipt Dates:  
Jan. 17, May 17, Sep. 18, 2005  
Application Receipt Dates:  
Feb. 17, Jun. 17, Oct. 18, 2005

This funding opportunity will use the STTR (R41/R42) and SBIR (R43/R44) grant mechanism(s). For more information see [http://cri.nci.nih.gov/4abst.cfm?initiativeparfa\\_id=2502](http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=2502).

Inquiries: Dr. Gregory J. Downing—downingg@mail.nih.gov.

## **Research on Mind-Body Interactions and Health**

PA-05-027  
Application Receipt Dates: Jan. 10, May 10, Sep. 10, 2005; Jan. 10, May 10, Sep. 10, 2006; Jan. 10, May 10, Sep. 10, 2007

This funding opportunity will use the NIH Research (R01) award mechanism.

For more information see [http://cri.nci.nih.gov/4abst.cfm?initiativeparfa\\_id=2483](http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=2483). Inquiries: Dr. Paige A. McDonald—pm252v@nih.gov.

## **Social and Cultural Dimensions of Health**

PA-05-029  
Application Receipt Dates: Jan. 10, May 10, Sep. 10, 2005; Jan. 10, May 10, Sep. 10, 2006; Jan. 10, May 10, Sep. 10, 2007

This funding opportunity will use the NIH Research (R01) award mechanism.

For more information see [http://cri.nci.nih.gov/4abst.cfm?initiativeparfa\\_id=2503](http://cri.nci.nih.gov/4abst.cfm?initiativeparfa_id=2503). Inquiries: Dr. Sabra Woolley—woolleys@mail.nih.gov.

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

*The NIH Roadmap provides a framework of the priorities NIH must address to optimize its research portfolio. It identifies the most compelling opportunities in three main areas: new pathways to discovery, research teams of the future, and re-engineering the clinical research enterprise. For information on Roadmap funding opportunities, go to: <http://nihroadmap.nih.gov>.* ♦



# Cancer Research Highlights

## Changes in Hormone-Pathway Genes Associate with Breast Cancer Risk

Single-nucleotide polymorphisms (SNPs) in genes for estrogen and progesterone receptors may be a factor that determines whether women are protected from breast cancer or are at risk for getting it, collaborative research teams from NCI's Center for Cancer Research (CCR), Memorial Sloan-Kettering Cancer Center, and Celera Diagnostics report in the December 15 *Cancer Research*.

Scientists collected DNA samples from 1,006 breast cancer patients, comparing them with DNA samples from 613 control subjects. They then examined SNPs in two estrogen receptor genes (ESR1 and ESR2) and looked at SNPs in a progesterone receptor gene (PGR). They found two SNPs in ESR1 that are linked to increased breast cancer risk—one in women over age 50 (though only rarely in African Americans) and the other exclusively in Ashkenazi women over the age of 50; three SNPs in ESR1 that conferred protective effects against breast cancer; a group of ESR2 SNPs that increased risk for breast cancer in Ashkenazi women; and neither protective nor risk-associated links to SNPs in PGR. Noting that only half of the familial breast cancer cases have been linked to specific genes, the results suggest that “Individual differences in hormonal regulation may result from haplotypes that confer an increased risk or protection from risk of breast cancer in a subset of the population.”

## Post-Op Chemo, Age, and Menopause Status

The National Surgical Adjuvant Breast and Bowel Project (NSABP), an NCI-sponsored clinical trial cooperative group, enrolled women with axillary lymph node-negative, estrogen receptor-negative breast cancer between 1981 and 1988. In 2003, NSABP reported that the addition of cyclophosphamide to methotrexate and 5-fluorouracil (CMF) improved outcomes after surgery and that doxorubicin with cyclophosphamide (AC) was equally as effective as the CMF regimen. In the December 15 *Journal of the National Cancer Institute*, researchers present new data that clarify the implications of these findings for women according to their age and menopause status.

The recent data show that women aged 49 or younger experienced a 65 percent reduction in treatment failure when given post-surgical CMF or AC chemotherapy, while women aged 50 to 59 experienced a 54 percent reduction in treatment failure with the chemotherapy. Women aged 60 or over, however, experienced an even lesser benefit; overall the younger the woman was upon entering the study, the greater the difference in recurrence rate with the treatment, compared with women who had surgery alone. Premenopausal women experienced a greater recurrence-free survival benefit than post-menopausal women (28 percent versus 48 percent) with the post-operative chemotherapy.

They conclude that outcomes in CMF- or AC-treated women with estrogen receptor-negative tumors and negative

axillary lymph nodes were similar in all age groups. The decreased benefit from chemotherapy with increasing age resulted from a better outcome associated with advancing age in women who underwent surgery alone rather than a poorer outcome resulting from the use of chemotherapy.

## Lung Screening Study Shows What Happens after Positive CT Scan

Research has shown that low-dose spiral computed tomography (CT) is more sensitive than chest X-ray at detecting abnormal lung tissue. CT is so sensitive that it poses a risk for false positives in lung cancer screening. Furthermore, there are no standard recommendations for follow-up after positive CT. Researchers from NCI's Division of Cancer Prevention surveyed the outcomes after a group of 1,660 current or former heavy smokers who had quit within the last 10 years were randomized to receive the procedure and were referred to their personal health care providers for next steps. These individuals were participants in the Lung Screening Study, a pilot for the National Lung Screening Trial. The results of the follow-up of the positive results appear in the January 1 *Cancer*.

Of the 522 patients with a positive CT scan at baseline or 1 year after baseline, researchers found that the most common follow-up procedure was a second CT scan without biopsy (55 percent) followed by follow-up biopsy or comparison of current CT results with those from a prior X-ray or CT (12 percent). Four percent of patients underwent only a clinical examination and 3 percent received no follow-up. Of those who were not diagnosed with lung carcinoma, 45 percent were diagnosed with another condition as part of the follow-up. “These data may be useful in estimating the potential burden and cost of CT screening,” the authors noted. ♦



# Featured Clinical Trial

## Cell-Based Immunotherapy for Metastatic Melanoma

### Name of the Trial

Phase II Study of Adoptive Transfer of Cloned Lymphocytes With Interleukin-2 After Cyclophosphamide and Fludarabine in Patients With Metastatic Melanoma (NCI-99-C-0158). See the protocol summary at <http://cancer.gov/clinicaltrials/NCI-99-C-0158>.

### Principal Investigator

Dr. Steven Rosenberg, NCI Center for Cancer Research



*Dr. Steven Rosenberg  
Principal Investigator*

### Why is This Trial Important?

The incidence of melanoma has risen significantly in recent decades, and the prognosis is poor for patients diagnosed with advanced, stage IV disease (cancer that has spread, or metastasized, to distant parts of the body). The five-year survival rate for these patients is less than 10 percent. No form of treatment currently available has been shown in randomized, controlled phase III trials to improve survival rates.

In this phase II trial, researchers are investigating a cell-based form of immunotherapy for stage IV melanoma that produced tumor shrinkage or disappearance in more than 50 percent of patients enrolled in an earlier part of the study. Immunotherapy involves harnessing immune-system components to treat or prevent disease.

Researchers will first harvest white blood cells (lymphocytes) from the patients' tumors. Next, the cancer-

fighting potential of these tumor-infiltrating lymphocytes (TIL) will be further stimulated in the laboratory, and their numbers increased. The TIL will then be injected back into patients—a procedure known as adoptive transfer—after the patients have undergone preparatory chemotherapy to improve TIL survival. TIL injection will be accompanied by the administration of cytokines, proteins that stimulate immunological responses. Interleukin-2 and filgrastim are the cytokines used in this trial.

“This research demonstrates that cell-based immunotherapy can work,” said Dr. Rosenberg.

### Who Can Join This Trial?

Researchers will enroll 200 patients aged 16 and over who have been diagnosed with metastatic melanoma resistant to standard therapy. See the list of eligibility criteria at <http://cancer.gov/clinicaltrials/NCI-99-C-0158>.

### Where Is This Trial Taking Place?

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

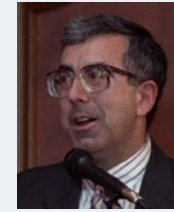
### Contact Information

For more information, contact the NCI Surgery Branch directly at 301-402-4124 or 301-496-2132 or the NCI Clinical Studies Support Center at 1-888-NCI-1937 (toll free). The call is confidential. ♦

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

### Dr. Daniel Ihde Dies at 61

Former NCI Deputy Director Dr. Daniel C. Ihde died on Thursday,



December 9 in Rio Rancho, N.M. He was 61 years old. Dr. Ihde's career at NCI spanned 21

years, from 1973 to 1994. During that time he served as director of the Division of Hematology and Oncology at the Uniformed Services University of the Health Sciences, editor-in-chief of the *Journal of the National Cancer Institute*, and NCI deputy director from 1991 to 1994. He was chief of oncology at the Washington University School of Medicine in St. Louis from 1994 to 1997.

Dr. Ihde authored or co-authored more than 100 articles and book chapters. He made many seminal observations about lung cancer and its treatment, and was the first to report on the role of drug combinations for the treatment of both small-cell and non-small-cell cancers as early as 1976.

Dr. Ihde received his degree in mathematics from Eastern New Mexico University in 1964. He earned his medical degree from Stanford University Medical School in 1969 and served his internship and residency at New York Hospital and Memorial Sloan-Kettering Hospital. Dr. Ihde received a number of awards, including the Stanford Medical Alumni Research Award, the U.S. Public Health Service Commendation Medal, the NIH Merit Award, and the Bristol-Myers Squibb Award for Excellence in Lung Cancer Research. He is survived by his mother, sister, wife, daughter, and two sons. ♦



## Notes

### Logothetis Discusses New Opportunities for Prostate Cancer Therapy

On December 14, Dr. Christopher Logothetis, director of the M.D. Anderson Cancer Center's Genitourinary Center, visited NIH to discuss "Biological Basis for the Development and Application of Therapy for Prostate Cancer." Dr. Logothetis outlined several key research projects at the genitourinary center, including the role of fat tissue as an endocrine organ in the development of prostate cancer among obese men (with relapse trends after surgery); analysis of small prostate tissue samples using laser-capture microdissection followed by RNA extraction and gene expression profiling; treatments that target metastatic cancer sites without affecting the primary tumor, effectively neutering the malignancy and rendering it more vulnerable to surgical elimination; and the extended survival seen in patients who undergo serial chemotherapy treatments. Dr. Logothetis presented prepublication data from several ongoing clinical trials, and emphasized his team's integrative strategy for analyzing the basic biology of prostate cancer and translating this into improved disease diagnosis and treatment.

### NCI Web Site Rated Best E-Government Main Site

The American Customer Satisfaction Index (ACSI), used by the federal government and the private sector to measure citizen satisfaction with the quality of goods and services, has rated <http://www.cancer.gov> first in citizen satisfaction in the E-Government Portals/Department Main Web Sites category. The redesigned Web site was ranked first in the 2004 fourth-quarter ratings. The

December 14 report announcing the first-place standing stated that the portals in the index face the challenging task of catering to a wide range of constituents—in this case, patients and their families, health professionals, researchers, and advocates, among others. ACSI is produced by the University of Michigan, in partnership with the American Society for Quality, ForeSee Results, and the CFI Group.

### NCI Director on WJFK-FM

On Saturday, January 8 at 9:00 a.m. on WJFK-FM (106.7), NCI director Dr. Andrew C. von Eschenbach will appear on "The Business of Government Hour." In this interview, Dr. von Eschenbach will discuss NCI's quest to eliminate suffering and death from cancer by 2015. He will discuss the convergence of medical research and technology and the [Cancer Biomedical Informatics Grid \(caBIG\)](#), an informatics infrastructure that allows cancer researchers to better develop and share tools and data in an open environment both nationally and internationally. For listeners outside of the Washington, D.C. area, the interview will be available at <http://www.businessofgovernment.org>.

### NCI Launches Nanotechnology Teaming Web Site

The NCI Alliance for Nanotechnology in Cancer has launched the [Nano Teaming Site](#) to serve the growing need within the research community to identify potential areas of collaboration across disciplines, organizations, and sectors. NCI is particularly interested in identifying medical oncologists with backgrounds in technology development.

The Nano Teaming Site contains information on investigators interested

in nanotechnology and its application to reducing suffering and death due to cancer. The site comprises a user-driven database that enables researchers to explore partnering opportunities with other participating researchers who have various areas of expertise. Each participant creates a simple profile with contact information, affiliation, and specific area(s) of expertise. Investigators can then search for other researchers with specific areas of expertise in particular organizations, identifying collaborative opportunities across disciplines participating in cancer nanotechnology research and development. As information is gathered, the Nano Teaming Site will be a valuable tool for the cancer research community by facilitating the initial interfaces among investigators across multiple disciplines and sectors.

The Nano Teaming Site is posted on the NCI Alliance for Nanotechnology in Cancer Web site at <http://nano.cancer.gov>. ♦

## CCR Grand Rounds

**January 11:** Dr. Louis M. Staudt, Chief, Lymphoid Malignancies Section, Metabolism Branch, CCR, "Molecular Diagnosis and Molecular Targets in Lymphoid Malignancies by Gene Expression Profiling"

**January 18:** Dr. Beverly Teicher, Vice President, Oncology Research, Genzyme Corporation, "Newer Cell-based Models and Therapeutic Targets Related to Tumor Vasculature"

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

## Radio Show Provides Cancer Community with Information, Resources

*The Group Room*® is a syndicated live cancer talk radio show that brings patients, survivors, family members, and oncology professionals together. The 2-hour weekly Sunday program is heard in select cities across the country, as well as on the Web and XM Satellite Radio. Hosted by Selma Schimmel, a breast cancer survivor, the program includes a team of medical and radiation oncologists and a therapist, providing support, information, and resources.

The radio program, launched in February 1996, is produced by Vital Options International, a nonprofit cancer communications, support, and advocacy organization dedicated to using communications technology to help people cope with cancer. The Web site—<http://www.vitaloptions.org>—features content in English, French, and German and provides links to a range of resources, including clinical trials and advocacy organizations in several countries.

“I originally founded Vital Options in 1983 as the first resource for young adults with cancer,” says Ms. Schimmel. “When I was diagnosed with breast cancer at age 28, I found very little support and helpful information to address the issues unique to young adults. There were many young adults in a similar situation and I began Vital Options to address those concerns. Since then, we’ve expanded to serve patients and survivors of all ages.

“*The Group Room* is the only program of its kind,” Ms. Schimmel continues. “Each week we focus on a different topic, ranging from broadcasts from major research conferences, to providing information about specific cancer types. We’re a credible news source for cancer information.” Callers can join the discussion at 1-800-GRP-ROOM.

“The initial idea behind *The Group Room* was to serve as an on-air support group,” Ms. Schimmel says. “But

over the years we’ve found that most of the patients who call in want specific clinical information. However, behind every question there is usually an emotional component that we talk about. In addition to addressing particular concerns, we provide callers with regional services and resources, as well as clinical trials information. Many times, this helps them have more meaningful conversations with their physicians and caregivers.”

In 2000, Vital Options expanded and *The Group Room* began broadcasting from the European Society for Medical Oncology meeting. The organization was renamed Vital Options International and began working with European advocacy organizations, helping them deliver their messages to wider audiences. Today, many listeners outside the United States hear *The Group Room* on the Internet and call in to the show through toll-free numbers in their home country. ♦

Dr. Julia Rowland, director of NCI’s Office of Cancer Survivorship, is scheduled to appear on *The Group Room* on January 9th to discuss issues faced by cancer survivors. Check <http://www.vitaloptions.org> for a list of participating radio stations and broadcast times. ♦

### Featured Meetings and Events

A comprehensive calendar of cancer-related scientific meetings and events sponsored by NCI and other scientific organizations, is available at: <http://calendar.cancer.gov/> ♦

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](mailto:ncicancerbulletin@mail.nih.gov).