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Eliminating the Suffering and Death Due to Cancer

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Mouse Hepatitis Virus at NCI-Frederick

An outbreak of mouse hepatitis virus (MHV) has been identified in animals from the Animal Production Area (APA) at NCI-Frederick. On Jan. 30, the University of Missouri diagnostic lab informed APA staff that some mice sent from Building 1029 on Jan. 23 for routine testing were showing borderline antibody levels to MHV. On Feb. 2, additional animals were sent from Building 1029 to the Animal Health Diagnostic Laboratory (AHDL) where antibodies to MHV were detected in the sera. All previous routine testing for MHV had been negative.

Building 1029 was immediately quarantined and all shipments stopped. The building has since been depopulated and is being decontaminated. The building housed DBA/2NCr, BALB/cAnNCr, C3H/HeNCr MTV-, Sencar A/PtCr, and CD2F1Cr mice. Mice from Building 1029 had been distributed to numerous animal facilities on both the Frederick and NIH campuses as well as to other organizations throughout the United States.

All 25 known strains of MHV are highly contagious within mouse colonies and easily transmitted in feces and by direct contact, aerosol, and fomites. An MHV infection typically runs its course in immunocompetent

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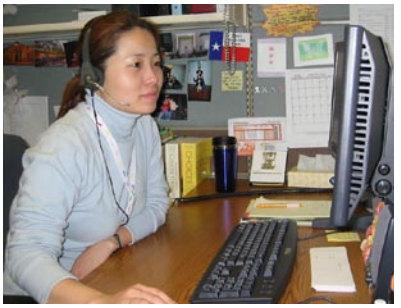
Director's Update

Helping Every Smoker Who Would Like to Quit

Last week, at a press conference attended by Surgeon General Richard Carmona, CDC Director Julie Gerberding, and me, HHS Secretary Tommy G. Thompson affirmed his strong opposition to tobacco and announced plans to take another important step in the ongoing effort to address the burden of tobacco use in this country. The National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC) will co-fund the implementation of a national network of smoking cessation quitlines. This network will provide all smokers in the United States with access to the support and the most up-to-date information they need to quit.



NCI CIS Information Specialist

Adult smoking rates have been cut nearly in half since the Surgeon General first recognized cigarette smoking as a cause of cancer and other serious diseases 40 years ago. Unfortunately, 46 million adults in this country continue to smoke today, and tobacco use remains the number one preventable cause of premature death in the nation.

While nearly three out of four smokers in the United States say they want to quit, sustained success rates for people who try to quit are abysmally low. Fortunately,

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(Mouse Virus continued from page 1)
mice within three weeks. However, immunocompromised mice tend to develop chronic infections, sometimes leading to death.

By the end of the day on Feb. 4, all organizations that had received mice from Building 1029 since Dec. 15, 2003, had been notified of the MHV outbreak. All NCI investigators who received mice from Building 1029 were notified by the animal facility managers that they might have received MHV-positive animals. NIH facility veterinarians who had received animals from Building 1029 were also notified of the outbreak. On Feb. 6, all recipients of APA animals, even those who did not receive animals from Building 1029, were notified of the outbreak.

All rooms in NCI facilities that received mice from Building 1029 have been quarantined, and all shipments to and from these NCI animal facilities have been stopped. Mice that were received from Building 1029 from Dec. 1, 2003, to Feb. 2, 2004, were removed to AHDL and tested for the presence of antibody to MHV. Serologic tests from these mice confirmed the presence of antibody to MHV in some mice that had been shipped from Building 1029 to the NCI animal facilities. Additional mice testing is being conducted to determine the extent of the outbreak and/or whether containment efforts have been successful.

Investigators should be aware that all tissues taken from mice obtained from or in contact with mice from Building 1029 should be tested for the presence of MHV prior to distribution or reintroduction into any NIH animal facility.

If you have any questions regarding the MHV investigation please call Dr. Rick Bedigian, director, Laboratory Animal Sciences Program, at (301) 846-1542. ◆

(Director's Update continued from page 1)
we now have evidence-based interventions, including telephone counseling and FDA-approved medications, that can significantly increase success rates for people who attempt to quit.

Currently, 38 states have telephone quitlines that deliver information, advice, support, and referrals to smokers, regardless of their geographic location, race, ethnicity, or economic status. Scientific evidence has shown that quitlines are especially useful for people without access to other cessation treatments, and they can be effective supplements for people who use other methods to quit.

As soon as possible, NCI will establish a new, easy-to-remember, toll-free telephone number that will serve as a single access point to the national network of quitlines. States that currently have quitlines will receive increased funding from CDC to enhance their services. These states will be able to use their supplements to expand hours of operation, hire bilingual counselors, build referral linkages with local health care systems, or promote their quitline. States that do not have quitlines yet will receive grants to establish one.

Making quitline services accessible across the country was a key recommendation of the smoking cessation subcommittee of the Interagency Committee on Smoking and Health—a group that Secretary Thompson created and charged with providing recommendations, based on expert and public opinion, to focus the government's cessation efforts.

The North American Quitline Consortium—which was formed last year by leaders in state, provincial, and federal health departments, quitline vendors, and national organizations in the United States and Canada to identify ways to improve quitline operations, promotion, and effectiveness—will serve as a valuable resource for the new national network. We are completely committed to working closely with our partners in the consortium, such as the American Cancer Society and the American Legacy Foundation, to ensure that the national network of quitlines will help all smokers quit.

Interested smokers can get the help they need right now from NCI. The NCI Cancer Information Service (CIS) has more than 20 years of experience providing help to smokers trying to quit. Cessation resources available include:

- http://smokefree.gov, a Web site that provides access to quitline numbers currently offered by individual states and NCI, an online guide to quitting, and downloadable cessation guides
- NCI's smoking cessation quitline, staffed by trained cessation counselors (call 1-877-44U-QUIT or TTY at 1-800-332-8615)
- print materials, including the booklet *Clearing the Air* and several fact sheets about smoking and secondhand smoke

In addition, people who contact the CIS at 1-800-4-CANCER (1-800-422-6237) can speak with a trained information specialist about smoking and cancer and can listen to recorded messages about the risks of smoking and tips on quitting. The services of the CIS are supplemented by a real-time, instant messaging site called LiveHelp, where people can "converse" online with an information specialist.

I encourage you to share this information with the smokers that you know, as quitting is one of the most important things they can do for their health. This is an important step forward in our efforts to eliminate suffering and death due to cancer. ◆

Andrew C. von Eschenbach, M.D.
Director, National Cancer Institute

Cancer Research Highlights

Estimating Cancer Risk from X-Rays

Using a new calculation to estimate the risk of cancer from exposure to diagnostic X-rays, Amy Berrington de González, of the University of Oxford, United Kingdom, and Sarah Darby, of Cancer Research UK, suggested in a recent article that in the UK around 700 of the 124,000 cases of cancer diagnosed annually could be attributable to exposure to diagnostic X-rays. The article appeared in the Jan. 31, 2004, issue of *The Lancet*.

The authors' estimate of around 700 additional cancer cases annually in the UK is equivalent to a cumulative risk of cancer to age 75 years of about 0.6 percent. That number rises to 3 percent in Japan, they calculated, the country with the highest estimated annual X-ray use in the world.

Berrington de González and Darby concluded that, "[a]lthough there are clear benefits from the use of diagnostic X-rays, that their use involves some risk of cancer is generally acknowledged. We provide detailed estimates of these risks." Because some of their calculations depended on assumptions, the results were somewhat uncertain.

Peter Herzog and Christina Rieger from Ludwig-Maximilians University Munich, Germany, stated in an accompanying commentary, "Berrington de González and Darby did not assess the indications or benefits achieved for patients in X-ray examinations. Benefits include the earlier detection of cancers by radiological examinations and the possibility of early treatment, which probably allows more cure of cancers than radiological exposure is able to cause."

Radiation Epidemiology Short Course and Lecture Series

Under the direction of Dr. Peter Inskip, NCI's Radiation Epidemiology Branch (in the Division of Cancer Epidemiology and Genetics) will offer a short course from May 4 to 14 on a variety of topics in radiation epidemiology. Speakers include NCI staff and scientists from other government agencies and academic institutions. The course is intended for those who have epidemiology backgrounds and are interested in the health effects of exposure to radiation, particularly the relationship between ionizing radiation and cancer. The course is free but advance registration is required.

The program offers an overview of the radiation epidemiology field, with a focus on radiation-related cancer. It begins with basic radiation physics, dosimetry, radiation chemistry, and radiobiology and continues with presentations on epidemiologic studies of radiation-exposed populations, including atomic bomb survivors in Japan, medically irradiated populations, and persons with occupational or environmental radiation exposures. Methods for quantifying radiation risks, the use of such information in setting radiation protection standards, and risk communication also will be discussed. The course focuses on ionizing radiation but also considers nonionizing radiation. Throughout the course, instructors will stress the importance of radiation dosimetry in epidemiologic studies and highlight key methodologic issues, including challenges in the study of low-dose effects. Possible new sources of radiation exposure and their potential risks will be covered.

For more information on the Radiation Epidemiology Course, please visit http://dceg.cancer.gov/epicourse.html.

NCI to Put Partial-Breast Irradiation to the Test

A clinical trial of partial-breast irradiation (PBI), slated to start in late summer 2004, will test whether this technique is equivalent to radiation treatment of the whole breast.

For early-stage breast cancer, lumpectomy followed by whole-breast irradiation (WBI) is an alternative to mastectomy. But it took 20 years of follow-up data to establish the scientific basis for lumpectomy. Now, PBI must be tested with similar scientific rigor. PBI often involves approximately one week of radiation treatment vs. six weeks of daily radiation for WBI. Since traveling to treatment may be a hardship for some women, the shorter duration of PBI is appealing.

"Many women are seeking out this treatment," said Dr. Paul Wallner of NCI's Radiation Research Program, especially since the Food and Drug Administration (FDA) approved a PBI device in 2002. The FDA, which based its decision on a study involving 25 women, declared the apparatus safe. The agency did not comment on the efficacy of PBI for treating breast cancer.

"We still don't know what types of patients are best suited to PBI, how much radiation to use, how much breast tissue to target, or if the end results will be equivalent to WBI," said Dr. Wallner.

In the Feb. 4, 2004, *Journal of the National Cancer Institute*, Dr. Wallner and colleagues detail issues that need to be addressed before PBI can become standard practice. A clinical trial dealing with these issues will be sponsored by NCI's Cancer Therapy Evaluation Program. Dr. Frank Vicini, of Michigan's William Beaumont Hospital, will head the multisite, 2.5-year study of 3,000 women. ◆

Special Report

Phase II Prostate Trials Use Pre-Prostatectomy Study Design to Identify Promising Prevention Agents and Biomarkers

A short window of opportunity between the histologic diagnosis of prostate cancer and definitive treatment (prostatectomy) is being used in several phase II prostate cancer trials to identify promising prevention agents and biomarker end points. The goal is to obtain key information about the effects of novel study agents on intermediate end point biomarkers (IEBs) and about the distribution of the agent in prostate tissue.

Because prostate cancer has a long natural history, IEBs such as serum markers (e.g., prostate-specific antigen [PSA]), histopathological markers, or tissue-based markers are used to find preliminary evidence of efficacy or biologic activity in phase II trials. Evaluation of these agents may lead to the next generation of phase III chemoprevention trials for prostate cancer.

In this "pre-prostatectomy" trial design, men with early-stage prostate cancer are randomly assigned to receive the study agent or placebo for about 3 to 6 weeks between a diagnostic biopsy and a prostatectomy. Investigators have direct access to prostatic tissue from transrectal ultrasound (TRUS)-guided biopsies and the entire gland following surgery, to systematically assess the biologic activity of agents in the target organ.

This clinical model has the advantage of allowing rapid screening of agents in relatively small, randomized, placebo-controlled pilot trials with 60 subjects or less and that are conducted within the standard of care of patients scheduled for radical prostatectomy, according to Dr. Ronald Lieberman, program director in NCI's Division of Cancer Prevention (DCP) Prostate and Urologic Cancer Research Group.

A variety of agents are being tested with this phase II trial design, including androgen receptor antagonists, anti-inflammatory agents (selective COX-2 inhibitors), vitamin D analogs, and micronutrient antioxidants. (See table.)

"The phase II pre-prostatectomy cancer prevention trials are a practical and efficient way to determine whether the chemopreventive agent concentrates in a man's prostate and has a biologic effect there. This is an important step in selecting agents for more definitive prostate cancer prevention trials," said DCP director Dr. Peter Greenwald.

One of these studies, for example, uses high-grade prostatic intraepithelial neoplasia (HGPIN) as a primary end point for toremifene. Since there is growing evidence that estrogens play a role in the development of prostate cancer, this study is evaluating the effects of toremifene, a selective estrogen receptor modulator. The trial is comparing the percent of HGPIN present in the radical prostatectomy tissue of patients with stage I or II adenocarcinoma of the prostate who were treated with toremifene orally once a day for up to 6 weeks, against the tissue of patients who received observation alone prior to prostatectomy.

Toremifene is the lead chemopreventive agent being developed by GTx, Inc., a Tennessee-based biotechnology company that focuses on men's health issues and is collaborating with DCP on this phase II study. Dr. Joel Nelson, principal investigator for the toremifene study at Hillman Cancer Center at the University of Pittsburgh Cancer Institute, noted that studies using this trial design are examining human tissues after defined exposure to a chemopreventive agent. The 4-week to 8-week lag time from diagnosis of prostate cancer until surgery provides a "unique window of opportunity to examine alterations in the prostate after exposure," he said.

Assuming that a chemopreventive agent will induce alterations after short exposure, the strategy is to identify those alterations and extrapolate to a longer exposure, according to Dr. Nelson. This is significantly easier and more cost effective, particularly in this case when there are so many compelling chemopreventive agents. But the challenges of the model, using

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Investigational Agents for Prostate Cancer Prevention Using Phase II Pre-Prostatectomy Trial Design

Category	Agent	Investigator
androgen receptor antagonists (antiandrogens)	bicalutamide	Donald Urban, University of Alabama
polyamine synthesis inhibitors	DFMO	Donald Urban, University of Alabama
selective estrogen receptor modulators (antiestrogens)	toremifene	Joel Nelson, University of Pittsburgh Cancer Institute
micronutrient antioxidants	vitamin E, selenium, lycopene	Jeri Kim, M. D. Anderson Cancer Center N.B. Kumar, H. Lee Moffitt Cancer Center
soy-derived agents	isoflavones, genistein	N.B. Kumar, H. Lee Moffitt Cancer Center Omer Kucuk, Wayne State University
anti-inflammatory selective COX-2 inhibitors	celecoxib	Michael Carducci, Johns Hopkins University
vitamin D analogs	doxercalciferol	George Wilding, University of Wisconsin
novel proapoptotic inducers	sulindac sulfone	Brad Leibovich, Mayo Clinic

(Special Report continued from page 4)
alterations in tissues as evidence for chemoprevention, remain unproven, he noted. The studies are clearly hypothesis generating, yet they must start somewhere, he stressed.

Dr. Jeri Kim, assistant professor in the Department of Genitourinary Medical Oncology at The University of Texas M. D. Anderson Cancer Center, completed the first phase II trial using this model to study selenium and vitamin E, recruiting 48 patients in 18 months. (See "A conversation with…") The trial used the same regimen currently being used in the Selenium and Vitamin E Cancer Prevention Trial (SELECT) to see if researchers could identify potential surrogate end point biomarkers in that large study. The analysis is still ongoing.

Dr. Lieberman noted that the pre-prostatectomy clinical model provides a way to evaluate both the structure/anatomy of the epithelial compartments (i.e., normal, precancer, and cancer) and the biology/function (specifically, the interface between the epithelium and stroma), which in turn allows investigators to assess the cellular, molecular, and biochemical effects of the experimental agent.

"Furthermore, effects on biomarker modulation can be correlated with changes in histology, proliferation, apoptosis, angiogenesis, and specific molecular targets related to the presumptive mechanism of action(s) of the agent," Dr. Lieberman added.

Evaluating agents for prostate cancer prevention is a major DCP research focus. For instance, the SELECT study has been enrolling a record number of participants to determine if these two dietary supplements can protect against the clinical diagnosis of prostate cancer and the phase III Prostate Cancer Prevention Trial (PCPT) has shown that finasteride can reduce the chances of getting prostate cancer by nearly 25 percent. ◆

A Conversation with Dr. Jeri Kim

Assistant Professor in the Department of Genitourinary Medical Oncology at The University of Texas M. D. Anderson Cancer Center

What makes this group of studies important to the broader research effort aimed at prostate cancer prevention?

The pre-prostatectomy model is important in studying the biological effects of chemopreventive agents in tissue.We have access to the entire organ and therefore the ability to study in detail the effects of a drug in different zones (areas) of the prostate. We can also study differential effects of a drug in normal tissue, in prostate intraepithelial neoplasia, and in prostate cancer. Since most prostate cancer occurs in the peripheral zone of the prostate, we are interested in effects there. If a drug of interest has no effect in the peripheral zone, it may not be useful.

How would you describe the novelty of searching for cancer prevention agents using the pre-prostatectomy model?

We are using the pre-prostatectomy model to study the biological effects of such agents as selenium and vitamin E to complement the national effort already under way to determine whether these agents can prevent prostate cancer. In this process, we will not only confirm the known mechanisms of action of these agents in prostate tissue, but we will also discover new mechanisms of action that may serve as new targets for chemoprevention or therapy for prostate cancer. Additionally, there needs to be a close collaboration among investigators from the laboratory and the clinic so new insights gained from *in vitro* and *in vivo* studies can be confirmed in the clinic and the questions raised from the clinic can be investigated in the laboratory.

What are the advantages and disadvantages of using this pre-prostatectomy cohort for studying novel agents such as selenium and vitamin E?

I think the major advantage, as mentioned, is the fact that we have access to the entire organ for correlative studies. On the other hand, there are disadvantages. Recruiting patients to a pre-postatectomy study using chemopreventive agents is difficult because patients who already have prostate cancer may not directly benefit from these agents and may be reluctant to participate in the study. Also, because chemoprevention studies in prostate cancer use biopsy as an end point (just as in the Prostate Cancer Prevention Trial, or PCPT), biomarkers studied in sections of the prostatectomy specimen will be compared with biopsy specimens of the prostate. ◆

Featured Clinical Trial

Breast Imaging Study

Name of the Trial

Pilot Screening Study of Breast Imaging Outcome Measures in Women at High Genetic Risk of Breast Cancer (NCI-01-C-0009). See the protocol summary at http://cancer.gov/clinicaltrials/NCI-01-C-0009.

Principal Investigator

Dr. Sheila Prindiville of the NCI's Center for Cancer Research and Division of Cancer Epidemiology and Genetics.

Dr. Sheila Prindiville
Principal Investigator

Why Is This Trial Important?

Breast cancer is the second most common type of cancer among women in the United States. Changes in certain genes (BRCA1, BRCA2, and others) increase the risk of breast cancer.

Imaging tests such as magnetic resonance imaging (MRI) or positron emission tomography (PET) scans may improve the ability to detect breast cancer in women who have a genetic risk for the disease. This breast imaging study is exploring whether MRI can detect cancer better than standard mammography in women who have a genetic risk. PET scans are being used for any study participant whose mammogram or MRI findings require additional evaluation. Breast Duct Lavage, a noninvasive technique in which breast cells are washed from the lining of breast milk ducts, is also being studied to determine if cellular or molecular changes in duct lavage fluid can be used to detect cancer before it is clinically detectable.

"We hope that these new breast imaging and nipple fluid sampling techniques will enable us to find breast cancer at an even earlier stage in women who are at high risk of this disease, particularly in younger women for whom mammography is less effective in finding early breast cancers," said Dr. Prindiville.

Who Can Join This Trial?

Researchers seek to enroll approximately 200 healthy women age 25 to 56 from the greater metropolitan Washington D.C. area who are known to carry a BRCA1 or BRCA2 mutation, or who are at higher risk of breast cancer because of their family history. See the full list of eligibility criteria for this trial at http://cancer.gov/clinicaltrials/NCI-01-C-0009.

Where Is This Trial Taking Place?

The breast imaging study is taking place at the National Institutes of Health (NIH) Warren G. Magnuson Clinical Center in Bethesda, Md.

Who to Contact

To speak with the recruitment nurse, Ms. Stephanie Steinbart, call 1-800-518-8474, or call the NCI's Clinical Studies Support Center (CSSC) at 1-888-NCI-1937 (1-888-624-1937). The CSSC provides information about cancer trials taking place on the NIH campus in Bethesda, Md. The call is toll-free and completely confidential.

For more information, visit the study's Web site at http://breastimaging.cancer.gov. ◆

Funding Opportunities

Developmental Projects in Complementary Approaches to Cancer Care

PA-04-053
Application Receipt Dates: June 1, 2004; Oct. 1, 2004; Feb. 1, 2005; June 1, 2005; Oct. 1, 2005

Investigators are invited to submit research grant applications to conduct innovative developmental pilot research investigating complementary approaches in cancer. This PA uses the R21 Developmental/Exploratory Grants award mechanism to encourage and support the development of basic and clinical complementary cancer research and to provide the basis for more extended research projects by establishing the methodological feasibility, strengthening the scientific rationale for these projects, and collecting preliminary data.

For information see http://cri.nci.nih.gov.

Inquiries: Dr. Wendy B. Smith, smithwe@mail.nih.gov

Improving Care for Dying Children and Their Families

PA-04-057
Application Receipt Dates: June 1, 2004; Oct. 1, 2004; Feb. 1, 2005; June 1, 2005; Oct. 1, 2005; Feb. 1, 2006; June 1, 2006; Oct. 1, 2006

NCI seeks R01/R21 applications for research on improving the quality of life for children who are approaching the end of life, the quality of the dying process, and the process of bereavement following the death for the children's families, friends, and other care providers. Research is needed to identify and test approaches that health care providers can implement to improve the care of dying children in all settings.

For information see http://cri.nci.nih.gov.

Inquiries: Dr. Ann O'Mara, omaraa@mail.nih.gov

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(Funding Opportunities continued from page 6)

Cancer Prevention, Control, and Behavioral and Population Sciences Career Development Award

PAR-04-055
Application Receipt Dates: June 1, 2004; Oct. 1, 2004; Feb. 1, 2005; June 1, 2005; Oct. 1 2005

NCI seeks K07 applications from investigators who have made a commitment to focus their research endeavors in cancer prevention, cancer control, and behavioral and population sciences research. Examples of relevant disciplines include any aspect of human cancer prevention; epidemiology; biostatistics; human cancer genetics; clinical oncology; human nutrition; behavioral and social sciences; health promotion, health services, and health policy research; and medical decision analysis, survivorship, and quality of life. This Program Announcement replaces PAR-01-135.

For information see http://cri.nci.nih.gov.

Inquiries: Dr. Lester S. Gorelic, gorelicl@mail.nih.gov

Pharmacogenetics Research Network and Knowledge Base

RFA-GM-04-002
Letter of Intent Receipt Date: July 19, 2004
Application Receipt Date: Aug. 19, 2004

Applications are invited for an open recompetition of the Pharmacogenetics Research Network and Knowledge Base. This is a network of multidisciplinary, collaborative groups of investigators that contribute their data to the publicly available knowledge base PharmGKB, which is an open research tool accessible to all scientists. NCI is interested in projects that can potentially lead to meaningful improvements in clinical and survival end points and in studies of genetic variability in human populations that may influence risk of preneoplastic conditions or primary and secondary malignancies after exposure to medications, including cancer therapies.

For information see http://cri.nci.nih.gov.

Inquiries: Dr. Ken Kobayashi, kobayashik@ctep.nci.nih.gov; Dr. J. Fernando Arena, arenaj@mail.nih.gov ◆

Notes

NCI Appoints New Deputy Director

Dr. Mark Clanton, former president-elect of the American Cancer Society, has been named deputy director for Cancer Care and Delivery Systems at NCI. Dr. Clanton received his M.D. from Tulane University Medical School and his M.P.H. in Health Policy and Management from the Harvard School of Public Health; he also holds a certificate in finance from the Cox School of Business at Southern Methodist University and is a graduate of Howard University. He is a fellow of the American Academy of Pediatrics. With 10 years of experience with managed care and health plan administration, he was the first African American to be promoted to the post of Chief Medical Officer of Blue Cross and Blue Shield of Texas. At Blue Cross, he was the executive responsible for new medical technology assessment, medical policy development, health services research, and leading the pharmacy drug program for more than 1 million members.

3,000 Patients Accrued to Cancer Trials Support Unit

Recently, NCI's Cancer Trials Support Unit (CTSU) achieved a significant milestone when it enrolled its 3,000th patient on a clinical trial. CTSU was created to make NCI-supported Cooperative Group treatment trials more accessible to qualified oncologists and their patients. It also has helped coordinate the multiple Cooperative Group regulatory systems, thereby helping to reduce the administrative burden on physicians participating in these large, multicenter trials. Since opening in October 2000, CTSU now offers a menu of 49 protocols across a variety of common solid tumors and hematologic cancers. Investigators and their staffs can access CTSU at www.ctsu.org, where protocol-specific and general educational materials can be easily downloaded. "CTSU has made it possible for investigators to participate in trials that are best for their patients, even if the trial is not being led by their group. This is helping to shorten the time needed to complete some important protocols, such as CALGB C40101, ECOG 3200 and NCIC-CTG MA.27. The original vision of the CTSU is starting to be realized," said Steve Riordan, CTSU project director.

New Deputy Directors Announced at All-Hands Meeting

Speaking at his second "all-hands" meeting since becoming NCI director, Dr. Andrew C. von Eschenbach announced the establishment of four new deputy director positions that "will be arrayed across the realm of the discovery, development, and delivery continuum," and "help to organize and orchestrate the entire NCI portfolio."

Dr. Anna Barker, currently deputy director for Strategic Scientific Initiatives, has been named deputy director for Advanced Technologies and Strategic Partnerships. Dr. Mark Clanton will serve as deputy director for Cancer Care and Delivery Systems. Negotiations are ongoing with candidates for the position of deputy director for Integrative Biology and Molecular Oncology as well as deputy director for Translational and Clinical Sciences.

NCI at AAAS

Attendees at the 2004 annual meeting of the American Association for the Advancement of Science can visit NCI in the meeting's exhibit hall from Feb. 13 through 16. Attendees will be able to learn about NCI, its research resources, and opportunities for training. ◆

Featured Meetings

This is a list of selected scientific meetings sponsored by NCI and other organizations. For locations and times and a more complete list of scientific meetings, including NCI's weekly seminars and presentations open to the public, see the NCI Calendar of Scientific Meetings at http://calendar.cancer.gov.

2004 NCI Advisory Committee Upcoming Meetings February-March

Date	Advisory Committee
Feb 18-19	National Cancer Advisory Board
Mar 15-16	Clinical Sciences and Epidemiology—Subcommittee 1, Board of Scientific Counselors, NCI
Mar 15-16	Basic Sciences—Subcommittee 2, Board of Scientific Counselors, NCI
Mar 15-16	NCI Board of Scientific Advisors

Selected Upcoming Meetings of Interest

Date	Meeting	NCI Speaker
Feb 11-13	Scientific & Technological Advances in Cancer Research: Integrated Approaches to Effective Detection, Prognosis and Treatment of Cancer	Dr. J. Carl Barrett, Director, Center for Cancer Research
Feb 12-14	Tumor Prevention and Genetics 2004	Dr. Peter Greenwald, Director, Division of Cancer Prevention
Feb 23-26	International Conference on Drug Development	Dr. Andrew C. von Eschenbach, Director
Feb 25-26	Central Florida Health Care Coalition's 11th Annual National Conference	Dr. Ellen Feigal, Acting Director, Division of Cancer Treatment and Diagnosis
Feb 26-28	The Last Miles of the Way Home: National Conference to Improve End-of-Life Care for African Americans	Dr. Harold P. Freeman, Director, Center to Reduce Cancer Health Disparities

NCI Exhibits

Date	Meeting	Location
Feb 12-16	American Association for the Advancement of Science	Seattle, Washington

NCI Exhibits are presented at various professional and society meetings. Further information about the NCI Exhibits Program can be found at: http://exhibits.cancer.gov.

This *NCI Cancer Bulletin* is produced by the National Cancer Institute (NCI). NCI, which was established in 1937, leads a national effort to eliminate the suffering and death due to cancer. Through basic and clinical biomedical research and training, NCI conducts and supports research that will lead to a future in which we can 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://cancer.gov.

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