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THE
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Cancer research news for clinicians

ASCO Annual Meeting: New Approaches For Treatment of Hematologic Malignancies

By Lawrence M. Prescott

ATLANTA—A wide variety of new therapeutic modalities are proving valuable in the treatment of patients with a number of different hematologic malignancies, including B-cell chronic lymphocytic leukemia (B-CLL) chronic myeloid leukemia (CML), and non-Hodgkin's lymphoma (NHL) according to investigators presenting their findings at the recent 42nd annual meeting of the American Society of Clinical Oncology. Following are some highlights of these presentations.

Alemtuzumab in B-CLL

Interim results from an international, comparative, phase III clinical trial comparing alemtuzumab (Campath, Berlex/Genzyme) with chlorambucil (Leukeran, GlaxoSmith Kline) in previously untreated patients with

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Practice Guidelines:

ASCO Updates Guideline On Antiemetics

The American Society of Clinical Oncology has updated its clinical practice guideline recommendations on the use of antiemetics with chemotherapy and radiation.

The guideline update, which also reviews the likelihood of various cancer treatments to cause vomiting, was published in the June 20, print issue of the Journal of Clinical Oncology.

Since the release of an evidence-based clinical practice guideline on the use of antiemetics in 1999, new research is available on treatments to prevent nausea and vomiting in cancer patients. Also, new cancer treatments such as trastuzumab, which treats advanced breast cancer, and erlotinib, which treats metastatic pancreatic and non-small cell lung cancer, are less likely to cause nausea and vomiting.

"Nausea and vomiting can be prevented in most patients undergoing cancer treatment with the right antiemetic treatments," said Mark Kris, lead author of the guideline and chief of the Thoracic Oncology Service at Memorial Sloan-Kettering Cancer Center. "The focus of this guide is not on the treatment of nausea and vomiting, but on its prevention. The best way to handle nausea and vomiting caused by cancer therapy is to prevent it."

Radiation therapy and some types of chemotherapy may cause nausea and vomiting, although not all patients who receive these treatments will have these side effects. The guideline outlines the likelihood of various

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ASCO Meeting: Dasatinib Effective For CML

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progressive B-CLL demonstrated excellent overall efficacy and safety findings with alemtuzumab, even in poor prognosis patients, said Peter Hillmen, consultant hematologist, department of hematology, Leeds General Infirmary, Leeds, U.K.

"Preliminary results of the secondary endpoint of this study showed that alemtuzumab has significantly higher complete and overall response rates compared to chlorambucil," Hillmen stated. "In addition, alemtuzumab is very well tolerated in this setting when given intravenously, certainly with no excess in mortality."

The trial randomized 297 previously untreated patients with progressive B-CLL requiring treatment at 44 medical centers in Europe and the United States. Patients were randomly assigned to alemtuzumab (n=149) 30 mg iv three times per week for a maximum of 12 weeks or chlorambucil (n=148) 40 mg/m^2 orally once every 28 days to a maximum of 12 cycles. Most patients had a performance status of 0-1 (96%) and maximum lymph nodes less than 5 cm (70%). The primary endpoint of the study is progression-free survival (PFS) with secondary endpoints of safety, response, and overall survival.

A prespecified independent interim review of the secondary endpoint data reported a nearly 30 percent greater overall response rate (ORR) among patients treated with alemtuzumab compared to those on chlorambucil, 83% in the alemtuzumab group and 56% in the chlorambucil group ($p<0.0001$). In addition, there was a twelve-fold increase in complete responses in patients receiving alemtuzumab therapy, with a CR of 24% on alemtuzumab versus 2% on chlorambucil ($p<0.0001$).

When comparing the safety profiles of alemtuzumab and chlorambucil, the rates of grade 3-4 thrombocytopenia, anemia, and serious infections were comparable in the two treatment arms. The rates of CMV, neutropenia, and leuko-penia were higher in the patients treated with alemtuzumab, but the difference in the incidence of febrile neutropenia was insignificant between the two treatment arms, being 2.7% in the chlorambucil treatment group and 4.8% on alemtuzumab. In this study, therefore, alemtuzumab was far better tolerated than has been seen in the refractory setting, suggesting that, in the refractory setting, many of the side effects are due to the disease rather than the therapy that was given to the patients.

"In addition to the excellent overall safety and efficacy findings we are observing thus far in this study, we also saw impressive responses in patients with poor prognostic cytogenetic abnormalities who received alemtuzumab, a group of individuals with very low response rates and a short survival when treated with conventional therapy," Hillmen said. "The good results seen with alemtuzumab, however, promise a novel, more effective therapeutic option for these patients with poor risk B-CLL."

Dasatinib in CML Resistant To Gleevec

In an update of the ongoing START-C study, dasatinib (Bristol-Myers Squibb), a novel oral, small-molecule tyrosine kinase inhibitor has proven to offer substantial hematologic and cytogenic activity in patients with chronic phase chronic myeloid leukemia (CML) who were resistant or intolerant to imatinib (Gleevec, Novartis), according to Andreas Hochhaus, professor of internal medicine, Faculty of Clinical Internal Medicine, Heidelberg University, Mannheim, Germany.

"Dasatinib is efficacious in both patients harboring a variety of BCR-ABL mutations associated with imatinib resistance, as well as in patients with BCR-ABL independent resistance," Hochhaus said. "Furthermore, the drug is well tolerated in all phases of CML.

This study is a phase II, multinational, nonrandomized, open-label clinical trial carried out in 20 countries. A total of 387 patients with pH-positive

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CML and chronic phase after resistance or intolerance to imatinib were recruited from 75 centers worldwide. In this group, 75% of patients were imatinib resistant and 25% were imatinib-intolerant. Dasatinib was given at 70 mg twice daily, with dose escalation to 0 mg twice daily in patients lacking response and dose reductions to 50 mg and 40 mg twice daily for toxicity. Evaluation of weekly blood counts were carried

out for the first 12 weeks, with bone marrow cytology and cytogenetics done every three months. The median duration of CML before imatinib resistance was 61 months (range 3 months to 251 months).

Prior therapy was by definition 100% treatment with imatinib, 87% hydroxyurea or anagreilide, and 65% prior interferon alpha. The best response prior to failure of imatinib was a complete cytogenetic response in 19% and a partial cytogenetic response in 17% of patients.

At a median followup of 7.8 months of dasatinib treatment, 90% of 385 patients received a complete hematologic response. Major cytogenetic responses were achieved in 51% of patients, with 40% of these being complete responses. Tests for molecular response showed a gradual decrease of the median BCR-ABL levels in the first six months after dasatinib treatment and an increase in the number of patients with major molecular responses starting at three months after therapy.

Overall, BCR-ABL mutations were discovered in 160 patients, of these 20% were found in the imatinib intolerant group and 52% were reported in the imatinib-resistant group. Independent of the presence or absence of a BCR-ABL mutation, the response rates were similar in patients with imatinib resistance, with 88% of patients without mutations achieving complete hematologic responses compared to 91% in patients with BCR-ABL mutations. The number of major cytogenetic responses and complete cytogenetic responses were comparable in the two groups. Ten month progression-free survival for the overall group, imatinib intolerant and imatinib resistant, was 88%.

Toxicities were usually mild to moderate. These included a reversible cytopenia, fluid retention, rash, diarrhea, and increased activity of liver enzymes. Dose was reduced in 63% of patients and escalated due to lack of efficacy in 12% of patients.

CHOP-R Followed by ^{90}Y Ibritumomab Tiuxetan And Rituximab in Untreated NHL

An abbreviated CHOP (cyclophosphamide, vincristine, doxorubicin, prednisone) plus rituximab (Rituxin, Biogen Idec/Genentech) regimen followed by ^{90}Yttrium ibritumomab tiuxetan (Zevalin, BiogenIdec) effectively induces a high complete response (CR/CRu) rate in previously untreated patients with follicular non-Hodgkin's lymphoma (NHL), reported Nicholas DeMonaco, fellow, hematology/oncology, University of Pittsburgh Cancer Institute, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

"In the imaging phase of the ibritumomab tiuxetan regimen, tumor uptake by indium-111 (^{111}In) after three cycles of CHOP-R was associated with a lower CR rate," DeMonaco said. "Functional imaging with fusion PET-CT scan seems to be a more accurate technique than CT scan alone in determining residual disease in "follicular lymphoma."

The combination of conventional chemotherapy with the monoclonal antibody rituximab in follicular lymphoma has resulted in an improvement of results, with overall response rates of more than 80%, and CR rates of 40% to 80%. A recent analysis of trial outcomes for previously untreated NHL patients suggests that the addition of monoclonal antibody therapy with rituximab or radioimmunotherapy improves overall survival in this disease.

In an attempt to evaluate the efficacy and safety of abbreviated CHOP-R followed by ibritumomab tiuxetan and rituximab in patients with previously untreated follicular NHL, eligible patients received CHOP-R for three cycles, followed by a ibritumomab tiuxetan regimen over 7 to 9 days. On day one, a rituximab 250 mg/m^2 infusion was followed by ^{111}In ibritumomab tiuxetan 5 mi Ci for imaging. Two gamma scans were performed at 2 to 24 hours and 48 to 72 hours after injection. On days 7, 8, or 9, if biodistribution was adequate, a rituximab 250 mg/m^2 infusion was administered, followed by a 10 minute iv infusion of ^{90}Y ibritumomab tiuxetan for therapy. One week after the ^{90} Y ibritumomab tiuxetan dose, patients received rituximab 375 mg/m^2 iv weekly for four doses. Bone marrow examination and fusion positron emission tomography-computed tomography (PET-CT) scans were performed at baseline, after CHOP-R and 12 weeks after radioimmunotherapy. The combined responses were based on IWG criteria, with a stipulation that a negative PET scan was required for a confirmed or unconfirmed complete response (CR/CRu).

At the present time, 30 patients have completed therapy and followup studies and are fully evaluable. Response rates were determined after 3 cycles of CHOP-R and 12 weeks after ibritumomab tiuxetan and rituximab. The CR rate of 35.7% after CHOP-R increased to 89.3% after ibritumomab tiuxetan radiotherapy using

the combined imaging results of the CR rate based on IWG CT criteria (CR rate of 46.4% after CHOP-R improved to 89.3% after radiotherapy) and the proportion of patients with a negative PET scan (63.0% after CHOP-R improved to 96.3% after radiotherapy). The CR rate for patients with tumor uptake by Indium-111 scan was 75% (6 of 8) versus 95% (19 of 20) for patients without tumor uptake by Indium-111 scan after three cycles of CHOP-R. Finally, while early progression-free survival rates are encouraging, with approximately 80% of patients progression-free at 20+ months, much longer followup is needed to evaluate the efficacy of this therapeutic regimen.

Kidney Cancer:

New Drug Combination Shrinks Kidney Cancers

By using a new combination of two anticancer drugs, researchers at Duke University Medical Center have dramatically improved response rates of patients with metastatic kidney cancer, which is now generally considered incurable.

The results suggest that combining the two drugs may slow the disease's progression in significant numbers of patients, although the drug combination is not a cure, said the researchers.

In the study, 40 percent of patients who received the newly approved drug sorafenib together with the established drug interferon-alpha experienced "major shrinkage" of their kidney tumors and tumors that had metastasized, or spread elsewhere. A "major" response is generally is defined as 30 percent or greater shrinkage of all tumors in the body.

In comparison, only 5 percent of patients who receive sorafenib alone show a major response, recent studies have shown. Similarly, just 10 percent to 15 percent of patients who receive only interferon alpha, considered the standard treatment for kidney cancer, show a major response.

"By combining the drugs, we are seeing more major responses in greater numbers of patients, but we don't yet know how long the responses will last," said Jared Gollob, associate professor of medicine and immunology at Duke. "There are great new drugs on the market with relatively low toxicity, but the question physicians now face is how to make them work better for patients."

Gollob presented the findings at the American Society of Clinical Oncology annual meeting in Atlanta.

"Sorafenib alone has been shown to delay progression of kidney cancer, but it induces major responses in only a small percentage of patients," he said. "Interferon alpha has a higher major response rate in kidney cancer, but it does not necessarily slow disease progression. By combining the two therapies, we will hopefully accomplish both goals."

In the current study, Gollob and colleagues at the University of North Carolina, Chapel Hill, used the new combination therapy on 31 patients with metastatic kidney cancer. Among patients who responded, the drug combination shrank both kidney tumors and tumors that had spread to the lungs, liver, pancreas and lymph nodes. The drug also shrank tumors in some patients who had failed to respond to interleukin-2, another drug commonly used for metastatic kidney cancer, the study showed.

Conventional chemotherapy has proved to be a weak weapon against kidney cancer, because the very cells that the drugs attack are programmed to handle toxic substances, Gollob said. The job of renal "tubule" cells is to pump toxic substances from the body into the urine, so these cells are well-equipped to pump out chemotherapy before it can perform its task. Likewise, it is believed that the necessarily hearty constitution of renal cells – tough by nature, given their job -- also makes them resistant to anticancer drugs.

Patients in the Duke study experienced the same type and degree of side effects as would be expected among patients receiving either drug by itself, Gollob said. Sorafenib can cause fatigue, hair loss, diarrhea and skin rash. Interferon alpha can cause fatigue, weight loss, and periodic flu-like symptoms. Patients experienced varying degrees of these symptoms in the study.

Gollob said the next step is to conduct a randomized clinical trial to determine if the drug combination extends progression-free survival, over and above the survival currently seen with sorafenib alone.

Esophageal Cancer:

Docetaxel, Oxaliplatin Active Against Esophageal Cancer

Preliminary findings from a phase II multicenter clinical study indicates that the combination of docetaxel and oxaliplatin is associated with good activity and manageable toxicity in patients with stage IV gastroesophageal and/or stomach cancer.

The preliminary findings were presented by the principal investigator, Donald Richards, of Texas Oncology-Tyler Cancer Center and an affiliate of US

Oncology, at the American Society of Clinical Oncology annual meeting.

"This study shows response rates and overall survival equivalent to any of the front-line regimens currently available for gastric cancer. However, overall toxicity of the treatment is less than reported for many of the regimens," Richards said. "Overall these patients tolerated the treatment very well."

Patients with metastatic (stage IV) AGEJ/S were eligible. Docetaxel 60 mg/m2 IV over one hour was administered followed by oxaliplatin 130mg/m2 over two hours on day one of each 21-day cycle.

Patients were treated until disease progression or unacceptable toxicity; primary endpoints are response rate, toxicity, and progression free and overall survival.

According to the researchers, 70 subjects were enrolled. The median number of cycles delivered was 6 (range, 1-19). Thirty-nine patients (56 percent) have required dose reductions or delay, primarily due to neutropenia, thrombocytopenia, vomiting, neuropathy, and fatigue.

Grade 3-4 toxicities include neutropenia (70 percent); leukopenia and vomiting (17 percent, each); nausea (16 percent); dehydration, fatigue, and diarrhea (13 percent, each), and thrombocytopenia and febrile neutropenia (7 percent, each). Sixty-six patients have completed greater than or equal to 2 cycles. The best overall confirmed response rate, by RECIST, was 23 PR (35.4 percent) for an overall response rate of 35.4 percent.

Clinical benefit rate (CBR=CR+PR+SD greater than or equal to 6 months) was 42 percent. Median time to response was 1.3 months and median duration of response was 4.6 months. Median survival was 9.2 months and median PFS was 4.3 months.

The conclusions showed that the best overall response rate of 35 percent, CBR of 42 percent, and median survival of 9.2 months is encouraging and comparable to other standard front-line regimens.

BRCA1&2:

BRCA2 Carriers Reduced BC Risk By Prophylactic Surgery

A new multicenter study is the first to suggest that the prophylactic removal of the ovaries and fallopian tubes may provide a different benefit for women who carry a genetic mutation in the BRCA2 gene than for those who have a BRCA1 genetic mutation.

The results of the study, presented at the annual American Society of Clinical Oncology meeting, also provide the strongest evidence to date that this surgery significantly reduces the overall risk of BRCA-associated breast and ovarian cancers.

These findings will help doctors to better counsel women who have an inherited predisposition to ovarian and breast cancers and allow tailoring of risk-reduction strategies depending on what particular mutation a woman has inherited, said the study's lead author Noah Kauff, a gynecologist and geneticist at Memorial Sloan-Kettering Cancer Center.

The study followed 886 women over the age of 30 who carry the BRCA1 or BRCA2 genetic mutation. Of this group, 561 opted to have their ovaries and fallopian tubes surgically removed—a procedure called risk-reducing salpingo-oophorectomy—while 325 chose to participate in ovarian surveillance. The women were followed for 40 months via questionnaire or medical review.

The results showed that overall the prophylactic surgery reduced the incidence of ovarian and related cancers by 89 percent and decreased breast cancer incidence by 47 percent. When broken down further, the results indicate that none of the women carrying the BRCA2 mutation who had the surgery developed ovarian cancer, while women carrying the BRCA1 mutation who had the surgery decreased their risk of developing ovarian or related cancers by 87 percent.

The study showed that women with BRCA2 mutations also reduced their risk of developing breast cancer by 72 percent, while those with BRCA1 mutations reduced their risk of breast cancer by 39 percent. Why the results of the procedure differ in BRCA1 carriers and BRCA2 carriers is a question that researchers are exploring, Kauff said.

Clinical Trials:

Communication Is Key To Clinical Trial Enrollment

Clinical trials are widely believed to be among the best treatment options for cancer patients. However, reports show the number of patients who actually decide to enroll in trials is significantly lower than what is needed to efficiently advance cancer research.

According to Terrance Albrecht, program leader for the Communication and Behavioral Oncology Program, Karmanos Cancer Institute, and John Ruckdeschel, lung cancer specialist, president and chief executive officer, Karmanos Cancer Institute, the problem isn't that patients are unwilling to enroll in clinical trials, rather

that patients aren't as fully informed as they could be.

Albrecht and Ruckdeschel led a panel discussion of their study at the annual American Society of Clinical Oncology meeting.

The research study showed two main forms of communication occur between a physician and patient when speaking about clinical trial enrollment. The first form is the legal, or informed, consent. This involves the physician discussing, with the patient, all of the relevant content information of the study. The conversation would include such things as the purpose of the study, a full description of the clinical trial, possible side effects of the research, alternative procedures/treatments and privacy and confidentiality.

The second model of communication used by a physician involves the dynamics of social influence and social support. This is a patient-centered strategy used to discuss clinical trial enrollment with the cancer patient. When facing a cancer diagnosis, often times patients bring family members or friends to an appointment as moral support. For this reason, the conversation between a physician and his/her patient can be more challenging. Not only does the physician need to address the questions and concerns of the cancer patient, but also the questions and concerns of a third party. Physicians need to be made aware of various communication complexities and how to address and deal with them appropriately.

"If you are having a conversation and the person you are talking to constantly interrupts you—steps on the ends of your sentences, presumes to know what you're going to say—that sets up a dominant situation," Ruckdeschel said. "So if a physician continually interrupts a patient or cuts off a family member's sentence, they are prolonging the communication process. Through our study, we're trying to understand how often this happens and the impact it has on clinical trial enrollment."

The study also examines several other factors such as gender, race and religion, and how these factors might affect a patient enrolling in a clinical trial.

"With our study, we hope to find a way to help our physicians more efficiently and effectively provide clinical trial information to their patients," Albrecht said. "There are many factors involved in the communication between a physician and his/her patient. It has a lot to do with education and a patient's knowledge about clinical trials."

Albrecht and Ruckdeschel developed a system for videotaping of the conversations that took place between physicians and their patients considering enrollment into a clinical trial. The video was captured by two small, unobtrusive cameras, with the footage being reviewed by the researchers. The data were then coded (i.e. number of sentence cut-offs in a session, number of times questions are answered in a ten minute period, etc.) and transferred to a database where the information was statistically analyzed.

The preliminary results of the study found that race is not an issue when enrolling a patient in a clinical trial. However, education and gender play a significant role in a patient's decision making process. "Men are more likely not to follow treatment, and younger people are much more likely to try aggressive therapies with higher toxicities than older patients," Albrecht said.

The study also found that a majority of questions during the consultation came from family members or friends of the cancer patients, not the cancer patient themselves.

Ruckdeschel and Albrecht hope to use their findings to train and educate physicians on the process of communication with their patients.

Practice Guidelines:

ASCO Updates Guideline On Use Of Antiemetics

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cancer treatments to cause vomiting using the following metrics:

—High risk, or cancer treatments that nearly always cause vomiting (such as cisplatin).

—Moderate risk, or cancer treatments that usually cause vomiting (such as doxurubicin and irinotecan).

—Minimal risk, or cancer treatments that usually do not cause nausea and vomiting (such as docetaxel or paclitaxel).

—Very minimal risk, or cancer treatments that rarely cause nausea and vomiting (such as methotrexate or vincristine).

Recommended treatments for preventing nausea and vomiting vary, depending on the level of risk associated with the chemotherapy treatment administered. The guideline also provides recommended treatments based on the risks of nausea and vomiting caused by radiation therapy to various parts of the body.

The guideline recommends that antiemetics be taken as prescribed both before and after radiotherapy or chemotherapy as directed by the patient's doctor, since the risk of nausea and vomiting may continue for several days after these treatments. The panel recommends that

oncologists testing antiemetic drugs in clinical trials assess the patient's vomiting and nausea for five days following cancer treatment as a standard for comparison to available treatments

FDA Approvals:

FDA Approves Treatment For Late-Stage Cervical Cancer

The U.S. Food and Drug Administration has approved a combination of Hycamtin (topotecan hydrochloride, GlaxoSmithKline) and cisplatin for use as the first drug treatment for women with late-stage cancer of the cervix when a physician determines that surgery or radiation therapy are unlikely to be effective.

The approval includes a new indication for Hycamtin, which was approved in 1996 for treating ovarian cancer and in 1998 for small cell lung cancer.

The combination of Hycamtin and cisplatin is specifically indicated for women with Stage IVB (incurable), recurrent, or persistent cancer of the cervix which spreads to other organs and is not likely respond to treatment with surgery or radiation.

In clinical trials involving this patient population, 293 patients were randomized to Hycamtin plus cisplatin or to cisplatin alone. Most of the participants had received prior radiation therapy as the standard treatment, while some may have undergone prior surgery. The combination therapy significantly improved survival compared to the use of cisplatin alone. Patients on combined therapy survived (9.4 months), about three months longer than patients on cisplatin alone (6.5 months).

* * *

FDA has given marketing approval for Cesamet (CII) (nabilone, Valeant Pharmaceuticals International) oral capsules, to treat nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional anti-emetic treatments.

Cesamet is a synthetic cannabinoid that is thought to act as an omnineuromodulator, interacting with the cannabinoid receptor, CB1, which is present throughout the nervous system. This receptor is involved in regulating nausea and vomiting.

Cesamet was evaluated for its effectiveness and safety in patients receiving a wide variety of chemotherapy regimens, including low-dose cisplatin in both placebo-controlled and active controlled (prochlorperazine) trials. Efficacy and safety results were derived from 11 well-controlled anti-emetic, double-blind, crossover studies with optional continuation into Cesamet open-label therapy. Either prochlorperazine or placebo was used as the comparator.

The prochlorperazine-controlled studies consisted of two flexible-dose, crossover studies (143 patients of which 112 were evaluable for efficacy) and three fixed-dose, crossover studies (126 patients of which 73 patients were evaluable for efficacy). The placebo-controlled studies were six fixed-dose, crossover studies (199 patients of which 129 were evaluable for efficacy). The crossover studies comprised two cycles of cancer treatment, Cesamet in one cycle and control drug in the other. The order of cycles for each patient was randomized. Efficacy was evaluated by comparing the number of vomits and the severity of nausea.

All statistical comparisons significantly favored nabilone, with the exception of one prochlorperazine-controlled flexible-dose study. However, even in this study, nabilone had a lower overall average frequency of vomits and a lower average severity of nausea score than prochlorperazine.

NCI-Approved Clinical Trials

The National Cancer Institute's Cancer Therapy Program approved the following clinical research studies last month. For further information about a study, contact the principal investigator listed.

Phase I

Phase I Study of Vorinostat (Suberoylanilide Hydroxamic Acid, or SAHA) in Combination with Cytosine Arabinoside (ara-C) and Etoposide for Patients with Relapsed and/or Refractory Acute Leukemias, Myelodysplasias and Myeloproliferative Disorders. University of Maryland Greenebaum Cancer Center, protocol 6829, Ross, Douglas, phone 410-328-3685.

Phase I Trial of Vorinostat and Decitabine in Patients with Relapsed, Refractory or Poor Prognosis Leukemia. MD Anderson Cancer Center, protocol 6878, Issa, Jean-Pierre, phone 713-745-2260.

Phase I Study of PXD101 in Combination with 5-Azacytidine (5-Aza) for Advanced Hematologic Malignancies. University of Chicago, protocol 7285, Odenike, Olatoyosi, phone 773-702-3354.

Phase I Study of Bevacizumab in Combination with SU11248. Case Western Reserve University, protocol 7537, Rini, Brian, phone 216-445-956.

Phase I Trial of Dose Dense (Biweekly) Carboplatin Combined with Paclitaxel and Group Pegfilgrastim: A Feasibility Study in Patients with Untreated Stage III and IV Ovarian, Tubal or Primary Peritoneal Cancer. Gynecologic Oncology Group, protocol GOG-9919, Tiersten, Amy, phone

212-731-5349.

Phase I Study Evaluating the Combination of Lapatinib and Everolimus (RAD001) in Patients with Advanced Solid Tumors. Southwest Oncology Group, protocol S0528, Gadgeel, Shirish, phone 313-`745-8389.

Phase I/II

Phase I/II Pilot Study of Ifosfamide, Carboplatin and Etoposide Therapy and SGN-30 in Children with CD30 + Recurrent Anaplastic Large Cell Lymphoma. COG Phase I Consortium, protocol ANHL06P1, Sandlund, John, phone 901-495-2427.

Phase II

Phase II Study of PXD 101 as Second-Line Therapy for Treatment of Patients with Malignant Mesothelioma. City of Hope National Medical Center, protocol 7255, Ramalingam, Suresh, phone 412-648-6619.

Phase II Study of the Histone Deacetylase Inhibitor PXD101 for the Treatment of Myelodysplastic Syndrome. Mayo Clinic Rochester, protocol 7258, Dipersio, John, phone 314-454-8306.

Phase II Study of PXD101 in Patients with Relapsed or Refractory Acute Myelogenous Leukemia or Patients Over 60 with Newly-Diagnosed Acute Myelogenous Leukemia. City of Hope National Medical Center, protocol 7265, Foon, Kenneth, phone 412-643-5898.

Phase II Study of SB-715992 in Advanced Renal Cell Cancer. University of Michigan University Hospital, protocol 7673, Beekman, Kathleen, phone 734-936-4991.

Randomized Phase II Study to Determine the Effect of 2 Different Doses of AVE0005 (VEGF Trap) in Patients with Metastatic Renal Cell Carcinoma. Eastern Cooperative Oncology Group, protocol E4805, Pili, Roberto, phone 410-502-7482.

Phase III

Phase III Randomized Trial of Gemtuzumab Ozogamicin Mylotarg Combined with Conventional Chemotherapy for De Novo Acute Myeloid Leukemia in Children, Adolescents, and Young Adults. Children's Oncology Group, protocol AAML0531, Gamis, Alan, phone 816-234-3265.

Treatment for Very Low, Low and Standard Risk Favorable Histology Wilms Tumor. Children's Oncology Group, protocol AREN0532, Fernandez, Conrad, phone 902-470-7290.

Randomized Study of Vincristine Dactinomycin and Cyclophosphamide versus VAC Alternating with Vincristine and Irinotecan for Patients with Intermediate-Risk Rhabodomyosarcoma. Children's Oncology Group, protocol ARST0531, Hawkins, Douglas, phone 206-987-3096.

Other

Assessment of SNP Genotypes in Men with prostate Cancer. Eastern Cooperative Oncology Group, protocol E1Y97T1, Hirshfield, Kim, phone 732-235-6028.