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THE
# CLINICAL CANCER LETTER

*Cancer research news for clinicians*

*Breast Cancer:*

## Phase III Trial Of PARP Inhibitor BSI-201 Opens For Triple-Negative Breast Cancer

Sanofi-aventis and its wholly owned subsidiary, BiPar Sciences announced the initiation of the pivotal phase III trial for BSI-201 in combination with chemotherapy in patients with metastatic triple-negative breast cancer (mTNBC), defined by tumors lacking expression of estrogen, progesterone receptors and without over-expression of HER2.

BSI-201 is a novel, investigational, targeted therapy which inhibits poly (ADP-ribose) polymerase (PARP1), an enzyme involved in DNA damage

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*Cancer Survival:*

## Studies Shed Light On Racial Disparities Between Blacks, Whites With Breast Cancer

Black women diagnosed with breast cancer have a greater chance of dying from the disease than white women, according to a new study published online July 7 in the Journal of the National Cancer Institute.

Age-standardized breast cancer mortality rates in the U.S. have remained higher and declined more slowly among black women. This study was undertaken because the underlying causes of this disparity were unclear.

To explore this, Idan Menashe, of the Division of Cancer Epidemiology and Genetics at the National Cancer Institute, and colleagues used the Surveillance, Epidemiology, and End Results program to investigate almost 250,000 women diagnosed with breast cancer from January 1990 through December 2003.

Researchers calculated black-to-white ratios of mortality, incidence, hazard of breast cancer death (probability of dying from the disease), and incidence-based mortality, with some analyses stratified by estrogen receptor (ER) status and age.

The researchers found a statistically significantly higher hazard of death in black women diagnosed with breast cancer compared to whites, especially in the first few years after diagnosis. Hazard rates of breast cancer death declined substantially for ER-positive tumors and modestly for ER-negative tumors but were persistently higher for blacks than whites.

"These differences in hazard may reflect racial differences in response and access to innovations in breast cancer treatment, as well as other biological and non-biological factors," the authors write. "Hence, greater emphasis should be placed on identifying the reasons for these increased hazards among black

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PO Box 9905
Washington DC 20016
Telephone 202-362-1809

## PARP Inhibitor To Be Tested In Phase III Randomized Trial

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repair.

The phase III trial is a multi-center, randomized trial designed to evaluate the safety and efficacy of BSI-201 when combined with gemcitabine and carboplatin (GC) in women with mTNBC. A total of 420 mTNBC patients, who have received 0-2 prior therapies in the metastatic setting, will be randomized to receive GC with or without BSI-201.

The primary objectives of this study are to assess improvement in progression-free survival and overall survival. The secondary objectives are to assess objective response rate and safety. An estimated 60-75 sites will be distributed throughout the U.S.

The trial will have a crossover provision that will ensure that all patients enrolled in the BSI-201 phase III clinical trial have the potential opportunity to receive BSI-201 (patients randomly assigned to the control arm may receive BSI-201 upon disease progression).

Joyce O'Shaughnessy, co-chair of the US Oncology Breast Cancer Research Committee, associate director for clinical research for US Oncology and co-director of the Breast Cancer Research Program at Baylor-Charles A. Sammons Cancer Center and Texas Oncology, will lead the study.

"We are very pleased to be participating in this clinical trial of BSI-201 which is a very promising new treatment for metastatic triple negative breast cancer," said O'Shaughnessy. "We expect that accrual will be very rapid within the US Oncology network and hope that this trial will lead to rapid FDA approval of what appears so far to be a well tolerated and effective therapy."

The decision to commence with the phase III study was made based on phase II study results presented during the plenary session of the American Society of Clinical Oncology annual meeting last May. The phase II clinical trial involved 116 women with metastatic TNBC who were randomly assigned to receive GC in combination with the investigational agent BSI-201 or GC alone.

Approximately 62 percent of patients receiving BSI-201 in combination with GC showed clinical benefit, compared with 21 percent in the group receiving chemotherapy alone ($p = 0.0002$). Tumor response (complete or partial response) was observed in 48 percent of patients who received BSI-201 combined with chemotherapy, whereas patients receiving chemotherapy alone showed a response rate of 16 percent. Women who received BSI-201 had a median progression-free survival of 6.9 months and overall survival of 9.2 months compared with 3.3 and 5.7 months, respectively, for women who received chemotherapy alone. The hazard ratios for progression-free survival and overall survival were 0.342 ($p < 0.0001$) and 0.348 ($p=0.0005$), respectively.

The most common severe (grades 3 and 4) side effects included neutropenia [25/57 in patients treated with GC and BSI-201; 31/59 patients treated with GC alone], thrombocytopenia and anemia. No febrile neutropenia was observed in patients receiving BSI-201 combined with chemotherapy. BSI-201 did not add to the frequency or severity of adverse events associated with chemotherapy.

"We are extremely pleased to be launching the phase III clinical trial so rapidly after the close of the Phase 2 trial," said Barry Sherman, head of clinical development at South San Francisco-based BiPar Sciences, which is developing BSI-201. BiPar is a wholly owned subsidiary of Paris-based sanofi-aventis. "Our primary focus now is enrolling patients in this trial with a similar sense of urgency."

Physicians within the US Oncology network are expected to enroll more than 100 participants in this 420-patient study. Enrollment in the study opened July 17 in centers nationwide.

Patients targeted for the study include adults with histologically documented metastatic breast cancer with measurable disease that is ER-negative, PR-negative,

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and HER2- non-overexpressing. They will receive the chemotherapy combination of gemcitabine/carboplatin with or without BSI-201.

Patients must have measurable metastatic breast cancer with zero to two prior chemotherapy regimens for metastatic disease; adjuvant chemotherapy is allowed.

*Cancer Survival:*

## Survival Rates For Blacks Lower For Some Cancers

(Continued from page 1)

women and on developing new therapeutic approaches to address the disparity."

In another study, also published in this issue, Kathy Albain, of Loyola University Medical Center, found that even when African American patients received the same care as all other patients, their survival rates were lower for breast, prostate and ovarian cancers, but were equivalent for all other major cancers.

Albain and colleagues analyzed records of more than 19,000 patients who participated in phase III cancer clinical trials conducted by the Southwest Oncology Group. "Patients of all races had the same doctors and received the same state-of-the-art treatments," Albain said. "It was a level playing field for everyone. So our findings cast doubt on a widely accepted theory that African Americans' lower survival rates for certain cancers are solely due to such factors as poverty and poor access to quality health care."

Albain's study found no statistically significant association between race and survival for lung cancer, colon cancer, lymphoma, leukemia, or myeloma.

The cancers that did show survival gaps – breast, prostate and ovarian – are gender-related and the survival disparity persisted after adjustment for treatment factors, tumor variables, and socioeconomic status. The findings therefore suggest that the survival gap for these cancers is most likely due to an interaction of tumor biologic factors, hormonal environment, and inherited variations genes that control metabolism of drugs, toxins and hormones, Albain said.

In an accompanying editorial, Otis Brawley, of the American Cancer Society, said results of the Albain et al. study provide evidence that racial differences in the U.S. for certain cancers can be attributed to unequal care. He points out that blacks are less likely to have disease detected early and less likely to receive adequate treatment when it is detected.

The Menashe et al. study, according to Brawley, showed clear differences in mortality by race.

"Taken together, the two studies and others do not suggest that blacks have a different kind of breast cancer, but rather that there are multiple kinds of breast cancer and a higher proportion of black breast cancer patients have the worse kinds," the editorialist writes. "No race has a monopoly on the good kind, nor the bad kind of breast cancer, but the prevalences differ."

*Clinical Trials:*

## Shorter, Simpler Consent Form Proposed For Phase I Trials

Researchers have developed a new, shorter, and simpler consent form that aims to increase cancer patients' understanding of phase I oncology trials, according to a report in the July-August 2009 issue of IRB: Ethics & Human Research.

Such understanding is essential if trial participants are to provide true informed consent. Because current consent forms are excessively long and feature complex language at an above-average reading level, potential trial participants may fail to understand that there is only a small chance of therapeutic benefit from phase I trials.

The research team included Shlomo Koyfman, from the Department of Radiation at the Cleveland Clinic; Mary McCabe, director of the Cancer Survivorship Program at Memorial Sloan Kettering Cancer Center; Ezekiel Emanuel, formerly chief of the Department of Bioethics at the National Institutes of Health and now health policy advisor in the White House Office of Management and Budget; and Christine Grady, acting head of the Department of Bioethics at NIH. All had participated in a previous initiative of the National Cancer Institute to create a simplified consent form template. However, that template was not specific to phase I trials.

"We believe that a simple, clear consent form is an important component of improving the informed consent process for phase I oncology trials," the researchers write.

The new template has a maximum eighth-grade readability level, making it as easy to read as *Reader's Digest*. It is targeted only to phase I cancer trials, is nearly half the length of the average consent form (3.5 pages vs. 6.4 pages), and is translated into Spanish. The researchers are currently developing a randomized controlled trail to evaluate its impact on patient understanding and satisfaction.

*Oncology Practice:*

## How Much Is Life Worth? The $440 Billion Question

The decision to use expensive cancer therapies that typically produce only a relatively short extension of survival is a serious ethical dilemma in the U.S. that needs to be addressed by the oncology community, according to a commentary published online June 29 in the Journal of the National Cancer Institute.

Tito Fojo, of the Medical Oncology Branch, Center of Cancer Research at the National Cancer Institute, and Christine Grady, of the Department of Bioethics, the NIH Clinical Center, tackle the controversy concerning the life-extending benefits of certain cancer drugs and the extent to which their cost should factor in deliberations.

The authors illustrate cost-benefit relationships for several cancer drugs, including cetuximab for treatment of non-small cell lung cancer, touted as "practice changing" and new standards of care by professional societies, including the American Society of Clinical Oncology.

"Is an additional 1.7 months [the additional overall survival for colorectal cancer patients treated with cetuximab] a benefit regardless of costs and side effects?" the authors ask.

According to Fojo and Grady, in the U.S., 18 weeks of cetuximab treatment for non-small cell lung cancer, which was found to extend life by 1.2 months, costs an average of $80,000, which translates into an expenditure of $800,000 to prolong the life of one patient by 1 year.

At this rate, it would cost $440 billion annually to extend the lives of 550,000 Americans who die of cancer annually by one year.

To address the issue, the commentators recommend that studies powered to detect a survival advantage of two months or less should test only interventions that can be marketed at a cost of less than $20,000 for a course of treatment.

Every life is of infinite value, the authors say, but spiraling costs of cancer care makes this dilemma inescapable.

"The current situation cannot continue. We cannot ignore the cumulative costs of the tests and treatments we recommend and prescribe," the authors write.

"As the agents of change, professional societies, including their academic and practicing oncologist members, must lead the way," the authors write. "The time to start is now."

*Kidney Cancer:*

## Sunitinib Prolongs Survival In Poor Prognosis, Study Finds

Sunitinib prolongs progression-free and overall survival, and is safe and well tolerated in advanced kidney cancer (metastatic renal cell carcinoma) patients with a poor prognosis such as the elderly and those whose cancer has spread to the brain, according to an article published online and in the August edition of the Lancet Oncology.

Sunitinib is an oral targeted drug that attacks cancer by inhibiting tumour growth and starving the tumour of blood, reducing its ability to divide and grow. In previous trials sunitinib has shown clear benefit in patients with advanced kidney cancer and has been approved worldwide for first and second-line treatment in these patients.

However, certain patients with advanced kidney cancer—often those with a poor prognosis such as those whose cancer has spread to the brain, those with a poor performance status (PS), and the elderly—are often excluded or inadequately represented in clinical trials. Thus, little is known about the activity, safety, and tolerability of sunitinib in these patients.

To resolve this uncertainty, Martin Gore and colleagues conducted an international expanded-access trial including subgroups of patients with advanced kidney cancer not usually entered into clinical trials, or those being treated in countries where the drug is not yet approved who would not normally receive the drug.

In total, 4,564 patients from 52 countries were recruited between June 2005 and December 2007. These included four subgroups of patients with brain metastases (321), poor performance status (582), non-clear-cell renal cell carcinoma (588), and patients aged 65 years or older (1,418). Patients received 50mg of sunitinib once daily in repeated 6-week cycles of 4 weeks of treatment followed by 2 weeks off. Tumour response, toxicity, and adverse events were assessed at regular intervals.

Overall, findings showed that sunitinib can be given safely and is well tolerated in all four subgroups of patients that might be expected to have a lower tolerance to therapy than the broader advanced kidney cancer patient population. Indeed, the safety profile was found to be very similar to that reported in previous trials and the overall incidence of adverse events was slightly less.

The most common treatment-related adverse events (AEs) were diarrhoea (44%) and fatigue (37%).

Importantly, there were no differences in incidences of grade 3 and 4 AEs between the overall population and patients with brain metastases, poor PS, non-clear RCC, and the elderly—with fatigue (8%) and thrombocytopenia (8%) reported as the most common.

Median progression-free and overall survival were 10.9 and 18.4 months respectively, an improvement on historical data. The overall objective response rate (ORR) was 17%, with all four subgroups showing clear evidence of response—brain metastases (12%), non-clear RCC (11%), poor PS (9%), and the elderly (17%).

The authors say that these results should "encourage the study of targeted agents in subgroups of patients otherwise excluded from trials and therefore potentially disadvantaged."

In an accompanying comment, Joaquim Bellmunt, of the Hospital del Mar, Barcelona, Spain and Dana-Farber Cancer Institute and Harvard Medical School, and Toni Choueiri, Dana-Farber Cancer Institute and Harvard Medical School, write: "As with sorafenib, the safety and efficacy of sunitinib in an older population are confirmed and evidence shows that age alone should not be a deterrent from attempting therapy. However, patients with brain metastases, non-clear-cell histology, and poor performance status benefit less from sunitinib, despite good drug tolerance, suggesting the need for prospective studies in these subpopulations. Thus, claiming sunitinib as a 'standard' in these subgroups remains controversial. An oncologist might not have access to such trials in practice, however, and based on available information the use of sunitinib may be justified in these subpopulations."

*Cancer Diagnosis:*

## Breast MRI Recipients More Likely To Choose Mastectomy

Reviewing the records of 577 breast cancer patients, Fox Chase Cancer Center researchers found that women with newly diagnosed breast cancer who receive a breast MRI are more likely to receive a mastectomy after their diagnosis and may face delays in starting treatment.

The study demonstrates that, despite the lack of evidence of their benefit, routine use of MRI scans in women newly diagnosed with breast cancer increased significantly between 2004 and 2005, and again in 2006.

The study is online and will be appearing in the August edition of the Journal of the American College of Surgeons.

"We have yet to see any evidence that MRI improves outcomes when used routinely to evaluate breast cancer, and yet more and more women are getting these scans with almost no discernable pattern," said Richard Bleicher, a specialist in breast cancer surgery at Fox Chase. "For most women, a breast MRI prior to treatment is unnecessary. MRI can be of benefit because it's more sensitive, but with the high number of false positives and costs associated with the test, more studies are needed to determine whether MRI can improve outcomes in women who have already been diagnosed with breast cancer."

Bleicher and his colleagues reviewed the records of 577 breast cancer patients seen in a multidisciplinary breast clinic where they were evaluated by a radiologist, pathologist, and a surgical, radiation, and medical oncologist. Of these patients, 130 had MRIs prior to treatment.

"Those who received an MRI had a three-week delay in the start of their treatment," said Bleicher. "But more strikingly, we're concerned that the well-documented false-positive rate with MRIs may be leading–or misleading–women into choosing mastectomies."

Bleicher said many of the women would have been candidates for a lesser procedure known as a lumpectomy. "There are a few reasons why we may be seeing higher mastectomy rates when MRIs are performed. An MRI scan is very sensitive, leading to a high number of false-positive findings. Rather than having a biopsy to see if those findings are real, women and their doctors may choose mastectomy out of an abundance of caution. Other studies have demonstrated that this often represents over-treatment because many of the mastectomies are later proven by pathology to have been unnecessary."

The study also revealed that younger women were more likely to have an MRI. "In our analysis, that trend, surprisingly, didn't correspond with various breast cancer risk factors, such as a family history of breast or ovarian cancer, nor with the characteristics of their disease," Bleicher said.

Another research conclusion included the failure of MRI's to help surgeons decrease positive margins during surgery, another hypothesized benefit of MRI.

"MRI is a valuable tool in some women, and these findings do not negate their value in screening women at high risk, such as those with genetic mutations. Without evidence, though, that routine pre-treatment MRI

improves a woman's outcome, its disadvantages suggest that it should not be a routine part of patient evaluation after diagnosis," said Bleicher. "Greater efforts to define MRI's limitations and use are needed."

*FDA Approvals:*

## Opioid Pain Reliever Approved With Risk Reduction Plan

The U.S. Food and Drug Administration approved Onsolis, medication intended for certain patients with cancer to help manage breakthrough pain.

Onsolis is in a class of drugs that deliver the potent opioid fentanyl through the mouth's mucous membranes. Onsolis delivers fentanyl via an absorbable film that sticks to the inside of the cheek. The drug is indicated for the management of breakthrough pain in patients with cancer, ages 18 and older, who already use opioid pain medication around the clock and who need and are able to safely use high doses of an additional opioid medicine. Such patients are considered opioid tolerant because of their current opioid medication use.

Because fentanyl is subject to abuse and misuse, Onsolis was approved with a Risk Evaluation and Mitigation Strategy, or REMS, which is a required plan for managing risks associated with a drug or biological product.

"Onsolis can provide strong pain relief to patients who are opioid tolerant. But for patients who are not opioid tolerant, it can lead to overdose, sudden serious breathing difficulties and death," said Bob Rappaport, director, Division of Anesthesia, Analgesia and Rheumatology Products in the FDA's Center for Drug Evaluation and Research. "For this reason, Onsolis should be prescribed only under the safeguards provided by the FDA-required REMS and by health care professionals knowledgeable about Onsolis and the use of potent opioid medications."

As part of the REMS, Onsolis will only be available through a restricted distribution program called the FOCUS program. Under this program, only those prescribers, patients and pharmacies registered with the program will be able to prescribe, dispense, and receive Onsolis. The FOCUS program will provide training and educational materials to prescribers and pharmacy personnel, and a counseling call will be placed to patients prior to dispensing to ensure they have been adequately educated about the appropriate use of the drug. Prescription orders will be filled only by participating pharmacies that send the product directly to the patients' homes.

Onsolis was approved with a boxed warning, which states that the medication should not be used for the management of migraines, dental pain, or postoperative pain or by patients who use opioids intermittently, or on an as-needed basis. It also warns that the drug should be kept out of the reach of children and should not be substituted for other fentanyl products.

In February, the FDA announced that it would require a REMS for a different class of opioids that offer long-acting and extended-release medication. The FDA has held a series of meetings with stakeholders, including a large public meeting, and also solicited written public comments to hear more about how to develop this REMS.

"The REMS for Onsolis was specifically tailored to that drug and should not be viewed as a model REMS for long-acting and extended-release opioid products," said Douglas Throckmorton, deputy director of CDER. "Developing the comprehensive REMS for these other products is a complex undertaking. We will take the time necessary to review all of the public comments and will proceed in a deliberate manner toward the mutual goals of patient access and patient protection."

Onsolis is manufactured by Aveva Drug Delivery Systems, Miramar, Fla., and marketed under license from BioDelivery Sciences International Inc. of Raleigh, N.C., by Meda Pharmaceuticals Inc., Somerset, N.J.

**FDA approved Alimta** (pemetrexed), the first drug available for maintenance therapy of advanced or metastatic lung cancer.

Patients with cancer often receive maintenance therapy to prevent the disease from progressing after their tumor has shrunk or the disease has stabilized in response to chemotherapy. Alimta disrupts metabolic processes that are dependent on the B-vitamin folate, a necessary ingredient for cell replication.

"This drug represents a new approach in the treatment of advanced non-small cell lung cancer," said Richard Pazdur, director, Office of Oncology Drug Products in the FDA's Center for Drug Evaluation and Research. "Typically, patients whose tumors respond to chemotherapy do not receive further treatment after four-to-six chemotherapy cycles. This study demonstrates an advantage in overall survival in certain patients who received Alimta for maintenance therapy."

Non-small cell lung cancer has several subtypes, including squamous cell, large cell, adenocarcinoma and mixed histology cancers. In a 600-patient clinical trial, people with predominantly squamous cell cancer

did not benefit from Alimta. But those with other subtypes of non-small lung cancer survived an average 15.5 months following treatment compared with 10.3 months for patients who received an inactive substance (placebo). All patients in the study received standard medical care.

Reported adverse events included damage to blood cells, fatigue, nausea, loss of appetite, tingling or numbness in the hands and feet, and skin rash.

Alimta initially was approved in 2004 for the treatment of patients with mesothelioma, a cancer frequently related to asbestos exposure. The drug was later approved for the treatment of patients with non-small cell lung cancer whose disease worsened on prior chemotherapy drugs and also as an initial therapy for advanced non-small cell lung cancer.

Alimta is manufactured by Eli Lilly & Co. of Indianapolis.

**FDA granted full approval for Sprycel** (dasatinib, Bristol-Myers Squibb Co.) for the treatment of adults in all phases of chronic myeloid leukemia (chronic, accelerated, or myeloid or lymphoid blast phase) with resistance or intolerance to prior therapy including Gleevec (imatinib mesylate).

Sprycel, an oral tyrosine kinase inhibitor, was originally approved under the accelerated approval regulations for new drugs for serious or life-threatening illnesses, based on its effectiveness on hematologic and cytogenetic response rates in CML.

The full approval was based in part on results from a phase III randomized, open-label dose optimization study that enrolled 670 chronic phase CML patients with resistance or intolerance to Gleevec. The primary endpoint of this study was major cytogenetic response (MCyR) (0-35 percent Ph+metaphases, which combines both complete and partial responses), in Gleevec-resistant patients. The data included a minimum of two years of follow up after the start of treatment with Sprycel 100 mg once daily, which is the recommended starting dose of Sprycel for chronic phase CML patients resistant or intolerant to Gleevec.

A summary of results from the 167 patients who received SPRYCEL 100 mg once daily include:

—80 percent progression-free survival (95% CI: 73%-87%) estimated rate at two years, based on Kaplan-Meier estimates

—91 percent overall survival (95% CI: 86%-96%) estimated rate at two years, based on Kaplan-Meier estimates

—63 percent of patients achieved MCyR (95% CI: 56%-71%; median duration of treatment was 22 months)

—93 percent of patients who achieved MCyR maintained that response for 18 months (95% CI: 88%-98%), based on Kaplan-Meier estimates

The approved label also now includes a new recommended starting dosage of Sprycel 140 mg once daily for accelerated, myeloid blast and lymphoid blast phase CML resistant or intolerant to prior therapy including Gleevec and Ph+ ALL resistant or intolerant to prior therapy.

Safety data in the labeling encompasses results from seven clinical trials and more than 2,100 patients with CML or Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL). The most frequently reported serious adverse reactions included pleural effusion (11%), gastrointestinal bleeding (4%), febrile neutropenia (4%), dyspnea (3%), pneumonia (3%), pyrexia (3%), diarrhea (3%), infection (2%), congestive heart failure/cardiac dysfunction (2%), pericardial effusion (1%), and central nervous system (CNS) hemorrhage (1%). The most frequently reported adverse reactions (reported in 20% of patients) included myelosuppression, fluid retention events, diarrhea, headache, dyspnea, skin rash, fatigue, nausea and hemorrhage.

## NCI Cooperative Group Clinical Trials Approved

The National Cancer Institute Cancer Therapy Evaluation Program approved the following clinical research studies last month. For further information, contact the principal investigator listed.

**Phase I**

8016 A Phase 1 Study of R-(-)-gossypol (Ascenta's AT-101) in Combination with Paclitaxel and Carboplatin in Solid Tumors. Cancer Institute of New Jersey, Stein, Mark Nathan (732) 235-5773.

ADVL0816 A Phase I Study of Obatoclax (Pan Anti-Apoptotic BCL-2 Family Small Molecule Inhibitor), in Combination with Vincristine/Doxorubicin/Dexrazoxane, in Children with Relapsed/Refractory Solid Tumors or Leukemia. COG Phase 1 Consortium, Aplenc, Richard (267) 426-7252.

S0716 Phase I Study of the Pharmacokinetics and Pharmacodynamics of ZD6474 in Combination with Docetaxel in Advanced Solid Tumors. Southwest Oncology Group, Mita, Monica Mirela (210) 450-1797.

**Phase I/II**

7080 Phase I/II Multicenter Clinical Trial of O6Benzylguanine and Topical Carmustine in the Treatment of Refractory Early-Stage (IA-IIA) Cutaneous T-Cell Lymphoma. Case Western Reserve University, Cooper, Kevin D. (216) 844-3111.

ADVL0912 A Phase 1/2 Study of PF-02341066, an Oral Small Molecule Inhibitor of Anaplastic Lymphoma Kinase (ALK) and C-Met, in Children with Relapsed/ Refractory Solid Tumors and Anaplastic Large Cell Lymphoma. COG Phase 1 Consortium, Mosse, Yael P. (215) 590-0965.

**Phase II**

8070 Phase II Randomized Trial of the Combination of Cetuximab and Sorafenib or Cetuximab and Placebo in Patients with Refractory, Recurrent and/or Metastatic Squamous Cell Carcinoma of the Head and Neck. Moffitt Cancer Center and Research Institute, Gilbert, Jill (615) 343-4677.

8288 Phase II Trial of Cdk Inhibitor SCH 727965 in Mutiple Myeloma. Mayo Clinic Rochester, Kumar, Shaji K. (507) 266-0523.

ACRIN-6687 A Phase 2, Multicenter Evaluation of 18F-Fluoride PET as a Pharmacodynamic Biomarker for Dasatinib, a SRC Kinase Inhibitor, in Men with Castration-Resistant Prostate Cancer and Bone Metastases. American College of Radiology Imaging Network, Yu, Evan Ya-Wen (206) 288-6525.

N0849 Randomized Phase II Trial of Extended Neoadjuvant Therapy for Locally Advanced Adenocarcinoma of the Esophagus, Gastroesophageal Junction, or Gastric Cardia. North Central Cancer Treatment Group, Alberts, Steven R. (507) 284-4918.

S0826 A Phase II Trial of SCH 727965 (NSC 747135) in Patients with Stage IV Melanoma. Southwest Oncology Group, Lao, Christopher D. (734) 615-1775.

S0902 Phase II Study of Bendamustine Plus Rituximab for the Treatment of Refractory B-Cell Chronic Lymphocytic Leukemia. Southwest Oncology Group, Kalaycio, Matt Etem (216) 444-3705.

WFU-08-08-08 Yoga During Breast Cancer Treatment: Establishing Community-Based Partnerships. Wake Forest University Health Sciences, Danhauer, Suzanne C. (336) 716-7980

**Phase III**

GOG-0258 A Randomized Phase III Trial of Cisplatin and Tumor Volume Directed Irradiation Followed by Carboplatin and Paclitaxel vs. Carboplatin and Paclitaxel for Optimally Debulked, Advanced Endometrial Carcinoma. Gynecologic Oncology Group, Matei, Daniela Elena (317) 278-0070.

RTOG-0815 A Phase III Prospective Randomized Trial of Dose-Escalated Radiotherapy with or without Short-Term Androgen Deprivation Therapy for Patients with Intermediate-Risk Prostate Cancer. Radiation Therapy Oncology Group, Martinez, Alvaro (248) 551-7058.

**Other**

ACOSOG-Z4093 Inflammatory and Angiogenic Biomarker Profiles for Early Detection of Lung Cancer. American College of Surgeons Oncology Trials Group, Lee, Jay Moon (310) 794-7333.

ACOSOG-Z4094 Circulating Epithelial Progenitor Cells as a Biomarker for Lung Cancer. American College of Surgeons Oncology Trials Group, Gomperts, Brigitte Nola (310) 267-1780.

CALGB-150901 MicroRNA Profiling Using an Updated Microarray to Prognosticate Early Lung Cancer. Cancer and Leukemia Group B, Yendamuri, Saikrishna S. (716) 845-5873.

CALGB-159905C-ICSC Intrinsic Breast Cancer Subtypes and Benefit of Paclitaxel in CALGB 9344 and Dose Dense Therapy in CALGB 9741. Cancer and Leukemia Group B, Ellis, Matthew James Clifford (314) 362-3447.

GOG-0244 The Lymphedema and Gynecologic Cancer (LEG) Study: Incidence, Risk Factors, and Impact. Gynecologic Oncology Group, Barakat, Richard R. (212)639-2453

NCCTG-N9831(C)-NCCTG-ICSC Round-Robin Clinico-Pathological Review of HER2 Testing in the Context of Adjuvant Therapy for Breast Cancer (N9831, BCIRG 006, and BCIRG 005). North Central Cancer Treatment Group, Perez, Edith A. (507) 284-1159.

NCIC-BR.19-A1C-LICSC Pharmacogenetic Correlative Study of the National Cancer Institute of Canada and U.S. Intergroup BR.19 Study of Post Operative Gefitinib Versus Placebo in Completely Resected Non-Small Cell Lung Cancer. National Cancer Institute of Canada Clinical Trials Group, Liu, Geoffrey (416) 946-4501 ext 3428.

**Pilot**

AMC-064 Evaluation of Serum Free Light Chains and Clonal Ig DNA in Plasma from Patients with Aggressive B-Cell Lymphomas. AIDS-Associated Malignancies Clinical Trials Consortium, Wagner-Johnston, Nina Delaney (314) 362-5654.