THE CANCER LETTER

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Varmus to Cut Five Percent From Centers As NCI Adjusts to "Financial Disaster"

By Paul Goldberg

NCI Director Harold Varmus said he would cut five percent from the NCI cancer centers program.

Varmus announced the magnitude of cuts at a meeting with the editorial board of the Boston Globe May 5.

In the past, the NCI director had mentioned the centers as a potential target for reductions that would have to be made as the institute struggles to operate in what he describes as a "financial disaster."

The centers receive $276.8 million from the institute. A five-percent cut would reduce this amount by $13.8 million.

The Association of American Cancer Institutes said the cut to the centers' core grants "raises serious concerns."

"AACI fully realizes the difficult fiscal environment Dr. Varmus is facing," the association said in a statement. "It should be clear, however, that the large majority of our cancer centers are already undergoing drastic budget reductions due to significant decreases in state funding, institutional

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I-ELCAP:

NEJM, Other Journals Seek Information on Confidential Review of I-ELCAP

By Paul Goldberg and Conor Hale

At least three journals said they asked the former employer of radiologist Claudia Henschke to provide additional information about her clinical research, after learning about a confidential report stating that informed consent couldn't be documented for as much as 90 percent of patients enrolled in a lung cancer screening study she conducted.

Stories about the confidential report to Weill Cornell Medical College, Henschke's former employer, appeared in The New York Times and in The Cancer Letter last week.

"We have asked Weill Cornell for the results of any investigation into this study, and we await their response," said Jennifer Zeis, a spokesman for the New England Journal of Medicine. NEJM published the highest-profile study by the Henschke group, called the International Early Lung Cancer Action Program, in the Oct. 26, 2006 issue.

Henschke left Weill Cornell for Mt. Sinai Medical Center and the Arizona State University Biodesign Institute in 2009, but the results of the independent review were apparently never intended to be made public, doctors accruing patients to the study were not notified, and the experiment continues.

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Editor Gives Henschke, WCMC 30 Days To Respond To Letter

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According to the most recent information, as many as 53,000 patients have now been screened in the I-ELCAP study.

Documents obtained by The Cancer Letter and the Times show that four independent experts who reviewed the I-ELCAP operations center at Weill Cornell in October 2008 also found that the study lacked a prospective sample size calculation, which means that researchers had no way to know when the hypothesis had been tested and the answer obtained. The study can run in perpetuity.

This is important because rules which most medical journals agree to uphold require clinical research to be conducted with informed consent. Ethical conventions require that clinical studies be calibrated to produce an answer.

While NEJM gave Henschke's group its most important publication, other journals could be involved in corrective actions.

Officials at the American Cancer Society, which published I-ELCAP's work and funded some of her studies, said to The Cancer Letter that they have demanded explanations from Weill Cornell. Separately, the editor of The Oncologist, a medical journal, said he is seeking additional information.

Officials at NCI, which funded some peripheral I-ELCAP work, weren't available for comment.

"The ACS is discussing the issue with its editors and its publisher, and it's anticipated that letters will be sent to both the coauthors of the paper and their institutions asking for assurances that IRB oversight of the clinical trial and that patients did sign consent forms," said Otis Brawley, the society's chief medical officer. "We will react depending on the response to those questions."

Responses would determine the range of reactions, Brawley said. "Hopefully, we'll have responses that are reassuring, and there will be no action," he said. "But there could be an expression of concern, with criticism of the authors and retraction of the paper."

Bruce Chabner, editor-in-chief of The Oncologist, said he sent letters to Antonio Gotto, the dean of Weill Cornell Medical College, as well as to Henschke.

"First, we asked them to verify that the review was done as reported and, second, to answer the questions about responses to the significant issues raised by the review, if it's correct. And, third, we asked them what the medical school has done to follow up on those issues."

Chabner said the letters give Henschke and Weill Cornell 30 days to respond.

"At that point, if we don't have an absolute response from them, we'll publish a retraction," Chabner said. The decision would be made at the next meeting of The Oncologist's editorial board, which will be convened at the annual meeting of the American Society of Clinical Oncology in Chicago next month.

For Brawley, this batch of letters is the second in a series.

In March, he received similar information informally and wrote letters to the institutions that employ the investigators.

"They gave me Washington answers," Brawley said. "I would call them responsive to my broad question before, but not responsive to these specific questions brought up from the review of the panel of four as published in The Cancer Letter."

In emails last week, Henschke said that I-ELCAP shouldn't be held to the same ethical and auditing standards as NCI-sponsored cooperative groups, because it's not a cooperative group, and it had never received federal funds for clinical studies.

"The idea that we need to act as if we are an NCI cooperative cancer network that focuses on federally funded randomized treatment trials reflects a lack of understanding of non-federally funded research," she said in an email responding to questions from The

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Times and The Cancer Letter. "I-ELCAP never had the responsibility of obtaining consents from participating patients."

This has been the case since her group's founding in 1992, Henschke said.

"I-ELCAP was conceived as a prospective pooling program rather than performing a meta-analysis after various studies are done," she wrote.

"The responsibility for obtaining consents rested with the individual researchers at each of the collaborating sites. The individual sites validated the consents had been obtained and that all the requirements of the I-ELCAP IRB were met."

The rules of an organization of premier medical journals state that retractions should be considered when editors believe that they published "unethical research." The rules are posted at http://bit.ly/jsej4O.

If consent cannot be documented, as the report states and as Henschke acknowledges, at least some papers could be retracted. PubMed lists 135 papers co-authored by Henschke and collaborator David Yankelevitz.

Moreover, Weill Cornell had an "assurance" with the federal government that research on human subjects would be conducted with proper safeguards, regardless of whether it is funded by the government or private entities. The terms of assurance are posted at http://1.usa.gov/kc0Tfq.

Federal guidelines that apply are posted at http://bit.ly/kBr6wQ.

Henschke said the Weill Cornell IRB didn't oversee the I-ELCAP operations center.

The review committee was chaired by Geoffrey Rubin, then-chief of cardiovascular imaging in Stanford University's Department of Radiology, who has since become chair of the Department of Radiology at Duke University.

Group members were:

• David Carbone, the Harold L. Moses Chair in Cancer Research and director of Specialized Program of Research Excellence in Lung Cancer at Vanderbilt-Ingram Cancer Center,

• Lawrence Goodman, professor of radiology and chief of thoracic imaging at the Medical College of Wisconsin, and

• Steven Piantadosi, director at the Samuel Oschin Comprehensive Cancer Institute at Cedars-Sinai Medical Center.

Weill Cornell paid the reviewers $10,000 each, and all signed non-disclosure agreements. The committee met at Weill Cornell Sept. 11-12, 2008, and produced a report on Oct. 7.

The committee's findings include:

• No sample size calculation for the group's single-arm study had been done.

• The group of researchers who conducted the clinical experiment was not supervised by the institution, either for ethics or validity of science. Given its global reach, "it is surprising that the WCMC administration has avoided direct oversight of this program."

• I-ELCAP leaders acknowledged that they were able to locate only 10 percent of informed consent forms, individuals involved in the review said.

• The reviewers asked for patient data files as well, but there is no evidence that these files have been provided.

"Recruitment of new subjects under the current protocol should be terminated and resources focused on the analysis and follow-up of subjects already enrolled," the review committee wrote.

"We do not believe that accrual of additional subjects will substantially enhance the present conclusion (e.g. that CT screening can detect a substantial fraction of early stage cancers) or provide further strong evidence that such screening should be implemented as a matter of public policy."

Because only 10 percent of informed consents have been documented historically, the investigators should discuss with the WCRC IRB a potential plan for the event that some study subjects do not have valid informed consent on file," the review committee wrote.

DISCLOSURE: ACS Chief Medical Officer Otis Brawley and The Cancer Letter Editor and Publisher Paul Goldberg are co-authors of an upcoming book about the U.S. health care system. The book is scheduled for publication by St. Martin's Press.

FDA News:

FDA Approves Afinitor for pNET; No Word On Sutent For Same Use

FDA approved the Novartis drug Afinitor (everolimus) for progressive neuroendocrine tumors located in the pancreas that cannot be removed by surgery or that have spread to other parts of the body.

The approval leaves open the question of what will happen with another drug, Pfizer's Sutent (sunitinib malate), for the same indication.

The agency presented both applications to the Oncologic Drugs Advisory Committee April 12 (The Cancer Letter, April 15).

After discussion of thorny methodological problems presented by the two applications, ODAC recommended approval for both supplemental New Drug Applications. The committee voted unanimously 10-0 to recommend approval for Afinitor, and 8-2 to recommend approval for Sutent.

Neuroendocrine tumors are rare. There are fewer than 1,000 new cases in the U.S. each year.

"Patients with this cancer have few effective treatment options," Richard Pazdur, director of the Office of Oncology Drug Products in the FDA's Center for Drug Evaluation and Research, said in a statement. "Afinitor has demonstrated the ability to slow the growth and spread of neuroendocrine tumors of the pancreas."

The Afinitor approval was based on a clinical trial in 410 patients with metastatic or locally advanced disease. Patients were selected to receive Afinitor or placebo. The primary endpoint was progression-free survival.

Results from the trial showed that Afinitor more than doubled median PFS from 4.6 to 11.0 months when compared with placebo and reduced the risk of cancer progression by 65 percent (hazard ratio=0.35 [95% CI, 0.27 to 0.45]; $p<0.001$) in patients with advanced pancreatic NET.

In patients treated with Afinitor for neuroendocrine pancreatic tumors, the most commonly reported side effects included stomatitis, rash, diarrhea, fatigue, edema, abdominal pain, nausea, fever, and headache.

Afinitor is also approved to treat advanced renal cell carcinoma after they fail treatment with Sutent (sunitinib) or Nexavar (sorafenib); and patients with unresectable subependymal giant cell astrocytoma associated with tuberous sclerosis.

Afinitor has another trade name, Zortress, and is approved to treat certain adult patients to prevent organ rejection after a kidney transplant. Zortress has a different safety profile in these patients.

The consideration of Afinitor and Sutent made ODAC confront the unprecedented events that can occur in trials that seek to measure delay in progression.

In the beginning, Novartis sought two indications for Afinitor, conducting a randomized study in each. The second trial of Afinitor ran in neuroendocrine tumors of gastrointestinal or lung origin, also known as carcinoid tumors.

In a protocol-specified analysis in the carcinoid indication, investigator review determined that the trial should be stopped because the drug had crossed the threshold of demonstrating efficacy. However, central review came to the opposite conclusion: the trial should be stopped because there is no chance that it would ever demonstrate efficacy.

Novartis ended up with two diametrically opposed conclusions based on the same scans. This was unprecedented in the history of the FDA oncology office, the agency's medical reviewer said at the ODAC meeting.

Days before the meeting, after release of the briefing documents, Novartis notified the agency that it wouldn't seek the carcinoid tumor indication. Prior to that, the company amended the protocol on the pNET indication.

In the Afinitor application, PFS was based primarily on investigator determination, and PFS determined by central review became a secondary endpoint. As a result of making that change in the pNET protocol, the company's Special Protocol Assessment agreement with the agency became invalid.

The pNET indication remained viable because the PFS metrics went in the same direction.

In the case of Sutent, the company had no SPA agreement with the agency.

Pfizer's pNET registration trial was designed to enroll 340 patients. The first interim analysis was to be conducted at 130 PFS events, to assess safety.

Originally, the experiment was monitored by an internal "pharmaco-vigilance group" comprised of Pfizer employees who were independent of the study team.

In 2008, while the trial was in progress, the company followed a guidance published by FDA and changed its standard procedures for monitoring trials.

It formed an independent data monitoring committee comprised entirely of outside experts, none of who were Pfizer employees.

Such groups are charged solely with protecting the interests of patient, as opposed to the interests of

sponsors.

The independent committee took a succession of looks, spaced at six-month intervals. The earlier reviews were conducted primarily for safety purposes, but looked at parameters of efficacy as well, in order to get a better sense of the overall risk/benefit basis for recommending that the study continue or be terminated. Following the second DMC meeting, the group requested to reconvene in three months, rather than six.

When the group met for the third time, it encountered a result that it viewed as stunning. It found what looked like an overwhelming benefit-to-risk relationship in favor of Sutent and recommended that the trial be stopped—and that the control group cross over to the treatment arm.

The board made this recommendation after assessing 73 PFS events and reviewing safety and efficacy data on 154 patients. The board found that there were 15 deaths on placebo and only five on Sutent.

There were 24 PFS events on Sutent and 49 events on placebo. The hazard ratio for PFS was 0.397 (95% CI: 0.243-0.0.649). There were 28 serious adverse events on placebo and 20 such events on Sutent.

President's Cancer Panel Report Warns of Race Bias In Studies

By Conor Hale

The President's Cancer Panel published its report, which focuses on the diverse population of the United States—with its range of demographic, cultural and socioeconomic differences—and how it affects cancer care, treatment and research.

The report, titled "America's Demographic and Cultural Transformation: Implications for Cancer," highlights the problems that face a growing minority population, and what a changing cultural landscape could mean for today's methods of cancer research.

The panel said that the number of minorities with cancer could double over the next 20 years. These populations are disproportionately affected by certain cancers, are often diagnosed at later stages, and have lower survival rates.

Cancer risk and outcomes are influenced by several different, complex factors. In order to personalize treatment for all cancer patients, a wider and deeper understanding of these lifestyle differences and their effects is imperative for success, said the report.

The panel notes that the majority of scientific research into cancer care and treatment—resulting in today's risk factors, treatment regimens and screening guidelines—was conducted with predominately white patients, and might not be fully effective in other populations with different behaviors.

In data collection, the terms of "race," "ethnicity," and "culture" are often confused or used interchangeably, even if they are not consistent, said the report.

"For example, race and ethnicity often are used as proxies for poverty, poor housing/living conditions, lower educational attainment, poor diet and obesity, low physical activity levels, high-risk behaviors (e.g., tobacco use), environmental exposures, and limited access to health care," said the report. "Yet these factors predict poorer health status and outcomes regardless of individuals' socially defined race or ethnic group."

The report warns that scientists should be more aware of institutionalized and unrecognized bias in study questions and when analyzing different populations. Also, categorizing a population under a single heading—such as "Non-Hispanic Whites"—does not allow for important cultural variations and other important health-related differences among subgroups, especially in those of European ancestry. National surveys conducted in such a manner could not be completely accurate, and need to be integrated with local providers for a more detailed picture.

As research explores the molecular and genetic processes behind cancer disease, it has not yet linked that science to health disparities in different populations. African-American men are 50 percent more likely than white men to be diagnosed with prostate cancer, and are twice as likely to be diagnosed with colorectal cancer by age 50.

"While genetic and biologic processes are rooted in the DNA inherited from one's ancestors, they can be modified—sometimes dramatically—by external factors," said the report. "Thus, genetic studies should focus both on the inherited genome and changes to the genome made over the course of a lifetime."

For example, when organized by race, Latinos have a higher risk of dying from stomach, liver and cervical cancers, compared to whites. Those cancers have all been linked to infectious agents. But as stated in the report, lifestyle choices and other factors affect cancer outcomes much more than race.

"Overwhelmingly clear is the fact that in order to advance our control of this disease we must understand the role that culture, habits, and environment play in cancer causation and the cancer treatment experience," said Otis Brawley, chief medical officer of the American Cancer Society. "The report clearly points out that race is a social and not a biologic construct, a point few

Americans understand."

The panel also published an addendum, containing their review of the effects of the Patient Protection and Affordable Care Act, which was passed by Congress last year after most of the report was finalized.

"In addition to increasing health care access, numerous other provisions of PPACA either directly address or potentially facilitate implementation of the Panel's recommendations in this report," the panel said.

The President's Cancer Panel is chaired by LaSalle Leffall, Jr., the Charles R. Drew Professor of Surgery at the Howard University College of Medicine. It includes member Margaret Kripke, the Vivian L. Smith Chair and Professor Emerita at the University of Texas MD Anderson Cancer Center, and executive secretary Abby Sandler of NCI.

Varmus Describes Strategy In Email to All NCI Grantees

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support and philanthropy. A 5% reduction in core grant funding on top of these other cuts would be a major hit.

"AACI shares Dr. Varmus's excitement about the value of independent investigator research, particularly in the area of genomics and molecular epidemiology.

"But AACI is very worried that cuts in the cancer centers' core grants will significantly limit their ability to provide the shared resources, like tissue processing and banking, DNA sequencing, microRNA platforms, proteomics, biostatistics and biomedical informatics, that these investigators need and depend on to complete their research. This infrastructure is expensive, and it is not clear where centers will turn for alternative funding if the current core grant contribution to these efforts is reduced."

The Globe's story on Varmus's talk is posted at http://www.boston.com/news/health/blog/2011/05/federally-funde.html.

On May 6, Varmus described the financial situation in a letter to the institute's grantees.

The text of his letter follows:

I am writing to bring you up to date on the fiscal picture confronting the National Cancer Institute (NCI) for the rest of FY2011 and to ask your help in making the best possible use of the reduced resources available to us this year.

Three weeks ago, Congress passed and the President signed a full-year Continuing Resolution (CR) for the government for FY2011. While the outcome is not as good for the NIH as we would like it to be – and is short of what the agency could use to take advantage of all of the envisioned opportunities and needs – the outcome could have been worse. (For instance, if HR1 had been enacted, not just passed by the House of Representatives, the NIH budget would have been cut by nearly 5%.) Furthermore, it is a relief to end the protracted uncertainties associated with short term CRs

Having said that, pending final resolution of the numbers with the Department of Health and Human Services, the total NIH budget of approximately $30.7 billion represents an almost 1% decrease from the NIH budget in FY2010. This drop reflects two major decreases from last year's NIH appropriated budget level: (i) a $260 million reduction (comprised of a $210 million cut to be distributed proportionately among the Institutes and Centers [ICs] and a $50 million cut in support for NIH buildings and facilities), and (ii) an across-the-board reduction of 0.2% for all discretionary programs. For NCI specifically, these two reductions are approximately $35 million and $10 million, respectively, resulting in an NCI budget of about $5.059 billion for FY2011.

In these constrained circumstances, NCI's first priority is to preserve funding for Research Project Grants (RPGs), to ensure that as many new RPGs as possible are awarded to our investigators, especially our young investigators, to allow them to pursue new ideas. Over the past two years, we have made about 1,250 competing awards of RPGs per year, exclusive of awards made with funds from the Recovery Act (ARRA). This year, for reasons that will be explained below, we will be unable to achieve these numbers; but, by trimming virtually all NCI budget categories, we believe we can award approximately 1,100 new RPGs, while also absorbing the costs of approximately 138 grants initiated with ARRA funds.

We are facing an especially difficult situation at the NCI this year because of several factors that contribute to an increased commitment base. When combined with the smaller budget for FY2011, the enlarged commitment base has reduced the funds available for making new awards. The largest factor is a substantial increase (approximately $40,000) that occurred in the average size of our competing RPGs in FY2010. In addition, as implied above, NCI made a decision in FY2009 to use appropriated dollars in FY2011 and FY2012 to extend some of the grants that were originally awarded with ARRA funds. Furthermore, the money available for new RPGs has been further reduced by costs associated with the ongoing construction of a new administrative facility in Shady Grove, Maryland,

a project that can't be stopped or suspended without much greater losses, although we have been able to cut some costs in existing construction contracts.

NCI has been hit harder by the confluence of such budgetary events than many of our sister ICs. For example, most other ICs sustained increases in the average size of their competing RPGs in FY2009 and were able to absorb that increase in FY2010, whereas the analogous change at the NCI did not occur until FY2010, requiring us to absorb the increase in FY2011. As a result, the measures we must take to preserve core funding for RPGs in FY2011 will need to be correspondingly greater. Thus, while other ICs will be reducing their non-modular, noncompeting (Type 5) awards by 1% below the FY2010 level, NCI will fund all of our noncompeting RPGs, both modular and non-modular, at 3% below the FY 2010 level. This will reduce the NCI's cash shortfall for RPGs by approximately $48 million compared to the hypothetical payment of the same awards at their FY 2010 level.

We recognize that this situation may create difficulties for our current grantees, who already face loss of customary inflationary adjustments – which they had hoped for and which they deserve – but it will allow more than 100 investigators to obtain grants that would otherwise not be made and, thereby, to carry out their highly meritorious projects.

To be able to provide enough funds to support 1,100 new RPGs, as well as the grants initiated with ARRA funds, the NCI also will need to make modest reductions (between 2 and 5%) in virtually all budgets for our many activities – including the intramural programs, contracts at NCI-Frederick and elsewhere, the NCI-designated Cancer Centers, and the operating budgets of all NCI components. Unfortunately, there is simply no way to get through this fiscal situation without taking these largely unprecedented steps. However, for competing awards, the other Institute Directors and I have agreed that the average cost should be as close to FY2010 levels as possible, acknowledging that ICs can't completely control the average costs.

These adjustments still leave us operating at a slight deficit, but one that we believe is manageable. We will continue to track the budget closely and expect to realize savings during the rest of the fiscal year. And if Congress passes the President's budget proposal for FY2012, we will aim to restore the levels of noncompeting awards to what they would have been if the NCI had not taken measures this year that are more severe than those taken by other ICs.

As you can see from the foregoing analysis, this will be a difficult year for the NCI. I am asking for your help and forbearance as we deal with the consequences of reduced appropriations and an increased commitment base, while also trying to maximize the number of competitively awarded research grants. At times like these, we need to make a concerted effort to use our still-considerable resources – more than $5 billion this year – in the best possible way to sustain the pace of discovery, broaden our understanding of cancer as a biological phenomenon, and turn our increased knowledge into better ways to prevent, diagnose, and treat cancers of many types. I am confident that we can do this while we adapt to this year's budgetary stringencies and attempt to improve the situation in the years to come.

Thanks for your understanding and for your devotion to the cause of cancer research.

Harold Varmus
Director, NCI

Note: This message is a slightly edited and updated version of a memorandum sent to all NCI staff on April 27th.

In the Cancer Centers:

Three NIH Scientists Elected to Academy of Arts and Sciences

Three NIH scientists have been elected to the American Academy of Arts and Sciences.

The scientists are: **GISELA STORZ**, a senior investigator and deputy director of the Cell Biology and Metabolism Program in the Eunice Kennedy Shriver National Institute of Child Health and Human Development; **JOSEPH FRANCIS FRAUMENI,** director of the NCI Division of Cancer Epidemiology and Genetics; and **OKIHIDE HIKOSAKA**, senior researcher and chief of the Section of Neuronal Networks in the Laboratory of Sensorimotor Research in the National Eye Institute.

EDWIN POSADAS joined **Cedars-Sinai Medical** Center as the clinical director of the Genitourinary Medical Oncology Program in the Samuel Oschin Comprehensive Cancer Institute.

Posadas has focused on mechanisms through which cancer cells metastasize. The protein FYN, which is a member of a cancer-causing gene family, was identified in his laboratory as a possible regulator.

ROSWELL PARK CANCER INSTITUTE has been named a Blue Distinction Center for Transplants by BlueCross BlueShield of Western New York for demonstrating better overall quality of care and patient results in bone marrow/stem cell (autologous and allogeneic) procedures.

Blue Distinction is a national designation awarded by BlueCross BlueShield companies to medical facilities that have demonstrated expertise in delivering quality healthcare in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery or transplants.

YONG-JUN LIU has been appointed vice president of the **Baylor Research Institute** and chief scientific officer and director of the Baylor Institute for Immunology Research.

Liu is an expert in immunology, particularly the function of immune cells that are central to fighting cancer. He was previously professor and chair of the Department of Immunology, director of the Center for Cancer Immunology Research, and Vivian L. Smith Distinguished Chair in Immunology at MD Anderson Cancer Center.

Before moving to MD Anderson in 2002, he was senior staff scientist at the biotech company DNAX Research Institute of Molecular and Cellular Biology Inc., in Palo Alto, Calif.; maitre de recherche at Laboratory for Immunology Research at Schering-Plough in Dardilly, France; and research fellow in the Department of Immunology at the University of Birmingham, School of Medicine, in Birmingham, England.

Liu developed the first technology for the detection of antigen-specific B cells in situ, which allows the determination of extrafollicular and germinal center reactions, two critical stages of antigen-specific B cell responses in the secondary lymphoid tissues. His laboratory also discovered the human plasmacytoid dendritic cells, a novel cell type in the immune system that is specialized in anti-viral immune responses and implicated in the development of autoimmune diseases.

EDWARD PHILLIPS, executive vice chair of Cedars-Sinai's Department of Surgery, has been elected as a fellow in the **American Surgical Association**, the nation's oldest surgical organization.

He serves at Cedars-Sinai as: director of the Saul and Joyce Brandman Breast Center; chief of the Division of General Surgery; director of the Wasserman Breast Cancer Risk Reduction Program; director of the Center for Weight Loss; and a surgeon at the Colorectal Cancer Center of Excellence.

Funding Opportunities:

AACR and Komen Offer Awards For Breast Cancer Research

THE AMERICAN ASSOCIATION FOR CANCER RESEARCH is opening for nominations for the 2011 AACR Outstanding Investigator Award for Breast Cancer Research, funded by Susan G. Komen for the Cure.

The award recipient will receive $10,000 and deliver a 25-minute lecture at the 34th annual CTRC-AACR San Antonio Breast Cancer Symposium, to be held Dec. 6-10 in San Antonio, Texas.

The award recognizes a scientist who is under 51 years old who is conducting novel and significant work that has had or may have an impact on the etiology, detection, diagnosis, treatment or prevention of breast cancer. Such work may involve any discipline in biomedical research including basic, translational, clinical and epidemiological studies.

Last year's award was presented to Klaus Pantel, professor at the Institute of Tumor Biology at the University Medical Center Hamburg-Eppendorf, Hamburg, Germany. Pantel was honored for his original work on the detection of minimal residual disease and on using this information to provide improved care for breast cancer patients.

The deadline for nominations is May 16.

For more information, email awards@aacr.org or visit http://bit.ly/lwaw2k.

THE HERA WOMEN'S CANCER FOUNDATION has launched the Sean Patrick Multidisciplinary Collaborative Ovarian Cancer Research Award.

The will provide funding for a project focused on the cause, early detection, treatment, or understanding of ovarian cancer. The award is named after Sean Patrick, who founded the foundation in 2002.

This grant application must identify at least two scientists with different yet corresponding skills and explain how these skills will be helpful in addressing the ovarian cancer problem.

The application deadline is June 1. More information is available at http://bit.ly/lSubqd.

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