THE CANCER LETTER

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The Walgreens Connection

ACS Calls on Drug Stores to Stop Tobacco Sales

By Paul Goldberg

Last week, a blistering opinion piece on The New York Times editorial page focused on the coziness of the relationship between the American Cancer Society and Walgreens.

The piece initially triggered criticism by ACS officials, but then—with no fanfare whatsoever—the society's CEO called on the drug store chain, as well as others, to stop selling tobacco products.

ACS isn't spinning this as a reaction to criticism, a change in policy, or a concession to critics. The policy continues to be what it has been, officials say. Yet, the letter specifically mentions the society's benefactor Walgreens by name in a very public forum.

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Conversation with The Cancer Letter

Youle: ACS Stance on Tobacco Sales is Clear

The American Cancer Society prefers to avoid public confrontation with corporate donors, even those who make money by selling tobacco products.

"We have come to the conclusion that in the case of Walgreens, CVS, and other business partners, the best strategy is to work with them rather than against them," said Robert Youle, vice chair of the board of the American Cancer Society and an attorney with the Denver firm Sherman & Howard.

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Eight Years Later

In a Change of Heart, LCA Endorses NLST

By Matthew Bin Han Ong

Almost one decade ago, Laurie Fenton-Ambrose, president and CEO of the Lung Cancer Alliance, described the National Lung Screening Trial as "failed" and "outdated."

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Seffrin's Letter Follows Blistering NYT Op-Ed

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"The society, a leader for decades in scientific research and public education efforts focusing on the lifesaving effectiveness of tobacco control measures, has encouraged CVS and Walgreens to give up tobacco sales throughout the course of our relationship with both companies," Seffrin wrote in a letter to the editor on the Times' opinion page. "Walgreens—and all pharmacies—should stop selling tobacco, and we firmly believe that we will get further faster by working with the pharmacy industry rather than against it to end tobacco-related death and suffering."

Seffrin's letter was published a week after Peter Bach, a pulmonologist who directs the Center for Health Policy and Outcomes at Memorial Sloan Kettering Cancer Center, wrote an editorial stating that the ACS reputation as "a vanguard of tobacco control efforts makes its support of Walgreens particularly sanitizing."

Bach argued that the society's financial ties with Walgreens contributed to its reluctance to challenge the retailer publicly. When a group of health organizations wrote an open letter to all drug retailers urging them to follow the example of CVS and stop selling tobacco products, ACS didn't sign on, Bach noted.

Bach was unable to find out exactly how much Walgreen had contributed to ACS, citing donor privacy. Seffrin's letter in the Times provides at least a part of the answer: last year, Walgreens raised over $6 million for ACS by prompting its retail customers to consider giving $1.00 to the charity, Seffrin disclosed.

"Bach would have us believe that those acts of generosity from its customers somehow bought Walgreens our permission to continue selling tobacco, but that could not be further from the truth," Seffrin wrote.

ACS has repaid Walgreens with awards and accolades to its chief executive for the company's smoking cessation programs for employees and other progressive public health moves.

Next week, for example, Walgreens CEO Greg Wasson and his wife Kim will co-chair the ACS Discovery Ball, a massive fundraising event in Chicago.

But as tobacco control is transformed by CVS's decision to stop selling tobacco products—with the Walgreens competitor possibly forgoing an estimated $2 billion in profits—anti-smoking groups see the potential for making all drug store chains kick tobacco. Walgreens, with more than 8,500 retail outlets, is the next big target.

Some on the outside have been asking whether ACS was using its access to Walgreens to push the drug chain away from the product. The society continues to make assurances that it's doing just that, but the answer isn't publicly known beyond that.

Robert Youle, vice chair of the ACS board, said the society will continue to pursue its strategy of not confronting partners publicly. However, Youle cited Seffrin's letter to the Times as an illustration of the society's public stance against the sale of tobacco.

"I don't see how you can be any less ambiguous than that or any more public than that," Youle said. "I suppose we could have dragged it from an airplane over every city in the country, but I doubt our donors would want us spending their money that way."

Youle's conversation with The Cancer Letter appears on page 1.

Bach responded on Twitter, saying "@AmericanCancer to @Walgreens: stop selling cigarettes. But will society still take their $$'s?"

"Basically the society thinks it can cleanse the proceeds of tobacco sales it gets from Walgreens by putting those funds to good use, maybe," Bach said to The Cancer Letter.

"But that doesn't justify the society promoting Walgreens as a place of health and wellness. They use cigarette sales to attract customers. How about the society adopts a clear and consistent policy: The American Cancer Society won't take money from tobacco wholesalers, manufacturers or retailers, and they

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won't celebrate the people who run those companies."

The stakes are high all around.

When CVS made the decision to forego tobacco sales, the estimated $2 billion in annual revenues it gave up amounts to more than twice the amount of money ACS collects in a year (The Cancer Letter, Feb. 7). However, ACS positions itself as the vanguard of tobacco control, and critics say that close association with a retailer that profits from tobacco undermines the society's own goals and harms its brand.

ACS officials initially responded by defending the society's relationship with Walgreens. An ACS official appears to have attempted to dissuade Bach from publishing the story even before his reporting was completed.

"As I was wrapping up my interviews, Robert Smith, the senior director of cancer screening for the society, emailed me with an 'F.Y.I.,'" Bach wrote in the Times. "He had unearthed a link between Walgreens and my nonprofit hospital, Memorial Sloan Kettering Cancer Center, which has a charity event called 'Cycle for Survival,' which raises money to support research programs in rare cancers. One of the event sponsors is the Duane Reade Charitable Foundation, a nonprofit affiliate of the pharmacy chain Duane Reade, which is owned by Walgreens. Mr. Smith implied that this information could become public if I published my critique, and warned of potential 'blowback.'"

After the story came out, Richard Wender, ACS chief cancer control officer, slammed Bach in a comment posted on the Times website.

"The innuendo asserted here—that our silence can be impacted by fundraising—is shameful and we have the track record to prove it," Wender wrote. "For decades, the American Cancer Society has been an aggressive leader in scientific research and public education efforts focusing on the lifesaving effectiveness of tobacco control measures. We strongly believe that we can have greater impact by working with the Retail pharmacy industry, and have encouraged CVS and Walgreens to give up tobacco sales throughout the course of our relationship with both companies.

"That's why the assertion that there was any meaning behind our decision not to sign on to an open letter is preposterous; we don't need to write a letter when we can just pick up the phone. Let me set the record straight on behalf of our organization: We want all pharmacies and drugstore chains to stop selling cigarettes."

Seffrin joined in, too, pointing out in his letter to the editor the $6 million contributed by Walgreens customers paid for free cancer screening, information and support for the underserved.

In interviews with The Cancer Letter, some ACS officials disagreed with Bach, while others accepted his criticism. However, all agreed that cancer control has been transformed by the CVS decision to stop selling tobacco products, and for the first time there is a reasonable chance that other drug store chains will follow suit.

"Peter Bach is one of the good guys," said Otis Brawley, chief medical and scientific officer of ACS. "The issues that he brings are legitimate issues of concern that need to be dealt with."

The decision not to sign the letter to drug retailers was made in Washington, by the ACS lobbying offshoot ACS Cancer Action Network.

"It never reached Atlanta," Brawley said. "I would have been for signing it, and would have sought consensus to get ACS to sign it."

Of course, ACS had the ability to place phone calls to the Walgreens executive suite, but there is no way for the public to know whether the calls have indeed been made and, if yes, what was said.

Has ACS pressed Walgreens on tobacco? Is it doing so at this time? What's the next step in the society's dealings with Walgreens, whether public or private?

"We asked to meet with their leadership," Wender said to The Cancer Letter. "That meeting was in the works before the Bach article was published. We wanted to talk to them about this issue and about our future relationship with them. It's not unusual. We request to meet with the leaders with a lot of partners. This particular issue of sale of tobacco was very much on the agenda. We don't have a date for the meeting, but it's something that I requested and Lin Mac Master [ACS chief revenue and marketing officer] requested."

Wender said the request was made about three

weeks ago. "I requested to begin by meeting with their senior leadership," Wender said. "I would love to have that conversation with their chief medical officer."

Asked to provide the correspondence requesting the meeting, Wender said the request wasn't made in writing.

Walgreens officials didn't respond to questions submitted by The Cancer Letter.

Smith, an epidemiologist at ACS, wasn't available for an interview. However, Tara Peters, a society spokeswoman, said he didn't intend to try to intimidate Bach. "Bob and Peter are friends," Peters said. "Bob called Peter to explain our relationship with Walgreens. He was simply alerting Peter to the fact that MSKCC has been a recipient of money from Walgreens, so he wouldn't be surprised if someone brought it to his attention. It was a friendly heads-up, and to suggest it was anything other than a friendly exchange between colleagues, is a misrepresentation of the facts."

The public affairs office at MSKCC also received a friendly "heads-up" communication about Bach's reporting and the fact that one of the center's fundraising events received funds from the Duane Reade Charitable Foundation.

"Frankly I was interested to see how it would play out," said Avice Meehan, vice president for communications and chief communications officer at MSKCC. "But more to the point, Peter did not share the piece with us until immediately before publication. He wrote it as an independent commentator/observer. I was aware of the point he was going to make, provided the background he needed, and let folks know what might be headed our way."

Conversation with The Cancer Letter

Youle: Renouncing Tobacco Is in Retailers' Best Interests

(Continued from page 1)

Youle described the society's controversial policy in a conversation with Paul Goldberg, editor and publisher of The Cancer Letter.

Paul Goldberg: *What do you think about the principal point that Peter Bach makes in his piece in The New York Times, which the cordial and financial relationship between the ACS and Walgreens is making the society pull its punches on the issue of tobacco sales by the retailer?*

Robert Youle: Well, I guess the first thing I would say is, I personally and we at the ACS, don't see this as some sort of personal conflict between the ACS and Dr. Bach.

I mean, we respect what he and the folks at Memorial Sloan-Kettering are doing, and we respect his opinion, as expressed in The New York Times piece, although we obviously don't necessarily agree with it.

What I would say is that, and I would assume Dr. Bach would agree with this, is that ACS has been the leader at the forefront of the fight against tobacco from the very beginning, even before the Surgeon General's Report.

We don't believe that anyone should sell tobacco products; we go very public about that. But the question, I guess, is what is the best way to see if we can invoke the kind of change—at least on this side of the table, which would include Dr. Bach—that we would like to see.

We happen to think that being an adversary isn't always the best approach, and what we can be most effective working with retailers like CVS and Walgreens rather than taking shots at them publicly.

So that is sort of the bottom line from our approach. I guess I would say that I look at CVS's business decision as the validation that that approach works.

I can't attribute their decision to our encouragement, but certainly with respect to them, the strategy seems to be well founded.

PG: *I guess ACS walks at different speeds. It is interesting to see that some people did see this as a personal matter between themselves and Peter [Bach], and there was slamming going on.*

RY: I'm telling you that I'm not aware of that, and certainly that is not what I'm prepared to do.

PG: *I hear that very clearly. And calling him and saying "Hey, we have something on your institution too, and there could be blowback." That is a classic intimidation technique.*

RY: I have no personal knowledge if that did or did not happen, in terms of what someone might have said to him, but as far as I'm aware of, no one at ACS has done anything against Dr. Bach, nor do we have any intention of doing so.

PG: *That is good to hear. Now, do you think that ACS should have signed that letter to drug stores, the letter that was cited by Bach? Should the society have taken a uniformly public stance on this matter?*

RY: Those are two very different questions, Paul, in my mind, so let's start on the first one.

Should we have signed onto the letter? My response to that is, no we should not have. I think our decision not to was the right decision.

The reason is that is we have been very public, with respect on our position on tobacco retailing. We couldn't be clearer on the fact that that we don't think anybody should be selling tobacco products, we did not need to sign an open letter to let Walgreens know our feelings on this. Walgreens already knows that.

As I have said before, it would not have been constant with our established practice of working with companies like Walgreens. Rather than working against them, we try to persuade them, like CVS has decided, that a decision to not sell tobacco products is not only in the interest of public health, it's in the interest of their shareholders. That is what we are trying to do, it is our strategy, and is a strategy we intend to continue.

For the second question, and I've almost forgotten,

PG: *Should the society taken a uniformly public stance on this matter?*

RY: I think we have.

PG: *Yeah, well, you could argue that a telephone call is not necessarily a public stance. It's kind of more a private negotiation.*

RY: Well, I don't know whether you have seen, for example, John Seffrin's letter to the editor to The New York Times today. I don't see how you can be any less unambiguous than that or any more public than that. I suppose we could have dragged it from an airplane over every city in the country, but I doubt our donors would want us spending their money that way.

PG: *Well, Peter Bach makes the argument that when ACS gives an award to the Walgreens CEO, it may look like you're basically saying that it's okay to sell tobacco products, kind of a wink, wink.*

Some society officials did mention in response to Peter Bach that they are able to pick up the phone to Walgreens. Should these matters be addressed in private phone calls and public statements directly addressing Walgreens and others in the industry?

RY: Well, I think that we have done both. We have a relationship with Walgreens. We have made it very clear to them that we think it would be good thing for the public and, indeed, for their business model and their shareholders, for them to not sell tobacco products.

We will continue communicating that message to them. Again, we have been completely public on our opposition to the sale of tobacco products.

John's letter to the NYT today was just the latest example, and I don't see how it could be more clear than that.

Do we call out Walgreens by name? No, we do not.

But anybody that reads that letter could not possibly come to the conclusion that the ACS endorses, condones, or in any way supports the sale of tobacco products by anybody. Walgreens or anyone else.

PG: *Are you aware of any ongoing effort on the part of ACS to convince Walgreens to not sell tobacco?*

RY: I'm certainly not privy to, and if I were, I would not disclose the private communications we are having with Walgreens on that subject. But, again, I can tell you they are going on, and Dr. Seffrin's letter is certainly evidence of our position with respect to Walgreens and anyone else.

PG: *What would be the ACS board role in setting these policies?*

RY: Well, it's an issue that has actually come before us on a number of occasions. We enter into these relationships with our eyes wide open, understanding the potential risks and benefits.

And we have come to the conclusion that in the

case of Walgreens, CVS, and other business partners, the best strategy is to work with them rather than against them.

This is something that the board has thought about for many, many years, and I'm sure we will continue to think about. But there are no plans at this point, to change our position, because, frankly, I think it's the right one, and I think that it's working.

PG: *At what point do you think it's not working? Is there a point where you say, 'We are just going public, and you say that this is a terrible thing, let's boycott'?*

RY: I guess I found that my experience tells me that speculating about things like that is not a good thing to do.

What I would say, Paul, is that we continue to monitor the situation as a board, we continue to think about the positions we take, we continue to think about our corporate relationships with every partner, and it's not something that we take lightly. These are decisions we make carefully, and again I think we are doing it the responsible way.

PG: *Do you think the editorial has brought about any evolution of thought on the level of the staff or the board?*

RY: Well, conversations in the sense that it's one bit of information we consider along with many others? Yes, we are aware of it, we have thought about it, but in terms of any change in position, no.

I would say the big game changer here is with CVS.

That is the headline, in my view. Here is a company that has made a decision, at least in the near term, to forgo revenue and profit in favor of a strategy that is more constituent with the public health.

That to me is the headline. And I am hopeful that we will see headlines like that, more and more, to the point where they are so common they are not headlines anymore.

PG: *Do you think we are at the tipping point? We might be.*

RY: I hope so. CVS is a big player. They presumably don't make business decisions like this without thinking through very thoughtfully and carefully. So I hope they have created a tipping point, and I hope that our influence can help that tipping point happen more quickly.

PG: *If you were Walgreens, you would be watching what your competition is doing, and realizing the benefits of doing this? Or how does this work?*

RY: I don't presume to be a decision-maker for Walgreens. But, again, I would hope that as they think about this more, as their thinking evolves, they hopefully in not too long will come to the same conclusion that CVS did.

PG: *Well, that helps a lot, is there anything that we have missed?*

RY: I don't think so. Again, the biggest point of emphasis for me is CVS is a game changer, and lets all salute them.

PG: *Thank you very much.*

Eight Years Later

LCA Recommends CMS Coverage Based on NLST

(Continued from page 1)

At that time, LCA spearheaded an effort to launch a congressional probe of the NLST investigators.

These days, Fenton-Ambrose refers to NLST as "indisputable" and has requested a National Coverage Determination seeking Medicare coverage for lung cancer screening based on the trial's results.

The Centers for Medicare & Medicaid Services' Medicare Evidence Development & Coverage Advisory Committee will hold a hearing on the NCD April 30.

"We base this request for coverage on the indisputable scientific evidence brought forward through the NLST and in anticipation of the release of final favorable recommendations by the United States Preventive Services Task Force, which we hope is completed by the end of this year," Fenton-Ambrose said in LCA's letter to CMS.

This is dramatically different from what Fenton-Ambrose said eight years ago.

"They [NCI] are so wedded to a failed trial that they can't grasp that the technology they are looking at is outdated," Ambrose said at the time (The Cancer Letter, Nov. 3, 2006). "The fact that the result will literally underestimate the benefits of screening ought to be of concern to them. What's going to happen after $220 million, with another four more years before we learn the results, we are going to learn that really screening doesn't help. Why?

"Because they've used technology that is outdated. It will underestimate the value of screening, and they know that."

At the time, LCA's allegations of conflicts of interest led to an inquiry by Reps. John Dingell (D-Mich.) and Bart Stupak (D-Mich.) into the investigators involved in the NLST. Dingell was chairman of the House Committee on Energy and Commerce, and Stupak headed its Subcommittee on Oversight and Investigations (The Cancer Letter, June 13, 2008).

The investigation was launched with considerable breast-beating on the part of legislators, but it petered out without notice.

LCA officials didn't explain their change of heart, saying instead that the NLST should have been done better. Fenton-Ambrose did not personally respond to questions from The Cancer Letter.

"Had the NLST included a uniform protocol for management and follow up as part of its design; had there been more than three rounds of screening; and had the technology been more updated, the mortality benefit would have been even greater," LCA spokesperson Kay Cofrancesco said to The Cancer Letter April 9.

Aberle: LCA Endorsement is "Appropriate"

LCA has been an outspoken proponent of screening. The group endorsed lung cancer screening prior to the emergence of evidence of mortality benefit through randomized trials, said Denise Aberle, national co-principal investigator of the NLST, vice chair of research in the Department of Radiological Science, and professor in the Department of Bioengineering at the University of California, Los Angeles.

"The NLST data were dominant influences on the recommendation of the USPSTF to provide a Grade B recommendation; it is appropriate that the LCA would recommend CMS coverage of screening based on the NLST data," Aberle said to The Cancer Letter.

"Several criticisms have been leveled against the NLST. While no trial is without weaknesses, the vast majority of the lung cancer community has praised the NLST for its methodological rigor, quality of data collection and reporting, standardization of image acquisition and interpretation, statistical analyses, and open access to its data to the entire scientific community.

"It should be understood that guidelines for managing positive screens were created trial-wide, but sites were allowed to manage participants according to local practices."

Aberle was one of the NLST researchers targeted in the congressional investigation.

"Even without strict protocol guidelines, the management of positive screens was fairly consistent across sites: clinical and imaging follow-up were most common, and the number of follow-up scans for positive screens (roughly one) were modest and appropriate relative to what we know now," Aberle said. "The imaging technology platforms evolved as the trial progressed, and ultimately included acquisition parameters currently being promulgated in the imaging community.

"One expects and hopes to see advances in imaging technology over time. Whether fixed management guidelines or the exclusive use of current technological platforms would have altered outcomes is dubious."

While the NLST was accruing patients, LCA was advocating an immediate change of healthcare policy to include computed tomography screening of current and former smokers. The proposed change was to be based on the findings of a single-arm study conducted by the International Early Lung Cancer Screening Program, a group of researchers based at Weill Cornell Medical College.

In a paper in the Oct. 26, 2006, issue of the New England Journal of Medicine, I-ELCAP claimed that their screening regimen could prevent 80 percent of deaths from lung cancer.

Skeptics said that screening could find a lot of

clinically irrelevant disease and lead to overtreatment, and a randomized trial powered to detect mortality, as opposed to survival, was needed to resolve the question.

Soon thereafter, The Cancer Letter reported that the I-ELCAP leaders, who promoted screening and opposed NLST, had failed to make disclosure of intellectual property rights and commercial ties manufacturers of screening equipment, as well as having received research funding from a tobacco company (The Cancer Letter, Jan. 18, 2008).

Medical journals, including the New England Journal of Medicine, the Journal of American Medical Association, Cancer, Cytopathology, The Oncologist, and Nature Clinical Practice Oncology, published corrections, clarifications and editorials stemming from these conflicts.

The assertion that the NLST was relying on outdated technologies was "seriously misinformed," Aberle said at the time (The Cancer Letter, Nov. 3, 2006).

"Frankly, if anything, the NLST has defined imaging standards for clinical trials," Aberle said. "I don't get the motivation behind trying to vilify the NLST. It's one of the most thoughtfully constructed and closely monitored trials ever. The lung cancer community needs to get behind a unified message that more research dollars must go into all areas of lung cancer—prevention, early detection, effective therapies, and response assessment. And we need the correct answers to these."

Now that the trial is concluded and widely endorsed in the lung cancer community, Aberle said recently the greater concern is whether these results can be replicated across community practices.

"The NLST was conducted at largely academic centers with subspecialty expertise," Aberle said to The Cancer Letter. "The medical community and its various organizations will need to collectively establish the criteria for screening centers, including definitions of screen-eligible individuals, scanning parameters and interpretation guidelines, management guidelines, quality assurance, concomitant smoking cessation programs, and minimum data collection to allow us to continuously revise screening paradigms moving forward based on evidence collected in the natural laboratory of clinical practice."

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Funding Opportunity

Defense Department Offering $30.5 Mil In Research Grants

The Department of Defense announced the availability of several grants through its Ovarian Cancer Research Program and its Lung Cancer Research Program.

The program is offering a total of $20 million to support ovarian cancer research and $10.5 million for lung cancer research, both administered by the U.S. Army Medical Research and Materiel Command through the Office of Congressionally Directed Medical Research Programs.

The grants include funding positions at a virtual ovarian cancer academy, including 10-12 early-career investigators, their mentors, a dean and an assistant dean.

Program announcements and general application instructions are available on the Grants.gov website.

The Clinical Translational Leverage Award offers a maximum of $250,000 in funding for direct costs, plus indirect costs, for an independent investigator at or above the level of assistant professor. The award supports leveraging of human-based ovarian cancer resources in translational research to address high-impact research or unmet needs in ovarian cancer. Early-stage clinical trials are allowed, with cost sharing required for applications including a clinical trial. Pre-applications are due June 3. Full applications are by invitation only, and are due Aug. 27.

The Investigator-Initiated Research Award offers a maximum of $450,000 in funding for direct costs in support of meritorious basic and clinically oriented research in ovarian cancer, with impact as an important review criterion. Applicants must be an independent investigator at or above the level of assistant professor. Clinical trials are not allowed and preliminary data are required. Pre-applications are due June 3. Full applications are by invitation only, and are due Aug. 27.

The Ovarian Cancer Academy Award is for early-career investigators within their first three years of their first faculty position or equivalent at the time of submission. The first position may be either tenure or non-tenure track. A designated mentor must be an independent ovarian cancer researcher and at the same institution as the investigator.

The award supports the addition of new early-career investigators to a unique, virtual academy that will provide intensive mentoring, national networking, and a peer group for junior faculty, offering a maximum of $725,000 in funding. An institutional match of

$50,000 per year is required. Preliminary data are required, with a period of performance of five years. Pre-applications are due June 3. Full applications are by invitation only, and are due Aug. 27.

The Ovarian Cancer Academy Leadership Award supports established ovarian cancer researchers with a strong record of mentoring and commitment to leadership. The award will support a dean to oversee the OCRP's interactive academy of 10 to 12 early-career investigators and their mentors, facilitate regular interactive communication among all academy members, and assess research progress and career progression of the early-career investigators.

The award offers a maximum of about $1,000,000 in funding. The dean must be an established ovarian cancer researcher. The award will also support an embedded assistant dean, who must be an independent ovarian cancer research at a different institution. The dean and assistant dean are expected to be partners in leading the academy, and the direct cost funding should be divided accordingly. The period of performance is five years.

Pre-applications are due June 3, and full applications, if invited, are due Aug. 20.

The Pilot Award is available for investigators at or above the postdoctoral level or equivalent, and offers a maximum of $225,000 to support conceptually innovative, high-risk/high-reward research. An additional $75,000 is available for an optional nested Teal Postdoctoral Scholar. Innovation and Impact are important review criteria, and preliminary data are not required, but allowed. Clinical trials are not allowed. Pre-applications are due May 22, and full applications, if invited, are due Aug. 20.

Applications for the ovarian cancer program must be submitted through the Grants.gov portal.

The Lung Cancer Research Program encourages research projects that focus on the following areas of emphasis: noninvasive or minimally invasive tools to improve the detection of the initial stages of lung cancer; screening or early detection of lung cancer, including; molecular mechanisms of progression; and predictive and prognostic markers to identify responders and nonresponders.

The program encourages research projects that are relevant to the health care needs of military service members, veterans, and their families. Investigators are encouraged to consider military relevance, such as the use of military or veteran populations or data in proposed research, or collaboration with DoD or VA investigators.

The Career Development Award is for independent investigators at the level of assistant professor, instructor, or equivalent, within five years of their first faculty appointment. The award requires a mentor at or above the level of associate professor that has a proven publication and funding record in lung cancer research.

Clinical trials not allowed and preliminary data not required, but military relevance is strongly encouraged. The award offers a maximum of $240,000 in funding. Period of performance should not exceed two years. Pre-applications are due June 3, with full applications due Sept. 17.

The Clinical Exploration Award offers a maximum of $450,000 in funding to support execution of hypothesis-driven, early-phase clinical trials to examine interventions that could have a major impact on lung cancer clinical management. It is anticipated that proposed studies will explore innovative and untested concepts to provide scientific rationale or initial proof-of-principle for larger clinical trials in lung cancer.

The application must include documentation of an existing Investigational New Drug or Investigational Device Exemption, if applicable, and requires that independent investigators be at or above the level of assistant professor. The proposed study is expected to begin no later than 12 months after the award date. Pre-applications are due June 3, and full applications are due Sept. 17.

This award's Correlative Studies Option supports studies that derive from ongoing or completed clinical trials that have the potential to significantly inform treatment strategies, identify subset of patients for treatment with specific therapies, provide increased understanding of biological changes resulting from the intervention in lung cancer, or provide other insights that will significantly enhance clinical management of lung cancer. The option offers a maximum of $250,000 in funding.

The Idea Development Award offers a maximum of $350,000 in funding for research in the early stages of development, with an emphasis on innovation and impact. Clinical trials are not allowed. Preliminary data are required, but may be from outside of lung cancer.

The award is for either established independent investigators, at or above the level of assistant professor, or new investigators that have not previously received an idea development award from LCRP, and are within 10 years of their first faculty appointment. Pre-applications are due June 3, and full applications are due Sept. 17.

Lung Cancer Research Program pre-applications must be submitted through the CDMRP electronic Biomedical Research Application Portal.

A listing of all USAMRMC funding opportunities can be obtained on the Grants.gov website by performing a basic search using CFDA Number 12.420.