THE CANCER LETTER

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

Children's Oncology Group To Select New Chairman; Four Leaders To Step Aside

The chairmen of the four U.S. pediatric oncology clinical trials groups that are in the process of merging said they would not be candidates for chairman of the newly formed Children's Oncology Group.

The announcement at the first meeting of the new cooperative group earlier this month removes a potential area of conflict between members of the existing organizations and clears the way for the group to select new leaders later this year, the chairmen said.

"We will not be candidates for the group chair so that the group can have a real 'new beginning' and truly move from the pediatric cooperative

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In Brief:

Plastic Surgeon James French Named To NCAB; Clinton Re-Appoints Nienhuis

FACE LIFT for the National Cancer Advisory Board: President Clinton appointed **James French Jr.** to the board earlier this week. French, of Great Falls, VA, is a clinical assistant professor of plastic surgery at Georgetown University, co-director of the Center for Facial Rehabilitation and former chief of plastic surgery at Fairfax Hospital in Falls Church, VA. The appointment of French follows Clinton's appointment of **Stephen Duffy**, executive vice president of the American Academy of Facial Plastic and Reconstructive Surgery, to the board last month (**The Cancer Letter**, March 17). Also this week, Clinton re-appointed **Arthur Nienhuis** to the board for a full term. Nienhuis, director of St. Jude Children's Research Hospital and professor of pediatrics and medicine at the University of Tennessee School of Medicine, was appointed in 1998 to fill the remainder of former NCAB Chairman **Barbara Rimer's** term. French is a Vanderbilt-trained plastic and reconstructive surgeon and formerly assistant professor at Johns Hopkins University School of Medicine. Previously, he practiced as a plastic surgical consultant to hospitals in Peru and Haiti, and as director of the Children's Facial Rehabilitation Center in Baltimore. He has worked as the chief of plastic surgery of Loch Raven Veteran Administration Hospital, as co-director of the Baltimore Regional Burn Center, and as chief of plastic surgery at the Baltimore City Hospitals. French received a B.A. degree from the University of Arkansas and an M.D. degree from the Louisiana State University School of Medicine. Nienhuis was chief of the Clinical Hematology Branch and deputy clinical director at the National Heart,

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Children's Oncology Group Launches First Protocol

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groups of the 20th century to the Children's Oncology Group of the 21st century," said Archie Bleyer, chairman of the Children's Cancer Group since 1992.

"The fact that none of us gong to stand for chair represents strong leadership and gives new group a new slate to write on," said Sharon Murphy, chairman of the Pediatric Oncology Group since 1992.

William Crist, chairman of the Intergroup Rhabdomyosarcoma Study Group for the past two years, will serve as interim chairman of the COG, and will step down following the group's first election in November or early December.

"The sense is to have a new beginning for the new millennium," said Crist, chairman of pediatric and adolescent medicine at the Mayo Clinic. "The COG is going to be a more effective vehicle than what we've had in the past."

Daniel Green, chairman of the National Wilms' Tumor Study Group, the fourth group involved in the merger, was on vacation and unavailable for comment.

In recent months, significant progress has been made in the formation of the COG:

—COG and the National Childhood Cancer Foundation, of Arcadia, CA, have a Memorandum of Understanding for NCCF to serve as the group's grantee and fundraising organization. A final agreement is expected to be signed in June. The group's operations headquarters will be located in Arcadia.

—COG selected the POG data center at the University of Florida in Gainesville to operate the new group's data center. Jim Anderson of the University of Nebraska will serve as interim COG statistician.

—COG members ratified the group's constitution and formed an interim Executive Committee.

—The first COG protocol was approved three months ahead of schedule. The trial is a randomized study of purged vs. unpurged PBSC transplant following dose intensive induction chemotherapy in patients with high risk neuroblastoma. The study's primary objective is to learn whether elimination of residual neuroblastoma cells improves survival. The secondary objectives are to study a new intensive induction chemotherapy regimen using fenretinide and to evaluate tumor resectability at second-look surgery.

—At the group's first meeting, held in Tampa in mid-April, the COG Nominating Committee was elected by the principal investigators and held its first meeting. The committee will identify candidates for chairman.

—Also in Tampa, the COG Patient Advocate Committee discussed the potential advocate roles and future directions within the new group with representatives from national patient advocate organizations including the Candlelighters Childhood Cancer Foundation, the Children's Cause, the Coalition of National Cancer Cooperative Groups, the Pediatric Brain Tumor Foundation, the Child Life Council, and the NCCF.

"We're still coming together, but all the roadblocks are gone," Crist said. "The groups had different ways of doing things, but we are seeing that the similarities are more than the differences. The administration of the groups have agreed to agree, and you have some actual leadership of the new group."

One of the major issues was where to locate the operations office. NCCF served as the grantee organization for the Children's Cancer Group. "POG in effect had to cede the operations office and turn that over to Arcadia," Crist said. "We have to go from four operations offices to one." POG also will phase out its fundraising organization, POG Foundation Inc.

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World Wide Web: http://www.cancerletter.com

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-362-1681
PO Box 9905, Washington DC 20016
E-mail: kirsten@cancerletter.com or paul@cancerletter.com

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724

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When the final agreement with NCCF is signed, "all the obstacles are gone and the merger is complete," Crist said. "Then there will be the gradual phase-out of the groups and phase-in of protocols, and transfer of legacy data to the new system. But operationally, group will function as one."

Over the next several months, the disease committees of the groups will be merging and selecting new leaders, Crist said. "We have had two chairs and two committees in the same room for two years, so now we are looking for them to merge," he said. If necessary, the interim COG Executive Committee will step in to select committee chairmen, he said.

At the meeting in Tampa, the COG held a luncheon on April 14 attended by 1,500 investigators to celebrate the new group's beginning, and the festive atmosphere infected the entire conference, several participants said.

"It was like a wedding," Murphy said. "Someone said to me that we should have passed out rice to throw."

"There was really a buzz about how well this is actually working out," Bleyer said. "We are together and we are already accomplishing studies together. It was a magnificent meeting."

Bleyer said he was particularly enthusiastic about the group's electronic data entry system which requires all 250 institutional sites to send data over the Internet to the statistical center. "We are the first cooperative group to my knowledge to have accomplished this and require every site to do this," Bleyer said. "This will improve the speed, accuracy, and analysis of study data."

Murphy said one "direct payoff" of the merger is the opportunity to work more effectively with FDA and the pharmaceutical industry. At the Tampa meeting, FDA and NCI officials and a group of pharmaceutical industry scientists met with investigators and patient advocates to discuss FDA's incentives to the industry to test more cancer drugs in children (**The Cancer Letter**, March 10).

The four pediatric groups will remain in existence for about two more years to finish current clinical trials, transfer the data to COG, and report results. "There is still a lot of work to do," Murphy said.

COG is scheduled to submit its first cooperative group funding application to NCI in February 2002. Current NCI funding ends Dec. 31, 2002.

Murphy said she had no regrets about the merger and the eventual phasing out of POG. "I feel that the new group is going to be far superior to what we had," she said. "I feel proud about that. It has been a tremendous amount of work, but gratifying to see it all come together.

"As always, pediatric oncology is a model and we are leading the way in creation of a group that is going to serve our patients and families very well," Murphy said.

COG's next semi-annual meeting is scheduled for Nov. 1-5, in Phoenix.

NCI Programs:
Report Calls For Expansion Of Colorectal Cancer Research

A report to NCI by experts in and advocates for colorectal cancer research calls for expanding the Institute's support for the study of this disease, particularly to promote multidisciplinary collaboration and informatics.

The report by the Colorectal Cancer Progress Review Group was unanimously accepted by the Advisory Committee to the Director, NCI, earlier this week. The Colorectal Cancer PRG was formed last year by NCI as the third in a series of external panels to advise the Institute on progress in and opportunities for research in specific cancers. PRGs on breast and prostate cancer presented reports to NCI in 1998.

The three most pressing needs in colorectal cancer research are linking existing data sets through informatics, better understanding of how to promote screening and early diagnosis, and the development of a biomarker for adenoma, said committee co-chairmen Raymond DuBois, of Vanderbilt University Medical Center, and Bernard Levin, of the University of Texas M.D. Anderson Cancer Center.

NCI should consider funding colorectal cancer "Centers of Excellence" to support better research access to materials and improve communication across disciplines, Levin said. The PRG liked the model of NCI's Early Detection Research Network, in which funded investigators make a commitment to share their data, he said.

NCI Director Richard Klausner said the Institute would analyze the report "as quickly as possible" and would meet with the Colorectal Cancer PRG for a day to discuss implementation plans. He called the report "beautifully written," and said the Institute is working on informatics issues. "We've done a lot of work in the last few months to deal with the NCI approach to informatics, databases, and standards,

as well as policy issues about privacy and sharing," he said. "We are beginning to come up with ways to generalize. That is a theme we are seeing everywhere and one of the most important things we are working on."

About 56,000 people in the U.S. die from colorectal cancer annually, but estimates are that 30,000 lives could be saved each year through better use of screening and early detection, Levin said. "We currently have screening technologies that are only accessed by a minority of the population," Levin said. "We need to find out why that is."

The Colorectal Cancer PRG report's Executive Summary summarized recommendations made by various breakout groups at the PRG Roundtable meeting. The full report is posted at http://planning.cancer.gov/cprgreport.

Biology

Alterations in key signaling pathways are responsible for the biologic behavior of transformed colonic epithelial cells. The fact that specific sets of genes are activated via alterations in signaling makes it possible to uncover potential biological targets for therapy. With regard to studies on the biology of colorectal cancer, two high-priority areas were identified:

1.Define the biological controls for the development of normal and abnormal colorectal epithelial development.

2.Define the pathways of progression of colorectal neoplasia.

Etiology

Gene-environment interactions play an important role in the underlying cause of many cancers, including colorectal cancer. The abundance of data now being generated from the Human Genome Project provides significant opportunities to further delineate the genetic alterations modifying the response to environmental factors that could initiate or promote neoplastic transformation. Three major research priorities were recognized as critical to improving our understanding of the underlying causes of colorectal cancer:

1.Support population-based epidemiologic studies, including special populations, that link genetic polymorphisms, diet and lifestyle variables, and endogenous factors with the molecular characteristics of colorectal cancer and its putative precursor lesions.

2.Validate early and intermediate biomarkers of exposure to environmental influences and genetic polymorphisms.

3.Resequence single nucleotide polymorphism-containing genes involved in carcinogen or hormone metabolism, DNA repair, cell growth control, and immune response and assess their functional polymorphisms in molecular epidemiologic studies in diverse ethnic populations using high-throughput genotyping methods.

Prevention

The goal of prevention is to decrease morbidity and mortality from colorectal cancer. In order to achieve this goal, it is important to delay the progression of early neoplasia or reverse or inhibit the development of invasive cancer. Epidemiologic studies have demonstrated that certain nutritional habits and lifestyle choices are associated with an increased risk of colorectal cancer. Identification of risk factors as well as natural and synthetic agents that modulate cancer risk at the molecular and cellular levels in carcinogen-induced, transgenic, and gene-knockout rodent models are crucial. Three priorities for research in these areas are recognized:

1.Define pathways that can be targets for nutritional and chemopreventive agent interventions.

2.Validate the applicability to early clinical trials of surrogate endpoint biomarkers of colorectal carcinogenesis defined in preclinical animal models.

3.Conduct studies of combined lifestyle and chemopreventive interventions.

Early Detection and Diagnosis

The natural history of colorectal cancer, from dysplastic aberrant crypts to adenocarcinoma, offers multiple opportunities for assessment and intervention. The molecular biology and pathology of colorectal cancer are among the best understood of all human cancers. In the future, early detection of premalignant disease is likely to substantially reduce mortality by decreasing its incidence. To that end, three research priority areas have been identified:

1.Support research into short- to medium-term (5-10-year) strategies for effective implementation of currently recommended methods of early detection at the population level.

2.Conduct rigorous clinical evaluation of promising markers and modalities, especially in adenoma detection, before their implementation at the population level.

3.Support developmental research into new

markers and modalities and improvements of current methods.

Treatment and Prognosis

Many new discoveries in the last decade have the potential for improving the management of colorectal cancer. Current adjuvant treatments are effective in reducing mortality for some patients but are associated with toxicities, which would be unnecessary for those who could be cured by surgery alone or who have tumors insensitive to treatment. The ability to identify such groups before treatment is initiated would represent a great advance in therapy. Moreover, a better understanding of the genetic changes that occur in colorectal cancer offers opportunities to better define prognosis, improve detection, and understand the likelihood of treatment benefits. Such improved understanding may also lead to the development of new, rational and/or targeted treatment opportunities.

1.Enhance local and regional therapy for colorectal cancer by fostering uniform delivery of accepted treatments and the development of new treatment regimens.

2.Expedite new drug development by identification of intermediate endpoints and surrogate markers of response that help to define mechanisms of action and predict clinical efficacy.

3.Comprehensively characterize the biological features of both host and cancer in order to discover new indicators of prognosis and of the likelihood of response to chemotherapy and radiation.

Cancer Control and Survivorship

Cancer control is the conduct of basic and applied research in the behavioral, social, and population sciences that, independently or in combination with biomedical approaches, reduces cancer risk, incidence, morbidity, and mortality. Because the use of cancer screening techniques relies heavily on their acceptance and appropriate use by both health care professionals and the general public, the role for cancer control research in reducing the colorectal cancer burden is significant. To further reduce the burden of colorectal cancer, a vigorous and substantial commitment to basic and applied cancer control research, conducted by scientists from diverse disciplines, is needed. To be successful, this must embrace an approach to research that addresses the behavioral, social, and population factors that affect disease across the continuum of health and illness: from monitoring, prevention, and surveillance in healthy and at-risk individuals; to early detection, treatment, symptom management, and follow-up of those diagnosed; to the provision of compassionate palliative care to those with metastatic disease or dying of their illness.

1.Conduct studies to identify the best standards of follow-up care after successful treatment of colorectal cancer, focusing attention on which tests give the most information about important outcomes such as resectability, survival, cost, and psychosocial distress.

2.Develop mechanisms for identifying people at risk for adverse psychological distress and investigate whether psychosocial factors affect compliance with diagnostic and therapeutic regimens and outcomes (e.g., overall survival, cause-specific survival, disease-free survival, and quality of life).

3.Assess the effectiveness of colorectal cancer screening, prevention, and treatment in elderly and special populations.

Genetics

Key genes responsible for encoding the proteins involved in the pathways that are important for neoplastic initiation and progression of colonic epithelial cells have been identified. This work has led the charge for research on the genetic basis for cancer in general. Three key priorities have been identified to maintain the momentum and continue our progress in understanding the genetic basis for colorectal cancer and to translate this information into clinical trials and clinical practice:

1.Identify the genes that predispose to colorectal cancer (including major and minor alleles of known predisposing genes).

2.Determine how morbidity, quality of life, and mortality are affected by genetic screening and interventions to address human issues (e.g., counseling, disclosure issues).

3.Determine whether there are specific tumor genetic subtypes, how these can be linked to histologic type and other known factors, and how knowledge of such subtypes can be used to improve drug development, intervention selection, and prognosis assessment.

Environment and Lifestyle

Better biological markers of exposure variables need to be developed and intermediate biomarkers of risk identified. Integration of screening and

epidemiological studies is needed, and collaborations between molecular and population scientists will be essential to achieve the desired level of understanding. Opportunities exist for study of populations at lower risk than that of whites, including Native Americans, Hispanics, and Filipinos, as well as those at higher risk, such as the Japanese in Hawaii. Warranting specific study is the finding that rates of death from colorectal cancer among blacks have not declined. Three specific priority areas warrant further research:

1.Integrate observational screening and interventional approaches in future studies.

2.Improve assessment and characterization of lifestyle and environmental factors.

3.Improve the biological coherence of studies by assessing genetic and environmental factors in studies of the etiology and pathogenesis of colorectal cancer.

Partnership Platforms

Greater interaction among the NCI, the Food and Drug Administration, pharmaceutical and biotechnology companies, physicians, and patient advocacy organizations will foster innovative approaches to drug discovery and development. Numerous opportunities exist that can be capitalized on in the near future to enhance such interaction, thus expediting and facilitating the discovery and development of drugs and devices to prevent and treat colorectal cancer.

1.Develop standard agreements for contract or grant award procedures for licensing and intellectual property rights, data collection, and auditing.

2.Develop validated markers of biological activity to facilitate clinical trials, as part of a strategy to link the development of diagnostics and therapeutics.

3.Foster partnerships among oncologists, gastroenterologists, surgeons, and radiologists, as well as pharmaceutical companies, to improve patient access to and facilitate the conduct of clinical trials.

Imaging

Research support is needed to enhance molecular imaging approaches (radiology and nuclear medicine) to evaluation of disease initiation and progression. Research initiatives include the development of suitable imaging systems, signal amplification strategies, and dedicated imaging systems. Further development of helical computed tomography scanning with two- and three-dimensional reconstruction in screening populations is needed. Although early clinical studies are encouraging, research is needed to perfect the technique in the area of bowel preparation, mucosal contrast agents and computer-assisted diagnosis. Outcomes analysis of the efficiency and cost-effectiveness of new imaging techniques is also critical. Three research priorities have been identified as central to these goals:

1.Apply functional and molecular imaging in the selection of screening, surveillance, and treatment strategies to enhance monitoring of chemopreventive and chemotherapeutic responses.

2.Further refine existing and develop novel imaging technologies for the advancement of colorectal cancer screening, staging, and surveillance strategies.

3.Allow for rapid assessment of the benefits and risks of emerging imaging technologies.

Behavioral and Health Services Research

Despite the availability of effective screening and diagnostic modalities for colorectal cancer, only about 40% of the population eligible for screening are actually receiving appropriate screening tests. Three high-priority areas of research will help to understand the problems in this area and lead to improvements:

1.Develop conceptual models and methods that relate to the efficacy, effectiveness, and cost-effectiveness of intervention strategies, including those that increase the use of effective colorectal cancer prevention, screening, diagnostic evaluation, and treatment modalities, as well as those that enhance the quality of care.

2.Characterize variations in patterns of colorectal cancer prevention, screening, diagnostic evaluation, and treatment, including quality of care, for populations, among providers, and in health care systems.

3.Develop and evaluate strategies for (a) improving access to screening, diagnostic evaluation, treatment, and clinical trials and (b) increasing participation in clinical trials of colorectal cancer prevention, screening, diagnostic evaluation, and treatment.

Common Themes Across the Groups

Several common themes emerged from the various breakout groups. Perhaps the most prominent

was the necessity of a multidisciplinary approach to colorectal cancer research to achieve optimal progress. Such an approach will require multidisciplinary training programs in major centers in addition to cross-training of various interested specialties.

Following are the other most prominent themes reiterated among several groups. In general, these themes are related to either challenges confronting the field of colorectal cancer research or opportunities that should be pursued.

Multidisciplinary collaborative efforts, such as SPORES, should be funded to expand research in colorectal cancer. In addition, the research community in general should be supported with technology development centers (for access to shared technology, development of methodology, and training in new methods) and by informatics centers. The latter would be charged with the development of new mathematical or statistical modeling methods for large data sets and the creation and possibly maintenance of databases to which investigators would have free access.

Better models and modeling capability are needed, including cell culture and animal models that reflect the full spectrum of human disease. These resources would greatly enhance research in basic science, epidemiology, the development of "markers" of biologic characteristics in preneoplasia and neoplasia, and developmental therapeutics. Appropriate models for behavioral and outcomes research also need to be developed in order to study and improve the utilization of established screening and treatment guidelines.

More information is needed about the biology and genetics of normal colorectal epithelia and the genetic and biochemical pathway perturbations that occur with neoplastic transformation.

Genetic and biologic studies need to be linked to population-based studies. Potential links to the Cancer Genome Anatomy Project and to the Colon Cancer Cooperative Family Registries are to be fostered.

More information is needed on the role of low-penetrance genetic mutations and the interaction of such mutations with diet and lifestyle risk factors.

Methods of subtyping tumors on the basis of genetic and biologic alterations need to be developed. Likewise, it is essential to define the biologic characteristics of premalignant and malignant lesions, as well as of the host, that indicate the likelihood of neoplastic transformation, recurrence after initial treatment, and favorable response to a particular treatment.

Repositories of tumor tissue and blood are needed and should be linked to clinical databases containing information about risk factors, clinical characteristics, and outcome.

The generalizability of clinical trial results to the general population needs to be assessed. It is estimated that only 2-3% of adults enter clinical trials, and these participants are usually younger than the general population with colorectal cancer or precancer. In addition, most are white and have near-normal organ function. Minority populations, elderly populations, and those with comorbidities need to be studied.

There is a need for increased development of new chemopreventive and therapeutic agents for colorectal cancer. These efforts should include drug design based on targets elucidated by biologic research as well as combinatorial approaches. This effort will also require validation of "markers" of drug target effect. Functional imaging technology needs to be developed to enable the effects of treatment to be ascertained noninvasively and to improve diagnostic ability for premalignant and malignant lesions.

There is a need to assess the penetrance of recommended screening and treatment procedures into the general population, and to assess the outcomes of these practices in the general population, given the reduction of mortality achievable by screening for colorectal cancer.

More research is needed on the behavioral determinants of compliance with screening and treatment recommendations in both majority and minority populations. Research is also needed on the effects of screening and treatment on quality of life.

More information is needed on the epidemiology of colorectal cancer.

Innovative methods to obtain such information, such as nesting epidemiology trials into treatment or prevention trials, should be pursued.

Research is needed across the spectrum of cancer control, including quality of life, stress issues encountered during treatment, the effects of aging, comorbidity, the effectiveness of palliative care and alternative methods of treatment, and the effectiveness and quality of end-of-life care.

Peer review needs to be enhanced with the addition of the expertise that is required to review

multidisciplinary research proposals in prevention, translational research, and behavioral and health sciences research.

The ethical issues involved in genetic and clinical research are challenging. Efforts should be made to achieve a national consensus on the risks and benefits of such research and the acceptability of such research to the public.

Funding Opportunities:

NCI Request for Applications

RFA CA-01-002: Comprehensive Minority Institution/Cancer Center Partnership

Letter of Intent: June 8, 2000

Application Receipt Date: July 26, 2000

NCI and the NIH Office of Research on Minority Health invite cooperative agreement applications for the establishment of comprehensive CMI/CC Partnerships between minority-serving institutions and NCI-designated cancer centers. Both MSIs with medical schools and MSIs with more focused education and research programs—Masters and Ph.D. Programs—are invited to participate in this initiative. The RFA will use the NIH cooperative specialized center U54 award mechanism.

Inquiries: Sanya Springfield, chief, CMBB, OCTR, ODDES, NCI, 6116 Executive Blvd., Suite 700, Bethesda, MD 20892-8347, phone 301-496-7344; fax 301-402-4551; e-mail springfs@mail.nih.gov or Brian Kimes, director, OCTR, phone 301-496-8537; fax 301-402-0181; e-mail kimesb@mail.nih.gov

NCI Cancer Prevention Fellowship Program

Application Deadline: Sept. 1,2000

Appointment Start Date: July 1, 2001

The program is offered to M.D's, other clinicians, and Ph.D's to train in the field of cancer prevention and control. Fellows may obtain Masters of Public Health training at an accredited university during the first year of their fellowship, which is followed by independent research assignments in cancer prevention and control at the NCI Bethesda, Rockville and Frederick, MD facilities.

The NCI Summer Curriculum in Cancer Prevention will be an integral part of the fellowship program providing specialized instruction in the principles and practice of cancer prevention and control. The minimum length of the program is three years and does not extend beyond five years.

Inquiries: Douglas Weed, director, Cancer Prevention Fellowship Program, NIH, NCI, Executive Plaza South, Suite T-41, 6130 Executive Blvd, MSC-7105, Bethesda, MD, 20892, phone 301-496-8640; fax 301-402-4863; e-mal br24v@nih.gov; website http://www.dcp.nci.nih.gov/POB.

In Brief:

HHS Won't Nominate Fischbach For NIH; Kirschstein In Charge

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Lung, and Blood Institute. He received his M.D. degree from the University of California, Los Angeles. The NCAB consists of 18 members appointed by the President for six-year terms. . . . **NO NIH NOMINATION**: Department of Health and Human Services will not nominate **Gerald Fischbach** for director of NIH. The Senate confirmation process would likely take about as long as the remainder of the Clinton Administration, HHS officials and Fischbach decided earlier this month. Fischback is director of the National Institute of Neurological Disorders and Stroke. Acting NIH Director **RUTH KIRSCHSTEIN** will continue to run the Institutes. Kirschstein "absolutely loves the job," a source close to her said to **The Cancer Letter**. . . . **VANDERBILT UNIVERSITY** School of Medicine established a Department of Cancer Biology, its first new basic science department in 45 years. **Lynn Matrisian**, associate director for education in the Vanderbilt-Ingram Cancer Center, was named chairman. Recruitment of scientists for the department will be made possible by a $100 million fundraising drive begun last year with a gift from the Ingram Charitable Fund for cancer research. . . . **MITCHELL MACHTAY** was named deputy chairman of the Radiation Therapy Oncology Group. Machtay is the principal investigator of the University of Pennsylvania Health Systems, member of the Lung Cancer and Head and Neck Cancer Committees and PI on several RTOG committees. He will work with group investigators and staff on protocol development and headquarters operational functions. . . . **AMERICAN CANCER SOCIETY** will honor the memory of oncology nurse and founder of the ACS journal Cancer Practice, **Patricia Greene**, by establishing the Trish Greene Quality of Life Manuscript Award. For further information contact Tamar Wallace, phone 212-382-2169. . . . **LYMPHOMA RESEARCH FOUNDATION** of America will present the Paul E. Tsongas Memorial Award to: **Sen. Barbara Boxer** (D-CA), **Sen. Harry Reid** (D-NV), **Rep. Patrick Kennedy** (D-RI) and **Rep. John Porter** (R-IL). . . . **NEAL NATHANSON**, director of the NIH Office of AIDS Research, will retire Sept. 1. He plans to return to University of Pennsylvania.