Amy Abernethy was named chair of a new CancerLinQ advisory committee within the Institute for Quality, an affiliate of the American Society of Clinical Oncology.

The American Society of Clinical Oncology is in the final stages of developing a request for proposals for its CancerLinQ system. The RFP is expected to be issued early in 2014. ASCO made the announcement last week at a White House Office of Science and Technology Policy event called “Data to Knowledge to Action: Building New Partnerships” at the Ronald Reagan Building in Washington, D.C.

“ASCO is not a business,” the professional society’s president, Clifford Hudis, said to The Cancer Letter. “If our participation in the market ultimately drives the development of a superior tool, but from somebody else, then I would say we have accomplished our goal.

“We are an honest broker,” said Hudis, chief of the Breast Cancer Medicine Service at Memorial Sloan-Kettering Cancer Center. “Our goal here is to get this job done and to profit, in terms of society and societal benefit, the maximum number of people. If we support somebody who can do better, that’s fine. We just need this to happen for the good of the patients we serve.”

List to the conversation on The Cancer Letter website.

Biospecimen Banks Program for NCTN Moves Forward With Approval From BSA

The NCI Board of Scientific Advisors approved a cooperative agreement to support the biospecimen banks for the NCI clinical trials network.

The agreement aims to consolidate the current cooperative group banks into a National Clinical Trials Network biospecimen banking networks for four adult groups and one pediatric group.

The RFA received unanimous approval at their Nov. 7 meeting.

The Cancer Letter will take a break from publication until Dec. 6.
ASCO's CancerLinQ Will Seek To Improve Quality of Care
(Continued from page 1)

The multi-phase development process will encompass a series of quality improvement tools for physicians, with the first components becoming available by early 2015.

The total cost of the project’s phases is uncertain. ASCO is seeking financial support through its Conquer Cancer Foundation, which has raised $7.8 million in commitments from Amgen, the Chan Soon-Shiong Family Foundation, Genentech BioOncology, Helsinn Therapeutics Inc., Eli Lilly & Co., Novartis Oncology, and Susan G. Komen for the Cure, as well as numerous individual supporters.

ASCO’s move into the full build follows completion of the CancerLinQ prototype, which demonstrated the feasibility of the system.

The first components of CancerLinQ will center on providing next generation quality measurement that builds on ASCO’s Quality Oncology Practice Initiative.

Future components will encompass more powerful quality improvement tools, real-time clinical decision support, and analysis of thousands of patient experiences to create a continuous cycle of learning.

It remains to be seen how ASCO’s participation will shape the power structure in bioinformatics in oncology, or whether it would be able to raise the funds the project would require.

Another umbrella group, National Comprehensive Cancer Network, which develops practice guidelines and pathways in oncology, is vying to expand its role as big data reshapes the field.

For-profit players, whose expertise covers at least some of the territory CancerLinQ would span, include the drug supplier McKesson, which has an alliance with NCCN to create clinical pathways and to produce software that will allow physicians to assess treatment options consistent with evidence-based standards.

The pathways and supporting software will also allow providers to consult coverage policies mandated by payers (The Cancer Letter, Nov. 30, 2012).

The market for clinical pathways and decision support and review systems, one of the segments of CancerLinQ’s activities, is competitive.

Players include the P4 Pathways, owned by CardinalHealth; Via Oncology Pathways; Eviti Inc.; ICORE Healthcare; and others.

Content libraries and software from these firms are used by a number of regional and national payers. IBM is also developing a decision support system using its Watson technology.

Other companies—including software developers, Internet companies and drug manufacturers—stand poised to jump in, insiders said.

Hudis spoke with Paul Goldberg, editor and publisher of The Cancer Letter.

Follow us on Twitter: @TheCancerLetter
Paul Goldberg: I guess what I am asking for is a tutorial: An idiot’s guide to CancerLinQ.

Clifford Hudis: That’s easy enough.

One: The simple issue is that 97 percent of adults in America who get treated for cancer—especially solid tumors—get treated outside of the context of clinical trials, and we—society—learn nothing from them.

Two: Over 60 percent of patients who have cancer in the U.S. get their care using electronic medical records. So the obvious opportunity is to start to mine all of that typing and clicking for outcomes, associations, safety—all the things you’d want to learn from medical records if you could mine them the way Google mines clicks and Amazon mines shopping patterns.

CancerLinQ is an attempt to do that. At first, you might say, isn’t that pretty straightforward, you take the data and you just crunch it. The problem is we don’t have standards for how the data is collected and stored in the various EMRs, so CancerLinQ is an attempt to solve that lack of interoperability. And, indeed, we’ve done a pilot study, which was able to demonstrate that we could draw data in from disparate EMRs, and then we could actually convert the data, analyze it, interpret it, and provide output.

And the output takes several forms: quality assurance, but also feedback to doctors in the form of clinical decision support, and, of course, aggregation of outcomes in terms of both safety and toxicity.

So, that’s the thumbnail.

PG: This is massive. How much would it ultimately cost?

CH: Many millions of dollars.

PG: Many, as in 10?

CH: Many multiples of 10, many, many multiples.

PG: 300?

CH: It’s all estimates at the moment about what the ultimate cost will be, because, of course, it’s all question about how much of it will be built. But to start with, I think it’s fair to estimate somewhere in the range of $80 million just to get this going through the first five years.

PG: What does $80 million get you to?

CH: That would get us, two years down the line, a stand-up product that would be in use, and it would get us, within several iterations over five years to version 2.0.

PG: And the money would come from?

CH: The money comes, obviously, from all the sources of revenue that ASCO currently has, and from the money that ASCO has been able to build up into its foundation over the years.

PG: You don’t have that kind of money; do you?

CH: Sure we do. Over time.

PG: Okay.

CH: It’s a little bit of a double-edged sword, because we don’t really think that ASCO should pay for it all alone. We think this has a huge potential societal benefit. We think that partners in pharma who will be able to benefit from some of the efficiencies that this provides should see the value in supporting it.

We, frankly, think that philanthropists should see its value. Maybe the government, if they had the money.

Here is a concrete example of what I mean. Right now, how do you do post-marketing drug surveillance for safety? You rely on voluntary reporting by scattered physicians who are or are not part of the clinical trial system, and it takes you forever to see important safety signals.

The poster child was Vioxx in terms of coronary artery events. It took about 62 months from approval data in from disparate EMRs, and then we could actually convert the data, analyze it, interpret it, and provide output.

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And we have a data governance committee with robust legal counsel so that all the protections that need to be there are, in fact, there.

Now, having said that, this is ground that has been covered before. This is fundamentally a quality project, not fundamentally a research project.

That’s an important distinction. Because it, of course, means that it mirrors on a large scale the kinds of data gathering that have been done in an isolated or focused ways for years.

As a simple example—maybe it’s too simple—but the CDC tracks all the influenza reports every season. They know where the flu is being identified. They track certain communicable diseases. They do all that under the appropriate guise of quality and public safety.

They are able to maintain confidentiality, and transfer data, and so forth. I think we are learning from that, but we are upscaling it tremendously.

PG: Where will you get the guidance on clinical decision support? Would you develop your own? Would you use NCCN?

CH: That’s a very good question, and I don’t think it’s 100 percent resolved right now. Of course, we, at ASCO have a history of focus on quality, starting with our education programs, extending to Quality Oncology Practice Initiative, which is the largest quality assurance program for cancer in the US.

More than a third of practices participate in QOPI. We write guidelines and guidance at times, but they are very focal and very in-depth. This system really does require something a little more generalized and faster to develop, something more like NCCN, in many cases.

PG: Would you work with them? Or would you make your own?

CH: Possibly. We are certainly in discussions with them. I’ll say a couple of things about that, though. Even within NCCN, certainly the majority of decision nodes that are enshrined in NCCN are not supported by high-level evidence.

They are just how doctors practice, and that’s made into a standard. One thing about [CancerLinQ] is that it’s a rapid learning system. Over time, as it learns what docs do and what the outcomes are, it would have the ability to inform better guidelines.

You are not locked in with what you start. The point is to improve outcomes through this system.

In terms of clinical decision support, the obvious question that comes up is [IBM’s] Watson. We are working closely with Watson. They have actually purchased extensive data, in terms of publications and guidelines from ASCO, and our program is modular, so it’s entirely possible that the clinical decision support module could be Watson, or something like Watson, which is providing feedback to doctors.

The difference is embedding that program in the larger CancerLinQ means that the program would not stay static, but would, in fact, be over time improved in terms of their treatment recommendations.

PG: I guess I am a little bit worried here. Really, the right word is anxiety. I am experiencing some of it as a political reporter, because I am seeing all these structures. Look at yourself, for example, you are ASCO, you are NCCN, you are Memorial, which has a deal with Watson. How do you keep these structures from colliding? How do you keep this from becoming a bumper car concession?

CH: I like to think one of the great things about medicine, and cancer medicine, is we are here to help patients. We are here to deliver the highest quality care most efficiently to the broadest array of patients.

All these people are working in a collaborative fashion normally anyway. The same people who are involved in this effort were involved in these various institutions historically.

Is it possible that we will find ourselves in competition?

Maybe so. But ASCO is not a business. If our participation in the market ultimately drives the development of a superior tool, but from somebody else, then I would say we have accomplished our goal.

PG: It’s almost a double-edged sword. There are huge advantages and huge potential disadvantages.

CH: One of the things about ASCO—and this can be true for other organizations—is that we are not for profit and we are an honest broker.

Our goal here is to get this job done and to profit, in terms of society and societal benefit, the maximum number of people. If we support somebody who can do better, that’s fine. We just need this to happen for the good of the patients we serve.
PG: There are private companies in that space, and IBM is only one of them.

CH: I have to point out with regard to Watson, it really represents a component of what we are trying to do. It’s not the whole thing.

Just as a quick aside, I am aware that there are others who are either in this space or claim to be in this space who have components of this. I met with one yesterday.

But again, we are more than happy to bootstrap. It’s important to point out that ASCO is not a software company. We are not writers of software. We are quality care deliverers. That’s what we do.

PG: What will the [RFP] look like? How close are you?

CH: We have an aggressive timeline. The request for proposals will be out early in 2014.

PG: That’s really soon. Do you know what it will look like? Could you, in general terms, describe it?

CH: No, I can’t yet, because it’s still being formed. We are in week 10 of a 12-week process, designing subjectively and qualitatively the capacity of the full build. And from that we will end up with the RFP.

PG: I am looking forward to covering it. I guess one last question is, are you running into any reluctance from anyone to give you data? Because data are the main currency...

CH: We anticipate that that will be a concern for some entities. Certainly, some competitive entities or some institutions I am sure will identify limits in what they can give or share. Maybe they will not participate at all.

On the other hand, one of the key take-home lessons from the pilot project was that a program that aimed for five or six practices and 30,000 patients in six or eight months garnered many more practices and 170,000 patients.

It’s pretty clear to us that there is some desire to take part in this. I’d expect that it will be biased a little more toward private practice and a little less toward academia, at least in the beginning.

PG: I am really looking forward to covering this. Is there anything we’ve missed?

CH: I don’t think so. You’ve given me a lot of time to cover it. I think the key thing is that it’s a quality project. The Q in CancerLinQ stands for quality, and that’s not just some marketing accent.

It’s really important to get the idea that what we want to do is improve the quality of care for all patients around the world.

Today many people today outside medicine are surprised that this kind of big data project doesn’t already exist and is not running.

And I hope we will look back and see that this is one of those turning points where we started to use all this work we put into recording data to actually get something out of it.
NCI News

BSA Also Approves IMAT Initiative, PPTP, and a Molecular Tumor Characterization Program
(Continued from page 1)

This network is funded through a U24 cooperative agreement and supported by the Cancer Therapy Evaluation Program and Division of Career Development and Transition to conduct large-scale phase II and III trials in the U.S.

Run by the Division of Cancer Treatment & Diagnosis, the biospecimen banks would support banking infrastructure for prospective collection and storage of specimens on ongoing and new NCI trials, and serve as a cataloging and retrieval system for “legacy specimens” and specimen-associated data.

“The primary uses of the legacy specimens are the validation studies of predictive and prognostic markers,” said Irina Lubensky, chief of the Pathology Investigation & Resources Branch in the Cancer Diagnosis Program of the NCI Division of Cancer Treatment & Diagnosis.

Legacy specimens are specimens that remain in excess after clinical trial requirements have been met. The banks would aid in distributing the specimens to investigators following a defined NCTN access and approval of the study by expert review.

The RFA will support the NCTN biospecimen informatics navigator system, which will have a central database with inventory of specimens available for research and with integrated search engines for investigators.

“Our new RFA builds on the progress and the achievements of the current nine cooperative group banks that are named after the nine cooperative oncology groups,” Lubensky said at the Nov. 7 meeting. “These banks are an integral part of the NCTN and they are a

U24 Banking RFA Goals

- Consolidate current CGBs into a harmonized NCTN biospecimen banking network for 4 Adult and 1 Pediatric NCTN Groups
- Support banking infrastructure for prospective collection and storage of specimens on ongoing and new NCI trials
- Build a system for cataloging and retrieving of “legacy specimens” and specimen-associated data
- Support NCTN Biospecimen IT Navigator system, a central inventory database of specimens available for research with an integrated search engine to access specimens for the research community
- Support a bank to collect, store, and distribute biospecimens from early phase trials performed by CTEP’s Experimental Therapeutics-Clinical Trials Network (ET-CTN)
- Streamline access to biospecimens:
  - Create a centralized Front Door specimen application process to support access to the NCTN Banks (CDP)
  - Create Central Correlative Science Review Committee to review NCTN biospecimen proposals (CTEP)

One of the slides the NCI presentation to BSA describing biospecimens banking for the NCTN. The RFA received unanimous approval. The entirety of this presentation, and all the slides presented at the Nov. 7 meeting, are available on the NCI website.
very unique resource as they can provide well-annotated specimens and clinical data from these trials—such data do not really exist in many other resources.”

These nine cooperative oncology groups are in the process of reorganizing into four adult groups and one pediatric group—the Alliance for Clinical Trials in Oncology, NRG, ECOG-ACRIN, SWOG, and COG.

“These historically separate banks have been supported by cooperative agreement grants from our Cancer Diagnosis Program since 2005, and the progress made in establishing standard operating procedures of the banks, as well as activities and the steering group banking committee, did a lot of work in harmonizing the procedures,” Lubensky said. “Recently, in 2012, the division and NCI supported the supplement to development a common informatics navigator system for specimen access.”

Access to biospecimens will be expedited via the creation of a centralized “Front Door” specimen application process and a “Central Correlative Science” committee to review NCTN biospecimen proposals.

The cost for the five banks is estimated to total $58.75 million over five years.

BSA also approved:

- The Innovative Molecular Analysis Technologies initiative’s request for reissuance of four RFA solicitations proposes that the program will continue to account for majority of NCI’s support for investigator-initiated technology development, addressing an area unmet by other FOAs.

The request for reissuance received unanimous approval. IMAT is a trans-divisional initiative comprised of representatives from all extramural divisions of NCI, as well as members of the Office of the Director and the Center to Reduce Cancer Health Disparities.

IMAT solicitations continue to receive a substantial number of high-scoring applications and achieve “a significant record of success,” as verified by multiple external program outcome evaluations.

IMAT requested $5 million for about 20 new R21
grants and $4 million for about 12 new R33 grants per year for innovative and emerging molecular and cellular analysis technology development for cancer research. IMAT also requested $800,000 to support about three new R21 grants and $700,000 for two new R33 grants per year for innovative and emerging technologies for cancer-relevant biospecimen sciences.

• **The Pediatric Preclinical Testing Program** seeks to enhance efficiency of childhood cancer clinical research—limiting lines of nonproductive research and provide evidence to support the presence or absence of a therapeutic window for specific agents against selected diseases.

The initiative was approved in favor of the proposal to open competition as an RFP, with one opposed and no abstentions.

PPTP aims to balance the inability of industry and clinical trials to validate results from the majority of publications on potential therapeutic targets by ensuring reliability of results through standard testing protocols, blinded testing and standard analytic metric for defining activity.

Run by the Cancer Therapy Evaluation Program, PPTP has a research contract with Peter Houghton of St. Jude Children’s Research Hospital as principal investigator and with six testing sites. Testing began in 2005, and PPTP has more than 80 executed MTA and has established collaborations with more than 50 companies.

Funding for PPTP in 2014 has not been decided. PPTP received $2.7 million per year in 2012 and 2013.

• **The Molecular Characterization of Screen-Detected Lesions** consortium proposes to support multidisciplinary research programs that undertake a comprehensive characterization of tumor cell and microenvironment components of screening-detected early lesions and missed interval cancers.

The RFA was approved unanimously.

Partners in the consortium would include molecular/cellular characterization laboratories, the Coordination and Data Management Group, and six NIH programs—EDRN, TMEN, NCATS, PLCO, PROSPR, and BETRNet.

Run by the Division of Cancer Prevention, the consortium aims to standardize data collection protocols and analyses, create a national resource for valuable samples of screen-detected and of interval cancers for future use, and centralize IRB management, material transfer agreements and protocols.

Applications to join the consortium will be required to include collaborative arrangement with existing or ongoing biospecimen networks or consortia as a partner, demonstrate the ability to procure appropriate specimens for the proposed study and share samples across the consortium on cross-laboratory discovery and verification.

The consortium is estimated to cost $5 million per year for five years.

• **The Metabolic Reprogramming to Improve Immunotherapy** initiative aims to generate a mechanistic understanding of the metabolic processes that support robust anti-tumor immune responses in vivo.

The concept is being developed and no vote was taken.

Run by the Division of Cancer Biology, the initiative seeks to determine how the metabolic landscape of the tumor microenvironment affects immune effector functions, and to use this information to manipulate or reprogram the metabolic pathways used by the tumor, the effectors of the immune response, or both to improve cancer immunotherapy.

The initiative plans to form collaborations between tumor immunologists, cancer biologists, computational modelers, and tool/technology specialists aimed at developing innovative approaches to utilize metabolic reprogramming to improve cancer immunotherapy.

To join the collaboration, applicants must propose cross-disciplinary research involving cancer biologists and immunologists aimed at complementary areas of metabolic research and, if justified, metabolomics, computational tools, or an imaging component.

The funding mechanism for this initiative proposes to supplement existing NCI funded grants to support collaborative research projects through revision applications. No budget has been set aside for the initiative.

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Piotr Kulesza, 46, Pathologist
At Northwestern, ECOG-ACRIN,
Dies in Fall After Group Meeting

By Paul Goldberg

Piotr Kulesza, a pathologist at Northwestern University Robert H. Lurie Cancer Center, who worked with the ECOG-ACRIN Cancer Research Group, died after a fall from a hotel balcony after attending the cooperative group’s semi-annual meeting. Kulesza was 46.

Police records, including 911 calls, indicate that the fall occurred shortly before 12:29 a.m., Nov. 17, when Kulesza dropped through the glass roof and into the lobby of the Westin Diplomat Resort in Hollywood, Fla., where ECOG-ACRIN had completed its meeting earlier that day.

A police report states that Kulesza had fallen from the 23rd floor balcony.

“Initial investigation does not reveal any suspected foul play,” Hollywood police said in a statement. “Detectives are actively investigating this case as to whether it was an accident or intentional.”

People who worked closely with Kulesza at Northwestern and ECOG-ACRIN described him as a top-level researcher who was energized by his work.

Colleagues who saw Kulesza at the meeting described him as upbeat, engaged and excited about his work with the ECOG-ACRIN project.

Kulesza was born in Warsaw. After coming to the U.S., he received his undergraduate degree at the University of Alabama, and his combined M.D./Ph.D degrees at Washington University in St. Louis.

He was a resident in anatomic and clinical pathology at Johns Hopkins University, where he stayed on for a fellowship in cytopathology. He joined the pathology faculty at Johns Hopkins in 2004 and was recruited back to the University of Alabama in 2006 before moving to Northwestern in 2009.

“Peter was a remarkable colleague, who will be remembered for his infectious enthusiasm and energy,” William Muller, the Magerstadt Professor and chairman of the Department of Pathology at the Northwestern University Feinberg School of Medicine, said in an email to the faculty and staff.

“He was dedicated to our academic mission, and this was evident in his interactions with colleagues, residents, fellows, and medical students. He was an ambitious researcher, who was a principal investigator on R01 grants as well as clinical trials,” Muller said. “His unique contribution to FSM was as the director of the pathology core facility of the Robert H. Lurie Cancer Center and director of the Eastern Cooperative Oncology Group Pathology Coordinating Office and Reference Laboratory at Northwestern.”

Information provided by ECOG-ACRIN said that Kulesza, who was appointed to the directorship of the coordinating office and reference laboratory in 2009, modernized ECOG-ACRIN’s pathology informatics systems and enhanced the role of that office in the development of group science by recruiting a staff of young, energetic pathologists and scientists to support the group, and by providing early-stage input to investigators on clinical trial concepts.

Kulesza implemented digital pathology in ECOG-ACRIN and oversaw pathology efforts for a number of landmark studies, such as tissue staining and evaluation for PACCT-1/TAILORx, the ECOG-led study that accrued over 10,000 women across the cooperative groups, who were prospectively tested using Oncotype DX to determine their recurrence score. The trial was designed to define the optimal therapeutic approach in women with intermediate-risk scores.

Kulesza represented ECOG-ACRIN as an ad hoc member of the NCI Group Banking Committee Steering Committee, where he was a champion of quality assurance measures to ensure high-quality science from the samples he was charged with banking.

“Piotr was an esteemed member of the scientific team of ECOG-ACRIN,” said group co-chair Robert Comis. “His boundless energy helped us reshape our approach to the role of the Pathology Coordinating Office and Reference Laboratory in the science of our group. He was leading and heralding our efforts in molecular and digital pathology, and was essential to our committees in designing molecularly-based clinical trials.

“Most importantly, he was a wonderful guy, full of energy and commitment to the field and to his colleagues. We all miss him terribly.”

He is survived by wife, Agnieszka Ardelt, assistant professor of neurology and surgery and director of the Neurocritical Care Research Laboratory at the University of Chicago Department of Neurology.
Abernethy is a tenured associate professor in the Duke University Schools of Medicine and Nursing, director of the Duke Center for Learning Health Care in the Duke Clinical Research Institute, and director of the Duke Cancer Care Research Program in the Duke Cancer Institute. She is also a medical oncologist and palliative medicine physician.

PETER DOTTINO was named director of the Division of Gynecologic Oncology at the Mount Sinai Health System.

He also holds an appointment as associate clinical professor at the Icahn School of Medicine at Mount Sinai. He is currently director of the Group for Women and co-director, with John Martignetti, of the Ovarian Cancer Translational Research Laboratory at Mount Sinai.

Dottino previously served as the director of Gynecologic Oncology at Mount Sinai and also is one of the founders of the Ovarian Cancer Research Fund, the oldest and largest charity in the United States funding ovarian cancer research, and of the Woman to Woman Program at Mount Sinai.

GIUSEPPE DEL PRIORE was named national director of gynecologic oncology of Cancer Treatment Centers of America. Based out of the CTCA Southeastern Regional Medical Center in Newnan, Ga., Del Priore will oversee the organization’s national gynecologic oncology practice.

Previously, Del Priore was the director of gynecologic oncology at the Indiana University School of Medicine, where he also taught and directed its gynecologic oncology fellowship program. He also has been an associate professor at Cornell University Weill College of Medicine, and an attending physician in the Division of Gynecology at Northwestern University School of Medicine.

THE BARBARA ANN KARMANOS CANCER INSTITUTE and McLaren Health Care signed an agreement that will create the largest cancer research and provider network in Michigan and expand access to advanced cancer care in Detroit and communities throughout the state.

Under the terms of the agreement, McLaren will provide a substantial capital investment over a multi-year period to assist with capital upgrades at Karmanos facilities and to fund clinical trials, basic and translational research programs.

Karmanos Cancer Institute will become a member of the nonprofit McLaren Health Care system. Both Karmanos Cancer Institute and Karmanos Cancer Center, which provides clinical care to patients, will retain their names and remain as separate legal entities, maintaining their assets and reporting to their existing respective boards of directors.

The McLaren Cancer Institute will be known as the Barbara Ann Karmanos Cancer Institute and McLaren’s cancer clinical trials program, operated as part of the McLaren Clinical Trials Management Program, will be merged into a single Karmanos Cancer Institute Clinical Trials Office.

CINCINNATI CHILDREN’S MEDICAL CENTER partnered with Claritas Genomics, a company formed by Boston Children’s Hospital and Life Technologies Corporation, to provide genomics-based diagnostics for pediatric patients.

Cincinnati Children’s will work with Claritas and Boston Children’s to build a collaborative network to enable pediatric hospitals to share data, expertise, best practices and infrastructure in medical genetics and genomics.

Claritas Genomics is a diagnostics laboratory that provides genetic testing for clinical providers and researchers with a focus on pediatric medicine. The company was spun out of Boston Children’s Hospital in February and combines advanced genetic analysis technology with clinical interpretive services informed by the expertise of pediatric specialists and bioinformaticians.

YALE UNIVERSITY formed a joint venture with Novogen Limited, an Australian biotechnology company, to develop personalized approaches to chemotherapy to treat ovarian cancer.

The venture will be known as CanTx Inc. Novogen will own 85 percent of the new company and Novogen CEO Graham Kelly will be CEO of the venture as well. The CanTx Board will be comprised of directors representing both Novogen and Yale.

CanTx’s first development candidate is expected to enter clinical studies in 2014. Novogen retains full ownership of its drug technology intellectual property and will grant CanTx access to that IP for drug development purposes. Novogen will continue to
explore applications of the same technology platform in a range of other clinical indications including glioblastoma, along with its anti-tropomyosin drug technology in the areas of prostate cancer, melanoma and neuroblastoma.

**ROCHE** announced the three winners of its first Pharma Research & Development Oncology Awards, which focused on novel, highly tumor-selective membrane targets for antibody-based cancer therapy. **Krishna Chaitanya**, of the Oncological Institute at the University Hospital Zurich, received first prize for his studies on a radioisotope-coupled antibody against fibroblast activation protein, which provides a new approach to attacking tumor stroma.

Second prize went to **Christian Jost**, of the Institute of Biochemistry at the University of Zurich, for a novel concept enabling the inactivation of the HER2 receptor with small, non-antibody based binding molecules.

**Vineeta Bhasker Tripathi**, of the UCL Institute of Ophthalmology in London, received third prize for her studies on the validation of Lrg 1 (leucine-rich alpha-2-glycoprotein-1) as a new target molecule for the suppression of blood vessel formation in tumors with the aid of function-inhibiting antibodies.

The award was presented by Roche’s Discovery Oncology Unit in Penzberg, Germany. The winners received cash awards of €4,000, €2,000 and €1,000, respectively.

A **former NCI fellow**, her husband, and their infant were shot to death Nov. 20 in an apparent murder-suicide in their New Market, Md., home, according to the Frederick County sheriff’s office. The deceased were identified as **Barbara Giomarelli**, 42, **Benyam Asefa**, 40, and **Samuel Asefa**, 3 months. Deputies found a handgun at the site.

The couple’s 5-year-old daughter escaped unharmed, and is now under custody of Frederick County Child Protective Services, according to the sheriff’s office.

The girl ran to a neighbor’s house and reported that her family members were injured—she hid in the house for as long as five hours before calling for help, but it is unclear whether she saw the shootings, police said. The neighbors called 911.

Local news reports suggested that a broken skylight window may indicate that a struggle occurred prior to the shootings.

“We are deeply saddened to hear of this terrible tragedy,” NIH officials said in a statement. “Barbara Giomarelli was a visiting fellow (trainee) at NIH in NCI’s Molecular Targets Development Program in the Center for Cancer Research from April 2004-April 2009.

“NIH can confirm that Dr. Benyam ‘Ben’ Asefa was employed by Lovelace Respiratory Research Institute, a subcontractor to Battelle Memorial Institute, as a clinical immunologist and supported work at the NIAID Integrated Research Facility in Frederick, Md., from March 19, 2012, to Sept. 26, 2013,” the statement said. “Dr. Asefa was not an employee of the NIH.”

**Funding Opportunity**

**LUNGevity Foundation Issues RFA for Several 2014 Awards**

The **LUNGevity Foundation** issued requests for applications for translational research in lung cancer for its 2014 Career Development Awards, Early Detection Awards, and Targeted Therapeutics Awards.

Career Development Awards support junior faculty members who are within the first five years of their first faculty appointment, and focus on early detection or targeted therapeutics projects, including immuno-oncology projects. Applicants may receive up to $100,000 per year for a possible period of three years and will participate as ex officio members of LUNGevity’s Scientific Advisory Board for the duration of the award. LUNGevity will grant only one Career Development Award per institution.

Early Detection Awards support approaches to improve clinical methods for detection and diagnosis of primary tumors. Targeted Therapeutics Awards include support targeted therapies and immuno-oncology projects.

Applicants for either Early Detection or Targeted Therapeutics awards may apply as individuals or in multidisciplinary teams of two or more investigators. Individual investigators may receive up to $200,000 over two to three years, while teams of investigators may receive up to $600,000 over two to three years.

More information on the RFAs is available on the LUNGevity website and on the proposalCENTRAL website, or contact Margery Jacobson at mjacobson@lungevity.org or 312-407-6109.

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