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## Shakeup at CTRC Puts Ian Thompson at Helm

BY ROBERT H. CARLSON

In 2007, when the CTRC merged with the University of Texas Health Science Center at San Antonio, changes in direction caused an exodus of research talent and a drop in philanthropic income. Well-known and well-respected, Dr. Thompson is the CTRC's third new leader in five years. His biggest challenges: regaining what was lost and, perhaps the greatest—getting back the NCI Comprehensive Cancer Center designation lost in 2002, along with a five-year (rather than the current three-year) term as an NCI-Designated Cancer Center.

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# Shakeup at CTRC Puts Ian Thompson at Helm

## Challenges: Keeping, Recruiting Research Talent; Financing New Sources of Income; Regaining NCI Comprehensive Cancer Center Designation

BY ROBERT H. CARLSON

**S**an Antonio's Cancer Treatment and Research Center (CTRC) at the University of Texas Health Science Center now has its third new leader in five years: Ian M. Thompson, Jr., MD, well known as principal investigator of the Prostate Cancer Prevention Trial, as well as numerous other national and international urology trials.

Dr. Thompson, Professor and Chair of the university's Department of Urology until appointed CTRC Interim Director in October, succeeds Tyler Curiel, MD, Professor of Hematology and Medical Oncology and the CTRC's Executive Director since 2007.

Keeping and recruiting research talent and financing new sources of income for the CTRC are two immediate tasks for Dr. Thompson. In 2007, when the CTRC merged with the University of Texas Health Science Center at San Antonio, changes in the direction the center was taking caused an exodus of research talent and a drop in philanthropic income.

The restructure of the executive team brings two other new members to the executive team. Thomas J. Slaga, PhD, Professor of Pharmacology at the Health Science Center, becomes the CTRC's Interim Deputy Director; and Susan L. Mooberry, PhD, Professor of Pharmacology, with cross appointments in Biochemistry and Medicine, is the new Interim Director for the CTRC's Institute for Drug Development (IDD), succeeding Francis J. Giles, MB, MD, who remains on the faculty as Professor of Hematology and Medical Oncology.

### Quest for 'Comprehensive'

The new leadership's greatest challenge may be to regain the National Cancer Institute Comprehensive Cancer Center designation it lost in 2002. And even before that, it has to work back to a five-year term as an NCI-designated Cancer Center, having been given just a three-year term.

Then there is funding. The CTRC has to maintain an operating budget of more than \$65 million in a time of sharply declining charitable giving and without having to dip into the corpus of its Foundation's endowment. The prestigious NCI grant brings in only \$5.4 million in federal funding through 2012.

And the new leadership will have to con-



IAN M. THOMPSON, JR., MD (who has the title of Interim Director because the state university system's policy is to conduct a national search for a permanent director, with an interim director in charge), said an immediate task is informing the San Antonio community of the CTRC's resources. "The fact is, patients come here from Europe for cancer care, while some in San Antonio drive 200 miles to Houston."

tinue to keep and attract the best research talent—this in light of the fact that several top researchers left the CTRC in protest after it was incorporated into the university in 2007.

### Change in Direction Caused Unrest

One principal investigator who left was Anthony W. Tolcher, MD, now Director of Clinical Research at the South Texas Accelerated Research Therapeutics (START) Center for Cancer Care in San Antonio.

Dr. Tolcher led the Phase I trial program at the CTRC, as he does now with two other investigators at START, the research arm of South Texas Oncology Hematology (STOH), a private practice located a few blocks away from the San Antonio Health Science Center.

In a telephone interview, Dr. Tolcher said he resigned because the CTRC took on a dramatic and fundamental change in direction after Dr. Curiel came aboard—"a more insular direction that wasn't really focused on things that made the CTRC and the university cancer center strong."

Dr. Tolcher said Dr. Thompson, whom he considers a personal friend, is in an unen-

viable position now, what with the sudden managerial shakeup, an overall decline in endowments, and the NCI grant currently renewed for only three years rather than five. Time lines for the next renewal are very short, Dr. Tolcher said.

"For Ian to be successful he's going to have to reach out and rebuild relationships [between the university and the oncology community] that had been lost over recent years," he said.

Dr. Tolcher recalled a time before the merger with the university when he said there were strong working relationships among private practitioners, clinicians at the university, and Phase I researchers at the CTRC.

"The CTRC's most successful years were when community oncologists and the university and the IDD under Dr. Dan Von Hoff were all working together side by side, with almost no division between the academic university, the Phase I trial programs, and community private practice oncologists. Ian needs to

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ANTHONY W. TOLCHER, MD, now Director of Clinical Research at the START Center for Cancer Care after resigning from CTRC's Phase I trial program because he considered that the CTRC had taken on a more insular direction that wasn't focused on what had made it and the university cancer center strong: "For Ian to be successful he's going to have to reach out and rebuild relationships [between the university and the oncology community] that had been lost over recent years."

When the CTRC merged with the University of Texas Health Science Center at San Antonio in 2007, changes in the direction the center was taking caused an exodus of research talent and a drop in philanthropic income.



Ian Thompson said his goal is to see the NIH grant re-funded for five years in the next cycle, and then, after one or two more years, petition for comprehensive cancer center status.

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reach out [to the community] to have best chance at succeeding.”

Dr. Tolcher said Dr. Thompson is an excellent choice because “he has a great deal of respect for clinicians in the city and works well in both academic and private proactive environments.”

“This is the opportunity for him to turn [the CTRC] around, if he is given the freedom and authority to make some difficult decisions.”

**‘Completely Different Vision for Phase I Program’**

Dr. Tolcher said Dr. Curiel had a completely different vision of how the Phase I program was going to be run.

“He didn’t seem to realize that every successful drug since 1989 developed for cancer treatment has come out of the pharmaceutical and biomedical industry, not from within the confines of universities or cancer centers,” Dr. Tolcher said. “Trying to rely only on studies that come from your own university’s discovery is not a successful strategy.”

**Started in 1975, Specialized in Radiation Oncology**

The CTRC was formed in 1975 and specialized in radiation oncology. When Charles A. Coltman Jr, MD, became CTRC Director in 1991 he formed an umbrella organization, the San Antonio Cancer Institute, comprising the CTRC and the new Institute for Drug Development for new drug discovery, both in partnership with the university health science center. In 1996 the CTRC attained the NCI comprehensive designation.

Dr. Curiel said Dr. Coltman is universally considered a visionary in San Antonio, but the organization’s troubles “started when Coltman was in the autumn of his leadership.”



TYLER CURIEL, MD: “What I really want to do now is to be back pursuing hot preclinical leads. I know there are other people on this campus who can run the cancer center.” The biggest frustration during his tenure as CTRC Executive Director, he said, was “never having enough dollars to do the things you want to do and see the need to be done.”

**Interim for the Meantime**

Dr. Thompson, a graduate of West Point who retired as a colonel from the US Army in 2000 before joining the Health Science Center, is the third person to head the CTRC since Dr. Coltman was named president emeritus in late 2004, following Karen K. Fields, MD (President/CEO, 2005-2007), and Dr. Curiel (Executive Director, 2007-2009).

Dr. Thompson has the title of Interim Director because the state university system’s policy is to conduct a national search for a permanent director, with an interim director in charge, he said. He would not speculate on his chances of making that cut, but was philosophical about his new responsibility.

“This should be analogous to a 6,000 yard dash, where the first guy took it 2,000 yards,” he said in an interview in his office. “I’m carrying the baton until we find an even faster runner than I, and then I hand it off.”

Meanwhile, he said, he is going forward with the strategic plans, long and short term.

An immediate task is informing the San Antonio community of the CTRC’s resources. “The fact is, patients come here from Europe for cancer care, while some in San Antonio drive 200 miles to Houston.”

He said his goal is to see the NIH grant re-funded for five years in the next cycle, and then, after one or two more years, petition for comprehensive cancer center status.

This means energizing his staff and bringing in “extraordinary” researchers and clinicians, shepherding financial resources, and bolstering sources of philanthropy in the city and state.

“There’s no simple answer to improving resources, it requires everyone to stretch—the scientists, the organization, and the community,” he said. He will call on his leadership training and experience in the military, he said, “where they do a fine job of exhorting people to do things they didn’t think they could do.”

Dr. Thompson said he’s the first to admit he doesn’t know a lot about Phase I programs, “and I’ll never be a Phase I medical oncologist, but one of my jobs is to learn.

“As a surgeon and genitourinary oncologist with expertise predominantly in prevention, early detection, prognostics, and therapeutics, I bring a different perspective to the organization.”

**Tyler Curiel: Back to Basics**

In news releases and in person, Dr. Curiel said he initiated the change in directorship with his resignation from the CTRC because he felt his work could have the most impact back in his own laboratory. His several major research focuses are on immunotherapy for cancer, particularly on gender and age differences in immunity.

“What I really want to do now is be back pursuing hot preclinical leads,” he said. “And I know there are other people on this campus who can run the cancer center.”

His biggest frustration during his tenure at the CTRC, he said, was “never having enough dollars to do the things you want to do and see the need to be done.”

What needed to be done, he said in an interview in his office, was to reorganize the cancer center, optimize resources, and get the



SUSAN MOOBERRY, PHD, is the new Interim Director for the CTRC’s Institute for Drug Development, succeeding Francis Giles, MB, MD, who remains on the faculty as Professor of Hematology and Medical Oncology.

NCI cancer center support grant renewed.

Dr. Curiel was recruited in 2006 from Tulane Medical Center to work on the next P30 cancer center support grant application.

Under Dr. Curiel the center secured a three-year renewed designation as an NCI cancer center in August 2009.

There were worries about that grant because the CTRC had lost its “comprehensive” designation after the 2002 review. Dr. Curiel said this was “because we didn’t have the depth in our clinical offerings, and we didn’t have a sufficient population-based program.”

In that review, he said, NCI reviewers felt the CTRC needed to improve in several areas, particularly getting more patients into research studies.

“When I applied for the next renewal, my strategy was to not request review as a comprehensive center and just continue our current NCI designation,” he said. “Then we would build, take advantage of our new configuration [within the university], and go back and petition for ‘comprehensive’ at a later time.”

There were some who were surprised Dr. Curiel didn’t at least try for a comprehensive designation, he said, but no one really expected it would happen in that cycle of competitive renewal, he said.

On the other hand, “I don’t think anyone here was disappointed. On the contrary, people were ecstatic that we maintained the support grant and maintained the NCI designation.

“They were concerned that there had been too many administrative changes and too many scientific changes in too short a time period, and that NCI might not appreciate all those changes.”

**Income in Decline**

The NCI cancer center grant covers about 5% of the CTRC’s operating budget, Dr. Curiel said, with the rest coming from institutional and philanthropic resources.

Philanthropic income, he said, is in sharp decline. “There are CTRC supporters who did not exactly understand the merger

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# For Breast Cancer Prognosis, Number of Nodes Not as Important as Type; For Early Disease, Preop Detection of Positive Nodes Effective

BY RABIYA S. TUMA, PHD

**S**AN FRANCISCO—Nodal status is a key prognostic factor for women with early breast cancer. Now, two studies presented here at the Breast Cancer Symposium indicate that the timing of node diagnosis and a refinement of nodal evaluation may lead to further improvements in cancer care for these patients.

## Preoperative Ultrasound Spares Extra Procedure

Surgeons regularly use sentinel lymph node biopsies to obtain a definitive diagnosis in women with clinically node-negative breast cancer. Women with positive sentinel lymph nodes then undergo axillary dissection. Recent studies have suggested that preoperative axillary ultrasound combined with fine needle aspiration cytology can identify a substantial proportion of women with node-positive disease and thus allow them to proceed directly to axillary dissection, avoiding an extra procedure.

To determine whether this preoperative technique is valuable in women with early disease who are eligible for breast-conserving surgery, Bedanta P. Baruah, MBBS, a Surgical Research Fellow in the Breast Cancer Unit of Cardiff University School of Medicine, and colleagues evaluated the technique in 274 women who underwent treatment at their institution between January 2007 and December 2008.

Prior to surgery, all of the women had axillary ultrasound with fine needle aspiration for suspicious nodes. Seventeen women were found to have positive nodes through the preoperative procedure. The remaining 217 underwent surgery with sentinel lymph node biopsy as usual and 40 additional women were found to have positive nodes, including seven with micrometastases.

Therefore, preoperative ultrasound and fine needle aspiration spared nearly one-third (30%) of the women with node positive disease from having a second procedure. The test did not lead to any false positives.

“On the basis of this study and previous studies looking at the role of [axillary ultrasound and fine needle aspiration cytology] in a mixed group of breast cancer patients, we would say that all patients eligible for breast-conserving surgery should have a preoperative ultrasound,” Dr. Baruah concluded.

## Encourage Others

“I congratulate Dr. Baruah on the excellent findings on axillary ultrasound, and hopefully this will encourage other programs to include axillary ultrasound in their armamentarium of staging breast cancer patients,” said Lisa Newman, MD, MPH, Director of the Breast Cancer Center at the University of Michigan, who gave a talk on the workup and management of women with clinically node-negative disease during the same session as Dr. Baruah.

“When axillary ultrasound shows node positive disease, those patients do not need to go on to sentinel lymph node biopsy. And many surgeons can tell you that the axillary node dissection is a much, much easier procedure when it is being performed in an axilla where the tissues have not already been disrupted by the prior sentinel lymph node biopsy. Also this technique can allow for identification of patients who might be candidates for neoadjuvant chemotherapy and even facilitate planning of breast reconstruction.”

Both Dr. Baruah and Dr. Newman noted, however, that while this test allows women with positive nodes found through ultrasound to avoid a sentinel node biopsy, it cannot be used to definitively rule out node-positive disease. Thus, women who appear to have node-negative disease after ultrasound still need to undergo sentinel node biopsy.

## ‘Can Really Make a Difference’

Although this is not the first study to show the value of this technique, the program committee chose to highlight the work because the technique “can really make a difference in the patients’ outcome,” said Program Co-Chair Lori J. Pierce, MD,

Professor of Radiation Oncology at the University of Michigan Health System.

“It really is an important approach. You can potentially spare patients an axillary surgery. And even though there are some centers that are using the approach, there are lots that are not yet. One of the reasons that we wanted to highlight it is to enlighten other places to say this is a very easy thing to do—to perform these axillary ultrasounds and biopsy the areas that look abnormal.”

## Regional Nodes Associated with Worse Prognosis

Current data indicate that women with fewer positive lymph nodes have a better prognosis than women with a greater number of positive nodes. However, researchers at the Mayo Clinic think that the type of node—sentinel vs nonsentinel—may be an even more important prognostic factor.

To test the hypothesis, James W. Jakub, MD, Assistant Professor of Surgery there, and colleagues examined data from women with clinically node-negative breast cancer who were treated at Mayo between 1997 and 2002. To be eligible, women had to have undergone a successful sentinel lymph node biopsy and been found to have positive nodes. Of the 449 women eligible for the study, 253 (56%) had metastatic disease confined to the sentinel lymph nodes, and the majority of them (82%) had only one positive node. The remaining 196 (44%) had disease spread beyond the sentinel nodes.

Looking at clinical outcomes, the investigators found no difference in disease-free or overall survival between women with one, two, or three more positive sentinel nodes. However, having one or more positive non-sentinel nodes had a statistically significant impact on overall survival compared with none.

Moreover, when the team restricted their analysis to women with just two positive nodes, there was a similar pattern. The 36 women with two positive sentinel nodes

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—Lori Pierce, MD, Program Co-Chair

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of CTRC and the university. They have been waiting to pass judgment—meaning, to write a check.”

Dr. Curiel said the CTRC is in the black now, with a small operating surplus, but is not able to contribute to the univer-

sity’s budget.

One of Dr. Curiel’s controversial decisions early on was to decrease the number of major CTRC research programs covered by the NCI support grant from five to three, on the theory that the cancer center could demonstrate high standards to NCI reviewers for three programs but not for all five.

“I did that in the first six weeks I was

here and I wasn’t exactly winning friends and influencing people,” Dr. Curiel recalled. “But it wasn’t conceivable to me to have five extraordinarily high-quality program that we could take into a competitive review and have all five programs rated at the highest level. I didn’t see that as possible.”

Researchers from those two programs

were reassigned, and resources integrated into the remaining programs.

“There was grumbling—imagine the leaders of the two programs I cut,” Dr. Curiel said. One of the programs lost was Dr. Thompson’s GU program, but neither Dr. Thompson nor Dr. Curiel said that had any effect on this latest management change. 