PEOPLE

Robert Carlson, MD, a medical oncologist specializing in breast cancer, has been appointed CEO of the National Comprehensive Cancer Network (NCCN), effective January 2, 2013. NCCN is a not-for-profit alliance of 21 leading American cancer centers dedicated to improving the quality and effectiveness of care for people with cancer.

Carlson is a professor of medicine in the division of oncology at Stanford University Medical Center in Palo Alto, CA, having joined the faculty in 1983. He serves as the medical director of inpatient oncology and hematology at Stanford Cancer Institute, an NCCN member. He has held several leadership roles at NCCN since the organization was founded in 1995.

AstraZeneca

Pascal Soriot, MBA, started his role as CEO of AstraZeneca and joined the company's board as executive director on October 1. He joins AstraZeneca from Roche AG, where he served as chief operating officer of the company's pharmaceuticals division since 2010. Prior to that, Soriot was CEO of Genentech and led the merger of the San Francisco-based biologics business with Roche.

Adam Donohue

Colleen Lawton, MD, a professor of radiation oncology at the Medical College of Wisconsin in Milwaukee, began her 1-year term as president of the American Society for Radiation Oncology at the end of October. She succeeds Michael Steinberg, MD.

Lawton's research focuses on the role of total body irradiation in stem cell transplantation. She has also worked extensively with the Radiation Therapy Oncology Group on several prostate cancer studies, examining nodal radiation and brachytherapy.

Varmus Highlights Funding Challenges

If sequestration, the automatic federal spending cuts triggered by the Budget Control Act of 2011, does kick in next January, National Cancer Institute (NCI) funding of new grant applications may drop by as much as 40%, estimates NCI Director Harold Varmus, MD.

Speaking at a press conference in Washington, DC, in September, Varmus explained that although sequestration would lower NCI (and overall NIH) budgets by only around 8%, new grant approvals may suffer a dramatic drop because most of NCI's $5-billion budget is committed to current investigations and personnel. "I have a lot of checks to write before I can start to write checks for new investigations," he said.

Sequestration "would be very damaging to biomedical research," he added. "I don't like it and I assume it won't happen," as Congress works to find a budget compromise by year's end that would prevent the automatic spending ax.

Varmus noted that NCI's effective buying power already has dropped by one fifth since 2003, and the success rate for grant applications has fallen to an all-time low of 14%.

"The pace of research is slower than it could be and should be, mostly because we are unable to fund all the people who have good ideas," the NCI director remarked. "It's always hard to predict what ideas will bear fruit."

With more stable funding for biomedical research available in other countries, "we are running the risk of losing leadership to Europe and parts of Asia," warned Varmus, who headed the NIH from 1993 to 1999.

One consequence of the ongoing budget crunch is "an inherent aversion to risk by grant applicants and peer review panels," he said. "There's a tendency to support safe science rather than revolutionary science."

Another byproduct is that researchers experience "severe feelings of competition and stress, feelings that transmit "unfortunately" to young trainees or foreigners who might want to come here and settle," Varmus said. He added, however, that he strongly encourages young cancer researchers to stick with the field, because "things will get better and the science is so good and so exciting." ■

Moores Pushes Clinical Sequencing

In the quest to provide personalized cancer treatment, the Moores Cancer Center at the University of California, San Diego (UCSD), is launching "My Answer to Cancer," a program that intertwines clinical care and research.

The initial goal of the program is in-depth targeted sequencing to examine tumor biopsies from 1,000 patients for mutations in hundreds of known cancer genes. If the analysis reveals a known mutation or other aberration that can be treated with an approved or experimental drug, the patient will be treated with that drug, explains Scott M. Lippman, MD, director of Moores, a National Cancer Institute–designated Comprehensive Cancer Center.

The analysis will be done with equipment and facilities that meet Clinical Laboratory Improvement Amendments (CLIA) standards, so the results can be used to direct patient care. The intent is to exploit the best technology available in the CLIA setting and to continually adopt newer technologies as they emerge, Lippman emphasizes.

If no known "actionable" mutations or other molecular aberrations are found in the CLIA setting, a subsequent more intensive evaluation may be done, including full genomic sequencing as well as proteomic and RNA analysis, where appropriate, to reach a better understanding of the underlying defects that drive the tumor's growth. The latter will initially be done in a research setting, and patterns noted and correlated with responses will inform further development of molecular tests to be applied in the clinical setting under stringent CLIA conditions.

"UCSD's new, cutting-edge Center for Advanced Laboratory Medicine will work to customize testing that is best coordinated with clinical studies at Moores," Lippman adds. There will be close synchronization between multiple specialists, including pathologists, surgeons, medical oncologists, and other clinicians, as well as bioinformatics