

oncology NEWS

INTERNATIONAL™

SEPTEMBER 1997
VOLUME 6 NUMBER 9

REPORTS
FROM
14 MAJOR
ONCOLOGY
MEETINGS

From the Publishers of the Journal ONCOLOGY

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New Policy Board Enters Tobacco Fray

■ WASHINGTON—A funny thing happened to the National Cancer Policy Board (NCPB) on its way to issuing a “white paper” on tobacco control (see box on page 12). Between its decision to do so and its public hearing on the issue, the tobacco industry and the attorneys general of 40 states announced their proposed \$368.5 billion settlement of the states’ lawsuit.

The proposed settlement gave a focus to the hearing

that it might otherwise have lacked—the vital need for tobacco-control advocates to persevere should Congress approve the agreement. [See articles on pp 4 and 35 for ACS and AACR recommendations.]

“The daily challenges of preventing tobacco use and helping people quit will be the same, whatever the terms of the deal that might be worked out,” said meeting co-chair Richard Bonnie, JD, of the University of Virginia Law School.

Speaker after speaker emphasized that the proposed agreement in no way diminishes the need for intensive tobacco-

control efforts. Left unanswered, however, was the question of what effect the settlement, if approved, would have on state, local, and federal programs. Certainly, a number of speakers saw potential negatives.

“Anybody who cares about this issue should be scrutinizing the entire document,” said FDA associate commissioner Mitchell Zeller, JD. “Forget the money. Are the states better off or worse off?”

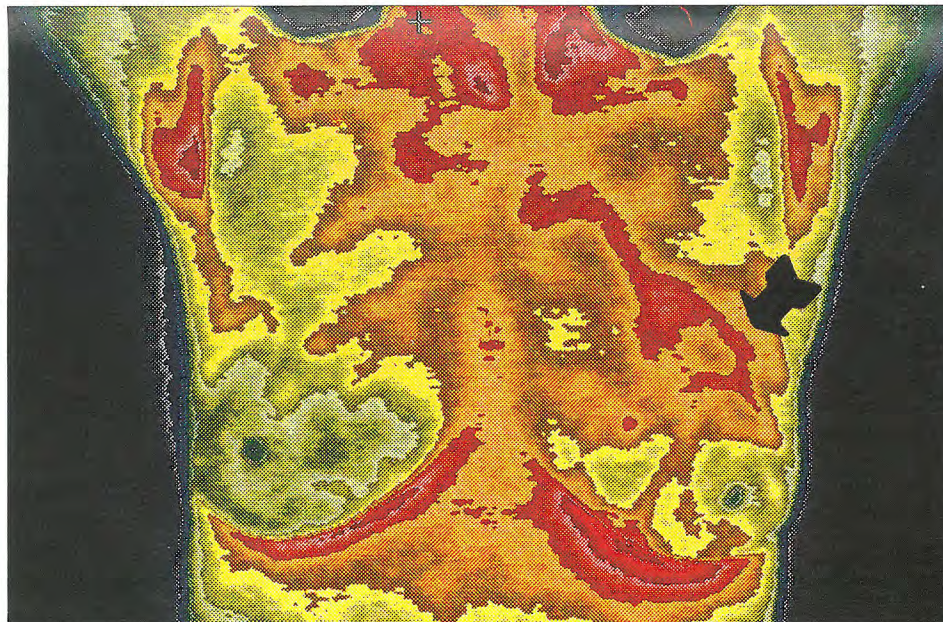
‘Forget the money. Are the states better off?’

The NCPB, a newly organized advisory group of the National Academy of Science’s Institute of Medicine (IOM), decided at its first meetings in March and April to focus its first policy statement on the issue of tobacco control.

The board gave three reasons for focusing on tobacco: (1) Tobacco use

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Infrared Imaging a Useful Adjunct to Mammography



In this 38-year-old woman with a lump in the upper midportion of the left breast, mammography showed bilaterally dense fibroglandular tissue, more prominent on the left side. Infrared imaging (above) shows an asymmetrical vascular pattern (arrow) over the left breast. Histopathology revealed a 2-cm infiltrating ductal carcinoma of the left breast. See article on page 3.

Index Quantifies Bone Disease in Prostate Ca

■ NEW YORK—Researchers at Memorial Sloan-Kettering Cancer Center have developed a method of quantifying bone involvement in patients with androgen-independent prostate cancer and have found that the resulting bone scan index (BSI) correlates with patient survival. In contrast, simply counting the number of bone lesions present did not provide useful prognostic information.

“At present, because of the difficulty in measuring bone disease, prostate cancer patients with bone-only disease are generally excluded from prostate cancer trials,” Paul Sabbatini, MD, said in an interview with ONCOLOGY NEWS INTERNATIONAL. “Since you can’t measure their disease, you can’t tell whether a patient is getting better or worse with treatment.”

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Panel Recommends FDA Approve First MoAb for Cancer Rx

■ BETHESDA, Md—The Biological Response Modifiers Advisory Committee has recommended that the FDA usher cancer therapy into a new era by approving IDEC Pharmaceutical’s Rituxan (rituximab) for patients with relapsed or refractory low-grade or follicular B-cell non-Hodgkin’s lymphoma.

If the FDA agrees with the committee’s unanimous decision, Rituxan, also known as IDEC-C2B8, will become the first monoclonal antibody (MoAb) approved in the United States for therapeutic use in cancer.

Although monoclonal antibodies are used in a variety of in vivo diagnostic tests, including ones for prostate, ovarian, and colorectal cancer, only two have won FDA approval for therapeutic uses: OKT3, to counter transplant rejection, and ReoPro, directed against platelet re-aggregation following angioplasty.

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Infrared Technology Has Advanced Greatly Since the 1970s

Time to Reassess Value of Infrared Breast Imaging?

■ MONTREAL—A group of Canadian physicians hope to spark renewed interest in the use of infrared breast imaging as a complement to mammography.

This technology lost favor some 20 years ago, but with new ultrasensitive high-resolution digital infrared devices, efficacy is much improved, and the Canadian researchers believe that infrared exams could prove a simpler and less expensive complement to mammography than some of the other newer imaging methods.

Researchers from the Ville Marie Breast Center examined infrared imaging in 100 women with noninvasive stage I and II breast cancer. In this study, the 84% sensitivity rate of mammography alone was increased to 95% when infrared imaging was added, John R. Keyserlingk, MD, a surgical oncologist at Ville Marie, said in his presentation of the findings at the recent American Society of Clinical Oncology annual meeting.

Mammography and ultrasound depend primarily on structural distinction

and anatomical variation of the tumor from the surrounding breast tissue, Dr. Keyserlingk said. Infrared imaging detects minute temperature variations related to vascular flow and can demonstrate abnormal vascular patterns

Infrared detects small variations in temperature

associated with the initiation and progression of tumors (see figures on pages 1 and 7).

The new generation of diagnostic infrared technology, Dr. Keyserlingk said, owes much to a decade of military research and development. "In July 1995, we installed a fully integrated high-resolution infrared station," he told ONCOLOGY NEWS INTERNATIONAL. The software allows high-precision pixel temperature measurements.

In their study, Dr. Keyserlingk and his colleagues, Paul Ahlgren, MD, a medical oncologist, and Edward Yu, MD, a radiation oncologist, reviewed 100 successive patients referred to the Ville Marie Breast Center between August 1995 and December 1996 who were subsequently found to have histologically proven noninvasive ductal carcinoma in situ (four patients) or stage I or II invasive breast cancer (96 patients).

All patients had undergone preoperative clinical examination, mammog-

raphy, and infrared imaging. (See page 7 for information on the infrared imaging protocol.)

Clinical examination alone was positive in 61% of the study patients. Mammography was highly suspicious in 65% of patients, with an additional 19% having contributory but nonspecific (intermediate) mammography findings. Infrared imaging was considered abnormal in 83% of patients.

Of the 39 patients with negative clinical examinations, 31 had at least one major abnormal infrared sign, and infrared was the major indication of a potential abnormality in 15 of these patients who also had a negative or intermediate mammogram.

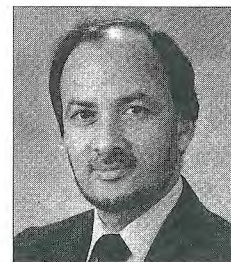
The 16 patients with a noncontributory mammogram were an average of six years younger than the overall group (mean age, 47 years versus 53 years). Among these patients, 11 had an abnormal infrared image, and in eight of these women, who also had negative clinical exams, infrared was the main indicator of a possible abnormality.

"This suggests that when done concomitantly with mammography, infrared imaging can add valuable information, particularly in those patients with nonspecific clinical and mammographic findings," Dr. Keyserlingk said.

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Lasting Melanoma Remissions With Biochemotherapy

■ SAN FRANCISCO—About 8,000 people will die of malignant melanoma in the United States this year, victims of a



Dr. Legha

mortality rate approaching 100% in recurrent disease. Sewa S. Legha, MD, painted this grim picture at the Proleukin First International Congress, sponsored by Chiron. Traditional chemotherapy produces response rates up to 40%, but complete remissions are rare, even with the most aggressive combination therapies.

Biological agents produce a different profile. Response rates to interferon-alfa (IFN-alfa) and interleukin-2 (IL-2, Proleukin) are around 20%, with duration of response and median survival similar to, and in some studies higher than, those of chemotherapy.

In the late 1980s at the University of Texas M.D. Anderson Cancer Center, where Dr. Legha is professor of medicine in the Department of Melanoma/Sarcoma

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Talking to Cancer Patients: How, When, Where, How Much?

■ NEW YORK—Along the long road that starts with a cancer diagnosis, good communication will ease the way for patients, families, and physicians alike.

"There are many barriers to communication, but

'Patients have asked the big question in a packed elevator'

there are many benefits if we can communicate," Ronald Blum, MD, said during a teleconference on end-of-life issues sponsored by Cancer Care, Inc., an organization that offers guidance, information, and referrals to cancer patients and their families.

Communication reduces stress, resolves problems and strengthens people's ability to cope. "It also can bring patients and family together," said Dr. Blum, medical director, St. Vincent's Comprehensive Cancer Center, New York.

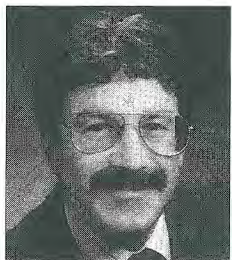
Many issues need to be discussed when a patient is first diagnosed with cancer. Medical plans need to be communicated and family concerns addressed, he said. "The way I try to convey the need to communicate is by saying, I'm going to share my thinking with you. I would hope you would share your thoughts with me, and, together, we can make a decision about your treatment."

Finding the right time and place to talk is important, and Dr. Blum often gives patients "the opportunity of some lead time. I say, look, I have some news

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Children Run Greatest Ca Risk from Nuclear Tests

■ WASHINGTON—Children living in the western United States in the 1950s learned to "duck and cover" at school in



Dr. Klausner

case of a nuclear attack, unaware that a more tangible nuclear danger lay in their lunchtime milk cartons.

Researchers at the National Cancer Institute have now calculated the levels of human exposure to iodine-131 released by 90 US atmospheric nuclear tests in the 1950s and 1960s. For most people, their largest exposure came from drinking milk produced by cows that had grazed on I-131-contaminated vegetation. Children experienced much greater exposure than adults because their thyroids are smaller and they drink more milk.

The actual risk of thyroid cancer from these exposures will be the subject of a related study due from the Institute of Medicine (IOM), a part of the National Academy of Sciences.

The Department of Health and Human Services (HHS) asked the IOM to

form a committee of experts to assess whether such risks can be determined and to recommend how physicians can identify, evaluate, and treat persons who might be at increased risk of thyroid cancer because of their I-131 exposure.

The IOM is currently organizing the effort and expects its review to take about six months once arrangements are completed. "In the meantime," the NCI said in a press release, "persons concerned about fallout exposure should consult a health professional."

The full 1,000-page NCI report, and its accompanying 100,000 pages of supporting data, is scheduled for release on October 1, but the NCI issued a brief summary of the report last month.

From 2 to 16 Rads Exposure

The report shows that the approximately 160 million people living in the contiguous 48 states at the time of the tests had an average cumulative thyroid dose of 2 rads from I-131 fallout.

The estimates of I-131 exposure, however, varied considerably, depending on proximity to the federal government's Nevada test site, meteorological conditions, age, and milk consumption.

In general, people living in states to the north and east, down wind of the test site, had the highest exposures. Five coun-

ties averaged between 12 and 16 rads cumulative exposure (Meagher in Montana and Custer, Gem, Blaine, and Lemhi in Idaho); 19 counties averaged between 9 and 12 rads.

"Adults in those counties would have received one-half to one-quarter of those

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Studies Show Who Seeks Mammography and Why

■ NEW ORLEANS—After years of hearing about the benefits of mammography screening, many women still resist the test. A number of posters at the annual meeting of the American Society of Preventive Oncology (ASPO) examined the question of who gets screened, who doesn't, and why.

One finding emerged from two studies: Specific worries about breast cancer

health behavior of generalized anxiety and cancer-specific concerns.

The study, reported by Michael Diefenbach, PhD, included 670 women undergoing diagnostic assessment and counseling because of a familial risk for breast cancer. Patients were interviewed prior to program enrollment and at a 12-month follow-up visit.

Higher levels of cancer-specific worries at intake into the study predicted future mammography use, controlling for age and family history. But depressive and anxious moods were not significantly associated with adherence to mammography. Correlations among cancer worry, depressive mood, and anxious mood were low, Dr. Diefenbach reported at the meeting.

A larger study from the University of Massachusetts Medical School, Worcester, included 2,507 women identified as underutilizers of mammography screening, from two HMOs.

Led by project director William Haddad, PhD, the researchers interviewed

these "committed underutilizers" to determine their prior mammography use, risk of developing breast cancer, attitudes toward breast cancer, sociodemographic factors, and intention to utilize mammography screening sometime in the next 24 months.

Women characterized as "definitely planning" to get screened were significantly younger and better educated, were three times more likely to work outside

More Breast Cancer on pages 5, 6, 10

the home, and were earning a higher income than the women who were less committed to mammography.

Three fourths of women in the "definitely planning" group, for example, earned \$40,000 or more, compared with only 14% in the "thinking about but not planning" group and about 14% in the "not planning" group, Dr. Haddad said.

In multiple regression analysis, variables significantly associated with inten-

tion to be screened included prior utilization, worry about breast cancer, fear of learning one has breast cancer, and perceived vulnerability.

These factors distinguished three groups of women who were not planning to have mammography: **Cancer-specific concerns, not general anxiety, spurred use of mammography** (1) Those who had never considered mammography, (2) those who had decided against it, and (3) those who remained undecided.

Women who had never considered mammography were most likely never to have had one and not to be worried about breast cancer, Dr. Haddad said. Those who had decided against mammography were also likely not to be worried about breast cancer. Those who were still undecided reported the highest level of worry about breast cancer and fear of the results of mammography. ▀

Who Do Women Listen to About Mammography?

Although breast cancer advocacy groups, with their media campaigns and networks of volunteers, play an important role in educating



Dr. Daniel

women about early detection, a study from the Medical University of South Carolina, Charleston, found that a mammography recommendation from a health care professional carries more weight.

At three mammography clinics, 749 women were surveyed to assess their likelihood of compliance with recommendations from different messengers.

Nearly all women said they would likely comply with a physician's recommendation, Donna Daniel, PhD, reported, and acceptance of nurses' recommendations was also high (79% to 90%).

However, the likelihood that women would follow a recommendation from a volunteer (32% to 51%) or media campaign (35% to 49%) was significantly lower.

Dr. Daniel noted that no racial or educational differences were observed in the women's responses. Women with a high school education and those with college degrees both said they would be more likely to follow a physician's recommendation.

are a motivating factor for many women who seek mammography.

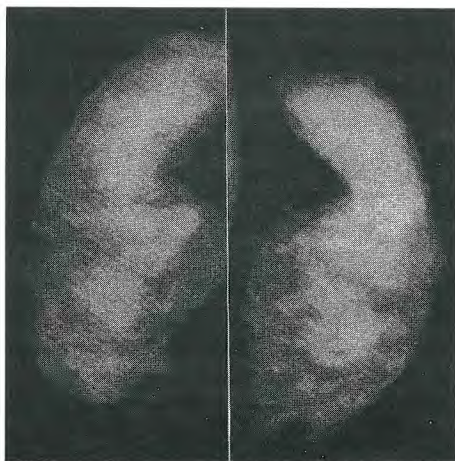
Previous research has suggested that anxiety and depression are related to non-adherence to health protective regimens, while specific cancer-related worries may initiate health-protective behavior. Researchers from the Fox Chase Cancer Center, Philadelphia, sought to distinguish between the different effects on

Time to Reassess Value of Infrared Breast Images?

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The mean size of tumors undetected by mammography was 1.73 cm versus 1.25 cm for infrared imaging, suggesting that infrared detection is related more to vascular and metabolic changes than strictly to tumor size.

Finally, for comparison, the researchers evaluated a series of 100 patients who had benign breast histology at open biopsy. Of these, 19% had an abnormal preoperative infrared study, while 30% had an abnormal mammogram, suggesting sufficient specificity as an adjuvant modality.



In this 39-year-old woman with a lump in the left breast, mammography (craniocaudal view) shows bilaterally dense fibroglandular tissue, more prominent on the left side.

Dr. Keyserlingk and his colleagues hope that their findings will stimulate interest in infrared imaging and ultimately lead to carefully controlled multicenter trials of the technique.

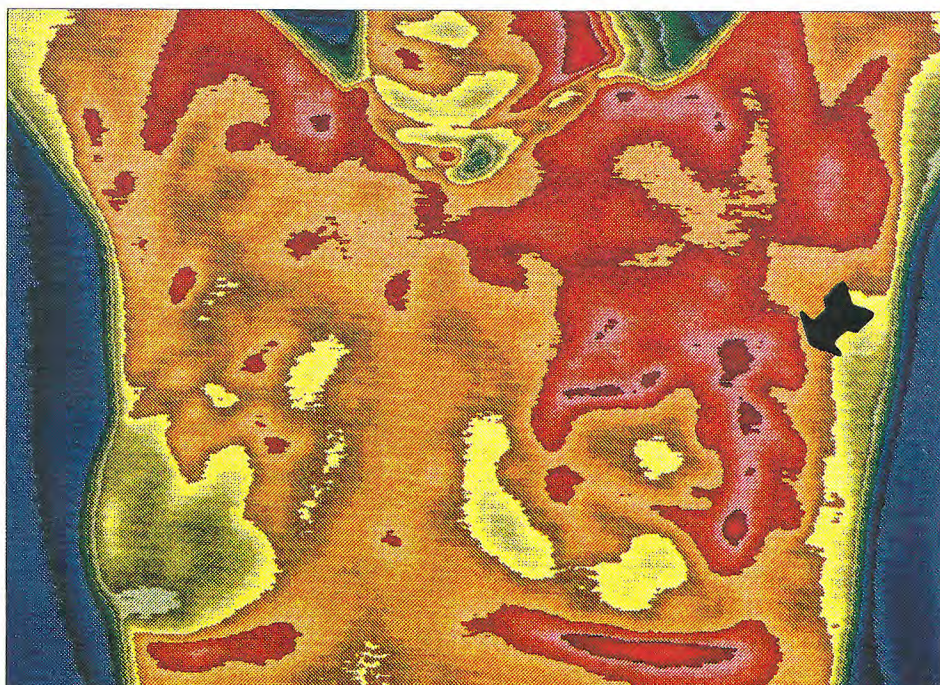
Dr. Keyserlingk noted that infrared imaging generally takes less than 10 minutes to perform. At the Ville Marie Breast Center, he said, patients are asked to avoid alcohol, coffee, smoking, exercise, deodorants, and lotions three hours before their infrared test.

The imaging room is maintained at between 18° and 20° C. The patient sits disrobed, hands supported over her head for a five-minute equilibration period. Imaging is then performed, consisting of four views—one anterior, one undersurface, and two lateral—which are taken, interpreted, and stored on laser disks in a

process that takes only two minutes.

Major abnormal findings on infrared range from significant vascular asymmetry to vascular "anarchy," consisting of unusual vessels that form clusters, loops, and abnormal branching. Focal increases in temperature from 1° to 3° C may be significant when compared with temperatures at the contralateral site.

For patients with significant clinical or infrared findings, use of an advanced dynamic infrared protocol is suggested, in which 80 frames are collected with a 1,900 millisecond delay. Normal scan rates range from 8 to 30 frames/second. ▀



The infrared image from the same patient (see mammography at left) shows a marked asymmetrical area of increased vascularity in the left breast (arrow). Histopathology revealed a 3-cm infiltrating ductal carcinoma of the left breast with 11 positive axillary nodes.