The Stanford Cancer Center has been awarded “cancer center” designation from the National Cancer Institute – a distinction that reflects high-quality patient treatment and excellent basic, population sciences and clinical research.

This status is shared with the Fremont-based Northern California Cancer Center, which worked with Stanford to achieve the designation.

Stanford Dean Philip Pizzo said the designation has already rallied faculty members around shared goals and programmatic efforts that started when the school applied for the award. “The new community that is formed by having an NCI cancer center is also invaluable in fostering more interdisciplinary education, research and patient care,” he said.

Stanford’s NCI designation also means that people in the local community will have more access to NCI resources, will be a benefit especially for underserved minorities with limited access to cancer care and prevention, said Beverly S. Mitchell, MD, deputy director of Stanford’s Cancer Center.

“The Northern California Cancer Center has expertise in studying cancer trends and outcomes, cancer prevention research and outreach that will make a real difference in preventing cancer and improving the quality of life for cancer survivors in the Bay Area,” said Donald Nielsen, the organization’s CEO.

As a result, patients will have greater access to clinical trials, and those eligible for Medicare can receive coverage for their participation in NCI clinical trials. “We can expect to see a larger number of clinical trials, in a wider area of cancers, that patients coming to Stanford can participate in,” Pizzo said.

In its review of Stanford’s programs, the NCI specifically noted the excellence of the school’s basic research and cancer care with a special nod to Stanford’s molecular imaging, cancer biology and bone marrow transplant programs, each of which received an outstanding rating from the review committee. Pizzo said he hopes the NCI designation will help propel additional cancer programs to the same level of excellence.

This designation is the latest in a year filled with significant accomplishments for the cancer center. In September 2006, the medical school received $25 million to establish the Jill and John Freidenrich Center for Translational Research at Stanford University. This center, which will be run in partnership with Stanford Hospital & Clinics and Lucile Packard Children’s Hospital, will be a hub for translating basic research into clinical care at Stanford.

The school also was awarded $20 million to form the Ludwig Center for Cancer Stem Cell Research and Medicine. Stanford researchers have taken a leading role in the hunt for cancer stem cells at the heart of cancers. Irving Weissman, MD, director of the Stanford Cancer Center, said he hopes the work will lead to new treatments for cancer, which will be tested first in clinical trials for Stanford patients.
Dear Friends,

We are happy to present the premier issue of the Stanford Cancer Center News, a newsletter for patients and friends of the Cancer Center. Each quarter the SCC News will introduce you to our clinical programs and services, cutting-edge advances in our labs and new breakthroughs being developed to improve early diagnosis, treatment and prevention of cancer.

This year has been marked by several major milestones that have bolstered our research and treatment programs. Most recently, in June, the Stanford Cancer Center was awarded “cancer center” designation from the National Cancer Institute, the primary source of funding for cancer research in the United States.

I share the belief with my colleague Martha Marsh, president and CEO of Stanford Hospital & Clinics, that the NCI designation “validates to our patients and our community that Stanford is one of the premier cancer treatment centers in the nation. Stanford physicians, nurses and other highly skilled medical professionals are proud to provide patients with the latest advances in diagnosis and treatment, in a beautiful and caring environment.”

Our goal to accelerate the application of scientific advances to patients was strengthened last September with the establishment Jill and John Freidenrich Center for Translational Research at Stanford University.

Shortly thereafter, the Virginia & D.K. Ludwig Fund of New York established an endowment at Stanford to create the Ludwig Center for Cancer Stem Cell Research and Medicine. This new center will enable us to expand our research to understand the regulatory processes and genetic changes that cause cancer stem cells to act abnormally and ultimately to identify novel imaging and life-saving targeted treatments that eliminate cancer at its source.

As leaders in the discovery of human cancer stem cells, Stanford scientists have already isolated several leukemia and cancer stem cells in a wide range of tumors, including colorectal, head and neck and breast cancers, and have expanded their investigations into tumors in the brain, ovaries, lungs, bladder, prostate and skin.

As director of the Stanford Cancer Center and a cancer survivor, I am profoundly aware of the toll that cancer can have on the lives of so many people. Every day our extraordinary team of cancer specialists and researchers, along with hundreds of nurses and staff, bring hope to our patients and their families. We are committed to improving the lives of cancer patients through advanced research and comprehensive services, and are grateful for continued support and encouragement from our friends.

Sincerely,
Irving Weissman, MD
Researchers at the Stanford University School of Medicine have identified the cancer stem cells that propagate tumors in colon and rectal cancer, a discovery that could lead to improved treatment of this type of cancer.

Stanford researcher discovers colon cancer stem cell

 Researchers at the Stanford University School of Medicine have identified the cancer stem cells that propagate tumors in colon and rectal cancer, a discovery that could lead to improved treatment of this type of cancer.

FROM MOLECULAR STUDIES TO NEW TREATMENTS

These are the latest class of cancer stem cells tracked down by a large, interdisciplinary group of researchers led by Michael Clarke, MD, Karel H. and Avice N. Beekhuis Professor in Cancer Biology and professor of medicine-oncology.

“This work will enable us to better understand how to identify these cells, and to do molecular studies to find potential new therapies,” said Clarke, the senior author of the paper.

Clarke was the first to find cancer stem cells in a solid tumor—breast cancer—in 2003. Since coming to Stanford in 2005, he joined existing efforts that have resulted in finding cancer stem cells in head and neck, pancreatic and now colorectal tumors.

These stem cells act like a spring at the source of a creek, constantly dividing to produce new tumor cells. Although the other tumor cells can divide and cause damage through their sheer bulk, they are shorter lived and can’t maintain the tumor’s growth. The cancer stem cells are also likely to be responsible when tumors spread to distant sites.

STANFORD’S TEAM APPROACH TO CANCER STEM CELL RESEARCH

Identifying new cancer stem cells has been a major push within both the Stanford Institute for Stem Cell Biology and Regenerative Medicine and the Cancer Center. The goal of Stanford researchers is to develop cancer therapies that specifically kill these cancer stem cells, eradicating the cancer entirely. Current therapies may kill the bulk of the tumor cells, but if any cancer stem cells remain the tumor may resurface or spread.

“We have brought together a team of scientists and clinicians who will help find the weak points in cancer, devise new immune and molecular diagnostics and therapeutics, test them in laboratory models that carry the cancer stem cells and, we hope, in a few years begin to test them in our patients,” said Irving Weissman, MD, Cancer Center director.

DETECTING COLON CANCER AT THE GENETIC LEVEL

The colorectal cancer stem cells highlight the importance of a protein that is a familiar face to this group of cancer researchers. A protein called CD44 that has already been found dotting the surface of both breast and head and neck cancer stem cells also turns up on the colorectal cancer stem cells. This finding could simply reflect the fact that all of those tumors arise from similar tissue.

It could also mean that a similar therapy could target all three cell types.

In breast cancer, Clarke and another team of researchers recently found a group of genes that show unique patterns of being turned on or off in people who either do or don’t respond well to treatment. The group hopes to do similar work with the colorectal cancer stem cells as a first step in identifying patients who may need more aggressive treatment.

By Amy Adams

Michael Clarke, MD
The Colorectal Cancer Program at Stanford

By making cancer research a centerpiece of its mission, the Stanford GI team is at the forefront of advances in clinical care.

Stanford Cancer Center’s Gastrointestinal (GI) Oncology Program offers wide-ranging expertise for patients with colorectal, esophageal, stomach, small bowel, pancreas, bile duct and liver cancers. The program brings together a multidisciplinary team of physician scientists who focus their research and clinical skills on preventing, diagnosing and treating this complex group of cancers. The team includes subspecialists in oncologic and colorectal surgery, radiation and medical oncology, gastroenterology, pathology, diagnostic and interventional radiology, nuclear medicine and genetics.

THE GI TUMOR BOARD
The GI team of cancer specialists meets each week in the Cancer Center’s GI tumor board. Patients are examined and their clinical history is then presented to the faculty physicians, following which their tumor biopsy, x-ray studies (for example, CT scans) and laboratory results are reviewed in detail. Having a team of medical oncologists, surgeons and radiation oncologists review all the data together with expert guidance of a Stanford pathologist and radiologist eliminates the miscommunication that may occur in routine office referrals.

Weekly conferences foster a continuum of care with seamless transitions from one specialist to another, as well as allow the newly diagnosed patients and their families to ask questions of each of the relevant specialists at one time. The result is a personal, comprehensive and expedited treatment plan for patients with GI cancer.

APPLYING NEW TECHNOLOGIES
Stanford is internationally renowned for technological innovation. Stanford scientists invented the linear accelerator, which revolutionized the delivery of radiation to cancers, and today continue to pioneer advances in the precision with which radiation is administered. Stereotactic body radiotherapy (using Cyberknife and Trilogy systems) and image-guided radiotherapy (IGRT) are the most recent advances in the field of radiation oncology.

Albert Koong, MD, assistant professor of radiation oncology, a leader in the application of these techniques to patients with GI cancers, has demonstrated the relative safety and improved focusing of stereotactic body radiotherapy in pancreas cancer.

The precision with which a radiation beam can be focused on a tumor is only as good as one’s ability to precisely image the tumor and delineate its relationship to adjacent critical organs. To define the extent of the tumor with as much accuracy as possible, Dr. Koong collaborates with diagnostic radiologists to develop tumor-specific imaging protocols. For example, standard CT scans give only a limited view of pancreas and rectal cancers; Stanford’s pancreatic protocol CT and rectal protocol scans allow three-dimensional reconstructions of the tumor volume. Better definition of the tumor as a target permits more precise delivery of radiation.

CLINICAL TRIALS
Clinical research is the process by which advances in the laboratory are translated to improvements in patient care. Research in the GI Oncology Program ranges from basic laboratory studies on cancer biology to testing novel prevention, detection and treatment strategies in the clinic. Patients at Stanford may be offered the option of participating in clinical trials. Clinical trials in the GI Oncology Program vary in scope and can range from collection of blood samples to help with basic research to the administration of
The 10 Percent Solution?

In Western countries, approximately 90 percent of colorectal cancers are believed to begin from adenomatous polyps—benign, protruding growths on the inner lining of the colon. Most screening and early intervention programs stress the removal of these polyps from the colon.

But what about the other 10 percent?

Since the 1980s, Japanese researchers have reported that 10 percent to 40 percent of early colorectal cancers appear as depressed or flat lesions rather than as polyps. One study concluded that flat colorectal lesions have as much risk of progressing to cancer as do protruding lesions (or polyps) when the flat lesions are smaller than 10 millimeters in diameter. However, results of the study also showed that larger flat lesions and depressed lesions are almost twice as likely to contain invasive cancer than protruding lesions of similar size.

Based on these early reports, Stanford physician/researcher Roy Soetikno, MD, head of the gastrointestinal section and the endoscopy unit at the Veterans Affairs Palo Alto Hospital, flew to Japan to learn its physicians’ techniques to detect flat or depressed lesions. He decided to perform similar endoscopic surveillance looking for flat lesions in a predominantly Caucasian, male, U.S.-born population at the Veterans Hospital.

In a recent study, Dr. Soetikno demonstrated that flat or depressed precancerous lesions were present in his study patients with approximately the same incidence as that found in the Japanese population. Flat and depressed lesions may go undiagnosed, since they are difficult to detect on routine colonoscopy, and most of these lesions—over 60 percent—are found only after use of special dyes that enhance visualization of abnormal tissues. It’s possible that the presence of these flat or depressed polyps accounts for the failure of colonoscopy to detect up to 10 percent of precancerous lesions.

Based on these early reports, Stanford physician/researcher Roy Soetikno, MD, head of the gastrointestinal section and the endoscopy unit at the Veterans Affairs Palo Alto Hospital, flew to Japan to learn its physicians’ techniques to detect flat or depressed lesions. He decided to perform similar endoscopic surveillance looking for flat lesions in a predominantly Caucasian, male, U.S.-born population at the Veterans Hospital.

In a recent study, Dr. Soetikno demonstrated that flat or depressed precancerous lesions were present in his study patients with approximately the same incidence as that found in the Japanese population. Flat and depressed lesions may go undiagnosed, since they are difficult to detect on routine colonoscopy, and most of these lesions—over 60 percent—are found only after use of special dyes that enhance visualization of abnormal tissues. It’s possible that the presence of these flat or depressed polyps accounts for the failure of colonoscopy to detect up to 10 percent of precancerous lesions.

Dr. Soetikno urges gastrointestinal specialists, including surgeons, to re-evaluate the significance of flat and depressed lesions in Western countries and to become as adept as Japanese specialists in identifying and treating these lesions.

Colorectal Screening Recommendations

Screening refers to tests that can be done in an attempt to discover early-stage cancers (that is, very curable) or polyps that might give rise to a cancer.

Men and women over 50 years old and of “average risk” should undergo screening for colorectal cancer.

Preferred tests include:

- A flexible sigmoidoscopy and digital rectal exam every five years AND an annual analysis of a stool sample (either fecal occult blood test [FOBT] or fecal immunochemical test [FIT])
- A total colon exam (colonoscopy) every 10 years.

People with a higher than average risk should begin colorectal cancer screening at a younger age, undergo screening more frequently and have colonoscopy in preference to sigmoidoscopy for complete evaluation of the colon.
‘If I had to be sick, I wanted to be treated at Stanford’

Ko attributes much of his success to some simple Zen Buddhist principles he learned from his grandmother: the importance of earning trust, attaining harmony and virtue and expressing appreciation.

KOICHI NISHIMURA, PHD
Dr. Koichi (Ko) Nishimura knows what constitutes outstanding service. During his 15 years as CEO, President and COO of Solalectron, the world’s largest and most profitable electronics manufacturing services company, Solalectron won over 250 quality and service awards. The company was the first in history to twice receive the prestigious Malcolm Baldrige National Quality Award for performance excellence in business.

Ko attributes much of his success to some simple Zen Buddhist principles he learned from his grandmother: the importance of earning trust, attaining harmony and virtue and expressing appreciation.

“By filling the cups of others, yours will continue to be filled,” was another of the core principles Ko’s grandmother instilled in him.

All of these precepts were at the heart of a recent gift of $1 million Ko and his wife Holly gave to the Stanford Cancer Center to honor his team of physician-researchers – oncologist George Fisher, MD, PhD, surgeon Mark Welton, MD, and Stanford-affiliated gastrointestinal specialist Harvey Young, MD – for their dedication to research and patient care.

A native Californian with deep roots in Silicon Valley and at Stanford University, where he received a PhD in applied science and engineering, Ko appreciates the entrepreneurial spirit of Stanford. Always drawn to the “creative flow” in people, Ko believes that value is achieved through innovation and excellence.

“If I had to be sick, Stanford was where I wanted to be treated. I met and was treated by doctors who are leaders in their field – doctors with tremendous empathy and intelligence. I was the beneficiary,” he said.

“Making this gift is my way of showing trust and appreciation for the people who saved my life, and honors them for their minds, ingenuity and spirit. The gift is intended to seed their creativity and to allow them to determine how to use it to help others,” Ko said.

To schedule an appointment at the Stanford Cancer Center, contact the referral nurse, who will direct your call.

Hours of operation:
Monday–Friday, 8 am to 5 pm
Phone: New patients: (877) 668-7535
Gastrointestinal Multidisciplinary Clinic: (650) 723-3913
Email: referral@stanfordmed.org
Canary Foundation and Stanford Create Center for Cancer Early Detection

Canary Foundation, a nonprofit organization that funds research in early cancer detection, and Stanford University will create a Center of Excellence for Cancer Early Detection Through Imaging.

Canary Foundation celebrates this alliance with a pledge of $7.5 million, $4 million of which will be matched by $4 million from the Department of Radiology, for a total of $11.5 million dollars for cancer early detection research. The Center of Excellence for Cancer Early Detection Through Imaging will be headed by Sanjiv Sam Gambhir, MD, PhD, professor of radiology & bioengineering, and director of the Molecular Imaging Program.

Don Listwin, founder and CEO of Canary Foundation, said: “Canary Foundation’s strategy is to pursue short-term goals by funding research that will lead to simple blood and imaging tests that can identify and isolate cancers at their earliest points, when it is most treatable and chances for full recovery are greatest.”

Funds from Canary Foundation’s pledge will go to fund Dr. Gambhir’s laboratory, which focuses on merging advances in molecular biology with those in biomedical imaging to advance the new field of molecular imaging. These imaging approaches are leading to better ways to diagnose and manage diseases as well as allowing fundamental studies of cancer biology in living subjects.

Another recipient is Patrick Brown, PhD, whose laboratory works with DNA microarrays to better understand how the molecular microenvironment influences the survival and proliferation of normal and cancer cells to identify patterns of gene expression that can be used to detect cancers and predict their potential for progression or response to specific therapies. James Brooks, MD, known for his research on the treatment of prostate cancer, and Simon Fredriksson, PhD, who has been studying proximity ligation technology, will also receive funds.

To learn more about The Stanford Challenge and how your gift can support the Cancer Center’s work, please contact the Office of Medical Development at (650) 234-0600 or givinginformation@med.stanford.edu.
FOUR QUESTIONS

Weight and diet are clearly associated with cancer risk, but the highest risk factor is smoking.

There were 369 fewer deaths from 2002 to 2003, followed by 3,014 fewer deaths from 2003 to 2004. The largest drop was in colon cancer, with significant drops also reported in breast and prostate cancers. We asked cancer specialist George Fisher, MD, PhD, associate professor of medicine-oncology, what this means.

SCC: With two consecutive years of decreases in cancer deaths, is it too early to say that we’re winning the war on cancer?

Fisher: The statistics show that the war is winnable. With trends going the other direction for many years, people felt the war wasn’t being fought. These statistics don’t include improvements in treatment during the past five years. I think in future years the trend will continue and these newer treatments will result in even fewer cancer deaths.

SCC: Why the decrease in colorectal, breast and prostate cancer?

Fisher: These are all cancers with effective screening tests to detect the cancer early. When we catch cancers at an early stage, they respond better to treatment. Uterine cancer (primarily cervical) has fallen from being the top cause of cancer death in women in 1930 to the sixth leading cause of cancer death today. That speaks to the value of the regular Pap smear to detect precancerous cervical cells and eliminate them before they develop into an invasive cancer. If we could apply that same standard to all cancers where we know there are effective screening tests, we’d see the cancer death rates fall even more. We also have a lot of work to do to find new markers for cancers such as pancreatic, ovarian and stomach cancer, where good diagnostics don’t already exist.

SCC: The decreases don’t hold up for all racial groups. What can be done to eliminate these disparities?

Fisher: These are all cancers with effective screening tests to detect the cancer early. When we catch cancers at an early stage, they respond better to treatment. Uterine cancer (primarily cervical) has fallen from being the top cause of cancer death in women in 1930 to the sixth leading cause of cancer death today. That speaks to the value of the regular Pap smear to detect precancerous cervical cells and eliminate them before they develop into an invasive cancer. If we could apply that same standard to all cancers where we know there are effective screening tests, we’d see the cancer death rates fall even more. We also have a lot of work to do to find new markers for cancers such as pancreatic, ovarian and stomach cancer, where good diagnostics don’t already exist.

Fisher: The biggest factor that explains racial disparity is access to care, prevention and screening. We’re also just beginning to understand genetic factors that underlie cancer risk. Certainly, programs that reach out to underserved communities will improve the outcomes for those populations, as will a better understanding of the unique biology of tumors in different populations.
Entering the Stanford Cancer Center, the first thing you’re likely to notice is the bright, spacious lobby and the circular welcome desk. Chances are there will be a person behind the desk—a smiling patient navigator expertly trained to help to guide you through your experience. The navigators are the first contact for a wide range of personal services available to patients and their families.

The Cancer Center’s patient navigators are specially trained volunteer ambassadors who provide the utmost in hospitality and customer service. Navigators personally accompany patients and families, taking them to and from appointments and providing them with information and resources.

For example, navigators roam the hallways, offering beverages, newspapers and magazines, and providing a friendly ear. They may also drive people in the tram to appointments, find housing and restaurants for people from out of town, play games with patients while they are receiving infusion therapy or find a wig or scarf for a chemotherapy patient. “No request is too large or too small,” said Anita Oltmans, associate director of Cancer Concierge Services.

Navigators are only the beginning of what the Cancer Concierge Services program offers. Other services include patient advocates, and an extensive Cancer Supportive Care Program. “The center gives us the opportunity to collaborate and work as a team on behalf of our patients. It’s designed to focus on the patient, and this service is part of that focus. We aim to offer continuity of care to patients and personalized attention throughout their experience at Stanford,” said Holly Gautier, RN, director of Cancer Concierge Services.

Patient Navigators: Helping Every Step of the Way

Advocates provide educational and emotional support during the decision-making period and entire treatment process.

TAKING THE MYSTERY OUT OF THE SYSTEM

Patient advocates help coordinate the services of nurses, dietitians, social workers, psychologists, financial counselors and administrative staff. They also provide educational and emotional support during the difficult decision-making period and throughout the treatment process.

The advocates also can help patients make appointments, accompany them during their clinical visits, and help them access their medical records.

ONGOING HEALING

While the navigators and patient advocates help patients and their families with their day-to-day needs in the center, the Cancer Supportive Care Program extends into an ongoing role, providing a bridge between medical services and other aspects of healing. Patients and their families can choose from a wide variety of therapies, workshops, support groups and activities — nutritional consultation, chair massage, restorative yoga, art and imagery, medical qigong and many others.

For more information, please call (650) 723-4268 or visit Cancer Concierge Services at: http://cancer.stanfordhospital.com/forPatients/amenities/cancerPatientServices
Hereditary Colorectal and Gastrointestinal Cancer

The Stanford Cancer Genetics Program focuses on prevention and on early detection, when treatment is most effective.

The majority of colorectal and other gastrointestinal (GI) cancers occur sporadically, due to chance, environmental exposures or lifestyle. However, family history increases the risk of GI cancers, and approximately 5 to 10 percent of people diagnosed with GI cancers have a form of the disease caused by known inherited mutations (changes) in cancer susceptibility genes. In families who carry one of these mutations, the chances of developing colorectal and or other GI cancers are significantly higher than in the general population.

Families with multiple members diagnosed with colorectal or other GI cancers, such as those of the stomach or pancreas, particularly at young ages (younger than 50) and in multiple generations, are encouraged to consider evaluation at the Stanford Cancer Center Cancer Genetics Program. This unique program offers genetic counseling and genetic testing for individuals concerned about the risk of inherited colorectal, GI and other cancers.

The Stanford program was among the first in the country to begin counseling families with inherited genes that increase the chance of developing GI cancers, particularly stomach cancers.

“Our goals are to educate people about familial cancer and options for genetic testing, to provide clear options for medical or surgical interventions and to identify strategies for prevention and early detection of cancer before it becomes invasive for families at high risk for developing cancer,” said James Ford, MD, associate professor of medicine-oncology and of genetics, who leads the Stanford Cancer Genetics Program.

He and Jeffrey Norton, MD, professor of surgery at Stanford, are known internationally for their clinical research on a mutation in a gene named E-cadherin (CDH1) that confers up to an 80 percent risk for developing hereditary diffuse gastric cancer (HDGC), a deadly form of stomach cancer that can occur in individuals less than 40 years of age.

Recently, Dr. Ford’s group detected the CDH1 mutation in 11 cousins from a large family in which many members had died of gastric cancer. None of the cousins, who were all in their mid-50s, had shown any signs or symptoms of gastric cancer.

After undergoing extensive genetic counseling and screening as part of a clinical protocol with Ford and colleagues in diagnostic radiology and GI endoscopy, six of the cousins decided to undergo preventive surgery to have their stomachs removed (gastrectomy) by Norton.

Remarkably, all six were found to have multiple microscopic areas of early gastric cancer scattered throughout their stomachs (and the 5 other cousins ultimately had similar results).

Despite the radical nature of the approach to disease prevention in this family, the surgeries likely resulted in curing all six of an otherwise lethal cancer. Therefore, the appropriate use of genetic testing and counseling can powerfully influence the ability to prevent and detect cancer early in cancer-prone families.

For more information on the Stanford Clinical Cancer Genetics Program, call: (650) 724-4363; email: cancer-genetics@lists.stanford.edu or visit their website at: http://cancer.stanfordhospital.com/forPatients/services/geneticCounseling/default.
FOSTERING A CONTINUUM OF CANCER CARE

The Colorectal Cancer Program at Stanford
CONTINUED FROM PAGE 4

new and potentially promising drug therapies. Examples of clinical research in prevention, detection and treatment of GI cancer, include:

Prevention: James Ford, MD, associate professor of medicine-oncology and of genetics, helped identify a mutation in a gene called E-cadherin that results in a very high incidence of gastric (stomach) cancer (see page 8).

Another example of clinical research leading to new prevention strategies for colorectal cancer is the subject of an article in this newsletter (see “The 10 Percent Solution,” page 5).

Chemotherapy: Stanford was the first institution to combine two unapproved drugs (oxaliplatin and a drug targeting the EGFR [epidermal growth factor receptor] protein) in patients with advanced colorectal cancer. The high remission rate observed in that clinical trial led to many other studies to find the best possible combination for patients. After further refinement, this approach has become a standard option for patients. George Fisher, MD, PhD, associate professor of medicine-oncology, and his colleagues are now testing the value of standard chemotherapy (capecitabine and oxaliplatin) in combination with a new agent, vandetanib, a drug that not only blocks production of the EGFR protein, but also interferes with new blood vessel formation in tumors. This study is available for patients with newly diagnosed advanced colorectal cancer.

The GI Oncology Program has many clinical trials available for patients with newly diagnosed rectal cancers, advanced colon cancers, untreated localized and metastatic pancreas cancer and for esophageal and gastric cancers. Studies also are available for some rare tumors, such as neuroendocrine tumors (including carcinoid).

Patients who have a new diagnosis of cancer should inquire as to the availability of clinical trials before starting on therapy. Other trials using novel therapies may be available for patients who have already received standard treatment that is no longer effective.

For information regarding the clinical trials that are currently available, please contact the Stanford Clinical Trials Office at (650) 498-7061 for information about additional open clinical trials.

ON THE HORIZON
Laboratory researchers at Stanford are working with the GI oncology physician scientists to bring new discoveries to patients. Michael Clarke, MD, an oncologist and nationally recognized expert on cancer stem cells, has discovered stem cells in the tumors of patients with pancreatic and colorectal cancer (see page 3).

Edgar Engleman, MD, professor of pathology and of medicine, is an authority on cell-based vaccine technologies. He and his laboratory colleagues have identified new ways of inducing an immune response to tumors in mice, resulting in cures in the majority of treated mice. Drs. Fisher and Engleman are collaborating on clinical trials testing these vaccines in selected patients with GI cancers.

By making research a centerpiece of its mission, the Stanford GI team remains at the forefront of clinical care and extends to patients the benefits of this knowledge. Close collaboration among experts from different disciplines, each specializing in GI cancers, affords patients and their family outstanding care.

COLONRECTAL SCREENING RECOMMENDATIONS
CONTINUED FROM PAGE 5

For more information on colorectal and other cancers, visit the Health Library at the Stanford Cancer Center Branch on Monday through Friday, 9 am to 5 pm, at 875 Blake Wilbur Dr., rm. CC108 (650) 736-1713, or http://cancer.stanfordhospital.com/forPatients/amenities/healthLibrary/default.
Nationwide, only 20 percent of Americans report having had a fecal occult blood test (FOBT) during the preceding year, and 30 percent report having had a sigmoidoscopy or a proctoscopy during the previous five years.

Screening rates are even lower among Vietnamese Americans: 65 percent of Vietnamese men and women aged 40 and older have never had an FOBT, compared to 61 percent of adults in the United States.

To reduce the illness and death caused by colorectal cancer among Vietnamese Americans, the Stanford-affiliated Northern California Cancer Center (NCCC) is conducting an intervention study to increase colorectal cancer screening and identify factors that can improve screening in this population. Bang Nguyen, DrPH, MPP, a scientist at the NCCC and the Stanford Cancer Center, directs the study.

The study focuses on educating Vietnamese Americans aged 50 to 74 and their doctors in Northern California, and includes face-to-face interviews, as well as development and distribution of culturally and linguistically appropriate health education and media campaign materials.

For more information on this study, call the NCCC at (510) 608-5000.