

# Melanoma Horizons

*This is a semiannual departmental newsletter from M.D. Anderson Cancer Center to referring physicians about the latest advances in melanoma cancer research in the Department of Melanoma Medical Oncology.*

Issue 4

August 2007

*Inside this issue:*

**New Immuno-therapy Clinical Trial** 1, 3

**Faculty Spotlight** 2

**CTT Grants** 2

**DoCM Employee Recognition** 2

**Clinical Trials** 4-5

**Melanoma Grants** 6

**EAB Review** 6

**How to Refer Patients** 6

**How to Help** 6

## New Immunotherapy Clinical Trial Using Patients Own Immune Cells Promises to Revolutionize Melanoma Treatment at M.D. Anderson Cancer Center – by Dr. Laszlo Radvanyi

There is an exciting new lab at the South Campus of M.D. Anderson Cancer Center that is at the center of a new and exciting clinical trial promising to revolutionize the treatment of melanoma by using the patients own immune system and immune cells to fight their cancer. This lab is working on an exciting new treatment method for melanoma called Adoptive T-cell Therapy or “ACT” for short. The basis for this new and powerful treatment is the patients’ own T-cells or lymphocytes that normally invade their own tumors and try to kill the tumor. But, for reasons we are still trying to find out, although these “tumor-infiltrating lymphocytes” (“TIL” for short) heroically try to kill the tumor, the tumor wins out because it suppresses the function of these T-cells. We have found that ACT can tip this balance the other way and get the T-cells to win and kill the tumor. The way ACT works is by harvesting a patients’ melanoma by surgery and in

a sterile fashion cutting up the tumor into small pieces (1-2 mm) and placing these pieces into cell culture medium. These tumor pieces still have the T-cells inside and we can drive these T-cells to migrate out of the small tumor pieces and to multiply to high numbers using a growth factor called “interleukin-2” or “IL-2”. As shown in the diagram, the T-cells are expanded over several weeks in cell culture from a few million to 10 to 100 billion cells! These cells are harvested and pooled into a sterile bag, and then infused into a waiting melanoma patient. The final T-cell expansion and pooling into the infusion bag takes place in M.D. Anderson’s state-of-the-art Good Manufacturing Product (GMP) facility licensed by the FDA. Our GMP facility is led by two highly talented individuals, **Dr. Elizabeth Schpall** (Medical Director) and **Dr. John D. McMannis** (Laboratory Director) who assure the sterility and safety of the infused cell product.

Previous clinical trials at The National Cancer Institute (NCI) in Bethesda, MD have already proven the success of this therapy. These clinical trials have found a remarkable 51% clinical response rate in Stage IV melanoma with many patients surviving for years. Part of the success of these clinical trials at the NCI is due to the inclusion of a novel step in the ACT process. The researchers there found that depleting the existing lymphocytes from the patient with two specific drugs (a process called “lymphodepletion”) greatly augments the ability of the infused T-cells to survive, and further expand and kill the tumors in the patient. We believe that the reason for this is that the infused T-cells don’t need to compete with the patient’s other T-cells for nutrients and growth factors, allowing these infused tumor-specific T-cells to survive and function much better. Our clinical ACT trial here at M.D. Anderson Cancer Center, headed by **Dr. Patrick Hwu**, also

*Continued on page 3*

### TIL Lab Group:

*Pictured (left to right):*

Rahmatu Bassie, Dr. Laszlo Radvanyi, Orenthial Fulbright, and Kathryn Bushnell.

*(Not pictured – Dr. Patrick Hwu and Marissa Gonzalez)*





### Faculty Spotlight: Dr. Patrick Hwu, Dr. Wen-Jen Hwu

Congratulations to Dr. Patrick Hwu, Professor and Chair of Melanoma Medical Oncology, winner of the **2007 Best Boss Award!**

Congratulations to Dr. Wen-Jen Hwu, Professor, winner of the **2007 Division of Cancer Medicine Hematology–Oncology Fellowship Teaching Award LBJ Hospital!**



Patrick Hwu, M.D.

Wen-Jen Hwu, M.D., Ph.D.

### Center for Targeted Therapy (CTT) Disease-Specific Therapy Grants (Melanoma)

The CTT in conjunction with the Department of Melanoma Medical Oncology announces a program to award up to ten grants of \$100,000 for 2 years for translational studies of new therapies for melanoma. The objective is to stimulate innovative, hypothesis-generating research relevant to the therapy of melanoma (mechanisms or agents) that can be used to obtain extramural funding. This includes but is not limited to studies of signaling pathways, targeted agents, gene therapies, non-antibody immune based therapies and novel agents.

The grants will be \$50,000 per year for 2 years (contingent on satisfactory progress after the first year)

- Applications will be accepted from all MDACC investigators (including NTRA)
- In order that the research will have translational benefit relevant to the disease a clinical investigator must be a co-investigator (for a list of potential clinical collaborators, see below) Letter of Intent Deadline October 1, 2007 sent to [ETDept@mdanderson.org](mailto:ETDept@mdanderson.org) marked CTT Grant Program.

- Grant Program Application Deadline November 1, 2007 sent to [ETDept@mdanderson.org](mailto:ETDept@mdanderson.org) marked CTT Grant Program.
- To download the grant application and additional application guidelines please visit <http://inside.mdanderson.org/departments/et/news.html>

Melanoma Clinical Collaborators:

- Agop Bedikian, M.D.,
- Janice Cormier, M.D., M.P.H.,
- Michael Davies, M.D., Ph.D.,
- Jeffrey E. Gershenwald, M.D.,
- Patrick Hwu, M.D.,
- Wen-Jen Hwu, M.D., Ph.D.,
- Kevin B. Kim, M.D.,
- Jeff E. Lee, M.D.,
- Anthony Lucci, M.D.,
- Paul Mansfield, M.D.,
- Nicholas Papadopoulos, M.D.,
- Merrick Ross, M.D.

### Fourth Annual DoCM Employee Recognition and Awards Ceremony

Congratulations to **Ryan Campbell**, Research Assistant II, on receiving a Citation for Excellence Award in the laboratory research category for the Division of Cancer Medicine’s annual Employee Recognition and Awards Program in June 2007.



Congratulations to **Priscilla Miller**, Senior Research Nurse, on her nomination for Exemplary Employee Award for the Division of Cancer Medicine’s annual Employee Recognition and Awards Program in June 2007.



Congratulations to **Michelle Rohlfs**, Advanced Practice Nurse, on her nomination for a Citation for Excellence Award in the advanced clinical practice category for the Division of Cancer Medicine’s annual Employee Recognition award.



## New Immunotherapy Clinical Trial ... continued

includes this new lymphodepletion step in the protocol to further improve our success.

The reason why this T-cell expansion and infusion process is so successful in treating metastatic melanoma is still under investigation. Our research has found that the process of taking the T-cells out of the patient and expanding them with IL-2 highly activates these cells to become more powerful "killer cells" that home into and kill remaining tumors when re-infused into the patient. To further help the T-cells, we infuse more IL-2 into the patient to keep the cells activated. ACT promises to revolutionize the way we treat melanoma, especially patients that have run out of other treatment options. The other reason why this process is successful is that it effectively removes the T-cells from the tumor environment and expands the cells in culture outside of the suppressive factors residing in tumors. So, when its time to re-infuse the expanded T-cells, they are "re-vitalized" and may no longer be sensitive to the tumors' effects when they hone back in to the tumor to kill it.

Another critical aspect to our new ACT approach here at M.D. Anderson Cancer Center is that it increases the number of treatment options for patients who relapse after being in clinical remission. Thus, ACT can be an excellent "insurance policy" for many patients. Here's how this works: Many patients are rendered disease-free following surgery and do not need additional therapy for a while. By consenting to enter our ACT, we will obtain a part of their excised tumor for expanding the tumor-infiltrating lymphocytes, as shown above. However, in this case we do not need to immediately infuse the expanded cells and can cryopreserve them for later use. Unfortunately the nature of melanoma is that very frequently (>50% patients) the disease aggressively returns with additional metastases that may not be amenable to surgery. Thus, the beauty of ACT, is that if the patient relapses, we can thaw the previously cryopreserved T-cells, and further expand them into the billions of cells. This increases the number of options patients have in the event of a relapse. At present we have recruited 70+ patients in our ACT clinical trial, and have successfully grown T-cells for over 40% of patients. Some of these patients are in clinical remission and will have T-cells ready for infusion in the event they relapse in the future. We expect to recruit up to 200 patients for this initial ACT trial and have started infusing our first patients.

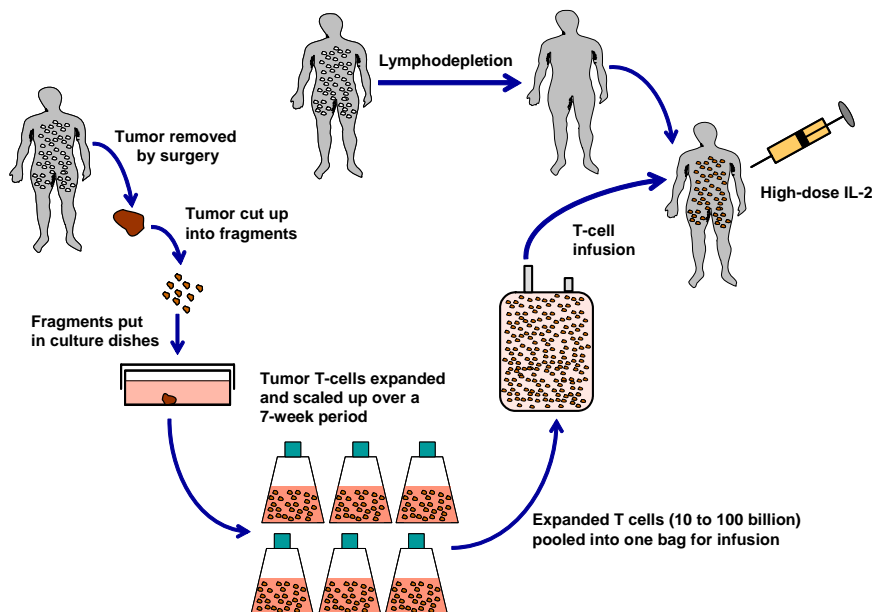
This whole process of ACT is quite labor intensive and requires the dedication and vigilance of a team of experts and technicians

at each step. The task of growing these delicate T-cells in the lab is being undertaken by a skilled group of people in our South Campus Lab, specifically **Kathryn Bushnell**, **Rahmatu Bassie**, **Orenthial Fulbright**, and the newest member of the lab, **Marissa Gonzalez**. In addition to this team effort in the lab, we rely on the hard work of a team of gifted surgeons (**Drs. Jeff Gershenwald**, **Jeff E. Lee**, **Merrick Ross**, **Paul Mansfield**, **Janice Cormier**, **Anthony Lucci**, and others) at M.D. Anderson Cancer Center without whom this whole treatment could not take place. In addition, a team of pathologists led by **Dr. Victor Prieto** is also involved in the initial part of the process. They take the tumors removed by the surgeons and make sure it is a good specimen for further processing. We then pick-up the tumor pieces from them and take it to the lab to expand the T-cells for infusion. Another critical link in the chain is our tireless Research Nurse, **Priscilla Miller** who identifies and consents patients for our ACT protocol with **Dr. Hwu**. It is really amazing how this talented multidisciplinary team functions and it's a pleasure to work with them.

In addition to the clinical work our lab is doing in expanding T-cells for ACT at M.D. Anderson Cancer Center, we are also actively involved in basic research on understanding how tumor-derived T-cells function and survive, and what specific protein markers can be used to isolate the most highly active ones for infusion into patients. This basic work is being undertaken by a group of talented postdoctoral fellows and graduate students in the lab. Our clinical work has greatly benefited these basic research efforts by allowing us to use any leftover tumor tissue not needed for T-cell expansion for our lab experiments. Thus, the tumors removed

from patients in our ACT clinical study is put to maximum use and no part of it is thrown away! Access to these valuable specimens has already led us to make a number of new and important discoveries on the biology of these T-cells and ways to improve their function. For example, we have found that we can further activate these tumor-derived T-cells in culture with specialized cells called dendritic cells. We are now beginning to test this in our patients by making dendritic cells from their blood and infusing them along with the expanded T-cells. Our pre-clinical experiments using mice have found this to be an even more potent way of eradicating tumor cells. Another research area we are pursuing is the identification of phenotypic markers on the expanded T-cells for infusion associated with longer-lasting and more active cells in the patients. Our initial data suggest that a subset of younger, less differentiated T-cells in the final cell product in ACT may be primarily responsible for most of the anti-tumor activity after infusion. In future clinical trials, we will attempt to specifically expand these younger and more active T-cells to further improve clinical success rates. Our eventual hope is that a number of different ACT protocols will be available in the future allowing us to select the best one for each individual patient.

Patients and referring physicians interested in participating in our ACT protocols at M.D. Anderson Cancer Center should contact the Melanoma Oncology Department offices at 713-792-2921.



## Current Clinical Advances in Melanoma Oncology

Major advances in the treatment of melanoma will only occur if we continue to aggressively pursue novel clinical trials. Due to recent discoveries in the basic science of immunology and cancer biology we have wonderful opportunities to make a major impact with these trials.

**Below is a list of current, approved Melanoma Oncology clinical trials as of 08/31/2007, to refer a patient please see page 6.**

### Adjuvant:

1. [Leuprolide + Peptide vaccine \(2004-0502\)](#) Phase II

Principal Investigator: Dr. Patrick Hwu  
Research Nurse: Priscilla Miller, R.N.

This study tests if sex hormone blockade will result in enhanced thymic activity in melanoma patients that will lead to improved anti-tumor T-cell responses following antigen-specific immunization. Patients will be randomized to receive different combinations of gp100, MAGE-3, and Leuprolide vaccine. Patients must be HLA-A2+, and have no history of immunization with gp100 or MAGE-3 vaccines.

### Neoadjuvant:

1. [Temozolomide alone or with Pegylated interferon-alpha 2b \(2005-0143\)](#) Phase II

Principal Investigator: Dr. Wen-jen Hwu and Dr. Merrick Ross  
Research Nurse: Minette Garcia, R.N.

Temozolomide is a drug that is designed to work by stopping cancer cells from making new DNA. Pegylated Interferon Alpha-2b is a protein made by the human immune system that helps to fight viral infections regulate cell function. Patient may not have had any prior systemic chemotherapy.

### Chemo-naïve patients (i.e. no previous chemotherapy):

1. [Palonosetron with Biochemotherapy \(2005-0506\)](#) Phase I/II

Principal Investigator: Dr. Agop Y. Bedikian  
Research Nurse: Sandy Mahoney, R.N.

Evaluation of two different schedules of palonosetron for the prevention of nausea and vomiting in patients with metastatic melanoma receiving concurrent biochemotherapy. Patients must have non-resectable stage III or stage IV metastatic melanoma with measurable disease, and agree to be treated with biochemotherapy.

2. [Biochemotherapy with Temozolomide \(DM03-0218\)](#) Phase II

Principal Investigator: Dr. Nicholas Papadopoulos  
Research Nurse: Suzanne Cain, R.N.

Concurrent biochemotherapy with cisplatin, velban, IL-2, interferon alfa, temozolomide, and thalidomide. Temozolomide has been shown to induce regression of brain metastases. Thalidomide may enhance the anti-tumor activity & decrease the toxicity of the biochemotherapy via a number of mechanisms.

3. [Taxol-Carbo +/- Avastin \(2006-1054\)](#) Phase II

Principal Investigator: Dr. Kevin Kim  
Research Nurse: Sandy Mahoney, R.N.

This study is designed to estimate the clinical benefit of the addition of bevacizumab to carboplatin + paclitaxel and to characterize the safety profile of bevacizumab when added to carboplatin + paclitaxel as first-line treatment of metastatic melanoma.

### Chemo-naïve patients OR patients who have had previous chemotherapy:

1. [BAY43-9006 \(Sorafenib\) + CCI-779 \(Temozolomide\) \(2005-0215\)](#) Phase I/II

Principal Investigator: Dr. Kevin Kim  
Research Nurse: Karen Woodard, R.N.

BAY43-9006 is an inhibitor of C-Raf, B-Raf, VEGFR and PDGFR, and CCI-779 is an inhibitor of mTOR. Whether inhibiting two of the commonly activated signal pathways in melanoma leads to better clinical outcome will be studied. Patients must have easily biopsiable tumor (skin, SQ, superficial lymph nodes) to enroll.

2. [T-cells +/- dendritic cells \(2004-0069\)](#) Phase II

Principal Investigator: Dr. Patrick Hwu  
Research Nurse: Priscilla Miller, R.N.

In this study, T-cells capable of recognizing and killing melanoma will be isolated from tumor biopsies and expanded in the laboratory. The T-cells will then be reinfused into the patients with or without dendritic cells, which are immune cells capable of potentially activating T-cells. This study is for patients with a good performance status, with measurable metastatic melanoma, and a site that can be easily biopsied.

3. [INGN 241 \(Ad-mda7\) \(2003-0590\)](#) Phase II

Principal Investigator: Dr. Kevin Kim  
Research Nurse: Ingrid Hernandez, R.N.

INGN 241 is an adenoviral vector carrying the mda-7 cDNA which is a tumor suppressor with cytokine properties. When administered as an intratumoral injection into melanoma in transit lesions, it is expected to induce apoptosis in regional uninjected lesions and initiate systemic immune activation. This study is for patients with melanoma in transit disease with at least three regional lesions.

4. [VSL1 \(Liposomal Vincristine\) \(2004-0360\)](#) Phase I/II

Principal Investigator: Dr. Agop Y. Bedikian  
Research Nurse: Anna Vardeleon, R.N.

This is a liposomal formulation of vincristine which is a chemotherapy drug that damages cancer cells during the cell division phase and may slow the growth of the cancer cells. The patient should have a serum bilirubin level between 1.5 mg/dl and 3 mg/dl to qualify for the study.

5. [Temodar + Thalidomide + CCNU \(2004-0595\)](#) Phase II

Principal Investigator: Dr. Nicholas Papadopoulos  
Research Nurse: Suzanne Cain, R.N.

Temozolomide, Lomustine and Thalidomide will be combined as a therapeutic agent. Temozolomide has shown activity against CNS metastases, and Thalidomide is an antiangiogenic agent. Lomustine, an oral nitrosore, has activity against disseminated melanoma. This study is for patients with brain metastases.

6. [IL-2 +/- gp100 \(2003-0835\)](#) Phase II

Principal Investigator: Dr. Patrick Hwu  
Research Nurse: Laura Bales, R.N.

IL-2 is a natural protein that boosts the immune system. A group of patients in the study will also receive the gp100 cancer vaccine in a combination with IL-2. This protocol is for patients with measurable stage IV or locally advanced stage III melanoma from a cutaneous primary.

7. [CRO11-vcMME \(2006-0378\)](#) Phase I

Principal Investigator: Dr. Patrick Hwu  
Research Nurse: Deborah Sanders, R.N.

CRO11-vcMME potentially inhibits the growth of a variety of melanoma cell lines in vitro by binding to cell surface Glycoprotein NMB. Patients must have unresectable stage III or stage IV melanoma

8. [TKI-258 \(2005-0838\)](#) Phase I

Principal Investigator: Dr. Kevin Kim  
Research Nurse: Laura Bales, R.N.

Chir-258 is a small molecule receptor tyrosine kinase inhibitor with potent activity against receptors for VEGF, PDGF, and FGF. Inhibition of these growth factors has been found to inhibit melanoma growth in animal models.

9. [CHIR-265 \(2005-0949\)](#) Phase I/II

Principal Investigator: Dr. Kevin Kim  
Research Nurse: Cora Cheung, R.N.

## Current Clinical Advances in Melanoma Oncology – *continued*

RAF265 is a novel small molecule with potent inhibitory activity against mutant B-Raf kinase, VEGFR-2 and also to a lesser degree, PDGF- $\alpha$ , and c-kit.

10. [PLX06-02 \(2007-0088\)](#) Phase I

Principal Investigator: Dr. Kevin Kim

Research Nurse: Deborah Sanders, R.N.

This study will Provide an assessment of the safety, tolerability, pharmacokinetics, and pharmacodynamics activity of ascending doses of PLX4032. This is the first assessment of PLX4032 in patients with solid tumors.

11. [INO \(2004-0833\)](#) Phase I

Principal Investigator: Dr. Agop Bedikian

Research Nurse: Shelly Glass, R.N.

This study will evaluate the safety and tolerability of combined therapy with oral temozolomide (TMZ) and intravenous INO-1001 in subjects with unresectable Stage III or Stage IV melanoma. INO-1001 is an ultrapotent PARP (a monomeric nuclear enzyme present in eukaryotes) inhibitor.

### Patients with metastatic choroidal melanoma:

1. [VSL1 \(Liposomal-Vincristine\) \(2004-0360\)](#) Phase I/II

Principal Investigator: Dr. Agop Y. Bedikian

Research Nurse: Anna Vardeleon, R.N.

This is a liposomal formulation of vincristine which is a chemotherapy drug that damages cancer cells during the cell division phase and may slow the growth of the cancer cells. The patient should have serum bilirubin level between 1.5 mg/dl and 3 mg/dl to qualify for the study.

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Concurrent biochemotherapy with cisplatin, velban, IL-2, interferon alfa, temozolomide, and thalidomide. Temozolomide has been shown to induce regression of brain metastases. Thalidomide may enhance the anti-tumor activity & decrease the toxicity of the biochemotherapy via a number of mechanisms.

9. [PLX06-02 \(2007-0088\)](#) Phase I

Principal Investigator: Dr. Kevin Kim

Research Nurse: Deborah Sanders, R.N.

This study will provide an assessment of the safety, tolerability, pharmacokinetics, and pharmacodynamics activity of ascending doses of PLX4032. This is the first assessment of PLX4032 in patients with solid tumors.

10. [Taxoprexin \(2005-0357\)](#) Phase II

Principal Investigator: Dr. Agop Y. Bedikian

Research Nurse: Sandy Mahoney, R.N.

DHA-paclitaxel is related to the taxane family of microtubule-stabilizing agents with the ability to expose melanoma cells to high concentration of paclitaxel for a prolonged period due to unique pharmacokinetics. This study is for patients with metastatic uveal melanoma.

### Brain Metastases Protocols:

1. [Temodar + Thalidomide + CCNU \(2004-0595\)](#) Phase II

Principal Investigator: Dr. Nicholas Papadopoulos

Research Nurse: Suzanne Cain, R.N.

Temozolomide, Lomustine and Thalidomide will be combined as a therapeutic agent. Temozolomide has shown activity against CNS metastases, and Thalidomide is an antiangiogenic agent. Lomustine, an oral nitrosore, has activity against disseminated melanoma. This study is for patients with brain metastases.

### Laboratory Protocols:

1. [Biomarkers of high dose IL-2 responsiveness \(LAB06-0762\)](#)

Principal Investigator: Dr. Laszlo Radvanyi

Research Nurse: Deborah Sanders, R.N.

Interleukin-2 (IL-2) therapy has been used extensively over the past fifteen years to effectively treat patients with advanced metastatic melanoma and renal cell carcinoma. This study will aide to map out a complete picture of what IL-2 is doing in the PBMC and tumor site in melanoma patients. Patients must receive high dose IL-2 in order to qualify for this study.

2. [Blood & Tumor Sample Collection for Long Term Storage \(2005-0466\)](#)

Principal Investigator: Dr. Kevin Kim

Research Nurse: Edwina Green

This study will collect blood and tumor samples from patients with suspected or confirmed melanoma and place these samples in long-term storage for future biological and/or surrogate marker studies.



## ABCD's of Melanoma Diagnosis

### Asymmetry



### Border



### Color Variation



### Diameter



## Melanoma Medical Oncology Grants Awarded

In 2003 it was determined that the Department of Melanoma Medical Oncology should forge new alliances for collaborative efforts that combined the strengths of clinical and basic science investigators. It was agreed that a strong multi-disciplinary approach to patient care must involve surgeons, medical oncologists, radiologists, pathologists and laboratory scientists in a cohesive effort to redirect understanding of the human body's immune response to melanoma tumors. We are pleased to say that we have proven that this team approach holds great promise for best methods for discovery of and improvement on novel therapies. The one focused mission of this melanoma research alliance is to bring basic research concepts from the laboratory to our patients, while taking what we learn from our patients back to the lab for further investigation.

In light of the national government cutbacks for research, we have continued to maintain a steady and healthy growth in our grant funding. Since the inception of our team oriented approach, we have been awarded five National Institute of Health grants totaling over \$4.53M over a five year period to support our research initiatives. We are confident that this is due to the strong collaborative groundwork our excellent clinicians and scientists have put into place.

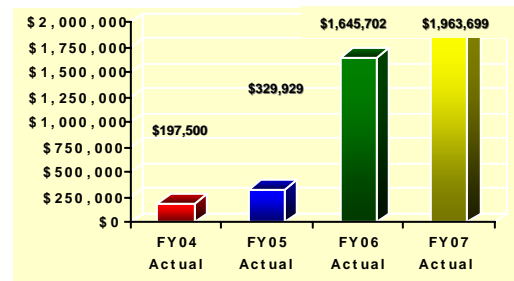
Most recently Melanoma Medical Oncology was awarded a \$1.1 million *UL Grant from the UT Health Science Center "Center for Clinical and Translational Science"* (5 years)

Philanthropic gifts from private donors and foundations also help support the advancement of translational research. The Melanoma Medical Oncology Department would like to acknowledge and thank donors for their generous contributions to cancer-related research projects.

### Melanoma Philanthropic Funding

*Aptia Systems*  
*Ashley Fister Cole Foundation*  
*Bradley O'Martin Melanoma Foundation*  
*Carl C. Anderson Sr., and Marie Jo Anderson*  
*Carol Cogdell Courtney Fellowship*  
*Kelly Golat Melanoma Research*  
*Gillson Longenbaugh Foundation*  
*Laura McMurrey*  
*Lehman Brothers Foundation*  
*Margaret T. Biddle Foundation*  
*Michael and Patricia Booker*  
*Modestus Bauer Foundation*  
*The Milkovich-Padilla Family*  
*The Reny Company*  
*William H. Prusoff Foundation*

### Melanoma Federal Grant Funding



... and many more who generously committed funds totaling \$628,429 in FY2007.

## External Advisory Board Review

The External Advisory Board (EAB) review for Melanoma Medical Oncology, held August 11, 2006, recognized the strong leadership of Department Chair **Patrick Hwu, M.D.**, particularly for bringing his immune-based research and treatment program from the NCI, obtaining three R01 grants, and successfully recruiting "a stellar group of young research faculty." "The department is now poised to be a major player in the field of immune-based research and treatment," the board noted. The EAB advised broadening the scope of the department's focus beyond immuno-

therapy to also build emerging research programs in targeted and anti-angiogenic therapies. This can be accomplished through increasing interaction with the melanoma SPORE and the Melanoma and Skin Center as well as with the six cross-disease research centers comprising the McCombs Institute for the Early Detection and Treatment of Cancer. In response to this review, the department has established a five year plan to develop three major new programs (details in next newsletter).

## How to Refer Patients

### Melanoma Patient Referral Office

Call 713-563-9716 or visit website:  
<https://www2.mdanderson.org/sapp/contact/preferral.cfm>

### Other Patient Referrals:

Call the M.D. Anderson Information Line  
 1-800-392-1611 OR 713-792-3245

If you need additional information or if you have any feedback regarding our newsletter, you can email us at: [melanoma@mdanderson.org](mailto:melanoma@mdanderson.org)

If you are a patient or physician and wish to set or track a patient appointment you may register for on-line access at: <https://my.mdanderson.org>

## You Can Make a Difference – How to Help

Gifts from individuals provide a significant portion of the funding needed to get new research off the ground. The Melanoma Oncology and Research Team is dedicated in helping our patients get the best treatment possible. Your contribution will help with our new research studies in the laboratory and the clinic, including studies of cancer vaccines, T-cell therapy, and new agents.

*To make a donation by phone* please call 713-792-3450 or 1-800-525-5841 and specify Melanoma Vaccines for your gift.

*To make an online donation*, you may visit our secure website page at [www.mdanderson.org/melresearch](http://www.mdanderson.org/melresearch)