

# Melanoma Horizons

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

Issue 7

February 2009

## Ocular Metastatic Melanoma – by Tina Dett, Agop Bedikian, M.D.

### Inside this issue:

Ocular Metastatic Melanoma 1, 3

DoCM Faculty Recognition 2

Multidisciplinary Publications 3

Clinical Trials 4-5

Melanoma Grants 6

Philanthropic Funding 6

How to Refer Patients 6

How to Help 6

Mention “melanoma” and skin cancer comes to mind. Melanomas vary and do not always involve the surface of our skin. Though, cutaneous melanomas are the most common type of melanomas, uveal or uveal melanoma warrants careful attention just the same. It is the most common primary intrauveal malignant tumor in adults and the second most common type of primary malignant melanoma.

Despite advances in diagnosis and management of primary uveal melanoma, systemic metastasis remains challenging. Treatment of metastatic choroidal melanoma has improved little over the past few decades. Since 40 to 50% of patients with primary uveal melanoma will ultimately develop metastasis, improvements in systemic treatments should be a primary focus in research as it could lead to better survival rates for these types of patients.

The majority of patients with metastatic uveal melanoma develop liver metastasis as the first site of metastatic disease. For 40% of patients it is the exclusive site. Median survival for these patients if left untreated is 2-3 months.

Unfortunately uveal melanoma has proven to be highly chemoresistant. Thus, therapeutic approaches have focused primarily on regional treatments. Regional treatments on the liver such as surgical resection, radiofrequency ablation, hyperthermic isolated hepatic perfusion, hepatic arterial infusion chemotherapy, and hepatic arterial chemoembolization (HACE) have proven to be beneficial for specific localized liver disease. Each has their limitations however. There are few patients that receive curative regional therapy. Most of the limitations are due to the presence of too many metastatic foci or large masses, tumors in difficult locations, tumors invading blood vessels, and insufficient hepatic reserve.

Of these treatments, chemoembolization (HACE) is a commonly used therapy for metastatic uveal melanoma to the liver. This works by injecting a foreign substance such as starch particle or Ivalon in the tumor to transiently stop the blood flow, depriving the tumor of needed oxygen and nutrients. This causes the cancer cells to eventually die. It also increases the contact time between the chemotherapeutic agent and the tumor. The addition of chemotherapy such as Cisplatin or BCNU together with an embolizing agent then stops the tumor blood supply and delivers the cytotoxic agent directly to the tumor. Higher concentrations of chemotherapy are delivered directly to the tumor compared to systemic treatment.

A retrospective analysis at MD Anderson showed chemoembolization was the only technique resulting in improved survival compared with other treatments, including systemic chemotherapy and chemotherapy

through a surgically implanted arterial port. Response rates to chemoembolization were associated with statistically significant longer survival (median 14.5 months) compared with nonresponders (5 months). Approximately one third of patients responded if they were previously treated with systemic therapy.

Uveal melanoma is classified as a type of melanoma. There are several differences between cutaneous and uveal melanoma types. Although there is a common embryologic origin of the melanocytes, there are many differences in clinical and biologic features. The etiology of uveal melanoma remains largely unknown, whereas cutaneous melanoma is linked to ultraviolet irradiation exposure. The eye lacks lymphatics, and uveal melanoma tends to spread by the hematogenous route, whereas cutaneous melanoma spreads more frequently through the lymphatic route. Furthermore, the molecular pathways altered in the development also differ.

These differences between cutaneous melanomas and uveal melanomas also translate into different treatment therapies. Research has shown that unlike cutaneous melanoma, uveal melanoma responds poorly to chemotherapeutic agents such as those in the “Dartmouth” regimen (DTIC, BCNU, Cisplatin, and Tamoxifen) or immunotherapies, such as interleukin or interferon.

Given the chemoresistance of choroidal melanoma cells to cytotoxic drugs, ATP-based tumor cell ex vivo chemosensitivity assays were used to examine the sensitivity of choroidal melanoma cells to single and multiple anticancer agents. Significant activity was observed with Gemcitabine, Treosulfan, Cytosine Arabinoside, Paclitaxel, and Mitoxantrone.

Here at MD Anderson we have screened several chemotherapeutic agents for efficacy in metastatic uveal melanoma during the past decade. Current clinical trials involve various novel chemotherapeutic agents such as DHA-paclitaxel (Taxoprexin), liposomal Vincristine (MARQIBO), and hepatic arterial nab-Paclitaxel (Abraxane). Future studies involve Abraxane + Gemcitabine and ABI-007 + Genasense.

Taxanes have been found to be active against metastatic melanoma. In particular Taxoprexin is likely to be more effective against choroidal melanoma than Paclitaxel in view its ability to expose the melanoma cell to high concentration of Paclitaxel for a prolonged period due to its unique pharmacokinetics.

MARQIBO is concentrated primarily by liver, metabolized and excreted via the biliary route. It has been found to concentrate in vascular tumors. The liver is a major site for the clearance of liposomes by macrophages and is the most common site for the recurrent uveal melanoma after treatment of the primary tumor.

*Continued on page 3*

## Third Annual DoCM Faculty Recognition and Award Program

Congratulations to **Nicholas Papadopoulos, M.D.**, Professor, on receiving the Melvin L. Samuels Awards for Excellence in Patient Care for the Division of Cancer Medicine's annual Faculty Recognition and Award Program in December 2008.



Congratulations to **Wen-Jen Hwu, M.D., Ph.D.**, Professor, on her nomination for the Gerald P. Bodey Award for Excellence in Education for the Division of Cancer Medicine's annual Faculty Recognition and Award Program in December 2008.



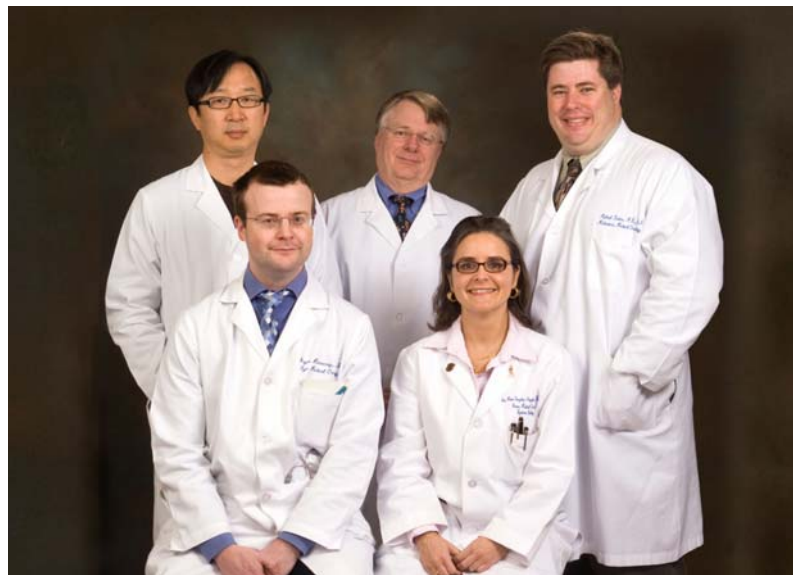
Congratulations to **Agop Bedikian, M.D.**, Professor, on his nomination for the Irwin H. Krakoff Award for Excellence in Clinical Research for the Division of Cancer Medicine's annual Faculty Recognition and Award Program in December 2008.



Congratulations to **Laszlo Radvanyi, Ph.D.**, Professor, on his nomination for the Emil Frei III, Award for Excellence in Translational Research for the Division of Cancer Medicine's annual Faculty Recognition and Award Program in December 2008.



Congratulations to **Michael Davies, M.D., Ph.D.**, Assistant Professor, on his nomination for the Waun Ki Hong Award for Excellence in Team Science for the Division of Cancer Medicine's annual Faculty Recognition and Award Program in December 2008.



## Ocular Metastatic Melanoma – cont'd

In a recently completed pharmacokinetics study of MARQIBO in patients with metastatic melanoma, 1 of 4 patients with uveal melanoma had durable complete remission. The patient remains in remission 18 months post discontinuation of therapy

Objectives for both the Taxoprexin trial and the MARQIBO trial involve evaluating objective patient response rates, safety profiles, overall survival, time to progression and time to treatment failure.

Another clinical trial that is soon to open will evaluate intrahepatic arterial Abraxane administration. The rationale for using this therapy is based on the studies done in Italy in patients with head and neck, anal carcinoma, and melanoma. Response rates were seen in up to 78% of patients. It was also well tolerated with the main dose limiting toxicity being myelosuppression.

Although uveal melanoma is highly resistant to systemic treatments, newer therapeutic agents are currently being studied that have shown promise for improving patient response rates and possibly survival. In addition to chemotherapeutic drugs targeted agents have shown promise in laboratory studies and in various cancers. Greater understanding of molecular pathogenesis of cancers in general has led to a new generation of agents that interferes with specific pathways of tumor development or progression. Targeted therapies differ from chemotherapy or immunotherapy in that they are less empiric in their approach and although targeted therapies is not a new concept, new agents have been developed and approved over the last several years.

The key to developing a drug specific for a type of cancer is understanding the molecular pathway of that cancer. Uveal melanoma has its limitations for several reasons. For one, it is a rare tumor overall, fifteen times less common than cutaneous melanoma. It lacks the same molecular pathways as cutaneous melanoma and since uveal melanoma is now most often diagnosed clinically and treated with brachytherapy, tissue is not routinely obtained. Despite these limitations as well as others, progress has been made and new drugs are emerging. Targeted therapies can be beneficial in terms of survival/progression parameters in the absence of an objective tumor response. Stable disease is more likely to be achieved than tumor response. And stable disease may be associated with improved survival.

Other current research is focusing on targeted therapy agents in combination or along with cytotoxic agents to disrupt the growth of uveal melanoma cells in laboratory studies. Agents such as Sorafenib, Sunitinib,

Lenalidomide are a few that have shown effectiveness thus far and require further research. As stated previously, we will soon be opening a trial with paclitaxel, carboplatin and Genasense, an agent that targets Bcl-2, a protein overexpressed in uveal melanoma that makes the cancer cell resistant to chemotherapy. Genasense has shown synergistic activity when administered in combination with cytotoxic agents such as paclitaxel and cisplatin. Another regimen that will go to clinical trial includes Gemcitabine and paclitaxel, drugs that were identified to be effective against uveal melanoma cells in ATP-based tumor cell ex vivo chemosensitivity assays. This combination was recently reported to be synergistic in a trial in patients with pancreatic cancer.

The efficacy of local or regional therapies is likely to improve as more effective drugs, including antiangiogenesis agents, targeted therapies, and melanoma vaccines are discovered that could control systemic metastasis more effectively. More importantly such systemic therapies when administered after the treatment of the primary tumor in the eye, could prevent appearance of clinical disease in high risk patients with subclinical micro-metastases.

Despite advances in diagnosis and treatment of uveal melanoma 5 year survival rates have changed little since 1973. However we are hopeful that progression free and overall survival rates will improve as we continue to gain a better understanding of the various molecular pathways that encompass this disease along with various target agents and unique regional therapies to counteract those pathways. We will continue our research and clinical trials just as we have over the past two decades.

### References:

Wöll E, Bedikian A, Legha SS. Uveal melanoma: natural history and treatment options for metastatic disease. *Melanoma Res* 9(6):575-581, 1999.

Bedikian AY: Metastatic Uveal Melanoma Therapy Current Options. *International Ophthalmology Clinics. Tumors.* (ed, Char DH) Lippincott Williams & Wilkins pp 151-166, 46(1); 2006

Sharma K V., Gould J E. et al Hepatic Arterial Chemoembolization for Management of Metastatic Melanoma. *American Journal of Roentgenology* 2008; 190: 99-104.

Trionzi PL et al., Targeted therapy for Uveal Melanoma *Cancer Treatment Reviews* (2008), doi:10.1016/j.ctrv.2007.12.002

Bakalian, S et al. Molecular Pathways mediating Liver Metastasis in Patient with Uveal Melanoma *Clinical Cancer Research* (2008); 14(4) 951-956.

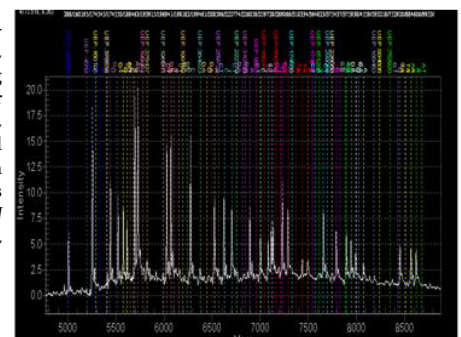
## Multidisciplinary Publications

### Discovery of a New Genetic Mutation in Melanoma

The recent discovery that more than half of melanomas harbor activating mutations in the serine-threonine kinase *BRAF* has suggested that the activation of signal transduction pathways may play an important role in this disease. However, experiments using multiple systems have demonstrated that activation of *BRAF* alone cannot express the aggressive nature of this disease. Indeed, even benign moles frequently have *BRAF* mutations, despite the fact that they almost never become melanomas. Dr. Michael Davies and his research team have developed mass spectroscopy based genotyping as a new method to screen small samples for up to 200 different mutations that have been reported in cancer. In an initial analysis of approximately 100 melanomas they identified a mutation in a gene called *AKT1*, which previously has been observed in breast, lung, and colon cancers. This initial study also identified in 2 melanomas the first reported mutations of *AKT3*, which is a gene that is closely related to *AKT1* and has been implicated in melanoma progression by studies of its expression. The analysis also identified *AKT3* mutations in 2 cell lines derived from melanoma patients, a discovery which will allow for testing how this mutation regulates the behavior of melanoma cells in the laboratory. The discovery of mutations of *AKT1* and *AKT3* in melanoma sug-

gests that the pathway they are components of, the PI3K-AKT pathway, may play an important role in melanoma. These are important findings, as many inhibitors of the PI3K-AKT pathway are now entering into clinical trials. The findings also demonstrate the potential of mass spectroscopy based genotyping to improve our understanding of the events that contribute to melanoma.

**Davies MA, Stemke-Hale K, Tellez C, Calderone TL, Deng W, Prieto VG, Lazar AJ, Gershenwald JE, Mills GB. A novel AKT3 mutation in melanoma tumours and cell lines. *Br J Cancer* 99(8):1265-1268, Epub 2008 Sep 23.**



## 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 1/21/09, 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.

2. [ECOG1697](#) Phase III

Principal Investigator: Dr. Homs

Research Nurse: Suzanne Cain, R.N.

Randomized Study of Four Weeks High Dose IFN- $\alpha$ 2b in Stage T2b No, T3a-b, T4a-b No, and T1-4, N1a, 2a, 3 (microscopic) Melanoma. Patients with melanoma of a cutaneous origin are eligible for this study. Patients are also eligible who have declined 1 year of interferon.

### Neoadjuvant:

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

Principal Investigator: Dr. Wen-Jen Hwu

Research Nurse: Suzanne Cain, 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. [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.

2. [DTIC +/- Genasense \(2007-0361\)](#) Phase III

Principal Investigator: Dr. Agop Bedikian

Research Nurse: Karen Woodard, R.N.

This study is designed to administer Dacarbazine, plus or minus a Bcl-2 antisense therapy. Antisense therapy involves the administration of synthetic oligonucleotides that are complementary to specific mRNA transcripts, and then RNase H cleaves the bcl-2 mRNA strand, rendering the message nontranslatable.

### 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. [Temozolomide + Thalidomide + CCNU \(2004-0595\)](#) Phase I/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 nitrosourea, has activity against disseminated melanoma. This study is for patients with brain metastases.

4. [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

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

Principal Investigator: Dr. Kevin Kim

Research Nurse: Cora Cheung, R.N.

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.

6. [Decitabine and PEG Intron \(2007-0450\)](#) Phase I/II

Principal Investigator: Wen-Jen Hwu, M.D.

Research Nurse: Ingrid Hernandez, R.N.

Determine the safety and tolerability of the combination of drugs at 6 pre-determined dose levels in patients with advanced melanoma. Also to determine clinical benefit and to determine progression-free survival. Patients may have one prior chemotherapy

7. [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.

8. [AZD6422 and DTIC \(2008-0499\)](#) Phase I

Principal Investigator: Kevin Kim, MD

Research Nurse: Sandy Mahoney, RN

This study is therefore designed to investigate the twice daily dosing of AZD6244, a MEK inhibitor, in combination with standard chemotherapies in patients with advanced solid tumors. This study will evaluate the safety profile, tolerability, and PK of AZD6244 in combination with 4 standard chemotherapies and support subsequent testing in Phase II.

### Patients with metastatic choroidal melanoma:

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

Principal Investigator: Dr. Kevin Kim

Research Nurse: Cora Cheung, R.N.

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.

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

Principal Investigator: Dr. Patrick Hwu

Research Nurse: Deborah Sanders, R.N.

CRO11-vcMME potently 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.

4. [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.

5. [AZD6422 and DTIC \(2008-0499\)](#) Phase I

Principal Investigator: Kevin Kim, MD

Research Nurse: Sandy Mahoney, RN

This study is therefore designed to investigate the twice daily dosing of AZD6244, a MEK inhibitor, in combination with standard chemotherapies in patients with advanced solid tumors. This study will evaluate the safety profile, tolerability, and PK of AZD6244 in combination with 4 standard chemotherapies and support subsequent testing in Phase II.

### 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 nitrosourea, has activity against disseminated melanoma. This study is for patients with brain metastases.

2. [AZD6422 and DTIC \(2008-0499\)](#) Phase I

Principal Investigator: Kevin Kim, MD

Research Nurse: Sandy Mahoney, RN

This study is therefore designed to investigate the twice daily dosing of AZD6244, a MEK inhibitor, in combination with standard chemotherapies in patients with advanced solid tumors. This study will evaluate the safety profile, tolerability, and PK of AZD6244 in combination with 4 standard chemotherapies and support subsequent testing in Phase II.

3. [MPC 2007-0445](#) Phase I

Principal Investigator: Dr. Wen-Jen Hwu

Research Nurse: Deborah Sanders, R.N.

Dose Finding Phase I Study of the Treatment of Melanoma Metastatic to Brain with MPC-6827 in Combination with Temozolomide. This protocol is for patients to determine the MTD (up to a maximum dose of 3.3 mg/m<sup>2</sup>) of MPC-6827 in combination with an extended dosing regimen of temozolomide.

### 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 aid 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: Karen Woodard, R.N.

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.

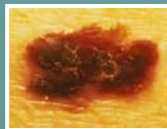


## ABCD's of Melanoma Diagnosis

### Asymmetry



### Border



### Color Variation



### Diameter



## Melanoma Grants Awarded

At M. D. Anderson Cancer Center we have a strong multi-disciplinary approach to patient care must involve surgeons, medical oncologists, radiologists, pathologists, dermatologists 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. Despite national government cutbacks for research, we have continued to maintain a steady 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 \$4.53 million 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 we were awarded a \$10 million (5 years) Program Grant with the National Institutes of Health, for a project "Activation of Plasmacytoid Dendritic Cells in to induce antitumor activity." In addition faculty members in our department have been awarded research grants from Baylor Center for Aids Research and the Susan G. Komen Breast Cancer Foundation.

Philanthropic gifts from private donors and foundations provide tremendous support to the advancement of translational research. Gifts from our generous donors provide researchers the necessary funding to receive competitive grants from organizations such as the National Institutes of Health. Our group would like to acknowledge and thank donors for their generous contributions to cancer-related research projects.

## Melanoma Philanthropic Funding

*The Arena Energy Foundation  
Margaret T. Biddle Foundation  
Mr. and Mrs. Lynn D. Campbell  
Kelly Golat Melanoma Research Scholarship Fund Inc.  
Mr. and Mrs. Rodney L. Hale  
Mrs. Warren C. Kingsbury  
El Paso Corporation*

*Mrs. Seymour Luckoff  
Dr. Carl Plager  
Mr. and Mrs. G. Heyward Preacher, Jr.  
The Reny Company  
Carol M. and Jack V. Roberston  
Sephora USA, Inc.  
Dwane L. and Velma Lunt Wallace Charitable Foundation*

... and many more who generously committed funds totaling \$277,569 July -January 2009.

## 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)