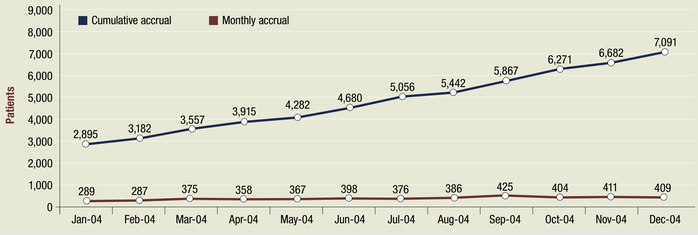
Cancer Trials Support Unit and Central Institutional Review Board

The primary goal of this system is to rapidly accelerate the pace of clinical cancer research by enabling oncologists in the United States to offer patients NCI-sponsored clinical trials and by simplifying and standardizing procedures related to participation. The Cancer Trials Support Unit (CTSU) promotes cross-group accrual among Cooperative Group members. Features include standardization of data collection and online data reporting, simplified informed consent and a Central Institutional Review Board (CIRB) process. The CIRB model shares responsibility for protection of research participants between the local IRB and the CIRB, which conducts full board review, the results of which are distributed to participating local IRBs via a confidential website.

CTSU ACCRUAL SUMMARY AS OF 12/31/04



SOURCE: CTSU correspondence, January 2005.

PHASE III BREAST CANCER TRIALS OPEN THROUGH THE CTSU

Study number	Study description	Accrual to date/goal	As of date
CALGB-40101	Adjuvant AC (four versus six cycles q2wk) versus paclitaxel (four versus six cycles q2wk) for women with node-negative breast cancer	1,396/4,646	12/27/04
CALGB-49907	Adjuvant chemotherapy with standard regimens, CMF or AC, versus capecitabine in women 65 years and older with node-positive or high-risk node-negative breast cancer	274/720	12/27/04
E1Z03	Quality of life companion study for NCIC-MA27	NA/1,253	12/22/04
IBCSG-24-02 (SOFT)	Adjuvant tamoxifen versus ovarian function suppression (OFS) + tamoxifen versus OFS + exemestane in premenopausal women with endocrine-responsive breast cancer	101/3,000	12/01/04
IBCSG-25-02 (TEXT)	Adjuvant triptorelin + exemestane versus triptorelin + tamoxifen in premenopausal women with endocrine-responsive breast cancer	206/1,845	12/01/04
IBCSG-26-02 (PERCHE)	OFS + tamoxifen or exemestane ± adjuvant chemotherapy in premenopausal women with endocrine-responsive breast cancer	4/1,750	12/01/04
NCIC-MA20	Regional radiation therapy in early breast cancer	1,146/1,822	01/02/05
NCIC-MA21	Adjuvant sequenced EC + filgrastim + epoetin alpha followed by paclitaxel versus sequenced AC followed by paclitaxel versus CEF for premenopausal women and early postmenopausal women with node-positive or high-risk node-negative breast cancer	1,913/2,100	01/02/05
NCIC-MA27	Exemestane versus anastrozole ± celecoxib in postmenopausal women with receptor-positive primary breast cancer	1,666/6,830	01/02/05
NSABP-B-35	Anastrozole versus tamoxifen in postmenopausal patients with DCIS undergoing lumpectomy with radiation therapy	1,389/3,000	01/02/05
NSABP-B-36*	Adjuvant FEC x six cycles versus AC x four cycles, ± celecoxib in women with node-negative breast cancer	327/2,700	01/02/05
NSABP-B-37	Observation or chemotherapy for radically resected locoregional relapse of breast cancer	NA/977	NA
NSABP-B-38	Adjuvant TAC versus dose-dense (DD) AC followed by DD paclitaxel versus DD AC followed by DD paclitaxel + gemcitabine	90/4,800	01/02/05
RTOG-98-04	Whole breast radiation therapy versus observation ± tamoxifen in women with DCIS	485/1,790	12/28/04
SWOG-S0012	Neoadjuvant standard AC followed by weekly paclitaxel versus weekly doxorubicin + daily oral cyclophosphamide + G-CSF followed by weekly paclitaxel for women with inflammatory and locally advanced breast cancer	282/350	12/31/04
SWOG-S0221	Adjuvant continuous-schedule AC + filgrastim versus every two-week AC + pegfilgrastim or filgrastim, followed by paclitaxel given every two weeks versus weekly for 12 weeks in women with node-positive or high-risk node-negative breast cancer	492/4,500	12/31/04
SWOG-S0226	Anastrozole versus anastrozole + fulvestrant as first-line therapy for postmenopausal women with metastatic breast cancer	26/690	12/31/04

*Effective 12/17/2004: Temporary suspension to accrual for NSABP-B-36

SOURCES: CTSU correspondence, January 2005; NCI Physician Data Query, January 2005.

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CENTRAL INSTITUTIONAL REVIEW BOARD

"The Central Institutional Review Board (CIRB) initiative is a pilot project sponsored by the National Cancer Institute (NCI), in consultation with the DHHS Office of Human Research Protections. Created to develop an innovative approach to human subjects' protection, the unique feature of the CIRB is its 'facilitated review' process that can streamline local IRB review for national multi-center cancer treatment trials. Local IRBs enrolled in the pilot can download CIRB reviews from a confidential webpage and decide whether or not to utilize the CIRB's review for a particular protocol. This 'facilitated review' can take place rapidly. …

"A major benefit for local IRBs participating in the pilot will be the reduction in review workload while still retaining its authority to accept or reject a 'facilitated review' on a protocol-by-protocol basis."

— CIRB website
www.ncicirb.org

RECRUITMENT OF PARTICIPANTS IN CLINICAL TRIALS

"An effective national cancer program can never be implemented without patient-oriented research. This requires that individuals be willing, able, and available to participate in clinical trials. Participation in clinical trials is an opportunity not only for discovery, but also to experience the most promising and valuable new preventions, diagnoses, screening procedures, and therapies. Despite the potential therapeutic advantage of participating in clinical trials, the current number of eligible cancer patients entering clinical research studies is less than three percent. This is related primarily to the impediments to enrollment into cancer clinical trials as well as the limited funding of cooperative groups, which is the critical rate-limiting barrier to increased accrual. And even in studies where accrual is good, compliance and retention are not optimal. As a result, slow accrual and retention rates give way to delayed completion of clinical trials, resulting in cost inefficiencies, slowed translation of bench science, and potentially inequitable distribution of the risks and benefits of research."

— NCI Armitage Report
http://deainfo.nci.nih.gov/advisory/BSA/bsa_program/bsactprgmin.htm

BENEFITS OF THE CTSU

The CTSU has developed a single regulatory support system. Instead of oncologists having to register and file different applications every year with each cooperative group they belong to, they register once and each group utilizes that information. The centralization of those data and the centralization of all IRB data on a per-study basis has been helpful. This system should ease the burden of clinical trial participation on investigators in the community and in academic institutions and increase the speed with which we complete important trials, as witnessed by the recent MA17 trial evaluating letrozole after adjuvant tamoxifen. More than 5,000 patients enrolled in that study and although the NCI of Canada led that trial, 3,500 of the patients enrolled were from the United States cooperative groups. We completed accrual to that trial in less than four years and had results about one and a half years later. The system works, and it can rapidly provide answers to important questions.

— Jeffrey Abrams, MD

The concept behind the CTSU is that a fairly large number of physicians don't want to belong to a cooperative group but would love to enroll their patients in clinical trials. The cooperative groups themselves were heavily involved in the development of the process. All of the major adjuvant breast cancer trials will be on the CTSU menu. Advertising the trials and educating physicians about participation is going to be important. This is a real experiment that is still being debugged, but I hope it works because we need more patients enrolled in these clinical trials. I suspect a large reservoir of oncologists have never filled out the CTSU form — not because it's difficult, but because no one suggested they do it.

— George W Sledge Jr, MD