**INDICATIONS AND USAGE**

RITUXAN® (Rituximab) is indicated for the treatment of patients with relapsed or refractory, low-grade or follicular NHL, B-cell chronic lymphocytic leukemia (B-CLL), and HIV-associated lymphoma who have been previously treated with chlorambucil and/or fludarabine.

**CONTRAINDICATIONS**

RITUXAN is contraindicated in patients with known anaphylaxis or IgE-mediated hypersensitivity to murine protein or to any component of the product. (See WARNINGS and ADVERSE REACTIONS.)

**WARNINGS**

Severe Hypersensitivity Reactions: Severe hypersensitivity reactions observed in the clinical trials occurred in 2% of patients, some with lifethreatening clinical consequences. The infusion should be interrupted and supportive care administered. The reaction should be treated according to accepted standards of care. Patients should be monitored throughout the infusion and immediate post-infusion period. Severe reactions may include: anaphylaxis, cardiorespiratory arrest, shock, bronchospasm, hypotension, urticaria, angioedema, musculoskeletal reactions such as arthralgia or myalgia, abdominal pain, dyspnea, edema, and pericardial effusion. Severe reactions may also involve the cardiac, respiratory, gastroenterological, dermatological, or hematological systems and may be associated with life-threatening clinical consequences. The RITUXAN infusion should be interrupted for severe hypersensitivity reactions and patients should be monitored for at least 6 hours after the completion of the infusion.

**PRECAUTIONS**

Laboratory Monitoring: Because RITUXAN targets all CD20-positive B lymphocytes, monitoring of complete blood counts (CBC) and platelet counts should be obtained at regular intervals during RITUXAN therapy and more frequently in patients who develop rashes or other skin reactions. Laboratory test abnormalities such as increased transaminase may occur in association with RITUXAN. However, recovery is the rule. Laboratory tests should be repeated if symptoms warrant.

**ADVERSE REACTIONS**

Cardiovascular: Most adverse cardiovascular events occurred in patients with Waldenstrom's macroglobulinemia. Following initiation of RITUXAN, or to determine its effects on fertility in males or females. Individuals of childbearing age should be placed on effective contraception in the 2 to 6 weeks before initiation of RITUXAN, and for at least 12 months after the last RITUXAN infusion. Infusion reactions and lymphopenia may also be associated with life-threatening clinical consequences. The RITUXAN infusion should be interrupted for severe hypersensitivity reactions and patients should be monitored for at least 6 hours after the completion of the infusion.

**RITUXAN** in 1999, and more than 200 additional studies followed. The incidence of adverse events in the clinical trials has been consistent with previous clinical trials. The table below shows the incidence of adverse events in the clinical trials.

### Incidence of Adverse Events in the Clinical Trials (N = 356)

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Any Adverse Event</th>
<th>Grade 3 and 4 Adverse Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Grades</td>
<td>99</td>
<td>87</td>
</tr>
<tr>
<td>Body as a Whole</td>
<td>86</td>
<td>74</td>
</tr>
<tr>
<td>Fever</td>
<td>53</td>
<td>3</td>
</tr>
<tr>
<td>Chills</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Infection</td>
<td>31</td>
<td>4</td>
</tr>
<tr>
<td>Anemia</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Headache</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Acute Pain</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Back Pain</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Throat Irritation</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Oral Ulcer</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Flu</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Nausea</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Dryness</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Rash</td>
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</tr>
<tr>
<td>Pruritus</td>
<td>4</td>
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</tr>
<tr>
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<td>3</td>
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<tr>
<td>Hot Flashes</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Urticaria</td>
<td>2</td>
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</tr>
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</tr>
</tbody>
</table>
Now enrolling adult patients with Ph+ chronic myeloid leukemia (CML) and other hematologic malignancies for a phase 2 study of a new, selective Bcr-Abl inhibitor

Study Ph2-21O1 is a multicenter trial designed to determine the safety, efficacy, tolerability, pharmacokinetic profile, and biologic activity of AMN107

Information about Novartis clinical trials for AMN107 and other agents is available through our clinical trials hotline (1-800-340-6843), or at www.novartisclinicaltrials.com (for U.S. residents only), www.amn107.com or www.clinicaltrials.gov
VIDAZA is the first FDA-approved treatment proven for all myelodysplastic syndrome (MDS) subtypes*: RA or RARS (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), RAEB, RAEB-T, or CMMoL.

*According to the FAB (French, American, British) Classification System.

Important Safety Information

VIDAZA is contraindicated in patients with a known hypersensitivity to azacitidine or mannitol and in patients with advanced malignant hepatic tumors.

In clinical studies, the most commonly occurring adverse reactions were nausea (70.5%), anemia (69.5%), thrombocytopenia (65.5%), vomiting (54.1%), pyrexia (51.8%), leukopenia (48.2%), diarrhea (36.4%), fatigue (35.9%), injection site erythema (35.0%), constipation (33.6%), neutropenia (32.3%), and ecchymosis (30.5%). Other adverse reactions included dizziness (18.6%), chest pain (16.4%), febrile neutropenia (16.4%), myalgia (15.9%), injection site reaction (13.6%), aggravated fatigue (12.7%), and malaise (10.9%).

Because treatment with VIDAZA is associated with neutropenia and thrombocytopenia, complete blood counts should be performed as needed to monitor response and toxicity, but at a minimum, prior to each dosing cycle.

Because azacitidine is potentially hepatotoxic in patients with severe preexisting hepatic impairment, caution is needed in patients with liver disease. In addition, azacitidine and its metabolites are substantially excreted by the kidneys and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, it may be useful to monitor renal function.

VIDAZA may cause fetal harm. While receiving treatment with VIDAZA, women of childbearing potential should avoid becoming pregnant, and men should avoid fathering a child.

In addition, women treated with VIDAZA should not nurse.

Please see the brief summary of prescribing information on the adjacent pages.

VIDAZA.com • 1-866-PHARMION (1-866-742-7646)
INDICATIONS AND USAGE
Vidaza is indicated for treatment of patients with the following myelodysplastic syndrome subtypes: refractory anemia or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia.

CONTRAINDICATIONS
Vidaza is contraindicated in patients with a known hypersensitivity to azacitidine or anemone. Vidaza is also contraindicated in patients with advanced malignant hepatic tumors. (See PRECAUTIONS.)

WARNINGS
Pregnancy - Teratogenic Effects: Pregnancy Category D
Azacitidine is clearly embryotoxic when excluded from the clinical trials.

Men should be advised to not father a child while receiving treatment with Vidaza.

Laboratory Tests
Complete blood counts should be performed as needed to monitor response and toxicity, but at a minimum, prior to each cycle. Liver function tests and serum creatinine should be obtained prior to initiation of therapy.

Drug Interactions
There are no significant interactions between Vidaza and other agents that have been conducted.

Use in Males
Men should be advised to not father a child while receiving treatment with Vidaza. (See PRECAUTIONS.)

Use in Pregnancy
Azacitidine is clearly embryotoxic when excluded from the clinical trials. (See WARNINGS.)

Patients with severe pre-existing hepatic impairment, caution is needed in patients with liver disease. Patients with extensive tumor burden, severe renal impairment, and those with serum albumin <30 g/L. Azacitidine is contraindicated in patients with advanced malignant hepatic tumors. (See PRECAUTIONS.)

Renal abnormalities ranging from elevated serum creatinine to renal failure and death have been reported rarely in patients treated with intravenous azacitidine in combination with other chemotherapy agents for non-MDS conditions. In addition, renal tubular abnormalities, defined as a fall in serum bicarbonate to <30 mmol/L in association with an alcaline urine and hypokalemia (serum potassium <3 mEq/L) developed in 5 patients with CML treated with azacitidine and etoposide. If unexpected reductions in serum bicarbonate <20 mmol/L or elevations of BUN or serum creatinine occur, the dosage should be reduced or held as described in DOSAGE AND ADMINISTRATION section of full prescribing information.

Renal function impairment may be observed in patients treated with azacitidine. (See PRECAUTIONS.)

Vidaza is indicated for treatment of patients with MDS and hepatic or renal impairment have not been established. (See PRECAUTIONS.)

Most Commonly Occurring Adverse Reactions

All Vidaza* Observation†

<table>
<thead>
<tr>
<th>All Vidaza (n=220)</th>
<th>Observation (n=82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea 155 (70.5)</td>
<td>16 (17.4)</td>
</tr>
<tr>
<td>Anemia 153 (69.5)</td>
<td>59 (64.1)</td>
</tr>
<tr>
<td>Thrombocytopenia 144 (65.5)</td>
<td>42 (49.7)</td>
</tr>
<tr>
<td>Vomiting 119 (54.1)</td>
<td>5 (5.4)</td>
</tr>
<tr>
<td>Pyrexia 114 (51.8)</td>
<td>28 (30.4)</td>
</tr>
<tr>
<td>Leukopenia 106 (48.2)</td>
<td>27 (29.3)</td>
</tr>
<tr>
<td>Diarrhea 80 (36.4)</td>
<td>13 (14.1)</td>
</tr>
<tr>
<td>Fatigue 79 (35.9)</td>
<td>23 (25.0)</td>
</tr>
</tbody>
</table>

Injection site erythema 77 (35.0) 0

Constitution 74 (33.6) 6 (6.8) |

Neutropenia 71 (32.3) 10 (10.9) |

Ecchymosis 67 (30.3) 14 (15.2) |

Cough 65 (29.2) 14 (15.2) |

Dyspnea 64 (29.1) 11 (12.0) |

Weakness 64 (29.1) 19 (20.7) |

Rigors 56 (25.5) 10 (10.9) |

Petechiae 52 (23.6) 8 (8.7) |

Injection site pain 50 (22.7) 0 |

Anthrax 49 (22.3) 3 (3.3) |

Headache 48 (21.8) 10 (10.9) |

Anemia 45 (20.5) 6 (6.5) |

Pain in limb 44 (20.0) 5 (5.4) |

Pharyngitis 44 (20.0) 7 (7.6) |

Back pain 41 (18.6) 7 (7.6) |

Constitution 41 (18.6) 9 (9.8) |

Dizziness 41 (18.6) 5 (5.4) |

Edema peripheral 41 (18.6) 10 (10.9) |

Arrhythmia 39 (17.7) 1 (1.1) |

Chest pain 36 (16.4) 4 (4.3) |

Euphoria 36 (16.4) 9 (9.8) |

Febrile neutropenia 36 (16.4) 4 (4.3) |

Myalgia 35 (15.9) 2 (2.2) |

Weight decreased 35 (15.9) 10 (10.9) |

Abdominal pain 34 (15.5) 2 (2.2) |

Palor 34 (15.5) 7 (7.6) |

Nasopharyngitis 32 (14.5) 3 (3.3) |

Pitting edema 32 (14.5) 9 (9.8) |

Skin lesion 32 (14.5) 8 (8.7) |

Dyspnea exertional 31 (14.1) 15 (16.3) |

Injection site bruising 31 (14.1) 0 |

Rash 31 (14.1) 9 (9.8) |

Injection site reaction 30 (13.6) 0 |

Anxiety 29 (13.2) 3 (3.3) |

Appetite decreased 28 (12.7) 6 (6.7) |

Fatigue aggravated 27 (12.2) 4 (4.3) |

Hypokalemia 26 (12.7) 12 (13.9) |

Upper respiratory tract infection 26 (12.7) 4 (4.3) |

Pruritus 27 (12.3) 11 (12.0) |

Abdominal tenderness 26 (11.8) 1 (1.1) |

Depression 26 (11.8) 7 (7.6) |

Productive cough 25 (11.4) 4 (4.4) |

Insomnia 24 (10.9) 4 (4.3) |

Malaise 24 (10.9) 1 (1.1) |

Pain 24 (10.9) 3 (3.3) |

Pneumonia 24 (10.9) 5 (5.4) |

Rhabdomyolysis 23 (10.5) 3 (3.3) |

Cranial nerve palsy 21 (9.5) 0 (0.0) |

Brown coloration 20 (9.0) 8 (8.7) |

Rhinorhea 20 (9.0) 2 (2.2) |

Gingival bleeding 21 (9.5) 4 (4.3)
### Table 4: Most Frequently Observed Adverse Events (25% in All Vidaza)* Continued

<table>
<thead>
<tr>
<th>Preferred Term**</th>
<th>All Vidaza (N=220)</th>
<th>Observation† (N=92)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 1 TEAE</td>
<td>219 (99.5)</td>
<td>89 (96.7)</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>21 (9.5)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>20 (9.1)</td>
<td>5 (5.4)</td>
</tr>
<tr>
<td>Hematoma</td>
<td>19 (8.6)</td>
<td>0</td>
</tr>
<tr>
<td>Night sweats</td>
<td>19 (8.6)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Rales</td>
<td>19 (8.6)</td>
<td>8 (8.7)</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>19 (8.6)</td>
<td>6 (6.5)</td>
</tr>
<tr>
<td>Wheezing</td>
<td>19 (8.6)</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>18 (8.2)</td>
<td>4 (4.3)</td>
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<tr>
<td>Dysuria</td>
<td>18 (8.2)</td>
<td>2 (2.2)</td>
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<tr>
<td>Breath sounds</td>
<td>17 (7.7)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Lethargy</td>
<td>17 (7.7)</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Oral mucosal petechiae</td>
<td>17 (7.7)</td>
<td>3 (3.3)</td>
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<tr>
<td>Stomatitis</td>
<td>17 (7.7)</td>
<td>0</td>
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<tr>
<td>Urinary tract infection</td>
<td>17 (7.7)</td>
<td>5 (5.4)</td>
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<tr>
<td>Periarterial swelling</td>
<td>16 (7.3)</td>
<td>5 (5.4)</td>
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<tr>
<td>Dyspepsis</td>
<td>15 (6.8)</td>
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<tr>
<td>Hemorrhoids</td>
<td>15 (6.8)</td>
<td>1 (1.1)</td>
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<tr>
<td>Hypotension</td>
<td>15 (6.8)</td>
<td>2 (2.2)</td>
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<tr>
<td>Injection site puritus</td>
<td>15 (6.8)</td>
<td>6 (8.9)</td>
</tr>
<tr>
<td>Transfusion reaction</td>
<td>15 (6.8)</td>
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</tr>
<tr>
<td>Pleural effusion</td>
<td>14 (6.4)</td>
<td>6 (8.5)</td>
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<tr>
<td>Abdominal distension</td>
<td>13 (5.9)</td>
<td>4 (4.3)</td>
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<tr>
<td>Muscle cramps</td>
<td>13 (5.9)</td>
<td>3 (3.3)</td>
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<tr>
<td>Post procedural hemorrhage</td>
<td>13 (5.9)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Postnasal drip</td>
<td>13 (5.9)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Rhinocytis</td>
<td>13 (5.9)</td>
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</tr>
</tbody>
</table>

Nausea, vomiting, diarrhea, and constipation all tended to increase in incidence with increasing doses of Vidaza. Nausea, vomiting, injection site erythema, constipation, rigors, petechiae, injection site pain, diaphoresis, and rates tended to be more pronounced during the first 1-2 cycles of SC Vidaza treatment compared with later cycles of treatment. There did not appear to be any adverse events that increased in frequency over the course of treatment. There did not appear to be any relevant differences in adverse events by gender.

In clinical studies of either SC or IV Vidaza, the following serious treatment-related adverse events occurring at a rate of <5% (not described in Table 4) were reported:

- Blood and lymphatic system disorders: agranulocytosis, bone marrow depression, splenomegaly.
- Cardiac disorders: atrial fibrillation, cardiac failure, cardiac failure congestive, cardiorespiratory arrest, congestive cardiomyopathy.
- Gastrointestinal disorders: diverticulitis, gastrointestinal hemorrhage, meleena, perirectal abscess.
- General disorders and administration site conditions: catheter site hemorrhage, general physical health deterioration, systemic inflammatory response syndrome.
- Hepatobiliary disorders: cholestasis.
- Immune system disorders: anaphylactic shock, hypersensitivity.
- Infections and infestations: bacterial infection, bacterial infection, Klebsiella sepsis, pharyngitis, Staphylococcal bacteremia, Staphylococcal infection, toxoplasmosis.
- Metabolism and nutrition disorders: dehydration.

Musculoskeletal and connective tissue disorders: bone pain aggravated, muscle weakness, neck pain.

Neoplasms benign, malignant and unspecified: leukemia cutis.

Nervous system disorders: convulsions, intracranial hemorrhage.

Psychiatric disorders: confusion.

Renal and urinary disorders: hematuria, loin pain, renal failure.

Respiratory, thoracic and mediastinal disorders: hemoptysis, lung infiltration, pneumonitis, respiratory distress.

Skin and subcutaneous tissue disorders: pyoderma gangrenosum, rash pruritic, skin induration.

Surgical and medical procedures: cholecystectomy.

Vascular disorders: orthostatic hypotension.

Manufactured for: Pharmion Corporation Boulder, CO 80301

Manufactured by: Ben Venue Laboratories, Inc. Bedford, OH 44146

Edition Date: August 31, 2004

Brief Summary of Prescribing Information

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## Blood Style Guide Online

For the convenience of authors and readers, Blood is building an online style guide. It may be found online linked to the Blood Author Guide (or at http://www.bloodjournal.org/misc/styleguideindex.shtml). Segments of this style guide are being developed and published online. Meanwhile, for answers to questions about aspects of Blood style not currently covered by the online style guide, please refer to a printed copy of the American Medical Association Manual of Style (9th edition) or contact the Blood Production Office at production@hematology.org.
References:

At present, there is a considerable amount of knowledge on the molecular biology of chronic myeloid leukemia (CML), providing an unparalleled platform for molecularly targeted therapy. While the \textit{BCR-ABL} gene remains the driving force in CML, ongoing research into the inhibition of additional molecular targets, including mutations of the \textit{BCR-ABL} kinase, may lead to new therapies.\textsuperscript{1,2}

\textbf{CML Is a Disease With More Than One Target}

\textit{BCR-ABL Kinase Mutations} within the \textit{ABL} kinase domain are emerging as the most frequent mechanism for the reactivation of \textit{BCR-ABL} activity and, thus, represent important potential targets in CML.\textsuperscript{2-5} The development of \textit{BCR-ABL} mutations can occur through either genetic instability or secondary mutational events over the course of the disease and is not limited to late-stage disease.\textsuperscript{5}

Recent evidence has also shown that certain mutations may bind and phosphorylate substrates distinct from wild-type \textit{BCR-ABL} and have the potential to activate alternative signaling pathways, providing additional insight into why certain mutations are associated with poor prognosis.\textsuperscript{6}

\textit{SRC-Family Kinases} are independent oncogenic pathways that are believed to be involved in late-stage disease progression. Two members of the \textit{SRC} family in particular, \textit{LYN} and \textit{HCK}, are highly overexpressed and activated in patients with blast crisis and have been implicated in leukemic tumor cell growth, apoptotic protection, and kinase inhibitory activity.\textsuperscript{7,8}

\textit{Heat-Shock Family Proteins (Hsp)} are molecular chaperones capable of maintaining the stability and function of \textit{BCR-ABL}.\textsuperscript{9,10}

\textbf{Downstream BCR-ABL Signal Transduction Pathways} are responsible for the development and proliferation of malignant cells through a signaling cascade of multiple oncogenic kinase events.\textsuperscript{11} These pathways represent potential new targets for molecular therapy.\textsuperscript{1}

\textbf{BCR-ABL Mitogenic Signaling Pathways}\textsuperscript{11}

Potential Multi-Targeted Approaches to CML Therapy

Significant progress has been made in the development of therapeutic agents directed against molecular targets specifically expressed or abnormally activated in patients with CML.\textsuperscript{1} While \textit{BCR-ABL} remains the primary target for CML therapy, there is hope that new research investigating synergistic approaches, simultaneously addressing multiple targets, may lead to new therapies for patients with CML.

Bristol-Myers Squibb is committed to investigating the molecular causes of cancer and developing potential new treatment alternatives to help address the needs of people living with cancer.
NOW AVAILABLE

Novartis is proud to announce the arrival of

EXJADE™
Tablets for Oral Suspension (deferasirox)
Taking cancer innovation to new heights
...one careful, practical step at a time

Research at Genentech BioOncology that led to important breakthroughs:
- Original research on VEGF, one of the key mediators of angiogenesis
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- Collaborative efforts on the CD20 antigen
- Collaborative research on a HER1/EGFR TK inhibitor

Key molecules now being investigated in our extensive clinical research program include:
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- Apo2L/TRAIL, an apoptosis promoter
- Hedgehog antagonist

For more information, visit www.BioOncology.com or call (800) 551-2231.
And it’s been that way since the very beginning.

In the early 1960s, Dr. Murray Thelin, a Baxter scientist with severe hemophilia, worked to develop the very first factor VIII concentrate, testing it on himself.

It was a triumph, and quickly revolutionized care.

Baxter has continued this total commitment to hemophilia therapies and the hemophilia community.

For example, it was in our blood to develop the first coagulation factor for patients with inhibitors.

And greatly heighten our viral inactivation procedures with solvent/detergent treatments and purification with monoclonal antibodies.

And introduce the first genetically engineered recombinant factor VIII therapy. Setting the highest standards for safety each step of the way.

The bloodline continues today. All over the world. Baxter scientists devote hours upon hours—year after year—working to improve care. Baxter has taken the lead in research and development of improved formulations for hemophilia therapy.

You see, it’s in our blood not to settle for the status quo.

So Baxter is investing considerable resources to expand processing facilities in both the U.S. and Europe.

And working to strengthen the bonds between patients, nurses, and physicians with new and different therapy management tools.

You’ll also find Baxter people actively involved in the hemophilia community worldwide. Whether it’s a cross-country fund-raising trek in Great Britain, or working with other nations to address their unmet treatment needs, Baxter employees are there.

And every year, hundreds of community grants are given out to hemophilia organizations from Costa Rica to Ireland to Tampa Bay.

After all, hemophilia can appear anywhere. And it’s in our blood to improve living with it wherever we go.

That’s what we call The Baxter Factor.

Baxter’s “A Drop of Blood,” by painter/illustrator John Rush, is a tribute to your work in hemophilia. For your own signed, art-quality complimentary print, please contact your Baxter representative.

Baxter is a Trade Mark of Baxter International Inc. and is registered in the U.S. Patent and Trademark Office. © 2002. Baxter Healthcare Corporation ADV1652 May 2002
The Lymphoma Research Foundation is announcing the launch of a new educational initiative called LAMP (Lymphoma Awareness for Multicultural Populations), to provide low-literacy English, Spanish and Chinese populations with much-needed education about lymphoma, the most common blood cancer and third most common cancer in children.

Why is it Important?
Access to healthcare information for low-literacy and non-English speakers is an increasing challenge in today’s healthcare setting and can negatively impact a patient’s response to treatment.

What is LAMP?
New, multilingual Fact Sheets and interactive website (www.lymphomafacts.org) featuring lymphoma information in English, Spanish and Chinese provides critical information for patients, families and healthcare providers dealing with this disease.

Five Fact Sheets
are available in all three languages, and include information on:
- What lymphoma is
- How lymphoma is treated
- How to take an active part in managing lymphoma
- Coping with lymphoma

Tools now available!
We see a bridge to the past, and a link to the future

GenPath
The Hematopathology Laboratory

We See What Others Don’t

GenPath is a Business Unit of BioReference Laboratories, Inc. (Nasdaq: BRLI) • www.bioreference.com
GAIN Trial

Gemtuzumab Ozogamicin Addition to Induction and Post-Consolidation Therapy in Younger Patients With Newly Diagnosed AML

**CRITERIA:**
- Patient eligibility
- Age: < 56 years of age
- Therapy: Untreated de novo acute myeloid leukemia (AML)

**OBJECTIVES:**
1. Determine whether using gemtuzumab ozogamicin in addition to standard treatment with daunomycin and cytosine arabinoside will increase relapse-free survival
2. Evaluate the safety and tolerability of this regimen

**SCHEMA**

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<th>Consolidation</th>
<th>Post-Consolidation</th>
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<td>Gemtuzumab ozogamicin</td>
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<tr>
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<tr>
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<tr>
<td>Cytosine arabinoside</td>
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</tbody>
</table>

**INDUCTION THERAPY:**
- Randomization into 2 arms
- **ARM 1**
  - Daunomycin 45 mg/m²
  - Days 1–3, cytosine arabinoside 100 mg/m²
  - Days 1–7, and gemtuzumab ozogamicin 6 mg/m² Day 4
- **ARM 2**
  - Daunomycin 60 mg/m²
  - Days 1–3, cytosine arabinoside 100 mg/m²
  - Days 1–7

**CONSOLIDATION THERAPY:**
- 3 cycles of high-dose cytosine arabinoside (Ara-C)-HiDaC (3 g/m² Days 1, 3, 5 every 28 days)

**POST-CONSOLIDATION THERAPY:**
- Randomization into 2 arms
- **ARM 1**
  - 3 doses of gemtuzumab ozogamicin 5 mg/m² at least 28 days apart
- **ARM 2**
  - No therapy

**CONTACT INFORMATION:** Go to www.swog.org/visitors/studies.asp. Select “Open Protocols,” then Study no. S0106. Click the “Start Search” button, which retrieves the protocol information. Click on “Where is This Study Open” (bottom right of page), then locate appropriate state and hospital. SWOG telephone number: 1-210-677-8808.
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*Blood*: Leading the world in reporting basic and applied hematology research.

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[Genentech](http://www.bloodjournal.org)
In addition to inhibitor safety, KOGENATE® Bayer demonstrates:

- Proven clinical safety and efficacy\(^3\)
- Zero confirmed cases of viral transmission\(^4\)
- 2.5 mL diluent volume, which minimizes the risk of repeated venipunctures\(^5\)

An important new publication shows: “The inhibitor formation rate that was observed with [KOGENATE® Bayer] is the lowest reported for prospective studies in PUPs and MTPs.”\(^1\)

In relation to inhibitors, one rFVIII stands out.

<table>
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<tr>
<td>KOGENATE® Bayer(^1)</td>
<td>ReFacto(^2)</td>
<td>Recombinate(^2)</td>
<td>Advate(^6)</td>
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</table>

In addition to inhibitor safety, KOGENATE® Bayer demonstrates:

- Proven clinical safety and efficacy\(^3\)
- Zero confirmed cases of viral transmission\(^4\)
- 2.5 mL diluent volume, which minimizes the risk of repeated venipunctures\(^3\)

Parameters other than product may contribute to the development of inhibitors. Please review Product Information before prescribing.

JOIN ASH TODAY

The American Society of Hematology (ASH) is the world’s largest professional society concerned with the causes and treatment of blood disorders. ASH represents over 13,000 clinicians and scientists committed to furthering the understanding, diagnosis, treatment, and prevention of disorders affecting the blood, bone marrow, and the immunologic, hemostatic, and vascular systems by promoting research, clinical care, education, training and advocacy in hematology.

Membership Benefits Include:

- Subscription to Blood, the Journal of the American Society of Hematology.
- Special annual meeting advantages, including:
  - Receipt of all annual meeting mailings in advance;
  - Members-only advance registration and dramatically lower registration rates;
  - Priority hotel reservations and exclusive access to rooms at headquarter and other close-in hotels;
- A copy of Hematology, the Education Program Book of the ASH annual meeting, which features manuscripts prepared by the annual meeting’s Education Program speakers.
- Eligibility to sponsor abstracts and Scholar Award applications.
- A subscription to ASH News, the Society’s print newsletter, and ASH NewsLink, ASH’s bimonthly e-mail news updates. These communications report on the Society’s latest activities and on other information pertinent to the field of hematology.
- Associate membership is offered at a subsidized rate for fellows in training for up to four years.

For more information Please visit our website at www.hematology.org or contact our Membership Department at (202) 776-0544 ext.1079.
KOGENATE® Bayer 250/500/1000 IU

Powder and solvent for solution for injection.

**Composition:** *Active ingredient*: recombinant coagulation Factor VIII (octocog alfa), 250/500/1000 IU/vial (100/200/400 IU/mL after reconstitution). *Excipients*: powder: glycine, sodium chloride, calcium chloride, histidine, polysorbate 80, sucrose. *Solvent*: water for injections. **Therapeutic indications**: treatment and prophylaxis of bleeding in patients with haemophilia A (congenital Factor VIII deficiency). This preparation does not contain von Willebrand's factor and is therefore not indicated in von Willebrand's disease. **Contraindications**: known hypersensitivity to the active substance, to mouse or hamster protein or to any of the excipients. **Pregnancy and lactation**: KOGENATE® Bayer should be used during pregnancy and lactation only if clearly indicated. **Undesirable effects**: rash/pruritus, local reactions at the injection site, hypersensitivity reactions, unusual taste in the mouth and fever. Furthermore, the possibility of an anaphylactic shock cannot be completely excluded. The formation of neutralising antibodies to Factor VIII is a known complication in the management of individuals with haemophilia A. In studies with recombinant Factor VIII preparations, development of inhibitors is predominantly observed in previously untreated haemophiliacs. In clinical trials, 9 out of 60 (15%) previously untreated and minimally treated patients treated with KOGENATE® Bayer developed inhibitors. Patients should be carefully monitored for the development of inhibitors by appropriate clinical observations and laboratory tests. During studies, no patient developed clinically relevant antibody titres against the trace amounts of mouse protein and hamster protein present in the preparation. However, the possibility of allergic reactions to constituents, e.g., to trace amounts of mouse and hamster protein in the preparation, exists in certain predisposed patients. **Medicinal product subject to medical prescription.**

**Version:** EU/4 Date: January 2005

Bayer AG, D-51368 Leverkusen, Germany

For any information about this medicinal product, please contact the local representative of the Marketing Authorisation Holder.
Most frequently reported adverse events (all causalities) in therapeutic trials were visual disturbances, fever, rash, vomiting, nausea, diarrhea, headache, sepsis, peripheral edema, abdominal pain, and respiratory disorder. Treatment-related adverse events that most often led to discontinuation in clinical trials were elevated LFTs, rash, and visual disturbances.

VFEND treatment-related visual disturbances are common. The effect of VFEND on visual function is not known if treatment continues beyond 28 days.

VFEND is contraindicated with terfenadine, astemizole, cisapride, pimozide, quinidine (since increased plasma concentrations of these drugs can lead to QT prolongation and rare occurrences of torsade de pointes), sirolimus, rifampin, rifabutin, carbamazepine, long-acting barbiturates, ergot alkaloids, efavirenz, and ritonavir (400 mg q12h).

There have been uncommon cases of serious hepatic reactions during treatment with VFEND (clinical hepatitis, cholestasis, and fulminant hepatic failure, including fatalities). LFTs should be evaluated at the start of and during the course of therapy. Patients have rarely developed serious cutaneous reactions, such as Stevens-Johnson syndrome, during treatment with VFEND.

Pregnancy Category D.

†In clinical trials, the majority of isolates recovered were Aspergillus fumigatus. There was a small number of cases of culture-proven disease due to species other than A fumigatus; please see full study descriptions on adjacent page.¹²
Antifungal efficacy that goes places others can’t

**IV/Oral VFEND** provides superiority in invasive aspergillosis and proven efficacy in candidemia*—wherever patients are.

- **Superior efficacy** to amphotericin B in invasive aspergillosis† (53% vs 32%, P<.0001)
- **22% relative survival benefit** in invasive aspergillosis (71% vs 58% for amphotericin B)
- **Extended-spectrum efficacy**
  - Proven efficacy in candidemia in nonneutropenic patients (as effective as a regimen of amphotericin B → fluconazole, 41% vs 41%)
  - The only agent indicated for serious infections due to *Fusarium* spp and *Scedosporium apiospermum* (in patients refractory to, or intolerant of, other antifungal therapy)
- **IV and oral formulations** allow patients to switch to oral therapy when clinically indicated

*In nonneutropenic patients.

Please see brief summary of prescribing information on adjacent pages.

www.vfend.com

It’s time for a change.
Invasive aspergillosis: Data from a global multicenter, open-label trial of 391 patients (277 evaluable for modified intent-to-treat analysis) with invasive aspergillosis randomized to either Velocept (voriconazole) (6 mg/kg IV q12h for the first 24 hours, then 4 mg/kg IV q12h) or Velocept (5 mg/ml PO q12h) or IV amphotericin B (1-1.5 mg/kg/d) for up to 12 weeks. One patient in each arm died within 24 hours of randomization. Efficacy was assessed by the use of double-arm studies, and the results were final when the last patient was randomized.

Candidiasis: From a prospective, global, comparative, open-label study of 420 non-neutropenic patients (370 evaluable for modified intent-to-treat analysis) with candidiasis randomized in a 2:1 ratio to either IV Velocept (6 mg/kg IV q12h on day 1, 3 mg/kg IV q12h on days 2 and 3, then switched to 200 mg PO q12h when clinically indicated) or IV amphotericin B (0.7 mg/kg/d, dosed to IV or oral amphotericin B dose of 300 mg q12h, duration of treatment was all days following oral completion of candidiasis; up to 8 weeks). A successful response required resolution or improvement in all clinical signs and symptoms of infection, blood cultures negative for Candida, endocarditis, and any other serious systemic infection, and no systemic antifungal therapy other than study drug.


Brief Summary of Prescribing Information

Velocept (voriconazole) for Oral Suspension

Indications and Usage

Velocept is indicated for the treatment of the following fungal infections:

- Invasive aspergillosis.
- Invasive candidiasis in neutropenic patients and other patients with severe infections. Treatment should be discontinued when Aspergillus or Candida has been confirmed as the cause of the infection.

Warnings

- Hypersensitivity reactions, including anaphylaxis and anaphylactic-like reactions, have been reported with Velocept.
- Mycotic keratitis has been observed in patients taking Velocept.
- Patients with severe liver disease may have an increased risk of developing liver toxicity.

Administration of the following agents may require dosage adjustment or monitoring:

- Phenytoin (Phenytin) may cause an increase in Velocept plasma levels.
- Phenytoin (Phenytin) levels may increase in patients taking Velocept.

Drug Interactions

- Velocept may interact with other drugs that have a narrow therapeutic index, including warfarin, digoxin, and digoxin.
- Velocept may interact with other antifungal agents, such as kaletra.

Monitoring of Hepatic Function: Liver function tests should be evaluated at the start of and during the course of Velocept therapy. Patients who develop abnormal liver function tests during Velocept therapy should be monitored for the development of more severe hepatic injury. Patient management should include liver evaluation of particular liver function tests and bilirubin. Discontinuation of Velocept must be considered in clinical signs and symptoms consistent with liver dysfunction.

Pregnancy Category: Velocept can cause fetal harm when administered to a pregnant woman. Patients should be advised to avoid pregnancy during treatment.

Velocept is teratogenic in rats (pale palate, hydrocephalus/hydroureter from 10 mg/kg q12h to 0.3 times the recommended maintenance dose (MDD) on a mg/m2 basis) and embryotoxic in rabbits at 10 mg/kg q12h. Other effects in rats included reduced survival, ataxial and caudal vertebrae, hock, pubic and hyoid bone, supernumerary ribs, anomalies of the sternum and diaphragm, and cerebrovascular aplasia. Plasma extract in pregnant rats was reduced at all dose levels. Velocept treatment in rats produced increased gestational length and distocia, which were associated with increased perinatal mortality at the 10 mg/kg dose. The effects seen in rabbits were increased mortality, decreased fetal weight, and increased incidences of skeletal variations, cervical ribs and extra sternal ossification sites. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be informed of the potential hazard to the fetus.

Galactose Intolerance: Velocept tablets contain lactose and should not be given to patients with severe hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption.

Precautions

General (See Warnings) Anticholinergic and Cytotoxic

Some azoles, including voriconazole, have been associated with prolongation of the QT interval on the electrocardiogram. During clinical development and post-marketing surveillance, there have been rare cases of arrhythmias (including ventricular arrhythmias such as torsade de pointes, cardiac arrest, and sudden death in patients taking voriconazole). These cases usually involved severely ill

Continued on following page
Carcinogenesis, Mutagenesis, Impairment of Fertility

Two-year carcinogenesis studies were conducted in rats and mice. Rats were given oral doses of 6, 18, or 50 mg/kg per day of verocincose, or 0.2, 0.6, or 1.6 times the recommended maintenance dose (RMD) on a mg/kg basis. Hepatocellular adenomas were detected in females at 50 mg/kg and hepatocellular carcinomas were found in males at 18 mg/kg. Mice were given oral doses of 10, 30, or 100 mg/kg verocincose, or 0.1, 0.4, or 1.4 times the RMD on a mg/kg basis. In mice, hepatocellular adenomas were detected in males and females and hepatocellular carcinomas were detected in males at 1.4 times the RMD of verocincose.

Voriconazole demonstrated clastogenic activity (mostly chromosome breaks) in human lymphocyte cultures in vitro. In vivo, voriconazole was not genotoxic in the Ames assay, CHO-GH assay, the mouse micronucleus assay or the DNA repair test (Undamaged Single Cell Assay).

Voriconazole produced a reduction in the pregnancy rates of rats dosed at 50 mg/kg or 1.6 times the RMD. This was statistically significant only in the preliminary study and not in a larger fertility study.

Teratogenic Effects

Pregnancy Category D (see WARNINGS).

Women of Childbearing Potential

Women of childbearing potential should use effective contraception during treatment.

Nursing Mothers

The excretion of voriconazole in breast milk has not been investigated. PFEND should not be used by nursing mothers unless the benefit clearly outweighs the risks.

Pediatric Use

Safety and effectiveness in pediatric patients below the age of 12 years have not been established. A total of 22 patients aged 12-18 years with invasive aspergillosis were included in the therapeutic trials. Twelve of 22 (55%) patients had successful response after treatment with a maintenance dose of voriconazole 4 mg/kg q12h.

Sparse plasma sampling for pharmacokinetics in adolescents was conducted in the therapeutic studies.

Geriatric Use

In multiple dose therapeutic trials of voriconazole, 9.2% of patients were ≥65 years of age and 1.8% were ≥75 years of age. In a study in healthy volunteers, the systemic clearance of voriconazole was reduced by 30% in elderly (≥ 65 years) compared to young adults. The pharmacokinetics of voriconazole were maintained in the elderly for up to 2 weeks after discontinuation of voriconazole therapy. Voriconazole was made available for patients 18 years or older.

Overview

The most frequently reported adverse events (all causality) in the therapeutic trials were visual disturbances, fever, rash, vomiting, nausea, diarrhea, headache, peripheral edema, abdominal pain, and dyspnea. Discontinuation of the treatment was required for 2% of patients (27/1371 patients) treated with voriconazole. The incidence of discontinuation of voriconazole therapy was higher in elderly patients compared to younger patients.

Acute visual disturbances, rashes, and in 136 patients receiving voriconazole for over six months. The table below includes all adverse events which were related at an incidence of ≥2% during voriconazole therapy in all therapeutic studies population, studies 307/602 and 608 combined, or study 305, as well as events of concern which occurred at an incidence of ≥2%.

In study 307/602, 347 patients (196 on voriconazole, 148 on amphotericin B) were treated to compare voriconazole to amphotericin B followed by another licensed antifungal therapy in the primary treatment of patients with acute invasive aspergillosis. In study 608, 403 patients with candidemia were treated to compare voriconazole (27/7 mg/kg) to the regimen of amphotericin B followed by fluconazole (137 patients). Study 305 evaluated the effects of oral voriconazole (700 patients) and oral voriconazole (151 patients) in the treatment of esophageal candidiasis laboratory test abnormalities for these studies are discussed under Clinical Laboratory Values below.

Treatment-Emergent Adverse Events

One or more % on common or severe Adverse Events of Concern in All Therapeutic Studies Population, Studies 307/602-604 Combined, or Study 305, Possibly Related to Therapy or Causality Unknown.

Special Senses**

All Therapy Studies

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<tr>
<th>Voriconazole</th>
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Cardiovascular System

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Metabolism and Nutritional Systems

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Nervous System

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All Adverse Events

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<tr>
<th>Voriconazole</th>
<th>N=1655</th>
<th>N=1686</th>
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<tbody>
<tr>
<td>Rash</td>
<td>88 (5)</td>
<td>92 (5)</td>
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</table>

** Special Senses: Abnormalities, Pharyngitis, Rhinitis

** Cardiac: Hypertension, Hypotension

** Hypersensitivity: Local skin test abnormal, Systemic reaction

** Metabolism: Abnormal liver enzymes increased, ALT increased, AST increased

** Thyroid: Thyroid function abnormal

** Creatinine: Creatinine increased

** Nervous: Hypertension

** All Adverse Events: Rash

All Therapy Studies: Voriconazole N=1655, N=1686

Studies 307/602-604: Voriconazole N=1655, N=1686

Study 305: Voriconazole N=1655, N=1686

** Abnormalities: Abnormal liver enzymes increased, ALT increased, AST increased

** Thyroid: Thyroid function abnormal

** Creatinine: Creatinine increased

** Nervous: Hypertension

** All Adverse Events: Rash
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**Blood Journal**

Subscription Office

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Washington, DC 20036

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**Leukemia and Lymphoma Section**

**Division of Pediatrics**

The Division of Pediatrics at the University of Texas M. D. Anderson Cancer Center currently has a faculty position available for Assistant or Associate Professor for an individual with interests in leukemia and lymphoma. Primary responsibility is patient care while serving as one of six attending physicians in the Leukemia/Lymphoma Section of the Division for the inpatient service, for the outpatient clinic and the ambulatory treatment center. Secondary responsibilities may include a potential opportunity for clinical research and/or academic productivity. Candidates must be knowledgeable in all aspects of the clinical care of infants, children, adolescents and young adults with cancer and have either a strong academic record or potential. Please forward letter of application, indicating position of interest, and curriculum vitae to:

Robert J. Wells, M.D.
Deputy Division Head, Pediatrics
The University of Texas M. D. Anderson Cancer Center
1515 Holcombe Blvd., Unit 87
Houston, Texas 77030
Phone: 713.563.1499
E-mail: rjwells@mdanderson.org

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Rochester, Minnesota

The Division of Hematology at Mayo Clinic in Rochester, Minnesota, seeks a board-certified/board-eligible hematologist or hematologist/oncologist to join the myeloma, amyloidosis, Waldenström’s macroglobulinemia group. The group seeks an individual with a strong commitment to patient care who would participate in all phases of the practice including stem cell transplantation. The group is heavily committed to clinical trial participation and clinical trial development. A research interest, either clinically based or laboratory based, would be considered an asset.

To learn more about Mayo Clinic and Rochester, MN please visit www.mayo.edu.

Interested individuals should send a cover letter and curriculum vitae to:

Morie A. Gertz, M.D.
Chair, Division of Hematology
Mayo Clinic
200 First Street SW
Rochester, MN 55905

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To place an advertisement in **Blood’s** Classified Advertising section, please contact Valerie Marvin at the following address: Blood, 180 Old Tappan Road, Old Tappan, NJ 07675. Phone: 201-767-4170; fax: 201-767-8065; e-mail: vmarvin@cunnasso.com.

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TRANSLATIONAL RESEARCH PROGRAM 2006
Leukemia - Lymphoma – Myeloma

The Leukemia & Lymphoma Society provides early-stage support for clinical research on leukemia, lymphoma and myeloma, which is intended to develop innovative approaches to treatment, diagnosis or prevention. The program fosters collaboration between basic and clinical scientists with the intent of enhancing the transfer of basic research findings to clinical usefulness. The Translational Research Program is specifically intended for the support of work that has clinical application as a near-term goal.

PROGRAM SCOPE
Proposal should be based on epidemiological, molecular, cellular or integrated systems findings and be conceptually innovative. The application should have a clear plan for the clinical exploitation of the studies proposed. This feature of the proposal will be an important consideration of the review process.

COORDINATION WITH THE NATIONAL CANCER INSTITUTE
The Translational Research Program was developed in consultation with the National Cancer Institute. Relevant NCI staff will be invited to participate with the Society in a review of the grantee’s research at the beginning of year three of the grant. We hope that this meeting may enhance the grantee’s opportunity to compete for sponsored funding to continue his her studies.

ELIGIBILITY REQUIREMENTS
Applications may be submitted by individuals working in domestic or foreign non-profit organizations, such as universities, colleges, hospitals, and laboratories.

Funds Available
Awards will be limited to a maximum of $200,000, which include direct costs and a maximum overhead of $20,000 or 11.1% of direct cost per year for three years. Budget requests should be carefully justified and commensurate with the needs of the project. Renewal of funding for two additional years may be available from the Society. Requests for renewal of support require a competitive renewal application and must include an IRB-approved clinical trial as the centerpiece of the research plan.

Deadlines (New and Renewal):
Preliminary Application (submitted via website): March 1
Full Application: March 15. w

Guidelines are available from: www.LLS.org
or
Director of Research Administration
The Leukemia & Lymphoma Society
1311 Mamaroneck Avenue
White Plains, NY 10605
(914) 821-8859
E-mail: researchprograms@LLS.org
Thrombosis-Hemostasis Specialist
University of Michigan Medical School

The Departments of Internal Medicine and Pathology invite applications for a physician-scientist with expertise in Thrombosis-Hemostasis to develop an independent research laboratory and to serve as Director of the Coagulation Laboratory, University of Michigan Hospital and Health System. Ideal qualifications for this tenure track position at the Associate or full Professor level include subspecialty training in Thrombosis-Hemostasis, Board Certification in Hematology and/or Hematopathology, clinical laboratory management experience, and a record of scholarly productivity in a field related to Thrombosis-Hemostasis. Ample opportunities exist for collaboration with clinicians and scientists with interests in coagulation disorders, vascular biology, and related disciplines. Candidates must be US citizens. The University of Michigan is committed to increasing representation of women and members of minority groups on its faculty and particularly encourages applications from such candidates. Please send curriculum-vitae and names and addresses of three potential references to: Robert F. Todd, III, MD, PhD, Frances and Victor Ginsberg Professor of Hematology/Oncology, Chief, Division of Hematology/Oncology, University of Michigan Medical School, 7216 CCGC, 1500 E. Medical Center Drive, Ann Arbor, Michigan, 48109-0948, email: robtodd@umich.edu.
Clinical Research in Blood and Marrow Transplantation

The Blood and Marrow Transplantation Program at the University of Minnesota is seeking an academic Physician with training and experience in hematology/oncology clinical research and blood and marrow transplantation.

At the University of Minnesota this individual will assume a leadership role in the development, implementation, and supervision of innovative clinical trials in transplantation therapy. This will involve collaboration with other Program faculty who are involved in research projects including selection and expansion of enriched stem cell populations; priming and preparation of transplant recipients; post transplant anti-tumor therapy as well as efforts to improve the safety and cost-effectiveness of transplant therapy. Opportunities for development and participation in clinical studies of non-transplant experimental therapies are also available. This position will provide opportunities for broad-based collaborations and external research funding. This individual will also participate in the inpatient and outpatient care of stem cell transplant recipients as well as teaching of medical students and postgraduate trainees.

Candidates for this position will have successfully completed residency in Internal Medicine and have formal subspecialty training through fellowship in Hematology and/or Oncology with specific training and experience in Blood and Marrow Transplantation. Clinical experience in Hematology/Oncology is preferred. The appointment, depending upon qualifications, will be at Assistant, or Associate Professor level (Clinical-Scholar Track) with compensation commensurate with experience.

Applications will be reviewed promptly and accepted until position is filled. Applicants should send a brief letter, curriculum vitae, and the names of three references to:

Daniel Weisdorf, M.D.
Division of Hematology, Oncology and Transplantation
University of Minnesota
MMC 480
420 Delaware Street SE
Minneapolis, MN 5545
Phone: 612-624-3101 Fax: 612-625-6919
Email:mmweisd001@umn.edu

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