Note From the Group Chairman

Congratulations to the many RTOG researchers whose work will be presented at the ASTRO 55th Annual Meeting this week in Atlanta. In addition to the “all-RTOG” plenary session featuring four outstanding RTOG presentations on Monday afternoon September 23rd, attendees will have many other opportunities to learn about exciting RTOG research results throughout the meeting. This year’s more than 20 RTOG presentations represent a considerable effort on the part of many, and I thank you all for your contribution in making this ASTRO meeting especially memorable.

As many of you may have heard, NRG Oncology has received formal notification that the group will be funded to conduct research as part of the NCI’s National Clinical Trials Network. NRG Oncology received a very favorable review from the NCI, with a very positive emphasis on the breadth and depth of our new group’s research, the tremendous history of accomplishments in all three of our legacy groups, and the pivotal role NRG Oncology will play in NCI’s new National Clinical Trials Network. Work continues on important scientific and operational integration of NRG Oncology, and we expect to learn about NCI funding details by the end of the year. Please hold the dates of February 6-9, 2014 as the first fully official NRG Oncology meeting in San Diego!

Meanwhile, RTOG research activity continues at an active pace. Highlighted in this issue are three new trials that I encourage you to review and consider opening at your research sites. Also spotlighted is the RTOG 0912 trial for anaplastic thyroid cancer, which has recently opened its third run-in component. Recognizing the effort involved to re-energize patient enrollment after a closure for toxicity evaluation, I thank site research teams for their continued focus on enrollment, which helps us move forward to the phase II trial evaluating a new treatment option for a very deadly cancer.

My congratulations to everyone who helped the RTOG 0813, 0913 and 1016 trials recently meet their accrual goals. Keep up the terrific work, and I look forward to seeing you in Atlanta!

RTOG Takes Center Stage at ASTRO

The American Society for Radiation Oncology (ASTRO) 55th Annual Meeting taking place September 22-25 at the Georgia World Congress Center, in Atlanta, promises to be an exciting event for RTOG investigators. RTOG research will be featured in 29 presentations throughout the meeting. Exceptionally exciting is the plenary session that will feature four RTOG presentations on Monday, September 23 from 2:00 to 3:10 PM. These include:

- **RTOG 9910:** Phase III Trial to Evaluate the Duration of Neoadjuvant Total Androgen Suppression and Radiation Therapy in Intermediate-Risk Prostate Cancer; Presenter: Thomas Pisansky, MD
- **RTOG 0617:** Quality of Life Analysis of the Randomized Radiation Dose Escalation NSCLC Trial: The Rest of the Story; Presenter: Benjamin Movsas, MD, FASTRO
- **RTOG 0841:** Two Item Questionnaire Effectively Screens for Depression in Cancer Patients Receiving Radiotherapy; Presenter: William Small, MD, FASTRO
- **RTOG 0933:** Memory Preservation with Conformal Avoidance of the Hippocampus during Whole-Brain Radiotherapy for Patients with Brain Metastases: Primary Endpoint Results; Presenter: Vinai Gondi, MD

“It’s very gratifying to have three ASTRO plenary session presentations reporting results of two RTOG Community Clinical Oncology Program (CCOP) trials and a trial reporting quality of life outcomes, funded by our CCOP,” says Deborah W. Bruner, RN, PhD, FAAN, principal investigator of the RTOG CCOP and associate director of outcomes at the Winship Cancer Institute of Emory University in Atlanta. “This achievement demonstrates the important role and capability of community-based radiation oncology programs in successfully carrying out radiation therapy side effects-reduction and quality-of-life clinical trials.”

For a complete listing of RTOG ASTRO presentations, visit www.rtog.org/Publications/ConferencePresentations.aspx or stop by the RTOG booth (#618) to pick up a schedule.

Remembering Kie Kian Ang, MD, PhD

RTOG is pleased to present remembrances of Kian Ang, MD, PhD on page 10 of this newsletter. Thank you to the many people from around the world who shared their thoughts and special memories. RTOG has established an award in his honor that will support two investigators attending the NRG Semianual Meeting.

Visit www.RTOG.org for the latest group news
RTOG Utilizing TRIAD™ for RT Digital Data Collection!

TRIAD is the American College of Radiology’s (ACR’s) image and information exchange application now in use by RTOG. TRIAD provides research sites participating in RTOG clinical trials with a secure method for transmitting DICOM-RT and other digital data. TRIAD anonymizes and validates images and information objects as they are transferred from a site to the clinical database via the Internet.

RTOG is now utilizing TRIAD to collect RT digital data on RTOG 1201 and 1306. Other RTOG trials will follow so Stay Tuned!

Here’s how TRIAD works.

Requirements:
1. All site staff members who transmit RT imaging data (medical physicists and dosimetrists) must have an active CTEP-IAM username and password.
2. Site rosters must be updated to include medical physics and dosimetry staff, with each being assigned a “TRIAD site user” role. The lead research associate at each RTOG member site should submit an RTOG Roster Update Form to add staff members along with their role (http://www.rtog.org/LinkClick.aspx?fileticket=q61ShTwNbFQ%3d&tabid=308).

Procedure:
1. Each site staff member obtains a CTEP-IAM account.
2. Each site staff member obtains a TRIAD site user role.
3. The site installs TRIAD on its computer. Information on this step will be available on the RTOG Web site, under the Core Lab tab located on the home page.

Please Note: Effective immediately, in preparation for this change, RTOG requires that sites adhere to the standard structure naming convention for all trials. Submissions not meeting this requirement will need to be resubmitted. The structure list of terms for each trial is available on the protocol-specific pages of the ATC Web site (http://atc.wustl.edu/).

The list of terms will be embedded within the protocol of new trials, and currently accruing trial protocols are being amended to include this list. Until these changes are effective, please visit the ATC Web site for the structure lists.

For TRIAD-specific questions, please contact TRIAD-Support@acr.org or call 1-703-390-9858. For other questions, please contact Tammy McGlade at tmcglade@acr.org.

New Streamlined Safety Report Notifications

RTOG will change the safety report broadcast process starting in October 2013. Under the new process, sites will receive a single RTOG broadcast on a bimonthly basis that contains the safety reports and any other relevant safety information for all applicable RTOG study drugs for the report-specified time period. The safety broadcast will no longer include safety reports as attached documents. Rather, sites will select the applicable hyperlink from the body of the broadcast, which will navigate to the password-protected safety report page on the RTOG Web site. From October onward, all safety reports will be accessible via the dedicated safety report page on the RTOG Web site, where they will be organized by study drug. The goal of this effort is twofold: to reduce the volume of RTOG broadcast messages and to improve organizational efficiency by housing all safety reports in a single location.

Navigating Access to Biospecimens

The National Cancer Institute (NCI) has made significant headway in the development of its consolidated informatics system called Research Navigator* (or “Navigator”) intended to provide uniform access and information to investigators about biospecimen inventory across all NCI cooperative groups. Work on the project across all 10 co-operative cancer groups began earlier in 2013. Navigator is intended to help investigators gain access to the comprehensive, group-wide inventory of banked specimens referred to as the Cooperative Group Banks (CGB). Several major goals for the Navigator system include:

- Connect biospecimen inventory data with associated trial data and clinical data to allow for the reasonable assessment of biospecimen availability based on trial design and clinical data end points
- Provide tools and standards definitions to facilitate automated data loading from multiple systems into the CGB Navigator database
- Provide a secure, role-based, highly functional user interface for performing data queries and reporting according to the needs of various stakeholders.

The NCI plan includes the implementation of a “Front Door” interface to manage investigator applications requesting access to biospecimens in CGB Navigator to carry out correlative research. The first step is the NCI’s “Front Door Concierge” review to insure adequate availability of biospecimens to achieve the research goal and to log and track the request process. Assessment of an application’s scientific merit will continue to be a responsibility of the respective cooperative group. For a detailed overview of the initiative that is expected to launch in October 2014, visit the Navigator slide presentation given by Richard Jordan, DDS, PhD, director of the RTOG Biospecimen Resource, at the June 2013 RTOG Semiannual Meeting.
Clinical Trial Updates

RTOG 1306: A Randomized Phase III Study of Individualized Combined Modality Therapy for Stage III Non-Small Cell Lung Cancer (NSCLC)

From the Trial Principal Investigators
“Erlotinib produces better response rates and improved progression-free survival compared with chemotherapy in patients with advanced non-small cell lung cancer whose tumor cells harbor activating mutations in the epidermal growth factor receptor tyrosine kinase mutation. Similar results have been reported with crizotinib in patients with advanced NSCLC whose tumor cells have evidence of EML-ALK translocation. Outcomes for patients with locally advanced NSCLC have reached a plateau after the introduction of concurrent chemoradiation. It is critical to test targeted therapies in defined molecular subsets of patients with potentially curable locally advanced NSCLC. RTOG 1306 is an innovative randomized trial to test the efficacy of induction therapy with erlotinib or crizotinib followed by conventional chemoradiation in patients with EGFR-mutant or ALK-positive locally advanced potentially curable NSCLC.”

RAMASWAMY GOVINDAN, MD
RTOG 1306 Principal Investigator
Washington University School of Medicine
St. Louis, Missouri

HAK CHOY, MD
RTOG 1306 Radiation Oncology Co-Chair
University of Texas Southwestern
Dallas, Texas

Overview
Despite the improved overall survival in patients with locally advanced NSCLC who undergo concurrent chemoradiation compared with sequential chemotherapy followed by radiation, more than 70% of this patient population is still expected to die from recurrent disease. Approximately 15% of patients with NSCLC harbor endothelial growth factor tyrosine kinase (EGFR-TK) mutations or echinoderm microtubule-associated protein-like-4-anaplastic lymphoma kinase (EML4-ALK) fusion rearrangements, and treatment with inhibitors (erlotinib and crizotinib, respectively) has produced significant responses in studies of these patients in the setting of advanced NSCLC.

This is the first study to provide customized therapy in addition to chemotherapy and radiation to patients with a less advanced form of NSCLC and either of these gene alterations. It will use targeted therapy only in the 12-week induction phase in a carefully selected group of patients with locally advanced NSCLC whose tumors have known “sensitive” mutations in the EGFR-TK domain (for erlotinib) or EML4-ALK fusion rearrangement (for crizotinib). The induction phase will be followed 2 weeks later by concurrent chemoradiation.

Patient Population: patients with histologically or cytologically confirmed, newly diagnosed, measurable, unresectable stage IIIA or IIIB nonsquamous NSCLC that is surgically staged to confirm N2 or N3 disease with no distant metastases, and who have a Zubrod performance status of 0–1. Pre-enrollment documentation of the presence of known “sensitive” mutations in EGFR-TK domain and EML4-ALK fusion arrangement is required.

Target Accrual: 234 patients

Primary Objective
To assess whether patients with unresectable locoregionally advanced NSCLC treated with targeted agents based on molecular characteristics have a longer progression-free survival than those treated with standard care therapy alone

Secondary Objectives
To evaluate the response rate, toxicity, and overall survival, and to correlate clinical outcomes with tumor molecular aberrations

Trial Schema

| Weight Loss (in prior 6 mo) | Stratification Stage | Chemotherapy
|-----------------------------|----------------------|-----------------
| 1. <5%                      | IIA                  | 1. Cisplatin & Etoposide
| 2. >5%                      | IIIB                 | 2. Paclitaxel & Carboplatin

EGFR-TK Mutation Cohort

**Arm 1:** Induction Therapy: Erlotinib, 150 mg/day for 12 Weeks*
**Arm 2:** Concurrent Chemotherapy† and Radiation, 60 Gy

EML4-ALK Cohort

**Arm 3:** Induction Therapy: Crizotinib, 250 mg/bid for 12 Weeks*
**Arm 4:** Concurrent Chemotherapy† and Radiation, 60 Gy

* If CT scan at 6 weeks into induction therapy does not show at least a partial response, the patient will proceed directly to concurrent chemotherapy and IMRT or 3D-CRT provided there is no progression that would preclude definitive chemoradiotherapy, in which case the patient will go off protocol treatment and be treated as appropriate for systemic disease.

† Per treating physician’s discretion, a choice of 2 chemotherapy regimens:
   - Cisplatin and etoposide, every 4 weeks, for 2 cycles
   - Paclitaxel and carboplatin weekly for 6 weeks followed by 2 cycles of consolidation therapy
RTOG 1221: Randomized Phase II Trial of Transoral Endoscopic Head and Neck Surgery Followed by Risk-Based IMRT and Weekly Cisplatin Versus IMRT and Weekly Cisplatin for HPV-Negative Oropharynx Cancer

From the Trial Principal Investigators
“We are excited about this first trial to compare a transoral endoscopic head and neck surgery (with or without adjuvant therapy) versus definitive chemoradiation for the treatment of HPV-negative oropharyngeal carcinoma—a disease subtype with currently dismal outcomes. The study provides an opportunity to collect baseline data regarding margin status and functional outcomes and to define the end points to be studied by a larger randomized phase III comparative trial.”

FLOYD CHRISTOPHER HOLSINGER, MD, FACS
RTOG 1221 Principal Investigator
Stanford University School of Medicine
Stanford, California

WADE L. THORSTAD, MD
RTOG 1221 Radiation Oncology Co-Chair
Washington University Medical Center
Saint Louis, Missouri

Overview
In RTOG 0129, the presence of the human papillomavirus (HPV) was shown to be a strong independent prognostic factor for significantly improved overall survival and progression-free survival among patients with squamous-cell oropharyngeal carcinoma (OPC). Patients with HPV-negative tumors, despite upfront treatment with primary RT and cisplatin, had a 25.1% reduction in overall survival and a 21% increase in locoregional relapse rates at 3 years when compared with the HPV-positive group. Up to this point, changing the method of RT delivery and the dosing and/or types of concurrent chemotherapy have not been sufficient to improve the oncologic outcomes of patients with HPV-negative OPC.

The option of performing surgery up front with this high-risk patient group has become more acceptable because of the emergence of transoral endoscopic head and neck surgery (eHNS)—a minimally invasive approach through the mouth that avoids the disfiguring incisions and postoperative swallowing deficits associated with open surgery. This randomized phase II trial will compare primary RT with concurrent cisplatin-based chemotherapy versus transoral eHNS with neck dissection and risk-based adjuvant therapy for the treatment of HPV-negative OPC. Investigators hope that the lower postoperative RT dose (60 Gy) rather than a definitive dose (70 Gy) combined with an intensity-modulated RT (IMRT) technique will reduce the risk of damage to normal tissue.

Patient Population: patients with stage III–IV (T1–2, N1–2b,) pathologically proven squamous cell carcinoma of the oropharynx localized to the tonsil, glossopharyngeal sulcus, and tongue base that is negative for p16 expression (surrogate biomarker for HPV status) and resectable through transoral endoscopic head and neck surgery (eHNS), and who have a Zubrod performance status of 0–1

Target Accrual: 144 patients

Primary Objective
To determine if primary treatment with transoral eHNS will improve progression-free survival for patients with HPV-negative OPC

Secondary Objectives
To evaluate patterns of failure and survival, head and neck cancer-specific quality of life, swallowing function, shoulder function, and association of molecular profiles with clinical end points

Trial Schema

<table>
<thead>
<tr>
<th>T Stage</th>
<th>N Stage</th>
<th>Zubrod Performance Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. T1</td>
<td>1. N0–1</td>
<td>1. 0</td>
</tr>
<tr>
<td>2. T2–3</td>
<td>2. N2</td>
<td>2. 1</td>
</tr>
</tbody>
</table>

Arm 1: eHNS* + Neck Dissection
(Experimental Arm)
“Risk-Based” Postoperative Adjuvant Therapy, +/- IMRT (60 Gy) +/- Weekly Cisplatin

Arm 2: Chemoradiotherapy
(Control Arm)
IMRT (70 Gy) + Weekly Cisplatin

*Endoscopic Head and Neck Surgery (eHNS) = Transoral Laser CO2 Microsurgery or Transoral Robotic Surgery.
NSABP B-51/RTOG 1304: A Randomized Phase III Clinical Trial Evaluating Post-Mastectomy Chest Wall and Regional Nodal RT and Post-Lumpectomy Regional Nodal RT in Patients With Positive Axillary Nodes Before Neoadjuvant Chemotherapy Who Convert to Pathologically Negative Axillary Nodes After Neoadjuvant Chemotherapy

From the Trial Principal Investigators

“The clinical dilemma of whether to change the current locoregional treatment strategy for patients with breast cancer who present with positive axillary nodes that become negative after neoadjuvant chemotherapy is something that’s debated at my institution’s tumor board every week. Currently, no established care standard exists for the use or extent of radiotherapy in these patients. The NSABP B-51/RTOG 1304 trial will provide valuable information about the best local regional radiotherapy treatment strategies for this increasingly common patient population.

“A helpful tool adopted for this study is the ‘Breast Cancer Atlas for Radiation Therapy Planning,’ developed by a consensus committee within the RTOG that provides guidelines for the definition of clinical target volumes and normal structures on CT for radiation treatment planning. This atlas is available on the RTOG Web site at: Breast Cancer RT Atlas.”

JULIA WHITE, MD
NSABP B-51/RTOG 1304 Co-Principal Investigator
Ohio State University
Columbus, Ohio

Overview

Patients with breast cancer that has spread to the axillary lymph nodes are generally recommended to receive regional nodal radiotherapy (RT) to the chest wall and regional nodal basins (after mastectomy) or to the breast and regional nodal basins (after breast-conserving surgery [lumpectomy]). RT for patients with negative nodes, however, is typically not recommended following mastectomy and is confined to the breast after lumpectomy. The increasing use of neoadjuvant chemotherapy to downstage large breast cancer tumors, allowing patients to undergo lumpectomy instead of mastectomy, has also resulted in the downstaging of involved nodes. The resulting potential for approximately 40% of patients with involved nodes at presentation to have pathologically negative nodes at the time of surgery has led to debate as to the appropriate use and extent of locoregional RT after mastectomy or lumpectomy, with no clear standard of care established.

Postmastectomy chest wall and regional RT has significantly reduced locoregional recurrence (LRR) and significantly prolonged overall survival for patients with positive nodes. For patients with negative nodes, the absolute reduction in LRR was small and there was no significant improvement in overall survival. Although not formally tested, clinician agreement to add regional nodal RT to breast RT post-lumpectomy for patients with 4 or more positive nodes can be extrapolated from the postmastectomy trials. In the NCIC-CTG MA.20 trial, the addition of regional nodal RT to breast RT after lumpectomy for patients with 1–3 positive nodes significantly reduced regional nodal recurrence, significantly prolonged disease-free and distant disease-free survival, and produced a nonsignificant trend in prolonging overall survival. The use of invasive breast cancer recurrence-free interval as the primary end point for NSABP-B-51/RTOG 1304 is based on the latter results.

Patient Population: patients with clinically T1–3, N1 breast cancer and pathologic confirmation of axillary nodal involvement who have undergone primary tumor hormone receptor and HER2 analysis before neoadjuvant chemotherapy and, after definitive surgery (lumpectomy or mastectomy), whose axillary nodes are histologically cancer-free

Target Accrual: 1636 patients

Primary Objective

To evaluate whether the addition of chest wall plus regional nodal RT after mastectomy or breast plus regional nodal RT after breast-conserving surgery will significantly reduce the rate of events for invasive breast cancer recurrence-free interval in patients who present with histologically positive axillary nodes but convert to histologically negative axillary nodes following neoadjuvant chemotherapy

Secondary Objectives

To evaluate overall survival, locoregional recurrence-free interval, distant recurrence-free interval, disease-free survival-ductal carcinoma in situ, and secondary primary cancer, as well as quality of life, toxicity, treatment adequacy, effect of RT, and molecular predictors of recurrence

Mark Your Calendars!
The next NRG Oncology meeting is scheduled for:
February 6-9, 2014
Manchester Grand Hyatt
San Diego, CA

Continued
Clinical Trial Updates

NSABP B-51/RTOG 1304 (continued)

Trial Schema

**Clinically T1-3, N1 Breast Cancer With Documented Positive Axillary Nodes by FNA or by Core Needle Biopsy**

- Minimum of 12 Weeks of Standard Neoadjuvant ChemotherapyPlus Anti-HER2 Therapy for Patients With HER2-Positive Tumors
- Definitive Surgery With Histologic Documentation of Negative Axillary Nodes (Either by Axillary Dissection or by Sentinel Node Biopsy + Axillary Dissection)

**STRATIFICATION**
- Type of surgery (mastectomy, lumpectomy)
- Hormone receptor status (ER-positive and/or PgR-positive; ER- and PgR-negative)
- HER2 status (negative, positive)
- Adjuvant chemotherapy (yes, no)
- pCR in breast (yes, no)

**RANDOMIZATION**

<table>
<thead>
<tr>
<th>Arm 1</th>
<th>Arm 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Groups 1A and 1B)*†</td>
<td>(Groups 2A and 2B)*†</td>
</tr>
<tr>
<td><strong>No Regional Nodal RT</strong></td>
<td><strong>Regional Nodal RT</strong></td>
</tr>
<tr>
<td>- Group 1A Lumpectomy: No regional nodal RT with WBI</td>
<td>- Group 2A Lumpectomy: Regional nodal RT with WBI</td>
</tr>
<tr>
<td>- Group 1B Mastectomy: No regional nodal RT and no chest wall RT</td>
<td>- Group 2B Mastectomy: Regional nodal RT and no chest wall RT</td>
</tr>
</tbody>
</table>

* Patients will be randomized to one of the following:
  - **Arm 1**
    - Radiation therapy for Group 1A (Whole breast irradiation + boost)
    - No radiation therapy for Group 1B
  - **Arm 2**
    - Radiation therapy for Group 2A (Whole breast irradiation + boost and regional nodal irradiation)
    - Radiation therapy for Group 1B (Chest wall and regional nodal irradiation)

† All patients will receive additional systemic therapy as planned (i.e., hormonal therapy for patients with hormone receptor-positive breast cancer and trastuzumab or other anti-HER2 therapy for patients with breast cancer that is HER2-positive).

**TRIAL FOCUS**

**RTOG 0912: Keeping an Eye on the Goal**

Sites participating in the RTOG 0912 trial evaluating the safety of a new treatment regimen (intensity-modulated radiotherapy, paclitaxel and pazopanib suspension) for patients with anaplastic thyroid cancer (ATC) are striving to accrue 11 patients into the trial’s third run-in component. Affecting primarily adults 65 and older, ATC accounts for only 1% to 2% of all thyroid cancer cases and is one of the most aggressive solid tumors, with a 1-year survival rate of approximately 10%.

Although these factors often make accrual of patients challenging, site research teams have been successful at meeting patient accrual goals for the prior two run-in components. RTOG leadership applauds this effort and encourages sites to again strive for this capability. With a focused effort, the current goal is to complete accrual for the third run-in component in 8 months or sooner. Once the treatment is determined safe, it will be tested in a randomized phase II trial component.

“The need for studies in this disease is significant due to the lack of prior trials and the poor prognosis for these patients. Due to the rarity and aggressiveness of this disease, we encourage investigators to open this trial at their institutions, even if they only see 1 or 2 affected patients per year,” says Walter J. Curran, Jr, MD, RTOG Group Chairman and Executive Director of the Winship Cancer Institute of Emory University in Atlanta.

“As co-principal investigator of this trial, along with my medical oncology colleague Dr. Eric Sherman, I am extremely excited and pleased to reopen and conduct RTOG 0912 in multiple centers. We hope that a difference can be made for these patients with this dismal disease.”

— Nancy Y. Lee, MD
RTOG 0912 Co-Principal Investigator and Radiation Oncologist
Memorial Sloan-Kettering Cancer Center

For more information about the trial, visit: RTOG 0912.
Clinical Trial Updates

Recognition of a Job Well Done

Four RTOG clinical trials recently met their target study participant accrual goals. Congratulations to the trial leadership and to each and every site research team that enrolled study participants on to one or more of these trials. RTOG recognizes the top-accruing sites for the four trials below for their extraordinary accrual results that helped RTOG reach these important milestones.

RTOG 0929: A Randomized Phase I/II Study of ABT-888 in Combination With Temozolomide in Recurrent Glioblastoma

Total Study Participants Accrued: 257

<table>
<thead>
<tr>
<th>Institution</th>
<th>Participants Accrued</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas MD Anderson Cancer Center</td>
<td>32</td>
</tr>
<tr>
<td>Northwestern Memorial Hospital</td>
<td>27</td>
</tr>
<tr>
<td>University of Kansas Cancer Center</td>
<td>12</td>
</tr>
<tr>
<td>National Cancer Institute Radiation Oncology Branch</td>
<td>10</td>
</tr>
<tr>
<td>University of Rochester Medical Center</td>
<td>8</td>
</tr>
<tr>
<td>Wilmot Cancer Center</td>
<td>8</td>
</tr>
<tr>
<td>University of Pittsburgh Medical Center - Shadyside</td>
<td>8</td>
</tr>
<tr>
<td>Medical University of South Carolina</td>
<td>8</td>
</tr>
<tr>
<td>University of Utah Health Sciences Center</td>
<td>8</td>
</tr>
</tbody>
</table>

RTOG 0813: Seamless Phase I/II Study of Stereotactic Lung Radiotherapy for Early Stage, Centrally Located, Non-Small Cell Lung Cancer in Medically Inoperable Patients

Total Study Participants Accrued: 120

<table>
<thead>
<tr>
<th>Institution</th>
<th>Participants Accrued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roswell Park Cancer Institute</td>
<td>8</td>
</tr>
<tr>
<td>Pocono Medical Center Dale and Frances Hughes Cancer Center</td>
<td>7</td>
</tr>
<tr>
<td>University of Kentucky Hospital</td>
<td>7</td>
</tr>
<tr>
<td>University of Texas Southwestern Medical School</td>
<td>7</td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>7</td>
</tr>
<tr>
<td>Mercy San Juan Radiation Oncology Center</td>
<td>7</td>
</tr>
<tr>
<td>Mayo Clinic</td>
<td>6</td>
</tr>
<tr>
<td>The Ottawa Hospital Regional Cancer Centre</td>
<td>5</td>
</tr>
</tbody>
</table>

RTOG 0916: Phase III Trial of Radiotherapy Plus Cetuximab Versus Chemoradiotherapy in HPV-Associated Oropharynx Cancer

A proposal is under review to amend the study to increase the sample size and re-open it to accrual.

Total Study Participants Accrued: 732

<table>
<thead>
<tr>
<th>Institution</th>
<th>Participants Accrued</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Oklahoma Health Sciences Center</td>
<td>39</td>
</tr>
<tr>
<td>Ohio State University Wexner Medical Center</td>
<td>34</td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>34</td>
</tr>
<tr>
<td>Stanford University Medical Center</td>
<td>34</td>
</tr>
<tr>
<td>James Graham Brown Cancer Center at University of Louisville Health Sciences Center</td>
<td>23</td>
</tr>
<tr>
<td>University of Texas MD Anderson Cancer Center</td>
<td>21</td>
</tr>
<tr>
<td>Emory University</td>
<td>20</td>
</tr>
<tr>
<td>University of Utah Health Sciences Center</td>
<td>17</td>
</tr>
<tr>
<td>H. Lee Moffitt Cancer Center &amp; Research Institute</td>
<td>16</td>
</tr>
<tr>
<td>Radiological Associates of Sacramento</td>
<td>14</td>
</tr>
<tr>
<td>Summa Akron City Hospital</td>
<td>13</td>
</tr>
<tr>
<td>University of Alabama at Birmingham Medical Center</td>
<td>13</td>
</tr>
</tbody>
</table>

RTOG 0913: Phase I/II Trial of Concurrent RAD001 (Everolimus) With Temozolomide/Radiation Followed by Adjuvant RAD001/Temozolomide in Newly Diagnosed Glioblastoma

Total Study Participants Accrued: 272

<table>
<thead>
<tr>
<th>Institution</th>
<th>Participants Accrued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Oncology Services Foundation</td>
<td>14</td>
</tr>
<tr>
<td>Carolinas HealthCare System/Levine Cancer Institute</td>
<td>13</td>
</tr>
<tr>
<td>H. Lee Moffitt Cancer Center &amp; Research Institute</td>
<td>11</td>
</tr>
<tr>
<td>University of Rochester Medical Center Wilmot Cancer Center</td>
<td>11</td>
</tr>
<tr>
<td>Massachusetts General Hospital</td>
<td>11</td>
</tr>
<tr>
<td>The Ottawa Hospital Regional Cancer Centre</td>
<td>11</td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>10</td>
</tr>
<tr>
<td>Tel-Aviv Sourasky Medical Center</td>
<td>9</td>
</tr>
<tr>
<td>Dana-Farber/Brigham and Women’s Hospital Cancer Center</td>
<td>9</td>
</tr>
<tr>
<td>Florida Hospital</td>
<td>8</td>
</tr>
</tbody>
</table>
Jeff M. Michalski, MD, MBA, FASTRO, from the Washington University School of Medicine in St. Louis, was recently elected secretary/treasurer of the American Society for Radiation Oncology (ASTRO) and will begin serving in this role as of the ASTRO 55th Annual Meeting. Michalski is also chair of the RTOG Advanced Technology Integration Committee and serves on several RTOG leadership committees.

William Small, Jr, MD, FACRO, FACR, FASTRO, will join the leadership of the Gynecologic Cancer Intergroup (GCIG) as chair-elect this fall. Small’s appointment marks the first time a radiation oncologist will serve as the GCIG chair-elect—a 1-year position that is followed by a 2-year term as the GCIG chair. Co-chair of the RTOG Gynecologic Working Group, Small also was recently named chairman of the Department of Radiation Oncology at Loyola University Health System in Chicago, a position he began on July 15.

Walter J. Curran Jr, MD, RTOG Group Chairman and Executive Director of the Winship Cancer Institute of Emory University in Atlanta, has been named a Georgia Research Alliance (GRA) Eminent Scholar and Chair in Cancer Research. A public–private partnership among Georgia research universities, businesses, and state government, GRA expands the research and commercialization capacity in Georgia’s universities to attract eminent scholars, launch new companies, create high-value jobs, and transform lives.

Steven G. Chun, MD, from the University of Texas Southwestern Medical Center at Dallas, and Bree R. Eaton, MD, from the Winship Cancer Institute of Emory University, have been awarded the two 2013 RTOG ACR Radiation Oncology Resident Training Fellowships. They participated in a 5-day fellowship program at RTOG Headquarters in Philadelphia. Both Steve and Bree have an interest in projects in non-small-lung cancer (NSCLC) and following their Fellowship experience are now reviewing potential projects with their mentors and RTOG lung leadership. They will then have discussions with RTOG statisticians and finalize their projects.

2013 Outstanding RTOG Research Associate

Congratulations to Sara-Jane Onyeama from the University of California on being named the RTOG Outstanding Research Associate for 2013! As in years past, the selection is made from an outstanding field of nominees. To view the full list of nominated research associates and the investigators who nominated them, click here.
What Do the Experts Say?

A journal club Web site for radiation oncologists features monthly editorials on critical research. Want to learn what others are saying about a critical paper? The ACR Journal Advisor™ for radiation oncologists provides free expert editorial commentary on groundbreaking and essential research. The program’s creator, Brian J. Goldsmith, MD, FACR, of Radiological Associates of Sacramento, in California, spoke on the origins of this grand undertaking.

Q: Why did you create ACR Journal Advisor?
A: I wanted to provide a resource in the form of a virtual journal club to tie together the world’s experts in different radiation oncology subspecialties—to bring them all together in the room with the individual clinician.

Radiation oncology residents often train in a facility renowned for expert management of one type of malignancy but may not see enough of other types. So, some residents may come out of these programs unevenly trained. I wanted to encourage cross-pollination of ideas across subspecialties and disease sites.

A late 1970s television show called Connections, created by science historian James Burke, had a profound influence on me as a physician. It portrayed “discovery” as the result of interconnected events, each consisting of a person or group acting for personal or collective reasons. Essentially, there was one guy over here working on this, and another guy over there working on that, and they bumped into each other and started talking. By “looking over the wall” of their own specialty area, they found the solution to their problem in a seemingly unrelated project. Such cross-pollination has always been one of my goals for the ACR Journal Advisor.

Read more Q&A and register today to access expert editorial commentary (known as Editors Choice), create a personalized medical library, and more.

Inspired Collaboration

Barbara Levy, RN, an RTOG data manager, learned about a free transportation service for patients in Philadelphia who struggle getting to important cancer treatment appointments. She contributed this overview of the program to alert Philadelphia-based clinicians about the service and others who would have an interest in checking with their local American Cancer Society branch for similar services in their communities.

Cancer patients face many challenges. Daily or weekly treatments over a period of months can be difficult and overwhelming. This burden for some patients may actually cause them to miss or forgo their treatments entirely. Some patients do not have a vehicle or may be too ill to drive or take public transportation; others may be without family or friends available to provide rides.

“PhillyPatientRide,” a collaboration between the American Cancer Society and Enterprise CarShare, provides transportation at no cost to patients who have no other means to get to their cancer treatment appointments. Patients must be ambulatory, live within the city limits, and be receiving cancer treatment. Patients are identified for the program by a health care professional at one of five partner hospitals: Thomas Jefferson University Hospital, Pennsylvania Hospital, Temple University Hospital, Hahnemann Hospital, and Hospital of the University of Pennsylvania (radiation oncology only). To date, the program (previously “PhillyCarShare”) has been recognized for its excellent environmental, economic, and social impact in Philadelphia and has provided more than 5700 rides to over 360 patients since its inception in January 2011. Pretty impressive!

The Philadelphia chapter of the American Cancer Society once again shows its leadership role in our community. Enterprise CarShare and its collaboration with the American Cancer Society is truly inspirational. What a wonderful reminder that business success does not preclude a commitment to the community it serves. For more information about this program, please contact the local American Cancer Society office at 215-985-5311 or phillypatientride@cancer.org.

Although PhillyPatientRide is specific to Philadelphia, the American Cancer Society’s Road to Recovery program is available in communities across the country. Road to Recovery, which was established in 1983, also provides transportation at no cost to patients who need assistance getting to and from their cancer treatments. The major difference between the two programs is that Road to Recovery volunteer drivers use their own vehicles to provide these rides. If you would like more information about the availability of the program in your community, please call 1-800-227-2345 or visit www.cancer.org.
Remembering Kie Kian Ang, MD, PhD

People from around the world have sent their thoughts and remembrances of Kian Ang, MD, PhD to be shared in a tribute to Dr. Ang’s life on the RTOG Web site. In honor of his memory, excerpts are presented here.

Kian was a wonderful friend and colleague, a world-renowned radiation oncologist, a modal clinician-scientist, a great teacher, and above all, an extraordinary human being. He demonstrated outstanding leadership in clinical research in head and neck cancer. His contributions to the international radiation oncology community have been enormous. We shall all miss him very much.

KAREN K. FU, MD

...One of my fondest memories is of a Sunday evening a few years back in Philadelphia. Kian had come to RTOG headquarters that weekend to work overtime on several projects. It so happened that this was Super Bowl Sunday. Despite his need to wake up at 4 a.m. the next morning, he graciously accepted my invitation to come to the Super Bowl party that I hosted each year for our residents and their families. Imagine the faces of our residents when they arrived at my house to see the World’s Greatest Head and Neck Radiation Oncologist as a special unplanned guest! Kian spent much of that evening chatting with our Philly residents, giving them advice on difficult topics, talking about the latest current events in our field, and enjoying the sports and social event. Kian had a great love of life, and of people, and both loved him back very much.

MITCH MACTAY, MD
RTOG Group Deputy Chair
Case Western University

...Like the rest of the oncology world, Hong Kong has lost a great teacher, but we will always remember his lessons and strive to follow his footsteps in pursuit of scientific excellence.

ANNE LEE

I knew him for more than 20 years as a very intelligent and kind person with a warm interest in people. He had a special twinkle of his eyes when you met him, giving a feeling of commitment and friendship. He had a special relationship with The Netherlands and was present in many congresses and other meetings in our country... For me, his gold medal award session in Miami was an overwhelming event. He surely deserved this important honor for his impressive scientific contribution to radiotherapy and oncology.

CHRIS TERHAARD
Radiation Oncologist
UMC Utrecht, The Netherlands

So privileged to have been one of Dr Kian Ang’s research nurses. Dr Ang was a great mentor. He was loved by his patients, his colleagues and by the people he worked with. An excellent scholar yet humble and kind hearted. His contribution and his legacy will live forever. We will miss him so much!...

BETH DEGRACIA RN, OCN, CCRC
The University of Texas MD Anderson Cancer Center

Some people are smart, some hardworking, some graceful and some just fun to be around. Kian Ang was all of these and more. A truly unique talent that we simply do not see often. He loved his family very deeply, and his eyes would always light up immediately when I would ask about his wife Sunny and the kids. No question we will miss Kian very much. But what wonderful gifts and inspiration he has given us throughout his career. So many colleagues and students worldwide will carry forth traditions of academic excellence and kindness learned from Kian. We salute you, Kian. Your contributions and diplomatic style will continue to inspire generations to come.

PAUL M. HARARI, MD, FASTRO
Jack Fowler Professor and Chairman
Department of Human Oncology
University of Wisconsin School of Medicine and Public Health

An intellectual giant. I was fortunate to work with him, and his gentle and humble personality was a special blessing.

WILLIAM F. DEMAS, MD