Note From the Group Chairman

I am pleased to report that 2014 is off to a strong start. The recently activated RTOG 1308 trial is the first phase III randomized trial to compare patient survival after photon versus proton chemoradiation for patients with stage III non-small cell lung cancer. With the availability of proton radiotherapy at many major cancer centers around the country, hypothesis-based scientific evidence about this technology is needed to guide treatment decision making. Congratulations to the RTOG Lung Cancer Committee for driving this trial to approval and activation!

In other exciting news, RTOG in coordination with the NCI made public the long-term follow-up results of the RTOG 9802 trial showing study participants with low-grade gliomas who received chemotherapy following radiation therapy (RT) achieved a median survival time of 13.3 years versus 7.8 years for patients who received RT alone, a difference of 5.5 years! These results were made public this week because of the significant impact this new information may have on patient care and on ongoing active clinical trials. (See the full announcement at RTOG 9802 results announcement.) Full details of the trial’s analysis will be reported at scientific meetings later this year and in a subsequent publication.

Progress in refining NRG Oncology’s scientific program has continued this past year, and work is ongoing to harmonize its operational processes. The program agenda for this week’s semiannual meeting demonstrates the ongoing integration of many committees to carry out research as NRG Oncology. I especially applaud the efforts of the translational research leadership for its collaborative work and for designing a well-integrated program for the Network Group Integrated Translational Science Centers grant application described by Dr. Adam Dicker in this newsletter. The scientific framework of the recently submitted NRG Oncology NCORP grant proposal is also highlighted herein. Led by Deborah Bruner, PhD, RN, the NCORP team who developed this research plan did an amazing job, and we look forward to favorable news about its funding.

I am very appreciative that Joe Chang, MD, PhD, will deliver the keynote address at the RTOG General Session to underscore the many contributions Kian Ang, MD, PhD, made to the RTOG and to the advancement of cancer patient care and to highlight his influence as a role model and mentor to many of us. As at past meetings, I look forward to highlighting RTOG accomplishments and the research programs and results accomplished in the past year. Please review the summary of 2013-activated trials in this newsletter and take steps to open one or more at your institution.

More than 1800 people are registered for this week’s meeting, and this is a strong indication of the enthusiasm for NRG Oncology’s scientific program. I hope you can join us to experience the excitement and “ENERGY” of our expanded meeting.

Expanded Educational Opportunities at NRG Oncology Semiannual Meeting

The February 2014 NRG Oncology Semiannual Meeting offers an expansive agenda reflecting the new group’s unique scientific foci within the National Clinical Trials Network. Continuing Medical Education (CME) credits will be offered for many sessions. Please note the nomenclature change from committee to workshop for a number of scientific sessions to better reflect their significant educational component, as required for CME credits. For example, what in prior years had been listed on the agenda as the Brain Tumor Committee session is now listed as the Brain Tumor Workshop.

Two Friday morning sessions will highlight NRG Oncology’s scientific depth and contributions to advancing the clinical care of patients with cancer. During the Scientific Session (8:00 AM to 10:00 AM), investigators from the three research groups that now comprise NRG Oncology will present “Results of Recent NRG Research.” Next on the agenda, from 10:00 AM to 11:00 AM, is the RTOG General Session, featuring a keynote address by Joe Y. Chang, MD, PhD, a professor in the Department of Radiation Oncology at The University of Texas MD Anderson Cancer Center in Houston, Texas. A long-time friend and colleague of Kian Ang, MD, PhD, who passed away on June 19, 2013, Chang will relay his experience working with Ang and highlight the scientific rigor that Ang brought to radiation oncology research. This session will include a report of RTOG 2013 research accomplishments from Group Chair Walter J. Curran, MD, Executive Director of the Winship Cancer Institute of Emory University in Atlanta.

Individuals interested in gynecologic cancer research are welcome to attend Thursday’s day-long “Clinical Trials for Rare Gynecologic Cancers” symposium. For more information, visit GYN Symposium.

To view the full roster of meeting sessions, visit NRG Meeting Agenda.
What’s New?

The transition to conducting research as NRG Oncology within the National Cancer Institute (NCI) National Clinical Trials Network (NCTN) brings new opportunities and ways of carrying out multicenter research. The research community will be kept apprised of new developments through the NRG Oncology Web site, newsletter, and targeted e-mails. A few changes already underway include the following:

New Protocol Numbering Convention
Now in use, NRG Oncology’s new protocol numbering convention includes two components—“NRG” and a disease site abbreviation separated by a hyphen, followed by a number assigned in the order of a research concept’s approval by the NCI Cancer Therapy Evaluation Program (CTEP). For example, NRG-GI001 is the first gastrointestinal protocol in the NRG Oncology research portfolio to obtain CTEP approval for a research concept, and NRG-BR001 will be assigned to the first CTEP-approved breast cancer protocol. The complete list of disease site identifiers includes BN (brain), BR (breast), GI (gastrointestinal), GU (genitourinary), GY (gynecologic), HN (head and neck), and LU (lung). The identifier for symptom management trials is CC.

Oncology Patient Enrollment Network (OPEN)
Study participant registration for all NCTN clinical trials will be accomplished through the Web-based registration system OPEN. This system is integrated with the Clinical Trial Support Unit’s (CTSU’s) Enterprise system, which maintains protocol regulatory and roster data. All site investigators who treat patients or provide medication, and research personnel who need access to protocol documents, forms, educational documents, patient enrollment, and data submission, will need to establish a CTEP-Identity and Access Management (IAM) account to access OPEN (see more CTEP-IAM information below).

In addition, registration for all trials initiated under the NCI Clinical Trials Cooperative Group Program and continuing under the NCTN will be accessed through OPEN. RTOG and CTSU staff members have been working to transition patient registration for such RTOG trials from the RTOG Data Center to the OPEN system. Before the transition occurs, research sites will receive a RTOG broadcast e-mail announcing the change. The transition to OPEN for all accruing RTOG trials is expected to be complete by March 1.

TRIAD Reminder
The protocol updates that include OPEN instructions will also include logistics about using TRIAD for the collection of radiotherapy (RT) digital data. As previously reported, TRIAD provides research sites with a secure method to transmit digital RT data in DICOM format, and the application will be used across the NCTN. Visit TRIAD for more information.

NRG Oncology Web Site
For ease of access and in lieu of thumb drive distribution, statistical reports for the February 2014 NRG Oncology Semiannual Meeting will be available on the group’s Web site. The username and password allowing access to the materials will be distributed soon.

Be on the lookout for more information about NRG Oncology memberships, including membership agreement details and a listing of Main Members, Voting Main Members, and Affiliates/CCOP Component institutions.

An Important Reminder From the Cancer Therapy Evaluation Program (CTEP) Identity and Access Management (IAM) Administration

Please remember that annual reregistration is required to maintain your CTEP-IAM account. Reregistration is a separate process from updating your password every 60 days. A CTEP-IAM user account is required to access the members’ area of the Clinical Trials Support Unit (CTSU) Web site, as well as the Oncology Patient Enrollment Network (OPEN) and Medidata Rave.

Prior to account expiration, investigators and associates will receive an e-mail notification. Please follow the instructions in the e-mail notification or go to https://eapps-ctep.nci.nih.gov/iam/, and follow the instructions to reregister.

For more information, please see the CTEP-IAM Fact Sheet.
NRG Oncology Lays Plans to Become an NCORP Research Base

Months of focused research planning and proposal writing went into NRG Oncology’s grant application, submitted this past January, to participate as a research base in the future National Cancer Institute (NCI) Community Oncology Research Program (NCORP). Expected to launch in early 2015, NCORP combines the work carried out by the Community Clinical Oncology Program (CCOP) and elements of the NCI Community Cancer Centers Program (NCCCP) into one program network. An NCORP research base will provide scientific and statistical leadership for developing, implementing, and analyzing multi-institutional clinical trials. Other NCORP components, funded by separate grants, include community sites (single-community organizations or consortiums of community hospitals and private practices able to enroll at least 80 participants onto NCI studies annually) and minority/underserved sites (those with at least 30% of cancer patients and accrual coming from racial/ethnic minority, or other underserved, populations).

The NRG NCORP Research Base proposal draws upon the more than 100 years of combined CCOP research base experience of the NRG Oncology legacy groups—the National Surgical Adjuvant Breast and Bowel Project (NSABP), the Radiation Therapy Oncology Group (RTOG), and the Gynecologic Oncology Group (GOG). The proposal’s three principal investigators (PIs) include

• Contact PI Deborah Bruner, PhD, RN, FAAN, who is PI of the RTOG CCOP Research Base, NRG Oncology Deputy Group Chair, Publications, and associate director for outcomes research at the Winship Cancer Institute of Emory University in Atlanta;
• PI/Executive Committee Chair Joan Walker, MD, who is the co-chair of the GOG Cancer Control and Prevention Committee and chair of the Department of Obstetrics and Gynecology at the University of Oklahoma Health Sciences Center; and
• PI/Steering Committee Chair Lawrence D. Wickerham, who is associate chairman of NSABP, NRG Oncology Deputy Group Chair, Membership, and an associate professor of human oncology at the Pittsburgh Campus of the Drexel University School of Medicine.

Overarching research themes the NRG NCORP plans to pursue include the following:

• Developing cancer prevention and symptom intervention trials in which biomarker status determines eligibility and/or treatment response
• Testing and further validating patient-reported measures across many cancer disease types to evaluate and design interventions to improve the quality of life of cancer survivors
• Improving early detection and diagnostic techniques that avoid overdagnosis and underdiagnosis of cancers
• Leveraging NRG Oncology’s therapeutic trials to provide a unique research portfolio—with particular foci on women’s cancers and radiation oncology innovation—to NRG Oncology’s research community and across the National Clinical Trials Network (NCTN)
• Reducing disparities in cancer care outcomes among minority and underserved populations

NRG NCORP addresses these thematic areas with high impact research across solid tumors with a particular unique focus in both women’s health and radiation therapy. “The real strength of the NRG NCORP,” said PI Deborah Bruner, PhD, RN, FAAN, “is the exemplary multi-disciplinary team of expert investigators and patient advocates, all working together to carry out practice and policy changing research while enhancing community access to treatment, symptom management, cancer control and cancer care delivery trials.”

**NRG NCORP Vision: Preserve & Enhance Cancer Research in the Community**

- Build upon clinical trial success of the Community Clinical Oncology Program (CCOP) and Minority-Based CCOP (MB-CCOP) network
  - Development and conduct of cancer prevention and control trials
  - Accrual to National Clinical Trials Network (NCTN) treatment and imaging trials
  - Enrollment of minorities into clinical trials
- Expand to include cancer care delivery research (CCDR)
- Enhance focus on disparities questions in clinical trials and CCDR studies

**Overarching Goal**

*Bring state-of-the-art cancer prevention, control, treatment, and imaging trials, as well as CCDR and disparities studies, to individuals in their own communities.*

*From a presentation to the NCI Board of Scientific Advisors - June 2013*

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“**A major NCORP goal is to work more closely across the NCTN, an effort already begun through past collaborations and planned new initiatives, to standardize cancer care delivery metrics and patient reported outcomes assessments. These are areas in which NRG NCORP leadership has provided national direction.**”

—Deborah Bruner, PhD, RN, FAAN
Principal Investigator
RTOG CCOP Research Base
Associate Director for Outcomes Research
Winship Cancer Institute of Emory University
Atlanta, GA

“**The NCORP network provides a great framework to learn and apply new statistical methods, especially for economic, cancer care delivery, and comparative effectiveness research. The formation of NRG Oncology allows for a broadened network of statisticians, investigators, and clinical data that will provide an exciting future in cutting-edge research.**”

—Stephanie Pugh, PhD
Senior Statistician
RTOG CCOP Research Base
Philadelphia, PA
Perspectives on Genomics and Cancer Research

Adam Dicker, MD, PhD, RTOG Translational Research Program Chair, and professor and chair of the Department of Radiation Oncology at Thomas Jefferson University in Philadelphia, provided insight about exciting translational research plans poised for pursuit by NRG Oncology.

Q: The Advances in Genomics for Cancer Clinical Trials symposium held during the 2013 RTOG Semiannual Meeting in June featured impressive presentations by leaders in the field of genomics. What was the impetus for this program?

A: The timing of the genomics symposium was critical for several reasons. First, we have three translational research programs coming together under NRG Oncology to respond collectively to the NCI Network Group Integrated Translational Science Centers grant (UC10) announcement to support translational research in the National Clinical Trials Network. Developing the grant proposals required us to think about how we could incorporate the advances of next-generation (or “next-gen”) sequencing, cancer genomics, and proteomics into research conducted in a cooperative group setting, which is logistically far more complex than single-institution research. The symposium was an outgrowth of our collaborative planning process.

Q: What resulted from this collaborative planning process?

A: Two parallel efforts got underway that span the three NRG Oncology legacy groups. One project, led by Rameen Beroukhim, MD, PhD, a neuro-oncologist at the Dana-Farber Cancer Institute in Boston and an associate member of the Broad Institute, is a multidisciplinary effort focused on glioblastoma multiforme (GBM). The grant proposal’s hypothesis is that there are genetic differences between a newly diagnosed GBM tumor and a tumor that recurs after treatment. With a better understanding about these genetic differences, we can learn a lot about why tumors recur and work to develop targeted therapeutics. The contribution of neuro-oncologists, neuropathologists, radiation oncologists, genomics experts, and computational biologists from many institutions across the United States was truly a tour de force.

The other effort is led by Matthew Ellis, MD, PhD, a medical oncologist at Washington University in St. Louis, who is well known for his breast cancer research involving next-gen sequencing and proteomics. This project proposes to extend the Genome Institute at Washington University’s successful track record of performing cancer genome sequencing with breast cancer specimens collected in multicenter clinical trials to colon, prostate, head and neck, and ovarian cancers. Designing trials involving next-gen sequencing across the different disease sites is a very ambitious approach; however, Matt took the proposal a significant step further to also look at what happens at the protein level. A comprehensive approach that includes both DNA/RNA and protein analysis will help us understand how the recoding of the cancer genome alters protein function. This is a big step toward the goal of individualized patient treatment, because we will be able to zero in on the most critical changes that drive the disease outcome.

Pulling these projects together represented huge interdisciplinary efforts, and—whether we get the grants or not—it was extremely beneficial for us to interact with each other and start laying plans for getting the benefits of genomic advances to the clinical community.

Q: You mentioned several factors prompting the genomics symposium. What was another factor?

A: Another driver making the timing right to strongly promote the integration of genomics research into NRG Oncology clinical trials is the dramatic decline in the cost of genome sequencing associated with the introduction of next-gen technology. For example, last year the National Human Genome Research Institute published cost analysis data for work performed at the sequencing centers it funds. The average cost of sequencing a
single human genome fell from more than $95 million in 2001 to less than $6000 in April 2013. I expect this cost to continue to drop, which makes it much more feasible to employ this technology in the cooperative group setting.

Q: What are some of the significant challenges facing cancer genomics research?

A: Education is a significant challenge from several perspectives. First, most oncology training programs across subspecialties provide little education in genomics. Also, because the field is changing so rapidly, it’s very difficult to develop text that will still be relevant 6 months later.

Also, from a big data perspective, most genetic findings in cancer are not actionable—we don’t know what to do with them. Take, for example, Rameen Beroukhim’s symposium presentation relating gene copy number variation (when parts of a person’s DNA are either lost or increased, resulting in an abnormal number of copies of the affected genes) to different types of cancer. Although this information helps to identify different molecular classifications of cancer, we still have much to learn about how this information can translate into improved therapeutics.

As also presented at the symposium, companies like Foundation Medicine are searching for actionable mutations in patients who are in bad situations. For example, a patient with breast cancer may have a mutation that no one suspected was related to breast cancer and a drug approved for, say, a hematologic malignancy that targets the same mutation could be used off-label to treat that patient’s breast cancer. The challenge is how to capture and take advantage of this type of information, because it’s not something that can be found on Clinicaltrials.gov.

Q: Any concluding thoughts?

A: Molecular signature is already being used by physicians to tailor patients’ treatment through, for example, the use of Genomic Health’s Oncotype DX® and GenomeDX’s Decipher® test. Work by Felix Feng, MD, at the University of Michigan, has identified a new biomarker that can significantly enhance known molecular signatures. Other examples include Javier Torres-Rocca, MD, who with colleagues at the H. Lee Moffitt Cancer Center in Tampa has developed a mathematical approach to integrate genomics, genotype, tissue type, and biological pathway interactions to identify radiation-specific biomarkers. In addition, Tim Showalter, MD, at the University of Virginia, is conducting research evaluating how molecular signatures such as Decipher® are incorporated into shared decision making with patients.

Learning how to use these molecular signatures in the care of our patients is going to become more and more a component of the art of medicine. Molecular signature analysis, now a part of standard-of-care treatment, will also be part of the national debate regarding quality and creating value in oncology.
Featured Trial: RTOG 1308—A Phase III Randomized Trial Comparing Overall Survival After Photon Versus Proton Chemoradiotherapy for Inoperable Stage II-IIIB Non-Small Cell Lung Cancer

From the Trial Principal Investigator
“The lack of level I evidence of the effectiveness of proton therapy and concerns regarding its cost and benefits have remained problematic. As a phase III randomized trial, RTOG 1308 will help to establish such evidence, which clinicians can use to guide treatment recommendations.”

ZHONGXING LIAO, MD
Professor and Clinical Medical Director
Department of Radiation Oncology
MD Anderson Cancer Center, Houston, TX

From the RTOG Lung Cancer Committee Chair
“We believe lung cancer is an ideal venue to test the value of proton beam radiation therapy compared with X-rays. The results of our prior trial, RTOG 0617, have taught us that the balancing of radiation dose to tumor and to adjacent normal tissues should be respected. This trial individualizes the tumor dose up to 70 Gy on both arms, as long as normal tissue dose constraints are achieved.”

JEFFREY D. BRADLEY, MD
Professor in Radiation Oncology
Chief of Thoracic Service
Washington University School of Medicine, St. Louis, MO

Trial Overview
Most patients are diagnosed with non-small cell lung cancer (NSCLC) at a stage at which it cannot be cured with surgery. Recent significant technological advances in radiotherapy have translated into improved patient treatment outcomes with reduced toxicity and improved survival. However, up to 50% of patients with inoperable disease will experience cancer recurrence after definitive concurrent chemoradiotherapy, and improving treatment outcomes remains a major problem.

Local tumor recurrence contributes to both morbidity and mortality in patients with locally advanced NSCLC. Further treatment improvements for these patients have been challenging because of the difficulty in escalating radiation doses to the tumor without increasing the radiation dose to adjacent critical organs, which can result in severe toxicity.

The physical and dosimetric characteristics of proton beam therapy theoretically make it an ideal radiotherapy modality for lung cancer treatment, having the potential to increase radiation dose to the tumor and greatly reduce the dose to adjacent organs. The great promise of this modality for reducing treatment-related toxicity, improving patients’ quality of life, and increasing overall survival has generated very high interest in its use for cancer treatment, and the number of proton treatment facilities has increased steadily worldwide in recent years. However, no standards or guidelines have been established to specifically address aspects of quality assurance, treatment planning, and delivery of proton radiation therapy.

Given the steady growth of new proton treatment facilities, now is a critical time to objectively and scientifically assess the potential of protons versus photons for the treatment of lung cancer. This trial’s results have the potential to change the current standard of care for inoperable NSCLC.

Patient Population: untreated histologically or cytologically proven diagnosis of NSCLC prior to registration; clinical American Joint Committee on Cancer (7th ed.) stage II-IIIB medically nonoperable disease, or surgically unresectable disease, or patients who refuse surgery; and patients who present with N2 or N3 disease and an undetectable NSCLC primary tumor.

Target Accrual: 560 patients

Continued
Featured Trial: RTOG 1308 (continued)

Primary Objective
To compare the overall survival in patients with stage II-IIIB NSCLC after image-guided, motion-managed photon radiotherapy (Arm 1) and after image-guided, motion-managed proton radiotherapy (Arm 2), both given with concurrent platinum-based chemotherapy.

Secondary Objectives
- To compare 2-year progression-free survival between the two arms
- To compare the development of grade 3 or higher adverse events definitely, probably, or possibly related to treatment
- To compare differences between the two arms in patient quality of life
- To compare cost-effectiveness outcomes between the two arms
- To compare pulmonary function changes by treatment arm and response
- To explore the most appropriate and clinically relevant technological parameters to ensure quality and effectiveness throughout radiation therapy processes

Study Schema

<table>
<thead>
<tr>
<th>Stage</th>
<th>STRATIFY</th>
<th>Arm 1: Photon dose—70 Gy (RBE)*, at 2 Gy (RBE) once daily plus platinum-based doublet chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. II</td>
<td></td>
<td>Arm 2: Proton dose—70 Gy (RBE)*, at 2 Gy (RBE) once daily plus platinum-based doublet chemotherapy</td>
</tr>
<tr>
<td>2. IIIA</td>
<td>RANDOMIZE</td>
<td>Both Arms: Consolidation chemotherapy x 2 cycles required for patients who receive concurrent carboplatin and paclitaxel</td>
</tr>
<tr>
<td>3. IIIB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Histology
- Squamous
- Nonsquamous

Concurrent Chemotherapy Doublet Type
- Carboplatin/paclitaxel
- Cisplatin/etoposide

* relative biological effectiveness

NCI Proton Therapy Guidelines
In April 2012, the NCI issued “Guidelines for the Use of Proton Radiation Therapy in NCI-Sponsored Cooperative Group Clinical Trials” (available at NCI Proton Guidelines). These guidelines provided helpful guidance for the radiation community.

Alliance Trial Testing Vaccine for Recurrent Glioblastoma: RTOG Research Sites Encouraged to Activate

The Alliance for Clinical Trials in Oncology activated a phase II randomized trial (A071101) in May 2013 evaluating the efficacy of the vaccine heat shock protein-peptide complex-96 (HSPPC-96) in patients with surgically resectable, recurrent glioblastoma multiforme (GBM). The HSPPC-96 vaccine, made from a person’s own tumor tissue, is hypothesized to help the body build an effective immune response to kill tumor cells that may remain after surgery. The trial’s target accrual goal is 222 patients.

The study’s primary objective is to determine whether there is an overall survival advantage when HSPPC-96 is administered concurrently with bevacizumab (Arm 1) or sequentially with bevacizumab administered at the point of disease progression (Arm 2) compared with administering bevacizumab alone (Arm 3), which is the current standard-of-care treatment.

The RTOG Brain Tumor Committee members are very interested in this trial based upon the reporting of favorable results from a single-arm phase II trial testing the vaccine. They are working to promote trial participation at the many research sites that have conducted RTOG-sponsored research to advance GBM treatment. The Alliance trial will be presented during the NRG Oncology Semiannual Meeting at the Brain Tumor Workshop on Friday, February 7, from 4:00 PM to 6:00 PM.

“RTOG has a strong track record leading international multicenter trials to advance treatment for patients with recurrent glioblastoma,” said Walter J. Curran, Jr, MD, the RTOG Group Chair and Executive Director of the Winship Cancer Institute of Emory University in Atlanta. “We are delighted to encourage participation in this landmark NCI-sponsored Alliance trial that is testing the emerging promise of cancer vaccines as a potential new treatment option for patients with glioblastoma.”

For additional information about the Alliance trial, visit ClinicalTrials.gov using the trial identifier NCT01814813.
RTOG research teams activated 5 trials, with another trial pre-activated during 2013, representing diverse disease sites. The RTOG 1216 protocol, exploring new treatment options in a phase II–III study for patients with HPV-negative head and neck cancers, activated in January 2013. Stanford University was the first site to obtain institutional review board (IRB) approval to conduct the trial and, as of the end of January 2014, University Hospitals of Cleveland is leading trial accrual efforts.

The phase III RTOG 1112 trial, evaluating if treatment with stereotactic body radiotherapy improves overall survival in patients with inoperable hepatocellular cancer treated with sorafenib, was the second trial to activate last year, with Ohio State University in Columbus leading the way with the first IRB approval. Princess Margaret Hospital in Toronto is ahead in participant accrual as of this newsletter’s distribution.

Although RTOG 1201 is temporarily closed to accrual, kudos go to the sites that received IRB approval to conduct this trial, including Miriam Hospital and Rhode Island Hospital, both in Providence, Rhode Island, which were the first sites to submit IRB approval documentation. The phase II trial was designed to determine if intensifying local therapy or systematic therapy shows a signal for improved survival of patients diagnosed with unresectable pancreatic cancer. The trial temporarily closed (prior to any study participants being enrolled) because of changing clinical practice due to (1) the presentation of the LAP-07 trial at ASCO 2013, which showed no survival benefit with intensified chemoradiation over gemcitabine-based chemotherapy alone, and (2) the recent approval of nanoparticle albumin-bound (nab)-paclitaxel (Abraxane®) plus gemcitabine in the first-line treatment of patients with advanced pancreatic cancer. The trial team is discussing possible strategies for modifying the protocol to ensure that it asks questions relevant to current clinical practice. Sites should stay tuned for future updates about an RTOG 1201 protocol amendment via e-mail broadcast.

A trial conducted in collaboration with the National Surgical Adjuvant Breast and Bowel Project (NSABP), NSABP B-51/ RTOG 1304, will provide valuable information about the best locoregional radiotherapy treatment strategies for patients with breast cancer who present with positive axillary nodes that become negative after neoadjuvant chemotherapy. Currently, no established care standard exists for the use or extent of radiotherapy in these patients. Activated in August 2013, the trial’s first patient enrollment is much anticipated.

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 endothelial growth factor (EGFR)-mutant or anaplastic lymphoma kinase (ALK)-positive locally advanced potentially curable non-small cell lung cancer (NSCLC). The trial pre-activated in September with the simultaneous IRB approval of Stanford University and Main Line Health Community Clinical Oncology Program in northwest Philadelphia, and word is expected imminently about enrollment of the first patient.

Activated in October 2013 with word that Mercy Hospital Springfield in Missouri had received IRB approval to conduct the study, RTOG 1221 is the first trial to compare transoral endoscopic head and neck surgery (with or without adjuvant therapy) versus definitive chemoradiation for the treatment of human papillomavirus (HPV)-negative oropharyngeal carcinoma—a disease subtype with currently dismal outcomes. The first patient enrollment is expected soon for this phase II study that provides an opportunity to collect baseline data regarding margin status and functional outcomes and to define the end points to be studied in a larger randomized phase III comparative trial.

**First Trial to Activate in 2014**

RTOG 1308 opened to accrual on February 3, with the University of Florida in Jacksonville being the first site to receive IRB approval. Congratulations to the research team, and now on to enrolling study participants!