Q&A: Robert Comis and Mitchell Schnall on Trials

The co-chairs of ECOG–ACRIN talk about combining forces to advance clinical studies

This spring’s merger of the Eastern Cooperative Oncology Group (ECOG) and the American College of Radiology Imaging Network (ACRIN) brought together more than 6,000 physicians, nurses, pharmacists, statisticians, clinical research associates, and patient advocates, representing almost 650 institutions in the United States and 11 other countries. Co-chairs Robert L. Comis, MD, and Mitchell D. Schnall, MD, PhD, former heads of ECOG and ACRIN, respectively, talked with Cancer Discovery’s Eric Bender about efforts to fully integrate their members’ skills and resources.

What’s the synergy in combining the two groups?

Comis: ECOG was one of the first cancer clinical trial groups, established by the government in 1955. We have developed into a multidisciplinary, therapeutically oriented cancer clinical trials organization, which runs the gamut of adult cancers, with an emphasis on developing new treatments and improving the standard of care for cancer patients with the major malignancies. ACRIN provides unique expertise in both functional and anatomic imaging, giving us opportunities in early detection, screening, and diagnosis that we never had before.

Schnall: The combination injected much more oncology biology into ACRIN. Now we have an organization that studies what I like to think of as the cancer care continuum. We can take a cancer-by-cancer approach in terms of finding the next chemotherapy combination for a particular disease site, but we can also study the molecular biology of cancer, and identify other interventions along the care continuum. I think we’re unique in taking that broad a look at opportunities to improve care from prevention and early detection through chemotherapy.

How do basic scientists become involved in your trials?

Comis: We have some of the largest and best annotated tissue banks in the world, and they are the magnets that bring basic scientists together with our clinicians. Over the past 15 years, ECOG has totally integrated laboratory scientists into its clinical program. We welcome and encourage and directly involve laboratory scientists. At any given time we have 25 to 35 grants with them that are funded through the NIH and other peer-reviewed mechanisms.

Schnall: Among our efforts now, we have organized a biomarker sciences research area that combines the members of our developmental therapeutics, pathology and lab sciences, and experimental imaging committees. We hope this group will draw in other scientists with basic biology, basic imaging, developmental therapeutics, and translational expertise, and provide opportunities for their ideas to be developed.

What are some projects that integrate molecular biomarkers with imaging?

Comis: One is that ECOG has been involved with Genomic Health in developing a 12-gene prognostic assay for ductal carcinoma in situ. We will combine that effort with an ACRIN approach looking at dynamic contrast-enhanced MRI into a protocol that integrates the existing gene-based biomarker work with advanced imaging technology.

Schnall: Another project is looking at hormonal therapies in breast cancer and imaging the estrogen receptor, using a PET [positron emission tomography] probe for identifying and predicting response to therapy in hormone-positive breast cancer. We’re looking for markers to detect metastasis early in prostate cancer to avoid undertreatment of disease at presentation. And like other groups, we’re looking at FDG [2(18F)fluoro-2-deoxy-D-glucose]-PET, but where we are really unique is that we’re integrating that into the decision-making process of treating patients. In fact, our first jointly developed trial, E2410/ACRIN 6700, is a phase II study of response-adapted chemotherapy based on PET scan for treating patients with bulky stage I and II classic Hodgkin lymphoma.

What is changing in today’s trials?

Schnall: For prevention, early detection, surveillance, and even post-treatment surveillance, we are going to be following large populations of patients for significant lengths of time. The traditional way to do this is quite expensive: Clinical staff at the local sites are constantly trying to call patients and send them letters, so that patients can give responses that are then sent in to a central database. We want to interact directly with the patient electronically, and we’re working on smartphone interactive applications to collect some of our data in trials going forward. With the restraints on funding, we think this is the only way that some of these studies can be done.

Comis: We’re in discussions with academic institutions, industrial partners, and the National Cancer Institute to provide the necessary resources for us to do genome-wide screening of large patient populations. There’s no question that clinical research involving new therapeutic interventions is becoming more and more tailored to individual cases.