Duke Cancer Institute

Founded in 1973, the Duke Cancer Center was designated by NCI as 1 of the 8 original comprehensive cancer centers. Today, Duke Cancer Institute (DCI) is 1 of only 41 cancer centers to hold that distinction. The DCI, established in 2010, is a single entity that integrates and aligns patient care and research from throughout Duke University and Duke Medicine. The DCI is dedicated to improving patient outcomes, decreasing the burden of cancer, and accelerating scientific progress in preventing, diagnosing, and treating the broad spectrum of malignant diseases.

More than 300 DCI clinicians and researchers are dedicated to a diverse array of cancer research activities, with a priority of translating that research into the most advanced patient care. The DCI has 9 dedicated research programs representing areas of specialized expertise spanning basic, translational, clinical, and population research.

The DCI cares for nearly 8000 patients annually, visiting from virtually every county in North Carolina, almost every state in the nation, and from throughout the world. The Duke Cancer Center, a state-of-the-art outpatient facility, was opened in 2012 and is a cornerstone of patient care activities at DCI.

Michael B. Kastan, MD, PhD (first small photo on cover), a renowned cancer scientist, serves as executive director of the DCI. He is a pediatrician and laboratory investigator in the Duke Department of Pharmacology and Cancer Biology. Among his numerous awards and honors,
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Featured Articles

**PERSPECTIVES**

**1409 Creating An Adolescent and Young Adult Cancer Program: Lessons Learned From Pediatric and Adult Oncology Practice Bases**

Damon Reed, MD; Rebecca G. Block, PhD; and Rebecca Johnson, MD

Driven by reports of unmet clinical needs and lack of survival improvement, programs for adolescents and young adults (AYAs) with cancer have become increasingly common across the United States during the past 10 years, and organizations have published guidelines for AYA cancer care and for the development of clinical AYA programs. This article reviews these publications, describes the growth and development of 2 nationally recognized AYA centers, and offers practical suggestions to assist developing AYA programs.

**ORIGINAL ARTICLES**

**1417 Cost-Effectiveness Analysis of Abiraterone and Sipuleucel-T in Asymptomatic Metastatic Castration-Resistant Prostate Cancer**

Cynthia L. Gong, PharmD, and Joel W. Hay, PhD

Approximately 10% to 20% of patients diagnosed with prostate cancer experience disease progression to metastatic castration-resistant prostate cancer (mCRPC). Recently, 4 novel therapies have been introduced for the treatment of mCRPC; of these, abiraterone and sipuleucel-T have been studied in the asymptomatic, pre-docetaxel population. Both have shown clinical benefits compared with placebo. This study evaluated the cost-effectiveness of abiraterone acetate and sipuleucel-T compared with prednisone in asymptomatic, pre-docetaxel mCRPC from a US societal perspective.

**1433 Predictive Biomarkers for Anti–Epidermal Growth Factor Receptor Therapy: Beyond KRAS Testing**

Noman Ashraf, MD; Nishi Kothari, MD; and Richard Kim, MD

In an era of personalized medicine, an increased effort is being made to identify patients likely to benefit from targeted therapy. Restricting the use of anti-epidermal growth factor receptor–targeted agents in metastatic colorectal cancer to only patients with KRAS exon 2 wild-type tumors has become well-established. However, lack of KRAS exon 2 mutations does not necessarily predict response, and a significant proportion of patients with KRAS wild-type tumors do not benefit from therapy with cetuximab or panitumumab. This article focuses primarily on emerging data on non-exon 2 KRAS mutations and additional RAS and BRAF mutations and how this information may impact clinical decision-making.

**1443 Optimizing Stem Cell Mobilization: Lessons Learned**

Pamela S. Becker, MD, PhD

Granulocyte colony-stimulating factor is the pivotal component of mobilization regimens and the growth factor most often used for peripheral blood progenitor cell collections. When used alone or after chemotherapy, products with adequate yields of CD34+ cells are obtained after leukapheresis, resulting in optimal blood count recovery after transplant. However, for patients who have had extensive prior treatment with chemotherapy and/or radiation, or treatment with specific agents, the yields may be limited. This article discusses the modern methods that allow a high success rate for procurement of adequate stem cell products.

More about the institution

Dr. Kastan was elected to the Institute of Medicine of the National Academies, the American Association for the Advancement of Science, and the American Academy of Arts and Sciences. Dr. Kastan received the AACR-GHA, Clovis Memorial Award for outstanding contributions to basic cancer research and has served as chair of the Board of Scientific Counselors for the National Cancer Institute. He has also served on the boards of directors for the AACR and the American Association of Cancer Institutes. Steven R. Patierno, PhD (second photo), an internationally recognized leading expert in cancer control, genomics, carcinogenesis and cancer health disparities, serves as deputy director of the DCI. He is a Professor of Medicine, of Pharmacology and Cancer Biology, and of Community and Family Medicine. Dr. Patierno serves as the senior administrator and scientific and operational leader for cancer control, population sciences, health equity and disparities, global cancer, cancer and the environment, cancer supportive services and survivorship, cancer health services and outcomes, and cancer policy.

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NCCN Report: Opportunities for Improvement in Breast Cancer

Vol 12; Suppl 1, 2014  www.jnccn.org/content/12/suppl_1

In 2010, NCCN initiated the Opportunities for Improvement (OFI) project. Each participating NCCN Member Institution was provided data on guideline concordance and information on time to treatment from the NCCN outcomes database. A project team at each center reviewed these findings and established a program “charter” that outlined a specific plan to address quality issues within their breast cancer treatment system. This supplement to JNCCN includes the final reports from each of the NCCN centers participating in the project. The reports illustrate the range of opportunities for quality improvement in large multidisciplinary practices.

Metastatic Colorectal Cancer

Vol 11; Suppl 4, 2013  www.jnccn.org/content/11/suppl_4

The past decade has enriched our understanding of colorectal cancer biology and added complexity to the therapeutic armamentarium for patient with advanced disease. In this special supplement to JNCCN, multiple articles integrate a spectrum of treatment approaches, strategies, and challenges, reflecting comprehensive care for patients with metastatic colorectal cancer. Articles include a case report on management of the patient with synchronous metastatic rectal cancer; a discussion of KRAS and multigene assays, including their current and potential uses in colorectal cancer; a summary of the array of treatment opportunities for metastatic colorectal cancer patients, and a discussion of treatment sequencing in advanced unresectable disease. Finally, the early introduction of palliative care for patients with advanced disease is discussed. Most of the articles offer individual CE.

NCCN Task Force Report: Bone Health in Cancer Care

Vol 11; Suppl 3, 2013  www.jnccn.org/content/11/suppl_3

This report is the result of a multidisciplinary task force on bone health in cancer care convened by NCCN to discuss the progress made in assessing bone health; cancer therapy and bone loss; therapeutic strategies for maintaining bone health in patients with cancer; role of antiresorptive agents in preventing recurrences; pathophysiology of bone metastases and its complications; imaging and treatment of bone metastases; and safety and toxicity considerations while using antiresorptive agents. This NCCN Task Force report focuses on bone health and bone metastases in patients with breast and prostate cancer.

Data Needs in Oncology: “Making Sense of The Big Data Soup”

Vol 11; Suppl 2, 2013  www.jnccn.org/content/11/suppl_2

Rising health care costs and continued concerns about safety, efficacy, and quality have resulted in the demand for more data and evidence by payors, regulators, providers, and patients alike. In June 2012, NCCN assembled a work group composed of thought leaders from NCCN Member Institutions and other organizations to identify and examine the challenges of data generation, collection, and application for clinical, regulatory, and coverage decision-making. The NCCN Data Needs Work Group identified 4 main areas for consideration: data sources, patient-derived data, payor-collected data, and regulatory policy toward data generation and use.

Early Initiation of Palliative Care Interventions in Patients With Cancer, With an Emphasis on Management of Breakthrough Pain

Vol 11; Suppl 1, 2013  www.jnccn.org/content/11/suppl_1

Optimal cancer care requires the integration of palliative care into practice. A group of international experts met to review the current status of concurrent palliative and oncology care in different countries and to address questions related to why this integration does not occur on a more regular and effective basis. This supplement is a product of these discussions, which focused on key issues: development of a standard definition of palliative care and its component parts; models for care delivery; standardization of tools for patient assessment; educational programs designed to meet the needs of health care professionals; and the importance of developing best practices in symptom management using breakthrough pain management as an example.