



In the face of cancer
annual report 2015

THE UNIVERSITY OF TEXAS
MDAnderson
~~Cancer~~ Center

Making Cancer History®



Mission

The mission of The University of Texas MD Anderson Cancer Center is to eliminate cancer in Texas, the nation and the world through outstanding programs that integrate patient care, research and prevention, and through education for undergraduate and graduate students, trainees, professionals, employees and the public.

Vision

We shall be the premier cancer center in the world, based on the excellence of our people, our research-driven patient care and our science.

We are Making Cancer History.

Core values

Caring

By our words and actions, we create a caring environment for everyone.

Integrity

We work together to merit the trust of our colleagues and those we serve.

Discovery

We embrace creativity and seek new knowledge.

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In the face of cancer.

It's a phrase that describes our patients, who, faced with a disease that is unpredictable and unforgiving, remain strong and determined.

It describes our doctors, researchers, educators and staff, who are relentless in their drive to stop a plague that robs us all of friends, family and loved ones.

At MD Anderson Cancer Center, we're confronting cancer through innovations and advancements generated by the Moon Shots Program. We're staring down the disease in laboratories, where new discoveries are leading to better understanding of a complex and elusive enemy. We're training the next generation of scientists and clinicians in the Graduate School of Biomedical Sciences and the School of Health Professions. We're harnessing and mining mountains of data to personalize treatments that best fit each patient. We're helping them beat the disease, as well as deal with the complications of living through treatment. We're supporting survivors and taking proactive steps to prevent cancer in the future.

We're at the forefront of cancer treatment and discovery, and we're on the front lines of this battle, standing shoulder to shoulder with our patients.



The Golden Era of Cancer Research and Care

When President Barack Obama called for a national moon shot to end cancer, the MD Anderson community and our patients cheered. For nearly 75 years, cancer has been our priority, and we are heartened to see it elevated to a true national priority.

At MD Anderson, our researchers and clinicians have moved us closer to meeting such a challenge, and we reinforced our commitment to doing so with the 2012 launch of our Moon Shots Program, an unprecedented effort to more rapidly convert scientific discoveries into lifesaving advances.

Our **mission** is clear. Our **commitment** is strong. And so is the **support** we receive, which is saving lives and accelerating progress in the years to come.

With a focus on patient care, research, prevention and education, we are discovering the causes of and cures for these devastating diseases. In the past year, we've made significant progress. We're thinking big and creatively to make game-changing discoveries. We even expanded our program to 12 moon shots, adding six more of the most intractable cancers plaguing humanity for intensive focus. Our multidisciplinary teams, enabled by deep expertise and advanced technology, are ready to defeat our foe. And only three years after the launch, we're already transitioning from an implementation phase to a results phase.

Giant leaps have been made to protect the future health of our children. Our cancer prevention and control platform, in collaboration with other organizations, continued its great work inspiring and educating legislators to enact valuable public health policies. During the 2015 Texas legislative session, this led to laws prohibiting access to and use of e-cigarettes by minors, the lifting of a hard-to-believe prohibition on children taking sunscreen to school, and implementation of a statewide strategic plan for preventing HPV-associated cancers.

New clinical trials bring to our patients innovative approaches to targeted therapy and immunotherapy. We've launched 125 immuno-oncology trials involving nearly 6,000 patients across all major cancer types, and our state-of-the-art immune system monitoring program — together with our big data framework — helps us understand who is helped by these drugs and why.

Speaking of immunotherapy, Jim Allison, Ph.D., a trailblazer in the field, who discovered a way to unleash the body's immune system to attack cancer, received the Lasker-DeBakey Clinical Medical Research Award, the nation's highest honor for clinical medical research. His findings led to the development of promising immunotherapy drugs that are benefiting patients around the world.

We're using disruptive technologies and working smarter to more efficiently attack cancer on myriad fronts. We've developed the world's most advanced data-generation, aggregation and analytics system to enable precision medicine for every patient. This platform, aptly named APOLLO for Adaptive Patient-Oriented Longitudinal Learning and Optimization, will revolutionize our ability to learn from each patient and dramatically accelerate translational research to a new level. Beyond our walls, our efforts to spread our knowledge and elevate the quality of care elsewhere continue with our development of a health care operating system that utilizes mobile devices, a secure cloud for data and IBM Watson cognitive computing.

Our ability to influence cancer care and share best practices throughout the world also is embodied in our Cancer Network, which continued to grow with the addition of our newest partner member, Baptist MD Anderson Cancer Center in Jacksonville, Florida, and three certified members, as well as the introduction of our first associate member, Hospital Israelita Albert Einstein in São Paulo, Brazil. With 20 Cancer Network members across the nation and around the world, we truly are making a difference in our collective fight to end cancer. These care-oriented collaborations join the 32 sister institutions in our Global Academic Program, which focuses on research and training opportunities in 23 countries.

As we prepare to celebrate MD Anderson's 75th anniversary, we also must look back on the brilliant, innovative work of legendary faculty members such as Josh Fidler, D.V.M., Ph.D., and Emil Freireich, M.D., who celebrated his 50th year with the institution in 2015. Their work in understanding cancer metastasis and combination chemotherapy, respectively, is some of the most important in the war on cancer over the past 100 years. It has been an honor to serve as their colleague.

Today, our clinicians and researchers are working on tomorrow's cancer care breakthroughs. Our clinical trials program — the world's largest and most impactful — offers hope and help to patients who don't respond to the current standard of care. The program's more than 1,200 protocols demonstrate the direct line from research to clinical care, two of the pillars elevating this institution. Of note, MD Anderson is responsible for leading the trials for one-third of all new cancer treatments approved by the Food and Drug Administration.

The importance of research goes beyond clinical trials. Every day, in our Texas Medical Center labs and our research facilities in Bastrop County, scientists are learning what drives cancer, a complex and evasive disease. They're hard at work to understand how cancer develops and grows, what fuels it and what its vulnerabilities may be. Those determinations are yielding pivotal discoveries, as evidenced by the more than 3,600 papers published by our faculty in scientific journals last year.

None of this would be possible without funding for research. This comes in many forms, such as tens of millions of dollars we have invested for shared core facilities, new granting mechanisms such as the Clark Fellows and Clinical Innovator Awards, an expanded Institutional Research Grant program and an ever-growing Graduate School of Biomedical Sciences. A most recent example is a transformational \$30 million gift established by the Andrew Sabin Family Fellowship Program that will fund the brilliant ideas of world-class cancer researchers who push the boundaries in our quest to end cancer and will ensure the support of our faculty for decades to come.

You'll read more about these and other inroads in the war on cancer in the pages of this Annual Report, which features many of our clinicians, researchers and brave patients on the front lines. These stories will explain why the institution is again ranked as the nation's No. 1 hospital for cancer care, and why Chancellor William McRaven describes MD Anderson as "the crown jewel" of The University of Texas System.

We are a family of 21,000 cancer fighters, made stronger by the commitment of our patients, their families and everyone joining us in this fight to end cancer. We're on a mission. Together, we are Making Cancer History.

Ronald A. DePinho, M.D.

A handwritten signature in dark ink, reading "Ronald A. DePinho". The signature is fluid and cursive, with a large, stylized initial "R" and "D".

Patient Care

Jim Boysen, 56

Leiomyosarcoma survivor

Being the first person to undergo a skull and scalp transplant gave Jim Boysen a new lease on life.

Chemotherapy and radiation treatment for leiomyosarcoma — a rare cancer of the smooth muscle under the scalp — left Boysen with a deep head wound that immune suppression drugs kept his body from healing. He was taking the drugs to prevent his body from rejecting a transplant he received more than 20 years ago because of complications from diabetes. In turn, the open wound stood in the way of a much-needed second kidney and pancreas transplant.

Reconstructive plastic surgeon Jesse Selber, M.D., saw Boysen as an ideal candidate for a first-of-its-kind composite tissue transplantation in which the 56-year-old received a partial skull and scalp, a pancreas and a kidney, all at once.

“This has been a long journey, and I am so grateful to all the doctors who performed my transplants,” says Boysen, who is back at home in Austin and doing well. “I’m amazed at how great I feel, and I’m forever grateful that I have another chance to get back to doing the things I love and be with the people I love.”

Read more about Boysen’s groundbreaking surgery on Page 9.

From first-ever surgeries to translational research and drug discoveries that are yielding previously unheard of benefits for patients, MD Anderson’s faculty members and staff continue to improve and advance treatment options. Last year, the institution’s doctors, nurses and other cancer fighters cared for more than 267,000 patients in the Houston area and through its Cancer Network, which is making MD Anderson-quality care accessible to more people.



Patient Care



Reconstructive plastic surgeon Jesse Selber, M.D.

In 2015, surgical history was made

Collaboration and a unique opportunity led to the world's first skull and scalp transplant

By Jacqueline Mason

After undergoing a first-of-its-kind surgery, music lover Jim Boysen is back home in Austin, doing the things he loves.

"I'm playing keyboards, riding my mountain bike and enjoying my favorite Tex-Mex foods," says the 56-year-old software engineer, who's also back at work and "feeling great."

"That pre-surgical diet was bland and boring. Give me enchiladas any day."

Last May, doctors from MD Anderson and Houston Methodist Hospital performed the world's first skull and scalp transplant on Boysen, whose treatment for a rare cancer of the scalp muscle left him with a deep head wound.

During the same surgery, he also received a kidney and pancreas transplant, making it the first time a patient has undergone a simultaneous craniofacial and solid-organ transplant.

Boysen's first kidney-pancreas transplant was in 1992, a result of diabetes he's had since he was 5 years old. The immune suppression drugs he took to keep his body from rejecting his kidney and pancreas raised the risk of cancer and he developed leiomyosarcoma, a rare type of cancer affecting the smooth muscle under his scalp.

The drugs also prevented his body from repairing the wound caused by radiation therapy for his scalp cancer. To make matters worse, the transplanted organs he received 23 years ago were starting to fail.

However, doctors couldn't perform a new transplant as long as he had an open scalp wound.

Jesse Selber, M.D., a reconstructive plastic surgeon at MD Anderson, saw a unique opportunity after first meeting Boysen several years ago. His solution was to give Boysen a partial skull and scalp, a pancreas and a kidney, all at once.

"Opportunity favors the prepared mind," Selber says. "I've been deeply interested in composite tissue transplant since I was in surgical training. I read immunology textbooks and got up to date on this state-of-the-art procedure, which is a kind of subset of reconstructive microsurgery."

From opportunity to orchestration of a world first

In composite tissue transplantation, doctors transfer skin, muscle, bone and nerve from a donor to a recipient. It's less established than solid-organ transplants and free-flap procedures that use tissue harvested from the patient's own body.

Fortunately for Boysen, MD Anderson has one of the most recognized microsurgery programs in the world.

Selber led Boysen's microsurgery team, which included professors Matthew Hanasono, M.D., and Peirong Yu, M.D., and assistant professors Edward Chang, M.D., and Mark Clemens, M.D.

"While the approach seemed radical at first, in practice, we perform these techniques every day," says Clemens. "By using them for Mr. Boysen, we helped him and, in the process, broke through certain surgical dogma and opened up a new reconstruction option for our cancer patients."

The moment Clemens cherishes most is when blood flowed to Boysen's scalp following hours of delicate surgery to connect blood vessels about half the diameter of a human hair.

"A blush of pink spread across the skin in a wave," he recalls. "The surgery itself is very mechanical. But seeing that suddenly reminds you of the magnitude at hand and the stunning realization that it is possible."

Chang, who performs more than 100 free-flap procedures a year, felt the enormity of this procedure resting on his shoulders.

"Every stitch I made seemed like a small step toward success, and even a little stumble or falter would mean failure."

In the end, the successful procedure, which involved a team of about a dozen doctors and 40 health care professionals, created a gateway to more composite tissue transfers in the future.

"It certainly opens a lot of doors for patients who take immunosuppressive medications for organ transplants to undergo transplant of skin, muscle and skeletal structures as well," Hanasono says.

Yu agrees.

"The experience really shows that by working together we can help many patients who need sophisticated multiple-organ transplantation."

To be the No. 1 cancer hospital, you need the best and brightest physicians

By Laura Sussman

Patients know that choosing a world-class institution means they'll be treated by world-class doctors. That's why they choose MD Anderson. It's where the next generation of outstanding physicians is caring for cancer patients today. Five of the institution's best young physicians share what motivates them, why they chose to work in oncology and how they are constantly inspired by their patients.



Van Morris, M.D.

Assistant professor of Gastrointestinal Medical Oncology

During his residency, Van Morris noticed a unique quality about cancer patients that drew him to pursue a career as a medical oncologist.

“When patients first hear the word cancer, the mask of who they want you, as their doctor, to see comes off. From that point, the doors open to form an authentic doctor-patient relationship. And as a clinician, that’s most gratifying to me.”

The quickly evolving field of molecular oncology offers Morris a chance to work as part of a team in what he calls the most fascinating science in medicine. He was drawn to MD Anderson’s Fellowship Program because of its combined emphasis on high-quality patient care and patient-centered research.

Under the guidance of Scott Kopetz, M.D., associate professor of Gastrointestinal Medical Oncology, Morris secured multiple grants and wrote a clinical trial of colon cancer that’s driven by a mutation in the BRAF gene. Five to 10% of all colon cancer patients carry this mutation, which is associated with particularly poor outcomes. Under Cathy Eng, M.D., professor of Gastrointestinal Medical Oncology, Morris wrote and developed the first-ever Phase II clinical trial of the drug nivolumab for the treatment of anal cancer that spreads and resists treatment — a collaboration with MD Anderson’s immunotherapy platform.

These types of high-caliber mentorship opportunities for hematology and oncology fellows and junior faculty aren’t available elsewhere, he says.



Isabella Glitza Oliva, M.D., Ph.D.

Assistant professor of Melanoma Medical Oncology

Without a doubt, Isabella Glitza Oliva is a high-energy adventurer. She’s an avid world traveler who, so far, has pins in 49 countries on the map. She’s a car and motorcycle enthusiast and is passionate about diving. She’s also a gourmet cook who doesn’t have the patience for baking.

But when it comes to caring for patients, she knows how to gear down when the time is right.

“I tell them cancer is a journey that comes with fast as well as slow passages,” says Glitza Oliva. “I’ll always let them drive, but I’ll be in the passenger seat with the map in my hand to help navigate the way.”

A melanoma medical oncologist, Glitza Oliva chose her specialty because of the mentorship she received as a fellow at MD Anderson and rapid developments in the field of immunotherapy, where new drugs and therapies that boost the immune system’s ability to fight cancer are being designed and used.

Glitza Oliva is particularly interested in leptomeningeal disease, or LMD — a complication that arises when melanoma spreads to the membranes surrounding the brain and spinal cord. MD Anderson has been a leader in the treatment of this rare condition, using an immunotherapy approach that involves injections directly into the spinal fluid.

“Ultimately, I’m driven by my passion to help people. By choosing this field, I hope to offer long-term care, and that’s very important to me.”



Nishin Bhadkamkar, M.D.

Assistant professor of General Oncology

Nishin Bhadkamkar is a second-generation contributor to MD Anderson's mission. His mom, Viju, has been involved in clinical research for more than 25 years.

"We talked about cancer at the dinner table. Obviously, as a kid, I didn't fully understand it, but it piqued my interest in medicine."

It was an MD Anderson summer program during college, working alongside physicians who would become his mentors, that solidified his interest in oncology.

Bhadkamkar calls oncology a great fit for his personality.

"Intellectually, it's an interesting and satisfying specialty; there's always new research on the horizon. There's also the human aspect and chance to develop meaningful relationships with patients. That's very important to me."

As an MD Anderson fellow, Bhadkamkar enjoyed his work at Lyndon B. Johnson Hospital, where MD Anderson doctors provide cancer care to underserved patients.

At LBJ, Bhadkamkar also is training MD Anderson's hematology and oncology fellows.

Delivering MD Anderson-quality care to those in need is a responsibility he and his LBJ colleagues take very seriously. He hopes to make MD Anderson's therapeutic clinical trials more accessible to LBJ patients.



Terri Woodard, M.D.

Assistant professor of Gynecologic Oncology and Reproductive Medicine

Terri Woodard was groomed to be a geriatrician before she switched her focus to obstetrics and gynecology, and then reproductive endocrinology. She began seeing a number of cancer patients who were struggling with fertility issues, and found it rewarding to counsel them about their options for having children.

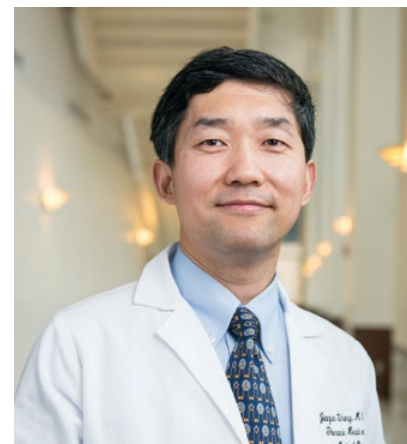
"There was this huge quality of life issue that was not being adequately addressed in the cancer population. I realized I could make a difference in these women's lives."

As MD Anderson's first reproductive oncologist, Woodard has helped build the institution's onco-fertility service — making patients aware of fertility options before and after cancer treatment.

Much like oncology, it's an exciting time in reproductive endocrinology, says Woodard. Just four years ago, freezing a woman's eggs was still considered experimental.

"We also have the possibility of freezing ovarian tissue and will soon open a research protocol," she says. "If a young woman or girl needs chemotherapy right away, we can harvest ovarian tissue and place it back into her body if she has ovarian failure. In the future, we'll be able to get immature eggs from the tissue and mature them in the lab."

After three years at MD Anderson, Woodard is now beginning to see patients who've completed cancer treatment and are going on to have children, using the eggs or embryos they froze before treatment. Others have used gestational carriers, or even donor eggs.



Jianjun Zhang, M.D., Ph.D.

Assistant professor of Thoracic Head and Neck Oncology

Physician scientist Jianjun Zhang was always fascinated with physics and biology, but he turned his interest to cancer science after his father died of the disease when Zhang was still in high school. Following training in China, he traveled to the United States to continue his education, which included an oncology fellowship at MD Anderson.

"Although many new drugs have been approved during the past several years, the help we can offer our patients, especially in lung cancer, is still very modest," he says. "That's why we need more research."

To maximize his impact, Zhang balances a career in both the clinic and the lab.

"I have to see patients so that I know I'm helping them. But I also feel it's our obligation to conduct research to advance the field so we can potentially help even more patients," he says.

Zhang's research involves genomic profiling of specific subsets of lung cancers. He's focused on understanding patients' response to therapy, with the goal of finding better approaches to improve treatments. He's also interested in immuno-genomics — applying genomic technologies to understand the immune system.

"We know the genomic profiles of cancers may be related to response to immunotherapy," he explains. "We're trying to use that as a tool to look at both the genomic profile of the cancer and the genomic profile of the immune cells to understand that relationship — and how to improve treatment efficacy."

Curing leukemia without debilitating side effects

By Scott Merville

Jamie Whittington has an aggressive form of chronic lymphocytic leukemia, but you'd never know it.

"I haven't experienced anything bad. No symptoms. No side effects, nothing," she says. "I tell my granddaughter that my blood is sick, but I'm not sick."

Whittington's experience reflects a shift in the treatment for the disease known as CLL, from traditional chemotherapy to newer targeted therapies that attack cancer cells without harming normal cells — an area in which MD Anderson is leading the way.

"With these new targeted drugs, CLL patients are doing very well, maintaining normal lives and have no symptoms or signs of their disease. Only traces of leukemia — found by our most sensitive tests — remain," says Jan Burger, M.D., Ph.D., associate professor of Leukemia and Whittington's oncologist.

In people with CLL, the white blood cells — specifically B cells — that protect against disease and infection grow out of control. As they multiply, they crowd out healthy cells in the blood, bone marrow, lymph nodes, spleen and liver.

Through a clinical trial Whittington joined two years ago, she's given ibrutinib, a drug that blocks a protein that aids B cells' growth. The trial is part of the CLL Moon Shot, which taps the expertise of Burger and his colleagues who played leading roles in the early clinical trials of the drug.

"The Moon Shot Program is closely linked to the clinical trial she's in, where we pursue a large number of laboratory studies to understand resistance to ibrutinib and develop new combination treatments with the goal to eradicate the leukemia," Burger says.



CLL survivor Jamie Whittington

Goal: Double the cure rate

Combination chemotherapy in which multiple drugs are given simultaneously, including a standard-of-care regimen developed at MD Anderson, has achieved a 35% cure rate for CLL, but comes with severe side effects that can force patients off treatment. CLL Moon Shot leaders think they can double the cure rate to 70% using ibrutinib and other targeted therapies.

Whittington's CLL was caught by a routine blood test at her annual well-woman checkup in 2013. CLL usually progresses slowly and many patients are monitored for years before treatment becomes necessary.

Whittington sought a second opinion at MD Anderson, where Burger found that her disease had a genetic mutation known as a 17p deletion, which causes CLL to progress faster and resist chemotherapy.

At the time, she stayed with her original oncologist for monitoring and Burger urged her to call when her disease progressed.

CLL — the most common adult leukemia — is a malignancy of immune system B cells (white blood cells that normally produce antibodies against infection). The American Cancer Society estimates almost 19,000 new cases will be diagnosed in 2016 in the U.S., and about 4,600 people will die of CLL.

Drug thwarts rapid progression

Seven months after diagnosis, Whittington's white blood cell counts rose to a level that prompted her oncologist to plan for chemo.

"I called Dr. Burger, came to MD Anderson and went on an ibrutinib clinical trial," she says.

Her white count went up the first few weeks, which is common with ibrutinib because the drug pulls CLL cells into the bloodstream from the lymph nodes, spleen and bone marrow to die.

Her symptoms — night sweats, swollen lymph nodes and spleen, lack of energy — vanished in a week. "I've never had any side effects from the drug."

After six weeks, her white blood cell counts began to plummet and her CLL went into remission. That was in October 2014.

Now Whittington takes three ibrutinib pills a day, comes in every three months for blood tests and has an annual CT scan, bone marrow aspiration and biopsy. She's never missed more than a day of work.

"I'm excited. I thank God every day because I couldn't have a better care team," she says.



Associate professor of Leukemia Jan Burger, M.D., Ph.D.

We're putting the best cancer care within reach

To truly eliminate cancer, MD Anderson must expand its footprint in Houston and form relationships with hospitals and health systems around the world.

And MD Anderson Cancer Network™ is collaborating with community hospitals and health systems to provide the highest-quality and most advanced cancer care to patients in the communities in which they live.

“The National Cancer Institute estimates that only about 15% of U.S. cancer patients are diagnosed and treated at the nation’s major academic-based cancer centers,” says Margaret Row, M.D., vice president of operations for the Cancer Network. “Through our network, we can reach more people nationally and internationally.”

With objectives to improve access to specialized care and clinical trials, disseminate knowledge, deliver high-quality, multidisciplinary care and drive new discoveries, the network has been growing quickly. More than 115 million people now have access to MD Anderson care or best practices through its network members.

Close to home

In a unique partnership, MD Anderson joined forces with Memorial Hermann to create an integrated breast-screening program across the Houston area. The collaboration combines the cancer center’s expert breast screening and diagnostic services with the convenience of Memorial Hermann’s locations. In less than a year, the program, which began in five locations before expanding to 10, provided more than 77,000 patients with approximately 147,000 procedures. The program grew again in February, expanding to 15 sites.

MD Anderson also provides cancer care to the underserved at Harris Health’s Lyndon B. Johnson Hospital. In the past year, MD Anderson doctors have provided cancer care to 3,800 patients from underserved populations of Harris County.

Partnering to deliver care

MD Anderson’s collaborations bring extensive expertise and resources to communities across the nation as co-branded, multispecialty cancer centers. More than 22,000 newly diagnosed cancer patients sought diagnosis or treatment at MD Anderson’s network affiliates this year. Covering a population of more than 100 million people, these sites are strategically located to

allow the institution to have the largest possible impact around the globe.

With partnerships at Banner MD Anderson Cancer Center (Gilbert, Arizona), MD Anderson Cancer Center at Cooper (Camden, New Jersey), Baptist MD Anderson Cancer Center (Jacksonville, Florida), an extension of the partnership of MD Anderson at Cooper with Summit Medical Group (Berkeley Heights, New Jersey), 14 current certified members across the country, as well as other national and international relationships in development, the care and knowledge that have made MD Anderson the nation’s top cancer hospital continue to have expanded worldwide reach.

Increasing access to MD Anderson quality and best practices

MD Anderson Cancer Network now has 14 certified members in 12 states, all of which take part in the MD Anderson quality improvement and best practices program. Through these sites, a population of more than 15 million people now has access to health systems and physicians certified by MD Anderson.

With a goal to more than double in size to over 30 member health systems by 2021, the number of potential patients who can receive oncology care that’s been shaped by MD Anderson will be increasing as well.

MD Anderson Cancer Network

Partner members

Banner MD Anderson Cancer Center
in Gilbert, Arizona

9,036
Patients served

36%
Increase from the previous year

MD Anderson Cancer Center at Cooper
in Camden, New Jersey

17,465
Patients served

21%
Increase from the previous year

Baptist MD Anderson Cancer Center
in Jacksonville, Florida
Opened Oct. 1, 2015

MD Anderson Breast Care with Memorial Hermann in the first year:

77,466
Patients served

146,781
Total procedures

107,591
Mammograms performed

293
Patients treated at MD Anderson locations following diagnosis

Affiliates

MD Anderson Radiation Treatment Center at American Hospital in Istanbul, Turkey

393 Patients served (12,000 treatments)

MD Anderson Radiation Treatment Center at Presbyterian Kaseman Hospital

in Albuquerque, New Mexico

624 Patients served

Associate members

Hospital Israelita Albert Einstein in São Paulo, Brazil

3,741 Patients served

MD Anderson Cancer Center Madrid in Madrid

25,321 Patients served

Certified members

14 health systems and hospitals in **12** states, reaching a metropolitan statistical area population of **15,124,000**

The Global Academic Programs (GAP) facilitates the Sister Institution Network — the largest global network of cancer centers working collaboratively on research and education.

32 sister institutions in **23** countries

MD Anderson is involved in **124** international research projects covering **25** cancer types in **37** countries.

Sabin gift encourages research that tests the limits, delivers big impact

By Sarah Watson

Thanks to a \$30 million commitment from New York-based Andy Sabin and his family foundation, promising young scientists at MD Anderson can independently pursue high-risk, high-impact research projects with one collective goal: to end cancer.

The Andrew Sabin Family Fellowship Program, through an endowment established by the Andrew Sabin Family Foundation, is designed to annually fund up to eight two-year research fellowships, at \$100,000 each. The program encourages creative, independent thinking and impactful research. The MD Anderson grant is the foundation's largest to date.

The gift will help MD Anderson researchers make substantial strides in the fight against cancer, says Ethan Dmitrovsky, M.D., executive vice president and provost of MD Anderson.

“Without the intellectual curiosity of leading young researchers who have the means to explore non-traditional solutions, progress in the fight against cancer will remain slow,” says Dmitrovsky. “The Andrew Sabin Family Foundation's legacy gift will help advance research that results in real hope for cancer patients and their loved ones.”

Sabin has served on the MD Anderson Cancer Center Board of Visitors since 2005 and is president of Sabin Metal Corp., the largest privately owned precious metals refiner and recycler in the country. He devotes much of his time and energy to advocating on a national level for increased cancer research funding and is widely known as an avid environmentalist, conservationist and wildlife enthusiast.

Sabin says he hopes his gift will eliminate the need for highly qualified researchers at MD Anderson to spend “50 percent of their time fundraising to sustain innovative projects.”

“Through this program, they have the opportunity to focus instead on important work that can truly help people who suffer from cancer,” he says.

An immunotherapy drug to bolster a T cell surge

By Scott Merville

MD Anderson Melanoma Moon Shot researchers are combining two immunotherapies for the first time to double-team melanoma that has spread to other organs and resisted all forms of treatment.

Patients in a first-of-its-kind clinical trial will receive a vastly expanded dose of their own T cells — white blood cells that are the specialized warriors of the immune system — followed by a cancer immunotherapy drug known to promote the activation and survival of T cells.

“We’re excited about this combination because there’s no standard of care now for our metastatic melanoma patients if immune checkpoint blockade drugs fail,” says clinical trial leader Rodabe Amaria, M.D., assistant professor of Melanoma Medical Oncology.

Checkpoint blockade drugs allow the immune system to unleash T cells to attack tumors. The drugs work by blocking molecules on T cells that act as brakes, which prevent the immune system from launching an attack. To date, researchers have developed two types of drugs that target two separate brakes. Brake No. 1 is called CTLA-4 and brake No. 2 is named PD1. The drugs have revolutionized melanoma treatment, producing powerful and lasting responses in about 10% to 30% of patients who take one drug only, and in more than 50% of those who take both drugs combined.



**Assistant professor of Melanoma Medical Oncology
Rodabe Amaria, M.D.**

That still leaves substantial numbers of patients in need of a new approach. For checkpoint blockade to work, there have to be T cells primed and willing to attack the cancer.

Enter T cell expansion and infusion. T cells that attempt to kill cancer are often found in tumors that are removed or biopsied. There just aren’t enough of them to succeed.

Patrick Hwu, M.D., head of Cancer Medicine and chair of Melanoma Medical Oncology, pioneered an approach that grows T cells on slices of a patient’s tumor in the lab, expands them to billions of cells over a few weeks, then infuses them back into the patient. The cells are called tumor-infiltrating lymphocytes, or TILs.

“We’ve treated about 100 patients with TILs. About 45 percent respond, and some of those responses last for years,” Amaria says. “There’s a lot of room for improvement.”

Patients in Amaria’s trial receive T cell expansion followed by a checkpoint blockade drug that blocks PD1. The trial is the first to combine TILs with a PD1 inhibitor.

This double-whammy combination may also stimulate small proteins that fire up the immune system, according to research conducted in Hwu’s lab by Weiyi Peng, M.D., Ph.D. In the clinical trial, 36 patients with metastatic melanoma will have surgery, so their tumor-attacking T cells can be expanded and then frozen. They’ll then be hospitalized and treated with chemotherapy to reduce their existing T cells before being infused with their TILs.

After that, they’ll receive interleukin-2, an immune stimulating protein, to bolster immune response. Three weeks later, they’ll receive the PD1 inhibitor drug Keytruda.

Patients’ tumors are biopsied once before and at least twice after treatment.

“Biopsies are a priceless learning opportunity,” Amaria says. “It’s so important to see what’s happening in tumors throughout the course of treatment so we can understand and improve how we manage disease.”

Bold advances require the latest technology

By Emily Watkins

To meet a growing demand for clinical, diagnostic and support services, ground was broken in 2013 for The Pavilion, an eight-story, 184,800-square-foot facility connected to the Main Building.

After more than 800,000 hours of construction work, the structure was completed in November 2015.

Among its many features, MD Anderson’s newest facility houses state-of-the-art surgical and interventional radiology suites that will allow MD Anderson to treat a greater number of patients at the highest level.

“The Pavilion is just an incredible facility,” says Ronald DePinho, M.D., president of MD Anderson. “It’s one of the most advanced infrastructures for surgery and interventional radiology in the world.”

The building’s six operating rooms, including one for intraoperative computerized tomography (IOCT), will open this spring. These ORs are designed to allow multiple teams to work simultaneously, aided by the latest innovations in navigation and image-guided technologies.

In the IOCT suite, a custom surgical table was created to optimize the patient’s position so that a CT scanner can move on rails and scan the patient in real time during surgery.

“This real-time imaging leads to a more effective and accurate surgery for the patient,” says Laurence Rhines, M.D., professor of Neurosurgery.

In addition to new operating rooms, The Pavilion houses a 27,000-square-foot Interventional Radiology facility that will allow multidisciplinary procedures and operations to be performed using robotic image guidance, reduced radiation doses for patients undergoing interventional procedures and real-time consultation with Pathology.

“The Pavilion is a great milestone in MD Anderson’s history,” says Robert Brigham, senior vice president for Hospital and Clinics. “Every time we get a chance to do an expansion like this, we do it not just to get larger and accommodate more, we do it to push the boundaries and transform the practice.”



The Pavilion serves as the new Main Building entrance and features state-of-the-art surgical suites, a new home for Interventional Radiology, an expanded Post-Anesthesia Care Unit and a larger space for sterile processing.

It also includes:

35	6	9
Pre- and Post-Anesthesia Care Unit beds	new surgery suites on Floor 5 (5 more surgery suites will be added on Floor 7 in the future)	Interventional Radiology procedure rooms

Research

Tatiana Demus, 9
Osteosarcoma survivor

When Tatiana Demus' leg started to hurt, her parents assumed a minor soccer injury was to blame. But when the pain got worse, a trip to the doctor and ensuing medical tests revealed she had osteosarcoma, the most common type of bone cancer in children.

Tatiana was referred to MD Anderson Children's Cancer Hospital and placed on a lifesaving treatment plan: chemotherapy to shrink the cancer, followed by surgery to remove the tumor, then more chemo to kill any remaining cancer cells and minimize chances of the cancer coming back.

A year later, she's finished with treatment and back in the game.

A straight-A honor student, Tatiana is doing well and enjoying her favorite things: Reading, video games, Chinese noodles and taking care of her guinea pigs, Bambi and Smores.

To help patients like Tatiana win their battles with cancer, MD Anderson researchers are developing leading-edge approaches to outwit the disease and, when possible, prevent it altogether.

At MD Anderson Children's Cancer Hospital, studies are underway to:

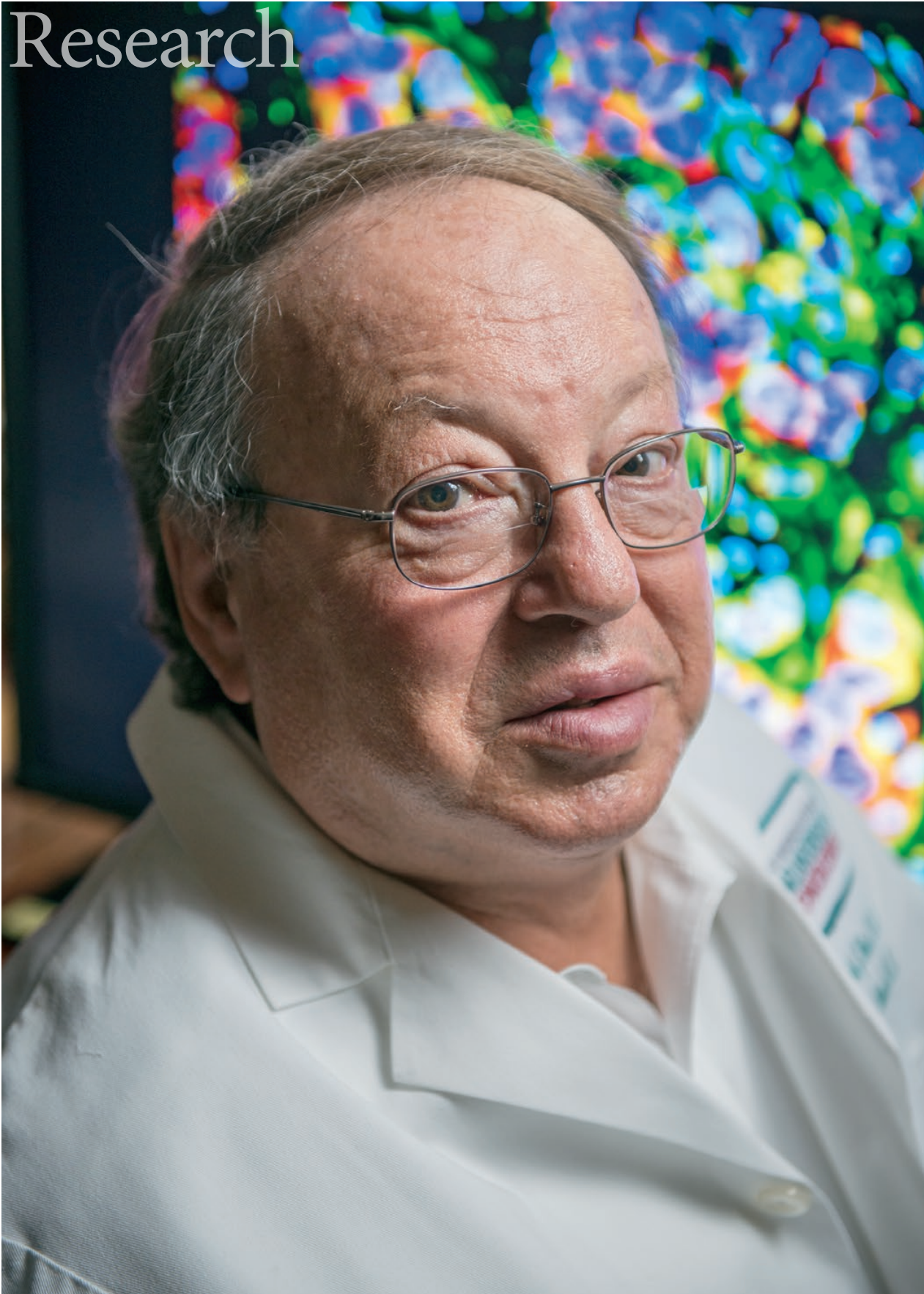
- Identify the genes and chemical interactions that may lead to osteosarcoma
- Train the immune system to recognize and attack cancer cells
- Test an aerosolized, inhaled chemo for cancer that has spread to the lungs
- Develop a blood test that detects cancer in its earliest stages

At the Children's Cancer Hospital, more than 770 patients have contributed tumor samples to a biobank — a repository of biological samples that will be used to advance research that will help pediatric and adult patients alike.

To ensure MD Anderson remains a powerhouse of cancer research, a significant commitment has been made to explore, create and support all avenues of discovery. In the past five years, the institution has nearly doubled its support for research. Those investments are critical in order to improve the standard of care across many diseases. This steadfastness wouldn't be possible without the generosity of donors and Board of Visitors members, and grants from the National Cancer Institute and the Cancer Prevention and Research Institute of Texas — all of which drive the engine of the nation's largest clinical trials program.



Research



Professor of Cancer Biology Isaiah Fidler, D.V.M., Ph.D.

He took on the mystery of metastasis. Now he's taking on brain cancer.

By Ron Gilmore

Few scientists have devoted as much of their career to understanding how cancer spreads as Isaiah Fidler, D.V.M., Ph.D.

From his days as the head of Metastasis Biology at the National Cancer Institute, to his current work at MD Anderson exploring new therapeutic approaches to challenging diseases such as brain cancer, his name has been heavily imprinted on the timeline of “firsts” in the quest to understand how cancer spreads.

Most recently, the professor of Cancer Biology published his team's findings on a potential new therapeutic approach to treating glioblastoma, a fast-growing and incurable form of brain cancer. The study indicated that combining the oral chemotherapy drug temozolomide (TMZ) with macitentan, a drug originally approved for treating pulmonary hypertension, significantly reduced brain cancer cells in mice.

“In five separate studies, 96% of mice treated with both drugs had no evidence of disease,” says Fidler. “Whereas, all mice in other groups died.”

Fidler's group previously showed that tumors that spread to the brain after originating elsewhere in the body tricked brain cells called astrocytes into protecting the cancer, making the tumors resistant to chemo. In this latest study, Fidler explored whether astrocytes — key to providing oxygen and nutrients to neurons — and brain endothelial cells, which form the inner lining of blood vessels, actually shield brain tumor cells from TMZ.

The results, Fidler believes, may very well represent a significant new therapeutic approach for treating glioblastoma.

An unlikely start

The path that Fidler followed — from his native Jerusalem via Oklahoma State University, where he earned his degree in veterinary medicine — did little to indicate his future as a pioneer of metastasis biology.

“I wanted to be a surgeon. But in Israel in the late 1950s and early 1960s, our education emphasized that we must ‘return to earth,’” he said in a 1999 profile that appeared in the *Journal of the National Cancer Institute*. “We had enough lawyers and doctors, and the nation encouraged people to be farmers. I compromised. If I couldn't be a human surgeon, I might as well be a veterinarian.”

After working as a surgical oncologist at the University of Pennsylvania's School of Veterinary Medicine, he earned a doctoral degree in human pathology at the university's School of Medicine. Nine years later, Fidler joined the NCI, where he headed Metastasis Biology. The institute was the site of some of his early and innovative work in unraveling the riddles of how cancer spreads.

A new understanding

In cancer firsts, Fidler and Margaret Kripke, Ph.D., MD Anderson *professor emerita* of Immunology, are noted for their groundbreaking studies that demonstrated tumors are composed of different, unrelated cells.

Fidler, who joined MD Anderson in 1983, also showed that metastases are non-random biologic events whose outcomes depend on the interaction between tumor cells and the cellular environment in which they exist. This cellular environment is called a microenvironment and includes the normal cells, molecules and blood vessels that surround and feed a tumor. A tumor can change its microenvironment, and the microenvironment can affect how a tumor grows and spreads.

By uncovering the complex underpinnings of these biological processes, Fidler showed that metastasis isn't random.

Thanks to the historical — and ongoing — work of Fidler and scientists like him, tumor microenvironments are now a field of intense investigation and a promising new incubator for innovative therapeutic solutions to some of the most deadly cancers.

Isaiah Fidler's NCI work was based largely on the findings of English surgeon Stephen Paget, who identified the role of host-tumor cell interactions and is credited with developing the “seed and soil” hypothesis in 1889. He likened the spread of cancer to seeds spread by the wind. Not all seeds germinate, and not all cancer cells metastasize. Just as seeds need the right soil, Paget postulated that cancer cells needed the right “host.”

Graduating to big things before returning to MD Anderson

By Ronda Wendler

When Joya Chandra, Ph.D., joined the faculty of MD Anderson's Pediatrics department in 2002, she felt an immediate kinship with the researchers, clinicians and, especially, with the students.

That's because Chandra herself spent four years as a student at The University of Texas Health Science Center (UTHealth) Graduate School of Biomedical Sciences, located on the MD Anderson campus.

Nestled in the heart of the Texas Medical Center and located in MD Anderson's George and Cynthia Mitchell Basic Sciences Research Building, the school is run by two institutions — MD Anderson and UTHealth. This unique partnership unites 580 faculty members from both institutions to teach students who conduct biomedical laboratory research. Two deans — one from each institution — work together to lead the school.

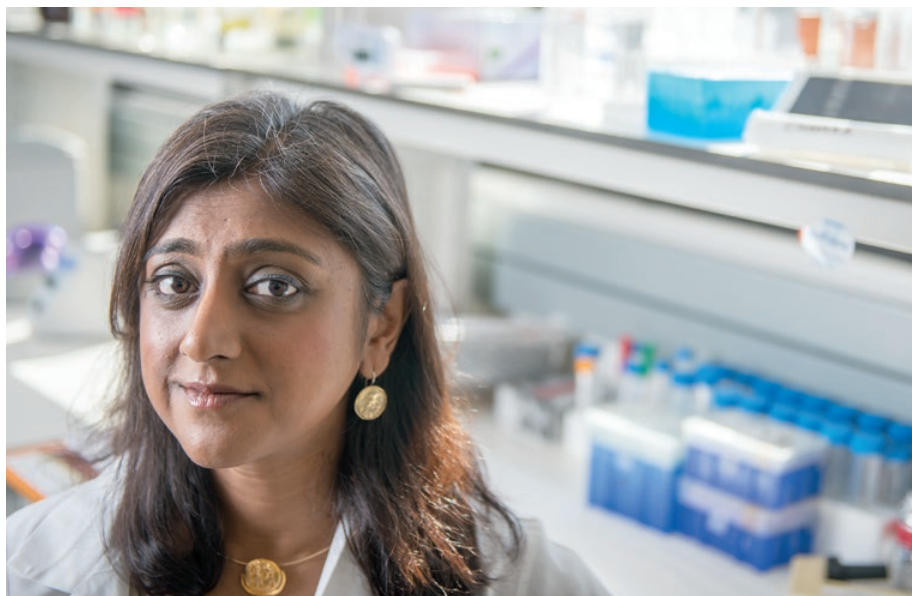
"I trained with some of the best scientists in the country," says Chandra, who graduated in 1998 with a Ph.D. in Cancer Biology and Immunology.

After earning her Ph.D., Chandra, like many GSBS graduates, became a postdoc — a Ph.D. recipient who continues learning by conducting research in a mentor's lab, typically for two to five years. This stint, called a postdoctoral fellowship, is frequently required to obtain tenure-track faculty positions, especially at research-oriented institutions.

Chandra completed not one, but two postdoctoral fellowships — the first at the Karolinska Institute in Sweden and the second at the Mayo Clinic. When she finished, she returned to Houston and joined the MD Anderson faculty.

"As a graduate student I was impressed by the culture of collaboration between clinicians and researchers," says Chandra. "MD Anderson was at the top of my list when I was deciding where to begin my independent career as a translational researcher (a scientist whose laboratory findings will be translated into medical therapies for patients)."

Fourteen years later, Chandra is an associate professor at the Children's Cancer Hospital where she studies how unstable molecules known as free radicals lead to cancer progression, resistance to chemotherapy and tissue damage. She encourages children with cancer to eat healthy foods that contain antioxidants — molecules that prevent free radicals from harming healthy tissue. In addition to her research, Chandra and colleagues created an online cookbook (mdanderson.org/recipes) filled with recipes taste-tested and approved by pediatric cancer patients and their families.



Joya Chandra, Ph.D.

Patrick Dougherty, Ph.D.

Professor of Anesthesia and Pain Medicine

Education: Ph.D. in Biomedical Science, Graduate School of Biomedical Sciences, 1988

Why I joined MD Anderson:

MD Anderson and the nearby institutions in the Texas Medical Center provide an outstanding biomedical science environment that fosters high-impact translational science unlike anywhere in the world. And Houston is a great place to live. It has all the amenities of a big city, but small, affordable neighborhoods in excellent school districts.

Key research: My research seeks a better understanding of the biologic mechanisms that cause peripheral nerve damage in patients undergoing chemotherapy. This research could allow current chemotherapies to be given in higher, more effective doses, and could help in the development of new chemotherapies with less severe pain-related side effects.

Ralf Krahe, Ph.D.

Professor of Genetics

Education: Ph.D. in Genetics, Graduate School of Biomedical Sciences, 1995

Why I joined MD Anderson: As a Graduate School of Biomedical Sciences alumnus, my decision to join the MD Anderson faculty was easy. I joined because of the exceptional research opportunities and environment, and outstanding colleagues in the Department of Genetics. My decision was facilitated by the unique institutional culture and the wonderful educational opportunities at the graduate school, which allow me to combine my passions for genetics research and education at my alma mater.

Key research: I identify and characterize disease genes and their mutations and variants, and am particularly focused on inherited cancers such as Li-Fraumeni syndrome, a rare disorder that leads to a higher risk of developing certain cancers at a younger-than-average age.

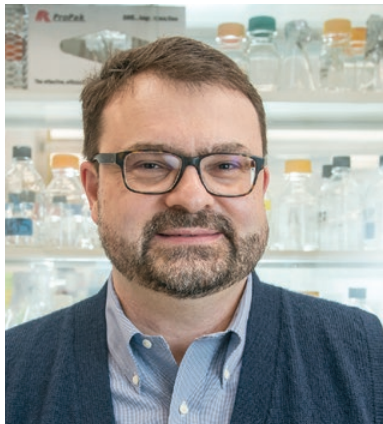
Peng Huang, M.D., Ph.D.

Professor of Translational Molecular Pathology

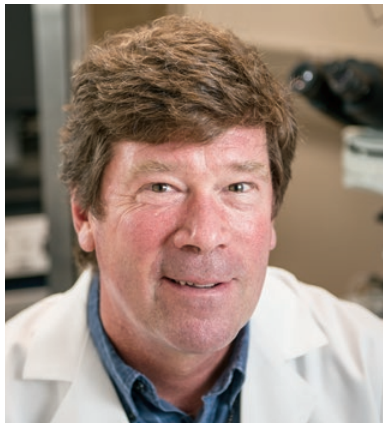
Education: Ph.D. in Pharmacology, Graduate School of Biomedical Sciences, 1990 (M.D., Zhongshan Medical College, Guangzhou, China, 1982)

Why I joined MD Anderson: Nothing compares to MD Anderson. The close interaction between scientists in the lab and patient-care professionals in the clinic provides a seamless pathway for translating laboratory findings into medicines and therapies for patients.

Key research: I'm investigating differences between leukemia cells and normal cells, which is research that provides a biochemical basis for the design of new drugs and strategies that will selectively kill cancer cells.



Ralf Krahe, Ph.D.



Patrick Dougherty, Ph.D.

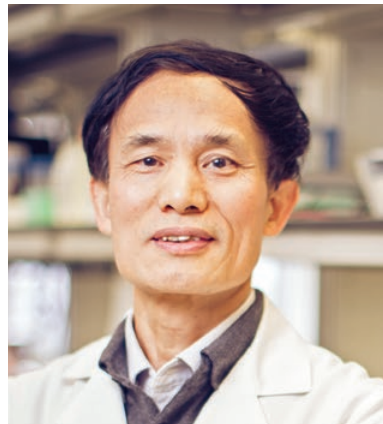
Dihua Yu, M.D., Ph.D.

Professor and deputy chair of Molecular and Cellular Oncology

Education: Ph.D. in Molecular and Cancer Biology, Graduate School of Biomedical Sciences, 1991

Why I joined MD Anderson: At MD Anderson, I'm privileged to work side by side with world-class biomedical scientists and physician-scientists. By pooling our knowledge, we've fast-tracked our laboratory research findings to clinical trials that are continually leading to new diagnostics and therapeutics to save cancer patients' lives.

Key research: My laboratory research focuses on how and why cancer begins, spreads and resists various treatments, with an emphasis on breast cancer.



Peng Huang, M.D., Ph.D.



Dihua Yu, M.D., Ph.D.

DEGREES AWARDED

Graduate School of Biomedical Sciences

Master of Science 15

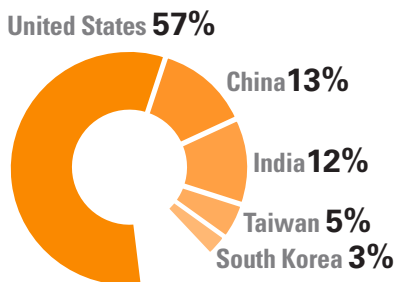
Ph.D. 78

MOST DEGREES AWARDED

- Cancer Biology 28**
- Biomedical Sciences 18**
- Genes and Development . . . 10**
- Medical Physics 9**
- Genetic Counseling 8**

TOP FIVE COUNTRIES OF ORIGIN

Graduate School of Biomedical Sciences



The man who helped cure childhood leukemia

By Ronda Wendler

A trailblazing oncologist who took on childhood leukemia by introducing combination chemotherapy — in which anticancer drugs are given simultaneously rather than singly — retired in September after 50 years at MD Anderson.

Yet Emil J Freireich, M.D., 88, who achieved legendary status as a pioneer in the early history of oncology triumphs, still comes to work every day, attending meetings and participating in the center's medical education program.

Retirement is “just a suggestion,” Freireich says. “I'm too motivated to lounge around the house like a dried-up old geezer.”

Freireich's motivation to stop cancer was born back in 1955 when he was hired at the fledgling National Cancer Institute (NCI) in Bethesda, Maryland. Built “way out in the country” on the campus of the National Institutes of Health, the center was the first full-time, patient-oriented clinical research center in the world. It was there that Freireich would alter the course of childhood leukemia for millions of patients in the years to come.

Stop the bleeding

On his first day at the institute, Freireich was assigned to care for children in the leukemia ward — a job no one else wanted.

“Leukemia at that time was a horrible illness — a death sentence,” he says. “Most children lived only eight weeks after being diagnosed. Ninety-nine percent died within a year.”

His first order of business was to halt the nonstop bleeding that is the hallmark of the disease.

“Leukemia prevents blood from clotting,” he explains. “Children bled to death. The leukemia ward looked like a slaughterhouse. Blood covered the pillowcases, the floor, the walls ... it was horrific.”

Early chemotherapy drugs were available, but patients bled to death before they could undergo treatment.

Freireich firmly believed his patients' bleeding was caused by insufficient platelets — tiny blood cells that help the body form blood clots. Recent research revealed that the platelets of World War II atom bomb victims had been wiped out by radiation, and that those victims died from hemorrhaging. The connection was indisputable, Freireich believed. Yet the medical community dismissed his idea.

To prove them wrong, Freireich mixed platelets from his own blood with blood from leukemic children. Without fail, the bleeding stopped.

Further studies confirmed not only that Freireich had been right all along, but also his belief that platelets were useless unless they were obtained from fresh blood.

“Platelets in donated blood last only 48 hours,” he explains. “Because blood bank protocol demanded that the oldest blood be used first, the children all along had been getting blood that was too dated to contain platelets.”

With these discoveries, bleeding as a cause of death was essentially eliminated.

Combo chemo

With the bleeding problem solved, Freireich turned his attention to curing childhood leukemia. Another difficult-to-treat disease, tuberculosis, recently had been cured. He believed the TB treatment approach might work for leukemia as well.

“We knew that three drugs controlled tuberculosis, but you had to administer them all at once. If given separately, they didn't work,” he says. “I had an inkling the same method would work for leukemia.”

So Freireich began combining chemo drugs instead of giving them one at a time.

First he administered two of the highly toxic drugs, then three. With each addition, children became seriously ill, and some were brought to the brink of death. When he upped the ante to four drugs in a 1961 trial, an outcry arose from the medical establishment.

“They said I was unethical and inhumane and would kill the children. Instead, 90 percent of them went into remission immediately. It was magical.”

Once children were in remission, Freireich continued their four-drug regimen for a full year to kill any residual cancer cells. That exact strategy, called early intensification, is still used today, and the cure rate for childhood leukemia is 92%.

Looking ahead

In 1965, Freireich and his NCI friend and colleague Tom Frei, M.D., were recruited by MD Anderson to launch a chemotherapy program. Until then, the cancer center had treated patients with surgery and radiation. The two doctors formed the Department of Developmental Therapeutics and hired brilliant young scientists who developed drug combinations that cured various cancers based on the same methods used to treat childhood leukemia. Today, nearly all successful chemotherapy regimens use this approach of administering multiple drugs simultaneously.

Curing cancer isn't synonymous with eradicating cancer, Emil J Freireich points out.

Our bodies contain 70 trillion cells, and when one of them misbehaves, you can get cancer. With that many cells, he says, mathematically, there's great potential for error.

“Cancer will always be around, but every day we're curing more and more patients who live a long time and do great things after their disease.”



Legendary oncologist Emil J Freireich, M.D.

They want to fill the void left by less federal funding for research

By Allison Schaffer

In today's economy, with government funding for cancer research difficult to come by, private philanthropy is essential.

Realizing this, four MD Anderson Board of Visitors members took matters into their own hands and personally endowed three new faculty research awards. Together, the awards funded by Bill Finneran, Jack Randall, Regina Rogers and Gary Stein will provide millions in support over several years for clinical research.

The Finneran Family Prize in Translational Research

Prostate cancer survivor Bill Finneran recalls the impeccable care he received at MD Anderson 21 years ago.

“The personal care and attention provided by the doctors and staff was phenomenal,” says Finneran, who divides his time between New York and Palm Beach, Florida. “I always found total commitment on every level of patient care, as well as the highest quality of research.”

He established the Finneran Family Prize, a \$50,000 cash award given annually to a deserving faculty member. Christopher Logothetis, M.D., Finneran's physician and chair of Genitourinary Medical Oncology, received the inaugural prize for his leadership and innovation in cancer care, particularly as co-leader of MD Anderson's Prostate Cancer Moon Shot.

He established the Finneran Family Prize, a \$50,000 cash award given annually to a deserving faculty member. Christopher Logothetis, M.D., Finneran's physician and chair of Genitourinary Medical Oncology, received the inaugural prize for his leadership and innovation in cancer care, particularly as co-leader of MD Anderson's Prostate Cancer Moon Shot.

The Jack and Beverly Randall Prize for Excellence in Cancer Research

Jack Randall and his wife, Beverly, know it takes big ideas to get big results, and they established the Jack and Beverly Randall Prize for Excellence in Cancer

Research to encourage innovative ideas and novel thinking among researchers.

“It takes creativity, passion and tenacity to have big breakthroughs,” says Jack Randall. “It's only through original ideas and a willingness to take a chance on the most promising concepts that vision becomes a reality.”

The \$100,000 cash prize is awarded annually and alternates between cancer research and patient care.

“We think it's important to build on MD Anderson's history of achievement by honoring, encouraging and advancing innovation,” says Beverly Randall. “This award is our way of supporting tomorrow's leaders so they have the incentive and resources needed to make this happen.”

Andrew Futreal, Ph.D., chair *ad interim* of Genomic Medicine, is the inaugural recipient. Futreal is recognized for his groundbreaking research in large-scale systematic cancer genomics.

The Shirley Stein Scientific Endowed Research Award

Gary Stein teamed up with longtime family friend Regina Rogers to create the Shirley Stein Scientific Endowed Research Award in honor of his mother and Regina's best friend, the late Shirley Stein.

“Mom was a force of nature,” says Stein. “She felt strongly that MD Anderson is one of Houston's crown jewels and needs to be taken care of. This is one way we can honor her memory.”

Two faculty members will receive a \$12,000 cash award each year to support outstanding clinical research performed with limited project resources.

The inaugural awards went to Alejandro Contreras, M.D., Ph.D., assistant professor of Pathology, and Yun Wu, M.D., Ph.D., associate professor of Pathology. Contreras' research focuses on identifying genetic alterations believed to contribute to aggressive forms of breast cancer. Wu's research focuses on identifying molecular biomarkers for breast cancer prognosis and targeted therapy.

The MD Anderson Cancer Center Board of Visitors is an appointed board of individuals committed to helping MD Anderson achieve its mission of eliminating cancer. Board programs emphasize private fund development, public relations and outreach on behalf of the institution. For a complete list of board members and more Development updates from FY15, see page 52.

The training ground for the next generation of scientists

By Gillian Kruse

It's only been a short time since graduation, and already the first students to earn master's degrees from the School of Health Professions are having a global impact.

When they enrolled in the new MS in Diagnostic Genetics program, the students were drawn to its unique features — access to state-of-the-art labs and classrooms that can only be found within a comprehensive cancer center, and the one-on-one support of a world-class faculty.

“We're one of only four graduate clinical diagnostic molecular science programs in the country recognized by the NAACLS (National Accrediting Agency for Clinical Laboratory Sciences),” points out Peter Hu, Ph.D., associate professor in the School of Health Professions and director of the new program.

The three members of that first graduating class are taking what they learned about clinical molecular diagnostics such as genetic disorder testing, cancer genetics testing and bioinformatics around the globe. One has returned home to the Bahamas, one has gone to a cytogenetics lab in Peoria, Illinois, and one has taken a research role at Baylor College of Medicine.

Information gained from molecular testing helps MD Anderson's physicians move closer to the goal of precision medicine tailored for each patient by providing the data needed to analyze each patient's genome. Graduates are able to provide good laboratory results efficiently, and are armed with the skills and knowledge to create new, more accurate testing procedures as needs arise.

A new degree

The students spend two years in a program that combines diagnostic genetics theory with hands-on practice in clinical rotations. They also participate in research aimed at making advances in

diagnostic genetics while learning about the world of academic medicine. (One of the students' final research projects is being submitted for publication in a leading journal.)

After graduation

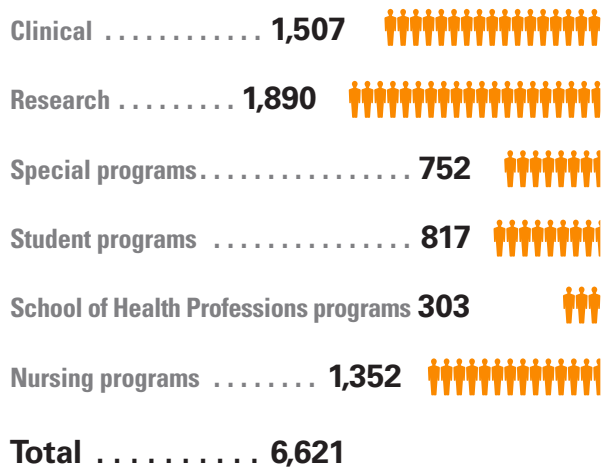
After receiving their diplomas, all graduates are eligible to take board exams in either molecular biology or cytogenetics — or in some cases, both — to become certified in one or both fields by the American Society of Clinical Pathology. Certification is required to work in a clinical diagnostic setting. Graduates' clinical and research training prepares them for a number of career options, and their rotations through many collaborative clinical partners — including UTMB Galveston, Baylor College of Medicine and Texas Children's Hospital — give them experience outside the world of cancer.

Looking to the future

The program is growing fast as word spreads about the unique opportunities students are offered in the cytogenetics and molecular genetics specializations within the master's degree. The second graduating class has seven members, and nine new students joined the program in the fall of 2015.

“As one of very few institutions that offer this program at both the undergraduate and graduate level, we're uniquely positioned to help guide the next generation of scientists through the study and creation of genetic testing,” notes Hu. “This field is quickly evolving and the clinical diagnostic information gained from genomics is becoming entwined with quality cancer care.”

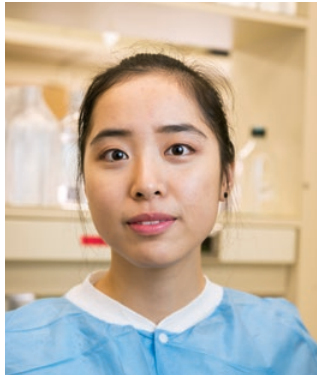
EDUCATIONAL TRAINEES



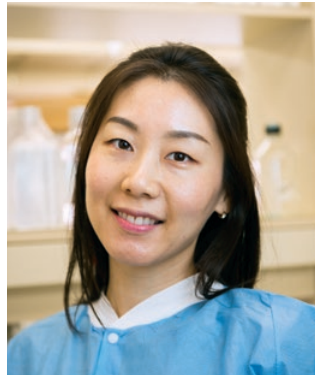
TOP FIVE SOURCES OF ROTATING TRAINEES

- **UT Health Science Center at Houston 56%**
- **Baylor College of Medicine 27%**
- **UT Medical Branch at Galveston 5%**
- **Methodist Hospital 2%**
- **San Antonio Uniformed Services Health Education Consortium 1%**





Xiqi Li (first-year student)



Adriel Kim (first year)



Ana Bolivar (first year)

SCHOOL OF HEALTH PROFESSIONS

Bachelor of Science degrees awarded 144

Diagnostic Imaging 29

Molecular Genetic Technology 27

Radiation Therapy 20

Medical Dosimetry 16

Clinical Laboratory Sciences 15

Cytogenetic Technology 15

Master of Science in Diagnostic Genetics 3

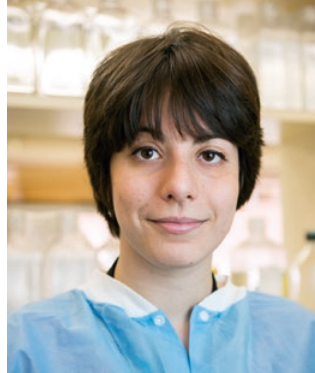
Histotechnology 14

Diagnostic Medical Sonography 7

Cytotechnology 1

Master of Science degrees awarded

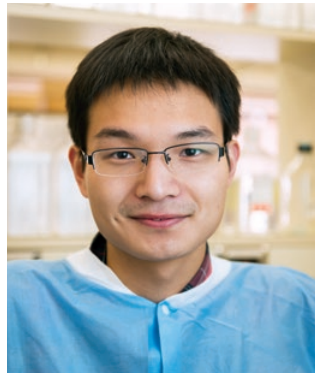
Diagnostic Genetics 3



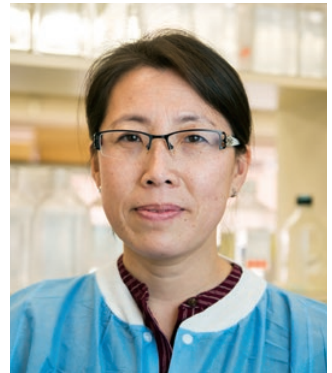
Varduhi Petrosyan (second year)



Vahid Bahrambeigi (first year)



Haowei Du (first year)



Xuemei Shi (first year)

POSTDOCTORAL FELLOWS

- China **31%**
- United States **16%**
- India **10%**
- South Korea **8%**
- Japan **4%**



TOP FIVE COUNTRIES OF ORIGIN

Clinical residents and fellows

- United States **70%**
- Canada **4%**
- South Korea **3%**
- China **3%**
- India and Lebanon **2%**



Bottom line: Converting discoveries into new treatments at a faster rate

By Scott Merville

When a clinical trial for a new breast cancer drug launched recently, researchers estimated it would take at least two years to enroll the 20 patients needed to make the trial a success. However, within four months, half the patients had already enrolled — and the drug worked for all 10.

“That’s the power of the Moon Shots Program,” says Jennifer Litton, M.D., associate professor of Breast Medical Oncology and the trial’s principal investigator.

Accelerating the conversion of scientific knowledge into new treatments for patients is a priority of the program.

“What moon shots has done for my patients is cut the time it takes to go from a clinical trial idea to the time a person gets a new drug down from

three years to about one. That’s huge,” says Litton, an experienced leader of clinical trials.

The drug, called talozoparib, is currently being tested in late-stage breast cancer patients who have BRCA1 and 2 gene mutations and whose disease has spread.

Those who test positive for BRCA mutations have a significantly higher risk of developing breast and ovarian cancers, as well as passing on the mutation to future generations.

Owned by Medivation Inc., talozoparib is what is known as a PARP inhibitor. PARP — short for Poly (ADP-ribose) polymerase — is an enzyme that helps repair damaged DNA. In cancer treatment, blocking PARP may prevent such repairs, causing the cells to die.

Litton’s trial uses a new targeted therapy for two months before proceeding to standard of care chemotherapy followed by surgery. The trial and accompanying moon shot studies will provide a detailed view of talozoparib in first-line use.

“In this and other studies, we’ve found that when companies know we have the moon shot behind us, we’ve been given access to drugs they won’t give to anyone else for investigator-initiated trials because we can promise them the trial will happen,” Litton says.

Not only does the moon shot provide funding for the study, it supplies a deep roster of scientists drawing on expertise from across the institution to provide the pharmaceutical corporation an unprecedented opportunity to learn about its drug.

“It’s low risk for them. And on top of that, they’re getting correlative study information they can’t get from other places now.”

The previously untreated patients enrolled in Litton’s trial have biopsies done before and after treatment. Moon shot co-leader Gordon Mills, M.D., Ph.D., chair of Systems Biology, will oversee genetic and molecular analysis of the tumors both before and after. Provost Helen Piwnicka-Worms, M.D., Ph.D., will cultivate grafts of the human tumors in mouse models to further understand the mechanisms of the disease and drug.



**Associate professor of Breast Medical Oncology
Jennifer Litton, M.D.**



The lab space design of the Sheikh Ahmed Bin Zayed Al Nahyan Center for Pancreatic Cancer Research is energizing researchers and leading to the creation of meaningful science, according to the center's director, Anirban Maitra and its director of Research Planning and Development, Bettina Marble.

Leading edge labs foster collaboration and ingenuity as research silos are torn down

By Andy Olin

In 2011, MD Anderson received a \$150 million gift — the largest in its history — from the Khalifa Bin Zayed Al Nahyan Foundation for the construction of the Sheikh Zayed Bin Sultan Al Nahyan Building for Personalized Cancer Care.

The 12-floor, 615,000-square-foot facility is the home of the Sheikh Ahmed Bin Zayed Al Nahyan Center for Pancreatic Cancer Research, which puts investigators with shared research vision into the same space to foster collaboration and encourage a cross-pollination of ideas.

“Our only goal is to do meaningful translational research in one disease — pancreatic cancer,” says Anirban Maitra, M.B.B.S., professor of Pathology and director of the center.

But traditional labs, which are built with walls, can be a hindrance to multidisciplinary problematic research. Literal walls become figurative walls that stifle collaboration, communication and creativity.

“No one lab can do everything or house the expertise required for this type of research,” Maitra explains. “In the pancreas center, because we have investigators with such diverse interests, we’re able to take on these multidisciplinary research initiatives where, for example, there’s a team that includes experts in imaging, metabolism and mouse models. Bringing these experts together in one space would not be possible in many research facilities.”

This is resulting in the creation of meaningful science and energizing researchers, which perpetuates the process. In the past two years, the footprint of the center has made a significant impact in terms of the big ideas and big grants being generated.

“I’ve seen the number of collaborations grow exponentially,” says Bettina Marble, director of Research Planning and Development for the center. “The excitement has grown and everyone is more engaged. There’s more buzz and unity.”

One such big idea is the development of a liquid biopsy that could be used to determine prognosis, guide targeted therapy and monitor treatment of pancreatic cancer.

Maitra’s research team found that pancreatic cancer tumors shed their complete DNA and RNA — wrapped inside protective lipid particles — into the bloodstream, essentially spilling their molecular secrets. This makes the tumors ripe for analysis with a noninvasive blood test.

The open-concept labs of the Sheikh Ahmed Bin Zayed Al Nahyan Center for Pancreatic Cancer Research place investigators from different specialties in the same space to promote collaboration, communication and creativity. The center’s director, Anirban Maitra, and its director of Research Planning and Development, Bettina Marble, say the layout of the facility is translating into excitement among MD Anderson scientists.

Prevention

Teresa Hall, 35

Colorectal cancer survivor

Teresa Hall has a family history of colorectal cancer, and at age 32, she learned she had the disease. Genetic testing at MD Anderson revealed she had a hereditary cancer syndrome known as familial adenomatous polyposis (FAP), which greatly increases the risk of the cancer. In fact, without treatment, people with FAP have a 100% chance of developing cancer. Because of the testing, Hall has been able to inform her family about their inherited genetic risk. In turn, they can get tested for FAP and, hopefully, catch any polyps before they become malignant and spread.

Through the Colorectal Cancer Moon Shot, there is new focus being placed on improving early detection and prevention of the disease, as well as the development of personalized treatment with immunotherapies before surgery.

MD Anderson researchers also are working to classify colorectal cancers by subtype based on integrated molecular and genomic analysis to improve targeted therapy.

Read more about Teresa Hall's cancer experience on Page 35.

MD Anderson is devoted to preventing cancer before it takes hold. The institution's unique cancer prevention and control platform focuses on policy, education and services designed to promote a healthy society. In Texas, it has made great strides in calling attention to the need for regulations on e-cigarettes and tanning beds, and promoting the importance of the human papillomavirus (HPV) vaccine. Each year, an estimated 17,500 women and 9,300 men develop a cancer caused by HPV, the most common sexually transmitted infection in the United States. Other efforts extend cervical cancer screening to women in medically underserved communities and develop HPV-related cancer screening for men.



Prevention and early detection



Patient Teresa Hall and her daughter

Outsmarting cancer with genetic testing

By Clayton Boldt, Ph.D.

Teresa Hall's visit to a gastroenterologist three years ago wasn't the first time she'd sought help for troubling symptoms.

Over the span of a decade, she'd consulted three other doctors, and all had diagnosed her with irritable bowel syndrome. But the gastroenterologist told her otherwise.

At age 32, Hall learned her colon and rectum were riddled with polyps. Two were cancerous.

"All three of those doctors missed it. They never once said, 'You know, maybe we need to do a colonoscopy on this girl,'" says Hall, despite the fact she shared her alarming family history with each doctor.

She told them about how her father's colon and rectum were removed when he was 36 because of thousands of pre-cancerous polyps.

"If I'd had a colonoscopy, my cancer would've been caught very early. It probably wouldn't even have been cancer at that point."

Like her father, Hall had her entire colon and rectum removed, and she underwent chemotherapy. When doctors discovered the cancer had spread to her liver and lungs, she sought help from MD Anderson. After more rounds of chemo and several surgeries, she's hanging tough.

Because of her young age and family history, Hall underwent genetic testing at MD Anderson. The test revealed she had a hereditary cancer syndrome known as familial adenomatous polyposis (FAP).

The lifetime risk of colorectal cancer for most people is 5%. For those with hereditary syndromes such as FAP or Lynch syndrome, it's much higher. Lynch syndrome carries a lifetime cancer risk of 50 to 80%, and those with FAP have a 100% chance of developing cancer without treatment.

Although only about 5% of colorectal cancer is caused by hereditary syndromes, the incidence tends to be higher in those diagnosed at a younger age. To learn more about hereditary syndromes in adolescents and young adults, MD Anderson researchers studied nearly 200 colorectal cancer patients diagnosed at age 35 or younger. All were evaluated by the institution's genetic counselors.

The study found that one-third of patients diagnosed before age 35 had hereditary-associated cancer.

"Based on our findings, patients younger than 35 must be evaluated by a genetic counselor," says Eduardo Vilar-Sanchez, M.D., Ph.D., the study's principal investigator. "They're encouraged to share their genetic risk with their parents, siblings and other relatives, who can also get tested."

Testing can identify relatives with high-risk mutations and allow them to take preventive measures, such as earlier screenings, explains Vilar-Sanchez, an assistant professor of Clinical Cancer Prevention.

Other than her father, Hall's family history contains no colorectal conditions of any kind. However, her family members are now being tested.

Hall's son doesn't appear to have the mutation, and her daughter is still too young for testing. Her sister and nephew, however, both carry the harmful FAP mutation. Hall's sister had her colon and rectum removed to reduce her cancer risk. Hall's nephew is watched closely and may enter clinical trials when he's old enough.

"My advice is, if you have symptoms, be an advocate for yourself, regardless of how embarrassing it can be," says Hall. "Get a colonoscopy. If one doctor won't do it, find another doctor. Getting tested saves lives. It really does."

If you think you might be at risk for an inherited cancer, it's a good idea to meet with a genetics counselor. They will review your family medical history, talk to you about the role of genetics in cancer and perform a hereditary cancer risk assessment.

Based on your results, the counselor may recommend genetic testing, which simply involves having a blood sample drawn. The findings may help determine if members of your family face higher risks for certain types of cancer.

Are you at high risk for pancreatic cancer?

By Scott Merville

A new clinic to identify and monitor those at high risk for developing pancreatic cancer continues to expand after opening last year.

The clinic's goal is to find ways to detect the disease early, when a cure may be possible, says its director, Florencia McAllister, M.D., assistant professor of Clinical Cancer Prevention.

"Due to the location of the pancreas, early tumors can't be seen or felt by health care providers during routine physical exams," McAllister says. "Patients are usually diagnosed when the cancer cannot be surgically removed."

Who's at risk?

Pancreatic cancer risk is higher in those whose parents, siblings or children developed the disease, particularly at a young age, and in those who have any of 10 genetic mutations, including a mutation in the BRCA2 gene, better known for raising breast cancer risk.



**Assistant professor of Clinical Cancer Prevention
Florencia McAllister, M.D.**

Family history coupled with genetic mutations place a person in the high-risk category. Some genetic mutations alone place a person at an increased risk, even without a family history of pancreatic cancer. One example is a mutation in the STK11 gene, which can be found in people with Peutz-Jeghers Syndrome. The syndrome causes noncancerous growths in the gastrointestinal tract and puts people at a greatly increased risk of developing certain types of cancer, including cancer of the gastrointestinal tract, pancreas, cervix, ovaries and breast.

Other factors such as chronic inherited inflammation of the pancreas, called pancreatitis, are powerful and well-known risk indicators.

At MD Anderson's high-risk clinic, patients are tested for a blood biomarker called CA-19-9, which can indicate cancer but also is prone to false positives. Magnetic resonance imaging and endoscopic ultrasound examinations follow, McAllister says.

Clinic participants are relatives of MD Anderson patients, referrals from other clinics, such as breast, or self-referrals — usually relatives of cancer patients.

Recent studies have found that about 1% of adult patients diagnosed with new-onset diabetes will also be diagnosed with pancreatic cancer within three years of the date of their diabetes diagnosis. The high-risk screening clinic will be expanding to screen new-onset diabetic patients during this three-year window.

Novel screening tests

To date, no screening test has been conclusively shown to lower the risk of dying from pancreatic cancer, and only about 6% of patients are alive five years after diagnosis.

Funded by the Pancreatic Cancer Moon Shot, researchers are working to change that by creating a blood test that signals the presence of cancer. When developed, the test will detect cells that are shed from tumors or other substances that are produced in response to tumors.

They're also investigating new imaging techniques to detect precancerous pancreatic lesions called PanINs (pancreatic intraepithelial neoplasias), early precursors of pancreatic cancer.

"They are unlike precancerous lesions for melanoma or polyps for colon cancer, which can be easily observed," McAllister notes. "PanINs are microscopic lesions that can't be seen by MRI."

We're creating partnerships to detect a deadly cancer earlier

By Ron Gilmore

Building on MD Anderson research, a new company named Codiak Biosciences has formed to create therapeutic and diagnostic products using exosomes — small parts of cells that break away and float around the body.

Long thought to be a kind of trash collection bin for cells, it turns out exosomes are instead one of the main ways cells communicate with each other.

“This makes them medically useful in a number of ways,” says Raghu Kalluri, Ph.D., chair of Cancer Biology at MD Anderson.

Kalluri has found that exosomes from healthy cells can be used to safely deliver drugs to penetrate tumor cells. Building on his discovery, Codiak plans to develop a drug to treat pancreatic cancer, using exosomes as a delivery vehicle.

“This cellular-to-cellular-transfer of drugs is a potent and safe delivery system for a number of therapeutic purposes,” Kalluri says.

He's also discovered a potential method for detecting pancreatic cancer sooner. The secret lies in fragments of DNA, RNA and proteins inside and on the surface of exosomes that are specific to cancer cells. Kalluri discovered one particular protein that has been found to detect pancreatic cancer with 100% accuracy.

Codiak plans to use this protein to develop a diagnostic test that can identify pancreatic cancer in its early stages when it's still treatable. The disease typically is detected so late that only 6% of patients survive five years after diagnosis.

“It's a feather in our cap and a real turning point for MD Anderson's growing collaboration with private industry,” says Ferran Prat, Ph.D., J.D., vice president for Strategic Industry Ventures. “Our ultimate goal is to bring innovative diagnostic and therapeutic solutions to our patients. The ability to add to our arsenal of cancer-fighting tools is greatly enhanced by ventures like Codiak.”

At MD Anderson, an office to attract, maintain and grow collaborations between the institution and bioscience and pharmaceutical companies was created in 2013.

Strategic Industry Ventures, headed by Ferran Prat, Ph.D., J.D., works with outside companies to look for potential partners that will help advance new biomedical discoveries. Their goal? Get treatments to patients faster.



Researchers in Raghu Kalluri's lab are working on a way to detect pancreatic cancer at an early stage, before it spreads to other organs and becomes too difficult to treat.

Let's protect ourselves against HPV-related cancers with the 'cancer vaccine'

By Laura Sussman

Kathleen Schmeler, M.D., vividly remembers the day a chance encounter on a flight to Amsterdam changed her life.

"The man sitting next to me happened to be reading the same novel I was, so we struck up a conversation," says Schmeler, who at the time was a mechanical engineer with Procter & Gamble. "As it turned out, he was a colon cancer researcher and doctor in the Netherlands."

Schmeler, who had always harbored an interest in medicine, chatted with her seatmate for six hours. The conversation led to a job offer.

"When we landed," she says, "I called my parents to let them know I was quitting my job and moving to Amsterdam to work for a scientist doing cancer research."

Twenty years later, Schmeler is an associate professor of Gynecologic Oncology and Reproductive Medicine and an impassioned advocate for women's health. She's on a mission to educate women — and men — about a vaccine that blocks transmission of the human papillomavirus (HPV), which causes 99% of cervical cancer. The virus also is linked to cancers affecting the middle throat and genital areas.

The HPV vaccine was approved by the Food and Drug Administration in 2006, and has the power to prevent all of these.

To the disappointment of Schmeler and others in health care, it's been slow to gain wide acceptance.

"It's disheartening," Schmeler says. "We have to do a better job of getting it out there. It's been slow, but we're making strides."

The Cancer Prevention Research Institute of Texas (CPRIT) awarded MD Anderson a \$1.4 million grant to increase cervical cancer screenings

and preventive treatments for underserved women along the Texas-Mexico border. CPRIT provides state funding for cancer research, prevention and product development programs. MD Anderson's efforts target Cameron, Hidalgo, Willacy, and Starr counties, where the cervical cancer rate is 30% higher than anywhere else in the state, and 70% of the population is uninsured.

Last year, MD Anderson expanded its ambitious Moon Shots Program to include HPV-related cancers. Co-led by Schmeler, the moon shot's goals include improving access and vaccination rates, developing HPV-related cancer screenings for men, developing targeted drugs that attack HPV-related cancers directly, and developing immunotherapies that rally the immune system to fight the virus.

"The moon shot has spurred us to organize our efforts and move our work benefiting patients to the next level. It's not acceptable to make small, incremental improvements," Schmeler says. "We must do something big and innovative on their behalf."

Cervical cancer is the 14th most common cancer in the United States. Yet in Latin America, Africa and the Caribbean, it's one of the leading causes of cancer deaths in women.

To bridge this gap, Kathleen Schmeler and colleagues run the Central America Oncology Education Program, or CONEP. The program brings gynecologists from MD Anderson and other institutions to Guatemala, Honduras, El Salvador, Costa Rica and Panama, where they make patient rounds and train local doctors. Since CONEP's inception in 2009, more than 100 Central American medical residents and faculty have participated in each of the visits. The program recently expanded to Mozambique in Southeast Africa.



Associate professor of Gynecologic Oncology and Reproductive Medicine Kathleen Schmeler

Breast cancer screening guidelines aren't a one-size-fits-all solution

By Clayton Boldt, Ph.D.

It's clear that breast cancer screenings save lives. But exactly when women at average risk of developing breast cancer should begin screening is much less clear.

Leading medical groups have conflicting guidelines. The American College of Obstetricians and Gynecologists (ACOG) and the National Comprehensive Cancer Network (NCCN) say starting at 40 is best. The U.S. Preventive Services Task Force (USPSTF) says women can wait until 50. And in October, the American Cancer Society (ACS) added to the confusion by revising its guidelines. For years, the ACS recommended women start mammograms at age 40, but the ACS now recommends starting at age 45, or at 40 if the patient chooses. The groups also vary on how often mammograms should be done. ACOG says annually, USPSTF says every two years, and the most recent ACS guidelines suggest getting annual mammograms between ages 45 and 54; after that, they say every two years is OK.

"My concern is that there is a lack of clear direction for woman and their doctors to best protect their health," says Therese Bevers, M.D., medical director of MD Anderson's Cancer Prevention Center.

To clarify the issue, Bevers urges a closer look at the new ACS guidelines. Although they recommend annual mammograms starting at 45, the guidelines suggest women should still have the opportunity to begin at 40.

"The guidelines still affirm the importance of annual screening for women in their forties and continuing for as long as they are in relatively good health," says Bevers.

Additionally, the ACS now recommends against clinical breast exams for women. Given a lack of new data supporting this change, Bevers feels it's premature to recommend against this important clinical practice.

"Annual clinical breast exams are a chance for women to meet with their doctors to discuss screening, risk and healthy lifestyles to reduce their breast cancer risk."

In line with the ACOG and the NCCN guidelines, MD Anderson continues to recommend annual screening and clinical breast exams beginning at 40.

"Our mission is to save lives, and data has shown this approach to be the best way to do that," says Bevers.

Screening for women at elevated risk

The above recommendations, however, apply only to women at average risk of breast cancer — not to those at elevated risk.

"There are many factors that may increase a woman's risk, including family history, hereditary cancer syndromes, previous cancers, age when first giving birth and age at first menstrual cycle," says Jennifer Litton, M.D., associate professor of Breast Medical Oncology.

Unfortunately, for those at high risk, there's no single answer for screening.

"Screening recommendations for women at increased risk depends on why they are at increased risk," explains Litton.

Depending on the situation, it may be appropriate to get screened earlier, more often or in different ways. Women should talk to their doctor to determine their risk, as well as individualized recommendations for screening or risk reduction. Risk assessment tools also are available from MD Anderson and the ACS.



Michelle Baumann

Baumann asked to get her first mammogram before she was 40 because her grandmother had breast cancer. As the mother of two young boys, she wanted to start her annual screenings early.

Her doctor agreed and nine months before her 40th birthday she was diagnosed with Stage 1 breast cancer. Because her cancer was caught early, Baumann's treatment consisted of a bilateral mastectomy and reconstruction.

"The thought of waiting until 45 for screening is scary," says the elementary school principal. "I would've been six years into my cancer by that point. You have to trust your gut, advocate for yourself and become a part of the process."



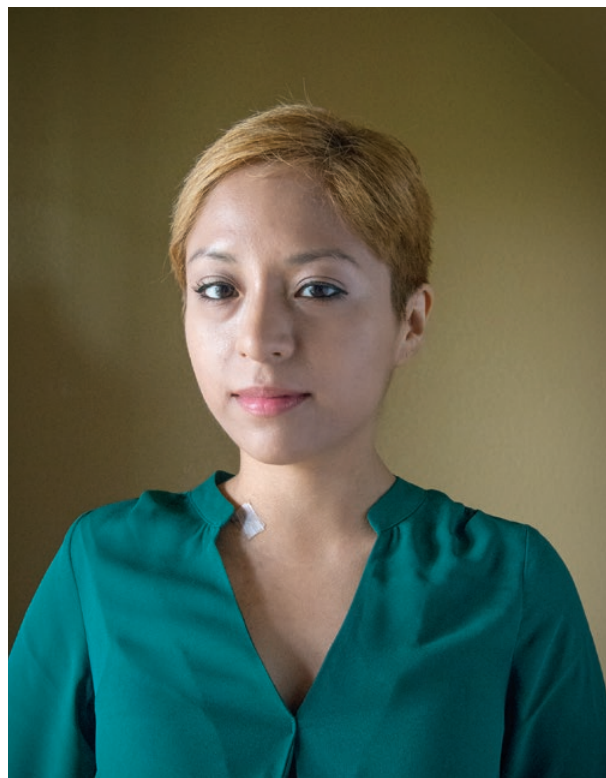
Nancy Lombard

Lombard is an advocate for early detection. She began having her annual mammograms at age 40. Three decades later, when she was 70, she decided to have a 3D mammogram for the first time. With this technology, doctors caught a Stage 1 cancer in her left breast, one that a standard mammogram would have missed.

Following her surgery, a CT scan revealed a small tumor in her lung that required a lobectomy. By catching both cancers early, Lombard successfully overcame breast and lung cancer in just a year.

With no family history of cancer she could have elected less-frequent screening, but she believes it's important to be vigilant. Lombard says she'll be sure to emphasize the importance of yearly mammograms to her two daughters and four granddaughters.

"I think screening is very important," she says. "Based on my experience, why take the chance? If these cancers hadn't been caught early, they would probably have already spread to other parts of my body."



Roxana Lopez

Lopez, an aspiring nurse, was diagnosed with Stage 2 breast cancer during a clinical breast exam when she was 25, two decades younger than the ACS' recommended screening start date for women at average risk of cancer. But Lopez wasn't average. After genetic testing confirmed she carried a BRCA1 mutation, she urged her twin sister, Ana, and two brothers to get tested. Turns out all three also have the mutation that increases the risk of breast and ovarian cancers in women. That wasn't entirely a surprise; their mother was diagnosed with breast cancer at 47, and died four years later.

After completing chemotherapy, Lopez will undergo a double mastectomy to reduce the risk of recurrence. Her sister is also having a preventive double mastectomy to reduce her risk of developing breast cancer.

"I still have a goal of going to nursing school. I look forward to getting all my treatments done and getting better, and then being able to move on with my life."

The Year of the Dragon

More than 1,300 patients, family members and staff worked for five months with artist Ian Cion to bring Okoa the Wave Rider to life. An open art studio was sent up in The Park area of MD Anderson's Albert B. and Margaret M. Alkek Hospital where visitors were invited to draw on paper dragon scales, create watercolor paintings that were used to represent waves, and make and paint paper flowers.

A contest was held to name the sculpture, which stretches 21 feet and stands 9 feet tall, and Okoa — a Swahili word that means rescue, save, redeem or deliver — was selected.

Created in 2010, The Arts in Medicine Program creates art with patients and their families in both one-on-one sessions and in art groups. Pediatric patients and their families are invited to work with the program while in treatment during both inpatient stays and outpatient visits.



Leaders prepare and plan today to prevent disease tomorrow

By Clayton Boldt, Ph.D.

Working on his family's farm as a boy in Puerto Rico, Joxel Garcia learned the importance of planning ahead to prevent hardships.

"We had to be ready for a drought or a flood, because both made our cows' milk production decrease," he says. Either could spell disaster for the family, so Garcia learned to prepare and guard against the worst.

Those lessons learned years ago still apply today in Garcia's career as a medical leader focused on disease prevention. He joined MD Anderson in August to further the institution's cancer prevention efforts.

"While efforts to develop new cancer treatments and therapies are important, it's preferable to prevent the disease in the first place," says Garcia, a medical doctor and executive director of MD Anderson's cancer prevention and control platform, which promotes community programs to prevent cancer, particularly among the poor and underserved.

Ernest Hawk, M.D., vice president and head of Cancer Prevention and Population Sciences, and Mark Moreno, vice president for Governmental Relations, led the platform's early efforts, which have achieved a number of successes.

MD Anderson's tobacco-free hiring policy is a direct result of the platform's EndTobacco program.

Platform experts have advised Texas legislators on various public health measures, including laws to restrict minors' access to indoor tanning devices and electronic cigarettes.

MD Anderson is lending its expertise to the Coordinated Approach to Child Health (CATCH) program, school-based lessons that help students and their parents adopt healthy lifestyle choices through nutrition and exercise. With MD Anderson's participation, the program now includes sun safety lessons to prevent skin cancer. CATCH has been introduced in 10,000 schools, preschools and after-school programs throughout the nation.

Project ECHO (Extension for Community Healthcare Outcomes) uses a Skype-like video conferencing program to connect MD Anderson experts with health care providers in underserved areas, teaching them how to screen for and treat cervical cancer.

Garcia, who formerly served as U.S. Assistant Secretary for Health, U.S. Representative to the World Health Organization and a four-star Admiral for the U.S. Public Health Service, says the platform prioritizes those Moon Shots Program targets that'll be most influenced by prevention and cancer control, including lung, melanoma and human papillomavirus (HPV)-related cancers.

"We'll increase genetic counseling and testing for patients with increased cancer risks, such as those with BRCA1 and 2 mutations; we'll increase screenings and identify biomarkers for the early detec-

tion of lung cancer; and we'll work with health departments and legislators around the nation to advocate for the HPV vaccine and for restricting tanning bed and electronic cigarette use by minors," Garcia says.

He intends to use big data to develop more personalized risk assessments and targeted interventions.

The platform is not meant to remain local, but to be shared with leadership at local, state, federal and international entities, he explains.

"Houston is our base, our home, and we want it to be as healthy as possible, but we have a global responsibility as well."



Executive director of MD Anderson's cancer prevention and control platform Joxel Garcia, M.D.

Spreading the word

What would you say to cancer?

By Andy Olin

In 2015, MD Anderson launched its “Confronting Cancer” campaign, which gave patients, caregivers, supporters, physicians and researchers the opportunity to confront the disease directly.

What did they say?

Physician and researcher Sapna Patel, M.D., warned, “My team will get you, cancer.”

Survivor Gail Morse told the disease it didn’t get the best of her: “You made me stronger, cancer.”

“No more hiding, cancer,” cautioned researcher Michael Curran, Ph.D.

And Board of Visitors member Tom Rushing split no hairs in his prediction: “MD Anderson will destroy you, cancer.”

The campaign, which included online, mobile, television, print and radio placements, began in Houston in July before going national in August.

“This campaign has caught the public’s attention and inspired even greater confidence in us,” MD Anderson President Ronald DePinho said during his state of the institution address in October. “They are the heroes on the front lines of our fight, and their real thoughts and emotions drive the campaign. The approach is bold, emotional and engaging.”

The goal of the effort is to raise national awareness of the institution, and by all measures, it succeeded. In 2010, MD Anderson had only 6% awareness nationally. Today, with the new campaign, that awareness has seen a boost to 13% in the final quarter of last year — a significant milestone for the MD Anderson brand.

The campaign has also increased philanthropic efforts, attracting additional support for the institution’s mission to end cancer.

MD Anderson is confronting cancer by investing in and collaborating with local community organizations to support cancer patients and survivors, as well as educating people about ways to reduce their cancer risk by making healthy choices.

In FY15, those investments and collaborations included:

- **Working with 409 local schools, churches, employers and community organizations.**
- **Participating in 1,128 programs and events to support local community fundraising and education efforts.**
- **Implementing 176 education programs targeted specifically for Hispanics, Asians and African Americans in Houston and the surrounding area to educate them on the importance of cancer screening exams and ways they can improve their health to lower their risk of cancer.**



Michael Curran, Ph. D.



Gail Morse



Tom Rushing



Sapna Patel, M.D.

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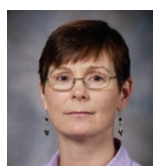
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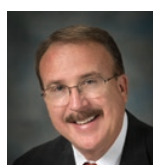
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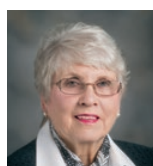
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In January, Omar Abou-Sayed and Mecklin Ragan presented a \$367,000 gift from Triumph Over Kid Cancer Foundation to Valerae Lewis, M.D., chair of Orthopedic Oncology, to help fund MD Anderson's Pediatric Genome Research and Sequencing Project. Ragan and her brother, James, created the foundation in 2010 to raise money for, and awareness of, pediatric cancers. James, an outspoken advocate for pediatric cancer patients, was diagnosed with osteosarcoma in 2007. He passed away in 2014.

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Texas 4000 riders made a stop at MD Anderson Children's Cancer Hospital on their 70-day, more than 4000-mile bike ride from Austin, Texas, to Anchorage, Alaska. The group of students from The University of Texas at Austin played games, created pottery and made art with patients and their siblings. Since 2007, Texas 4000 has contributed \$1.52 million to MD Anderson's research and patient care programs. This June, the group presented MD Anderson with \$130,000 and Houston mayor Annise Parker declared June 3, 2015, to be "Texas 4000 Day."

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Patrick Zweidler-McKay, M.D., Ph.D., and graduate research assistant Marisa Hornbaker participated in a handprint ceremony to celebrate Childhood Cancer Awareness month in September. Zweidler-McKay, who is section chief of Pediatric Leukemia and Lymphoma, received a \$250,000 research grant from Hyundai Hope on Wheels, a nonprofit that raises awareness of childhood cancer and donates funds to support research.

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 Ms. Patricia S. Lyle
 Mr. and Mrs. Jeffrey L. Lyman
 Estate of Rachel Lyman
 Lymphoma Research Foundation
 LyondellBasell Industries
 Mr. Allan R. Lyons
 Lytle Arche Ranching, LLC

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 March of Dimes Foundation
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Monroe Dunaway Anderson Society

New members, Sept. 1, 2014-Aug. 31, 2015

Established in 1995, the Monroe Dunaway Anderson Society recognizes individuals and families who have selected the programs at MD Anderson to benefit from a planned gift such as a bequest, life insurance policy or other similar vehicle. Listed here are new members of the society who recently named the institution in their estate plans.

Dr. Madeleine Alcover	Ms. Deanna B. Ingram
Mrs. Renza Moscatelli Baker	Mr. Jerald D. Johnston
Dr. James R. Ballinger	Mr. David Jones
Mr. Darrell W. Barrett	Mr. Johnathan Martin Juricek
Mr. Hugh C. Berry, Jr.	Ms. Mary B. Kite
Mrs. Raymona B. Bomar	Mr. Robert L. Knauss
Mr. John Brandt	Mrs. Lucille Larsen
Mr. and Mrs. Joel Brochstein	Mr. Bruce E. Latimer
Ms. Roberta Bunch	Dr. Frederic G. Lauder
Mr. Jerry J. Burgdoerfer, Jr.	Mrs. Mary Ann Way Lauder
Ms. Hutis O. Carlson	Mr. Richard Lenzner
Mr. John B. Crangle	Dr. Mary Ruth Lewis
Mr. Hall J. Debusk	Ms. Lois F. Lunin
Mr. Jeff Drabing	Mr. Andrew MacKechnie
Mr. Jon A. Ferris	Dr. John Richard Martin
Ms. Karen L. Getty	Mr. Stuart (Deceased) and Mrs. Flora Mason
Mrs. Susan Hill	Mr. Charles R. McClure

Mrs. Laura McNemar
Ms. Sandra Mobly
Mrs. Page Davis Parker
Mr. Steve G. Rapfogel
Mrs. Beverly B. Rodriguez
Mr. John Rodriguez
Ms. Dianna Archer Semon
Mrs. Rose A. Sinkin
Mrs. Jessamine Slataper
Dr. Margaret P. Sullivan
Mr. and Mrs. Kenneth J. Valach
Ms. Jamie L. Villegas
Mr. Winfred D. Weldon
Ms. Joan S. Werner
Mrs. Bette C. Whitlow
Mr. and Mrs. Jack Zbar

Estate of Betty B. Marcus
 Ms. Nancy W. Marcus
 Mr. Steve J. Marcus
 Mr. Edward Mardigian
 Mr. and Mrs. Joe A. Marek
 Ms. Violet R. Margly
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 Estate of Josephine Williams Martin
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 Ms. Patricia Martinez
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 Maurices
 Mr. Richard Mauro
 Mr. and Mrs. Ronny Maxey
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 Ms. Marjorie Jean Meyer and Mr. Allan Brian Korsakov



Through the Ivy Foundation, Catherine Ivy is helping fund the fight against glioblastoma, the deadly brain cancer that took her husband, Ben. The foundation has invested more than \$60 million in brain cancer research in the past 10 years, including \$2 million for research led by Amy Heimberger, M.D., professor of Neurosurgery.

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 Ms. Victoria L. Meyer
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Since its inception in 1989, The Anderson Assembly has recognized those whose support and financial contributions have enabled MD Anderson's continued growth and progress. Listed here are members who have committed \$1 million or more through cash gifts, documented cash pledges, irrevocable planned gifts and/or charitable remainder trusts to support MD Anderson programs.

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Rosemary Herron is a 14-year breast cancer survivor and longtime Pink Ribbon Volunteer at MD Anderson's Nellie B. Connally Breast Center. She also volunteers at MD Anderson in Sugar Land. Rosemary and her husband, Don, recently contributed \$25,000 to support a HER2 vaccine research program, Injecting Hope. The program is led by Elizabeth Mittendorf, M.D., Ph.D., associate professor of Breast Surgical Oncology.

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 Ms. Sara Stumberg Walker
 Mr. and Mrs. Steven Walker
 Mr. William Walker
 Mr. Donald E. Wall
 Mr. and Mrs. Ken Wall
 Ms. Anne Marie Wallace
 Mr. H. Dalton Wallace
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 Wallgren Environmental Services, Inc.
 Mr. Harold H. Walling
 Mr. and Mrs. Christopher Wallis
 Wal-Mart / Sam's Club Foundation
 Walmart Stores, Inc.
 Mr. and Mrs. Dale M. Walsh



Robert Earl Keen provided the entertainment as more than 1,000 MD Anderson supporters raised over \$305,000 to fund the fight against cancer at the 29th annual Polo on the Prairie in Albany, Texas. Effects of the severe drought ruled out polo play, but that didn't deter hosts Henry Musselman and his wife, Melinda, who dubbed the event "Party" on the Prairie.

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 Mrs. Mary Kathleen Walt
 Ms. Elisse Barbara Walter and Mr. Ronald
 Alan Stern

Jean and Tom Walter
 Mr. and Mrs. Joseph C. Walter III
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 Lorraine and Ed Wulfe
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 Mr. and Mrs. Merrill D. Wynne
 Merrill D. Wynne and Sheila Wynne
 Foundation
 Dr. Mary Ann Wyss-Cummings

Y

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 Dr. James R. Yates and Dr. Alba A. Ortiz
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 Mrs. Virginia Young
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 Chapter
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 Younger Foundation
 Colonel James Youngson
 Mr. and Mrs. Dean F. Yow, Jr.
 Mr. Anthony Yurgaitis
 Mr. Joseph Yzardiaga

Z

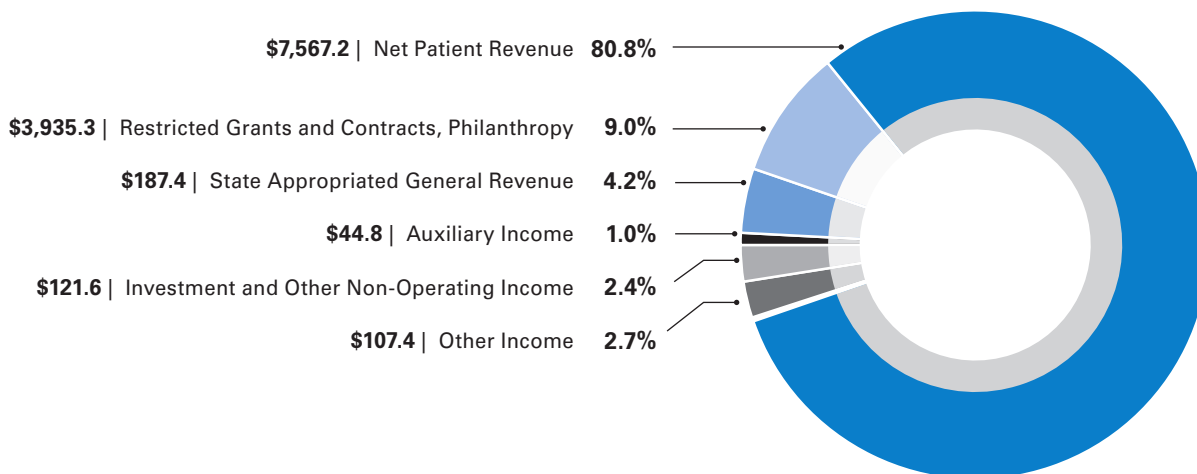
In Blessed Memory of Carol and Gordon
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 Zaplin Lampert Gallery, Inc.
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 Zavitsanos
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 Mrs. Sophie Zurquiyah
 Mrs. Melanie Zwernemann
 Mr. Ron Zyzelewski

Fiscal Year 2015
financial and statistical data
Sept. 1, 2014 - Aug. 31, 2015

Sources of revenue (unaudited)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Patient Revenue					
Gross patient revenue (Includes inpatient, outpatient and professional services)	\$5,544,009,390	\$6,144,132,636	\$6,582,112,827	6,994,996,215	7,567,179,285
Deductions from gross patient revenue ¹	2,813,830,643	3,185,346,342	3,403,247,816	3,659,313,782	3,935,319,324
Net patient revenue	\$2,730,178,747	\$2,958,786,294	\$3,178,865,011	3,335,682,434	3,631,859,960
Restricted grants and contracts, philanthropy	\$436,638,273	\$426,455,579	\$505,144,559	421,761,275	402,702,183
State-appropriated general revenue	168,730,376	170,383,019	154,562,093	185,393,182	187,350,746
Auxiliary income ²	33,232,458	36,957,473	40,674,618	41,502,690	44,808,473
Other income ³	52,954,731	56,151,131	75,564,178	99,702,455	107,422,200
Investment and other non-operating income	239,483,083	87,098,290	180,428,432	328,881,907	121,624,475
TOTAL REVENUE	\$3,661,217,668	\$3,735,831,786	\$4,135,238,891	4,412,923,943	4,495,768,037

Sources of revenue (in millions)



¹ Amounts discounted from established rates as a result of agreements with third-party payors, including Medicare, Medicaid and insurance companies. Also includes deductions associated with indigent care and bad debt.

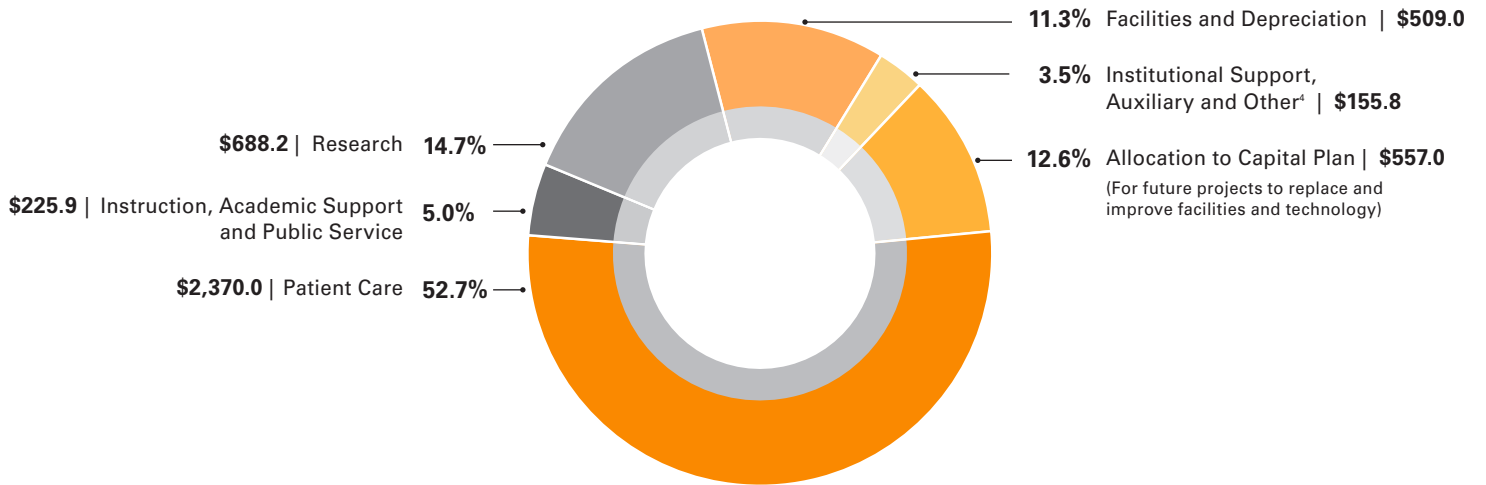
² Funds received from parking fees, valet services, dining facilities, hotel charges, gift shop sales and vending-machine sales

³ Includes tuition and student fees, Children's Art Project sales, management fees and other sources

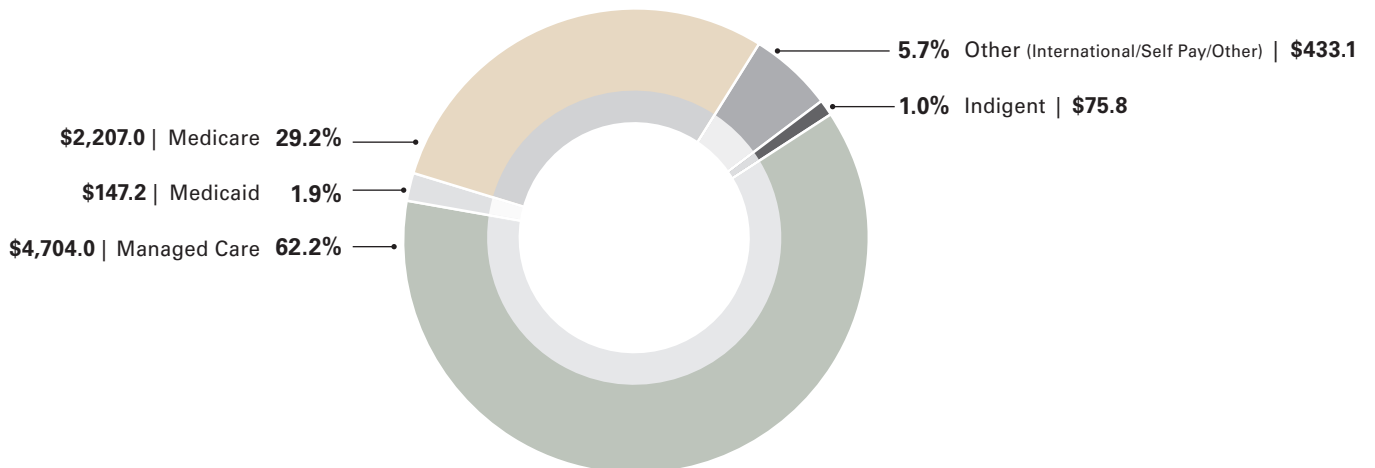
Uses of revenue

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Research	\$520,582,209	\$546,836,560	\$588,664,553	631,944,987	668,243,371
Instruction, academic support and public service	153,409,591	164,580,132	209,633,502	195,958,981	225,871,577
Patient care	1,704,851,239	1,880,230,560	2,013,554,826	2,055,617,566	2,369,972,993
Facilities and depreciation	427,461,242	460,445,328	471,935,938	486,793,306	508,973,014
Institutional support, auxiliary and other ⁴	248,601,648	280,844,123	305,390,616	312,865,408	155,828,553
Allocation to capital plan (For future projects to replace and improve facilities and technology)	606,311,739	402,895,083	546,059,455	729,743,695	566,878,529
TOTAL EXPENSES	\$3,661,217,668	\$3,735,831,786	\$4,135,238,891	4,412,923,943	4,495,768,037

Uses of revenue (in millions)



Gross revenue by payor classification (in millions)




⁴Includes support for parking, food and gift shop services, as well as general institutional support (e.g. information technology, human resources, administration, development activities, etc.)

Clinical profile

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Hospital admissions	25,230	26,726	27,905	27,761	28,167
Patient days	180,354	191,735	202,553	202,636	202,483
Average daily census	504	536	569	571	574
Average length of stay	7.1	7.2	7.3	7.3	7.2
Average number of inpatient beds	594	616	635	654	665
Outpatient clinic visits, treatments, procedures	1,190,568	1,281,489	1,338,706	1,363,008	1,440,684
Pathology/laboratory medicine procedures	10,937,213	11,619,591	11,718,405	12,005,766	12,334,917
Diagnostic imaging procedures	515,999	497,660	501,887	523,297	530,590
Surgery hours	63,230	66,241	70,221	69,506	69,987
Total active clinical protocols	1,048	1,078	1,065	1,101	1,197

Workforce



20,722
total employees




1,714
faculty



906
onsite trained
volunteers



2,224
offsite myCancerConnection
trained survivor volunteers



145,452
volunteer hours



MD Anderson provided more than **\$186.2 million** in uncompensated care to Texans with cancer in FY15.*

**This figure includes unreimbursed costs of care for patients who either have no insurance or are underinsured, or whose care was not fully covered by government-sponsored health programs.*

Total philanthropic gift support by type

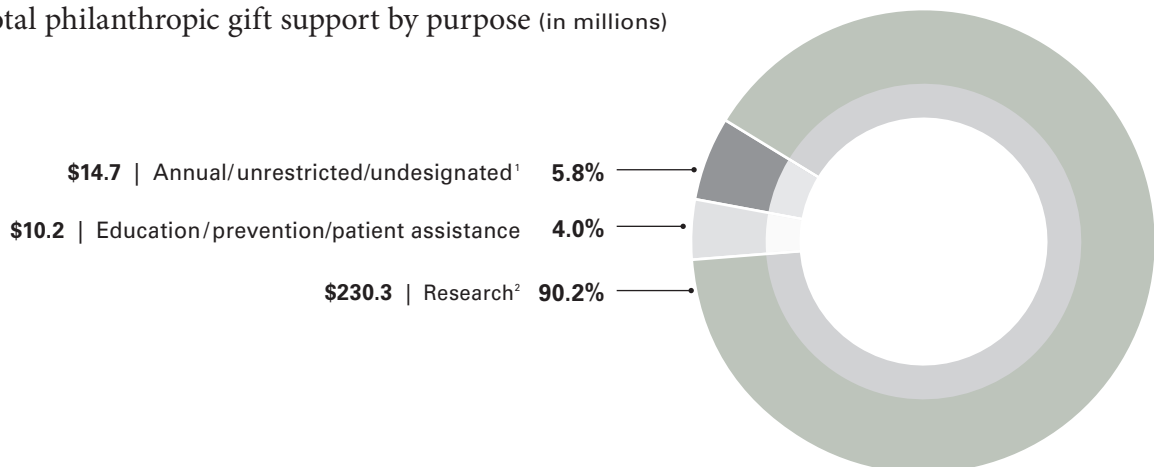
Cash gifts	Amount
Corporations	\$11,561,214
Foundations	31,879,345
Individuals	45,129,641
Organizations	5,228,055
Trusts and estates	3,753,821
Subtotal	\$97,552,076

Pledge gifts	Amount
Corporations	\$8,410,928
Foundations	20,006,229
Individuals	18,086,352
Organizations	12,214,275
Trusts and estates	98,700,886
Subtotal	\$157,418,670

Gifts-in-kind	Amount
Corporations	\$195,073
Foundations	1
Individuals	37,180
Organizations	24
Subtotal	\$232,278

TOTAL	\$255,203,024
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Total philanthropic gift support by purpose (in millions)



¹ These dollars fund institutional peer-reviewed research.

² Donor-targeted gifts to research conducted in all mission areas.

Sources of research expenditures

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
External funding for research					
Federal grants, contracts	\$236,413,656	\$196,753,104	\$182,970,502	\$158,986,303	\$161,170,908
Private industry grants, contracts	59,582,449	68,413,794	65,579,036	75,307,463	81,076,353
Philanthropy, foundations	98,150,749	100,794,491	101,642,898	147,016,586	172,412,727
Total external funding	\$394,146,854	\$365,961,389	\$350,192,436	\$381,310,352	\$414,659,988
State funding allocated for research					
State-appropriated general revenue	\$14,767,719	\$11,618,126	\$11,776,785	\$13,636,669	\$13,658,113
Tobacco settlement receipts	10,654,928	8,854,774	5,837,249	11,175,016	10,227,690
CPRIT	8,670,289	19,546,278	24,262,525	\$25,072,890	\$32,049,453
Total state funding	\$34,092,936	\$40,019,178	\$41,876,559	\$49,884,575	\$55,935,256
Internal funding allocated for research					
Hospital operating margins	\$175,424,228	\$215,527,886	\$182,770,342	202,607,346	198,607,568
Institutional grants ¹	20,239,439	26,032,444	95,730,271	102,391,157	111,374,655
Total internal funding	\$195,663,667	\$241,560,330	\$278,500,613	\$304,998,503	\$309,982,223
TOTAL RESEARCH EXPENDITURES	\$623,903,457	\$647,540,897	\$670,569,608	\$736,193,430	\$780,577,467

¹Philanthropic donations to the institution internally designated to support research and PRS funds internally allocated to support research activities. Source - THECB Report (Research Finance)

Education profile

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Clinical residents, fellows	1,141	1,187	1,231	1,276	1,507
Research trainees	1,629	1,714	1,743	1,853	1,890
Observers, visitors, special programs	429	431	507	452	752
Nursing trainees	2,320	2,531	1,306*	1,238	1,352
Student programs participants	1,102	1,317	1,396	1,204	817
School of Health Professions students	248	316	291	318	303
TOTAL TRAINEES	6,869	7,496	6,474	6,341	6,621

*Total includes academic credit clinical placement only. Previous data included outreach and CPRIT education programs.

THE UNIVERSITY OF TEXAS SYSTEM BOARD OF REGENTS

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LOCATIONS

MD Anderson has Houston-area locations in the Texas Medical Center, Bay Area, Katy, Sugar Land, The Woodlands, Bellaire and West Houston (diagnostic imaging), Memorial City (surgery) and The Woman's Hospital of Texas (gynecologic oncology). MD Anderson physicians also provide cancer care to Harris County's underserved patients at Lyndon B. Johnson Hospital. In addition, there are two research campuses in Bastrop County, Texas. The institution also has developed a network of national and international locations.

MD ANDERSON CANCER NETWORK®

www.mdanderson.org/cancernetwork

PARTNER MEMBERS

- Banner MD Anderson Cancer Center (Gilbert, Arizona)
- MD Anderson Cancer Center at Cooper (Camden, New Jersey)
- MD Anderson Cancer Center at Summit Medical Group (Berkeley Heights, New Jersey)
- Baptist MD Anderson Cancer Center (Jacksonville, Florida)

CERTIFIED MEMBERS

- 14 health systems and hospitals in 12 states

ASSOCIATE MEMBERS

- Hospital Israelita Albert Einstein (São Paulo, Brazil)
- MD Anderson Cancer Center Madrid (Spain)

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- MD Anderson Radiation Treatment Center at American Hospital (Istanbul, Turkey)
- MD Anderson Radiation Treatment Center at Presbyterian Kaseman Hospital (Albuquerque, New Mexico)

Julie Penne, *interim director, External Communications*

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Andy Olin, *program director, External Communications*

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Michael Clarke

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Additional photography by Adolfo Chavez III (inside front cover), Eric Kayne (pages 12 and 27) and Nick de la Torre (pages 17, 23, 30 and 43).

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For information on patient services at MD Anderson, call askMDAnderson at 877-632-6789, or log on to www.mdanderson.org/ask.