December 2002

Clinical Center News

In this issue:

HHS mandate restructures Human Resources

The Department of Health and Human Services mandated that Human Resources activities throughout HHS be centralized. The November 2001 decision cited a need for department-wide consistency. Officials felt many individuals hoping to work for HHS found it difficult to navigate through the myriad of departmental personnel offices. At NIH alone there were more than 25 different HR offices. HHS' goal was to decrease the number of personnel offices in HHS from 40 to 4 by October 2003. Thus, NIH had to restructure the individual institute and center HR offices into a central Office of Human Resources.

As part of the restructuring, the Clinical Center's HR office was reassigned to the NIH, Office of the Director, Office of Human Resources, Division of Human Resources Operations and became the Clinical Center HR Operations Branch. Several staff members moved to other NIH OHR offices. At the same time four more personnel specialists from other institute and center HR offices joined the Clinical Center Branch. Two significant changes occurred —Tom Reed, formerly Clinical Center HR Director, now serves as HR Program Advisor to the Clinical Center senior

See **Human Resources**, page seven

Breaking ground for The Edmond J. Safra Family Lodge are (l-r): Dr. Michael Gottesman, Deputy Director for Intramural Research, NIH; Dr. Elias Zerhouni, Director, NIH; Dr. John Gallin, Director, Clinical Center, NIH; Jeffrey Keil, President, Ellesse LLC; Amy McGuire, Executive Director, Foundation for NIH; and Susan Lowell Butler, member, Clinical Center Patient Advisory Group. The groundbreaking ceremony was held indoors due to inclement weather.

Groundbreaking signals start of much-anticipated Family Lodge

A groundbreaking ceremony was held on Oct. 29, for The Edmond J. Safra Family Lodge, a home-away-from-home for the families and caretakers of NIH Clinical Center patients. The event, which occurred at the future Lodge location near the corner of Center and Convent Drives, formally signals the project's start.

The rain-soaked day did not deter a large crowd, which included patient partners and NIH management and staff, from attending. Clinical Center Director Dr. John Gallin served as master of ceremonies. Program remarks were given by NIH Director Dr. Elias Zerhouni; Jeffrey Keil, President of Ellesse, LLC, representing The Edmond J. Safra Philanthropic Foundation; Dr. Michael Gottesman, Deputy Director for Intramural Research, NIH; Amy McGuire, Executive Director, Foundation for NIH; and Susan Lowell Butler, member, Clinical Center Patient Advisory Group.

Dr. Gallin welcomed attendees stating that the Family Lodge has been much anticipated. "The concept for such a facility started in the early 1990s when volunteers from the Clinical Center's nursing,

See **Breaking ground**, page three

Eclipsys to build core system of CRIS project

A contract to build the largest component of the NIH Clinical Research Information System has been awarded to the Eclipsys Corporation.

The Clinical Research Information System—CRIS—is a $60 million project that will link and support patient care, research and management at the Clinical Center.

Under the contract announced Nov.14, Eclipsys Corporation will develop and implement the components of CRIS that comprise the patient-care aspects of clinical research. Included in this core system is the electronic medical record, which houses information such as lab results, pharmacy orders and multidisciplinary care documentation.

The Clinical Center developed and has used an electronic medical information system for more than a quarter century. The system was one of the nation's first.

"This phase of the CRIS project replaces and expands the original system," explained Dr. Stephen Rosenfeld, CRIS project manager and chief of the Department of Clinical Research Informatics. "It's a critical component to complete before the new Clinical Research Center opens in 2004. As CRIS evolves, we will be building an information technology foundation to support future clinical research at NIH."

Dr. Rosenfeld will discuss CRIS project next steps during Clinical Center Grand Rounds Dec. 18 at noon in Masur Auditorium.

"The Clinical Research Information System will be a valuable resource for both patient care and clinical research," said Clinical Center Director Dr. John Gallin. "It will provide innovations in managing, analyzing and using valuable information surrounding clinical research."

More information about the CRIS project is available on the web: **http://cris.cc.nih.gov**.

–by Sara Byars

Training Programs in Clinical Research

Applications for the 2003-2004 NIH-Duke Training Program in Clinical Research and the University of Pittsburgh Training in Clinical Research Program are available in Building 10, Room B1L403.

Duke Training Program in Clinical Research

The NIH-Duke Training Program in Clinical Research, implemented in 1998, is designed primarily for physicians and dentists who desire formal training in the quantitative and methodological principles of clinical research. The program, offered via videoconference at the Clinical Center, allows the integration of a student's academic coursework with his or her clinical training.

Academic credit earned by participating in this program may be applied toward satisfying the degree requirement for a Master of Health Sciences in Clinical Research from Duke University School of Medicine.

For additional information regarding course work and tuition costs, please refer to the program website at **http://tpcr.mc.duke.edu/**. E-mail queries regarding the program may be addressed to tpcr@mc.duke.edu. The deadline for applying is March 1, 2003. Applicants who have been accepted into the program will be notified by July 1, 2003.

Pitt Training Program

The University of Pittsburgh Training in Clinical Research Program, designed for Ph.D. and allied health professionals (i.e. pharmacists and nurses), allows trainees to gain the knowledge and skills required for the conduct of clinical investigation, as well as more extensive knowledge relative to a specific area of concentration.

Participants in this program have the option of receiving a Certificate in Clinical Research (15 credits) or a Master of Science in Clinical Research (30 credits) from the University of Pittsburgh.

For more information, please visit the program website at **www.cc.nih.gov/ccc/cc_pitt/index.html** or send an e-mail to tcrp@imap.pitt.edu. The deadline for applying is March 1, 2003. Successful applicants will be notified by May 29, 2003.

Physicians and dentists are also eligible to matriculate in this program.

Enrollment in these programs is limited. Prospective participants should consult with their institute or center regarding the official training nomination procedure.

Clinical Center News

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Contributing writers: Dianne Needham, John Iler, Sara Byars

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Breaking ground for 'quiet seclusion and supportive fellowship'

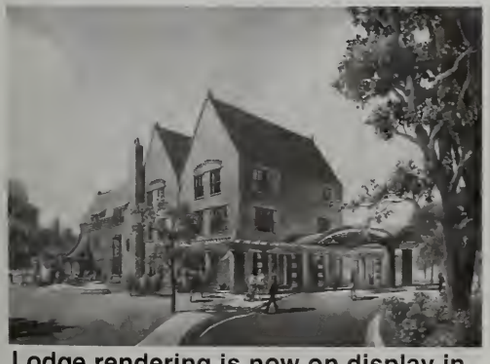
continued from front page

housekeeping and social work departments launched this idea purely on a voluntary basis because they recognized the deep need to provide patients' families with a place of respite," he said.

The Clinical Center is the largest hospital in the world totally dedicated to clinical research. "The Lodge will complement the work we do by providing quiet seclusion and supportive fellowship to families and patients participating in our research protocols. I predict the Lodge will become a model for other institutions that conduct clinical research," said Dr. Gallin.

Dr. Gallin introduced Dr. Elias Zerhouni highlighting the NIH Director's commitment to clinical research as a top priority. Dr. Zerhouni said that the Lodge "embodies the connection of humanity and science and the connection of government and enlightened citizenry."

Dr. Zerhouni expressed how impressed he was that a federal agency such as NIH was receiving the highest mark of recognition from philanthropy. "It is because of the ground breaking research that the Clinical Center has done over the years that we're now able to be at such a groundbreaking ceremony. Would you ever imagine a foundation funding something for the IRS? I think only NIH can attract that sort of recognition because philanthropy by definition is the concept of loving another," he said.



Lodge rendering is now on display in the Clinical Center.

Foundation for NIH Executive Director Amy McGuire echoed Dr. Zerhouni's sentiment. "The Foundation has learned a great deal by conducting this project. We feel the Safra Lodge is really a symbol—a symbol of what Congress intended the Foundation to do when they authorized and created us. The Safra Lodge is a public/private partnership that will help the whole NIH family, the patients, their families, and ultimately the American public," she said.

Noting that the first cancer treatment using chemotherapy took place at the Clinical Center, Dr. Michael Gottesman, deputy director for Intramural Research at NIH, spoke poignantly of the courageous acts of patients. "Think about the very first patient who had serious cancer who was asked to be part of this clinical trial. He was asked to take a toxic chemical at risk of life to find out whether this would be a treatment that would help other patients in the future. In no way is this different from the bravery shown by firemen who run into a burning building, or John Glenn in his first orbital maneuver, or Neal Armstrong when he stepped out on the surface of the moon. These patients and many, many others have come to NIH to put their lives on the line to advance human knowledge, to improve public health." The Family Lodge, said Dr. Gottesman, is a very small payback to these "amazing patients."

Susan Lowell Butler, member, Patient Advisory Group, Clinical Center, shares her thoughts on being an NIH patient.

Susan Lowell Butler, an NIH patient and member of the Clinical Center's Patient Advisory Group, has intimate knowledge about such courage. "I was treated for simultaneous breast and ovarian cancer here in 1995 on a clinical trial. When I tell you I'm glad to be here, I'm not just using a tired old phrase," she said.

She spoke about the caregivers' burden. "I'm blessed with a magnificent husband. He supported me when I had been given a death sentence. One night he was with a group of other caregivers and I heard him say, 'In seven months, no one ever spoke to me without starting with the question 'How's Susan?'" That's what the caregiver role really feels like. It is loneliness, isolation and fear."

"Anything that helps ease the caregiver's suffering and distress is quite a miracle," she said. And The Edmond J. Safra Family Lodge may be just that.

Actual construction should begin early next year with completion in the summer of 2004. For more information contact Jan Weymouth, Program Manager, at 301-496-2925 or visit: **www.cc.nih.gov/ccc/family/lodge.html**.

–by Dianne Needham

Saving life and limb

Doctors give life back to woman with nearly fatal blood clot

Three months ago Rebecca McDonald gave birth to her third child, Jordan. A couple of weeks later, a blood clot had formed in her pelvic area and stretched its way down to her calf. The swelling from her leg became crippling. Her life began to revolve around a wheelchair, her bed and doses of morphine for the pain.

"The scary part was not knowing what the future was going to be," said Rebecca, a stay-at-home-mother of three from Boise, Id. "How was I going to parent my children from a bed?"

And how was her husband Robert going to care for her, a newborn, two daughters, ages five and seven, and still hold down his job as a dentist.

They were unsure; but, more than 2,300 miles away, Clinical Center Doctors Richard Chang and McDonald Horne were searching for patients like Rebecca.

"She's very healthy and runs every day," said Robert McDonald. "She was running before she became pregnant and started running again after the baby was born."

It was then that she began to have pain in her left calf area. "We thought that maybe she just stretched the muscle. She took Ibuprofen, but it got worse," said Robert. "So we went on a Saturday to a clinic just to get it checked out."

The clinic sent them to the emergency room at St. Luke's Hospital in Boise. "After they ran some tests, the nurse came in with tears in her eyes and said she was happy that we came in when we did because she had a pulmonary embolism and it was life threatening."

A pulmonary embolism is a blocked artery in the lungs that is generally caused when a blood clot or a portion of a clot from another part of the body travels to the lungs.

Rebecca was placed on anticoagulants, medications used to dissolve and prevent blood clots. After a week in the hospital she was sent home. "The treatment wasn't working. Her leg was getting bigger and becoming worse. It was twice the size of her other leg." said Robert. "I rented a hospital bed because she couldn't go up and down the stairs. The pain pills were like TicTacs…they just weren't working…so we went back to the emergency room and they put her on morphine."

Pictured are (l to r): Denise McLaughlin, R.N., 7E charge nurse; Rebecca McDonald; 3-month-old Jordan; Robert McDonald; Dr. McDonald Horne and Dr. Richard Chang.

As a dentist, Robert said he was familiar with clinical trials. So he went to his computer and began looking for websites that could give him information about clinical trials for severe blood clots.

"NIH was the first website I found. I called them the next day at six o'clock in the morning and they said Rebecca would be the perfect candidate," said Robert. "We took a flight out that same night."

According to Dr. Chang, chief, Special Procedures Section, Department of Radiology, Imaging Sciences Program, nearly 200,000 people suffer annually from deep venous thrombosis or DVT, a blood clot in the lower part of the body.

"Most of these cases will be treated with anticoagulation drugs alone. This would be great if anticoagulation was perfectly effective," said Dr. Chang. "Anticoagulation is extremely effective in the prevention of pulmonary embolisms, and it is also fairly good at preventing DVT in the first place. Where it fails, is in clearing the clot in the leg and preserving the function of the veins in the legs."

In Rebecca's case, anticoagulation wasn't working. As her uterus expanded during the pregnancy, it pressed against the veins in her pelvic area, narrowing the vein channel. This reduced blood flow and allowed the blood to clot.

According to Dr. Horne, senior clinical investigator, Hematology Services, Department of Laboratory Medicine, even if the anticoagulants worked in clearing the blockage, the vein would still be narrow, increasing the chance of developing another blood clot.

Anticoagulants will dissolve a clot within several weeks or several months. However, it leaves behind

See **Thromboytic**, page six

Beating the odds:

Dickinson given life-saving treatments for 25 years

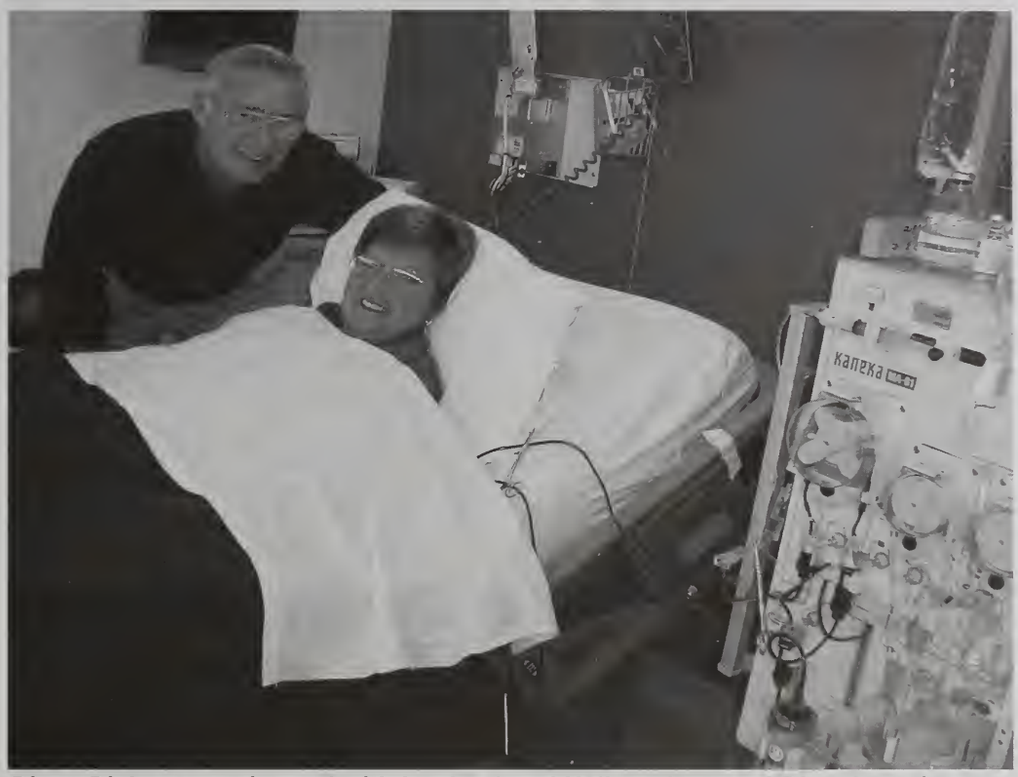
You could say Diane Dickinson is "one-in-a-million," and you'd be right in a number of ways. She's feisty, outgoing, yet laid back, has a good sense of humor and is, if anything, persistent. But she's also one in about every million Americans with homozygous familial hypercholesterolemia (FH) type IIa, a genetic disorder that causes too much LDL (the "bad" cholesterol) to accumulate in her body.

By all counts, she said, she should never have made it this far.

"Thanks to the attention I've received at NIH, I've had the chance to raise a family and have grandchildren. It's all so phenomenal because I wasn't supposed to live beyond my teens."

Mrs. Dickinson, who was diagnosed when she was 2, is one of the lucky pioneers who blazed a trail from research to reality—a trail that's led her through 25 years of varying treatments including drugs and blood-cleansing techniques. Now, at 63 years of age, she's the longest living patient with FH.

Dickinson grandchildren (l-r) Morgan, Mitch and Sidney, with baby Haley, sport t-shirts proclaiming "Thank you NIH."



Diane Dickenson, pictured with her husband Neil, undergoes LDL apheresis at the Clinical Center's Department of Transfusion Medicine, a process she must do every two weeks.

"She's very unique," said Dr. Robert Shamburek, a staff physician researcher with the Molecular Disease Branch, NHLBI, who spent a decade following Mrs. Dickinson through her ongoing journey. "When she came to us in 1976, she had perhaps six months to live. She was picked up under one of our protocols, and, as so often happens, an investigational process leads to a number of proven treatments. You could say that Mrs. Dickinson is a milestone in modern cholesterol treatment."

Because of two defective genes, low density lipoprotein cholesterol (LDL) in FH patients cannot be metabolized by liver cells into useful nutritional components. As a result, LDL continues to circulate in the blood stream, where it accumulates in dangerous levels along arterial walls, creating obstructions.

"There's no housekeeping function to get rid of it," explained Dr. Susan Leitman, chief, Blood Services, Department of Transfusion Medicine. "The excess LDL becomes oxidized, which makes it even more dangerous. It enters the walls of blood vessels, causing inflammation and forming deposits known as arteriosclerotic plaques. These plaques block blood flow in the coronary arteries, causing severe, life-threatening and lethal heart disease."

To illustrate her point, Dr. Leitman pointed to figures devised by the Adult Treatment Panel of the National Cholesterol Educational Program. For normal, healthy people, the panel recommends an LDL level of less than 160. For victims of coronary heart disease, the recommended level is less than 100. "In patients like Mrs. Dickinson," she added, "LDL levels are characteristically between 600 and 800."

Mrs. Dickinson's condition was so precarious that when she first arrived at NIH, she had to undergo coronary artery bypass surgery, using saphenous vein grafts from her legs. Although the use of arteries was later standardized, increasing the efficiency of the bypass, Mrs. Dickinson's graft has survived without blockage well beyond the 10-year range expected—and at 25 years shows no sign of atherosclerotic disease.

See **Pioneer**, page six

Thrombolytic therapy gives life back to patients

continued from page four

damage to the vein. Within each vein are delicate valves that allows blood to flow up the leg. Without the valves, or with damaged valves, pressure builds up in the veins, leading to swelling, and potentially reclotting, and possibly skin ulcers.

"But if we move the clot out quickly, the venous valves remain functional," said Dr. Horne.

And that was the theory behind their research. In 1998, Dr. Chang and Dr. Horne began recruiting patients for a clinical trial for treatment of acute deep vein thrombosis.

For almost 15 years, Dr. Chang treated cancer patients who developed blood clots in the neck and arms caused by catheters used during chemotherapy. "We studied and tried different ways of dissolving the clots, but we weren't quite happy with the results from techniques used in the general medical community," said Dr. Chang.

By 1994, Dr. Chang and Dr. Horne decided to test rtPA, a natural protein that was generally used for patients who have had heart attacks. By using a catheter to spray the enzyme directly into the clot, the doctors hoped to dissolve the clot within days, if not hours after treatment. Unlike the other alternative choices of clot dissolving enzymes, rtPA sticks directly to the clot, allowing prolonged enzymatic action, dissolving the clot to restore a channel for blood to flow again. Anticoagulants themselves do not dissolve clots and when patients are placed on anticoagulant therapy alone, their physicians are relying on natural clot-dissolving enzymes to penetrate the clot and dissolve the clot. This is a very slow process when the clot is large and blocks flow of enzyme reaching the area.

"Ideally, patients should get rtPA treatment within two weeks of diagnosis. Referring doctors should not delay if the patient has extensive DVT," said Dr. Chang. "Thrombolytic therapy is very effective when the clot is fresh. Doctors and their patients should not adopt a wait-a-month-and-see approach, because they will miss the period when thrombolytic therapy is most effective."

However, many doctors have been reluctant to support what Dr. Chang and Dr. Horne have found to be successful among patients they have treated with DVT.

"We received limited patient referrals from other physicians," said Dr. Chang. "They said it wasn't proven, it doesn't work, it's too dangerous; all information from older studies over 10 years ago. I think this is no longer true and thrombolytic therapy deserves a fresh reevaluation."

And the results are starting to prove him right.

See **Protocol**, page eight

Patient pioneer is one-in-a-million

continued from page five

"It was research that evolved through many treatments," Dr. Shamburek said. The late and renowned researcher and physician Dr. Jeffrey Hoeg, who now has an award lecture series in his honor by the American Heart Association, was a leading player. And though Mrs. Dickinson herself credits her success to "being in the right place at the right time," the focus on her rare condition led to treatments and knowledge that would benefit large numbers of Americans at risk from high cholesterol.

One achievement was drugs called statins, which increase the liver's ability to metabolize LDL. Others included plasma exchange or plasma clearance, and more recently, LDL apheresis, which physically deletes, or adsorbs, LDL from the circulating blood.

"In Mrs. Dickinson's case, statins were only marginally effective," Dr. Leitman said. "Drug therapy lowered her LDL levels from 800 to 600, which wasn't adequate. Since 1977, Mrs. Dickinson has come to the Clinical Center every two weeks, first for the plasma exchange, which was replaced in 1989 by LDL apheresis. Both processes take between 4 to 6 hours."

"She's a real trooper," said her husband, Neil. "The changes in treatments over the years have been remarkable. We're both very thankful for the help we've received from NIH. Before we came here, we felt more like we were a research project."

"It's been very successful," Mrs. Dickinson said. "It's what's kept me alive for 25 years." She marvels that the apheresis clinic she visits so often is named after Regina Dowling, one of her original nurses.

"The people here could not be kinder or nicer and, of course, we've established many enduring friendships," she said. On June 1, she celebrated her 25-year mark by throwing a dinner party and inviting the people at the Clinical Center she has come to know and love.

"I've been on the pioneer's edge the entire time," she said. "And I've been very fortunate. I was able to go into nursing, so I have a medical understanding to follow my condition. But everyone's been so supportive and has taken very good care of me."

Even so, nothing's perfect. But the Dickinsons do enjoy life and their families, especially their grandchildren. Once a year, they visit Florida, where Diane receives treatment at a medical facility in Tampa. And though there are some adverse effects to the apheresis, including headaches and nausea, these, too, are being systematically addressed along the way by an unrelenting science—a science with a very human touch.

–by John Iler

Holidays bring joy, happiness and the blues

The holiday season can be one of the most stressful and emotionally difficult times of the year. Despite the joys and happiness of being surrounded by family and friends, this particular holiday season may prove difficult for many individuals. In addition to the stresses of the holiday season, military families may be celebrating the holidays away from home, the slowing economy may place financial burdens on some and the loss of loved ones to illness or even violence may cause people to feel isolated from those who are enjoying the holiday.

During this holiday season remember that many are coping with anxiety, trauma and depression. Instead of feeling joy, many people may experience the holiday blues and not feel like celebrating.

Tips for Coping

•Try to set realistic goals for the holidays. Keep expectations simple for yourself and others.
• Make a budget and stick to it. Spend what you can afford.
•Try not to overeat or drink excessively to escape stressful feelings. Eat healthy foods and get plenty of exercise.
•Remember that the holidays are more than one day; they are part of a whole season. Pace yourself. Spread enjoyable activities throughout the entire season.
•Helping others can also help you feel better. Volunteer at a homeless shelter, buy a present for a child in need or visit people in nursing homes.
•If you do not have friends or family to visit with, reach out. Contact local clubs, religious groups or community centers to see if they are holding activities that may interest you.
•Nurture yourself. Take some time out each day to care for and celebrate yourself.
•Try to stay in the present. Look forward to the future. Life is full of changes. Consider what is important in your life and good about these times.

Signs to Seek Help

Some people may experience the holiday blues, but others may have profound feelings of sadness or depression that do not go away over time. Symptoms may include:
•Persistent sad, anxious or empty mood
•Sleeping too much or too little; middle-of-the night or early morning waking
•Reduced appetite and weight loss or increased appetite and weight gain
•Loss of interest or pleasure in activities, including sex
•Irritability or restlessness
•Difficulty thinking, concentrating, remembering, or making decisions
•Fatigue or loss of energy
•Thoughts of death or suicide
•Feeling inappropriate guilt, hopelessness or worthlessness

For help with issues of depression, anxiety or stress that may be affecting work and family life, contact the NIH Employee Assistance Program at 301-496-3164. All information is confidential.

Source: National Mental Health Association

The QWI and Diversity Council bids farewell to one of its co-facilitators, Sue Fishbein. Fishbein helped establish the council in 1996 and is credited with much of its success. "Through boundless energy and a genuine interest in employees' welfare, she was the main protagonist in promoting quality of worklife and diversity at the Clinical Center," said co-facilitator Jacques Bolle. Her accomplishments include planning and organizing a two-day retreat for council members; developing a regular column for Clinical Center News; stewarding a QWI/Diversity library; developing a QWI/Diversity web page and drafting a new diversity award as part of the Clinical Center Director's award. She supported the expansion of the 14th floor exercise room for employee use, and was an advocate for child care issues. Fishbein is succeeded by Deborah Dozier-Hall who will serve as co-facilitator with Jacques Bolle.

HHS reorganizes Human Resources

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management, and Barbara Lang, formerly Associate Personnel Officer under Tom Reed, is now Chief, Clinical Center Human Resources Operations Branch.

Reed and Lang both agree that for the Clinical Center the restructuring is seamless to the vast majority of employees.

"The change is transparent to managers and staff. The federal personnel process did not change," said Reed. "We know that the Clinical Center HR Operations Branch understands the Clinical Center's mission and is committed to its biomedical research patient care environment."

The HR centralization creates greater consistency, improves timeliness of hiring and brings global identification of compensation problems throughout NIH. "Our goal is to provide timely and effective HR support and advice to the Clinical Center," said Lang.

The Clinical Center HR Operations Branch is located at 6100 Executive Boulevard, Room 3E01. The telephone number is 301-496-6924.

Protocol receives positive results, helps patients in need

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Of the 14 people who have participated in the study, all have had successful results–including Rebecca. Within three days Rebecca was walking. Within a week, she was back to running two miles a day.

"It's not a coincidence that this clotting occurred after Rebecca's pregnancy. We were surprised that it didn't happen during the pregnancy," said Dr. Horne. "However this case was unique because of the severity of it. This is a young, active individual who had pain and swelling in her leg that was not improving with anticoagulants. Eventually, she would have been severely debilitated and crippled."

Blood clots can develop from pregnancy, birth control pills, hormone replacement, cancer, and several other rare situations, according to Dr. Chang. "Many people who are athletic or have an active lifestyle are at a higher risk, especially if they become sedentary or confined to a chair or a bed for a period of time," he said.

That's exactly what happened to Dr. Ryszard Pluta, clinical staff physician, Surgical Neurology, NINDS. After returning from a 17-hour flight from China, Dr. Pluta felt a pain in his right calf. He decided to have an ultrasound and found that he was suffering from economy class syndrome.

This condition results from long hours of minimal movement on an airplane when passengers are crammed into small quarters.

"Nearly ten percent of travelers develop DVT, but less than one percent are actually diagnosed," said Pluta. "Many fly in business class or first class, but the same percentage get DVT."

Pluta was accepted into the clinical study and within a week returned to his regular activities of running, tennis, swimming, and golfing.

"This is a blessing," said Pluta, who now flies more European airlines that remind passengers to stretch and move around every hour to avoid the risk of blood clotting. "The fact that this is giving people a real chance to go back to their normal life is great."

–by Tanya Brown

2002 Medicine for the Public Lecture Series premiers on Research Channel

The Medicine for the Public lecture series help people understand the latest developments in medicine. Topics of current relevance are presented by NIH physicians who can relate stories of science to the lay public. The 2002 lecture series is being videocast/webcast weekly on the ResearchChannel.

Tune in to the ResearchChannel video and webcasts each week on Tuesdays at (Eastern Standard Times) 6 a.m., 11 a.m., 4 p.m., 9 p.m. and Wednesdays at 1 a.m.

Specific programs premier on the following dates:

Dec 3 - Nutritional Therapies for Age-related Eye Diseases
Dec. 10 - Coping with Anxiety and Depression in Uncertain Times
Jan. 7 - The Teen Brain
Jan.14 - Endometriosis: Scrambled Eggs and Killer Cramps

To access the ResearchChannel programming visit their website at: **www.researchchannel.org**.

december

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Grand Rounds
noon-1 p.m.
Masur Auditorium
When is a Child a Research Subject?
Greg Koski, M.D., Office of Human Research Protections, HHS

Wednesday Afternoon Lecture, 3 p.m.
Masur Auditorium
From Genes to Pores: Nuclear Transport and Growth Control
Pamela Silver, Ph.D., Harvard Medical School

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Grand Rounds Great Teachers Series
noon-1 p.m.
Masur Auditorium
Osteoporosis: New Approaches for Old Bones
Clifford Rosen, M.D., Maine Center for Osteoporosis Research and Education

Wednesday Afternoon Lecture
3 p.m.
Masur Auditorium
An Ecological Role for Pseudomonas Virulance Factors
Roberto Kolter, Ph.D., Harvard Medical School

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Grand Rounds-Clinical Research Information System
noon-1 p.m.
Masur Auditorium
CRIS: The First Deliverables
Stephen Rosenfeld, M.D., M.B.A., CRIS Project Manager

Wednesday Afternoon Lecture
3 p.m.
Masur Auditorium
Prometheus' Vulture and the Promise of Stem Cells
Nadia Rosenthal, Ph.D., Harvard Medical School

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Grand Rounds
noon-1 p.m.
Masur Auditorium
No Grand Rounds

Wednesday Afternoon Lecture
3 p.m.
Masur Auditorium
No Wednesday Afternoon Lecture