



The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 226 – April 2010

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Thought For Today

Don't you wish there were a knob on the TV to turn up the intelligence?

There is one marked "Brightness", but it doesn't work.

- Jim Leddy.

Medical Advisors to The Manitoba Prostate Cancer Support Group

- => Paul Daeninck M.D.
Pain Management
- => Darryl Drachenberg
M.D. Urologist
- => Graham Glezerson
M.D. Urologist
- => Ross MacMahon
M.D. Urologist
- => John Milner
M.D. Urologist
- => Jeff Sisler M.D.
Family Practitioner
- => Gary Schroeder M.D.
Radiation Oncologist

Thanks!

NEXT MEETING:

Thursday, April 15th, 2010 7 - 9 P.M.

Dr. Graham Glezerson, Urologist

"Treating Erectile Dysfunction After Prostate Cancer - The Hard Facts"

Location: AUDITORIUM of the Seven Oaks General Hospital -
Leila & McPhillips



The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

Feel free to ask basic or personal questions without fear of embarrassment. You need not give out your name or other personal information.

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians. All information is however freely shared.

Special Thanks

Many thanks to the U. of M. Bison Men's Chorus for their donation to our Support Group. We thank them for making us a worthy recipient of donations collected at their December Christmas Concert. We would also like to thank member, Joe Stephanson, for putting our name forward for consideration. We appreciate your kindness.

DVD's Available

Did you know that Lorne Strick makes a DVD copy of all our guest speakers?

They can be purchased for individual or group use

Phone Lorne at
204-667-9367 or
email Brian Sprott at
jbsprott@shaw.ca

Cost is \$5.00 plus shipping



Check out the list of *our speakers* for 2010
on the back of our newsletter
or at our website - www.manpros.org

Canadian Cancer Society

Call toll free: 1-888-939-3333

When you call the toll free number of the **Cancer Information Service**, your questions will be answered by someone who understands how confusing the subject of cancer can be.



All calls are kept confidential

Medroxyprogesterone Most Effective Hormone Therapy for Reducing Hot Flashes in Men With Prostate Cancer

NEW YORK - December 6, 2009 - Cyproterone acetate and medroxyprogesterone acetate show the highest efficacy in reducing hot flashes in men receiving hormone therapy for prostate cancer. But overall, medroxyprogesterone should become the standard treatment for preventing hot flashes in these patients. That's the finding of a study published online (www.thelancet.com) and in an upcoming edition of The Lancet Oncology.

Previous research has shown that hormonal treatments (eg, cyproterone acetate) and progestogens (eg, medroxyprogesterone), as well as non-hormonal treatments such as selective serotonin-reuptake inhibitor antidepressants (SSRIs, eg, venlafaxine) are all effective at preventing hot flashes, but direct comparisons between these drugs have not been made in men being treated with androgen-suppression therapy for prostate cancer. In this randomised trial, Jacques Irani, MD, Poitiers University Hospital, Poitiers, France, and colleagues

(Continued on page 3)

WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

Have you used any of our services?

Newsletter - General Meetings - Hospital visits - One-on-one visits - Speakers

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(Continued from page 2)

examine the efficacy of 3 drugs - cyproterone acetate, medroxyprogesterone acetate, and venlafaxine - at preventing hot flushes to establish clear treatment recommendations for these patients.

A total of 919 men with prostate cancer were recruited from 106 urology centres in France between 2004 and 2007. All patients were initially treated with the gonadotrophin-releasing hormone (GnRH) analogue leuporelin for 6 months. After 6 months, patients who had 14 or more hot flushes in the week before assessment or those who spontaneously requested treatment were randomly assigned to further treatment with either venlafaxine (n = 102), medroxyprogesterone (n = 108), or cyproterone acetate (n = 101). Patients were assessed at weeks 4, 8, and 12 after randomisation, and asked to complete a self-evaluation questionnaire to calculate the frequency and severity of hot flushes for a week before each assessment.

Overall, findings showed that all 3 drugs reduced the occurrence of hot flushes with little difference in tolerance, but the hormonal treatments cyproterone acetate and medroxyprogesterone acetate were significantly more effective at reducing hot flushes than the SSRI venlafaxine over all time periods.

After 4 weeks of treatment, 219 (70.9%) patients had an improvement of at least 50% in their hot flush scores, and 70 (22.7%) patients reported a complete absence of hot flushes.

The median daily hot-flush score relative change between randomisation and week 4 was -47.2% for venlafaxine, -94.5% for cyproterone, and -83.7% for medroxyprogesterone.

Serious side effects occurred in 16 patients - 4, 7, and 5 cases in the venlafaxine, cyproterone, and medroxyprogesterone groups, respectively. Only 2 cases were thought to be related to the drugs.

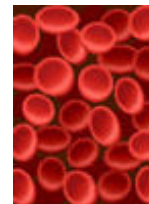
The authors conclude: "Cyproterone acetate and medroxyprogesterone acetate are more effective at 12 weeks for treating hot flushes in men treated with GnRH analogues for prostate cancer ... [however] as cyproterone is a recognised treatment in prostate cancer, and its use could interfere with hormone therapy, medroxyprogesterone should be the standard treatment."

SOURCE: The Lancet Oncology

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PSA Value 2 Years Post-Radiation Predicts Long-Term Survival in Prostate Cancer Patients

FAIRFAX, Va - December 3, 2009 - Patients with prostate cancer and a prostate-specific antigen (PSA) value of ≤ 1.5 at 2 years after external beam radiation therapy (EBRT) are less likely to have a cancer recurrence and cancer-related death, according to a study published in the December 1 issue of the International Journal of Radiation Oncology**Biology*Physics*, the official journal of the American Society for Radiation Oncology (ASTRO).



After a successful course of EBRT, PSA levels should decline gradually over the following 18 to 24 months. A continued rise in PSA can indicate relapsing disease.

Prior studies have attempted to categorise PSA response patterns after treatment to identify patients with an increased likelihood of relapsing earlier; however, most did not use a fixed point after treatment to predict outcomes.

Researchers at the Memorial Sloan-Kettering Cancer Center, New York, New York, sought to determine the significance of a patient's reaching a certain PSA level at a specific point in time after EBRT.

The study authors found that patients with a PSA value of ≤ 1.5 at 2 years had a 2.4% incidence of distant metastases at 5 years after treatment and a 7.9% incidence at 10 years. Patients with a PSA value > 1.5 experienced a significantly higher rate of metastases at 5 and 10 years after treatment (10% and 17.5%, respectively).

"In the past, patients with a relapsing cancer after receiving radiation were not identified until several years after treatment, and at that point it may be too late to effectively salvage their recurrence," said Michael Zelefsky, MD, lead author of the study, Memorial Sloan-Kettering Cancer Center, New York, New York. "If we can catch these future instances of cancer recurrence earlier in prostate cancer patients, then we have a much higher chance of reducing the mortality associated with the cancer."

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Why Join a Support Group???

Support Groups are made up of people with common interests and experiences. People who have been through, or are going through, a similar circumstance can do more than sympathize with you. They can relate to what you are going through and keep you from feeling alone. Support Groups can also be a great place to find information, practical tips and resources. Think about joining a Support Group in your area.

You may be able to help others!

Results Unproven, Robotic Surgery Wins Converts

GINA KOLATA The New York Times February 14, 2010

At age 42, Dr. Jeffrey A. Cadeddu felt like a dinosaur in urologic surgery. He was trained to take out cancerous prostates the traditional laparoscopic way: making small incisions in the abdomen and inserting tools with his own hands to slice out the organ.

But now, patient after patient was walking away. They did not want that kind of surgery. They wanted surgery by a robot, controlled by a physician not necessarily even in the operating room, face buried in a console, working the robot's arms with remote controls.

"Patients interview you," said Dr. Cadeddu, a urologist at the University of Texas Southwestern Medical Center at Dallas. "They say: 'Do you use the robot? O.K., well, thank you.'" And they leave.

On one level, robot-assisted surgery makes sense. A robot's slender arms can reach places human hands cannot, and robot-assisted surgery is spreading to other areas of medicine.

But robot-assisted prostate surgery costs more — about \$1,500 to \$2,000 more per patient. And it is not clear whether its outcomes are better, worse or the same.

One large national study, which compared outcomes among Medicare patients, indicated that surgery with a robot might lead to fewer in-hospital complications, but that it might also lead to more impotence and incontinence. But the study included conventional laparoscopy patients among the ones who had robot-assisted surgery, making it difficult to assess its conclusions.

It is also not known whether robot-assisted prostate surgery gives better, worse or equivalent long-term cancer control than the traditional methods, either with a four-inch incision or with smaller incisions and a laparoscope. And researchers know of no large studies planned or under way.

Meanwhile, marketing has moved into the breach, with hospitals and surgeons advertising their services with claims that make critics raise their eyebrows. For example, surgeons in private practice at the New Jersey Center for Prostate Cancer and Urology advertise on their Web site that robot-assisted surgery provides "cancer cure equally as well as traditional prostate surgery" and "significantly improved urinary control."

Robot-assisted prostate surgery has grown at a nearly unprecedented rate.

Last year, 73,000 American men — 86 percent of the 85,000 who had prostate cancer surgery — had robot-assisted

operations, according to the robot's maker, Intuitive Surgical, the only official source of such data. Eight years ago there were fewer than 5,000, Intuitive says.

Dr. Sean R. Tunis, director of the Center for Medical Technology Policy, a nonprofit organization that evaluates medical technology, said few other procedures had made such rapid inroads in medicine.

Medical researchers say the robot situation is emblematic of a more general issue. New technology has sometimes led to big advances, which can justify extra costs. But often, technology spreads long before investigators know whether it is worthwhile.

With drugs, the Food and Drug Administration requires extensive tests to determine safety and efficacy. But surgeons are free to innovate, and few would argue that surgery can or should be held to the same standards as drugs. Still, a situation like robot-assisted surgery illustrates how patients may end up making what can be life-changing decisions based on little more than assertive marketing or the personal prejudices of their surgeon.



"There is no question there is a lot of marketing hype," said Dr. Gerald L. Andriole Jr., chief of urologic surgery at Washington University. Dr. Andriole does laparoscopic prostate surgery, and although he tried the robot, he went back to the old ways.

"I just think that in this particular instance, with this particular robot," he said, "there hasn't been a quantum leap in anything."

Evaluating technology is complicated. As often happens in surgery, doctors can become enthusiasts without rigorous studies ever being done.

And with prostate cancer, more is at stake than just an academic dispute, said Dr. Jason D. Engel, director of urologic robotic surgery at George Washington University Medical Center in Washington. One in six American men develop prostate cancer in their lifetime. Treatment options include radiation and watchful waiting, but the most popular is surgery.

"With the stream of prostate cancer patients that come through," Dr. Engel said, "this is a big, big business."

Dr. Michael J. Barry, a professor of medicine at Massachusetts General Hospital in Boston, said that once a hospital invests in a robot — \$1.39 million for the machine and \$140,000 a year for the service contract, according to Intuitive — it has an incentive to use it. Doctors and patients become passionate advocates, assuming that newer means better.

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“Doctors and medical centers advertise it, and patients demand it,” Dr. Barry said, creating a “folie a deux.”

The robot’s ability to reach into small spaces comes with tradeoffs. Ordinarily, doctors can feel how forcefully they are grabbing tissue, how well they are cutting, how their stitches are holding. With the robot, that is lost. And the robot is slow; it typically takes three and a half hours for a prostate operation, according to Intuitive, twice as long as traditional surgery.

A few highly experienced doctors are much faster. Dr. Vipul Patel, for example, at Florida Hospital in Celebration, Fla., has done more than 3,500 robot-assisted prostate surgeries. He often does six a day, taking about one and a half hours for each.

“From Day 1, when I sat down at that robotic console, I knew we would give patients a better outcome,” Dr. Patel said. “I have not seen anyone who has done a good amount of robotic surgery go back.”



Dr. Patel also started The Journal of Robotic Surgery to provide a forum, he said. Dr. Engel said he and others who use robots welcome it. They had had difficulty getting published in traditional journals, Dr. Engel said.

But papers in the new journal tend to report on one surgeon’s experience. Studies like that, which were also published in the past to promote traditional surgery, have methodological problems — biases in patient selection and evaluation are likely and, because the surgeons tend to be much better than average, it is hard to generalize.

In contrast, the national study of Medicare patients from 2003 to 2007, by Dr. Jim C. Hu of Brigham and Women’s Hospital in Boston, included 6,899 men who had surgery with four-inch incisions and 1,938 who had laparoscopic surgery, many with a robot.

The study was not ideal — patients were not randomly assigned to have one type of surgery or another, and laparoscopic operations done without a robot were included with the robot-assisted ones because Medicare did not distinguish between the two. But it is the only large national study that compares what is thought to be a largely robot-assisted surgery group with a group that did not have a robot.

The paper, published last October in The Journal of the American Medical Association, found that laparoscopic surgery patients had shorter hospital stays, lower transfusion rates and fewer respiratory and surgical complications. But they also had more incontinence and impotence.

It is not known whether the extra costs of robot-assisted surgery are balanced by lower costs for shorter hospital stays and fewer surgical complications.

Experts in robotic surgery say studies like Dr. Hu’s can be misleading. Medicare data, they say, include results from surgeons who may have little experience with robots.

Dr. Barry, an author of Dr. Hu’s paper, said Medicare data reflect the real world. “Everyone tends to cite data from centers of excellence as though they were their own,” he said.

Highly skilled surgeons, like Dr. Ashutosh K. Tewari at Weill Cornell Medical College in New York, say it takes about 200 to 300 robot-assisted operations to become highly proficient. Dr. Tewari has done 3,200.

Surgeons who do nonrobotic prostate surgery agree.

“What happens is that if you take leading experts, whether they do open or robotic, they are going to get good results,” said Dr. Herbert Lepor of New York University, who has done more than 4,000 traditional open prostatectomies.

“I say robotic surgery has to be better to justify its learning curve,” Dr. Lepor said, “to justify its unknown cancer control, to justify its increased cost.”

Both traditional surgeons and those who do robot-assisted surgery point to patients who did extremely well.

Among them is James Lamb, a 40-year-old New York City police officer who had robot-assisted surgery with Dr. Tewari on Jan. 5. Two days later, while he was in the hospital and still had a catheter in his penis, Officer Lamb had an erection.

Two days after that, Officer Lamb said, he was home and had sexual intercourse. (In one study by Dr. Barry, which surveyed patients a year after surgery, only half the men, regardless of surgical method, were back to their presurgery potency a year later, with or without the use of a drug like Viagra.)

But, Dr. Barry and Dr. Tewari note, an extraordinary patient or two can be misleading. “The message for patients is not to assume that newer is better,” Dr. Barry said. Measures like the number of operations a surgeon has done “still matter a lot,” he said.

Dr. Cadeddu, though, said that sort of message is falling on deaf ears. Patients want the robot. So Dr. Cadeddu has now begun offering robot-assisted surgery to those who want it.

“The battle is lost,” Dr. Cadeddu added. “Marketing is driving the case here.”

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Robotic Surgery Does Not Compromise Clinical Outcomes For Prostate Cancer Surgery

3 March 2010 04:01

Robotic surgical technology with its three-dimensional, high-definition view gives surgeons the sensation of touch, even as they operate from a remote console. A new study describes the phenomenon, called intersensory integration, and reports that surgical outcomes for prostate cancer surgery using minimally invasive robotic technology compare favorably with traditional invasive surgery.

Led by physician-scientists at New York-Presbyterian Hospital/Weill Cornell Medical Center and appearing in the March issue of *British Journal of Urology International*, the study is the first to show that a lack of tactile feedback during robotic surgery does not adversely impact outcomes in patients with prostate cancer. It also identified various visual cues that surgeons can use to improve clinical outcomes.

"Anatomical details and visual cues available through robotic surgery not only allow experienced surgeons to compensate for a lack of tactile feedback, but actually give the illusion of that sensation," says Dr. Ashutosh Tewari, the study's lead author; professor of urology, urologic oncology, and public health at Weill Cornell Medical College; and director of the Lefrak Center of Robotic Surgery and the Institute of Prostate Cancer at New York-Presbyterian Hospital/Weill Cornell Medical Center. "For patients, this means the safety of knowing the benefits of a robotic approach - including a quicker recovery - don't compromise the surgery's primary mission of removing the cancer."

In recent years, robotic-assisted laparoscopic prostatectomy (RALP) has become a popular surgical method for treating prostate cancer because it is less invasive than traditional surgery. No studies have shown that RALP leads to worse outcomes, but doctors have wondered whether this was the case because surgeons often use their fingers

to feel the prostate during traditional surgery to refine how much they cut to achieve the best outcome.

Cancer cells produce changes in tissue firmness that surgeons can sense. Because this tactile evaluation is not possible for surgeons using RALP, clinicians have wondered whether the robotic approach could lead surgeons to miss some cancer, and thus subject patients to a greater risk of cancer recurrence.

To find out, the investigators videotaped 1,340 RALPs. After every couple hundred procedures, they examined the pathology results of the prostate that was removed to determine the incidence of positive surgical margins, an indication that a surgeon might not have removed all of the cancer. In this study, the investigators focused on the posterolateral surgical margin (PLSM+), the area where the prostate is attached to the nerves.

"When you look at the entire specimen after surgery is done, you want to see cancer inside of the prostate but you don't want to see cancer touching the surface," Dr. Tewari says. "After surgery we look at the specimen, and if there are no cancer cells touching the surface, we call that a negative margin. If cancer is touching the edge, then we say it has positive margins. This means there may be some cancer left in the patient."

The investigators then studied the videotapes to determine what refinements in the procedure resulted in negative margins. Using this new knowledge to refine the surgery, they conducted the next couple hundred RALPs, reviewed the videotapes, refined their techniques, conducted the next round of RALPs, reviewed, refined and so on.

The investigators found that robotic surgery did not compromise outcomes. The incidence of PLSM+ was 2.1 percent, which gradually declined to 1 percent in the last 100 patients. Positive PLSMs are found in 2.8 percent to 9 percent of patients undergoing traditional prostatectomy.

The researchers say that the enhanced

vision allowed by the robotic approach brings about a "reverse Braille phenomenon" or the ability to "feel" when vision is enhanced. They have identified a number of visual cues that clinicians can use to improve outcomes, including the color of tissue, the location of veins as a landmark for the location of nerves, signs of inflammation, and appreciation of so-called compartments outside the prostate.

Surgeons use a three-level approach to optimize outcomes in prostate surgery: the clinical exam including the prostate-specific antigen (PSA) test, magnetic resonance imaging (MRI) tests, and cues during the actual surgery itself. They use the clinical exam and MRI to determine which one of four types of nerve-sparing surgeries to conduct before the operation and then refine their technique during the actual procedure if cues indicate a need.

"Treat each patient individually, get as much as information from the clinical exam, biopsy, imaging, and learn to appreciate the anatomical changes," Dr. Tewari says. "The outcomes of prostate cancer surgery are not just technology dependent, but rather they are dependent on surgical experience, anatomical details and attention to basic surgical techniques. Robotic surgery does not seem to compromise outcomes."

"As someone with 30 years of experience as a pathologist, I, too, have developed the ability described in this paper. I can look at a tissue sample and know if it is firm or soft and what to expect in its pathology - something that helps me to home in on the area with the abnormality," says Dr. Maria M. Shevchuk, the study's senior author, associate professor of pathology at Weill Cornell Medical College, and a pathologist at New York-Presbyterian Hospital/Weill Cornell Medical Center. "It is only natural that this ability would also be present in experienced robotic surgeons."

Source: New York- Presbyterian Hospital/Weill Cornell Medical Center/Weill Cornell Medical College

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What To Ask Your Doctor If..... You're Considering Surgery For Early-Stage Prostate Cancer Treatment

- Which surgical technique will be used?
- Based on your experience, why is this the right approach for me?
- Do you plan to employ a nerve-sparing technique with the aim of conserving my ability to get an erection following surgery?
- What level of success have you had in preserving potency (ability to get an erection) in your patients following surgery?
- What about preserving urinary continence (bladder control)?
- What will you do if you find cancer outside of my prostate during the surgery?
- Will that change my prognosis and future treatment?
- Do I need to be concerned about blood loss during the surgery? Should I store my blood or get my family and friends to donate blood in case it is needed?
- What can I expect following the surgery in terms of recovery time? How long will it be before I can return to my normal activities?
- What are the likely or possible side effects of the surgery, both short-term and long-term?
- What will we do to monitor my prostate cancer following the surgery?

Knowing what to expect before, during, and after surgery for the treatment of early-stage disease will help in the decision-making process when choosing the best therapeutic strategy.

What to ask your Doctor if..... You're Considering Radiation Therapy For Early-Stage Prostate Cancer Treatment

- Which radiation technique will be used?
- Based on your experience, why is this the right approach for me?
- How will this procedure precisely target the cancer tissue but leave the normal tissue unharmed?
- Are there specific radiation therapy approaches that we should discuss or consider, such as IMRT or brachytherapy?
- What dose of radiation will you be using and why did you select that dose?
- Where are the treatments given and how many will I receive?
- Do you recommend that we initiate androgen deprivation therapy (hormone therapy) before the radiation treatments? Why or why not?
- What are my chances of preserving erections following this treatment?
- What are the chances of bowel and urinary incontinence?
- What can I expect for recovery time before I can return to normal activities?
- What side effects can I expect over time?
- What will you do to monitor my prostate cancer following treatment?

www.prostatecancerfoundation.org

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Radical Prostatectomy: Pros and cons

By Mayo Clinic staff

Radical prostatectomy may be an effective way to treat your prostate cancer.

Consider the following pros and cons before making your decision:

Pros of Radical Prostatectomy

If the cancer is confined to your prostate, this is the most effective treatment to remove cancer.

Your doctor is able to gather information about the extent of your cancer during surgery and after a laboratory examination of the removed prostate tissue. Lymph nodes can be analyzed to determine if additional treatment is required.

Surgery can also treat pre-existing problems with urination caused by enlarged prostate.

Without the prostate to produce PSA, PSA testing will show no PSA in your system immediately after your surgery. If your cancer comes back, your PSA levels will increase. An increase would be an accurate way to tell your cancer has returned.

You can still use radiation after the surgery, whereas surgery after prior radiation is much more difficult and not offered in most cases.

Cons of Radical Prostatectomy

All operations carry some risk, including a low risk of death, which increases with age.

It takes time for you to regain urinary continence and return of erectile function. You may have permanent issues with urinary continence and erectile function.

If people have a problem with erectile function before surgery, they'll usually have permanent problems after surgery.

Surgery requires a hospital stay and longer recovery period than does radiation therapy.

Two Surgical Methods Equally Successful for Prostate Cancer

Comparison study of open and laparoscopic surgery found few differences in outcome

By Robert Preidt

Monday, Feb. 22 (HealthDay News) - Results are similar for men with prostate cancer whether they have open surgery or laparoscopic surgery, a new study has found.

Currently, open radical prostatectomy (ORP) is considered the standard treatment but the use of laparoscopic radical prostatectomy (LRP), with or without robotic assistance, is becoming more widespread.

In the new study, researchers at Memorial Sloan-Kettering Cancer Center in New York City compared ORP and LRP outcomes in nearly 6,000 men, age 66 or older, with localized prostate cancer.



After they adjusted for patient and tumor characteristics, the researchers found no differences in the rates of general medical/surgical complications, genital/urinary/bowel complications, or in use of postoperative radiation and/or androgen deprivation.

Patients in the LRP group had a 35 percent shorter hospital stay and a lower rate of bladder neck/urethral obstruction, the study authors noted.

"All men considering radical prostatectomy should be clearly informed about the differences between the two techniques and similarities in their expected outcomes, and make treatment decisions in collaboration with an experienced surgeon," Dr. William T. Lowrance and colleagues wrote in their report, which is published in the Feb. 22 issue of the *Journal of Urology*.

SOURCE: The Journal of Urology, news release, Feb. 22, 2010

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2010 MEETINGS:

- Jan. 21.....Dr. Anne Katz, Clinical Nurse Specialist
"Sexual Relationships Following Prostate Cancer"
- Feb. 18.....Dr. Aldrich Ong, Radiation Oncologist
" Radiation and Chemotherapy for Prostate Cancer"
- Mar. 18.....Dr. Piotr Czaykowski, Medical Oncologist
"New Developments in Drug Treatment"
- April 15.....Dr. Graham Glezerson, Urologist
"Treating Erectile Dysfunction After Prostate Cancer - The Hard Facts"
- May 20.....Dr. Spencer Gibson,
Provincial Director, Research, Cancercare MB.
"Research at Cancercare Tumour Bank"
- June 17.....Nursing Staff from the Prostate Centre, Cancercare MB
"What Happens at the Manitoba Prostate Centre"
- July 15.....TBA
- Aug. 19.....Dr. Paul Daeninck, Pain Management Specialist
"Insights into Pain Management"
- Sept. 16.....Dr. Robert Wightman, Pathologist
"Understanding Your Biopsy Report"
- Oct. 21.....Katherine Gottzmann, Psychosocial Oncology
- Nov. 18.....TBA
- Dec. 16.....Potluck Party Time

Executive Committee:

(204)

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