

The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 227 – May 2010

manpros@mts.net

Thought For Today

Change is inevitable,
except from vending
machines.

- Pat Feschuk

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, May 20th, 2010 7 - 9 P.M.

DR. SPENCER GIBSON,
PROVINCIAL DIRECTOR, RESEARCH, CANCERCARE MB.

"RESEARCH AT CANCERCARE TUMOUR BANK"

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.

Winnipeg Relay for Life

Date: May 28, 2010 - 7:00 p.m.

Location: Canwest Park, Home of the Winnipeg Goldeyes

The Canadian Cancer Society's Relay for Life is an opportunity to get together with family and friends and celebrate cancer survivors, remember loved one's lost to cancer, and fight back in the hope of finding a cure for this disease. Your participation gives strength to our mission to eradicate cancer.

For more information, contact: Nona Barratt
at (204) 789-0884 or
winnipegrelayforlife@mb.cancer.ca

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

Prostate Cancer Radiation Side Effects May Subside With Time

*Ten years later, many men weren't bothered
by treatment's effects, study finds*

TUESDAY, March 16 HealthDay News

The balance between using enough radiation to shield patients from prostate cancer's return while keeping side effects at bay may not be as tricky as once thought, new research shows.

That's because radiation-linked side effects appear to lessen with time. In fact, 10 years after treatment, prostate cancer patients didn't report suffering more severe side effects after doctors boosted their radiation to levels that made tumor recurrence 50 percent less likely, researchers say.

"A surprising number of men who reported symptoms that had bothered other patients surveyed before or soon after prostate cancer treatment described their current symptoms as normal," said Dr. James Talcott of the Massachusetts General Hospital Cancer, who led the study, in a statement.

The study examined two dose levels used for patients with early-stage prostate cancer. The higher doses— 79 Gy— lowered the risk of recurring tumors by half. Of 398 participants, 280 returned surveys.

"Symptoms that seem to bother other patients early in the course of their prostate cancer were regarded as normal by these patients nearly a decade after treatment," Talcott says. "As clinicians, we know that patients adapt to their situation and accept physical changes as the 'new normal.' When talking with prostate cancer patients, I've been surprised when, for example, a patient in his late 60s who became impotent two or three years after treatment would comment, 'Well it would have happened anyway to a man my age.'

"While these results need to be confirmed, since this is just one study, it's looking like we should tell patients that treatment side effects probably will bother them less than they originally fear because they are likely to adjust and experience less distress over time," he added. "We also may need to rethink our standard measures of treatment outcomes, which assume that the impact of symptoms on patients' quality of life does not change over time. While that may be true for pain, it doesn't seem to be true for these sorts of symptoms."

The study appears in the March 17 issue of the Journal of the American Medical Association.

*SOURCE: Massachusetts General Hospital, news release,
March 16, 2010 HealthDay*

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WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

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705 - 776 Corydon Ave., Winnipeg R3M OY1

Charity number: 88907 1882 RR001

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What to Consider When Your PSA Is Rising During Hormone Therapy

This section summarizes key points to consider when your PSA is rising while undergoing hormone therapy. The list is by no means exhaustive, and there might be other points that you want to think about as well. The goal is to help you focus on what you need to know about each stage of disease so you can hold meaningful, regular dialogues with all members of your health care team as you find the treatment path that's right for you.

- 1) A rising PSA during hormone therapy doesn't mean you're out of options—it means you need to consider the use of other systemic therapies such as chemotherapy or agents that target prostate cancer bone metastases.
- 2) The primary goal of chemotherapy is to stop the cancer cells from dividing and the cancer cells from growing. But when we look at whether a drug is working, there are generally two levels of effectiveness—whether a drug is palliative, meaning whether it can alleviate symptoms, and whether it can affect the cancer cell growth significantly enough to prolong life.
- 3) The benefits of chemotherapy in prostate cancer were only first realized recently: mitoxantrone (Novantrone) was approved by the FDA in 1996 when it was shown to provide palliative benefit to men with advanced prostate cancer; docetaxel (Taxotere) was approved in 2004 when it was shown to prolong the lives of the men who took it and relieved symptoms better than mitoxantrone.
- 4) Although all chemotherapy drugs are designed to slow or stop the growth of cancer cells, each one tends to work in a slightly different way, and using two or more together or one after another in a row can often be more effective than just using one drug alone.
- 5) Pay close attention to your reactions to the different chemotherapy drugs. You're the only one who really knows your own body, so you're the only one who can know whether you are able to tolerate a particular treatment regimen.
- 6) Don't be too tough or "macho." There are plenty of drugs available to help ward off or treat the different side effects of chemotherapy.
- 7) Focus on yourself. It doesn't matter what you do, as long as it can help you relieve stress and can help you with the most important part of your cancer treatment—getting well.
- 8) Prostate cancer cells that have spread beyond the prostate seem to prefer bone tissue and tend to migrate there after escaping the pelvic region. Once the cells settle in, they're known as prostate cancer bone metastases. Unlike bone cancer, which originates in the bone, prostate cancer bone metastases are actually collections of prostate cancer cells that happen to be sitting within the bones.

9) When prostate cancer cells settle in the bones, they interact with the bone cells, causing new bone cells to grow and causing the bone tissue to break down. The dye-like material that's injected during a bone scan highlights areas of bone metabolism or activity—areas where bone tissue is changing more rapidly than it normally would in a healthy adult male.

10) Men who experience pain from a bone metastasis will often be treated with radiation targeted directly to the metastasis or with radiation-emitting drugs that settle in the metastasis after being injected through a vein. The radiation will kill the prostate cancer cells in the metastasis and thereby relieve the pain.

11) Bisphosphonates are drugs that are designed to help reset the balance in the bone between bone growth and bone destruction which is disrupted by the prostate cancer bone metastases. Zoledronic acid (Zometa) is a bisphosphonate given intravenously that can delay the onset of complications associated with prostate cancer bone metastases and relieve pain. It is typically given once every three weeks as a 15-minute infusion.

12) As the bones in the spine weaken, they can collapse one of top of the other, compressing the spinal cord and the nerves that run out from it. Cord compression associated with metastatic prostate cancer can cause serious problems if not managed immediately, so be sure to tell your doctors about any new pain, weakness, or changes in bowel habits, any of which can result from spinal cord compression.

13) Cancer can be painful, and there's no benefit in acting stoic and pretending it doesn't affect you. There are plenty of very effective pain medications available, and using them will allow you to feel better and stay stronger.

14) Don't assume that you can't get pain relief unless you're completely doped up. Some very simple and easy to take oral medications might be enough to ease your pain.

15) Don't worry about becoming addicted to pain medication. Taking pain medications so that you can spend your days feeling healthier and stronger is the opposite of addictive behaviour. However, both physical dependence and tolerance are possible as your body starts to get used to the drugs, so you and your doctors should take them into consideration as you start and stop different pain medications.

16) Consider enrolling in a clinical trial of an experimental new treatment or regimen. Clinical trials are the only way that new and better treatments will be developed and tested appropriately.

www.prostatecancerfoundation.org

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Prostate Cancer Screening Guidelines Updated

Christine S. Moyer, amednews staff. Posted March 16, 2010

Physicians should discuss the risks and benefits of screening with patients, according to recommendations from the American Cancer Society.

The American Cancer Society has updated its screening guidelines for prostate cancer, emphasizing that doctors educate patients about the potential risks and benefits of screening.

The updated guidelines, published online March 3 in *CA: A Cancer Journal for Clinicians*, keep the society's core recommendations on what age to begin discussions. The main difference from the last ACS guidelines issued in 2001 is the emphasis on informing patients about screening uncertainties and involving patients more in the decision-making process

(<http://caonline.amcancersoc.org/cgi/content/full/caac.20066v1/>).

"With all the evidence we've got, it's increasingly clear that the benefits are uncertain for prostate cancer screening," said Andrew Wolf, MD, lead author of the ACS guidelines and associate professor of medicine at the University of Virginia School of Medicine. "We felt it was time to really emphasize the informed and shared-decision making [approach]."

The cancer society continues to recommend that physicians begin discussing prostate cancer screening with male patients when they are 50 years old. Screening discussions should begin at age 45 for those considered at higher risk for prostate cancer, including blacks and men with a father or brother diagnosed with the disease before age 65.



Men with multiple family members diagnosed with the disease before age 65 should receive screening information at age 40. Patients with

less than a 10-year life expectancy, due to age or health status, should not be screened.

Urologist Brantley Thrasher, MD, said the revised guidelines won't likely change how he talks about screening with patients. He said doctors need to ensure adequate dialogue with patients to help them in the decision-making process.

"It basically is echoing what many of us have said for quite some time— that you need to make sure you're discussing

the pros and cons of this with your patients," said Dr. Thrasher, a professor and chair of urology at the University of Kansas Medical Center.

A leading cause of cancer

Prostate cancer is the most commonly diagnosed cancer among U.S. men and remains the second leading cause of cancer death in males, following lung cancer, according to the ACS. In 2009, about 192,000 men were diagnosed with prostate cancer, with 27,000 expected to die from the disease.

The revised ACS guidelines intend to help physicians detect who is most at risk of dying and who could survive without potentially harmful treatment. To do this, the society updated clinical recommendations on screening intervals.

The ACS recommends men whose PSA level is 2.5 ng/mL or higher be screened annually. For men whose PSA levels are between 2.5 ng/mL and 4.0 ng/mL, physicians are encouraged to consider individual risk factors, including age, ethnicity and family history.

Men at an average risk of developing prostate cancer and who have PSA levels of 4.0 ng/mL or higher should be referred for further evaluation or biopsy.

The guidelines also call for talking to patients about the benefits and harms associated with screening, including false test results and side effects of treatment. The ACS suggests that doctors enhance their discussions with written information or videos with balanced, up-to-date information.

If a patient still can't decide what to do, the screening decision should be left to the physician. That differs from previous ACS guidelines, which said men should be tested if they can't make a decision.

The revised guidelines say men who have had a PSA test do not need a digital rectal exam, because the exam has not clearly shown a benefit.

Physician participation in community-based prostate screening programs, such as those held at health fairs, is discouraged unless the programs adequately provide an informed decision-making process with the patient and appropriate follow-up care. "We're not recommending that all these [community] programs end," Dr. Wolf said. "We're just saying they need to be held to the same standards that physicians are held to."

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Seeking a Second Opinion

Pat Rich

While many patients may feel that it is disrespectful to their doctors to consult other physicians, getting a second opinion is a perfectly acceptable option if you are not satisfied with the medical advice you have received.

But in Canada, the reasonableness of that option is somewhat at odds with results from a recent study by the Frontier Centre for Public Policy. Both in 2008 and 2009, this independent think tank, based in western Canada, teamed up with researchers in Europe to produce a consumer health index for Canada and 30 European countries. The index looked at a number of measures of health care, including patients' rights and access to information.



In both years, the index rated Canada last when it came to the issue of access to second opinions, because the right is not enshrined in Canadian law. "Many

provinces and regional health authorities encourage consumers to request a second opinion if they are not confident in the diagnosis or recommendations of their physicians, but they provide no recourse for patients if such a request is denied," says the Euro-Canada Health Consumer Index 2009 report. "Further, since a second opinion, from a specialist requires a referral and often a lengthy wait, even those regions that seek to provide second opinions have great difficulty in translating this into reality."

In contrast, several of the provincial bodies that license physicians in Canada expressly note that patients have a right to a second opinion. Even so, professional feelings can be bruised when second options are sought.

"Whenever I have been involved in getting a second opinion, there always seems to be hard feelings," says Nancey Roach, a registered nurse who serves as a patient navigator for Cancer Care Nova Scotia and deals with physicians who specialize in cancer care.

"I do not discourage people from seeking a second opinion if their minds are made up," says Pelletier

Family doctors note that their patients rarely request second opinions, but when they do, most doctors are more than happy to arrange them. "I never resent a patient asking for a second opinion" says Vancouver family physician Dr. Jack Burak. Adds Dr. John Maxted, associate executive director of health and public policy at the College of Family Physicians of Canada, "Patients do ask for second opinions, just as you might want a second opinion on anybody else's advice for a non-health-related issue. There are many situations where, as the patient's physician, I myself would like a second opinion to make sure that I have done the right thing and am providing the right advice."

But Maxted admits that some physicians may take offence and see such a request as "a vote of non-confidence" in their services. But for Dr. Mike Evans, a Toronto-based family physician and researcher, the patient may have a different motivation. "There are quite a few times when patients are seeking second, third or fourth opinions, but in a way they are looking for an answer they want to hear - not necessarily the right one." That can be tricky to manage. "Do you let them go on their journey or do you intervene? I probably do a bit of both," says Evans.

For Dr. Steve Pelletier, a family physician in Rockland, Ont., requests for second opinions usually boil down to a communication problem between doctor and patient rather than a lack of confidence in the expertise of the physician. A patient may not fully understand what he has been told and really just want someone to explain the situation more fully. "I do not discourage people from seeking a second opinion if their minds are made up," he says. "Where I think it is in the best interest of the patient, I try to explain why it might be better to pursue the issue with the specialist they have already seen and perhaps clarify their own expectations for a future visit."

Remember: you have a right to seek the opinion of another physician if you are dissatisfied with a diagnosis or suggested course of treatment. Although you may feel awkward doing so, it's your health that's at stake and, ultimately, you are its master.

Canadian Medical Association

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Choosing— And Sticking With— Active Surveillance: A Patient's Story

****Please note that this is part one of a patient's prostate cancer journey – the rest to follow in a subsequent newsletter****

In 1997, Jeffrey Caruso's physician recommended prostate-specific antigen (PSA) screening as part of Caruso's annual checkup. Then a 57-year-old businessman and avid bicyclist, Caruso* hadn't had any prostate problems, but he agreed that regular PSA screening was probably wise for someone his age. The result — 3.9 ng/dl — raised some concern because it fell at the upper end of what was considered the normal PSA range: 0 to 4.0 ng/dl.

**Editor's note: To protect his privacy, the patient's name and some biographical details have been changed. All medical details are as reported. In keeping with editorial policy, the patient's physicians are not named.*

Caruso and his doctor chalked it up to his daily bike rides. During a long ride, the bicycle seat can put a lot of pressure on the perineum, the area between the anus and the scrotum, which can raise the PSA level even when cancer isn't present. So neither doctor nor patient worried much about the finding.

The next year, however, Caruso's PSA had risen to 4.4 ng/dl. Anxiety set in. He soon saw a urologist, who monitored changes in his PSA and performed digital rectal exams. (See "Feeling the prostate," below.) During one of these exams, the urologist noted that a small part of the prostate seemed slightly firmer than the rest, a possible sign of cancer. In

April 1999, Caruso had his first prostate biopsy. It was negative, but the initial surge of relief was quickly tempered. "The urologist called me with the results and said that he did not find any cancer," Caruso recalled. "But then I asked him, 'Does that mean I don't have cancer?' And I remember he said, 'No, it means we just didn't find any.' When he said that, I started to worry. Not finding cancer and not having cancer are two different things."

Annual PSA tests and digital rectal exams followed, and Caruso's PSA level continued its slow upward climb. In 2005, it hit 5.0 ng/dl, and both Caruso's urologist and an oncologist felt a more pronounced hardening on the right apex of the prostate (see Figure 1). A second prostate biopsy followed, as did the diagnosis that Caruso feared: prostate cancer.

In this interview with Perspectives' editors, Caruso describes his cancer diagnosis and the seemingly endless research he conducted regarding his condition. He also explains his decision to pursue active surveillance, sometimes called watchful waiting, a strategy he has stuck with for more than three years. (Active surveillance involves frequent monitoring of the cancer, rather than actual treatment, to gauge its activity. Because patients can opt for treatment at any time, doctors may use the phrase "active surveillance with delayed intention to treat" instead.) Caruso also offers advice for men recently diagnosed with prostate cancer who are sorting through treatment options.

Feeling the prostate

During a digital rectal exam (DRE), the doctor inserts a lubricated, gloved finger into the rectum. Because the prostate sits in front of the rectum, the doctor can feel part of it through the rectal wall. A normal prostate is small — about an inch and a half from side to side — and feels smooth and rubbery. A firm knot suggests malignancy, but it can be a sign of other conditions, such as benign prostatic hyperplasia. Not all cancers can be felt, however.

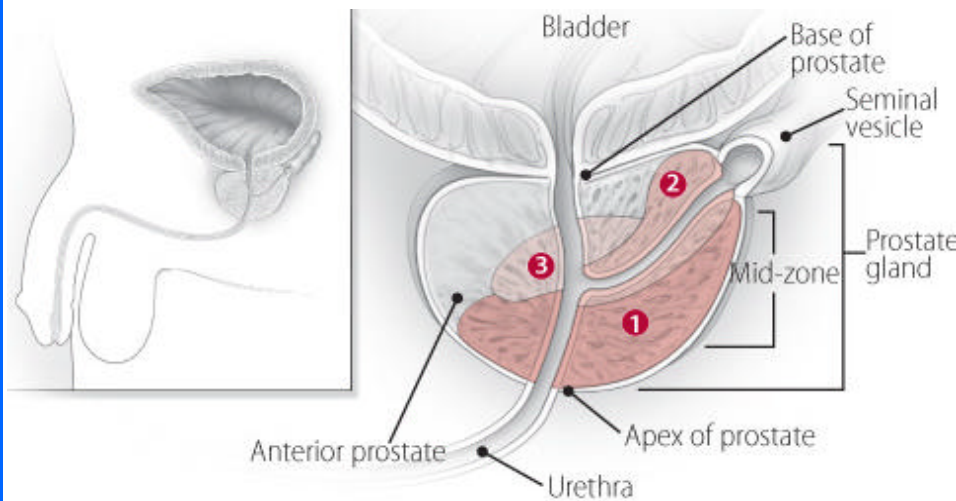
There are two schools of thought about the best position for the DRE. Some physicians prefer that the patient stand and bend at the waist, with his arms extended on the examination table. Others opt to have the patient lie on one side with one or both knees drawn up toward the chest. There are no data showing one position is superior to the other.

If you've had a DRE, you already know that it's awkward and uncomfortable. However, it shouldn't be painful — if it is, say so! The exam usually doesn't last very long, but it should be done slowly enough that the doctor can assess the size of the prostate, feel its lobes, and detect any bumps or hardness or changes in consistency from one side to the other. Although every rectal exam should be thorough, some patients report that specialists seem to be more meticulous in performing DREs than their general practitioners.

Continued on page 7

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Figure 1: Zones of the prostate



When doctors talk about parts of the prostate, they may refer to the apex, located at the bottom of the prostate; the base, counterintuitively at the top; and the mid-zone, the space between the apex and the base. Alternatively, they may refer to three distinct areas of the prostate: the peripheral zone (1), the central zone (2), and the transition zone (3). Most prostate cancers arise in the peripheral zone, which includes the apex. Few arise in the anterior, or front, of the prostate.

Aside from the findings, how did your second biopsy vary from the first one?

There were several differences. During my first biopsy, the urologist took 15 cores, or tissue samples. In 2005, he did 20, so there was a greater likelihood that he'd find cancer if it was there.

The needle was also smaller, and he gave me local anesthesia, which made a huge difference. If there's no anesthesia, the biopsy is kind of painful. It's not excruciating, but it does hurt. With the local anesthesia, it still wasn't a pleasant experience, but it was more bearable.

How extensive was the cancer?

The pathologist found cancer in 40% of one of the cores from the right apex of the prostate. It was a Gleason 6 cancer, scored at 3 + 3. I asked to have the tissue samples sent to a pathologist at another hospital for a second opinion, which confirmed the original findings.

How did you react to the diagnosis?

I probably had the same reaction anyone else would: panic for several months and the fear that I was going to die in a year or two. When the panic finally went away, I was depressed. It was just like reactions I had read about in a number of books — that feeling of “Why me?” I also remember having a very strong urge to do something immediately. I didn't want to wait and then have it be too late. My urologist said that I qualified for surgery and that he could perform the procedure, but he said that radiation and active surveillance were also options.

But you didn't have a radical prostatectomy. Why not?

I was ready to have surgery when I left the urologist's office, but he wanted me to see other specialists and consider other options. I went to see a radiation oncologist. Although

he said I could have surgery or another form of treatment, he specifically recommended that I have seed implants, or brachytherapy. After that, I was ready to have seeds put in. I guess when you're panicked and you want to do something immediately, you tend to go with the most recent recommendation you've gotten from a knowledgeable and articulate professional who really believes that it's a good option for you.

But between these appointments, I saw an oncologist who also described all the options but stressed active surveillance. He also emphasized the fact that I didn't have to rush to make a decision. Some studies had shown that people like me with early-stage prostate cancer and no symptoms could wait a year or so to make a decision. Knowing that, I calmed down and decided to study the whole situation. How could I beat this cancer? I started to study the natural history of the disease and the available treatments, and I became increasingly aware of the side effects that accompany any and all of the treatments.

Which side effects particularly concerned you?

I was concerned about all of the side effects. I had started talking to several patients and personal friends who had dealt with prostate cancer. Some of them had been operated on, others had radiation. One of the patients I talked to suffered from both urinary and fecal incontinence for several years. He ended up having two operations to minimize these problems, but he confided in me that he was ready to “call it quits” after two years of both fecal and urinary incontinence.

So he initially opted for a radical prostatectomy?

(Continued on page 8)

(Continued from page 7)

No. It's hard to believe, but he actually had seeds. He became convinced that the seeds were misplaced or moved, because the degree of the side effects was so great and fecal incontinence is uncommon with this treatment. He finally had corrective surgery done. [See "Common side effects," below.]

For me, the worst side effect of treatment would be fecal incontinence; second would be long-term urinary

incontinence, and third would be erectile dysfunction. There is a very high potential for erectile dysfunction, especially in an older man. (Somebody might say that I'm an older man, but I certainly don't feel like one!)

There are lots of data on the side effects of prostate cancer treatment. Even the very best practitioners, both radiation oncologists and surgeons, will tell you that they cannot guarantee zero side effects. They will then tell you their complication rates. Those are real percentages that you need

Common side effects

Sexual side effects, urinary incontinence, and bowel problems occur to varying degrees with all prostate cancer treatments. A recent Harvard study polled 1,201 patients about side effects and quality of life following prostatectomy, external beam radiation, and brachytherapy. Among men who underwent brachytherapy, the rate of urinary incontinence rose from 5% before the procedure to 13% two months later. But within a year, just 6% reported the problem. Fecal incontinence, which less than 1% of the men experienced before brachytherapy, was reported by 6% at two months and by 4% after a year. Long-term incontinence requiring surgery, like that reported by Caruso's friend, is rare.

To be continued in our next issue

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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.....Dr. Aziz Mhanni, Medical Geneticist.
- Dec. 16.....Potluck Party Time

Executive Committee:

(204)

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