Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 298 1,300 copies printed/e-mailed **June 2016**

Managing Urinary Incontinence after Prostate Treatment

Surgery or radiation therapy may irritate the urethra or bladder or damage the urinary sphincter (muscles that contract to prevent urine from flowing out of the bladder). As a result, some degree of incontinence (inability to control bladder function) is common after prostate treatment.

Urge incontinence (the strong and sudden need to urinate, followed by a bladder contraction and involuntary loss of urine) is common for a few days after catheter removal in men who have undergone TURP for the treatment of BPE. However, in the initial period after radical prostatectomy for prostate cancer, men typically experience stress incontinence, in which urine leakage occurs during moments of physical strain (such as sneezing, coughing or lifting heavy objects). Recovering bladder control is a slow process that may take up to six months. Fortunately, severe incontinence occurs in less than 1 percent of men after surgery for BPE and in fewer than 3 percent of men following radical prostatectomy or radiation therapy for prostate cancer. The following approaches can be taken to manage incontinence:

Lifestyle measures

Simple changes in diet and behavior can be helpful. Excess weight increases pressure on the bladder and worsens incontinence. Weight loss through calorie restriction and increased physical activity will help. Because constipation can worsen symptoms, it is important to eat high-fiber foods, such as leafy green vegetables, fruits, whole grains and legumes. Caffeine and

(Continued on page 2)

Medical Advisors

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Family Practitioner

Thanks!

Next meeting: June 16, 2016
Kristen Bilenky, Social Worker
Topic: Cancer System Navigation
Location: Wellness Centre, Room 4
Seven Oaks General Hospital
Time: 7:00 General Discussion
8:00 Guest Speaker

SHARING IS CARING

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians.

MPCSG – active since 1992.

Thought of The Day

Never ask Google for medical advice: I have gone from mild headache to clinically dead in three clicks!

(Continued from page 1)
alcohol increase urinary frequency and should be limited. If nighttime urination is a problem, avoid consuming liquids during the last few hours before bed.

Kegel exercises
These exercises are performed by squeezing and relaxing the pelvic floor muscles that surround the urethra and support the bladder. To locate the pelvic floor muscles, try slowing or stopping your urine flow midstream as you urinate. Strengthening these muscles may improve bladder control after radical prostatectomy.

Collagen injections
If urinary incontinence persists, injection of a synthetic collagen-like material around the bladder neck to add bulk can provide increased resistance to urine leakage during times of physical strain. Repeat injections often are needed because these materials are gradually broken down by the body.

Surgical treatments
Placement of an artificial urinary sphincter (a doughnut-shaped rubber cuff) around the urethra is a treatment for more severe urinary incontinence after prostate cancer surgery. The cuff is filled with fluid and connected by a thin tube to a bulb implanted in the scrotum. The bulb in turn is connected to a reservoir implanted within the abdomen. The fluid in the cuff creates pressure around the urethra to hold urine inside the bladder. When a man feels the urge to urinate, he squeezes the bulb. This transfers fluid from the cuff to the reservoir and deflates the cuff for three minutes so that urine can drain through the urethra. Afterward, the cuff automatically refills with fluid and urine flow is again impeded. Urethral sling procedures are a surgical option usually reserved for less severe cases. The sling is made of synthetic material and it lifts and compresses the urethra, thereby preventing urinary leakage.

Absorbent products
Wearing absorbent pads or undergarments is the most common way to manage incontinence. These products are often used right after surgery and are effective for managing all degrees of incontinence, ranging from mild to severe. Absorbent products are also ideal for men who have minimal leakage on occasion.

Penile clamps
An option for severe incontinence, penile clamps compress the penis and urethra to prevent urine leakage. The clamps are not recommended immediately after treatment because they interfere with the development of the muscle control needed to regain urinary continence.

External collection devices
These condom-like devices can be pulled over the penis and held in place with adhesive Velcro straps or elastic bands. A tube drains urine from the device into a bag secured on the leg. Collection devices should not be used immediately after surgery when men are attempting to regain urinary control.

Catheters
A Foley catheter is a small tube that is inserted through the urethra to allow urine to flow continuously from the bladder into a bag. This option is not recommended for long-term use because it can cause irritation, infection and, possibly, loss of bladder muscle control.

Medications
Although medication can be used to help control mild to moderate incontinence, it is not effective for severe cases. Medications such as oxybutynin (Ditropan) and tolterodine (Detrol) may reduce urge incontinence by decreasing involuntary bladder contractions. Other options include nasal decongestants, such as pseudoephedrine, or the antidepressant imipramine (Tofranil), which can reduce stress incontinence by increasing smooth muscle tone in the bladder neck. Because pseudoephedrine is a stimulant that can increase heart rate and blood pressure, it should only be used under a doctor's supervision.

source: www.healthafter50.com

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<u>Important Notice</u>
Our Support Group meetings are moving
NEW LOCATION
Cindy Klassen Recreation Complex - 999 Sargent Ave.
Effective July 21, 2016. Meetings 7 – 9 p.m.
Phone: (204) 989-3433
Free admission – Free parking

Bicalutamide

Prostate cancer occurs when there is an uncontrolled growth of cells in the prostate, a gland found in men's reproductive system. The prostate is located below the bladder, near the rectum and around the urethra, and its main function is to produce a fluid that combines with sperm and makes semen more liquid.

Given the location of the gland, prostate cancer affects both the reproductive and urinary systems. The disease causes symptoms such as urinary problems like a slow or weak urinary stream or the need to urinate more often, especially at night, blood in the urine, erectile dysfunction, pain in the hips, back, chest, or other areas from cancer spread to bones, and weakness or numbness in the legs or feet, or even loss of bladder or bowel control from cancer pressing on the spinal cord.

How Bicalutamide Works

Bicalutamide is one of the drug options included in a type of treatment for prostate cancer known as hormone therapy. Bicalutamide binds to androgen receptors in target tissues, thereby inhibiting the receptor binding of androgens. This agent does not bind to most mutated forms of androgen receptors. The anti androgen drug Bicalutamine is used in combination with other agonists like leuprolide or goserelin for the treatment of metastatic cancer.

It is classified as nonsteroidal anti androgen, since it works by blocking the normal effect of the male hormone androgen. The main type of androgens produced by the body are testosterone and dihydrotestosterone (DHT). These are formed in testicles, adrenal glands and tumors themselves, and they stimulate the growth of prostate cancer cells. Bicalutamide blocks this ability in order to stop the growth and spread of cancer.

The U.S. Food and Drug Administration (FDA) approved the use of Bicalutamide in the country in September 2009, and it is particularly indicated for patients whose cancer has spread too far to be cured by surgery or radiation, whose cancer remains or comes back after treatment, along with radiation therapy as initial treatment, or before radiation to try to shrink the cancer and improve treatment's effectiveness. Bicalutamide is commercialized under the brand name Casodex by the Pharmaceutical Company AstraZeneca.

Source: Prostate Cancer News Today.

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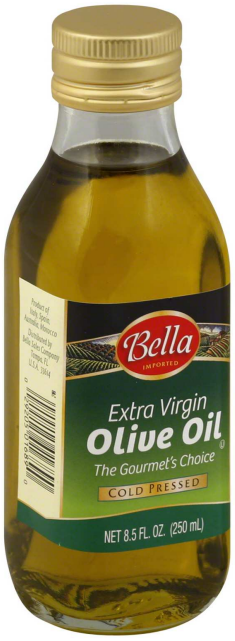
Extra-Virgin Olive Oil: Cancer Fighter?

Could extra-virgin olive oil be a cancer fighter? In the latest Prostate Disorders Bulletin, Jacek L. Mostwin, M.D., D. Phil (Oxon), professor of urology at the Brady Urological Institute at Johns Hopkins Medicine, discusses the issue:

Who hasn't drizzled extra virgin olive oil over a nice garden salad? Not only does it taste good, but the olive oil may actually be fighting prostate cancer cells at the same time, according to researchers from Rutgers University in New Brunswick, New Jersey and Hunter College in New York City.

We already know from the 2013 Health Professionals Follow-Up Study that a diet rich in healthful vegetable oils can possibly help prevent prostate progression in men newly diagnosed with prostate cancer. What the Rutgers nutritional scientist and two cancer biologists at Hunter College have recently reported in the journal Molecular and Cellular Oncology is that an ingredient in extra-virgin olive oil can kill a variety of prostate cancer cells without harming healthy cells.



The killer ingredient they have isolated in the lab is called oleocanthal, a compound that bursts a part of the cancerous cell, which then releases enzymes that cause cell death within 30 minutes to an hour, without harming nearby healthy cells.

The researchers say the logical next step is to go beyond the research laboratory and show that oleocanthal can kill cancer cells and shrink prostate—and other cancer—tumors in living animals. While waiting for those studies to be conducted, continue to enjoy your olive oil. And perhaps consider adopting a Mediterranean-type diet. The Mediterranean diet consists of foods traditionally consumed by people living along the coast of the Mediterranean Sea, characterized by smaller portions and a focus on fresh rather than processed foods.

Posted in Prostate Disorders on November 12, 2015

Source: www.healthafter50.com

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Melbourne Consensus Statement - On The Early Detection Of Prostate Cancer.

Introduction:

Recent guideline statements and recommendations have led to further confusion and controversy about the use of PSA testing for the early detection of prostate cancer. Despite high-level evidence for the use of PSA testing as a screening tool, and also for its role as a predictor of future risk, the USA Preventive Services Taskforce (USPSTF) has called for PSA testing to be abandoned completely, and many men are therefore not given the opportunity for shared decision-making. Other groups, e.g. the Australian Urology Associates (AUA), National Comprehensive Cancer Network (NCCN), and European Association of Urology (EAU), support a role for PSA screening but with conflicting recommendations. Most guideline statements have endorsed the role of shared decision-making for men considering PSA testing.

To address these conflicting and confusing recommendations, a group of leading prostate cancer experts from around the world came together at the 2013 Prostate Cancer World Congress in Melbourne, Australia, and generated a set of consensus statements about the use of PSA testing and the early detection of prostate cancer. The signatories to the Melbourne Statement include representatives from urology, radiation oncology, medical oncology, general practice, psycho-oncology and nursing. The goal of these statements is to bring clarity to the confusion that exists with existing guidelines and to present reasonable and rational guidance for the early detection of prostate cancer today. These statements are based on an appraisal of existing guideline statements and an overview of published data about the early detection of prostate cancer.

The 5 Melbourne Consensus Statements are listed below followed by an explanation.

Consensus Statement 1: For men aged 50-69 years, Level 1 evidence shows that PSA testing reduces the incidence of metastatic prostate cancer and prostate cancer-specific mortality rates.

In the European Randomized Study of Screening for Prostate Cancer (ERSPC), still with early follow-up, screening reduced metastatic disease and prostate cancer-specific mortality by up to 30% and 21% respectively in the intent-to-treat analysis, with a greater reduction after adjustment for noncompliance and contamination. Statistical modelling studies of ERSPC data have reported that with steady-state application of the ERSPC protocol, that the prostate cancer-specific mortality benefit would reach 67% reduction at the beginning of 12 years of follow-up. In addition, the Göteborg randomised population-based randomised trial showed a reduction in metastatic disease and prostate cancer mortality with screening starting at age 50 years, and the greatest reduction was seen in the youngest age group. The extent of over-diagnosis and over-treatment decreases considerably with longer follow-up, such that the numbers needed to screen (293) and numbers needed to treat (12) to avert one prostate cancer death, compare very favourably with screening for breast cancer. While routine population-based screening is not recommended, healthy, well-informed men in this age group should be fully counselled about the positive and negative aspects of PSA testing to reduce their risk of metastases and death. This should be part of a shared decision-making process.

Consensus Statement 2: Prostate cancer diagnosis must be uncoupled from prostate cancer intervention.

Although screening is essential to diagnose high-risk cases within the window of curability, it is clear that many men with low-risk prostate cancer do not need immediate aggressive treatment. Active surveillance protocols have been developed and have been shown to be a reasonable and safe option for many men with low-volume, low-risk prostate cancer. While it is accepted that active surveillance does not address the issue of over-diagnosis, it does provide a vehicle to avoid excessive intervention. Active surveillance strategies need standardisation and validation to ensure that this is a safe strategy and to reassure patients and clinicians.

Consensus Statement 3: **PSA testing should not be considered on its own, but rather as part of a multivariable approach to early prostate cancer detection.**

PSA is a weak predictor of current risk and additional variables, e.g. age, ethnicity, family history, medical history, DRE findings, prostate volume, risk prediction models and new tools, such as the Prostate Health Index (phi) test and prostate cancer antigen 3 (PCA3) test, can help to better risk stratify men, potentially reducing over-diagnosis and over-treatment of indolent prostate cancer. Further developments in the area of biomarkers, as well as improvements in imaging will continue to improve risk stratification, with potential for reduction in over-diagnosis and over-treatment of lower risk disease.

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Consensus Statement 4: Baseline PSA testing for men in their 40s is useful for predicting the future risk of prostate cancer and its aggressive forms.

Although these men were not included in the two large randomised trials, there is strong evidence that men may benefit from the use of PSA testing as a baseline to aid risk stratification for their likely future risk for developing prostate cancer, including clinically significant prostate cancer. Studies have shown the value of PSA testing in this cohort for predicting the increased likelihood of developing prostate cancer 25 years later for men whose baseline PSA level is in the highest centiles above the median. For example, those men with a PSA level above the median are at considerably higher risk and need closer surveillance. The median PSA level for men aged 40–49 years ranges from 0.5 - 0.7 ng/mL, with the 75th percentile ranging from 0.7 - 0.9 ng/mL. The higher above the median, the greater the risk of later developing life-threatening disease. We recommend that a baseline PSA measurement in the 40s has value for risk stratification and this option should be discussed with men in this age group as part of a shared decision-making process.

Consensus Statement 5: **Older men in good health with a > 10-year life expectancy should not be denied PSA testing based on their age.**

Men should be assessed on an individual basis rather than applying an arbitrary chronological age beyond which testing should not occur. As life expectancy improves in many countries around the world (men aged 70 years in Australia have a 15-year life expectancy), a small proportion of older men may benefit from an early diagnosis of more aggressive forms of localised prostate cancer, just as it is clear that men with many competing co-morbidities and less aggressive forms of prostate cancer are unlikely to benefit irrespective of age. Likewise, a man in his 70s who has had a stable PSA level at or below the median for a number of years previously, is at low risk of developing a life-threatening prostate cancer and the screening protocol can be appropriately modified.

Disscusion.

An important goal when considering early detection of prostate cancer, is to maintain the gains that have been made in prostate cancer-specific survival over the past 20 years since the introduction of widespread PSA testing, while minimising the harms associated with over-diagnosis and over-treatment. This is already happening in Australia, where >40% of patients with low-risk prostate cancer are managed with surveillance or watchful waiting, and in Sweden where 59% of very-low-risk patients are on active surveillance. This is also reflected in current guidelines from the EAU, NCCN and other expert bodies.

Abandonment of PSA testing as recommended by the USPSTF, would lead to a large increase in men presenting with advanced prostate cancer, and a reversal of the gains made in prostate cancer mortality over the past two decades. However, any discussion about surveillance is predicated on having a diagnosis of early prostate cancer in the first instance.

A key strategy therefore is to continue to offer well-informed men the opportunity to be diagnosed early, while minimising harms by avoiding intervention in those men at low risk of disease progression.

The Melbourne Consensus Statement provides some practical guidance to help clinicians and patients achieve these goals as part of a shared decision-making process.

Source: British Journal of Urology International. www.bjui.org

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In Memory

It is with sadness that we announce the passing of Board member and friend, Mike Talgoy on April 19, 2016 from metastatic prostate cancer. Mike was 63 years old. He has been a Board member since 2011. Mike's knowledge, energy and enthusiasm will be especially missed by our Board and those who attended our monthly meetings.

We send our sincere sympathy to Mike's two sons and family members.

"The beauty of days gone by ….. Is the memory that lives on forever"

How Prostate Cancer Clinical Trials Work, from R& D to Human Trials

Developing a new medical treatment for diseases such as prostate cancer takes many years. The process is intended to best improve the treatment of diseases and medical conditions without harming people. Here you can read about how new therapies are developed, tested in clinical trials, and eventually made available to patients.

Basic Research & Development

Before clinical trials can begin, there needs to be evidence that a treatment is effective. Sometimes this evidence comes from academic labs that largely explore science for its own sake, not necessarily for the development of a drug. This is called basic research. From ideas generated in basic research or from company-sponsored R&D, experiments typically proceed to pre-clinical research.

Pre-clinical Research

Pre-clinical testing is necessary before a medication or treatment proceeds to clinical trials. This testing involves experiments with animals, and also with cells in a dish (*in vitro* testing). While still necessary to advance potential therapies for diseases such as prostate cancer, modern-day animal testing is generally governed by three principals: Reduce the use of animals to a minimum but utilize animal test subjects to collect data indicating that a treatment is safe and effective in people; minimize animal suffering and assure animal welfare as much as possible; and replace animal experiments with other alternatives when possible.

A great deal of pre-clinical testing focuses on assuring that a treatment is safe — for example, that the treatment does not cause birth defects or other medical problems. Pre-clinical testing can also focus on how a treatment works and whether it is predicted to work effectively.

Clinical Trials Defined

Clinical trials focus on administering an experimental therapy in humans rather than animals. They are well-designed studies that collect information about new treatments for diseases and disorders. Most of the time, this means medications, but clinical trials can also test other things, such as stem cell therapies, surgical techniques, tests for diagnosis, and medical devices, among the most common.

Clinical Trial Design

Often in a clinical trial, effectiveness is compared against a placebo (sugar pill with no medication in it), or another means of comparison. In the case of life-threatening diseases such as prostate cancer, it is not acceptable to use a complete lack of real treatment as a comparison, so a comparison is typically made using another type of medication that is commonly prescribed and already approved for use in that particular indication or disease type. A comparison is needed to determine if the medication works (efficacy) and also to see if the medication is safe (adverse events). Researchers will design the clinical trial for a specific period of time, during which participants either get the treatment being tested or the placebo (comparison). Sometimes the treatment is added on to the comparison as an extra treatment (called add-on therapy).

Typically, a study is conducted using the “double-blind” method. This means that neither the researchers giving the treatments nor the participants know who is getting which treatment. This prevents bias, or expectations that could influence the outcome of the study.

Researchers providing the treatment will have a code that is later “unblinded” so that they can find out what treatment they were giving. The researchers also record measurements while the participants are receiving the treatment. These measurements can be for different things, such as to determine if the treatment is working, as well as to assess safety and side effects.

Assessments in a prostate cancer trial might include survival, how long a person is cancer-free (remission), or if a person experiences reduced cancer (partial remission). Other measurements might include blood levels of the medications. If someone participates in a clinical trial, that person will be informed about the measurements that will be taken before the trial starts. An Informed Consent document tells participants about the trial.

Clinical Trial Phases

Phase 1 testing is the first step in

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studies involving humans. The purpose is to determine safety and to evaluate side effects. Phase I studies also test how the drug is absorbed, distributed and eliminated from the body. Often people who do not have the disease (healthy individuals) participate in Phase 1. The number of people involved at this stage is usually small.

Phase 2 trials are often divided into Phase 2a and Phase 2b. Sometimes these two sub-phases are combined. Phase 2 trials further assess dosing and are designed to determine the best drug dose to use and how much of a dose is safe. Phase 2 studies can also measure efficacy and safety testing in small numbers of participants. Often a treatment must pass Phase 2 in order to proceed to Phase 3.

Phase 3 trials are where most medical treatment studies are focused. These are the large trials that are required for a drug or other treatment to receive approval for use. The purpose of this phase is to test efficacy and safety as well as to monitor for side effects. The main drug effects are often called the primary efficacy endpoints. Other measurements may be called the secondary endpoints. Adverse events refer to the side effects that occur during a study. These are defined as being due to the medication or therapy given (treatment-emergent adverse events) or as simply things that occurred during the trial, whether they were due to the treatment or not (overall adverse events).

Phase 3 trials can include additional testing time after the main measurements are taken. This is known as an "extension" or "extension study."

Occasionally, researchers conduct **Phase 4 trials**, after a drug has been approved. These trials collect additional information about the drug or treatment. They are sometimes called "post-marketing" trials.

The Need for Clinical Trial Participation

Throughout the world, clinical trials are constantly recruiting patients and initiating studies to test investigational therapies and novel therapeutic options for diseases and conditions with unmet medical needs. Although people who are chronically ill or afflicted with a disease such as prostate cancer participate in these trials, how clinical trials work or what they are designed to accomplish is not widely understood. However, as more people are made aware of the critical importance of clinical trial participation and how it advances research and the developing of next-generation therapies, increased support of the clinical trial process can potentially lead to accelerating the development of new treatments that can improve patient outcomes for diseases such as prostate cancer.

Source: www.prostatecancernewstoday.com

APRIL 20, 2016

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Sexual Function After Prostate Cancer Surgery: What You Should Know

Even an expertly performed nerve-sparing radical prostatectomy causes some degree of trauma to nerve bundles. Below are some important facts about sexual function and what to expect after robotic or traditional open radical prostatectomy:

You can no longer produce ejaculate after radical prostatectomy. However, you can still have a normal sensation and sex drive. This change, which is permanent, occurs because ejaculatory fluid is produced in the prostate and the seminal vesicles—glands next to the bladder— which are removed during surgery. This also results in a loss of fertility. Almost half of all patients in the survey were unaware that they would no longer be able to ejaculate.

You can still achieve pleasurable, though dry, orgasm. However, the surgery puts you at risk for leakage of urine during orgasm (called climacturia). Most men that achieve urinary control do not have climacturia long term.

While the ability to have an erection sufficient for intercourse is common in the immediate period after surgery, it can be enhanced with oral or injectable ED drugs or a vacuum pump.

On average, as many as 40 percent of patients who have a nerve-sparing radical prostatectomy will typically recover erectile function within six months—if function was good before surgery and sexual activity was an important part of life.

The surgery shortens penile length by up to 1 to 2 centimeters. However, if you undergo a nerve-sparing operation, the reduction in length is often temporary.

The good news is that if a surgeon skilled in nerve-sparing prostatectomy performs the operation, most men will eventually recover satisfactory erectile function—often with an oral ED drug or some other therapy.

Source: healthafter50.com

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315-971 Corydon Ave.,
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Publications Agreement
40037332

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Special Thanks to Sanofi and representative Del Michie

The Board of the Manitoba Prostate Cancer Support Group would like to thank Sanofi for their kind donation. Backed by decades of service to Canadian healthcare professionals and patients, Sanofi has partnered with their customers in the search for solutions to Canada's healthcare challenges. These include innovative initiatives to promote the appropriate use of medicines, make healthcare more efficient, cost-effective, and help people better manage their health. Eligard, Taxotere and Jevtana are 3 drugs produced by Sanofi. We appreciate their efforts in advancing the treatment of prostate cancer.

Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL
Answering Machine - (204) 989-3433 ***Help us lower our costs :***
Receive this newsletter by email ~ Please notify us and we'll make the changes. ***Thank-you***

2016 MEETINGS

June 16 Kristen Bilenky, Social Worker
Topic: Cancer System Navigation

The June meeting will be held at Seven Oaks Hospital Wellness Centre, Room 4.

Our July and August meetings will be held at our new location: Cindy Klassen Rec. Complex at 999 Sargent Avenue

July 21 Member's Forum
Topic: Snacks/Juice and shared members stories

August 18 Dr. Eric Saltel, Urologist
Topic: Sub-urethral sling option for urinary incontinence

The September meeting will be held at the Caboto Centre at 1055 Wilkes Avenue
Sept. 15 Awareness Evening
Topic: TBA

All meetings are 7 – 9 pm. Everyone Welcome

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