Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 306 1,300 copies printed/e-mailed **March 2017**

Hormone Blockers Can Prolong Life if Prostate Cancer Recurs

Men whose prostate cancer comes back after surgery are more likely to survive if, along with the usual radiation, they also take drugs to block male hormones.

The finding, published Wednesday in The New England Journal of Medicine, comes from a long-running study that experts say will help clarify treatment for many patients.

After surgery to remove the prostate, more than 30 percent of men have a recurrence, and until now there has not been clear evidence about the best way to stop the disease from killing them. Most are given radiation, but prescribing drugs to counter the effects of male hormones has been inconsistent.

The study, paid for by the National Cancer Institute, showed that among men who received radiation and hormonal treatment, 76.3 percent were still alive after 12 years, compared to 71.3 percent who had radiation alone.

At 12 years, the men who had both treatments were also much less likely to have died from their prostate cancer — 5.8 percent versus 13.4 percent — or to have the cancer spread around their bodies — 14.5 percent versus 23 percent.

"This is a big deal," said Dr. Ian M. Thompson Jr., of the Christus Santa Rosa Health System in San Antonio, who was not part of the study but wrote an editorial accompanying it.

"There are so many things we do in

(Continued on page 2)

Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel 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

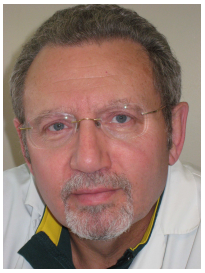
Thanks!

Next Meeting: Mar. 16
Dr. Graham Glezerson
(Manitoba Clinic; Urologist)

Topic: *"Prostate Cancer.....Then and Now"*

Location: Cindy Klassen Recreation Complex at 999 Sargent Avenue

Time: 7 – 9 pm.
Free Admission Everyone Welcome



SHARING IS CARING

The Manitoba Prostate Cancer Support Group offers support to prostate cancer patients but does not recommend any particular treatment modalities, medications or physicians ; such decisions should be made in consultation with your doctor.

MPCSG – active since 1992.

Thought of The Day

*If tomatoes are technically a fruit, is ketchup a smoothie?"

(Continued from page 1)

prostate cancer that we don't know if they make a big difference in survival. This is one of the things where now we can say for sure."

He added that he hoped the findings would change medical practice.

The medical term for blocking male hormones is chemical castration, and the treatments can cause hot flashes, sexual problems and other side effects. So to put a man through it, said Dr. Anthony L. Zietman, an author of the study, "you'd better have some decent justification."

Dr. David F. Penson, the chairman of urologic surgery at Vanderbilt University Medical Center, said the study "gives more credence to the concept that you have to treat the whole patient," rather than just irradiating the area where the cancer used to be.

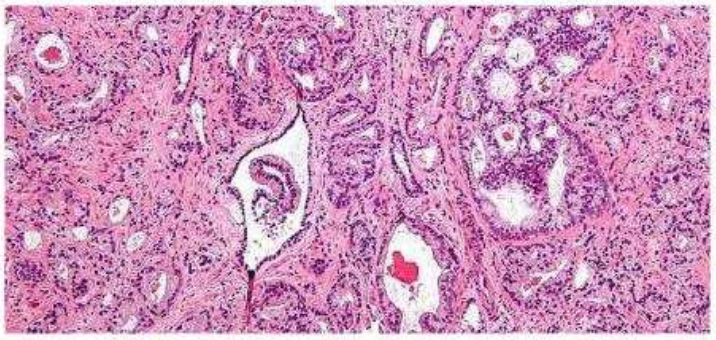
He said the idea of blocking hormones in men like those in the study was finding its way into medical practice.

About 161,360 new cases of prostate cancer and 26,730 deaths are expected in the United States in 2017, according to the American Cancer Society.

The average age at diagnosis is 66. Globally, there were 1.1 million cases and 307,000 deaths in 2012, the most recent data available from the World Health Organization.

The study, begun in 1998 and led by Dr. William U. Shipley, a radiation oncologist at the Massachusetts General Hospital, had an ambitious goal: to follow the patients long enough to find out whether hormone-blocking treatment would affect their survival.

Prostate cancer grows slowly, so it took well over a decade for answers to emerge. Researchers and patients from 150 sites in North America participated. The patients were 760 men who had their prostates removed for cancer that had not spread, but who then had a sign of recurrence — a rise in their blood levels of prostate-specific antigen, or PSA, a protein associated with prostate cancer. The men in the study had PSAs of 0.2 to 4 nanograms per milliliter.



"That's just like the first wisp of smoke," said Dr. Zietman, who is a professor of radiation oncology at Massachusetts General Hospital and Harvard Medical School. "There'll be fire someday."

The fire might take five, 10 or 15 years to break out, but Dr. Zietman said, "Many are in their 50s or 60s, and will live long enough to get into trouble."

The traditional practice for a rising PSA after surgery has been to give radiation, which targets only the pelvis.

The idea of the study was to add hormonal treatment, which might stop minute clumps of cancer that had spread to other parts of the body.

All the men in the study had radiation for six and a half weeks. For two years, half also received a hormone-blocking drug, bicalutamide, and the other half were given placebos. They were followed, on average, for about 13 years.

"This is the first trial that's shown, if you follow these patients long enough, there is a real difference," Dr. Zietman said. "More people survive 15 years later."

Men who had more aggressive cancers — reflected by higher PSA readings after surgery and by the pathology and surgical reports on their tumors — had the most to gain from the hormone-blocking treatment.

The results do not mean that every man with a rising PSA after surgery should have hormone treatment, Dr. Zietman said. Men 75 or older may not need it, because they may die from other causes before the cancer can catch up with them.

"But if they're younger and with a longer life expectancy, treatment is reasonable," he said.

Bicalutamide causes men to develop breasts and potentially other problems, and the high dose given in the study is no longer used in the United States.

Other hormone-blocking drugs like Lupron have mostly taken its place, and may be even more effective, Dr. Zietman said. The study proved the concept that hormone blocking increases survival, he added, so other drugs that do the same thing should also help patients live longer.

Another study in progress in Canada and Europe uses the newer drugs, and is trying to determine whether taking them for six months, rather than two years, might be enough.

By DENISE GRADY FEB. 1, 2017

https://www.nytimes.com/2017/02/01/health/prostate-cancer-hormone-blockers.html

• • •

Special Scan May Curb Need For First Biopsy In 1 In 4 Men With Prostate Cancer

Caroline White *Friday, 20 January 2017*

Giving men with prostate cancer a particular type of scan, known as a multi-parametric magnetic resonance imaging scan, or mpMRI for short, may cut out the need for initial exploratory biopsies in around one in four men with the disease, reveals research* published today in The Lancet.

Men with high prostate specific antigen levels or symptoms suggestive of cancer usually have to undergo a transrectal ultrasound guided (TRUS) biopsy to find out if they have prostate cancer, but the procedure carries risks of bleeding, pain and infection.

An mpMRI scan provides more detailed pictures of the prostate than can be obtained with a standard MRI scan, because it combines up to four different types of image.

In the trial, which involved nearly 600 men, the mpMRI scan correctly spotted twice as many aggressive cancers as the TRUS biopsy (93% vs 48%). And for those with a negative scan result, nine out of 10 had no cancer or a slow growing cancer that wasn't life threatening.

The scan also reduced the number of men overdiagnosed with clinically insignificant forms of the disease by around 5%.

Based on their findings, the researchers calculate that triaging men with mpMRI might allow a quarter of them to avoid an initial TRUS biopsy.

They conclude: "Cost-effectiveness analyses of the PROMIS data are underway and will be reported elsewhere, but the primary outcome data provide a strong argument for recommending mpMRI to all men with an elevated serum PSA before biopsy.

"Using mpMRI as a triage test would reduce the problem of unnecessary biopsies in men who have a low risk of harbouring clinically significant cancer, reduce the diagnosis of clinically insignificant disease, and improve the detection of clinically significant cancers."

Angela Culhane, Chief Executive of the charity Prostate Cancer UK, which helped fund the study, said: "This complex technique can only become a routine part of the diagnostic pathway once it can be guaranteed that it can be rolled out safely and in a way that produces the best outcomes for men. We are committed to doing everything we can to make this happen."

Prostate Cancer UK submitted Freedom of Information requests to 164 NHS Trusts and equivalent bodies across the UK between May and October 2016 to determine how easy it would be for men to access the technique.

The responses revealed that only a third (32%) of eligible men with suspected prostate cancer would routinely benefit from having an mpMRI scan before biopsy.

Specific challenges include having enough of the right scanners in the right places, appropriate training, and the workforce headcount of radiologists and radiographers.

Prostate Cancer UK is already taking action to support and encourage health bodies at a national and local level across the UK to address the resource issues. The charity is also working with relevant professional bodies, to put training, guidelines and quality assurance processes in place.

"The current diagnostic process for prostate cancer is notoriously imperfect, so any developments which offer improvements must be adopted as a matter of priority. Whilst it's clear that the roll-out of mpMRI before biopsy can't just happen overnight, it's critical that urgent action is taken to make it available to men," emphasised Ms Culnane.

Dr Philip Haslam, consultant uroradiologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust and chairman of the British Society of Urogenital Radiology, described the findings as a "huge leap forward in prostate cancer diagnosis."

But he pointed out: "It takes a good deal of skill and expertise to effectively conduct and interpret mpMRI scans for everyone involved. Accurate interpretation and confidence amongst radiologists is crucial if we are to be sure that this technology will benefit men. In addition not all MRI scanners are capable of carrying out mpMRI scans of the prostate that are accurate enough to enable clinicians to confidently rule out the need for further investigation.

"It is vital that both these issues are tackled otherwise roll out of mpMRI before biopsy across the UK could in fact have some unintended negative consequences - men could be incorrectly told that they do not need to go for further tests when they do in fact have a prostate cancer that needs treating, or there could be no decrease in biopsies at all due to lack of confidence to rule men out."

* Ahmed H, et al. Diagnostic accuracy of multi-parametric MRI and TRUS biopsy in prostate cancer (PROMIS): a paired validating confirmatory study. The Lancet, January 2017. DOI: 10.1016/S0140-6736(16)32401-1

• • •

" To our online donors from Canada Helps.....thank you for your donations to the Manitoba Prostate Cancer Support Group. It's not possible for us to thank each of you personally, but rest assured that we truly appreciate your generosity. Your contribution makes a difference and helps us provide free support to those prostate cancer patients who want and need it. Every bit helps us to better serve our prostate cancer patient community. Thanks again."

The Board,
Manitoba Prostate Cancer Support Group

Genetic Testing Can Predict Metastasis and Death in Prostate Cancer

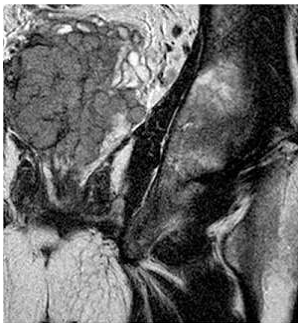
The Decipher test can be used to predict death and metastases in some patients with prostate cancer, according to findings that were recently presented.

Metastasis and prostate cancer-specific mortality (PCSM) was predicted using the genomic-based Decipher test that used biopsy specimens for patients with intermediate- and high-risk prostate cancer, according to findings presented at the 2017 GU Cancers Symposium.

Overall, 23.4 percent of those classified as high-risk by the test developed metastasis. The PCSM was 9.4 percent at five years. Additionally, the findings for Decipher held up regardless of the frontline therapy utilized. The next steps in the research will be to conduct a clinical trial using the test to determine when intensification of therapy is warranted, according to lead author Paul L. Nguyen, M.D.

"The Decipher classifier obtained from biopsy samples was associated with distant metastases and PCSM after radical prostatectomy or radiation therapy and androgen deprivation therapy," said Nguyen, from the Brigham and Women's Hospital and the Dana-Farber Cancer Institute. "Further validation is ongoing in larger cohorts. Work is planned to study the test in completed randomized trials to determine predictive value."

For the study, diagnostic biopsy samples were obtained from 175 patients from the Cleveland Clinic, Brigham and Women's Hospital, and Johns Hopkins. Testing with Decipher was used on the highest-grade core from the biopsy. Overall, by NCCN classification, 87 percent of patients had intermediate (50.9 percent) or high-risk (33.7 percent) prostate cancer. Forty-three percent of patients had received frontline radical prostatectomy and 57 percent were treated with frontline radiation therapy (RT) plus androgen deprivation therapy (ADT).



After six years of follow-up, 32 patients had developed metastases and 11 had died from prostate cancer. Of those classified as intermediate- and low-risk by Decipher, 9.3 percent and 5.0 percent developed metastasis at five years, respectively. By NCCN alone, 33.1 percent of those with high-risk disease developed metastasis, as did 11 percent and 1.2 percent of those with intermediate- and low-risk, respectively.

Use of Decipher improved the overall c-index for metastasis compared with risk levels alone. The five-year post-biopsy c-index was 0.74 for Decipher alone and 0.75 for Decipher and NCCN combined compared with 0.66 with NCCN risk classification only. "[Decipher] adds to what we already know and enhances our ability to decide which patients are going to develop metastases," said Nguyen.

By univariate and multivariate analysis, the only statistically significant variable for predicting metastases was Decipher. The investigators also assessed Gleason score, clinical stage, and type of frontline treatment, but none were statistically significant.

The use of Decipher also improved upon NCCN staging for PCSM. Those listed as being genomic high-risk had a PCSM of 9.4 percent. Those in the intermediate- and low-risk groups had a PCSM of 0 percent. For every 10 percent increase in Decipher score, the risk of PCSM increased by 57 percent. The low number of overall mortality prevented a multivariate analysis of survival. However, "by univariate analysis, Decipher was the only factor associated with PCSM," said Nguyen. The Decipher test utilizes the expression levels of 22 RNA biomarkers. The test has been explored on samples from over 2,000 patients in clinical studies following surgery for men with prostate cancer. In these studies, 60 percent of those classified as intermediate and high-risk were reclassified as low-risk. Of those reclassified, 98.5 percent had not developed metastasis after five years of assessment post radical prostatectomy. The c-index for Decipher across trials remained around 0.75.

SILAS INMAN @silasinman

FEBRUARY 18, 2017

http://www.curetoday.com/articles/genetic-testing-can-predict-metastasis-and-death-in-prostate-cancer

• • •

Does Penis Length Recover After Prostate Removal?

After prostate removal for cancer, men sometimes complain to their doctors that their penis shrank, but a new study from Japan suggests they should not lose hope.

Following men for up to two years after surgery, researchers found the patients' penises were shortest a few days after their procedures. Penis lengths generally returned to normal after one year, however.

The study's lead author said the research was started after encountering a few patients complaining of penis shortening after prostate removal, which is known medically as a radical prostatectomy.

Past reports mentioned shortened penises after prostate removal, but the results were a bit different, said Dr. Yoshifumi Kadono, of Kanazawa University Graduate School of Medicine Science.

"Therefore, we started our study to obtain our data," he told Reuters Health.

For the new study, the researchers measured the penis lengths of 102 men before having their prostates removed and then at 10 days after surgery and again one, three, six, nine, 12, 18 and 24 months later.

The men's stretched penis lengths were shortest 10 days after surgery, when measurements were an average of about 0.10 centimeters (0.04 inches) shorter than before prostate removal.

By the one-year mark, the men's penises generally returned to original lengths, which averaged about 11.72 centimeters (4.61 inches), according to the results in BJU International.
The researchers wanted to know what caused the shortening and if any particular variable, such as the size of a man's prostate gland, would predict which men would experience this effect.

Based on magnetic resonance imaging (MRI)of the patients, the researchers noticed some internal changes. Specifically, the portion of the urethra directly below the bladder moves up into the body after surgery, but moves back down after some time.

"However, further research is needed to elucidate long-term changes of (penis length) with respect to the influence of sex hormones or changes in penile blood flow after (radical prostatectomy)," said Kadono.
The new findings may be useful for men who have low-to-moderate self esteem tied to their perceived lost penis length after their surgery, he added.

The findings may not represent reality for all men, however.

Most men will have some penis length loss after surgery and sometimes that will be permanent, said Dr. John Mulhall, who is director of the Male Sexual and Reproductive Medicine Program at Memorial Sloan Kettering Cancer Center in New York.

"If you have documental length loss at six months, then you shouldn't expect that to improve at 12 months," said Mulhall, who wasn't involved in the new study.

He told Reuters Health that loss of penis length can be attributed to two issues. For example, muscle contractions may pull the penis into the body, but that relaxes over time. Men may also experience after surgery the loss of erection tissue. "Once that muscle degenerates, it's gone," he told Reuters Health.

Dr. Drogo Montague, who wasn't involved in the new study but often treats urological issues in men after prostate removal, also said some penises may appear shorter after surgery due to scar tissue that builds up when men have sex with partial erections.

The patients included in the new study would generally be considered to be normal weight, noted Montague, who is a professor of surgery at the Center for Genitourinary Reconstruction Glickman Urological and Kidney Institute Cleveland Clinic in Ohio.

"So these findings won't necessary be generalizable because of the prevalence of obesity," he told Reuters Health.

Mulhall said medications like Viagra and Cialis - known as PDE5 inhibitors -are shown in previous research to guard against lost penile length after prostate removal.

In addition to PDE5 inhibitor, Montague said men can get prostheses and other interventions to strengthen their penises.

By Andrew M. Seaman
Reuters Health

SOURCE: bit.ly/2lctQla BJU International, online February 8, 2017.

http://www.reuters.com/article/us-health-cancer-prostate-penis-idUSKBN15V2XI

• • •

Adjuvant Trials in Post-radical Prostatectomy Prostate Cancer Are Feasible

Jason Hoffman, PharmD, RPh February 17, 2017

A phase 3 study presented at the 2017 Genitourinary Cancers Symposium demonstrated the feasibility of conducting adjuvant trials.

ORLANDO, FL – A phase 3 study presented at the 2017 Genitourinary Cancers Symposium demonstrated the feasibility of conducting adjuvant trials for patients with prostate cancer who have undergone radical prostatectomy.1

"In 1999, preoperative PSA of 20 ng/mL or greater, poorly differentiated histology, seminal vesicle or extensive surgical margin involvement, extraprostatic extension, or nodal metastases defined a high risk group of patients with, at the time, a 50% or greater biochemical relapse rate at 5 years," said lead study author Michael Glode, professor of the division of medical oncology at the University of Colorado School of Medicine in Denver. "Longer-term adjuvant androgen deprivation therapy (ADT) improved outcomes for curative-intent radiation therapy."

For the open-label, phase 3 trial (ClinicalTrials.gov Identifier: NCT00004124), investigators enrolled 961 patients with clinically localized prostate cancer. Patients were randomly assigned 1:1 to receive ADT consisting of bicalutamide and goserelin for 24 months or ADT with mitoxantrone plus prednisone for 6 cycles. The study permitted radiotherapy in both arms at physician discretion.

The study was terminated early due to an increased incidence of acute myeloid leukemia in the mitoxantrone arm. "Mitoxantrone plus prednisone significantly increases the risk of leukemia and other cancers when added to ADT," said Dr Glode.

The intention-to-treat analysis showed no significant difference in disease-free survival (hazard ratio [HR], 1.01; 95% CI, 0.80-1.27; P = .94) or overall survival (HR, 1.06; 95% CI, 0.79-1.43; P = .70). Dr Glode noted, however, that survival was greater than anticipated in both arms.

"Mitoxantrone plus prednisone does not improve prostate cancer survival or freedom from progression when added to 2 years of adjuvant ADT in high risk patients," conclude Dr Glode. "This trial demonstrates the feasibility of doing adjuvant trials in prostate cancer post radical prostatectomy."

When asked if he and his colleagues should have used docetaxel in place of mitoxantrone for the chemotherapy, Dr Glode responded that docetaxel plus prednisone was not shown to be superior to mitoxantrone plus prednisone in advanced disease until 5 years after the development of this trial.

Reference

Glode LM, Tangen CM, Hussain M, et al. Adjuvant androgen deprivation (ADT) versus mitoxantrone plus prednisone (MP) plus ADT in high-risk prostate cancer (PCa) patients following radical prostatectomy: A phase III intergroup trial (SWOG S9921). Paper presented at: 2017 Genitourinary Cancers Symposium; February 16-18, 2017; Orlando, FL.

• • •

New Prostate Cancer Treatment Uses Laser-Activated Drug

Although no definitive cure for all types of cancer will is likely to be discovered anytime soon, researchers are hard at work trying to find new ways to either treat individual cases of cancer or at least slow its growth. A new clinical trial reveals that a light-activated drug completely eliminates early prostate cancer without any side-effects caused by surgery.

The new prostate cancer treatment uses a revolutionary technique known as vascular-targeted photodynamic therapy or VTP for short. It involves injecting a drug sensitive to light into the patient's bloodstream. Then it is activated by exposing to a laser which fires several pulses to optical fibers inserted into the prostate of the patient.

More specifically, the drug is made out of bacteria which live in the darkness of the ocean floor. The bacteria attacks other cells when exposed to light. However, scientists designed so that the bacteria in the drug only attack the cancerous cells in the prostate leaving the healthy cells behind.

To test the efficiency of the new prostate cancer treatment, scientists developed a clinical trial involving 413 men, of which only 196 received the VTP prostate cancer treatment, while the rest were put under active surveillance. From the total number of patients which received the treatment, almost half were completely cured of prostate cancer even two years after the clinical trial. This is a significant increase in men cured of cancer compared to the 13.5 percent of patients who don't report any signs of prostate cancer after standard care.

Besides the higher chance of being definitively being cured of prostate cancer, the VTP treatment has the added benefit of not having any side effects such as urinary incontinence or impotence which are linked with surgery or radiotherapy.

The clinical trial results which were published in the journal The Lancet Oncology revealed that the only six percent of patients who received the VTP treatment required radical treatment, compared to the 30 percent of the patients under active surveillance. The new prostate cancer treatment also managed to double the average period of cancer progression from 14 to 28 months.

By Joseph Decker February 18, 2017

www.lighthousenewsdaily.com/prostate-cancer-treatment/8728/

• • •

Metastatic Prostate Cancer Death Rates Declining

Jody A. Charnow, Editor February 16, 2017

Cancer-specific mortality rates dropped from 72.8% in 1995 to 55.8% in 2011, according to a Danish study.
Cancer-specific mortality rates dropped from 72.8% in 1995 to 55.8% in 2011, according to a Danish study.
Mortality rates from metastatic prostate cancer (mPCa) are declining, researchers concluded in a poster presentation at the 2017 Genitourinary Cancers Symposium in Orlando, Florida.

The trend may be due to the new and improved treatment options for advanced PCa that have come along in recent years although lead time introduced by increased use of PSA very likely are contributing, said lead investigator Thomas Helgstrand, MD, of the University of Copenhagen in Denmark.
Using the Danish Prostate Cancer Registry, Dr Helgstrand and colleagues identified 6874 men newly diagnosed with metastatic PCa from 1995 to 2011 and stratified them into 3 groups according to the period during which the men were diagnosed: 1995–2000, 2001–2005, and 2006–2011. The PCa-specific mortality rate decreased from 72.8% in 1995–2000 to 63.3% in 2001–2005 and 55.8% in 1995–2011. Other cause mortality during these periods increased from 11.4% to 15.2% and 17.1%, respectively, the investigators reported.

Cancer-specific mortality rates dropped from 72.8% in 1995 to 55.8% in 2011, according to a Danish study.

In addition, results showed that the age at diagnosis significantly decreased by 1 year and mean PSA level at diagnosis decreased significant from 276 to 142 ng/mL.

Compared with patients diagnosed with mPCa in 1995–2000, those diagnosed in 2001–2005 and 2006–2011 had a significant 31% and 47% lower risk of PCa-specific mortality, respectively, in multivariate analysis, according to the researchers.

Reference

1. Helgstrand JT, Klemann N, Toft BG, et al. Survival trends in patients diagnosed with metastatic prostate cancer – a nationwide analysis. Data presented in poster format the 2017 Genitourinary Cancers Symposium in Orlando, Florida. Poster Session A Board #F25. Abstract 171.

http://www.renalandurologynews.com/genitourinary-cancers-symposium/metastatic-prostate-cancer-mortality-down-denmark/article/638434/

• • •

"Raising Awareness.....Spreading the Word"

The Manitoba Prostate Cancer Support Group works to increase education, awareness and support for the prostate cancer community. These services are provided through a variety of activities and are available without cost to the existing patient population as well as to the public at large.

Raising awareness is especially important to encourage more men, who may already have prostate cancer but don't yet know about it, to get checked.

Early detection makes all the difference in effecting a cure. As part of our efforts to raise awareness our group provides speakers to community groups, as well as attending "health fairs" in shopping malls and the like.

If your group would like to have a speaker talk about prostate cancer contact board member Pat Feschuk (Special Events organizer; telephone 204-654-3898; or email at lizpat@shaw.ca) to make arrangements.

• • •

Return undeliverable Canadian addresses to
Manitoba Prostate Cancer Support Group
315-971 Corydon Ave.,
Winnipeg R3M 3S7

Publications Agreement
40037332

MANITOBA PROSTATE CANCER SUPPORT GROUP TAX DEDUCTIBLE DONATION

NAME:_____

ADDRESS:_____ POSTAL CODE_____

THIS GIFT IS IN MEMORY/HONOUR OF_____ PLEASE SEND NOTIFICATION TO:_____

NAME:_____

ADDRESS:_____ POSTAL CODE_____

***Make payment to**: Manitoba Prostate Cancer Support Group;*
Box 315 – 971 Corydon Ave., Winnipeg, Manitoba, R3M 3S7
***A tax deductible receipt will be issued. Charity number: 88907 1882 RR0001*

Credit Card** donations can be made by going to our website at: www.manpros.org and clicking on the donate tab. Canada Helps will issue a tax receipt.* ***Amount: *$25 $50 $75 $100 Other_____*

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***

2017 MEETINGS

Mar. 16 Dr. Graham Glezerson
(Manitoba Clinic; Urologist)
"Prostate Cancer.....Then and Now"

Apr. 20 Monique Woroniak
(Winnipeg Public Library; Information Specialist)
"Health Info Checkup: Finding and Evaluating Information Sources About Prostate Cancer"

May 18 Dr. Kevin Saunders
"Managing Prostate Cancer Along With Other Health Issues in Elderly Males"

All meetings (except September) will be held at :
Cindy Klassen Recreation Complex
at 999 Sargent Avenue

All meetings are 7 – 9 pm.
Everyone Welcome

MPCSG BOARD

Jim Leddy - Outreach	(204) 326-1477
Al Petkau - Treasurer	(204) 736-4398
Betty O'Grodnik – Secretary	(204) 661-8549
Jos Borsa - Chair	(204) 219-7726
Liz Feschuk - Special Projects	(204) 654-3898
Ernie Schade – Member at Large	(204) 489-1648
Pat Feschuk – Special Events	(204) 654-3898
John O'Grodnik - Vice Chair	(204) 661-8549