Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 342 1,300 copies printed/e-mailed **June 2020**

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Thanks!

Thought of The Day

A bend in the road is not the end of the road...
unless you fail
to make the turn.

~Author Unknown

June Meeting:

CANCELLED

* Due to Covid-19 crisis all public meetings of MPCSG are suspended until further notice.

Getting Our Activities Back On Track

While most of the social restrictions flowing from the Covid-19 crisis are still with us there appears to be a "light at the end of the tunnel" with normal activities gradually emerging. We are optimistic that our own meetings will be possible within perhaps a couple of months or so.

When that happens we'll be delighted to resume our regular monthly schedule of real, as opposed to virtual, meetings. Watch this newsletter for information about progress towards that happy day. In the meantime stay safe.

The Board

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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.

Combining Different Biopsies Reduces Uncertainty In Prostate Cancer Diagnosis

Are prostate cancer biopsies reliably accurate?

Not always.

The most common method, called a systematic biopsy, sometimes misses tumors, and it can also misclassify cancer as being either more or less aggressive than it really is. During systematic biopsy, a doctor takes 12 evenly-spaced samples of the prostate, called cores, while looking at the gland with an ultrasound machine.

A new method, called MRI-targeted biopsy, guides doctors to suspicious abnormalities in the prostate, and emerging evidence suggests that it's better at detecting high-grade, aggressive tumors that need immediate treatment. These biopsies require doctors to get an MRI of the prostate first. Computer software then fuses the high-resolution MRI scan with ultrasound images gathered in real time during the biopsy procedure. Since doctors only sample from where the MRI reveals possible evidence of cancer, they can take fewer cores.

Some experts are now saying that systematic biopsies should be replaced by the MRI-targeted approach, even though it requires specialized training, and is generally available today only in large academic cancer centers.

However, new evidence suggests that the best way to reduce diagnostic uncertainties is to take both biopsies together. The findings come from a study performed at the National Cancer Institute in Bethesda, Maryland.

Investigators enrolled 2,103 men with suspected prostate cancer based on abnormal PSA readings and digital rectal exams. Each was given an MRI-targeted biopsy, followed immediately by a systematic biopsy. Cancer was detected in 1,312 of the men, and 404 of them were surgically treated. The investigators wanted to compare the two biopsy methods in terms of being able to find cancer and classify it correctly as high- or low-grade. The surgically removed prostate specimens provided a final confirmation.

As it turned out, 208 more cancers were detected by giving both biopsies together than by giving systematic biopsies alone, and 59 of the additional cancers were in high-risk categories. MRI-targeted biopsies by themselves detected 91% of the high-risk cancers identified by both techniques combined. But they also made some incorrect calls: 123 men classified by MRI-targeted biopsies as having low-risk prostate cancer actually had intermediate-risk disease. And 41 men classified by the MRI approach as having low- or intermediate-risk tumors actually had high-risk cancer.

The investigators emphasized these figures in their conclusion. The combined biopsy, they wrote, "has high predictive value… reduces the likelihood of misdiagnosis, and should translate to decreased diagnostic uncertainty."

"This is an important study, as it adds significantly to the ongoing evolution of identifying the roles and limitations of traditional systematic biopsies, MRI-targeted biopsies, and the combination of both," says Dr. Marc Garnick, Gorman Brothers Professor of Medicine at Harvard Medical School and Beth Israel Deaconess Medical Center, and editor in chief of HarvardProstateKnowledge.org. "Again, as with many ultra-sophisticated technologies, significant training and expertise is needed in both the actual performance of the MRI-targeted biopsy itself and its interpretation."

Charlie Schmidt
Editor, Harvard Medical School

MAY 26, 2020

Source: www.health.harvard.edu/blog/combining-different-biopsies-limits-uncertainty-in-prostate-cancer-diagnosis-2020052619938

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'Alarming' Rise In Deadly Prostate Cancer Cases As Screening Declines

Cases of advanced prostate cancer have increased among American men ages 50 and older, while cases of early-stage disease have declined, a study published Wednesday found.

The study looked at cases diagnosed between 2005 and 2016, during which time federal guidelines began recommending against prostate-specific antigen, or PSA, screening for prostate cancer detection because of concerns that the overall benefits of the once routinely recommended blood test did not outweigh the risks.

The prostate cancer trends observed in the new study "likely" resulted from the recommendations against screening, leading to undetected cases that advanced, lead author Ahmedin Jemal, scientific vice president for surveillance and health services research at the American Cancer Society, speculated.

Each year in the United States, there are about 192,000 new cases of prostate cancer and 33,000 deaths.

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Thankfully, most cases are slow-growing and not life-threatening. Many cases can take a decade or more to show symptoms, if at all, and may never be fatal.

So there have been concerns that diagnosing too many early cancers can lead to unnecessary worry, biopsies and treatments than can leave men with side effects such as incontinence and impotence. But there's also concern that not screening may miss aggressive cancers that become deadly.

In 2008, the U.S. Preventive Services Task Force recommended against PSA screening for men ages 75 and older, and in 2012 advised against routine screening for all men. Then in 2018, the group issued further changes, recommending individual decision-making for men ages 55 to 69 and against screening for men 70 and up.

Jemal said other risk factors for advanced prostate cancer, such as family history of the disease or obesity, probably can't explain the increases seen in his study.

"These data illustrate the trade-off between higher screening rates and more early-stage disease diagnoses (possibly overdiagnosis and overtreatment) and lower screening rates and more late-stage (possibly fatal) disease," Jemal and his colleagues wrote in the study released in the Journal of the National Cancer Institute, or JCNI.

The researchers analyzed nationwide data on more than 2 million prostate cancer cases, mostly early-stage disease, diagnosed in men 50 and older between 2005 and 2016. They found that the incidence of early-stage cancer among men 50 to 74 decreased by 6.4 percent per year from 2007 to 2016 while incidence among men 75 and up declined by 10.7 percent per year from 2007 to 2013, then stabilized through 2016. The researchers did not have data on prostate cancer cases beyond 2016.

By comparison, the incidence of advanced cancers that had spread beyond the prostate gland — known as regional-stage or distant-stage cancers — increased at "an alarming rate," Jemal told NBC News.

For instance, among men 50 to 74, the incidence of distant-stage, metastatic cancers increased by 2.4 percent per year from 2008 to 2012 and by 5.6 percent per year from 2012 to 2016. Among men 75 and older, the incidence of distant-stage disease increased by 5.2 percent per year from 2010 to 2016.

Statistics show that PSA testing rates in men 50 and older declined from 40.6 percent in 2008 to 38.3 percent in 2010 and 31.5 percent in 2013, the researchers noted. Rates remained unchanged in 2015.

Jemal said he hopes current federal screening recommendations will prompt men to talk with their doctors about the pros and cons of PSA screening so more aggressive cancers may be caught. "There has to be a balance," he said.

The American Cancer Society advises men to start these conversations beginning at age 50 for most or earlier if they have risk factors such as a family history of the disease or they are African American. The group says men whose life expectancy is less than 10 years probably won't benefit from screening because tumors often grow slowly. While the average life expectancy for men of all races in the U.S. is 76.1 years, according to the Centers for Disease Control and Prevention, PSA screening advice is based more on each man's individual life expectancy.

Dr. Edward Schaeffer, chair of urology at Northwestern University Feinberg School of Medicine, said the new study adds to earlier research, including his own 2016 study, that raised concerns about an increasing incidence of advanced prostate cancer.

Though the explanation is unclear and could potentially include environmental, lifestyle or other factors, he said he believes the changing screening guidelines were a driving factor. "When you relax screening, these are the downstream effects," he said. "There are more cancers that show up in a more advanced stage."

Schaeffer says that because aggressive cancers are so deadly when they spread, he advises men to talk with their doctors about the best time to get PSA screening.

While overtreatment concerns remain, doctors today have knowledge and tools to help minimize invasive tests and treatment, he said. Patients, for instance, may undergo "active surveillance" in which doctors aim to keep tabs on a tumor without rushing into treatment.

Dr. Jonathan Simons, president of the Prostate Cancer Foundation, said the study findings point to the need for more "precision screening."

The foundation recommends men start talking to their doctors about screening at age 40 if they have a family history of prostate cancer – or breast, ovarian, pancreatic or other cancers that may be genetically linked - or are African American. If men are not in these higher risk categories, they should start the conversation at 45, the group says.

"One size does not fit all men for prostate cancer screening," Simons said.

Jacqueline Stenson, NBC News
May 20, 2020

Source: https://news.yahoo.com/alarming-rise-possibly-fatal-prostate-161700975.html

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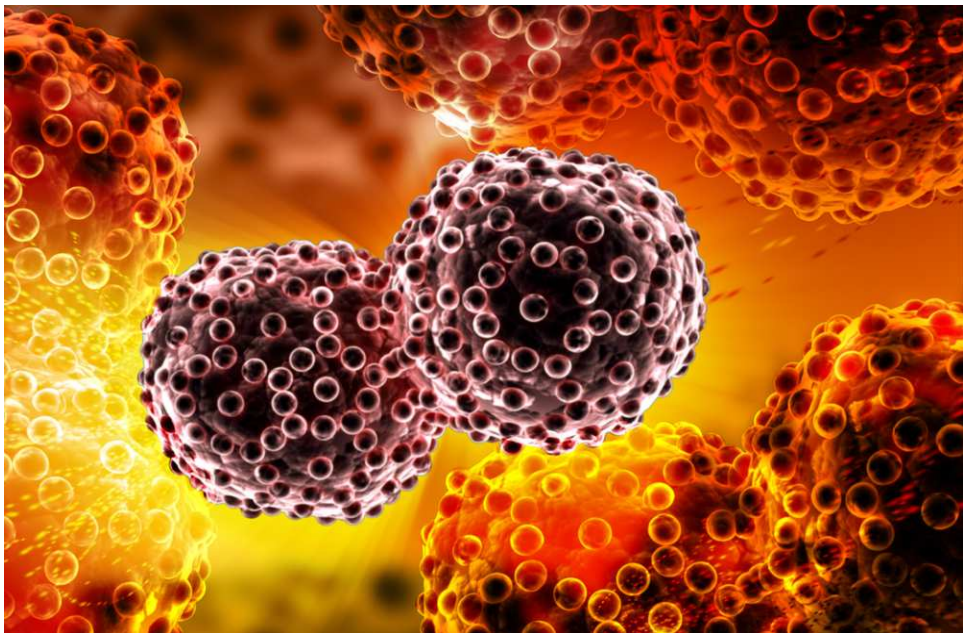
Breakthroughs in Prostate Cancer Treatments

Prostate cancer is being diagnosed in an increasing number of men, but many of them will be non-aggressive forms that run an indolent course over the man's lifetime, never requiring treatment at all.

On the other hand, the treatment of aggressive prostate cancer is constantly evolving, with a wide spectrum of treatment modalities available at present.



Cancer Staging
Staging of cancer is vital to decide on the right treatment. Until a few years ago, CT (computerized tomography) and MRI (magnetic resonance imaging) scans were the most accurate technologies available to stage prostate cancer, since the organ is buried deep beneath the superficial pelvic organs. Moreover, they tend to miss small areas of tumor in lymph nodes.

Newer forms of imaging include multiparametric MRI, which combine standard MRI with one or more other types. These could include diffusion-weighted imaging (DWI), dynamic contrast-enhanced (DCE) MRI, or MRI spectroscopy. The results of the scans are compared to arrive at the final report.

MRI with enhancement is another modality used to find cancerous lymph nodes. Here a standard MRI is followed by the injection of a magnetic particle dye, and a repeat scan is done the next day, to detect the presence of cancer cells.

Newer PET (positron emission tomography) use a type of tracer called radioactive sodium fluoride, fluciclovine, choline, or carbon acetate to track metabolically active cells, such as the rapidly dividing cells of cancer.

Cancer Risks
Another type of testing attempts to assess the risk of aggressive cancer. Genomic and proteomic testing can complement more traditional tests like the prostate-specific antigen (PSA) testing to help predict cancer growth and spread.

Some examples include the Oncotype DX Prostate which measures and reports specific gene activity levels from 0 to 100, Prolaris based on the same principle but measuring another set of genes, ProMark which measures protein activity for the same purpose, and Decipher, which looks at gene activity in surgically resected samples to help patients decide whether further treatment following surgery is desirable.

Another tool is the PREDICT prostate questionnaire, which takes only a few minutes for the patient with nonmetastatic prostate cancer to fill, with the doctor's help, and provides the expected odds of dying of the disease or other illnesses within 10-15 years. It also gives the odds of survival following the treatment.

The risks of complications like urinary incontinence and erectile dysfunction following the suggested treatment are also provided. The patient can then choose among different modalities of treatment, including active surveillance.

Researchers believe such tools could reduce unnecessary and potentially harmful interventions as well as save the healthcare system millions every year, by giving patients the power to choose treatments in consultation with their healthcare providers based on sound evidence and probable risks.

Liquid biopsy to exclude men with biomarkers of drug resistance from first-line chemotherapy, routing them to other therapies instead. In principle, they could use magnetic nanoparticles with DNA capture probes on their surface to target circulating tumor cells that contain the specific biomarkers.

Treatment
Different techniques and refinements of existing techniques are being

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evolved constantly to improve the quality of life and enhance survival among prostate cancer patients.

Surgical techniques have moved from the traditional open or laparoscopic radical prostatectomy, where the whole gland is removed plus the seminal vesicles and other tissues nearby, to robotic techniques that may reduce the time and blood loss associated with the surgery.

Newer forms of treatment include high-intensity focused ultrasound (HIFU) that uses the heat produced by ultrasonic energy.

Hormone Treatments
Prostate cancer is driven by testosterone. As a result, androgen deprivation therapy (ADT) can stop the growth of prostate cancers in many cases. Earlier forms of ADT included orchiectomy or surgical castration, and the use of LHRH agonists which inhibit testosterone production by the testes called medical castration.

LHRH antagonists are another form of medical castration. Antiandrogens prevent the action of androgens on androgen receptors. Newer drugs in this class include enzalutamide, apalutamide, and darolutamide, and early research indicates that ADT can be paired with these drugs for a better outcome.

Earlier used only for men with castration-resistant prostate cancer patients with metastatic cancer, these could now be approved for earlier use as well.

Newer forms of hormone therapy include antiadrenal hormones like the new drug abiraterone, a cytochrome P17 antagonist that reduces androgen production within the adrenal cell and can delay cancer growth. However, this must be given with a glucocorticoid, which limits its application.

Immunotherapy
Immunotherapy harnesses the body's immune system to detect and destroy cancer cells.

One type of immunotherapy is the **prostate cancer vaccine**, like sipuleucel-T, which is already approved for this indication. Others are in clinical trials. Vaccines seem to have fewer and less serious side effects than other modes of treatment.

Immune checkpoint inhibitors are another form of immunotherapy which exploits the body's natural ability to not react to its self-antigens with an immune reaction, via checkpoint molecules that must be turned off or on to initiate the immune response. Sometimes, cancer cells hijack these checkpoints to disguise their immune 'foreignness'.

Newer drugs inhibit one or more of these checkpoints such as PD-1, or its associated PD-L1 protein. Similar drugs are being examined for their usefulness in prostate cancer. The combination of a checkpoint inhibitor with a vaccine, for instance, might make the vaccine response more durable and stronger. Another possible combination is when it is used with a drug that makes the cancer cells more recognizable as non-self, allowing the checkpoint inhibitor to stimulate the body more effectively.

Chimeric antigen receptor T (CAR) cell therapy uses the body's immune cells to strengthen and specify the immune response against the cancer cell. T cells are removed from the patient and engineered to have receptors for antigens incorporating 'foreign' tumor components on their surface. These will bind specifically to the patient's prostate tumor cell surface.

The engineered cell is stimulated to multiply, and reintroduced to the patient's blood, to detect the cancer cells and attack them. This is complex, experimental and could have potentially serious adverse effects.

Interleukin-27 therapy is another promising therapy that may help reduce the growth of the tumor and stop cancer by signaling immune cells to come to the areas containing the tumor cells, kill the tumor, and initiate healing and wound repair.

Targeted therapy
Some therapies attack only one specific part of the cell or the environment of the tumor cell, to inhibit its growth, division, repair, or multiplication.

PARP Inhibitors
If the prostate tumor has mutations in BRCA2 or similar genes, DNA damage cannot be repaired, leading to the persistence of possibly harmful mutations in these cells. Drugs called polyadenosine diphosphate ribose polymerase (PARP) inhibitors are more toxic to such faulty cancer cells than normal cells.

Olaparib is one PARP inhibitor that can enhance survival and disease-free progression rates more than abiraterone or enzalutamide.

Monoclonal antibodies
These molecules are synthetic derivatives of immune proteins that bind to specific cancer cell targets like the PSMA antigen on a prostate cancer cell. Many of these are associated with chemotherapeutic agents or small radioactive molecules, so that the antibody will home in on the cancer cell, bringing with it the therapeutic agent.

Newer experimental drugs include a monoamine inhibitor used decades ago to treat depression, which has been found to disrupt androgen receptor signaling.

By Dr. Liji Thomas, MD

Source: www.news-medical.net/health/Breakthroughs-in-Prostate-Cancer-Treatments.aspx

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Lynparza Becomes Second Parp Inhibitor Approved For Prostate Cancer

Just Days Behind the First

Clovis Oncology's Rubraca remained the only PARP inhibitor approved for prostate cancer for only a handful of days. Today, that medication is joined by AstraZeneca and Merck's powerhouse PARP inhibitor, Lynparza.

This morning, the U.S. Food and Drug Administration (FDA) approved Lynparza (olaparib) for patients with homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC). HRR gene mutations occur in approximately 20-30% of patients with mCRPC. Rubraca was greenlit Friday for patients with a deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy.

Prostate cancer is the second-most common cancer in men. mCRPC occurs when prostate cancer grows and spreads to other parts of the body despite the use of androgen-deprivation therapy to block the action of male sex hormones. Approximately 10-20% of men with advanced prostate cancer will develop CRPC within five years, and at least 84% of these will have metastases at the time of CRPC diagnosis.

Lynparza's approval was based on results from the Phase III PROfound trial, which showed a statistically-significant and clinically-meaningful improvement in the primary endpoint of radiographic progression-free survival (rPFS) with Lynparza versus enzalutamide or abiraterone in men with mCRPC selected for BRCA1/2 or ATM gene mutations, a subpopulation of HRR gene mutations. Specifically, Lynparza reduced the risk of disease progression or death by 66% and improved rPFS by 7.4 months compared to the 3.6 months of the comparison treatment. Lynparza also showed an rPFS benefit in the overall HRR gene-mutated trial population, a key secondary endpoint. The drug and reduced the risk of disease progression or death by 51% and improved rPFS to a median of 5.8 months versus 3.5 months with enzalutamide or abiraterone.

Additionally, Lynparza reduced risk of death by 31% and significantly improved overall survival by a median of 19 months compared to 14.6 months with enzalutamide or abiraterone. To date, Lynparza is the only PARP inhibitor to improve overall survival vs. enzalutamide or abiraterone in a biomarker-based subset of prostate cancer patients with BRCA1/2 or ATM mutations, AstraZeneca and Merck said.

PARP inhibitors are designed to disable DNA repair pathways in cancer cells, which make it difficult for those cells to survive. Lynparza is a first-in-class PARP inhibitor. It is the first targeted treatment that blocks DNA damage response in cells and tumors that have a deficiency in homologous recombination repair (HRR), such as BRCA1 and BRCA2 mutations.

"Today marks the first approval for Lynparza in prostate cancer. In the PROfound trial, Lynparza more than doubled the median radiographic progression-free survival and is the only PARP inhibitor to improve overall survival, versus enzalutamide or abiraterone for men with BRCA or ATM mutations. These results further establish that genomic testing for HRR mutations should be a critical step for the diagnosis and determination of treatment options for men with advanced prostate cancer, Dave Fredrickson, head of AstraZeneca's Oncology Business Unit said in a statement.

Roy Baines, Chief Medical Officer of Merck Research Laboratories, said Lynparza is the only PARP inhibitor approved for this indication and added that the results highlight the importance of genomic testing to help identify treatment options for men in this patient population.

Lynparza is currently under regulatory review in the EU and other jurisdictions as a treatment for men with HRR gene-mutated mCRPC. AstraZeneca and Merck are studying Lynparza in additional trials in metastatic prostate cancer including the ongoing Phase III PROpel trial as a 1st-line treatment in combination with abiraterone acetate for patients with mCRPC versus abiraterone acetate alone.

AstraZeneca secured a regulatory milestone payment of $35 million from Merck following the approval.

In addition to the latest approval, Lynparza has been previously approved as first-line maintenance treatment of BRCA-mutated advanced ovarian cancer after response to platinum-based chemotherapy, for germline BRCA-mutated, HER2-negative, metastatic breast cancer that was previously treated with chemotherapy, and for germline BRCA-mutated metastatic pancreatic cancer.

By Alex Keown May 20, 2020 BioSpace

BioSpace source: www.biospace.com/article/lynparza-wins-fda-approval-in-prostate-cancer-second-parp-inhibitor-greenlit-for-the-indication-in-days

Source: www.pharmalive.com/lynparza-becomes-second-parp-inhibitor-approved-for-prostate-cancer/

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10 Best Foods for Prostate Health

Prostate cancer is one of the most common cancers among men, according to the American Cancer Society. By following a healthy diet, you can help lower your risk of developing prostate cancer and improve overall prostate health. Try adding the following 10 prostate friendly foods to your diet.

Tomatoes
Tomatoes contain lycopene — an antioxidant that may help prevent prostate cancer and reduce tumor growth in men who have already been diagnosed with prostate cancer. The lycopene from cooked or pureed tomatoes — such as tomato paste, pasta sauce, or tomato juice — is more easily extracted by our bodies than lycopene in raw tomatoes.

Broccoli
Cruciferous vegetables, such as broccoli and cauliflower, contain certain phytochemicals that some studies show may help fight cancer cells. Other research has shown that men who eat more cruciferous vegetables tend to have a lower risk of developing aggressive prostate cancer.

Legumes
Studies have found that certain phytoestrogens, a type of biologically active plant compound, have cancer-fighting properties that can suppress tumor growth in prostate cancer cells. Good sources of legumes include beans, peanuts, and lentils.

Fish
Consuming both omega-3 and omega-6 fatty acids is important, as they are found only in foods and are not made by the body. Studies have shown that omega-3 and omega-6 fatty acids may help prevent both the development and progression of prostate cancer. Good sources of these healthy fats include salmon, herring, mackerel, trout, nuts, and seeds.

Sesame seeds
Zinc has been found to be an essential mineral for prostate health. Researchers have determined that men with prostate cancer have lower levels of zinc in their bodies than men with healthy prostates. Zinc found in food is easier for our bodies to absorb than zinc supplements. Good sources of zinc include sesame seeds, pumpkin seeds, oysters, crab, lobster, beef, and poultry.

Bell peppers
While many fruits and vegetables contain vitamin C, the vitamin C found only in certain vegetables may help lower risk of an enlarged prostate. The vegetable with the most vitamin C is bell peppers, but other vegetable sources include broccoli, cauliflower, kale, and Brussels sprouts.

Avocados
Avocados contain beta-sitosterol, which has been shown to help reduce symptoms associated with enlarged prostate. Beta-sitosterol can also help strengthen the immune system and reduce inflammation and pain. Other sources of the plant sterol are pumpkin seeds, pecans, and wheat germ.

Beans
A diet rich in fiber can help protect the body from certain types of cancers. Beans are not only a great source of fiber, but they also provide a healthy alternative to red meat as a source of protein. Eating too much red meat has been linked to increased risk of prostate cancer.

Garlic
Consuming garlic may help reduce the risk of developing several types of cancer, according to the National Cancer Institute. It appears that garlic has an anti-inflammatory effect that may help with prostate cancer prevention. Research suggests that garlic has the ability to block the formation of certain cancer-causing substances and decrease the activation of such substances.

The bottom line
According to the Prostate Cancer Foundation, the biggest risk factors for developing prostate cancer include age, race, genetics, lifestyle factors, and dietary habits. Maintaining a healthy weight, eating a diet limited in processed foods, and consuming more fresh fruits and vegetables are some of the best things you can do to decrease your risk of prostate cancer.

Jacqueline Ho CONTENT PRODUCER
Jan 24, 2019

MEDICALLY REVIEWED By Carmen Roberts, M.S., R.D., L.D.N.

Source: https://www.healthcentral.com/slideshow/10-best-foods-prostate-health

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FUTURE MEETINGS 2020

Watch this space for speakers for future meetings which will resume once the Covid-19 crisis passes

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All meetings (except September) will be held at :
The First Unitarian Universalist Church of Winnipeg, 603 Wellington Crescent

All meetings are 7 – 9 pm.
(First hour for general discussion;
second hour for expert guest speaker)

Everyone Welcome Plenty of free parking

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