

Hormone Therapy for Advanced Prostate Cancer

Key Messages

- => Some types of hormone therapy can help slow the growth of prostate cancer.
- => Before beginning treatment, discuss the risks and benefits of hormone therapy with your doctor.
- => Talk with your doctor about potential short- and long-term side effects of your treatment.

Background

Advanced prostate cancer includes cancer that has spread, cancer that has returned after treatment, and cancer that continues to grow or spread despite treatment or while under surveillance. Because androgens (male sex hormones), such as testosterone, help the growth of prostate cancer, lowering the levels of androgens helps slow the growth of prostate cancer. Androgen deprivation therapy (ADT) is a hormone therapy that slows the growth of prostate cancer by lowering the levels of androgens or blocking the

androgens from getting to the prostate cancer cell.

ADT includes the following treatments:

=> Bilateral orchiectomy is the surgical removal of the testicles, the main source of testosterone production. Although this treatment is surgery, it is considered hormone therapy because it effectively removes most of the testosterone from the body. This treatment is also called surgical castration.

(Continued on page 2)

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Thanks!

Next Meeting: May 21, 2015
Dr. Paul Daeninck, Medical Oncologist
Topic: Medical Marijuana:
Is This "Bud" For You?
Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 – 9 p.m.



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

MPCSG – active since 1992.

Thought of The Day

Why do banks leave vault doors open and then chain the pens to the counters?

(Continued from page 1)

=> Luteinizing hormone-releasing hormone (LHRH) agonists are drugs that lower the body's production of testosterone by stopping the testicles from making testosterone. These drugs are usually given as injections. This treatment is sometimes called medical castration.

=> Anti-androgen drugs prevent the body from using testosterone. These drugs are in the form of a pill.

=> Combined androgen blockade (CAB) is a treatment strategy to eliminate any remaining androgens in the body. It is a combination of an anti-androgen drug and either surgery or an LHRH agonist drug. Surgical or medical castration eliminates about 90% to 95% of the body's testosterone, and adding the anti-androgen eliminates the remaining 5% to 10% of the body's testosterone.

Some common side effects of hormone therapy may include:

- => Psychological effects resulting from testicle removal
- => Loss of sex drive
- => Impotence (inability to have erections)
- => Hot flashes
- => Tiredness
- => Mood changes
- => Muscle shrinkage
- => Enlarged and/or tender breasts
- => Osteopenia and osteoporosis (loss of bone mass, which may result in a broken bone)
- => Weight gain

Some uncommon or rare side effects of hormone therapy include:

- => Rise in cholesterol
- => Diabetes
- => Heart disease
- => Liver damage (rare)

Many of these side effects are treatable, and most side effects go away once treatment is finished,

except those resulting from an orchiectomy, which are permanent. Men who have received an LHRH agonist drug for more than two years frequently experience persistent side effects for more than one year after the drug is discontinued, and some men never fully recover. In addition, recent research suggests that LHRH agonist therapy may also increase a man's risk of heart disease, heart attack, and death from cardiac arrest (sudden loss of heart function).



Recommendations

To help doctors determine when to use hormone therapy for men with advanced prostate cancer that responds to treatment with anti-androgens, ASCO recommends the following:

For most men, the initial recommended treatment is the removal of testosterone through a bilateral orchiectomy or with an LHRH agonist drug. Each procedure has a specific set of physical and psychological side effects, and it is important to talk with your doctor to understand the risks and benefits of each treatment.

An alternative to surgical or medical castration is a nonsteroidal anti-androgen drug. Bicalutamide (Casodex), flutamide (Eulexin) and nilutamide (Nilandron) are examples of anti-androgens. This treatment is as effective as a bilateral orchiectomy or an LHRH agonist drug, but it has different side effects (most notably, less effect on a man's sex drive).

For men with prostate cancer that continues to grow and spread, CAB treatment lowers the risk of death by more than either method listed above. However, there may also be an increase in potentially serious side effects. It is important to talk with your doctor about risks and benefits of this treatment, especially in the context of your own health history.

The timing of starting ADT should be discussed with your doctor. Research shows that starting treatment right away may not always be better. Most doctors recommend beginning treatment when a man shows symptoms of recurrent or progressive cancer. Men who are not treated right away should meet with their doctors every three to six months to monitor the cancer.

Intermittent hormone therapy is given for a specific time, stopped temporarily, and restarted again once the PSA hits a certain predetermined level. At this time, the use of intermittent hormone therapy is still considered experimental. Although a man's quality of life will likely be better during the "off therapy" periods (the time when the hormones are temporarily stopped), it is not known whether intermittent hormone therapy controls the cancer as long as continuous hormone therapy.

What This Means for Patient

Hormone therapy for prostate cancer comes in several forms: surgical removal of the testicles, LHRH agonist drugs, anti-androgen drugs, and a combination of these treatments. Men with advanced prostate cancer should discuss with their doctors the risks and benefits of all the treatment options and when to begin treatment. This discussion should address the current state of the cancer (such as

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whether PSA levels are rising or steady and whether the cancer has spread to the bones), your health history, and other medical conditions, such as diabetes. You may also want to discuss any concerns you may have about how your sexual and physical functioning might be affected by hormone therapy. For some men, the side effects of prostate cancer treatment are a bigger risk to their health than the prostate cancer itself, so it is important to talk with your doctor about the long-term side effects of a particular treatment.

Questions to Ask the Doctor

To learn more about hormone therapy for advanced prostate cancer, consider asking your doctor the following questions:

- => What are my options for treatment?
- => What are the possible side effects of these treatment options?
- => How will treatment affect my sexual and emotional well-being?
- => How will treatment affect my fertility?
- => Which treatment do you recommend, given my health history?
- => What type of follow-up care is necessary after treatment?
- => Do I need to begin treatment right away?
- => If my treatment is delayed, how will the cancer be monitored?
- => Am I eligible for a clinical trial?
- => Who should I talk with if I have questions about health insurance and the cost of follow-up care?

About ASCO's Guidelines:

The information in this guide is not intended as medical or legal advice, or as a substitute for consultation with a physician or other licensed health care provider. The decisions you and your doctor make will be based on your individual circumstances.

Due to the rapid flow of scientific information in oncology, new evidence may have emerged since the time a guideline was submitted for publication. As a result these guidelines may not reflect the most recent evidence.

Source: Guidelines from the American Society of Clinical Oncology (ASCO)

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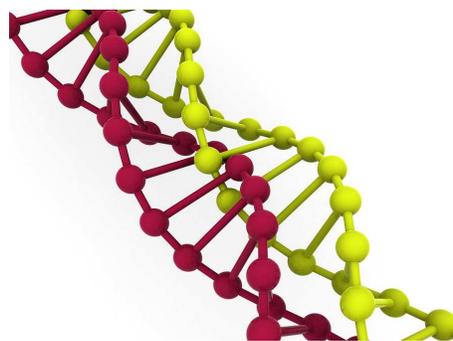
A Question About Familial Prostate Cancer

An important question: "My father had prostate cancer and so did his brother. I am 56 years old. Are there any foods that I can add to my diet to make it less likely that I will get this disease?" Here's the advice from Johns Hopkins Health Alerts.

Given your family history of prostate cancer, you are right to be concerned about an increased risk of developing prostate cancer. The studies performed on hereditary forms of prostate cancer at Johns Hopkins and the National Cancer Institute have shown that men with one close relative, such as a father or brother, with prostate cancer have a two-fold increase in the risk of developing the disease. If two close relatives are affected, there may be as much as a five-fold increase.

Although a great deal of research has been directed toward the roles of diet and dietary supplements in prostate cancer risk, the results have been inconclusive in terms of hard data. There is a general consensus that a

reduction in the consumption of red meat is associated with lower prostate cancer rates, but the reason is not known.



Cruciferous vegetables, such as broccoli, cabbage, and brussels sprouts, and leafy greens, such as kale and collards, contain compounds that seem to reduce prostate cancer risk. A compound called lycopene, found in tomatoes and best absorbed from cooked tomatoes (as in sauce), is also thought to be helpful. For a while, selenium and vitamin E were believed to have a significant effect on the risk of

developing prostate cancer, but a large multi-institutional trial failed to show any benefit.

Whether or not you make changes in your diet, **your prostate health should be monitored at least once a year with a PSA and digital rectal examination.** And it is not just the absolute value of the PSA that is important, but also the rate of rise from one year to the next. If your PSA goes up more than 0.5 ng/mL/year, regardless of the absolute value, there is a greater risk that prostate cancer may be developing. Under those circumstances, biopsy should be considered, assuming that there are no other special considerations related to your overall health or personal preferences.

Source:

*Johns Hopkins Health Alerts
November 2014*

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Incontinence: Causes and Treatments

In men, incontinence is often caused by problems with the prostate. This walnut-sized organ, located just below the bladder, produces the milky fluid that combines with sperm to produce semen.

Benign prostatic hyperplasia — (BPH, also called enlarged prostate): Prostate enlargement is common in men over the age of 40. As it gets bigger, the prostate can block the flow of urine through the urethra, resulting in frequent urination, a slow stream of urine and sometimes urge or overflow incontinence. More than half of men in their 60s and up to 90% of men over 70 have urinary symptoms linked to BPH.

Prostate cancer — Men with prostate cancer may experience incontinence as a side effect of their treatment (usually surgery, radiation or both). Surgery can damage the urinary sphincter or bladder wall, while radiation may cause bladder irritation.

Prostatitis — This inflammation of the prostate gland can cause urinary symptoms including painful and frequent urination

Diagnosis

One of the first things a doctor will do when a man complains of incontinence is check for prostate problems. This is usually done with a rectal exam to evaluate the size of your prostate (the prostate can be felt by inserting a finger in the rectum). In some cases, your doctor may also ask for a PSA test. This simple blood test measures the amount of prostate-specific antigen (PSA) - a substance naturally produced by the prostate - in the blood. Elevated levels of PSA could be a sign of an enlarged prostate, prostate cancer or prostatitis.

Pharmaceutical Treatment

Men whose incontinence is caused by an enlarged prostate may benefit from drugs used to treat BPH. Medications available in Canada include:

Alpha-blockers: These drugs relax the smooth muscle of the prostate and the opening of the bladder, reducing the urge to urinate and allowing urine to flow normally. Available medications: silodosin (Rapaflo®), tamsulosin (Flomax-CR®), alfuzosin (Xatral®), terazosin (Hytrin®) and doxazosin (Cardura®)



5-alpha reductase inhibitors: These medications block the production of the male hormone DHT, which is believed to be responsible for prostate enlargement. These types of drugs are most useful for men with more severe BPH. Available medications: finasteride (Proscar®), dutasteride (Avodart®)

Surgical Treatment

Surgical procedures for male incontinence often centre on correcting prostate problems or reversing the damage caused by prostate cancer treatments. Recently, sling procedures for men have also been developed. Here are some of the most common procedures.

Transurethral resection of the prostate (TURP): is a treatment for benign prostatic hyperplasia (BPH), a condition that may cause incontinence (usually urge incontinence). In this procedure, a small portion of the prostate is cut away using a wire heated with electrical current that's threaded up the penis, through the urethra.

Artificial urinary sphincter: Men who have had a radical prostatectomy for prostate cancer may suffer from incontinence, because the urinary sphincter can be damaged during the surgery. To correct this, a fluid-filled ring that keeps the urethra shut is implanted around the urethra, acting as an artificial urinary sphincter. A valve that causes the ring to deflate is implanted under the skin: when you need to go to the bathroom, you press it to allow urine to flow through.

Male sling procedures: Though they have been performed in women for years (see above), sling procedures for men are relatively new. As in women, a strip of synthetic tissue supports the urethra, keeping pressure on it to prevent leakage. Initial studies have shown a good success rate (80% improvement) but there isn't much data yet and the procedure is still under study.

ProAct®: Another option for post-prostatectomy relief from stress incontinence is an inflatable implant inserted near the bladder neck in a minimally invasive procedure and controlled through a port placed under the skin. The balloon lifts the bladder neck to improve continence.

Source: *The Canadian Continence Foundation*

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MRI Improves Prostate Cancer Biopsy Accuracy

Prostate biopsies that combine MRI technology with ultrasound appear to give men better information regarding the seriousness of their cancer, a new study suggests.

The new technology -- which uses MRI scans to help doctors biopsy very specific portions of the prostate -- diagnosed 30 percent more high-risk cancers than standard prostate biopsies in men suspected of prostate cancer, researchers reported.

These MRI-targeted biopsies also were better at weeding out low-risk prostate cancers that would not lead to a man's death, diagnosing 17 percent fewer low-grade tumors than standard biopsy, said senior author Dr. Peter Pinto. He is head of the prostate cancer section at the U.S. National Cancer Institute's Center for Cancer Research in Bethesda, Md.

These results indicate that MRI-targeted biopsy is "a better way of biopsy that finds the aggressive tumors that need to be treated but also not finding those small microscopic low-grade tumors that are not clinically important but lead to overtreatment," Pinto said.

Doctors performing a standard biopsy use ultrasound to guide needles into a man's prostate gland, generally taking 12 core samples from predetermined sections.

The problem is, this type of biopsy can be inaccurate, said study lead author Dr. Mohummad Minhaj Siddiqui, an assistant professor of surgery at the University of Maryland School of Medicine and director of urologic robotic surgery at the University of Maryland Marlene and Stewart Greenebaum Cancer Center in Baltimore.

"Occasionally you may miss the cancer or you may glance the cancer, just get an edge of it, and then you don't know

the full extent of the problem," Siddiqui said.

In a targeted biopsy, MRIs of the suspected cancer are fused with real-time ultrasound images, creating a map of the prostate that enables doctors to pinpoint and test suspicious areas.

Prostate cancer testing has become somewhat controversial in recent years, with medical experts debating whether too many men are being diagnosed and treated for tumors that would not have led to their deaths. Removal of the prostate gland can cause miserable side effects, including impotence and incontinence, according to the U.S. National Cancer Institute. But, even if a tumor isn't life-threatening, it can be psychologically difficult not to treat the tumor.

To test the effectiveness of MRI-targeted biopsy, researchers examined just over 1,000 men who were suspected of prostate cancer because of an abnormal blood screening or rectal exam. The researchers performed both an MRI-targeted and a standard biopsy on all of the men, and then compared results.

Both targeted and standard biopsy diagnosed a similar number of cancer cases, and 69 percent of the time both types of biopsy came to exact agreement regarding a patient's risk of death due to prostate cancer.

However, the two approaches differed in that targeted biopsy found 30 percent more high-risk cancers, and 17 percent fewer low-risk cancers. "You're missing low-risk cancer. This is the type of cancer where this person certainly would have lived their whole life and died of something else," Siddiqui said.

An MRI is great for guiding doctors to serious cancers, but is not able to detect lesions smaller than 5 millimeters, said Dr. Art Rastinehad, director of focal

therapy and interventional urological oncology and an associate professor of urology and radiology at Icahn School of Medicine at Mount Sinai in New York City.

"MRI's greatest weakness is also its greatest strength when it comes to prostate cancer," ignoring low-risk tumors while accurately directing a biopsy to potentially lethal cancers, Rastinehad said. "This study does lay the foundation for a possible paradigm shift in the way we screen men for prostate cancer," he added.

Clinical trials still are needed to show whether MRI-targeted biopsy will save lives or reduce future recurrence of cancer. "A new test should not be widely adopted in the absence of direct evidence showing benefits on quality of life, life expectancy, or ideally both," wrote Basch.

Another open question also remains -- whether the new technology, which requires an MRI for each suspected case of prostate cancer and new equipment to fuse the MRI with an ultrasound scan, would be worth the extra expense. Pinto believes the new technology might actually save money in the long run, by reducing overtreatment.

"We have to be very thoughtful, especially where health care dollars are scarce, to bring in technology that will not only help men but will be cost-efficient," he said. "That work has not been done completely, although some studies imply this technology may decrease considerably the number of unnecessary biopsies performed every year, and so could help control costs."

*Source: (HealthDay News)
January 2015*

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Older Men With Prostate Cancer Benefit From Radiation Plus Hormone Therapy



Adding radiation treatment to hormone therapy saves more lives among older men with locally advanced prostate cancer than hormone therapy alone, according to a new study in the *Journal of Clinical Oncology* this week from Penn Medicine researchers.

The researchers found that hormone therapy plus radiation reduced cancer deaths by nearly 50 percent in men aged 76 to 85 compared to men who only received hormone therapy. Past studies have shown that 40 percent of men with aggressive prostate cancers are treated with hormone therapy alone, exposing a large gap in curative cancer care among baby boomers aging into their 70s.

"Failure to use effective treatments for older patients with cancer is a health care quality concern in the United States. Radiation plus hormone therapy is such a treatment for men with aggressive prostate cancers," said lead author Justin E. Bekelman, MD, an assistant professor of Radiation Oncology, Medical Ethics and Health Policy at Penn's Perelman School of Medicine and Abramson Cancer Center. "Patients and their physicians should carefully discuss curative treatment options for prostate cancer and reduce the use of hormone therapy alone."

Locally advanced prostate cancer is cancer that has spread outside but near the prostate gland. Unlike slower growing tumors, locally advanced prostate cancer is an aggressive

malignancy that is prone to metastasize and cause cancer deaths. Hormone therapy lowers or blocks the levels of testosterone and other androgens (male hormones) that feed prostate cancer tumors.

Two landmark clinical trials have shown that radiation plus hormone therapy produces a large and significant improvement in survival in younger men relative to hormone therapy alone, but until now there has been no comparable research on treatment for older men with advanced prostate cancer.

Addressing this question for the first time, Penn's research team compared the combination of radiation plus hormone therapy versus hormone therapy alone among 31,541 men with prostate cancer ranging in age from 65 years to 85 years old, radiation plus hormone therapy was associated with a reduction in prostate cancer deaths of 57 percent relative to hormone therapy alone (from 9.8 percent to 4.4 percent of patients at 7 years follow up). Similarly, among men age 76 to 85 years old, radiation plus hormone therapy was associated with a reduction in prostate cancer deaths of 49 percent relative to

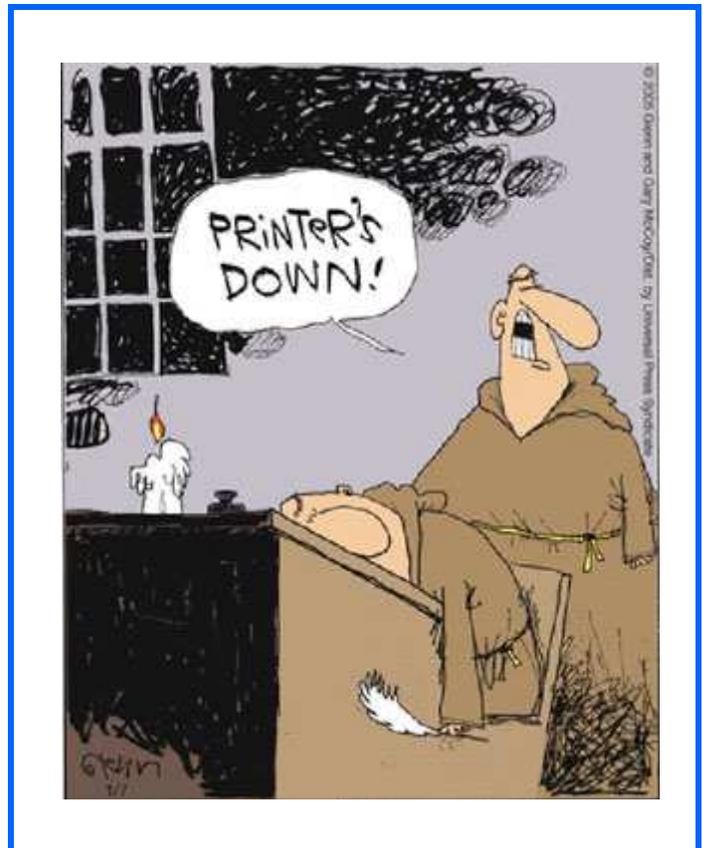
hormone therapy alone (from 9.8 percent to 5.0 percent of patients at 7 years follow-up). In both groups, radiation plus hormone therapy was also associated with about one-third fewer deaths from any cause.

Importantly, the clinical trials have shown that the side effects of radiation plus hormone therapy are very acceptable relative to hormone therapy alone.

"Older men with aggressive prostate cancers should know that the combination of radiation plus hormone therapy is both tolerable and effective in curing prostate cancer," said Bekelman.

*Source: MedicalNewsToday.com
January 2015*

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Medical Marijuana

Ottawa's new rules for obtaining medical marijuana are getting under the skin of some local medicinal users.

Richard Barahona, 44, was diagnosed with cancer almost two years ago. He tried more traditional methods of treatment but found they were either worsening his condition or not working.

He says the new system is nothing more than a money grab.

"We should be able to practise our alternative and make ourselves feel better and recuperating in what we're suffering from," said Barahona, a former respite worker who is now a co-owner of Vapes on Main, a downtown medical marijuana café.

Until last March, people with a doctor's prescription for medical marijuana were allowed to grow their own supply. Since March, new regulations make a small number of Health Canada-approved companies the only option to get medical marijuana.

Those who were approved to grow their own before March 21, 2014, are still allowed to do so on a temporary basis pending the outcome of a court case addressing the issue. The Federal Court trial is expected to be heard in February 2015.

Bill VanderGraaf is a medical-marijuana user and a co-founder of Vapes on Main. The café is relocating to Albert Street so is closed at the moment, but VanderGraaf said hundreds of people have come by or contacted the café looking for advice and information about medical marijuana.

He said he gets a lot of complaints about the lack of access and the cost of the product that is available.

"The chief complaint is pricing," VanderGraaf said. "It's really

expensive."

Health Canada's statistics show about 1,400 kilograms of marijuana were sold by licensed producers between Jan. 1 and Oct. 31. The price ranged from \$2.50 per gram to as high as \$15, depending on the producer and type of marijuana. The average price was between \$8 and \$10 per gram.

Health Canada statistics say there were about 38,000 patient authorizations under the old system, and patients who bought from Health Canada paid \$5 a gram for marijuana.

Under the new system, there are 13,671 patients registered as of Oct. 31.

There are currently only 15 companies licensed to sell medical marijuana in Canada; seven in Ontario, five in B.C. and one each in Saskatchewan, Manitoba and New Brunswick.

Under the new system, Health Canada has received more than 1,100 applications from prospective producers. Almost 600 have been deemed incomplete, more than 200 have been outright rejected and 35 were withdrawn. Health Canada was still reviewing 301 applications as of Nov. 24, 13 of which are waiting for inspection - the final step before approval.

VanderGraaf, a former police officer, said people are on long waiting lists and others are paying through the nose for shipping costs.

"It's basically the same as street prices," he said.

VanderGraaf said the government could help by increasing the number of producers, but he said the best solution is legalizing marijuana.

"If the regulations are reasonable we

should be able to grow it and take it away from the black market," he said.

He said some dispensaries aren't bothering to get a licence from Health Canada because the process is so bureaucratic.

Criteria for users of medicinal marijuana:

To qualify for medical marijuana you must exhibit the following symptoms, according to Health Canada. You also need proof from a medical professional that more "traditional" treatments have already been considered. They include any symptom treated within the context of

compassionate end-of-life care and symptoms related to specific medical conditions, such as:

- ◆ Severe pain and/or persistent muscle spasms from multiple sclerosis.
- ◆ Severe pain and/or persistent muscle spasms from a spinal cord injury.
- ◆ Severe pain and/or persistent muscle spasms from a spinal cord disease.
- ◆ Severe pain, cachexia, anorexia, weight loss, and/or severe nausea from cancer.
- ◆ Severe pain, cachexia, anorexia, weight loss, and/or severe nausea from HIV/AIDS infection
- ◆ Severe pain from severe forms of arthritis.
- ◆ Seizures from epilepsy.

For more information, visit the Health Canada website and check out their section on medical marijuana at <http://www.hc-sc.gc.ca/dhp-mps/marijuana/index-eng.php>

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Thanks to Abbvie



The Manitoba Prostate Cancer Support Group Board would like to thank Abbvie for a recent generous donation. We gratefully acknowledge this contribution and the relationship fostered over many years of assisting our Support Group. Because of this financial assistance, we are able to work towards our goal of providing awareness, education and support for those with prostate cancer. Abbvie produces Lupron a prostate cancer drug used for hormone therapy.

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2015 MEETINGS

Jan. 15 Dr. Rashmi Koul, Radiation Oncologist

Topic: Prostate Cancer and Bone Health

Feb. 19 Bill Martin, Gimli Author

Topic: Ripped Out: One Man's Journey Surviving PCa

Mar. 19 Dr. Robert Wightman, Pathologist

Topic: Biopsy Report and its Role in Determining Therapy

Apr. 16 Dr. Sabeer Rehsia, Urologist

Topic: Biochemical Recurrence: What are Your Options?

May 21 Dr. Paul Daeninck, Medical Oncologist

Topic: Medical Marijuana: Is This "Bud" For You?

June 18 Edith Mulhall, Lymphedema Assoc. of Manitoba

Topic: TBA

July No Meeting

Aug. 20 Dr. Reece Malone, Sexuality Educator

Topic: Reclaiming Intimacy and Nurturing Connection after Prostate Cancer.

Sept.17 Prostate Cancer Awareness Evening at

Caboto Centre - 1055 Wilkes Ave. 7 – 9 pm

Dr. Rashmi Koul, Radiation Oncologist

Dr. Piotr Czaykowski, Medical Oncologist

Oct. 15 Dr. Kelli Berzuk, Incontinence Physiotherapist

Topic: Living With Incontinence: Do I Have To?

Nov. 19 Christmas Pot Luck Party

Dec. No Meeting

All meetings 7 – 9 p.m. at

Seven Oaks General Hospital Auditorium

(except September)

Everyone Welcome

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