



The Manitoba Prostate Cancer Support Group NEWSLETTER



Vol. 219 – September 2009

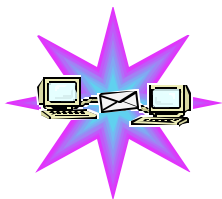


The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

Feel free to ask basic or personal questions without fear of embarrassment. You need not give out your name or other personal information.

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians. All information is however freely shared.

Want to reach us
by email ?



manpros@mts.net

Thought For Today

TOO BAD THAT ALL THE PEOPLE
WHO REALLY KNOW HOW TO RUN THE COUNTRY
ARE BUSY DRIVING TAXI CABS AND CUTTING HAIR

- GEORGE BURNS

Name Change For Our National Organization

*THE CANADIAN PROSTATE CANCER NETWORK (CPCN)
Becomes Prostate Cancer Canada Network (PCCN)*

"It's a new day for prostate cancer support groups across Canada," remarks Bob Shiell, president of the Canadian Prostate Cancer Network (CPCN). "What makes this day different from other days is that CPCN is no longer alone in its mission," he continues. "We have amalgamated with Prostate Cancer Canada, formerly known as the Prostate Cancer Research Foundation of Canada." The result? Ultimately, the benefit to men newly diagnosed with prostate cancer will be a coast-to-coast network of strengthened support groups that will have more and better tools and training.

Since its inception on Remembrance Day 1995, the Canadian Prostate Cancer Network has moved from strength to strength. The organization speaks for thousands of men who, each year, are diagnosed with prostate cancer, the most common cancer among Canadian men. Each week, an average of 490 Canadian men are diagnosed with this disease.



(Continued on page 2)

Medical Advisors to The Manitoba Prostate Cancer Support Group

J. Butler M.D.
Radiation Oncologist

Paul Daeninck M.D.
Pain Management

Darryl Drachenberg M.D.
Urologist

Graham Glezerson M.D.
Urologist

Len Leboldus M.D.
Urologist
[Honorary]

Ross MacMahon M.D.
Urologist

John Milner M.D.
Urologist

Jeff Sisler M.D.
Family Practitioner

Gary Schroeder M.D.
Radiation Oncologist

Thanks!

Cancer Information Service

Call toll free:
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1-905-387-1153

When you call the toll free number of the Cancer Information Service, your questions will be answered by someone who understands how confusing the subject of cancer can be. *All calls are kept confidential*

NEXT MEETING:

Thursday, September 17th, 2009 7 - 9 P.M.

Dr. Jeff Sisler, Family Physician -
" Prostate Cancer : Post Treatment Concerns "

Location: AUDITORIUM of the Seven Oaks General Hospital - Leila & McPhillips

(Continued from page 1)

"Through our affiliated support groups across Canada, CPCN has been able to reach out to these men and their families, helping them cope by providing up-to-date medical information and individual support," says Wally Seeley, executive director of CPCN. "We have also run a wonderfully successful public awareness campaigns promoting early detection, and we've lobbied for increased funding to combat prostate cancer through improvements in research, treatment facilities, and programs," he adds.

PCCN is lucky to have an individual with so much experience and vision at the helm during this time of transition. Shiell is president of Calgary's prostate cancer support group Prostaaid, he has served as president of CPCN since 2001, and he is a founding member of the World Wide Prostate Cancer Coalition (WWPCC).

Prostate Cancer Canada is dedicated to the elimination of this disease through research, education, advocacy, survivorship support, and awareness. "PCC's scope, like CPCN's, is national, so the fit is very good," says Shiell about the upcoming amalgamation.

The future does indeed look promising. "Prostate Cancer Canada Network, working as a division of Prostate Cancer Canada, will have stable funding, access to administrative staff, higher visibility, and the support of an established player in the prostate cancer arena," Shiell comments.

"Working together, we will be able to go from strength to strength to benefit Canadian men and their families on their journey with prostate cancer.

For more information on Prostate Cancer Canada, please visit www.prostatecancer.ca

The Manitoba Prostate Cancer Support Group has been a member of CPCN since it's inception in 1995. We look forward to a continued relationship with PCCN, sharing the vision of a unified approach to fight prostate cancer through research, education, support and awareness.

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MOVING?
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Stats Favor Five-Year Prostate Survivors

Published: July 6, 2009 at 2:31 PM Source: upi.com

U.S. researchers say prostate cancer patients disease-free after five years will likely be disease-free after 10 years.

The study of prostate cancer patients receiving brachytherapy, published in the International Journal of Radiation Oncology*Biology*Physics, finds cancer recurrences at 10 years unlikely in those who were deemed disease free at five years.

Brachytherapy is either the temporary or permanent placement of radioactive sources in or just next to a tumor.

"Our data have indicated that improvements in treatment are continuing and that these will continue to have an effect on prostate brachytherapy data for years to come," lead author Dr. Richard Stock of The Mount Sinai Medical Center in New York says in a statement.

"Late failure rates will continue to decrease, making prostate brachytherapy alone and combined with hormonal therapy and/or external beam radiation therapy an increasingly attractive treatment option."

The study followed 742 prostate cancer patients treated with brachytherapy alone, brachytherapy and hormonal therapy, or combined brachytherapy and external beam radiotherapy from 1991 to 2002.

None of these patients had recurrences during their first five years post-treatment. Prostate-specific antigen level taken at five years was an indicator of how well a patient would do in the future and the overall chance of being cancer free at 10 years was 97 percent, the study said.

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Vegetarians May Have Lower Cancer Risk

By CancerConsultants.com

Compared with meat eaters, vegetarians and those who eat fish but not meat appear to have a lower risk of several types of cancer. The results of this study were published in the British Journal of Cancer.

Studies have suggested that consumption of red or processed meat may increase the risk of several types of cancer, including cancers of the colon and rectum, esophagus, stomach, pancreas, lung, endometrium (uterus), and prostate.

To explore whether vegetarians (people who do not eat fish or meat) have a lower risk of cancer than meat eaters, researchers evaluated information from more than 61,000 British men and women; 32,403 were meat eaters, 8,562 ate fish but not meat, and 20,601 were vegetarians.

Study participants have been followed for an average of 12 years. During this time, a total of 3,350 new cancers were diagnosed.

When assessing the risk of cancer in the three dietary groups (meat eaters, fish eaters, and vegetarians), the researchers accounted for several underlying differences among the groups, including age, smoking status, alcohol use, body mass index, and physical activity.

The cancers that clearly differed in frequency among the groups were stomach cancer, ovarian cancer, bladder cancer, and hematologic cancers (non-Hodgkin's lymphoma, multiple myeloma, and leukemia).

=> Compared with meat eaters, vegetarians had a 64% reduced risk of stomach cancer, a 53% reduced risk of bladder cancer, and a 45% reduced risk of hematologic cancers. Vegetarians did, however, have an increased risk of cervical cancer (risk was roughly twice as high as in meat eaters).

=> Fish eaters had a 63% reduced risk of ovarian cancer and a 43% reduced risk of prostate cancer.

=> The risk of all cancers combined was 18% lower in fish eaters and 12% lower in vegetarians.

The results of this study suggest that cancer risk is lower in fish eaters and vegetarians than in meat eaters.

Reference: Key TJ, Appleby PN, Spencer EA et al. Cancer incidence in British vegetarians. British Journal of Cancer. 2009;101:192-197.

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Most Not Worried by Delayed Prostate Cancer Therapy

Little anxiety noted in survey of men who opt out of aggressive treatment

HealthDay Peter West Monday, July 27, 2009

MONDAY, July 27 (HealthDay News) - Men who delay treatment for their early prostate cancer are not especially anxious about living with the disease, new Dutch research shows.

The evidence seems to contradict the assumption that living with untreated prostate cancer is nerve-wracking for most patients, according to Dr. Roderick van den Bergh, of Erasmus Medical Center in Rotterdam, and colleagues. The findings are published in the Sept. 1 issue of Cancer.

The researchers surveyed 129 men regarding their levels of depression and anxiety over their treatment decision. More than 80 percent scored favourably low and compared well emotionally with patients who had opted for more aggressive treatment, the study found.

Men who were in poor general health and those with neurotic personalities expressed higher levels of anxiety and distress, suggesting that factors other than cancer may impact a patient's emotional response, the researchers noted.

The study is especially useful in an era when prostate-specific antigen tests and other screening exams are uncovering prostate cancer at increasingly earlier stages. Many physicians practice a "wait-and-see" approach to treatment, saving the more aggressive therapies for when the cancer grows or spreads, according to information in a news release from the American Cancer Society.

Nationally, prostate cancer is one of the most common cancers and is expected to strike more than 190,000 men this year, and result in over 27,000 deaths, according to the American Cancer Society. But thanks to more effective screenings and treatments, while one in six U.S. men will develop prostate cancer during their lifetime, only one in 35 will actually die of the disease. What's more, there are more than 2 million men in the United States who have been diagnosed with prostate cancer at some point and are still alive today, according to the society.

SOURCE: American Cancer Society, news release, July 27, 2009

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In Health Reform, a Cancer Offers an Acid Test

By DAVID LEONHARDT The New York Times July 8, 2009

WASHINGTON — It's become popular to pick your own personal litmus test for health care reform.

For some liberals, reform will be a success only if it includes a new government-run insurance plan to compete with private insurers. For many conservatives, a bill must exclude such a public plan. For others, the crucial issue is how much money Congress spends covering the uninsured.

My litmus test is different. It's the prostate cancer test.

The prostate cancer test will determine whether President Obama and Congress put together a bill that begins to fix the fundamental problem with our medical system: the combination of soaring costs and mediocre results. If they don't, the medical system will remain deeply troubled, no matter what other improvements they make.

The legislative process is still in the early stages, and Washington is likely to squeeze some costs out of the medical system. But the signals coming from Capitol Hill are still worrisome, because Congress has not seemed willing to change the basic economics of health care.

So let's talk about prostate cancer. Right now, men with the most common form — slow-growing, early-stage prostate cancer — can choose from at least five different courses of treatment. The simplest is known as watchful waiting, which means doing nothing unless later tests show the cancer is worsening. More aggressive options include removing the prostate gland or receiving one of several forms of radiation. The latest treatment — proton radiation therapy — involves a proton accelerator that can be as big as a football field.

Some doctors swear by one treatment, others by another. But no one really knows which is best. Rigorous research has been scant. Above all, no serious study has found that the high-technology treatments do better at keeping men healthy and alive. Most die of something else before prostate cancer becomes a problem.

"No therapy has been shown superior to another," an analysis by the RAND Corporation found. Dr. Michael Rawlins, the chairman of a British medical research institute, told me, "We're not sure how good any of these treatments are." When I asked Dr. Daniella Perloth of Stanford University, who has studied the data, what she

would recommend to a family member, she paused. Then she said, "Watchful waiting."

But if the treatments have roughly similar benefits, they have very different prices. Watchful waiting costs just a few thousand dollars, in follow-up doctor visits and tests. Surgery to remove the prostate gland costs about \$23,000. A targeted form of radiation, known as I.M.R.T., runs \$50,000. Proton radiation therapy often exceeds \$100,000.

And in our current fee-for-service medical system — in which doctors and hospitals are paid for how much care they provide, rather than how well they care for their patients — you can probably guess which treatments are becoming more popular: the ones that cost a lot of money.

Use of I.M.R.T. rose tenfold from 2002 to 2006, according to unpublished RAND data. A new proton treatment center will open Wednesday in Oklahoma City, and others are being planned in Chicago, South Florida and elsewhere. The country is paying at least several billion more dollars for prostate treatment than is medically justified — and the bill is rising rapidly.

You may never see this bill, but you're paying it. It has raised your health insurance premiums and left your employer with less money to give you a decent raise. The cost of prostate cancer care is one small reason that some companies have stopped offering health insurance. It is also one reason that medical costs are on a pace to make the federal government insolvent.

These costs are the single most important thing to keep in mind during the health care debate. Making sure that everyone has insurance, important as that is, will not solve the cost problem. Neither will a new public insurance plan. We already have a big public plan, Medicare, and it has not altered the economics of prostate care.

The first step to passing the prostate cancer test is laying the groundwork to figure out what actually works. Incredibly, the only recent randomized trial comparing treatments is a 2005 study from Sweden. (It suggested that removing the prostate might benefit men under 65, which is consistent with the sensible notion that younger men are better candidates for some aggressive treatments.)

"There is no reason in the world we have to be this uncertain about the relative risks and benefits," says Dr. Sean Tunis, a former chief medical officer of Medicare.

Drug and device makers have no reason to finance such trials, because insurers now pay for expensive treatments

(Continued on page 5)

(Continued from page 4)

even if they aren't more effective. So the job has to fall to the government — which, after all, is the country's largest health insurer.

Obama administration officials understand this, and the stimulus bill included money for such research. But stimulus is temporary. The current House version of the health bill does not provide enough long-term financing.

The next step involves giving more solid information to patients. A fascinating series of pilot programs, including for prostate cancer, has shown that when patients have clinical information about treatments, they often choose a less invasive one. Some come to see that the risks and side effects of more invasive care are not worth the small — or nonexistent — benefits. "We want the thing that makes us better," says Dr. Peter B. Bach, a pulmonary specialist at Memorial Sloan-Kettering Cancer Center, "not the thing that is niftier."

The current Senate bill would encourage doctors to give patients more information. But that won't be nearly enough to begin solving the cost problem.

To do that, health care reform will have to start to change the incentives in the medical system. We'll have to start paying for quality, not volume.

On this score, health care economists tell me that they are troubled by Congress's early work. They are hoping that the Senate Finance Committee will soon release a bill that does better. But as Ron Wyden, an Oregon Democrat on the committee, says, "There has not been adequate attention to changing the incentives that drive behaviour." One big reason is that the health care industry is lobbying hard for the status quo.

Plenty of good alternatives exist. Hospitals can be financially punished for making costly errors. Consumers can be given more choice of insurers, creating an incentive for them to sign up for a plan that doesn't cover wasteful care. Doctors can be paid a set fee for some conditions, adequate to cover the least expensive most effective treatment. (This is similar to what happens in other countries, where doctors are on salary rather than paid piecemeal — and medical care is much less expensive.)


Even if Congress did all this, we would still face tough decisions. Imagine if further prostate research showed that a \$50,000 dose of targeted radiation did not extend life but did bring fewer side effects, like diarrhea, than

other forms of radiation. Should Medicare spend billions to pay for targeted radiation? Or should it help prostate patients manage their diarrhea and then spend the billions on other kinds of care?

The answer isn't obvious. But this much is: The current health care system is hard-wired to be bloated and inefficient. Doesn't that seem like a problem that a once-in-a-generation effort to reform health care should address?

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Become informed – Plan to attend



DR. JEFF SISLER DR. ANNE KATZ DR. JEFF SARANCHUK DR. ALDRICH ONG BRIAN SPROTT


Prostate Cancer Awareness Evening

Tuesday, September 22, 2009 | 7pm to 9pm
Basic Medical Sciences Building | Theatre A
730 William Avenue

FREE ADMISSION **Guest Speakers:**

- Dr. Jeff Sisler, Family Physician
- Dr. Anne Katz, Clinical Nurse Specialist
- Dr. Jeff Saranchuk, Urologist
- Dr. Aldrich Ong, Radiation Oncologist
- Brian Sprott, Chair, MPCSP

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September is Prostate Cancer Awareness Month

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[two responses to the previous article]

To the Editor:

"In Health Reform, a Cancer Offers an Acid Test," by David Leonhardt (Economic Scene column, front page, July 8), misses an essential principle in the genomic age of prostate cancer research: one cost and treatment cannot benefit every patient.

Prostate cancer is not one disease for policy reform: we finance research on more than six molecular and clinical subtypes of prostate cancer. Some are lethal, while others do not require treatment.

We do not yet have tests that can distinguish between the two. Thus, we often overtreat, overburdening the resources of our health care system. Without intensified research now, we can never know perfectly who should receive which treatment.

Some 192,000 American men will receive a diagnosis of prostate cancer this year, and some 27,000 men (one every 19 minutes) will die annually from advanced, metastatic disease.

Prostate cancer provides the ideal place to test policy reform and immediate reinvestment of any savings from waste into research that ends death from prostate cancer.

Jonathan Simons
President and Chief Executive
Prostate Cancer Foundation
Santa Monica, Calif., July 8, 2009

To the Editor:

While I agree with David Leonhardt's premise that prostate cancer is an appropriate litmus test for health care reform, I disagree with

his analysis of treatment issues.

Mr. Leonhardt defines the "fundamental problem" in health care as "the combination of soaring costs and mediocre results." That would apply to the expense and results to date with proton therapy, but it certainly does not apply to I.M.R.T. The actual costs of treatment are significantly less than those cited by Mr. Leonhardt. Numerous recent studies have shown that higher doses of radiation delivered by I.M.R.T. eradicate cancer more effectively with dramatically fewer side effects than any other treatment.

Most men who forgo treatment and pursue "watchful waiting" (a.k.a. "watchful worrying") ultimately end up on female hormones as the disease progresses. The hormones are not only extremely costly but also lead to heart disease, hyperlipidemia, diabetes, osteoporosis, cognitive impairment and "andropause" (hot flashes, depression, erectile dysfunction). Treating these hormone-induced maladies is more costly than treating prostate cancer, since they frequently result in mega-medications and repeated hospitalizations.

Those patients still have prostate cancer, and while screening and advances in treatment have lowered the death rate significantly over the past decade, prostate cancer still kills almost 30,000 patients a year.

Michael J. Dattoli
Sarasota, Fla., July 13, 2009

The writer is chief physician at the Dattoli Cancer Center and Brachytherapy Research Institute.

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False-positive Results Are Common with Cancer Screening

CancerConsultants.com

Researchers affiliated with the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial have reported that the risk of obtaining a false-positive result from screening for prostate, lung, colorectal, and ovarian cancer is high and becomes cumulatively higher with ongoing screening—after 14 screening tests, the cumulative risk of a false-positive is 60.4% for men and 48.8% for women. The results of this study were published in the May/June 2009 issue of the *Annals of Family Medicine*.^[1]

Cancer screening has become an important component of preventive care because cancer is most treatable when caught in the early stages of development. In many instances screening has been shown to reduce mortality from cancer; for example, regular screening with Pap smear has significantly reduced the death rate from cervical cancer in the United States. There is also evidence that colorectal screening reduces mortality. Mammography screening remains controversial with some data suggesting overdiagnosis in one-third of patients. Screening for prostate

cancer is so controversial that it is still not recommended by some major medical organizations. However, it is unclear whether or not screening for some types of cancer reduces the mortality rates, as evidence indicates that some slow-growing cancers are being overdiagnosed; in such cases patients would often die of other causes before the cancer started causing symptoms. As a result, there is some controversy over the frequency and interval of cancer screening.

The PLCO Cancer Screening Trial is a randomized, controlled trial designed to evaluate the effects of prostate, lung, colorectal, and ovarian cancer screening on disease-specific mortality. The study included 68,436 patients aged 55 to 74 who were randomized to receive screening or usual care. Participants received up to 14 screening tests over the course of three years. For women, the tests included vaginal ultrasounds, chest X-rays, sigmoidoscopies to examine the colon, and measurement of an ovarian cancer marker called CA-125. Men underwent chest X-rays, digital rectal examination, sigmoidoscopy, and measurement of prostate specific antigen (PSA).

After four screening tests, the cumulative risk of a false-positive result was 36.7% for men and 26.2% for women.

After 14 tests, the cumulative risk for a false-positive result jumped to 60.4% for men and 48.8% for women. Furthermore, the cumulative risk of undergoing an unnecessary invasive biopsy procedure based on the results of a false-positive screening test was 28.5% for men and 22.1% for women.

Comments: The high rate of false-positives does not mean that all

screening is “bad”; however, it indicates one of the risks of consistent, long-term screening. It is important to understand both the risks and benefits of screening and to make informed choices about preventive care.

Reference:

- [1] Croswell JM, Kramer BS, Kreimer AR, et al. Cumulative incidence of false-positive results in repeated, multimodal cancer screening. *Annals of Family Medicine*. 2009; 7: 212-222.

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PSA Kinetics Did Not Enhance Predictability Of Outcome In Prostate Cancer

Source: Hemonctoday Posted July 6, 2009

PSA velocity and PSA doubling time were not superior to PSA alone in predicting patient outcome.

According to data from a recent analysis, PSA dynamics, specifically PSA velocity and doubling time, did not improve the predictability of patient outcomes among men undergoing radical prostatectomy. However, half of the pretreatment dynamics were associated with outcome in a univariate analysis.

“These improvements were small with wide CIs,” the researchers wrote of their findings. “We believe these improvements could have been produced by chance, given the large number of definitions tested.”

Using data gathered in their database, researchers from Memorial Sloan-Kettering Cancer Center identified 2,938 patients with two or more PSA values before radical prostatectomy. Three hundred eighty-four patients experienced biochemical recurrence and 63 experienced metastases. The median follow-up for patients without biochemical recurrence was 2.1 years. The purpose of the study was to assess whether pretreatment PSA velocity and doubling time predicted outcome.

The researchers used 11 definitions of PSA doubling time and seven definitions of PSA velocity; PSA velocity was analyzed as both a continuous variable and categorized as >2.0 ng/mL per year based on data from D’Amico et al.

PSA alone was associated with recurrence ($P<.001$) and metastases ($P=.002$). In a univariate analysis, 11 PSA definitions were associated with biochemical recurrence or metastasis, though a longer PSA doubling time predicted shorter survival in one definition. Two PSA doubling time and four PSA velocity definitions were associated with both biochemical recurrence and metastasis ($P<.05$).

Compared with PSA alone, one PSA doubling time and one PSA velocity definition had a higher predictive accuracy for biochemical recurrence; four PSA velocity definitions improved prediction of metastasis.

“However, the improvements in predictive accuracy were small, associated with wide CIs and markedly reduced if additional predictors of stage and grade were included alongside PSA,” the researchers wrote of the findings.

In addition, the researchers reported that the two PSA doubling time definitions and four PSA velocity definitions associated with biochemical recurrence and metastasis could have occurred by chance.

In an accompanying editorial, Anthony V. D’Amico, MD, PhD, chair, division of genitourinary radiation oncology, Brigham and Women’s Hospital and Dana-Farber Cancer Institute and professor of radiation oncology, Harvard Medical School, and Ming-Hui Chen, PhD, department of statistics, University of Connecticut, discussed the findings from O’Brien et al.


“This analysis is accurate and comes to a sound conclusion when considering all men who present with localized prostate cancer,” D’Amico told HemOnc Today. “However, the conclusion of their study can be misleading when one considers the subgroup of men with low-risk prostate cancer where PSA kinetic measures have been shown to be clinically important in determining outcomes such as cancer-specific and all-cause mortality.”

Though O’Brien and colleagues found that PSA kinetics did not add to the predictive accuracy of pretreatment PSA alone, D’Amico noted the importance of PSA kinetics.

“Given that in the United States the vast majority of people present with low-risk prostate cancer due to PSA screening, PSA kinetic measures maintain an important clinical role,” he said. – by Stacey L. Adams

D’Amico AV. *J Clin Oncol*. 2009;doi:10.1200/JCO2009.22.6068.
O’Brien MF. *J Clin Oncol*. 2009;doi:10.1200/JCO.2008.19.9794.

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<p>2009 MEETINGS:</p> <p>Jan. 15.....Dr. Paul Daeninck, Pain Management specialist - " Supportive Care for The Prostate Cancer Patient and his Family "</p> <p>Feb. 19.....MPSGC member stories - " Let's Share Some of our Stories (Good & Bad) "</p> <p>Mar. 19.....Dr. John Milner, Urologist - " Prostate Cancer : What Does "Cure" Mean for This Disease? "</p> <p>April 16.....Dr. H. R. Wightman, Pathologist - " Explaining the Role of The Pathologist "</p> <p>May 21.....Dr. Janice Dodd, PhD, Physiology - " What's New in Prostate Cancer Research "</p> <p>June 18.....Tom Roche, Social Work - " So You've been referred to a Social Worker: Now What? "</p> <p>July 16.....Jason Bachewich, Naturopath - " New Science & Nutritional Breakthroughs in Prostate Cancer Support "</p> <p>Aug. 20.....Robin Chambers, Oncology Dietician - " Common Myths About Diet and Cancer "</p> <p>Sept. 17.....Dr. Jeff Sisler, Family Physician - " Prostate Cancer : Post Treatment Concerns "</p> <p>Oct. 15.....Kim Hodgins, Physiotherapist - " Incontinence and The Pelvic Floor Muscle "</p> <p>Nov. 19.....Greg Harochaw, Pharmacist - " Treating Erectile Dysfunction after Prostate Cancer Treatment "</p> <p>Dec. 17.....Party Time: Don Swidinsky - guitarist.: Celtic Group " Beggars Brawl " - Miriam, Darrell, Mike & D'Arcy</p>	<p>Executive Committee: (204)</p> <p>Pam Boomer, Executive Member 663-1351 Tom Boomer, Executive Member 663-1351 Joseph Courchaine, Treasurer 257-2602 Laurette Courchaine, Executive Member 257-2602 Michael Doob, Newsletter Coordinator 488-0804 Darlene Hay, Membership Coordinator 837-6742 Kirby Hay, Information Coordinator 837-6742 Ken Kirk, New Member Coordinator 261-7767 Jim Leddy, Executive Member 831-6119 Norm Oman, Events, Speaker Coordinator 487-4418 Brian Sprott, Chairman 668-6160 June Sprott, Secretary 668-6160 Lorne Strick, Videographer 667-9367 Arthur Wortzman, Executive Member 287-8621 Our Answering Machine 989-3433</p>
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