Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 408 *MPCSG – active since 1992.* **June 2026**

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Thanks!

Next Meeting

Date: Wednesday, June 17, 2026

Speaker: Dr. Aldrich Ong & Dr. Shen Zhang
Radiation Oncologists at CancerCareMB

Topic: "**Radiation Therapy for Prostate Cancer: Past, Present and Future**"
(Have your questions answered in the Q&A)

Location: The First Unitarian Universalist Church of Winnipeg, 603 Wellington Crescent, Winnipeg

Time: 7-9 pm

Free Admission *Everyone Welcome*
Plenty of free parking *Door Prizes*

Thought of The Day

"It's not whether you get knocked down,
it's whether you get back up."

-Vince Lombardi

ASPIRE trial explores survival benefits of adding chemotherapy to standard prostate cancer treatment

The Alliance for Clinical Trials in Oncology is now enrolling patients in the ASPIRE trial (A032302)-a large-scale, phase III clinical study investigating whether adding chemotherapy to current standard treatments extends survival for men with advanced prostate cancer.

ASPIRE is designed to answer a critical question in prostate cancer care. We want to know if intensifying treatment early-by adding the chemotherapy medication docetaxel-to the standard hormone therapy can help patients live longer and maintain a better quality of life."

Deepak Kilari, MD, principal investigator for the trial and associate professor in the division of hematology and oncology at Froedtert and the Medical College of Wisconsin

"The genomic analysis built into ASPIRE is an important feature of the study. Examining TP53, PTEN, and RB1 alterations may help clarify which patients

(Continued on page 2)

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.

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benefit most from treatment intensification and may inform more tailored approaches over time" said Rana McKay, MD, vice-chair of the Alliance Genitourinary Committee and professor of medicine, urology, and radiation medicine at the University of California San Diego.

Since the trial opened in October 2025, 177 cancer centers across the United States have begun offering the trial to patients. To date, 18 men at sites in Arizona, California, Kansas, Illinois, Montana, New Jersey, Pennsylvania and Washington, D.C., have joined the study. As part of the National Clinical Trials Network, the Alliance works with community cancer centers across the nation to ensure patients have access to life-changing trials, regardless of their proximity to an urban center or major research hospital.

The ASPIRE trial aims to ultimately enroll about 1,200 participants. The study is open to men 18 years of age or older with metastatic prostate cancer as confirmed by imaging studies.

Prostate cancer remains one of the most common cancers among men with an estimated 1.5 million cases diagnosed worldwide. While hormone therapy has long been the cornerstone of treatment for metastatic disease, recent advances have introduced newer agents like apalutamide that target the androgen receptor more effectively. However, questions remain about whether combining these agents with chemotherapy can further improve outcomes.

Participants in the ASPIRE trial will be randomly assigned to one of two treatment arms:

- ◊ Standard Arm: Hormone therapy plus apalutamide.
- ◊ Intervention Arm: Hormone therapy plus apalutamide and docetaxel, administered intravenously every 21 days for up to six cycles.

The trial's primary endpoint is overall survival, but researchers are also evaluating secondary outcomes, including progression-free survival and quality of life. Importantly, the study includes genomic analysis to assess whether patients with mutations in TP53, PTEN or RB1-genes associated with more aggressive disease-derive greater benefit from the intensified treatment.

The ASPIRE trial is notable not only for its scale but also for its long-term follow-up. Patients will be monitored every six months for up to 10 years, allowing researchers to gather robust data on survival, disease progression and treatment-related side effects.

The inclusion of genetic profiling in the ASPIRE trial reflects a growing trend toward precision oncology, where treatments are tailored to the molecular characteristics of each patient's cancer. By identifying which subgroups benefit most from docetaxel, researchers hope to refine treatment strategies and avoid unnecessary toxicity in patients unlikely to benefit.

The ASPIRE study is being conducted by the Alliance for Clinical Trials in Oncology and supported by the National Cancer Institute through the National Clinical Trials Network.

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www.news-medical.net/news/20260504/ASPIRE-trial-explores-survival-benefits-of-adding-chemotherapy-to-standard-prostate-cancer-treatment.aspx#

Editorial Checklist Reviewed

Alliance for Clinical Trials in Oncology

May 4 2026

Source:
Alliance for Clinical Trials in Oncology

www.news-medical.net/news/20260504/ASPIRE-trial-explores-survival-benefits-of-adding-chemotherapy-to-standard-prostate-cancer-treatment.aspx

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Learning the basics about prostate cancer

As part of our outreach activity we provide speakers available to any community service group interested in learning about and upgrading their knowledge about prostate cancer. If you are part of a group that would like to learn, or review, the important basics that everyone should know about this disease, presented at an easy-to-understand layperson level, please contact any board member to schedule a presentation.
It takes about an hour and allows for active engagement between speaker(s) and audience to explore a variety of interests and concerns. There is no cost for this service. Size of the group doesn't matter, but the more the merrier. You provide the audience and we'll provide the speaker.

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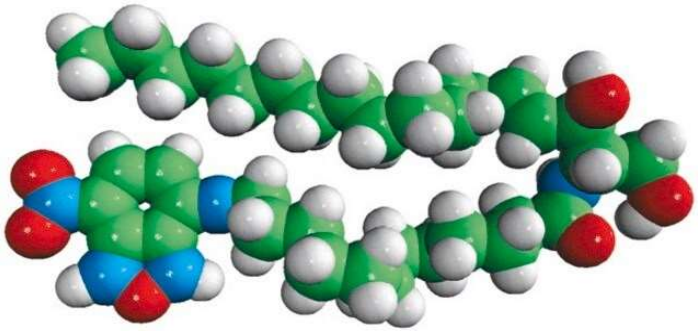
Does ceramide lipidmetabolism affect response to prostate cancer drugs?

Ceramides—lipid molecules in cells that affect many physiological functions including cell differentiation, migration, and death—and their metabolites have been implicated in the development of cancer and other conditions. New research indicates that different ceramide metabolism in Black and white individuals with metastatic castration-resistant prostate cancer may help explain why they tend to experience different responses to anti-prostate cancer androgen receptor pathway blocking medications.

The findings are published in Cancer.



In two previous clinical studies, investigators observed differences in response between Black and white individuals who were treated with androgen receptor pathway inhibitors (which decrease or block the effects of hormones such as testosterone) for metastatic castration-resistant prostate cancer.

This cancer is a form of advanced prostate cancer that continues to grow and spread even when testosterone is suppressed to castrate levels.

Because certain genetic ancestry-related variants of ceramide metabolism genes were linked to indicators of faster cancer progression in one of those studies, the researchers analyzed ceramide metabolism prior to and during androgen receptor pathway inhibitor therapy in Black and white participants in the two studies.

The team focused on what's called the carbon acyl chain length of ceramides because evidence suggests that ceramides with a 24-carbon acyl chain length promote cell survival while ceramides with a 16-carbon acyl chain length induce cell death. The ratio of 24- to 16-carbon acyl chain length ceramides can influence cancer cells, with higher ratios protecting cells and lower ratios promoting cell death.

When the researchers analyzed trial participants' blood, they found that pretreatment total ceramide levels were lower among Black patients compared with white patients. Among pretreatment ceramides, Black patients had higher values of C24- to C16-ceramide ratios compared with white patients.

An opposite trend was seen during treatment, with lower C24- to C16-ceramide ratios among Black patients, whereas higher C24- to C16-ceramide ratios were observed among white patients. Also, certain C16-, C20-, and C24-ceramides were associated with shorter time to cancer progression or worse survival, with differences between Black and white patients treated in the studies.

"The two previous clinical studies we conducted were unique with respect to including equal numbers of Black and white patients and collecting trial participants' blood. This created an unprecedented opportunity to explore potential biomarkers that may associate with patient self-reported race and genetic ancestry and treatment outcome," said senior author Jennifer A. Freedman, Ph.D., of the Duke University School of Medicine.

"The findings from this research offer valuable observations into ceramide metabolism, including genetic ancestry-related ceramide metabolism, and its potential relationship with prostate cancer outcomes. Continued investigation of genetic ancestry-related ceramide metabolism has the potential to improve prostate cancer outcomes for all patients and mitigate prostate cancer disparities."

Publication details

Sean A. Piwarski, et al. Genetic Ancestry Concordant Ceramide Metabolism and Response to Androgen Receptor Pathway Inhibition in Metastatic Castration-resistant Prostate Cancer, Cancer (2026). DOI: 10.1002/cncr.70371

May 26, 2026

Edited by Sadie Harley, reviewed by Andrew Zinin

Sadie Harley
BSc Life Sciences & Ecology. Microbiology lab background with pharmaceutical news experience in oil, gas, and renewable industries.

Andrew Zinin
Master's in physics with research experience. Long-time science news enthusiast. Plays key role in Science X's editorial success.

Source: https://medicalxpress.com/news/2026-05-ceramide-lipid-metabolism-affect-response.html

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BCL-2 inhibition may make aggressive prostate cancers more treatable

Researchers at Roswell Park Comprehensive Cancer Center have shown that a key regulator protein plays a critical role in the development of the most aggressive form of prostate cancer. In a new publication in the journal Signal Transduction Targeted Therapy, Dean Tang, PhD, Chair of Pharmacology & Therapeutics and the George Decker Endowed Chair of Developmental Therapeutics, and colleagues report this important discovery — pointing the way to a promising treatment strategy that uses existing drugs.

The newly reported findings resolve earlier conflicting reports about the role of BCL-2, a key regulator protein, in "castration-resistant" prostate cancer — a highly aggressive and often fatal form of the disease. In the new study, the team shows that combining the BCL-2 inhibitor venetoclax (brand name Venclexta) with an androgen blocker can make these aggressive tumors more responsive to treatment.

Patients with advanced prostate cancer who cannot undergo prostatectomy — surgical removal of the prostate — are typically treated with androgen deprivation therapy (ADT), sometimes called chemical castration. ADT uses drugs called androgen receptor pathway inhibitors (ARPIs) or other types of hormone therapy to block testosterone and other male hormones that promote the growth of prostate cancer. But in most patients, the disease stops responding to treatment within two years, at which point it is generally incurable.

"Understanding prostate cancer resistance to hormone therapy and androgen receptor signaling inhibitors, the standard-of-care treatment for the disease, is crucial for developing novel combination-therapy strategies to improve long-term survival for prostate cancer patients," says Dr. Tang.

With co-corresponding author Anmbreen Jamroze, PhD, Research Assistant Professor of Oncology in Pharmacology & Therapeutics at Roswell Park, and Gurkamal Chatta, MD, Clinical Chief of Genitourinary Research, Dr. Tang initiated the current study to better understand how BCL-2 impacts castration resistance. Using multiple state-of-the-art techniques, the team analyzed data from a phase 1B clinical trial conducted at Roswell Park as well as hundreds of tissue samples.

Their work revealed for the first time the relationship of the proteins BCL-2 and androgen receptor (AR), both of which enable prostate cancer cells to survive. They found that BCL-2 is usually held in check by AR at the genomic level, but treatments with ADT and ARPIs enable BCL-2 to break free and promote the progression of castration-resistant prostate cancer. Adding the BCL-2 inhibitor venetoclax to an androgen blocker can prevent that outcome.

This analysis is the first to map changes related to AR and BCL-2 in prostate cancer cells during treatment and progression to castration-resistant prostate cancer, explains Dr. Tang. The team also found that as the tumors became castration-resistant, BCL-2 and AR exhibited a negative correlation — when one increased, the other decreased.

Their findings help explain the inconsistent results of earlier studies. "Our study provides indisputable evidence that BCL-2 is the only molecule among the five BCL-2 family members that is upregulated by ADT and ARPIs and should be therapeutically targeted across different subtypes of castration-resistant prostate cancer," says Dr. Tang.

The team recently completed a phase 1B clinical trial led by Dr. Chatta that treated metastatic castration-resistant prostate cancer patients with a combination of the ARPI enzalutamide (brand name Xtandi) and the BCL-2 inhibitor venetoclax (brand name Venclexta). Three of the 10 patients enrolled in the trial showed clear responses after multiple cycles of the combination treatment.

Based on the study findings, the Roswell Park team plans to take the ADT/ARPI treatment combination with venetoclax to a phase 2 trial for patients with advanced and castration-resistant prostate cancer.

This project was funded in part by the National Cancer Institute (grants R01CA237027, R01CA240290, 2R01CA240290-06A1, R21CA218635 and P30CA016056), U.S. Department of Defense (PC220273), a Prostate Cancer Foundation Challenge Award and additional support from the

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Roswell Park Alliance Foundation and the George Decker Endowment.

From the world's first chemotherapy research to the PSA prostate cancer biomarker, Roswell Park Comprehensive Cancer Center generates innovations that shape how cancer is detected, treated and prevented worldwide. The Roswell Park team of 4,000+ makes compassionate, patient-centered cancer care and services accessible across New York State and beyond. Rated "Exceptional" by the National Cancer Institute, Roswell Park, founded in 1898, was one of the first NCI-designated comprehensive cancer centers in the country and remains the only one in Upstate New York.

To learn more about Roswell Park Comprehensive Cancer Center and the Roswell Park Care Network, visit www.roswellpark.org, call 1-800-ROSWELL (1-800-767-9355) or email ASKRoswell@RoswellPark.org.

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May 4, 2026

Roswell Park Comprehensive Cancer Center
BUFFALO, N.Y.

Source: https://buffalonews.com/news/community/article_f3ff5364-3f06-5bc2-af97-55496fcb6b7c.html

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Prostate cancer overdiagnosis risk sharply rises after age 70 – new research

Over the past decade, millions of men without symptoms of prostate cancer have voluntarily undergone a prostate-specific antigen (PSA) test in the UK to find out if they might have prostate cancer.

While research has shown that PSA screening in men aged 50-69 years can reduce cancer deaths, many countries hesitate to recommend or implement formal prostate cancer screening programmes that would offer PSA testing systematically and fairly to all men. The hesitation stems from concern about overdiagnosis and overtreatment.

But our latest research shows that prostate cancer overdiagnosis from PSA screening is mainly a risk for men over the age of 70.

Prostate cancer overdiagnosis occurs when a person is diagnosed with prostate cancer through PSA testing – even though that cancer would not otherwise have been diagnosed within the patient's lifetime. So had the person not been tested, they might never have known they had prostate cancer.

Overdiagnosis from PSA testing occurs for two main reasons.

The first reason is because PSA tests might identify a cancer that is so slow growing it would never cause problems – even if the man lives to be 100 years old.

The second reason is because a PSA test is able to find prostate cancer a decade or more before it would cause symptoms. Some patients may die from other causes in that time. Had they not been screened, they might have died without ever knowing they had prostate cancer.

Prostate cancer overdiagnosis is a concern because of what follows diagnosis. Subsequent treatment, such as surgery, may lead to harm – including loss of ability to maintain an erection and urinary incontinence.

Had the cancer not been found through screening, the man would not have been treated and would have avoided the side-effects of treatment. Overdiagnosis affects quality of life – and results in costs both to patients and to the healthcare system.

To help men make an informed choice, our research looked at how risk of overdiagnosis changes with age at screening. We found that the risk of prostate cancer overdiagnosis from a PSA test is low in otherwise healthy men in their 50s and early 60s. But this risk sharply increases in men screened from age 70 onward.

First, we looked at long-term data from a large UK trial of more than 400,000 men to examine, over a 15-year period, what proportion of men developed prostate cancer – and whether that proportion differed between those who were screened and those who weren't.

We found that, on average across all age groups, 12% of prostate cancers were so slow-growing that they would not have caused symptoms or been picked up by a doctor within 15 years of a PSA test. We also found that 88% of prostate cancers detected by PSA tests would, if not treated earlier, cause symptoms and be diagnosed within 15 years – provided the patient lived long enough and did not die of other causes.

We then used national data on men's deaths in England to understand how many men die from causes other than prostate cancer after a PSA test. Risk of death from other causes within 15 years of a PSA test increases from 10% aged 50, to 49% aged 70 and 89% if aged 80. This steep rise in risk of death drives increased overdiagnosis with old age, because, naturally, the older you are the more likely you are to die from other causes.

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Taking these findings together, we projected that there was a 16% chance that the average English man diagnosed with prostate cancer at age 50 from a PSA test would not otherwise have been clinically diagnosed within 15 years. This doubled to 32% for men diagnosed aged 70, and jumped to 58% for men diagnosed at age 80 years. Essentially, as men age, they are more likely to die from other natural causes before prostate cancer would be detected. For men older than 70 years at screening, screening offers very little, if any, benefit, but carries a high risk of unnecessary harm from overdiagnosis.

It's also worth noting that health is more than a number based on age. Overdiagnosis risk will be lower for men who are in generally in good health and follow a healthy lifestyle.

It's important to point out as well that healthcare is evolving. Our findings are based on data from prostate cancer screening done in the UK between 2001 and 2007. Today, doctors use magnetic resonance imaging (MRI) for targeted prostate cancer biopsy in those with an elevated PSA test. This is expected to lower overdiagnosis compared with our estimates by filtering out slower-growing cancers. More significantly, the use of MRI substantially reduces the risk of overtreatment, so the harms of overdiagnosis are smaller than they were 15 years ago.

Two new trials are also evaluating whether such innovations can improve the benefits of screening without increasing the harms.

In the meantime, men without symptoms of prostate cancer who are concerned about their risk have to decide for themselves whether to request a PSA test. For now, our recommendation, as statisticians, is to consider your age before making a decision. But if you do have symptoms, regardless of your age, you should definitely see your GP.

Published: April 28, 2026

Source: https://theconversation.com/prostate-cancer-overdiagnosis-risk-sharply-rises-after-age-70-new-research-281166

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Estradiol Patch Matches LHRH Agonists for Locally Advanced Prostate Cancer

— Similar 3-year metastasis-free survival, fewer hot flashes, more gynecomastia

Key Takeaways

- ◊ Transdermal estradiol patches and LHRH agonists led to similar metastasis-free and overall survival in locally advanced prostate cancer.
- ◊ Estradiol was associated with substantially lower incidence of hot flashes but substantially more gynecomastia.
- ◊ Unlike oral estrogen, transdermal estradiol avoids first-pass hepatic metabolism, lowering the risk of thromboembolic cardiovascular complications.

Transdermal estradiol for locally advanced prostate cancer matched luteinizing hormone-releasing hormone (LHRH) agonists as androgen deprivation therapy (ADT) for reducing distant metastasis, and with fewer vasomotor symptoms, a large randomized trial showed.

Men treated with the transdermal patches had a 3-year metastasis-free survival (MFS) of 87.1% versus 85.9% with LHRH agonists, a difference that met prespecified statistical criteria for noninferiority. Overall survival (OS) at 5 years also did not differ between groups. The two interventions maintained castrate levels of testosterone in an identical proportion of patients.

Hot flashes occurred less frequently with estradiol but gynecomastia occurred more often, reported Ruth E. Langley, PhD, of University College London, and colleagues in the New England Journal of Medicine.

"Given these findings, tE2 [transdermal estradiol] patches can be considered an alternative choice for testosterone suppression in men with metastasis stage M0 and nodal stage N0 or N+ prostate cancer," the authors concluded. "The patches appear to be as effective as standard LHRH agonists against prostate cancer and are associated with a lower incidence of the short-term and long-term deleterious adverse events related to estrogen depletion during treatment with LHRH agonists."

For more than 80 years, shortly after Huggins and Hodges reported prostate cancer regression after marked reductions in testosterone, ADT has been a mainstay of treatment for the cancer. Most often, LHRH agonists have been used to reduce serum testosterone to <50 ng/dL (castrate levels).

However, LHRH agonists have several toxic effects, Langley and colleagues noted. Notable adverse effects include erectile dysfunction, loss of muscle mass and bone mineral density, adverse cardiometabolic changes, and hot flashes.

Exogenous estrogen offers an alternative approach to lowering testosterone, effected by means of a negative feedback loop involving the

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hypothalamus and pituitary gland. The approach also mitigates adverse effects of estrogen depletion, the authors continued.

Studies of oral estrogen confirmed the suppressive effect on testosterone but was associated with an increased incidence of thromboembolic events, attributed to first-pass hepatic metabolism and increased levels of liver-derived plasma proteins and coagulation factors. Langley and colleagues previously showed that estrogen administration by transdermal patch avoids first-pass hepatic metabolism, conferring a lower risk of thromboembolic complications.

The accumulation of evidence provided the rationale for a phase II-III adaptive trial to assess the safety and efficacy of transdermal estradiol patches in patients with locally advanced prostate cancer. The phase II component of the study examined cardiovascular morbidity and mortality in 200 patients and showed a better metabolic profile and no early evidence of increased cardiovascular risk.

During phase III, investigators randomized patients with locally advanced prostate cancer to receive daily estradiol patches or standard LHRH agonist therapy. The primary outcome was 3-year MFS. The trial had a noninferiority margin of four percentage points, corresponding to a hazard ratio of 1.31.

Data analysis included 1,360 patients, enrolled at 75 centers in Great Britain. The patients had a median age of 72, 85% had stage T3 tumors, and 65% had N0 nodal status.

The primary analysis showing slightly better 3-year MFS with transdermal estradiol translated into an HR of 0.96 and an upper limit of confidence intervals of 1.11, satisfying criteria for noninferiority. Among men who continued assigned treatment, castrate testosterone levels were maintained in 85% of patients in each treatment arm. The 5-year OS also slightly favored transdermal estradiol (81.1% vs 79.2%, HR 0.90, 95% CI 0.75-1.07).

The two testosterone-suppressing treatments involved toxicity tradeoffs. Hot flashes occurred twice as often with LHRH agonists (89% vs 44%), whereas transdermal estradiol was associated with a twofold increase in gynecomastia (85% vs 42%).

The results initially were reported at the 2025 American Society of Clinical Oncology Genitourinary Cancers Symposium by Nicholas James, MD, of Royal Marsden Hospital in London. During a discussion that followed the presentation, James said investigators did not offer radiation therapy for gynecomastia because the treatment could cause tissue damage and usually does not relieve pain associated with the condition, which most patients find more bothersome.

An unidentified member of the audience pointed out the side effects observed in the study were similar to those from the ENZAMET trial of enzalutamide (Xtandi) plus ADT and that progression-free survival were similar between enzalutamide paired with an LHRH agonist or estrogen. She wondered whether the results were driven primarily by the androgen receptor pathway inhibitor.

"Do we really need to give the ADT? Can we drop the testosterone suppression completely?" James replied. "That's a very interesting question that we can't really answer from these data, but it's something we should pursue much more."

Disclosures

The study was supported by Cancer Research U.K. and the U.K. Research Institute Medical Research Council.

Langley reported no relevant financial disclosures.

James, who was a co-author of the study, disclosed relationships with Astellas Pharma, AstraZeneca, Bayer, Janssen, and Novartis.

Source Reference: Langley RE, et al "Transdermal estradiol patches in locally advanced prostate cancer" N Engl J Med 2026; DOI: 10.1056/NEJMoa2511781.

by Charles Bankhead, Senior Editor, MedPage Today

Charles Bankhead is a senior editor, with primary responsibility for oncology, as well as urology, ophthalmology, and dermatology. He joined MedPage Today in 2007.

March 25, 2026

Primary Source

New England Journal of Medicine

Source: www.medpagetoday.com/hematologyoncology/prostatecancer/120496

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FUTURE MEETINGS

15 Jul: Dr. D. Drachenberg
This will be an especially interesting and informative session

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15 Jul: TBA

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