



Montreal West Island

Prostate Cancer Support Group

EVERYONE IS INVITED TO ATTEND OUR MEETINGS

We meet every fourth
Thursday of each month except
July, August and December

MEETING LOCATION

Sarto Desnoyers Community Centre
1335 Lakeshore Drive, DORVAL

OUR NEXT MEETING

Thursday, January 27, 2011

Robin Glance, P. Dt.

Clinical Nutritionist at MGH

The title of her talk is

"Eating Right to Reduce Your Risk"

The talk will include a discussion on diet and life-style habits that reduce the risk of cancer and its recurrence."

Thursday, February 24, 2011

T.B.A.

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This Newsletter is available at our website:

<http://mtlwiprostcansupportgrp.ca/>,
as well as at www.cpcn.org

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Our Website

Be sure to check out our website. Our internet address is <http://mtlwiprostcansupportgrp.ca/> The website provides information about our group, links to PCPN and Procure and gives access to current and past issues of our newsletter as well as up-to-date information about our meetings and other items of interest. Check it out and give us your feedback. Our Director Monty Newborn is the creator and manager of the site and our WEBMASTER.

A New Look at Cryosurgery

Also known as cryotherapy or cryoablation, cryosurgery is a minimally invasive treatment that kills cancer cells by freezing them. Cryosurgery is not a new prostate cancer treatment -- it's been used for more than 40 years, most commonly as "salvage" therapy in men whose cancer has recurred locally in the prostate after radiation therapy. But today, it's getting more attention as a first-line option thanks to technological advances in the tools used to perform the procedure. Nonetheless, it is not right for everyone. Here are some issues to consider before making your decision.

How Cryosurgery Is Performed -- The surgeon inserts a catheter containing warm saline into the urethra to protect it from the freezing temperatures. Next, thin needles called cryoprobes are inserted through the perineum (area between the scrotum and anus) and into the prostate. An ultrasound probe placed in the rectum allows the surgeon to see the prostate and surrounding tissue, which helps guide placement of the needles. Freezing argon gas rapidly lowers the temperature of the cryoprobes to about -40° C. The extremely low temperatures create ice balls that freeze the entire prostate and some of the nearby tissue. After the prostate is frozen, it is thawed, and the freeze-thaw cycle is repeated again to reduce the chances that any cancerous tissue remains. The procedure takes about two hours. Often men go home the same day, although an overnight stay is sometimes required.

Issues and Concerns -- Although the American Urological Association considers cryosurgery an acceptable option for the treatment of newly diagnosed prostate cancer, it's been hard for urologists to give the procedure a whole-hearted thumbs up for a number of reasons.

First, the effectiveness of cryosurgery relative to radical prostatectomy and radiation therapies has not been well studied. Only one small head-to-head randomized trial comparing cryosurgery with another therapy (EBRT or external beam radiation therapy) has been published. The results, reported in *Prostate Cancer and Prostatic Diseases*, suggest that cryosurgery is less effective than EBRT. But this study

was conducted in men with prostate cancer affecting the entire prostate or extending beyond it (stage T2c, T3a, or T3b). Emerging data indicate that in men with early-stage (T1 to T2b), low-risk prostate cancer, cryosurgery may be as effective as EBRT and brachytherapy.

Second, there are no long-term (10 years or more) data from studies in which investigators only used the most up-to-date equipment. Newer, third-generation systems, in use since 2000, use smaller probes and argon gas instead of liquid nitrogen, and they create smaller ice balls than older instruments. These and other refinements give the surgeon more control over ice-ball formation, improving the chances for complete destruction of the cancerous tissue while reducing the risk of adverse effects.

Another concern: Comparison of study results is difficult because there is no standard definition of disease recurrence when evaluating the effectiveness of cryosurgery. Some researchers define a recurrence following cryosurgery as a detectable prostate-specific antigen (PSA) -- the marker used to determine if cancer has recurred after prostatectomy. Others define it as consecutive increases in PSA -- the marker used to determine recurrence following radiation therapy. And to further complicate the issue, there are two ways of defining a PSA increase -- the American Society for Therapeutic Radiology and Oncology (ASTRO) definition (three consecutive increases in PSA) and the newer Phoenix definition (a PSA increase of 2 ng/mL).

Is Cryosurgery for You? According to the American Urological Association (AUA), cryosurgery is a treatment option for prostate cancer of any grade that is limited to the prostate and has not spread to surrounding organs, although results are best in men with PSA levels of less than 10 ng/mL and a Gleason score of 6 or below.

It may be a good choice for men who aren't able to have a radical prostatectomy because of, for example, obesity or a history of pelvic surgery. Cryosurgery may also be a reasonable option for men who cannot undergo radiation therapy for reasons such as a narrow pelvis, inflammatory bowel disease, previous pelvic radiation, or a rectal disorder. But the AUA notes that men with very large prostates are not good candidates, because the

larger the prostate, the more difficult it is to cool the entire gland uniformly.

In some cases, the urologist may administer hormonal therapy to shrink the prostate before surgery. Although this has never been proven to increase the success rate, urologists have reason to believe that it might. Most men who have undergone a transurethral resection are poor candidates for cryosurgery.

Posted in [Prostate Disorders](#) on September 16, 2010

Prostate Cancer Testing Goes to the Dogs

In the quest to come up with a highly sensitive and highly specific prostate cancer test that will predict with the utmost accuracy whether or not a man has prostate cancer, "man's best friend" -- the dog -- is being brought in to sniff out prostate cancer cells found in urine. The results of a small French study presented at the American Urological Association (AUA) meeting have been quite impressive so far.

We know from previous work that cancer cells emit different metabolic wastes when compared to healthy cells and that their particular odor is so different that it can be detected and differentiated by a trained dog. Over the past decade, specially trained dogs have been used in experiments to sniff out skin, lung, bladder, and breast cancers. In the recent study presented at the AUA, Jean-Nicolas Cornu, M.D. and fellow researchers from Tenon Hospital in Paris, used fresh urine samples from 66 men who had been referred to a urologist because they had elevated PSA and abnormal DRE (digital rectal exam) findings. Half of the men had prostate biopsy-detected cancer and half were cancer-free. Using a Belgian Malinois -- a working shepherd breed with a keen sense of smell that has been used in previous cancer tests -- the French researchers had the dog identify urine from men with the biopsy-confirmed prostate cancer. The dog was specially trained to detect and correctly identify certain prostate cancer cell-derived volatile organic compounds

(VOC's). in urine.

Dr. Cornu believes that these data suggest that prostate cancer tumors may excrete certain VOCs that are present in a patient's urine and that this particular "scent" may be very specific to prostate cancer. The next step is to determine what those particular VOCs are and whether or not a specific test can be developed to identify them very early in the testing phase.

While this French research is certainly impressive, scientists at many leading medical centers here and abroad are currently at work on various prototypes of "electronic noses," sophisticated diagnostic devices they hope eventually will outdo even a dog's sensitive nose in signaling the presence of VOCs produced by prostate cancer cells. The ENose, which typically uses nanotechnology and multiple polymer films to pick ups scents, will be programmed to recognize almost any molecule or combinations of molecules. It's hoped that with this new technology, doctors will be able distinguish prostate cancer VOCs from non-cancer VOCs, something that the talented Belgian dog can now do -- but can't explain to the researchers

Special Diagnostic Tests for Benign Prostate Hyperplasia (BPH)

If you experience moderate to severe symptoms of benign prostatic hyperplasia or BPH, your doctor may order one or more of the following tests to aid in diagnosis and rule out other conditions that mimic BPH.

Uroflowmetry for BPH. In this noninvasive test, a man urinates into an electronic device that measures the speed of his urine flow. A slow flow rate suggests an obstruction of the urethra; if the flow rate is high, urethral obstruction is unlikely, and therapy for BPH will not be effective in most instances. A normal urine flow rate is 15 mL per second or higher.

Pressure-flow urodynamic studies for BPH. These studies measure bladder pressure during urination by placing a recording device into the bladder and often into the rectum. The difference in pressure between the bladder and the rectum indicates the pressure generated when the bladder mus-

cle contracts. A high pressure accompanied by a low urine flow rate indicates urethral obstruction. A low pressure with a low urine flow rate signals an abnormality in the bladder itself, such as one related to a neurological disorder.

Imaging studies for BPH. In general, imaging studies are done only in patients who have blood in their urine, a urinary tract infection, abnormal kidney function, previous urinary tract surgery, or a history of urinary tract stones.

Ultrasonography is the imaging study used most often in men with lower urinary tract symptoms. The test involves pressing a microphone-sized device (transducer) onto the skin of the lower abdomen. As the device is passed over the area, it emits sound waves that reflect off the internal organs. The pattern of the reflected sound waves is used to create an image of each organ. Ultrasonography can be used to detect structural abnormalities in the kidneys or bladder, determine the amount of residual urine in the bladder, detect the presence of bladder stones, and estimate the size of the prostate.

Filling cystometry for BPH. This test involves filling the bladder with fluid and measuring how much pressure builds up and how full the bladder is when the urge to urinate occurs. It is recommended for evaluating bladder function only in men who have a prior history of urological disease or neurological problems that could be affecting bladder function.

Cystoscopy for BPH. In this procedure, a cystoscope (a small lighted viewing device) is passed through the urethra into the bladder to directly view the two structures. Cystoscopy is usually performed just before prostate surgery to guide the surgeon in performing the procedure or to look for abnormalities of the urethra or bladder.

When -- and When Not -- To Use Antibiotics for Prostatitis/Chronic Pelvic Pain Syndrome

Most men with chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) don't have a detectable bacterial infection. Nevertheless, some doctors prescribe antibiotics "just in case." In fact, a study in the American Journal of Medicine found that 69% of more than 23,000 men with CP/CPPS were prescribed antibiotics, most often a fluoroquinolone

such as ciprofloxacin (Cipro) or levofloxacin (Levaquin).

But experts say that number is far too high. According to two randomized, controlled trials, only 20 to 30% of men with long-standing symptoms of CP/CPPS, most of whom had previously taken antibiotics, experienced symptom relief from a fluoroquinolone—the same percentage who responded to a placebo. On the other hand, up to 75% of men with CP/CPPS who had symptoms for a relatively short period (usually no more than eight weeks) and had not yet been treated with antibiotics benefited from treatment with Cipro or Levaquin.

Why would antibiotics work in men who have no sign of bacterial infection, and then only in those with newly diagnosed disease? Some experts suspect that it may simply be a placebo effect. Others theorize that the beneficial effect of antibiotics may be due to their anti-inflammatory action, but that effect may not be strong enough to combat long-standing inflammation. Still others believe that the usual tests used to check for bacterial infection -- urinalysis and urine culture -- may miss some types of bacteria. When caught early, taking an antibiotic can eradicate the infection. But longstanding symptoms are more likely a result of the damage that inflammation causes, and that damage is less responsive to antibiotics.

What's the Harm? What's wrong with taking an antibiotic "just in case," even though you have long-standing symptoms and have previously tried these drugs? There could be plenty. Taking an antibiotic often leads to side effects like nausea, vomiting, diarrhea, headache, dizziness, and skin rash. More worrisome, increasing use of antibiotics contributes to the development and spread of antibiotic-resistant bacteria. Also, why spend time and money on a treatment approach that will likely offer no symptom relief?

What Is PSA Velocity and How Is It Used to Screen for Early Prostate Cancer?

The prostate-specific antigen (PSA) test measures an enzyme produced almost exclusively by the glandular cells of the prostate. It is secreted during ejaculation into the prostatic ducts that empty into the urethra. PSA liquefies semen after ejaculation, promoting the release of sperm. Normally, only very small amounts of PSA are present in the blood. But an abnormality of the prostate can disrupt the normal architecture of the gland and create an opening for PSA to pass into the bloodstream. Thus, high blood levels of PSA can indicate prostate problems, including cancer. PSA blood levels are expressed as nanograms per milliliter

(ng/mL). PSA velocity is a measurement that takes into account annual changes in PSA values, which rise more rapidly in men with prostate cancer than in men without prostate cancer. A study from Johns Hopkins and the National Institute on Aging found that an increase in PSA level of more than 0.75 ng/mL per year was an early predictor of prostate cancer in men with PSA levels between 4 ng/mL and 10 ng/mL.

PSA velocity is especially helpful in detecting early cancer in men with mildly elevated PSA levels and a normal digital rectal exam. It is most useful in predicting the presence of cancer when changes in PSA are evaluated over at least one to two years. In a study reported in *The New England Journal of Medicine*, a rapid rise in PSA level (more than 2 ng/mL) in the year before prostate cancer diagnosis and surgical treatment predicted a higher likelihood that a man would die of his cancer over the next seven years.

Moreover, a Johns Hopkins study published in the *Journal of the National Cancer Institute* found that a man's PSA velocity 10 to 15 years before he was diagnosed with prostate cancer predicted his survival from the disease 25 years later. In the study, 92% of men with an earlier PSA velocity of 0.35 ng/mL or less per year had survived, compared with 54% of men whose PSA velocity was greater than 0.35 ng/mL.

What Can We Learn by Looking at the Percentage Free PSA or Bound PSA?

Prostate-specific antigen (PSA) is an enzyme produced by the glandular cells of the prostate and secreted in the seminal fluid released during ejaculation. High blood levels may indicate prostate cancer but can also be caused by benign prostatic hyperplasia (BPH) and infection. By looking at the percentage of free PSA or complexed (bound) PSA, doctors can determine the cause of elevated PSA levels. Here's how ...

PSA in the blood is either bound (attached to proteins) or unbound (free). PSA assays usually measure the total PSA (both free and complexed). Other assays measure the percentage of free PSA or the percentage of complexed PSA. Compared with men with BPH, men with prostate cancer have a higher percentage of bound PSA and a lower percentage of free PSA. Research suggests that determining the ratio of free to total PSA in the blood helps distinguish between PSA elevations due to cancer and those caused by

BPH. Using the percent free PSA result to help determine the need for biopsy might help reduce the number of unnecessary biopsies.

Researchers estimate that in men whose PSA levels are between 4 ng/mL and 10 ng/mL, performing a prostate biopsy only when the percent free PSA is 24% or below would detect more than 90% of prostate cancers while reducing the number of unnecessary biopsies by 20%. In addition, some investigators are enthusiastic about using complexed PSA measurements to detect cancer, believing that this provides the same information as free PSA and total PSA.

The Prostate Biopsy: What to Expect

If the results of your digital rectal exam, PSA test, or both suggest prostate cancer, your doctor will perform a transrectal ultrasound to determine the size of the prostate and to identify areas of possible cancer. Ultrasound also is used to direct the needles used for prostate biopsy. Here's what you should expect ...

Most doctors use a local anesthetic such as lidocaine (Xylocaine) to reduce discomfort during the biopsy. The ultrasound examination is performed with the man lying on his side. An ultrasound probe (which is about the size of a finger) is gently inserted 3 to 4 inches into the rectum. The probe emits sound waves that are converted into video images corresponding to the different prostate zones. Small prostate cancers are usually not detectable by ultrasound examination.

Fitted to the ultrasound probe is a biopsy gun with a needle that is fired through the rectal wall. The needle extracts small pieces of prostate tissue in less than a second. Ideally, at least 10 to 12 tissue samples ("cores") are taken from the prostate. A pathologist examines the samples under a microscope to determine whether cancer is present. A prostate biopsy usually causes only minor discomfort. Common side effects include minor rectal bleeding; blood in the stool, urine, or semen; and soreness in the biopsied area. All of these side effects disappear with time.

If the prostate biopsy shows no cancer but the physician still suspects that cancer is present because of an abnormality on the rectal examination or PSA test, a repeat biopsy may be performed

Each year, approximately 800,000 men undergo prostate biopsy. About 9% will be told they have high-grade prostatic intraepithelial neoplasia (PIN). Formerly called dysplasia or atypical hyperplasia, PIN is believed to be a premalignant lesion. But recent studies suggest the likelihood of finding

cancer on a repeat biopsy is no greater in men with PIN than in men with normal biopsy findings. Therefore, the finding of PIN alone is not a reason to perform a repeat biopsy.

Some prostate biopsies reveal abnormal or atypical cells that suggest the possibility of cancer but are not sufficient to make a diagnosis. In such cases, a repeat biopsy should always be performed because there is a 50% chance of finding cancer on a repeat biopsy. If the biopsy results indicate cancer, additional diagnostic tests will need to be conducted to determine the extent of the disease.

10th Year of Robotic Surgery For Prostate Cancer

Ten years ago, the first robotic assisted surgery for prostate cancer took place in the United States at the Henry Ford Hospital's Vattikuti Institute.

Today, the majority of prostate cancer surgeries are done robotically. At Henry Ford alone, more than 6,000 procedures have been performed during the past decade.

Next week, the international leaders in the field will meet at the world's largest medical robotic conference Jan.13-16 at the Wynn Las Vegas.

The International Robotic Urology Symposium 2011 is hosted by the Henry Ford Vattikuti Urology Institute and the Vattikuti Foundation.

At the conference, Henry Ford's Mani Menon, M.D., the pioneer behind the robotic revolution, will discuss the last decade in the field and its expanded use by physicians around the world, as well as what the future holds for the technology.

After 10 years, the use of robotic technology is no longer confined to removing cancerous prostates.

Lectures and plenary sessions will cover bladder, kidney and pediatrics, as well as alternative therapies to treat patients with benign and malignant prostate cancer.

Live surgeries, transmitted from hospitals in the United States, India and South Korea, will be shown throughout the four days of the symposium. The surgeries, both live 3D and 2D, will allow the attendees to observe differences in technique.

The Symposium Sessions include:

- ❖ How to Make Robotic Programs Efficient and Cost-Effective

- ❖ What is New in Radical Cystectomy?
- ❖ What is New in Robotic Technology?
- ❖ Functional Limitations of Anatomical Neuronal Preservation During Radical Prostatectomy
- ❖ Competing Techniques of Robotic Urinary Diversion
- ❖ My Prostate Cancer: A Urologist's Account of His Own Experience
- ❖ Technique Modifications that Impact the Return of Urinary Continence After Radical Prostatectomies
- ❖ Molecular Predictors for Behavior of Early Prostate Cancer
- ❖ Suprapubic Tube After RALP: Should We?
- ❖ Minimally Invasive and Focal Therapies for Prostatic Diseases
- ❖ Early Prostate Cancer: The Dilemma
- ❖ Unusual Urologic Applications of Robotic Surgery

Source:

Dwight Angell
Henry Ford Health System

Risk Of Death For Men With Prostate Cancer May Be Reduced By Exercise

A new study of men with prostate cancer finds that physical activity is associated with a lower risk of overall mortality and of death due to prostate cancer. The Harvard School of Public Health and University of California, San Francisco researchers also found that men who did more vigorous activity had the lowest risk of dying from the disease. It is the first study in men with prostate cancer to evaluate physical activity after diagnosis in relation to prostate cancer-specific mortality and overall mortality.

The study appears in an advance online edition of the *Journal of Clinical Oncology*.

"Our results suggest that men can reduce their risk of prostate cancer progression after a diagnosis of prostate cancer by adding physical activity to their daily routine," said Stacey Kenfield, lead author of the study and a Harvard School of Public Health researcher. "This is good news for men living with prostate cancer who wonder what lifestyle practices to follow to improve cancer survival."

Prostate cancer is the most frequently diagnosed form of cancer among men in the United States and affects one in six U.S. men during their lifetime. More than 2

million men in the U.S. and 16 million men worldwide are prostate cancer survivors.

The study was conducted in 2,705 men diagnosed with prostate cancer in the Health Professionals Follow-Up Study over an 18-year period. The participants reported the average time per week they spent doing physical activity, including walking, running, bicycling, swimming and other sports and outdoor work.

The results showed that both non-vigorous and vigorous activity were beneficial for overall survival. Compared with men who walked less than 90 minutes per week at an easy pace, those who walked 90 or more minutes per week at a normal to very brisk pace had a 46% lower risk of dying from any cause.

Only vigorous activity - defined as more than three hours per week - was associated with reduced prostate cancer mortality. Men who did vigorous activity had a 61% lower risk of prostate cancer-specific death compared with men who did less than one hour per week of vigorous activity.

"We observed benefits at very attainable levels of activity and our results suggest that men with prostate cancer should do some physical activity for their overall health, even if it is a small amount, such as 15 minutes of activity per day of walking, jogging, biking or gardening," said Kenfield. "However, doing vigorous activity for three or more hours per week may be especially beneficial for prostate cancer, as well as overall health," she said.

Notes:

This study was funded by the National Institutes of Health, Charles A. King Trust and the Prostate Cancer Foundation.

"Physical Activity and Survival After Prostate Cancer Diagnosis in the Health Professionals Follow-Up

Study," Stacey A. Kenfield, Meir J. Stampfer, Edward Giovannucci, June M. Chan, *Journal of Clinical Oncology*, online January 4, 2011.

A Note of Appreciation to Bill Corless

Bill Corless who has been a writer for the newsletter for the past several years (2005-2010), has had to retire from that job, due to personal reasons.

Bill and I go a long way back as he was my boss at Spar Aerospace for many years. He underwent radical prostatectomy a year after my operation and we exchanged notes on our experiences. He started attending our monthly meetings and I asked him if he was interested in helping out with the group's activities. He said he was and I suggested that he take on the job as a writer for the newsletter. He attended a Steering Committee meeting in April 2005 and agreed to work with Tom Grant to produce articles for the newsletter.

Over the past five years he has produced 20 informative articles on our speaker's talks, working with a voice recorder and in some cases with copies of the slides the speaker used in his/her presentation. Getting the medical



Bill Corless (center) at a Christmas function while with Spar Aerospace.

Newsletter Disclaimer:

All articles appearing in this newsletter, are for information purposes only and not intended to be a substitute for the advice of a doctor or healthcare professional or recommendations for any particular treatment plan. It is of utmost importance that you rely on the advice of a doctor or a healthcare professional for your specific condition.

2011 West Island Prostate Cancer Support Group Meeting Calendar

JANUARY							FEBRUARY							MARCH						
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30	31																			

The 2011 WIPCSG's meeting calendar. The Steering Committee meetings are highlighted in red, the general monthly meetings in blue, and the annual Christmas luncheon in green.

terms correct is not an easy feat and producing an article about a page in length and preserving the essence of the topic is not easy.

He worked with three different editors, Ludwick Papaurelis, myself and most recently. Francesco Moranelli, each with their own style and ideas. This no doubt required some patience and understanding of each editor's objectives. I can personally attest that he spent a great deal of time to produce an article that was both accurate and informative.

On behalf of the Steering Committee thank you for the wonderful contributions you have made to the newsletter and to our group.

George Larder



Telephone Helpline (514) 694-6412

IMPORTANT NOTICES:

- ❖ The Montreal West Island Prostate Cancer Support Group Inc encourages wives, loved ones and friends to attend all meetings. Please ask basic or personal questions without fear or embarrassment. You need not give your name or other personal information.
- ❖ The Montreal West Island Prostate Cancer Support Group Inc does not recommend treatment procedures, medications or physicians. All information is, however, freely shared. Any errors and omissions in this newsletter are the responsibility of the authors.
- ❖ The Montreal West Island Prostate Cancer Support Group Inc. is a recognized charitable Organization. All donations are acknowledged with receipts suitable for income tax deductions. Your donations and membership fees (voluntary) are a very important source of funds vital to our operations. Together with contributions from several pharmaceutical companies these funds pay the cost of printing and mailing our newsletter, hall rental, phone helpline, equipment, library, etc.

Your support is needed now!

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VOLUNTEERS URGENTLY NEEDED!

<http://mtlwiprocansupportgrp.ca/>