Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

2014 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: www.ipcsg.org

We Meet Every Third Saturday (except December)

Tuesday, February 04, 2014 Volume 7 Issue 1

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Table of Contents

Editor: Gene Van Vleet

Next Meeting
Feb. 15, 2014
10:00AM to Noon

Meeting at

Sanford-Burnham Auditorium

10905 Road to the Cure, San Diego CA 92121

SEE MAP ON THE LAST PAGE

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PC are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Be your own health manager!!

PROSTATE CANCER IT'S ONLY 2 WORDS, NOT A SENTENCE

Our first meeting of the new year was well attended by 90 participants. Refreshments were provided through the generosity of Ken Audibert, representative of Algeta-U.S. the producers of the new medication Xofigo—the subject of this month's meeting.

Dr. Michael Kipper, Director of PET/CT Imaging, Genesis Healthcare, San Diego was the speaker on the subject. Radium 223 dichloride is the chemical name of Xofigo. It is available for the treatment of castration resistant prostate cancer (PCa) with symptomatic bone metastases. Radium is found in uranium ore. It was discovered in 1898 by Marie

Video DVD's

DVD's of our meetings are available in our library for $10ea. Refer to the index available in the library. They can also be purchased through our website: http://ipcsg.org

Click on the 'Purchase DVDs" button.

INFORMATION PRESENTED HEREIN REPRESENTS THE EXPERIENCE AND THOUGHTS OF OUR MEMBERSHIP, AND SHOULD NOT BE ANY SUBSTITUTE FOR MEDICAL COUNSEL.

(Continued from page 1)

Curie. It takes 1 ton of ore to find 1/10 of a gram of radium. It glows. In the early discovery years it was used to illuminate watch/clock dials. It has a half-life of 11 days.

Xofigo is used to treat men with bone predominant metastases. One qualification is that men must have a testosterone level of < 50 (normal is about 300 or more). You can be at the required castrate level if the testicles have been removed or if you are on treatment that keeps your level <50. Another qualification is that you have to demonstrate disease progression. This is demonstrated by a rise in PSA, radiographically measurable disease (usually accomplished by a bone scan) or you must have other signs or symptoms that the disease is progressing. There are some exclusionary factors if it is in areas other than bones. It is estimated that there will be about 240,000 new cases of PCa this year. Fourteen percent of men with castration status will develop metastases and 90% of those will have it in their bones. About 46% of men will develop metastases in about 2 years after becoming castrate resistant.

In the past only 1 new chemotherapy drug was approved. In the last 5 years 6 new agents have been approved, creating the challenge to determine the optimal timing and use of therapies. Xofigo mimics calcium. It is an alpha particle emitting pharmaceutical that exerts an antitumor effect on bone metastases. It forms complexes with the bone mineral hydroxyapatite and is incorporated at areas of increased bone turnover (metastases). The alpha particles cause breaks on both strands of DNA which destroys the cells. The range of alpha particles emitted limits damage to surrounding normal tissue.

Side effects may include a slight reduction in white cell count and platelets may go down a little but not to the degree of chemotherapy. Blood counts are monitored and in his experience or in the experience of those in the study it is generally not an issue. Xofigo cannot be given if you are on taxotere which also has a negative effect on bone marrow but it could be given later after the blood counts recover. Other side effects can include nausea, diarrhea and swelling of the legs but are relatively uncommon in their experience. You can still get other approved treatments after you have had Xofigo treatment.

Dosing is 1 injection every 4 weeks for 6 injections. There are no restrictions, such as driving, after each injection. Insurance coverage is generally not an issue.

The foregoing is a recap of Dr. Kipper's presentation which included many specific details and charts as well as an extensive Q & A session following his lecture. We encourage you to get the DVD of the session from our library at the next meeting or by ordering through our website: www.ipcsg.org On the mail page click on the Purchase DVDs button.

FUTURE MEETINGS

February 15, 2014 - Dr. Christopher Kane, Dr. Christopher Kane, Professor and Chair of the Urology Department at UC San Diego. Subject: Enhanced prostate cancer detection and risk stratification using MRI targeted biopsies and genetic testing.

March 15, 2014 - Dr. Russell Low, Medical Director of Sharp and Children's MRI Center. DCE MRI Techniques for Prostate Cancer Diagnosis and Surveillance.

April 19, 2014 - Dr. Fabio Almeida, Medical Director Southwest PET/CT Institute. Dr. Almeida returns to present updated information relating to Carbon C-11 Acetate PET/CT imaging for recurrent prostate cancer.

(Continued on page 3)

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(Continued from page 2)

May 17, 2014 - Roundtable.

June 21, 2014 - Dr. Irwin Goldstein, Director of Sexual Medicine, Alvarado Hospital speaks about the effects of PCa treatments on sexuality and Dr. Andrew Goldstein updates his work in stem cell research in relation to PCa.

July 19, 2014 - Not yet committed.

ON THE LIGHTER SIDE

Dr Willet Whitmore: Many more men die with prostate cancer that of it. Growing old is invariably fatal. Prostate cancer is only sometimes so.

California Crazy Laws:
No vehicle without a driver may exceed 60 miles per hour.
In San Diego, the owners of houses with Christmas lights on them past February second may be fined up to $250.
In San Francisco, elephants are prohibited from strolling down Market Street unless they are on a leash.

Bumper Stickers:
You are depriving some poor village of its idiot!
If at first you do succeed, try not to look astonished.
Health is merely the slowest possible rate at which one can die.

As the doctor completed an examination of the patient, he said, "I can't find a cause for your complaint. Frankly, I think it's due to drinking." "In that case," said the patient, "I'll come back when you're sober"

"Even if you are on the right track, you'll get run over if you just sit there." — Will Rogers

(Continued on page 4)

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(Continued from page 3)

Sign in a restaurant: "We reserve the right to serve refuse to anyone."

Q: Ever wonder about people who pay $2 for a bottle of Evian water? A: Just spell "Evian" backwards

"When you're in jail, a good friend will be trying to bail you out. A best friend will be in the cell next to you saying, 'Damn, that was fun'." — Groucho Marx

"Reader, suppose you were an idiot. And suppose you were a member of Congress. But I repeat myself." — Mark Twain

"What would men be without women? Scarce, sir...mighty scarce." — Mark Twain

NOTEWORTHY ARTICLES

Prostate Imaging with Color Doppler Ultrasound

Posted: 28 Jan 2014 11:56 AM PST

BY MARK SCHOLZ, MD

Prostate cancer is the most common form of cancer in men. While some types are life-threatening others are not. Recently the media have been reporting on serious concerns that have surfaced about men with the benign forms of the disease undergoing unnecessary radical treatment. PSA screening has been receiving most of the blame, but the real problem is over reliance on random needle biopsies performed by an aggressive medical community made up of surgeons.

Significance of an Elevated PSA

An elevated PSA can occur as a result of any physical alteration of the environment in the prostate--recent sexual activity, infection, cancer, and gland enlargement (BPH). A modest elevation of PSA is medically nonspecific. As one man explained, "Think of the Check Engine light on the dashboard of your car. It's significant if it is ON, but further specifics need to be determined before taking any action."

Time for a Random Biopsy?

PSA elevation typically triggers an immediate 12-core random biopsy. Presently, over a million men are undergoing biopsy every year at a cost of billions of dollars. Unfortunately, low grade prostate cancer is so prevalent in the general male population that a random biopsy will find prostate cancer 20% of the time, even when PSA is normal. Obviously a great preponderance of all this "cancer" must be harmless. After all, historical death rates from prostate cancer before 1987, when PSA screening first became available, were only 3%.

Damn the Possible Side Effects, Treat it Anyway

Cancer is a frightening word. To many, it portends death. Therefore it's hardly surprising that both doctors and patients swing into immediate action when the biopsy shows CANCER. Amending and tempering words such as "low grade" or "microscopic" seem to produce no soothing affect whatsoever on the instinctual fears generated by this venomous diagnosis. Despite the universal agreement of hundreds of prostate experts at a consensus conference back in 2007 which concluded that low-grade prostate cancer can be safely monitored, 85% of all men diagnosed still throw caution to the wind and get treatment anyway.

Imaging is "Blind" to Small Low-Grade Cancers

Back when doctors regarded all types of prostate cancer as universally dangerous, prostate imaging, which is prone to miss small, low-grade lesions, was deemed inadequate. However, with our modern perspective, knowing that only larger, higher-grade lesions are clinically relevant, imaging makes perfect

(Continued on page 5)

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(Continued from page 4)

sense. There are two types of prostate imaging: High-resolution Color Doppler Ultrasound, which is the subject of this blog, and multiparametric 3-Tesla MRI which was the subject of my last blog.

Color Doppler Ultrasound Imaging

It's no longer appropriate to needle the prostate multiple times with the outdated belief that it's essential to diagnose every tiny prostate cancer. Practically speaking, only prostate cancers large enough to be "seen" (with imaging) need to be considered. Color Doppler Ultrasound scanning of the prostate is performed by a physician in the doctor's office. It is actually two scans in one: Standard "Grey Scale" imaging and Color Doppler imaging to detect areas of increased blood flow. First, ultrasound enables accurate measurement of the gland size. Second, from a cancer point of view, imaging with Color Doppler has three possible outcomes:

A) Completely clear
B) An overtly suspicious lesion is detected
C) Ambiguous lesion(s) are detected

Targeted Rather than Random Biopsies

When an overtly suspicious lesion is detected, a targeted biopsy (a limited number of cores aimed directly at the lesion) is typically recommended. Lesions that are biopsy-negative or show low-grade cancer are simply monitored. When high-grade disease is diagnosed, a process of further staging followed by pertinent counseling about the different treatment options is initiated.

When to Biopsy Ambiguous Lesions

Expert judgment, with appropriate attention to the individual patient characteristics, comes into play during a discussion between patient and doctor about whether or not to do a targeted biopsy. Color Doppler "sees" all sorts of things including scar tissue, areas of active prostatitis, and nodular areas from BPH. A follow-up scan in six months to see if a lesion shows further growth may be preferred to immediate biopsy. Lesion characteristics that raise greatest concern tend to be located in the peripheral zone of the prostate, and include lesions over a centimeter, lesions that bulge the prostate capsule and lesions that have increased blood flow. Targeted biopsy is advised more frequently in men who are younger, are more anxious about missing cancer, and in men with PSA levels higher than they "should be" relative to the size of their prostate.

"Cross Checking" Ambiguous Lesions with Multiparametric MRI

Color Doppler Ultrasound and Multiparametric MRI (MP-MRI) are complimentary. In our experience the imaging findings match. However in a minority of cases one imaging modality will illuminate a specific lesion substantially more clearly. Therefore, in ambiguous cases, a combination of both modalities increases confidence that high-grade cancer isn't being overlooked. Doing a second imaging procedure with MP-MRI is often preferable to doing an immediate biopsy. If subsequently a targeted biopsy is deemed necessary, the additional imaging information obtained from MP-MRI may further increase the accuracy of the targeted biopsy.

Color Doppler for Monitoring Low-Grade Cancer

These days' experts advise men with low-grade prostate cancer to forgo surgery or radiation and monitor their condition with Active Surveillance. The most common protocol used presently is regular PSA testing and periodic random biopsy. However, multiple random biopsies are associated with discomfort and progressive risk of serious infections and impotence. Sequential monitoring of small lesions with Color Doppler to determine if they are growing or stable is a far more logical approach than subjecting men to repeated biopsies.

Final Thoughts

(Continued on page 6)

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(Continued from page 5)

Men with elevated PSA, who initially undergo a Color Doppler, rather than random biopsy, are often spared biopsy altogether if their scan is clear. Men who do require biopsy will need far fewer cores taken because the biopsy is targeted to a specific lesion within the gland. Men on Active Surveillance and men who have undergone previous treatment with surgery, radiation, cryotherapy, HIFU or hormone blockade are also candidates for Color Doppler Ultrasound to determine how well they are responding to treatment.

Finasteride Reduces the Risk of Low-Grade Prostate Cancer in Men 55 and Older

From National Cancer Institute 8/28/13

Summary

Long-term follow-up results from a phase III trial called the Prostate Cancer Prevention Trial (PCPT) continue to show that regular use of finasteride (Proscar®) for up to 7 years decreased the risk of low-grade prostate cancer in men age 55 and older compared with that in men who received a placebo. Although high-grade cancers were more common in the finasteride group, the finasteride and placebo groups had similar 15-year overall survival rates.

Source

New England Journal of Medicine (NEJM), August 14, 2013

Background

Launched in January 1994, the PCPT was a large randomized clinical trial designed to test whether the drug finasteride could help prevent prostate cancer in men age 55 and older. Finasteride blocks the activity of 5-alpha reductase, an enzyme that helps control the activity of the hormone testosterone. This hormone influences the size of the prostate and can fuel the growth of prostate tumors.

Finasteride was approved by the Food and Drug Administration in 1992 for the treatment of benign prostatic hyperplasia and is also approved to treat male pattern baldness. It has not been approved for preventing prostate cancer.

The PCPT was stopped in February 2003, 15 months earlier than planned, when a scheduled data analysis showed a 25 percent reduction in prostate cancer risk among participants taking finasteride compared with those taking a placebo (and a 38 percent reduction in risk of low-grade prostate cancers). That original analysis also showed a small but statistically significant increase in the risk of high-grade prostate cancer—cancers with a Gleason score of 7 to 10, which are considered more likely to be aggressive and life threatening—in the men taking finasteride. The original analysis focused on the men who had undergone a biopsy or other diagnostic procedure during the trial (approximately half of the study population), whereas the updated analysis included the entire study population.

Subsequent analyses of the PCPT data suggested that the observed increase in high-grade prostate cancers in men taking finasteride was due, at least in part, to improved detection. For example, finasteride shrinks the volume of the prostate, potentially making high-grade cancers easier to detect on biopsy. However, concerns that finasteride might cause a true increase in the risk of high-grade prostate cancer—and death—have remained, so the PCPT investigators analyzed long-term follow-up data for trial participants to look for mortality differences between finasteride-treated men and placebo-treated men.

The Study

Nearly 19,000 men age 55 and older who were in good health and showed no evidence of prostate cancer were enrolled in the PCPT. The men were randomly assigned to take 5 mg of finasteride or a placebo daily for 7 years. The study's primary endpoint was prostate cancer incidence.

Participants in the trial had their health status monitored at regular intervals, including two tests con-

(Continued on page 7)

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(Continued from page 6)

ducted annually to look for signs of prostate cancer: a digital rectal exam and a prostate-specific antigen (PSA) test. At the end of the study, the researchers asked participants who had not been diagnosed with prostate cancer to have a prostate biopsy to check for prostate tumors.

The updated results published in NEJM included up to 18 years of follow up on all trial participants, including prostate cancer incidence data for an additional year beyond the period previously reported and mortality rates for men in the trial, which the researchers gathered using data from the Social Security Death Index (SSDI) from the time the trial was stopped through October 2011. The SSDI does not provide information about the cause of death.

This NCI-funded study was conducted by SWOG and led by Ian Thompson, MD, of the University of Texas Health Science Center at San Antonio.

Results

In the updated analysis, men taking finasteride had a 30 percent decrease in the relative risk of developing prostate cancer compared with men who took a placebo: 10.5 percent of men in the finasteride group were diagnosed with prostate cancer versus 14.9 percent of men in the placebo group. This reduction in risk was explained solely by the prevention of low-grade cancers—those with a Gleason score of 6 or less—which present little health risk but, nonetheless, are often treated with radical surgery or radiation. The risk of such cancers was 43 percent lower in the finasteride group than the placebo group.

The men who took finasteride were more likely to be diagnosed with high-grade cancer compared with the men who took a placebo: 3.5 percent of all men in the finasteride group versus 3.0 percent of all men in the placebo group, a relative increase of about 17 percent.

The survival rates at 15 years were very similar between the two groups: 78.0 percent in the finasteride group versus 78.2 percent in the placebo group. When the researchers looked specifically at men who had been diagnosed with prostate cancer, the survival rates for individuals diagnosed with prostate cancer were also very similar between the two groups.

Limitations

Howard Parnes, MD, of NCI's Division of Cancer Prevention and a co-author of the study, noted that the increased risk of high-grade cancer in the finasteride group "was a secondary finding, which the trial was not specifically designed to address."

Because information on the cause of death for the majority of participants who died was not available for the trial update, prostate cancer-specific mortality could not be determined. This is important, wrote Michael LeFevre, MD, MSPH, in an accompanying editorial, because "a small difference in [prostate cancer-specific] mortality can exist in the absence of a difference in all-cause mortality."

Comment

Nevertheless, the study shows that, "for men who choose regular prostate-cancer screening, the use of finasteride meaningfully reduces the risk" of being diagnosed with the disease and, as a result, of any side effects associated with prostate cancer treatment, Dr. LeFevre wrote.

"Whether the use of the drug has either a positive or a negative effect on prostate-cancer-specific mortality remains unknown," continued Dr. LeFevre, "but either way the effect is probably very small and does not result in any difference in life expectancy.…For men who choose regular prostate-cancer screening, the use of finasteride meaningfully reduces the risk of prostate cancer and thus the morbidity associated with treatment of the disease," he concluded.

(Continued on page 8)

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(Continued from page 7)

Final results from the Phase 3 PREVAIL trial of enzalutamide
From Medical News Today January 30, 2014

Medivation Inc. and Astellas Pharma Inc. have announced final results on the primary and secondary efficacy endpoints from the Phase 3 PREVAIL trial of enzalutamide in patients with chemotherapy-naïve metastatic prostate cancer who have failed androgen deprivation therapy and have few or no symptoms. Data will be shared in a late-breaking oral presentation at the upcoming American Society of Clinical Oncology (ASCO) 2014 Genitourinary (GU) Cancers Symposium in San Francisco on Thursday, January 30, 2014.[i]

"This is a significant step forward in prostate cancer therapy for men whose cancer has progressed, despite treatment with androgen deprivation therapy" said Professor Bertrand Tombal, MD, PhD, Chairman of the Division of the Urology, Cliniques Universitaires Saint Luc, Université Catholique de Louvain (UCL) and European Principal Investigator for PREVAIL. "As well as the clear efficacy benefits, what impressed me most about the results is that treatment with enzalutamide delays the time to initiation of chemotherapy, a key factor in maintaining quality of life in men with advanced prostate cancer."

The PREVAIL study results in men with metastatic prostate cancer who have progressed on androgen deprivation therapy are as follows:

- Treatment with enzalutamide demonstrated a statistically significant overall survival benefit compared with placebo treatment. Enzalutamide reduced the risk of death by 29% (HR=0.71; p<0.0001), compared with placebo. This benefit was observed despite substantial use of subsequent therapies (40% in the enzalutamide and 70% in the placebo groups).
- Treatment with enzalutamide significantly reduced the risk of radiographic progression or death by 81% compared with placebo treatment (HR=0.19; p<0.0001).
- Consistent benefits on these co-primary endpoints of overall survival and radiographic progression-free survival were observed across patient subgroups.
- Men taking enzalutamide experienced a 17-month delay in the time to initiation of chemotherapy compared with men taking placebo (28.0 months versus 10.8 months; HR=0.35; p<0.0001).
- The majority of men (58.8%) with soft tissue metastatic disease treated with enzalutamide versus 5% of patients treated with placebo had objective responses (complete responses or partial responses) including complete responses in 19.7% of enzalutamide patients compared with 1% of placebo patients.
- Enzalutamide extended the median time to PSA progression from 2.8 months (placebo) to 11.2 months (HR=0.169; p<0.0001).
- Nearly 4 out of 5 patients in the enzalutamide group experienced a PSA decline of 50% or more, compared to less than 4% in the placebo group (78% vs. 3.5%; p<0.0001).
- The median times to deterioration in a measure of prostate cancer-specific quality of life, the Functional Assessment of Cancer Therapy-Prostate or FACT-P, were 11.3 months for the enzalutamide-treated patients and 5.6 months for the placebo patients (HR= 0.625, p<0.0001).
- The median treatment duration for enzalutamide was more than 3 times longer than for placebo (16.6 versus 4.6 months).
- Common side effects occurring during treatment and more common in the enzalutamide treated men included fatigue, back pain, constipation and arthralgia. Hypertension was observed in 13.4% of enzalutamide versus 4.1% of placebo-treated patients. Grade 3 or higher cardiac adverse events were reported in 2.8% of enzalutamide versus 2.1% of placebo-treated patients. Investigators reported zero

(Continued on page 9)

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(Continued from page 8)

seizures in the enzalutamide-treated group and one in the placebo group prior to the data cut-off date. One seizure was reported in the enzalutamide group after the data cut-off date.

Cancer patients who exercise could HALVE their risk of death, claims study

From MailOnline – Health - by Sarah Griffiths

We all know exercise is good for us but now scientists have found that physical exercise significantly increases the life expectancy of cancer survivors.

Men who beat cancer and who burned more than 12,600 kilojoules or 3,011 calories a week exercising, almost halved their risk of death, a new study found.

The research supports a previous study that found the most physically active cancer survivors are much less likely to die of cancer and heart disease.

Scientists from the Loyola University Chicago Stritch School of Medicine studied 1,021 men with an average age of 71 who had been previously diagnosed with cancer.

They found that men who burned more than 3011 calories per week by exercising, were 48 per cent less likely to die than those that did little exercise and expended less than 2,100 kilojoules (502 calories) a week, Medical Express reported.

Co-author of the study, Dr Kathlee Wolin explained that many cancer survivors are living longer because of early diagnosis and better treatment.

'Physical activity should be actively promoted to such individuals to enhance longevity,' she said in the study, which was published in the Journal of Physical Activity & Health

While there has been plenty of research that shows regular exercise boosts the life expectancy of healthy people, this study is among very few that show exercise also extended the life of cancer survivors.

Scientists used data from Harvard's Alumni Health Study, which surveys male alumni who attended the university between 1916 and 1950.

In 1988, participants detailed their exercise habits in a questionnaire that quizzed hem how often they went walking, climbed stairs and participated in sports.

The exercise of the same men was updates in 1993 and they were followed until 1998.

The study found that men who burned more than 12,400 kilojoules per week were 48 per cent less likely to die of any cause following cancer treatment and their findings were adjusted for age, weight, smoking and early parental mortality.

A previous study revealed that the most physically active cancer survivors were 38 per cent less likely to die of cancer and 48 per cent less likely to die of cardiovascular disease after their cancer treatment.

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NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: http://ipcsg.org

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them

WE NEED HELP

All services for our group are performed by volunteers. As is usual in our type of organization we have a few doing a lot for many. We need people to step up and help in the following areas:

1. Fund Raising. We need help from anyone with any knowledge or willingness to become involved in acquiring grants to support our organization. We need someone to organize fund raising activities.
2. Information Technology. Any techies out there that can help take advantage of the facilities available where we meet--such as live remote conferencing.

Anyone interested please contact: Gene Van Vleet, Vice President. 619-890-8447 gene@ipcsg.org or-Lyle LaRosh, President 619-892-3888 lyle@ipcsg.org

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142

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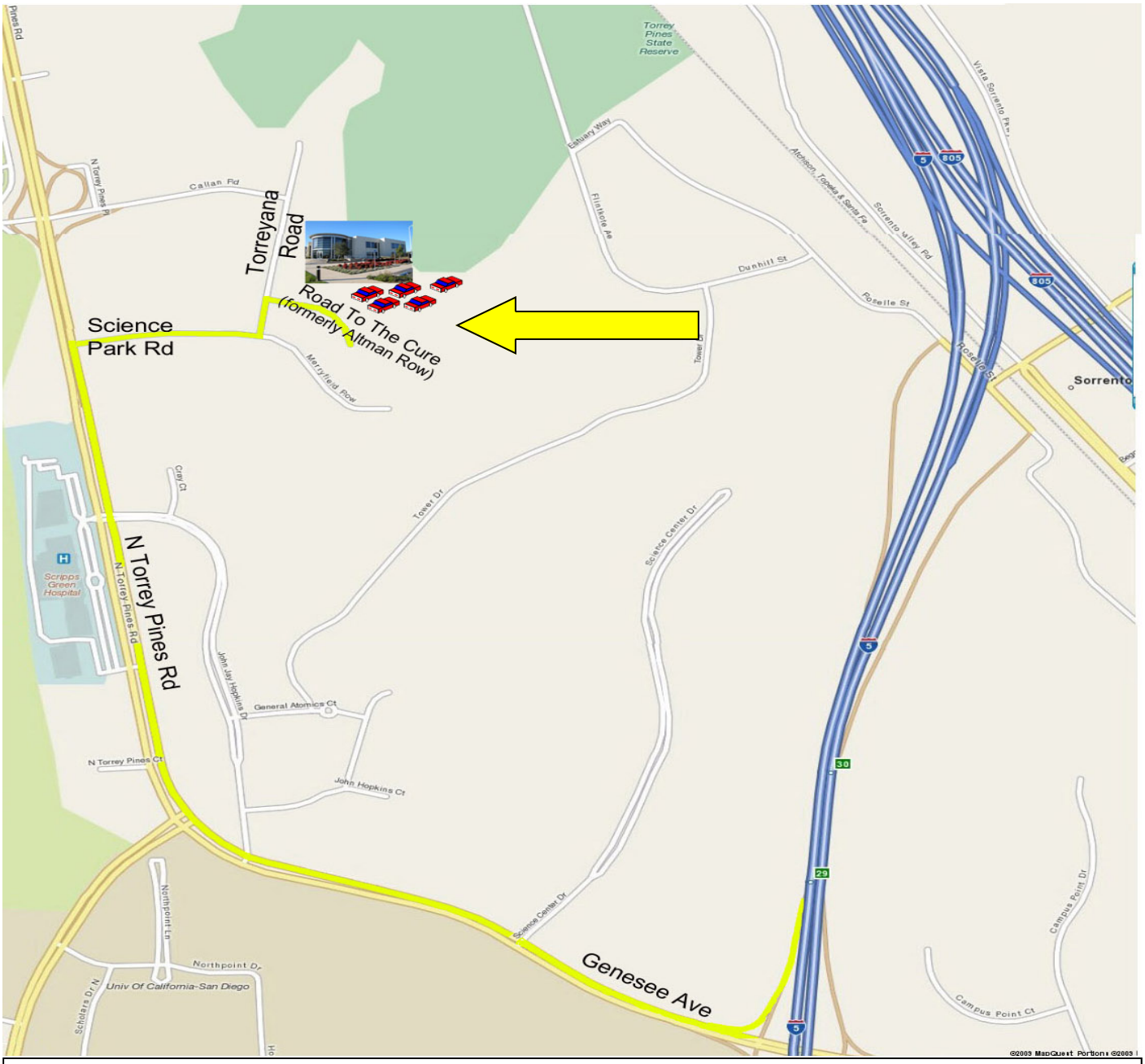

Directions to Sanford-Burnham Auditorium
10905 Road to the Cure, San Diego, CA 92121

Take I-5 (north or south) to the Genesee exit (west).
Follow Genesee up the hill, staying right.
Genesee rounds right onto North Torrey Pines Road.
Do not turn into the Sanford-Burnham Medical Institute or Fishman Auditorium
Turn right on Science Park Road.
Turn Left on Torreyana Road.
Turn Right on Road to the Cure (formerly Altman Row).

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