Informed Prostate Cancer Support Group Inc.

"A 501 C 3 CORPORATION ID # 54-2141691"

JUNE 2014 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142

Phone: 619-890-8447 Web: http://ipcsg.org

We Meet Every Third Saturday (except December)

Sunday, June 01, 2014 Volume 7 Issue 5

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Editor: Gene Van Vleet

Next Meeting
June 21, 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

The May meeting was a panel presentation by "patient experts", a few members who told of their experience in learning and making treatment decisions. Each answered audience questions relating to their presentation.

Darrel is 73 yrs old. He had Cryoablation in May of 2013. He had for several years been experiencing symptoms of low testosterone---lethargy, low libido, weight increase and poor muscle tone. His testosterone level ranged from 100 to 300. After considerable research he decided on testosterone replacement therapy. He began such therapy late in 2011. His PSA level had been fluctuating be-

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.

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tween 2 and 3. Shortly after beginning the testosterone replacement protocol, his PSA began to rise. In April 2012 it was 6.30 and by January 2013 it was 9.2. It was his belief that a tumor was present and growth was being accelerated. A biopsy was performed by the VA in June 2012 with a result of a 3+4=7 Gleason score. A radical prostatectomy was suggested and he also consulted about IMRT. He heard about our support group and improved his overall knowledge by networking with members, reading books and literature available through its library. He developed an interest in High Intensity Focused Ultrasound (HIFU) wherein heat is used for cell destruction. This is not available in the U. S., but rather in Mexico, Canada and Europe. He also researched Cryoablation, a method of freezing for cell destruction. In Jan 2013, he met with Dr. Duke Bahn of Prostate Institute of America to be evaluated for Cryoablation. Dr. Bahn performed a Color Doppler Ultrasound (CDUS) followed by a targeted needle biopsy of seven suspected areas of his prostate and commented that the VA had missed several tumors in their biopsy. He concluded that there was no extracapsular extension and that he would be a good candidate for Cryoablation. He visited Dr. Mark Scholz of Prostate Oncology Specialist in March 2013 for a second opinion. He ordered an MRI and a bone scan, which were negative, and he concurred with Dr. Bahn's assessment that Cryoablation would be a viable option. In May 2013, Cryoablation was performed at Memorial Hospital in Ventura, CA. Rather than performing a Focal Cryoablation just on the known tumors, it was decided to treat the whole right side of the prostate so as to ensure even small tumors would be eradicated. He was released one day later with a catheter which was removed a week later. Later in 2013 he re-introduced the testosterone replacement therapy regimen and in December, 2013, he had a follow-up CDUS by Dr. Bahn which showed no evidence of cancer in either prostate lobe. He intends to continue having CDUS with Dr. Bahn every six months unless he says they are no longer needed. He has experienced no long term side effects.

Ruben is 56 years old. Prior to 2014, he had no knowledge or indication of prostate cancer. During discussions with his doctor, he asked about low hormone levels and from that discussion they began monitoring PSA levels. From late summer 2013 to the beginning of 2014 his PSA rose from 3.8 to 5.0 causing him to have a biopsy in January, 2014. The result was a Gleason 4+4=8, indicating an aggressive type of prostate cancer. He contacted our support group from which he received much valuable information. He went to 3 different doctors for opinions and decided on a robotic prostatectomy with Dr. Christopher Kane of UCSD who he had heard speak at our February meeting. He learned that Dr. Kane performs 200 such operations a year. The procedure was performed May 8th, just 9 days prior to our meeting. He was advised that there was bilateral nerve sparing and no cancer was detected in the nearby lymph nodes. He was released one day after the procedure and the catheter was removed May 16th. He already has full control of his bladder functions. It is too early to tell about sexual functions, but because of nerve sparing he is confident of adequate recovery in that aspect.

Larry is 56 years old. He is following active surveillance rather than any invasive treatment. His father had prostate cancer at the age of 65 treating it with radiation therapy. His father is now 80 with a very low and stable PSA. Larry was 42 at the time his father was diagnosed which caused him to being testing his own PSA. Over the next 10 years his PSA ranged from 2.5 to 3.5. His urologist often recommended doing a biopsy, but he refused until he was 52. His Gleason was 3+3=6 and only one core showed 40% cancer. His urologist highly recommended immediate surgery and kept hounding him to do so, so he fired that doctor. He went to several other doctors including City of Hope and Loma Linda who recommended their specialty treatments, but also concurred that he was a good candidate for active surveillance. He has been seeing Dr. Parsons, a urologist at UCSD, for the last 2 years and became involved in his Meal study through which a nutritionist has helped him with a diet program. He exercises

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regularly. He has not had another biopsy for 4 years and tests his PSA every 3 months. It fluctuates upward sometimes but returns to lower levels. At one point last year it got up to 4.87, but his doctor was not concerned because it was not a significant rise over a period of a year. Because he was concerned he went to Loma Linda and had an MRI performed that, according to the report, showed his cancer had spread to his seminal vesicles and other places and that he was a Stage 3 cancer. He showed the report to Dr. Parsons who doubted the veracity of the report and had him do an MRI at UCSD which clearly showed the cancer had not spread. On his next PSA test it had dropped back down to 2.5. He intends to continue on active surveillance. His advice is to not rush into decisions and get second or third opinions to validate advice that does not seem fitting to your experience or knowledge.

Gene is 75 years old. His problems started with trusting his doctor's advice and not seriously considering alternative treatments. In his era and having been raised in a rural community, what the doctor said was considered unquestionable. Because he initially had BPH or issues with urination, he had been following his PSA for several years with his family doctor in the Sharp Rees Stealy Hospital group. In late 2002, during a digital rectal exam, the doctor felt a lump and referred him to a urologist. The urologist performed a biopsy with a result of 3+4=7. He did considerable research on treatment alternatives but could not overcome his urge to get the cancer out of his body. An MRI and bone scan indicated no issues outside the prostate. A retropubic prostatectomy was performed in January 2003. He didn't check the qualification of the surgeon but rather believed what he was told---that this would be a good treatment for him. He did get a second opinion from a doctor his urologist recommended, only to find out later that he was a partner who naturally concurred with his urologist. One year later his PSA began to rise above the post-surgical <0.1. He went back and read the post-surgery pathological report of the removed prostate and learned that the cancer was already in the seminal vesicles, proving it was outside the prostate before surgery. He was then referred to a radiation oncologist who recommended external beam radiation of the prostate bed, or salvation radiation. His PSA had climbed to 4.0 before he began treatment which consisted of 33 sessions over a 6 week period. Subsequently his PSA dropped back to <0.1 and remained there for 15 months. Unfortunately it then began to rise again, causing him significant mental anguish. Fortunately an acquaintance upon hearing of his plight, recommended that he call Lyle LaRosh, President, of the Informed Prostate Cancer Support Group. Through the Group he learned how to obtain the best insurance since he had just retired and needed to initiate Medicare. More importantly, he learned of Prostate Oncology Specialists in Marina Del Rey and had been their patient since April 2007. His PSA had risen back to 4.0 at that time. Alternatives were limited to hormone therapy, so he initially began a program of 150mg of Casodex (Bicalutamide) and .5mg Avodart. This reduced his PSA to 0.2. He would try taking a vacation or "Holiday" from treatment, but within 3 months his PSA rose to 10 the first time and to 15 after the second holiday. Each time after starting back on the drug, the low PSA point was higher, indicating he was becoming resistant to the drug. He then decided to go on Lupron, a treatment he initially refused because of the negative side effects he had heard about. He requested a one month shot, rather than the usual three month dosage to see how he would react to this medication. Dr. Lam had advised him of the debilitating effects if the drug—including loss of muscle tone, fatigue and perhaps some short term memory loss. To overcome these issues, the doctor strongly recommended getting to the gym and becoming involved in strenuous cardio and strength exercises. He went to a local YMCA, had a trainer work with him to develop a program and has become an avid regular, exercising 6 days a week for over an hour each day. Several positive things have resulted from this activity. He has no significant side effects from the Lupron drug other than minor flushing once or twice a day. His heart is much healthier. His PSA while on Lupron varies from 0.6 to 0.3. **AND** after over 30 years of being on

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high blood pressure medication, he has been able to discontinue that altogether. He has been on Lupron plus Avodart about 3 years and has tried taking holidays with the same results with Casodex---his PSA escalates rapidly. Further, there are signs that the nadir or low point when re-starting Lupron is slightly higher, just as it was doing with Casodex. This caused Dr. Lam to suggest doing the Provenge treatment which is a method of bolstering your own immune system to fight the prostate cancer. He knew of the approval of the drug some time ago, but was wary because there seemed to be no way of telling if it was working although the FDA approval study showed that it does prolong life. After Dr. Lam compared it to taking a flu shot where the only way you know if it works is that you don't get the flu, he began to warm up to the idea and in April 2014 he began the Provenge treatment. It is three cycles of two appointments. Each cycle is 2 weeks apart. The first appointment is at a Red Cross station where, over a 4 hour period, your blood is circulated through a machine that removes white blood cells. This collection is couriered to Seal Beach where the blood is purified and Dendritic cells are added which are what bolsters your immune system. The second appointment is within 3 days after the initial blood draw at which time it is infused at the doctor's office. The only negative side effects he experienced was a case of chills during the second infusion cycle and flu-like symptoms later in the day plus the day following the third infusion cycle. Since then there have been no noticeable effects of the treatment. If you continue to see Gene involved with the Support Group, you know it is working!

The details of each presentation including audience questions will be on the DVD which will be available in the library by the next meeting date or on our website: http://ipcsg.org. Click on "Purchase DVD's" on the main page.

Should you wish to communicate with any of the participants, please contact Gene at 619-890-8447 or gene@ipcsg.org who will put you in contact with them. We have a policy of not releasing contact information without the approval of the member.

FUTURE MEETINGS

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 - David S. Karow, M.D., Ph.D., Assistant Clinical Professor of Radiology, Director of Body MRI, will be presenting "New imaging innovations in prostate cancer detection and targeted biopsies".

August 16, 2014 - Karen Kunz, Medical Science Liaison, Myriad Genetics. Prolaris Genomic Test as an aid in predicting prostate cancer aggressiveness.

September 20, 2014. Roundtable Discussion. A panel of members will speak about their treatment experiences, followed by networking among members

October 18, 2014. Dr. A.J. Mundt, Professor and Chair, Department of Radiation Oncology UCSD, will present updated information about IMRT AND Dr. John P. Einck Associate Clinical Professor Radiation Oncology UCSD will present updated information about brachytherapy.

ON THE LIGHTER SIDE

If you get a diagnosis, get on a therapy, keep a good attitude and keep your sense of humor.--Teri Garr

If teachers taught, why didn't preachers praught? If a vegetarian eats vegetables, what does a humanitarian eat?

As the plane was flying low over some hills near Athens, a lady asked the stewardess: "What's that stuff on those hills?" "Just snow," replied the stewardess. "That's what I thought," said the lady, "but this fellow in front of me said it was Greece."

Patient: Doctor, if I give up wine, women, and song, will I live longer?
Doctor: Not really. It will just seem longer.

A woman walked up to a little old man rocking in a chair on his porch.
"I couldn't help noticing how happy you look," she said. "What's your secret for a long happy life?"
"I smoke three packs of cigarettes a day," he said. "I also drink a case of whiskey a week, eat fatty foods, and never exercise."
"That's amazing," the woman said. "How old are you?'
"Twenty-six," he said.

"Meow" means "woof" in cat." — George Carlin

"Who was the guy who first looked at a cow and said 'I think I'll drink whatever comes out of these when I squeeze 'em?" — Bill Watterson

"One morning I shot an elephant in my pajamas. How he got in my pajamas I'll never know."
— Groucho Marx

"Too bad that all the people who know how to run the country are busy driving taxicabs and cutting hair." — George Burns

"Sometimes the road less traveled is less traveled for a reason" — Jerry Seinfeld

NOTEWORTHY ARTICLES

Introduction to Hormone Therapy for Prostate Cancer

Posted: 20 May 2014 06:00 AM PDT Prostate Snatchers Blog

BY MARK SCHOLZ, MD

Testosterone is the primary male hormone. It comes mostly from the testicles and to a lesser degree, from the adrenal glands. Testosterone causes the common male characteristics such as bigger muscles, facial hair growth and increased sex drive. Testosterone is also essential for prostate cancer to grow.

Why Blocking Testosterone Kills Prostate Cancer

The prostate gland, located near the bladder, makes semen. Prior to puberty the gland is only the size of a peanut. However, when the testicles begin making testosterone, the prostate comes to life and grows to the size of a walnut. The cells of the prostate, therefore, require testosterone to proliferate. Since prostate cancer originates from the prostate gland, the cancer also depends on testosterone.

Hormonal therapy works by blocking testosterone. When prostate cancer cells are deprived of testosterone they commit suicide in a cell death process called apoptosis. The amount of cell death in early-stage prostate cancer is usually dramatic. Not uncommonly, when men are pretreated with potent forms of hormonal therapy, there is no residual cancer after surgery. More typically, there is a dramatic reduction in the number of cancer cells, but not total elimination of the cancer.

The mechanism for testosterone to stimulate cancer growth occurs through the activation of a multi-faceted protein called the androgen receptor. Before binding with testosterone the androgen receptor is inactive. Once the receptor comes into contact with testosterone, the activated androgen receptor is transported into the nucleus of the cell where it stimulates DNA. As a result, a plethora of cell-growth-enhancing proteins are synthesized that stimulate cancer growth and progression.

Hormone Therapy Comes in Many Forms

Prior to the advent of modern medications, hormone blockade was accomplished by surgical castration. These days, testosterone is blocked with shots or pills. Agents that block testosterone by inhibiting the pituitary gland are Lupron, Zoladex, Firmagon, Eligard and Trelstar. Medications that work by interposing themselves between testosterone and the androgen receptor to block its activation are Casodex, Nilutamide or Flutamide. A third milder type of hormonal agent, the 5-alpha-reductase inhibitors, such as Avodart and Proscar, work by inhibiting the chemical conversion of testosterone into its more potent form, dihydrotestosterone (DHT).

Recently the FDA approved two new, and more potent, hormonal agents, Zytiga and Xtandi. Their increased anticancer efficacy was demonstrated through prolonged survival in men whose cancer became resistant to Lupron. Zytiga and Xtandi work by different mechanisms. Zytiga inhibits cancer cells from making their own testosterone. Xtandi works by blocking the activity of the androgen receptor.

The Nitty Gritty of Treatment Selection

The most potent anticancer action is achieved through complete blockade with agents from different functional classes administered together for a prolonged period of time. Therefore, the variables that affect the intensity of hormone blockade treatment are: 1. the type of medicine; 2. how many medicines are used; and 3. how long the medications are continued. Of course, medical skill and experience is required to fine-tune the selection and duration of therapy. Nevertheless, here is a brief presentation of some rough guidelines.

1. A short course, say three to four months, to shrink the prostate or to improve cure rates in men with intermediate-risk disease (Teal Shade of Blue) undergoing radiation

2. A short course of four months to improve cure rates with radiation in men with intermediate-risk disease (Teal Shade of Blue)

3. An intermediate course (6-12 months) for treatment for intermediate-risk disease (Teal Shade of

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Blue) as a sole form of therapy

4. A long course (18-24 months) to improve cure rates in men with high-risk (Azure Shade of Blue) prostate cancer undergoing radiation
5. An intermediate to long course in conjunction with radiation to improve cure rates in men with a rising PSA after surgery (Indigo Shade of Blue) who are undergoing salvage radiation
6. Intermittent use to suppress a rising PSA after surgery or radiation (Indigo Shade of Blue)
7. Intermittent or continuous use to treat men with metastatic disease (Royal Shade of Blue)
8. Salvage treatment with Xtandi or Zytiga to control disease in men on Lupron who have progressive disease (Royal Shade of Blue)

Over the last ten years the medical community has been roiled by the discovery that some forms of prostate cancer are truly harmless, raising a serious concern about men receiving surgery and radiation they don't need. However, overtreatment with hormone therapy also occurs. The overriding goal is to use a hormone therapy approach that achieves a maximum anticancer benefit while minimizing side effects as much as possible. Treatment always has to be personalized so the intensity and duration of treatment is appropriate for each individual's specific situation.

'Low-risk' Prostate Cancer Often Not Low-risk When Targeted Biopsy Is Used

Source: University of California, Los Angeles (UCLA), Health Sciences May 19, 2014

More and more men who believe they have low-risk prostate cancers are opting for active surveillance, forgoing treatment and monitoring the cancer closely with prostate-specific antigen (PSA) tests, digital rectal exams and ultrasounds at regular intervals to see if their tumors are growing. Nearly 400 men are now enrolled in the UCLA Active Surveillance program, the largest in Southern California.

However, according to a new UCLA study, selection of men for active surveillance should be based not on the widely used conventional biopsy, but with a new, image-guided targeted prostate biopsy. The new biopsy method, pioneered by a multi-disciplinary team on the Westwood campus, is now a routine part of the UCLA active surveillance program.

UCLA researchers found that conventional "blind" biopsy failed to reveal the true extent of presumed low-risk prostate cancers, and that when targeted biopsy was used, more than a third of these men had more aggressive cancers than they thought. Their aggressive cancers were not detected by conventional blind biopsy using ultrasound alone, and the men were referred to UCLA's active surveillance program thinking they were at no immediate risk.

The study appears in the May 19, 2014 issue of the peer-reviewed Journal of Urology.

The targeted biopsy method, under study at UCLA since 2009, is performed by combining magnetic resonance imaging (MRI) with real-time ultrasound, a method of fusion biopsy, in a device known as the Artemis. Previous work from UCLA demonstrated the value of the new procedure in finding cancers in men with rising PSA who had negative conventional biopsies. This study is the first to show the value of using it early in the selection process for men interested in active surveillance.

"These findings are important as active surveillance is a growing trend in this country," said study senior author Dr. Leonard Marks, a professor of urology and director of the UCLA Active Surveillance Program. "It's an excellent option for many men thought to have slow-growing cancers. But we show here that some men thought to be candidates for active surveillance based on conventional biopsies really are not good candidates."

Marks and his team identified 113 men enrolled in the UCLA active surveillance program who met the criteria for having low-risk cancers based on conventional biopsies. Study volunteers underwent an

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MRI to visualize the prostate and any lesions. That information was then fed into the Artemis device, which fused the MRI pictures with real-time, three-dimensional ultrasound, allowing the urologist to visualize and target lesions during the biopsy.

"Prostate cancer is difficult to image because of the limited contrast between normal and malignant tissues within the prostate," Marks said. "With the Artemis, we have a virtual map of the suspicious areas placed directly onto the ultrasound image during the biopsy. When you can see a lesion, you've got a major advantage of knowing what's really going on in the prostate."

Of the 113 volunteers enrolled in the study, 41 men -- or 36 percent -- were found to have more aggressive cancer than initially suspected, meaning they were not good candidates for active surveillance. The findings should result in a re-evaluation of the criteria for active surveillance, Marks said.

"We are hesitant now to enroll men in active surveillance until they undergo targeted biopsy," Marks said. "Fusion biopsy will tell us with much greater accuracy than conventional biopsy whether or not they have aggressive disease."

Michael Lewis, 70, of Channel Islands Harbor, had a slightly elevated PSA, but was told after a conventional biopsy that he had no cancer. Six months later, his PSA had jumped 50 percent and he was given another biopsy, which again found no malignancy. A third biopsy showed a tiny amount of cancer, which qualified him for active surveillance at UCLA

However, six months later, as part of this study, a targeted biopsy revealed more cancer in Lewis' prostate than originally suspected. Despite what he thought at first, he had an aggressive tumor.

"It was a shock. No one wants to hear they have cancer," said Lewis, who recently finished stereotactic body radiation therapy at UCLA. "With the targeted biopsy system, we were able to find my cancer early. It might have been missed otherwise -- it actually was missed. Before I came to UCLA, I was told I didn't even have cancer. I could have been dead -- simple as that. Frankly, I owe my life to UCLA."

Lewis' prognosis is good, Marks said, because the cancer was detected early. Had he continued to receive conventional biopsies, the cancer may have spread before it was detected.

Prostate cancer is the most frequently diagnosed cancer in men aside from skin cancer. An estimated 233,000 new cases of prostate cancer will occur in the United States in 2014. Of those, nearly 30,000 men will die.

"For men initially diagnosed with low-risk prostate cancer, MRI-ultrasound confirmatory biopsy including targeting of suspicious lesions seen on MRI results in frequent detection of tumors," the study states. "These data suggest that for men enrolling in active surveillance, the criteria need be re-evaluated to account for the risk inflation seen with targeted prostate biopsy."

On the other hand, Marks said, for men with a negative targeted biopsy, a degree of reassurance is provided that is much greater than that offered by the older, blind biopsy method.

Over the last ten years the medical community has been roiled by the discovery that some forms of prostate cancer are truly harmless, raising a serious concern about men receiving surgery and radiation they don’t need. However, overtreatment with hormone therapy also occurs. The overriding goal is to use a hormone therapy approach that achieves a maximum anticancer benefit while minimizing side effects as much as possible. Treatment always has to be personalized so the intensity and duration of treatment is appropriate for each individual’s specific situation.

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.

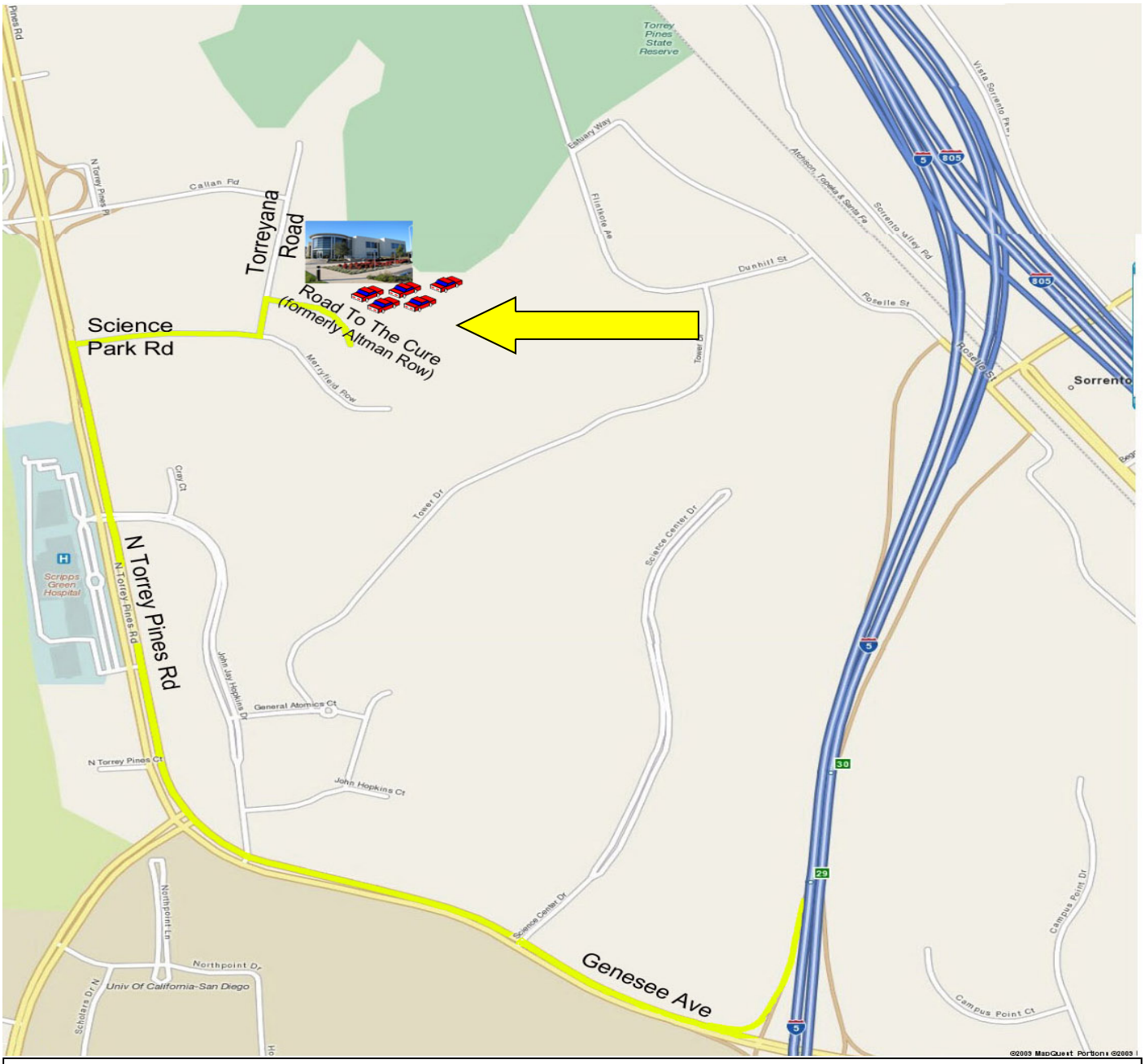
Anyone interested please contact: Gene Van Vleet, Chief Operating Officer. 619-890-8447 gene@ipcsg.org orLyle LaRosh, President 619-892-3888 lyle@ipcsg.org

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



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).