Informed Prostate Cancer Support Group Inc.

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

APRIL 2016 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142

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

We Meet Every Third Saturday (except December)

Thursday, April 14, 2016

Volume 9 Issue 4

Next Meeting
April 16,2016
10:00AM to Noon

Meeting at

Sanford-Burnham-Prebys 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 PCa 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!!

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Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

Our guest speaker for the March meeting was James Rucks, Regional Sales Manager, GenPath Diagnostics / BioReference Laboratories. Subject: Opco "4Kscore" which is the only test to assess a patient's risk for aggressive prostate cancer prior to a prostate biopsy. He first introduced Lauren Willock who is the San Diego representative.

He began with some of the fundamentals of cancer. It occurs when cells are no longer able to regulate themselves. There is rapid growth and multiplication. They don't maintain structure. There are different pathological classifications of tumors. Benign tumors are most commonly moles and

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.

The DVD of each meeting is available by the next meeting date.

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polyps. Malignant tumors most common in men are: skin cancer, prostate, lung and colorectal.

Cancer can start in a single cell which can multiply very fast. As it grows, normal tissue around it is destroyed causing growth in the organ which may metastasize to the local area or spread to other organs which might be fatal.

Prostate cancer (PCa) is the second most common cancer in men after skin cancers. There were 220,000 new cases and 27, 500 deaths in 2015. About 14% of all men will be diagnosed with prostate cancer at some point in their life. There are 2.8 million men with prostate cancer in the United States. It usually is an indolent cancer. The 5 year mortality rate has increased from 66% in 1975 to the most current rate of 98.9%. Lung cancer has a 17.4% five year survival rate. The earlier it is detected the better the chance of survival. It is more common in older men and African Americans. The median age of diagnosis – 66 yrs. Death is more likely in those with distant spread and for African Americans. Median age at death – 80 yrs. Treatments have improved but the biggest change is brought about by earlier detection.

Some aspects of the biopsy: it doesn't require the whole tumor or organ, it does have complications that can include serious infection and it can miss the cancer if the wrong area is sampled. Most commonly, they take 12 or more cores from different regions of the prostate by using an ultrasound to guide. Usually a local anesthesia or sedation is used. They can miss the cancer so what looks like a negative or low grade cancer on biopsy might be high grade in the prostate Too often patients choose surgery because of the fear of missing cancer. Over one million biopsies are performed annually in the US

As men get older, almost all of them will eventually have an enlarged prostate. The most common cause is Benign Prostatic Hypertrophy (BPH). 3 out of 4 men will have BPH by the age of 70. Many of the signs/symptoms are similar to prostate cancer. It can be treated with medication in most cases.

The PSA dilemma. PSA has been very successful in reducing deaths from prostate cancer, but there are a lot of cases that go on to biopsy that have no cancer or indolent cancer which leads to overdiagnosis and overtreatment. Elevations can occur with: cancer, benign prostatic hypertrophy, prostatitis, trauma (BPH) or instrumentation. In 2012, the United States Preventative Services Task Force (USPSTF) gave PSA screening a "D" grade. This has had a profound impact on how PSA is perceived by physicians, especially primary care. The problem with PSA is that it is both disease and test related. It has a poor ability to tell high grade cancer from low grade or even no cancer. Too many cases proceed to biopsy who have no disease and go on to have further treatment. However, stopping PSA screening could miss Gleason 7 or higher – high grade cancer. Recently the detection rate of high-grade cancers has decreased and more men have progressed to aggressive cancer before testing. More clarity is needed in the medical community about the need for testing.

Is there a better way to keep finding prostate cancer but not over diagnose? A solution is more intelligent testing, It needs better specificity and it needs to separate high grade cases from low grade cases. **The 4Kscore® Test** is the only blood test that accurately identifies an individual's risk for aggressive prostate cancer. It predicts aggressive prostate cancer. Aggressive prostate cancer is defined as both high-grade disease and long term clinical outcomes (rate of prostate cancer metastases). It is recommended in the 2015 NCCN Guidelines for Prostate Cancer Early Detection. In a prospective, blinded, multicenter US study of 1012 men it predicted biopsy results. 12 peer-reviewed clinical studies using the 4Kscore® Test biomarkers & algorithm in 22,017 subjects confirmed test accuracy. The 4Kscore® Test identifies the risk of metastases within 20 years. It influences physician/patient decision making in 88% of cases. 95% of low risk cases opt to avoid biopsy while 91% of high risk cases opt for biopsy.

James supplied the following information about getting the test:

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1. Their primary care physician or urologist will need to have an account with OPKO/GenPath. The doctor can call 1-800-627-1479 or go to http://clinical.opko.com/contact-opko-lab to have an account set-up and to be given supplies.
2. Patient can then take a 4KScore blood kit given to them from their doctors office to any West Pacific Medical Lab to have their blood drawn. West Pacific Medical Lab Locations are below. There is a $38 dollar fee from West Pacific Medical labs to draw blood.
3. Results for the 4KScore will be returned to the patients physician.

For Billing:

1. For patients paying cash, the cost of the test is $395.
2. For patients using insurance, we will bill their insurance. There are two results here. If the insurance does not reimburse us, we will not bill the patient. Zero Charge. If the insurance does pay us, then we are obligated to charge any copay or deductible to the patient.
3. Recommendation: For those patients with a high deductible (ex: $5000 deductible), it is recommended to just pay the $395 cash price and not submit insurance.

4K Score Draw Sites – West Pacific Medical Labs http://wpmlabs.com/
Alvarado 6719 Alvarado Rd., Suite 209 San Diego, CA 92120
Balboa Park 2970 5th Ave., Suite 140 San Diego, CA 92103
Chula Vista 629 Third Ave., Suite A Chula Vista, CA 91910

Lauren, the local representative answered these specific questions after researching:

1. Is the 4K score test available in Australia? No
2. What % of PSA results are less than 1.5%? Information provided by Jay Newmark, MD from our Medical Affairs Department: "roughly 70% at BioReference Labs. Dave Crawford has similar data from another source"
3. Have we done any studies on indolent prostate cancer that turn into aggressive cancer? Current data shows that indolent PCa (Gleason 6 and below) will not turn into aggressive cancer. The concern is that a cancer is called a Gleason 6 and there may have been other Gleason 7 and above that was missed on biopsy. This is sometimes caught during another biopsy or is seen when the prostate is sent for post radical prostatectomy analysis (called upstaging if a higher Gleason grade is found when the tissue is examined).
4. Clarification: We are not indicated for use in patients with diagnosed PCa, including patient's that have Gleason 6 and are currently on active surveillance.

Lauren Whillock
Account Executive
GenPath Diagnostics / BioReference Laboratories
Cell: 760.707.6857

As always a DVD of the presentation, including slides, will be available by our April meeting from our website: www.ipcsg.org/shop or from the library at the meeting.

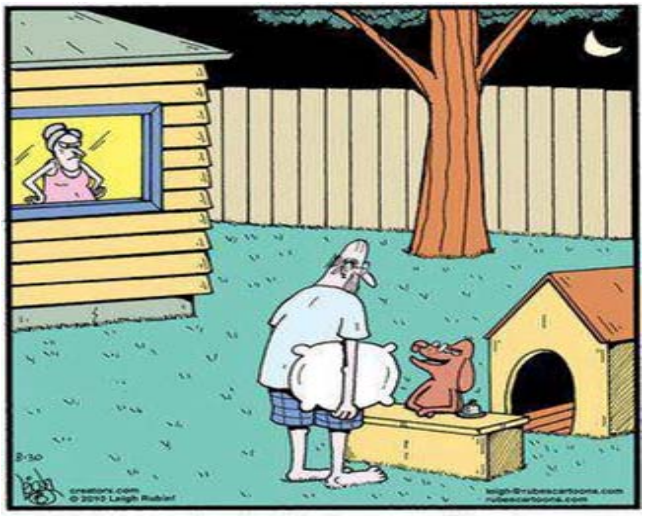
FUTURE MEETINGS

Apr 16. Bernadette Greenwood, BScRT(R)(MR) from Desert Medical Imaging. Update on Focal Laser treatment and MP-MRI Biopsy. (SEE ARTICLE ON PAGE 5)

May 21. Not yet confirmed.

Jun 18. Roundtable. A panel of members talk of their experiences followed by Q&A, then break-out sessions by treatment type for networking.

ON THE LIGHTER SIDE



"Welcome back, sir. Are you planning on being our guest for one night only, or will this be your usual extended stay?"

"Didn't you get my e-mail?"

From the Union Tribune 4/1/16

Dear Abbey: I'm getting ready to undergo my first ever prostate exam. To be honest, I'm a bit nervous. What should I expect? Also, what's the dress code for something like this? I'm thinking about wearing nice slacks and a collared shirt. The doctor has been patient and kind. He hasn't put any pressure on me. I want this to be special. I'm thinking about bringing a bottle of wine. After all, it's only the first time once. Advice?

Dear Untouched: Your attire isn't as important as your attitude. Just relax and let the doctor "handle" things. As to the wine, I have it on good authority that a nice bottle of cabernet sauvignon goes well with a prostate exam if you drink enough beforehand.

More oxymorons: Government organization; sanitary landfill; alone together; legally drunk; silent scream; small crowd; soft rock; new classic; sweet sorrow; tight slacks; childproof

One day, the Devil challenged the Lord to a baseball game. Smiling the Lord proclaimed, "You don't have a chance; I have Babe Ruth, Mickey Mantle, and all the greatest players up here". "Yes", snickered the devil, "but I have all the umpires."

Puns:
I wasn't originally going to get a brain transplant, but then I changed my mind.
I wondered why the baseball was getting bigger. Then it hit me.
Claustrophobic people are more productive thinking outside the box.
The experienced carpenter really nailed it, but the new guy screwed everything up.

INTERESTING ARTICLES

Clinical Trial: Dr. John F. Feller Laser Focal Therapy

Excerpt from Prostatepedia Newsletter April 2016

Dr. John F. Feller is a radiologist at Desert Medical Imaging in Indian Wells, California**.(NOTE: Bernadette Greenwood RT)(MR), Director of Clinical Services will be our guest speaker at our next IPCSG meeting April 16th).**

Prostatepedia spoke with him recently about a clinical trial on focal therapy for which he is seeking patients.

What is focal laser focal therapy and how does it work?

Dr. Feller: Laser focal therapy is an outpatient procedure done with a combination of local anesthetic and intravenous conscious sedation. There is no general anesthesia. The patient is not put to sleep. He walks into an outpatient imaging center and walks out, hopefully, with definitive therapy for his cancer.

Focal therapy is reserved for those with low- and intermediate-risk prostate cancers. Patients with Gleason scores 3 through 6 large-volume cancers are candidates, as are those with intermediate-risk prostate cancers, i.e. Gleason scores 3 + 4 = 7 and 4 + 3 = 7. Those with small-volume Gleason score 3 through 6 very low- risk cancers are not candidates; they need to be followed with active surveillance.

An important component that we've added in the last year to our program is what we call risk stratification using genomics. Risk stratification means we'd like to be able to assess patients better than just with a Gleason score and a multiparametric MRI. We want to sort out which patients should stay on active surveillance, which are good candidates for focal therapy, and which are likely to recur or develop a more aggressive prostate cancer.

Laser focused therapy is done transrectally. We use the same device for laser focal therapy that we use for MR-guided in-bore biopsies, but rather than inserting the biopsy needle into the prostate gland to diagnose the cancer, we insert a laser applicator under MRI guidance. Then we use something called MR thermometry, which is a real-time technique that allows us to monitor the temperature inside the patient's body in two different planes with a large field of view while we're treating the cancer.

Laser therapy uses thermal energy to treat the cancer, so it physically heats the gland. Heating the gland to a temperature over 60 degrees Celsius causes instantaneous cell death. The idea is to put the tip of the laser right where the cancer is, to just destroy the cancer while you're monitoring it with the MR thermometry, thereby protecting important structures. Because we're monitoring the temperature inside your body with the MRI machine, we can put cursors on the rectal wall, on the neurovascular bundles that control erectile function, and on the external urethral sphincter that controls continence. The laser shuts off if any of those structures heat up.

As a result of this very strong safety capability and our ability to focally treat just the cancer without destroying important structures inside the prostate gland, during the course of our clinical trial we haven't had any patients develop any permanent erectile dysfunction or urinary incontinence. None of the patients have developed a hole in the wall of the rectum called a rectal fistula, either.

The advantage of focal therapy for appropriately selected patients is that it eliminates the morbidity, or bad side effects, effects associated with whole-gland therapy.

Those side effects associated with whole-gland therapy are usually significant, are they not?

Dr. Feller: Yes, they can be significant depending on who does the radical prostatectomy. The erectile

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dysfunction rate after radical prostatectomy can be as high as 40-50%. The urinary incontinence rate can be as high as 25%.

Patients who go through radiation therapy get those same side effects, but they tend to be a little more delayed rather than occurring immediately after treatment. In addition, radiation therapy patients have roughly a 15% risk of getting proctitis, or inflammation of the rectum.

The real vision of focal therapy is to first obtain cancer control, and second, to get rid of the morbidity and side effects associated with whole-gland therapy.

Are recent advances in focal therapy associated with recent advances in imaging?

Dr. Feller: Yes. We have a saying in interventional radiology, where we treat things under image guidance: If you can't see it, you can't treat it.

In recent years, we've had a prostate syzygy. Over the last ten or so years, we've seen the emergence of multiparametric MRI, which is a type of MRI that uses multiple different pulse sequences, or ways of looking at the prostate gland, to detect what we call tumor-suspicious regions— or areas likely to be cancer.

After that happened, hardware and software emerged that allowed us to do MRI-guided, or targeted, biopsies of those tumor-suspicious regions so that we can prove whether or not they were in fact cancer.

Thirdly, we developed an improved understanding of the natural history of prostate cancer, especially our understanding of the index lesion. The index lesion is defined as the largest, highest Gleason score focus of the prostate cancer.

In the last few years, there has been a growing body of knowledge, originally introduced by an article in the New England Journal of Medicine by Dr. Hashim Ahmed, that talked about the fact that even though prostate cancer is multifocal, meaning in more than one place, 80% of the time it turns out that only the largest, highest Gleason score focus of the prostate cancer, the index lesion, is the one that tends to determine the prognosis for the patient—his survival and the natural history of his disease.

Now we know that if we can find the index lesion reliably with multiparametric MRI and MR-guided in-bore biopsy, we can treat just that index lesion and ignore the smaller, less significant areas of prostate cancer.

Those three things all came together, which is why there is a lot of infrastructure right now in studying and investigating focal therapy for prostate cancer to see if we can obtain an adequate degree of cancer control.

The one thing we know for sure is that it's safe. We've had no morbidity. Secondly, it's very feasible. Third, we have follow-up coming up on six years and none of our patients have developed metastatic disease and nobody has died from their prostate cancer. We are getting useful information about cancer control and the local control, as well.

In the scenario you describe, adequate monitoring after focal therapy would be really important, wouldn't it?

Dr. Feller: Absolutely. That is why, as part of our clinical trial, in the first year following treatment all of our patients get an MRI and PSA at three months, six months, and a year. At six months, we biopsy the treatment site, and then assuming everything is fine, we follow them—once a year, they get a follow-up MRI and a follow-up PSA.

What do you think about the criticism that some of these focal therapies are being offered to patients who should really be on active surveillance?

Dr. Feller: It is inappropriate to try to replace active surveillance with focal therapy.

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Patients who are candidates for active surveillance should choose active surveillance. It is very cost effective. There is no morbidity. There is no risk of any side effects or complications, because they're not undergoing a procedure. Patients get a follow-up PSA. More and more of these patients are also getting a multiparametric MRI as part of their active surveillance.

Any clinical trial that is investigating focal therapy needs to be looking more at intermediate-risk patients, not just low-risk or very low-risk patients, because those low-risk patients should be on active surveillance.

The other group that is very interesting that we are also investigating for focal therapy is salvage patients. Up to 25-30% of patients who have had a radical prostatectomy or radiation therapy go on to develop biochemical recurrence. This means that their PSA, after going to almost zero or a very low value, slowly starts to creep up. We know based on experience, that most of the time that rising PSA is due to recurrent prostate cancer.

When that prostate cancer is locally recurrent, meaning inside the gland or where the gland was located in the pelvis, we can detect it with multiparametric MRI and we can biopsy it under MR guidance.

If the patient does have a local recurrence, in the past there were very few options for what we call salvage therapy. Once a patient has been fully radiated, he can't have more radiation therapy. They're not good surgical candidates. If a patient has already had a radical prostatectomy, he can't really have additional surgery. They may be able to have a little bit of radiation, but generally there have not been good options for salvage therapy.

Part of our clinical trial includes a group of patients who are salvage therapy patients. They have locally recurrent prostate cancer and biochemical recurrence, but didn't have any other options for treating that local recurrence. Focal therapy may be a solution for these patients.

But only as part of a clinical trial?

Dr. Feller: Correct. In 2016, anyone investigating focal therapy for prostate cancer should clearly be doing so as part of an institutional review board (IRB)-approved and regulated clinical trial. It's something that should be posted and followed on ClinicalTrials.gov.

Focal therapy is still investigational. While we know it's safe and feasible, we're just getting emerging data about efficacy and local control. Remember, prostate cancer, in general, is a relatively indolent cancer. It's slow- growing. We need follow-up for 10, 15, 20 years to really know what cancer control looks like in these patients. Right now, we're just six years into that.

Frequently patients mistake the latest thing with the best. Frequently the media encourages this. We all need to take a step back and realize that medical progress requires that clinical trials and research are done: Phase I, II, and III trials; and cost effectiveness studies.

That is why I really encourage patients to focus on sites that have ongoing clinical trials. Currently the laser that we use is FDA-approved. It's an outpatient procedure. It's safe. We have a rigorous follow-up program to make sure that if the patient does develop a recurrence at the treatment site, or a new focus of cancer in a different site, we can re-laser it. Unlike radiation or radical prostatectomy, where once it's done, it's done, with focal therapy, you can go in and retreat if the cancer comes back. This is one of focal therapy's big upsides.

Another big upside is that if a patient we've treated with laser focal therapy develops a more aggressive cancer in a different location that we pick up on follow-up MRI, he can still go on to whole-gland therapy if he needs to. Say he develops a Gleason 8 or 9, which is not currently appropriate for laser focal therapy in patients that have been treated before, he can still go on to have a radical prostatectomy or radiation therapy. Laser focal therapy does not alter that in any way. In fact, we've had four patients who have gone

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on to whole-gland therapy in the form of radical prostatectomy. The surgeon involved called us back and said had he not been told that the patient had had laser previously, there was no way he would have known.

We're just putting a little hole inside the prostate gland. We're not doing anything outside the prostate gland. Laser focal therapy does not make it technically more difficult or create any problems for the patient or the surgeon to remove the whole gland with robotic-assisted surgery. After laser focal therapy, patients can have additional focal therapy or whole-gland therapy.

Let's talk about cost. I'm assuming most of this is covered by insurance?

Dr. Feller: That's partially true. The multiparametric MRI and the MR-guided in-bore biopsy is covered by insurance—Medicare and commercial insurance. We've not had any problem with any insurance carriers. We've had to negotiate specific contracts with HMO groups separately, but those two components of our program are covered.

Anything that is part of the clinical trial is not covered by insurance and is not covered by Medicare. When a patient enters a clinical trial for focal therapy, like our laser focal therapy trial, they're either going to be entering a trial that is extramurally funded, meaning there is an NIH grant or something like it in place, or they'll enter a trial that is called patient-funded research, in which the patient pays to enter the clinical trial to have access to the technology.

Some of the technology is expensive. The one-time use kit with the disposable 980 nanometer laser that we use for focal therapy costs between $3,500 to $4,000.

In our trial, the cost for the patient for the focal therapy plus one year of follow-up—the one month, three month, one-year MRI, and the MR biopsy—is $23,000 total.

There are some expenses associated, obviously, with entering this type of clinical trial.

How To Get Involved…

Contact: Director of Clinical Services, Bernadette Greenwood, RT(R)(MR), directly at 760-766-2047 or Bernadette.Greenwood@ desertmedicalimaging.com

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Shorter, intensive radiation works for prostate cancer: Study

From HealthDay News, April 4, 2016

A slightly higher dose of radiation therapy for early stage prostate cancer may reduce treatment time without compromising effectiveness, researchers report.

The study included about 1,100 men with early-stage prostate cancer that had not spread beyond the gland. Half received the traditional radiation therapy program of 41 treatments over eight weeks, while the others received slightly higher doses during 28 treatments over about 5.5 weeks.

After five years, cancer-free survival rates were just over 85 percent for those in the traditional group and just over 86 percent for those in the shorter treatment group, while overall survival rates were 93.2 percent and 92.5 percent, respectively.

"This study has implications for public policy," said lead investigator Dr. W. Robert Lee. He is a professor at the Duke Cancer Institute's department of radiation oncology, in Durham, N.C.

"Because the shorter regimen has advantages such as greater patient convenience and lower costs, it's important to establishing whether we can cure as many patients with the shorter regimen. Our study provides that information for the first time," he added in a university news release.

"An estimated 220,000 men are expected to be newly diagnosed with prostate cancer each year in the United States, and the majority will have early-stage disease at low risk for recurrence," Lee said.

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The study, published April 4 in the Journal of Clinical Oncology, was partly funded by the U.S. National Institutes of Health and the U.S. National Cancer Institute.

Low-Risk Prostate Cancer Patients Opting to Delay Treatment Report Positive Life Quality

From Prostate Cancer News Today, March 15, 2016

Men with less aggressive prostate cancer who opt for active surveillance instead of surgery or radiotherapy have a good quality of life, similar to that of men without cancer, according to long-term research presented at the 2016 European Association of Urology Congress in Munich, titled "Long-term quality of life outcomes after active surveillance or curative treatment for prostate cancer."

Prostate cancer affects some 400,000 men every year in Europe, and most patients are treated either with radiotherapy (RT) or radical prostatectomy (RP). These treatments, while necessary in many cases, are associated with side effects that can include erectile dysfunction or incontinence. An alternative for patients with less aggressive prostate cancers is to avoid or delay initial treatment, undergoing what's known as Active Surveillance (AS). The cancer in these people is monitored regularly, and they have the option of switching to curative treatment should the tumor change.

Researchers evaluated whether AS helps patients with prostate cancer enjoy, over the long term, a better quality of life. A total of 427 patients with low-risk prostate cancer, ages 66 to 69, were assessed for life quality and then followed for five to 10 years after diagnosis. Of these, 121 patients opted for AS, 74 had surgery, and 232 were treated with radiotherapy. A control group of 204 men without prostate cancer, matched for age, was also examined.

Patients choosing AS reported higher quality of life scores compared to those who had undergone surgery (RP), and better urinary function, sexual function, and fewer reports of urinary incontinence. Results of a comparison of AS with radiotherapy, likewise, found a significantly higher sexual satisfaction score in the AS group. Overall, the quality of life in AS patients was identical to that of men without prostate cancer, although this result was not statistically significant.

Dr. Lionne Venderbos, of the department of Urology at Erasmus University Medical Center in Rotterdam, who led the research, said in a press release: "When choosing treatment, it is important that men think about the potential side-effects that are related to immediate curative treatment, like becoming incontinent or losing the ability to have an erection. When considering active surveillance they should try to imagine whether living with untreated cancer would cause any stress, or that the follow-up visits lead to stress instead of reassurance. Balancing the advantages and disadvantages per type of treatment, will make that a man chooses that type of treatment that fits his wishes and preferences best."

Dr Alberto Briganti, section editor of European Urology Focus and a member of EAU Scientific Congress Committee, added: "This is an interesting study which corroborates the notion that active surveillance is not only safe but well accepted by patients as possible initial management of low risk prostate cancer. While we could have … anticipated overall lower sexual and urinary function in men treated with surgery or radiation therapy as compared to men receiving AS, it is interesting to note that long-term quality of life of men on AS was comparable to that of men without prostate cancer. Proper patient counseling about [the] safety of AS is key to maintain both good quality of life, and intact psychological and functional well-being over time. We also need to note that it is possible that patients choosing AS may be less disposed to accept any form of treatment, and this might be difficult to uncover via the retrospective comparisons of validated questionnaires."

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.

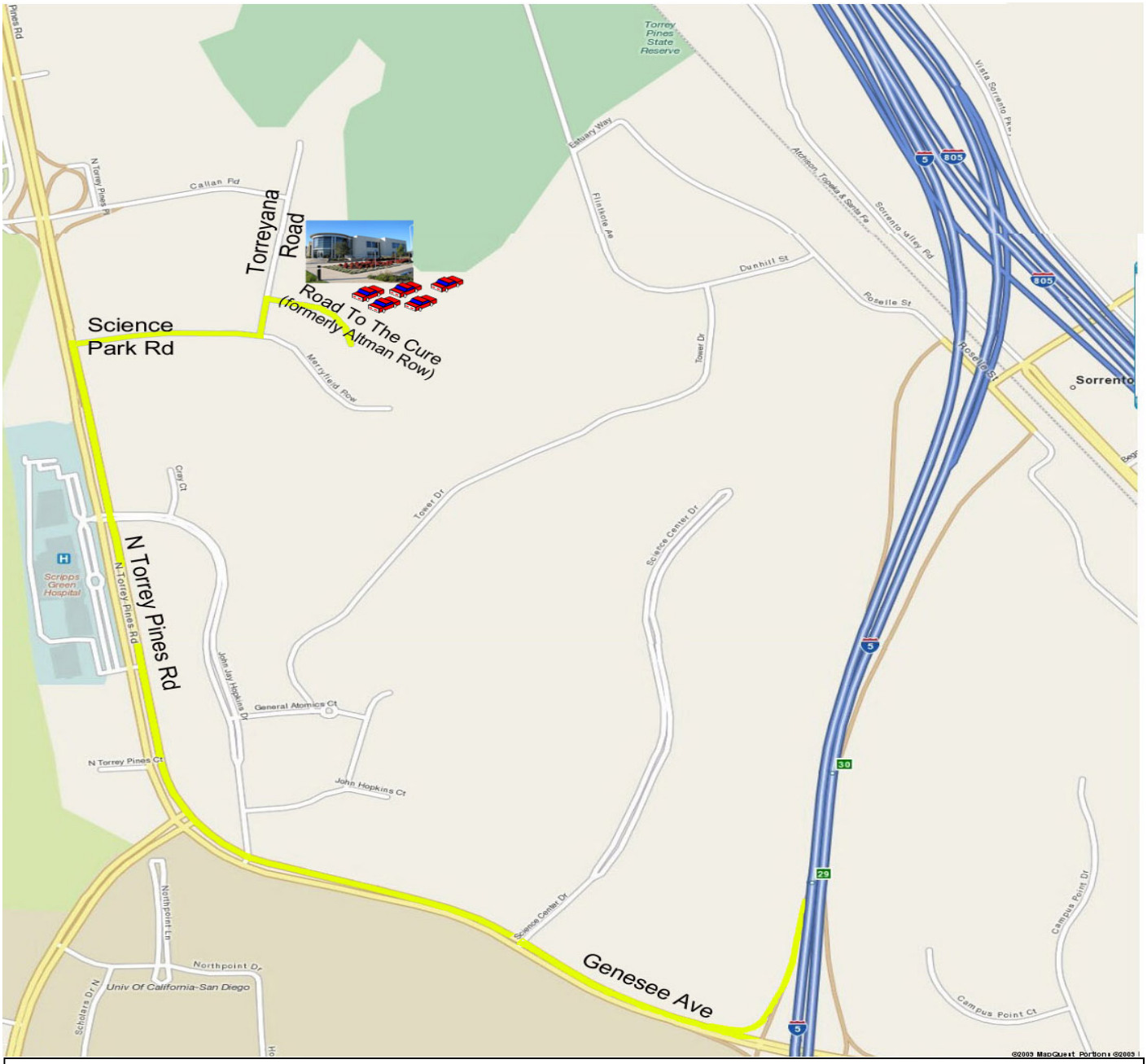
Ads about our Group are in the Union Tribune 2-3 times prior to a meeting. Watch for them.

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-Prebys 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-Prebys Medical Discovery Institute or Fishman Auditorium
Turn right on Science Park Road. Watch for our sign here.
Turn Left on Torreyana Road. Watch for our sign here.
Turn Right on Road to the Cure (formerly Altman Row). Watch for our sign here.