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

Wednesday, May 17, 2023

MAY 2023 NEWSLETTER

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

Volume 16 Issue 05

Next Meeting Saturday, May20, 2023 IPCSG—10:00am PT.

- Our May meeting will be a double header covering 2 very important and timely subjects:
  - **Provenge Immunotherapy** - is a personalized immunotherapy that activates the immune system to help fight advanced prostate cancer and has been proven to help certain men live longer. It works differently from other cancer treatments, such as chemotherapy or hormone therapy.
  - **Sparrow Search** - is a patient-friendly search engine that allows patients to directly search for and match to clinical trials. Patients who match to clinical trials are connected with clinical research sites, thereby increasing the pool of potential study candidates and expediting the recruitment process..
- As always, spouses/partners and caregivers are welcome and encouraged to attend!
- *After the meeting a light lunch will be served in the foyer outside the meeting room*
- **For links to further Reading: https://ipcsg.blogspot.com/ (includes member suggested links)**
- **If you have Comments, Ideas or Questions,** email Newsletter@ipcsg.org
- **For more information, please send email to bill@ipcsg.org or call Bill at (619) 591-8670 or Gene at (619) 890-8447**

April 2023 Informed Prostate Cancer Support Group Meeting

Summary by Bill Lewis

The Medical Journeys of a Prostate Cancer Patient

Dr. Richard Lam of Prostate Oncology Specialists in Marina del Rey, California is a double board-certified internist and oncologist, who has been specializing in the treatment of prostate cancer since 2001.

Key elements that patients face: Elevated PSA and Making a Diagnosis, Picking Treatment (or Active Surveillance), Managing Side Effects, Dealing with Relapse, Managing Advanced Disease.

Making a diagnosis involves noting the PSA kinetics (rate of rise), imaging the prostate using MRI or ultrasound (color doppler ultrasound at Prostate Oncology Specialists, or micro-ultrasound at Genesis Healthcare) for size and possible lesion locations, predictive testing when imaging doesn't give a definitive result (4K score, Exo-Dx or Select-MDX – see last month's talk for more info about these tests) and deciding on having a biopsy or not.

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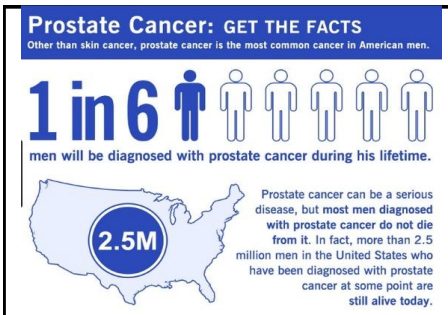

Organization

a 501c3 non-profit organization - all positions are performed gratis

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NEWSLETTER
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PROSTATE CANCER—*2 WORDS, NOT A SENTENCE*

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.

Join the IPCSG TEAM

If you consider the IPCSG to be valuable in your cancer journey, realize that we need people to step up and HELP. Call **President** Bill Lewis @ (619) 591-8670 "bill@prostatecancerhelp.info"; or **Director** Gene Van Vleet @ 619-890-8447.

From the Editor

In this issue:

Bill Lewis produced a summary of Dr. Lam's talk last meeting. For further articles see the blog at https://ipcsg.blogspot.com/ The following items of interest are included:

1. ExoDx prostate test as a predictor of outcomes of high-grade prostate cancer – an interim analysis | Prostate Cancer and Prostatic Diseases [*of particular interest for active surveillance, urine test for predicting biopsy need*]
2. Salvage lymphadenectomy after primary therapy with curative... : Current Opinion in Urology [*imagery of lymph node metastases to cut them out can extend survival or even cure*]
3. Decision regret and bother with the addition of androgen deprivation therapy to definitive radiation treatment for localised prostate cancer - ScienceDirect [*few regret ADT after treatment]*
4. LDR brachytherapy offers superior tumor control to single-fraction HDR prostate brachytherapy: A prospective study - Jimenez-Garcia - The Prostate - Wiley Online Library—[*long duration brachytherapy gives better results]*
5. Too Many Older Men Are Still Screened for Prostate Cancer—New York Times— *[Active surveillance is frequently choice]*

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Picking Treatment (or Active Surveillance) – available options include Surgery vs Radiation (External beam traditional 28 visit or SBRT 5 visits, or brachytherapy seeds), Focal Therapy (Cryotherapy, IRE/Nanoknife, HIFU (50% effective), or HDR brachytherapy (90% effective on a spot)), Hormone Therapy (now only 4 months if following surgery or radiation), or delaying therapy (Active Surveillance). See prior talks by Dr. Lam.

Insertion of a hydrogel (Spaceoar) helps avoid side effects (1.7% vs 5%) on the rectum from external beam radiation. 15-year survival of patients who were qualified for / given active surveillance was the same vs. either surgery or radiation but half of the AS patients never needed treatment, based on a large study in England. Factors that Guide Decision-Making include the aggressiveness (Gleason score) of the cancer – High risk patients likely need a combination of treatments, intermediate risk patients may be "cured" by a single type of treatment, and most low-risk patients should be offered AS. Additional biopsies for AS patients used to be annual, but now are much less frequent – perhaps not for 5 years. Unfavorable intermediate patients get "cured" 70% of the time by surgery or radiation alone, but the rate rises to 80% if followed by 4 months of ADT.

Managing side effects: Impotence (which increases with age, but also with treatments) can often be dealt with using pills. An ultrasound system helps 25% of men dissolve scar tissue. Penile injections are another option with 80-90% success (but 5% get persistent erections needing intervention). Penile implants are the most drastic, but most successful option. Libido can decrease due to low testosterone from age or treatments, and can be treated by testosterone supplementation. Urinary Inflammation may occur in 5% of men treated with LDR or HDR brachytherapy (less with external radiation) for 6 to 24 months. Other than waiting it out, anti-inflammatories (including pentoxyphylline) or Vitamins C & E can help. If there is bleeding, dilution with hydration can help, or cauterization, or hyperbaric oxygen (1 hour per day for two months).

Incontinence is the greatest fear of men facing treatments, ahead of sexual dysfunction. Cryotherapy gives the highest risk (50%, which is why it is less favored), followed by Surgery (5-10%), with Radiation giving only 1% risk. Age and surgeon skill are factors. It is managed with rehab (Kegel exercises), overactive bladder pills, or surgically with an artificial sphincter (90% satisfaction, but needs replacement after 10 years).

Rectal Toxicity – mucous discharge, blood in the stool, more frequent bowel movements – due to radiation treatments. With the hydrogel, occurrence is less than 2%. Kegel exercises, cauterization or just elapsed time can help. Hyperbaric oxygen is the other option.

ADT-effects. ADT is used with intermediate and high-risk patients to improve the "cure" rate. Common effects are fatigue, hot flashes, brain fog, depression, muscle atrophy, weight gain, decreased libido, and thin skin (all like menopause effects in women). Severity of effects depends on patient age, length of treatment and not taking breaks. New studies have led to reducing the time of ADT after treatment from 6 to 4 months for unfavorable intermediate patients, and from 36 months to 18 for high risk -- and even to 6 months for "certain" high risk patients. Side effects may persist after ADT is stopped, and the recovery time is somewhat proportional to the time on ADT. Sometimes, testosterone supplementation is used to boost recovery. This is an easy decision if there is no cancer left, and a calculated risk for others who need relief from the effects of low testosterone. While on ADT, diet and exercise (especially weightlifting) are very important, to minimize side effects.

Dealing with relapse: Where's the cancer -- local or remote? The PSA should be below 1.0 for surgical patients, or below 4.0 for radiation patients, for a good likelihood that the cancer is still local. PSMA scan availability has greatly improved our detection of wherever the cancer is. It is sensitive down

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to a PSA level of 0.2. Are there symptoms? How/where to treat? (Many factors to discuss with your doctor!) To cure or not to cure? Prognosis?

Due to the many questions discussed during the talk, Dr. Lam chose to delay discussion of "**Managing Advanced Disease**" to his next visit to our group. Topics will be Scans (CT, Bone scan, PET scan), OligoMets (few metastases) vs (more numerous) Mets, Androgen Deprivation Therapy, Radiation, CRPC (castrate resistant prostate cancer), and New Treatments.

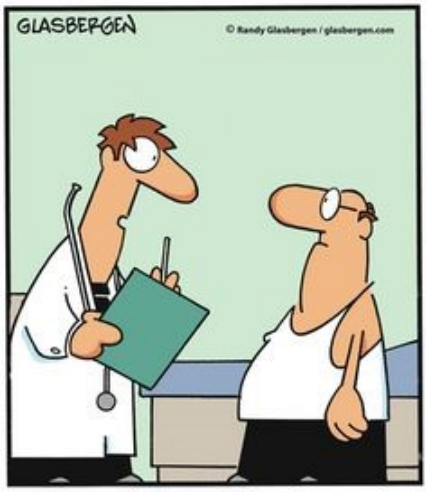
New treatments were also covered in the October 2022 meeting – see https://www.youtube.com/watch?v=VVD_aupYkRA&t=4307s A copy of the slides from the talk and documents mentioned therein, are all available from Dr. Lewis at pcahelpmail@gmail.com, or by request through the IPCSG mailing address. These include all of the cancer book chapter drafts, and summaries of the books Radical Remission and How To Starve Cancer.

See also talks on advanced treatments, proton therapy and PSMA in the 2023 mid-year PCRI prostate cancer patient conference at https://pcri.us7.list-manage.com/track/click?u=e61bab2d681f6500ca8a92f0e&id=efd8fcc442&e=481b6deffb

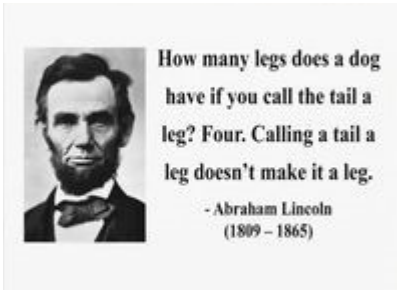
For the video of Dr. Lam's talk in this April 2023 meeting, see https://www.youtube.com/watch?v=1rJJvLay4TM&t=5091s Note that you can skip directly to the talk (at 14:38) using a link in the information section under the video.

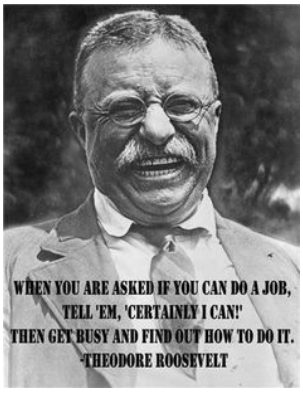
DVD's of IPCSG meetings are no longer being made. See the talk online on your own device, or on that of a friend or relative, or elsewhere.

On the Lighter Side



"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"





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Items of Interest

ExoDx prostate test as a predictor of outcomes of high-grade prostate cancer – an interim analysis | Prostate Cancer and Prostatic Diseases

Prostate Cancer and Prostatic Diseases

Abstract

Background

Patient outcomes were assessed based on a pre-biopsy ExoDx Prostate (EPI) score at 2.5 years of the 5-year follow-up of ongoing prostate biopsy Decision Impact Trial of the ExoDx Prostate (IntelliScore).

Methods

Prospective, blinded, randomized, multisite clinical utility study was conducted from June 2017 to May 2018 (NCT03235687). Urine samples were collected from 1049 men (≥50 years old) with a PSA 2–10 ng/mL being considered for a prostate biopsy. Patients were randomized to EPI vs. standard of care (SOC). All had an EPI test, but only EPI arm received results during biopsy decision process. Clinical outcomes, time to biopsy and pathology were assessed among low (<15.6) or high (≥15.6) EPI scores.

Results

At 2.5 years, 833 patients had follow-up data. In the EPI arm, biopsy rates remained lower for low-risk EPI scores than high-risk EPI scores (44.6% vs 79.0%, $p < 0.001$), whereas biopsy rates were identical in SOC arm regardless of EPI score (59.6% vs 58.8%, $p = 0.99$). Also in the EPI arm, the average time from EPI testing to first biopsy was longer for low-risk EPI scores compared to high-risk EPI scores (216 vs. 69 days; $p < 0.001$). Similarly, the time to first biopsy was longer with EPI low-risk scores in EPI arm compared to EPI low-risk scores in SOC arm (216 vs 80 days; $p < 0.001$). At 2.5 years, patients with low-risk EPI scores from both arms had less HGPC than high-risk EPI score patients (7.9% vs 26.8%, $p < 0.001$) and the EPI arm found 18% more HGPC than the SOC arm.

Conclusions

This follow-up analysis captures subsequent biopsy outcomes and demonstrates that men receiving EPI low-risk scores (<15.6) significantly defer the time to first biopsy and remain at a very low pathologic risk by 2.5-years after the initial study. The EPI test risk stratification identified low-risk patients that were not found with the SOC.

Salvage lymphadenectomy after primary therapy with curative... : Current Opinion in Urology

Abstract

Purpose of review

To provide a summary of the current literature on salvage lymph node dissection (sLND) in patients with nodal recurrent prostate cancer (PCa) with focus on imaging, the extent of sLND and oncologic outcomes.

Recent findings

The clinical practice guidelines recommend performing PET/CT in patients with biochemical recurrence (BCR) after primary therapy. PSMA PET/CT has demonstrated superiority over choline PET/CT and MRI, especially at low prostate-specific antigen (PSA) levels. Although the heterogeneity in available

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literature does not allow standardization of surgical templates for sLND and PET/CT scan can guide the extent of surgical dissection, an anatomically defined extended template is typically considered. Radio-guided surgery (RGS) suggests an improved positive lymph node yield compared with standard sLND. However, long-term data are needed to evaluate the oncologic impact of sLND. The main aims of sLND are to delay recurrence and to postpone the need for systemic therapy. Available evidence suggests that around 40–80% of men can achieve complete biochemical response after sLND and 10–30% remain BCR free after 5 years. Robotic sLND might represent an option to reduce the risk of complications without compromising oncological outcomes; validation in controlled prospective studies is, however, needed.

Summary

sLND is a valid treatment option for patients with nodal recurrence only after primary therapy for PCa. Further optimization of patient selection based on highly sensitive and specific imaging and clinical factors remains an unmet need. To maximize the benefit of this approach, sLND should be discussed with patients who harbor lymph node-only recurrence after primary therapy in a shared decision-making.

Decision regret and bother with the addition of androgen deprivation therapy to definitive radiation treatment for localised prostate cancer - ScienceDirect

sciencedirect.com

DE Spratt

Abstract

Background and Purpose

Androgen deprivation therapy (ADT) combined with radiation treatment (RT) is recommended by the NCCN guidelines for unfavourable intermediate and high risk localised prostate cancer. Whilst there is a variable survival benefit conferred by ADT, there are potential side effects to consider for patient decision-making. We aimed to assess the side effects and bother of adding ADT to RT, the degree of regret, and what overall survival(OS) benefit men would want to justify adding or extending the duration of ADT, following their experience with this treatment.

Methods and Materials

Men receiving ADT with definitive RT completed a questionnaire asking about the side effects and degree of bother from ADT using a 4 point scale. They were also asked about regret, and what survival benefit would warrant ADT.

Results

846 patients received definitive RT, of whom 356 received ADT and were asked about their experience with ADT. Of these, 234 responded (66%). In 54%, ADT caused some bother, most commonly hot flushes (32%), fatigue (29%) and sexual problems (29%). 5% regretted receiving ADT "quite a lot" or "very much". Approximately one third of men deemed a 1% OS benefit from ADT worthwhile, whilst one third (34%) would want a >10% OS benefit enough to justify choosing ADT again. 49% of patients who received short-term ADT would accept longer duration ADT for a 6% OS benefit.

Conclusions

Significant regret for ADT was low (5%). There was a clear dichotomy between those who deemed any OS benefit from ADT worthwhile versus those who needed a significant survival benefit to justify the side effects. Given that some men may change their opinion on the relative value of ADT after experiencing its effects, this study emphasises the importance of re-visiting patients after 6 months to given patients an opportunity to re-negotiate their treatment.

Introduction

Combining androgen deprivation therapy with definitive dose-escalated radiation therapy (RT) has been shown to improve metastasis-free survival, overall survival, and biochemical failure in men with localized prostate cancer (PCa) [1,2]. Yet it remains unclear whether men who have been through the experience of ADT *themselves* believe the benefits justify its side effects[3], which include hot flushes, sexual dysfunction and weight gain[4]. These symptoms are a burden for patients whilst reducing health-related quality of life (HQOL) [2,5, 6, 7], mitigating patient and practitioner enthusiasm for ADT. Despite this, we identified no long-term follow-up studies which investigated whether men regretted the ADT component of their treatment.

Patients have few resources to draw upon when deciding about the duration of ADT treatment. Although both the RTOG9202[8] and DART01/05[9] trials demonstrated men with high risk PCa gain a survival benefit from a longer course of ADT, there is limited evidence on whether patients feel that the degree of side effects justifies the improvement seen. A recent meta-analysis suggested long-term ADT (LTADT)

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(duration of 18-36 months) increases 10-year overall survival (OS) by approximately 6% compared to short-term ADT (STADT) (duration of 4-6 months) [1]. Consequently, one of our aims was to investigate whether men treated with short-term ADT would have preferred to extend their ADT treatment for this degree of survival benefit. Thus, this study aimed to understand what patients (who have been through the experience of ADT themselves) think of the risk-benefit balance when comparing RT alone, STADT and LTADT.

LDR brachytherapy offers superior tumor control to single-fraction HDR prostate brachytherapy: A prospective study - Jimenez-Garcia - The Prostate - Wiley Online Library

Isabel E. Jimenez-Garcia PhD, Sebastia Sabater MD, PhD, Rocio Martinez-Gutierrez PhD, Pedro Sanchez-Galiano BsC, Roberto Berenguer-Serrano BsC … See all authors

First published: 07 May 2023
https://doi.org/10.1002/pros.24548

Abstract

Purpose

To compare the clinical outcomes of single-fraction high-dose-rate (HDR) brachytherapy and single-fraction low-dose-rate (LDR) brachytherapy as the sole treatment for primary prostate cancer.

Material and Methods

A quasi-randomized study that allocated, *from March 2008 to February 2012*, 129 low and intermediate risk prostate cancer patients to one single-fraction HDR of 19 Gy (61 patients) or to a 145 Gy ^{125}I LDR permanent implant (68 patients. Biochemical relapse-free survival (bRFS) and overall survival (OS) were compared using the Kaplan–Meier method and Cox regression analysis.

Results

After a median follow-up of 72 months in the HDR group, 26 patients relapsed, and after a median follow-up of 84 months in the LDR group, 7 patients relapsed ($p < 0.0001$). The 5-year bRFS was significantly better for the LDR group than for the HDR group (93.7% and 61.1%, respectively) ($p < 0.0001$). The 5-year OS also was significantly better in the LDR group (95.5% vs. 89.9%) ($p = 0.0436$).

Conclusions

Permanent LDR prostate implant brachytherapy offers better clinical outcomes than single-fraction HDR for prostate cancer.

Too Many Older Men Are Still Screened for Prostate Cancer—New York Times

By Paula Span
May 8, 2023, 5:00 a.m. ET

Last summer, Joe Loree made an appointment to see his urologist. He'd occasionally noticed blood in his urine and wanted to have that checked out. His doctor ordered a prostate-specific antigen, or P.S.A., test to measure a protein in his blood that might indicate prostate cancer — or a number of more benign conditions.

"It came back somewhat elevated," said Mr. Loree, 68, an instructional designer who lives in Berkeley, Calif. A biopsy found a few cancer cells, "a minuscule amount," he recalled.

Mr. Loree was at very low risk, but nobody likes hearing the c-word. "It's unsettling to think there's cancer growing within me," he said.

But because his brother and a friend had both been diagnosed with prostate cancer and had undergone aggressive treatment that he preferred to avoid, Mr. Loree felt comfortable with a more conservative approach called active surveillance.

It typically means periodic P.S.A. assessments and biopsies, often with M.R.I.s and other tests, to watch for signs that the cancer may be progressing. His hasn't, so now he can get P.S.A. tests every six months instead of eve-

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ry three.

Research shows that a growing proportion of men with low-risk prostate cancer are opting for active surveillance, as medical guidelines now recommend.

The diagnosis used to lead directly to aggressive treatment. As recently as 2010, about 90 percent of men with low-risk prostate cancer underwent immediate surgery to remove the prostate gland (a prostatectomy) or received radiation treatment, sometimes with hormone therapy.

But between 2014 and 2021, the proportion of men at low risk of the cancer who chose active surveillance rose to nearly 60 percent from about 27 percent, according to a study using data from the American Urological Association's national registry.

"Definitely progress but it's still not where we need to be," said Dr. Matthew Cooperberg, a urologic oncologist at the University of California, San Francisco, and lead author of the study.

Changing medical practice often takes a frustratingly long time. In the study, 40 percent of men with low-risk prostate cancer still had invasive treatment. And approaches vary enormously between urology practices.

The proportion of men under active surveillance "ranges from 0 percent to 100 percent, depending on which urologist you happen to see," Dr. Cooperberg said. "Which is ridiculous."

The latest results of a large British study, recently published in the New England Journal of Medicine, provide additional support for surveillance. Researchers followed more than 1,600 men with localized prostate cancer who, from 1999 to 2009, received what they called active monitoring, a prostatectomy or radiation with hormone therapy.

Over an exceptionally long follow-up averaging 15 years, fewer than 3 percent of the men, whose average age at diagnosis was 62, had died of prostate cancer. The differences between the three treatment groups were not statistically significant.

Although the cancer in the surveillance group was more likely to metastasize, it didn't lead to higher mortality. "The benefit of treatment in this population is just not apparent," said Dr. Oliver Sartor, an oncologist at the Mayo Clinic who specializes in prostate cancer and who wrote an editorial accompanying the study.

"It doesn't help people live longer," Dr. Sartor said of the treatment, probably because of what is known as competing mortality, the likelihood of dying from something else first.

Men whose P.S.A. readings and other test results indicate higher-risk tumors, or who have family histories of prostate cancer deaths, fall into a different category, experts cautioned.

"The point of screening is to find the aggressive tumors — a small minority, but they kill more men than any other cancer except lung cancer," Dr. Cooperberg said.

But most prostate cancer grows so slowly, if it grows at all, that other illnesses are likely to prove lethal first, especially among older men. During the British study, one in five men died from other causes, predominantly cardiovascular or respiratory diseases and other cancers.

That's why guidelines from the U.S. Preventive Services Task Force and the American College of Physicians recommend against routine prostate cancer screening for men over 69 or 70, or for men who have less than a 10- to 15-year life expectancy. (Men ages 55 to 69 are advised to discuss the harms and benefits with health care providers before deciding to be screened.)

Newly revised guidelines from the American Urological Association recommend shared decision-making after age 69, taking into account age, life expectancy, other risk factors and patients' preferences.

"If you live long enough, prostate cancer is almost a normal feature of aging," Dr. Cooperberg explained. "By the 70s or 80s, half of all men have some cancer cells in their prostates."

Most of those tumors are deemed "indolent," meaning that they don't spread or cause bothersome symptoms.

Nevertheless, about half of men over 70 continue P.S.A. screening, according to a new study in JAMA Network Open. Though testing declined with age, "they really shouldn't be getting screened at this rate," said the lead author Sandhya Kalavacherla, a medical student at the University of California, San Diego.

Even among men over 80, almost 40 percent were still getting routine P.S.A. tests. An elevated P.S.A. reading can prompt a cascade of subsequent tests and treatments, because "'cancer' is an emotionally charged term," Dr. Sartor acknowledged. He still sees patients, he said, whose response to very low-risk cancer is, "I want it out, now."

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But treatment involves significant side effects, which often ease after the first year or two but may persist or even intensify. The British data showed, for instance, that six months after treatment, urinary leakage requiring pads affected roughly half of the men who'd had a prostatectomy, compared to 5 percent of those who underwent radiation and 4 percent of those under active surveillance.

After six years, 17 percent of the prostatectomy group still needed pads; among those under active surveillance, it was 8 percent, and 4 percent in the radiation group.

Similarly, men under active surveillance were more likely to retain the ability to have erections, though all three groups reported decreased sexual function with age. After 12 years, men in the radiation group were twice as likely, at 12 percent, to report fecal leakage as men in the other groups.

The financial costs of unnecessary testing and treatment also run high, as an analysis of claims from a large Medicare Advantage program demonstrate. The study, recently published in JAMA Network Open, looked at payments for regular P.S.A. screening and related services for men over 70 with no pre-existing prostate problems.

"The initial screening, which is unnecessary, triggers these follow-up services, a series of events catalyzed by anxiety," said David Kim, a health economist at the University of Chicago and lead author of the study. "The further it progresses, the harder it is to stop."

From 2016 to 2018, each dollar spent on a P.S.A. test on men over 70 generated another $6 spent for additional P.S.A. tests, imaging, radiation and surgery.

Extrapolated to traditional Medicare beneficiaries, Medicare could have spent $46 million for P.S.A. tests for men over 70 and $275 million in follow-up care, Dr. Kim said.

"We need to change the incentives, how providers get paid," he said.

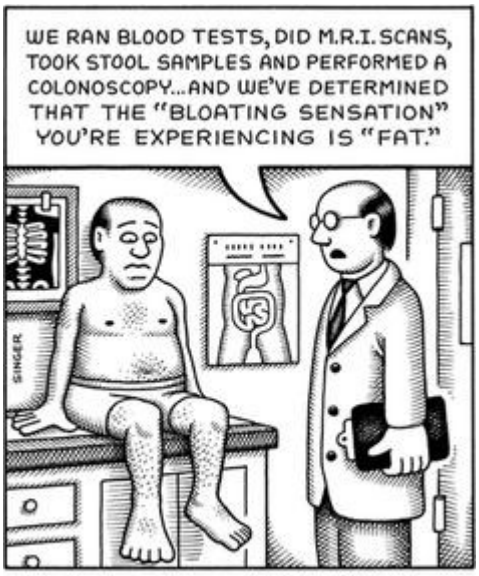
He suggested that refusing to reimburse them for procedures that receive low recommendations from the U.S. Preventive Services Task Force could mean fewer inappropriate P.S.A. tests and less aggressive treatment in their wake.

Some urologists and oncologists have called for a different kind of shift — in nomenclature. "Why are we even calling it 'cancer' in the first place?" asked Dr. Sartor, who has argued against using the word for small, low-risk tumors in the prostate.

A less frightening label — indolent lesions of epithelial origin, or I.D.L.E., was one suggestion — could leave patients less inclined to see test results as lethal portents and more willing to carefully track a common condition that might never lead to an operating room or a radiation center.

On the Lighter Side

"Pump vigorously if you feel a palpitation. We're still battling with your insurance company for a better pacemaker."



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NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Gene Van Vleet and Bill Lewis is available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org or Bill 619-591-8670 (bill@prostatecancerhelp.info) to coordinate.

Member 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: https://ipcsg.org/personal-experience

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!

DIRECTIONS TO MEETINGS

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.

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