

### Prostate-Specific Antigen (PSA) Test

#### Key Points

- The PSA test measures the blood level of PSA, a protein that is produced by the prostate gland. The higher a man's PSA level, the more likely it is that he has prostate cancer. However, there are additional reasons for having an elevated PSA level, and some men who have prostate cancer do not have elevated PSA.
- The PSA test has been widely used to screen men for prostate cancer. It

is also used to monitor men who have been diagnosed with prostate cancer to see if their cancer has recurred (come back) after initial treatment or is responding to therapy.

- Some advisory groups now recommend against the use of the PSA test to screen for prostate cancer because the benefits, if any, are small and the harms can be substantial. None recommend its use without a detailed discussion of the

pros and cons of using the test.

#### 1. What is the PSA test?

Prostate-specific antigen, or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man's blood. For this test, a blood sample is sent to a laboratory for analysis. The results are usually reported as nanograms of PSA per milliliter (ng/mL) of blood.

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*Thanks!*

**Next Meeting:** June 18, 2015

Edith Mulhall,

Lymphedema Assoc. of MB

**Topic:** Lymphedema Basics

**Location:** Main Floor Auditorium

Seven Oaks General Hospital

Leila and McPhillips

**Time:** 7 – 9 p.m.



*The Manitoba Prostate Cancer Support Group  
does not recommend treatment modalities,  
medications, or physicians.*

**MPCSG – active since 1992.**

Thought of The Day

*Money can't buy happiness - - but somehow it's more comfortable to cry in a Cadillac than in a Yugo.*

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The blood level of PSA is often elevated in men with prostate cancer, and the PSA test was originally approved by the FDA in 1986 to monitor the progression of prostate cancer in men who had already been diagnosed with the disease. In 1994, the FDA approved the use of the PSA test in conjunction with a digital rectal exam (DRE) to test asymptomatic men for prostate cancer. Men who report prostate symptoms often undergo PSA testing (along with a DRE) to help doctors determine the nature of the problem.

In addition to prostate cancer, a number of benign (not cancerous) conditions can cause a man's PSA level to rise. The most frequent benign prostate conditions that cause an elevation in PSA level are prostatitis (inflammation of the prostate) and benign prostatic hyperplasia (BPH) (enlargement of the prostate). There is no evidence that prostatitis or BPH leads to prostate cancer, but it is possible for a man to have one or both of these conditions and to develop prostate cancer as well.

## 2. Is the PSA test recommended for prostate cancer screening?

Until recently, many doctors and professional organizations encouraged yearly PSA screening for men beginning at age 50. Some organizations recommended that men who are at higher risk of prostate cancer, including African American men and men whose father or brother had prostate cancer, begin screening at age 40 or 45. However, as more has been learned about both the benefits and harms of prostate cancer screening, a number of organizations have

begun to caution against routine population screening. Although some organizations continue to recommend PSA screening, there is widespread agreement that any man who is considering getting tested should first be informed in detail about the potential harms and benefits.

## 3. What is a normal PSA test result?

There is no specific normal or abnormal level of PSA in the blood. In the past, most doctors considered PSA levels of 4.0 ng/mL and lower as normal. Therefore, if a man had a PSA level above 4.0 ng/mL, doctors would often recommend a prostate biopsy to determine whether prostate cancer was present.

However, more recent studies have shown that some men with PSA levels below 4.0 ng/mL have prostate cancer and that many men with higher levels do not have prostate cancer. In addition, various factors can cause a man's PSA level to fluctuate. For example, a man's PSA level often rises if he has prostatitis or a urinary tract infection. Prostate biopsies and prostate surgery also increase PSA level. Conversely, some drugs—including finasteride and dutasteride, which are used to treat BPH, lower a man's PSA level. PSA level may also vary somewhat across testing laboratories.

PSA-(Prostate-specific antigen) is a protein that is produced by prostate gland cells.

PSA test measures the level of PSA in man's blood.

Another complicating factor is that studies to establish the normal range of PSA levels have been conducted primarily in populations of white men. Although expert opinions vary, there is no clear consensus regarding the optimal PSA threshold for recommending a prostate biopsy for

men of any racial or ethnic group. In general, however, the higher a man's PSA level, the more likely it is that he has prostate cancer. Moreover, continuous rise in a man's PSA level over time may also be a sign of prostate cancer.

## 4. What if a screening test shows an elevated PSA level?

If a man who has no symptoms of prostate cancer chooses to undergo prostate cancer screening and is found to have an elevated PSA level, the doctor may recommend another PSA test to confirm the original finding. If the PSA level is still high, the doctor may recommend that the man continue with PSA tests and DRE's at regular intervals to watch for any changes over time.

If a man's PSA level continues to rise or if a suspicious lump is detected during a DRE, the doctor may recommend additional tests to determine the nature of the problem. A urine test may be recommended to check for a urinary tract infection. The doctor may also recommend imaging tests, such as a transrectal ultrasound, x-rays or cystoscopy.

If prostate cancer is suspected, the doctor will recommend a prostate biopsy. During this procedure, multiple samples of prostate tissue are collected by inserting hollow needles into the prostate and then withdrawing them. Most often, the needles are inserted through the wall of the rectum. A pathologist then examines the collected tissue under a microscope. The doctor may use ultrasound to view the prostate during the biopsy, but ultrasound cannot be used alone to diagnose prostate cancer.

## 5. What are some of the limitations

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### **and potential harms of the PSA test for prostate cancer screening?**

#### **Detecting prostate cancer early may not reduce the chance of dying from prostate cancer.**

When used in screening, the PSA test can help detect small tumors that do not cause symptoms. Finding a small tumor, however, may not necessarily reduce a man's chance of dying from prostate cancer. Some tumors found through PSA testing grow so slowly that they are unlikely to threaten a man's life. Detecting tumors that are not life threatening is called "overdiagnosis" and treating these tumors is called "overtreatment."

Overtreatment exposes men unnecessarily to the potential complications and harmful side effects of treatments for early prostate cancer, including surgery and radiation therapy. The side effects of these treatments include urinary incontinence, problems with bowel function, erectile dysfunction and infection.

In addition, finding cancer early may not help a man who has a fast-growing or aggressive tumor that may have spread to other parts of the body before being detected.

**The PSA test may give false-positive or false-negative results.** A false-positive test result occurs when a man's PSA level is elevated but no cancer is actually present. A false-positive test result may create anxiety for a man and his family and lead to additional medical procedures, such as a prostate biopsy, that can be harmful. Possible side effects of biopsies include serious infections, pain, and bleeding.

Most men with an elevated PSA level turn out not to have prostate cancer; only about 25 percent of men who have a prostate biopsy due to an elevated PSA level actually have prostate cancer.



A false-negative test result occurs when a man's PSA level is low even though he actually has prostate cancer. False-negative test results may give a man, his family, and his doctor false assurance that he does not have cancer, when he may in fact have a cancer that requires treatment.

#### **6. What research has been done to study prostate cancer screening?**

The United States Preventive Services Task Force has analyzed data from 2 large trials and estimated the following results. They state that for every 1,000 men ages 55 to 69 years who are screened every 1 to 4 years for a decade:

- 0 to 1 death from prostate cancer would be avoided.
- 100 to 120 men would have a false-positive test result that leads to a biopsy, and about one-third of the men who get a biopsy would experience at least moderately bothersome symptoms from the biopsy.
- 110 men would be diagnosed with

prostate cancer. About 50 of these men would have a complication from treatment, including erectile dysfunction in 29 men, urinary incontinence in 18 men, serious cardiovascular events in 2 men, deep vein thrombosis or pulmonary embolism in 1 man, and death due to the treatment in less than 1 man.

#### **7. How is the PSA test used in men who have been treated for prostate cancer?**

The PSA test is used to monitor patients who have a history of prostate cancer to see if their cancer has recurred (come back). If a man's PSA level begins to rise after prostate cancer treatment, it may be the

first sign of a recurrence. Such a "biochemical relapse" typically appears months or years before other clinical signs and symptoms of prostate cancer recurrence.

However, a single elevated PSA measurement in a patient who has a history of prostate cancer does not always mean that the cancer has come back. A man who has been treated for prostate cancer should discuss an elevated PSA level with his doctor. The doctor may recommend repeating the PSA test or performing other tests to check for evidence of a recurrence. The doctor may look for a trend of rising PSA level over time rather than a single elevated PSA level.

#### **8. What does an increase in PSA level mean for a man who has been treated for prostate cancer?**

If a man's PSA level rises after prostate cancer treatment, his doctor will consider a number of factors before recommending

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further treatment. Additional treatment based on a single PSA test is not recommended. Instead, a rising trend in PSA level over time in combination with other findings, such as an abnormal result on imaging tests, may lead a man's doctor to recommend further treatment.

### 9. How are researchers trying to improve the PSA test?

Scientists are investigating ways to improve the PSA test to give doctors the ability to better distinguish cancerous from benign conditions and slow-growing cancers from fast-growing, potentially lethal cancers. Some of the methods being studied include:

- **Free versus total PSA.** The

amount of PSA in the blood that is "free" (not bound to other proteins) divided by the total amount of PSA (free plus bound). Some evidence suggests that a lower proportion of free PSA may be associated with more aggressive cancer.

- **PSA density of the transition zone.** The blood level of PSA divided by the volume of the transition zone of the prostate. The transition zone is the interior part of the prostate that surrounds the urethra. Some evidence suggests that this measure may be more accurate at detecting prostate cancer than the standard PSA test.

- **Age-specific PSA reference ranges.** Because a man's PSA level tends to increase with age, it has been suggested that the use of age-specific

PSA reference ranges may increase the accuracy of PSA tests. However, age-specific reference ranges have not been generally favored because their use may delay the detection of prostate cancer in many men.

- **PSA velocity and PSA doubling time.** PSA velocity is the rate of change in a man's PSA level over time, expressed as ng/mL per year. PSA doubling time is the period of time over which a man's PSA level doubles. Some evidence suggests that the rate of increase in a man's PSA level may be helpful in predicting whether he has prostate cancer.

*Source: National Cancer Institute*

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## Len Bueckert

Len Bueckert has decided to retire from the Board of the Manitoba Prostate Cancer Support Group. He joined our Board in July 2010 and held a variety of positions – most recently as Chair of the Presentations Committee.

As well as assisting our Support Group, Len had an interest in the National Prostate Cancer Canada Network organization. He spent 18 months serving on a steering committee working hard to make some changes that would benefit men and Support Groups across the country. Len attended a Regional Conference in Huntsville, Ont. and a PCCN National Conference in Regina, Sask.

Locally, Len worked on the CancerCare MB Foundation Gala dinner committee for several years. He has a great interest in finance and was keen to raise funds for prostate cancer research as well as assisting men at the local level.

The Board wishes to recognize Len for his years of commitment to our Support Group. Len always had ideas to share and made a significant contribution to our discussions. His heart was always focused on how to make things better for others. The Board will miss his involvement and wish to thank Len for his dedication. We wish him well!

## Sugar And Cancer: What's the link?

Concerned about sugar?

*You're not alone.*

Many popular diets target this simple carbohydrate as a dietary villain. The volume of information on sugar and health can be overwhelming and sometimes misleading.

“Carbohydrates, which break down into glucose, are the primary fuel source for your body. You require a normal level of glucose in your bloodstream to maintain body function,” says Clare McKindley, clinical dietitian at MD Anderson’s Cancer Prevention Center.

You get sugar naturally in foods like fruits, vegetables and dairy products, which are packed with nutrients like fiber, vitamins and minerals essential for a healthy diet.

Added sugars are a different story. Sugars that are added to foods and beverages translate to extra calories. Those added calories can have an impact on your health.

### The problem with added sugar

While sugar doesn’t contain unique metabolic qualities that cause weight gain, it does provide additional and unnecessary calories without additional nutritional benefit. This can result in weight gain.

The link between obesity and several types of cancer is well established. The American Institute for Cancer research says consuming less sugary drinks and energy dense foods is among the top ways to reduce your cancer risk.

Energy dense foods tend to be processed foods with sugar and fat to improve the taste. The result is more calories per ounce.

So how much added sugar is too much?

The American Heart Association recommends no more than six teaspoons of added sugar per day for women and nine teaspoons per day for men. That adds up to about 100 calories for women and 150 calories for men.

Americans consume significantly more than that. The average person eats about 22 teaspoons of added sugar per day. That adds up to nearly 2,500 calories a week.



### Tips for cutting added sugar

If you want to eat a healthy diet low in added sugar, our experts urge you to cut back on processed foods. “You should consume whole foods and reduce processed foods whenever possible,” says Diana Bearden, clinical nutrition supervisor at MD Anderson. “For example, a fresh peach is a whole food, but a canned peach in syrup is a processed food with added sugar.”

While tracking added sugar can be tricky – manufacturers don’t list it by teaspoons on their labels – taking the time to do it is a healthy choice.

McKindley suggests several ways to trim sugar from your diet.

#### 1. Shop on the perimeter of store.

Whole foods like fresh fruits and vegetables are on the outer edges of the supermarket and provide more nutrients than processed foods. You also can study your receipt after you check out. Highlighting the processed foods will help you identify your vulnerabilities.

2. **Check labels.** If sugar is one of the top three ingredients, think about making a better choice. Keep in mind that sweeteners come in a variety of names, including fructose, lactose and sucros
3. **Slowly taper the amount of sugar.** Look for the food products you eat that have the highest sugar content and replace them with something healthier. For example, try a baked apple with some cinnamon instead of cake or pie for desert. Also, try to put one less packet of sugar in your coffee or tea.
4. **Cook from scratch.** Making things from scratch gives you more control over your ingredients. And you can make healthy substitutions.
5. **Mind what you drink.** Soda, sports and energy drinks can be loaded with sugar. So, check your beverage label closely. Also, watch the fruit juice. While it may not contain added sugar, the sugar in juice is concentrated, and many of the nutrients of the original whole food, like fiber, may have been removed. Try to drink more water. And for more flavor, add fresh cut fruit to your water glass.

The bottom line: Reducing added sugars is a good step in improving your diet, reducing your calorie intake and maintaining a healthy weight.

Source: MD Anderson Cancer Center - 2015

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## MRI - Guiding Future of Prostate Cancer Diagnosis

Most prostate cancer experts aren't ready to call the incorporation of MRI fusion into prostate biopsies the gold standard in prostate cancer imaging and diagnosis. But they envision a day when it will be.

Generally, MRI-ultrasound fusion biopsy involves taking an MRI, then, at a separate appointment, fusing these data with real-time ultrasound images to help guide biopsy procedures.

"The beauty of it is that it brings the MRI into the clinic, where urologists can perform targeted biopsies in much the same way they do standard transrectal ultrasound [TRUS] biopsies," said Leonard S. Marks, MD, professor of urology at UCLA, where nearly 1,200 biopsies using the new technology have been performed since 2009.

### Fusing accuracy, confidence

Fusion biopsies deliver important clinical advantages, including use in men with a rising PSA despite multiple negative biopsies. "In the battle against prostate cancer, our difficulty as physicians is selecting the right patients to biopsy, screen, and treat," said Dr. Art Rastinehad, assistant professor of urology at Hofstra North Shore-LIJ School of Medicine in New York.

In men with a PSA of 4.0 to 10.0 ng/mL, Dr. Rastinehad said, the typical 12-core TRUS biopsy finds cancer 27% to 40% of the time, leaving around 70% of men with a negative biopsy—but not necessarily free of prostate cancer. "In our cohort overall," said Dr. Rastinehad, "fifty-five percent of patients had clinically significant cancer. So the impact of high-quality MRI is that we're selecting more patients with higher-grade and higher-volume disease for biopsies. One of our future goals is to incorporate the MRI into the screening paradigm to possibly allow some men to avoid biopsy altogether."

Fusion biopsies yield a much lower false-negative rate than random 12-core

biopsies, said Samir Taneja, MD, professor of urology and radiology and director of the division of urologic oncology at New York University, where physicians have used the Artemis system to perform approximately 460 fusion biopsies. "If you're sampling the most suspicious area of the prostate," Dr. Taneja explained, "then it's unlikely you've missed a significant cancer. Over time, we believe that reduces the need for repeat biopsies.

"We believe that when we use the fusion biopsy technique, we are more able to target smaller abnormalities on MRI and lesions in tough spots like the anterior prostate and the apex than we would have been by sheer visual estimation of the location of an MRI abnormality. And that's in fact what our recently published data show," said Dr. Taneja. Ultimately, said Dr. Taneja, "If you were only to do targeted biopsies, we believe it lowers the likelihood that you will find small, indolent cancers or clinically insignificant cancers."

"The advantage of having MRI is that we see the whole gland. This cuts down on the sampling error that you get with a systematic biopsy, where even if you do 18 to 20 cores, you're only sampling a very small portion of the gland," he said.

Regarding whether MRI can spot all prostate cancers, Dr. Kurhanewicz said, "Absolutely not. We know that systematic TRUS biopsies often detect small amounts of disease that we don't see on MP-MRI imaging. We don't know if that's good or bad. We know we're over diagnosing prostate cancer when we diagnose a lot of clinically insignificant disease."

The MRI-TRUS fusion approach allows one to perform a combination of systematic and targeted biopsies with MR guidance in the urologist's office. "The MR guidance will give you confidence that you're not missing any large, significant tumors with your biopsy approach. That's probably its

biggest advantage clinically," said Dr. Kurhanewicz.

### Setting the standard

Accordingly, experts interviewed by say the key question is not whether MR guidance including fusion biopsy will become the gold standard in prostate cancer detection, but when.

"Although fusion biopsies are too new to be pronounced a gold standard, use of MRI in evaluating men who have had multiple repeat biopsies should ultimately be a standard of care," said Dr. Taneja, predicting that this will happen within 2 to 3 years. "Also during that time frame, the use of MRI in prostate cancer detection and treatment will completely change the paradigm by which we think of prostate cancer—the way we detect it, assess its risk, and treat it. This will completely change the approach to prostate cancer from one-size-fits-all to a very individualized approach."

"We're still awaiting a true randomized, controlled trial to determine the cancer detection rates of this new proposed paradigm using an MRI as an intermediary step to sub-stratify a patient's risk of cancer prior to a biopsy and then comparing this to the standard TRUS biopsy approach," said Dr. Rastinehad.

"As with PCs in 1975," said Dr. Marks, "there are some deniers, but not many once they see the dramatic results of fusion-guided biopsies. Despite the cost, the learning curve, the new technology, and the time investment, the train has left the station."

In fact, he said that his department believes MRI-ultrasound fusion represents the gold standard for prostate biopsies today.

*Source: Urology Times 2014*

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## Carrots Have Anti-Prostate Cancer Properties!

**Have you ever seen a rabbit with glasses or with prostate cancer or with constipation or high blood pressure?!**

### BOTTOM LINE

Carrots are low in calories, high in fiber and potassium and contain natural salicylates (aspirin-like compounds), which is why they may have anti-prostate cancer properties.

### WHAT ELSE DO I NEED TO KNOW?

Numerous fruits and vegetables have and continue to receive plenty of attention because of their ability to potentially reduce prostate cancer risk. However, despite 10 completed studies no summarized conclusion over carrot intake has been completed. So, a meta-analysis was conducted utilizing data from 8 casecontrol and 2 cohort studies. The quality of each study was determined by 2 investigators who rated every study using a standardized scoring system. A significant 18% reduction in the risk of prostate cancer was associated with an increased intake of carrots. The dose-response analysis showed that for each serving per week (10 gram increment) of carrot consumption the risk of prostate cancer was reduced by 5%. No evidence of a publication bias existed for overall past studies on carrots. Thus, there was not only a hint of carrots to prevent prostate cancer, but I also believe this data suggests they may reduce the risk of prostate cancer recurrence after treatment.

Remember all the folks that got excited about tomatoes and lycopene only to realize the benefit was not that great. Next came cruciferous veggies (aka broccoli and others that kids love to eat daily - sarcasm alert...although have you ever had steamed broccoli with a lot of butter - yummy!).

Recently, it was all about the pomegranate and I bet that will also get humbled in some way. When are we going to learn that eating healthy, being healthy and whatever eating patterns help someone reach that point will be associated with a reduction in the risk of prostate cancer. Carrots are awesome but simply do not have the publicity dollars of pomegranate nor the money to throw at researchers around the world to make them look good. Arguably, carrots are as healthy as any other healthy food. They are loaded with fiber, low in calories, contain one of the highest concentration of natural salicylates (aka aspirin) versus any food/beverage and they are one of the biggest friends of the urologist because they contain one of the highest concentrations of potassium and very little sodium. How cool is that! Of course they are known primarily for their beta-carotene and vitamin A and maintaining good eye health (ever seen a rabbit with poor eyesight - nope!). Researchers focused on the beta-carotene and vitamin A as a potential mechanism of disease reduction but I disagree. It's time to move away from the cliché or jaded nutrition profile of carrots and talk about the other stuff (fiber, salicylates, calories, potassium ...). Still, the carrot has a few other problems to deal with besides the vitamin A permanent tag.

They were ridiculed during the low carbohydrate movement as being high in glycemic load (aka causing a large insulin response) but that turned out to be false when looking at a normal or moderate carrot intake.

Carrots are boring because they have been around a long time and they aren't "sexy" like the newer more expensive and exotic fruits and vegetables. Regardless, what research has taught us through the years is that it is precisely the boring and nonsexy

advice (lower blood pressure, cholesterol, exercise, no tobacco...) that has stood the test of time and has the greatest impact on reducing disease risk and improving life expectancy - not the latest and greatest anti-aging food or high antioxidant juice that comes and goes with time like the latest celebrity gossip. So, at my house and when talking to patients, boring is the new cool and carrots (not stripped of their outside fiber) will always take up more space in the refrigerator compared to pomegranate, lycopene, resveratrol, fish oil, krill pills or any other product du jour will ever hope to occupy! Oh and by the way I put in a call to Bugs Bunny the other day and asked him a few questions and he told me he is now approximately 75 years old (debut was in a film in 1940 called "A Wild Hare") and he has never needed glasses, Metamucil, prostate cancer treatment or hypertensive medications. What's up with that doc!

Written by Mark A. Moyad,  
MD, MPH, Univ. of Michigan.

**Source:** [www.paactususa.org](http://www.paactususa.org)  
(Patient Advocates for  
Advanced Cancer Treatments)

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Brian Sprott visits with Motorcycle Ride For Dad members at the April 2nd Kick-off at McPhillips Street Casino. *Picture courtesy of Board member, Joseph Borsa.*



**Special Thanks**

Motorcycle Ride For Dad has recently made a very generous donation to our Support Group. Their annual fund raising ride is dedicated to assisting prostate cancer research and giving support to those affected with the disease. Our Board wishes to acknowledge Motorcycle Ride For Dad and extend our sincere appreciation for their donation. Our work in the community has been enhanced due to their kindness.

*Thank you.*



Board members attending the MRFD Kick-off were (l to r) John and Betty O'Grodnik, Brian and June Sprott and Al Petkau. *Picture courtesy of Joseph Borsa.*

Email - [manpros@mts.net](mailto:manpros@mts.net)

ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL

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**2015 MEETINGS**

- Jan. 15 Dr. Rashmi Koul**, Radiation Oncologist  
Topic: Prostate Cancer and Bone Health
- Feb. 19 Bill Martin**, Gimli Author  
Topic: Ripped Out: One Man's Journey Surviving PCa
- Mar. 19 Dr. Robert Wightman**, Pathologist  
Topic: Biopsy Report and its Role in Determining Therapy
- Apr. 16 Dr. Sabeer Rehsia**, Urologist  
Topic: Biochemical Recurrence: What are Your Options?
- May 21 Dr. Paul Daeninck**, Medical Oncologist  
Topic: Medical Marijuana: Is This "Bud" For You?
- June 18 Edith Mulhall**, Lymphedema Assoc. of Manitoba  
Topic: Lymphedema Basics
- July No Meeting**
- Aug. 20 Dr. Reece Malone**, Sexuality Educator  
Topic: Reclaiming Intimacy and Nurturing Connection after Prostate Cancer.
- Sept.17 Prostate Cancer Awareness Evening** at Caboto Centre - 1055 Wilkes Ave. 7 – 9 pm  
**Dr. Rashmi Koul**, Radiation Oncologist  
**Dr. Piotr Czaykowski**, Medical Oncologist
- Oct. 15 Dr. Kelli Berzuk**, Incontinence Physiotherapist  
Topic: Living With Incontinence: Do I Have To?
- Nov. 19 Christmas Pot Luck Party**
- Dec. No Meeting**

All meetings 7 – 9 p.m. at  
 Seven Oaks General Hospital Auditorium  
 (except September)  
 Everyone Welcome

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