Make an In Memoriam Donation

Consider making a gift in memory of a loved one who has died of prostate cancer. While flowers are beautiful, many people today prefer to make memorial contributions in honour of a loved one’s memory. A tax receipt will be issued upon receipt of a donation.

Newsrelease

Dr. Yosh Taguchi to receive Outstanding Contribution Award from the Prostate Cancer Canada Network – Montreal West Island

Dr. Taguchi addressing an audience from a podium at a recent cancer conference.

(Cont’d on p. 2)

Special Appeal

Please help us continue producing and distributing our Newsletter through a tax deductible donation. At recent Steering Committee meetings, due to reduced contributions from corporate sponsors, and the sharp rise in the cost of mailing the Newsletter prompted us to thoroughly consider ways whereby we could reduce (cont’d on p 7)

Support your local prostate cancer support group – PCCN - Montreal West Island through a financial contribution (tax deductible) to support our activities or through your direct involvement in our functions.

Our Website

Be sure to check out our website. Our internet address is http://mtlwiprostcansupportgrp.ca/ The website provides information about our group, links to PCCN and Procure and gives access to current and past issues of our newsletter as well as up-to-date information about our meetings and other items of interest. Check it out and give us your feedback. Our Director Monty Newborn is the creator and manager of the site and our WEBMASTER.
Newsrelease (con’t from p1)

At its upcoming Annual General Meeting on April 24, 2014, Dr. Yosh Taguchi will receive the 2014 Outstanding Contribution Award from the Prostate Cancer Canada Network – Montreal West Island. He is receiving the award from the prostate cancer support group “in appreciation of his distinguished career dedicated to the treatment of so many of us in the Montreal area so afflicted.”

Dr. Taguchi, born in Japan, came to Canada just before the age of four. During the Second World War, and from the age of eight to twelve, he was interned in a camp with others of Japanese origin. Following the war, his family moved to Montreal. He subsequently went to McGill University where he carried out his undergraduate studies, receiving a Bachelor of Science (with Honours) in 1955. He graduated from McGill’s Medical School four years later and then continued there for another five years of training in urology. From 1964 through 1970, he had a fellowship leading to a Ph. D. in Immunology at McGill. His research was related to organ transplantation. His long career has been spent at the Royal Victoria Hospital, where he has helped train over a hundred urologists, typically two a year. These include a number of prominent urologists currently practicing all around the world. He was Program Director and held the title of Associate Professor in McGill’s Department of Surgery, Division of Urology for many years.

Dr. Taguchi performed his first surgery, then as a trainee, in 1960, and his first as a practicing surgeon in 1966. During his long career, he performed over 10000 operations, including over 2000 prostatectomy operations, almost all to men in the Montreal area. For his excellence as a teacher, he received a Best Teacher Award in 1990. During his career, he introduced new surgical techniques, including the use of the Taguchi U-stitch, a technique used in transplantation to join the kidney to the bladder. He also developed surgery tools for others and himself that made prostatectomies more successful.

As evidence of his stature in his field, in September of 2011 McGill University’s Faculty of Medicine announced the creation of the $1 million Yosh Taguchi Chair in Urology. The chair was established thanks to the generosity of businessman and philanthropist Lucien Rémillard. It was intended to focus on cancer-related research in urology.

Dr. Taguchi has published three important books:

Private Parts: An Owner’s Guide to the Male Anatomy, The Prostate: Everything you Need to Know about the Man Gland, and Zen in Action: A Surgeon Reveals his Life Philosophy. In addition, he has published numerous scientific papers including one as recent as last year in the journal Cancer Medicine entitled “Early detection of clinically significant prostate cancer at diagnosis: a prospective study using a novel panel of TMPRSS2:ETS fusion gene markers.”

Those afflicted with prostate cancer often wonder “why me?” Dr. Taguchi feels that the consumption of animal fat is a likely contributing cause. In Japan, the rate of prostate cancer is very low, and he attributes this to the Japanese diet, low in animal fat.

In addition to his passion for his work as a surgeon, Dr. Taguchi is an avid tennis player, playing twice a week to keep fit. He also enjoys an occasional game of golf.

The ceremony will take place in the Sarto Desnoyers Community Center in Dorval at 7:30PM on April 24, 2014. The public is welcome to attend. There is no admission charge and parking is available and free. For further information, contact Monty Newborn at 514-487-7544 or by e-mail at: newborn@cs.mcgill.ca.

Marcel D’Aoust: A Salute

A tribute to our dear colleague appeared in the January 2008 issue of the Newsletter (and reproduced here on the following page) in which his many achievements in a remarkable career were recounted. Sadly, in the January 2014 issue, his passing was announced. Now we will try to offer some insight into the effect this very special man had on the Support Group.

First, Marcel never said no. If some event or function was proposed, Marcel was front-and-center, enthusiastic, supportive and willing. His instincts were to do things on a grand scale and always to promote the well-being of the members and the mission of the Group. His main duty
as the Head Greeter was to usher in newcomers to the meetings. All received a package of material relating to our common affliction and everybody was made to feel important and very welcome. Another duty was to formally thank the guest-speakers. His speech was a set-piece, varying little from time to time, but always sincere and heartfelt and apparently much appreciated.

In addition to his role as a Support Group director, his volunteer activities included the following:

- Founding the Richelieu Club of Sainte-Anne’s.
- A founder during 1958 to 1963 of the Lakeshore General Hospital as the only French director for over 20 years.
- On the board of various associations for retarded children.
- Several years as a director of the West Island Victorian Order of Nurses (V.O.N.).
- Over 15 years at the Sainte-Anne-de-Bellevue Veterans Hospital. A result was the Governor General’s Caring Canadian Award in 2005.
- Active membership in the Canadian Legion.

His funeral at the parish church of Ste-Anne-De-Bellevue was very well attended. His family was and is prominent in the history of Sainte-Anne. The Legion, Veterans Hospital and VON were represented at the service as well as some members of our Group. A Canadian flag was draped over his casket and his Military Service medals were placed on the flag. They reflected his service overseas in World War II as a major with the Fusiliers Mont-Royal regiment.

It was a somewhat low-key good-bye to a man who lived life large with a lot of joy. He will not be forgotten by those he touched.

Marcel D’Aoust—Director 1996-2007
(reproduced from January 2008 issue)

Marcel D’Aoust has taken the advice of his doctor and has ceased all of his volunteer activities including his role as a Director on the Steering Committee of our Support Group. The one exception will be his involvement as a volunteer with the Ste-Anne’s Hospital and its Liaison Centre.

Marcel is a veteran of World War II having served with distinction overseas as a Major with the Fusiliers Mont-Royal regiment. He continued his association with the military through the Canadian Legion and the Ste-Anne’s Hospital. One of his most rewarding activities was with the Lakeshore General Hospital where he was a director on the founding committee and later as a governor of the Foundation. Another was his involvement in the VON, (Victorian Order of Nurses), presently known as NOVA, where he served as a director for many years.

Marcel joined our group in 1996 after undergoing surgery for prostate cancer. He became a director shortly after that and served in that position until his recent resignation.

Governor General’s Award

Marcel D’Aoust was presented with The Governor General’s Caring Canadian Award in a ceremony at La Citadelle in Quebec City on March 2, 2005. The presentation was made by Governor General Adrienne Clarkson and the citation read in part: “…a World War II veteran (who) has worked at the Sainte-Anne-de Bellevue Hospital for some 15 years…”.

Marcel’s Story

Our November 2005 issue of the newsletter contained Marcel’s story in his own words, part of which is now superseded, as follows:

“Let me tell you about some of my volunteer work.
In 1940 I founded the Richelieu Club of Ste-Anne’s, which still exists today; it is like the ‘Kiwanis Club’.

I was asked to join a group of Lakeshore citizens to discuss, to plan, to achieve something - and to build a hospital for the West Island of Montreal population. I was proud to be the only French Director of the group for over 20 years and to serve under a prominent Chairman in the person of Clarence Campbell, ex-President of the National Hockey League.

During those same years, I was invited to join the

Marcel D’Aoust is shown accepting a pen and pencil set from his fellow directors, Les Poloncsak, Charles Curtis and Joe Soul following his retirement from our support group in January, 2008.

Tom Grant and Joe Soul
Montreal West Island board of the Lakeshore Association for the Retarded Children. At the time, these kids were not accepted in our schools. I was promoted to the Quebec Association, and to the Canadian Association - with meetings in Vancouver and Halifax.

Ten years ago, after surgery for prostate cancer, I was named a Director Founder of Montreal West Island Support Group for Prostate Cancer ‘to help’, ‘to advise’, and ‘to assure’ those who have this disease.

Since five years, I am a Director of the ‘West Island Victorian Order of Nurses’, known as the V.O.N. We have a restaurant called AU PETIT CAFE that serves only lunch, at noon. We also have two stores that sell clothing, furniture, objects and books that are given to the V.O.N. We have 12 nurses that are helping old, sick people from Lachine to Vaudreuil.

When I returned from the last war, I was asked to join the Liaison Centre and the Ste-Anne’s Hospital as a volunteer to help those who need some help in many ways. I am still doing it.”

“Helping others is helping yourself”
Marcel D’Aoust

Lakeshore General Hospital’s Plaudit
The same newsletter issue referred to a full-page article in the West Island section of the October 20 Montreal Gazette telling of the conception and realization of the Lakeshore General Hospital and Marcel’s role in this remarkable endeavour. The article includes a photograph showing Marcel standing before a plaque honouring the founding directors. Marcel, formally known as Jean-Marcel D’Aoust according to the inscription, was among a group of ten couples at a party in 1958 where it was decided that the West Island needed a hospital. From there it took five years of petitioning politicians and business people, raising money and finding the site before work began in 1963. The hospital opened in 1965 and the 40th Anniversary Celebration recognized the contributions of the wonderful people who started it all.

Gracious Greeter
The Support Group and the Steering Committee are going to really miss our great friend, colleague and collaborator. Marcel was the super-volunteer. He never said ‘no’, and very often took the lead in any project. Tall, ram-rod straight with a military bearing, and a grand smile with warm welcoming words and gestures, he was the perfect Greeter. His over-the-top Thank-you’s to the guest speakers became part of his legend. He was and will remain a very important part of our existence.

By Tom Grant, George Larder and Joe Soul

“My Prostate Cancer (Sex) Diary” by Don Truckey

Don Truckey, an award-winning screenwriter and author, has released his unflinchingly honest 20,000-word memoir about his battle with prostate cancer. Being only fifty-four when he was diagnosed, Truckey sought to uncover what was rarely talked about in the world of prostate cancer – how treatments for the disease often cause devastating setbacks to a man’s sexual function. Truckey opens up about his experiences, giving readers a frank, detailed look into his treatment and recovery, along with the facts that men need to know. It’s a must-read for anyone affected by prostate cancer – this e-book is not from a clinical perspective, it contains important man-to-man insight from someone who has been through it. Truckey cuts through the medical jargon to speak to his readers about the disease from the patient’s perspective, and what one can expect through diagnosis, treatment, and sexual recovery.
Metastatic prostate cancer currently is treated with drugs that inhibit a protein called Androgen Receptor. This treatment initially halts cancer growth, but eventually the cancer becomes resistant to the drugs. Dr. Kittler’s findings offer a new avenue of research.

**Journal Reference:**


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**Target for shutting down growth of prostate cancer cells identified**

March 6, 2014
UT Southwestern Medical Center

Scientists have identified an important step toward potentially shutting down the growth of prostate cancer cells. Metastatic prostate cancer currently is treated with drugs that inhibit a protein called Androgen Receptor. This treatment initially halts cancer growth, but eventually the cancer becomes resistant to the drugs. These new findings offer a new avenue of research.

Scientists at UT Southwestern Medical Center have identified an important step toward potentially shutting down the growth of prostate cancer cells.

Dr. Ralf Kittler, Assistant Professor of Pharmacology, studies ERG, a protein that facilitates the transformation of normal prostate cells into cancer cells. His lab found that an enzyme called USP9X protects ERG from degradation and subsequently found that a molecule called WP1130 can block USP9X and lead to the destruction of ERG.

"We now have a target that we could potentially exploit to develop a drug for treatment," said Dr. Kittler, UT Southwestern's first Cancer Prevention and Research Institute of Texas (CPRIT) Scholar in Cancer Research.

The findings are published in the *Proceedings of the National Academy of Sciences*. Dr. Kittler’s team tested the molecule successfully in mice, but the process needs to be improved to be effective in humans, he said. Toxicity and side effects also will be tested, so much work lies ahead, and it could take many years before knowing whether the molecule can be developed into a drug that is effective in humans.

"It's a good start, and now we are in a position to develop the findings further in an effort to move into the clinic," said Dr. Kittler, the John L. Roach Scholar in Biomedical Research of UT Southwestern's Endowed Scholars Program.

The observation may represent an important advance against one of the major cancer killers. Prostate cancer is the most common type of cancer in men and the second most common cause of male cancer death in the United States. The disease caused nearly 30,000 deaths in 2013, according to the American Cancer Society.

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**When It Comes to Radiation Therapy for Prostate Cancer, More May Be Better**

News | March 07, 2014 | By Anna Azvolinsky, PhD

An intense higher-dose radiotherapy regimen may be a better treatment option for men with localized prostate cancer, according to the 10-year results of the international phase III RT01 trial. The results are published in the *Lancet Oncology*.

The RT01 trial shows that at a median of 10 years, more fractions of radiotherapy (37 fractions compared with 32) and at a higher dose (74 Gy compared with 64 Gy) resulted in a better biochemical progression-free survival. Prior to the start of radiotherapy, men in both treatment arms also received neoadjuvant androgen deprivation therapy for 3 to 6 months, which was continued until the end of the radiotherapy regimen. The measurable progression-free survival advantage, however, did not translate into improvement in overall survival.

“Our study has proven that treating men with localized prostate cancer using higher doses of radiotherapy is more effective than a less intensive regimen. The dose-escalated regimen is safe in the long term, and reduces the chances that a cancer will return and men will require further hormone deprivation treatment,” said lead study author David Dearnaley, MD, professor of uro-oncology at the Institute of Cancer Research in London, in a statement. “The side effects of hormone treatment do need to be balanced against those of the extra radiotherapy doses, but overall our study has shown men are better off after having the escalated regimen, as is now the norm in the UK,” he added.

The RT01 trial is an open-label, randomized trial that enrolled men with confirmed T1b (no tumor can actually be visualized) to T3a (the prostate tumor extends
outside of the prostate but not to the seminal vesicles) prostate cancer, with no lymph node involvement and no metastasis. Men had prostate-specific antigen levels of less than 50 ng/mL. Patients were randomized 1:1 to either the standard-dose radiotherapy (64 Gy in 32 fractions) or the escalating-dose radiotherapy (74 Gy in 37 fractions). A total of 843 men were randomized between 1998 and 2001. The study was conducted in the United Kingdom, New Zealand, and Australia. As of August 2011, 118 men from each treatment group had died.

The overall survival at a median of 10 years was 71% in each group (hazard ratio [HR] = 0.99; P = .96). Biochemical progression or progressive disease occurred in 391 patients: 221 (57%) in the standard-dose treatment arm and 170 (43%) in the intense-dose treatment arm. At 10 years, biochemical progression-free survival was 43% in the standard-dose treatment arm compared with 55% in the intense-dose treatment arm (HR = 0.69; P = .0003).

“These efficacy data for escalated-dose treatment must be weighed against the increase in acute and late toxicities associated with the escalated dose and emphasize the importance of use of appropriate modern radiotherapy methods to reduce side effects,” cautioned the authors in their conclusion. However, few men had severe side effects and those who received the intense dose regimen were not as likely to require hormone therapy as a follow-up, which also has side effects. The 5-year results of this study had shown the positive benefits of a higher-intensity radiotherapy regimen and had been part of the evidence used to change the standard radiotherapy regimen recommended in the United Kingdom for men with localized prostate cancer.

“Radiotherapy in general is both a safe and an effective treatment for localized prostate cancer,” said Dr. Dearnaley, in a statement. “Almost three quarters of men treated with either the more or less intensive radiotherapy regimens are still alive after 10 years, and of the men who have died, less than half actually died from prostate cancer.”

Whether prostate cancer detected through screening is overdiagnosed can vary depending on patient characteristics, such as age and on the status of the tumor itself. An overdiagnosed cancer is one that would not become symptomatic and would not endanger the life of the patient. Because of the prevalence of prostate-specific antigen (PSA) screening and the general slow growth of many prostate tumors, overdiagnosis and overtreatment are a concern. The US Preventive Services Task Force recommendations now highlight these potential harms and state that careful diagnosis and discussion with the patient are crucial to help prevent overdiagnosis.

The model predicts overdiagnosis among patients with PSA-detected prostate cancer. The chances of overdiagnosis in the model range from 2.9% to 88.1%.

"Men with screen-detected prostate cancer are making decisions about treatment based on limited information about the chances that their cancer has been overdiagnosed," said Gulati in a statement. "We think this is a useful tool for patients and their providers because it helps to tailor knowledge of the risks and benefits of different treatment choices to their individual situations."

One 2009 study published in the Journal of the National Cancer Institute estimated that in the United States, anywhere from 23% to 42% of men between the ages of 50 and 84 who are screened have been overdiagnosed. But, the authors noted, the chance that any patient is overdiagnosed can vary widely depending on the patient’s age and tumor characteristics.

The new publication describes the development of a nomogram—a graphical calculating device—for overdiagnosis of prostate cancer, which the study authors said is different from nomograms that predict the presence of indolent cancer. An indolent tumor is characterized by its biology, but whether a tumor is overdiagnosed also depends greatly on the age and life expectancy of the patient. For very elderly patients, even a relatively aggressive tumor may be overdiagnosed and overtreated, as death from other causes are more likely to occur.

The new nomogram integrates the patient’s age, PSA level, and Gleason score to determine the chance that prostate cancer detected through screening has been overdiagnosed.

The authors used a virtual patient population of US men between the ages of 50 and 84. Data on PSA levels, biopsy, and cancer diagnosis patterns from the Surveillance, Epidemiology, and End Results Program were used to understand the trends in cancer progression among patients who have undergone screening and those who chose not to undergo screening. Data on PSA dynamics in non-cancer patients from the Prostate Cancer Prevention Trial were used. The information was then combined with screening and biopsy patterns to determine the timing of diagnosis either by PSA screening, and how they depend on patient and tumor characteristics,” stated the authors in their discussion. The tool can serve clinicians and patients in helping to weigh both the potential harms and benefits of different care strategies and can help make important decisions about whether to undergo treatment or to delay treatment of early prostate cancer.

with screening or without screening. Whether each patient would have likely died of other causes was also

http://www.cancernetwork.com/news/when-it-comes-rt-prostate-cancer-more-may-be-better?
Prostate cancer treatment takes its toll

Avoid over-treating and watch for complications, researcher says

BY GILLIAN WANSBROUGH
Toronto

A recent study of the major complications of prostate cancer therapy offers physicians a reminder of the importance of carefully weighing treatment options with patients, according to the study’s lead author. The population-based retrospective cohort study included Ontario men who had either surgery or radiotherapy alone for prostate cancer between 2002 and 2009. Of the 32,465 patients, 19,870 (median age 62 years) had surgery, and 16,595 (median age 70 years) had radiotherapy. Results showed that men who had radiotherapy experienced higher incidences of hospital admission, rectal or anal procedures, open surgical procedures and secondary malignancies than those who had surgery.

It’s the first large-scale study of its kind to look at the incidence rates of complications beyond incontinence and erectile dysfunction, according to Dr. Robert Nam, the study’s lead investigator and a urologic oncologist at Sunnybrook Health Sciences Centre in Toronto. The findings were published in the Lancet Oncology (online Jan. 17).

“The intention was not to say surgery is better than radiation or vice versa,” but to provide a trigger for physicians and patients to carefully discuss options, avoid overtreatment and be on the watch down the road for complications that can be missed, said Dr. Nam. “Together we need to take another step back and say, ‘Does this patient really need treatment, or can they go the route of watchful waiting?’”

There is undoubtedly a role for radiation in certain patients with prostate cancer, stressed Dr. Nam, and it’s up to the physician to individualize which treatment the patient should optimally get.

In the study, the strongest predictor of complications was the type of treatment received. Patients treated with radiotherapy had fewer minimally invasive urological procedures, but had higher incidences of the above-mentioned outcomes. After accounting for differences in age and comorbidity, patients who had radiotherapy experienced two to 10-fold higher rates of these types of complications (such as admission for bladder or rectal bleeding, or bladder removal) compared with those who had surgery. “What surprised me most were the rates of urologic procedures, up to 32%, and hospital admissions, 22%, for both groups,” said Dr. Nam. “Then there were the rates of secondary malignancies, up to 4.5% (in the radiotherapy group versus 1.8% in the surgery group, in years five to nine). We know that being imposed on radiation does cause secondary cancers over time, but the relative rates were higher than in any other study.”

Secondary cancers

The most common site of secondary cancers was the gastrointestinal tract. Compared with the general population, younger patients (ages 40 to 65 years) in the radiotherapy group experienced up to a 3.5-fold higher rate of developing secondary cancers, while rates in the surgery group were the same as for the general population.

Dr. Nam told the Medical Post that even after statistical adjustments, the effects were more pronounced in the radiotherapy group. He noted, however, that innovations in radiotherapy methods since the study period could influence outcomes.

Future research will look at other determinants of complications, such as surgical and radiation oncology volume, as well as the role of the treating physician. Dr. Nam and his colleagues also want to look at patients who have undergone both surgery and radiation. MP

modeled. The calibrated model has 33% of men being diagnosed with prostate cancer in their lifetimes, and 38% of these diagnoses would have been made regardless of screening.

The major factor in overdiagnosis using this model is age.

“The results of this study extend our understanding of the range of risks of overdiagnosis in US men detected. “This information, coupled with the relatively high frequencies of overdiagnosis projected by the model for these patients, should provide a compelling reason to carefully consider the appropriateness of active surveillance for low-risk disease, particularly in older men,” concluded the authors.

Source URL: http://www.cancernetwork.com/prostate-cancer/tool-determine-individual-prostate-cancer-overdiagnosis

Operating costs to enable us to continue to provide services at current levels. In reality, the only place where there is some flexibility in doing this, is in the distribution of the Newsletter - particularly in postal delivery. Attempts to reduce the number of surface mailings by transferring recipients to digital delivery by e-mail has had limited success. Over 250 newsletters are still delivered by postal services. If you receive yours by this route, and wish to continue to do so, please contact us by e-mail or by any other method you wish and give us your thoughts on how we could minimize the costs. Members of your Steering Committee will be calling the membership over the next few weeks or month to see if we can reduce the number of mailings to offset the large increase in postal rates. In the meantime if at all possible, a contribution to offset these increases in cost would be appreciated.

Francesco Moranelli

Newsletter Disclaimer:

All articles appearing in this newsletter are for information purposes only and not intended to be a substitute for the advice of a doctor or healthcare professional or recommendations for any particular treatment plan. It is of utmost importance that you rely on the advice of a doctor or a healthcare professional for your specific condition.
REPORT OF THE NOMINATION COMMITTEE

The nominees recommended by the committee to be the officers and directors of the board for the year 2014/2015 are as follows, and the specific responsibilities are as listed:

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**Temporary

Telephone Helpline  (514) 694-6412

IMPORTANT NOTICES:

- The PCCN—Montreal West Island Prostate Cancer Support Group encourages wives, loved ones and friends to attend all meetings. Please ask basic or personal questions without fear or embarrassment. You need not give your name or other personal information.
- The PCCN—Montreal West Island Prostate Cancer Support Group does not recommend treatment procedures, medications or physicians. All information is, however, freely shared. Any errors and omissions in this newsletter are the responsibility of the authors.
- The PCCN—Montreal West Island Prostate Cancer Support Group is a recognized charitable Organization (registration # 87063 2544 RR0001). All donations are acknowledged with receipts suitable for income tax deductions. Your donations and membership fees (voluntary) are a very important source of funds vital to our operations. Together with contributions from several pharmaceutical companies these funds pay the cost of printing and mailing our newsletter, hall rental, phone helpline, equipment, library, etc.

Your support is needed now!