Prostate Cancer Support Association of New Mexico

Celebrating 25+ years of supporting men

LIFELINE

PCSANM Quarterly | October 2017 | Volume 24, Issue 4

Issue Highlights

Our website address
www.pcsanm.org
e-mail
pchelp@pcsanm.org

Meeting Place:

PCSANM is meeting at Bear Canyon Senior Center, 4645 Pitt St NE in Albuquerque. This is two blocks from Montgomery and Eubank; go north one block to Lagrima de Oro St, and east one block to Pitt, and left 50 yards to the Bear Canyon parking lot. We are in room 3, at the west end of the building. Meetings are usually the first and third Saturdays of the month; from 12:30-2:45 pm.

Map: **http://binged.it/1baQodz**

Full Conference Schedule is on page 3

FOUNDER Rae Shipp, established 1991, celebrating 25+ years of supporting men

Board Members

Steve Denning, Chairman Charles Rowland, Treasurer

Jan Marfyak, Secretary

Dave Ball

Jerry Cross

Rod Geer

Eli Maestas

Lou Reimer

Prostate Cancer Support Contacts Around the State

City	Contact	Phone
Clovis	Kim Adams	(575) 769-7365
Farmington	Fran Robinson	(505) 609-6089
Grants	Dorie Sandoval	(505) 285-3922
Los Alamos	Randy Morgan	(505) 672-3486
Las Cruces	John Sarbo or Ron Childress	(915) 503-1246 (575) 522-1083
Silver City	Herb Trejo	(575) 574-0225 C (575) 538-3522 H

In Memory of

Gary D. Cable
Euselio Marquez
Paul R. Tafoya
Jean T. Thysse

With deep sympathy and regret, we list these names

DISCLAIMERS:
The PCSA of New Mexico gives education, information and support, not medical advice. Please contact your physician for all your medical concerns.
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Articles are selected from a variety of sources to give as wide a range of content as possible.
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PCSANM *Lifeline*

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The Prostate Cancer Support Association of New Mexico, Inc.
2533 Virginia St NE, Suite C
Albuquerque, NM 87110
(505) 254-7784
(505) 254-7786 Fax
In New Mexico, Call Toll Free
(800) 278-7678

Office open Monday thru Thursday, 10 am-2 pm;
or by appointment
Phone and email checked daily by Board Members

E-MAIL
pchelp@pcsanm.org

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LIFELINE EDITOR/ WEBMASTER/FACEBOOK

Jerry Cross

MEETINGS Lou Reimer

OFFICE ADMINISTRATIVE ASSISTANT

Ann Weinberg

PROSTATE CANCER SUPPORT ASSOCIATION OF NEW MEXICO

Conference: **What's next for Prostate Cancer Diagnosis and Treatment**

A conference dedicated to the memory of Dr. Peter Lindberg

Saturday, November 4, 2017

At Sandia Preparatory School 532 Osuna Road NE Albuquerque, NM

Morning

9:00 – 9:15 Welcome - PCSA –Steve Denning, Board Chairman
Intro to Morning Moderator – Joe Diaz
9:15 – 10:00 – History of Prostate Diagnosis and Treatment to date Dr. Andrew Grollman (Albuquerque Urology Associates)

10:00 - 10:15 – Break

10:15 – 11:00 - Current scanning tools Dr. Stephan Eberhardt, (UNM)
11:00 – 11:45. – The Key to Prostate Cancer Dr. Mark Scholz (Prostate Oncology Specialists)

11:45- 12:45 Lunch Break, lunch available for purchase at venue

12:45 PCSA- Steve Denning, PCSANM Board Chairman
Intro to Afternoon Moderator Robert Wood, retired PCSANM Chairman
1:00– 2:00 – Risk Assessment Panel 4 current testing reps 8- 10 min presentations each, then questions from panel moderator &/or floor
ProstateNext – Ambry Genetics-Rachel Toepfer
Prolaris – Myriad Genetics-Bernadette Malloy
GenomicDX – Genomic Genetics-Jessica Pompa
4K test – GenPath-Mohit Mathur

2:00 – 2:15 Break

2:15 – 3:50 -(2 cycles of 45 min each, 5 min shift time between cycles) each session on a different topic
Initial Treatments, Urology- Dr. Aaron J. Geswaldo (Pres. Health Services, Urology)
Initial Treatments Radiology- Dr.Ramesh Gopal (Pres./MD Andersen Cancer Center)
Advanced PCa Treatments- Dr.Jose W. Avitia (NM Cancer Center)
3:50- 4:35 - What's next?- Dr. Thomas Schroeder (UNM Cancer Center)
4:35- 4:45 Thank you for attending - Closing remarks
PCSA Steve Denning, Board Chairman
5:00 Shut down - Clear the building

Exhibitors

AccumetRx/Urology Group of New Mexico
Albuquerque Urology Associates
Bayer
Cancer Center at Presbyterian
Genomic Health
Janssen Biotech (Zytiga)
Medivation Inc. (Xtandi)
New Mexico Cancer Center
Santa Fe Radiology
UNM Cancer Center
American Cancer Society
Cancer Services of New Mexico

The schedule was current as of print deadline, August 30, 2017. If any changes occur, they will be posted on the website prior to the conference.

ASCO, Cancer Care Ontario Update Recommendations on Brachytherapy in Prostate Cancer

Megan Garlapow, PhD

April 10, 2017 http://www.oncologynurseadvisor.com/

The American Society of Clinical Oncology (ASCO) and Cancer Care Ontario issued a joint update to guidelines for brachytherapy in men with prostate cancer to take into account new evidence.[1]

An Update Panel conducted a directed systematic literature review to identify recent randomized controlled trials that compared dose-escalating external beam radiotherapy (EBRT) with brachytherapy in men with prostate cancer. The Update Panel assessed results from 5 randomized controlled trials.

This analysis yielded some adjusted guidelines on brachytherapy in men with prostate cancer. Recommendations include that for patients with low-risk disease who require or elect active treatment, low-dose brachytherapy (LDR) alone, EBRT alone, and/or radical prostatectomy should be offered.

In patients with intermediate-risk disease who choose EBRT with or without androgen-deprivation treatment, brachytherapy boost (LDR or high-dose brachytherapy [HDR]) should be offered.

Recommendations state that LDR alone can be offered to patients at low-intermediate risk. Clinicians should offer brachytherapy boost (LDR or HDR) to patients at high risk who are undergoing EBRT and androgen-deprivation therapy.

A directed systematic literature review yielded some adjusted guidelines on brachytherapy in men with prostate cancer

These recommendations state that iodine-125 and palladium-103 are reasonable options for isotopes in patients undergoing LDR brachytherapy. Notably, these guidelines made no recommendation against cesium-131 or HDR monotherapy.

Finally, these recommendations encourage patients to participate in clinical trials to test new or targeted treatment options.

Reference

1. Chin J, Rumble RB, Kollmeier M, et al. Brachytherapy for patients with prostate cancer: American Society of Clinical Oncology/Cancer Care Ontario joint guideline update. *J Clin Oncol*. 2017 Mar 27. doi: 10.1200/JCO.2016.72.0466

PCSANM depends on a NM Department of Health grant and member donations for its livelihood. We gladly accept any donations through the year, and especially IRA Directed Distributions. We thank all who have supported us over the years.
We also depend on manpower to get things done; we can always use members to sit at our table at health fairs or other community events. Contact the office to see how you can help.

Active Surveillance May Increase Likelihood of Adverse Outcomes in Low-Volume Intermediate-Risk Prostate Cancer

Patricia Inacio, PhD **Prostatecancernewstoday.com** July 21, 2017

Active surveillance may expose men with intermediate-risk prostate cancer to adverse outcomes that could be avoided by immediate intervention, according to the findings of a large cohort study.

The study, "Adverse Pathologic Findings for Men Electing Immediate Radical Prostatectomy," was published in the journal ***JAMA Oncology.***

Active surveillance is currently recommended to patients with very-low-risk (VLR) and low-risk (LR) prostate cancer. But more recent clinical guidelines have suggested that active surveillance also may be considered in men with low-volume intermediate-risk (LVIR) disease, a decision that remains controversial.

In active surveillance, patients do not undergo immediate radical treatment, which includes surgery or radiation therapy. Instead, they are monitored carefully over time for signs of disease progression.

Now, researchers at Johns Hopkins University School of Medicine performed a retrospective cohort study and compared the rate of signs of disease among VLR, LR, and LVIR men undergoing radical prostatectomy and evaluated retrospectively at Johns Hopkins Hospital. Specifically, researchers asked, "Is there a subset of men with Gleason 3+4=7 intermediate-risk prostate cancer with favorable characteristics to minimize risk of adverse pathologic findings at surgery?"

In total, the study included 1,264 men with clinically localized VLR, 4,849 with LR, and 608 with LVIR, as defined by National Comprehensive Cancer Center (NCCN) criteria.

Researchers found that the rate of adverse pathologic findings was significantly higher for LVIR disease when compared to those with LR or VLR disease, at 24.7%, 5.8%, and 4.7%, respectively. This means that men with LVIR had almost a 4.5-fold increase in the risk of adverse pathologic findings compared with men who had LR disease, and a 5.2-fold increase compared with men with VLR disease.

According to current NCCN guidelines, some LVIR patients may consider active surveillance, but the practice is controversial. "Our observations suggest use of active surveillance may place similar men with Gleason 3+4=7 (GG2) cancer at risk of adverse outcomes that could have potentially been avoided with immediate intervention. This study could have important implications for men with LVIR prostate cancer electing, active surveillance, and further study is clearly needed," researchers wrote.

To stratify the risk of the LVIR group, researchers analyzed both preoperative clinical and pathologic criteria. However, none of these could define a favorable subgroup within the LVIR group with a rate of adverse pathologic findings as low as those of VLR and LR patients.

Overall, these results do not support the presence of a "favorable" subgroup among men with intermediate-risk prostate cancer. "Men with Gleason 3+4=7 prostate cancer otherwise eligible for curative intervention should be fully informed as to the avoidable risk associated with use of active surveillance," the study concluded.

The UNM HERO 12 week exercise and meditation study continues to need enrollees. You may be eligible if you have been diagnosed with prostate cancer, are age 60 or older, and live within 75 miles of Albuquerque. The study does pay for your time. For more information and to see if you are eligible to participate, please contact the UNM HERO team at **505-272-6557**. There is a more detailed flyer on our website.

Cabazitaxel Does Not Prolong Overall Survival vs Docetaxel in Metastatic Prostate Cancer

James Nam, PharmD July 31, 2017

http://www.oncologynurseadvisor.com/

Cabazitaxel does not prolong overall survival (OS) in patients with chemotherapy-naïve metastatic castration-resistant prostate cancer (mCRPC) compared with the first-line chemotherapy agent docetaxel, according to a trial published in ***The Journal of Clinical Oncology***.

Data from previously conducted studies demonstrated that cabazitaxel may significantly improve OS once administered after initial docetaxel therapy. The authors investigated the potential of cabazitaxel as a first-line chemotherapeutic agent for patients with mCRPC.

In the phase 3 FIRSTANA trial (ClinicalTrials.gov Identifier: NCT01308567), researchers randomly assigned 1168 chemotherapy-naïve patients with mCRPC 1:1:1 to receive intravenous (IV) cabazitaxel 20 mg/m^2 (C20), cabazitaxel 25 mg/m^2 (C25), or docetaxel 75 mg/m^2 (D75) every 3 weeks with daily prednisone.

Patient characteristics at baseline were well balanced across the various treatment arms. The primary end point of the study was OS.

The study showed that median OS was 24.5 months for C20, 25.2 months for C25, and 24.3 months for D75. The hazard ratio (HR) for C20 vs D75 was 1.01 (95% CI, 0.85-1.20; *P* =.997). The HR for C25 vs D75 was 0.97 (95% CI, 0.82-1.16; *P* =.757).

Treatment-related grade 3 to 4 adverse events (AEs) occurred in 41.2%, 60.1%, and 46.0% of patients in C20, C25, and D75, respectively. The treatment arm receiving C25 reported higher incidence of febrile neutropenia, diarrhea, and hematuria, and the treatment arm receiving D75 reported high incidence of peripheral neuropathy, peripheral edema, alopecia, and nail disorders.

The final results of the study show that cabazitaxel is not superior to docetaxel in improving OS. The authors concluded that the similarity between the 2 agents however, "may offer additional flexibility to prescribing physicians with regard to treatment choices for individual patient-specific profiles in men with neuropathy, edema, or other conditions that may be preferentially exacerbated by docetaxel."

Reference

1. Oudard S, Fizazi K, Sengelov L, et al. Cabazitaxel versus docetaxel as first-line therapy for patients with metastatic castration-resistant prostate cancer: a randomized phase III trial – FIRSTANA [published online July 28, 2017]. ***J Clin Oncol.*** doi: 10.1200/JCO.2016.72.1068

We just received word that Dr. Charles "Snuffy" Myers is retiring after 50 years in practice. He has done so much work for PCRI and men with PCa. We have quoted or referenced him many times in our information. We thank him for his service.

Gene Editing Improves Prostate Cancer Survival, Study in Mice Shows

Patricia Inacio, PhD May 2, 2017

https://prostatecancernewstoday.com/2017/05/02/gene-editing-therapy-shrinks-prostate-cancer-tumors-in-mice/

A new therapy targeting genomic rearrangements, such as fused genes that promote tumor development, significantly improved survival in mice with aggressive forms of prostate and liver cancer.

The study, "Targeting genomic rearrangements in tumor cells through Cas9-mediated insertion of a suicide gene," was published in the journal ***Nature Biotechnology.***

"This is the first time that gene editing has been used to specifically target cancer fusion genes. It is really exciting because it lays the groundwork for what could become a totally new approach to treating cancer," the study's lead author, Dr. Jian-Hua Luo, said in a press release. The pathology professor directs the High Throughput Genome Center at the University of Pittsburgh School of Medicine.

Fusion genes occur when two genes, which normally are separated, fuse to create an abnormal gene with altered functions. Fusion genes are often associated with cancer, but targeting them to develop a cancer treatment has been difficult.

Using CRISPR-Cas9 genome editing technology, researchers targeted DNA sequences in a fused gene that was in prostate and liver cancer cells. They used viruses to deliver the genome editing tools to the cells. The editing process involved replacing the fused DNA with a gene that could trigger the death of the cancer cell.

They edited only cancer cells for death, leaving healthy cells unharmed. That targeting would be crucial to doctors being able to use editing to treat cancer patients.

To see if editing can be used as a cancer treatment, the scientists inserted genomic-edited cells into mice, then tracked the animals' tumor growth for three weeks. The team delivered viruses with no edited genes to mice that constituted a control group.

The tumor size of mice with edited cancer fusion-genes shrank by 30% during the eight weeks, researchers said. The mice also remained free of metastasis, or the spread of cancer to other locations, the team said.

Overall, the findings support the idea of genome editing as a new cancer strategy, the team said.

"Other types of cancer treatments target the foot soldiers of the army. Our approach is to target the command center, so there is no chance for the enemy's soldiers to regroup in the battlefield for a comeback," Luo said.

The strategy also allows researchers to target genomic mechanisms that cancer cells use to become resistant to standard therapies like chemotherapy. This includes the cells' acquisition of new mutations.

Researchers plan further studies to find if genome editing can eradicate cancer, rather than just induce remission.

Finding a Way to Hit an 'Undruggable' Prostate Cancer Target

Nicole Fawcett March 23, 2017 http://labblog.uofmhealth.org/lab-report

A novel strategy to target a genetic anomaly that occurs in half of all prostate cancers may provide a path for developing new therapies against it.

It was truly a breakthrough in understanding how prostate cancer develops.

University of Michigan Comprehensive Cancer Center scientists found that half of all prostate cancer tumors harbor a certain genetic anomaly in which the genes iTMPRSS2 and_ERG relocation a chromosome and fuse together. This fusion was found to be an on-switch for prostate cancer development.

The problem has been what to do with this knowledge. It turns out ERG is really challenging to target with the kind of small-molecule inhibitors that have had recent successes for treating cancer.

Now, researchers are reporting on a novel strategy to target the ERG gene fusion using large molecule peptides. Studies in cell lines and animal models suggest this approach can effectively target and degrade the ERG fusion with little impact on normal cell function. Their findings are published in ***Cancer Cell.***

"Targeting this gene fusion product has been a major challenge. We had to approach this through a different angle," says senior study author Arul M._Chinnaiyan, M.D., Ph.D., director of the Michigan Center for Translational Pathology and S.P. Hicks Professor of Pathology at Michigan Medicine.

The researchers identified a panel of peptides that interacted specifically with the ERG protein. They tested the panel in cell lines harboring the gene fusion and found the peptides disrupted ERG function. In cells without the gene fusion, the peptides had little or no impact on gene expression.

They also looked at how the peptides impacted other biological processes regulated by ERG. These tests suggested that the peptides very specifically target the gene fusion without affecting normal cellular functions.

One problem was that peptides degraded quickly, not lasting long enough to travel to the desired target. So the researchers generated mirror images of the peptides. These peptidomimetics avoid the machinery that causes degradation of normal peptides in the body, leading to longer stability.

Tests in animal models showed the peptidomimetics reduced the growth of prostate tumors that harbored the ERG fusion. After extended treatment, more than a third of the mouse tumors showed no signs of recurrence a month later.

"This is an example of how we can deliver precision therapy for prostate cancer: Only patients who have the ERG gene fusion would be matched with this agent. But it's useful because the ERG fusion is so prevalent," Chinnaiyan says.

One drawback to the peptide approach is that large molecules like this can't slip past the cell membrane. That means that the peptides need to be modified in some way or be delivered across the cell membrane. Small molecules are the preferred target for drug development because they can get inside of cells and bind to their target more easily.

Continued on page 9

Cesium-131 Brachytherapy May Be Prostate Cancer Game-changer, Study Reports

Carolina Henriques **prostatecancernewstoday.com** August 14, 2017

About 161,360 new cases of prostate cancer will be diagnosed in the United States in 2017, according to the American Cancer Society. The usual treatment options are radiation or surgery, both of which are costly.

A new brachytherapy isotope, Cesium-131, could be a game-changer, a study indicates. Brachytherapy involves placing radioactive implants, or seeds, directly on-to tumors to destroy cancer cells while limiting damage to healthy tissue.

IsoRay Medical markets the Cesium-131 brachytherapy that it developed as GammaTile. It is not only more cost-effective than other treatments, but also generates fewer side effects, researchers said.

Their study, "Long-Term Quality of Life in Prostate Cancer Patients Treated with Cesium-131," was published in ***The International Journal of Radiation Oncology, Biology and Physics.***

Scientists have refined brachytherapy many times since its introduction in 1901. Some experts see Cesium-131 as an optimal version because it is both fast-acting and has a shorter delivery time than other brachytherapies-about 30 days.

A key advantage of Cesium-131 is shorter recuperation periods, meaning patients can recover their urinary, bowel, and sexual functions quicker than with other brachytherapy solutions.

Ninety-five percent of GammaTile's radiation is confined to the tumors it treats, and the rate of radiation injury is very low, IsoRay said.

The findings suggest that Cesium-131 brachytherapy offers patients an ability to maintain the quality of life they had before treatment better than other options.

"For far too long, patients have been treated for prostate cancer based on a medical professional's familiarity [with a therapy] or, in some cases, due to far greater financial benefits to the physician," Brian Moran, medical director of the Chicago Prostate Cancer Center, said in a press release. "This study reinforces that a new, patient-friendly treatment exists. Brachytherapy with Cesium-131 leverages the isotope's short half-life to significantly reduce the duration of long-term symptoms and side effects."

Those who would like to learn more about GammaTile can click on this **link**.

Continued from page 8

Chinnaiyan's team will next work to create a three-dimensional outline of how the peptides bind to ERG in the hopes of turning this into a small molecule to inhibit ERG. In parallel, researchers will focus on making the peptidomimetics work better, with more potency in degrading the target.

Disclosure: The University of Michigan has filed a patent on peptidomimetic inhibitors of ERG described in this study, in which Chinnaiyan and Xiaoju Wang are named as inventors and the patent has been licensed by OncoFusion Therapeutics. Chinnaiyan and Shaomeng Wang are co-founders of OncoFusion, own stock and serve as consultants.

Bone Loss: Prevent fractures through early prevention

From Patient Resource.com http://www.patientresource.com/Bone_Health.aspx?utm_source=081017&utm_campaign=081017&utm_medium=email

Strong bones are an important part of overall health and well-being and are especially important for people with cancer. Maintaining healthy bones can help avoid loss of bone mass, which is common as people age. However, the loss of bone mass can also be triggered by cancer treatment as well as the disease itself.

The loss of bone mass or bone density is known as osteoporosis. This condition occurs when the bone cells that help rebuild bone (osteoblasts) don't get replaced at the same rate as those that naturally break down bone (osteoclasts). Bones become thin and porous (full of tiny holes).

Editor Note: This article is quite lengthy, but wanted to share the tables with you. Many of our members are on hormone treatment regimes, and might find these resource tables useful

Table 1. Bone-modifying agents and their recommended uses for people with cancer

Bone-modifying agent	Recommended use
zoledronic acid (Zometa)	▪ Premenopausal women receiving hormone therapy after surgery for breast cancer ▪ Men treated with hormone therapy for early-stage prostate cancer ▪ Men with hormone-refractory metastatic prostate cancer ▪ People with lung cancer with bone metastasis ▪ All people treated for symptomatic multiple myeloma
pamidronate (Aredia)	▪ Men treated with hormone therapy for early-stage prostate cancer ▪ People with breast cancer that has spread to the bones ▪ People with lung cancer with bone metastasis ▪ All people treated for symptomatic multiple myeloma
denosumab (Prolia)	▪ Postmenopausal women with breast cancer and osteoporosis who are at high risk for fractures ▪ Men receiving androgen deprivation therapy for early-stage prostate cancer who are at high risk for fractures
denosumab (Xgeva)	▪ People with solid tumors that have spread to the bones

Table 2. Medications to prevent/treat osteoporosis

Drug	Indication	How Given
alendronate sodium (Fosamax)	Prevention/treatment	Oral
calcitonin (Miacalcin, Fortical)	Treatment	Nasal spray Injection
denosumab (Prolia)	Treatment	Injection
estrogen therapy	Prevention/treatment	Oral Skin patch
ibandronate (Boniva)	Prevention/treatment	Oral Injection
raloxifene (Evista)	Prevention/treatment	Oral
risedronate (Actonel, Atelvia)	Prevention/treatment	Oral
teriparatide (Forteo)	Treatment	Injection
zoledronic acid (Reclast)	Prevention/treatment	Intravenous

Table 3. Ways to decrease risk of osteoporosis

Include enough calcium and vitamin D in your diet (1,200 mg of calcium and 400-800 IU of vitamin D each day for women, according to the American Society of Clinical Oncology)	Calcium: ▪ Dairy products (low-fat milk, yogurt, and cheese) ▪ Calcium-fortified orange juice ▪ Dark green leafy vegetables (broccoli, spinach, collard greens, bok choy) ▪ Tofu ▪ Almonds ▪ Vitamin-fortified cereal ▪ Calcium supplement • Vitamin D: ▪ Vitamin D-fortified milk ▪ Herring, salmon, tuna ▪ Vitamin-fortified cereal ▪ Multivitamin
Engage in weight-bearing exercise and/or strength training (3-4 times per week for maximum benefit)	Walking, jogging, tennis (or other racket sports), dancing, lifting weights, yoga
Minimize the risk of falls	▪ Use hand rails on stairs and in bathroom ▪ Keep your house well-lit inside and out ▪ Secure or remove rugs ▪ Use a cane or walker if necessary ▪ Don't be shy about asking for help walking ▪ Wear nonslip shoes that fit properly and have a low heel
Control what you consume	▪ Drink little or no alcohol ▪ Avoid smoking

PCSANM *Lifeline* Newsletter
October 2017

Celebrating 25+ years of supporting men
Prostate Cancer Support Association
of New Mexico, Inc.
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

Chairman's Report October 2017

It's been a year since I was elected chairman and I'm happy to say the organization is doing well. Hiring Ann Weinberg to run the office has expanded our ability to reach men and their families in their hours of need. Besides expanding our office hours, she has been instrumental in getting us opportunities to spread the word about the work we do. Just last week we were able to make a presentation to an association of nurse practitioners around the state. This on-line presentation was especially aimed at some of the more rural communities where facilities and information are scarce. But prostate cancer knows no such boundaries. Our point was that many of these men will have to travel to Albuquerque for treatment and while they are here we want to support them.

In fact, statistics say that nearly 1300 men a year in New Mexico will be diagnosed with prostate cancer and we aren't talking to but a small percentage of them. We'd like to change that but to do so will require a lot more help. Currently we have 8 dedicated board members and 32 men on our buddy list all of whom are ready and willing to share their experience. The point is that as we expand our reach we need more volunteers. A few areas of need include accounting, making presentations, social media expansion, conference support including distribution of posters and ushering, and yes - serving on the board. In fact, if you have a skill or a desire to serve others we need you. Please consider making what looks like a negative life experience into a positive by being there for others.

Thank you.

Chairman of the Board PCSANM