

Prostate Cancer Support Association of New Mexico



LIFELINE

PCSA Quarterly Newsletter

January 2012 Volume 19, Issue 1

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LOOK FOR US ON FACEBOOK!

We have a Facebook page. If you, or anyone in your family does FB, please LIKE us to get meeting announcements and other info, and check out the new hours for the office. We are at www.Facebook.com/ProstateCancerSupportNM

Message from the Board Chairman Bob Wood

Our lead article in this Newsletter is to inform you that the PCSANM is in transition from an organization with a paid full-time staff to one manned by volunteers from your Board of Directors. These changes reflect a lack of funds. We have instituted a number of cost saving operational changes, which I will describe below, but we want you to know our support to men and their families facing prostate cancer will NOT change.

First, a bit of history. In 1991 Rae Shipp, our founder, was diagnosed with prostate cancer. He searched for help and information as he wrestled with what to do (no Google at the time). None was to be found. So he and his wife created the Prostate Cancer Support Association of New Mexico at their kitchen table to fill that void. What started as one man and his wife is now a non-profit, tax exempt Association with a membership of over 700 and growing.

Rae was fortunate in finding generous donors and state monies to fund this new organization. For 21 years it has been the only source of non-medical information and support to those facing this disease. Unlike 1991 we now have easy access to information via the net, many more treatment options and dedicated experts in the field. However, the trickle down effects of our economy has forced us to change our operating procedures but not our mission. Your Board of Directors is emphatic about maintaining a viable organization that is a source of information and support for those facing prostate cancer.

Services to our members and newcomers will not change: Newsletters will still be mailed, Saturday meetings will take place, Health Fairs will be covered, telephone contact will be available 24/7, and our extensive library will be open. And last, but not the least, our services will provide information to men and their partners so that they, in consultation with their physicians, can make informed decisions.

Here are the specific changes that have been made and why:

1. Office space has been reduced (lower rent)
2. Paid office staff has been eliminated (no salaries and payroll taxes)
3. Office hours are Monday and Thursday, 10 AM to 2 PM (no longer M-F, 10 to 3), (reduced walk-ins and all phone contacts will be remotely monitored daily)

Office space is still at 909 Virginia St NE, 1st flr, first door on the left upon entering the building (convenient to visitors by avoiding security doors)

There will be times when we will ask the membership for help with special projects such as preparation and mailing of the newsletter, PSA testing, fund raising and outreach activities. Please call us at 505-254-7784 if you can donate a few hours of your time and/or skills toward these and other upcoming projects.

In closing, a VERY special "Thank You" to all who responded so generously to our recent fund raising request.

P.S. it's not too late to send a check.

Bob Wood

FOUNDER Rae Shipp**Board Members**

Chairman of the Board Bob Wood

Board Members

Marian Bruce Tom Davis

Leonard Carter Jan Marfyak

Jerry Cross Lou Reimer

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In Memory of

Charles Bailey
Max Pyeatt
Bill Tarbell
Hilburn "Hib" Rein
William Rader
Dick Starnes
Thomas Harnish
Harry Toppin

With Deep Sympathy and Regret,
We List These Names

**PC SUPPORT GROUP
MEETINGS**

Support Meetings are usually held on the first and third Saturday of each month at 12:30 PM. We meet at the Bear Canyon Senior Center, located at 4645 Pitt NE (on Eubank go one block north from Montgomery - Right (East) on Lagrima De Oro - Left (North) on Pitt to Senior Center).

Please call ahead to verify time and dates.
254-7784 or (800) 278-7678

PCSA Lifeline

A quarterly newsletter addressing issues of prostate cancer

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Jerry Cross/Jan Marfyak

MEETING

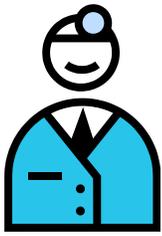
Lou Reimer

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Jerry Cross

DISCLAIMERS

The PCSA of New Mexico gives medical information and support, not medical advice. Please contact your physician for all your medical concerns.



Report from American Society of Clinical Oncology - Dr. Lindberg's Take

Dr. Peter Lindberg

1. Dr. Scher from Memorial-Sloan-Kettering showed that the circulating cancer test in men treated with abiraterone (Zytiga) predicts the benefit of this treatment as early as 6 weeks from starting this oral drug. These were men in a clinical trial who had failed hormone and chemotherapy when the cancer had returned after prostatectomy or radiation. The cell count number also helped predict survival. Using the psa test in this late stage cancer can be very misleading. I have used the Circulating Tumor Cell (CTC) count to help me judge response to chemotherapy. This blood test is done at the Mayo Clinic and other labs. Helpful and should be more used.

2. Finally, a USA-Canadian study reported on 1400 men, 1/2 received with Lupron plus I think anti-androgen like Casodex (bicalutamide) continuously while the other half were treated for 8 months and the treatment stopped until the psa rose back up to a predetermined level then hormones started again. The overall survival was the same. When off therapy, the men had better energy, fewer hot flashes and better sex drive. A rising psa after a radical or radiation therapy would get you into the study. In my practice many men have 10 or more years with the intermittent approach. I use triple therapy ® with Lupron or Firmagon + Casodex (bicalutamide) + Proscar or Avodart to get the psa to 0. I think it is a BIG error to use Lupron alone even though national guidelines suggest Lupron alone is OK. I keep men on continuous Avodart. This allows men to have good recovery of their testosterone, feel well, and keep cancer under control suppressing dihydrotestosterone (DHT).

Getting the psa below 0.05 is crucial. (For men without proven mets (ie positive bone scan), I do not start hormone therapy UNLESS the psa is doubling in value in less than one year.)

3. M. Hussain U. of Michigan, reported great results, especially in bone disease from cancer metastasis. With ---drumroll please ----- Cabozantinib (XL 184). Response rate up to 70%. Striking improvement in bone scans. Psa did not show who the patients were who were helped. (Could the cancer cell test help in this situation???) This drug is available for certain patients who have failed chemotherapy, but the criteria of who is eligible are VERY, VERY strict. It is available in Phoenix and possibly Las Vegas. Bob Leibowitz is also very excited about this drug.

What's Next for Provenge?

Johns Hopkins Health Alert

The U.S. Food and Drug Administration's (FDA's) approval of sipuleucel-T (Provenge) - the first vaccine for the treatment of cancer - marks an important milestone in the war against prostate cancer. Provenge doesn't prevent prostate cancer (in the sense that most traditional vaccines prevent disease), or cure it or even slow its spread. But it does prolong life in some men with advanced prostate cancer. The extra time, slightly more than four months, is modest, at best, but important because it is proof that a cancer vaccine to boost the immune system can prolong life, suggesting that future vaccines might be even better.

Unlike traditional vaccines, this type of vaccine, also called cancer immunotherapy, is designed to help a person's immune system recognize its own cancerous cells as foreign. Once the cancer cells are perceived as intruders, the person's immune system can mount an attack against them. However, this is particularly challenging with prostate cancer because a man typically has had the disease for several years before it metastasizes. During that period, his immune system has seen the cancer but has grown complacent.

Provenge is approved only for men with advanced prostate cancer who have not responded to other treatments like hormonal therapy and are experiencing few or no symptoms. While the FDA's approval of Provenge is a victory, it is not the end of the fight. Researchers are already studying a number of ways to improve the vaccine's effectiveness.

For example, investigators at Johns Hopkins have found that combining Provenge with androgen deprivation therapy increases the chances of stopping prostate cancer early on. Similarly, investigators have found that combining Provenge with radiation therapy also appears to have a synergistic effect.

Provenge is also being tested in several other clinical trials, including a phase 3 study called Provenge Treatment and Early Cancer Treatment (PROTECT). This study involves men with early-stage, nonmetastatic prostate cancer. Many experts believe that immunotherapy maybe most effective in men who have earlier-stage disease.

Newer vaccines also are under development. In one phase 2 study, a vaccine called Prostavac prolonged median survival by 8.5 months. However, like Provenge, Prostavac failed to improve time to disease progression. If Prostavac makes it through the FDA approval process, it promises to be cheaper than Provenge, since it does not have to be customized for each patient and will be available "off the

Canola Oil Protects Against Colon Cancer, Study Suggests

ScienceDaily
April 20, 2011

A new study of canola oil finds that it reduces the size and incidence of colon tumors in laboratory animals, a South Dakota State University scientist says. The research suggests using canola oil in household cooking may protect against colon cancer development.

Distinguished professor Chandradhar Dwivedi, head of SDSU's Department of Pharmaceutical Sciences, led the study. "This is the first time anyone has done work on the effect of canola oil in animals on colon cancer prevention. Canola oil was able to reduce the incidence of colon cancer in animals almost to one-third," Dwivedi said.

The study showed that canola oil inhibited the average number of tumors per rat by 58 percent compared to one of the other two control diets in the experiment, and inhibited the size of the tumors that occurred by 90 percent.

Colon cancer causes more deaths than any other form of cancer in men and women in the United States. American Cancer Society statistics say there were about 102,900 cases of colon and 39,670 cases of rectal cancer in 2010, resulting in an estimated 51,370 deaths.

Dwivedi said professor Padmanaban Krishnan in SDSU's Department of Health and Nutritional Sciences suggested the study of canola oil's potential in protecting against colon cancer because Dwivedi had already led similar studies looking at the cancer-fighting properties of flaxseed meal and flaxseed oil. Krishnan was one of the collaborators in the study. The project was carried out under the auspices of grants from North Central Canola Research, North Dakota State University, and National Canola Growers. Value addition of oilseeds is also supported by the South Dakota Agricultural Experiment Station.

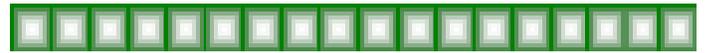
Flaxseed oil has a much higher level of Omega-3 fatty acids that are partly responsible for the health benefits - more than 50 percent compared to about 10 percent in canola oil - but canola oil may be easier to include in a typical American diet.

"The advantage of canola is it can be used for day to day cooking, frying and anything else, in contrast to the flax," Dwivedi said. "You could not use flax oil for frying. If people start using canola oil, replacing other oils

with canola oil, it gives them the advantage of including Omega-3s in their diet.

Dwivedi adds that studies have indicated that if consumers use canola as household cooking oil, it could push their ratio of Omega-6 to Omega-3 fatty acids to about 3 to 1. That's very desirable. Humans need Omega-6 fatty acids, too, but they typically consume way too much of them in countries such as the United States.

"It should be less than 4 to 1. But in a typical American diet, when we use other oil and butter, our ratio is 10 to 1 or higher. We consume a lot more Omega-6 than Omega-3 fatty acids," Dwivedi said. "So anything we could do to bring that ratio more in favor of Omega-3 is always good."



Changes for Support Group Meetings early next year

We are looking forward to an active program for our PCSANM meetings early next year. We continue to meet on the first and third Saturdays of the month at Bear Canyon Senior Center. Sometime in April or May, the senior center will be closing for about 6 months for renovations, so look for an announcement regarding an alternate meeting place. In the meantime, our planned meeting dates are January 7, 21; February 4, 18; March 3, 17; and April 7, 21 at Bear Canyon Senior Center.

We are considering the following topics for talks to present at the meetings; many have been volunteered by potential presenters:

- Erectile dysfunction
- Testosterone replacement
- Video of Dr. Strum presenting at the 2010 PCRI
- Video of Dr. Bahn's color Doppler ultrasound technique
- Cancer legal services
- Several local doctors have offered to talk about their specialties

We ask the members to make us aware of topics they would be interested in hearing about. Please let us know by e-mail, phone, website, or facebook.

Thanks

Lou Reimer, program chairman



Slow-Growing Prostate Cancer: “Active Surveillance” May be Better Option Than Treatment for Older Men

*Medical News Today
12 April 2011*

“Active Surveillance”, involving annual biopsy, may be a better treatment option than tumor removal through surgery or radiation therapy for older men with slow-growing prostate cancer that does not dramatically worsen over time, said US researchers.

The Johns Hopkins study of 769 men across the US found that close monitoring with biopsy did not raise risk of death and discouraged overtreatment in this group of older men with low-risk, very non-aggressive form of prostate cancer.

Every year in the US about 217,000 men find out they have prostate cancer. Most of them are in their mid-60s or older and have a low risk of dying from the disease if they defer treatment. But more than 90% with low-risk cancer, including 80% of those aged 75 and over, opt for treatment rather than surveillance.

Carter told the press that their study showed the “most conclusive evidence” so far that active surveillance may work better for most older men diagnosed with a very low grade or small prostate cancer tumor.

“Our findings really underscore the need to address excessive treatment of this milder stage of the disease in older men, especially seniors,” said Carter.

“These are men with a favorable risk disease profile to begin with,” he added.

Although he acknowledges that some men just can’t bear the thought of living with prostate cancer and just want it removed, Carter said active surveillance may be a better option for the vast majority of older men with this type of prostate cancer because it avoids the risks and complications of surgery and radiation, which can include incontinence, and other problems with bowel, urinary and sexual function.

However, he also cautioned that active surveillance is more suited to men who can be relied on to keep to their surveillance schedule and turn up for appointments. They make the best candidates for active surveillance, he said.

The prospective study started in 1995, when most of the recruited men were already past their 65th birthday, and followed them for a median period of 2.7 years (ranging up to 15 years, through to 2010). The surveillance comprised checkups every 6 months and biopsy every year.

The study is thought to be the largest and longest run-

ning study of men with slow growing non-aggressive prostate cancer.

Slow-growing, non-aggressive prostate cancer means the patient has a small chance of dying from the disease.

To take part in the study, the participants (90% white and 6% black) had to have very low risk cancers with a tumor at clinical stage T1c.

All of them met the key criteria that the cancer had to have a Gleason severity score of 6 or less (a score of 7 to 10 means the cancer is more aggressive and probably needs treatment).

80% of the participants involved in the latest analysis also met at least one of the other criteria for small-volume tumors. These included having a PSA density under 0.15 ng/mL, and biopsy findings with up to only two biopsy cores with cancer, and disease present in only up to 50% of any core.

The results showed that:

- The median period of treatment-free survival after diagnosis was 6.5 years (range was 0.0 to 15.0 years).
- The proportion of men who did not have treatment after 2 years was 81%, after 5 years it was 59% and after 10 years it was 41%.
- 255 men (33.2% of the total participants) had treatment at a median of 2.2 years (range was 0.6 to 10.2 years) after diagnosis.
- Of these 255 men, 188 (73.7%) had treatment because of reclassification of the tumor after biopsy.
- The proportions of men that had curative treatment or biopsy reclassification were significantly lower in those who met the full enrollment criteria than those who did not.
- The men who met the full enrollment criteria were 30% less likely to be reclassified to a high-risk category during surveillance and thus require treatment compared to the men who did not meet them.
- None of the participants died from prostate cancer.

Carter and colleagues concluded that:

“For carefully selected men, active surveillance with curative intent appears to be a safe alternative to immediate intervention.”

“Limiting surveillance to very low-risk patients may reduce the frequency of adverse outcomes,” they added.

To help men newly diagnosed with prostate cancer to find out more about active surveillance as an option, the study sponsors, the Prostate Cancer Foundation, and the team at Johns Hopkins are going to publish a web-based education program, and they also hope to develop improved screening tests to identify prostate cancer patients who would be best suited to active surveillance.



PVP: A Surgical Alternative to TURP

Johns Hopkins Health Alert
26 April 2011

Surgery is the fastest, most reliable way to improve symptoms of benign prostatic hyperplasia (BPH). Of the available surgical treatments, transurethral resection of the prostate (TURP) is considered the gold standard for BPH treatment - the one against which other therapies are compared.

However photoselective vaporization of the prostate (PVP) is increasingly being used as an alternative to TURP. Now a study reveals that PVP can cut costs, primarily by reducing the need for an overnight stay in the hospital.

Also called Green Light laser vaporization, PVP uses a wavelength that is highly absorbed by hemoglobin. This results in minimal blood loss during the procedure. PVP allows tissue removal similar to that of the traditional TURP procedure while maintaining the safety characteristics of lasers.

The study, which was reported in the *Journal of Urology* (Volume 83, page 1469), included 470 men with BPH; 250 underwent TURP and 220 had PVP with the Green Light laser. The researchers found that men who had PVP were less likely than those who had TURP to require an overnight stay in the hospital: 78 versus 95 percent. This finding largely explained why the average cost of the procedure was lower for PVP: \$4,266 instead of \$5,097.

None of the men who had PVP required care that cost more than \$10,000. More than half a dozen men who had TURP needed more expensive care, however, for reasons such as severe electrolyte disturbance, severe urinary tract infection, unstable angina and hemorrhage. This study was conducted in Texas, so the savings may not be as great in other regions.

Expense is just one factor to weigh when deciding on a treatment for BPH. If PVP is an option for you, your doctor and insurance provider should be able to provide you with information about costs.

Man-made proteins sustain life

Scientists at Princeton Univ. have created the first artificial proteins that enable the growth of living cells. In a study in the journal *PLoS One*, they say they produced about 1 mil. genetic sequences not found in nature. They inserted some of proteins into bacteria in which natural genes had been deleted. Those with the artificial proteins survived while untreated ones didn't. The scientists say the discovery could aid research on currently untreatable diseases like Alzheimer's.

Acupuncture: an Alternative Treatment for Prostatitis

Johns Hopkins Health Alert
5 April 2011

Should you try acupuncture to relieve the pain of chronic prostatitis? Results from a recent study provide the answer.

Like other forms of chronic pain, chronic prostatitis is a complex condition with no simple solutions. Successful management of chronic prostatitis depends on treating the original source of the pain as well as the neurological and psychosocial problems that often accompany it.

As a result, your doctor may prescribe several different types of medication. Some men also benefit from cognitive behavioral therapy, which can help improve coping strategies and psychological well-being.

But what if you've tried medications and they haven't helped your chronic prostatitis? Should you give acupuncture a try?

Results from a small study in *The American Journal of Medicine* suggest that acupuncture may provide relief to men with chronic prostatitis. The study compared the potential benefits of acupuncture versus sham (inactive) treatments in 89 men who had symptoms of chronic prostatitis for three or more of the past six months and who had a score of 15 or higher on the National Institutes of Health Chronic Prostatitis Symptom Index.

The men were randomly assigned to receive two acupuncture treatments or two sham treatments a week for 10 weeks. The sham treatments were nearly identical to genuine acupuncture needle insertions except for the location and depth of placement.

True acupuncture was nearly twice as effective as the sham procedure in relieving chronic prostatitis symptoms. Moreover, patients treated with acupuncture were more than twice as likely as the men given the inactive treatment to experience long-term prostatitis relief. Few of the men experienced complete resolution of their symptoms.

This study supports findings from other trials showing a benefit from acupuncture for chronic prostatitis. More study is needed before the treatment can definitively be recommended, but if nothing else has worked for you, a trial of acupuncture might be worth considering.

Estrogen patches like those used by menopausal women may help men with advanced prostate cancer, say British researchers. They cost a 1/10th of hormone treatments and have milder side effects.

Does hormone therapy exacerbate the adverse effects of radiotherapy in men with prostate cancer?

UroToday - UCLA
1 April 2011

We examined whether short course androgen deprivation therapy as an adjunct to radiotherapy would impact health related quality of life outcomes in patients with localized prostate cancer treated definitively with external beam radiation therapy or permanent brachytherapy.

From 1999 to 2003 patients were enrolled in a prospective study at our institution and completed validated health related quality of life surveys at defined pretreatment and posttreatment intervals. A total of 81 men received radiotherapy alone and 67 received radiotherapy plus androgen deprivation therapy. Median androgen deprivation therapy duration was 4 months. Univariate and multivariate analysis was done to compare time to return to baseline in 6 distinct health related quality of life domains.

On univariate analysis the radiotherapy plus androgen deprivation therapy group achieved baseline urinary symptoms more rapidly than the radiotherapy group (5 months, $p=0.002$). On multivariate analysis time to return to baseline in any of the 6 health related quality of life domains was not significantly affected by adding androgen deprivation therapy. Factors associated with longer time to return to baseline mental composite scores on multivariate analysis included nonwhite ethnicity, cerebrovascular disease history and alcohol abuse history. Men treated with permanent brachytherapy monotherapy experienced longer time to return to baseline for urinary function and symptoms. Baseline sexual function and lack of a partner were associated with longer time to sexual recovery.

Adding androgen deprivation therapy to definitive radiotherapy does not significantly impact the time to return to baseline health related quality of life. These data may be valuable for patients and physicians when weighing the toxicity and benefits of androgen deprivation therapy when added to definitive radiotherapy.

Testosterone Replacement: Yea or Nay?

Johns Hopkins Health Alerts
26 May 2011

A reader asks: *Is it true that testosterone replacement therapy can increase the risk of prostate cancer?* Here's what the research suggests.

A study from Johns Hopkins published in *BJU International* found that older men with high levels of free testosterone in their bloodstream were more likely to develop aggressive prostate cancer. This supports the idea

that supplemental testosterone might be harmful.

But other studies have linked low testosterone levels to an increased risk of prostate cancer, worse five-year survival rates, higher Gleason scores and more cancerous samples on biopsy - as well as worse pathological stage.

How can this be? It's well known that men with higher testosterone levels are more likely to develop prostate cancer. The question is whether this truly implicates testosterone.

For example, it's possible that prostate cancer cells secrete an androgen inhibitor that lowers levels of testosterone in the bloodstream. Or testosterone therapy might influence the body differently over time. For instance, testosterone might offer some protection against prostate cancer in younger men without cancer cells, and promote its progression in older men who already have cancerous cells.

Until more is known, we recommend avoiding testosterone therapy unless it's essential to your well-being. A recent study in the *Journal of the American Medical Association* found that testosterone therapy failed to improve quality of life, so there seems to be no reason for most men to use it.

Balding in 20s Linked to Cancer

Albuquerque Journal
17 February 2011

Men who go bald in their early 20s have a doubled risk of developing prostate cancer, but those who lose hair in their 30s and 40s apparently are not at greater risk, French researchers reported this week. The findings suggest that men who lose their hair very early in life might benefit from increased screening.

Because the same male hormone that are involved in hair growth also play a role in prostate cancer, researchers have been tantalized by possible links between balding and prostate cancer. But past studies have yielded conflicting results or none at all.

Dr. Phillippe Giraud, a professor of radiation oncology at Paris Descartes University, and Dr. Michael Yassa, a radiation oncologist who is now at the University of Montreal, studied 388 men being treated for prostate cancer and 281 healthy men, questioning them about their history of hair loss. They reported in the *Annals of Oncology* that 37 of the men with prostate cancer had some balding at the age of 20, but only 14 of the healthy men had had balding at that age. But there was no association with the type or pattern of hair loss, they reported, and no association with balding at older ages.

Androgenic alopecia, sometimes known as male pattern baldness, is common in men, affecting about half of them throughout the course of their lives. It is related to androgenic hormones, and androgens also play a role in the onset and growth of prostate tumors.

PCSA *Lifeline* Newsletter

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Meet the Newest Board Member

I am Jerry Cross, and joined the Board in November. I am the FaceBook page administrator, Web Master, and co-editor of the Newsletter. Any help you can provide by sending articles or links in, helping stuff and label the newsletters for an hour or so, or join our FB page, would be appreciated. Just call or email the office with your phone number or email, and I will get in touch with you.

I taught Special Education and Science for 35 years, and retired 2 and a half years ago. I am active in Albuquerque Rocket Society, Civil Air Patrol, Science Fair judging and other science competitions.

I have a very supportive wife, Jan, and a daughter and granddaughter in Aurora, CO. Everyone in my family is/was a Special Education Teacher.

I am 61 years old and was diagnosed with cancer June 2011 by biopsy, Gleason 9, and had a Radical Prostatectomy August 16. I underwent radiation from October 31-December 22; 37 treatments of CT Tomography. Pre-surgery PSA was 7.3, and 5 week post-op was .03.

I look forward to helping with the mission of education and support. I hope all of you will commit to helping the Board out in one way or another.