



Prostate Cancer Support Association

of New Mexico

Celebrating
over 30 years of
supporting men
and their families

LIFELINE

PCSANM Quarterly
October 2023
Volume 30, Issue 4

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Visit our website:
www.pcsanm.org

Email us:
pchelp@pcsanm.org

Support Group Meetings

Meetings are held at
Bear Canyon Senior Center,
4645 Pitt St. NE in Albuquerque,
from 12:30 to 2:45 p.m.
on the first and third Saturday
of most months.
Many meetings may also be
accessed virtually.

Meeting topics and login
information may be found at:

<https://www.pcsanm.org/meetings/>

Please call 505-254-7784 or
email pchelp@pcsanm.org
with questions.

12th Annual Prostate Cancer Conference

Saturday, November 4, 2023

Sandia Preparatory School
532 Osuna Rd. NE, Albuquerque

Save the date! The Prostate Cancer Support Association of New Mexico (PCSANM) will be hosting its annual conference from 8:30 to 12:45 on the 4th.
The conference is free, and registration is not required.

Presentations will cover the fundamentals of and latest developments in:

- **Diagnosis & Staging**–
Damara Kaplan, MD, Urologist
New Mexico Cancer Center
 - PSA, DRE, biopsy, Gleason score
 - Scans: MRI, CT, PSMA, bone, and others
 - Criteria for grade groups and risk groups
- **Local Treatments**–
Thomas Schroeder, MD, Radiation Oncologist
University of New Mexico Comprehensive Cancer Center
 - Determining appropriate treatment
 - Treatment options
 - Role of androgen deprivation therapy with surgery or radiation
- **Advanced & Recurrent Prostate Cancer**–
Neda Hashemi, MD, Medical Oncologist
University of New Mexico Comprehensive Cancer Center
 - Determining location of cancer using scans
 - Androgen deprivation therapy
 - Testosterone absorption blockers
 - Immunotherapy and chemotherapy
- **Importance of Biomarkers in Cancer Care**–
Lora A. Wilson, PhD, Director of Genitourinary Oncology Therapies
Pfizer
 - Precision medicine and biomarker testing
 - Biomarker testing pathways and barriers
 - Actionable biomarkers in clinical practice

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In Memory

With deep sympathy and regret, we list this name:

Derek Swinson

PCSANM Lifeline

A quarterly newsletter addressing issues of prostate cancer

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Prostate Cancer Foundation: August 3, 2023

Teamwork: The Benefits of Multidisciplinary Prostate Cancer Care

Janet Farrar Worthington

Prostate cancer is often a multidisciplinary problem. At any stage, you may need some help beyond your family doctor, oncologist, or urologist. If your doctor doesn't suggest this, it may be up to you to ask for it.

What's the best initial treatment for you? The answer isn't always obvious. For example:

Maybe you have been diagnosed with cancer that is localized to the prostate, but the pathology findings from the biopsy suggest it is high-risk. Should you undergo surgery by itself or with a course of hormonal therapy or radiation therapy? Or would you be better off with external-beam radiation, with or without hormonal therapy?

Maybe you have other health conditions to take into consideration in determining your treatment. Maybe there are practical concerns: maybe you don't have reliable transportation and would have trouble getting to the hospital every day for radiation treatment. Maybe you have scar tissue or mesh from previous abdominal surgery that could make a robotic prostatectomy difficult. Or maybe you have been diagnosed with cancer that is within the prostate – but a PSMA-PET scan also showed cancer in one isolated location. Should you undergo surgery or external-beam radiation – and also stereotactic “spot” radiation?

These are just some of the scenarios where two (or more!) heads may be better than one. Many hospitals and medical centers have a multidisciplinary clinic where you as a patient might see a urologist, a radiation oncologist, and perhaps a medical oncologist on the same visit: medical one-stop shopping. These providers then meet regularly as a group “to come up with a comprehensive plan of care,” says Anne Calvaresi-Lizardi, DNP, a urology nurse practitioner at Jefferson Health-Thomas Jefferson University Hospitals in Philadelphia. “The benefit of a multidisciplinary approach is that it's different, intelligent minds coming together with your best interests at heart.” At Jefferson Health, a typical multidisciplinary clinic meeting might also include a pathologist, nurse practitioner, social worker, and a radiologist.

What if your hospital doesn't have a multidisciplinary clinic, or you weren't given this option? Seek a second opinion. You could do this two ways: If you're talking to a surgeon, for example, and want to know if radiation might be a better option for you, ask for a referral to a radiation

oncologist. However, if you are talking to a doctor, have some doubts and want to talk to another doctor of the same specialty, you may want to pay out of pocket for a consultation (you can allow that doctor to see your biopsy and imaging results). It's perfectly common and okay to get a second opinion! As Johns Hopkins urologist Patrick Walsh, M.D., says, “People ask for a second opinion all the time. If the situation were reversed, do you think your doctor would not make every effort to find the best possible surgeon (or radiation oncologist, etc.)? It's your prostate, and it's your life.”

Calvaresi-Lizardi says: “I always tell patients, if you're uncomfortable or unsure with one provider and you feel you would benefit from seeing other specialists and getting a second opinion, there's nothing wrong with that! Some people are almost ashamed to ask. But if you were building a house, you probably wouldn't hire the first contractor who comes along. You might get a couple of quotes and go with the one you think is right for you.” How much more important is it, she continues, to take that kind of care with your own body? “We get one body! We can have many houses, but we just get one body, and we want to get the treatment that's best suited for us.”

Who's the quarterback of your treatment if several doctors are involved? Who's in charge of your care? “Whoever is leading that treatment.” If you have localized prostate cancer and decide on radiation therapy, then the radiation oncologist would become the quarterback – but the quarterback can change. “If the patient is finished with radiation and then starts to develop lower urinary tract symptoms, the urologist becomes the quarterback again.” Or, if you need longer-term hormonal therapy or chemotherapy, your family doctor or oncologist would become your quarterback.

Note: Beware of the internet! “Your second opinion should not come from the internet. It's a can of worms,” says Calvaresi-Lizardi. “There are many websites with false information.” One website that is *not* a can of worms is pcf.org, she adds. “PCF has a wonderful amount of great information for patients.”

What if you just have the one doctor and that's fine with you? “If you're comfortable with your urologist or oncologist and don't want a different one, that's great! But you can still get multidisciplinary care if you also have a cardiologist, gastroenterologist, or other specialist, and providers are communicating with each other. “It doesn't have to be a brick-and-mortar multidisciplinary clinic.”

Medical News Today: August 13, 2023

What Is the Best Type and Combo of Exercise to Lower Death Risk?

Robby Berman

According to a new study, a balanced regimen of moderate and vigorous activity, along with two muscle-strengthening sessions a week, can reduce the risk of various forms of mortality. The study also found even greater reductions in mortality risk by exceeding current physical activity guidelines. The study suggests that clinicians should ease their physically inactive patients into a healthy mix of exercises.

When it comes to lowering the risk of all-cause mortality or death from cardiovascular disease and cancer, is there a particular combination of exercises that optimizes one's chances of longevity? A new study looks into the ideal combination of exercise types for living longer. It assesses various combinations of moderate aerobic physical activity (MPA), vigorous aerobic physical activity (VPA), and muscle-strengthening activity (MSA).

The study finds that a balanced amount of MPA, VPA, and MSA were most closely associated with a lower risk of dying, although the mix of activities depended on the type of mortality.

The optimal combination for lowering the risk of:

- all-cause mortality — was greater than 0–75 minutes each week of MPA together with over 150 minutes of VPA, plus two or more MSA sessions each week.
- cardiovascular disease (CVD) and cancer mortality — was more than 150–225 minutes of MPA, more than 0–75 minutes of VPA, plus two or more MSA sessions.

The 2020 World Health Organization exercise recommendations per week are 150 to 300 minutes of MPA, 75 to 150 minutes of VPA, or some relatively equivalent combination of them, plus MSA sessions on two days.

The study also found that MPA exercise levels greater than the current recommendations may reduce the risk of mortality even further.

With more than 300 minutes of MPA, greater than 0 to 75 minutes of VPA, and two or more MSA sessions per week, the researchers observed an approximately 50% lower mortality rate for all-cause and cancer mortality, along with a roughly three-fold lower mortality rate for CVD mortality.

The researchers analyzed data from the 1997 to 2018 U.S. National Health Interview Survey. It included 500,705 adults who were followed up for a median of 10 years (5.6 million person-years). Participants, ages 18–85, with a median age of 46.4, self-reported their exercise.

A seemingly paradoxical finding of the study is that two times the amount of VPA was associated with a reduction in all-cause mortality risk, but that twice the amount of MPA reduced the risk of cardiovascular and cancer mortality.

Professor Emmanuel Stamatakis, professor at the School of Health Sciences at the University of Sydney, and co-author of the study, suggested reasons why. “MPA can be sustained for longer periods than VPA and MSA. It can be, therefore, a larger contributor to physical activity-related energy expenditure and weight maintenance or weight loss. [MSA] can contribute to the maintenance of muscle mass as we age,” said Prof. Stamatakis.

Maintaining muscle mass is beneficial for “dozens of chronic conditions,” he said. These include type 2 diabetes, cardiovascular disease, and avoiding falls that can result in fractures, loss of mobility, and loss of independence as people age.

“Such conditions and events are often treated as ‘age-related’ diseases, when in reality, they are the result of the population being chronically inactive with little muscle mass to support healthy metabolic function and sarcopenia,” said Prof. Stamatakis.

He noted at the same time that VPA and MSA offer benefits that MPA does not. VPA can improve cardiorespiratory fitness, for example.

The study's corresponding author, Dr. Rubén López-Bueno, from the Department of Physical Medicine and Nursing at the University of Zaragoza, Spain, said of MSA that “prior research has observed an inverse association between MSA and cancer incidence, but mechanisms to explain the reasons under such phenomenon are still being investigated.”

Prof. Stamatakis suggested a possible mechanism behind MSA's effect on cancer risk: “Strength training can lower circulating levels of sex hormones, reducing the risks of breast and endometrial cancer in women, and prostate cancer in men.”

Continued on page 5

Medical News Today: August 13, 2023

What Is the Best Type and Combo of Exercise to Lower Death Risk?

Robby Berman

Continued from page 4

He added that for cancer patients with cachexia, strength training may help manage muscle dysfunction.

Dr. Melody Ding, associate professor at the Faculty of Medicine and Health at the Sydney School of Public Health, who was not involved in the study, was not so sure. “I won’t jump to the conclusion that MSA reduces cancer yet.”

“Although for some specific combinations, it seems to trend that way, the overall patterns of the combinations involving MSA and not involving MSA are still quite similar, and the confidence intervals tend to overlap,” she explained.

It is possible that MPA, VPA, and MSA also have a combined effect, though “The design of our study does not allow us to ascertain if there are synergistic effects among MPA, VPA, and MSA,” said Dr. López-Bueno.

“Whether these separated effects of each type of physical activity have a synergistic effect among them remains unknown and should be further investigated,” he said.

Each Type of Exercise Matters in Reducing Death Risk

The key message of these findings, according to Dr. López-Bueno, “is that each type of physical activity matters in order to optimize mortality risk reductions.”

“No isolated type of physical activity or even the addition of two types of physical activity, even at higher levels, seems superior in terms of mortality risk reduction to the other three types combined,” he said.

“I think physicians should recommend participation in a range of activities, such as MPA, VPA, MSA, to the best of one’s capacity,” said Dr. Ding. “This is just one study.”

Dr. Ding also expressed concern that “we struggle to get people to meet the recommended levels, [so] raising the bar is likely to discourage people even more.”

While Prof. Stamatakis called for “holistic and thorough physical activity advice” for physicians, he cautioned that “clinicians should ideally tailor advice to baseline activity levels and ability levels.”

For physically inactive people, he said, “a wiser goal” would be to introduce moderate-intensity walking with just a few bursts of VPA and then later on build up to undertaking muscle-strengthening.

Renal and Urology News: August 14, 2023

Prostate Cancer Survival Tied to Radiation Facility Volume

Natasha Persaud

High-volume radiation treatment facilities contribute to better survival outcomes in men with very high-risk prostate cancer compared with low-volume centers, a new study suggests.

In the study of 25,219 men with very high-risk prostate cancer, median overall survival was significantly longer for patients treated at a center with high vs low average cumulative facility volume: 123.4 vs 109.0 months, Sagar A. Patel, MD, of Winship Cancer Institute at Emory University in Atlanta, Georgia, and colleagues reported in *JAMA Network Open*. On multivariable analysis, treatment at a high-volume radiation facility was significantly associated with an 11% decreased risk of death. Academic setting did not influence results.

The radiation facility volume was defined at the patient level and represents the case load and experience level of the treating facility at the time that specific patient was treated, the investigators explained. The study period was 2004 to 2016. Included men received a total radiation dose of 60 Gy or more for external beam radiation alone or 37.5 Gy or more for external beam radiation plus brachytherapy boost as first-line definitive radiation therapy. The men also received concurrent androgen deprivation therapy (ADT).

A survival benefit was observed at high-volume facilities even after adjustment for brachytherapy boost, radiation therapy fields, ADT, and chemotherapy use, the investigators reported.

According to Dr Patel’s team, “treatment for these patients with [very high-risk] prostate cancer may be nuanced, complex, and resource intensive — features that may be more readily navigated at high-volume cancer centers.”

Future studies are needed to identify which factors accounted for the survival advantage at high-volume centers. Dr Patel’s team suggested expertise in intensity-modulated radiation therapy and managing toxicity, advanced imaging, and closer collaboration among multidisciplinary team members as possible contributors. The study could not fully account for age, comorbidity burden, and socioeconomic status, which are limitations.

Very high-risk prostate cancer was defined as nonmetastatic clinical T3b-T4, primary Gleason pattern 5, more than 4 cores containing grade group 4-5 cancer, or more than 1 high-risk feature, per National Comprehensive Cancer Network criteria. The median age of the cohort was 71 years, and 78.7% were White.

Roswell Park Comprehensive Cancer Center: September 18, 2023

Sex After Prostate Cancer

Prostate cancer treatments can have side effects that may result in changes that affect intimacy, desire and function. While these symptoms are often temporary, they can be distressing and it's important to talk to your physician about what to expect and the steps you can take to improve them.

Why this happens

As men become sexually aroused, the brain sends messages through the nervous system to the muscular walls of the blood vessels in the penis. The vessels enlarge, allowing more blood to flow into the penis. The incoming blood makes the penis bigger and harder, causing an erection.

Even if your libido is normal, your hormones, nervous system, muscles and blood vessels need to work properly to get an erection. Cancer treatments may affect your hormones, which in turn can affect your libido as well as the nerves, muscles or blood vessels that play important roles in causing an erection.

Prostate cancer treatment and erectile dysfunction

Erectile dysfunction (ED) is one of the most common side effects of prostate cancer treatment. Nearly all men will have trouble getting an erection for a period of time after undergoing different types of treatment, such as:

- **Surgery.** The nerves responsible for an erection (the cavernous nerves) travel very close to the prostate gland and may be injured during the removal of the prostate. Nearly all men who have their prostate removed will have trouble getting an erection for some time, even if they have a "nerve-sparing" operation. However, most men recover with time.
- **Radiation therapy.** Damage to the delicate tissues involved in getting an erection, such as nerves, blood vessels or blood flow, can occur with radiation therapy. These side effects appear more slowly during the year after treatment. Men may have softer erections, lose their erection before climax (orgasm) or not be able to get an erection at all.
- **Chemotherapy.** The drugs used in chemotherapy treatment of prostate cancer may affect your libido and erections if it affects testosterone production, but most men still have normal erections. Chemotherapy can also cause fatigue or distress, which can affect your sexual desire and ability to have an erection, but normal desire usually returns when treatment ends.

- **Hormone therapy.** The prostate depends on androgens, such as testosterone, to do its work. Unfortunately, testosterone may help some prostate cancers to grow. The hormone treatment used in prostate cancer, called androgen deprivation therapy (ADT) blocks androgens to slow the growth of prostate cancer, but it can also decrease libido and sexual function. (ADT does not cure prostate cancer.)

Recovery after prostate cancer treatment

Time is the most important factor in recovery. The healing process for men who have had nerve-sparing radical prostatectomy (removal of the prostate) is often 18 to 24 months, because nerve tissue requires a longer time to heal. How much erectile function returns depends on:

- **The type of operation you had** (one, both, or no nerves spared). Most men with intact nerves will see a substantial improvement within a year of treatment.
- **Your age:** Men under 50 or 60 are more likely to recover their erections than older men.
- **Your erectile function before the operation.** Men who had good erections before surgery are more likely to recover their ability to get an erection than those who had previous erection problems.

It is common to need medications to assist with erectile function, even if you did not need them before surgery.

Rehabilitation and aids

Studies suggest that starting a program to promote erections about six weeks after surgery can help some men recover sexual function. Different methods are available, depending on your case, your level of motivation and the judgment of your surgeon. These penile rehabilitation programs focus on increasing blood flow to the area to encourage healing and help men have regular erections that are hard enough for penetration. Having two to three erections a week, even if there is no sexual activity, helps keep the tissues in the penis healthy. Several options are available to treat erectile dysfunction:

- **Medication:** sildenafil/Viagra®, tadalafil/Cialis® or vardenafil/Levitra MUSE™ (a prostaglandin suppository that you insert into your urethra)
- Vacuum erection devices
- Penile implant
- Penile self-injection with a prostaglandin

Prostate Cancer Foundation: January 21, 2021

Stress and Prostate Cancer

Janet Farrar Worthington

Does stress make prostate cancer worse? This one's not so easy to answer. "Everybody has an individual response to stress," says medical oncologist Suzanne Conzen, M.D., Prostate Cancer Foundation (PCF)-funded investigator and Chief of Hematology and Oncology at the University of Texas Southwestern Medical Center in Dallas. And that's the key, she adds: **it's not so much the stress itself but the physiological response that can take a toll, and that may hinder our ability to fight cancer.**

The body responds to stress with a surge of corticosteroids; primarily cortisol. When our ancient ancestors were running for their lives from a savage beast, it was this stress hormone, cortisol – along with adrenaline – that kicked in and saved their bacon. "We are hard-wired to respond to stress with this 'fight or flight' response." Unfortunately, many of us react to everyday troubles with the same surge of stress hormone as if we were facing a sabertooth tiger – as if we were under attack. Our hypothalamus, located in the most primitive part of the brain, tells our adrenal glands, "This is the big one! Go to Defcon 3." And cortisol, revving up in its effort to save us – a chemical version of someone running around in a panic, shouting, "Oh my God, oh my God," can cause harm instead, affecting normal functions including the immune system, and even changing genes that are expressed in cancer cells.

"Some people have a higher stress response than others. It could be an inherited tendency; or they haven't necessarily developed effective ways of coping with exposure to stressors," says Conzen. "However, not all people who have a high stress response get cancer; and a lot of people are under stress and don't get cancer. But that's the complexity: not everybody who smokes gets lung cancer, but smoking is a risk factor. What you want to do is reduce your risk factors," and your *response* to stress – like a bad diet, or smoking, or being overweight – is a risk factor for prostate cancer that can be changed.

"We think high cortisol levels are probably not a good thing in men who have prostate cancer. At least a subset of those men may have tumors that respond to high levels of stress because the prostate cancer expresses a protein, the glucocorticoid receptor, that is activated by cortisol," says Conzen. Although Conzen is working on how to determine who these men are, right now, there's no way to know.

Cortisol, a hormone, attaches to a protein called the glucocorticoid receptor (GR) in cells throughout your body, and this is like flipping a switch that activates stress in all those cells, including cancer cells. In ovarian cancer, Conzen has shown, higher levels of these receptors in the

tumor tissue are linked to more aggressive, even lethal, disease. And in prostate cancer, she has found that the GR "is more highly expressed in cancer that is resistant to androgen deprivation therapy (ADT)."

But it's complicated: "We think it's not only *how much GR* your tumor has, it's *how active* it is." With a PCF Challenge Award, Conzen and her lab colleagues are working to find a way to measure how active cortisol and GR are in a prostate tumor, "whether it's turning on and off a lot of genes, or just a few genes. The amount of GR does not necessarily correlate with the protein activity."

So, how to fix it – if a man has aggressive prostate cancer, and high cortisol/GR activity? "One hypothesis would be, deprive that tumor of your body's stress hormone receptor activity, by keeping the stress hormones relatively low." This could happen with some type of medication – or, it could happen with stress reduction. What is that, exactly? It could mean making changes in your life, so there are fewer stressful factors in it. It also could mean making changes in *you* – with the help of such things as exercise, yoga, meditation, and counseling.

Note: **Conzen does not believe that stress, all by itself, causes prostate cancer.** "My guess is that GR-mediated stress signaling in the tumor cells probably has more to do with *promoting* aggressiveness and progression of cancer," and perhaps recurrence of cancer. When Conzen talks about stress, she doesn't mean a single traumatic incident, such as a car crash: **"The kind of stress we're talking about is daily unremitting stress." Those countless little things that add up, day after day.**

Conzen and colleagues are working to identify which genes in prostate cancer cells are involved with the stress response, and what those genes are doing when the tumor cell GR is activated in a man who already has prostate cancer. "If we knew that, we would know when it would be useful to give a drug [a GR-modulator] to block it."

In the meantime, stress reduction may help achieve similar results, by lowering circulating cortisol activity in prostate cancer patients. Clinical trials are needed, Conzen notes, to show the effectiveness of stress response-reducing measures including cognitive behavioral therapy, medication, yoga, and mindfulness in prostate cancer patients. Such trials have been done in breast cancer, she says, "and have shown that there is a beneficial effect." The good news is that for general health, there are several concrete steps those with prostate cancer can take to help deal with stress more effectively, including spending time with friends, getting enough sleep, and exercising daily.



Prostate Cancer Support Association

of New Mexico

PCSANM *Lifeline* Newsletter
**Celebrating 32 years of supporting men
and their families**

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A Message from the Chairperson

October 2023

As you read this, 2023 is slightly more than 75% complete. In that time, this cancer support group has accomplished some important fundraising work, which will soon allow us to expand our reach. It was only several years ago that PCSANM, a 501(c)3 organization funded primarily by the New Mexico Department of Health, realized the importance of generating additional revenue to thrive. This year, the organization has had two new opportunities to enhance its funding.

First, Terry Riddle, a community member whose 67 year-old husband Dave Riddle passed away from prostate cancer in 2010, organized the Dave Riddle Memorial Golf Tournament in his memory. Wanting to do her part to ensure that others do not endure loss similar to that of her family's, Terry worked tirelessly to pull off an amazing event at Santa Ana Golf Club, and then donated proceeds to PCSANM. Many, many thanks to her, tournament sponsors and donors, and to the dedicated group of PCSANM volunteers who helped make the inaugural September event (with 32 teams of four) a success. We're already getting excited for the next Dave Riddle Memorial Golf Tournament, to be held in September 2024!

In addition, a PCSANM supporter who wished to remain anonymous donated \$5,000 and offered a matching gift challenge. In August, PCSANM was then able to conduct its first-ever fundraising campaign of this kind. The initial \$5,000 donation was more than matched, and it, combined with August donations, added more than \$10,000 total to our bottom line. Thank you to all who rose to meet the challenge; we are so grateful for your support!

So, congratulate yourselves, and stay engaged. Wonderful things are happening within this organization. With your support, we will continue to grow and provide life-changing information to more and more of those in need.

A handwritten signature in cursive script that reads "Rod Geer".

Rod Geer
Chairperson of the Board, PCSANM