POUGHKEEPSIE MAN TO MAN

Prostate Cancer Education & Information Support Program since July 1993

May 6, 2004 Issue 5 (Meetings to date # 145)

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Man to Man (M2M) is an educational, not for profit, prostate cancer support program of the American Cancer Society. It is a forum for discussing medical developments & experiences. Protocols discussed at M2M meetings are sometimes based on anecdotal information. It is always advisable to consult a physician before adopting any form of treatment

In This Issue:

A joint meeting of Man to Man (M2M) and Side by Side (SXS), the prostate cancer (PCa) support and education groups sponsored by the American Cancer Society, was held on May 6, 2004 in the Central Hudson Electric Company Auditorium-♿, Rt.9, Poughkeepsie, NY. There were 65 in attendance including 3 new M2M members and 15 SXS. Several of the new members were given our NEWBIE BOOK.

PLEASE NOTE Poughkeepsie M2M has back issues of our newsletters & information on PCa. go to http://www.geocities.com/charl2ep/Cancer/ or http://www.boodrow.com

PRESENTATION - MAY 6, 2004

INCONTINENCE

DR.GARY LEACH

A video from the 2003 Burbank Conference on PCa was shown to summarize recent progress in handling the incontinence problem which many men experience after local treatment such as radical prostatectomy or radiation.

Dr. Gary Leach is the Clinical Professor of Urology at USC and former Director of the Department of Urology and the Urodynamics Laboratory at Kaiser Los Angeles Medical Center. He is a respected domestic and international leader within the local urology community. He is registered in " The Best Doctors in America " text.

SUMMARY OF TALK

Dr. Leach started by defining incontinence. When a person's quality of life is affected by loss of bladder control, then it becomes a problem which is treatable.

Five to 10% of surgical patients have a serious problem due to damage to the external or internal sphincters at the ends of the prostate.

The bladder is a low pressure storage device which can be affected by bladder overactivity or sphincter inability to squeeze the urethra adequately.

A simple urodynamic test which takes 20 to 30 minutes tells what the problem is:
• **Stress incontinence** or leaking during physical activity such as lifting, coughing or sneezing.
• **Urge incontinence** which is an overwhelming mental urge to release urine.
• **Mixed incontinence** which is a combination of stress and urge problems.

The diagnosis of incontinence involves a voiding diary by the patient, medical history, physical exam, diagnostic tests (urinalysis and cystoscopy) and post-void residual measurement.

The options for symptom treatment range from symptom management with protective undergarments, behavioral therapy, or catheters and clamps or to more elaborate things.

Medication for overactive urge may use drugs like Detrol, but some patients object to side effects of oral medicine. A patch on the skin (twice a week) is a new approach. Also, there are a number of new medicines in test.

Injections of collagen to help the sphincter are also used, but do not seem to be effective for long because they must be frequently supplemented.

During the last 2 to 3 years a male sling system has become available for mild incontinency. Essentially, a sling of tissue is cradled beneath the urethra in the perineal area. A small incision is made to allow 6 titanium screws with sutures to be fastened to the pelvic bone. The sling tissue is fastened in place and exerts pressure on the urethra to help the sphincter to be more effective. The procedure takes about 45 minutes and is done on an outpatient basis.

The results with the sling have been good. Most of the patients have had prior RP or RP and RT. Forty percent report being totally dry, forty percent say >50% better and 20% are not satisfied. There have been few complications, and immediate symptomatic improvement. The short term clinical results for durability have also been good with the sling.

The last option, for the most severe incontinency, is the artificial sphincter which has been proven since 1972. Fifty thousand men have had an artificial sphincter implanted. This device is totally within the body. It has three essential elements: a pump placed in the scrotum, a cuff around the urethra and a reservoir in the lower abdominal cavity. The cuff is normally closed, clamping the urethra. During the pumping from the scrotum, the cuff opens and allows urine to pass. When the pumping stops, the cuff closes again in 2 to 3 minutes. During surgery the cuff is held open by a catheter. Four to six weeks later, when healing has occurred, the artificial sphincter is allowed to operate normally.

The results have been very good, with a 90% long term success. There appears to be no significant difference whether radiation or radiation plus surgery is used earlier. Satisfaction is reported at 96%.

The artificial sphincter is not considered a big operation. Its cost is comparable to collagen injections. Erosion of the urethra is <5%; infection <3%; mechanical failures affect 15%, demanding replacement or repair at 10 years.

For more information contact Dr. Leach's website: **www.towerincontinence.com** .

Paul Totta
Poughkeepsie M2M

GENERAL MEETING NOTES

The Man to Man and Side by Side groups met on May 6 at the Central Hudson Auditorium. The

women broke off into a separate room and rejoined the men later for the main lecture. The men then proceeded to follow our general outline for an open floor meeting.

The meeting started with Paul Totta explaining a very important part of every meeting. And, that is, our general disclaimer that is more than a page long and brings up important things to remember. He summarized the gist of the list by saying that we do not give medical advice but are an educational and information source for Prostate Cancer. We purport no bias against any medical professionals or treatment centers. We strongly suggest that all patients seek the aid of their doctors in pursuing anything new or discussing alternatives in treatment. Of course, it goes without saying, always keep in touch with your doctor in following your progress.

The subject of PC 101 was addressed. PC 101 is run by Herb Ilker and is run as a little subset of the main meeting. Herb convenes his session after the main lecture and is joined by newly diagnosed men who are seeking more information. The new men are presented with a Newbie book that summarizes treatments and helps in the decision making process. Herb needs help from more of the veterans in the group, since he is overwhelmed on the nights we have had 5 or more new men. He cannot possibly address all their questions alone. So, please volunteer to help out here.

LIBRARY

We are starting a new procedure to handle books and tapes. Our inventory is so large now that it is not feasible to load and tote these many boxes to every meeting. We have thoroughly indexed all the tapes and books on a list, which is now displayed on the front tables. Sign up sheets are available for requesting material and signers can call Jim Kiseda to arrange getting the material. In order to avoid missing out on any new material that is added to the library new books or tapes will be briefly described at the meeting before entering inventory.

MEETINGS

Dennis O'Hara gave us news of 2 important meetings. The first one is the Survivors Day get together on June 13th from noon to 5pm at Vassar Brothers Medical Center. This is always a fun day with entertainment, guest speakers, raffles, giveaways, children activities and a tour of the Dyson Cancer Center. In addition, there will be a delicious lunch served.

The second meeting mentioned occurs on May 12th. It is a training session sponsored by the ACS for training meeting facilitators. It will be held at the senior center in Mahopac and will begin at 10am and end in mid afternoon. Lunch will be served. We recommend that more of our men volunteer for this in order to help us out in carrying out our normal meeting schedule when the current facilitators are out of town or sick. This has happened and is an inevitable part of life. You do not have to be a super emcee to do this. You have plenty of support from our veterans and we have a strong meeting outline to follow. Please volunteer.

CONGRESSIONALLY DIRECTED MEDICAL RESEARCH PROGRAM

We felt compelled to speak about this program since three of our members were honored to be chosen to participate in judging dozens of research proposals seeking grants for the 85,000,000 dollars Congress approved for Prostate Cancer research. The three men were Dennis, Paul and Jim. Our summary was of a general nature so as to not violate the confidentiality agreements. Anything that was said is already in the public domain.

The meetings took place April 19 to the 23rd at a conference center near Leesburg, Va., which is located 30 miles northwest of Washington. There were 5 separate panels for Prostate Cancer and these addressed pathology, radiology experimental therapy and other miscellaneous treatments. Each panel looked at about 60 to 65

research proposals. The panel consisted of scientists, MD's and consumer reviewers (this was the name given to us, there were 3 in each panel). Each proposal was described and discussed at the panel session and then graded on a list of criteria. The initial voting was done by the 2 scientist reviewers and one of the the consumer reviewers and then thrown open to the full panel discussion and then final voting.

The point, here, in going into this detail is to show that we, as patients and survivors, had the same voting weight as the scientists and were able to sometimes sway them in changing their scores for the benefit of cancer survivors and future cancer patients. Real patients, with PCa, were given a voice to be heard in fighting this disease. We recommend that any of our men, who would wish to participate in this yearly event, let us know so that we can start the nomination process.

Getting on to the content of the proposals, it was evident that excellent research is forthcoming on many of the topics we discuss at our meetings. The new proposals extend the past research into looking at the molecular pathways of what is happening when you intervene using the many protocols mentioned. Many of these protocols are used because they seem to work but there is not full understanding of how they work. These studies dig into this in a way that will make the use of more powerful techniques available to us much sooner than thought. I hope that this is inspiring to our group, in that science is starting to pay off and men with PCa will have much more choices in battling this disease in the near future.

EXECUTIVE MEETING

An executive meeting was held on May 4th in order to get more people involved in running the group. As mentioned before, a group can only be effective if enough volunteers participate. We addressed the committees that were needed to spread the workload. These are: PC101, master mailing list and roster, attendance monitor, publicity, speaker programs, facilitators, library maintenance and newsletter publication. We will finalize the list of men, who volunteered, and publish it soon.

PROSTASCINT

One of the attendees, recently diagnosed, wondered about other tests that would be useful to help him chart his treatment. We went over the standard array of tests most of which he was familiar. Then it was pointed out that the new Prostascint was a useful tool to look for metastasis but, was found to be the best single predictor of positive lymph nodes. The new version is very enhanced by using either a CAT or MRI scan and then overlaying the results on the Prostascint scan. This allows the extreme enhancement of the Prostascint scan by registering it with the actual physiology of the patient. This allows looking at the tumor mass in a slice by slice fashion with the tumor highlighted by the radioactive monoclonal antibody. Patients with a low nodal risk are not appropriate candidates. Using all the standard tests can identify low risk. However, if a patient fails his primary treatment, then the Prostascint is a good way to try identifying where the cancer is.

PCRI Insights published an excellent full explanation and article in their August 2003 issue. The author is Samuel Kipper, MD, of Pacific Coast Imaging. Color pictures of the scans are shown.

Jim Kiseda M2M Poughkeepsie

Newcomers & PCa. 101

1) He is 63 years old. His PSA was 4.7. He underwent a biopsy, 16 core samples were taken. One had 5% cancer. His GG was 3 which seems quite low. RP has been recommended, but he does not accept this. He is here for more information.

2) His age is unknown. He has had 40 external beam radiation treatments, his PSA went down

to 0.26. It has now risen to 0.35 and he was concerned about this. From a few of the men who had this treatment, assurance was given that this is normal spike in PSA following EBRT.

3) He is 78 years old. His PSA was 10 with a GG of 6. He underwent seed implantation 4 years ago. His PSA is presently 0.2. He has changed his diet and exercises regularly.

Herb Ilker-PCA 101
Poughkeepsie M2M

ADDITIONAL BLOOD MARKERS

We've recently talked a bit about additional blood markers that many men use to keep abreast of their PCa. PSA in conjunction with PAP are all valid and valuable markers. There are others, though, that are a tougher sell to our physicians sometimes. The following are the ones used most by men who want to track their PCa. PCa can be on the move even with a low PSA. Many men keep these additional blood markers in their tool boxes, so to speak, to supplement their regular blood work.

CEA (Carcino Embryonic Antigen) is a cell surface-fetoprotein expressed by many different tumor types, including poorly differentiated PC. Prior to the advent of PSA elevated CEA was found in 30% of newly diagnosed prostate cancers. Moderately elevated CEA concentrations have been found only in patients with either “pure”or “predominantly” hormone insensitive disease (without soft tissue lesions) and particularly after suppression of hormone sensitive cell subpopulations.

CGA (Chromagranin A), there is a B, C, etc,. These "markers" are products of the tumor cell population and sometimes are clues as to the tumor taking on an identity that is associated more with certain clinical behavior, such as small cell prostate cancer. Such small cell tumors grow faster, involve liver lung and lymph nodes in unusual sites and frequently don't express much PSA and have lytic bone lesions instead of dense blastic lesions, etc. CGA is an excellent marker for neuroendocrine tumors, particularly nonfunctioning tumors, and the measurement of CGA is also useful to detect prostatic carcinoma in patients whose PSA is not elevated."

DHT (DiHydroTestosterone) 5 alpha-dihydrotestosterone is the male hormone which is most active in the prostate. It is made when an enzyme (5 alpha reductase) in the prostate stimulates the transformation of testosterone to DHT. There are reports that DHT is as much as 4X more active in prostate cancer than Testosterone. Proscar (finasteride) is considered a potent 5 alpha reductase inhibitor and often prescribed as part of a complete androgen blocade (CAB).

NSE: (Neuron-Specific Enolase) is a specific marker for neuroendocrine tumors which express proteins or enzymes that are reflective of a differentiated tumor cell population such as small cell prostate cancer. When both CGA and NSE are elevated, the prognosis is considered poor.

PAP (Prostatic Acid Phosphatase) is an enzyme measured in the blood whose levels may be elevated ina patient with prostate cancer, that has invaded or metastasized elsewhere. PAP is not elevated unless the tumor has spread outside the anatomic prostatic capsule. A persistently elevated serum PAP is considered evidence of metastasis, but only 75% of patients with mets have an elevated PAP. Serum PAP noted at the time of diagnosis of prostate cancer is usually associated with extra prostatic spread. In a study at the Johns Hopkins University School of Medicine, 21 of 460 men or 4.6% had elevations of PAP. Of those men fully evaluated evidence of extra prostatic disease was documented in all. Positive bone scans, extraprostatic extension of disease, PSA > 100, positive lymph nodes and positive seminal vesicles were found. Most of the above patients with increased PAP's (17 of

21) had abnormal DRE's consistent with disease outside of the prostate orPSA's >100. Therefore, in these patients, the PAP was not that helpful. In the remaining 4 patients, the PAP was helpful in directing treatment towards systemic therapy as opposed to local therapy. A PAP determination as part of the initial staging evaluation is still reasonable. In addition, in some patients PSA may be normal or zero while the PAP is elevated proving the PAP to be the only remaining biologic marker that can be followed.

PSA (Prostate Specific Antigen)is a protein secreted by the epithelial cells of the prostate gland including cancer cells. An elevated level in the blood indicates an abnormal condition of the prostate gland, either benign or malignant. PSA is used to detect potential problems in the prostate gland and to follow the progress of treatment. PSA is currently used as a specific diagnostic marker for the early detection of prostate cancer.

Free PSA analysis sometimes called “PSA-II” (Prostate-Specific Antigen type II) reports the percentage of free-PSA to total-PSA (total-PSA = free-PSA + bound-PSA)and is helpful for screening purposes when PSA values are above the normal threshold for an age group and less than 10. One study showed that men with PSA II > 25% had no PCa; those with < 10% were likely to have PCa.

PSADT (PSA Doubling Time) has been evaluated in patients with a rising PSA after local treatment with either RP or RT. In these settings, PSADT has been shown to be significantly shorter in those patients who developed metastases than in those who did not develop metastatic disease. If the PSADT is < 10 months there is a high probability of metastatic disease. Patients post-RP with this finding would not be good candidates for local RT; however patients with a long PSADT would be such candidates. Patients post-RT with a short PSADT have a high likelihood of metastatic disease whereas those with a long PSADT might be candidates for salvage cryosurgery.

PROLACTIN (PRL) is a trophic hormone produced by the pituitary which increases androgen receptors and increases sensitivity to androgens. Prolactin modulates prostatic androgen uptake, affects its intracellular metabolism and utilization, and thereby promotes differentiation, growth and secretory function of the prostate. Many, but not all, men treated with hormone manipulations develop elevated prolactin levels and men who develop hyperprolactinemia during estrogen, diethylstilbestrol, cyproterone or estramustine treatment have been reported to have a much higher rate of disease progression and death from prostate cancer. It has been theorized that prolonged prolactin stimulation from long-term hormone therapy could play role in the onset of androgen resistant tumors.

ProstaScint™ Monoclonal Antibody Scan (111 In-CYT-356) The Prostascint scan may prove useful in the staging of prostate cancer prior to any local therapy. It involves the use of an Indium-111 labeled monoclonal antibody which reacts with prostate cancer, benign prostatic hypertrophy and to a lesser extent, normal prostate tissue. An abnormal scan may detect metastatic prostate cancer to lymph nodes or other sites and identify patients who are not candidates for local therapy. It may also prove valuable in assessing patients who have a PSA elevation after RRP. If an abnormal Prostascint scan is found confined to the prostatic bed it may support the rationale for local radiation therapy.

TESTOSTERONE (T) is the male hormone or androgen which comprises most of the androgens in a man's body; chiefly produced by the testicles; may be produced in tissues from precursors such as androstenedione; T is essential to complete male sexual function and fertility.

AGING: NO BARRIER TO STRENGTH

In the last few months I have written about the benefits of good testosterone levels in aging men, contrary to the sacred assumption that Testosterone is the fertilizer of prostate cancer growth. Among its advantages are enhanced sexual functioning and cognitive functioning, improved strength and general well-being.

I had a knee injury from skiing (which I took up at 71 years old) and ended up doing strength training not just in relation to my injury but in general.

New research has emerged showing that age is much less of a limiting factor in regard to strength training than was previously believed. It's now accepted that muscle strength can be significantly increased at any age.

A brochure from one of the local fitness centers cites a recent study at Tufts University in Boston of a group of elderly nursing home residents increasing their strength by over 300% IN 8 WEEKS ON A WEIGHT LIFTING PROGRAM. These residents were no Spring Chickens, ranging in age from 84 to 99!

The brochure writer concludes that many of the problems attributed to aging are actually the result of reduced activity that most people fall into as they grow older. Conclusion: 'Use it or lose it;' but also, 'It's never too late.'

Mike Kulla, Poughkeepsie Man Man

OUTSOURCING -- HOW FAR DOES IT GO? PCa?

Not long ago, I had a problem with my computer monitor. I called the computer company technical services twice and customer services twice. All four calls were outsourced to India and I got through the accent OK. The monitor was replaced under warranty. The new monitor had a label -- Made in Mexico.

What's next?

Recently, I requested copies of some of my medical records/reports (paper, not films) from a hospital in NY State. To my surprise, the medical records I requested were provided by a health information outsourcing service in Georgia. There were significant problems with the requested copies provided. The cost per copy averaged about 60 cents. How can a remote outsourcing service, 800 miles from a hospital, know anything about the content, completeness, and quality of the medical records it sends directly to a patient?

Where are we headed?

Not long ago, I read about a growing number of people flying to Asia for significant medical services. Fly down, live in a quality hotel, eat good food, receive quality medical service, etc., at a lower total cost than the cost of U.S. medical service alone. Based on PCa patient dissatisfaction with the U.S. Medical Establishment, perhaps some PCa medical services should be outsourced to India and Southeast Asia to join the outsourcing by U.S. corporations of about everything else? If you can't afford expensive U.S. procedures or don't want to wait four years as in Britain, you may be glad for outsourcing treatment followed by an extended beach vacation to recuperate?

Gene Mentzer Poughkeepsie M2M

March 17, 2004
Advice for Treating Prostate Cancer Revival
By ANAHAD O'CONNOR

A n estimated 30,000 men who have had surgery for PCa will relapse this year, and 1/2 of them will die. But many of those patients can be saved, a new study says, if doctors treat them with radiation therapy at the earliest signs of recurrence.

In cases where prostate cancer appears to be returning after surgery, doctors usually forgo local radiation because they assume the disease has spread. Hormones, which are helpful but cannot cure the disease, are typically given instead.

But the latest study, published today in the Journal of the American Medical Association, looked at 501 men who were given radiation therapy in lieu of hormones and found that about half lived at least four years without another relapse.

In roughly two-thirds of patients who do not receive the treatment, the cancer will spread within 10 years, said Dr. Kevin M. Slawin, an author of the study and director of the Baylor Prostate Center at the Baylor College of Medicine in Houston.

Doctors can look for prostate cancer - the second-leading cause of cancer deaths among men - by conducting blood tests for rising levels of a protein called prostate-specific antigen, or PSA. When levels start climbing after surgery, it usually signals that the cancer is returning. But many doctors either wait too long to give the therapy or rule it out altogether, Dr. Slawin said.

"**W**hen it's rising, that's when radiation treatment should be given," he said. "In a lot of these patients where it was thought the disease would advance and little could be done, we're finding that these men can actually be cured."

About 64 percent of subjects in the study whose levels of the protein doubled within 10 months after surgery, and whose initial prostate cancer was deemed moderately aggressive, remained cancer-free for four years.

People who undergo radiation therapy can suffer unpleasant side effects, including impotence, bladder dysfunction and frequent bowel movements.

Dr. Timothy Wilson, director of the prostate cancer program at the City of Hope medical center in Los Angeles, said that the study's lack of a control group for comparison was a flaw, but that he hoped the findings would lead to more widespread use of radiation therapy.

"It adds to a small but growing body of evidence that this is the right strategy," Dr. Wilson said. "Many of us already know it's a good idea. Now, hopefully, it will work its way into the medical literature and become the standard of care."

Fewer than 20 percent of patients whose prostate cancer returns undergo radiation therapy. Dr. Mitchell A. Anscher, a professor of radiation oncology at Duke University medical center, suggested that some patients would be better off getting radiation treatment immediately after surgery, when it is more effective and lower doses are administered.

"People need to be aware that this is a problem we have a potential solution for," Dr. Anscher said. "Only 13 percent are offered radiation; the rest are offered nothing or treated with hormones, which aren't curative."

Dr. Slawin warned that pre-emptively treating patients after prostate surgery carried the risk of over treating men who might never have suffered a relapse. "We already have a blood test that's very good at detecting recurrences," he added.

(SOURCE) -The New York Times
Leo Vanderpot M2M Poughkeepsie

ANNOUNCEMENT TO MEN & THEIR OTHER HALVES

Are you a frustrated communicator?

We are looking to improve communication at M2M and Side By Side toward being better informed and more empowered.

We want to hear from you about your 'walk

through PCa' so as to put your comments in our newsletter. Please don't be shy. Do notworry about grammar or punctuation; we can help with that. We only ask that you keep it under 750 words if possible, in other words make it short as possible.

You might write about your reaction when you got the bad news. How did you decide what to do about it? What was your experience with your doctor(s)? What do you know now that you didn't know before? Would you do anything different? Has PCa changed your life? How? How has Man to Man or Side by SIde helped? This is merely a guideline. We're interested in your ideas.

Please e-mail to Dennis O'Hara @ IGGY41@AOL.COM

We're waiting to hear from you.
Mike Kulla M2M Poughkeepsie

Joke Du Jour

Anyone who has ever served in the Armed Forces, for any length of time, will say that the experience had a lasting effect on their lives. Even though it has been many a decade since my stint in the U.S. Army Signal Corps, I find that now, as a Senior Citizen, **I pee in Morse Code.**

Herm London-M2M Poughkeepsie

Guest Speaker - June 3, 2004 Meeting.

DR. FRED PESCATORE. The voice of the next generation of physicians.

Fred Pescatore M.D., M.P.H., is a traditionally trained physician who chooses to practice Integrative Medicine and is thus able to combine traditional and alternative medical techniques for true 21st century breakthrough healing.

Break Through

While studying for a Masters Degree in Public Health at Columbia University and traveling extensively throughout Asia and India, Dr. Pescatore trained with practitioners who specialized in alternative healing techniques. This invaluable exposure provided him with the seeds of knowledge that opened his eyes to the world of Alternative Medicine and the realization that by combining traditional and alternative medical techniques, it is possible for a truly holistic process of healing to take place.

Current Situation

In order to further expand his knowledge of alternative medicine, Dr. Pescatore joined the world's preeminent center for complementary medicine and worked along side Dr. Robert C. Atkins where he quickly rose to the position of Associate Medical Director. After 5 years, he opened The Centers for Integrative and Complementary Medicine with offices in New York and Dallas.

Speaking the Message

Dr. Pescatore hosted the #1 health talk radio program in New York City for 7 years before moving his talents to Dallas, where he is now the co-host of "Healthy by Nature" on KWRD-FM. These programs teach the audience about integrative medicine and its ability to link the "fix-it" mentality of traditional medicine with the Body-Mind-Spirit philosophies that play a critical role in the healing process. Dr. Pescatore appears regularly on national news magazine shows, national morning shows, and local New York and Dallas television as the guest expert on all things integrative. He lectures to crowds around the globe to share his insights on this important subject. Feed Your Kids Well, his first book, was the number 1 best selling children's health book for more than a year. His subsequent books, Thin For Good, and the just released The Allergy and Asthma Cure – are enjoying equal success. As president and CEO of Healthy for Good, Dr. Pescatore is now taking on the food industry and importing foods that not only taste great but are

healthy too. His first product, MacNut Oil has just reached stores in the past month.

Dr. Pescatore's Medical History

Dr. Pescatore's traditional medical knowledge comes from his training at three of New York's preeminent teaching hospitals; St. Vincent's, Mt. Sinai Medical Center and St. Luke's/Roosevelt Hospital Center and his treatment of thousands of patients using traditional methods. Dr. Pescatore is a member of the American Medical Association, is president-elect of The International and American Association of Clinical Nutritionists and a member of the American College for the Advancement of Medicine.

Dr. Pescatore will also speak regarding-AHCC and GCP -- A Nutritional Approach to the Treatment of Prostate Cancer.

"PCa is probably the most over treated cancer in America today. This presentation will help to explain some novel nutritional approaches to the issue of prostate cancer, including nutritional supplementation, dietary regimens, and enhancement of the immune system."

Fred Pescatore, MD

For additional information please contact Dr. Pescatore at (212) 779 – 2944 or at www.macnutoil.com

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TO ALL RECIPIENTS OF OUR NEWSLETTER.

If you are experiencing any problems with receiving the newsletter, possibly your name, address or zip code are wrong. If you are receiving duplicate or triplicate issues or if you know of any other members who are experiencing mailing problems, contact Peter & Teresa Hardin, phone: 845-897-9667,e-mail: <hardin.pt@verizon.net>, or regular ground mail: Peter Hardin, 12 Penn Street, Fishkill, NY 12524

Meetings and speakers for 2004

June---3 ((Fred Pescatore, MD., M.P.H., Active Hexose Correlated Compound (AHCC) adjunct therapy cancer, hepatitis & immune enhancer.
July---8 (TBA)
August--5 (TBA)
September--- 2 (TBA)
October----7 (TBA)
Nov,---4 (TBA)
Dec---2 (TBA)

Attention All Members

M2M POUGHKEEPSIE WILL BE IMPLEMENTING A NEW TIME CHANGE. OUR MEETINGS WILL BEGIN AT 6:30PM NOT THE USUAL 6PM. THIS CHANGE WILL TAKE PLACE IN THE FALL. THE REASON FOR THIS CHANGE IS TO SEE IF WE CAN ATTRACT MORE NEW MEMBERS WITH A LATER STARTING TIME. WE WILL KEEP YOU POSTED AS TO THE EXACT DATE THIS WILL TAKE PLACE.

MARK YOUR CALENDERS
Survivors Day Celebration
SUNDAY June 13, 2004- 12-5PM
VBH MEDICAL CENTER
BE READY TO VOLUNTEER TO SET UP TABLES, CHAIRS, REGISTRATION, AND HAVE A GREAT TIME.!!
call 877-729-2444 to register to attend.

Attention:
We always meet the first THURSDAY OF THE MONTH UNLESS OTHERWISE SPECIFIED
Next meeting Thurs, June 3, 2003 at 6pm held at Central Hudson Auditorium Rt 9 in Poughkeepsie--
SXS Joins us For Directions Call 452-2932 press 3 and then 10 to reach local receptionist