



POUGHKEEPSIE MAN TO MAN



Prostate Cancer Education & Information Support Program since July 1993

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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

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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 October 7, 2004 in the Central Hudson Electric Company Auditorium-6, Rt.9, Poughkeepsie, NY. There were 63 in attendance including 2 new M2M members and 12 SXSs. 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>**

PROGRAM GENERAL MEETING

Man to Man held its monthly meeting on Oct. 7 at the Central Hudson Auditorium with our new start time of 6:30.p.m. The meeting covered many subjects before the presentations of our two speakers.

Our annual dinner, in September, was a rousing success, with 62 attendees. Several representatives from ACS and Vassar Brothers Hospital were present and contributed to the congenial atmosphere. Pete Hardin emceed the event and Dennis O'Hara added by presenting several plaques to some of our M2M members for their contribution to the organization.

M2M supported Vassar Brothers Hospital in their program for PCa month in September. The hospital had two large display tables near the cafeteria. A free raffle plus a lot of literature was displayed. People from the radiology group and some of our volunteers manned the tables. The hospital support staff did a great job. ACS supplied the literature. The event was held on every Friday of September from 11: a.m. to 2: p. m. So many people stopped at the tables where we handed out over 1000 pieces of literature and answered many questions.

We supported VBH for the prostate screening on September 29. The screening was free for men who were not already being treated and consisted of a PSA test and DRE, 50 men were screened.

Mike Kulla was kind enough to find a good source of fish oil (omega 3) that can be had in bottled liquid form. We can get this at a discount and inquiries should go to Mike.

We still have all of the DVD's from the PCRI conference in 2003. These talks are so apropos for us and loaded with info. Paul Totta is custodian.

Paul Totta gave a brief rundown on the ongoing controversy, in the medical field, about the importance of PSA testing. Some newspaper reports have quoted some papers by doctors who railed against the inaccuracy of the test and unwanted side effects from unnecessary treatments. Research will eventually replace it. We do know that, since the wide spread use of the test in the mid nineties, newly diagnosed men are in Stage T1 and T2, where before the test most diagnosed men were T3 and T4. This is fact. Seems to me this is helping men. The other point about men getting treated unnecessarily is bogus. What man, would have surgery unless he had confirmed PCa from a biopsy. PSA is only one of the tests for PCa, which is usually backed by DRE and ultrasound.

Mike Kulla reported on a fine article written by Dr. Wheeler in PAACT about 4 years ago. It still has impact. The gist of it was that matching the diagnosis with the best treatment is still elusive for many and requires a more concerted effort to correct this.

For us in the Northeast, remember to start getting your supplemental vitamin D in the form of Cod Liver Oil. The sun is now at low latitude here and vitamin D conversion will be limited. Only supple-

mentation until late spring will suffice.

NEWS SQUIBS

Research at Australia's Southern Cross University suggests that a proprietary formula (containing saw palmetto berry, bromelain powder, licorice root, grape seed and skin, passion fruit seed, other herbs, and selenium) works much like the chemo drug, Taxol, in preventing cancer cells from multiplying. The investigation was small but this is how they all begin. Half of the patients saw a reduction in PSA and the others saw a decrease in the acceleration of PSA. There were no side effects. Of course this bears a confirming study but the fact that it compares to Taxol is worth a hard look.

A study in the Journal of the American Medical Association, in August, found that 88% of men who received radiation plus only 6 months of hormones were alive after five years compared to 78% of men who received radiation alone. This short treatment of hormones, compared to the standard three years, can spare some side effects. Lead researcher was Dr. Anthony D'Amico. Others want more research to confirm this.

MAIN SPEAKERS

We had the pleasure of having two speakers from Vassar Brothers Hospital. The first speaker was Dr. Papadopoulos, head of the Dyson Cancer Center Oncology. The second speaker was Dr. Ken Chu, the Chief Medical Physicist at Vassar. Dr. Papadopoulos gave an overview of PCa Oncology and then detail of IMRT. Dr Chu explained his role in bringing these complex machines on line for treating patients.

DR. PAPADOPOLOS:

There are, at any given time, 1.2 million surviving cancer patients. Cancer is the 2nd leading cause of death with a 4 out of 10 five-year survival. The main treatments, at this time, are surgery, radiation, chemo and combinations of these. Radiation oncology is the most cost effective of these and has a long-term survivor rate of forty percent. This is for all cancers lumped together.

PCa has over 200 thousand new patients a year and over 30 thousand deaths. These numbers move up and down throughout the year and are the best prediction. PCa, most of the time, has no symptoms until the disease is advanced. Factors in getting the disease are age, race and genetics. Environmental factors for PCa are fat, carotenoids, lycopene, vitamin E and selenium, with fat being bad and the rest good.

Some of the tools used for assessment are PSA, DRE, PSCA (prostate stem cell antigen), IGF-1, Complex PSA and RTPCR.

Imaging modalities include B&W ultrasound and Color Doppler. These are not good for looking at single or complex structures less than 2 cm.

The evolution of radiology was radioactive Cobalt in the 1960's, Linac in the 70's, 3d Conformal in the 80's and IMRT in the 90's. IMRT is the state of the art today and has the ability to deliver highly focused doses while protecting normal tissue.

The community benefits are improved cure rates, reduced side effects, efficient delivery, cost effective and less invasiveness.

All planning is custom driven & takes into account patient info, delivery system & plan verification.

Toxicity is lower for IMRT. Typical numbers are:

	3D	IMRT
Gastro Intestinal	14%	2%
Rectal	10%	2%
Urinary	13%	4%

The clinical process includes simulations, CT scans, inverse planning, plan verification, treatment delivery system, and treatment verification afterward. Patient selection depends on their extreme cooperation on the table and omission of all pain. They can not be very obese. Simulation prep needs bowel prep, supine immobilization, and a full bladder. Future improvements would be higher dose rates and lower side effects.

DR. KEN CHU:

Dr. Chu, in explaining why good physics is so important in radiology, cited some examples of bad physics. In Panama, an improperly set up machine delivered 20 to 100 % greater doses to many patients before discovery. In another location, a software problem left unchecked gave patients 100 times the required dose. The NRC found that most of the errors are caused by data entry and some by planning software. A lot of this can be avoided by quality staff who are well trained and certified. Dr. Chu has brought his staff up to 4 PHD physicists and 5 dosimetrists with 3 board certified.

The physicist's role is to see that the entire system works as proposed. This includes hardware, software, mathematics and checks and balances. This is all lumped into what is called Quality Assurance (QA). This is done with a check off list that includes daily QA, monthly QA, full annual inspections, outside checkers, NYS audits, and other external audits. There is also a patient QA driven by patient 2nd checks and patient charts reviewed weekly.

Advanced duties are equipment selection, acceptance and commissioning the machine. Also, new

procedures must be discovered regularly to continuously improve systems.

Dosimetry plans set up the dose rates and field contours for the various radiation schemes, i.e. 2D, 3D Conformal and IMRT. The 3D Conformal uses mostly a 6-field delivery system but there are still some old 4 field systems out there. The 6-field advantage is that the delivery beams mostly miss the critical organs, the bladder and rectum.

Verification of the IMRT can't be done manually since the calculations by hand would take forever even if possible. Instead a flat matrix of detectors is placed in the radiation field and then read out and interpolated into a quasi contour to match that of the plan.

The complexity of the physicist's role can be seen by this brief description and it behooves anyone contemplating radiation to question the quality of staff when picking an institution. In fact here is a list of 10 questions that can be used to make a choice.

They are:

1. Is your Department accredited by ACR? (similar to ISO 9000 form manufacturing)
2. Do you have R&V on the LINAC, and is the input computerized and manually verified?
3. Do you have adequate number of staff working for you or are they consultants?
4. Is the physicist certified by the American Board of Radiology & NYS Licensed or in your state
5. Are dosimetrists board certified and how many years experience do they have?
6. How long have you been doing IMRT and what is the staffs experience level?
7. Does a physicist perform IMRT QA for each patient prior to treatment?
8. Are your LINACs calibrated to TG-51 & independently cross verified by RPC?
9. What are the recent side effects of your last 10/50/100 patients, and what were their outcomes?
10. Is any of your data published or presented at major national conferences?

All in all, the two speakers gave excellent presentations and we have received several laudatory comments from the audience, even days later.

JIM KISED A M2M Poughkeepsie

PSA Testing-----A Bad Idea?

During September, there was an article in the Poughkeepsie Journal from Knight-Ridder News Service which essentially said that PSA (Prostate Specific Antigen) testing is not good because it leads to unnecessary treatments like radical prostatectomies or radiation treatments. These treatments may or may not work and can have some negative residuals like incontinence, impotence, etc. The article could not have come at a more inopportune time, during National Prostate Cancer Month, when there is a strong effort to get men to "pay attention" and have PSA blood tests and DREs (Digital Rectal Exams).

Can a PSA result be misused to scare someone into unnecessary treatments? Yes, of course, but not very often by caring physicians. Second opinions are always worthwhile to avoid this. After going through the whole procedure of being diagnosed and treated myself, and hearing numerous patients and doctors talk, I have come to an "integrated" opinion about this disease, its detection and treatment which I would like to share.

The detection of prostate specific antigen in the blood has actually been a great milestone in helping men learn about the health of their prostate glands. Unfortunately, it is not perfect and not specific to prostate cancer. It is found as a secretion of normal prostate tissue as well as cancerous tissue, in other organs and even in women! A single reading is not significant unless it is abnormally high --- like greater than 20ng/mL. A single reading above 4 (now 2.7) is not necessarily meaningful by itself. It might be high due to infection of the prostate or pressure on the prostate just before blood taking. The

consistent movement of the PSA upward with time is very important, and a clue that something like cancer growth is happening. Since PCa cells secrete more PSA than normal cells, a growing cancer produces more and more PSA. A graph of PSA versus time can show PSA acceleration or doubling time. These are pretty good signals that cancer is advancing and deserves further analysis.

It is a fact that some men have a high PSA, like 7 or 12, but repeated PSA tests show no movement of the PSA in the upward direction. If it isn't moving, it is unlikely that the PCa will spread or kill you. Some men with high PSAs have been biopsied over and over again with negative results, just because their PSAs are high.

Dr. Bob Leibowitz from California cites data from Detroit where autopsies on males of all ages show some PCa from puberty on. Some of these cancers appear to be of a type which is non-growing or "benign". These cells would probably not kill you --- the so-called cancer that you die with, not from. However, many urologists would recommend treatment simply due to the discovery of a small amount of cancerous tissue. Here is where PSA movement might be an important consideration. If the PSA isn't moving then treatment might be safely deferred. We in our group think that simple "watchful waiting" is not such a good idea. It is better to do "active watchful waiting" which means that lifelong bad habits will be changed to healthy living habits. Stop eating fatty red meats, or too many hydrogenated oils in fried foods, cookies, etc. Greatly reduce butterfat (butter, cheese, whole milk, ice cream). Do eat 5 to 9 servings of colorful vegetables or fruits every day. Take a good multivitamin, natural vitamin E and selenium. Exercise!

If a DRE detects a lump in the prostate and the PSA is high, a biopsy is warranted. Most urologists would use random sampling and the help of simple ultrasound to extract tissue and perform tissue analysis, leading to gleason grading of the cancer. Ultrasound technology has become

more refined, and a Color Doppler Ultrasound is the leading edge technology for finding the cancer by following the blood vessels which feed the cancer.

If a growing cancer is discovered, then it is time to select a treatment from a smorgasbord of alternatives. If the cancer is discovered early, and is clearly within the gland, then almost anything has a good chance of subduing it. Local treatments like prostatectomy, radioactive seed, external radiation or cryotherapy all work to some extent. If there is any hint that the cancer is out of the prostate, then the systemic treatment of using triple hormone blockage appears more successful. Some of the most successful practitioners now combine a local treatment to debulk the cancer with simultaneous, prolonged hormone therapy to control distant cancer.

So, it may be sensational for a newspaper to declare that PSA is a bad test, but it is a disservice to men at risk. PSA is not perfect by any means, but it is a useful bloodmarker tool, and when used in a sensible manner, can be a strong aid to dictate treatment, determine treatment success and be a guide to retreatment to extend lives. A new, gene-based measurement of proteins (PCA3) in the urine after a DRE where the gland is purposely squeezed, is showing great promise, is more accurate than PSA, and may supplement or replace PSA in time.

However, the 15 to 20 year old PSA test with early detection has resulted in about a 2% per year reduction in PCa deaths in the US. The death toll is now about 30,000 men per year instead of the rate of 40,000 per year without early detection. This may include unnecessary procedures on men who would not have died, but no one knows how to sort those people out. Better tests and better "cures" are on the way, but for now, early PSAs and DREs are the best that medicine has to offer.

**Paul Totta, Co-facilitator of
Poughkeepsie M2M**

Newcomers & PCa 101

1) He is 67 years old. He was diagnosed 2 weeks ago with a GG= 6. His PSA was 4.2. He is presently taking Lupron shots and will soon undergo radiation. He attended our meeting to acquire more knowledge of PCa.

2) He is 81 year old. He was diagnosed with PCa 2 years ago. His PSA at that time was 10. He is presently on a protocol of Lupron. His PSA dropped to less than 1.0

Herb Ilker PCa 101

**PCRI announces conference in
Washington for 2005
SAVE THE DATE!**

**National Conference on Prostate Cancer
June 16-19, 2005**

**Omni Shoreham Hotel – Washington, DC
Moderator – Dr. Charles “Snuffy” Myers
Over 20 PC Experts will be Speakers**

Patient’s Job

We patients with prostate cancer now have detection and treatment options that can let us live longer and live better. Our responsibility is to know that they exist and seek their benefit.

Taken with permission from an article written by Jules Reichel in the Fall 2004 issue of Quest under “One Man to Another.” Also credit given to the Urological Research Foundation.

Guest Speaker NOV 4th

The November 4 M2M meeting will feature Kenneth Bock, MD as the speaker. Dr. Bock practices integrative medicine, bringing a "new perspective to chronic illness and the pursuit of wellness, by integrating conventional and alternative approaches." He is co-founder and co-director of practices in Rhinebeck and Albany, NY.

He has many presentations and publications to his credit on such topics as the aging immune system, surviving and thriving in a toxic world, use of herbs in medicine, healthful aging, heavy metal toxicity and **ALTERNATIVE APPROACHES TO PROSTATE CANCER.**

Dr. Bock is an important addition to our roster of speakers.

Mike Kulla- M2M Poughkeepsie

OVERLOOKING SCIENTIFIC EVIDENCE

A surprising article published in the New England Journal of Medicine (8-28-03) takes to task the medical profession for overlooking proven methods of preventing and treating disease. The article was authored by a leading physician who is director of the National Heart, Lung and Blood Institute, a huge government agency. It really questions establishment medicine by being critical of its own members.

The author points out that life expectancy in the US lags behind 22 other countries! He attributes this to doctors not applying what we know. For instance, science has established that if a cancer or congestive heart disease patient is anemic, the chances of survival is compromised. Yet few doctors evaluate or test anemia in these cases.

According to Life Extension "most conventional oncologists are not utilizing novel information contained in their own journals...which explains why more Americans are dying of cancer than ever before, despite major advances made in the research laboratory,"

On September 26, 2003, The Wall Street Journal featured an article by the former president of the American Heart Association, who echoed the findings in the New England Journal of Medicine. He observed that "a large part of the problem is the real resistance from physicians...many of these independent-minded sorts don't like being told that science knows best." While it is easy to

point to physician shortcomings, patients may also fail to assume responsibility for their health. More on this perhaps in another article.

The New England Journal piece presents an abundance of data. For example, in the 1980s drugs became available to dissolve coronary artery clots, yet emergency room doctors were slow to catch on. Sighted in the article, was that one-third of patients presenting with an acute heart attack received neither angioplasty nor clot-busting therapies, both proven methods, resulting in suffering and death in many cases.

In 1981, beta-blockers were conclusively established to save lives of recovering heart attack patients. Yet, 15 years later, beta-blockers were being prescribed to only 62.5% of eligible patients, causing, according to Life Extension, millions of needless American deaths.

While Europeans were using beta-blockers in 1965, the FDA did not approve them for treatment of hypertension and angina until 1978. Thus 37.5% were not benefiting from beta-blockers for 31 years after they were given the green light in Europe.

Aspirin, a highly effective short-term therapy for acute heart attacks and prevention medicine in those with cardiovascular disease was prescribed to only 33% of patients as late as 2000. (Seventeen years earlier Life Extension recommended low-dose aspirin to prevent heart attacks.) Obesity has become an epidemic that threatens to play havoc with years of progress in reducing coronary heart disease, yet in a 1999 study, only 42% of obese patients were advised to lose weight.

Looming large has been the advent of HMOs where good medicine & cost-effectiveness often clash. What managed care has failed to see is that taking measures to prevent and diagnose illnesses earlier will actually save dollars and lives. Prolonging life assures that insurance premiums will be sustained. Thus, everyone benefits.

How can we arm ourselves so that we are informed about the latest advances for our particular medical situation? We could attend M2M meetings and read our newsletter and other informative newsletters. Becoming a member of Life Extension automatically brings with it their 1500 plus page reference book, Disease Prevention and Treatment, a veritable treasure trove of information not used routinely in clinical settings.

Mike Kulla, Poughkeepsie M2M

**Doctors less prepared to say people
are 'cured' of cancer
The Associated Press
Posted 9/19/2004**

At a time when more people are cured of cancer than ever before, fewer doctors seem willing to say so. They call the cancer undetectable, or in remission. They tell patients they can quit seeing cancer specialists. They quote statistics and say chances are slim that the disease will come back. They say these things because the simple truth is, they can't tell when or if someone has been cured. Even the most widely used benchmark — being alive five years after diagnosis — has no real basis in science, experts admit.

There wasn't any doubt six years ago that Doug Jensen had cancer. The Oregon engineer's blood was clogged with the immature cells that are sure signs of leukemia. Treatment with a new wonder drug, Gleevec, made them disappear.

Since then, doctors repeatedly have searched his blood, even individual molecules, for bits of DNA and other substances that would reveal he still had the disease. None has been found.

Is he cured?

"They don't use that word," said Jensen, who would dearly love to hear it. There's a label for people like Jensen who are in cancer limbo —

"survivor." Some wear it with pride, having fought the enemy and lived to tell about it. Others think it drafts them into a club to which they don't want to belong — Veterans of Forever Wars.

Nearly 10 million Americans have battled cancer, including 1.4 million who had it more than 20 years ago and are called "long-term survivors" by those afraid to call them cured.

Their ranks include Lance Armstrong, who heads a survivorship foundation and boasts of beating testicular cancer that had spread to his lungs and brain. Can he ever be declared cured, or must he always carry "survivor" with his Tour de France titles?

"The medical community has backed off the term 'cured,'" said Julia Rowland, a psychologist who directs the federal Office of Cancer Survivorship, which was started in 1996, the year Armstrong began treatment. The reasons involve more than just semantics, she and others say. Cure is a term with emotional and medical meanings about which there is little agreement.

To many people, it means that the cancer is gone and is not going to come back.

But some cancers — certain lymphomas and leukemias in particular — never go away completely yet are controlled so that they're no longer life-threatening. Some call that a remission, but others consider it a cure.

Other cancers look like they've gone away — no signs of them can be found by exquisitely sensitive and sophisticated tests — but recur many years later, suggesting that they weren't really cured after all. Breast cancer is notorious for this.

"What today does 'cure' really mean?" asked Dr. Len Lichtenfeld, deputy chief medical officer of the American Cancer Society. "Does that mean there's no cancer cells in your body from this cancer any more, or does that mean that at this particular time, there's only 2, 3, 4 or 5% chances

it's going to come back?" He's not the only one trying to define the concept.

"It's something we've had discussions about internally," said Diane Balma, public policy director for the Susan G. Komen Breast Cancer Foundation, which calls its fund-raiser Race for the Cure, not Race for the Remission. She is distrustful of absolutes. Diagnosed with breast cancer at age 30 but with no sign of it nearly a decade later, "I will never consider myself cured," she said. "Cure means there's no possibility of recurrence, and that's why I don't like the word. We all know there's a possibility of recurrence."

Ellen Stovall, who had Hodgkin's disease and now heads an advocacy group, the National Coalition for Cancer Survivorship, tries to ignore the issue. "Cure is a term that I don't need to have in order to feel well and healthy," she said. "It's a word without meaning in some respects. It may be useful for testifying before Congress or getting a job," but it doesn't predict future health.

When doctors do declare someone cured, how can they tell? In the past, it was when they could cut out a tumor and surrounding tissue until no more abnormal cells could be seen. Many doctors today are willing to call testicular, prostate and certain other kinds of cancer cured if the tumors are small and confined to a gland or organ that can be removed.

But Dr. David Carbone, a lung cancer expert at the Vanderbilt-Ingram Cancer Center in Nashville, would be reluctant to say that about the type of cancer he treats.

"All the time, I see patients who had surgery done and the surgeon says they got it all, they're cured. Statistically, they may have a good chance of being cured. But it's all a probability. Has that surgeon done them a favor by saying that?"

The opposite situation also is true: Doctors sometimes declare a cancer cured even after it

had spread beyond the place it originated. This used to be considered an inevitably terminal condition, but it's often conquered now with chemotherapy, radiation and other treatments.

Still, it's much harder to predict someone's ultimate survival after cancer has spread. Doctors look at factors like how aggressive a tumor is and where and how quickly it traveled, but not all patients get such tests. Most of the time, only time will tell.

"Some of these people have long-term survival, and some of them are going to be cured of their disease. We don't know what to tell them," Lichtenfeld said.

Which is why many doctors turn to statistics, and five-year survival is their favorite. By that measure, cancer surely is being cured: Nearly two out of three patients make it to that point today; only half did 25 years ago.

However, there is nothing magical about that benchmark. Survival is a continuum, and five years is no more meaningful a dividing point than two, three, six or nine years. "I honestly don't know where that came from. It goes back a long time," said Rowland at the federal cancer agency. She and others think it grew from a need to have some way of measuring survival and tracking cancer trends in the overall population.

More relevant statistics take into account the type of cancer someone has. With some, like bladder cancer and many of the blood and bone marrow malignancies, if someone is alive after a year or two, their long-term outlook is pretty good. But much to the chagrin of breast cancer advocacy groups and people with the deadly skin cancer melanoma, five-year survival doesn't bring great assurance that those diseases won't come back years later.

Dr. David Johnson, deputy director of Vanderbilt-Ingram Cancer Center and president of the American Society of Clinical Oncology, thinks the

five-year benchmark became balm for doctors and patients who found the unpredictability of their situations intolerable.

"Physicians were reluctant to say 'you might recur,' so they'd use these terms like 'OK, in five years, you'll be cured,'" he said. Johnson and his colleague, Carbone, both have survived lymphoma and are past the five-year mark. But statistics only tell what happens to the masses, not to individual patients. "They can't be half-cured, like they can't be half-pregnant. So a lot of time discussing percentages often isn't productive," Johnson said. "You're either cured or you're not," Carbone agreed.

Complicating matters is the risk of second cancers. Some of the very treatments used to cure cancer, like chemotherapy and radiation, actually can trigger new cancers down the road. People with an inherited genetic flaw that predisposed them to cancer still have that underlying problem after being treated successfully. "The fact that you've had cancer once means that you can get it again," Johnson said.

But some of the trickiest situations today involve people like Jensen. Average survival for his form of cancer, chronic myelogenous leukemia, was only five years until 2001, when Gleevec, one of a new generation of drugs that more precisely target cancer, came on the market.

More than 95% of CML patients do stunningly well on Gleevec, "but this may be more akin to controlling diabetes with insulin than curing diabetes," said Dr. Brian Druker, the Oregon Health & Science University cancer specialist who pioneered the drug's development.

"When we look at our patients with extremely sensitive techniques, we can still see leukemia cells," he said. "Our concern is that if we stop Gleevec, then their leukemia will come back. Are they cured? Probably not. Are they well controlled? Absolutely, yes."

Jensen is one of the few CML patients who show

absolutely no sign of cancer. He has taken Gleevec since 1999, when he enrolled in an experiment that still provides him the drug for free. It doesn't make him sick because it attacks the root causes of his cancer without killing healthy cells. He feels like he could take it forever, and wants to. But he and his doctors are considering taking him off.

"I honestly don't know what the right thing to do is," but stopping the drug is the only way to find out if he and others like him are cured, Druker said.

"That's a little scary, I have to admit. Everything's going along so well," Jensen said. But he talked it over with his wife and decided that if Druker and his other doctors ask him to, he'd probably go off the drug.

"They say it's undetectable," he said of his cancer. "I'd like to have them say I'm cured."

Joke Du Jour

I asked a friend of mine if he's going to dress up or celebrate on the last day of the month of October. He said no. Last year he went to his urologist on that date and the doctor did a rotor-rooter" job on him. Now he has a hollow weenie

Herm London-M2M Poughkeepsie

ARNOLD'S HEALTH FOODS

Purity Perfect Multi Vitamin are available along with many other supplements at Arnold's. He also offers a 20% discount (mention M2M) on all his Vitamins etc. **Call him at 845-462-6511 or visit ARNOLD'S RT #376, New Hackensack Plaza, Poughkeepsie NY. 12603.**

Getting Better

Bob Smalley is at home recuperating after a long stay at VBH, St. Francis and River Valley Care Ctr. Keep him in your thoughts and prayers.

Attention: M2M Meeting cancellations

In the future we will base our decisions whether to cancel a M2M & Side by Side meetings dependent on what the school systems in our area do. When the schools either delay or close the schools in our area, we will probably cancel. Call the local ACS at 845-452-2932, press 3, then 10 to reach the operator or answering machine. Listen to the local radio stations; they will also announce cancellations of M2M meetings. You can also call our own hot line 297-7737 and listen to message.

TO ALL RECIPIENTS OF OUR NEWSLETTER.

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Meetings and speakers for 2004

Nov,---4 Dr. Kenneth Bock- His subject will be- ALTERNATIVE APPROACHES TO PROSTATE CANCER.

Dec--- 2, Dr. Schacter from Schacter Institute.

Meetings and speakers for 2005

Jan, 6- Doug Menelly, son of Mario Menelly will speak on how he is following in his dad's footsteps.

Feb, 3- Dr. Bob Sullivan:-Good & bad diet oils.