Awareness

The "PCCN-Toronto" and "Side by Side" Prostate Cancer Support Groups

B.C.'s Dr. Juanita Crook delivers powerful message about Brachytherapy

We've seen her before. We've also heard her before.

But now, **Dr. Juanita Crook** lives in Kelowna BC, and it was great to have her back "home" in Toronto before another enthusiastic Awareness Night audience.

She knows her topic - brachytherapy - very well, now not only for men with prostate cancer, but also for some women diagnosed with breast cancer!

She started by giving a brief history of when brachytherapy started, which was in the 1970's.

The city of Seattle became an important centre for brachytherapy early on, as Dr. John C. Blasko and Dr. Haakon Ragde, two pioneers in brachytherapy, opened private clinics there.

During the evening, she discussed the many benefits of seed implants and high-dose rate brachytherapy (HDR).

She categorized prostate cancer with a Gleason Score of 6 or less, as "non-lethal", and those with Gleasons of 8 to 10 as "lethal". Although all cases are detected by the PSA blood test, these latter examples require effective and aggressive treatment.

Speaking of the PSA blood test, Dr. Crook made it very clear that this blood test **must be used as a very important screening tool!**

She was proud to point out that the long-term results of brachytherapy equal that of the **radical prostatectomy**, thought to be the "gold-standard" for many years.

She told us how brachytherapy was first-introduced as a treatment for breast cancer by radiation oncologist Dr. Jean-Philippe Pignol at Sunnybrook's Odette Cancer Centre. Dr. Crook currently treats prostate cancer **and** breast cancer with brachytherapy.

During her presentation, she showed the audience various scans of how radioactive seeds are placed within the prostate gland and the breast. She commented that *"it is much easier to access the breast than the prostate!"*

She showed examples of how little scarring there is on the breast after treatment, which is normally a 90-minute procedure.

An unfortunate series of small technical problems couldn't deter Dr. Crook from delivering her very professional message about brachytherapy to our audience. Her only comment was said, jokingly: *"I'll never give a talk again on the 13th!"*

We sincerely thank Dr. Juanita Crook for coming to Toronto and presenting such an interesting lecture on Brachytherapy!

2017

Prostate Cancer Canada Network Toronto

OCTOBER

PCCN-Toronto Prostate Cancer Support Group

541 Finch Avenue West
Toronto, Ont. M2R 3Y3
Phone: 416-932-8820
Fax: 416-291-3025

Email:
info@pccntoronto.ca

CONTENTS

In Memoriam

William Dwight Griffin (1945-2017)

Died peacefully on August 22, 2017, but his spirit will live on in his family, friends, those he worked with and those he taught. What a truly wonderful, witty, intelligent and caring man. His slightly warped humor and his interest in everyone and everything will be missed by his wife Pam (Chappell), his daughters Lisa Griffin, Sarah Griffin and Kate Alton, grand-children Eleanor and Luca Alton, sister Joanne (Bob), brothers Carm (Judy) and Glenn (Susan) and so many in the theatre community, choirs, Sugar's, former students of Dalhousie University and well, pretty much everyone with whom he came in contact. He had so much more life to share, travels to take and books to read. The world has been a better and kinder place with him in it.

Jerry Stevens

On Saturday, September 2, 2017 at his home. Best friend and partner for 48 years to Gina Kyron. Loving father and father-in-law of Joyce Kwart and Steve Salkovitch, Joel Stevens, Jordan and Sigal Stevens, Joanne and Fred Enzel, and Jason Kyron. Devoted grandfather of Jared, Dylan, Blake, Tamara, Stephanie, Melanie, Jacqueline, Hershel, Sara, Kinor, Chana, and great-grandfather of Mendu and Chaikel. A graveside service was held on Tuesday September 5, 2017.

Memorial donations may be made to the Princess Margaret Hospital Foundation - 416-946-6560 - or Agudas Chabad - 905-731-7000.

PCCN-Toronto offers our sincere condolences to all members of these two families.

PCCN-Toronto thanks Dr. Rob Bristow

Dr. Rob Bristow, for years a senior scientist at the Princess Margaret Cancer Centre in Toronto, has relocated to Manchester England and has become the new Director of the Manchester Cancer Research Centre.

He was a Clinician-Scientist at the Ontario Cancer Institute/ Princess Margaret Cancer Centre and Professor within the Departments of Radiation Oncology and Medical Biophysics at the University of Toronto. He received his MD, PhD from the University of Toronto (1992; 1997) with post-graduate training at the MD Anderson Cancer Center, Massachusetts General Hospital and Erasmus University-Rotterdam. His laboratory has shown that the tumour microenvironment alters DNA repair which may be Achille's heel in resistant cancer cells. He is currently developing novel genomic signatures relating to DNA repair and prostate cancer to predict treatment response. Dr. Bristow was Co-Director of the STTARR Innovation Imaging Facility (MaRS Complex) and was Lead for the Canadian Prostate Cancer Genome Sequencing Project (CPC-GENE); part of the International Cancer Genome Consortium (ICGC).

Dr. Bristow was one of our Awareness Nights speakers, and made himself available to us whenever possible.

All of us at Man to Man/PCCN-Toronto wish him the best of luck in his new and challenging position.

Our 2017 newsletter sponsor!

PCCN-Toronto is supported by:

Janssen Pharmaceuticals / KELLER WILLIAMS Neighbourhood Realty / Mi5 Print & Digital / Macgregors Meat & Seafood Ltd. / Prostate Cancer Canada

PCCN-Toronto & Side by Side

invite you to attend our final 2017

Janssen Awareness Night Meeting

at the
Toronto Botanical Garden
In The Garden Hall
777 Lawrence Ave. East at Leslie Street

on Wednesday

November 22, 2017

at 7:30 p.m.

our guest speaker

Leah Jamnicky

Princess Margaret Cancer Centre

will host a:

Partner, caregiver, and survivor forum!

A question period will follow.
All family members, partners & friends are most welcome!

FREE parking!

If you have any questions, please call us at
416-932-8820

2017 Meetings Benefit North York Harvest Food Bank

Please bring some non-perishable food with you to our Janssen Awareness Night Meetings, which PCCN-Toronto will donate to the *North York Harvest Food Bank*.

Here is a list of their much-needed items. Please note that all expiration dates must be valid and canned goods cannot be damaged (dented). Thank you very much.

- √ *Canned fish & meat*
- √ *Canned vegetables*
- √ *Canned fruit*
- √ *Cooking oil - canola or olive oil*
- √ *Cereals - high fibre*
- √ *Peanut/almond butter*
- √ *Cookies (arrowroot, digestive, oatmeal)*
- √ *Flour*
- √ *Brown pasta*
- √ *Powdered milk*
- √ *Canned or dried beans*
- √ *Rice - white & brown*
- √ *Baby formula & diapers*
- √ *Baby food & cereals*
- √ *Fruit juice - 100%*

NORTH YORK HARVEST FOOD BANK

www.northyorkharvestfoodbank.com

All of our 2017 *Awareness Night meetings* at the Toronto Botanical Garden and our *PCCN-Toronto Man to Man Peer Support Group* meetings at Valleyview Residence are being supported by a grant from Janssen Pharmaceuticals.

We sincerely thank *Stacey Silverberg* and all the people at Janssen for their very generous financial support.

The Board of PCCN-Toronto.

Dr. Perlis discusses Focal Therapy

The first thing **Dr. Nathan Perlis** said, after being introduced by our chairman Phil Segal, was: *"What Phil didn't tell you is that he has known me since I was a baby!"*

Chairman Phil Segal and guest speaker Dr. Nathan Perlis.

He started his presentation by saying that Partial Gland Ablation is equivalent to Focal Therapy. Dr. Perlis mentioned that Focal Therapy is still considered to be somewhat experimental, as it has only been around for ten years. He then thanked one of his mentors, and a long-time supporter of our group, Dr. John Trachtenberg, for being a pioneer with Focal Therapy.

To watch Dr. Perlis' entire presentation on Focal Therapy, please go to **www.pccntoronto.ca/videos**.

We sincerely thank **Dr. Perlis** for speaking at our July Awareness Night meeting.

2018 AWARENESS NIGHT MEETING SCHEDULE!

A committee has been working hard, planning another exciting lineup of awareness night speakers and topics for 2018!

We are pleased to announce that our first speaker of the New Year will be **Dr. Stanley Flax**, from North York General Hospital. His presentation, on Wednesday **January 31st**, will discuss the new perineal biopsies that their Branson clinic has been doing for several months, with tremendous success. He will be joined by **Dr. Adam Tunis**, a radiologist at NYGH, who will highlight the important role that imaging plays in the success of these biopsies.

Dr. Sidney Radomski, a friend of our support group for many years, has also agreed to speak at our **November 28th** meeting: his topic will be - incontinence, erectile dysfunction, and sexual "toys". This promises to be a very interesting talk!

Other topics we are still pursuing: a) an update on treatments and clinical trials; b) "Survivor Forum" night; c) a night on exercise and diet. More information to follow.

TrueNTH (True North) Peer Navigation

This is a new program at the Princess Margaret Cancer Centre that connects prostate cancer (PCa) patients or caregivers with trained **peer navigators** who have been through the journey first-hand.

They are looking for PCa patients and caregivers who are looking for one-on-one support from someone who has already been there!

1. Have you been diagnosed with PCa, who will receive or have received treatment for PCa? 2. Are you a caregiver of a man with PCa? 3. Are you comfortable using computers and the Internet?

What's involved:

1. Use a website to be matched with a peer navigator who has been through the PCa journey and has been trained to provide peer support. 2. Get one-on-one support from your peer navigator, who will support you through your journey for 6 months. 3. Complete the program evaluations.

For more information or to volunteer, please contact program coordinator Mihaela Dirlea at miheala.dirlea@uhn.ca or 416-581-7652.

If you would rather receive this newsletter electronically, please email info@pccntoronto.ca and we'll remove you from our regular mailing list and add your name to our email list. Thank you.

Meet our newest board member: Keith Braganza

I live in Toronto with my wife Sharon and daughter Bianca. The last thirty-two years of my life were spent selling medical equipment to hospitals and clinics in India, the Middle East and Canada. My wife works as a Clinical Research Associate with cancer treatment trials at Sunnybrook's Odette Cancer Center, while my daughter is completing her Master's degree in Global Health.

I was diagnosed with prostate cancer in June 2015. My PSA readings had been steadily rising over the past few years and climbed to 9 when my urologist suggested I undergo a biopsy. Out of twelve biopsy cores, three were positive – two with Gleason score of 6 and one with Gleason score of 7 (3+4).

After meeting with a Urologist from North York General Hospital and a Radiation Oncologist from Sunnybrook, I was leaning toward surgery because I felt that if the cancer was contained within the prostate, removing it may rid me of the disease. I asked my family physician to refer me to Princess Margaret Cancer Centre for a second opinion. I met with Dr. Neil Fleshner who felt surgery was a better option for me, considering my age (59 at the time) and Gleason score. He also felt that radiation could result in secondary tumors down the road assuming normal longevity.

Dr. Fleshner performed a Robot-Assisted Laparoscopic Radical Prostatectomy on me in November 2015. My pathology report indicated that the cancer had escaped my prostate capsule and my post surgery PSA readings did not go down to "undetectable" levels. A follow up test three months later showed that my PSA reading had gone up further by a factor of 10. I underwent salvage External Beam Radiotherapy in July/August of 2016 and also started concurrent Androgen Deprivation Therapy (ADT). I will continue on ADT for another year.

Since my diagnosis, I have been attending PCCN-Toronto meetings regularly. I found the meetings and interactions with the other volunteers very helpful in dealing with my prostate cancer situation. I decided that helping other prostate cancer patients was what I wanted to do going forward.

I am now a Peer Navigator mentor with the TrueNTH project, set up as a joint venture between Princess Margaret Cancer Center, Prostate Cancer Canada and the Movember Foundation. I am hoping to use my knowledge and experience to help newly-diagnosed prostate cancer patients deal with their illness by providing emotional and educational support on a one-on-one basis. My wife Sharon is also a Peer Navigator, who will assist caregivers of prostate cancer patients to deal with their partners' illnesses.

The PCCN-Toronto prostate cancer support group provides an invaluable service to prostate cancer patients and survivors. I would like to help PCCN-Toronto in their current function as well as assist in educational programs to create awareness about prostate cancer so men can be more diligent in getting themselves screened with a view to early detection.

Keith was recently invited to join the Board of PCCN-Toronto. We all wish him the best of luck in his new position as Director.

"The biggest lie I tell myself is:
I don't need to write that down. I'll remember it!"

ASK THE DOCTOR

Radical prostatectomy in Canada: Trade-offs between open and robotic approaches.

by DR. NATHAN PERLIS

For over 30 years, a nerve-sparing, radical prostatectomy has been a cornerstone treatment for men with localized prostate cancer. In intermediate-risk/Gleason 7 prostate cancer, most men are faced with the challenge of deciding between a radical prostatectomy and radiotherapy. The choice is complex. Thus, many men take time to synthesize information from clinicians, decision aids, patient advocacy groups, colleagues, family, and friends. For patients, this decision is made even more challenging by the perpetual evolution of technologies used in surgery and radiation oncology. It is hard to account for how a novel technology may modify treatment effect and toxicity. This is the case when contemplating the differences between an open prostatectomy (ORP) and a robotic-assisted laparoscopic, radical prostatectomy (RALRP). In this article, I will review the similarities and fundamental differences between the two operations including the relative benefits and harms. I will then discuss the adoption of RALRP globally and locally, and review the recent recommendation against funding robotic prostatectomy by the Ontario Health Technology Advisory Committee (OHTAC).

As a brief overview, a radical prostatectomy, whether done open or robotic, is comprised of virtually identical steps. A pelvic lymph node dissection is often performed to see if cancerous cells have spread. The prostate and bladder are mobilized, the veins overlying the prostate are clamped, the neurovascular bundle is separated from the prostate when feasible, the prostate and seminal vesicles are separated from their attachment to the pelvic floor, urethra, and bladder. The bladder is then sutured back to the urethra at the pelvic floor. Patients have a urethral catheter for 1-2 weeks and are hospitalized for 1-2 days. While the cases are very similar, there are times that one is particularly preferred over the other. For example, men with previous complex abdominal surgery may be better suited for ORP because RALRP incisions are higher on the abdomen and might compromise previous work done in an abdominal operation. Occasionally, the size of the prostate or the aggressiveness of the tumour would influence the surgeon to suggest one approach over the other.

There are, however, some important differences for the surgeon and patients between the two forms of surgery. The most obvious example for the surgeon is that in open surgery the urologist is able to have tactile feedback during the case. In a surgery like ORP, where even a millimetre can mean the difference between complete cancer excision or not, it is an obvious advantage to rely on touch. When comparing this to RALRP, the surgeon's eyes become his or her "tactile" feedback. With experience, the robotic surgeons learn how various tissues respond to the instrument's energy and this can inform them of whether they might be in the appropriate location during a particular part of the surgery. Proponents of the robotic approach highlight that the lack of real tactile feedback is offset by the magnification of the robotic camera and dexterity of robotic instruments which mimic a human wrist to allow the surgeon to suture freely deep in the pelvis.

For patients, the main difference is the incision. In ORP a single incision roughly 10-15 cm long is made in the lower abdomen, while in robotic surgery 5 or 6 keyhole incisions are used to perform the case. At the end of a RALRP, one incision is lengthened so that the prostate specimen can be extracted.

In considering the relative benefits and harms of ORP and RALRP and the quality of a patient's experience, its simplest to compare short-term and long-term issues. To measure short-term quality, we look at blood loss, operative time, length of stay in hospital, post-operative pain, major surgical complications, and hospital readmissions. In the long-term, the main three domains are cancer control, urinary continence, and erectile dysfunction, although other items such as bladder neck contracture (scarring of the urinary passage) are vital too. Finally, let's not forget the surgeon him or herself, and the ergonomic impact these operations have on their bodies.

One caveat for most of the studies in this field is that they are non-randomized. The reports come from "observational studies" where outcomes of men undergoing the two forms of surgery are compared. Unfortunately, these types of studies are prone to what is called "selection bias", because, for example, if men were selected for RALRP instead of ORP because they were healthier and had better tumours, then even if the technique were inferior, they could have better outcomes. The best way to avoid this bias is to perform a randomized trial where patients are randomly assigned to ORP or RALRP. There is one such trial, which I will discuss. Unfortunately, it has its own limitations.

Short-term complications seem to be higher with ORP than with RALRP, but the differences are not major. For example, in a study reviewing the 30-day complication rates in 28,497 men treated with prostatectomy between 2009 and 2014 as collected by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), RALRP had longer operative times (209 vs 168 minutes) but fewer 30-day complications [1]. Specifically, length of stay was shorter with RALRP (1.7 vs 2.8 days), blood transfusions were less frequently utilized (1.5% vs 13.6%), and wounds infections were rarer (0.3% vs 1.4%). These findings are supported by a recent study that combined the results of 78 studies with information on short-term complications of ORP and RALRP [2]. Here the authors suggest that robotic surgery is accompanied by less intraoperative blood loss, lower blood transfusion rates, shorter time to remove catheter, shorter hospital stay, and fewer overall complications and readmissions.

In the long-term, cancer control, urinary continence, and erectile function are comparable for both ORP and RALRP. In a study of 3000 patients from 14 centres in Sweden, at 12 months after surgery, urinary function was similar between patients receiving ORP and RALRP [3]. In the same study, erectile dysfunction was slightly less common in men undergoing RALRP.

The randomized study previously alluded to was performed by a group in Australia, where, between 2010 and 2014, 326 men were randomly assigned to ORP or RALRP [4]. It demonstrated that at 3 months following surgery, urinary control and erectile function were similar between the groups. The proportion of positive margins (microscopic cancer left behind) was similar, too. Surgical time was actually longer in the ORP, which also had higher blood loss and length of stay in hospital. Although rare, significant post-operative complications were more common in ORP than RALRP (7 vs 1 event). Overall, the authors suggest that the trial did not demonstrate major differences between the techniques when assessing patients 12 weeks after surgery. The major limitation of this study is that all the ORPs were done by a single experienced urologist while the RALRPs were done by a single, junior faculty. Thus, while the study does compare ORP to RALRP, its hard to separate that comparison from the comparison of surgical skills of just two surgeons. It is possible that if the cases were done by multiple surgeons with equal experience the outcomes could have been different.

This is the context in which OHTAC had to consider whether to fund RALRP in Ontario. The committee recognized the shortened length of stay and blood loss with RALRP. They acknowledge (mostly based on the Australian randomized trial) that urinary and sexual function are similar at 3 months after surgery. They also appreciated the fact that RALRP offers a more ergonomic option for surgeons with a reasonable learning curve and that many patients seek out this approach. However, this was all offset by the cost. The additional per-case cost of RALRP is approximately $6,000 CAD. If utilization would increase from 30% of cases (current Ontario estimate) to 60% (current usage is ~80% in the US) the budget impact would be greater than 3 million dollars. In light of its relative benefits and other priorities in the province, OHTAC, in a preliminary publication, is suggesting that the cost should not be footed by the province.

Continued on page 7

"I used to think that 'growing old' would take much longer!"

CEO Rocco Rossi leaving Prostate Cancer Canada

On September 7, 2017 President and CEO of Prostate Cancer Canada (PCC), **Rocco Rossi**, announced that his time leading the organization will officially come to a close on December 31, 2017.

"To have had the honour of serving the 1 in 7 Canadian men who will be diagnosed with prostate cancer in their lifetime, and their families over the past five years, has been no less a humbling journey than it has been an inspiring one," explained Rossi.

Rocco attended our September Awareness Night and thanked PCCN-Toronto for once again raising the most money among all the PCCN support groups in Canada (for the **Do it For Dads Walk**).

He added that it has been a real pleasure working with the PCCN-Toronto survivors/volunteers.

We all wish him the best of luck in his new position of CEO with the Ontario Chamber of Commerce.

ASK THE DOCTOR - continued

If the government won't pay for RALRP, will it vanish? Who has been paying for it for the past 10 years in Canada? This is a complicated issue and the answer varies between provinces and hospitals. But for the most part, robotic surgery is paid for by generous patients and donors in philanthropy campaigns. So far this has kept the handful of robotic programs running, but there is no guarantee that the generosity of our fellow citizens can continue to support these initiatives.

I think there needs to be a balance here. It does not make financial sense to have a robot in every hospital and robotics is not appropriate for all cases. But it has been demonstrated to offer good functional outcomes with perhaps lower rates of complications. In my practice, if patients and tumours are amenable to RALRP I generally offer it. It turns out that roughly half of my cases are done open and half robotically. This may be a judicious way to use resources. At the end of the day, I strongly believe that the most important consideration is who is doing the surgery and not how the surgery is being performed. We still have a lot to learn and explore on this subject.

Nathan Perlis, MD MSc FRCSC
Assistant Professor, University of Toronto
Urology Staff – Princess Margaret Cancer Centre and Toronto General Hospital
Urologic Oncology, Minimally Invasive Surgery

Ottawa Regional Conference
by Chairman Phil Segal

Ari Katz, Winston Klass and I attended PCCN-Ottawa's Prostate Cancer Conference "Discover the Future", held in Ottawa on Friday night and all-day Saturday - Sept. 15 & 16th.

The conference was PCCN-Ottawa's first all-day conference and was very successful, with over 120 persons in attendance from as far away as Thunder Bay, many from the GTA (Burlington, Brampton, Oshawa and Toronto), and a number of participants from Quebec. The majority of participants were from the greater Ottawa area.

The conference opened on Friday night with a 2-hour registration and networking meeting. Rocco Rossi, the President and CEO of Prostate Cancer Canada, addressed all the attendees.

The conference officially began on Saturday morning with breakfast, followed by a terrific session with the urological doctors from the Ottawa Hospital. Items discussed were: robotics, clinical trials, screening, imaging, radiation and advanced prostate cancer. Each doctor gave a brief but thorough presentation and, after a nutrition break, there was a panel discussion with all the doctors answering questions from the audience.

I think all the conference attendees agreed that it was an excellent morning, and we came away with an increased appreciation of the Ottawa group's commitment and excellence.

Following an excellent buffet lunch, the afternoon sessions focused on the psychosocial aspects of prostate cancer. A representative from the Ottawa Hospital discussed their psychological oncology program, and a representative from the Ottawa Regional Cancer Foundation discussed a program they run called **Cancer Coaching**. There was a brief testament by a recent prostate cancer patient, describing the benefits he felt he had received from the coaching. This was followed by a naturopathic doctor from the Ottawa Integrative Cancer Centre discussing Naturopathy and its role in complementary cancer care. Both of these sessions included a question and answer period with the presenters.

After a final afternoon break, the meeting was closed with an enthusiastic presentation by Dr. Rob Rutledge, a radiation oncologist from Halifax, who is the chair of the Healing and Cancer Foundation. Dr. Rutledge's presentation was entitled "Mind-Body medicine for prostate cancer: practical advice based on science and medicine". His presentation included participant involvement with exercises. This final presentation left everyone enthused and was a great way of ending the conference on a high.

Kudos to the PCCN-Ottawa team, who worked long and hard to put on this excellent conference.

Are you interested in becoming a PCCN-Toronto volunteer?

Please call our support line - 416-932-8820
or email us at info@pccntoronto.ca

Our on-going projects for 2017

THE JANSSEN AWARENESS NIGHT MEETINGS

These meetings are held at the **Toronto Botanical Garden (in the *Floral* or *Garden* Hall)**, at the corner of Lawrence Avenue East and Leslie Street, from 7:30 - 9:30 p.m. Leading medical professionals speak on a range of topics related to prostate cancer and then, following a refreshment break, answer your questions. Family members and friends are welcome to attend. If you are on our mailing list, a notice of each meeting will be sent to you. **PARKING IS FREE.**

Please bring some non-perishable food with you for the North York Harvest Food Bank. (See page 3)

DATE	RM	SPEAKER	TOPIC
Nov 22	G	**Leah Jamnicky** *Princess Margaret Cancer Centre*	Partner, caregiver, and survivor forum.

2018

Jan	31	Dr. Stanley Flax & Dr. Adam Tunis	Perineal biopsies and the use of imaging.
Nov	28	Dr. Sidney Radomski	Erectile dysfunction, incontinence, and sexual "toys'.

Man to Man Peer Support Meetings - 7 p.m. to 9 p.m.
These meetings take place on the **FIRST** and **THIRD** Tuesday evenings of each month at the **Valleyview Residence**, 541 Finch Avenue West (just west of Bathurst Street on the Branson Hospital site) in the All-Purpose Room. They provide an opportunity for men to talk in a safe and comfortable setting about dealing with their diagnosis of prostate cancer.

Side by Side Peer Support Meetings
This program has undergone some recent changes. Our ladies' support group, although still very active, now provides advice by appointment only. Please visit our website for more information.

Visitation
Trained volunteers, all prostate cancer survivors, will talk to you/your family in your home, by telephone or in the hospital. Each week our volunteers visit surgical patients at **Toronto General Hospital** (Thursday & Saturday) and **Sunnybrook Hospital** (Thursday), bringing them messages of hope and support.

Counseling
Our volunteers counsel men (and their families) in prostate cancer clinics at the **Princess Margaret Cancer Centre (**Monday through Friday), the **Odette Cancer Centre** (on Thursday), and **The Gale & Graham Wright Prostate Centre at North York General's Branson site (**on Tuesday afternoon).