Courtney D. DiNardo, MD, MSCE
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(Inaudible group chat 0:00 – 8:04)

J: … ask for an understanding of what it exactly is. It is very complicated and Leslie and I were talking about her time (inaudible 8:16) and I was just explaining to her that MDS was not known about 10 years ago… 14… 12 years ago. Sorry. Give or take 12 years ago. It was known as a preleukemia. We have a terminology for it. We have a name for it. So, this is all of the things that we should (inaudible 8:38) that people are going through. This is all new. This is a new development. So, if that's the case could you just imagine the new doctors that are coming on board? (inaudible 8:50) MD Anderson. The new doctors. They may not even know about MDS. They may just know that people, there's some kind of (inaudible 8:59) problem. We're not sure what it is, but there's a problem. I mean, a key point is to understand that there's a problem is know who to refer it to, who the right doctor is that he knows that there's a need for education and even the doctors don't know about it.

Q1: Twelve years, that's a long time when you're talking about medicine. Technically, (inaudible 9:26) imagine if there's still doctors that that's… I've heard that another person, friend that I met here was stating that a transplant right now. She's diagnosed a month before me and she was the same way and said they kept on seeing those white counts and said, "Oh, (inaudible 9:45) white counts." So, they followed probably two or three years and so…

J: You have to do with doctors on board practicing to some degree and how to keep up with continuing educating. Like with any job that anybody ever does, you have to maintain certain amount of credits for a (inaudible 10:09) or whatever. So, it's a similar concept. I think it's hard to kind of keep up with such a small little kind of entity of a disease. I think in general people are well known or familiar with solid tumor cancers, lung cancer, GI cancer. Hematology has a blood cancer is you really have to (inaudible 10:33) with… like Dr. DiNardo, who's sitting here. She is a (inaudible 10:38) in taking care of specifically for leukemia (inaudible 10:42)

Q1: The other thing is that this is really rare and there's… In the US, I think, it goes into like 10,000 diagnosis (inaudible 10:56) right now per year and so when you think there are 400 million people in the US and 10 dozen are going to come up with that is really, really, really rare and so even the hematologist may only have one patient with MDS even in a relatively big city. I'm talking about Houston, but I'm talking about maybe the capital city and maybe…

J: Dallas, Austin…

Q1: Someplace that is you would think would be sophisticated on being state capital of a smaller city, a smaller capital.

Q2: I've heard 20, but by the time you go through 10 years, you got 200,000 people. My hematologist before I came over here probably had 100 patients, but she's got her own practice.

Q1: Two hundred thousand, that's one in 2 million.

Q2: Pardon?

Q1: If you go back… even if it's 200,000 is that 1 in 200,000. But it's still in 1 on 200,000. That's a lot, but we (inaudible 12:24) that that's very small.

J: You got to understand though if people are not being diagnosed properly from a few stories that we already kind of confirmed, you can understand that how many (inaudible 12:36) people are being diagnosed with being, say, iron deficiency, anemia and not classify that as a truly (inaudible 12:46) That being said, that's what I'm trying to just make a point of is that it needs to be still a lot more education from the (inaudible 12:56). It's a growing field and it's going to (inaudible 13:00), but breast cancer is (inaudible 13:02) involved in breast cancer management. The same thing is going to happen with MDS. The unfortunate part is with MDS is that these are the different types of MDS and you're probably saying, "Oh, my God, Jay. I don't understand what that is. All I know is that it's a very busy slide." Well, that's what it is. It is so complicated because in this room, all of you guys or caregivers or your family members or your spouses, all of you guys that have MDS here, you all have different form of MDS. There is not one person in this room that has the same. That's what I mean is that it's a disease specific based type of disorder/cancer. So that being said, everybody has to have a specific recipe to treat that person.

Q1: Well even (inaudible 14:03) to me the (inaudible) still even though this is a new name for what a lot of people. They used to call it preleukemia, but Myelodysplastic Syndrome still doesn't indicate cancer.

J: And it's true and it is the wording of it, but it is cancer because if you leave it untreated long enough it can definitely cross over the line of becoming with 20 percent blasts, it can cross over to (inaudible 14:32).

Q1: Right, but is it really cancer though? Is it low risk? Is it really still considered a cancer that when you're low risk?

J: There's lots of debate about that. (inaudible 14:44) knowing that question because you asked. Half of the community doctors or any physician on one side, they'll say that is cancer and the other one will say no. It's not cancer. It's preleukemia or dysplastic… the something. With MDS, it's so convoluted because you can have atoxic anemia with it. You can have myelofibrosis with it. You can have other type of red cell disorders with it. So, it's all kind of just said it's… That being said, what I want to make to make a point of it is that the stem cells

itself is a defective stem cell (inaudible 15:29), but it doesn't work properly is when it becomes known to be as cancer.

Q3: So, the (inaudible 15:40) all things you just mentioned, it's in the bone marrow?

J: Yes.

Q3: So, then why then it's just called (inaudible 15:45) cancer. You're talking about breast cancer, you're talking about lung cancer. I mean, that's…

Q2: It probably is.

Q3: Because you don't hear that. I tell a few of my colleagues when I was explain what she had, (inaudible 15:56) it took me a couple of months just to put the myelodysplastic and so like I said, Dr. DiNardo when she said what it is is it's the bone cancer and she explained it so simply.

Q2: It's also true that MDS can migrate into ALS and some other forms which are more…

Q3: Which is a blood cancer.

Q2: So, that's why it's a branch of leukemia really.

Q1: It is, but until they really have a good handle on what was going on with all of these… all of the people that have that they diagnosed with MDS, it wasn't even considered a cancer until about seven or eight years ago, eight or nine years ago. I mean, so, until they knew what the mechanism was and how… and I think that the diagram… the definition of cancer has changed. The definition of cancer now is that it's going on the cells, the genetics of the cells and the genetics of the cells that the genes in the cells are causing the cells to reproduce abnormally, produce abnormal cells and produce those abnormal cells much, much faster that whole (inaudible 17:18) cells is growing a whole lot faster than the normal cells are rounded that should have been and so the whole definition and the whole idea of cancer is that it's these cells that are defective genetically and are overtaking the surrounding population.

J: I'd like to always try to make a simple analogy so people can, my patients who have MDS how it (inaudible 17:48). So, they can go home and it would be like, "Oh, what did I hear? It's not complicated." I present it as a garden guarding the (inaudible 17:59) for the plant (inaudible) to grow. Those seeds are different forms of seeds. Cucumber seeds, tomato seeds (inaudible 18:10). So each seed represents either red blood cells, white blood cells or platelets. Those seeds if you look at them, they're cracked. They're not perfect the way they're supposed to be. They're not going to grow. It's the same concept in the garden if you have broken seeds that are not functioning which is the stem cell and the hematopoietic stem cell which represents the seed is

not going to grow. That means that they are either dysplastic or they become cancer, truly a form of cancer. The representation of a blast which is identified as cancer.

I like this slide just to kind of what Dr. DiNardo was explaining. Cells are abnormal in shape, dysplastic. They don't work well. Their function, those seeds, they have a message already in them. Today I need to grow as a green tomato, a red tomato, a purple tomato. Those seeds have a message already. They are programmed. Preprogrammed. That's why we plant them because I want a green tomato. I don't want a purple tomato. It's the same concept, but when they're weeds in a garden, you don't like those weeds because we got to pluck them out. Otherwise those tomatoes and cucumbers and jalapenos won't grow. Those weeds represent basically mutations. An overgrowth of abnormal cells. I don't want that and get rid of those weeds. We need chemicals. We try the natural way sometimes tabasco sauce or something else or whatever, weed spray, whatever. It doesn't work. So then we you have a goal. Hence that becomes our chemotherapy. That becomes our hypomethylating agent. Stuff like that. Revlimid. Stuff like that. You throw it in there to say stop those weeds from growing and let the stem cells do its job.

Q4: Are these slides in this stuff?

J: They actually are not, but all of the information I'm presenting is in there. It's broken up into (inaudible 20:32) and if you ever want these slides, just ask Debra. She will forward them over to you by E-mail. On your way out if you want it, just let her know or Audrey will be happy to send it to you. I like these. They're simple and when patients get a diagnosis of MDS they're processing and maybe understanding it, but their friends and family, so they're trying to understand. They're like what are you talking about? I don't understand. It's different when you have blood cancer versus a solid tumor cancer. So, solid tumor, I could show you an x-ray I have to show you what's normal with a lump, beautiful lump, nice and open, tissue that you can see throughout and you can see the diaphragm and a nice curvature of the lung and when there's lung cancer, you can see that spot right there and say that's where we need to go. We're trying to shrink that sucker, surgically remove it or radiation. Done. In, out, gone. When dealing with blood, it's complicated (inaudible 21:46) all of this and it's hard to explain or conceptualize in our mind that these. That's why my patients say, "Jay, I don't understand. How do I know except when you do a CBC?" When you do a blood count that's when you know that there's something going on. You can also tell by a patient's color looking at him and you probably (inaudible 22:11) going back. (Attendee) didn't look that well. You see that color is a little off, a little grayish, kind of a tinge to it. You can see that happening. You can see if a doctor know what to do with it.

I like this slide because it explains very simply. I like pictures. On the left hand side is the bone marrow which the main bone marrow is right here in the iliac crust. The other bone marrow that you have in other areas is the sternum and also a little bit in the femur. Very little in the femur, but mostly in the sternum right here because sometimes people will need to do biopsy if you can't get it here, they go here. You probably think, "Oh, my God. They're going to go right

through the heart, Jay." No. They're trained. They know what to do and how deep to go in to get the biopsy sample. They need that liquid and they need a bone chip. So, we need two things from that and that information from that you're going to get the cytogenetics which is what you are made of, and me, made of right now. Right now time wise. If you go back 10 years ago, I would have to do a bone marrow 10 years ago. People are always wondering, "Jay, how did I get all these mutations? What happened?" I always try to explain to them whatever happens in the last 57 years of your life and now you have mutations. It's probably evolved over time or you got exposed to something. Maybe you had a different cancer and you got treated like Robin Roberts. Breast cancer, a couple years later she got MDS and it's (inaudible 24:06). Who knows what triggered what. Nobody knows.

(inaudible 24:12) having a hematopoietic stem cell. Those are the seeds that I was referring to in your garden. Your bone marrow is your garden. So, those stem cells are given to you from your mom and your dad already preprogrammed. (Attendees)'s stem cells, they're already preprogrammed before she got the transplant. It's there to do whatever it is programmed to do.

Q5: What is hematopoiesis?

J: That's just your cell line, your cell line.

Q6: What that means to me (inaudible 24:51) it makes the blood.

J: So, that's just your stem cell, your make up of who you are. From that they already is programmed to say I'm going to make a myeloid red blood cell, a lymphoid cell, already preprogrammed. Today, I feel like making a white blood cell. Today I feel like making a platelet. So, that's what it does. Is that cool? I think that's so cool that our body knows what to do. It's preprogrammed. We have no control over it, but we do. Nutrition, rest, less stress, it's not possible, but we try. All of the good things to stay happy and focus on good things of life what we all have to think of at the end of the day. All of those different little (inaudible 25:51) over here. These are the different white blood cells that we have, neutrophils, (inaudible 25:56), monocytes. Platelets help you clot. So, those are numbers that you get on the CBC. You get a white blood cell, too. A total white blood cell count and the red blood cell which is your hemoglobin. The white blood cells is your differential. That's what those little different types of white blood cells are. Some are not (inaudible 26:19), some are. So intrinsic and extrinsic factors we defect the normal hematopoiesis. That just basically means that intrinsic means (inaudible 26:33) something goes awry and get that, "Oh. You know what? Today I'm going to make up one mutation and cause this problem." Extrinsic means something like a chemotherapy or a radiation. The patient gets prostate cancer. They need (inaudible 26:53), they need radiation piece to be implanted. Well, that procedure is done. Five years later something happens in that process where the bone marrow is that says you know what? I'm tired. I'm going to shut down. I'm not going to make those white blood cells now. I'm not going to make that hemoglobin now and I'm not going to make platelets now. Hence, maybe they start developing MDS to come out.

It's a possibility. It creates an immature precursor cell, which I call that weed. Hence, in peripheral, peripheral meaning outside and closer to the blood. When you collect blood sampling, it creates cytopenias. Cytopenias is when we can look at CBC and evaluate what is going on. That's when we know that there's a problem. It creates a hypercellular bone marrow. So, that's one concept. The other concept is it can also create that hypocellular bone marrow. Hypocellular is when the bone marrow doesn't have a lot of weeds. It has nothing. It's called plastic (inaudible 28:09) completely gone. Patients who have aplastic anemia, they may present with a cleaned out bone marrow and the stem cell, maybe just a few here and there. Those patients getting different treatment. Why? They have a little clone similar to MDS (inaudible 28:31) able to treat with different type of auto rejection type of medication.

Q6: Don't all MDS people have high (inaudible 28:41)?

J: No. Some have hypo, some have hyper. (Attendee) has a combination. She has multiple myeloma blood cancer type of pre/baby multiple myeloma plus a little touch of MDS. So, it's that combination. So, every person is unique. I know, you say, "Oh, God, Jay. Oh, no."

Q7: Get back in the weeds (inaudible 29:08)

J: But your understanding that that's what makes this so complicated is that all those tests on the left hand side is a basic workup for a potential, maybe an MDS, patient. It involves a whole bunch of stuff. It involves a lot of follow up, making sure those that check up properly and they're negative. This is all the different types of MDS, which I showed you earlier on the left hand side. The names of the top, the classification system, (inaudible 29:48) dysplasia and a percentage. It's basically just like big doctors like Dr. Garcia Manero and (inaudible 29:58) soon to be Dr. DiNardo in the future also other doctors getting together and coming up with classifying and coming up with the verbiage of identifying preleukemia as calling it MDS. So, getting together as a group, big shot doctors, they know a lot more about it and kind of grouping it together to have people understand it.

So, they created the IPSS scoring. What is IPSS? It's basically a prognostic scoring system. So, that is basically to say okay, a lung cancer patient, a stage four lung cancer patient. Their survival is anywhere from eight months to 15 months if they do not have a specific mutation. That being said, we know that prognosis that's the prognosis that's the median survival give or take. For MDS, they had to come up with a median survival. Hence, these are all the different (inaudible 31:04) abnormalities that patients can present with and they classified this. This is a revised version IPSS. Revised is the new one that MDS Anderson doctors with other world doctors that specialize in MDS. They came together, Dr. Greenberg in (inaudible 31:25) I don't know which doctor, one of the European countries they got together to play golf and they said, "You know what? We need to do this revised version because the old version was a general." Then they said, "You know what? Let's break it up even more to give a better understanding for patients, so they can understand it because the category, their median survival may be a lot higher or better.

Hence, (Attendee)'s survival maybe he was told oh, it's going to be five - eight years. Well, why. Well, let's break it down in history a little bit more and look in depth where you started off with. The cytogenetics they looked at blasts, hemoglobin, platelets and ANC. ANC stands for absolute neutrophil count which are baby white blood cells.

Q8: (inaudible 32:26) that number of (inaudible) cells.

J: Right. Those are absolute number of baby white blood cells. That's how I explain it to them, too, classifying it. Those are the ones that protect you against infection.

Q9: The neutrophils are baby white cells?

J: Yes. So, you have neutrophils, basophils, monocytes.

Q10: The neutrophil and the white work together.

J: Yes. That is what your white blood…

Q11: (inaudible 32:55) Tell me if I'm wrong. I got… I've read something that why can't white cells keep you from getting a disease, but the neutrophils don't come back (inaudible 33:09). Does that sound right?

J: Are you asking in relation to a transplant? Because that's different.

Q11: No. Well, I'd like to see in a normal person.

J: So, neutrophils you need a specific amount of neutrophils to maintain a good system. Total white blood cells is a combination of all of the five different types of white blood cells. They fit together.

Q11: So, one doesn't do something different from the other?

J: They do.

Q11: As far as the neutrophils and the (inaudible 33:39)

J: So, neutrophils is part of the white blood cell, total white (inaudible).

Q11: But it doesn't have a specific function.

J: They do (inaudible 33:49). This is nice information. This is the revised version now. The mean overall survival is 8.7 years for a very low classified MDS patient and, again, this is the

transformation to AML, it would be 25 percent of patient that get it. It can vary for different patients, different types, again, of MDS patients.

Q12: I don't know if acute myelo (inaudible 34:25) leukemia. So, that's what acute (inaudible) leukemia. The same thing.

J: They may not know what that is. It's acute form of… greater than 20 percent of blast count, but a specific type of white blood cells deficient even a short time (inaudible 34:49). The leading cause of death is the disease itself is approximately 80 percent falling short as Dr. DiNardo mentioned is transplant. Individualized treatment which we talked about. Every person gets specific type of recipe to manage their MDS. The (inaudible 35:15) right now who has transfusion. we have Revlimid, Lenalidomide, Azacitidine, Decitabine. We have Cytarabine, Clofarabine, (inaudible 35:25), transplant, investigational drugs. You guys are like a blind place in being infused because Dr. DiNardo herself, she (inaudible 35:35) a case run trial herself for MDS patients which is nice. It's nice to know that there is in fact a plan B if plan A doesn't work or plan B which is nice. Those are the other therapy from the left hand side that are in the works in regards to the different trials available and, again, if you guys want a copy of this slide deck or whatever information feel free to reach out to Debra or Audrey and they'll be happy to E-mail it to you. Age alone should not include active therapy and I can't encourage high enough, I know. I think you got to look at the whole patient and then in general whether or not they can receive treatment. It's worth a shot. Before we had the Azacitidine or Revlimid or Decitabine, the only treatment was growth factors meaning Aranesp, Procrit, Neupogen and blood transfusions and antibiotic and that's it. So, (inaudible 36:46) we've made some strides into the management of MDS, but we've got a long ways to go and I'm hoping next couple years when I come back here I can tell you guys, "You know what? We have three other drugs available, which is great. Try it and it's worked," and even key point is that MDS patients, it's so important to find that patient early on and the education needs to happen and this is what I'm seeing early on to tell people go for your follow up yearly checkups. If it's not yearly, make it every two years at least. Just go for those checkups. Make sure those numbers are right and ask questions.

So, when your hemoglobin… sorry, when your bone marrow looks on the first part of this list right here, when it looked congested with black because, "Jay, what does black mean?" Those are basic… those are platelets, the little beige ones over here and (inaudible 38:00). That's the platelets over there. The red blood cell is over there. These are blasts. They all belong there. What it does is wipes it out, the good cells and hence those blasts are gone. This is like the normal pattern for patients that have 5-Aza or have a methylating agent. With MDS, it's not a one shot deal of oh, yeah, you gave me this drug, it's going to work and kill all of those weeds in one shot. That's why people need Vidaza every month because you need a shot here and there and to keep it going. That's what happens. They key point is you got to keep it going because if you stop then you get the reverse the effect and it stops working.

This is just another slide to give you a perspective of the different responses to Azacitidine (inaudible 39:06) Vidaza. This is a patient of Sandy. Sandy Curtin is a nurse practitioner at Arizona. She's the one that developed this entire slide deck as well as the information in the book that you have. It was combined with a lot of our other nurses that are part of the MDS Foundation and the leadership board, nurses from the leadership board which is what I'm part of and the combined all of the information with iron overload information, what to do, teachings, little practices here and there and this is her patient who started a little (inaudible 39:46) Revlimid and started with low count, a hemoglobin of nine and has an 18 to some degree of hemoglobin between 12 and 13 had great success for ten years. That's great, but, again, it's a balance of trying to figure out how to maintain it, how to keep them safe. So, what can you do? Stick to a balanced diet. Again, (inaudible 40:11) daily activity, exercise, don't become a couch potato. Stuff like that. Avoid infection, bleeding, but don't put yourself in a bubble. I always tell my patients don't stay home because that will make you depressed. Go out. Do stuff. Use common sense. Don't go to a concert every Friday or (inaudible 40:34) or something where's there's tons of people and there's germs everywhere. Go at a matinee any time. You know, you watch a movie or something, but do something and don't put yourself in a bubble. That's the point.

Again, get rest. Very important. (Inaudible 40:51) troubles (inaudible) you need to tell your doctor or practitioner because we have different things that we can help you with to help you sleep. Sleep is important because you heal when you sleep. If you don't get proper sleep, you don't get to heal. I've had many patient ask me, "Jay, (inaudible 41:14) the sniffles." Well, why do you have the sniffles? Let's talk about this. What's been going on in your life? "Well, I was working for a month. I'm running around, I'm not getting enough sleep." Well, okay. So, let's regroup then. What if you changed a few things here and there and got proper sleep. Come back to me in a couple days and we'll recheck and if you feel like you're still are needing something, we'll talk about it. Antibiotics given (inaudible 41:42) because they don't want to deal with this issue of feeling sick, but it's a simple thing to face like getting proper sleep.

Understanding MDS is number one is super complicated. That is understandable. Seeking treatment is number two meaning find a physician, an oncologist to be your advocate and truly believe that MDS and in the management of MDS whatever form, way that they propose. Seek a second opinion. A third opinion. (Inaudible 42:21) complicated because then you probably just comparing and you're like oh, one said this and one said that. I don't know which one to believe anymore. Those are the one that are in your book. They're great just for resource purpose to kind of use along the way. Iron overload, again, is a possibility for patients who get multiple (inaudible 42:44) transfusions. So, keep in perspective that if that happens and you have a low risk type of MDS or even patients who go for a transplant, make sure your doctors are checking your ferritin level. Why? Patients who have iron overload issue and they live long enough to have MDS in the timeframe of median survival or whatever or they're expected to, you're probably preventing other comorbidities like diabetes, liver failure, heart problems, all kinds of

other things. So, make sure that's part of your package. So, make sure your doctors are checking that.

This whole (inaudible 43:30)

Q13: And there is treat you for iron overload, too. It's become easier and easier as time has gone on. It used to be that (inaudible 43:47) and the injection and now it's just a pill. It's much easier to take.

J: Again, you have the MDS Foundation as a resource. Use them. Contact them. E-mail them. They will get back to you and help you in whatever way they can whether it be to make a connection, if you have an appointment. Whatever you need. And that's it for slides. (inaudible 44:15) people that were part of this project developing (inaudible 44:21) Foundation, the strategies for patient and caregivers living with MDS and making these booklets and supporting you guys (inaudible 44:30).

Q14: I'd like to add one thing (inaudible 44:35). I just checked with Debra to find out if it's okay. There's AAMDS which is aplastic anemia and myelodysplastic (inaudible 44:48). We absolutely do have existing support group that meets on usually a monthly basis. We did skip October, but our meeting is in November, November 1st and we meet at the Memorial (inaudible 45:11) Presbyterian Church. It's off of Rider Forrest.

J: Do you have a contact number or (inaudible 45:22)

Q14: It's at ten o'clock in the morning. Lillian Kemper is the person that runs it and let me see if I can get you her… find I can find her E-mail address.

Q15: What is the purpose of that (inaudible 45:48)

Q14: Support group. They just get together on like in September I did a workshop on test results. Now, what does the test results mean? What's the blood sugar and what did the platelet counts mean and I went through how the… educational thing and then we had a nutritionist from Methodist come and talk to us about… she basically works in the transplant unit, but there are lots of things that you can do like I have a real bad problem with the Revlimid with colon distress and that's what the underlying thing is (inaudible 46:57) Revlimid hits your… it causes neuropathy. So, it probably the nerves in your colon sometimes. So, I have to be more careful what I eat, but there are… and how to… she talked to us about how to make sure that fresh fruits and vegetables, how to make sure that…. If you're not feeling well and you want to make sure that all the bacteria off them. She taught us how to handle those like they did with the transplant unit so that they're safe to eat. So, we did that and sometimes we… there's that KMDS (inaudible 47:51) in the spring and so we figure out how we can help with that without compromising and lots of times we just check up on how our friends are doing that have MDS.

It's a (inaudible 48:11) to Houston. I was begging for my doctors to tell me somebody else that I could talk to that had MDS because it's relatively rare. Now, I talked to somebody on the phone, but as far as having a more of a relationship than just talking to somebody on the phone. That is important. So, that's what we do and so it's not any… I've been in support groups that have turned into psychiatry sessions. We don't do that. There was one we had a support group that up in the Woodlands that was started off it being the lymphoma society which is also… MDS is also under their umbrella, but then the hospital took it over and they seem to want… they wanted to… they say that it's all their cancer people and they wanted it to be a… they brought in hospital social workers and it's like no, that's not what we wanted. When we were doing our support group, we just got together on a monthly basis and checked in and encouraged people and gave people advice based on our experience and we had a bunch of different blood cancers involved in that, but it was a whole lot better because we were in that nebulous group of blood cancers versus mixed in with all the solid tumor people who were saying, yes, I just started (inaudible 50:19) and they got it all and it's like… and I'm in remission and it's like well, please I can't say that and you need the support when the other shoe is going to drop. You might be okay right now, but sometimes there's the other shoe that dropped, too.

Q16: (inaudible 50:44) phone number. Feel free to drop by.

Q17: (inaudible 50:53)

Q14: No. It's Saturday November 1st at 10:00. It's usually the first Saturday of the month and it's at Memorial… the (inaudible 51:16) Presbyterian Church and you go in and if you're interested in going (inaudible 51:22) the very first driveway it's on the… looking at the front of the hospital it's on the left side just after the sanctuary here. You go into the left... the driveway on the left of the sanctuary and you go into the first section parking lot and you'll see signs. She's very good about that.

(General conversation 52:02 - 58:37)

Q14: The contact E-mail for Linda Kemper is houstonaamds@(inaudible).com.

(General chat 58:52 – 1:44:49)