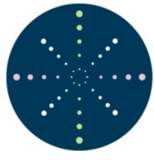

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Some thoughts for patients on the recent PSA controversy

Michael Levin, M.D. 10/9/11

The new report of the US Preventative Task Force recommendation against PSA prostate cancer screening has attracted a fair amount of attention. An earlier recommendation from the same group discouraging mammography for women in their 40s came out two years earlier with similar controversy. The recommendations put both patients and their physicians in a difficult position. Do we stop using this screening test?

In science and medicine we have to be open to new information that challenges our previous ideas. If screening for PSA were to be proven not to offer benefit to patients then certainly we have to be willing to abandon it. I read the task force report and found a major flaw rendering it not very helpful, however.

In science if an irrelevant question is asked then the answer will also be irrelevant. The task force question was “Does PSA testing change the mortality (death rate) of the general population over a ten year period?” This is not a helpful question. They could have looked at the data and asked “Will PSA testing protect me from unicorn attack over a ten year period?” and would come up with a similar answer. The answer is no, but that doesn’t matter. Ten years is far too short of an interval to be relevant to how PSA is used. I read the task force report and its sources extensively and was surprised and disappointed by how any other evidence was just ignored to reach their conclusion.

Prostate cancer is usually a slow growing disease and for this reason when we see a patient in the office who has less than ten year life expectancy we usually discourage PSA testing or prostate cancer treatment unless there are specific symptoms or suspicion of advanced disease. Thus using studies showing little to no improvement in life expectancy *over ten years* is just not relevant and does not change a given patient’s options. People are living much longer now than in the past, and a 65 year old man in good health has a reasonable chance of surviving past 80 or even 85 years old now. If this hypothetical patient had clinically significant prostate cancer he might want to know about it to make the best informed choice he can. Does this risk over diagnosis and overtreatment? Certainly, but I believe that an empowered patient is allowed to make an informed decision for himself rather than being denied information.

There are studies showing that over a longer than 10 year time period (ignored by the task force) that prostate cancer treatment prevents both morbidity (harm from the disease) and mortality compared to not

treating. Prostate cancer treatment can have side effects but if you live long enough the cancer itself can have many effects. Particularly helpful is finding the higher grade, larger volume, and more aggressive cancers at an earlier stage. The treatment plan has to be individualized to each person.

When I diagnose someone with prostate cancer, we put the follow up visit at the end of the day to be able to spend a long time with the patient and family to go over the above controversies in detail. The key question that we need to try to answer- “Is this prostate cancer clinically significant?” If the biopsy points to a small volume of low grade cancer we can consider avoiding treatment. I have a large and growing number of patients on active surveillance- we are not treating them but keep a close eye on their cancer. A full and honest discussion of the side effect potential of various treatment modalities is very important. The goal is to arrive at an individualized treatment plan that the patient and his family feel comfortable with.

PSA has been in wide use for more than twenty years and has changed the diagnosis of prostate cancer significantly. In the pre-PSA era a great number more prostate cancer cases were diagnosed at an advanced stage when symptoms finally began. Having seen a fair number of patients with advanced prostate cancer I can honestly state it is not a good way to die. Generally these patients have come to the office with a first PSA drawn in many years as a very high number. Usually the patient or their family member eventually tells me they wish they had been detected with cancer years earlier at a possibly more treatable stage. In some cases they had a very aggressive and rare cancer that perhaps screening might not have helped- in other cases it may have been prevented.

PSA is an imperfect test and we hope to have more specific tests readily available soon. It is most useful as a biologic marker after treatment for prostate cancer. Stopping its use before we have an alternative risks putting our patients back to diagnosis after the cancer has spread. I always respect patients’ right to decide for themselves what testing or treatment they want to have done but found the task force recommendation misleading and disappointing. Rather than throw out a useful tool, we should focus on having an intelligent conversation between patient and physician to allow each patient to make his own personal choice. In the meantime, I’m encouraging my father to keep drawing his yearly PSA.