

New task force guideline returns PSA screening to center stage

This year marks the 26th anniversary of PSA testing, but has the screening tool's time come and gone? Experts weigh in on the pros and cons of the PSA test.

By STEVEN K. WAGNER

When the U.S. Preventive Services Task Force reported that routine prostate cancer screening for older men appears to result in little benefit, the announcement raised more than a few eyebrows in the urologic medical community.

The independent panel of private sector experts said that testing men age 75 and older for the prostate-specific antigen (PSA) can cause so much harm later on, including tests and treatment resulting in erectile dysfunction, urinary incontinence, bowel dysfunction, and even death, that the risks outweigh the benefits, which it said include only a small likelihood of living any longer.

The group also found inadequate evidence to determine whether treatment for prostate cancer detected using the test improves the outcomes of men younger than 75.

"These harms are especially important because some men treated for prostate can-



JUDD W. MOUL, MD

cer would never have developed symptoms related to cancer during their lifetime," the USPSTF wrote. "Because a 75-year-old man has an average life expectancy of about 10 years, very few men age 75 years or older would experience a mortality benefit."

The organization urged that clinicians not order PSA testing without discussing with patients the possible benefits and known harms of screening. Needless to say, their advice was not met with great enthusiasm by practitioners.

An arbitrary age cutoff?

"To create a specific cutoff age without considering a patient's various health factors is a move away from individualizing treatment decisions and discussions for patients," said Raj Pruthi, MD, director of urologic oncology at the Lineberger Comprehensive Cancer Center, University of North Carolina in Chapel Hill.

Dr. Pruthi pointed out the USPSTF does not have a urologist, radiation oncologist, or medical oncologist on the panel, and he was disappointed that the panel concluded screening may lead to complications that might never occur. He added that older men do die of prostate cancer, and the correct approach is to watch them closely if cancer is found.

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Through the years, the benefits of screening have included early detection, diagnosis, and treatment and a greater likelihood of survival—especially among younger men, whose cancers may be more aggressive. However, the standard of care for certain cancers is watchful waiting, raising questions about the usefulness of screening. Additionally, false-positive findings can result in unnecessary biopsies, and any invasive procedure creates a risk of complications.

"Not using a PSA is the incorrect response to overreacting a disease," Dr. Pruthi said.

Judd W. Moul, MD, chief of the division of urologic surgery and director of the Duke

Prostate Center at Duke University Medical Center, also rejected the age cutoff, saying it could be considered discriminatory. He said more than half of men over 75 may live longer than 10 years, meaning some would die painful deaths from prostate cancer if not diagnosed early. The better option might be to offer all men PSA tests and to treat those with higher baseline rates more aggressively, since some cancers found would likely grow more quickly. Those with a normal life expectancy of less than 10 years could be watched.

"I agree in principle that we should probably limit PSA testing," Dr. Moul said. "In the US, since we've been doing screening over the last 15 years, we've seen the rates of metastatic prostate cancer drop signifi-

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Treatment options in prostate cancer

Surveillance: Observation and regular monitoring without invasive treatment. It is often used when the patient has an early-stage tumor.

Prostatectomy: Surgical removal of the prostate. Radical retropubic prostatectomy is the removal of the prostate through an abdominal incision. Radical perineal prostatectomy is the removal of the prostate through the perineum, or the skin between the scrotum and anus. Laparoscopic radical prostatectomy does not require a large incision but is instead minimally invasive. Also, robot-assisted laparoscopic prostatectomy (pictured above) may reduce positive surgical margins. Salvage prostatectomy can be performed after radiation therapy with the prostate and surrounding tissues, including irradiated tissue, removed.



Radiation therapy: Options include external-beam radiation therapy, 3D conformal radiotherapy, intensity-modulated radiation therapy, and brachytherapy. Proton-beam therapy remains controversial.

Pharmacology (chemotherapy): The most common regimen combines docetaxel (Taxotere) with prednisone. Mitoxantrone (Novantrone) plus prednisone is approved for use in advanced disease. Anti-angiogenesis strategies including bevacizumab (Avastin) and thalidomide (Thalomid) are under investigation.

Hormone therapy: Medications or surgery to block dihydrotestosterone (DHT), which often causes the cancer to stop growing and even shrink. Cancer cells, however, become resistant after a year or two. Androgen-deprivation therapy (ADT) is designed to stop testosterone from being released or to prevent the hormone from acting on the prostate cells. Other therapies include diethylstilbestrol (DES) and LHRH analogs (goserelin, leuprolide).

High-intensity focused ultrasound (HIFU): Method uses high-intensity focused ultrasound to destroy the tissue of the prostate. Sound waves heat the tissue and destroy the cancerous cells. The procedure is not yet approved for use in the United States.

Cryosurgery: The prostate gland is exposed to freezing temperatures. Impotence, however, occurs up to 90% of the time.

Emerging technologies: Photodynamic therapy, interstitial prostate brachytherapy, microwave and radiofrequency interstitial tumor ablation, bisphosphonates.

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Reasonable data; controversial PSA testing guidelines

cantly. However, it's not always clear who we should continue to screen and who we shouldn't."

Uncertain benefits

Michael L. Lefevre, MD, a professor of family and community medicine at the

University of Missouri School of Medicine in Columbia, is a USPSTF member who stands by the guidelines.

"The task force really found convincing evidence that treatment for prostate cancer detected by screening can cause moderate to substantial harm and that the harms ex-

ceed the benefits of what we can expect," he said. "Estimates of deaths as a consequence of treatment range from one in 100 to one in 400."

Dr. Lefevre disputed the notion that a small number of older men will be sacrificed if the guideline is followed.



MICHAEL L. LEFEVRE, MD

"Not true," he said. Regarding the guideline for younger men, Dr. Lefevre was emphatic.

"The task force is not saying 'Do not screen.' It is not saying 'Do screen.' It is saying that the balance of benefits is uncertain and that we should explain this to our patients," he said.

Mitchell Anscher, MD, chair of the department of radiation oncology at Virginia Commonwealth University School of Medicine, was more tepid in his support.

"I think the guidelines are pretty reasonable—the data are controversial," he said. "We are seeing a decline in the number of people dying from prostate cancer over the years, but we haven't proved that it's due to screening."

Dr. Anscher continued, "having said that, I believe it's going to be difficult to sell to the American public that we shouldn't be screening people."

Dr. Anscher said that as a physician his first obligation is to advocate for his patients. He said he believes the guideline should be more individualized, taking into account the likelihood that some men over 75 will live beyond 10 years and thus benefit from treatment. ■



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