Opinion > Outlook

Some facts to consider in prostate-screening debate

By LEONARD A. ZWELLING and JAMES S. GOODWIN | October 25, 2011 | Updated: October 25, 2011 7:27pm

One of the major goals of the Comparative Effectiveness Research Institute of Texas (CERCIT), a research consortium sponsored by the Cancer Prevention and Research Institute of Texas (CPRIT), is the dissemination of useful information about cancer to the public. Some of the letters to the editor in the Houston Chronicle on Oct. 15 might tend to confuse rather than clarify the actual findings of the U.S. Preventive Services Task Force (USPTF) about the use of a routine blood test called the prostate-specific antigen (PSA) to screen for prostate cancer. We at CERCIT believe that we might be able to shed some light on this issue to allow better individual decisions for men over the age of 50.

Last week, the USPTF released a recommendation against the routine use of the PSA blood test to screen for, detect and eventually treat otherwise asymptomatic men with no increased risk for prostate cancer. The task force's conclusions were based on its analysis of large studies that failed to demonstrate a significant decrease in prostate cancer deaths in a group of men who were screened with PSA versus those who were not.

As expected, no sooner did the recommendations hit the media than a flood of personal testimonials claiming PSA saved the lives of men with prostate cancer also made news. The letters in the Houston Chronicle were two compelling examples. Some of these men taking exception to the recommendations of the USPTF are quite prominent. The media covered their protests right along with the analysis of the task force. Unfortunately, giving equal time to the analysis of more than 100,000 test subjects versus two or three famous survivors might not allow those facing the decision of whether or not to be screened using PSA to make an informed decision for their own care.

As a way to help each individual man determine for himself whether to be tested or not, here are some facts that might be the basis of research:

Prostate cancer is a common malignancy.

The incidence of prostate cancer increases with age.

Prostate cancer is not always lethal. Many men die with prostate cancer, not of it, but some die of it.

The introduction of PSA testing in the U.S. was accompanied by a near-doubling of men diagnosed with and treated for prostate cancer, suggesting that many prostate cancers detected by PSA never would have become symptomatic in a man's lifetime

No blood test can distinguish between potentially fatal prostate cancer versus nonlethal, incidental and asymptomatic disease. Furthermore, an elevated PSA test is not always caused by prostate cancer.

The prostate biopsies that would follow the finding of an elevated PSA test to confirm the presence of cancer are not without potential risks. Even if prostate cancer is identified in a biopsy, this does not mean that the cancer will be lethal to the individual man.

The therapies of localized prostate cancer - several different surgical approaches and/or several different forms of radiotherapy - can also be debilitating with complications like incontinence, impotence or gastrointestinal irritation.

Without a doubt, many men are treated for prostate cancer who would have done fine without the treatment, but some are undoubtedly helped. Surviving the treatment does not mean you needed it and these various treatments are not without risks.

Thus, there is no certain way forward at any point in the decision tree: screening, diagnostic biopsy or invasive therapy for localized disease.

The bottom line is this. The population-based studies can predict the likely occurrence of prostate cancer in a large group of men who were and were not screened with PSA. PSA screening had little if any influence on the number of deaths from prostate cancer among these men.

This does not predict what will happen to *you*, which, after all, is your focus, as it should be. The correct course can best be determined by each man and his caregivers.

There is no one right answer in most cases. Screening and follow-up is an individual decision by each man and his medical team.

To quote from Dr. H. Gilbert Welch's superb op-ed piece in the New York Times on Oct. 10, 2011:

"When it comes to ... prostate cancer screening, there are no right answers, just tradeoffs."

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