

## **MEditorial October 2011**

### **“PSA Redux”**

**In October, 2009, I wrote a MEditorial on this website [you can find it in the archives] entitled “PSA: Cool your Jets”. In light of the recent US Preventive Services Task Force (USPSTF) data published in the medical journal “Annals of Internal Medicine” and lay citations to the work, I have reviewed my own thoughts from then and wish to update these now. The USPSTF, which not too long ago also had controversial recommendations about mammography in younger women, gave the PSA (prostate specific antigen) test a “D” [as in “bad grade”] rating, based on their review of a huge amount of data and their conclusion that PSA has minimal benefit to the population at large--and risks of assessing any PSA elevation further, as well as treatment, may outweigh any benefits.**

**If anything, my own experience and the recent data (as well as urology meetings I have attended) make me concur more with the task force and less with some in “organized urology” who will continue to defend PSA screening--perhaps more on an emotional basis for the patients [and, cynically, on an economical basis for themselves and all who can benefit from CaP screening and treatment]. The argument would be something to the effect “If you are the one whose prostate cancer was cured (and “life was saved”) by PSA screening, would there be any doubt in your mind that PSA screening is useful... it’s only an inexpensive blood test”.**

Statistics are difficult, confusing, and can be misused to gain advantage. I try to stay away from these in my discussions of urologic evaluations and care with patients. However, I will reiterate two statistics about prostate cancer screening. First, 1400 men will have to be “screened” to identify one life-saving prostate cancer (CaP) treatment. Second, nearly 50 men will need to be treated for their prostate cancer to see one life saved by an aggressive intervention, e.g., surgery or radiotherapy.

We have to be sure we are on the same page. By screening, I mean taking a man in the age range susceptible to prostate cancer who has no symptoms and is seeing me to be “checked for prostate cancer”; or is sent to me with (often an isolated) elevated PSA. It does not include men who have other suspicions for prostate cancer such as those with symptoms referable to the urinary tract or concerning for advanced/metastatic disease, suspicious DRE’s (finger exam of the prostate) or men who have had CaP in the past, whether treated or not.

If it were only a matter of getting a blood test, that might be acceptable. However, these tests have consequences, including biopsies, not infrequently repeated over time, which can harm the prostate and patient, especially creating chronic inflammation, sometimes significant infections, and perhaps a cycle of “bumps” in PSA causing further concern and testing. Anxiety, I feel, is a too-often overlooked issue; and I do wonder whether cancer phobia caused by somewhat inadequate screening tests can lead to physical or emotional illness and even perhaps decrease longevity.

If I were “king” of urology, I would avoid PSA screening without a discussion 1<sup>st</sup> of the consequences. I’d like to ask the man why he wishes to be screened. Does he understand that a biopsy might need to be done to “find out”--and that side effects could occur and perhaps 10% of biopsies, more so in large prostate glands, are falsely negative (they fail to detect cancer cells that really are there)? Should the biopsy show cancer and more so, if the man is older (we used to say 75+ but now I’d lower that to 65+), does the man know that the natural history of prostate cancer, once diagnosed, is often more like a benign disease which, if at all, progress slowly, and is easily consistent with another 20 years of life even with no treatment? Is he cognizant of the data that CaP is often over treated and therefore one cannot simply justify surgery or radiation complications (impotence, poor bladder control, severe radiation sequelae) based on the argument “it was worth it to have been cured”. [Many do not need to be cured]. I see many older men whose argument to be screened and either followed closely for their PSA or biopsied and even [aggressively] treated is “I do not want to die of prostate cancer”. What they are missing in this logic is that they will die of something, most likely well within the time it would take CaP to bring about their demise. Better to die of some other cancer?; or of a stroke?

Primary care doctors are busy and are trying to handle the multiple medical issues of an aging population. It is easier for them to include a PSA as “screening” in pre-physical comprehensive lab tests than to discuss its (or for that matter, other tests’) utility in a given patient.

I would suggest that if a man wants prostate cancer screening, either the PCP take the time to have the right conversation; or this duty

should be relegated to a urologist before that blood test is even drawn.

In my practice, I would try to convince asymptomatic men over 65 NOT to even start with PSA screening; and perhaps to consider no biopsy if the PSA is elevated. PSA's in such cases can certainly be followed--but the past reliance on PSA velocity (rate of increase in PSA over time) is now also being questioned as to its utility in distinguishing between those who do and do not have CaP. I would likely advise men by their mid-40's to have ONE screening PSA, since there do appear to be data indicating a very low PSA at this age cohort (usually PSA <1.0) correlates with a minimal chance of developing a clinically significant prostate cancer within 20 years. I would also "screen" patients as well as offer biopsies to men between 50 and 65, but only after a heart-to-heart discussion and informed consent. That advise to have PSA screening and potentially a biopsy would be stronger in higher risk groups including men who are African-American and those with a strong familial (?-hereditary) history--especially prostate cancers occurring in relatives only in their 50's.

PSA has been in clinical practice of medicine/urology for over 25 years. Even the pathologist who 1<sup>st</sup> discovered the molecule has serious doubts as to whether the whole thing has been worthwhile. Since it took this long to have increasing doubts about PSA's role in preventive medicine, I would not be willing to quickly embrace any newer screening test "out there" for prostate cancer, even though we do not always have the luxury in medicine to "vet" a new diagnostic tool or therapy over a 25 year period before it is introduced into clinical practice.