Scribe Focus
Men's Health & Wellness

Each month, *The Scribe* focuses on a health topic, providing a deeper look into issues and advances that impact the area's medical community and patients. In August, we'll focus on Medical Education.

Prostate cancer screening:
Middle ground may be reachable with latest recommendations

By Cliff Collins
For The Scribe

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– Ruben O. Halperin, MD

The gap in how primary care physicians and specialists view PSA tests for prostate cancer screening may narrow some after the release of new national guidelines.

The U.S. Preventive Services Task Force's latest recommendations, issued in early May, restore more flexibility to when PSAs should be given for asymptomatic men age 55–69, and also offer patients more choice in the matter. The guidelines were revised for the first time since the task force's controversial grade D recommendations in 2012.

The new grade C recommendation falls more in line with guidelines issued by several leading health and medical organizations, noted **Tomasz M. Beer, MD, FACP**, an oncologist who chairs prostate cancer research and is deputy director of **Oregon Health & Science University's Knight Cancer Institute**. In addition, the task force's recommendations "have come closer to my opinion," as well as that of an ad hoc OHSU committee that examines certain clinical issues and determines the institution's policies toward those, he said.

TOMASZ M. BEER, MD, FACP

According to the U.S. task force's new guidelines, published in the *Journal of the American Medical Association*, evidence from randomized clinical trials shows that PSA screening programs in men 55 to 69 years old may prevent approximately 1.3 deaths from prostate cancer over approximately 13 years for every 1,000 men screened. Screening programs also may prevent about three cases of metastatic prostate cancer per 1,000 men screened.

The panel concluded "with moderate certainty that the net benefit of PSA-based screening for prostate cancer in men aged 55 to 69 years is small for some men. How each man weighs specific benefits and harms will determine whether the overall net benefit is small."

It added: "In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening."

However, the task force stayed with its previous policy against screening men age 70 or older, once again giving that a grade D recommendation. It cited evidence showing that the harms of screening in men over 70 are at least moderate, and are greater than in younger men because of increased risk of false-positive results, diagnostic harms from biopsies and harms from treatment. Thus, the potential benefits of screening members of this age group "do not outweigh the expected harms."

After the U.S. Preventive Services Task Force issued its 2012 guidelines, the American Academy of Family Physicians endorsed the task force's grade D recommendation against PSA screening, "because evidence indicates that the harms of the test outweigh its benefits," the academy stated. By contrast, the family physicians' group advocates that its members use the task force's new recommendations as "a valuable resource" in treating patients; the academy also stated that it will review the task force's guidelines, and determine the academy's stance on those.

One of the factors the academy cited in concurring with the task force's previous recommendation against screening was that "90 percent of U.S. men with PSA-detected prostate cancer are treated," often for cancers that would never threaten their lives but have a high risk of adverse side effects.

That latter situation has changed during the six-year period since the task force's 2012 recommendations. One reason is increased awareness of potential harms of screening, which the task force points out include frequent false-positive results, psychological harms, erectile dysfunction, urinary incontinence and bowel symptoms. About one in five men who undergo radical prostatectomy develop long-term urinary incontinence, and two in three men will experience long-term erectile dysfunction.

"There's definitely a trend toward discussing the perceived value and not overselling the value of doing this," observed **Ruben O. Halperin, MD**, a general internist and faculty member of the residency training program at **Providence Medical Group Northeast.** "Over the last few years, people in primary care have done a lot less PSA testing," he said. "Most people in primary care are still skeptical of the value."

He also noted that after the 2012 task force recommendations came out, the American Urological Association changed its own guidelines the following year toward "more shared decision-making."

"It's reasonable to have that discussion," because using PSAs for screening for cancer is problematic, Halperin added. "There is a good chance it would lead you to get a lot of care that is probably unnecessary. A lot of false positives historically have led to seeking biopsies and repeat biopsies," leaving "a trail of overvigilance." PSA tests "are not perfect," and don't indicate whether the patient does or does not have cancer, he said.

For Halperin, the new grade C recommendation "for practical purposes, does not change a lot" for him, in that he continues not being "a regular screener" of his patients.

But he emphasized that reaching a middle ground between how primary care and specialty care regard PSA screening depends on future developments. "The important thing is not being super dogmatic either way," he said. When studies come out that show additional benefits and more definitive information, Halperin said he can see his views changing.

OHSU's Beer said the task force's new guidelines could alter providers' perceptions. "The prior change had a big impact," he said. "That tells us that people pay attention to" what the task force endorses. The 2018 recommendations "will be noticed, and some people will modify their practices," because recommending having discussions and taking individual patients' views into account represent "a different recommendation" from discouraging discussion and PSA screening, as before.

He said specialists have been responsive to the primary care community's concerns about overdiagnosis, and as a result, we are seeing more active surveillance and less aggressive care. At the same time, patients' preferences are given thoughtful consideration.

Halperin agreed, noting that the increasing prevalence of surveillance is a positive trend that "may make screening more valuable."

Beer applauds the task force's modified recommendations, and believes there is an emerging consensus about the use of PSAs.

On one point, though, he differs with the task force's grade D recommendation for patients 70 and over. For these men, applying individual decision-making between doctor and patient should still hold, he believes, because men on average are living longer, and those who are in good health may have a longer life expectancy than average and may benefit from detection, he said.

Beer added that recent developments such as using MRIs to guide biopsies could help address overdiagnosis. ■

What are the current guidelines?

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