

# Survey: Men may not be adequately involved in decisions about prostate cancer screening

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Men largely make decisions about prostate cancer screening based on conversations with their clinicians, but these discussions often do not include information about the risks of testing in addition to the benefits, according to a report in the September 28 issue of *Archives of Internal Medicine*, one of the JAMA/Archives journals. A second report in the same issue uses statistical modeling to estimate the benefits and risks of prostate-specific antigen (PSA) screening in men of various ages and risk levels.

The majority of American men older than 50 have been screened with the PSA blood test, according to background information in one of the articles. However, the practice is controversial because there is no convincing evidence that screening prevents deaths from the disease, and treating early-stage cancers detected by screenings may lead to important complications. "Given the uncertain benefit for screening and known treatment risks, prostate cancer screening decisions should be guided by patient preferences," the authors write. "Indeed, most professional organizations recommend that the first step in screening should be a discussion between [health care providers](#) and patients about the risks and benefits of early detection and treatment so that patients can make informed decisions about whether to be screened."

Richard M. Hoffman, M.D., M.P.H., of New Mexico VA [Health Care System](#) and University of New Mexico School of Medicine, Albuquerque, and colleagues conducted a telephone survey of 3,010 randomly selected English-speaking adults age 40 and older in 2006 and

2007. The sample included 375 men who had either undergone or discussed PSA testing with their clinicians in the previous two years. These men were asked what they knew about prostate cancer, what their discussions with clinicians were like and what factors and sources of information influenced their screening decisions.

Overall, 69.9 percent of the men had discussed screening with their clinician before making a decision, including 14.4 percent who chose not to undergo testing. Most often, clinicians raised the idea of screening (64.6 percent), and 73.4 percent recommended it. Recommendation from a clinician was the only characteristic of the discussion associated with testing.

"Although respondents generally endorsed shared decision-making process and felt informed, only 69.9 percent actually discussed screening before making a testing decision, few subjects [32 percent] reported having discussed the cons of screening, 45.2 percent said they were not asked for their preference about PSA testing and performance on knowledge testing was poor," with only 47.8 percent of men correctly answering any of three questions about prostate cancer risk and screening accuracy, the authors write. "Therefore, these discussions—when held—did not meet criteria for shared decision making. Our findings suggest that patients need a greater level of involvement in screening discussions and to be better informed about prostate cancer screening issues."

In a second study, Kirsten Howard, B.Sc., M.App.Sc., M.P.H., M.Health.Econ., Ph.D., of the University of Sydney, Australia, and colleagues constructed a statistical model to provide information for men age 40, 50, 60 and 70 years at low, moderate and high risk for prostate cancer based on family history. Using Australian prostate cancer incidence rates before PSA screening began in 1989 and cancer death rates in 2005, along with data from the European Randomized Study of

Screening for Prostate Cancer and the Australian Bureau of Statistics, the authors examined two hypothetical cohorts of men who either participated in or declined annual PSA screening.

The model predicts that benefits and harms of annual PSA screening vary with age and risk level. For example, for every 1,000 60-year-old men at low risk, 53 of those who were screened yearly would be diagnosed with prostate cancer and 3.5 would die of the disease during a 10-year period, compared with 23 diagnoses and 4.4 deaths in unscreened men. "For 1,000 men screened from 40 to 69 years of age, there will be 27.9 prostate cancer deaths and 639.5 deaths overall by age 85 years compared with 29.9 prostate cancer deaths and 640.4 deaths overall in unscreened men," the authors write. "Higher-risk men have more prostate cancer deaths averted but also more prostate cancers diagnosed and related harms."

In the model, screened men are two to four times more likely to be diagnosed with prostate cancer than unscreened men, but death rates from prostate cancer and from all causes are not significantly different. This implies that many men whose cancer is detected by PSA screening may be undergoing treatment for clinically insignificant cancers, the authors note.

"In conclusion, before undergoing PSA screening, [men](#) should be aware of the possible benefits and harms and of their chances of these benefits and harms occurring," they write. "Even under optimistic assumptions, the net mortality benefit is small, even when [prostate cancer](#) deaths are cumulated to 85 years of age. These quantitative estimates can be used to support the goal of individual informed choices about [PSA screening](#)."

More information: *Arch Intern Med.* 2009;169[17]:1611-1618, 1603-1610.

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