

Prostate cancer screening and treatment decisions must act on evidence, not beliefs

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Physicians advising men whether to be screened for prostate cancer with a PSA test must rely more on available evidence when recommending screening, biopsies and treatments rather than long held beliefs that PSA-based testing is beneficial for all, Beth Israel Deaconess Medical Center prostate expert Marc B. Garnick, MD, says.

Writing in the February edition of *Scientific American*, Garnick states the current system that relies on prostate-specific antigens levels in the blood is "deeply flawed," and [physicians](#) must take into account the fact "the [PSA test](#) does not tell you if a man has cancer, just that he might have it."

The recent US Preventative Services Task Force's assessment of studies published in 2009 shows more harm than good results from PSA testing, and that evidence favors moving away from aggressive early treatment for all and toward a more cautious, individualized approach – an approach currently underway at BIDMC.

"Most people outside the medical community do not realize how flimsy evidence has been in favor of the PSA screening data," says Garnick, who is also an editor-in-chief of Harvard Medical School's Annual Report on Prostate Diseases and associated website.

"In a perfect world, a screening test would identify only cancers that would prove lethal if untreated. Then, men who had small, curable cancers would be treated, and their lives would be saved. Ideally, the

treatments would not only be effective, they would have no serious side effects. Such a scenario would justify massive screening and treatment of everyone with a positive test."

However, doctors currently do not have a reliable way to determine which of these small cancers, caught by [biopsy](#), are potentially dangerous and which would not cause harm throughout a man's lifetime. Moreover, all of the current treatments carry significant risks and long term side effects.

Despite successfully preventing a single death from [prostate cancer](#), the number of men who would have to be treated and potentially suffer the consequences of treatment to achieve this prompted the Task Force to recommend against wide spread PSA testing for all men without symptoms of prostate cancer. according to Garnick.

In two studies from 2009, one conducted in Europe and the other in the US, healthy men in their 50s and 60s were randomly divided into two groups; one was periodically screened for prostate cancer using PSA testing or a digital rectal exam, or both. The other group was not offered routine testing, but received standard medical care as needed.

The European study showed that only the men who were tested and treated for prostate cancer had a 20 percent likelihood of dying from the disease, while neither study showed if the men who were tested and treated lived any longer than those who were not offered routine testing. Such a decrease in prostate cancer mortality was not found in the U.S. study.

In the European study, researchers then determined that in order to save one life from prostate cancer, approximately 1,400 men would have to undergo screening, which would result in 48 having to undergo treatment. The remaining 47 could suffer serious side effects, such as

incontinence and impotence, as a result of radiation or surgery.

"The overall death rate from all causes was not statistically different in both the screened and unscreened groups," says Garnick. "Unfortunately, the mortality data collected over the past 25 years shows that the natural history of prostate cancer is not as straightforward as my colleagues and I once believed. Many cancers will never cause problems during the patient's lifetime, and hence do not need to be treated, at least immediately."

Results from a long-term Canadian study indicate that the death rate from the disease for men who elect active surveillance, or choosing to delay treatment after a PSA test led to the diagnosis of cancer is 1 percent over 10 years, compared with a 0.5 percent risk of dying from complications in the first month after prostate cancer surgery.

"The point is that the initial decision to forgo treatment is not necessarily the final one. Surgery, radiation and other therapies are still available later on, and most current data indicate that the outcome will not be negatively affected by the delay. Such an approach is improving our ability to tailor treatments for individuals rather than always treating everyone the same," says Garnick.

The outcomes of this decision indicate that doctors and patients need to be clear about their knowledge, and lack of knowledge, from a scientific point of view especially as we discuss these issues with our patients. "We need to have the courage to act on the evidence and not just our beliefs," says Garnick.

Provided by Beth Israel Deaconess Medical Center

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