United States Preventative Services Task Force is wrong to recommend an end to PSA screening

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Prostate Specific Antigen (PSA) is the blood test that has been used since 1986 to screen men for prostate cancer, which generally causes no symptoms until it has spread. The United States Preventative Services Task Force (USPSTF), an independent panel composed entirely of primary care physicians and public health professionals, last week issued a recommendation against PSA screening. This has confused the public and caused deep concern in the Urology community. We want to explain why it's not time to throw out the PSA.

USPSTF recommendations often influence Medicare coverage decisions. The task force has done the public a great disservice with what amounts to an irresponsible oversimplification of the complex medical issue that is the screening, diagnosis, and treatment of prostate cancer. Prostate cancer remains the second leading cause of cancer death of men in the United States with more than 200,000 men diagnosed and 25,000 dying of the disease each year. According to the American Cancer Society, the number of men diagnosed with prostate cancer continues to rise annually. The death rate, however, has decreased every year since 1994. Urologists believe (albeit without proof from high quality studies) that this success is in large part due to the widespread use of PSA screening.

Prostate cancer becomes more common with age such that by the age of 80, 70-80% of men will have prostate cancer. With higher age at diagnosis, the chance that prostate cancer will ever cause a symptom or clinical problem falls significantly. For all men who are diagnosed with prostate cancer, only 3% will die of the disease. Although there are rare aggressive variants, prostate cancer by and large behaves in a slow-growing fashion.

The problem is not using the PSA test to find a common and largely non-aggressive cancer early. The challenge is using the PSA appropriately to decide which man should or shouldn't have a biopsy. This decision is based on many individual factors like age and other illnesses present. Once a diagnosis is made, another complicated and nuanced decision is required to decide first *if* to treat the prostate cancer- not all men need to or should be treated. If treatment is recommended, deciding upon *which* treatment is the next difficult decision. Each treatment option: surgery, radiation, cryotherapy (freezing), and hormone therapy has well-publicized potential side effects: urinary symptoms, urinary leakage, sexual dysfunction, and bowel symptoms.

The technology we have available in 2011 to diagnose and treat disease is astounding. In prostate cancer, however, we are still searching for a "better PSA" and for more specific tests to separate the aggressive prostate cancers from the harmless ones. This will allow us to treat only the aggressive, life threatening tumors and to be able to observe the harmless ones without treatment. But for now, the PSA- imperfect as it is, is the only tool we have to find this cancer early and at least begin the conversation about whether or not to treat. The USPSTF recommendation against PSA testing is a short-sighted bureaucratic pronouncement that ignores clinical necessity.