New PSA Guidelines Discourage Overscreening

By Judy Peres

T

he new prostate cancer screening recommendation that the U.S. Preventive Services Task Force issued in October provoked the predictable firestorm of controversy between proponents of early detection and critics who believe many screening tests have been overpromoted. But the reaction was more muted than expected, leading some to suggest that the pendulum might be swinging away from routine screening.

“I’m extremely hopeful we’re near the tipping point,” said Virginia Moyer, M.D., task force chair and professor of pediatrics at Baylor College of Medicine in Houston. “People are beginning to recognize that all early detection is not good. Just because it falls under the heading of prevention doesn’t mean it’s good without data to demonstrate the benefit.”

Moyer believes the tipping point has to do with a more sophisticated understanding of what cancer is. “The public thinks once you have a cancer cell in your body, it will progress predictably and inevitably to a terrible death,” she said. “That is simply not true of most cancers. It’s certainly not true of prostate cancer, not true of breast cancer, not true of most skin cancers, not true of all cervical cancers. You have a disease that is highly variable. Knowing you have cancer cells in your prostate or breast doesn’t mean that, unless you do something radical, you’re going to die of that. A significant proportion of people whose disease is detected by screening never would have known about their disease in their entire lifetime. A good proportion would have died of something else before the cancer progressed to being clinically significant, and many would have died of old age.

“That’s not true for everyone,” she concedes. “Some people will have progressive, terrible disease. But unfortunately, much of the aggressive disease is rapidly progressing and, therefore, not likely to be caught by screening.”

Prostate cancer is the most common malignancy in U.S. men, not counting skin cancer. The American Cancer Society expected 240,890 prostate cancer diagnoses in 2011 and expected that 33,720 men would die of the disease.

What the Guidelines Say

On Oct. 7, the Task Force issued a draft of its new guidelines on prostate-specific antigen (PSA) testing for prostate cancer. Giving the test a “D” rating (“moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits”), it recommended that healthy men, regardless of age, race, or family history, not undergo routine PSA screening. The statement noted, however, that the recommendation did not apply to using the PSA test as part of a diagnostic strategy in men with suspicious symptoms or for surveillance after diagnosis or treatment of prostate cancer.

“The evidence is convincing,” the statement said, “that for men aged 70 years and older, screening has no mortality benefit. For men aged 50 to 69 years, the evidence is convincing that that reduction in prostate cancer mortality 10 years after screening is small to none.” On the other hand, it said, the harms of screening are well established. They include false-positive results, which are associated with psychological distress as well as additional testing and biopsies; infection and bleeding from biopsies; and “substantial overdiagnosis,” or detection of a cancer that does not progress to cause illness or death during a man’s lifetime. The harms related to treatment of screen-detected cancer are also well established, including erectile dysfunction, urinary incontinence, bowel dysfunction, and occasionally death.

The immediate reaction to the statement was predictable: Financier Michael Milken, chairman of the Prostate Cancer Foundation, wrote in a Washington Post op-ed, “The USPSTF recommendation could produce a cruel form of rationing . . .  The argument against testing reflects the same false economy seen throughout America’s health system.” Republican presidential candidate Newt Gingrich, in HumanEvents.com, dubbed the recommendation “death by bureaucracy.” And Deepak Kapoor, M.D., chairman of Integrated Medical Professionals, told the New York Times, “We will not allow patients to die, which is what will happen if this recommendation is accepted.”

But the American Urological Association issued a fairly measured response, saying it was “concerned that the Task Force’s recommendations will ultimately do more harm than good to the many men at risk for prostate cancer” while conceding that “not all prostate cancers require active treatment and not all prostate cancers are life threatening.”

Screening Still Contentious

Moyer cited the association’s response as one indicator that things are changing: “That’s very different from standing up and saying, ‘You’re killing people!’” She
also pointed to many articles in the popular media aimed at helping people understand the downside of screening. In October alone, the New York Times ran editorials on the potential harms of PSA testing and mammography screening.

Otis Brawley, M.D., chief medical and scientific officer of the American Cancer Society, also sees indications of a move away from screening. “Some people are starting to be open to the fact that some tests are not as good as advertised,” he said. “And some are realizing there’s been a lot of over-promise and overpromotion in screening tests.” But Brawley, who has been outspoken in his criticism of advocates whom he accuses of “lying” to men about the benefits of PSA testing, is among those who believe the task force may have gone too far by discouraging all use of PSA screening.

While saying no man should have his PSA level tested without his understanding and consent—including at shopping malls and state fairs—the task force said it was under no illusion that PSA testing would go away. “Some men will continue to request and some physicians will continue to offer screening,” the statement said. “An individual man may choose to be screened because he places a higher value on the possibility of benefit, however small, than the known harms that accompany screening and treatment of screen-detected cancer . . . This decision should be an informed decision, preferably made in consultation with a regular care provider.”

Brawley said he agreed completely with that sentiment, adding, however, “I’m concerned that a task force recommendation to not screen is inconsistent with informed decision making.”

H. Gilbert Welch, M.D., professor of medicine at Dartmouth Medical School and author of many books and articles on the unadvertised risks of screening tests, said the task force draft recommendation on PSA testing had led him to question his prior position that clinicians should help patients make their own decisions about screening by informing them of the risks and benefits. “Shared decision making is easy to say but really hard to do,” he said. “We can’t share every decision—there are only so many minutes in a clinic visit. We have to make judgments about what decisions we truly try to inform.

“The task force [implicitly] said PSA screening is not a decision worth sharing, because it’s a distraction from other issues in health care—like what’s bothering you right now.”

Scott Eggener, M.D., a urologic oncologist at the University of Chicago Medical Center, agrees that both patients and physicians need to be better informed about what the PSA test can and can’t do. To Eggener, the bigger concern is that the wrong patients are being tested.

Eggener advocates “aggressive PSA screening” for every man young and healthy enough to have a life expectancy of at least 8–10 years. But according to a study done by Eggener published May 1, 2011 in the Journal of Clinical Oncology, based on data from the National Health Interview Survey, older men are almost twice as likely as younger ones to be tested. In 2005, he said, 47% of men aged 70–74 years reported having had a PSA test in the past year, compared with 24% of men aged 50–54 years.

Eggener also believes that better use of risk stratification tools can reduce the overtreatment of prostate cancer patients. According to the task force, nearly 90% of men with PSA-detected prostate cancer undergo early treatment with surgery, radiation, or androgen-deprivation therapy. But Eggener said he has anecdotal evidence that this practice is changing. “Data have emerged in the last 5 years that surveillance is a safe and reasonable option for men with low-risk prostate cancer,” he said. Acknowledging that “change can often occur at a glacial pace,” Eggener added, “I strongly suspect a greater proportion of men are choosing active surveillance over the last 5 years.”

Public Still Tied to Screening

Leonard Berlin, M.D., professor of radiology at Rush University and the University of Illinois at Chicago, believes it will be a long time before the trend moves away from widespread cancer screening and its associated overtreatment. He sees three main reasons: The American public wants to believe that early detection saves lives, the malpractice system creates a strong incentive to screen, and physicians don’t have time to educate patients (even if they themselves are educated).

“Screening tests are so ingrained in the public’s mind,” said Berlin, “it’s very difficult to convince people that there’s a downside. Explanations about overdiagnosis and overtreatment from those who counsel that screening isn’t always beneficial usually get twisted into the argument that they’re only trying to save money. That’s the reality.”

(The task force explicitly stated that it “does not consider the costs of providing a service” when it assesses effectiveness.)

Berlin cites a malpractice case in which a patient sued his internist for not advising a routine PSA test. “The plaintiff’s attorney argued that the only purpose of evidence-based medicine is to ration care and save money for payers,” he said.

On an even more basic level, he said, “People want their doctor to do something—write a prescription, order a test, do a procedure. I’ve never heard of a physician getting sued for not doing a mammogram or a PSA test, but many get sued for not doing them.”

And if that weren’t motivation enough, one must deal with the constraints of the typical medical practice, in which the physician may see dozens of patients in a single day. “Is he going to take 20 minutes to sit down and explain the benefits and harms of a test—which the patient may not accept anyway—or is he going to just order the test?”

Berlin has written extensively about medical malpractice issues related to cancer screening tests. He argues that overselling the benefits of screening while underemphasizing their costs and limitations is directly related to the huge number of lawsuits alleging failure to diagnose cancer.

“If you say, ‘A mammogram caught my cancer early and saved my life,’ what’s the reverse? ‘The radiologist missed my cancer—so he cost me my life.’”

Moyer said one thing should be clear after the task force analysis of the data: “The vast majority of men who have aggressive treatment for a screen-detected prostate cancer will not have their lives saved. Their lives would have been fine anyway. They need to make their decision [about whether to have a PSA test] knowing that.”

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