To Screen or Not to Screen for Prostate Cancer
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The Journal of the National Cancer Institute recently published (12/2011) that regular PSA (prostate specific antigen) testing does not save lives and can lead to aggressive treatments that leave men impotent, incontinent, or both. Although this statement made the recent medical news cycle, their conclusion is anything but new. This conclusion has been debated for over 10 years but it has only been since the last 4 years that the studies backing this originally contrarian view began to be reported in the mainstream.

However, after each new declaration of the PSA inaccuracy, pro-screening groups counter the recommendations not to screen with their view that PSA testing saves lives. Thus the confusion for patients is understandable. The honest truth from the data does show that since PSA screening for prostate cancer began that the overall mortality from the disease has modestly decreased. However the rate of diagnosis of the disease greatly increased. This was due to the great number of slightly elevated PSA patients that were biopsied when they otherwise would not have been. These positive PSA screens are automatically translated into a biopsy that then, if positive, leads to surgery, whether the cancer would have been fatal or not. The overall problem then has become that for each life saved from an eventual metastasis of the cancer due to PSA screening, there are on average 4-5 men (depending on study) that had surgery who would never have died from the disease at all. Since prostate cancer surgery typically leads to severe side effects as erectile dysfunction and incontinence, a 1 to 4 risk ratio make many men feel after surgery that they now suffer from unnecessary life changing side effects. However, as stated, the screening does save lives.

The problem for the proponents of these two opposing views is determining what the ‘proper ratio’ should be of risk. Many in the prescreen camp believe that “if PSA testing can save only one life then it is worth the side effects for everyone else”. The anti-screen camp says that ‘only’ 1 in 4 is not good enough when quality of life issues can routinely be so severe, especially when these odds risks are not typically explained to them before the procedure. When you further add in the exploding increase in medical costs for surgeries and their original PSA screens that are all thought to be unwarranted, the need to reanalyze reflex PSA screening is necessary.

Overall it seems that both sides, especially in the quick manner the media explains it, are missing the underlying point of the recommendations. The PSA is not being advised to stop in its use as a screen but only when used as a sole screening measure. What is being advised is an advanced aggregate approach of screening that employs numerous PSA values to see trends and patterns, a detailed patient history, new DNA molecular lab studies, urinalysis, urinary history, and new imaging like color Doppler. Used in this constellation of data, the PSA is a good marker but when put into context rather than using it to rush into the preordained reflex medical system that would immediately order a biopsy and then surgery. Essentially, if the physician, hospital, cancer prevention association, or especially one’s health insurance cannot provide multiple data to serve in an aggregate assessment approach, then the PSA by itself is too unreliable to stake the patient’s future on it, ergo, to omit the PSA screen entirely.

The PSA will no doubt be superseded by a more reliable test eventually. However until then the PSA will continue to bring debate and will challenge a broken medical system to find a more ethical and pragmatic way to incorporate this outdated lab test. For information on how the new advanced aggregate screen and assessment for prostate cancer is utilized, feel free to contact me at this office at 480-767-7119.