EDITORIAL

Celebrating the Death of PSA Screening?

The U.S. Preventive Services Task Force (USPSTF) issued a preliminary recommendation against PSA based screening for prostate cancer in October 2011. Their "D" recommendation discourages the use of screening in all men. Opinions expressed in the media ranged from outrage and disappointment to exuberant celebrations of the possible end of PSA screening in a fashion befitting the death of a tyrant. Terms such as 'welcomed", "long overdue","faith-based" or "profit-based practice of medicine" were used. Accusations of prostate cancer screening "conspiracies", "profiteering" and "media manipulation" were made by well-known influential medical editors. One on-line medical editor called the PSA test "nefarious" while the editor of a well-known text blogged that "D" is for "do nothing" and "screening for prostate cancer leads to worse outcomes and always has".

Both sides in this important public health issue should have the opportunity to select their data to argue for the benefits or the harms. However, when the rhetoric by some becomes so vitriolic against PSA screening, the use of such accusatory and incriminating language has no place in the discourse of a major health issue.

The disciplines that manage prostate cancer have been struggling with the best approach to the second leading cause of cancer death in men. To abandon PSA testing in all men will move us back to the days when prostate cancer usually presented with symptomatic, advanced disease. While we know that the PSA test is far from perfect, the USPSTF draft did not acknowledge the evidence that PSA based testing leads to diagnosis of earlier stage and potentially more curable disease.

The task force, by design, is composed of primary care providers, including gynecologists, and was chaired by a pediatrician. This uniform USPSTF approach does bring some objectivity that is needed in these deliberations. However, it disconnects a much larger body of the peer reviewed literature from the practical needs of the physicians and their unique patients they care for on a daily basis. Participation of some specialists in the topic under study should comprise part of the USPSTF panel's deliberations to improve its credibility. The "one size fits all" evidence based medicine movement is central to the USPSTF mission. Consider this: would you endorse a panel's recommendations on the management of newborn heart disease composed of urologists, radiation oncologists and medical oncologists who cite less than 50 articles on the topic?

The two major prostate cancer screening trials, one positive and one negative, weighed heavily in the recommendation. The 25% reduction in metastatic disease and a 20% reduction in mortality are noted by the panel as "minor". The fact that almost 50% of the men in the negative trial had a PSA outside of the study that compromised its results was acknowledged but not important in the panel's recommendations. Further analysis of the "negative" PLCO data shows that in younger men with minimal or no comorbidity, there was significant reduction of prostate cancer death.

The evolution of the "thoughtful use" of PSA based screening to optimize the utility of the only test we have to identify men at risk for prostate cancer, as suggested by the American Urological Association, defines the next phase in screening for prostate cancer. Until new markers are available, PSA is the best we have. The panel's 2008 prostate cancer statistics reflect the earliest approaches to PSA based screening from the mid 1990s. They minimized the current screening focus on men with a 10 year life expectancy and failed to emphasize the growth of active surveillance. The challenge today is overtreatment and not overdiagnosis of prostate cancer.

Consider the implications of the USPSTF recommendations as a government sponsored panel empowered in the era of healthcare reform. The USPSTF assigns one of five letter grades to each of its recommendations (A, B, C, D, or I). The Patient Protection and Affordable Care Act mandates that A or B recommendations must be covered. The USPSTF disclaimer states: "...clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation". A final "D" will take any individualized decision for or against PSA screening out of this equation as the service might not be covered by carriers.

Based on other recent controversial recommendations, the USPSTF now makes preliminary reports open to public comment before the final recommendations. One can only hope that appropriate, balanced and thoughtful comments will be made and the reports of the death of PSA based screening will be premature when the task force issues its final report.

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