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# EDITORIAL

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## Prostate Cancer Screening: Perhaps a Little Patience is the Answer

Several primary care providers were in the doctor's lounge discussing a recent article "Radical prostatectomy versus observation for localized prostate cancer" in the *New England Journal of Medicine*.<sup>1</sup> They placed the findings of this study in the context of the recommendations of the U.S. Preventive Services Task Force (USPSTF). The initial sentiment amongst my colleagues was that screening for and treatment of early stage prostate cancer should not be a priority for the medical field. They concluded that PSA testing would be best avoided in the primary care setting where abnormal values lead to patient anxiety and the interpretation of results is confusing for the clinician. I joined in the conversation and after adding some further information, all agreed that at this point, the issue is not a clear one. Their general consensus was that they would continue to offer screening for their patients, but discourage it in those with limited life expectancy.

I agree that the data used by the USPSTF does not support the widespread use of PSA testing. Gomella et al<sup>2</sup> recently provided an excellent overview of the evidence and controversies for further information. However, it does not seem wise to completely cease almost all efforts for early diagnosis and treatment of prostate cancer without further information. Several factors need to be considered before burying the screening efforts; prostate cancer is still the number two cause of non skin cancer death in males and the death rate from prostate cancer has dropped dramatically over the past three decades despite an increase in life expectancy. PSA testing alone cannot explain the drop in prostate cancer deaths but no other alternative explanation has been provided.

The conclusions of the USPSTF were based on several screening trials [European Randomized Study of Screening for Prostate Cancer (ERSPC), Prostate, Lung, Colorectal and Ovarian (PLCO), and Goteborg]. What was not completely considered was the relatively short follow up (< 10 years) of these trials. When the ERSPC trial was carried out to 11 years, the cumulative hazard deaths become markedly different between the control and treatment groups.<sup>3</sup> Loeb et al studied the ERSPC trial and extrapolated the study beyond 8 years to 10 and 12 years and saw a marked decrease in the number of men needed to screen and treat at the extended time points.<sup>4</sup> The above study "Radical prostatectomy versus observation for localized prostate cancer", was carried out to only 10 years. Perhaps with further follow up, this study will also show a separation in survival between the treatment and control arms as the screening studies have shown.

It is clear from all studies that early diagnosis and treatment in those with limited life expectancy is not going to show any significant benefit. What is equivocal; however, are the results of screening and treatment in those with longer life expectancies. I must admit that I am biased as I was diagnosed with prostate cancer at age 46 due to PSA screening. I have more than a handful of close friends who were also diagnosed with prostate cancer at a young age by PSA screening. It is hard for me to believe that we will not benefit from our screenings. Until we have all the answers, I hope that we can continue our efforts at early diagnosis and treatment of prostate cancer in reasonable candidates. In addition, we need to get the word out to our colleagues to have some patience with this issue as we sort out the long term impact.

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### References

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