If I Had a Prostate

by Brenda Denzler

The doctor looked one more time at the computer screen, turned toward the patient and leaned in with his elbows on his knees. Being careful to make eye contact, he delivered the news.

"The tests show that you have a small cluster of cellular abnormalities. The good news is, it isn't serious right now, and it may never become serious. This is the kind of thing we need to watch, but not worry about too much. And that's what we're going to do—keep an eye on this little group of cells, but not get too stressed out about them."

"Cellular abnormalities?" the patient asked, looking befuddled. "I don't know what that means. What's abnormal about them?"

"They don't quite look like normal cells are supposed to look," the doctor replied, failing to actually answer the question and trying not to use the word he desperately wanted to avoid.

Suddenly the patient's look of confusion turned to realization. "You mean cancer?!!"

"Not invasive cancer," the doctor said quickly. "This is more like a proto-cancer. The cells look funny, but they don't seem to be growing and invading surrounding tissues. That's why we want to watch and wait. If they show signs of becoming invasive, we'll begin treating you right away. But most cells like this never do. We'd hate to put you through treatment that you don't need."

"I don't know," said the patient, looking justifiably skeptical. "If this thing could become cancer, I'd like to do something right now to make sure it never does."

"That's understandable," conceded the doctor. "Many people feel this way. Studies show, however, that this just isn't necessary, and the guidelines for treating this kind of proto-cancer suggest watchful waiting. That doesn't mean ignoring it. It means keeping a close eye on it so that we can do the right thing at the right time."

The question is, what really is the right time, and what is the right thing to do then?

Throughout human history, anything that was identifiable as "cancer" was the kiss of death. Nothing could be done. As a result, the very idea of it was so frightening that the word itself was only whispered in polite company. In the last 50 years, our understanding of cancer has grown exponentially. We have all kinds of conventionally sanctioned treatments for it, as well as better data on alternative and integrative therapies.

At first, the fruits of all this knowledge were applied without a great deal of discrimination. A breast cancer was a breast cancer, and every tumor got the same treatment. A prostate cancer was a prostate cancer, and it had to be dealt with the way we dealt with all prostate cancers.

As the survival curves became more favorable, however, and people began to have to live with the results of their treatments, which can put a damper on survivors' quality of life, researchers began to experiment with a more nuanced, "less-is-more" approach—giving less intensive treatments to those with earlier-stage cancers than to those with later-stage. Recently they've fine-tuned this distinction even further. In the September 18, 2018, online issue of the journal Oncology, an article suggests that some patients with Stage III colon cancer may need more chemotherapy, while others diagnosed at the same stage may do better with less. Go figure….

It's in the context of this less-is-more approach that the "wait and see" tactic for very early-stage disease has gained a lot of traction. Nowhere is this more apparent than in the case of two sex-linked cancers: prostate cancer and breast cancer. I have a dog in the fight when it comes to breast cancer. On the chance that this might cloud my judgment when thinking about the practicalities and politics of cancer treatment, for the last couple of years I've focused my attention on prostate cancer as well. Is what's touted as good for the goose also being touted as good for the gander? For the most part, it sure seems like it.

About the only big difference I can see between the "wait and see" tactics being promoted to women and men is in how the malignancy is characterized. Even the slowest-growing, most non-invasive, most localized prostate cancer is still called by the name "cancer." Some researchers, however, are saying that the small, localized, non-invasive masses found in women's breasts, which have traditionally been called DCIS, or ductal carcinoma in situ, should not even be called "carcinoma (cancer)" because they aren't invasive and—can you believe it?—because the term "cancer" scares women. Maybe men aren't as spooked by the word "cancer"…but I have my doubts.

It has been said that more men will die with prostate cancer than of prostate cancer. According to the American Cancer Society, 1 out of every 9 men will get prostate cancer at some point in his life, but only 1 out of every 41 men will die of prostate cancer. This is not because the treatments for prostate cancer are so effective. They're actually pretty brutal. Rather, it's because most prostate cancer is not aggressive, and in many cases it's so localized and slow-growing that it would never be a threat.

Because of this, men's equivalent to women's screening mammogram—the prostate-specific antigen, or PSA test—has been de-emphasized since 2008. There's no point in finding small, symptomless cancers, the thinking goes, so save the testing for when there is enough disease to create symptoms that need to be managed. Even when an early-stage cancer is discovered, the guidelines for treatment often suggest watching and waiting rather than treating.

I've often thought that I was "lucky" to have an aggressive form of breast cancer. I didn't have to make a decision about whether to treat or to watch and wait. What would I do, I've wondered, if I had a prostate and an early-stage cancer had been found? I don't know.

Cancer treatment is seldom no big deal. For DCIS, the usual treatment (if one is pursued) is surgery. Whether women opt for a small excision or choose complete removal of the breast, the long-term side effects for them tend not to be as extreme as they are for men. For prostate cancer, the most common treatments are surgery or radiation. They often cause unpleasant side effects such as incontinence, impotence, or bowel problems. According to the Journal of Clinical Oncology (May 2017), 15 percent of long-term survivors of prostate cancer come to regret their treatment decisions. The longer they live with the side effects, the more likely they are to have regrets.

If I had a prostate, I could see myself refusing a PSA test because I just wouldn't want to know and be faced with making a difficult decision—to treat or not to treat, and if I treated, what set of side effects I'd be able to live with. I'd put off getting tested as long as possible.

But prostate cancer can kill. It does kill. Every day. Would I want to take a chance that I'd forfeit my life because I was afraid to know the truth early enough to do something about it? What are the chances that refusing a PSA screening test could increase my risk of dying?

What really is the right thing to do, and the right time to do it? In my next column, I'll take a look at the impact of 10 years of reducing PSA testing.

Brenda Denzler was diagnosed with inflammatory breast cancer in 2009. She became a cancer survivor on the very day she was diagnosed.