If I Had a Prostate — Part 2

by Brenda Denzler

In 2009, women were informed that we didn't have to get mammograms as early or as often as we had always been told. This went against the grain of the breast cancer community's "early detection saves lives" mantra and caused a small uproar. Meanwhile, on the male side of the health care world, the same thing was happening. In 2008, men aged 75 and older were told that having a PSA test to screen for prostate cancer was unnecessary; in 2012, that roll-back was extended to men of any age.

The same kind of reversal was happening with regard to treating early cancer. "Less is more" became the new slogan as women with ductal carcinoma in situ (DCIS) and men with low-grade prostate cancers were told that immediate treatment wasn't necessarily best. Rather, we were told to just watch and wait—keep an eye on things and see what happens.

Most of us grew up with the idea that cancer was the enemy and the only way to defeat it was to catch it early, before it had a chance to spread. It's hard to adjust to the idea that early detection isn't always beneficial, much less the idea that not treating some cancers may be better than doing everything in your power to get it out of your body.

John and Jane Q. Public aren't the only ones having trouble with this. Doctors who regularly treat prostate cancer still have PSA tests, themselves, and recommend them to their immediate family (according to a presentation at the 2017 American Urological Association meeting). Similarly, in 2017 JAMA Online reported that doctors who have had a patient, family member or friend who didn't have screening mammograms and then developed advanced, life-threatening breast cancer are more likely to advise ignoring the new BC screening guidelines.

The problem is that "low-risk" is not "no-risk." Though the number of tiny, slow-growing breast and prostate cancers that go on to become invasive and life-threatening may be small, it still means that for some people a small, supposedly indolent cancer is going to wind up trying to kill them.

It would be easier if we could be pretty sure that the new guidelines wouldn't cost us our lives by causing us to miss more easily-treated, early-stage cancers…or if we could tell the difference between early-stage disease that was going to progress and kill us, versus early-stage disease that's so slow-growing it will never become a problem. But we can't.

So here we are, 10 years out from the first change to the prostate cancer screening guidelines for older men, and six years out from when the changes were suggested for all men. The "less is more" approach to (non-) treatment for early-stage prostate cancer has also had a chance to bear some fruit. What are the results?

In the 1990s, after the PSA test was introduced and screening became the norm, there was a 50 percent decline in deaths from prostate cancer and 70 percent fewer cases of men presenting with metastases at the time of diagnosis, according to a May 2017 article in JAMA Oncology. However, in the wake of the new, minimalist screening guidelines, the way prostate cancer shows up in patients has changed "significantly." Today, more men are once again being diagnosed with more-advanced stages of cancer that are harder to cure, and more older men receive a first-time diagnosis of cancer that includes metastases—--a terminal diagnosis.

As for watchful waiting, this approach has resulted in a higher rate of disease progression, according to an October 2016 issue of the New England Journal of Medicine. We know that about 1/3 of early-stage prostate cancer cases will become more invasive and threatening, so it's no surprise that active surveillance as an initial approach has resulted in a higher rate of disease progression.

What's more concerning is that those who watched and waited had twice the risk of developing not just localized progression, which could still be curable, but metastatic disease, which is not. The treatments for metastatic prostate cancer can be as unpleasant to endure as the treatments for early-stage cancer…but they don't include the hope for a cure. One standard treatment is androgen deprivation therapy, otherwise known as "chemical castration." That name right there says a lot about what the side effects are. As the article says with masterful understatement, they are "not inconsequential."

But what about death? All this talk about progression and metastases and treatment or no treatment or when to treat—-so what? The bottom line is, has less frequent PSA screening caused a rise in the death rate from prostate cancer? It depends on whom you ask.

A 2017 article in the Annals of Internal Medicine said that the new recommendations in the U.S. for less PSA screening were based on one European study that showed no benefit in terms of survival. However, another major European study showed exactly the opposite. A new examination of the issue using data from both of these studies found that there is indeed a survival advantage to PSA screening. In fact, it can "significantly reduce" the chances of prostate cancer death.

On the other hand, this year the British Medical Journal reported that PSA screening either "may" or "probably" has no effect on prostate cancer death rates, depending on which article you're reading. This, despite the fact that they also report the "European Randomized Study of Screening for Prostate Cancer…suggests that screening may reduce the long-term risk of prostate cancer-specific mortality by at least 9 percent (relative reduction)." This means that men's risk of dying from prostate cancer in their lifetime (2.45 percent according to the American Cancer Society) is reduced by 9 percent if they do PSA screening—-leaving them with a lifetime risk of 2.23 percent instead. These are awfully small numbers, I'll admit. Unless you or someone you care about is one of that tiny percentage.

As far as I can tell, what it all really boils down to is not just human suffering and death—referred to in research quarters as "morbidity" and "mortality." It's money. No surprise there, eh?

This same BMJ article winds up with a cost-effect analysis of PSA screening in the U.S. They conclude, using a $100K cut-off, that it's not worth it to screen more often than every four years. After all, two-thirds of men who have an elevated PSA and get a biopsy will have normal results. (We've already seen what this means for the 1/3 who do not get normal results.) Meanwhile, those with "normal" PSA tests aren't really off the hook. Fifteen percent of them will go on to develop prostate cancer anyway. The PSA test, in short, is not foolproof.

Nor is it worth it, the article says, to offer immediate treatment to men who test positive for early-stage prostate cancer, because only 2 percent of them will die of the disease within the next decade of their lives. Of course, once you join the ranks of those who have metastatic disease, you have a 70 percent chance of dying within five years.

So if I had a prostate, would I get a PSA test? Yeah. I probably would, just like I got occasional mammograms before my IBC diagnosis. Nearly 1,000 men in NC died of prostate cancer in 2017. I'd want to know if I was likely to join their ranks, because for me knowledge is power. But in today's world, knowledge also demands a certain amount of responsibility—-the subject of next month's rumination.

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