US government panel recommends an end to prostate cancer screening

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The United States Preventive Services Task Force (USPSTF) has recommended against Prostatic Specific Antigen (PSA) screening for men in all age groups to detect prostate cancer. By calling for a halt to screenings, the panel is recommending an end to a serious search for the second most lethal cancer in adult males in the US, second only to lung malignancies.

While the USPSTF is nominally an "independent" government body, in recent years it has increasingly recommended cuts in health care services. The 16-member panel is the creation of the federal Health and Human Services Department, and its advisories have a direct impact on what Medicare and private insurers will underwrite for preventative testing. In 2009 the USPSTF recommended that women under the age of 50 not undergo annual mammogram screenings for breast cancer, provoking widespread opposition from patients and health care providers alike.

The USPSTF has issued the PSA screening test a grade "D" rating, enabling the Obama-sponsored Affordable Care Act to slash coverage for prostate cancer prevention, which requires health planes to cover without cost-sharing only preventative services that are rated "A" or "B" by the USPSTF. A commentary period on the panel's new PSA screening recommendation, open to the public and the health care community, concludes November 8.

In 2010, some 217,730 men in the US were diagnosed with prostate cancer at the average age of 67. About 32,050 died last year from the disease. African-American men contract prostate cancer substantially more often than white males and die at over twice the rate.

The USPSTF concedes that autopsy studies have shown about one third of men (dying of causes other than prostate cancer) aged 40 to 60 years of age have prostate cancer confirmed microscopically. In service to the larger governmental agenda of cutting spending for health care, the Task Force states the obvious, "The detection of lesions (prostate cancer) that are unlikely to be of clinical significance (as well as the cancers that are certain to cause sickness and dreadful suffering from spread to pelvic, back, rib and leg bones) increases with the frequency of PSA testing …"

To which any serious clinician dedicated to the care of his patients might reasonably be expected to reply, "Well, yes, that would be the declared enterprise in the search for disease; to actually find it, and to care for the persons discovered in the diagnostic search."

The Task Force seizes on an artificial "weakness" of a screening tool (in this instance, the PSA; in 2009, in was breast mammography), epidemiologically defined as a test with a great degree of sensitivity. In other words, in the search for the diagnosis in an apparently well population at proven increased risk, it will miss very few people who actually have prostate cancer while gathering a large number who do not have the disease. This at-risk population includes men over age 50, those with a family history of prostate cancer, and African Americans.

Another epidemiologic basic, which the USPSTF panel understands very well, is used by every primary care and urologic specialty office in the country taking care of older men. The appropriate tools of specificity are then used to accurately identify the persons with prostate cancer, including digital rectal exam and prostate gland ultrasound. When a nodule suggestive of cancer is felt or seen, the doctor may then recommend to the patient that he consider biopsy.

The government panel seeks to muddy the waters with assertions that the PSA screenings are the cause of needless pain, anxiety, impotence and incontinence in

men who receive biopsies and other treatment when cancer is detected. In a discussion on the Washington Post web site, Deepak Kapoor, MD, president of Advanced Urology Centers, dismissed this claim, "Screening in and of itself provides information to doctors and patients; there is virtually no risk to the screening process. Once screened, the decision for biopsy, and ultimate treatment is between physician and patient, and needs to be customized for every circumstance."

The overwhelming emphasis in the October Task Force draft is to deride and debase the search for prostate cancer, as though it is an utter waste of the patients' and clinicians' time and money. One can be certain, however, that for the wealthiest few who can afford to pay out of pocket the search for prostate cancer will continue, using the best existing technologies and practices.

One searches in vain for one line in the USPSTF draft recommending an expanded vigilance for prostate cancer, or for increased care for the almost one quarter million men a year who will contract the disease—or the 32,000 who will die from it.

Philip Kantoff, MD, director of Dana-Farber's Lank Center for Genitourinary Oncology in Boston, Massachusetts, reacted to the panel's recommendations as reported by *Medscape News*: "This is the wrong message at this point in time. The whole issue of PSA-based screening is complex. It involves multiple steps and decision points. The blanket statement saying that PSA-based screening is of no value is the wrong message right now."

In the *New York Times*, Carl Olsson, MD, chief medical officer for the largest urology practice in the United States, pointed out that deaths from prostate cancer in the US have steadily declined since widespread testing with PSA began. He was quoted, "I think the concept of having us give up on the identification of people who have prostate cancer, as well as on their treatment, is a backward step, to say the least."

These points are indeed accurate. The Task Force draft recommendations go much farther than simply dismissing a test with well-known limitations, which by its design as a screening test captures virtually all persons with cancer, both slower growing and the unquestionably lethal. Critics of the panel's advisory understand the implications of halting PSA screenings: to diminish and undercut the vigilance and care provided to potential prostate cancer sufferers.

The Task Force arguments bear weight for what is not said as well. The panel makes virtually no mention of prostate cancer morbidity (sickness from the disease, including urinary obstruction and extraordinarily debilitating bone pain from cancer spreading to pelvis, ribs, back, and legs).

Murray Feldstein, MD, from Phoenix, Arizona commented to *The Annals of Internal Medicine* following the USPSTF recommendations, "As an elderly urologist who spent nearly half of his career in the pre-PSA era, I can personally attest to another and perhaps even more important factor that is being overlooked—suffering from advanced prostate cancer. No longer do I see patients with bulky cancer who bleed and obstruct their urinary tracts." He pointed out that painful prostate cancer that had spread to bones was now rare, a situation undoubtedly attributable to the widespread use of PSA screenings.

The panel's latest recommendation on PSA screenings dovetails perfectly with the medical austerity prescription embodied in the Obama administration's health care legislation signed into law last year. It is another example of how this health care "reform" has nothing in common with expanding care and saving lives, but rather is aimed at cutting costs for the government and boosting profits for the health care industry.