

Anil Kapoor, MD, FRCSC;*
D. Robert Siemens, MD,
FRCSC†

*Associate Editor, CUAJ;
Professor of Surgery
(Urology), McMaster
University, Hamilton, ON;
†Editor-in-Chief, CUAJ;
Department of Urology,
Queen's University,
Kingston, ON

Cite as: *Can Urol Assoc J* 2014;8(11-12):387-8.
<http://dx.doi.org/10.5489/cuaj.2604>
Published online December 15, 2014.

A 62-year-old man presents to the emergency room with severe back pain. A workup reveals a rock-hard prostate, PSA of 75 and widespread prostate cancer bone metastases to his pelvic bones, rib cage, and spine.

Most of the readers of this issue of the CUAJ will be keenly aware of the recent release of the Canadian Task Force on Preventive Health Care (CTFPHC) guidelines recommending against routine PSA screening for prostate cancer.¹ Furthermore, many of you will be experts in the management of patients with prostate cancer, well-versed in the ambivalent literature surrounding population-based PSA screening and cognizant of the intricacies associated with the need for disconnecting diagnosis and treatment of early disease. You may be greatly concerned that the CTFPHC recommendations, aimed at a primary care audience and policy makers, have bolstered those of others including the US Preventive Services Task Force and Choosing Wisely. Will these recommendations cautioning against PSA screening result in a set-back in the prostate cancer conversation? Will we start to see the above patient present more commonly in our practices?

The CTFPHC states that the evidence supports an increased risk of harm with routine testing, with uncertain benefits. Their key recommendations include:

- For men under age 55 and over age 70, the Task Force recommends not using the PSA test to screen for prostate cancer.
- For men 55 to 69, the Task Force also recommends not screening, although it recognizes that some men may place high value on the small potential reduction in the risk of death and suggests that physicians should discuss the benefits and harms with these patients.

The overarching goals and objectives of the CTFPHC to put forward evidence-based recommendations about clinical maneuvers aimed at primary and secondary prevention is important in our current healthcare landscape. The make-up of the CTFPHC includes volunteer clinicians and methodologists, and specifically excludes content experts in the field, presumably to obviate any perceived conflicts of interest. However, the methodology for the process, well-described on the Task Force website,² does allow for more widespread consultation with such experts in prostate cancer biology and management. Such input into the current recommendations appears to be lacking in the document and, in our opinion, contaminates the effort with a few unfortunate mistakes and substantively misleading statements.

So what do the experts say? The CUA has released a number of excellent commentaries outlining some factual errors and concerns with interpretation of the CTFPHC document.^{3,4} Perhaps most concerning is the observation that although the Task Force confirms that PSA screening likely results in a reduction in cause-specific mortality, it highlights that there is “conflicting evidence suggesting a small and uncertain potential reduction in prostate cancer mortality.” The messaging confuses the reader and distracts from best evidence to date suggesting that screening reduces prostate cancer deaths by 21% to 44%. We encourage you to read the full response from the CUA, which includes further relevant information the Task Force has yet to adequately address.

Similarly, a number of key stakeholders and opinion leaders, experts in contemporary prostate cancer diagnosis and management, have spoken up and offered thoughtful and rational advice for primary care physicians and prostate cancer specialists alike.^{3,5} We summarize some of these thoughts below:

1. Men should have a discussion about the risks and benefits of PSA testing especially those between the ages of 55-69 and those at higher risk of aggressive disease.
2. Prostate cancer diagnosis must be uncoupled from prostate cancer treatment.
3. Avoid PSA testing in men with less than 15-year life expectancy, unless these men have a previously elevated value.

4. Men with a low initial PSA (<1.0) could be tested less frequently, perhaps every 5 years.
5. Digital rectal exam (DRE) has value as a routine part of the periodic health exam.
6. Men with low-risk prostate cancer or older men with intermediate-risk prostate cancer should be counselled towards active surveillance.

Any dispassionate observer would surely question the underlying reasons for such a disparity between these recommendations. Much has been debated in the scientific and lay press around the potential dangers of “content expert” involvement in medical research, advocacy and policy endeavours for fear of perceived and, undoubtedly, occasional real conflicts of interest. The polarized conversation around the early detection of prostate cancer has, in our opinion, suffered from this subliminal concern. So where do we go from here? It would seem obvious that next steps need to focus on a concerted refinement of the CTFPHC living document, incorporating input from patients, primary care providers and our balanced and level-headed Canadian

content experts. The CTFPHC has a stated responsibility for leading knowledge translation and evaluating the impact of its products. Let’s work together to help produce a consistent and balanced message, and ensure its appropriate dissemination, so that Canadian men and their primary care providers are not lost in a potentially never-ending debate.

References

1. Canadian Task Force on Preventive Health Care. Recommendations on screening for prostate cancer with the prostate-specific antigen test. *CMAJ* 2014;186:1225-34. Epub October 27, 2014. <http://dx.doi.org/10.1503/cmaj.140703>
2. Canadian Task Force on Preventive Health Care. Procedure Manual. <http://canadiantaskforce.ca/files/procedural-manual-en.pdf>. Accessed December 8, 2014.
3. Klotz L, Breau R, Chin J, et al. Press release. AdvancingIn.com; October 27, 2014. <http://www.advancingin.com/info/emails/assets/pdf/CUA-response-to-CTFPHC-PSA-Oct-2014.pdf>. Accessed December 8, 2014.
4. Kassouf W. CUA responds to recommendations by the Canadian Task Force on Preventive Health Care (CTFPHC) on prostate cancer screening [press release]. Montreal, QC: PR Newswire; November 3, 2014. <http://prn.to/1A8nEuf>. Accessed December 8, 2014.
5. Murphy DG, Ahlering T, Catalona WJ, et al. The Melbourne Consensus Statement on the early detection of prostate cancer. *BJU Int* 2014;113:186-8. <http://dx.doi.org/10.1111/bju.12556>