

The confusion surrounding prostate cancer screening faced by family physicians

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Primary care physicians, in the forefront of prostate cancer screening, are challenged with confusing and often conflicting guidelines. The lack of uniformity on the optimal prostate cancer screening recommendations stems from conflicting interpretations of the results of recent screening studies. Unfortunately, two large trials, initially planned to define the usefulness of screening, were both significantly flawed and provided conflicting results and further fueled the debate.^{1,2}

Not surprisingly, these results have led to a lack of consensus on the best screening practices among various medical associations and guideline committees. The limitations of prostate-specific antigen (PSA) itself as a screening tool have precluded standardized and widely adopted guidelines from being developed to date.³ Several guidelines have been established; the American Urological Association and Canadian Urological Association favour the inclusion of PSA testing as a tool for prostate cancer screening,^{4,5} while the Canadian Task Force on Preventative Health Care and the U.S Preventative Services Task Force (USPSTF) recommend against screening.^{6,7} These are in addition to provincial and advocacy organizations' recommendations – it is no wonder physicians and patients are confused.

Controversy surrounding optimal prostate cancer screening for primary care physicians was renewed with the recent publication of the USPSTF statement, which attracted considerable media attention. Their recommendations were against PSA-based screening for prostate cancer in all men. PSA screening was labelled a “Grade D” recommendation, which states that there is moderate or high certainty that PSA screening has no benefit, or that the harms outweigh any benefits.⁷

It is important to stress the results of the European Randomized Study of Screening for Prostate Cancer, considered the best PSA screening study to date. It was demonstrated that screening reduced the rate of prostate cancer death by 20%, with additional two-year follow-up consolidating these findings.^{2,8} Being the largest trial to date and suffering fewer methodological limitations than its U.S. counterpart, this European study represents “level one” evidence that screening does reduce prostate cancer-specific mortality. It was proposed that the modest benefit conveyed should support a “grade C” recommendation; this leaves the decision regarding PSA screening to the patient and primary care physician.⁹

The results of the survey in this issue of *CUAJ* provide evidence to suggest that Ontario family physicians use their own management strategies in deciding whether to offer prostate cancer screening to their patients.¹⁰ As well, there is apparent heterogeneity in the use of screening, as well as in the attitudes concerning its value. Interestingly, although almost 80% screen for prostate cancer, a considerably lower percentage of family physicians believe that the benefits of screening outweigh its risks, which suggests that other patient factors prompt the decision to screen.

Obviously, a primary weakness of the paper is the poor response rate. The results do, however, provide a glimpse into the practice patterns of physicians directly involved in screening. It is likely that the results can be extrapolated to the rest of the country, as these findings have been corroborated by other papers addressing the same question in Newfoundland and British Columbia.^{11,12}

Most importantly, the survey shows the need not only to provide clear and evidence-based guidelines, but also for better education on prostate cancer screening for family physicians. A significant onus of responsibility for this lies with our own association and members. It highlights the importance of relaying our own CUA guidelines to family physicians, and educating them regarding the evidence and considerations surrounding prostate cancer screening.

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