EDITORIAL PSA screening: Time to overcome our brand confusion

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In this issue of *CUAJ*, you will undoubtedly scrutinize with interest the latest instalment of the CUA guidelines on prostate cancer screening.[1] These well-reasoned recommendations are a welcome update from our association's previous iteration, published in 2011.[2] Beyond the typical literature review and evidence synthesis that prefaces these endeavors, the authors formulate the recommendations to speak to the audience to which it is most relevant: primary care physicians (PCP), as well as Canadian men and their families concerned about the risk of the significant threat to quality of life that prostate cancer can represent. The messages are well laid out as five preliminary questions, four of which speak directly to this intended target audience:

1) Should men undergo prostate cancer screening?
2) What age should it begin?
3) When should it stop?
4) How often should it be performed?

The fifth additional question, outlining the current reflex tests used to support appropriate early diagnosis beyond a single prostate-specific antigen (PSA) reading, seems to be directed more to the urological crowd, although perhaps it also reinforces to our PCP colleagues that we continue to make progress in mitigating the over- and under-diagnosis associated with PSA.

Interested Canadians (public and healthcare providers alike) would have to have been hiding under a rock not to have been inundated with all the ambivalent and confusing messaging around prostate cancer screening over the last decade. Since the previous CUA guidelines,[2] then giving PSA screening a Grade A recommendation, the U.S. Preventive Services Task Force (USPSTF) changed their previous stance and downgraded their recommendation from C to D. Soon after, our Canadian equivalent (CTFPHC) similarly gave a weak recommendation to abandon PSA and digital rectal exam use for men of any age. Multiple groups and associations had in the meanwhile produced somewhat conflicting recommendations. Although in general supportive of early diagnosis of prostate cancer, they all reiterate the need for balance mandated by the well-recognized potential harms of subsequent biopsy and curative treatments — globally endorsing the central theme of shared decision-making. In the interim, we have had time to digest the evidence provided by the three pivotal randomized studies informing the conversation. More comprehensive interpretation of the PLCO, ERSPC, and Göteborg randomized trials — including issues of non-compliance, contamination, and understanding of effect size with longer follow-up — has allowed more confidence on the impact of early diagnosis on incidence of metastatic disease and prostate cancer mortality. Ongoing observational studies, including those determining men at very low risk of prostate cancer mortality and the outcomes of active surveillance, as well as important investigations exploring the role of imaging and predictive biomarkers, has forever changed the conversation from a simple "yes/no to screening" to a more nuanced "if so, how to best screen."[3]

One might argue that the recommendations of the USPSTF and the CTFPHC had, without meaning to, some positive effect by pushing the pause button on past, less optimally informed prostate cancer care practices. In Canada, however, population-based PSA screening had never really come to fruition, with only modest penetration of true screening in various regions across the country. Active surveillance has, and continues to have, significant uptake; indeed, Canada has led the world in using active surveillance to uncouple diagnosis from treatment. Most providers are now more likely to be concerned about under-treatment in the current paradigm. In any case, the messaging to our PCP colleagues from the task forces has had its impact. Webster et al, in a recent issue of *CUAJ*, nicely illustrates one region's experiences on PSA use and its impact of early diagnosis in a relatively captured/stable market in Ontario.[4] Several observational and modelling studies have quantified something we all seem to have witnessed over the last few years: decreased incidence of prostate cancer with a subsequent stage migration and

more metastatic disease in our clinics. In a recent turnabout this spring, the USPSTF has subsequently issued a new draft revision for prostate cancer screening upgrading its recommendation back to a C, encouraging physicians to discuss with their patients whether or not early prostate cancer detection is appropriate for them. The more inclusive and transparent process has resulted in a thoughtful reflection of the available evidence and is very much more in alignment with these current CUA recommendations, as well as others, such as the American Urological Association's clinical practice guideline. Interestingly, perhaps due to the fact that it is still in draft form, there has been relatively little Canadian exposure given to this change in stance on PSA screening. In fact, after the announcement of the reversal, a request to submit a commentary to a premier national general medical journal discussing its potential impact in Canada was subsequently rejected. Perhaps, this is reflective of more than a little fatigue surrounding the subject matter.

So what is our path forward? In the world of marketing, there is little doubt that what is described above has, maybe permanently, led to a bad case of "brand confusion." The early prostate cancer diagnosis "brand" has continuously struggled with getting people to understand what it truly represents. The brand's image has become inconsistent and disjointed. The schizophrenic recommendations to our PCP colleagues, landing most often on a mandate of shared decision-making, with its requisite conveyance of all the potential downstream consequences of sending off a simple blood test all the while incorporating the patient's "values and preferences," is a tall task in any primary care office. The CUA has created an excellent product in these recommendations: we now endorse (as a Grade B recommendation) and delineate how a PCP could discuss with men the potential benefits of doing a PSA, balancing the real benefit of reducing metastatic disease and mortality with negative issues of over-diagnosis. It's something most of us will likely believe in and be passionate about. But is there not a real concern that we won't be able to "sell" our product? The not-so-simple solution to reversing this confusion is effective communication: set brand standards; engage the stakeholders in the discussion; don't focus on over-explaining the minutiae; and avoid overly complex explanations, mixed messages, or vague buzzwords. The screening guidelines herein provide a good springboard and a clear message; now the hard work begins.

References

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