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Opinion

PSA Testing? Over-Treatment? Active Surveillance? Biopsy value? No PSA for Elderly?

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Opinion

I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued deep research and study in order to serve as an advocate for prostate cancer awareness, and, from an activist patient's viewpoint, as a mentor to voluntarily help patients, caregivers, and others interested develop an understanding of this insidious men's disease, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make their journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Importantly, readers of medical information I may provide are provided this "disclaimer" to make certain they understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as MY OPINION, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing their prostate cancer care.

I wrote this paper a few years back, and as anticipated then has now come to pass. The USPSTF made a grevious error when recommending against PSA testing in 2012. Please read the following papers bringing to light my anticipation [1,2]. And though USPSTFS amended its recommendation in May 2018, they still left open much to be desired (required!). "Prostate Cancer Foundation Statement on U.S. Preventive Services Task Force Updated Prostate Screening Guidelines." The USPFTS has upgraded their recommendation to a "C:" "Yesterday, the USPSTF updated its 2012 position on prostate cancer screening recommending that clinicians should selectively offer or provide periodic prostate-specific antigen (PSA)–based screening for prostate cancer for men between the ages of 55 to 69 (C recommendation). The USPSTF maintained its recommendation against PSA-based screening for prostate cancer in men 70 years and older (D recommendation) [3,4]. Regarding PSA testing: With continuing prostate cancer (PCa) since 1992 and deep research and study of our insidious men's disease since 1996 that has led to my being a prostate cancer advocate, activist, and mentor, I have seen way too many men in their 40s presenting with metastasized PCa at diagnosis. This is obviously the result of failure to have at least annual PSA testing to make note of unusual PSA elevation.

With more than 200,000 men diagnosed annually and more than 15% of that number dying "of" prostate cancer annually in the United States alone, it is obvious prostate cancer is a serious threat to male lives. It is certainly not a cancer to ignore by not providing at least a simple blood serum PSA test. Both the PSA blood test and a Digital Rectal Examination (DRE) should be provided at least annually and physicians should explain what this test and examination entails, what it can tell the physician and patient, and patient consent should then be obtained prior to administering. The DRE compliments what the PSA might miss, and vice versa. However, since many men are adverse to the DRE and would possibly opt out of any testing if both the PSA and DRE were required, then most certainly the simple PSA blood test should be recommended pending something more exact, and the PSA blood test cost should be covered by health insurers. (A pathologist friend, in supporting everything in this paper, made one exception. He remarked that the DRE should absolutely be a dual requirement with the PSA. I obviously concur but was considering those men who are turned off by the visual of anyone inserting anything up their anus and might refuse. However, as he remarked further, they should be explained and made to recognize the importance of the DRE. If they still refuse, the onus is on them.

Regarding "Over-treatment" and "Active Surveillance:" With a Gleason 3+4=7 or above, Active Surveillance (AS) is not a reasonable consideration. However, with Gleason 3+3=6 and only one or two tissue samples from biopsy evidencing prostate cancer and both less than 15%, AS could be considered. The concern that I am sure comes up in every man's mind when diagnosed with

prostate cancer despite it being low level is the recognition that cancer is present and wanting that cancer out rather than dwelling over time wondering if it is growing and becoming more aggressive. Thus, though some men would rather maintain close observation with at least quarterly PSA and DRE checks, and I would hope other diagnostics, others want to get rid of it "now." I have a suspicion that the studies that have concluded that too many patients have been "over-treated" erroneously included those patients who made their own choice to be treated early on. These patients should not have been included in such studies since it was their personal choice, thus not an "over-treatment."

The problem we have (and not as much as in the past) with the supposed "over-treatment" are urologists or radiation oncologists encouraging - sometimes near demanding- immediate treatment despite a man's diagnostics only Gleason 6 with one or two tissue samples with near insignificant cancer development. That is where "over-treatment" can occur. And it is these urologists and radiation oncologists who must avoid encouraging immediate treatment under these conditions. They should explain all options "including" AS. What I found of particular error in an ABC report March 19th, 2009 was when the ABC physician consultant remarked that a biopsy does not identify aggressive prostate cancer. Say what? There is no doubt that a pathology report of biopsy indicating, for example, Gleason 8 or above as well as extensive HGPIN (High Grade Prostate Intra-epithelial Neoplasia) or PNI (Perineural Invasion) presence would indicate an aggressive cancer, or at the very least, a cancer that requires more immediate concern. Regarding "no-PSA testing for the elderly:" I know of many healthy men in their mid-70s as well as in their 80s who could very well have another ten to twenty years of life who would be placed in this suggested category of "no-PSA testing."

This galls me no end. I was born in December 1932, and if I were to just now be found to have an elevating PSA at 86 years of age in 2019, I would most certainly want to know what is going on. My Mother lived to 96 and my Father to 95; I have every possibility of living to those ages, so why in the world would I not want to know if I had developing cancer? Most certainly without such knowledge my cancer could be very aggressive and metastasize before I had any indication of its presence. Then, most assuredly, I would have to go through several very costly treatments that would likely include toxic chemotherapy agents. And I would then more likely have to go through the pain of dying "of" the prostate cancer rather than "with it." Had I been aware of developing prostate cancer early on, I could have treated it, hopefully have "disposed" of it, or at least have been able to manage it, rather than dying "of it." Absolutely, PSA testing should be available and covered by health insurance for ALL men at ALL ages!

I noticed a posting by a urologist who is also a lawyer who made note that at trial the defense would cringe when the plaintiff's attorney announced to the jury that his client was not made aware that a simple PSA blood test would have determined that his client had developing prostate cancer and could have saved his life. And by his client's physician failing to discuss this test and making it available to his client, his client now has prostate cancer that has metastasized into his system, has caused extreme pain and loss of quality of life, and his client can now anticipate an early and painful death due to his physician failing to offer what could have been a life-saving simple blood test. Can you imagine the sizeable amount of "damages" that would most likely be awarded the plaintiff?

References

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2. (2018) More High-Risk Prostate Cancer Now in the US Than Before.
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