New PSA Screening Guidelines & What the Top Medical Experts Are Saying …

A recent headline suggesting that physicians should not perform the PSA screening test caught the eyes of the Healthnetwork staff. One of our most frequent requests is for recommendations for second opinions or treatment of prostate cancer. We believe in the power of preventive care and advanced screening tests. Concerned for the health of our members, we present information about the recent recommendation as well as the opinions of several of our top urology and oncology specialists from across the country. When it comes to your health, our recommendation is to review the information, talk to your physician and make the decision together on whether to test or not.

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The United States Preventive Services Task Force (USPSTF) announced in its final recommendation that healthy men should no longer get screened for prostate cancer with a prostate-specific antigen (PSA) test because a resulting diagnosis may do more harm than good. The USPSTF is an independent agency made up of experts in preventive or family medicine who serve a 4-year term. Their recommendations are made for primary-care physicians; the task force does not include an urologist or an oncologist on its team. They are the same task force that recommended against mammograms in women over 40.

Men all over the country and their doctors are trying to understand why this recommendation was made. About 70% of men over 50 have gotten a PSA blood test. Some are convinced that it is a lifesaver. Prostate cancer can be cured when it is detected early. PSA is a protein produced by the prostate and it can be detected with a simple blood test. It is specific to the prostate but not prostate cancer. Other factors such as infection and inflammation of the prostate could cause an elevated PSA. The decision to biopsy the prostate is one made by the treating urologist. There has been a 40% decrease in deaths from prostate cancer since the PSA screening was introduced in the early 1990s, as patients are being diagnosed earlier at a more curable stage.

Prostate cancer does not always present with symptoms in the early stages. Without the PSA screening, men are left with the digital rectal exam performed by a urologist. Some patients who present with prostate cancer felt on a rectal exam may have an advanced stage where a cure is not an option and palliative care is the only treatment.

So we asked some of the experts who diagnose and treat prostate cancer every day for their opinion on this recent ruling. The physicians represented here are some of the foremost authorities in the country.

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What was your initial reaction to the announcement?

Agus: PSA testing saves lives. Countries that do prostate screening have a much lower prostate cancer death rate than countries that don’t. That being said, we also over treat prostate cancer in this country. The real argument should be about which prostate cancers need to be treated, not eliminating all screening. Many cancers can be followed on an active surveillance protocol, while others need to be treated. This is the art of medicine.

Schaeffer: I thought this ruling was a move in the wrong direction for patients. The new guidelines state that doctors do not need to discuss the test with their patients and do not need to obtain it. Today patients are very well educated about their health and want an open discussion about what tests/studies/labs their doctors are thinking about obtaining for them.

Klein: It is disappointing that a government agency would recommend taking the option for discussion about whether one should have a PSA out of the patient’s hands. The Task Force ignored a substantial amount of data that suggest there is value to PSA screening in reducing mortality in younger men and men with higher risk tumors. The urologic community has recognized the issues of over diagnosis and over treatment raised by the Task Force and has increasingly embraced active surveillance as a management strategy for low grade cancers detected by PSA.

Furthermore, we are on the threshold of having robust genomic-based tests of tumor tissue obtained at biopsy, similar to those already available for other tumors that are recommended by ASCO (American Society of Clinical Oncology) and NCCN (National Comprehensive Care Network) treatment guidelines, that will allow a personalized approach to identifying those with indolent tumors who can safely defer or avoid therapy. The negative shadow of the Task Force’s recommendation is likely to deter men from learning about or using these tests.

Rodriguez: My initial reaction is profound disappointment and dismay. The USPSTF is an organization tasked with making recommendations regarding health care disease prevention and evidence-based medicine. The panel for the prostate-specific antigen recommendation did not consist of any experts in prostate cancer, which is a serious defect. Yet despite true expertise, they issued a recommendation with profound potential adverse impact on the health of men in the US.

What are your thoughts on how our members should interpret this information?

Schaeffer: I still think that members should bring up PSA testing to their doctors. By mentioning the test, a physician and patient can then have an informed discussion about the pros and cons of the test.

Rodriguez: I think that unfortunately, men will have to become their own advocates for prostate health screening. One of the most important features of this new ruling is that the new health care system will implement this recommendation as part of their reimbursement criteria. PSA testing in the future will not be generally covered as a screening maneuver. If a patient wants to be screened in the future, they will need an indication other than general screening to justify the cost. Given the relatively low cost of PSA testing, it may become necessary for patients to simply pay out of pocket for these screens. The unintended consequences of such a system would be a significant barrier for those with limited income, and hence access to care for underserved populations and at-risk populations (e.g., African-American men) will result in disparity in the detection of occult cancer.
What is your experience with success in the treatment and diagnosis for an early intervention based upon an elevated PSA level?

**Klein:** Tumors associated with a lower PSA are usually less aggressive and easier to cure.

**Rodriguez:** When I first came to Johns Hopkins in 1992, PSA testing was just starting to be used widely. A few years prior to this, as many as 1 man in 5 presented with advanced disease and surgical cure was not feasible. Currently, about 1 in 20 men present with prostate cancer in this stage. The difference is almost entirely due to PSA testing, which prompted a huge increase in awareness of prostate cancer, a huge increase in early detection and screening, and a sizable spike in the diagnosis of prostate cancer around 1992, when the PSA test was widely used. Subsequently, the spike resolved and the overall survival from prostate cancer has significantly improved. While it is true that the majority of men who undergo prostate biopsies for an elevated PSA do not actually have cancer, the morbidity of a biopsy is so low now and the yield on a positive result (e.g., the ability to intervene at an early stage of disease) have been profound.

What is your recommendation for scheduling PSA screenings?

**Schaeffer:** I recommend a frank discussion between patients and their doctors about the blood test, their risk factors and their overall health. Generally I still believe in an initial PSA test beginning at age 50 (age 40 in men with family history or in men of African descent).

**Klein:** I recommend a baseline PSA for men in their 40s - it helps identify who is at highest risk of developing cancer to be followed more closely, and who is at lower risk who then need not be screened until age 50. Generally yearly PSA is appropriate at age 50, but if it’s 2 or below it can be done every other year. Men with a PSA of <2 at age 60 are very unlikely to get aggressive prostate cancer and need not be screened after that.

**Rodriguez:** I recommend that men continue with the screening process which has been in place for many years. All men should have a PSA test by the age of 50, with annual digital rectal exams and urinary symptoms assessment. Men with a family history should start screening at a younger age (e.g., 40 years old). If the PSA is very low at an early age in such men, then the next test can be deferred for up to five years, until they reach age 50. Men of African-American descent are of increased risk and screening should begin earlier (at least age 45). However, with the new recommendations, insurance reimbursement for such screening will not allow such tests to be ordered unless the patient is self-pay. Alternatively, men with other reasons for testing may potentially still get coverage (palpable nodule on rectal exam, or severe urinary symptoms), though it remains to be seen precisely how insurance companies will respond to these issues.

Clearly the testing debate is not yet concluded. Healthnetwork’s staff will continue to monitor the news and curate information for our members. Our goal is to help you make the most informed medical decisions as possible.

Your health is our priority.

When you need to reach medical experts in prostate cancer detection and treatment, Healthnetwork is your best source of information and access. One call to our office and you will be in the hands of experts who will make a difference in your life.

Call us at 866-968-2467 or 440-893-0830 or email help@healthnetworkfoundation.org.

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