

PROSTATE CANCER: INFORMED DECISION MAKING FOR PRIMARY

The USPSTF has now clarified the importance of shared decision-making in prostate cancer. Its 2018 recommendation strongly encourages informed decision-making between clinicians and patients that supports personal values and preferences.

PLEASE REVIEW THE 10 PATIENT QUESTIONS AND ANSWERS ON THE REVERSE SIDE

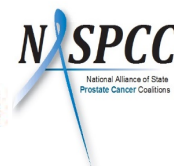
1. Some aggressive prostate cancers produce only small amounts of PSA and therefore DRE's should always be performed in addition to the PSA test. Prior to the blood draw, the physician should tell the patient that the physician is only looking for potentially lethal prostate cancer.
2. After obtaining an initial PSA for a patient, the physician should refer to guidelines that stratify the patient's risk for life-threatening prostate cancer. Frequency of future PSA testing depends on that risk assessment. (www.mskcc.org/cancer-care/adult/prostate/screening-guidelines-prostate)
3. Having a father or brother with prostate cancer more than doubles a man's risk of developing prostate cancer. The risk is greater for men with several affected relatives, especially young relatives. Men who eat a lot of red meat or dairy products seem to have a higher chance of developing prostate cancer. Other possible risk factors include obesity, prostatitis, STD's, exposure to Agent Orange and lack of exercise.
4. To determine if a biopsy is warranted, asymptomatic patients with a high PSA and at least a 10-year life expectancy should have a repeat PSA. A free calculator (<http://tinyurl.com/caprisk>) can integrate PSA, age, family history, and other factors to generate risks of prostate cancer diagnosis and high-risk cancer diagnosis. Other tests used in some cases include free-versus-bound PSA and the PHI algorithm. (Journal of Urology Volume 185, Issue 5, Pages 1650-1655, May 2011)
5. Since the 1990s when PSA testing became widespread, there has been a >40% decline in prostate cancer mortality. (American Cancer Society). Most of this decline can be attributed to screening efforts and improvements in treatment for high-risk disease detected early through screening.
6. A large European randomized trial of screening vs. no screening (ERSPC) found a 21-29% reduction in prostate cancer mortality risk through PSA screening. (Schroder, NEJM 2012) A randomized trial in the U.S. (PLCO) found no benefit—but 79% of the men in the “usual care” arm of this study received at least one PSA test, so the trial authors concluded that the trial shows only that annual screening offers no clear benefit over ad hoc PSA testing associated with routine primary care. (Andriole, JNCI 2012) Thus the PLCO does not contradict the ERSPC, and there really should be no controversy about the fact that screening saves lives.
7. Risk of infection with a biopsy is minimized when the patient pre-medicates with antibiotics; and pain from a biopsy should be minimized with anesthetic compounds.
8. Most prostate cancers found today are low-risk and do not require treatment. Active Surveillance (AS) is an accepted alternative for low-risk, non-aggressive prostate cancer. Currently there are tools, including genomic and imaging tests, that help determine who is an appropriate candidate for AS. Overtreatment of low-risk disease does remain prevalent in the U.S., however, and patients should be referred to urologists who understand risk stratification of prostate cancer and who routinely offer the surveillance option to men with low-risk disease.
9. When cancer has progressed to the point that symptoms are present, the disease has usually spread and is no longer curable.
10. A man cannot begin to make any decision about his prostate health without knowing his PSA and keeping track of any changes. Focusing testing on men at highest risk of life-threatening disease helps balance the potential benefits and harms of screening.

PSA testing is currently a man's best defense against dying of potentially lethal prostate cancer and against developing metastatic prostate cancer. Individuals have a fundamental right to choose whether or not they want to know if they have prostate cancer, prior to becoming symptomatic.

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California Prostate Cancer Coalition

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PROSTATE CANCER: INFORMED DECISION MAKING FOR MEN 40

There is much debate on the value of PSA testing and the diagnosis of prostate cancer.

10 QUESTIONS TO ASK YOUR DOCTOR ABOUT YOU AND PROSTATE CANCER

1. I want to know my risk for developing aggressive prostate cancer. What tests are there to learn my risk?

The two basic methods for determining your risk for developing aggressive, life-threatening prostate cancer are the prostate specific antigen (PSA) blood test and the digital rectal exam (DRE).

2. What is a "baseline PSA" and what is the value of a "baseline PSA"?

A baseline PSA is your initial PSA blood test at about age 40 that allows you and your physician to watch how your PSA varies over time.

3. What is the importance of family history, ethnicity and exposure to Agent Orange?

A family history of prostate cancer, especially in a first-degree relative (father, brother, son), increases your risk of developing prostate cancer. Certain ethnicities also carry a high risk of developing aggressive prostate cancer, i.e., African-American men have approximately twice the incidence and death rate from prostate cancer as Caucasian men. Prior exposure to Agent Orange may also increase the risk of developing aggressive prostate cancer.

4. If I have a PSA test and it comes back high, what other tests are there that I can have to determine if I need a biopsy?

Your physician will want to rule out an infection and/or an enlarged prostate, both of which can cause the PSA levels to increase. A repeat PSA should be obtained. There are other tests such as free PSA, PCA3, PHI and others which may be useful in some instances. Free calculators can help integrate your PSA with your age, family history, and other parameters to estimate your risk of prostate cancer and high-grade prostate cancer. See <http://tinyurl.com/caprisk>.

5. What are the benefits of detecting aggressive or potentially aggressive prostate cancer early?

As with most cancers, the earlier aggressive prostate cancer is diagnosed the greater the chance that the cancer will still be confined to the prostate and thus curable.

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6. What are the risks of NOT detecting an aggressive or potentially life-threatening prostate cancer early?

It will be more difficult, even impossible, to cure. Once the cancer escapes the prostate it can invade the lymph nodes and may spread to the bones and elsewhere (metastasis).

7. What are the risks of a biopsy?

There is a risk of bleeding which is usually minor, and of an infection, which is reduced through pre-biopsy antibiotics. Most men would think this is worth the risk, but this is a personal decision.

8. If I have a biopsy and it reveals cancer, do I necessarily have to have treatment? What is "Active Surveillance"? You do not necessarily have to have treatment. If a relatively low-risk cancer is found, you may be a candidate for Active Surveillance, (AS), under which PSA and other tests are performed periodically to ensure that you receive timely treatment, if necessary.

9. Why shouldn't I wait until I have urinary or other symptoms to have my first PSA?

When cancer has progressed to the point that symptoms are present, the disease has usually spread and is difficult or impossible to cure.

10. If I am willing to live with the potential side effects of a biopsy or of treatment, shouldn't the decision be mine?

Weighing side effects of any possible testing, diagnosis and treatment against the chance of living a full life is a very personal decision based upon your own values. Most men would at least like to know if they have prostate cancer. Then you can make a joint decision with your physician as to what steps, if any, to take.

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