mhfs
mens health forum SCOTLAND
Spring 2003

Prostate Cancer Update

Prostate cancer is the second most common cancer in men in the UK, with over 22,800 new cases diagnosed in 1998. The lifetime risk for being diagnosed with prostate cancer is 1 in 14[i].

The statistics for Scotland show that in 1980 prostate cancer caused 460 deaths per 100,000 of the population, whilst in 2000 this had risen to 773 per 100,000[ii]. A rise of 68%. It has been estimated that by 2005 it will be the most common cancer in UK men.

As public awareness of prostate cancer grows the calls for some kind of general testing program for men are becoming more common. Public perception is that screening for cancer is a pro-active measure leading to early detection and successful treatment, saving the lives of patients and costing the NHS less money in the long run.

Would this be the answer? Unfortunately dealing with the problem of prostate cancer isn't simple. Research into the causes of the disease and its natural history is a long way behind that of other cancers. The question of whether early detection and treatment actually saves lives awaits a definitive answer. The effect of treatment on the quality of men's lives means that it may not always be the most desirable option.

For the moment then, what should the health service in Scotland be doing for men?

[i] Cancer Research UK. Website data.
[ii] General Register Office (Scotland) January 2002.

The Men's Health Forum Scotland recommend the following interim action:

1) Increased funding for research into (a) effective diagnostic testing (b) effective treatment and (c) the nature of the cancer.

2) Ensuring accurate and impartial information is available to the general public, to enable informed choice regarding prostate screening. Campaigning work should be linked together for maximum impact, following the positive example of bodies already working in the field such as the Coalition against Prostate Cancer, Cancer Research and the Prostate Cancer Charity.

3) Identifying and disseminating protocols for impartial 'pre-screening counselling' to ensure informed choice.

4) The adoption of a nationwide Informed Choice Programme with a particular focus on supporting GPs to put this into practice.

5) Given that current restraints on the health service do not allow patients the above freedom to choose, immediate investment in specialist uro-oncology nursing staff to fill this gap in service provision.

How have we reached these conclusions? Read on…

PSA test for all over 50s?

That's a very good question

Many people are keen to see all men over 50 in Scotland routinely offered a Prostate Specific Antigen (PSA) test. Would this be worthwhile? To examine the situation we looked at current research and asked Prasad Bollina (Consultant Urologist at Edinburgh Western General Hospital) and Iain Dickson (then Chairman of the Scottish Association of Prostate Cancer Support Groups) to give us their views in an mhfs debate around the issue. Here's what they said.

In answering the question we should first look at PSA testing and what may follow it.

The PSA test is a simple blood test, and at face value seems to provide an obvious route to combating the spread of prostate cancer. It is a useful snapshot indicator of potential problems with the prostate, and having a positive predictive value of 22% is a comparatively effective tool in early determination of the presence of cancer, (a mammogram has a positive predictive value of 16%). It is also reassuring for those whose test results show there is no problem with the PSA level.

However, PSA levels rise and fall for other reasons than prostate cancer, with the 'normal' level differing between age groups and even individuals, so it can only be used as an indicator to show where further tests may be necessary. These would normally be digital rectal examination (DRE), and if deemed necessary a trans rectal ultra-sound biopsy. The success of DRE in pinpointing abnormalities can depend largely on the skill and experience of the practitioner. Biopsies carry a small (2%) risk of serious complications and can fail to detect cancerous cells. Once a diagnosis has been made another dilemma arises; some men show no, or very slow, progression of cancer, whilst some show very rapid growth and death.

Current treatment options, other than active monitoring (sometimes referred to as watchful waiting) are removal of the prostate by surgery, or treatment by radiotherapy or brachytherapy. These procedures carry the risk of side effects such as incontinence and impotence, and according to the Department of Health, are 'not very effective… and have not yet been shown to reduce prostate cancer mortality'[iii]. Hormone therapy is available in cases where the cancer has spread to other parts of the body; again this carries the risk of side effects, possibly increasing the risk of heart attack, stroke or bone fractures.

Table 1. Is a national population screening programme justifiable at present?

Criteria for developing a population screening approach.	Prostate cancer: Does it meet the criteria?
The disease must present an important public health problem.	Prostate cancer will be the most common cancer in men within the next three years.
There must be a test which is safe and acceptable.	PSA test is safe but not acceptable to many as a general screening tool.
The test must be able to identify the disease at an early stage.	PSA does this accurately in 22% of cases.
Effective treatment must be available.	Current treatments have major side-effects and are not very effective.
Treatment for asymptomatic early stage diagnosis should improve prognosis.	Radical surgery or radiotherapy have not yet been shown to reduce prostate cancer mortality.

Table 1 suggests that the current situation does not support the introduction of a national screening programme, and prompts the question: What research is being undertaken to move things forward?

[iii] Department of Health press release 0185/2001.

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Some of the relevant research

ProtecT

This is a large randomised UK study designed to measure the effects of the different treatment options on survival, disease progression, physical and psychological health and quality of life. Results will be seen over the next five to ten years.

European Randomised Study for Screening of Prostate Cancer (ERSPC), 1994 onwards.

The primary aims of this study were to evaluate the utility of monitoring PSA levels for prostate cancer screening and to determine the impact of active screening on prostate cancer mortality.
A potential for over-diagnosis has been indicated in this approach, but the study also points toward potential survival benefit for some men.

Mass screening study in the Federal State of Tyrol, Austria

The objective of this study was to monitor the impact of screening in a natural experiment by comparing prostate cancer mortality in Tyrol, where PSA testing was introduced at no charge, with the rest of Austria, where it was not introduced. Results show a decrease in mortality rates from prostate cancer, but it is suggested that most of the decline is likely to be due to aggressive downstaging and successful treatment and that any contribution from detecting and treating early cancers will only become apparent in the years to come.

Quebec City, Canada

In this small study (8,137 men were screened) there were 59% fewer deaths from prostate cancer in the screening group.

Qualitative study on perception of screening

This recent UK study explored the attitudes of men with confirmed or suspected prostate cancer to PSA testing. The few men in this study who subscribed to the argument that evidence of the benefits of treatment is a prerequisite for a screening programme did not want to see screening introduced. Men who proposed an alternative set of principles for testing gave reasons that did not all relate to over-optimism about the benefits of early diagnosis.

PSA test for prostate cancer: "To have it or not to have it." What is the answer?

The desire for a screening test for prostate cancer is a natural instinct for men at risk.
PSA testing **may** provide an answer yet it can raise more questions as well.
We at the Western General Hospital are currently undertaking a major trial for case finding and treatment (ProtecT Study) where men are counselled (for up to 45 minutes) about the benefits of the PSA test.

The session involves discussion with a Research Nurse to explain the purpose, value and limitations of the PSA test. They are made aware of the prospect of a biopsy (if the PSA is raised) with the possible diagnosis of prostate cancer. In addition, the important issues of the management of localised prostate cancer, the controversies and the possible benefits and risks are also discussed at the counselling session.
Our experience suggests that this should be the model that needs to be available to all men who seek to have a PSA test, and that comprehensive

counselling would be the only way to address men's genuine concerns about prostate cancer and help them to make their own decision in choosing to have a PSA test or not.

Mr P. Bollina, Consultant Urologist. Norma Lyons, Lead Nurse. Men's Cancer Centre, Edinburgh.

Mr Iain Dickson summed up the situation in the following way:

Current policy in the US is for an annual PSA test to be available for the over 50s as a personal decision after consultation. In the EU an informed decision to take a test or not follows full counselling.

The existing evidence on screening by PSA test is limited and contradictory and there is great need for further research into an effective and definitive diagnostic tool, the natural history of the disease, and the effectiveness of treatment.

Here in Scotland a large percentage of GPs are not adopting an 'informed choice' policy, in many cases, as they are not aware of it. Lack of a testing policy for men over 45 years means that at diagnosis 30% of men will have a cancer that has progressed so far that there is little chance of a cure.

The Scottish Association of Prostate Cancer Support Groups recommends:

- The nation wide adoption of the Informed Choice programme, encouraging GPs in particular to take it up.
- That research be increased to identify non-invasive tests to enable a population screening programme to be initiated.
- The exploration of the cost benefits of early treatment as compared to prolonged palliation.
- An increase in the efforts made to raise awareness of these issues with the general male population.

Prostate cancer organisations

Organisation	Telephone	Website or email address
The Prostate Cancer Charity	0845 300 8383	www.prostate-cancer.org.uk
everyman	0800 731 9468	www.icr.ac.uk/everyman
Cancer BACUP Scotland	0808 800 1234	www.cancerbacup.org.uk
Orchid Cancer Appeal	020 7601 7808	www.orchid-cancer.org.uk
The Prostate Cancer Charitable Trust	020 8340 7216	
Scottish Association of Prostate Cancer Support Groups	01764 663631	www.pcansupportscot.f9.co.uk
Prostate Cancer Support Association	0845 601 0766	www.prostatecancersupport.co.uk
Cancer Research UK	020 7242 0200	www.cancerresearchuk.org
GaysCan	020 8368 9027	gayscan@blothlom.dircon.co.uk
Tenovus Cancer Information Centre	0808 808 1010	www.tenovus.com
Better Prostate Health	01992 452009	
Prostate Help Association		www.pha.u-net.com

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