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## Fall in PSA Screening Resulting in More Advanced Disease

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MUNICH — Studies looking at the consequences of American recommendations against routine screening for prostate cancer with the prostate-specific antigen (PSA) have already had an impact on older men, who are now diagnosed with more advanced prostate cancers. The same is being predicted for younger men. Findings from two studies were presented here at the European Association of Urology 2016 Congress.

The recommendation against routine PSA screening in men older than 75 years was made in 2008 by the US Preventive Services Task Force (USPSTF). The group expanded that recommendation against routine PSA use to all men, regardless of age, in 2011.

The impact of the 2008 USPSTF recommendation covering elderly men has already been measured.

"Our study highlights the upward risk migration and increased likelihood of high-risk and metastatic prostate cancer diagnoses in elderly men," said Deepansh Dalela, MD, from the Henry Ford Hospital in Detroit, who was co-investigator of one of the studies. He predicts that a similar pattern will be seen in men younger than 75 years.

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"The underlying message is clear: by recommending uniformly against PSA screening, we may be throwing out the baby with the bathwater," Dr Dalela told *Medscape Medical News*.

“ **By recommending uniformly against PSA screening, we may be throwing out the baby with the bathwater.** ”

"My guess is that for the next 3 to 5 years, we are going to see a decreasing incidence of high-risk and metastatic disease [in younger men] because we are doing less screening and detecting less cancer. But eventually, down the line, we are going to start seeing an upward risk migration for newly diagnosed prostate cancer cases, and that is troubling because those are the cancers that are most likely to be potentially lethal," he said.

In their study, Dr Dalela's team looked at men with prostate cancer who were older than 75 years in the National Cancer Data Base. They compared diagnoses in the 3 years before with those in the 3 years after the 2008 USPSTF recommendation against PSA screening in this age group.

On multivariate difference-in-difference analysis that controlled for all available sociodemographic covariates, mean PSA level was higher in men diagnosed after 2008 than in those diagnosed before (20.7 vs 17.1 ng/mL), and there were more biopsies with a Gleason score of 8 to 10 after 2008 (30.9% vs 24.9%).

Older men were 20% more likely to be diagnosed with high-risk prostate cancer (cT1–T3NxM0) after 2008 than before (odds ratio [OR], 1.20;  $P < .01$ ), and were 34% more likely to be diagnosed with metastatic disease ( $P < .01$ ).

When men were classified by Charlson-Deyo comorbidity index, the healthiest men faced the highest risk for an advanced diagnosis.

It is "somewhat surprising that this higher risk was only seen in men who were healthy; in fact, this is the group of men who could have benefited the most from early diagnosis and treatment," Dr Dalela noted.

The second study presented at the meeting looked at the effect of the 2011 USPSTF guidelines, which extended the recommendation against the routine use of PSA screening to all men, regardless of age.

Lead author Christopher Meyer, MD, from Brigham and Women's Hospital in Boston, is concerned that the same pattern will emerge as has been seen in older men.

"I expect, personally, to see patients with more advanced disease in clinic," Dr Meyer said.

Using data from the National Ambulatory Medical Care survey, his group assessed the prevalence of PSA screening by primary care physicians (including general and family practice and internal medicine) and urologists in 2010, before the 2011 recommendation, and in 2012.

"The message is clear — both decreased from 2010 to 2012. However, whereas among urologists the decrease was not significant (from 38.7 to 34.5%; OR, 0.34;  $P = .089$ ), there was a significant decrease for primary care physicians (from 36.5 to 16.4%; OR, 0.43;  $P = .009$ )," he said.

By 2012, the difference in screening prevalence between primary care physicians and urologists was statistically significant ( $P < .001$ ).

The reasons for this difference?

While acknowledging that urologists likely see a different patient population than primary care physicians, Dr Meyer said he believes it's a matter of guidance.

"We are more inclined to use the American Urology Association or European Association of Urology guidelines, which advise for shared decision-making and informed consent between provider and patient. So I think we're less inclined to use the USPSTF recommendations, which, by the way, did not have a urologist on their panel," he said.

He added that "moving forward, this emphasizes the need to continue the interdisciplinary dialogue to achieve a consensus statement on prostate cancer screening."

Asked to comment on the findings, Jonas Hugosson, MD, from the University of Gothenburg in Sweden, said the USPSTF's move away from universal screening is an attempt to balance the harms with the benefits of PSA screening.

"I can agree with that.... We have the same concerns ourselves," he told *Medscape Medical News*.

But rather than reducing screening to reduce harm, Dr Hugosson believes it should be a matter of refining screening instead.

"There's a lot of research trying to select the right men for biopsies with the aim of decreasing the risk of overdiagnosis. I am quite positive that we will come to a balance where the benefit is more than the harm of screening," he said.

Indeed, in a separate session at the meeting, he reported 18-year follow-up data from the famous Gothenburg screening study, which show a clear mortality benefit of screening for men 50 to 69 years, [as reported](#) by *Medscape Medical News*. *Dr Meyer, Dr Dalela, and Dr Hugosson have disclosed no relevant financial relationships.*

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