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The Great Prostate Mistake

Richard J. Ablin, New york Times, March 9, 2010

EACH year some 30 million American men undergo testing for prostate-specific antigen, an enzyme made by the prostate. Approved by the Food and Drug Administration in 1994, the P.S.A. test is the most commonly used tool for detecting prostate cancer.

The test's popularity has led to a hugely expensive public health disaster. It's an issue I am painfully familiar with — I discovered P.S.A. in 1970. As Congress searches for ways to cut costs in our health care system, a significant savings could come from changing the way the antigen is used to screen for prostate cancer.

Americans spend an enormous amount testing for prostate cancer. The annual bill for P.S.A. screening is at least $3 billion, with much of it paid for by Medicare and the Veterans Administration.

Prostate cancer may get a lot of press, but consider the numbers: American men have a 16 percent lifetime chance of receiving a diagnosis of prostate cancer, but only a 3 percent chance of dying from it. That's because the majority of prostate cancers grow slowly. In other words, men lucky enough to reach old age are much more likely to die with prostate cancer than to die of it.

Even then, the test is hardly more effective than a coin toss. As I've been trying to make clear for many years now, P.S.A. testing can't detect prostate cancer and, more important, it can't distinguish between the two types of prostate cancer — the one that will kill you and the one that won't.

Instead, the test simply reveals how much of the prostate antigen a man has in his blood. Infections, over-the-counter drugs like ibuprofen, and benign swelling of the prostate can all elevate a man's P.S.A. levels, but none of these factors signals cancer. Men with low readings might still harbor dangerous cancers, while those with high readings might be completely healthy.

In approving the procedure, the Food and Drug Administration relied heavily on a study that showed testing could detect 3.8 percent of prostate cancers, which was a better rate than the standard method, a digital rectal exam.

Still, 3.8 percent is a small number. Nevertheless, especially in the early days of screening, men with a reading over four nanograms per milliliter were sent for painful prostate biopsies. If the biopsy showed any signs of cancer, the patient was almost always pushed into surgery, intensive radiation or other damaging treatments.

The medical community is slowly turning against P.S.A. screening. Last year, The New England Journal of Medicine published results from the two largest studies of the screening procedure, one in Europe and one in the United States. The results from the American study show that over a period of 7 to 10 years, screening did not reduce the death rate in men 55 and over.

The European study showed a small decline in death rates, but also found that 48 men would need to be treated to save one life. That's 47 men who, in all likelihood, can no longer function sexually or stay out of the bathroom for long.

Numerous early screening proponents, including Thomas Stamey, a well-known Stanford University urologist, have come out against routine testing; last month, the American Cancer Society urged more caution in using the test. The American College of Preventive Medicine also concluded that there was insufficient evidence to recommend routine screening.

So why is it still used? Because drug companies continue peddling the tests and advocacy groups push "prostate cancer awareness" by encouraging men to get screened. Shamefully, the American Urological Association still recommends screening, while the National Cancer Institute is vague on the issue, stating that the evidence is unclear.

The federal panel empowered to evaluate cancer screening tests, the Preventive Services Task Force, recently recommended against P.S.A. screening for men aged 75 or older. But the group has still not made

a recommendation either way for younger men.

Prostate-specific antigen testing does have a place. After treatment for prostate cancer, for instance, a rapidly rising score indicates a return of the disease. And men with a family history of prostate cancer should probably get tested regularly. If their score starts skyrocketing, it could mean cancer.

But these uses are limited. Testing should absolutely not be deployed to screen the entire population of men over the age of 50, the outcome pushed by those who stand to profit.

I never dreamed that my discovery four decades ago would lead to such a profit-driven public health disaster. The medical community must confront reality and stop the inappropriate use of P.S.A. screening. Doing so would save billions of dollars and rescue millions of men from unnecessary, debilitating treatments.

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Lawrence J. Bookbinder. Ph D. .Reviews
Invasion of the Prostate Snatchers
by Ralph H. Blum and Dr. Mark Scholz

Prostate Snatchers, published in August of 2010, is the best book I know of to help newly diagnosed men decide what to do about their prostate cancer (PCa). Co-written by one of the best medical oncologists specializing in PCa (MOSPC) in the USA, it's filled to the brim with gems of cutting-edge, authoritative information. Below are some of these gems, which, unfortunately, only a small minority of PCa
patients have seen:

There is not one but three basic categories of PCa--Low-Risk, Intermediate-Risk, and High-Risk.

High-Risk, also known as “aggressive,” should be treated aggressively
whereas Low-Risk often can be safely managed with no treatment.

A typical scenario after a primary care doctor refers a patient to a urologist because of an abnormal PSA test and/or digital rectal examination (DRE): The urologist biopsies the patient's prostate and finds PCa. The patient views this finding as a death sentence, panics, and feels pressured to get rid of his cancer immediately. He avoids taking time for second opinions and agrees quickly to have the urologist cut out his entire prostate (radical prostatectomy or RP)--an aggressive treatment.

Unfortunately, of the 50,000 RPs done in the USA every year, more than
40,000 were not necessary. That is, the vast majority of PCa patients would have lived as long without having their prostates removed.

RP is no longer the most effective treatment for PCa. Radiation therapy (RT), another aggressive treatment, has evolved into being at
least as effective. If the patient consults a radiation therapist for help with making a treatment decision, the doctor is often, of course, biased in favor of recommending RT.

A third type of PCa doctor is a medical oncologist. They are trained to treat all types of cancer--lung, blood, bladder, pancreas, etc, Their training in PCa treatment only focuses on advanced disease. Early-stage disease is left to the urologists.

Medical oncologists treat some PCa patients with testosterone inactivating pharmaceuticals (TIP, also known as “hormone blockade” or
“androgen deprivation therapy”). TIP has its own set of side effects but, unlike RP, RT, or cryotherapy, the side effects are often reversible when the medical oncologist discontinues the TIP. And he then, depending on the PCa’s response to the discontinuation, may re-

start the TIP a year or two or three later.

Unfortunately, only a minority of urologists are as skilled as MOSPCs in providing TIP.

Of the more than 10,000 medical oncologists in the USA only less than 100 are MOSPCs.

MOSPCs often do a more comprehensive evaluation of PCa than some urologists. In addition to PSA tests, DREs, PSA velocity calculations, and PSA density calculations, they may use spectrographic endorectal MRI (S-MRI) scans, color doppler ultrasound scans, and PCA-3 urine tests to determine whether a patient is Low-, Intermediate-, or High-Risk. These tests also help monitor a patient's PCa (known as "active surveillance" or AS).

The comprehensive evaluation helps to determine whether the patient should have an immediate initial biopsy. If the patient has had a biopsy, the evaluation may reduce the number of repeat biopsies needed for AS.

Typically, a MOSPC will offer the Low-Risk patient the option of no treatment but with AS. If the patient rejects this option because he wants to kill his PCa, the MOSPC will mention the advantages and disadvantages of aggressive treatments such as RP, RT, and cryotherapy, and with less bias than most urologists, radiation therapists, and cryotherapists, respectively.

Chapters written by Ralph H. Blum, a patient of his co-author, vividly illustrate the struggles of and benefits received by a patient who educates himself about PCa, finds the right doctor for him, and avoids blindly following his and other PCa doctors' advice. Blum's knowledge and story of his 20-year PCa journey is likely to calm many patients, instill hope, and empower them to play an active role in their journey.

Blum traveled from the USA to Holland to have a recommended Combidex MRI because it was the only place in the world that performed the scan. My guess is that no more than 10 percent of PCa patients are able to take the time off and/or pay for out-of-state/country trips for tests or second opinions. I wish the book would have acknowledged this unfortunate obstacle to obtaining state-of-the-art help.

Snatchers adds much to the meager literature on the role of the MOSPC in working with Low-Risk patients and helping patients decide on a treatment.

The preliminary international list of MOSPCs might help some patients find the "right doctor." Also helpful are a glossary, annotated bibliography, index, and lists of acronyms and websites.

Snatchers replaces my former #1 choice, A Primer on Prostate Cancer: The Empowered Patient's Guide (2nd edition, 2005) by Stephen B. Strum, M.D. (a distinguished MOSPC) and Donna L. Pogliano. Snatchers is easier to read and understand; more up-to-date, of course; and destined to become a classic, which is the status of Primer.

My qualifications for writing this review are 10 years of reading authoritative PCa literature; participating in PCa internet discussion forums; leading PCa support group discussions; seeing the MOSPC co-author of Snatchers every three months for nine years; consulting other PCa doctors; undergoing biopsies, S-MRIs, Color Dopplers; avoiding aggressive treatment (on light TIP--Avodart only for both my benign prostatic hyperplasia and PCa); writing my PCa story (prostate-cancer-story.net).

Lawrence J. Bookbinder, Ph.D.

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A Rush to Operating Rooms That Alters Men's Lives

By DANA JENNINGS, New York Times, August 30, 2010

As I scuffed through the stations of the prostate cancer cross these

past two years, I sometimes wondered whether I wasn't a dupe caught up in a Robin Cook medical thriller.

Sure, the biopsy (so I was told) showed that my prostate was cancerous. And after it was removed, the pathology report revealed that the cancer was unexpectedly aggressive, thrusting me from the relative comforts of Stage 1 to the deep woods of Stage 3.

But at least on the surface, the cancer itself never did any damage. It was the treatments that razed me — the surgery, radiation and hormones producing a catalog of miseries that included impotence, incontinence and hot flashes. And a small voice kept whispering: What if this is all a lie? A dark conspiracy of the global medical-industrial complex?

And now comes "Invasion of the Prostate Snatchers," by Ralph H. Blum and Dr. Mark Scholz, effectively confirming my whimsical paranoia. Mr. Blum, a cultural anthropologist and writer, has lived with prostate cancer for 20 years without radical treatment, and Dr. Scholz is an oncologist who has treated the disease exclusively since 1995.

Their book, written tag-team style, is a provocative and frank look at the bewildering world of prostate cancer, from the current state of the multibillion-dollar industry to the range of available treatments.

About 200,000 cases of prostate cancer are diagnosed each year in the United States, and the authors say nearly all of them are over-treated. Most men, they persuasively argue, would be better served having their cancer managed as a chronic condition.

Why? Because most prostate cancers are lackadaisical — the fourth-class mail of their kind. The authors say "active surveillance" is an effective initial treatment for most men.

They add that only about 1 in 7 men with newly diagnosed prostate cancer are at risk for a serious form of the disease. "Out of 50,000 radical prostatectomies performed every year in the United States alone," Dr. Scholz writes, "*more than 40,000 are unnecessary*. In other words, the vast majority of men with prostate cancer would have lived just as long without any operation at all. Most did not need

to have their sexuality cut out."

Yet radical prostatectomy is still the treatment recommended most often, even though a recent study in The New England Journal of Medicine suggested that it extended the lives of just 1 patient in 48.

And surgery, of course, is most often recommended by surgeons and urologists — who are also surgeons. Mr. Blum writes: "As one seasoned observer of the prostate cancer industry told me, 'Your prostate is worth what Ted Turner would call serious cash money.' " As for patients, their rational thinking has been short-circuited by the word "cancer." Scared, frantic and vulnerable — relying on a doctor's insight — they are ripe to being sold on surgery as their best option. Just get it out.

Every urologist I met with after my diagnosis recommended surgery, even though it was believed then that I had a low-risk Stage 1 cancer. The best advice came from my personal urologist, who declined to do my operation because it was beyond him: "Avoid the community hospital guys who do a volume business in prostates."

I did, but I'm still maimed. In my experience, doctors play down punishing side effects like incontinence, impotence and shrinking of the penis. Those are just words when you hear them, but beyond language when you go through them.

Despite the impression the authors give, though, judging the velocity or voraciousness of a prostate cancer can still be imprecise. I know this firsthand.

After my biopsy, it appeared that I had a Stage 1 cancer, a doddering old nag that the authors would have designated for active surveillance. As it turned out, I had an especially pure Stage 3 cancer, a real top-fuel eliminator in terms of velocity (and hunger).

I'm a wild card, the 1 man in 48 saved by surgery. Without it, my doctors wouldn't have learned the cancer was so advanced, and wouldn't have given me the hormones and radiation that helped keep me alive.

So yes, prostate cancer is a dark and mysterious country, and Mr.

Blum and Dr. Scholz are good, levelheaded guides through these thickets. And in telling men to slow up and take a deep breath after they learn they have prostate cancer, they provide an invaluable service. I wish I had had this book back in 2008.

But all of this raises one last stark question: Was my life worth the 47 other prostatectomies that probably didn't have to be performed?

I don't know. I'm a man, not a statistic.