EDITORIAL

Prostate Cancer: Has Patience Paid Off?

In 2012, I wrote an editorial on prostate cancer screening in reaction to the USPSTF (United States Preventative Services Task Force) recommendations against PSA screening.[1] At that time, I recommended that before we completely throw PSA screening out of the door, we should have a little patience. This was based on the following: 1) updates of studies on prostate cancer screening that showed decreasing mortality as screening was carried out more years that were not available[2] (or not recognized by the task-force) and 2) the increasing use of active surveillance for low risk disease that would decrease the morbidity of overtreatment. I was happy to see that the USPSTF in 2017[3] has recognized that prostate cancer screening may be beneficial for those between 55 and 69 years old and in high risk populations.

The recommendation against prostate cancer screening has brought us all to a higher level in the treatment of the disease. Studies show that treatment of prostate cancer especially of low risk variety has gone down considerably over the past several years. For patients who have gone on active surveillance and been followed appropriately, the risk of progression to metastatic disease or prostate cancer mortality is extremely low. This quickly avoids some of the problems of overtreatment and the morbidity associated with those being treated who were at little risk for disease progression... We have also seen from the European studies that the longer prostate cancer screening is carried out, the increasing benefits in the screened versus unscreened groups. Lastly, those were screened and treated may experience lower morbidity of advanced disease even though they would not have died of prostate cancer itself.

I look forward to the future as we further define what groups need to be treated and which groups can be safely watched. Further research into clinical markers and refining treatment algorithms will give patients the best outcomes with the least morbidity. Even more important is work into optimizing treatment and screening of those in high risk groups such as the African American population where there is insufficient data. It was a shame that we had to have a recommendation against screening, but at the end of the day, I think we have come to a better place on how we approach this disease.

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References

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