

The long-running disparity in early detection and treatment of prostate cancer in African American men

Judd W. Moul, MD

Division of Urology, Department of Surgery and Duke Cancer Institute, Duke University, Durham, North Carolina, USA
Referring to article published on pp. 10992-11002 in this issue.

MOUL JW. The long-running disparity in early detection and treatment of prostate cancer in African American men. *Can J Urol* 2021;29(1):11003-11004.

This is an important paper and matches my clinical experience. In the past one- and-a-half decades in the private sector at a major Southeastern US center, I have had very large clinical experience with screening and treatment of African American men for localized and advanced prostate cancer. After the death of three single black men within 2 weeks of radical prostatectomy to presumed pulmonary embolus (PE), we started a proactive effort with our team to address this disparity. Using aggressive deep venous thrombosis prophylaxis (enoxaparin sodium 40 mg daily for 2-4 weeks), planned call-backs by an advanced practice provider (APP), and focused patient education, we have not had a further early death in the last 8 years. Liu and associates analysis of Cumulative Incidence Function (CIF) of Prostate Cancer Mortality from over 200,000 patients demonstrated that single black men had the highest CIF in the follow up time after surgery at 30 days, 20 months, 40 months and 60 months compared to other groups.¹

Address correspondence to Dr. Judd W. Moul, Division of Urologic Surgery, Duke Cancer Institute, DUMC 3707-Room 1562 Duke South, Durham, NC 27710 USA

As virtually all prior studies of prostate cancer and African American race/ethnicity, Liu et al rightly note that etiology of disparity is multifactorial. One of the most interesting findings in this paper is the difference between single black vs. single white men. Why would black race interact with being single be so different being single and white? Compared with white patients, black patients are increasingly less likely to have health insurance and receive job-based health coverage. This likely led to less access to preventative and primary care services compounded by lower literacy rates, higher health system distrust, unhealthy diet, lower exercise rates, housing deficiencies, lack of transportation and possible adverse biologic factors.

My professional experience has spanned both the equal-access military health care system and the private sector and I have now spent almost 20 years in each setting caring for African American men. Looking back, it is not surprising to me that the military system mitigated, but did not completely eliminate, the race/ethnicity disparity. In 1995, we showed that, even in the military at the nation's premier center (Walter Reed), black race/ethnicity was an independent prognostic factor for recurrence after radical prostatectomy.² We also showed that black men had higher PSA levels due to larger tumors and we developed age and race adjusted PSA screening guidelines to help address the disparity.^{3,4} Later at Duke, we also demonstrated

black patients had higher PSA and worse outcomes.^{5,6} Our latest effort is trying to increase early detection and education on risk by focusing on baseline PSA in younger African American men and decreasing the rates of non-attendance (no show) for elevated PSA consults and for prostate biopsy.^{7,8}

In summary, this important paper adds to the longstanding literature showing that African American men remain disadvantaged with regard to prostate cancer early detection and treatment. The solution is complex and multi-factorial. Sadly, we are discussing the same issues now that we did more than 30 years ago when the start of the PSA-Era first brought these disparities to light. One discrete pearl from this paper is to be extra mindful when managing single black men with elevated PSA and prostate cancer. □

References

1. Liu S, Wang Z, Long X et al. Single black men have the worst prognosis with localized prostate cancer. *Can J Urol* 2022;29(1):10992-11002.
2. Moul JW, Douglas TH, McCarthy WF, McLeod DG. Black race is an adverse prognostic factor for prostate cancer recurrence following radical prostatectomy in an equal access health care setting. *J Urol* 1996;155(5):1667-1673.
3. Moul JW, Sesterhenn IA, Connelly RR et al. Prostate-specific antigen values at the time of prostate cancer diagnosis in African-American men. *JAMA* 1995;274(16):1277-1281.
4. Morgan TO, Jacobsen SJ, McCarthy WF, Jacobson DJ, McLeod DG, Moul JW. Age-specific reference ranges for serum prostate-specific antigen in black men. *N Engl J Med* 1996;335(5):304-310.
5. Tsivian M, Bañez LL, Keto CJ et al. African-American men with low-grade prostate cancer have higher tumor burdens: results from the Duke Prostate Center. *Prostate Cancer Prostatic Dis* 2013;16(1):91-94.
6. Caire AA, Sun L, Polascik TJ, Albala DM, Moul JW. Obese African-Americans with prostate cancer (T1c and a prostate-specific antigen, PSA, level of <10 ng/mL) have higher-risk pathological features and a greater risk of PSA recurrence than non-African-Americans. *BJU Int* 2010;106(8):1157-1160.
7. Shah A, Polascik TJ, George DJ et al. Implementation and impact of a risk-stratified prostate cancer screening algorithm as a clinical decision support tool in a primary care network. *J Gen Intern Med* 2021;36(1):92-99.
8. Han T, Gagnon J, Barth P et al. No-shows in adult urology outpatient clinics: economic and operational implications. *Urol Pract* 2020;7:342-348.