

Confusing, Incomplete NYT Column - "A Watch-and-Wait Prostate Treatment"

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Several readers contacted me with concerns about a *New York Times* column, "[A Watch-and-Wait Prostate Treatment](#)."

So I asked the physician-reviewer I turn to most often for review of prostate cancer stories on [HealthNewsReview.org](#) to analyze it. Here is a guest post by Dr. Richard Hoffman, MD, MPH. He is a general internist, a Professor of Medicine at the University of New Mexico School of Medicine and a staff physician at the Albuquerque VA Medical Center. He also serves as Interim Director for Cancer Prevention at the University of New Mexico Cancer Center. His areas of research interest are prostate and colorectal cancer screening and prostate cancer treatment outcomes, with expertise in clinical epidemiology, health services research, and meta-analysis. He is a medical editor for prostate cancer topics for the Foundation for Informed Medical Decision Making and works with the Foundation to develop shared decision making tools for prostate cancer screening and treatment of localized prostate cancer. The Foundation is also the sole financial supporter of my web work.

This article, which notes the controversies surrounding prostate cancer screening and treatment, also inadvertently highlights the confusion, misinformation, and opportunism surrounding the disease.

First, the discussion of the treatment strategy (active surveillance) is misleading -- monitoring patients by checking PSA, digital rectal examinations, and biopsies is not "unconventional" -- the American Urological Association treatment guidelines endorse this strategy for men with low-risk cancers. What is unconventional -- because there is no convincing supporting evidence -- are the various recommendations for lifestyle and dietary changes and proprietary dietary supplements.

Second, presenting cryosurgery as an acceptable alternative approach for men who are not candidates for surgery or "thrilled by the prospect of radiation treatments" misses the point -- the purpose of active surveillance is to avoid the complications of any unnecessary treatment. There is no convincing clinical evidence supporting the use of cryosurgery, and the National Cancer Institute classifies it as "an option under clinical investigation." While Dr. Katz decries the expenses of radiation and robotic surgery, the article does not discuss the costs -- or complications -- associated with cryosurgery. Dr. Katz pleads for guidelines as to who should be treated -- they exist and they would advise against treating an 82-year-old man with an early-stage, PSA 5, Gleason 7 cancer.

The article also glosses over a number of troubling issues related to the prominent (but unnamed) New Yorker's experiences with screening and treatment. While autopsy series have shown that 30% of men over 50 harbor occult prostate cancers; the percentage is at least 70% for men in their 80s. Many experts consider a PSA of 5 to be within the normal range for a man over 70 -- as men age their prostates enlarge and produce more PSA. Regardless, PSA is not a very accurate test and the first thing to do with a borderline elevation is to repeat the test.

Cancers that are low-risk -- and not likely to ever require treatment -- are defined by a low PSA value and a low Gleason score. The New Yorker had a low PSA value, though the Gleason score was intermediate. However,

the other important determinant in assessing risk is the biopsy results. Usually urologists obtain at least 12 biopsies -- the number of positive biopsies and the proportion of prostate tissue that is cancerous are also indicators of tumor aggressiveness. The article describes the biopsy as finding an early-stage cancer on one side of the gland; however, sometimes these cancers are so insignificant that they can be completely removed by the biopsy.

When the United States Preventive Services Task Force recommended against screening men older than 75 in 2008, they were accused of ageism. Indignant urologists questioned an intrusive government agency that sought to deny their 80-year-old golfing partners the opportunity to be screened (and treated) for prostate cancer. However, the 10-year life expectancy seen as justification for screening is probably an underestimate. A study of men with screen-detected cancers found no survival benefit with undergoing surgery compared to no treatment after 12 years of follow-up -- suggesting that men would need perhaps 15 or more years of life expectancy to expect any benefit. Of course, no clinical trials have enrolled men over 75, so the presumed benefits are merely hypothetical.

The bottom line is that the prominent New Yorker's story was an odd one to profile -- at least in the way it was reported.

Patients do need to be educated about screening -- and the potential downstream consequences related to false positive tests, biopsy complications, diagnosing clinically insignificant cancers, the uncertainty about how and whether to treat prostate cancers, and treatment complications. Studies have shown that informed patients are less willing to undergo PSA testing or receive aggressive treatments.
