Plan puts prostate cancer treatment progress at risk

By KEVIN KOO  
For the Monitor  
Sunday, November 22, 2015

It's not always easy for doctors to admit their mistakes.

I was in my urology clinic seeing a gentleman in his late 60s. A recently retired college professor, Jim had been referred by his family doctor with a concerning PSA blood test, which raised suspicion about prostate cancer. A recheck showed the same abnormal result. We discussed the findings and his options, and he decided he wanted a more definitive answer. A biopsy confirmed the diagnosis: prostate cancer.

One in seven American men will face prostate cancer, but because of advances in our understanding of how the cancer behaves and how we can treat it, most of these men will die with the disease, not because of it.

Jim was nonetheless anxious. He explained that 15 years ago his neighbor had had prostate cancer. Surgery was recommended and performed. The cancer was cured, but he later developed occasional incontinence and erectile dysfunction, both consequences of the way the surgery was done back then.

Could my patient avoid surgery? The biopsy showed that Jim’s cancer was in the “low-risk” category, meaning that it had not spread beyond the prostate and was not likely to be an imminent threat to his health. Together, we could choose to observe his cancer with annual checkups or monitor its behavior with periodic PSA tests and biopsies. Relieved, Jim opted to watch and wait.

The approach to treating prostate cancer has evolved over two decades. Thousands of men who were screened for and found to have prostate cancer in the late 1990s and early 2000s underwent surgery, and some have developed long-term side effects.

We now know that the men with low-risk cancer like Jim’s might not have needed to have surgery and could have monitored their cancer instead.

We overtreated prostate cancer; we made a mistake.

Times have changed. Low-risk cancers are managed very differently than high-risk ones, which means treatment options can be tailored to each individual.

This is the case in New Hampshire. Using data from the state cancer registry, researchers at Dartmouth-Hitchcock Medical Center have found that patients are increasingly choosing prostate-cancer treatments aligned with their risk, a positive step toward reversing the trend of overtreatment.
But the progress we've made is under threat.

In 2012, the United States Preventive Services Task Force recommended against the PSA test for all men. The decision was based on a selective interpretation of scientific evidence without the input of urologists or our patients. Although the USPSTF’s congressional mandate was never intended to force decisions between patients and physicians, the recommendation may soon be used precisely in this way.

The Centers for Medicare & Medicaid Services have proposed that, based on the USPSTF recommendation, not using PSA tests should be a way to judge the quality of a physician’s care. Doctors who order PSA tests would be penalized for doing so.

This is a potentially disastrous step backward in the fight against the second most common cancer among men.

PSA testing, like any test or procedure, has certain benefits and risks. After discussing them, some men choose not to have the test, in the same way that patients with low-risk cancer can opt for monitoring instead of surgery.

But the Medicare proposal would punish this right to choose. My patient’s prostate cancer would have gone undetected, potentially until it was much more complicated and expensive to treat, or altogether too late.

What about the patients with high-risk prostate cancer? Earlier this month, the New England Journal of Medicine reported that in 1990, before PSA testing was available, 70 percent of prostate cancer cases were metastatic – in short, too late to treat – when they were found. Since the introduction of PSA testing, this figure has fallen dramatically to 25 percent in 2010, meaning that most patients today are diagnosed with prostate cancer early enough to cure.

The USPSTF has argued that its recommendation is meant only as a guide, not a commandment. But the effect of its advice not to perform PSA testing is already coming into focus.

According to a new study in the Journal of the American Medical Association, rates of PSA testing have declined since the 2012 recommendation, particularly among men under age 75, when the opportunity to catch and treat prostate cancer is greatest.

It’s unclear whether this change is because patients are refusing the test, physicians are reluctant to offer it, or both. It’s too early to tell whether less testing will lead to more deaths from prostate cancer that was diagnosed too late.

What I do predict is that if the federal proposal to equate not doing PSA testing outright with “quality” medicine is put into place, rates of PSA testing will continue to fall, and the promise of health care reform to reward individualized decision-making between patients and doctors will be undermined.

It’s not always easy for doctors to admit their mistakes. It will be much harder to explain one that we all saw coming.

(Kevin Koo lives in Lebanon.)