

Prostate Cancer Screening Position Statement

The Cancer Council Australia

Background

The prostate is a gland found only in men. It sits just below the bladder and surrounds the urethra. The prostate gland produces a fluid that forms part of the semen.

Impact (prevalence, incidence, mortality)

Prostate cancer is the most commonly diagnosed cancer in Australian men (apart from non-melanoma skin cancers) and is the second-leading cause of cancer death in Australian men¹. It is estimated that there are over 61,000 Australian men currently living who have had a diagnosis of prostate cancer.² In 2004, 11,334 men were diagnosed with the disease. In the same year, 2792 men died from the disease³.

Risk factors

Increasing age is the most significant risk factor for prostate cancer. Prostate cancer affects mostly men in older age groups with over 85% of new cases and over 96% of deaths occurring in men over 60 years.⁴ It is rare in men under 45 years of age.⁵ If younger men are diagnosed with prostate cancer, they are more likely to die prematurely from the disease as there is more time for the cancer to progress and they are less likely to die from other causes. A family history of prostate cancer is also a risk factor for the disease although less significant than age. There is some evidence that environmental and lifestyle factors may also increase the risk of prostate cancer, however more research is required before any conclusions can be drawn.

The Cancer Council Australia position

The benefits of population screening for prostate cancer are, at this time, unproven. The central concern is that many prostate cancers will not progress sufficiently to cause harm in the man's lifetime, while others will progress and be lethal. No current test (including the PSA test) adequately differentiates between these types of cancer.

The Cancer Council Australia does not support population-based screening of asymptomatic men for prostate cancer, because as yet there is no direct evidence showing a net benefit of screening in terms of reduction in mortality rates.

Recommendations

- In the absence of direct evidence showing a clear benefit of population based screening for prostate cancer, a patient centred approach for individual decisions about testing is recommended.
- Ideally this takes the form of an informed, shared, decision-making process between the doctor and man, discussing the benefits, risks and uncertainties of testing, and discussion about treatment options and side effects.
- Screening discussions and decisions should always include and take into account, age and other individual risk factors such as a family history of the disease.
- Research into prostate cancer diagnosis and treatment must continue to be a high priority. In particular, the development of an accurate test to detect the potentially lethal form of prostate cancer.
- Education and resourcing of GPs and other relevant health professionals needs to occur to enable them to adequately inform men of the benefits and risks of testing for prostate cancer and to enable men to make an informed decision as to whether or not they should be tested.

The prostate specific antigen (PSA) test

Prostate specific antigen (PSA) is a protein produced by the cells of the prostate gland. When the prostate gland enlarges, PSA levels in the blood tend to rise. PSA levels can rise due to cancer or benign (not cancerous) conditions. Benign prostatic enlargement, urinary tract infections and prostatitis are examples of non-cancer conditions, which can cause PSA levels to rise.⁵

There is inconclusive evidence about the benefits of the PSA test as a population-based screening method. PSA levels do not give enough information to differentiate between benign prostate conditions and cancer, or between cancers, which, while present, would never cause harm, and those with the potential to cause death. A low PSA result does not always mean that cancer does not exist. Similarly, PSA elevations do not always mean cancer⁶. PSA testing may identify very slow growing cancers that are unlikely to cause death. Conversely, PSA testing may lead to the early detection of a fast growing or aggressive cancer that has the potential to spread to other parts of his body before being identified.⁷

A test result that falsely indicates the presence of cancer (“false positive”) may lead to additional medical procedures, with significant financial costs and anxiety for the individual. A positive test will generally lead to a prostate biopsy. Based on the results of the biopsy, the Gleason score (which indicates how aggressive the cancer is), age and other health factors, will be considered, and surgery, radiotherapy or other treatments may be the outcome. All treatments have associated risks and benefits. The majority of men with an elevated PSA test turn out **not** to have cancer.⁵

Current research on the PSA test

Prostate cancer screening approaches are still being investigated. There is currently no formally established, or consistently taken, approach in how to interpret the results of a PSA test or how to proceed on the basis of that interpretation. Two major trials looking at the impact on mortality of the PSA test are underway. The European Randomised Study of Screening for Prostate Cancer (ERSPC) started in 1994, involves 239,000 men and is due for completion in 2008.⁸ The United States Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial (PLCO) involves 74,000 men aged 55–74 and is due for completion in 2006.⁹ The release of findings from these trials will help to inform future policy and provide evidence in relation to PSA testing and screening in Australia.

Digital Rectal Examination (DRE)

A DRE is a manual examination of the prostate gland by the insertion of a gloved finger into the patient’s rectum to check any abnormality in size, shape or texture in the prostate.

Like PSA, there are mixed findings in relation to the sensitivity of the examination for detecting prostate cancer. There is no direct evidence that screening DRE reduces mortality from prostate cancer.⁹ If PSA testing is performed, a DRE is also recommended. The benefit of screening for prostate cancer using PSA testing together with digital rectal examination (DRE) is unclear and currently under evaluation in the PLCO randomised prospective trial.⁸

Benefits of prostate cancer screening

For many types of cancer, finding and treating the disease early has benefits. In terms of years of life saved, men in their 50s and 60s may benefit more from prostate cancer screening than men in their 70s and 80s.

Early death from prostate cancer is more likely to occur in men diagnosed in their 50s compared with men diagnosed in their 70s because older men are more likely to develop other life threatening health problems and younger men have a longer life expectancy.¹⁰ Like all cancers, prostate cancer is more likely to be cured if it has not spread. Men choosing to have a test to maximise their chance of early detection will need to discuss with their GP when they should commence testing, how regularly to be tested and at what point testing is no longer required.

Treatments and side effects

The treatments following diagnosis of prostate cancer consist of watchful waiting, surgical removal of the prostate, radiotherapy or hormonal treatments. Men undergoing treatments may experience adverse side effects. Research findings for adverse effects across different studies are particularly varied, making it difficult to accurately predict the level of harms associated with treatments. It has been found that erectile dysfunction occur in 20-70% of men, between 15-50% of men develop urinary incontinence and between 6-25% develop bowel problems.⁶ Considerable information and discussion is required to enable men to make an informed decision about treatment.¹¹

Population-based screening

Population-based screening of asymptomatic men for prostate cancer cannot be supported until more information is available about the natural progression of the disease and there is direct evidence showing a net benefit of screening. PSA and DRE do not have appropriate sensitivity and specificity to be used as screening tools for prostate cancer. Due to the significant gaps in evidence about the effectiveness of prostate cancer screening and early treatment, the prevailing public health approach is to not recommend population-based screening but to support patient-centred informed decision-making when individual decisions about prostate cancer testing need to be made.

Men at above-average risk

While increasing age is the most significant risk factor for prostate cancer, it has been suggested that between 5 and 10% of prostate cancers may be caused by inherited genetic defects.¹² While researchers have not yet confirmed the specific gene mutations that increase the risk of prostate cancer, it is known that men with a family history of prostate cancer in a first degree relative (father, son, brother) have a higher (2–3 times) lifetime risk of developing the disease.¹³ There is some evidence to suggest that this risk is higher if the relative was diagnosed before the age of 60 years.¹⁴ Other people at above-average risk include those who have had elevated PSA tests or abnormal biopsies in the past.

Men at above-average risk of prostate cancer should discuss the risks and benefits of prostate cancer screening with their doctor, taking age and other individual risk factors into account. They also should be given adequate objective information about the potential benefits and harms of screening, diagnostic procedures and treatment for prostate cancer to allow them to make a fully informed decision on whether to be tested or not.

For further information

- The Cancer Council Australia – www.cancer.org.au
- The Cancer Council's Cancer Helpline – 13 11 20 (cost of a local call)
- Visit: www.prostatehealth.org.au
- Visit: www.urosoc.org.au

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- ¹³ Ibid.
- ¹⁴ Ibid.