The PSA controversy: is overtreatment a price worth paying for earlier diagnosis?

As a consultant urological of 18 years standing and very much on the front line, I was very disappointed to read the piece on PSA testing under 'screening' on page 18 of the special feature: cancer and the GP, in the *British Journal of Family Medicine* March/April 2014. volume 2, issue 2.

The article puts a wholly negative spin on PSA testing. I wonder how the authors think earlier diagnosis of prostate cancer can be achieved bearing in mind early prostate cancer is often asymptomatic?

There is much evidence to show that screening by PSA saves lives. The issue is not that lives are saved but there is overdiagnosis and overtreatment. Even then there are strategies to reduce the downsides.

The authors make no mention of the Prostate Cancer Risk Management Programme,[1] which in its different iterations has been sent to every GP in the land.

I am happy to provide evidence to support what I say, for example the Melbourne Consensus 2014.[2]

I acknowledge that this is a complex area but I fear that the article does GPs and importantly men a disservice by dissuading PSA testing.

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The authors respond....

We thank Mr Chinegwundoh for his response to the article in the *British Journal of Family Medicine* March/April 2014.

As GPs, we would welcome a screening test that was reliably able to identify those patients with early prostate cancer who would benefit from treatment, whilst sparing those with low-risk disease from the morbidity (both physical and psychological) of investigations and treatment.

AIR YOUR VIEWS

If you have an opinion or a comment to make about this or any other issue relevant to family medicine, why not share it with other readers?

Write to the editor at the address on page 1, or email **BJFM@pavpub.com**. We welcome all feedback.

Evaluation of the evidence of PSA screening has led national bodies in both the UK[3] and the United States[2] to advise against using PSA testing as a screening test in asymptomatic men. Screening using PSA testing fails to meet all of the World Health Organisation guidelines[5] for population screening.

The morbidity associated with investigation and treatment of men found to have a raised PSA has been well documented.[6] Sadly, the impact on mortality from prostate cancer diagnosed after PSA screening has been small or absent, depending on the studies considered.

We appreciate that this is an area in which new studies, seeking to clarify the place of PSA testing, are appearing. No doubt there will continue to be vigorous debate over the evidence and its interpretation.

An editorial in the British Medical Journal last month[7] made two compelling statements: "*Though some men may benefit from screening, many more are harmed by testing and the cascade of diagnostic and treatment related events that follow*" and "*For most men, doctors can recommend against routine PSA screening confident that this provides their patient with the best balance of benefits, harms and costs.*".

We believe that, in the light of current evidence and recommendations, the statements in the article remain valid. It remains crucial that asymptomatic men requesting a PSA test are appropriately counselled – failure to do so would be an abdication of an important professional responsibility.

The role of PSA testing in symptomatic men is a separate issue. Its role in this group is not disputed.

We look forward to the day when we have something better to offer our male patients than the PSA testing currently available.

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References

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5. http://www.who.int/cancer/detection/variouscancer/en/
6. BMJ 2012;344:d7894 doi: 10.1136/bmj.d7894 (Published 9 January 2012)
7. BMJ 2014;348:g2559 (Published 15 April 2014)

BJFM Challenge answers (see pages 4-5)

1.	a,b,d,e	(See pages 14-17)
2.	b	(See pages 14-17)
3.	b,e	(See pages 29-33)
4.	c,d	(See pages 29-33)
5.	a,c,d	(See pages 29-33)
6.	ranking 1-4 = b,c,a,d	(See pages 23-26)
7.	c	(See pages 23-26)
8.	a,c	(See pages 23-26)
9.	b,d	(See pages 11-13)
10.	d	(See pages 11-13)
11.	a,c,e,f,g	(See pages 11-13)
12.	a, c, e, f	(See pages 35-38)