

CLINICAL DECISIONS

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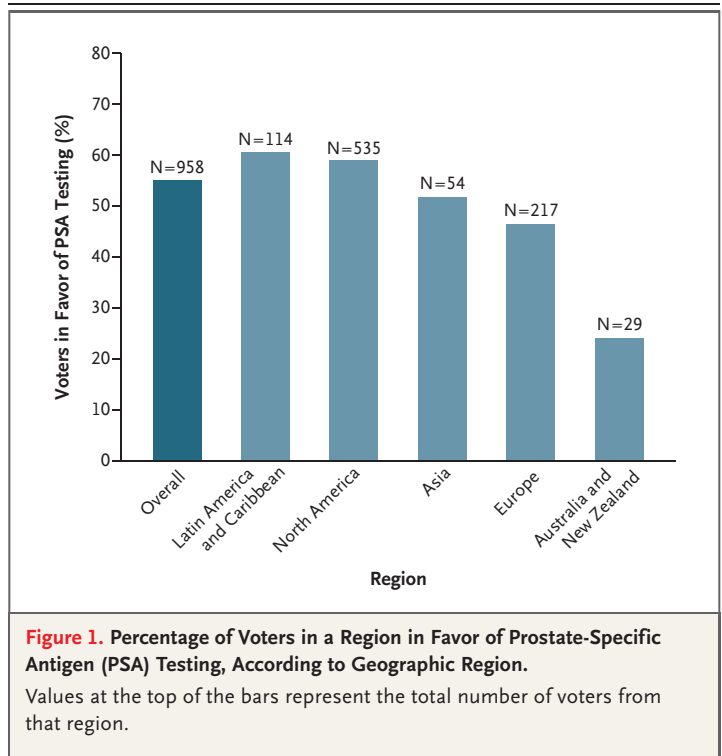
Prostate Cancer Screening — Polling Results

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In August, we presented a case involving a 55-year-old man seeking guidance from his primary care physician on whether to pursue screening for prostate cancer with a yearly digital rectal examination and prostate-specific antigen (PSA) testing in Clinical Decisions,¹ an interactive feature designed to assess how readers would manage a clinical problem for which there may be more than one appropriate approach to the care of patients. Two experts in the field presented arguments, one in favor of PSA testing and one opposed. We asked our readers to decide between these two approaches and to share their thoughts on this controversial topic.

We received 958 votes from readers in 67 countries. A little over half (55%) of all voters recommended PSA screening for the man in our clinical vignette — a split that revealed the lack of clinical consensus surrounding this important issue. North American voters preferred to screen with PSA testing: 59% of 489 voters from the United States and 67% of 46 Canadians voted in favor of PSA screening. European voters were less enthusiastic, with only 47% of 217 voters in favor of PSA screening. Other trends according to geographic region are presented in Figure 1.

We also received 91 comments, with 71% of the comments written in favor of PSA screening — a much higher percentage than that in the voting alone. A large number of comments stressed the importance of informed and shared decision making between the patient and his physician. Many physicians believe strongly that the best way to approach PSA screening is to have a detailed discussion with the patient about screening options and treatment options, including the possibility of not treating a low-grade tumor (i.e., watchful waiting). In agreeing to screening, a patient must realize that he is also agreeing to the possibility that a prostate biopsy will be performed if the PSA value is elevated. Depending on the results of the biopsy, the patient may be advised to un-



dergo surgery or radiation treatment — with potential adverse effects, including erectile dysfunction and incontinence.

A large number of respondents remarked that they recommended PSA screening on the basis of personal experience with elevated PSA levels that led to lifesaving treatment. Other respondents believed that data from the European Randomized Study of Screening for Prostate Cancer² provide compelling evidence that PSA screening saves lives. Finally, a number of comments touched on patients' fears with regard to cancer diagnosis, and some clinicians were of the opinion that measuring the PSA level can reassure a patient that his physician is actively performing surveillance.

The comments against PSA screening focused

on widespread overdiagnosis and overtreatment of an often indolent disease that is life-threatening in only a minority of patients. Some comments highlighted the side effects produced by these treatments, including erectile dysfunction and incontinence. Finally, we received comments that cited conflicting data from prostate-cancer screening trials as evidence that PSA screening does not have a meaningful effect on mortality.

These polling results and comments reflect a lack of consensus within the medical field on the best approach to prostate-cancer screening. Future research may help settle this polarizing debate, but as clinicians we should be grateful for

recent contributions from high-quality studies — even if the results are not all coincident. In the meantime, physicians should maintain an informed, sensitive balance in counseling patients regarding the decision whether to pursue PSA testing.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. D'Amico AV, Smith MR. Screening for prostate cancer. *N Engl J Med* 2012;367(7):e11.
2. Schröder FH, Hugosson J, Roobol MJ, et al. Prostate-cancer mortality at 11 years of follow-up. *N Engl J Med* 2012;366:981-90.

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