

The media and prostate cancer screening

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Provision of incorrect information or incorrect data interpretation does not serve anyone well

In this issue of the Journal (*page 507*), MacKenzie and colleagues present data to show that, over an 18-month period, media reports about prostate cancer were dominated by statements emphasising Australian men's risk of prostate cancer, encouraging screening for early detection, and providing reassurance about side effects for treatments that emphasise emerging technologies.¹ In particular, they draw attention to rhetoric that unequivocally supports screening, which would seem to be irresponsible, given the lack of definitive data to show that population-based screening will reduce mortality.

Although this is a fair comment to make, the enthusiasm with which the media has responded to the call to promote screening should not take anyone by surprise. Prostate cancer is the most common internal male malignancy in Australia and the second most common cause of cancer deaths in men.² In 2003, there were 13 526 new cases of prostate cancer and 2837 deaths. By contrast, in that same year, 11 788 women were diagnosed with breast cancer and 2710 died of this disease. Although the biology of these cancers may differ, from the lay public point of view it is a "line ball" call. Little wonder then that, in the face of seeming inaction by government, consumer advocacy groups and some clinicians find a willing media to enter into a discourse that promotes action. In the context of a disease with a high community and individual burden, uncertainty about effective management plans and with no clearly articulated national public health strategy in place, advocacy such as this may be inevitable.

A particular characteristic of this debate has been the polarisation of views for and against screening to the point where, at times, constructive debate has been constrained. However, it is important to differentiate between prostate-specific antigen (PSA) screening, with indiscriminate testing of all men (between prescribed ages), and testing after informed consent, as recommended by peak Australian cancer control and health agencies.³⁻⁶ Apart from the fact that PSA is not a test for prostate cancer and has no threshold level providing a high sensitivity and specificity, but rather has a continuum of prostate cancer risk at all values,⁷ a raised PSA level often commits men to the invasive procedure of transrectal ultrasound (TRUS) guided biopsies. Most men presenting for TRUS biopsies have serum PSA levels of 4–10 ng/mL and do not have prostate cancer detected with extended numbers of biopsy cores. If the diagnostic process were non-invasive and treatments with curative intent were not associated with significant unwanted effects, few would quibble about whether it is appropriate to be tested.

Although estimates vary, there is no doubt that many men having treatment with curative intent are unlikely to benefit in terms of survival.⁸⁻¹⁰ Problematically though, such men are at risk of physical and psychosocial adverse effects from treatment that will affect both them and their partners.^{11,12} As a consequence, there is increasing support for stratifying patients, with an active surveillance protocol advocated for men identified as having low-risk prostate cancer.¹³ One expert advocates an intense monitoring protocol to identify the minority of low-risk patients (about 30%)

with unappreciated aggressive disease for whom definitive therapy should be considered.¹³ However, this strategy can be undertaken only after biopsy diagnosis.

There is no doubt that timely intervention does save lives. However, at the outset, men need to be fully informed of the possible adverse effects of potentially curative treatments and then consider whether, in the event of an abnormal PSA result and subsequent prostate cancer diagnosis, they would wish to proceed to treatment. Only then should they have a PSA test. Nomograms indicating cardiovascular life expectancy accurately may have a role in the future to allow a more tailored approach to overall management, including whether to proceed with prostate cancer testing.

MacKenzie et al call for health authorities to commission and promote decision aids to assist men in making an informed decision about PSA testing for the early detection of cancer.¹ Such decision aids already exist in a wide range of formats and have been shown to improve men's understanding and knowledge about prostate cancer and to reduce decision-related conflict, although they have little effect on actual testing behaviour.¹⁴ The current need is not to develop more decision aids, but to translate shared and informed decision making about prostate cancer testing into primary care, the place where the decision to test is enacted.¹⁵

Barriers to translation include time constraints in busy general practices, general practitioner concerns about medicolegal risks, and GPs' own knowledge and attitudes to prostate cancer testing. To address these barriers, a consortium, led by The Cancer Council Queensland and including The Cancer Council Australia, Australian Prostate Cancer Collaboration, Urological Society of Australia and New Zealand, and the National Cancer Control Initiative, developed an educational program and decision-aid showcard to support shared decision making about the early detection of prostate cancer in primary care.¹⁵ With funding from Andrology Australia, these materials are now available online, and uptake from general practice has been steady, with positive review by users.⁶ Importantly, the Prostate Cancer Foundation of Australia, as the leading prostate cancer consumer group in Australia, has been included in this initiative. This has been an important step in moving towards a constructive dialogue about this contentious issue.

Whatever strategies emerge in terms of diagnosis and treatment in the future, provision of incorrect information, incorrect data interpretation or adverse consequences of the editing process itself do not serve anyone well, least of all patients and their relatives. Moreover, the task of supporting informed patient decision making is made more difficult when having to address misconceptions that may be derived from such reports. Articles such as that by MacKenzie et al highlight the need for media spokespeople to ensure that public discussion of prostate cancer is directed towards a realistic representation of the current status and limitations in relation to PSA testing and prostate cancer management in this country.

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