Strang Cancer Prevention Institute
Dedicated to Promote Cure by Early Detection and Research to Prevent Cancer since 1933

Prevention

Prostate Cancer Awareness Month September 2018

PROSTATE CANCER SCREENING: Making Shared Decisions

Of the most common cancer screening decisions, prostate cancer is the most difficult. Prostate cancer is common and often lethal, but most men don't require treatment, and treatment side effects harm most men. Curative surgery or radiation makes most men impotent, and urinary or bowel problems occur in many others. The results of large randomized screening and treatment trials conflict.

The US Preventive Task Force recommended against screening (D recommendation) but recently recommended provider-patient discussion (C recommendation). The "right" decision depends on the patient and his preferences.

The Strang Foundation Screening Trial, a cluster-randomized trial of educational supports for PCPs, studied screening discussions for breast, cervical, colorectal, lung and prostate cancer. The study surveyed doctors and their patients immediately after the exam. Final analysis is pending, but we have learned (and reported in abstracts) much about screening discussions.

We focus this newsletter on shared decision making about PSA screening. Each man's decision is his own, but the following information may help produce an informed, shared screening decision

ESSENTIAL INFORMATION

Results of screening trials differ but show that most men don't benefit: One randomized screening trial, the ERSPC (European Randomized Study of Screening for Prostate Cancer), found that screening reduced prostate cancer deaths. The U.S. PLCO (Prostate, Lung, Colorectal and Ovarian) trial found no benefit. Neither found that screening reduced overall mortality. A third randomized trial, the British ProtecT trial, has not reported the results of screening. It found no mortality difference between surgery, radiation and active surveillance patients after 10 years, but progression was more common after surveillance.

ERSPC, which combined separately designed studies, found a 31% reduction in prostate cancer-specific mortality, or 1.28 per 1000 screened men, after 13-year follow-up. Prostate cancer was diagnosed 57% more often in the screening group. Most of the benefit came from the Swedish study screened every 2 years and biopsied for a PSA of 3.0 ng/ml. The US (in which about half of control patients had a PSA test, actually lower than expected) and British studies found no evidence of any benefit from screening.

What do the trial results tell us? Preventing a cancer prostate cancer death requires screening many asymptomatic men (781 in ERSPC, the only positive study so far) and treating many prostate cancers (27 in ERSPC). One analysis concluded that benefit was found in studies that most aggressively screened, followed up and treated cancers (like the Swedish population).

What does the Strang Screening Trial tell us? 1) Patients surprisingly often report they heard recommendations different from what their doctor reported (about 25% of the time). 2) Older patients (70 or older) far more often report wrong. Almost always, they report that treatment was recommended when it wasn't. 3) When doctors report an element of shared decision making occurred (reasons for screening, arguments against or that the patient has a choice), agreement improved. The line between a lecture and a discussion may be small and important.

High-risk groups have not been studied. African-American men and men with first-degree relatives with prostate cancer (a father, brother or son) are at higher risk. We do not know if screening or treatment benefits them more than normal-risk populations. The recommended age to start screening for these patients is 40 or 45 years.

Who should not be screened: Patients with less than 10 years of expected survival (most men over 75) and normal risk men under 50.

REFERENCES:

1. Schroder FH, Hugosson J, Roobol MJ, Tammela TL, Zappa M, Nelen V, et al. Screening and prostate cancer mortality: results of the European Randomised Study of Screening for Prostate Cancer (ERSPC) at 13 years of follow-up. Lancet 2014;384(9959):2027-35.
2. Andriole GL, Crawford ED, Grubb RL, 3rd, Buys SS, Chia D, Church TR, et al. Prostate cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: mortality results after 13 years of follow-up. J Natl Cancer Inst 2012;104(2):125-32.
3. Hamdy FC, Donovan JL, Lane JA, Mason M, Metcalfe C, Holding P, et al. 10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer. N Engl J Med 2016;375(15):1415-24.
4. Talcott JA. In the Clinic. Prostate Cancer. Ann Intern Med 2015;163(11):ITC1-12.

The Strang Cancer Prevention Cookbook

Reduce your Risk for Cancer by Eating a Healthy Diet!

Tomato-Basil Sauce 4 Servings

2 pounds plum tomatoes (10-12)
1 tablespoon olive oil
2 garlic cloves, crushed
1 small onion (about 1/4 pound), chopped
½ cup fresh basil leaves cut into long strips
Salt and freshly ground black pepper

Core the tomatoes and drop them into boiling water for 20 to 30 seconds.
Slip off the skins and slice the tomatoes in half horizontally. Gently squeeze the halves over a bowl to squeeze out the seeds. Use your fingers to remove any remaining seeds. Discard the seeds, chop the tomatoes and reserve.

Heat the olive oil in a medium nonstick skillet over high heat. Add the crushed garlic and cook until lightly browned, then remove and discard. Add the onion to the skillet and cool over medium heat until soft, about 5 minutes, stirring often. Add the reserved tomatoes and bring to a simmer. Cook uncovered over medium heat, stirring occasionally for 30 minutes, until the sauce thickens.
Stir in basil, season with salt and pepper, and simmer for 2 to 3 minutes.

Calories 93, protein 3g, carbs 14 g, fat 4 g, cholesterol 0 mg, dietary fiber 3 g, saturated fat 1 g

MAJOR SOURCES OF POTENTIAL CANCER FIGHTERS

Phytochemicals: allium compounds, plant polyphenols (flavonoids, phenolic acids) plant sterols, phytic acids, terpenes, (carotenoids, monoterpenes)

Recipe by Laura Pensiero, R.D., Strang Consultant
Chef, Dietitian, Restaurateur, Author
Owner, Gigi Hudson Valley (Trattoria & Catering) Rhinebeck, New York

Authors: James A. Talcott MD, SM, Consultant Strang Cancer Prevention Institute
Michael P. Osborne MD, MSurg, FRCS, FACS President Strang Cancer Prevention Institute

September is Prostate Cancer Awareness Month

Strang Cancer Prevention Institute
575 Madison Avenue 10th Floor
New York, NY 10022
Tel: (212) 501-2111 www.strang.org

Editor
Merle K. Barash MA AEd, MA Psya

© Strang Cancer Prevention Institute