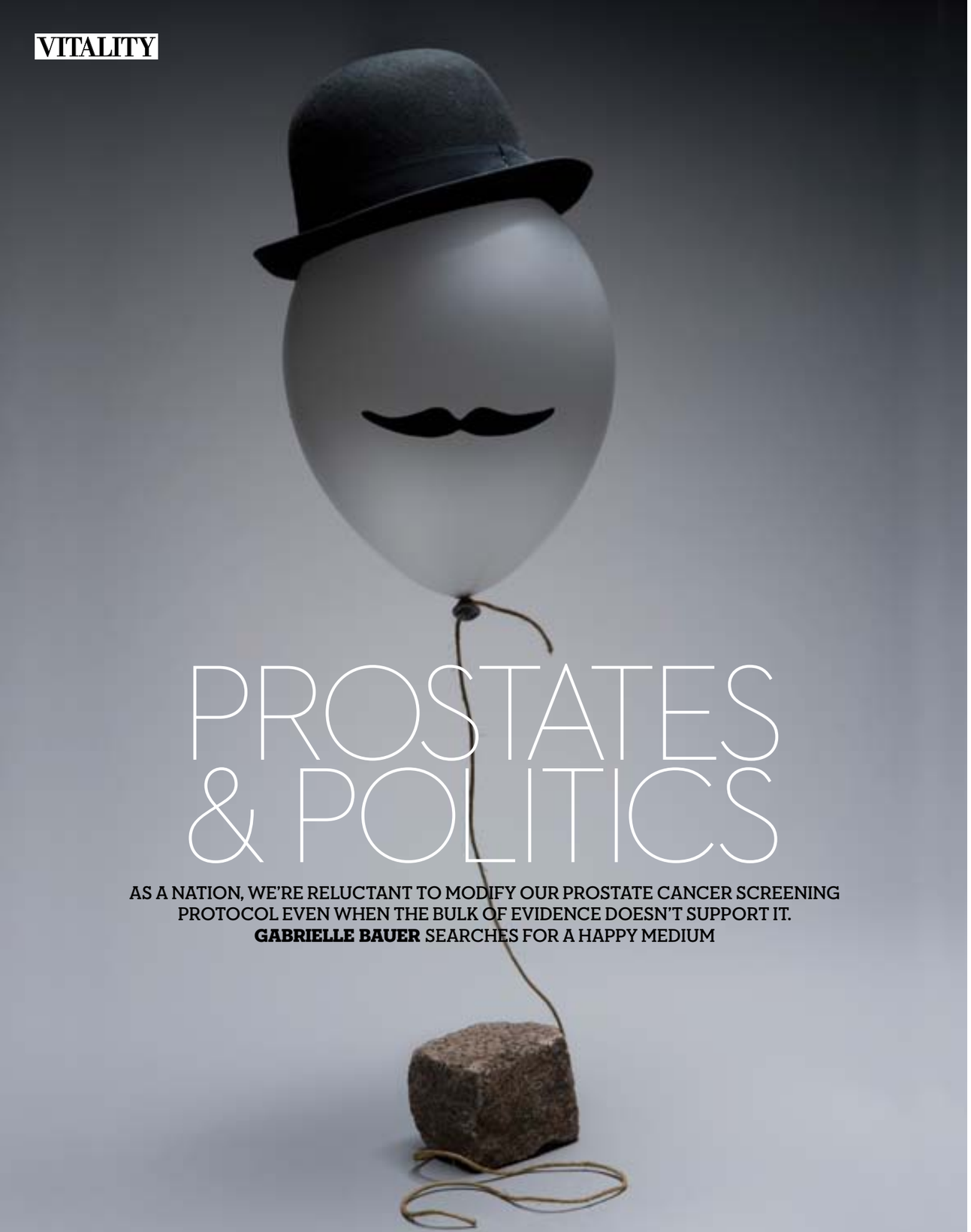

PROSTATES & POLITICS

AS A NATION, WE'RE RELUCTANT TO MODIFY OUR PROSTATE CANCER SCREENING PROTOCOL EVEN WHEN THE BULK OF EVIDENCE DOESN'T SUPPORT IT. GABRIELLE BAUER SEARCHES FOR A HAPPY MEDIUM

PHOTOGRAPHY, VINCENT BESNAULT/GETTY IMAGES

THE MERE MENTION OF THE WORD "prostate" makes my husband shudder these days. Within the past two years, he has had a heart attack, leading to the insertion of three cardiac stents, and a prostate biopsy triggered by a positive prostate-specific antigen (PSA) test. If he had to pick one of these ordeals to go through again, he tells me he'd choose the stent insertion, hands down. I have rarely seen him cry, but the biopsy unnerved him so much it drew those rare tears to his eyes.

While he was being prepped for the procedure, the nurses assured him it would be no big deal. It *was* a big deal. (For context, I should add that my husband is one of those stalwart types who normally start complaining three days into a searing backache.) "They took 12 samples from my prostate," he recalls. "Each one felt like the zap of a staple gun, only more powerful." And nobody had told him to expect a huge blood clot – "the size of a misshapen golf ball" – to pass through his urethra when he had a pee after the procedure.

For the next eight weeks, he saw blood in his urine and semen. Still more disconcerting, he tells me that things have never felt the same down there since the procedure: fewer and weaker erections, more sluggish urinary flow and a general sense that "things aren't working the way they did before."

Doctors don't paint such scenarios when they recommend the PSA test to men. Still, men need to know what often happens after the test because that's where the rubber hits the road. They also need to know that the test itself leaves a lot to be desired.

THE EVIDENCE

Catch a prostate tumour early, save a life. Men have been getting this message since 1992, when the prostate cancer screening test first hit the market. More recently, the Movember Canada education campaign has been encouraging men over 50 to have the test, and many Canadian men have taken the prod to heart.

A report issued in late 2011 by the U.S. Preventive Services Task Force suggests they may be wasting their time. Based on a review of the evidence to date, the report concluded that regular PSA screening does not appreciably save lives and leads to further tests that cause needless anxiety, pain, incontinence and impotence. Translated into policy talk: the harms outweigh the benefits. The latest strike against the test came in March of this year, when a study of more than 180,000 men concluded that routine PSA screening in men aged 50 to 74 does not prevent deaths.

And yet nobody can deny that PSA screening does save individual lives. Former New York City mayor Rudy Giuliani, who went public with his prostate cancer diagnosis in 2000, maintained that he owed his timely diagnosis and recovery to the detection of high levels of PSA in his blood. A rash of other celebrities have disclosed their prostate cancer and argued passionately for the merits of early detection: Bob Dole, John Kerry, Arnold Palmer, Harry Belafonte ...

These self-styled activists send a clear message to the public: get the test. What they typically don't say is that, among men over 50 who have an elevated result, no more than three out of 10 have a trace of prostate cancer at the time of screening. In the hands of the media machine, the science behind the test, shaky as it is, quickly turns into "broscience," leaving men confused and afraid of making the wrong move.

THANKS BUT NO THANKS

Arthur Valens (a pseudonym), 56, a friend of ours in Richmond Hill, Ont., has made his choice: no more tests. When his PSA levels showed an upward trend, his doctor recommended a prostate biopsy. So far so good. A year later, his PSA levels still high, Valens went for a second biopsy. "I wasn't too happy about it but went along with my doctor's recommendation," he says. Twenty-four hours later, he came down with a high fever that landed him in the emergency room, where he was diagnosed with acute prostatitis from an E. coli infection. It took three rounds of different antibiotics for the acute infection to clear, but Valens's problems were hardly over. His prostatitis turned chronic, with severe pain on urination and debilitating fatigue – "like it was 11 p.m. the whole day long."

Valens remained in this limbo state for more than a year, his infection never fully clearing up despite powerful doses of sulfa antibiotics. He's finally starting to feel like his old self again, minus a few important perks. "The area is still sensitive, and my sexual function is not where it was," he says plainly. He has turned away from traditional Western treatment, opting for natural supplements such as Silexin and Relexin instead. "Every once in a while, my wife will concoct an herbal potion for me," he adds.

Describing the chain of events following his PSA test as a nightmare, Valens says he wants nothing further to do with the protocol, though he concedes that his position may not rest on entirely rational grounds. "None of my previous biopsies revealed any cancer, and my experience has been so negative that I refuse to have another biopsy without a strong indication of malignancy," he says. "That's how turned off I am."

AND WHAT IF IT'S CANCER?

At the other extreme, some men get so jittery at the sound of the word "cancer" that they'll happily undergo test after test, biopsy after biopsy, and surgery after surgery to either rule it out or root it out. But here's the thing: most prostate tumours grow slowly and don't threaten life. That's why it's often said that men often die with rather than from prostate cancer. The biopsies that often follow positive PSA tests →

don't differentiate between these indolent cancers, which occur in up to half of men over 50, and the more aggressive and dangerous kind. Overtreatment of harmless tumours not only drains megabucks from the health-care system but takes a significant physical and emotional toll on men. To add insult to injury, close to 30 per cent of men have incontinence and as many as 85 per cent have compromised sexual function awaiting them at the finish line.

Still, if the PSA test pulls those few aggressive cancers from the haystack of innocuous tumours, isn't it worth all the trouble?

"The only statistic that really counts is lives saved," says Dr. Mark Emberton, director of the division of surgery and interventional science at University College London and founding partner of London Urology Associates. According to Emberton, the latest evidence shows that, while PSA screening may reduce mortality from prostate cancer, it doesn't affect all-cause mortality. "PSA screening simply changes what you see on your death certificate" is how he puts it. While not all studies come out so clearly on the zero-impact side, many stakeholders feel the human cost of eking out a small drop in mortality rates is simply too high.

Not so fast, says Dr. Antonio Finelli, chair of the Canadian Urological Association (CUA) Guidelines Committee. If we weren't so quick to jump to biopsies, radiation and surgery, we could reduce the frequency of treatment side effects.

"The PSA test isn't perfect, but it's the best we have," says Finelli. This reasoning is what led the CUA to part ways with the U.S. task force and stand by its June 2011 recommendation to offer the PSA test to all men aged 50 or older with a life expectancy of at least 10 years. "We decided not to throw out the test but to use it more judiciously," he explains. In a man with a PSA level lower than 1.5 at age 50, for example, "the likelihood of metastatic lethal prostate cancer is close to nil, so annual testing wouldn't be necessary in such a case."

THE POLITICS

Some stakeholders believe a reduction in mortality trumps all other considerations, but most concede the issue has many shades of grey. Dr. Murray Krahn, director of the Toronto Health Economics and Technology Assessment Collaborative, frames the conundrum this way: "From a policy point of view, can we justify spending a lot of money in the pursuit of a relatively modest – if any – reduction in mortality while putting people's health at risk from treatment-related problems?"

Whether justifiable or not on health-economic grounds, policy-makers are loath to relinquish a screening protocol once it's in place. That's perhaps because humans respond more to story than to statistics, to anecdote than to evidence. As Dr. Ben Goldacre argues in his bestselling book *Bad Science*, "No matter what you do with statistics about risk or recovery, your numbers will have inherently low psychological availability, unlike miracle cures, scare stories and distressed parents." In other words, numbers will never pack the same punch as narratives. Stories of individual triumph over prostate cancer thanks to a PSA test have a way of moving the boulder of political will, and advocacy groups put all their energy and passion into such stories.

Do politicians pander to these special interest groups? Of course they do, says Emberton. "Many screening programs, irrespective of the disease area or the country in which they are implemented, were initiated on the back of lobbying by interested groups," he says.

What's more, "any science that refutes the experience of personally affected people feels like a slap in the face to them," says Dr. Brian Goldman, an emergency room physician at Toronto's Mount Sinai Hospital and host of the CBC radio show *White Coat, Black Art*. Confusing the message with the messenger, "they get angry at groups that come down against screening" – like the U.S. task force – and start lobbying to preserve the test.

DECISION POINTS

Right now, most provinces and territories offer routine PSA screening to men over 50. British Columbia and Alberta do not cover the test as a screening tool, while Ontario and Alberta cover it if a doctor suspects prostate cancer on clinical grounds. Individual men always have the option of paying for the test themselves – or, conversely, of declining it even if it's offered at no cost.

My husband, for his part, had another PSA test on our family doctor's recommendation. The numbers came back "on the high side," meaning not quite high enough to warrant a specific course of action but too close for comfort.

So what now? Another biopsy? Watchful waiting? More PSA tests?

"That's the critical decision point," says Goldman. "It's difficult for doctors to give patients the full picture in a busy primary care setting, so it falls on the patient to weigh the pros and cons."

At this juncture, avoiding another biopsy is Drew's top priority. If his PSA levels keep climbing, he'll seek a second – and third and fourth – opinion before going under the staple gun again. He's also lost some confidence in the PSA test itself and wonders if he should simply wash his hands of it, as Valens has done. "I'd like to find out if there's a more reliable test I could take," he says.

Researchers are scrambling to find just such a test. In the meantime, the PSA test is the best the medical community can offer.

Could this slice of the health-care pie be put to better use? Nobody dares to answer. Z