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WELL

Screen or Not? What Those Prostate Studies Mean

By [TARA PARKER-POPE](#)

Last week, two major studies from the United States and Europe found that [P.S.A.](#) testing — the annual blood test used to screen men for [prostate cancer](#) — saves few if any lives, while exposing patients to aggressive and unnecessary treatments that can leave them impotent and incontinent.

The news was unsettling and confusing to many middle-age men, particularly those who already have diagnoses of prostate cancer as a result of P.S.A. testing. Doctors say some men are reconsidering surgery or radiation treatment they have planned. Others, convinced that their lives were saved by P.S.A. screening, wonder how anyone could question the value of early detection of prostate cancer.

In the face of all this confusion, what's a man to think? Here are answers to some frequently asked questions.

WHAT DID THE STUDIES REALLY SHOW?

The bottom line of both studies is that P.S.A. screening does find more prostate cancers — but finding those cancers early doesn't do much to reduce the risk of dying from the disease.

The [American study showed no statistical difference](#) in prostate cancer death rates between a group of men who had the screening and a control group who did not. The [European researchers found that P.S.A. screening](#) does reduce the risk of dying from prostate cancer by about 20 percent.

But in terms of individual risk, even that is not a huge benefit. It means that a man who isn't screened has about a 3 percent average risk of dying from prostate cancer. If that man undergoes annual P.S.A. screenings, his risk drops to about 2.4 percent.

And there is an important tradeoff. P.S.A. testing increases a man's risk of being treated for a [cancer](#) that would never have harmed him in the first place. The European study found that for every man who was helped by P.S.A. screening, at least 48 received unnecessary treatment that increased risk for impotency and incontinence. Dr. Otis Brawley, chief medical officer of the [American Cancer Society](#), summed up the European data this way: "The test is about 50 times more likely to ruin your life than it is to save your life."

SO DO THESE STUDIES SETTLE THE DEBATE ABOUT THE VALUE OF P.S.A. SCREENING?

Not necessarily. Both have problems that make it difficult to interpret the data. The American study found no benefit in P.S.A. screening over a period of 7 to 10 years. But so far, only about 170 men out of 77,000 studied have died of prostate cancer. Prostate cancer is slow-growing, so it's possible that in the next few years, meaningful differences in mortality rates between the two groups will emerge.

A larger concern is what statisticians call "contamination" in the unscreened control group. Because it would have been unethical to tell men in the control group that they could not be screened, many either sought the test or were offered it by their doctors.

Investigators initially estimated that 20 percent of the control group would fit in this category, but the numbers ended up being far higher — 38 to 52 percent. As a result, the study doesn't really compare the risks and benefits of screening and no screening. It compares aggressive screening and some screening.

The fact that so many men in the nonscreening group "dropped in" to the screening category "is a serious concern," said Dr. Eric A. Klein, chairman of the Glickman Urological and Kidney Institute at the Cleveland Clinic, who added:

"The argument for screening today is no different than before. These studies do not settle the issue definitively one way or another."

The American investigators said that while contamination did complicate the interpretation of the data, they were still confident in the finding that there is little or no benefit to P.S.A. screening. "Our statisticians still felt the power of the study to detect a medically meaningful benefit was retained," said Dr. Barnett S. Kramer, co-author of the study and associate director for disease prevention at the [National Institutes of Health](#).

The European research has its own set of problems. Although the finding that P.S.A. screening reduces cancer deaths by 20 percent is statistically significant, experts say it's on the borderline, and a few more years of data could weaken the result. Finally, parts of the study were not "blinded," meaning that biases could have crept into the interpretation of the data.

DOES THIS MEAN MEN SHOULD NOT RECEIVE PROSTATE CANCER SCREENING?

No. Before the studies were released, most major medical groups said P.S.A. testing was a personal decision that a man should discuss with his doctor. The two new studies are unlikely to change that advice, experts say; instead, they give men and their doctors more information with which to make the decision.

For older men, the screening decision should be easier. P.S.A. screening is already not advised for those 75 and older. And the American research confirms that P.S.A. testing is not helpful for men with 10 years or less of life expectancy. In the European study, among men 70 or older, there were more deaths in the P.S.A. screening group, although the trend could be caused by chance.

The advice is murkier for middle-age men. In the European study, 50- to 54-year-olds didn't benefit from screening. But men ages 55 to 69 were 20 percent less likely to die from prostate cancer than those who weren't screened. (Still, men in that age group must decide whether the high risks of unnecessary treatment are worth it.)

A co-author of the American study, Dr. Gerald L. Andriole Jr., a surgeon at [Washington University](#), says that while every man shouldn't get a P.S.A. test, he also doesn't recommend "wholesale stoppage."

Middle-age men or older men with a life expectancy of 10 years or more "need to be informed about the potential pros and harms of screening," he said, adding:

"If they want to embark on it, that's fine. I'm still open to accepting that we learn a lot about a man's prostate and about the probability of him getting or having prostate cancer by measuring P.S.A.."

Dr. Brawley of the American Cancer Society agreed that individual men might come to different decisions after talking with their doctors.

"There is a guy out there whose personal experience is such that he's very frightened of prostate cancer, so maybe he should be screened," Dr. Brawley said. "Then there are the guys out there who see that 48-to-1 ratio and say, 'I don't want to be screened.' It's an individual personal decision. You can't criticize guys who want it versus guys who don't want it."

WHAT IF I'M IN A HIGH-RISK GROUP, LIKE AFRICAN-AMERICANS OR MEN WITH A STRONG FAMILY HISTORY OF PROSTATE CANCER?

The studies don't include enough data to make definitive recommendations for either group. Dr. Andriole said men at higher risk

who receive a diagnosis of prostate cancer as a result of screening should be reassured by the data that they don't have to rush into aggressive treatment. Bear in mind that prostate cancer is usually not fatal.

"It's a terrific tool for helping a man assess his risk for having prostate cancer," Dr. Andriole said. "Does it necessarily mean it's a killer cancer? The answer is no. We should be more judicious. We should modify the way we're reacting to the abnormal screens in light of what we now know."

SHOULD MEN STILL UNDERGO A DIGITAL RECTAL EXAM?

Neither study offers insights into the value of this traditional test, in which a doctor feels the prostate for hardness or bumps that may signal risk for prostate cancer. The American study looked at a combination of P.S.A. and rectal screening and found no benefit. The European study provides no specific evidence about the exam.

DO THE NEW STUDIES MEAN I SHOULD CANCEL SURGERY OR RADIATION?

The study data speak only to the risks and benefits of P.S.A. screening in healthy men without symptoms. If your cancer was detected as a result of symptoms, nothing in the study should change the medical advice you have already received. Early signs of prostate cancer may include difficulty urinating or [blood in the semen](#) or urine.

And even if the cancer was detected as a result of P.S.A. screening, the data have limited applicability to one's personal situation. The two studies look at the average risk and benefits across a large group of men, but they don't take into account the specific factors that influence a man's individual risk.

What is your Gleason score — a measure of the cancer's aggressiveness? What is your family history? How much cancer was in each [biopsy](#)? Did you do a repeat biopsy to confirm your case? The answers to those questions will give a man better information about how to proceed. At the same time, even those answers can't reliably predict a man's risk for having a serious cancer.

"The regrettable truth of the matter is we don't have really good tools to determine from the sea of cancers we discover, which ones are the bad ones," Dr. Andriole said. "A man who has surgery scheduled tomorrow who is now not sure what to do, we don't have a whole lot to tell him right now."

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