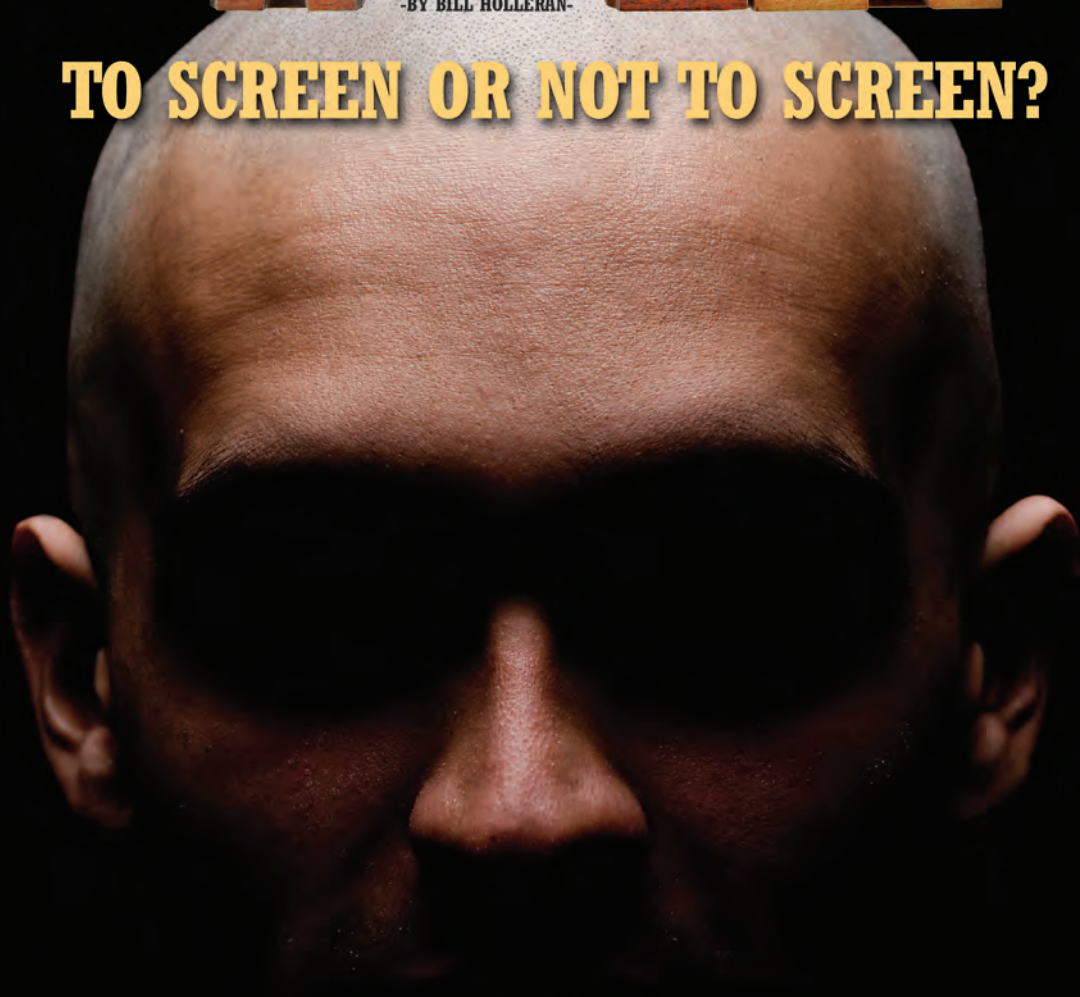


PROSTATE CANCER

-BY BILL HOLLERAN-

TO SCREEN OR NOT TO SCREEN?



After skin cancer, prostate cancer is the second most common cancer in men in the U.S., according to the National Cancer Institute (NCI).

Of all American men who are diagnosed with cancer each year, more than a quarter

have prostate cancer. This fall, two major health groups issued statements disagreeing on whether prostate-specific antigen (PSA) testing—a way to screen for prostate cancer—is a valuable tool in the battle to save lives.

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Recent research by the Barbara Ann Karmanos Cancer Institute at Wayne State University in Detroit highlighted the challenges of detecting prostate cancer. Based on an autopsy study of men under 50 who had died of other causes, researchers concluded approximately 30 percent of men in their 40s may have asymptomatic prostate cancer. That is, the cancer is there but fails to show detectable symptoms.

Robert M. Chiamonte, M.D., a staff urologist at Southern Maryland Hospital Center in Clinton who is also in private practice, is familiar with the Wayne State University study. “Because it was a cadaver study, and these were not clinical cancers (defined by the NCI as the stage of cancer based on tests that are done before surgery), the interpretation is open to debate,” he says. “But, if anything, it alerted us to the fact that younger men could harbor prostate cancer, and should spur men to start getting PSA testing starting at age 40—especially if they have risk factors such as race or family history.”

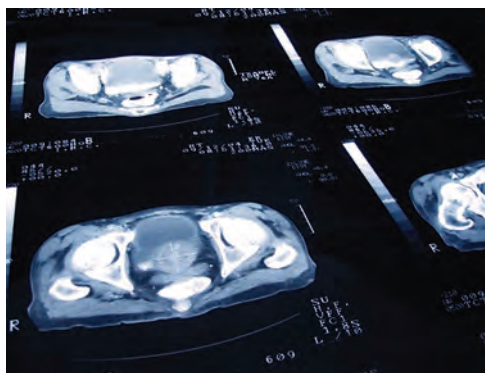
This fall, two national health groups publicly disagreed about whether PSA testing is valuable. The U.S. Preventive Services Task Force (USPSTF) recommended against it. An independent panel of non-federal experts in prevention and evidence-based medicine, the task force says there is no proven net benefit to the screening, and its potential harms, which can include erectile dysfunction and urinary incontinence, outweigh its benefits.

The American Urological Association (AUA), on the other hand, issued a statement supporting it, saying that “when interpreted appropriately, the PSA test provides important information in the diagnosis, pre-treatment staging or risk assessment and monitoring of prostate cancer patients.”

A PSA test measures the blood level of prostate-specific antigen, a protein produced by tissues of the prostate gland. High PSA levels could indicate a cancerous tumor is present, according to the Mayo Clinic.

Chiamonte believes most urologists do not agree with the task force’s recommendation against the test.

“I remember the dark days, before PSA testing was widely available in the mid-1980s, when 25 to 30 percent of men we saw with prostate cancer already had incurable cancers,” he says. Currently, the lifetime risk of prostate cancer death is only about 3 percent, according to the AUA.



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Those at higher risk for prostate cancer—which forms in tissues of the prostate gland, part of the male reproductive system found below the bladder and in front of the rectum—include African-American men, those who have a father or brother with the disease and men over 60, according to PubMed Health, a health information service of the U.S. National Library of Medicine.

“Nowadays, virtually all prostate cancers are asymptomatic,” says Barry Aron, M.D., chair of the urology section at Shady Grove Adventist Hospital in Rockville. “Unlike enlarged prostates, which are detectable based on symptoms, the cancers themselves are asymptomatic.”

Doctors use a PSA test along with a digital rectal exam (DRE) to help detect the cancer in men who show no symptoms, according to the NCI.

“Most men are offered prostate cancer screening after hitting age 50 by their family physicians,” says Mark Goldstein, M.D., a hematologist/oncologist with Oncology Care Consultants in Frederick, a Frederick Memorial Hospital-based practice. “I suspect that most primary care physicians do not have time to counsel patients thoroughly about the pros and cons of PSA testing with or without a DRE.”

◀ An enlarged cancerous prostate is shown on a tomography scan.

Screening needs to include family history and an overall health evaluation in addition to PSA testing and a DRE, according to Aron.

“In the pre-PSA era, patients presented with advanced disease, including bone pain or kidney failure,” he says. “With the advent of PSA testing, we are diagnosing patients much earlier and, yes, they are asymptomatic, but they are treatable.”

In Aron’s view, the primary issue “is who should be treated and who should not. Patients with tumors that reduce their life expectancy should be treated.”

With the advent of PSA testing, according to Goldstein, “more cancers have been detected, usually at a younger age and usually with a lower Gleason score (a pathology scoring system to assess tumor aggressiveness).”

“This testing leads to more biopsies, more expense and perhaps overtreatment of the population,” Goldstein says.

The key to determining treatment strategies, Aron believes, is knowing which cancers will kill a patient early and should be treated, and which cancers can safely be watched.

“Not all prostate cancers require active treatment and not all prostate cancers are life threatening,” according to AUA President Sushil S. Lacy, M.D. “The decision to proceed to active treatment is one that men should discuss in detail with their urologists to determine whether active treatment is necessary, or whether surveillance may be an option for their prostate cancer.”

“Prostate cancer is one of the most treatable forms of cancer—very treatable—and treatments have become less and less traumatic,” says Aron. “Years ago, before the advent of nerve-sparing and robotic surgery around 1980, a radical prostatectomy was a virtual guarantee of (urinary) incontinence and impotence.”

Currently accepted treatments, he says, include radiation; brachytherapy, where radioactive seeds are implanted directly into the prostate; and surgery, which can include open surgery, robotic surgery and, decreasingly, laparoscopic surgery.

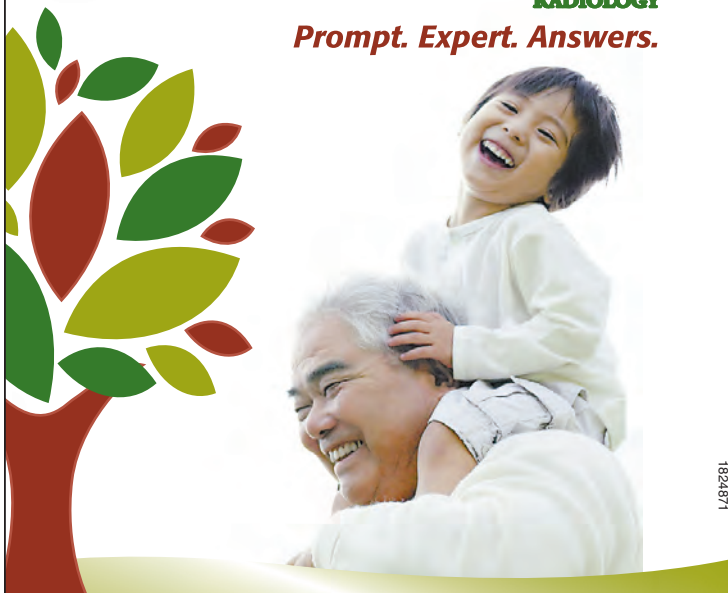
Aron says robotic surgery has largely replaced laparoscopy because of improved range of motion of the surgical instruments and 3D imaging.

Operative mortality, within 30 days of surgery, is very low—less than 1 percent, according to Aron. With brachytherapy, it’s even lower, he says. But “the [continued on 30]

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jury is still out on several unorthodox, non-mainstay therapies that are considered investigational," he notes. These include CyberKnife (robotic radiosurgery that delivers high doses of radiation to tumors), cryosurgery (application of extreme cold to destroy abnormal or diseased tissue) and high-frequency ultrasound.

According to Aron, one of the treatment strategies for low-grade prostate cancer is "active surveillance," in which biopsies are taken at regular intervals. For most patients, he says, this means annually.

"When you measure outcomes with prostate cancer, you have to look at 20- to 30-year horizons," Aron says. "For many patients, (having) no therapy can be relevant because they will outlive their cancers. That is where a team approach to decision-making is critical."

New technologies and advancing knowledge of human anatomy have reduced the treatment complication rates, he says, explaining that some potency is usually preserved 70 to 80 percent of the time. "Even for patients who are left impotent, there are treatments to restore normal sexual activity."

Studies that have looked at quality of life in men who have had any type of prostate cancer treatment show "the outlook is good," Chiamonte says. "Patients who were operated on had better quality-of-life scores than age-matched patients who didn't have prostate cancer."

Chiamonte, part of a three-doctor practice serving southern Prince George's and Charles counties, says in the past eight years, he and his partners have operated on more than 300 patients and "not a single one has died" from prostate cancer.

"As a result of treatment, the prostate cancer mortality rate has fallen to 20,000 per year from 30,000 10 or 15 years ago," Aron says. "The bottom line on screening is that we're saving 10,000 lives a year."

Stressing the importance of having annual checkups with PSA testing and a DRE, Chiamonte strongly cautions men over 40 "not to ignore prostate health...We don't want to take a step backward because of this recent USPSTF study."

"For now," Aron says, "we have to use the tools available to us and play the hand we're dealt. It's worth saving 10,000 lives a year."

Goldstein, however, sees the long-range outlook a bit differently. "While preventing even one death is important," he says, "given our nation's limited resources, a more cost-effective program for prostate cancer screening should be given a higher priority."

ERECTILE DYSFUNCTION, continued from 15

bottle of medicine, which I sell for \$100, is sold by these clinics for \$1,300."

If injection therapy fails, "either because the medicine doesn't work or the patient is unable or unwilling to learn how to do it, there's an array of surgically implantable devices that allow for an erection," says Emanuel. "One consists of rigid rods, like the neck on the desk lamps you can bend. The other is an inflatable device with a pump mechanism."

Implants present risks, says Kumar. "There can be problems with infection and, like any prosthesis, the implants can come out to the skin. The pump, being a mechanical device, can malfunction."

ALTHOUGH ED HAS BECOME MORE SOCIALLY ACCEPTED, due primarily to "the advertisements that bombard us, there's still a stigma associated with it," says Kowalczyk. "More often men will come in to talk about their prostate and say, 'Oh, by the way, do you have any Viagra?' It's important to know that the majority of men experience this...It's a normal part of aging and...can be treated."