PSA TESTING? OVER-TREATMENT? ACTIVE SURVEILLANCE? BIOPSY VALUE? NO PSA FOR ELDERLY?

My Opinion – Charles (Chuck) Maack – Prostate Cancer Advocate/Mentor

Regarding PSA testing: With continuing prostate cancer (PC) since 1992 and deep research and study of our insidious men's disease since 1996 that has led to my being a prostate cancer advocate and mentor, I have seen way too many men in their 40s presenting with metastasized PC at diagnosis. This is obviously the result of failure to have at least annual PSA testing to make note of unusual PSA elevation. With around 200,000 men diagnosed annually and more than 10% of that number dying "of" prostate cancer annually in the United States alone, it is obvious prostate cancer is a serious threat to male lives. It is certainly not a cancer to ignore by not providing at least a simple blood serum PSA test. Both the PSA blood test and a Digital Rectal Examination (DRE) should be provided at least annually. However, since many men are adverse to the DRE and would possibly opt out of any testing if both the PSA and DRE were required, then most certainly the simple PSA blood test should be recommended pending something more exact, and the PSA blood test cost should be covered by health insurers. (A pathologist friend, in supporting everything in this paper, made one exception. He remarked that the DRE should absolutely be a dual requirement with the PSA. I obviously concur but was considering those men who are turned off by the visual of anyone inserting anything up their anus and might refuse. However, as he remarked further, they should be explained and made to recognize the importance of the DRE. If they still refuse, the onus is on them. (A different mental description was proffered, but we decided to be more polite).

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Regarding "Over-treatment" and "Active Surveillance:" With a Gleason 3+4=7 or above, Active Surveillance (AS) is not a reasonable consideration. However, with Gleason 3+3=6 and only one or two tissue samples from biopsy evidencing prostate cancer and both less than 10%, AS could be considered. The concern that I am sure comes up in every man's mind when diagnosed with prostate cancer despite it being low level is the recognition that cancer is present and wanting that cancer out rather than dwelling over time wondering if it is growing and becoming more aggressive. Thus, though some men would rather maintain close observation with at least quarterly PSA and DRE checks, and I would hope other diagnostics, others want to get rid of it "now." I have a suspicion that the studies that have concluded that too many patients have been "over-treated" erroneously included those patients who made their own choice to be treated early on. These patients should not have been included in such studies since it was their personal choice, thus not an "over-treatment." The problem we have with the supposed "over-

treatment" are urologists or radiation oncologists encouraging - sometimes near demanding- immediate treatment despite a man's diagnostics only Gleason 6 with one or two tissue samples with near insignificant cancer development. That is where "over-treatment" can occur. And it is these urologists and radiation oncologists who have to be directed to avoid encouraging immediate treatment under these conditions. They should explain all options "including" AS.

What I found of particular error in an ABC report March 19th, 2009 was when the ABC physician consultant remarked that a biopsy does not identify aggressive prostate cancer. Say what? There is no doubt that a pathology report of biopsy indicating, for example, Gleason 8 or above as well as extensive HGPIN (High Grade Prostate Intra-epithelial Neoplasia) or PNI (Perineural Invasion) presence would indicate an aggressive cancer, or at the very least, a cancer that requires more immediate concern.

Regarding "no-PSA testing for the elderly:" I know of many healthy men in their mid 70s as well as in their 80s who could very well have another ten to twenty years of life who would be placed in this suggested category of "no-PSA testing." This galls me no end. I am 76 years of age and if I were to just now be found to have an elevating PSA, I would most certainly want to know what is going on. My Mother lived to 96 and my Father to 95; I have every possibility of living to those ages, so why in the world would I "not" want to know if I had developing cancer? Most certainly without such knowledge my cancer could be very aggressive and metastasize before I had any indication of its presence. Then, most assuredly, I would have to go through several very costly treatments that would likely include toxic chemotherapy agents. And I would then more likely have to go through the pain of dying "of" the prostate cancer rather than "with it." Had I been aware of developing prostate cancer early on, I could have treated it, hopefully have "disposed" of it, or at least have been able to manage it, rather than dying “of it." ABSOLUTELY, PSA testing should be available and covered by health insurance for ALL men at ALL ages!

I noticed a posting by a urologist who is also a lawyer who made note that at trial the defense would cringe when the plaintiff’s attorney announced to the jury that his client was not made aware that a simple PSA blood test would have determined that his client had developing prostate cancer and could have saved his life. And by his client’s physician failing to make this test available to his client, his client now has prostate cancer that has metastasized into his system, has caused extreme pain and loss of quality of life, and his client can now anticipate an early and painful death due to his physician failing to offer what could have been a life-

saving simple blood test. Can you imagine the sizeable amount of "damages" that would most likely be awarded the plaintiff?