

Maryland Comprehensive Cancer Control Plan

Chapter 11. Prostate Cancer Addendum

Prostate cancer continues to impact thousands of Maryland men. In 2009, a total of 4,221 cases of prostate cancer were reported and 542 men died of the disease in Maryland. The 2009 age-adjusted prostate cancer incidence rate in Maryland was 148.4 per 100,000 men (143.9-153.1, 95% C.I.), and the 2009 age-adjusted mortality rate was 25.5 per 100,000 men (23.4-27.8, 95% C.I.).

Current evidence is insufficient to determine whether screening for prostate cancer with prostate-specific antigen (PSA) or digital rectal exam (DRE) reduces mortality from prostate cancer. Screening tests are able to detect prostate cancer at an early stage, but it is not clear whether this earlier detection leads to any change in the outcome of the disease. Screening can have negative psychological effects in men who have a prostate biopsy, but not prostate cancer. Screening can also lead to overtreatment, and current prostate cancer treatments can result in permanent side effects including erectile dysfunction and urinary incontinence.

Since the Maryland Comprehensive Cancer Control Plan was originally published in 2011, many organizations have revised their prostate cancer screening recommendations. Current screening recommendations are summarized below.

- The United State Preventive Services Task Force (USPSTF) recommends against PSA-based screening for prostate cancer.
(2012, <http://www.uspreventiveservicestaskforce.org/prostatecancerscreening.htm>)
- The National Comprehensive Cancer Network (NCCN) recommendations state that men should discuss risks and benefits of testing with their physician. Those that do opt for screening should receive a baseline PSA and DRE at age 40.
(2012, http://www.nccn.org/professionals/physician_gls/pdf/prostate_detection.pdf, create user name to view)
- The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place: at age 50 for men who are at average risk and are expected to live at least 10 more years; at age 45 for men at high risk (including African Americans and men who have a first-degree relative diagnosed with prostate cancer before age 65); or at age 40 for men at even higher risk (men with more than one first-degree relative who had prostate cancer at an early age). After this discussion, men who want to be screened should be tested with the prostate-specific antigen (PSA) blood test.
(2012, <http://www.cancer.org/acs/groups/cid/documents/webcontent/003182-pdf.pdf>)

Public Health Intervention for Prostate Cancer

The decision to be screened for prostate cancer should be an individual one involving shared decision-making. If a patient raises the issue of PSA screening, or the clinician believes his individual circumstances warrant consideration of PSA screening, the clinician should thoroughly discuss with the patient the benefits and harms so that he can make an informed decision. The decision to start or continue PSA screening should reflect the patient's understanding of the possible benefits and expected harms and should respect his preferences.