For Prostate Cancer, The Latest Recommendation Is, 'Talk To Your Doctor'

By Chuck Dinerstein — May 15, 2018

The USPTF, the US Preventative Task Force has released their latest guidelines with respect to prostate cancer, that frequently slow growing but most common of cancers in men. My colleague, Dr. Wells wrote an extensive piece on the tentative guidelines last year at about this time. Let me summarize briefly. Screening using a blood test, the prostate specific antigen or PSA is beset with some problems. An elevation in the value often results in prostate biopsy which is considered “minimally invasive” if you consider having a sharp object repeatedly placed in your rectum to obtain tissue samples. And often these biopsies are negative, the rise in PSA is a false positive. This adds cost to care along with retrospectively unnecessary worry. And even when cancer is detected, its slow growing course makes watchful waiting, in many instances, as good an option as surgery or radiotherapy (including the oft advertised “Cyberknife”) as a treatment.

Given the problem of false positive tests and the additional confusion of what is the right treatment if and when prostate cancer is identified, the USPTF guidelines have found a small net benefit to screening for the men at greatest risk based upon age, 55 to 69. But their final recommendation is perhaps the best one they have made so far. Consult your physician.

That’s right, instead of hard and fast guidelines it calls for a discussion between you and the person you feel has both adequate knowledge and your interests at hand, your doctor. I cannot overstate the importance of this decision. Not only is the physician returned to their rightful role as advisor and explainer but it quietly heralds the return of thoughtful discussion.

In looking over their recommendations they are really giving physicians the green light to act as
they have been trained as the patient’s advocate. To explain the risks and benefits of diagnostic testing as it pertains to the patient sitting in front of them – truly personalized medicine. It also recommends that while the physician can raise the issue of PSA testing, they shouldn’t be adamant about proceeding; the choice rests with the patient - shared decision making with the power in the hands of the patient, not the physician or the guidelines. And it notes that a decision not to proceed with further testing may change over time and circumstance so physicians should circle back and broach the issue later on.

As with any guidelines there are caveats. Afro-Americans and men with a family history of prostate cancer need earlier screenings because they are at greater risk; again a nod to personalizing the care.

Guidelines help to standardize care. Standardized care works well when all the patients are the same just like assembly lines work best when all the parts are standardized and fit together. Judgment has little role on an assembly line. But screening for prostate cancer is far from neat and simple, judgment has a real role and the best judgment of all is that of your own physician in discussion with you. This is a win for patients because it affirms shared decision making (the end of paternalism), autonomy and the primacy of the patient’s decision. But this is also a big win for physicians who are beset by automation and “artificial intelligence” just like everyone else. Computers cannot empathize, nudge or wait for a better time to re-address a problem, physicians can.

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