

Bring Back Prostate Screening

By DEEPAK A. KAPOOR JULY 6, 2015

FOR years, research on [prostate cancer](#) has sought an approach to screening that is more individualized than a one-size-fits-all measurement of the level of [prostate-specific antigen](#) in a man's blood. These efforts are now paying off.

That's why it's time to re-evaluate the nation's current approach to prostate cancer. Even though we anticipate 221,000 new diagnoses this year, and 28,000 deaths, recommendations drafted in 2010 and finalized in 2012 strongly discourage PSA screening men without symptoms for this disease.

Those decisions didn't take into account adaptations that urologists have made to help better identify patients likely to develop deadly prostate cancers. Some tools, called PSA derivatives, were being developed as early as the mid-1990s, and all have been refined since.

The result: Rather than use the historical arbitrary cutoff of a 4.0 PSA reading to define abnormal, we now have tools to adjust our interpretation of readings for age (PSA levels normally rise with age); for race (this, too, affects what is considered normal); and for the size of a man's prostate, which affects how much PSA he produces. We can test for how fast PSA levels rise over time. And we can analyze how PSA circulates in the bloodstream (free or bound to serum proteins), which can predict prostate cancer risk.

MELVILLE, N.Y. — When we use these markers together, these varied interpretations of PSA levels give us a clearer picture of who does, or doesn't, need further testing.

And we keep refining our approach. Already, a urine test can find and measure the presence of genes associated with prostate cancer. [M.R.I.](#) images can help identify high-risk prostate lesions. And tests for the presence or activity, or both, of genes present in prostate tissue can help distinguish which patients can safely defer therapy from those who cannot.

When prostate cancer is found, we also have better actuarial data to help identify those men likely to live long enough for that [cancer](#) to become a fatal risk.

Nevertheless, in 2012 the United States Preventive Services Task Force [made official its recommendation](#) that no asymptomatic man undergo screening with a PSA test. And that decision grew in importance when the Affordable Care Act elevated the task force's recommendations from advisory to a basis for [Medicare](#) payment policies.

To be fair, measuring PSA as a stand-alone test is far from perfect. Cancer is just one of several conditions that can elevate PSA. Using the test alone often led to painful biopsies that found no cancer. And we faced a more difficult problem: Even when a [biopsy](#) found cancer, uncertainty remained. If aggressive cancer was present, a decision to treat it was straightforward. But prostate cancer can grow slowly or remain dormant — indolent, in medical parlance. And until recently, we didn't have the tools to determine whether cancers were likely to spread quickly enough to shorten the patient's life.

In that circumstance, some patients whose cancers might have grown very slowly chose surgery or other rigorous treatment just to be safe, not sorry. But the price could be high; surgery always involves some risk of complications, including death, and cancer treatment can reduce quality of life.

Adding to the confusion was conflicting data on the effectiveness of prostate cancer screening. Despite strong evidence that the prostate-cancer-specific death rate has decreased since PSA testing started in the 1980s, the two largest studies of the screening produced contradictory results — one saw a decrease in prostate-cancer-related deaths among men screened, the other no advantage. Equally problematic, both were flawed methodologically. Yet instead of acknowledging uncertainty, the task force said PSA testing offered no benefit to anyone.

At the time, I and many other urologists warned of public health repercussions. Our fears have materialized. Since 2010, fewer biopsies have been performed and fewer prostate cancers found. But studies show an increase in the risk that a cancer, when found, will be more aggressive.

No increase in cancer mortality has been observed, but that may be a matter of time; aggressive cancers are less treatable. One study concluded that annual prostate cancer deaths may increase as much as 5 percent, for the first time in more than 20 years.

That is what frustrates urologists most: Rather than using refined screening techniques to identify those who will benefit most from treatment, we're just evaluating fewer men. So the task force needs to re-evaluate its recommendation based on the current state of medical knowledge.

But men should not wait for a government agency to tell them what's best. My own strongest recommendation is that men insist on a baseline PSA test while in their 40s. From this baseline, a personalized screening regimen that considers risk factors and other indicators can be developed.

Men must understand that screening does not commit them to further testing or treatment, even if abnormalities are found. Screening, followed up with today's sophisticated tools, simply provides information that helps them and their doctors make sound decisions — which could prolong their lives, or leave them reassured that they have little to fear from an indolent tumor.

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