PSA Testing: Making Sense of the Rhetoric/Patient/Doctor Communications

I. Patient-Doctor Communications

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Executive Director, Prostate Cancer Coalition of North Carolina

This disease is very complicated for researchers, physicians, as well as patients, caregivers, and activists who need to educate themselves in order to make good decisions. To understand prostate risk, every man should know his family history and have a complete physical including a baseline PSA at age 40. The PSA test can help identify prostate cancer, benign prostatic hyperplasia, and some prostate infections.

Our learning objectives will be risk-benefit discussion and what constitutes that discussion; the role of screening in prostate health; early detection to support clinical treatment guidelines for patients that should be screened; and tools that support an informed pretreatment consultation for men who are diagnosed with prostate cancer.

Looking at the risk-benefit discussion, every man should have a risk assessment at age 40 which includes a complete physical examination and a baseline PSA. A patient needs to have a relationship with, as well as a good conversation with, his doctor such that the clinician understands the big picture of the male patient. The decision-making process does not end with screening but continues to diagnosing a potential problem and choosing the best course of action, working in collaboration with one's doctors.

Screening can help to identify but it is not specific to prostate cancer, and there are numerous causes of elevated PSA, including BPH. Screening can be normal even for the man who has prostate cancer, which emphasizes the importance of routine physical exams. The lack of follow-up after screening is low: an abnormal screening is not a diagnosis and such a screening should be followed up a physician visit to determine next steps to take. Also, every man diagnosed with prostate cancer should consider the larger picture of his overall health.

Benefits of screening include its ability to help identify several noncancerous conditions, and it is also the only known method of detecting prostate cancer during its early stages. The biggest benefit to screening is one has access to better options as well as more time to research and understand those options, with one of those options being active surveillance, which if a man is better engaged with the health care system and has a better understanding of his health, he is in all likelihood going to become a healthier man in the long-term anyway.

These guidelines were developed from the NCCN guidelines. Part one involved guidelines for when is the best time for men to be referred for follow-up, and in speaking with North Carolina's three leading cancer academic research centers, namely, Duke,

UNC, and Wake Forest, they overwhelmingly agreed that the NCCN guidelines were very consistent with this time. Part two involved guidelines for a risk-benefit discussion between a male patient and his physician, such that the patient is equipped with information for him to understand pertinent concepts and what to expect from his physician.

This project just launched last year is a tutorial for newly diagnosed men. Prostate cancer carries with it a whole new language; this tutorial provides relevant information which is important to understand especially when speaking with one's physician. This brings the male patient to a level of understanding where he knows his position within the health risk spectrum such that when he is speaking with his doctor, he can understand why certain recommendations are being made.

We are trying to encourage more multidisciplinary consultations, which is taking the entire patient ownership to a whole new level and having a discussion which addresses that full spectrum of what are appropriate treatment options, possibly with a team of treating doctors.

Moving forward, our goals are to reduce the prostate cancer death rate, continue to identify and address gaps in patient education, do everything possible to support highly personalized care which is necessary for prostate cancer treatment, and do everything possible to facilitate that informed shared decision-making. In conclusion, we would like: to avoid underdetection of aggressive and potentially fatal cancers which today probably means that all cancers have to be identified in order to find the aggressive ones; to manage overdetection with the guidance of modern clinical treatment guidelines; to empower patients to be more actively involved in their treatment choice; and to get PCPs, urologists, and oncologists working together as a team to improve the overall health of those affected by prostate cancer.