This coverage is not sanctioned by, nor a part of, the American Urological Association.

From Medscape Medical News

Avoiding Prostate Cancer Screening Might Be Costly

Emma Hitt, PhD

May 23, 2012 (Atlanta, Georgia) — The 2011 US Preventive Services Task Force (USPSTF) draft policy for prostate cancer screening, which became final this week, might result in significant costs related to disease burden and treatment, according to detractors of the recently revised recommendation.

E. David Crawford, MD, head of the section of urologic oncology at the University of Colorado Health Sciences Center in Denver, and colleagues presented an analysis of the recommendations in a late-breaking oral session here at the American Urological Association 2012 Annual Scientific Meeting.

This week, the USPSTF gave prostate cancer screening a grade of D (not recommended; harm outweighs benefits or no net benefit). However, the analysis by Dr. Crawford and colleagues suggests that avoiding prostate cancer screening might ultimately cost more in terms of treating advanced disease and missing significant numbers of cases.

Participants of the Prostate, Lung, Colorectal, Ovarian (PLCO) Screening Trial without cancer at T0 (n = 33,709) in 2011 formed the basis of their conclusions. Subjects were at least 55 years of age with adequate prostate-specific antigen (PSA) levels or a positive digital rectal exam at entry. A Gleason score of at least 7 defined clinically significant cancer.

Expenses related to prostate cancer were based on Medicare costs and estimates published in 2010. The results were projected to a Surveillance, Epidemiology, and End Results (SEER) incident population with localized cancer (n = 202,500).

A total of 2580 men from the PLCO Screening Trial were treated for prostate cancer after T0. Total expenditures were $61.5 million ($23,804 per patient). Estimated total expenditures for 377 treated patients with clinically significant prostate cancer after T0 were $8.6 million ($22,742 per patient). After extrapolation at a national level to 96,000 patients with clinically significant prostate cancer (SEER data), annual initial diagnosis/treatment costs were estimated to be $2.4 billion.

Savings at First, But Expenses Later

Adopting draft USPSTF recommendations would result in $2.4 billion in initial savings, Dr. Crawford and colleagues conclude; however, many of these men will subsequently present with clinically significant prostate cancer, with total treatment costs far exceeding $2.4 billion, Dr. Crawford said.

"A 'no-screening' policy is a bad investment at the societal level. It would decrease prostate cancer health expenditure, and would miss from 0.57% to 1.22% of significant prostate cancer cases, depending on the amount of increase in the screening interval," he explained.

"Many missed prostate cancer cases will subsequently present with significant prostate cancer [often metastatic], incurring significant consequences and risk," he said, and suggested that a more rational policy might be to screen appropriate men for prostate cancer for identification and early treatment of clinically significant disease.

A Wake-Up Call

"I believe the USPSTF recommendations are a 'wake-up' call that it is not business as usual with screening," Dr. Crawford told *Medscape Medical News* after his presentation. "There were warning signs this was coming, and these were ignored, but a lot of the comments in [the USPSTF] paper are very accurate," he said.

Dr. Crawford recommends that all urologists read the report and that they keep an open mind. "We should all work together to address and implement some suggestions, such as extending screening intervals, using a better marker of progression, and separating diagnosis from treatment," he said.

According to Dr. Crawford, the greatest impact of the new recommendations will be on family practice physicians, who are "looking for reasons to stop screening for prostate cancer. Why? Because of the confusion in understanding PSA levels and legal action (i.e., lawsuits) against them for failure to diagnose prostate cancer," he said.

Diagnosis Doesn't Always Lead to Treatment

Session moderator Anthony J. Schaeffer, MD, a urologist from Northwestern Memorial Hospital in Chicago, Illinois, told *Medscape Medical News* that he thinks this issue "is evolving." One of the key concepts is that diagnosis doesn't always lead to treatment, and that is something that people need to appreciate, he said.

"Testing gives you options. Each person might want to decide how all the variables affect them and what the next step is, but the concept that once you begin the path, you are automatically destined to go all the way to the end is just not the way it plays out in the real world," he said.

According to Dr. Schaeffer, whether or not a patient wants a PSA test should be left up to the patient. "It is a free world — some people are risk adverse and other people aren't; our job is not to sway them but to provide them with the knowledge."

The debate continues.

The study was not commercially funded. Dr. Crawford and Dr. Schaeffer have disclosed no relevant financial relationships.

American Urological Association (AUA) 2012 Annual Scientific Meeting: Abstract LBA4. Presented May 22, 2012.

Emma Hitt is a freelance editor and writer for Medscape.

Disclosure: Emma Hitt, PhD, has disclosed no relevant financial relationships. Dr. Hitt does not intend to discuss off-label uses of drugs, mechanical devices, biologics, or diagnostics not approved by the FDA for use in the United States. Dr. Hitt does not intend to discuss investigational drugs, mechanical devices, biologics, or diagnostics not approved by the FDA for use in the United States.