Doctors discussing PSA screening with their male patients

Reducing numbers of doctors in New Zealand are now initiating discussion about PSA screening with their male patients. In my opinion, this decline results from a misunderstanding of the research, which has been inadequate in several ways.

I have had no medical training, but I think, nevertheless, that I have something to bring to the debate on prostate cancer screening: a Men's Rights centred approach. At Law School students of the New Zealand Bill of Rights Act 1990 have been encouraged to take a rights-centred approach to cases. What is very rare in the World today is a Men's Rights centred approach, and that is what I bring to the table.

Moyer (2012) reports on two major studies of PSA-based screening for prostate cancer: the U.S. PLCO (Prostate, Lung, Colorectal and Ovarian) Cancer Screening Trial, and the ERSPC (European Randomized Study of Screening for Prostate Cancer). The latter is the focus of Bangma (2009) and of Schroeder et al. (2009).

Moyer (2012) states that:

The U.S. trial did not demonstrate any reduction of prostate cancer mortality. The European trial found a reduction in prostate cancer deaths of approximately 1 death per 1000 men screened in a subgroup aged 55 to 69 years. This result was heavily influenced by the results of 2 countries; 5 of the 7 countries reporting results did not find a statistically significant reduction (page 122).

The obvious thing to do, on reading this, is to investigate why:

• The two studies produced different results; and
• Two of the countries in the European study produced different results from the other five countries.

As regards the first question, Bangma (2009, page 2) states that, in the U.S. PLCO Cancer Screening Trial, “a large proportion of men in the control arm of the study had already undergone a PSA determination before or during the study, and therefore that arm of the study has to be regarded as contaminated.”

As regards the second question, I note that Moyer (2012) states that the two countries involved are Sweden and The Netherlands (page 125). Well, what is particular about those two countries that might account for the discrepancy?

As far as Sweden is concerned, Schroeder et al (2009) state (on page 1322) that:

The screening interval at six of the seven centers was 4 years (accounting for 87% of the subjects); Sweden used a 2-year interval. In Belgium, the interval between the first and the second rounds of screening was 7 years because of an interruption in funding.

Although prostate cancers are generally slow-growing, some prostate cancers grow fast, and it may be that a four-year screening interval is not frequent enough to detect these cancers in time to prevent them from killing the patient. There is a need for studies to investigate this possibility, in my opinion.
As far as The Netherlands is concerned, Bangma (2009, page 3) states that offering screening to the individual is allowed in most European countries, with the exception of The Netherlands.

In both the U.S. PLCO Cancer Screening Trial and the ERSPC, the issue of contamination of the control group of non-screened men (because control-group men got themselves screened outside the framework of the study) was a serious one.

In The Netherlands, it would probably have been much harder for men in the control group to be contaminated in this way, with the result that statistical comparisons between the screened group and the control group would have been much more valid than in the other countries (including the USA). There is a need for studies to investigate ways of dealing with the issue of contamination, in my opinion.

Two other questions that need to be addressed are the harms of diagnosis and treatment, and also the associated costs. As far as the harms are concerned, I believe that any decision as to whether the harms outweigh the benefits is one that the individual man needs to be allowed to make after consulting a doctor.

This is not a decision that researchers (especially females such as Virginia Moyer) or governments have the right to make on their behalf. The decision as to whether the financial costs are bearable is a political one which should take into account the balance between the amounts spent on research into, teaching about, prevention of, and treatment of men's health conditions, in comparison to women's health issues.

The above remarks, in my opinion, cast serious doubt on the validity of the recent conclusion of both Moyer (2012) and of the Health Committee of the New Zealand House of Representatives that PSA-based population screening for prostate cancer should not be implemented.

Peter D Zohrab
Paraparaumu, New Zealand

References: