EDITORIAL

"Sheepish about being Bullish"

When you know a thing, to hold that you know it; and when you do not know a thing, to allow that you do not; that is knowledge. So said Confucius.

An interesting paradox has emerged regarding our approach to PSA screening. There is a very clear consensus on the part of those clinicians with an interest in prostate cancer that PSA screening is a good thing. Everyone in the field, virtually without exception, holds this view. Opinions vary over the strength of the evidence, concerns about long term morbidity, when screening should start and finish, what interval, and so on. However, virtually all North American prostate cancer experts believe that the benefits of screening outweighs the harm in appropriately selected individuals.

One would assume that this consensus would be communicated to 'our listeners'; patients, our community, primary care colleagues, and health policy experts. In fact, this is not the case. The current Canadian position is best summarized by the consensus statement of the Prostate Cancer Alliance, an umbrella group of prostate cancer stakeholders. The position states that men have the right to be informed about the pros and cons of screening, and to avail themselves of the test if they so choose. The advice is neutral, in contrast to the views of the experts.

Why is it that we have accepted this consensus when it does not reflect our conviction that PSA screening is a good thing? The reason, obviously, is that the quality of the data is insufficient. We do not have the prospective randomized trials (currently ongoing) which would provide the basis for an evidence based pro-screening position.

There is increasing evidence that this is an overly simplistic view. Randomized trials have demonstrated a survival benefit for screening mammography. Has this resolved the debate over breast cancer screening? Not at all. Recent evidence suggests that some of the early positive trials were misleading. PAP screening for cervix cancer has never been subjected to a randomized trial; indeed, it would be considered unethical. The point is that randomized trials should be seen as an important part of the database supporting a particular approach, rather than the only legitimate form of evidence.

This perspective would radically change our approach. There is a great deal of evidence for a benefit of PSA screening. This evidence includes good PSA test performance compared to other screening interventions; dramatic stage migration, the fact that PSA screened cancers have volume and grade characteristics that suggest they are clinically significant in over 90%; falling prostate cancer mortality in screened populations; a low level of long term morbidity from recent advances in treatment; and improved patient selection of low risk patients for conservative management, thereby reducing the risk of over treatment.

This evidence has been largely discounted by methodologists because it is not derived from randomized prospective trials. The single published randomized trial of screening, by Labrie in Quebec, which showed a 3.4 fold reduction in the risk of prostate cancer mortality, has been severely criticized and discounted.

There is also disturbing evidence that the case for screening is being suppressed. I am aware of two academic uro-oncologists, one Australian and one Canadian, who wrote position papers over the last year supporting screening, only to have these rejected by the medical editors, on the grounds of being inherently biased. In these cases, it was the position being taken, rather than the quality of the argument, that led to non-acceptance.

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It is time for us to stop being sheepish about being bullish. We owe it to our community to be open with our convictions about the value of PSA screening. Our patients and colleagues will appreciate our taking a robust and public stance. As a urological community, there is agreement in favor of PSA screening. We don't need to apologize for supporting screening in the absence of randomized trials. These trials may or may not provide definitive evidence for screening. The accumulated evidence to date has convinced most of us; there is every reason to be open about this.

The review article by Yves Fradet on recent advances in superficial bladder cancer should be required reading for all urologists who manage this disease. It is a model of clarity and insight. It contains a number of practical recommendations.

This includes the use of risk stratification to determine follow up strategy; with molecular markers to detect recurrence; the use of adjuvant intravesical therapy immediately post TUR; and a useful guideline for making critical treatment decisions in high grade T1 TCC.

This issue of the journal includes the abstracts for the 2002 CUA Annual Meeting. The CJU anticipates that this will be an outstanding meeting, both scientifically and socially. We would like to take this opportunity to thank the urological community, and our industry sponsors, for your support and encouragement.

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Canadian Journal of Urology