PSA Screening Gets Short Shrift in Exam Room

BY MARY ANN MOON

Men who have undergone screening for prostate-specific antigen or who have declined such testing say they often received only limited information about the test from their physicians, according to a survey of a nationally representative sample of men in the general U.S. population.

Only 21% of the men said that their physicians discussed the pros and cons of PSA screening and asked about their preference, as is recommended in virtually all guidelines from major professional organizations.

Dr. Richard M. Hoffman of the New Mexico VA Health Care System, Albuquerque, and his associates assessed these issues as part of the National Survey of Medical Decisions (DECISIONS) study, a survey of Americans aged 40 and older designed to characterize the decision-making process in various medical issues. The prostate cancer module of this study surveyed men who had accepted or declined PSA screening during the past 2 years.

Overall, 30% of the respondents said they never discussed PSA testing with their physician before deciding whether to undergo screening, a finding that Dr. Hoffman and his colleagues termed "disconcerting." Fully 45% said they were never asked about their preference regarding PSA testing.

Of those whose physicians did discuss PSA testing, 87% discussed only the benefits and not the disadvantages of screening. Among men whose physicians discussed PSA testing, 79% went on to have the test done (Arch. Intern. Med. 2009;169:1611-18). No financial conflicts of interest were reported. ■

Heart Risks

Prostate *from page 1*

The men received endocrine therapy as primary treatment for predominantly locally advanced or metastatic prostate cancer between 1997 and 2006, with 3,391 receiving antiandrogens, 5,340 orchiectomy, 9,066 gonadotropin-releasing hormone (GnRH) agonists, 11,646 GnRH agonists plus short-term antiandrogens, and 1,199 other.

The incidence of ischemic heart disease was increased by 15% in men who were treated with antiandrogens, compared with a 33% increase in those treated with GnRH agonists.

This suggests that endocrine therapy may reduce the suggested cardioprotective effects of testosterone, said Ms. Van Hemelrijck, a PhD candidate in cancer epidemiology at King's College London.

The analysis also showed a less pronounced increase in risk in men who already had a history of heart disease at the time of their prostate cancer diagnosis. This could be because these patients were already receiving treatment for their heart disease, said Ms. Van Hemelrijck, stressing that they are still at increased risk. Data on the exact type of nonprostate treatment, including statin use, were not available.

The researchers calculated the incidence and mortality rates by comparing data from the National Prostate Cancer Register of Sweden, which covers more than 96% of prostate cancer cases, with rates from the general Swedish population based on data from the Hospital Discharge Register and the Cause of Death Registry. The calculations took into account age, calendar time, number of previous heart disease events, and time since last heart event.

The increased risk of all types of heart disease was observed even when absolute risk was calculated, Ms. Van Hemelrijck said in an interview.

Ms. Van Hemelrijck called for additional studies, especially on the underlying mechanisms of heart disease and testosterone. In the meantime, the findings raise a red flag and should prompt providers to ask about symptoms of heart disease in their patients, she said.

The study was supported by Cancer Research U.K., the Stockholm Cancer Society, and the Swedish Research Council. Ms. Van Hemelrijck reported no conflicts of interest. ■