Prostate Cancer Roundtable

www.prostatecancerroundtable.net
Email: www.prostatecancerroundtable.net/contact-us
236 Massachusetts Avenue, NE, Suite 301 : Washington, DC 20002

December 20, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: USPSTF draft recommendation on PSA screening

Dear Secretary Sebelius,

The choice to be tested for prostate cancer is an individual one that should be made between a man and his doctor based on complete and accurate data. Though the United States Preventive Services Task Force (USPSTF) appears to appreciate this, if their draft recommendation were to move forward in its current form, it would systematically undermine it.

High risk subgroups are especially endangered by the USPSTF's draft recommendation. African Americans, veterans exposed to Agent Orange, American Indians / Alaska natives, and those with a family history of prostate cancer are all substantially more likely to be diagnosed with prostate cancer, more likely to be diagnosed in advanced stages of the disease, and/or more likely to die from it. We are also concerned for those individuals who are not in any of the high risk groups but who are initially diagnosed through screening with aggressive forms of this devastating cancer. These groups stand to suffer substantial harm by the USPSTF's decision to apply its recommendation to them, despite their high risk.

Before the PSA test was introduced, most men diagnosed with prostate cancer were receiving that diagnosis when the disease had already spread to the point that there was almost nothing left to do. The PSA test changed the situation 180 degrees. The USPSTF is correct that we need better treatment options. They're also correct that we need improved tests that tell us more. But while science works to improve testing and care, we cannot simply go back to the way it was before.

Now that the National Institutes of Health has convened a State-of-the-Science Conference to develop a Consensus Statement on Active Surveillance for Localized Prostate Cancer, we know that the PSA is a critical tool for deciding which men could benefit from Active Surveillance. If a "D" Recommendation were allowed to stand, men would not know whether their prostate cancer was within the acceptable range of PSA. This is an even more compelling argument against a "D" Recommendation, because if men qualify as appropriate candidates for Active Surveillance, they will not be over-treated.

Attached are the original comments submitted by the Prostate Cancer Roundtable to the USPSTF as well as answers to the USPSTF's follow up questions. The Prostate

Cancer Roundtable is made up of the independent, patient-centric, not-for-profit organizations working together to foster the development and implementation of a national policy agenda supporting high quality prostate cancer research, the prevention and early detection of clinically significant prostate cancer, the appropriate care and effective treatment of men with prostate cancer, and the appropriate education of all men at risk for this disease.

Sincerely,

Ed Randall's Fans for the Cure
Malecare Prostate Cancer Support
Men's Health Network
National Alliance of State Prostate Cancer Coalitions
Prostate Cancer Foundation
Prostate Cancer International
Prostate Conditions Education Network
Prostate Health Education Network
The Prostate Net
Us TOO International Prostate Cancer Education & Support Network
Women Against Prostate Cancer
ZERO – The Project to End Prostate Cancer

cc: AHRQ Director Carolyn Clancy

Prostate Cancer Roundtable

www.prostatecancerroundtable.net
Email: www.prostatecancerroundtable.net/contact-us

October 27, 2011

Dr. Robert Cosby
c/o USPSTF
540 Gaither Road
Rockville, MD 20850

This document contains the Roundtable's original comments (pages 1-3) plus the response (questions) from the Task Force, and the Roundtable's response to the questions.

Re: USPSTF Proposed Recommendation Statement on Screening for Prostate Cancer

Dear Dr. Crosby,

We, the member organizations of the Prostate Cancer Roundtable appreciate the opportunity to submit the following comments to the United States Preventive Services Task Force (Task Force**)** draft recommendation statement concerning screening for prostate cancer. The Prostate Cancer Roundtable, representing America's prostate cancer community, is a group of independent, patient-centric, not-for-profit organizations that cooperate to foster the development of policies supporting high quality prostate cancer research, the prevention and early detection of clinically significant prostate cancer, the appropriate care and effective treatment of men with prostate cancer, and the appropriate education of all men about this disease.

The undersigned members of the Prostate Cancer Roundtable are, understandably, severely disappointed by the U.S. Preventive Services Task Force's recent draft "D" recommendation regarding use of the PSA test in screening of otherwise healthy men for risk of prostate cancer. We believe that this draft recommendation:

- Fails to accurately convey the message that the Task Force appears to be making – that the choice to be tested for prostate cancer is an individual one that should be made between a man and his doctor based on complete and accurate data,

- Discourages appropriate individual decision-making by doctors and their patients, and

- Ignores facts associated with the situations faced by a significant number of men in well-defined groups who are at the highest risk of clinically significant disease and at additional risk of dying from prostate cancer if it is not treated early.

Specifically, the Task Force has failed to address the benefits of screening for groups of men well known to be at high risk, including

- African-Americans,

- Men with a family history of prostate cancer, and

- Veterans who have been exposed to Agent Orange.

Men who are at higher risk for prostate cancer are also more likely to be diagnosed with more advanced stages of disease that are more aggressive and more difficult and expensive to treat if they are not diagnosed at the earliest possible stage of their disease. By recommending against the use of the PSA for the early assessment and diagnosis of otherwise healthy men with no symptoms of prostate cancer, a significant number of men will be diagnosed too late to stop localized and/or disseminated progression of their disease, thereby significantly increasing their likelihood of metastasis and prostate cancer-specific mortality.

We would also observe that there have been no published, prospective studies that address the risks and benefits of screening in the high-risk populations mentioned above. Even though a significant number of African-Americans were included in the PIVOT trial, data from this trial are not yet published, and it seems unlikely (given the low recruitment levels) that that trial included sufficient numbers of African-American patients to be able to draw any statistically or clinically significant conclusions.

Since the PSA was introduced in the mid-1990s, mortality from prostate cancer has dropped by 40 percent -- from over 39/100,000 in 1992 to 23.5/100,000 in 2007. Today, 90 percent of all prostate cancers are discovered before they spread beyond the prostate and the 5-year survival rate is nearly 100 percent when treated in these cases. By comparison, the 5-year survival rate for men whose cancer is detected after it has spread beyond the prostate is only 29 percent.

As a test specifically for risk of prostate cancer, current research clearly demonstrates that the PSA test is inconclusive at best. That is not in question. The PSA test itself is not a cancer test. It is diagnostic tool that is an important part of the decision-making process for men and their doctors when monitoring their health. Testing is just the first step in a journey that may include active surveillance and other forms of expectant management or timely treatment for appropriately selected patients. Without this important first step, each additional step is more complicated and reduces the chance for a positive outcome. We would note very specifically that we appreciate the very significant risk for over-treatment of this disease -- which is attributable to historical perceptions of the benefits of early intervention and other drivers. We believe a positive change in the over-treatment problem is attributable at least in part to the revised guidance from the National Comprehensive Cancer Network guideline that appropriate first-line therapy for all men of > 65 years of age with low- and very-low risk disease is active surveillance. This guideline was not in place at the time of conduct of any study on which the Task Force's draft recommendation is based.

Healthy men should not be discouraged from getting a PSA test and should be able to use information associated with the outcome of that test to make an educated decision with their doctor in assessing their health care choices. The way in which the Task Force's recommendation is currently framed most certainly appears to discourage that possibility. We understand the method the Task Force used to reach its conclusions, but we would argue that the very nature of the studies completed to date -- and on which the Task Force's draft recommendation are based -- were never structured to stratify men into risk groups or to provide outcomes data that could show whether men in specific risk groups did or did not benefit from screening. To discourage screening for

such men based on such a complete lack of relevant data appears to us to be callous at best.

The proposed draft recommendation will have a significant impact on the doctor-patient relationship by sending the message to both the man and his health care providers that his access to care options for early detection of prostate cancer should be restricted.

The undersigned organizations include the largest and most active prostate cancer-specific, patient-centric organizations in the US today, from the 37 state chapters of the National Alliance of State Prostate Cancer Coalitions (NASPCC) to the 300 local support groups coordinated by Us TOO International. We all feel frustrated, disappointed, and disempowered with and by the draft recommendation issued by the Task Force, which appears to dismisses any value of PSA testing in healthy men. We hear and are highly familiar with the individual stories, the successes, and the problems, which all begin from a simple PSA test. The constant in all the stories is that patients want early detection and the ability to decide with their own doctor how to proceed clinically.

We are the voices of and for patients and their families, and patients want early detection and the ability to be able to make fully informed decisions in consultation with their doctors and their families. They also need better and more consistent education of the primary care community about the appropriate use of PSA testing and how to discuss such testing with male patients as a component of an annual physical examination and health check.

These comments are submitted by the following members of the Prostate Cancer Roundtable (www.prostatecancerroundtable.net):

- Ed Randall's Fans for the Cure (www.edrandallsfansforthecure.org)
- Malecare Prostate Cancer Support (www.malecare.org)
- Men's Health Network (www.menshealthnetwork.org)
- National Alliance of State Prostate Cancer Coalitions (www.naspcc.org)
- Prostate Conditions Education Council (www.prostateconditions.org)
- Prostate Health Education Network (www.prostatehealthed.org)
- The Prostate Net (www.prostatenet.org)
- Us TOO International Prostate Cancer Education and Support Network (www.ustoo.org)
- Women Against Prostate Cancer (www.womenagainstprostatecancer.org)
- ZERO – The Project to End Prostate Cancer (www.zerocancer.org)

USPSTF questions following the

Prostate Cancer Roundtable submission of comments

The Prostate Cancer Roundtable submitted comments on October 27, 2011.

The USPSTF replied with questions about some of the comments, as seen below:

> *Thank you for your detailed letter and for taking the time to address each of your points on behalf of the Prostate Cancer Roundtable.*
>
> *...We know that decisions around screening for cancer are deeply personal and encourage individuals and families to make decisions that are right for them in consultation with their trusted health care providers.*
>
> *You mentioned the PIVOT Trial which was also reviewed by the Task Force. To the extent that you have additional evidence that you can share with us I would be pleased to forward to the Task Force and those that are reviewing the evidence. The USPSTF mission is to improve the health of all American by making evidence-based recommendations about clinical preventive services. Since the Task Force only comments based on evidence, what are you suggesting be done with the recommendation in absence of the evidence as with high risk populations?*
>
> *The Task Force has already stated that more research is needed, particularly with high risk populations.*

The Prostate Cancer Roundtable reply to these questions is attached.

Prostate Cancer Roundtable

www.prostatecancerroundtable.net
Email: www.prostatecancerroundtable.net/contact-us

November 8, 2011

Dr. Robert Cosby
c/o USPSTF
540 Gaither Road
Rockville, MD 20850

Re: Response to USPSTF questions about the Prostate Cancer Roundtable comments

Dear Dr. Cosby,

Thanks again for offering the Prostate Cancer Roundtable the opportunity to respond to questions about our original comments. I have included comments from various member organizations. These are complimentary with each other and reflect the views of those members who participated in the discussion, and submitted the original comments.

While we may disagree with the Task Force on the PSA recommendation, we are sympathetic with the daunting nature of the task, and appreciative of the effort.

= = = = = = =

Comment on the Pivot Trial from member organization 1:

The Pivot trial indicates the importance of baseline PSAs as part of determining low risk vs. high risk prostate cancers. It also indicates how treatment needs to be separated from diagnosis. - the baseline PSA helps predict mortality outcomes, if doctors believe in the quality and design of the PIVOT trial then they would offer watchful waiting to patients with a PSA less than 10 and a Gleason score less than 6. Without first having the PSA baseline the high risk patients who will benefit from treatment will not receive it.

Concerns about the Pivot trial include the primary VA patient inclusion and 70% of the participants having a low risk Gleason score of 6 or less, the study averages 10 year follow up where half (354) THE men had died. For men with low PSA, low stage and low risk disease prostate cancer mortality was less than 6%. For men with higher PSA or risk disease mortality was 10% to 20%. This mortality reduction is significant to patients.

Comment from member organization 2:

Because of the lack of specific scientific evidence presented in the PLCO and ERSCP trials, all men deemed to be at high risk for prostate cancer should be excluded from

any recommendation against the use of the PSA test for early detection screening. High risk men would include African American men, men with a family history, men exposed to Agent Orange, and men identified as high risk through testing available now and in the future. To issue a "Grade D" rating, the USPSTF must find moderate to high certainty that there is no scientific merit to performing screening. Without the necessary randomized controlled trial, or other peer reviewed scientific evidence, for African American and other high risk men this can not be concluded.

Comment from member organization 3:

(1) The Task Force should specifically recommend baseline risk assessment for prostate cancer for all men and especially for certain groups such as African-American men, those with a certain or an indeterminate family history, and those exposed to Agent Orange.

After risk assessment is made, then routine testing through PSA (and additional adjunctive tests approved by the FDA) would only be recommended for certain men deemed to be at higher risk of being diagnosed with potentially lethal prostate cancer.

(2) Newer prostate cancer-risk tests which will better assess true risk of clinically significant prostate cancer are meant to be used in conjunction with, or following PSA testing already in use. They are not tests in a vacuum. If PSA testing is thrown out (by a "D" Recommendation") these tests will never be used and will deprive men of that crucial additional information which would provide the sensitivity and specificity the Task Force feels is lacking with PSA.

(3) As to the PIVOT Trial, its conclusions make it clear that active surveillance is an appropriate option only for men with truly low-risk disease; it should therefore not be offered or recommended to men outside of that group since it may lead to the development of aggressive disease in patients who needed timely treatment. That is not an answer to the PSA issue.

We need to separate the issue of over-diagnosis from over-treatment. Furthermore, to condemn PSA testing unless a man has prostate cancer symptoms would most definitely lead to more cases of advanced disease at diagnosis, since symptomatology with prostate cancer is almost always a late sign."

# # #