

A Simple Schema for Informed Decision Making About Prostate Cancer Screening

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Screening for prostate cancer with prostate-specific antigen (PSA) testing is a problematic aspect of primary care. With the exception of the U.S. Preventive Services Task Force, which made an influential (1) but highly criticized (2) recommendation against any early detection efforts based on PSA testing, most organizations recommend that an informed decision be made by the patient after discussion with a physician. For example, the American College of Physicians is generally skeptical of the benefits of PSA testing (“for most . . . men, the harms will outweigh the benefits”) but recommends that “doctors and patients should discuss the potential benefits and harms of screening” (3, 4). Similarly, the American Urological Association, although more favorably disposed to screening, “strongly recommend[s] shared decision-making” (5).

Implementing shared decision making in primary care is not straightforward because it must account for the wide range of information and data that could be discussed, the complex tradeoff between immediate harms and long-term benefits, and the limited time primary care clinicians have for in-depth discussions about PSA testing in the context of the many other issues in a typical visit. Recent years have seen a considerable amount of literature develop on decision making for PSA screening, including specific advice to primary care providers about what they should tell patients. Our multidisciplinary group, which comprises a statistician specializing in localized prostate cancer, a bioethicist who has conducted empirical research about decision making in PSA screening, an academic urologic oncologist and epidemiologist, and an academic primary care physician, has followed this literature closely. We believe that recommendations specify either too little information to allow patients to make a decision or so much that it overwhelms their ability to decide rationally. Recommendations requiring extensive information also have low clinical feasibility (one suggests that physicians inform patients on 16 separate points and ask 12 questions about preferences [6]); include data that might be hard for patients to understand or assign a value to, such as the risk for deep venous thrombosis (7); or cite estimates that are conflicting and questionable, such as PSA screening leading to either 30 (8) or 110 (7) extra prostate cancer diagnoses per 1000 men screened.

Given the inadequacies of current recommendations and attendant poor adherence, we propose an alternative approach to informed decision making about PSA testing in primary care. This approach is based on 3 primary principles. First, the information given to the patient must be based on best evidence and must—to the extent possible in such a controversial field—be beyond dispute. This would

help to avoid the situation of many decision tools, such as the infographic provided by the National Cancer Institute (7), in which many of the key numbers cited, such as the risk for overdiagnosis, are subject to considerable controversy. Second, the patient should be presented with a clear framework for a decision, in contrast to complex decision aids that provide patients with a large number of estimates and then ask them to somehow integrate these into a discrete choice. Third, the schema should be appropriate for primary care. It should not assume that the provider has detailed knowledge of PSA testing and prostate cancer and should not require more than a few minutes to implement.

As a starting point, we assume that primary care providers would correctly identify eligible patients: men in their mid-40s through mid-70s with minimal comorbidity. We also assume that providers would adopt the “ask-tell-ask” approach that has been previously advocated (9). Starting with the initial “ask”, the clinician would gain critical information on what the patient already knows about PSA screening or what the patient’s level of concern or interest may be. This would allow the clinician to then tailor the “tell” portion of the conversation more succinctly and directly to the patient’s particular needs and level of current understanding. This portion of the conversation would follow the simple schema outlined in the **Table**. The **Supplement** (available at www.annals.org) provides evidence supporting each point.

The brief decision tool shown in the **Table** meets our criteria of being evidence-based, facilitating a discrete decision, and being appropriate for primary care in that it requires a relatively limited amount of time and only general knowledge about PSA screening. This sharing of information would be followed by a final “ask” (9), in which the clinician would confirm that what he or she has just explained makes sense and would ask for the patient’s preference regarding the decision. With this revised, streamlined approach, clinicians can follow the recommendation of having an informed, evidence-based discussion that provides a clear framework for decision making about PSA screening.

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See also:

Web-Only
Supplement

Table. Decision Tool for Prostate Cancer Screening**Key facts about prostate cancer and screening**

- Prostate cancer is common; most men will develop it if they live long enough.
- Although only a small proportion of men with prostate cancer die of the disease, the best evidence shows that screening reduces the risk for prostate cancer death.
- Screening detects many low-risk or "indolent" cancer cases.
- In the United States, most low-risk cancer is treated and the treatment itself can lead to complications, such as incontinence, erectile dysfunction, and bowel problems.

Key take-home messages

- The goal of screening is to find aggressive prostate cancer early and cure it before it spreads beyond the prostate.
- Most cancer cases found by screening do not need to be treated and can be safely managed by a program of careful monitoring known as "active surveillance."
- If you choose to be screened, there is a good chance that you will be diagnosed with low-risk cancer and you may face pressure from your physicians or family to treat it.

Discrete decision

- If you are concerned that you would be uncomfortable knowing that you have cancer and not treating it, screening may not be for you.
- If you are confident that you would only accept treatment for aggressive cancer and would not be unduly worried about living with a diagnosis of low-risk disease, you are probably a good candidate for screening.

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