

Prostate Cancer
Minimal Elements for Information, Screening, Diagnosis, Treatment, and Follow up
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
July, 2002; Revised May 2005; Revised May 2010, Revised November 2012

Summary of major updates or decisions agreed to by the Prostate Cancer Medical Advisory Committee compared to the prior version of the Prostate Minimal Elements, 2010

- Updated the information a man should be given for informed decision making (What You Need to Know about Prostate Cancer Screening, page 6).
- Deleted information about offering baseline PSA test and DRE to men at age 40 years, about when to stop screening and about interpretation of screening results.
- Added information from the most recent US Preventive Services Task Force statement
- Recommended against screening men for prostate cancer with PSA testing in the Cigarette Restitution Fund Program.
- Allowed PSA testing in the Cigarette Restitution Fund Program when used for diagnosis, active surveillance, and treatment when ordered by the medical case manager.
- Updated the membership of the Prostate Cancer Medical Advisory Committee (page 5).

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The following Minimal Elements are based on medical and epidemiologic information available to the DHMH Prostate Cancer Medical Advisory Committee at the time of their discussions beginning in the spring, 2002, updated in May 2005, May 2010, and September, 2012. The Prostate Minimal Elements will continue to be updated as medical information and recommendations change.

Education and Outreach Regarding Prostate Cancer Screening

- Education and outreach efforts to the general public and health care professionals should be consistent with the U.S. Preventive Services Task Force (USPSTF) recommendation, revised May 2012. The message should include information that:
 1. The USPSTF has recommended against prostate-specific antigen (PSA)-based screening for prostate cancer for men in the general U.S. population, regardless of age;
 2. The potential benefit of PSA-based screening for prostate cancer does not outweigh the expected harms, and that the reduction in prostate cancer deaths from PSA screening is at most very small;
 3. The decision to be screened for prostate cancer should be an individual one involving shared decision-making. If a patient raises the issue of PSA screening, or the clinician believes his individual circumstances warrant consideration of PSA screening, the clinician should discuss with the patient the benefits and harms thoroughly so he can make an informed decision. The decision to start or continue PSA screening should reflect the patient's understanding of the possible benefits and expected harms and should respect his preferences; and
The PSA is still recommended to be used to follow men who have had prostate cancer or an elevated PSA in the past.

See **What You Need to Know about Prostate Cancer Screening**, Page 6

Payment for Prostate Cancer Screening with PSA

- Payment for screening with PSA in a public health screening program is not covered under the Cigarette Restitution Fund (CRF) grant. A digital rectal exam (DRE) may be performed if done as a routine part of a physical examination in the CRF program.

Payment for Diagnosis and Treatment

- Payment for diagnosis and treatment or referral for diagnosis and treatment for a man with *abnormal* PSA or Digital Rectal Exam test results, is as follows:
 - if the man has insurance or is not program eligible, then refer to a source of care; or
 - if a man is eligible under the local Cancer Prevention Education, Screening, and Treatment Program of the CRF grant for diagnosis or treatment services (by residence, income, insurance, etc.), then either:
 - pay for diagnosis and treatment if the local program has sufficient funds and will cover the specific services (either direct payment to providers or

payment for Maryland Health Insurance Premiums/co-payments/deductibles);

- pay for diagnosis and treatment using Maryland Cancer Fund funds pending availability (either payment for Maryland Health Insurance Program premiums/co-payments/deductibles or direct payment to providers); or
- have a prearranged method for follow-up, referral and complications to appropriate care providers for diagnosis and treatment.

Considerations when testing for PSA level for any purpose:

- If possible, draw blood for PSA test before performing DRE.
- Ejaculation: PSA test results are more reliable if the man has abstained from ejaculation for 48 hours. If the man ejaculated within 48 hours before the specimen was drawn and the original sample was marginally elevated, repeat PSA after the man abstains from ejaculation for 48 hours.
- Medicines that affect PSA:
 - Finasteride (e.g., Proscar or Propecia) and dutasteride (e.g., Avodart) can lower the PSA. (In patients using these drugs, failure to have a substantial decrease [approximately 50%] in PSA or having an increase while on medication can be associated with an increased risk of prostate cancer.)
 - Androgen receptor blockers.
- If client was referred to urologist in the past for PSA elevation or abnormal DRE, then the Medical Case Manager should follow the urologist's guidance regarding the findings that would signal the level of PSA of concern, the need to return to the urologist for evaluation, the timing of subsequent repeat PSAs, the need for biopsy, etc.

Screening: Screening for prostate cancer not recommended; the USPSTF recommends *against* screening for prostate cancer with PSA.

Payment for screening with PSA is not covered under the CRF grant.

The decision to be screened for prostate cancer should be an individual one involving shared decision-making. If a patient raises the issue of PSA screening, or the clinician believes his individual circumstances warrant consideration of PSA screening, the clinician should discuss with the patient the benefits and harms thoroughly so he can make an informed decision. The decision to start or continue PSA screening should reflect the patient's understanding of the possible benefits and expected harms and should respect his preferences; however, payment for screening with PSA is not covered under the CRF grant.

Diagnosis and Treatment: A man can be eligible for referral to a urologist for diagnostic and treatment services including PSA testing in the CRF program if he:

- a) has been referred because he has a PSA \geq 2.5 ng/ml, has an abnormal PSA velocity, or has an abnormal DRE suggestive of cancer and needs referral to a urologist;
- b) has been diagnosed with prostate cancer and is undergoing active surveillance;
- c) has been diagnosed with prostate cancer and needs treatment or post-treatment follow-up services.

Diagnosis / Further Evaluation

- Based on the DRE and PSA results or a prior history of prostate cancer, **additional testing may be indicated for evaluation and staging** per the urologist or other medical case manager using protocols such as the National Comprehensive Cancer Network (NCCN), or the American Urological Association.
- CRF programs **may pay** for the following tests **if life expectancy is >5 years or man is symptomatic, and the following indications are present:**

Test	Indications for Payment in CRF Program
PSA and/or DRE	Prior PSA \geq 2.5 ng/ ml or abnormal PSA velocity, active surveillance, or prior history of treated prostate cancer
Bone scan	One or more of the following: T4; T3; T1 and PSA > 20ng/mL; T2 and PSA > 10ng/mL; Gleason score \geq 8; or Symptomatic with bone pain
Pelvic CT or MRI	One or more of the following: T4; T3; or T1 or T2 with nomogram indicating probability of lymph node involvement >20% (see Reference 3).

Histologic Classification of Tumor

- A specimen should be classified by its Gleason score.

Staging

- The urologist should report the:
 - **Clinical characteristics of the tumor (T), nodes (N), and metastasis (M),** and
 - **Pathologic TNM Stage** if there is a prostatectomy specimen.

Management

- Based on the findings on DRE, PSA, transrectal ultrasound (TRUS), other screening/diagnostic tests, and further evaluation and consultation, the urologist will recommend, on a case-by-case basis, management using protocols such as the NCCN, or American Urological Association, and future PSA testing.
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References:

1. U.S. Preventive Services Task Force, Screening for Prostate Cancer; Current Recommendation, July 17, 2012, Ann Intern Med, July 2012; 157 (2), **120-134**. (<http://www.uspreventiveservicestaskforce.org/prostatecancerscreening/prostatefinalrs.pdf>)
2. National Comprehensive Cancer Network [NCCN] V.3.2012, Prostate Cancer (http://www.nccn.org/professionals/physician_gls/PDF/prostate.pdf)
3. Prostate nomogram example: <http://urology.jhu.edu/prostate/partintables.php>

Prostate Cancer Medical Advisory Committee Members, October 2012

Stanley Watkins, MD, Chairman	<p>Medical Oncologist Medical Director of Research for the DeCesaris Cancer Institute Anne Arundel Medical Center Assistant Professor of Oncology The Johns Hopkins University School of Medicine (part time)</p>
Pradip Amin, MD	<p>Radiation Oncologist Associate Professor of Radiation Oncology Department of Radiation Oncology University of Maryland Medical Center</p>
H. Ballentine Carter, MD	<p>Urologist Professor of Urology, Oncology Director, Division of Adult Urology The James Buchanan Brady Urological Institute The Johns Hopkins University School of Medicine</p>
Jonathan Epstein, MD	<p>Pathologist Professor, Department of Pathology, Urology, and Oncology The Johns Hopkins University School of Medicine</p>
Ann Klassen, PhD	<p>Epidemiologist Associate Professor, Dept. of Health Policy and Management The Johns Hopkins Bloomberg School of Public Health and Department of Oncology The Johns Hopkins University School of Medicine</p>
Boris Naydich, MD	<p>Radiation Oncologist and Medical Director Chesapeake Potomac Regional Center Care, Holy Cross Hospital and Washington Hospital Center, Waldorf Radiation Oncology Center, Waldorf, MD Charlotte Hall Radiation Oncology Center, Charlotte Hall, MD</p>
Elizabeth A. Platz, ScD, MPH	<p>Epidemiologist Professor, Dept. of Epidemiology The Johns Hopkins Bloomberg School of Public Health</p>
Jay Weiner, MD	<p>Director of Scholarly Activity Director, Family Medicine Maternal-Child Health Curriculum Family Physician Medstar Franklin Square Medical Center</p>
Courtney Lewis, MPH, Director Diane M. Dwyer, MD, Medical Director	<p>Maryland Dept. of Health and Mental Hygiene Center for Cancer Prevention and Control Baltimore, Maryland</p>

What You Need to Know about Prostate Cancer Screening

- Prostate cancer is the most common cancer in men. It is the second leading cause of cancer deaths in men.
- Certain men are at higher risk of prostate cancer:
 - African American men, men of African descent, men who have a father, brother, or son with prostate cancer, and all men over 50 are at higher risk.
- Screening for prostate cancer
 - There are two tests that may be used as screening tests for prostate cancer: PSA and DRE.
 - The PSA (prostate specific antigen) is a blood test.
 - The DRE (digital rectal exam) is where a doctor feels the prostate gland by putting a gloved finger inside the rectum.
 - The PSA test can find prostate cancer earlier than the DRE alone.
 - The PSA test result can be high because of *other* prostate problems--so an elevated PSA does *not* always mean cancer. PSA can be higher because a man ejaculated in the 1-2 days before the test. Also, the PSA test results can sometimes be normal even if a man has prostate cancer. Certain medicines can lower the PSA test results.
- After looking at the expected harms and the possible benefit from PSA screening, the United States Preventive Services Task Force in May 2012 recommended against PSA-based screening for prostate cancer.

Possible benefit of screening:

1 man in 1,000—at most—avoids death from prostate cancer because of screening over 10 years (based on current information.)

Expected harms of screening:

For every 1,000 men who are screened with the PSA test:

- 30 to 40 men will develop erectile dysfunction or urinary incontinence due to treatment
- 2 men will experience a serious cardiovascular event, such as a heart attack due to treatment
- 1 man will develop a serious blood clot in his leg or lungs due to treatment

For every 3,000 men who are screened with the PSA test:

- 1 man will die due to complications from surgical treatment

- If a man is considering prostate cancer screening, he should have a thorough discussion with his medical provider to learn about the expected harms and the possible benefit of screening, subsequent diagnostic testing, and possible treatment so he can make an informed decision about whether he wants to be tested.
- If a man chooses to be tested for prostate cancer and if either the DRE or PSA is abnormal, he should be referred to a specialist (urologist) for further work-up.
- If a man has a high PSA test result or a PSA result that is rising over time, a doctor may recommend a biopsy to see if the man has prostate cancer. The biopsy and cancer treatment may cause side effects. The biopsy and treatment may or may not be paid for by the local cancer program.
- If a man has early prostate cancer, he can choose how to handle the cancer.
 - He and his doctor may choose to wait and see if the prostate cancer is changing, known as “active surveillance.”
 - He may choose to have surgery, radiation therapy, and/or hormonal therapy.
 - The treatments often have side effects, some of them are significant.