LETTERS—CONCISE RESEARCH REPORTS

PSA Screening: a Kind of Russian Roulette?

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Using the database of a health care plan, Presti et al.¹ showed that the rate of PSA screening, prostate biopsy, and incident prostate cancer detection rates declined, and the rate of metastatic cancer increased, following the 2012 USPSTF guideline change. They assert that this information may be valuable in the shared decision-making process.

There are several similar reports.² However, they only observed a part of the overdiagnosis problem retrospectively, using lower quality databases, while the data of three RCTs regarding PSA screening already show that early cancers are more common in screening groups and advanced cancers are in non-screening groups and that screening has little impact on cancer mortality.³ Prostate cancer progresses slowly and is unlikely to cause death. Even if it progresses, it can be controlled for some time by hormonal treatment, so early detection and early treatment do not reduce prostate cancer death. This “overdiagnosis” problem is exactly the essence of PSA screening.

PSA screening is multi-stage Russian roulette. The bullet does not punch through the head, but the biopsy needle touches the prostate, the prostate is cut off, and patients suffer from sexual dysfunction, urinary incontinence, and unnecessary concerns. There are few benefits. Why play it? It is no concession that the USPSTF upgraded the recommendation to C and concluded that shared decision making is necessary. I guess the USPSTF thought that even general people other than medical staff could easily see that harm outweighs the benefit, by looking at the fact sheet.³ It is a shame that urologists try to confuse the public with misinterpretation of the data.⁴

Shared decision making requires accurate and deep knowledge about the natural history of prostate cancer, surgery, and radiation therapy; urologists’ decisions regarding their own health would shed light on this subject. There has been only one published survey of urologists on how they view PSA screening on themselves;⁵ most had undergone or planned to undergo screening when reaching a relevant age. However, this was a small study with a low response rate, and we do not

know how this correlates with actual behavior with respect to their patients or themselves should they develop prostate cancer.

Urologists who have performed the largest numbers of prostatectomy will now be over 55 years old; some urologists in high-volume centers have thousands of experiences. We can find out if they have “actually” undergone PSA screening in the last 10 years and have undergone active prostate biopsy and surgery for themselves. It would be easy for the American Urological Association, and major urological associations in the world to conduct such a comprehensive survey.

I hope urologists all over the world will follow the Golden Rule as taught by Sir William Osler. In *Analects of Confucius*, it is said, “Do not do to others what you do not want done to yourself.”

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