Check up that saved my life

By Martin Johnston

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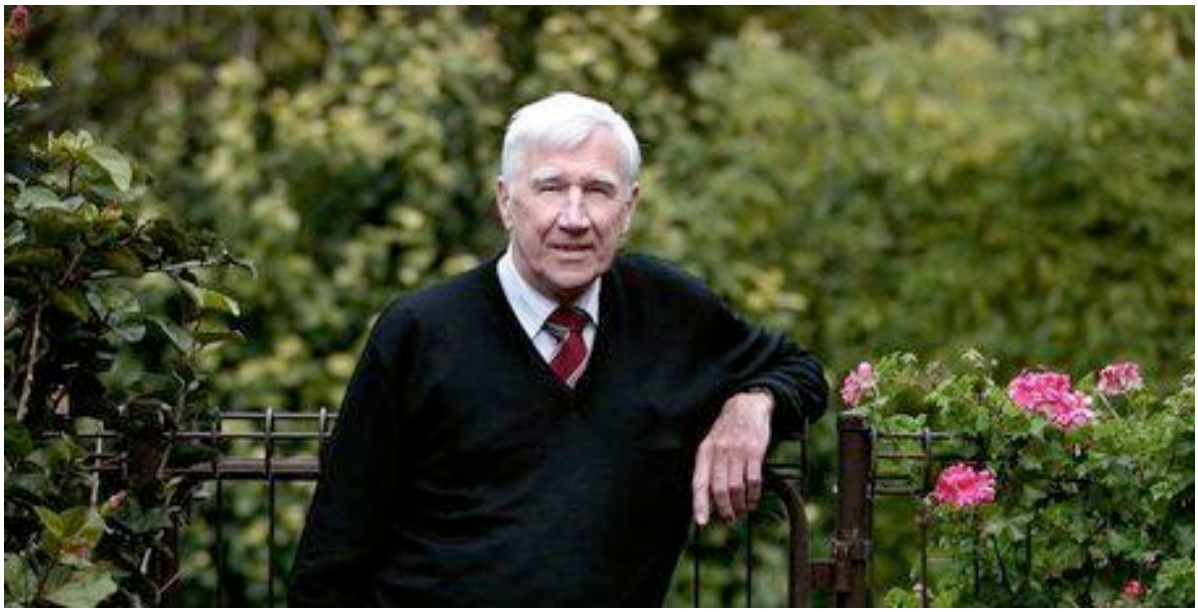

Bill Walsh, now 75, was 67 years old when diagnosed with cancer and eventually he had surgery to remove his prostate gland. Photo / Brett Phibbs

Bill Walsh is in no doubt he is alive today because his doctor suggested doing a blood test for New Zealand's most commonly diagnosed cancer.

Aged 67 at the time, Walsh was having a general check-up when his GP ordered a blood test for prostate disease. It returned a slightly elevated result.

The doctor did a digital rectal check of the prostate, a walnut-sized gland in males. It surrounds the tube that carries urine from the bladder and produces a component of seminal fluid.

Walsh was referred to a specialist urologist, who repeated the rectal check and took tiny biopsy tissue samples from the gland. Cancer was diagnosed from the biopsy.

"My specialist said it was contained [the cancer had not spread outside the prostate to bones or other tissue] but very aggressive."

Walsh's response was emphatic: "If there's something rotten inside of me, get rid of it. I guess I'm an ordinary bloke in that sense."

He had surgery to remove his prostate and now, aged 75, , remains full of life. He's still working - as a real estate agent - and says he owes his survival to his GP's diligence.

"I had no symptoms, so it was a matter of chance, good luck, call it what you like, that my prostate cancer was discovered."

So how in the face of the numerous cases like this, many people wonder, can the Ministry of Health continue to oppose setting up a national screening programme based on the prostate specific antigen (PSA) blood test?

Parliament's multi-party health select committee conducted a two-year-long inquiry into prostate screening and its recommendations met agreement from the Government.

But crucially, the committee did not support creating a screening programme "at this stage", because the large overseas clinical trials of prostate screening did not establish that the benefit outweighed the harm caused.

This may seem odd to many after hearing of the life-saving benefits of the early detection of breast, cervical and bowel cancers - all of which have New Zealand screening programmes (although the bowel cancer scheme, which is just starting, is a pilot and currently restricted to the Waitemata health district).

But not all cancers can be tested in the same way and the main screening test for prostate cancer, the PSA, has unfortunate weaknesses. This hasn't stopped its wide use. More than 40 per cent of men over 50 in New Zealand have been tested with it, in what is now considered to be an "unorganised" screening programme.

But whether or not men without prostate problems should be screened - and whether there should be a national screening programme - remains highly contested.

Otago University cancer epidemiologist Brian Cox and his colleagues strongly oppose the idea, while the Urological Society of Australia and New Zealand, some cancer specialists and some GPs are adamant supporters.

Men are caught in the middle of this academic and clinical wrangle.

Prostate cancer was New Zealand's most commonly registered cancer in 2008. There were 2939 new cases, and 670 deaths.

Symptom-less men who screen positive for prostate cancer and who then have prostate cancer treatment, tend to become advocates for screening. Understandably. It may have saved their life.

And if your life has been saved, the impotence or incontinence (urinary and/or bowel) that some suffer as side-effects of the treatments such as surgery or radiotherapy, in some cases permanently, may seem a small price to pay.

The committee was told of long-term complication rates of up to 40 per cent for urinary incontinence, and up to 50 per cent for erectile complications among men potent before treatment - however rates varied hugely, were said to be much lower for newer treatments, and were less than 5 per cent in some situations.

Although the committee was equivocal on the value of screening, its chairman Paul Hutchison, a doctor, said following the inquiry: "Some specialists say the death rate from prostate cancer

could be halved through better education and the wider use of screening."

The figure he selected broadly reflects the 40 per cent reduction in relative risk of prostate cancer death for men screened in a study in Gothenburg, Sweden.

But Cox said this research was part of a wider European study that found a smaller mortality reduction and they could not be considered in isolation.

"There are another four studies published, one with 20-year follow-up, which have not found any reduction in prostate cancer mortality."

He argued the PSA test is simply not good enough at indicating possible cancers which would cause clinical disease and need to be treated. Consequently it led to over-diagnosis and over-treatment.

"At least 30 per cent of men aged 50 years or more have at least one tumour in their prostate, but only 5 per cent [of men] develop symptomatic disease in their lifetime."

Furthermore, around half of PSA-detected cancers in asymptomatic men would never become clinically significant or produce symptoms in the man's lifetime.

"We estimate that in New Zealand about 600 to 900 cases a year of prostate cancer diagnosed are tumours that would never have caused illness in a man's natural life."

Cox said the trebling of the annual number of diagnosed prostate cancer cases since PSA testing began in the early 1990s led to the overloading of radiation therapy clinics a decade later and the consequent sending of many women to Australia for breast cancer treatment.

He wants wide restrictions put on GPs' access to PSA testing - a proposal ignored by the committee report.

Cox hopes a better test will be found, one that can identify which prostate abnormalities will threaten a man's life - and find them early enough to be able to reduce the risk of dying from prostate cancer.

Work aimed at doing just that is proceeding at his university. Research fellow Elspeth Gold and colleagues are trying to develop a test for activin C, a protein that regulates prostate growth.

"I have experimental evidence in mice, human cell lines and patient biopsies that increased activin C is associated with prostate cancer," Gold said. "I am now moving to making assays to assess circulating levels in men with prostate cancer and will compare my results with PSA."

But her work is still at the proof-of-concept stage.

Urologist Robin Smart and Lannes Johnson, a leading GP, strongly disagree with Cox's line.

Smart favours creating a national screening programme, saying that the current level of PSA testing is saving well over 100 men's lives a year.

His answer to the objections over side effects in men treated for disease that wouldn't have harmed them is to carefully monitor those whose prostate biopsies indicate less-aggressive cancer, who may comprise up to 25 per cent of PSA-detected cases.

"This selection is not perfect in that one-third of these patients subsequently require treatment for significant cancer."

Johnson is enthusiastic about the prospects for screening, saying the evidence is growing, as shown by the Gothenburg trial.

"Other studies are coming out with evidence and there's anecdotal reports. Probably in a year or two we can do a national screening programme."

He said dying of prostate cancer once it had spread was a miserable experience. With modern treatment, it took several years.

"Better to be cured by early diagnosis and treatment."

Predictably, the MPs were unable to resolve the disagreement over the value of PSA screening. The committee's main recommendations focus on improving information to help men to choose whether or not to be screened.

It wants the ministry to encourage GPs to discuss screening with men at the age-45 heart and stroke check and from age 40 for men with a strong family history of prostate cancer. The Government agreed on the ages, but said the talk could happen independent of the cardiovascular check.

One committee member, Kevin Hague, who was on the National Health Committee when it opposed organised prostate screening, questioned the value of the inquiry. He said it had done nothing to change the existing ministry advice that men should discuss the pros and cons of screening with their GP.

"The tricky bit - what the consistent advice given to men by their GPs will be - still remains to be done, by groups of professionals with strongly held, inconsistent views."

For Bill Walsh, however, the answer is simple.

"My message to all men over 50 and women, to make sure your man does so, is to have a regular PSA check. Knowledge is everything and it might just save your life."

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