UROLOGICAL SOCIETY
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USANZ RESPONSE TO ARTICLE ON PROSTATE CANCER TREATMENT IN DVA NEWSLETTER VETAFFAIRS VOL 33 NO. 1 AUTUMN 2017

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The Urological Society of Australia and New Zealand (USANZ) is concerned by the recent article by Prof Ian Gardner, Chief Medical Advisor to the Department of Veterans Affairs. Prof Gardner expresses a generally critical view of the urological management of prostate cancer. This may result in undermining treatment decisions taken by men with prostate cancer - or worse, lead them to take inappropriate decisions.

Prostate cancer is a common condition with a natural history that varies from indolent to aggressive and potentially lethal. A blood test to check the level of Prostate-specific Antigen (PSA) is the best test currently available for the early detection of prostate cancer. It is not a diagnostic test for prostate cancer, rather only providing an assessment of the risk that a man has prostate cancer. In this context, it has limitations that are similar to other comparable "screening" tests such as mammography or Pap smears. Nonetheless, current recommendations from a multidisciplinary expert panel convened by the Prostate Cancer Foundation of Australia (PCFA) and Cancer Australia, and endorsed by the National Health and Medical Research Council suggest the test be offered to men aged 50 to 69 years after a discussion of potential benefits and harms (http://www.prostate.org.au/awareness/for-healthcare-professionals/clinical-practice-guidelines-on-psa-testing/). This would typically be undertaken under care of a general practitioner (GP).

A confirmed abnormal PSA test should lead to further clinical assessment along well-defined pathways, which would typically entail referral for consultation with a urologist. Further diagnostic testing for prostate cancer, usually a biopsy of the prostate, would be reserved only for those in whom there is a sufficient suspicion based on this assessment. This assessment will not only include the PSA blood test, but its derivatives such as the free/total ratio, physical examination findings, family history and in some cases a Magnetic Resonance Imaging (MRI) scan of the prostate. Whilst MRI scanning may have some utility in the diagnostic pathway for prostate cancer, it is not yet funded by the government nor fully established as standard practice.

Men diagnosed with prostate cancer are also faced with the prospect of choosing between multiple treatment options, including active surveillance, surgery, and radiation therapy. The optimal decision-making for the treatment of prostate cancer is complex and needs to take into account numerous factors, including features of the cancer as well as the patient's age, general health, other co-morbidities and preferences. Having been involved in the initial diagnosis, urologists are typically heavily involved in this decision-making process, which is necessarily challenging and time-consuming. In the process of prostate cancer treatment decision-making, men and their families need support and information. In addition to resources outlined in the article, the PCFA provides both through its publications, website, and the Prostate Cancer Support Nurse program.

The majority if not all urologists provide advice with their patients' best interests in mind. An increasing proportion of patients are managed with multidisciplinary input, including radiation oncologists and medical oncologists. Some prostate cancers are best treated by active surveillance or primary radiation therapy, and not surprisingly, data from the Victorian Prostate Cancer Outcomes Registry (http://pcr.registry.org.au/Home.aspx) shows that over the years 2013 to 2015, 40 to 50% of men with prostate cancers are treated non-surgically. Thus, Prof Gardner's assertion that very few men are told about treatment options other than surgery appears to be based on anecdotes rather than real-world evidence.

Unfortunately, none of the available treatment options for prostate cancer are free of side-effects - these should be thoroughly discussed with the patient and their family prior to proceeding with treatment. Just as surgery for prostate cancer can result in incontinence and impotence in some men, so does radiation therapy cause damage to the bladder (cystitis), bowel (proctitis), scarring (strictures), sexual dysfunction and second malignancies. Some of these side effects can emerge or worsen over time and require repeated or extensive surgical treatments which can then lead to further negative impact. Hormonal therapy is rarely if ever used with surgery for the treatment of non-metastatic (not spread beyond the prostate) prostate cancer, but maybe combined with radiation therapy in many instances. Hormonal therapy itself has significant adverse effects, including hot flushes, tiredness, cognitive changes, mood changes, weight gain, muscle wasting, osteoporosis, worsened cholesterol levels, diabetes & related metabolic conditions and cardio-vascular disease including heart attacks and strokes. Thus, the implication contained in the article that alternative treatments for prostate cancer should be sought to avoid the potential side effects of surgery is misleading. In reality the consideration of potential benefits and risks of all available & suitable treatments is an integral part of the decision-making that each man has to go through.

The article also appears to directly link potential costs of treatment to prostate cancer decision-making by urologists in a way that is erroneous. Any clinician treating prostate cancer by definition has a financial interest in some way - this is as applicable to radiation oncologists as it is to urologists. Ethical principles should dictate that the clinician's financial interest does not influence their advice to the patient. From the patient's perspective, both surgery and radiation therapy for prostate cancer can be accessed without out-of-pocket expenses through the public health system. In the private sector, there are often out-of-pocket expenses, but again, this is applicable to both surgery and radiation therapy. USANZ and the Royal Australasian College of Surgeons have stated policies to curb excessive fees, and the majority of surgeons abide by these recommendations. The range of out-of-pocket fees quoted in the article misrepresents the reality – about 20% of surgeons charge no out-of-pocket fees, and the median out-of-pocket charge is about $2500 (https://www.surgeons.org/media/24417293/16046_RACS-Urology-Report_web_FA.PDF). In the particular case of DVA patients, there are circumstances where the re-imbursement does not fully cover the treatment. As advised in the article, this needs a special application lodged for additional coverage on a case-by-case basis.

USANZ and its member urologists are keen to work co-operatively with other colleagues and their peak organisations to advance the care of men with prostate cancer. Erroneous and divisive views as expressed in Prof Gardner's article are counter-productive, and can only result in worsening outcomes for men with prostate cancer.

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