Prostate Cancer Foundation of Australia

Cancer Council Australia

23 March 2015

Dear Support Group

Thank you for your recent submission on the draft clinical practice guideline on PSA testing and early management of test-detected prostate cancer. The Expert Advisory Panel greatly appreciates your feedback.

There were a number of common themes in submissions made by prostate cancer support groups. We have therefore decided to write to each of the individuals and support groups who made a submission responding to the comments and questions received. The feedback has been taken into account in the final draft guideline which will be submitted to the National Health and Medical Research Council (NHMRC) for approval.

It is important to recognise that the Expert Advisory Panel contains representatives from a number of organisations that already have established policies on PSA testing. The purpose of developing the guideline was to achieve consensus on the advice to Australian men and health professionals and to end the controversy and confusion concerning PSA testing. Thus each organisation involved will, to some extent, have to adjust their existing policies.

Each of the underlined headings below summarises one of the common themes in support groups' submissions and is followed by a comment on the theme or a brief statement of what is being done to address it.

<u>Consumers were not involved in development of the draft guideline</u>

There are three consumer representatives on the Expert Advisory Panel for development of the guideline, Mr David Sandoe OAM, Mr Peter Teiermanis and Dr Ian Roos OAM. All three have been diagnosed with and treated for prostate cancer and are well acquainted with the perspective of men and their families who have experienced prostate cancer first hand.

<u>The timeline for submissions was too short</u>

A public consultation period of four weeks is required by NHMRC. Because of the timing over the holiday period we specifically asked permission from NHMRC to extend this to six weeks. The timeline to obtain NHMRC approval of the draft guideline is very tight and it was not possible to accommodate a longer period of public consultation.

Why is it necessary to produce another guideline?

Many submissions made reference to the Melbourne Consensus Statement and questioned why it is necessary to produce another guideline set. There are a number of reasons as follows:

- The Melbourne Consensus Statement was not developed using NHMRC procedures which are the gold standard for clinical guidelines in Australia. In particular, the Melbourne Consensus Statement was not based on a full systematic review of the relevant scientific and medical literature. Because of the controversy and confusion concerning PSA testing, PCFA and Cancer Council Australia felt it was essential to develop the guideline to the highest Australian standard.
- The group of authors of the Melbourne Consensus Statement does not include representatives from all medical specialties involved in diagnosis and treatment of prostate cancer e.g. the group does not include any GPs or pathologists. In order to achieve consensus it is essential that all relevant medical specialties have input.
- The Melbourne Consensus Statement does not cover as many aspects of PSA testing and early management of test-detected prostate cancer as the guideline e.g. it does not cover protocols for active surveillance.

The draft guideline is written in very technical language

By their nature the draft guideline and associated technical report are intended to be technical documents. We are currently developing a communications plan which includes a concise and simple summary written in less technical language than the guideline itself. This summary is intended for use by consumers. We will include a comment to this effect in the introduction to the guideline. We will also prepare a summary of the guideline especially for GPs.

A decision aid is being developed for use by GPs and patients considering PSA testing. The Expert Advisory Panel will review and advise on the draft decision aid and we anticipate that PCFA, Cancer Council Australia and the various medical colleges will endorse it.

Some of the recommendations seem to be motivated by cost saving

All of the recommendations are based on the latest available scientific and medical evidence and are not influenced by cost considerations.

The draft guideline ignores recent developments in multi-parametric MRI

The Expert Advisory Panel reviewed literature on use of multi-parametric MRI after a negative biopsy. In accordance with advice at the time, it did not review the evidence on use of multi-parametric MRI in the primary investigation of a positive PSA test. However, given some very recent publications on this subject, such a review has now been initiated and will be used to inform a future update of the guideline. The guideline has been developed on Cancer Council Australia's wiki platform to enable it to be kept up to date as new diagnostic and treatment options emerge.

Why does the draft guideline not recommend baseline testing at age 40?

The Expert Advisory Panel did not recommend baseline testing at age 40 for two reasons. First, a baseline PSA test at age 40 is effectively beginning PSA testing at this age. The available evidence, however, suggests there is very little to be gained in terms of reducing prostate cancer mortality by beginning testing at 40. Secondly, whilst it is true that the PSA level at a particular age can be used to predict future risk of prostate cancer death, the evidence shows that it is as strongly predictive if measured at age 45 or 50 years as it is if measured at age 40. Thus a baseline test at age 40 does not have a unique value in this respect.

Why does the guideline not recommend testing from an earlier age for men with a family history of prostate cancer?

The guideline recommends (Chapter 2) that:

> *"For men whose risk of prostate cancer is estimated to be at least 2.5–3 times higher than average due to the presence of risk factors (e.g. a brother diagnosed with prostate cancer, particularly if younger than 60 years at diagnosis), and who decide to undergo testing after being informed of the benefits and harms, offer testing every 2 years from age 45–69 years.*
>
> *For men whose risk of prostate cancer is estimated to be at least 9–10 times higher than average due to the presence of risk factors (e.g. father and two brothers diagnosed with prostate cancer), and who decide to undergo testing after being informed of the benefits and harms, offer testing every 2 years from age 40–69 years.*
>
> *If initial PSA is at or below the 75th percentile for age, advise no further testing until age 50.*
>
> *If initial PSA is above the 75th percentile for age, but at or below the 95th percentile for age, reconfirm the offer of testing every 2 years.*
>
> *If a PSA test result before age 50 years is greater than 95th percentile for age, offer further investigation.*
>
> *Offer testing from age 50 years according to the protocol for men who are at average risk of prostate cancer."*

It makes these recommendations because the degrees of increased risk specified for a 45 year-old man and for a 40 year-old man put them at about the same risk of death from prostate cancer in the next 10 years as a 50 year old man at average risk.

The evidence that family history is associated with an increased risk of prostate cancer is reviewed in Chapter 1 of the guideline. The evidence suggests that risk is increased 2 to 2.5 times for a man whose father had prostate cancer and 2.5 to 3 times for a man whose brother had prostate cancer. Thus, the recommendation to start testing at 45 years of age would apply to a man who had a brother with prostate cancer or a stronger family history than that. Similarly, the evidence suggests that risk is increased about 9 times for a man who had three brothers or his father and two brothers with prostate cancer. Thus, the recommendation to start testing at 40 years of age would apply to a man who had this or as stronger family history.

The recommendation not to offer PSA testing to a man who is unlikely to live another 7 years is unnecessarily harsh

The evidence shows that the benefits of PSA testing only become apparent after 7 years. Hence, men who because of their age and health status are unlikely to live another 7 years are unlikely to derive any benefit from testing. We accept that the wording could be considered harsh and have revised the wording of this recommendation to:

> *"Since any mortality benefit from early diagnosis of prostate cancer due to PSA testing is not seen within less than 6-7 years from testing, PSA testing is not recommended for men who are unlikely to live another 7 years."*

Many men are diagnosed with prostate cancer as a result of an abnormal DRE

The advice that DRE is not recommended as a routine test by GPs must be seen in the context of the recommended PSA testing protocol. The Thomson study referred to in the draft guideline shows that PSA testing with a cut-off of 3ng/mL is equivalent to PSA testing and DRE with a cut-off of 4ng/mL. Hence, when a cut-off of 3ng/mL is adopted, as in the guideline, it is possible to dispense with the DRE. Note that although DRE is not recommended as a routine test by GPs, the guideline indicates that it still has an important role in assessing the prostate prior to biopsy in a specialist setting.

Finally, thank you once again for taking the time to comment on the draft guideline.

Yours sincerely

Professor Villis Marshall AC
Chair of the Expert Advisory Panel