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Thursday, 10 March, 2011

Dear

PSA Screening for prostate cancer – response to the National Screening Committee announcement

As someone who has always supported the cause of prostate cancer, you will be aware of the recent announcement by the National Screening Committee of their decision, once again, not to recommend the development of a screening programme for prostate cancer. The lead time for any change in this policy is at least three years, so, with 10,000 men dying of this disease every year, this decision is inevitably a death sentence for many thousands of men.

It is our belief that this issue, which for so long has been a matter of fierce controversy, is now clearly settled in favour of introduction of a screening programme. You may not agree with that, but we feel sure that you will agree that the matter should be properly and fairly examined. As explained in the Annex to this letter, this has not happened and as a result the decision is deeply flawed.

In short, a very bad decision has been made, which is not supported by the evidence, and which will only serve to continue the appalling death rate from this disease. We believe it should be challenged by all who have at heart the well being of men at risk of prostate cancer.

We, the undersigned, representing, respectively, the UK's largest patient-led support organisation, a pressure group that has been campaigning for prostate cancer screening for some years, and one of the most respected clinical centres of excellence in the UK, call on all those who have men's health at heart to join us in a National Campaign to have the decision reviewed urgently, using the latest data. This campaign will be subject to a nation-wide publicity campaign and we hope we can rely on your support, which you can signify by logging on the a petition website at http://www.theprostateclinic.com/screening, sending an email to screening@prostatecancerfederation.org.uk, or writing to us at the above address.

We look forward to hearing from you or seeing your name on the petition.

Yours sincerely

Sandy Tyndale-Biscoe	**Doug Gray**	**Christopher Eden**
Hon Chairman, Prostate Cancer Support Federation	**Leader, National Screening Interest Group**	**Consultant Urologist**
		The Prostate Project
		www.prostate-project.org.uk

Attachment: Summary of Flaws in NSC Decision

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Annex A: Summary of Flaws in NSC Decision

Our concerns about the process by which the NSC decision was arrived at lie in four key areas.

1. Evidence has been ignored that clearly shows the benefits of screening.

The NSC decision was based on the report commissioned from the Sheffield School of Health and Related Research (ScHARR). This report draws extensively on the European Randomised Screening for Prostate Cancer (ERSPC) studies which conclude that PSA screening would reduce the number of deaths from prostate cancer by up to 31% for men who are screened. However, on the basis of mathematical sleight of hand, the ScHARR report concludes that there is only a small reduction in death from prostate cancer due to prostate cancer screening, and no evidence for lives being extended because of early diagnosis and treatment. Thus, the ScHARR report effectively neglects the benefits demonstrated by the ERSPC studies. The ScHARR report also completely neglects the findings from the 2009 Göteborg trial which showed that PSA testing reduces the number of deaths from prostate cancer by 56% for men who are screened. Referring to the results of the Göteborg trial, Prof David Neil has written (The Lancet – Oncology; Vol 11, August 2010): "These outcomes compare favourably with well-established screening programmes for breast and colorectal cancer …".

The underlying problem is that there was insufficient rigour in the process used to check the validity of the contents of the ScHARR report. For example, we were able to find numerical errors in this report which were acknowledged but still remain uncorrected. When the NSC issued the ScHARR report for peer review, our attempts to engage with the NSC and the ScHARR team to ask serious detailed scientific questions were largely ignored. Finally, despite receiving extensive comments during the consultation process, the ScHARR report remains completely unchanged.

2. The decision is based on out of date assumptions about prostate cancer treatment

As so much of the source material for the ScHARR report is old research, some of it going back nearly 15 years, it is based on treatment standards and clinical practices that no longer apply. As a result, assumptions are made about decisions to treat, and morbidities associated with treatment, that bear no relation to what actually goes on in a modern prostate cancer clinic. One of the most obvious of these is the impact of the increasing use of Active Monitoring for low risk disease, which is revolutionising the negative impact of the risk of "over-treatment". The ScHARR work makes little acknowledgement of this. Similarly, the report is based on assumptions about the levels of morbidities (e.g. incontinence and sexual dysfunction) that were common in the last century, and takes little account of the enormous advances in clinical practice that have taken place over the past ten years. Were these factors to be properly taken into account, the disadvantages of screening assumed in the report would be greatly reduced.

3. The decision is based on demonstrably false assumptions about the QoL impact of prostate cancer detection and treatment

The ScHARR report seriously exaggerates the disadvantages of screening, particularly where they relate to morbidities associated with treatment: it completely ignores studies on risk-based screening, which is designed to reduce the level of overtreatment; it makes the extraordinary and arbitrary assumption that sexual dysfunction, caused by prostate cancer treatments, reduces the quality of life of patients by 10%, thereby

equating the loss of life of a prostate cancer patient to ten men suffering from sexual dysfunction; it takes no account of the enormous loss of QoL implicit in treatment for late stage disease, including the psychological effect of knowing that a "death sentence" could have been avoided by earlier detection.

The ScHARR researchers would appear to have their own answer to the question "how many men with treatment complications is one man's life worth?" but it is not detailed, and its validity cannot therefore be confirmed, nor is there evidence that this crucial factor entered into the calculations that led to the NSC's decision.

4. The report of the decision falsely implied a level of consensus that does not exist

The claim, in the published minutes of the NSC meeting that made the decision, that "the consultation replies and the stakeholder meeting which took place on 11th October 2010 to discuss the findings from the review were in the main content with the recommendation …" is a gross misrepresentation of the actual tenor of the replies, and of the general discussion at the stakeholder meeting. At the meeting it was acknowledged that the ScHARR report has used data which is out of date. For example, based on data from 1994, it was assumed that patients diagnosed with Gleason <=7 invariably had radical treatment. In 2011, a high proportion of these patients are managed with Active Surveillance. This alone would make a considerable difference to the over-treatment argument. It was pointed out that the fact that Urinary Incontinence and Erectile Dysfunction can be treated was ignored, as were new minimally invasive techniques which can only be carried out if the cancer is caught early enough. Most significantly, as described above, the Swedish Göteborg Study was ignored. All of the above shortcomings in the analysis supporting the NSC decision were acknowledged by NSC staff at the stakeholders meeting, but had been forgotten by the time the NSC meeting took place. This is no way to conduct a business on which the lives of thousands of men depend.