AACU
American Association of Clinical Urologists, Inc.
Two Woodfield Lake, 1100 E. Woodfield Road, Suite 350, Schaumburg, IL 60173 • Phone: (847) 517-1050 • Fax: (847) 517-7229
email: info@aacuweb.org • website: www.aacuweb.org

May 8, 2017

Kirsten Bibbins-Domingo, Ph.D., M.D., M.A.S.
Chairperson, U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Dear Dr. Bibbins-Domingo:

The American Association of Clinical Urologists (AACU) respectfully submits these comments on the U.S. Preventative Services Task Force (USPSTF) Recommendation Statement on Screening for Prostate Cancer.

Founded in 1968 by urologists concerned by the government's increasing role in the practice of medicine, the AACU is a professional organization representing the interests of more than 3,000 urologists across the United States, as well as urologic societies engaged as advocacy affiliates. We are dedicated to developing and advancing heath policy education as it affects urologic practice in order to preserve and promote the professional autonomy of our members and support the highest quality of care for patients. Our members care for hundreds of thousands of prostate cancer patients each year, with a variety of disease management strategies.

The AACU agrees with the USPSTF draft recommendation statement on prostate cancer screening for men ages 55 to 69 years, which recognizes that the decision to screen for prostate cancer should be based on an individualized approached after discussion with a physician "so that each man has an opportunity to understand the potential benefits and harms of screening and to incorporate his values and preferences into his decision." The related C grade for this age group represents an improvement over the Task Force's 2012 recommendation and in estimating the magnitude of net benefit of this improvement, we concur with the USPSTF's appraisal that it may be "useful for clinicians to regularly revisit the decision…with their patients."

The serum prostate-specific antigen (PSA) test is the best currently-approved biomarker for prostate gland abnormalities. Over time and after multiple tests, reports of an elevated PSA measurement lead men to careful, deliberate and informed decisions based on their values and preferences. If further tests confirm a cancer diagnosis, the disease is found to be at its earliest stage 90% of the time, up from 35% when PSA-based screening was not available. Early detection of prostate cancer made possible by the PSA test affords men the

opportunity to consider many disease management options, including active surveillance for slow-growth cancer.

Modern management of prostate cancer is rooted in patient education and shared decision-making. Neither physicians nor patients rush to treatment with surgery, radiation or androgen deprivation therapy. Indeed, when interpreted correctly and administered in combination with digital rectal examinations, PSA measurements inform physicians' assessments of cancer risk, expected disease progression and recommendations that will promote positive outcomes and the highest quality of life.

We are satisfied that the Draft Recommendation specifically addresses men at increased risk of death from prostate cancer, including African American men and those with a relevant family history, and believe the proposed statement for men ages 55 to 69 years adequately avoids a blanket recommendation for all men, regardless of those factors. We do not agree, however, with the "D" grade for men age 70 years and older and therefore urge the Task Force to reconsider its recommendation against screening for this age group.

With the expectation of life for men age 70 now reaching an additional 14.4 years (up from 13.4 years reported 10 years before)[1] and the age 85-and-over population projected to increase 351% between 2010 and 2050,[2] we believe select men age 70 years and older may benefit from prostate cancer screening. Moreover, as evidenced by the ProtecT trial,[3] the potential benefits of individualized and shared decision making afforded to men ages 55 to 69 years can very well be experienced by those age 70 and above, provided that they have a potential life expectancy of 15 years or more.[4] Indeed, in some cases, men age 70 years and older without comorbidities actually have longer life expectancies—10 to 15 years or more—than men in their 50s or 60s.[5]

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[1] Centers for Disease Control and Prevention. United States Life Tables, 2013 - Table A: Expectation of life, by race, Hispanic origin, age, and sex: United States, 2013. *Nat'l Vital Statistics Reports*. 2017 Apr 11;66(3):3. https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_03.pdf; Centers for Disease Control and Prevention. United States Life Tables, 2003 - Table A. Expectation of life by age, race, and sex: United States, 2003. Nat'l Vital Statistics Reports. 2006 Apr 19;54(14):3. https://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf.

[2] National Institute on Aging, et al. Global Health and Aging: Living Longer. NIA. https://www.nia.nih.gov/research/publication/global-health-and-aging/living-longer. Published October 2011. Updated January 22, 2015.

[3] Hamdy FC, Donovan JL, Lane JA, et al. ProtecT Study Group. 10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer. *N Engl J Med*. 2016 Oct 13;375(15):1415-1424. doi: 10.1056/NEJMoa1606220.

[4] *See also* The American Urological Association, et al. to Dr. Kirsten Bibbins-Domingo, Chair, U.S. Preventive Services Task Force, May 8, 2017.

[5] Cho H, Klabunde CN, Yabroff KR, et al. Comorbidity-adjusted life expectancy: A new tool to inform recommendations for optimal screening strategies. *Ann Intern Med*. 2013 Nov 19;159(10):667-76. doi: 10.7326/0003-4819-159-10-201311190-00005.

In short, because many men age 70 and older may expect to live longer than men ages 55 to 69, we urge the Task Force to reconsider its rigid cut-off at age 70 and instead give men age 70 and older the same consideration as men age 55 to 69 by assigning a “C” grade for all men age 55 and older.

We continue to caution against associating PSA-based screening with potential harms of overtreatment. Prostate cancer screening does not always lead to prostate cancer treatment. Continuing to tie potential complications with the awareness-raising test does not match up with the Task Force's own acknowledgement that "[active] surveillance has become a more common treatment choice for men with lower-risk prostate cancer over the past several years." We concur with an assessment in the April 11, 2017, USPSTF Bulletin, which explains that this disease management strategy offers men "the opportunity to delay active treatment and complications—or avoid active treatment completely."

More than two million men are alive today because of early detection and improved management of prostate cancer. We must continue to encourage physicians to speak freely to their patients about PSA-based screening for prostate cancer and endorse informed decision-making based on each individual man. The USPSTF Draft Recommendation Statement allows for men ages 55 to 69 years to determine whether they feel that the potential benefits of prostate cancer screening outweigh the potential harms. We urge the Task Force to amend its recommendation for men age 70 and older, thereby providing them with the opportunity to make the same balanced determination.

The AACU again wishes to thank you for the opportunity to comment on this Draft Recommendation Statement and welcomes the chance to work with you and the Task Force further to develop a recommendation that will ultimately ensure men at risk for prostate cancer receive the best care.

Sincerely,

Charles A. McWilliams, MD
President, AACU

Jonathan Henderson, MD
Health Policy Chair, AACU