Prostate cancer: progress and perplexity

Editorial

Éditorial

John Hoey, MD

Dr. Hoey is Editor-in-Chief of *CMAJ*.

CMAJ 1998;159:491-2

See related article page 509

So much and yet so little is known about prostate cancer. The basic fact confronting us is that the disease is so common. It is the second most frequently diagnosed cancer in Canadian men and, after lung cancer, the most common cause of cancer-related death. The lifetime risk of prostate cancer for men born in this country has been estimated as 1 in 8, and in 1997 its incidence exceeded that of breast cancer. Postmortem studies indicate that almost 70% of men have malignant cells in their prostates by the time they reach the age of 80.[1]

These essential facts are far from simple. In this issue (page 509) Dr. Isra Levy and colleagues begin our Clinical Basics prostate cancer series with an overview of the questions that surround the descriptive epidemiology of the disease in Canada. For example, to what extent are rising incidence rates related to the widespread adoption of prostate-specific antigen (PSA) testing early in this decade? Some have argued that the recent upsurge in incidence is primarily a function of the sensitivity of the PSA test: by detecting "clinically insignificant" tumours, PSA testing exaggerates the risks. On the other hand, incidence rates had begun to rise before the advent of PSA testing. The aging of the Canadian population, together with environmental risk factors that we have not even begun to understand, may be partly responsible for current epidemiological trends. What does appear to be beyond dispute is that, as elderly men account for a growing proportion of the population, physicians will encounter cases of prostate cancer with increasing frequency.

If accounting for statistical rates is difficult, no less is the task of translating those rates into an individual patient's risk of being diagnosed with and dying from prostate cancer. The patient who has survived to age 65 free of the disease may take comfort in the fact that his lifetime risk is now considerably lower than the grim and much-cited 1 in 8; at the same time, his annual risk will continue to rise for the next 10 years — that is, until it is overtaken by his chances of dying from another cause. Patients might also be encouraged to know that the rise in mortality rates has not kept pace with incidence and seems in fact to have levelled off in recent years. Given that the annual case fatality rate stands at about 20%, many men who are diagnosed with prostate cancer have a reasonably good prognosis. Many more men die *with* prostate cancer than *of* the disease.

Does this suggest that we are making progress in the treatment of prostate cancer? Again, the situation is difficult to interpret. Because there have been no randomized controlled trials of surgery and radiotherapy for prostate cancer, we have an imperfect picture of the effectiveness of these interventions, either of which may exact the heavy price of impotence and incontinence. Is "watchful waiting" as good a bet as early intervention? Does androgen ablation significantly improve survival? What about quality of life? What do we tell the patient who asks

The Clinical Basics series

With this issue *CMAJ* launches Clinical Basics, a new publishing initiative designed to provide physicians with up-to-date and authoritative information on important subjects in clinical medicine. Written, edited and peer reviewed by practising experts, each set of articles in the Clinical Basics series is intended to help the nonspecialist keep abreast of the latest diagnostic procedures, treatments and technologies in a range of clinical fields. After publication in *CMAJ* each set of articles will be made available in a convenient reference volume. Each article will also be posted on our web site simultaneously with publication in *CMAJ*.

Practice Basics begins with our Prostate Cancer series, edited by Dr. Neill A. Iscoe, Medical Oncologist with the Toronto–Sunnybrook Regional Cancer Centre, and Dr. Michael Jewett, Chairman of the Department of Urology, University of Toronto. Currently in preparation is a series on common rheumatologic conditions, edited by Dr. John M. Esdaile of the University of British Columbia, and a series on tuberculosis, edited by Dr. Anne E. Fanning of the University of Alberta. Proposals for other series are welcome; interested physicians can contact Dr. John Hoey at 1 800 663-7336 x2118, or by email at hoeyj@cma.ca.

whether the side-effects of therapy are "worth it"?

These uncertainties give rise to another: Does early diagnosis by means of routine annual PSA screening have any real benefit? Given the ambiguities that surround the efficacy and optimal timing of available treatment options, not to mention their implications for quality of life, a 40-year-old patient may decide that, in the short term at least, ignorance is bliss.

Prostate cancer is about fear, sex, indignity and death. A growing number of our patients will need support in coping with these issues. They will need the best available information to help them to make informed choices with regard to screening, diagnosis, treatment, symptom management and palliation. Under the editorship of Dr. Neill A. Iscoe, Medical Oncologist with the Toronto–Sunnybrook Regional Cancer Centre, and Dr. Michael Jewett, Chairman of the Department of Urology, University of Toronto, the Clinical Basics prostate cancer series will provide physicians with a reliable and accessible source of that information. Written by leading clinicians and researchers, the 13 articles in the series give a comprehensive overview of epidemiology, risk factors, screening, diagnosis, prognosis, treatment of localized and advanced disease, the state of the art in surgery, radiotherapy and endocrine therapy, management of side effects, therapeutic advances on the horizon, the economic burden of the disease, and patient advocacy. We are confident that they will provide a practical and reliable guide for the perplexed.