

Letters

AUTHORS of two recent articles about prostate cancer screening correctly call for revision of existing information resources.^{1,2} As they say, longer-term trial data have refined our knowledge, and several recent innovations (ie MRI, transperineal biopsy, increased active surveillance) have reduced harms.

However, I have concerns. My first is that Rashid et al inaccurately portray disagreement between the existing PSA testing guidelines and The Royal Australian College of General Practitioners' (RACGP) Red Book.^{3,4} Neither guideline recommends prostate cancer screening for the general population, and both agree that a discussion of benefits and hazards should precede testing. Rashid et al write that the prostate-specific antigen (PSA) testing guidelines 'recommend that men aged 50 years and over should be made aware of prostate cancer', but the guidelines make no such recommendation. To the contrary, they state:

*'This guideline does not recommend a population screening program for prostate cancer... Current evidence does not support such a program. This guideline does not make recommendations about ... whether, or how, primary care doctors should raise the topic of prostate cancer testing with their male patients.'*³

My second concern is of balance. Just as patients deserve balanced information about the benefits and harms of screening,³ so do this Journal's readers. But these two articles emphasise benefits more than harms. Diagnoses and deaths are tallied; overdiagnoses and complications are not. Benefits appear larger when quoted in relative rather than absolute terms, and when drawn from trials of treatment rather than screening. Tse et al share 'numbers needed to screen' and 'numbers needed to diagnose', but omit 'numbers needed to harm'.²

More balance is possible. For example, the Harding Centre shows that, comparing 1000 screened versus unscreened men aged >16 years, two fewer would die of prostate cancer, but 155 more would experience false alarm (and often biopsy) and 51 more would be overdiagnosed or overtreated.⁵ Recent improvements mean that these estimates of harms are likely now overstated, but without balanced, up-to-date modelling, it is difficult for GPs to accurately counsel their patients.

As the authors state, revision of the PSA testing guidelines is underway. I look forward to fair-minded collaboration between all parties in this process, in the interests of all Australians with prostatitis.

Author

Brett D Montgomery MBBS, DCH, FRACGP, MMedSci, General Practitioner and Senior Lecturer, School of Medicine, University of Western Australia, Crawley, WA

References

1. Rashid P, Zargar-Shoshtari K, Ranasinghe W. Prostate-specific antigen testing for prostate cancer: Time to reconsider the approach to screening. *Aust J Gen Pract* 2023;52(3):91-95. doi: 10.31128/AJGP-08-22-6509.
2. Tse T, Wu B, Vaghholkar S, Willcock S. Shared decision making in prostate cancer screening: An update. *Aust J Gen Pract* 2023;52(3):99-101. doi: 10.31128/AJGP-07-22-6498.
3. Prostate Cancer Foundation of Australia and Cancer Council Australia PSA Testing Guidelines Expert Advisory Panel. PSA testing and early management of test-detected prostate cancer: Clinical practice guidelines. Sydney: Prostate Cancer Foundation of Australia and Cancer Council Australia, 2016.
4. The Royal Australian College of General Practitioners. Early detection of cancers: Prostate cancer. Red Book: Guidelines for preventive activities in general practice. RACGP, 2021. Available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr-early-detection-of-cancers/prostate-cancer [Accessed 12 June 2023].
5. Harding Center for Risk Literacy. Early detection of prostate cancer with PSA testing. Harding Center for Risk Literacy. Available at www.hardingcenter.de/en/transfer-and-impact/fact-boxes/early-detection-of-cancer/early-detection-of-prostate-cancer-with-psa-testing [Accessed 12 June 2023].

Reply

We thank the writer for engaging with our paper on screening for prostate cancer.¹

Without a clear recommendation to general practitioners (GPs), there remains confusion about whether or how a GP would raise awareness of prostate cancer and whether or when to order a prostate-specific antigen (PSA).² The Prostate Cancer Foundation helps address the confusion by making a recommendation that, 'For men at average risk of prostate cancer who have been informed of the benefits and harms of testing and who decide to undergo regular testing for prostate cancer, offer PSA testing every 2 years from age 50-69 years, and offer further investigation if the total PSA is greater than 3 ng/mL'.³

As prostate cancer is largely asymptomatic and most men do not have a family history, how does a man become aware of prostate cancer in the primary care setting? How does a GP make a decision about cancer risk without knowledge of the PSA (given a digital rectal examination is not recommended)?

PSA is an inevitable next step and for most men it will be less than three, negating the need for any further action apart from when to repeat the test. Once a PSA is known and if abnormal, a more detailed discussion can ensue. Not considering a PSA continues to offer no added appreciation of cancer risk.

We do agree that collaborative multi-disciplinary consensus on updated guidelines is needed and fortunately that process is underway. However, guidance about raising the topic of prostate cancer testing should be provided by the GP regulatory bodies, aligning with the collaborative guidelines.

We do not agree that 'diagnoses and deaths are tallied; overdiagnoses and complications are not.' This is covered in our paper. The Prostate Cancer Outcomes Registry (PCOR-ANZ) offers much detail in this area.⁴ Furthermore, we have presented current evidence that demonstrates better

risk stratification for harm minimisation, increased accuracy of staging, improved compliance with active surveillance, better medical therapies and improved metastasis-free survival.

The European Association of Urology guidelines and the Position Statement from the Urological Society of Australia and New Zealand confirm that knowing a PSA helps assess prostate cancer risk.^{5,6}

Authors

Prem Rashid MBBS, PhD, DClinSurg, FRACS(Urol), Urological Surgeon, Conjoint Associate Professor, Rural Clinical School, Faculty of Medicine and Health, The University of New South Wales, Sydney, NSW
 Kamran Zargar-Shoshtari MBChB, MD, FRACS(Urol), Associate Professor, University of Auckland, Auckland, New Zealand; Consultant Urologist, Te Whatu Ora, Counties Manukau, Auckland, New Zealand
 Wernaja Ranasinghe MBChB, PhD, MRCS, FRACS(Urol.), Urological Surgeon, Associate Professor, Monash Health and Monash University, Melbourne, Vic

References

- Rashid P, Zargar-Shoshtari K, Ranasinghe W. Prostate-specific antigen testing for prostate cancer: Time to reconsider the approach to screening. *Aust J Gen Pract* 2023;52(3):91–95. doi: 10.31128/AJGP-08-22-6509.
- The Royal Australian College of General Practitioners. Early detection of cancers: Prostate cancer. Red Book: Guidelines for preventive activities in general practice. RACGP, 2021. Available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/early-detection-of-cancers/prostate-cancer [Accessed 12 June 2023].
- CancerCouncil. Clinical practice guidelines for PSA testing and early management of test-detected prostate cancer. Cancer Council of Australia, 2016. Available at https://wiki.cancer.org.au/australia/Guidelines:PSA_Testing [Accessed 9 June 2023].
- Papa N, O'Callaghan M, Mark S, Millar J, Breen S. Prostate cancer across Australia and New Zealand: PCOR-ANZ 2015–2019 Summary Report. Prostate Cancer Outcomes Registry Australia and New Zealand (PCOR-ANZ), 2022. Available at https://prostatecancerregistry-org.s3.amazonaws.com/pcor_cms/media/filer_public/79/70/7970c55a-2635-4c58-a46b-09da85ad972a/cst-2991_2021_pcor-anz_annual_report_digi_fa.pdf [Accessed 9 June 2023].
- Urological Society of Australia and New Zealand (USANZ). Position Statement: PSA testing. Urological Society of Australia and New Zealand, 2022. Available at www.usanz.org.au/info-resources/position-statements-guidelines [Accessed 13 April 2023].
- Van Poppel H, Roobol MJ, Chapple CR, et al. Prostate-specific antigen testing as part of a risk-adapted early detection strategy for prostate cancer: European Association of Urology Position and Recommendations for 2021. *Eur Urol* 2021;80(6):703–11. doi: 10.1016/j.eururo.2021.07.024.

A sustainable vision for general practice

THE TWO ARTICLES by Sturmberg et al regarding 'A sustainable vision for general practice,' published in the March 2023 edition of *AJGP* are both interesting and thought-provoking.^{1,2} They highlight systems and complexity thinking and the fact that concentrating on improving one part of a complex, interconnected, interdependent system may not improve the system as a whole.

Much is currently being written and discussed about problems in our health system and, in particular, general practice. As general practitioners (GPs), we need to be careful not to adopt an external locus of control. We should also consider how we, as a profession and individuals, have contributed to the current situation with its many problems well highlighted.

Cost pressures are impacting on the ability of GPs to provide quality care.^{3,4} Could our collective response to this have contributed to our current standing in the community, the state of our profession and our seeming powerlessness?

There are passionate pleas for Medicare rebates to increase so that general practices can remain viable. 'Only 3% of GPs stated that the current Medicare rebate is sufficient to cover the cost of care'.³ With the apparent material wealth of many Australians, could a more significant number of Australians comfortably contribute directly to the cost of their general practice care, particularly if they are as convinced as Sturmberg et al are when they say that this care enabled them to live and cope better with their disease; in other words, if it led to improved health experience?

Sturmberg et al say, 'For too long general practice has been demeaned and oversimplified by non-general practitioner (GP) colleagues, as well as members of the community and politicians.' I believe that as a profession and as individuals, we have also contributed to this. Perhaps it is up to us to start to turn this particular aspect and contributor around, acknowledging that on its own, it will not 'fix the whole system.'

Author

Murray Ludington, MB, BS, FRACGP, MRCP, DA(UK), DRCOG, Casual External Clinical Teaching Visitor, The Royal Australian College of General Practitioners, East Melbourne, Vic

References

- Sturmberg JP, Hogan CD, Price KL. A sustainable vision for general practice: Understanding the challenges. *Aust J Gen Pract* 2023;52(3):143–48. doi: 10.31128/AJGP-08-22-6539.
- Sturmberg JP, Hogan CD, Price KL. A sustainable vision for general practice: Addressing the challenges. *Aust J Gen Pract* 2023;52(3):150–57. doi: 10.31128/AJGP-08-22-6540.
- The Royal Australian College of General Practitioners. General practice: Health of the Nation 2022. East Melbourne, Vic: RACGP, 2022. Available at www.racgp.org.au/general-practice-health-of-the-nation-2022#:~:text=The%202022%20General%20Practice%3A%20Health,the%20provision%20of%20patient%20care [Accessed 13 June 2023].
- Desloires V. GPs split over 'six-minute medicine'. *Financial Review*. 16 January 2015. Available at www.afr.com/politics/federal/gps-split-over-six-minute-medicine-20150116-12rt91#:~:text=The%20medical%20profession%20is%20dividing,sessions%20to%20fill%20the%20coffers.&text=Doctors%20are%20split%20over%20so,six%2Dminute%20medicine [Accessed 13 June 2023].

Erratum

Hunter J, Harnett JE. Interactions between complementary medicines and drugs used in primary care and oral COVID-19 antiviral drugs. *Aust J Gen Pract* 2023;52(6):345–57. doi: 10.31128/AJGP-12-22-6631.

In this article, there was a misprint in Table 1 (Complementary medicine–drug interaction resources). Footnote C should have been placed after 'DynaMed/Micromedex' (along with footnote A) and not after 'MedicinesComplete Stockley's interactions checker'.

The authors apologise for this error and any confusion this may have caused our readers.

correspondence ajgp@racgp.org.au