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Prevention of Prostate Cancer 02/03

-- Significance --

-- Incidence and Mortality --

Carcinoma of the prostate is the most common tumor in men in the United States with 189,000 new cases and 30,200 deaths expected in 2002.[1] A wide range of estimates of the impact of the disease are notable. The disease is histologically-evident in as many as 34% of men in their fifth decade and in up to 70% of men 80 years of age and older.[2] [3] Prostate cancer will be diagnosed in almost one fifth of U.S. men during their lifetime, yet only 3% of men will be expected to die of the disease.[4] The estimated reduction in life expectancy of men who die of prostate cancer is approximately 9 years.[5]

The extr rdinarily high rate of clinically occult prostate cancer in the general population compared to the 20-fold lower likelihood of death from the disease indicates that many of these cancers have low biologic risk. Concordant with this observation are the many series of patients with prostate cancer managed by surveillance alone with relatively good survival rates at 5 and 10 years of follow-up.[6] Data demonstrate, however, that with prolonged 10-year follow-up of moderately differentiated (which constitute the majority of tumors detected at this time [7]) and poorly differentiated tumors there is a substantial risk of disease progression and death from prostate cancer.[8]

Treatment options available for prostate cancer include radical prostatectomy, external-beam radiation therapy, brachytherapy, and surveillance. A comprehensive literature review leading to development of guidelines for prostate cancer management concluded that there are no compelling data to demonstrate the clear superiority of any of these forms of treatment for an individual patient and therefore urged the presentation of all of these treatment options to any patient with newly-diagnosed, localized prostate cancer.[9] Confounding issues in the treatment of prostate cancer include side effects with treatment, inability to predict the natural history of a given cancer, patient comorbidity that may affect an individual's likelihood of surviving long enough to be at risk for disease morbidity and mortality, as well as an increasing body of evidence suggesting that careful prostate-specific antigen (PSA) monitoring following treatment may indicate a substantial fraction of treatment failures.

Because of considerable uncertainty regarding the efficacy of treatment and the difficulty with selecting patients for whom there is a known risk of disease progression, there is division of opinion in the medical community regarding screening for carcinoma of the prostate. While both digital rectal examination and PSA have demonstrated reasonable performance characteristics (sensitivity, specificity, positive predictive value) for the early detection of prostate cancer, the lack of evidence that screening and treatment affects ultimate population morbidity or mortality has led many organizations to eschew screening.

The tremendous impact of prostate cancer on the U.S. population, as well as the financial burden of the disease both for patients and society, has led to an increased interest in primary disease prevention.

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