

2017

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## Recommended Citation

Leu, Rose Kristine, "Community Awareness of Burgeoning Prostate Cancer Screenings" (2017). *Family Medicine Block Clerkship, Student Projects*. 267.

<http://scholarworks.uvm.edu/fmclerk/267>

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# Community Awareness of Burgeoning Prostate Cancer Screenings

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# Problem Identification

- Prostate-specific antigen (PSA) is widely accepted as a valid method to detect prostate cancer recurrence; PSA is currently controversial in its use in prostate cancer screening (1,2)
- In May 2017, US Preventive Services Task Force proposed a change in their previous recommendation for prostate cancer screening from “grade D” to “grade C” (3)
- Guidelines for prostate cancer screening from American Cancer Society and American Urological Association are not in complete agreement (4,5)
- With no standardization of a prostate cancer screening protocol amongst various providers and previous guidelines recommending against screening, patients are understandably confused about if they should be screened

# Public Health Cost

- In the US, prostate cancer is the most common cancer in males (excluding skin cancer) resulting in an expected 26,730 deaths in 2017, making it the 3<sup>rd</sup> leading cause of cancer death (6)
- Prostate cancer is associated with \$12 billion in medical costs (7)
- Since USPSTF previous recommendation of “grade D” was published in 2012, there has been significant decrease in PSA screening (8)
  - Patients who could benefit from treatment are potentially identified too late, decreasing favorable outcomes

# Community Perspective

Thanks to the Champlain Valley Prostate Support Group who let me interview them, we had a wonderful discussion about their thoughts on screening and their own experiences! Here are some of their responses

Phyllis A. Knight (partner of group member): she has a family history of ovarian cancer and laments that there is no current screening methods for that, says her relative only lived for 3-4 months after finding out. She acknowledges that PSA is not the perfect screening tool, but believes that it is better than having nothing and that it's important to take advantage of this tool.

George Schiavone (group member): his PSA hovered in the 1-2 ng/ml and then climbed up to 3-4 ng/ml over a 8 year span. However, his provider was hesitant to do anything based on his PSA and decided to wait. When he ended up getting his prostate biopsied, his Gleason score was 9. He is a firm believer in using PSA for screening and adamantly did not agree with the USPSTF's previous recommendation to not use PSA screening at all.

# Community Perspective II

Anonymous (group member): he doesn't believe in using PSA or digital rectal exam for screening and endorses that it should be used only when symptoms appear because it treadmills into surgery and radiation and these treatments can have a lot of side effects.

Anonymous (group member): she has a family history of prostate cancer and now has sons. She fully supports having PSA screening done for them and urges them to start having those conversations with their providers when they turn 40-years-old. She was very happy to learn that the USPSTF has recently decided to change their recommendations and believes things are heading in the right direction.

# Intervention

- Poster motivating patients to start a conversation with their provider about prostate cancer screening
  - Also educate them about the risk factors associated with prostate cancer to ensure that high risk males are more effectively captured in the screening process
- Current research is underway at the UVMCC and UVM Cancer Center
  - The Modern Approach to Prostate Cancer Screening (MAPS): Headed by Dr. Wallace and Dr. Landrey for Primary Care Physicians and Urologists to collaborate on a standardized risk-adapted, PSA-based prostate cancer screening to identify clinically significant prostate cancer

# Results

- Result is a poster promoting awareness among males over 40 to have a shared decision-making conversation with their provider about appropriateness of prostate cancer screening
- Posters can be distributed to all UVMHC family practice sites and any other sites part of the University of Vermont Health Network



# Effectiveness and Limitations

- Patients with certain risk factors are particularly prompted to consider screening
- Posters are more visually noticeable; this can be an effective initial step of promoting awareness
- Posters are distributed in high yield locations
- To assess for effectiveness:
  - Survey providers to see if they noticed having more conversations with patients about prostate cancer screening
  - On PRISM, research how many times providers and patients had a talk about screening from provider documentation within the past 3 months
- Limitations include:
  - dissemination not being widespread enough to capture as many eligible males as possible
  - Some may not take the time to read the poster

# Recommendations for Future Interventions

- To reach a more widespread audience, further dissemination of importance of prostate cancer screening by:
  - writing an article for the Hinesburg Record and UVMHC blog
  - Presenting at the Men's Health and Cancer Conference
- Update information if new guideline recommendations or knowledge regarding screening practices change
- To assess if more shared decision-making conversations about screening resulted in diagnosis of clinically significant prostate cancer

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