Prostate cancer screening: should family physicians discuss it with their patients?

I read the recent editorial[1] on prostate cancer with interest. The issue of screening for this disease is important for family physicians and their patients. With some concern, however, I noted the recommendation for increasing awareness among Canadian men about the risks and benefits of prostate-specific antigen (PSA) and digital rectal examination (DRE) screening. This has been a very difficult area for us in primary care; along with one of my colleagues, I recently wrote an article outlining some of our deliberations around this issue.[2] Both DRE and PSA remain as "D" recommendations for prostate screening (fair evidence against) in the *Guide to Clinical Preventive Services*.[3] It is therefore not surprising, as the author noted, that many of us choose a passive stance on this issue; I must disagree with Dr Gray's statement that the current uncertainty about PSA … is not a good enough reason for doing nothing in clinical practice." I think that the lack of evidence is a good enough reason.

There are 20 recommended screening maneuvers applicable to men in the 50 to 65 age range.[4] Evidence shows that many of those measures are not implemented.[5] There are time constraints in clinical practice, and, if done properly, counseling men about PSA involves a considerable amount of time. Should our resources not be marshalled toward other interventions of more proven benefit?

There was an interesting discussion recently about a similar screening issue: colorectal cancer (CRC) screening.[6,7] Again, the expert panel recommends that every patient be informed about the risks and benefits of screening for CRC. The rebuttal, by a family physician, discusses the very low absolute reduction in risk, along with the point that: "Society is becoming more and more obsessed by disease. Every new screening program generates fear. Population-based screening for colon cancer has not been proven to save lives, but it will almost certainly decrease our quality of life. Now is not the time to screen."[7] It should be noted that this screening test (fecal occult blood testing) does carry with it a greater amount of evidence of benefit in terms of morbidity reduction than does PSA screening.[8]

The decision to offer PSA screening might have drawbacks, both in terms of the danger of harming our patients and of possibly reducing our ability to practise more effective preventive care. A debate on whether to recommend that every family physician discuss this issue with all eligible patients should take these factors into consideration.

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Linguistic bullying

In the September issue of *Canadian Family Physician*, I read with interest the response[1] to Dr Kents' letter[2] about the term "baby-friendly."

I now understand that, in the eyes of the College of Family Physicians of Canada (CFPC) (along with the World Health Organization and UNICEF), "baby-friendly" does not mean baby-friendly, but rather what it was trademarked to mean.

My first reaction was that this level of linguistic bullying would have to be considered clarity-unfriendly and discussion-unhelpful (unless, of course, those phrases have been trademarked to mean something else). I then, however, fondly recalled that "100% beef" is not necessarily 100% beef and that "ice cream product" is not necessarily an ice cream product and decided that such hijacking of language has precedents and some value as entertainment.

I guess, then, I should jump on the bandwagon and hurry to trademark the phrases "I love you" and "beautiful day today" before some august bureaucracy tells me what they mean and when to use them.

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