What about prostate cancer?

I was annoyed but not surprised that Dr Jeffery Sisler's editorial[1] on delays in diagnosing cancer made no mention whatsoever of prostate cancer. I assume his rationale to be the ongoing benefits and harms debate and dilemma regarding screening for this disease, particularly prostate-specific antigen (PSA) testing.

As a prostate cancer survivor (1994) and educator, I have heard at support group meetings and from many telephone calls the anger and resentment of too many men who feel their family physicians let them down by not telling them about the prevalence of prostate cancer and not discussing the risks, symptoms, or the pros and cons of PSA screening. The patients were diagnosed when their symptoms became pronounced enough to bring them to their physicians, or in some cases when they themselves requested a PSA test. They were shocked to find they had prostate cancer, advanced beyond its earliest stages, and in some cases, already metastatic. I suggest that Dr Sisler's editorial, in its failure to acknowledge this disease and its challenges to family physicians, perpetuates these oversights.

These men understandably feel that their prospects of effective treatment would have been enhanced by earlier diagnosis, in Dr Sisler's words, that the delay might have affected their chances of "beating" the disease. Too many of these men never confronted their physicians with their anger or dissatisfaction and simply moved on to the care of specialists who too often had bad news for them about the limitations of their treatment choices and the lost or reduced chances of cure because of the delay in diagnosis. I also speak with the authority of personal experience on this matter.

As a cancer care specialist and professor of family medicine, Dr Sisler knows well that prostate cancer is the most prevalent cancer in Canadian men, and, after lung cancer, the second leading cause of their death by cancer. He also knows that issues of screening, early or late detection, and debates about timeliness of treatment are very pointed and relevant for family physicians and their patients—or in some cases, their former patients, and in some very unfortunate cases, their late patients. Yet in his editorial, he does not even acknowledge prostate cancer's existence, let alone highlight the dilemma it poses to physicians about appropriate patient care and moral responsibilities to them.

I think this is a very unfortunate and, I assume, deliberate omission for someone in his position writing an editorial for such a widely circulating family physician journal. Avoidance and denial will not make prostate cancer or its pressing issues of detection and responsibilities to patients go away. This disease is an ongoing major health care concern for Canadian men and their families. It is an important topic for any discussion of delays in cancer diagnosis.

Dr Sisler advises physicians that they "need to be alert to patient concerns about delay whenever serious illnesses, such as cancer, are diagnosed." With respect to prostate cancer and its omission in his editorial, Dr Sisler does not serve as a good example for his own injunction. In many cases, after-the-fact discussions come too late for patients' best interests and might appear only self-serving for physicians.

—Doug Scott, PHD
Toronto, Ont
by e-mail

Reference

1. Sisler JJ. Delays in diagnosing cancer. Threat to the patient-physician relationship [editorial]. *Can Fam Physician* 2003;49:857-9 (Eng), 860-3 (Fr).

Response

I share Dr Scott's belief that family physicians must be active in assessing their patients' risks of prostate cancer, educating them and the public about its symptoms, investigating thoroughly when symptoms appear, and discussing the pros and cons of screening. As part of a recent prostate health initiative, CancerCare Manitoba wrote to all Manitoba family physicians on this matter and provided a copy of a recent article in *Canadian Family Physician* on prostate-specific antigen screening.[1]

Make your views known!

Contact us by e-mail at
letters.editor@cfpc.ca
on the College's website at **www.cfpc.ca**
by fax to the Scientific Editor at
(905) 629-0893 or by mail to
Canadian Family Physician
College of Family Physicians of Canada
2630 Skymark Ave
Mississauga, ON L4W 5A4

...

Faites-vous entendre!

Communiquez avec nous par
courriel:
letters.editor@cfpc.ca
au site web du Collège: **www.cfpc.ca**
par télécopieur au Rédacteur scientifique
(905) 629-0893 ou par la poste
Le Médecin de famille canadien
Collège des médecins de famille
du Canada
2630 avenue Skymark
Mississauga, ON L4W 5A4

I think Dr Scott misses the point of the editorial, however. It does not focus on improving early detection, but rather addresses how doctors might respond in the aftermath of any serious diagnosis and ensure that concerns about delay, if present, are addressed. Individual cancer types are mentioned only briefly, and prostate cancer was not included only because I was unable to identify studies that assessed how delay affects stage at diagnosis or survival in non–screen-detected prostate cancer, as were noted for other cancer sites. The effect of screening on prostate cancer outcomes remains uncertain, and we await the results of ongoing randomized trials to provide direction.

Dr Scott mentions an important barrier to conversations about delay that the editorial does not address. Follow-up visits with a family physician after a cancer diagnosis might not occur because of the intensity of tests, specialist visits, and treatment, as well as patients' dissatisfaction with their family physicians or uncertainty as to the family physicians' role in their care (personal communication from Smith-Gorvie et al, 2003). Family physicians need to take the lead in arranging follow-up visits after referral to a cancer specialist, so that concerns about delay can be discussed, support offered to patient and family, treatment options reviewed, and the family physician's ongoing role clarified.

—Jeffrey J. Sisler, MD, MCLSC, CCFP, FCFP

Reference

1. Hickey J. Prostate-specific antigen testing. Should we recommend it? [Published erratum appears in *Can Fam Physician* 2003;49:568.] *Can Fam Physician* 2003;49:303-4.

"Timely communication" needs redefining

Having initiated an early discharge summary at the Halifax hospital some 30 years ago (**Figure 1**), I was interested in your article on oncologists and family physicians.[1]

Figure 1. Early discharge summary used by Dartmouth General Hospital and Community Health Centre

DARTMOUTH GENERAL HOSPITAL
AND COMMUNITY HEALTH CENTRE

INTERIM DISCHARGE SUMMARY

TO: DR. _____ DATE: _____

YOUR PATIENT_____

WAS ADMITTED ON _____ AND DISCHARGED ON _____

DIAGNOSIS:

PROCEDURES:

MEDICATIONS:

SUMMARY:

FOLLOW UP:

_____
PHYSICIAN SIGNATURE

_____
DATE

A FULL REPORT WILL BE FORWARDED
TO YOU IN THE NEAR FUTURE
COPIES: ORIGINAL - DARTMOUTH GENERAL CHART
COPY - TO ACCOMPANY PATIENT
F0010 Mar 94