30 jaar onderzoek naar de effecten van vroege opsporing prostaatkanker

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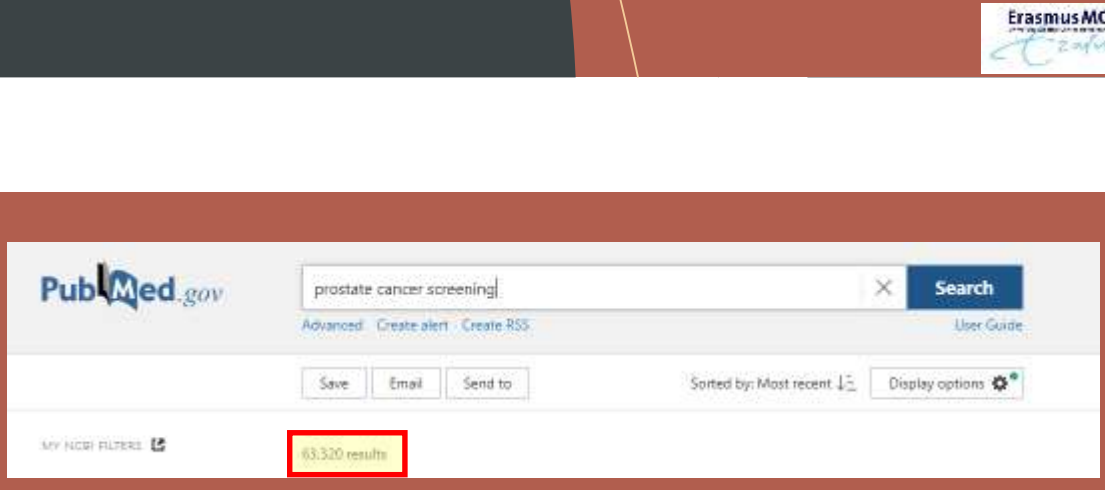

The NEW ENGLAND JOURNAL of MEDICINE

Before we start…

The founders of ERSPC

Fritz Schröder

Louis Denis † 2021

ERSPC
European Randomized Study of Screening for Prostate Cancer

25 JAAR
Prostaatkankerstichting

Overview

- **What triggered us to consider screening for PCa?**
- The trials in the 90s
- The results: Benefit!!! Harm……
- How do we balance it?
- The future

Beyond cure…

- 1984: With the DRE as the only method of diagnosis, 30-35% of men had bone metastases, and 40-45% had nodal disease

The Journal of Urology
Volume 132, Issue 4, October 1984, Pages 690-692

Adenocarcinoma of the Prostate: Results of Routine Urological Screening

Ian M. Thompson, Joseph J. Ernst, Mauro P. Gangai, C. Ritchie Spence

The use of adjunctive screening tools for detection of adenocarcinoma of the prostate is suggested.

Then it started

October 8, 1987
N Engl J Med 1987; 317:909-916
DOI: 10.1056/NEJM198710083171501

ORIGINAL ARTICLE Archives

Prostate-Specific Antigen as a Serum Marker for Adenocarcinoma of the Prostate

Thomas A. Stamey, M.D., Norman Yang, Ph.D., Alan R. Hay, M.D., John E. McNeal, M.D., Fuad S. Freiha, M.D., and Elise Redwine, B.A.

We conclude that PSA is more sensitive than PAP in the detection of prostatic cancer and will probably be more useful in monitoring responses and recurrence after therapy. However, since both PSA and PAP may be elevated in benign prostatic hyperplasia, neither marker is specific. (N Engl J Med 1987; 317:909–16.)

1991, 30 years ago in the NEJM

1156 THE NEW ENGLAND JOURNAL OF MEDICINE April 25, 1991

MEASUREMENT OF PROSTATE-SPECIFIC ANTIGEN IN SERUM AS A SCREENING TEST FOR PROSTATE CANCER

WILLIAM J. CATALONA, M.D., DEBORAH S. SMITH, PH.D., TIMOTHY L. RATLIFF, PH.D., KATHY M. DODDS, R.N., DOUGLAS E. COPLEN, M.D., JERRY J.J. YUAN, M.D., JOHN A. PETROS, M.D., AND GERALD L. ANDRIOLE, M.D.

Table 4. Accuracy of Rectal Examination, Serum PSA Measurement, and Ultrasonography in Detecting Prostate Cancer on First Biopsy in 300 Men in the Comparison Group.

MEASURE*	RECTAL EXAMINATION	ULTRASONOGRAPHY	SERUM PSA†
		percent	
Sensitivity	86	92	79
Specificity	44	27	59
Positive predictive value	33	28	40
Negative predictive value	91	91	89
Overall accuracy	58	43	64

We conclude that serum PSA measurement is a useful addition to rectal examination and ultrasonography in the detection of prostate cancer and that it is the most accurate of the three tests for this purpose. Our results suggest that measurement of serum PSA and rectal examination combined, with the addition of ultrasonography in patients with abnormal findings, will provide a better method of detecting prostate cancer than rectal examination alone.

1990
Visiting Professor W. Catalona

Prof. Catalona visits Erasmus MC Urology headed by Prof. Schroder.

The basis for an European screening trial

1991 in Rotterdam

TABLE 1 Characteristics of the screening protocols 1–10

Protocol number	Period	Recruitment rate (%)	Men (N)	Biopsy indication used
1	10/91–01/93	35.6	1 186	DRE and/or TRUS abnormal with lesion ≥8 mm. PSA in all men.
2	01/93–03/93	36.5	256	DRE and/or TRUS abnormal with lesion ≥8 mm or PSA ≥ 20.0 ng/mL
3	03/93–05/93	42.4	297	DRE and/or TRUS abnormal with lesion ≥8 mm or PSA ≥ 20.0 ng/mL
4	05/93–11/93	42.4	679	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL
5	12/93–05/94	40.6	450	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL
6	06/94–11/95	43.4	8 642	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL
7	11/95–01/96 03/96–10/96	53.9	4 147	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL. No screening if PSA < 1.0 ng/mL
8	01/96–03/96	52.8	1 404	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL. No screening if PSA < 1.0 ng/mL
9	10/96–04/97	50.7	6 000	DRE and/or TRUS abnormal or PSA ≥ 4.0 ng/mL. No screening if PSA < 1.0 ng/mL
10	05/97–12/99	48.0	21 733	PSA ≥ 3.0 ng/mL. No screening if PSA < 3.0 ng/mL
Total	Protocol 5–10		42 376	

BJUI 2003

Prostaatkankerstichting

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Screening trials initiated in the 90s

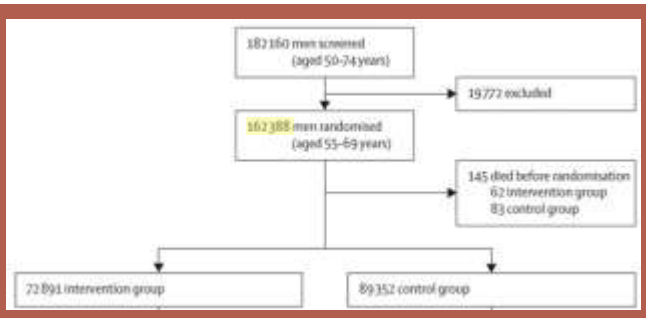
Study	Setting, country	Enrolment criteria	Study conducted	No of men randomised (intervention/control)	Screening method	Screening frequency	Primary outcomes	Secondary outcomes
ERSPC (core)[11]	RCT, multicentre, 9 European countries	Men aged 55-69 years	1993-2003, 13 year follow-up	72 891/89 352	PSA ± DRE. If PSA ≥3 ng/mL standardised prostate biopsy	Screening every 2-4 years	Prostate cancer-specific mortality	All-cause mortality, prostate cancer incidence, clinical stage, quality of life, harms
Labrie (Quebec)[12]	RCT, Quebec, Canada	Men aged 45-80 years	1988-1999, 11 year follow-up	31 133/15 353	PSA ± DRE. If PSA ≥3 ng/mL standardised prostate biopsy	Annual screening	Prostate cancer-specific mortality	Prostate cancer incidence, clinical stage
Lundgren (Stockholm)[13]	RCT, Stockholm, Sweden	Men aged 55-70 years	1988-2003, 20 year follow-up	2400/25 081	PSA, DRE, TRUS. Biopsy depended on DRE and TRUS findings, PSA >10 ng/mL	One-time screening	Prostate cancer-specific mortality	All-cause mortality, prostate cancer incidence
PLCO[14]	RCT, multicentre, US	Men aged 55-74 years	1993-2001, 15 year follow-up	38 340/38 343	PSA, DRE	Annual screening	Prostate cancer-specific mortality	All-cause mortality, prostate cancer incidence, clinical stage, Gleason grade, harms

RCT=randomised controlled trial. PSA=prostate-specific antigen. DRE=digital rectal examination. TRUS=transrectal ultrasound.

To assess the effect of PSA based screening on prostate cancer-specific mortality more than 300,000 men were included in studies

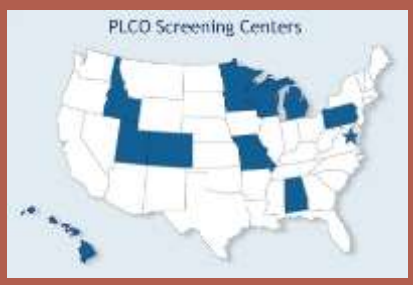
ERSPC

Started in 1993 In 8 European countries
www.erspc.org



- Screening interval: 4 years in 87%, 2 years in 13% (Sweden)
- Biopsy indication (sextant lateral): PSA >= 3.0 ng/ml
- Standardized causes of death evaluation
- Quality control by independent committees (e.g. pathology, PSA)

PLCO



- From 1993 through 2001, **76,693** men were randomly assigned at 10 U.S. study centers
- They received either annual screening (38,343 men) or usual care as the control group (38,350 men)
- Men in the screening group were offered annual PSA testing for 6 years and digital rectal examination for 4 years.
- Diagnostic evaluation was decided by the patients and their primary physicians.

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Prostaatkankerstichting

Results…….. Debate, debate and debate….


2009

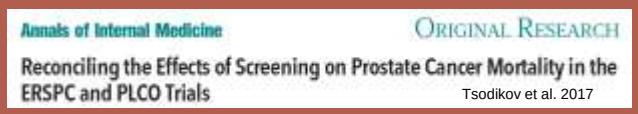
Screening and Prostate-Cancer Mortality in a Randomized European Study

ERSPC:

- Rate ratio for death from prostate cancer in the screening group, as compared with the control group, was 0.80 (95% CI: 0.65 to 0.98)
- Reduction in M+ advanced disease 30-40% (Eur Urol 2012)

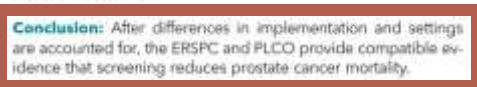
And clarity


Reevaluating PSA Testing Rates in the PLCO Trial

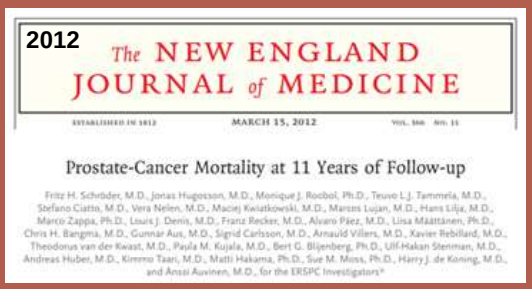

Annals of Internal Medicine ORIGINAL RESEARCH

Reconciling the Effects of Screening on Prostate Cancer Mortality in the ERSPC and PLCO Trials

Tsodikov et al. 2017


Conclusion: After differences in implementation and settings are accounted for, the ERSPC and PLCO provide compatible evidence that screening reduces prostate cancer mortality.

Confirmation of results: harm <> benefit


2012

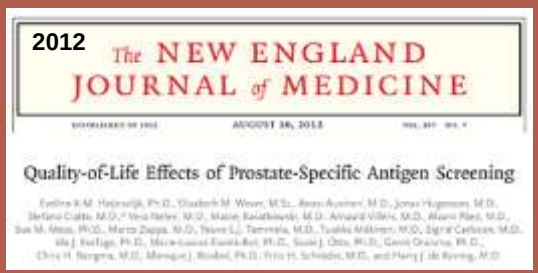
The NEW ENGLAND JOURNAL of MEDICINE

MARCH 15, 2012

Prostate-Cancer Mortality at 11 Years of Follow-up

ERSPC:

- Rate ratio for death from prostate cancer in the screening group, as compared with the control group, was 0.79 (95% CI: 0.68 to 0.91)


2012

The NEW ENGLAND JOURNAL of MEDICINE

AUGUST 30, 2012

Quality-of-Life Effects of Prostate-Specific Antigen Screening

Adjusting for harm:

- The benefit of screening was diminished by loss of QALYs owing to postdiagnosis long-term effects **(overdiagnosis and subsequent overtreatment)**

Should we treat all screen-detected PCa?

2012

Among screen detected localized PCa, radical prostatectomy did not significantly reduce all-cause or prostate-cancer mortality, as compared with observation, through at least 12 years of follow-up.

2016

At a median of 10 years, prostate-cancer–specific mortality was low irrespective of the treatment assigned, with no significant difference among treatments.

No, certainly not , **Active Surveillance** is the way to go

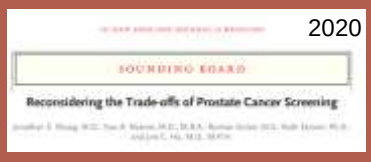
Even better:

AVOID the diagnosis and stop making men cancer patients

Reflection on what we had learned..

2017

2020



2020

There is a critical need for strategies to reduce the burdens associated with the diagnosis of **indolent disease**, through a combination of **not diagnosing** it in the first place and accurately classifying it as **not needing any further follow-up or treatment**, while still maintaining any mortality benefits for men with aggressive disease. Perhaps that is the **most pressing research challenge** going forward.

We have learned that the conventional goal of screening — to maximize cancer detection — is wrong. The appropriate goal is more complex: **identify the few cancers that matter**, while not disturbing the rest of the population.

Based on long-term FU and **new developments**: As clinicians who screen, diagnose, and treat patients with prostate cancer and as statisticians who are devoted to understanding the effects of cancer screening, we suggest that the **balance of benefits and harms of screening may be more favorable than is generally appreciated.**

mpMRI in clinical and screening setting

2018

PRECISION trial: MRI, with or without targeted biopsy, led to **fewer men undergoing biopsy**, more clinically significant cancers being identified, **less overdetection of clinically insignificant cance**r, and fewer biopsy cores being obtained than did standard transrectal ultrasonography–guided biopsy.

2020

Among patients with MRI-visible lesions, **combined biopsy** led to more detection **of all** prostate cancers. However, MRI-targeted biopsy alone **underestimated** the histologic grade of some tumors.

2021

STHLM3MRI trial: MRI with **targeted and standard biopsy** in men with MRI results suggestive of prostate cancer was noninferior to standard biopsy for detecting clinically significant prostate cancer in a population-based screening-by-invitation trial and resulted in **less detection of clinically insignificant cancer.**

25 JAAR

Prostaatkankerstichting

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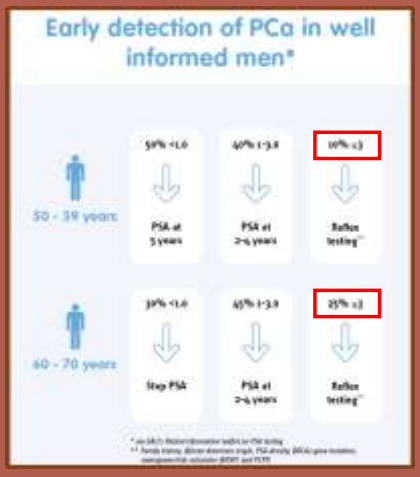
Population based screening



12,750 men enrolled → 1,532 randomized with PSA ≥ 3 ng/ml

STHLM3MRI trial : 12% directly referred for mpMRI

Proportion MRI-negative correlates to disease risk distribution

	STHLM3MRI Main Study n=1,532	Göteborg-2 n=551	Precision n=500	MRI-First n=251	STHLM3MRI Phase 1 n=532
Cohort	Screening	Screening	Clinical	Clinical	Clinical
Age, yrs (median)	66	57	64	64	64
PSA, ng/ml (median)	4.3	3.3	6.7	6.5	6.3
MRI not suggestive of significant cancer	56%	77%	28%	21%	19%

In Europe: 55 Million men aged 55-75 yr, with a PSA cut-off as only risk stratification step:
6.6 Million men eligible for MRI , 60% unnecessary?

25 JAAR

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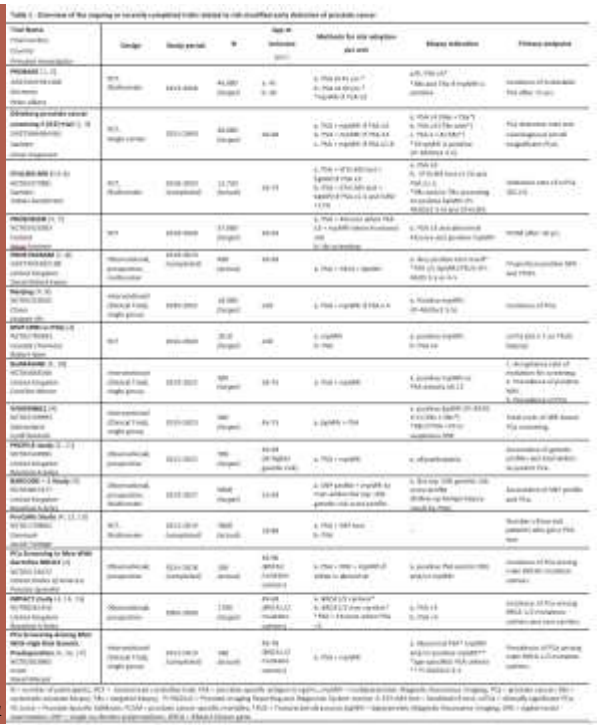
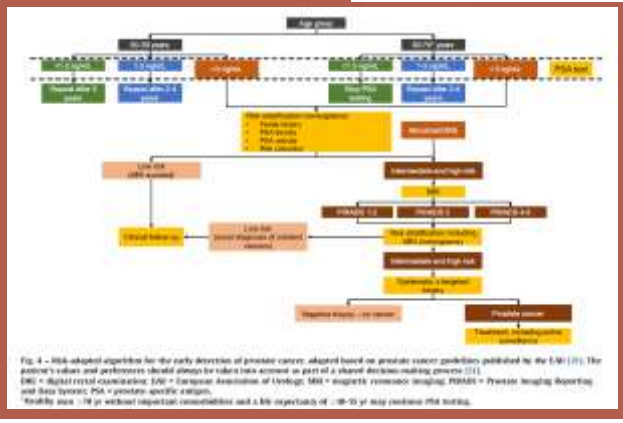
Trials, trials, trials.

- Prostate cancer screening is a dynamic field of research
- What are we waiting for?



Hogenhout et al. Eur Urol Oncol 2021

30 years of knowledge brought together



- 30 years have passed
- We have learned so much
- Isn't it time we implement our knowledge in an organized way accessible for all men in Europe?

Why Urology ? why Prostate Cancer?

- The text from my inaugural address:

- **Why urology?**
- Not the most appealing subject to talk about at a birthday party, unless it is a joke….
- Just because urological problems are not or rarely discussed it is a fascinating part of medicine.
- In particular, **prostate cancer** often has **a long-lasting considerable impact on daily life**.
- Patients often **suffer in silence** and feel they are **alone**

- To help these men is a privilege

- *Working at the department of Urology since September 1991.*

Thank you for listening