Guidelines should be assessed based on the underlying evidence

On behalf of the membership of the National Comprehensive Cancer Network (NCCN) Prostate Cancer Early Detection Panel, we disagree with the assertions of Drs. Jatoi and Sah that the NCCN guidelines drive the overuse of health care services and conflict with evidence-based recommendations of other independent organizations.[1]

Without specific evidence, Drs. Jatoi and Sah argue that, through its advocacy of population-based prostate-specific antigen (PSA) screening for early detection of prostate cancer in selected, well-informed men, the NCCN guideline[2] serves the financial interests of providers rather than patients. They extol the recommendations of "independent" multidisciplinary panels, including the US Preventive Services Task Force (USPSTF),[3] and assert that, unlike these panels, the NCCN promotes recommendations biased in favour of specialists.

However, the authors fail to note that the USPSTF currently recommends consideration of PSA screening as part of shared decision-making for men aged 55 to 69 years.[3] This inconsistency in their argument is troubling. Moreover, they cite 2 outdated recommendations against PSA screening — from the Canadian Task Force on Preventive Health Care of 2014[4] and the European Society for Medical Oncology Consensus Panel of 2012[5] — that do not incorporate the latest level I evidence (from at least 1 properly randomized controlled trial) on this topic.

The NCCN guideline is updated at least annually and includes detailed information on who and how to screen. The current guideline addresses the benefits and harms of screening and is clear on several relevant issues: in alignment with the USPSTF recommendations, the decision to undertake screening is shared between patient and provider; patients in poor health and with limited life expectancy should not be screened; in those with an elevated PSA level, alternatives to prostate biopsy exist that substantially reduce the risk of unnecessary biopsies; active surveillance is the appropriate form of treatment for many men diagnosed with prostate cancer; and optimal guidelines for those who are black or those with a family history of disease remain undefined, but these groups should be considered for early assessment.[2]

Furthermore, the NCCN guideline notes that the rationale for considering screening at an earlier age is based on data showing the following: a baseline serum PSA level at age 45 is a strong predictor of the future risk of lethal prostate cancer; there is less confounding of the PSA level by benign prostatic hyperplasia at earlier ages; a small but important number of men already have high-risk or advanced prostate cancer by their early 50s; and screening can be tailored to baseline risk (i.e., lower PSA level at younger ages allows for less frequent PSA testing). The guideline also points out that, based on serum PSA levels in men in their 60s, many may safely stop screening at age 70 years.[2]

Guidelines for screening for any cancer should not simply be attributed to specialty bias, but assessed based on the strength, currency and depth of the evidence on which they are based.

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