Editorial

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In April 2004, a patient awareness campaign with a difference entitled 'Ignorance Isn't Bliss' was launched with support from the Prostate Research Campaign UK.¹ The campaign was the brainchild of a patient Kit Hobday, himself a victim of delayed diagnosis of prostate cancer and now under treatment for metastatic disease with androgen ablation therapy. In essence, the campaign urges the female partner of men suffering lower urinary tract symptoms to encourage their spouse to visit a doctor and seek help. The initiative stems from the observation that men are notoriously reluctant to seek help from physicians, even though their quality of life is negatively affected by symptoms. In the UK and elsewhere, men visit their doctor on average only half as often as their female counterpart, and as a consequence they tend to present later with a variety of diseases including diabetes, hypertension and cardiovascular disease. It has been suggested that later presentation is one important factor in the 5 y difference in life expectancy between men and women.² Men tend not to talk to each other about health issues. A recent poll found that when men do have troublesome symptoms 71% of them discuss them first with their female partner, so who better than her to advocate a consultation with a physician?

Of course not everyone agrees or approves. Dr Margaret McCartney, a family physician in Glasgow, has written that the campaign is 'patronising and even emasculating'.³ She seems to take issue mainly with the contention in the campaign leaflet that one in three men with a high PSA will have prostate cancer and that his chances are greatly improved by early diagnosis and early intervention. What is the evidence for that statement? Admittedly studies to confirm the effectiveness of PSA screening are still in progress and the results are not expected until at least 2008. In the meantime, men continue to die of metastatic prostate cancer: around 10 000 per annum in the UK and more than 40 000 every year in the USA. There is now evidence that early intervention can be effective. In 2002, Holmberg *et al*⁴ reported the first prospective, randomised trial to show that radical prostatectomy decreases metastases and mortality from prostate cancer. In an intent-to-treat analysis of 695 men these authors demonstrated that men in a radical prostatectomy arm had lower cancer-specific mortality, distant metastasis and local progression than those in a watchful waiting arm (Figure 1).

Significantly, the campaign is specifically not calling for PSA screening of asymptomatic men, but rather for the investigation and treatment of men with bothersome lower urinary tract symptoms. The majority of these, by far, will turn out to be suffering from benign prostatic hyperplasia (BPH) rather than prostate cancer. In this situation, there is evidence that earlier intervention can be helpful. The recently reported Medical Treatment of Prostate Symptoms (MTOPS) study⁵ demonstrated clearly that medical therapy with a combination of an alpha

Figure 1 Cumulative hazard rate of development of distant metastasis. Reproduced with permission from Holmberg *et al*, NEJM; 347:781–789, September 12, 2002.

blocker with a 5 alpha-reductase inhibitor significantly reduced disease progression and the incidence of acute urinary retention (AUR) as well as the need for BPH-related surgery. Moreover, medical therapy has been shown to improve quality of life, not only by improving lower urinary tract symptoms but also by a positive impact on the frequently associated sexual dysfunction.⁶ Furthermore, there are other causes of lower urinary tract symptoms where earlier intervention is likely to be beneficial. One of a number of these is transitional cell carcinoma-*in situ*, a condition with a poor prognosis if left untreated, but one that responds well to intravesical BCG immunotherapy.

So where does that leave campaigns like the one in the UK as well as sundry other prostate awareness programmes? Most would agree that more evidence is required, but in the meantime it is hard to see the harm in providing the public with more information and, since women are often more proactive than men in health matters, encouraging the partner to persuade her spouse to seek help when symptoms are present. Moreover, it should not be forgotten that when the sufferer does consult a family physician the opportunity also presents itself to screen for other conditions such as diabetes, hypertension and dyslipidaemia. Ignorance isn't bliss in any of these prevalent disease areas, indeed knowledge is power and earlier intervention can save lives. The challenge for those of us with an interest in the prostate is to improve the evidence base; only that way will we take the controversy out of one of the most hotly debated areas of medicine, and serve our patients and the public better.

References

- 1 Website:prostate-research.co.uk.
- 2 Kirby RS, Farrah R, Kirby MG, Carson C (eds). *Men's Health*. Taylor & Francis, London 2004.
- 3 McCartney M. Screening must remain a personal choice. *BMJ* 2004; **328**: 1023.
- 4 Holmberg L *et al.* A randomised trial comparing radical prostatectomy and watchful waiting. *N Engl J Med* 2002; **347**: 781.
- 5 McConnell JD *et al.* The long-term effect of doxazosin, finasteride, and combination therapy on the clinical progression of benign prostatic hyperplasia. *N Eng J Med* 2003; **349**: 2387–2398.
- 6 Rosen R *et al.* Lower urinary tract symptoms and male sexual dysfunction: the multinational survey of the aging male (MSAM-7). *Eur Urol* 2003; **44**: 637–649.