

# Anticipatory Science PSA Screening

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# Background

PSA screening for Prostate Cancer had been a controversial topic for several years.

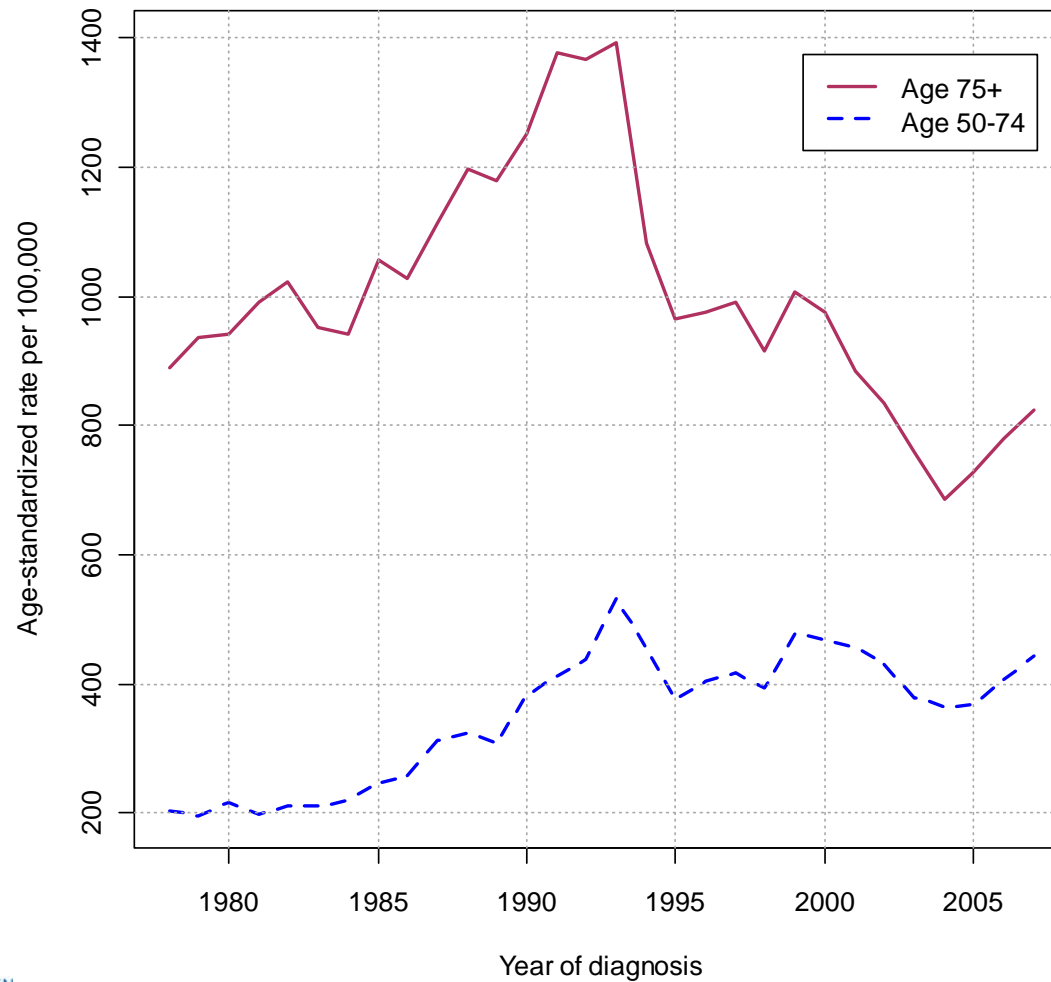
Unlike breast and cervical cancer no prostate cancer screening programs exist in Canada.

Some provinces did not reimburse for PSA tests used in asymptomatic men whilst others did.

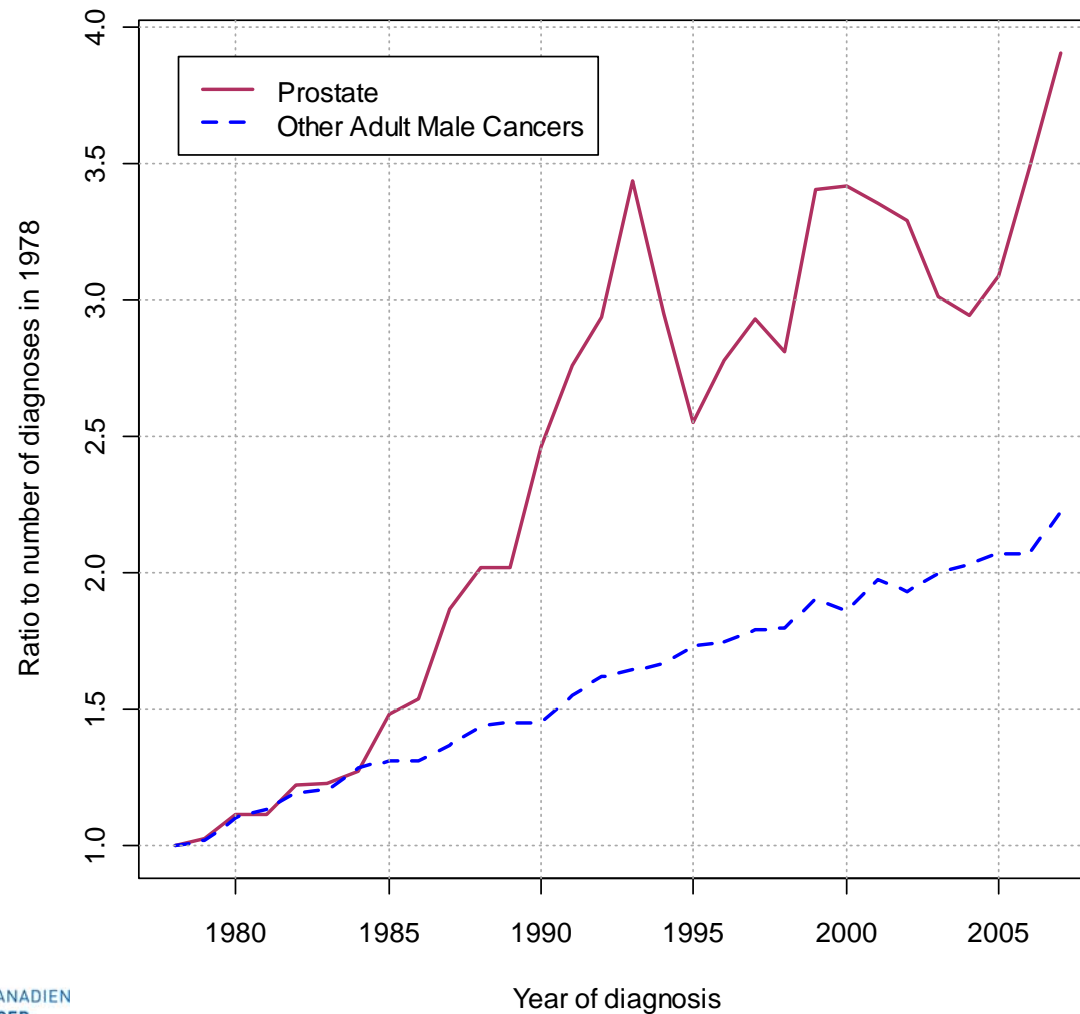
PSA screening was both controversial and important:

- Prostate cancer was the 2<sup>nd</sup> leading cause of cancer death among men
- PSA use had been found to significantly influence work load of cancer centres

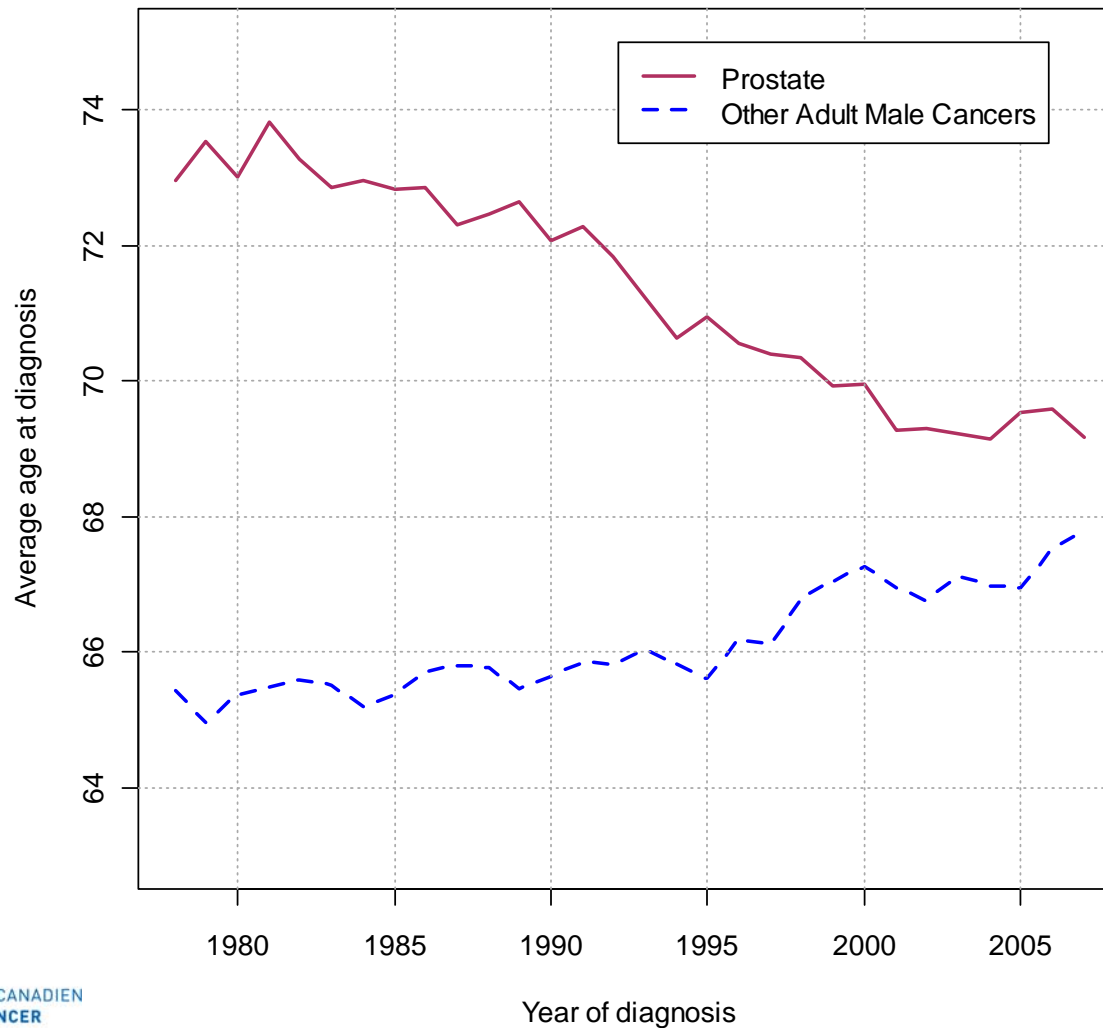
# Incidence Rates of Prostate Cancer in British Columbia by Age and Year



# Relative (to 1978) Numbers of Prostate and Other Male Cancer Cases in British Columbia by Year



# Average Age at Diagnosis of Prostate and other Cancer Cases in British Columbia by Year



# Background

Thus to “screen or not-to-screen” with PSA screening was anticipated to be a high impact issue because of

- Public interest
- Controversy
- Implications - health & cost
- Diversity in approach

# What was the Aim?

Given the preceding conditions the Screening Action Group (SNAG) of CPAC anticipated that the (impending) publication of the first large scale randomized trials would have a significant impact and preparation was appropriate.

SNAG developed a strategy which involved the development of a statement of knowledge with associated dissemination strategy.

# Process

- This strategy would be implemented by a purposively developed committee - review panel.
- CPAC would support the operation of the review panel.
- The panel would be asked to summarize relevant current knowledge on PSA screening and prostate cancer prior to the availability of results from the randomized trials.
- Identify a panel chair. Based on knowledge of SNAG members a potential panel chair was selected (Tom Pickles) and approached by the SNAG chair.
- The two chairs identified potential panel members who were then approached. The committee was to be constructed to draw from interested constituencies (family practice, urology, oncology, patients etc).
- Potential members were approached and the panel constructed.

# Process

- Initial panel meetings conducted by teleconference and a single face-to-face meeting. Document drafted (Tool-Kit).
- Notification of earlier than anticipated publication of trial results lead to rapid completion of the Tool Kit.
- Dissemination strategy not fully developed and relied on pre-existing relationships (cancer agencies etc).
- Post dissemination review conducted by panel and need identified for additional guidance for family practitioners, planners for incorporation into tool-kit.
- Additional dissemination strategy to include Webinar dissemination of updated tool-kit.

# Overall Strategy

The overall strategy consisted of the following “generic elements”

1. Identification of an issue on which new information was imminent
2. The issue was important and cross-cutting
3. A process developed to provide factual background to the issue including different perspectives
4. Presentation would try to assist and not dictate interpretation
5. The final document would be supported by a dissemination strategy to stake-holders.