Letters to the Editor

When to Discuss Prostate Cancer Screening with Your Patients

Original Article: Counseling Patients About Prostate Cancer Screening [Editorial]

Issue Date: October 15, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/1015/p478.html

To the Editor: In their editorial, Drs. Stevermer and Fink presented the American Academy of Family Physicians' (AAFP) clinical preventive services recommendation against adoption of the new U.S. Preventive Services Task Force (USPSTF) guidelines for prostate cancer screening[1]; however, the editorial does not provide clear direction for physicians to apply this new information. The ambiguity can be particularly challenging for resident physicians who are learning to negotiate the equivocal informational environment of competing guidelines.

The AAFP recommendation indicates that physicians should rely on patients to introduce the topic of prostate cancer screening in the clinical encounter. This requires patients to be informed, assertive, and confident communicators. We know, however, that many men are sometimes reluctant to disclose information to their physicians.[2] This also introduces a bias against black men who, though they experience a higher incidence of prostate cancer, are reported to have lower rates of health literacy and patient activation,[3] which are two characteristics that predict whether patients volunteer concerns to their physician.

The editorial states that "the AAFP supports providing PSA [prostate-specific antigen]-based screening to men 55 to 69 years of age who express a clear preference for the test after having an opportunity to participate in shared decision making." Shared decision-making includes three steps: introducing choice, describing options, and helping patients to explore preferences and to make decisions.[4] Under this recommendation, how do physicians discern a patient's desire to engage in shared decision-making without first introducing the concept of choice? When patients are not informed, they are not as capable of thinking about what is important to them.[4]

The risk in this position is that when patients have not been prompted to communicate potential prostate screening concerns, the physician will interpret silence as assent. The physician who chooses to not mention screening may leave patients with unvoiced concerns, unmet informational needs, and frustration with the system. Incorporating decision aids can improve patients' decision-making about prostate cancer screening, without increasing actual screening rates, and simultaneously reduce decisional conflict up to 13 months later.[5] By reducing decisional conflict, a single shared decision-making conversation may impact this decision that men face annually for up to 30 years.[5]

Considering these issues, we are left questioning the way in which to implement this recommendation. From a medical and ethical viewpoint, how do family physicians know when to introduce the subject of prostate cancer screening and when to rely on the patient to introduce the topic?

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Editor's Note: Dr. Seehusen is an Assistant Medical Editor for *AFP*.

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This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor.

ommendation statement [published correction in *JAMA*. 2018;319(23):2443]. *JAMA*. 2018;319(18):1901-1913.
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In Reply: We appreciate the thoughtful comments from Drs. Ledford and Seehusen regarding the application of the AAFP's new recommendations on screening for prostate cancer.[1] We agree this is a challenging topic and suspect that it will remain controversial for the foreseeable future.

The USPSTF guidance suggests that physicians should have a shared decision-making discussion with all men age 55 to 69 years[2]; however, we do not agree that the balance of benefit and harm warranted universal counseling, which may impose significant opportunity costs by diverting time from higher priority preventive services. The 2018 USPSTF recommendation was based on an estimated screening benefit of prostate cancer mortality reduction of 1.3 per 1,000 men screened.[1] The previous USPSTF recommendation discouraged prostate cancer screening based on an estimated prostate cancer mortality reduction of 0.9 per 1,000 men screened.[3] This increased benefit estimate was derived from only one of the four large randomized clinical trials evaluating screening; the other three found no difference. Overall, the evidence suggests, at best, a small mortality benefit from prostate-specific antigen–based prostate cancer screening, with a significant risk for nontrivial harms to patients who undergo screening. As stated in our editorial, the AAFP recognizes the importance of providing patient-centered care, incorporating patient values in decision-making, and respecting patient choice. In an established doctor-patient relationship, physicians often have a good sense of a patient's values.

We agree that the onus for this decision should not be on the patient. One purpose of the AAFP's recommendation is to ensure that all men who receive prostate-specific antigen–based screening are properly informed about the risks beforehand.[1] The wording of the AAFP's recommendation allows physicians a range of options in their approach and discourages setting a universal standard of required counseling.

The incidence and mortality of prostate cancer are higher in black men and men with a family history of prostate cancer, and we agree that prostate cancer screening is a particularly vexing challenge for these men. Men at higher risk may perceive a greater net benefit from screening; however, there are inadequate data from clinical studies to know the balance of benefit and harm of screening in these populations. This is an area we believe merits further research.

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Medical Screening and Care of Incarcerated Transgender Patients

Original Article: Care of Incarcerated Patients

Issue Date: November 15, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/1115/p577.html

To the Editor: Dr. Davis and colleagues are to be commended for compiling this comprehensive set of best practices for caring for incarcerated people. As the primary provider of gender-affirming telemedicine to transgender people incarcerated in California's 35 prisons, I find it immensely challenging to partner with on-site health care teams in this area.

Transgender people have a significantly higher lifetime rate of incarceration compared with the general population,[1] and nearly 40% of incarcerated transgender people have reported sexual victimization.[2] Rape and sexual violence are more likely to occur when incarcerated people are

housed according to their sex assigned at birth, thereby placing transgender women in men's facilities.

The National Commission on Correctional Health Care notes that medical screening should include inquiries about an individual's sexual activity, sexual orientation, and gender identity.[3] However, screening for these factors creates the illusion that transgender women, particularly, will engage in only consensual sex. Incarcerated people lack access to condoms (legal in only three state prison systems and rarely in local facilities despite World Health Organization recommendations) or medications for HIV preexposure prophylaxis (currently not available in any state).[4] Because sex is nearly universally illegal while incarcerated, attempts to obtain limited available protection can lead to self-incrimination.

Most states do not require testing for sexually transmitted infections (STIs) at intake or during incarceration. Therefore, family physicians are well positioned to provide stigma-free preventive care for incarcerated transgender people, in part by adopting a universal approach that considers increased STI transmission risk in an environment with frequent sexual assault and criminalized consensual sex behaviors.

Routine approaches to screening based on the Centers for Disease Control and Prevention's recommendations for STI screening in high-risk populations are inadequate,[5] leading to too-infrequent screening and often limiting testing to only the urethra. The *accompanying table* includes the schedule that should be used for STI screening in transgender women, whose risk is at least as high as that for men who have sex with men.[5] Appropriately screening for and treating STIs is an essential public health issue that will improve care for incarcerated transgender people and their partners.

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TABLE

Centers for Disease Control and Prevention's STI Screening Recommendations for Populations at Increased Risk

	Screening frequency		
STI	**High risk**	**Increased risk**	**Sampling site**
HIV infection	At least annually	Every 3 to 6 months	Blood
Syphilis	At least annually	Every 3 to 6 months	Blood
Gonorrhea	At least annually	Every 3 to 6 months	Sites of contact (e.g., urethra, rectum, pharynx)
Chlamydia	At least annually	Every 3 to 6 months	Sites of contact (e.g., urethra, rectum)

STI = sexually transmitted infection.

Information from Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015 [published correction appears in MMWR Recomm Rep. *2015;64(33):924].* MMWR Recomm Rep. *2015;64(RR-03):1-137.*

In Reply: We appreciate Dr. Nass for highlighting some of the challenges correctional care clinicians face when caring for transgender people. Although transgender people represent only a small percentage of inmates, they are disproportionately likely to be incarcerated compared with the general population, and they are more likely to be sexually victimized in correctional settings.[1] We agree that intake assessments should include inquiries about gender identity, biological sex, sexual orientation, and sexual practices. This allows for selection of an appropriate sampling location for gonorrhea/chlamydia testing (e.g., urethra, rectum, pharynx). We also agree that incarcerated people should be provided access to condoms, and recognize that this is not routinely available.[2,3] We encourage clinicians to discuss consensual and nonconsensual sexual activity with all incarcerated patients. Preventive care for transgender incarcerated people should include expanded STI screening based on current anatomy[4,5] and may include additional laboratory monitoring if the inmate is receiving gender-affirming hormone therapy.[4]

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Fasting vs. Nonfasting Lipid Profile for Assessing Cardiovascular Risk

Original Article: The Adult Well-Male Examination

Issue Date: December 15, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/1215/p729.html

To the Editor: In this article, Dr. Heidelbaugh describes a fasting lipid profile as the preferred screening test for assessing cardiovascular risk. This is not correct and should be updated to reflect current guidance. Nonfasting samples are more convenient for patients, and there is no appreciable difference between fasting and nonfasting results for total cholesterol or high-density lipoprotein cholesterol. Because these are the parameters that are used to assess cardiovascular risk, a fasting lipid profile should not be called "preferred."

The article cites the National Cholesterol Education Panel guidance from 2001 and the U.S. Preventive Services Task Force guideline on statin use for the primary prevention of cardiovascular disease from 2016. The article acknowledges that nonfasting total cholesterol and high-density lipoprotein cholesterol are sufficient for using most cardiovascular risk calculators, but the article is clear in both the text and Table 3 that fasting is preferred. Recommendations from the National Institute for Health and Care Excellence,[1] Canadian Cardiovascular Society,[2] and American College of Cardiology/American Heart Association[3] all consider a nonfasting test to be an equal alternative to a fasting test for screening unless the patient is known to have significantly elevated triglycerides. I was unable to find any support in the 2016 U.S. Preventive Services Task Force guideline for the claim that fasting is preferred.[4]

I could not help but be struck by the irony that in the very same issue of *American Family Physician*, there was an editorial regarding the slow adoption of evidence-based practice.[5] The authors cited the continued use of fasting lipid profiles, rather than nonfasting testing, as one of the examples of practice changes that have not been widely adopted. They note that "measurement of nonfasting lipids is a more accurate predictor of cardiovascular risk."[5] Their editorial could not have been more timely.

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In Reply: Many thanks to Dr. Ehrlich for his thoughtful and referenced discussion regarding fasting vs. nonfasting lipid panels to assess cardiovascular risk. His arguments are acknowledged, and I agree that either fasting or nonfasting lipids are acceptable for this purpose.

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Personal Experience Is Not Always Consistent with Published Evidence

Original Article: Why Are We So Slow to Adopt Some Evidence-Based Practices?

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See additional reader comments at: https://www.aafp.org/afp/2018/1215/p709.html

To the Editor: I read this editorial with great interest. Although I believe that many of the factors that the authors presented have contributed to the lack of adoption of evidence-based processes, there is one more that I would like to add. For those who have been in medicine long enough to see evidence-based processes be proved wrong with follow-up studies, it is hard to jump on board a change that one's experience also has shown to be false. The good news is that medicine continues to grow and change, and physicians scientifically evaluate and incorporate new data.

In my family medicine consulting practice, physicians refer patients to me for colposcopies and loop electrosurgical excision procedures. I had never seen so many cervical intraepithelial neoplasia 3 biopsy results until guidelines began recommending that Papanicolaou (Pap) tests be performed every three to five years. As physicians, we sometimes forget that many research studies are conducted under optimal conditions, but in practice there seem to be more false-negative Pap test results.

In the past, physicians have prescribed fish oil supplements for cardiovascular disease; however, studies subsequently found that these supplements are ineffective for primary or secondary prevention of cardiovascular events.[1] Many other examples could be listed.

Evidence-based practices need to incorporate contradictions in studies, change as medicine progresses, address concerns about changing for change's sake (despite being well-meaning), evaluate real-life vs. study processes and results, protect our patients because less is not always more, and realize that the latest is not always the best.

Thank you for the editorial in *American Family Physician*. It obviously got the attention of this reader.

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Reference

1. Rogers TS, Seehusen DA. Omega-3 fatty acids and cardiovascular disease. *Am Fam Physician*. 2018;97(9):562-564.

In Reply: Thank you for your thoughtful comments. We agree that there are factors beyond those we discuss in the editorial that contribute to practice change. We feel that there are two kinds of evidence: disease oriented and patient oriented. Many studies primarily report disease-oriented outcomes, such as improvements in a biomarker, a physiologic measure, or other surrogate outcome. These often mislead us: examples include hormone therapy,[1] vitamin E,[2] omega-3 oils,[3] and tight control of type 2 diabetes mellitus.[4] More reliable guidance comes from well-designed, unbiased studies that report patient-oriented outcomes such as improvements in morbidity, mortality, and quality of life. These studies are also less likely to be reversed than evidence from disease-oriented studies.

Regarding the impact of recommendations to change the interval for cervical cancer screening with cytology alone from one to three years, we are not sure that your experience of an increased prevalence of cervical intraepithelial neoplasia (CIN) 3 is typical. A 2017 study reported the incidence of CIN1, CIN2, and CIN3 in females in New Mexico from 2007 to 2014 and found significant

decreases in the incidence of each finding.[5] A possible explanation for the perception of more CIN3 is that the denominator has changed, with fewer normal Pap tests being performed in the setting of screening every three years. That said, it is important that physicians be vigilant and that we adhere to longer screening intervals, and not let three years (or five years if screening for high-risk human papillomavirus with or without cytology in women older than 30 years[6]) become five or seven years. Our goal should always be the right amount of care, for the right patients, at the right level of intensity. Both too much and too little care can be harmful.

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Editor's Note: Dr. Ebell is Deputy Editor for Evidence-Based Medicine in *AFP,* and Dr. Shaughnessy is an Assistant Medical Editor for *AFP.*

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Corrections

Incorrect FDA approval. The article, "Lower Extremity Peripheral Artery Disease: Diagnosis and Treatment" (March 15, 2019, p. 362), contained an error in the last sentence of the "Anticoagulant Therapy" section in the first column of page 367, which stated that the combination of rivaroxaban (Xarelto) with aspirin had not been approved by the U.S. Food and Drug Administration (FDA) for use in patients with coronary artery disease or symptomatic peripheral artery disease. Although this statement was accurate when the article was submitted, in October 2018 the FDA issued an approval for the use of rivaroxaban in combination with aspirin "to reduce the risk of major cardiovascular events (cardiovascular [CV] death, myocardial infarction [MI] and stroke) in patients with chronic coronary artery disease (CAD) or peripheral artery disease." Before publication, the article was not updated to reflect this approval. The sentence regarding lack of FDA approval has been removed. ■