Letters to the Editor

CPCs Should Be a Resource for Patients With Unintended Pregnancy

To the Editor: I am concerned about inferences and biases in the article about options for unintended pregnancies in the April 2025 edition of *American Family Physician*.[1] In the article, Table 2 on counseling resources for physicians and patients categorizes crisis pregnancy centers (CPCs) as a resource to avoid. This is unfortunate because CPCs are the only resource in the table that might specifically support a woman in continuing an unintended pregnancy and parenting. Instead, the listed website, crisispregnancycentermap.com, mischaracterizes all CPCs as "fake clinics." I disagree with this disparaging generalization because I have volunteered as a family physician in three CPCs. These centers provided excellent care, classes, and physical resources for pregnant patients. In my experience, a CPC is a place where a woman with an unintended pregnancy can review her options and often receive ultrasonography and accurate pregnancy dating to inform her decision. She can also access extra resources for pregnancy and parenting if that is her choice. Rather than discouraging patients from seeking assistance from CPCs, I suggest that clinicians first visit the centers in their area to determine what kinds of services they provide.

Kathleen Castellanos, MD
Lima, Ohio
kicjohn316@gmail.com

Author disclosure: No relevant financial relationships.

REFERENCE

1. Valerio C, Norby M, Kremsreiter P. Options for unintended pregnancies. *Am Fam Physician*. 2025;111(4):352-360.

In Reply: Thank you for your thoughtful letter and for sharing your perspective as a family physician who has volunteered in CPCs. Your firsthand experience supporting patients facing unintended pregnancies is deeply valued, and we appreciate your commitment to their care.

Our goal in the article was to provide evidence-based resources for comprehensive, nondirective counseling on all pregnancy options, including continuation, adoption, and abortion. The inclusion of information about CPCs was not intended to dismiss their importance to patients who choose to continue a pregnancy, but rather to reflect documented concerns regarding the variability in services and accuracy of information provided at many of these centers.

Research has shown that many CPCs present themselves as medical clinics but offer limited or no licensed medical care. Studies have also identified dissemination of misinformation about abortion risks and reproductive health at many CPCs.[1] These concerns have been echoed by the American College of Obstetricians and Gynecologists, which emphasizes that CPCs often do not adhere to principles of informed consent or evidence-based counseling.[2]

We acknowledge that not all CPCs operate this way. We agree that clinicians who are considering referring patients to a CPC should personally evaluate local centers to ensure alignment with evidence-based, patient-centered care. We appreciate the opportunity to engage in this important conversation about how best to support patients facing complex reproductive health decisions.

Christina Valerio, MD, MPH
Travis Air Force Base, California
christina.r.valerio.mil@health.mil

Author disclosure: No relevant financial relationships.

REFERENCES

1. Bryant AG, Swartz JJ. Why crisis pregnancy centers are legal but unethical. *AMA J Ethics*. 2018;20(1):269-277.
2. American College of Obstetricians and Gynecologists. Crisis pregnancy centers. Issue brief. October 2022. Accessed May 15, 2025. https://www.acog.org/advocacy/abortion-is-essential

Reconsidering the Harms of Delayed Prostate Cancer Screening

To the Editor: In Dr. Lin's editorial, his argument that physicians should not screen for prostate cancer overrules the patient's right to receive early diagnosis and make their own treatment decisions.[1] Prostate cancer will kill between 30,000 and 40,000 men this year, comparable to the number of women who will die of breast cancer. Discouraging prostate-specific antigen (PSA) screening makes little sense when early screening improves outcomes and lowers the risk of metastatic disease, even with the high probability of treatments resulting in impotence and incontinence; both have been reduced with nerve-sparing surgery and high-dose brachytherapy.[2,3]

As Dr. Lin notes, the pretesting shared decision-making recommended by the US Preventive Services Task Force (USPSTF) often does not occur. Instead of observation and serial testing, many physicians screen all men between ages 50 and 70 years and then discuss active treatment options. The PSA test is a simple blood test that can be added to annual or periodic testing. When PSA levels rise, options can be discussed with the attention this cancer deserves. Patients can ask questions, research, and seek additional opinions if they desire.

Free-PSA testing and prostate magnetic resonance imaging can improve sensitivity.[4] Prostate biopsy, although an uncomfortable procedure for the patient, has limited risks and can

Email submissions to afplet@aafp.org.

Downloaded from the American Family Physician website at www.aafp.org/afp. Copyright © 2025 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the website. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

accurately guide treatment. A study on MyProstateScore 2.0 urine testing after a digital examination, now covered by Medicare, found 97% specificity for high-risk cancers.[5] Therefore, Dr. Lin's specificity argument may soon be moot.

PSA testing is not perfect, yet the argument that we should quit screening because of possible complications, anxiety, and discomfort could apply to almost any treatment for any condition. With this common and dangerous cancer, we should screen and provide treatment options. Sacrificing early diagnosis and keeping patients in the dark disrespects patient maturity, resilience, and autonomy.

A study published after Dr. Lin's editorial indicated a marked increase in metastatic prostate cancer since screening guidelines were relaxed by the USPSTF.[6] We need more aggressive screening, not less.

Kevin C. Kelleher, MD
Roanoke, Virginia
mtnd0c@aol.com

Author disclosure: No relevant financial relationships.

REFERENCES

1. Lin KW. PSA screening: shared decision-making is a flawed approach. *Am Fam Physician*. 2025;111(1):10-11.
2. Gacci M, De Nunzio C, Sakalis V, et al. Latest evidence on post-prostatectomy urinary incontinence. *J Clin Med*. 2023;12(3):1190.
3. Gesztesi L, Kocsis ZS, Jorgo K, et al. Alterations of sexual and erectile functions after brachytherapy for prostate cancer based on patient-reported questionnaires. *Prostate Cancer*. 2024:5729185.
4. Tay JYI, Chow K, Gavin DJ, et al. The utility of magnetic resonance imaging in prostate cancer diagnosis in the Australian setting. *BJUI Compass*. 2021;2(6):377-384.
5. Tosoian JJ, Zhang Y, Xiao L, et al.; EDRN-PCA3 Study Group. Development and validation of an 18-gene urine test for high-grade prostate cancer. *JAMA Oncol*. 2024;10(6):726-736.
6. Van Blarigan EL, McKinley MA, Washington SL 3rd, et al. Trends in prostate cancer incidence and mortality rates. *JAMA Netw Open*. 2025;8(1):e2456825.

In Reply: Dr. Kelleher proposes that physicians perform PSA testing universally in men between ages 50 and 70 years and then discuss the benefits and harms of active treatment based on the results, rather than have decision-making conversations about PSA screening with eligible male patients.

I disagree with this approach for three reasons. First, indiscriminate PSA testing would lead to many more false-positive results, which studies show can produce lasting psychological harm.[1] Dr. Kelleher asserts that all eligible men should have the opportunity for prostate cancer screening; I contend they should also have the right to avoid screening.

Second, more screening results in more overdiagnosis and overtreatment. Harms are associated with long-term active surveillance, which can involve multiple prostate biopsies in addition to PSA tests and digital rectal examinations. A high percentage of men who choose surveillance switch to definitive treatment within the first few years, even when no objective evidence shows treatment is necessary.[2]

Finally, physicians are no better at having shared decision-making discussions about treatment than about screening. A 2025 US Department of Veterans Affairs study showed that among men with intermediate-risk prostate cancer and a life expectancy of less than 10 years who were unlikely to benefit from treatment (and who I believe should not have been screened in the first place), those who underwent radiotherapy or prostatectomy increased from 38% in 2000 to 60% in 2019.[3]

Regarding the increasing incidence of metastatic prostate cancer in California between 2011 and 2021,[4] the timing of this trend relative to the 2012 and 2018 USPSTF recommendations is inconsistent with a cause-and-effect relationship. Given continuing increases in metastatic prostate cancer after the USPSTF stopped discouraging PSA screening in men younger than 70 years, it is difficult to believe clinicians changed screening practices 1 year before the 2012 recommendation but ignored the 2018 recommendation. Since PSA testing mostly identifies indolent and low-grade cancers, studies show it takes several years for routine screening to cause a reduction in metastatic prostate cancer.[5]

Kenneth W. Lin, MD, MPH
Lancaster, Pennsylvania
kenneth.lin@georgetown.edu

Author disclosure: No relevant financial relationships.

Editor's Note: Dr. Lin is the deputy editor of *AFP*.

REFERENCES

1. McNaughton-Collins M, Fowler FJ Jr, Caubet JF, et al. Psychological effects of a suspicious prostate cancer screening test followed by a benign biopsy result. *Am J Med*. 2004;117(10):719-725.
2. Drost FH, Rannikko A, Valdagni R, et al.; PRIAS Study Group. Can active surveillance really reduce the harms of overdiagnosing prostate cancer? A reflection of real life clinical practice in the PRIAS study. *Transl Androl Urol*. 2018;7(1):98-105.
3. Daskivich TJ, Luu M, Heard J, et al. Overtreatment of prostate cancer among men with limited longevity in the active surveillance era. *JAMA Intern Med*. 2025;185(1):28-36.
4. Van Blarigan EL, McKinley MA, Washington SL 3rd, et al. Trends in prostate cancer incidence and mortality rates. *JAMA Netw Open*. 2025;8(1):e2456825.
5. Aus G, Bergdahl S, Lodding P, et al. Prostate cancer screening decreases the absolute risk of being diagnosed with advanced prostate cancer—results from a prospective, population-based randomized controlled trial. *Eur Urol*. 2007;51(3):659-664. ■