Letters to the Editor

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This series is coordinated by Kenny Lin, MD, MPH, Associate Deputy Editor for *AFP* Online.

The Preparticipation Sports Evaluation: Losing the Forest for the Trees?

Original Article: The Preparticipation Sports Evaluation

Issue Date: September 1, 2015

See additional reader comments at: http://www.aafp.org/afp/2015/0901/p371.html

TO THE EDITOR: Ensuring that adolescents are physically well and knowledgeable about self-care prior to athletic participation is important. Similarly, assessment for stress, risk behaviors, and vaccinations is paramount to adolescent wellness. Are these initiatives mutually exclusive?

Approximately 40% of adolescents receive the recommended yearly comprehensive preventive visits; in these encounters, 60% of patients do not have time alone with their clinician.[1] Because 30 million student-athletes in the United States play organized sports and many require clearance, the preparticipation evaluation (PPE) may be an adolescent's only exposure to the medical system.[1-3]

The PPE was not designed to replace health maintenance. However, it provides an excellent opportunity to address issues commonly overlooked in this vulnerable patient population. At least 25% of PPEs occur outside of the adolescent's medical home, and the extent to which adolescents are offered essential care (e.g., confidential psychosocial screening, vaccinations) in PPEs is unknown.[3] Because 70% of deaths among 10- to 24-year-olds in the United States involve unintentional injuries, suicide, and homicide, compared with 5% from heart disease and congenital malformations, we wonder if clinicians miss the opportunity to incorporate psychosocial risk assessment in the PPE.[2,4]

Through this lens, we read this article with great interest. Written in accordance with national recommendations, Mirabelli and colleagues emphasize screening for physical pathology with relatively brief attention paid to psychosocial risk. As the highly technical and important debate over appropriate cardiovascular risk assessment in the PPE ensues, physicians may find themselves entrenched in the search for rare physical diseases. Unfortunately, the PPE is not particularly effective in preventing mortality associated with these diseases.[2]

Most morbidity in adolescents results from risk-taking behaviors and psychosocial stressors. In a survey of behaviors from the previous month, 40% of adolescent drivers reported texting while driving and 24% reported using marijuana; during the previous year, 15% reported being electronically bullied and 8% attempted suicide.[5] Issues related to sexuality, social media, eating, and other stressors are rampant.[5]

As a result, we endorse the provision of preventive care, including confidential psychosocial history-taking and vaccination, in all visits, including the PPE. An essential step is to build this conceptual framework into family physicians' approach to the PPE. Useful resources for psychosocial history-taking are available at http://www.modernmedicine.com/tag/heeadsss-30-and-sshadess. Expanded efforts in sports clearance will identify significant risk to be addressed, and it will often have nothing to do with sports.

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The opinions and assertions contained herein are the personal views of the authors and are not to be construed as official or as reflecting the views of the U.S. Armed Services or any of their medical departments.

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Current Prostate Cancer Screening Guidelines May Lead to More Deaths from the Disease

Original Article: Prostate Cancer Screening; Prostate Cancer Screening: The Pendulum Has Swung, and the Burden of Proof Is with Proponents [Editorial]

Issue Date: October 15, 2015

See additional reader comments at: http://www.aafp.org/afp/2015/1015/p683.html and http://www.aafp.org/afp/2015/1015/p678.html

TO THE EDITOR: An important fact that is never stated in articles that recommend against routine screening for the potentially fatal disease of prostate cancer, including the one recently published in *American Family Physician*,[1] is that if the U.S. Preventive Services Task Force and the American Academy of Family Physicians current recommendations for prostate cancer screening are followed, then more men will die of the disease.

Prostate cancer screening has become less common since 2012, and it is estimated that more than 1,200 more men will eventually die from prostate cancer because they have not been screened.[2,3] Maybe that number is not high enough for researchers to be concerned, but it concerns me and my patients. I have no doubt that once deaths from prostate cancer begin to rise because of a lack of screening, then these recommendations will change. In the meantime, individual physicians will need to decide what to do. I know that I will advise my male patients older than 50 years to ignore these recommendations and to receive prostate-specific antigen (PSA) screening. The more appropriate question is not whether to screen for prostate cancer, but whether to treat it if it is found. That is where the focus of this debate should be.

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3. Penson DF. The pendulum of prostate cancer screening. *JAMA*. 2015;314(19):2031-2033.

IN REPLY: The goal of our article was to review current evidence regarding the value of PSA to screen for prostate cancer.[1] Although many modeling studies have tried to predict the future effect of PSA screening, these studies are based on many assumptions, and we did not include them in our review. The European Randomised Study of Screening for Prostate Cancer (ERSPC), with 13 years of follow-up, showed that mortality from prostate cancer was about 0.4% of the total mortality in both the screening and control groups with no difference in overall mortality.[2] This meant that 99.6% of the men who died during the 13 years of follow-up died for reasons other than prostate cancer, with no difference in the total number of men who died in each group. The only U.S. screening randomized controlled trial[3] and a Cochrane review of all prostate cancer screening trials did not show a reduction in prostate cancer–specific mortality or overall mortality with screening.[4] The best evidence we have consistently shows that PSA screening does not reduce overall mortality. Perhaps the discussion should move on to how we can focus our effort on other topics in medicine that we know will decrease overall mortality.

Although one study estimates that without screening more than 1,200 more men will die from prostate cancer in 13 years,[5] this estimate is based on many assumptions, including that the cancers detected from screening are identical to the cancers detected in the ERSPC, and that the underlying risk of prostate cancer is similar between the ERSPC population and the general U.S. population.[6] The ERSPC results show that we need to screen 800 men to save one life after 13 years, with 27 extra prostate cancer diagnoses. This presents a real dilemma for a practicing physician: If you believe that you have saved the life of one patient by diagnosing prostate cancer through PSA screening, then the next 27 patients you diagnose with prostate cancer using PSA screening will only be harmed.

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IN REPLY: Dr. Stevens argues that others and I have failed to consider that current recommendations to scale back routine PSA screening will increase national prostate cancer mortality by 1,200 deaths per year. This invented statistic is precisely what I dispute. The 1,200 number comes from the fact that since PSA screening guidelines changed, fewer men have had the test, and around 33,000 fewer cancers have been detected. Remember, all these men are spared the anxiety, treatments, and complications of a prostate cancer diagnosis.[1] Then, it assumes that the number needed to detect—number of diagnoses needed to avert one prostate cancer death—is 27, as it was in one out of five randomized trials of the PSA screening.[2] But, in my editorial, I explained why looking at this one trial in isolation is misleading. A Cochrane review looking at all the trials shows no reduction in prostate cancer mortality.[2]

Based on the Cochrane review, it is expected that a reduction in PSA screening will avert many complications and harms with no increase in deaths due to prostate cancer. The refusal of many physicians to stop screening will result in many men continuing to suffer harms of screening with no countervailing benefits to justify it.[3]

Also, this discussion omits a growing concern that looking solely at prostate cancer deaths does not take into account many of the harms of PSA screening. A diagnosis of prostate cancer can lead to increases in cardiovascular death and suicide,[4] and treatment for prostate cancer can lead to increases in second malignancies.[5] For these reasons, it is possible that reductions in prostate cancer death seen in some trials are offset by deaths from other causes. Elsewhere, I have argued that, at a minimum, ▶

patients undergoing PSA screening should be told explicitly that it has not been shown to improve overall mortality, and therefore cannot be said to "save lives."[6]

PSA screening has clearly resulted in much harm to many men. Whether it has also resulted in any benefits is the point of dispute. For a widespread public health intervention, that simply is not good enough.

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Hyperbaric Oxygen Therapy for Radiation Cystitis

Original Article: Prostate Cancer Screening

Issue Date: October 15, 2015

See additional reader comments at: http://www.aafp.org/afp/2015/1015/p683.html

TO THE EDITOR: In their cautionary review of prostate cancer screening, Mulhem and colleagues did not mention a potentially life-threatening long-term complication of radiation treatment. Symptomatic hematuria occurs in 2.1% to 8.2% of patients treated with external beam radiation or brachytherapy.[1] The pathophysiology is chronic fibrosis and progressive endarteritis, which cause sloughing of the bladder mucosa and bleeding that may occur many years after treatment. These patients can suffer greatly from urinary frequency, dysuria, urgency, incontinence, blood clots, obstruction, catheterization, irrigation, cauterization, or transfusion. Radiation cystitis is one of the most common diseases I treat as medical director of a hospital-based hyperbaric medicine facility. A retrospective review of 60 patients who received an average of 33 hyperbaric oxygen therapy (HBOT) treatments showed that 80% of patients had total or partial resolution of hematuria. When HBOT was started within six months of hematuria onset, 96% had total or partial resolution of symptoms.[1] The treatment consists of breathing 100% oxygen in a single-place or multi-place pressure chamber at 2.4 atmospheres absolute for 90 minutes. Contraindications are few, and significant complications are rare, even in older patients. It is important for family physicians to know about the effectiveness of HBOT for soft tissue radionecrosis and for them to inform affected patients about this important treatment modality.

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IN REPLY: The main goal of our article was to review the current evidence for prostate cancer screening. We did mention common complications associated with treatment of prostate cancer. Because the focus of the article was screening, we did not focus in depth on the complications of treatment. Although HBOT is one of the many available treatments for hemorrhagic radiation cystitis, conservative management continues to be the best option.[1]

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Physicians Making Eye Contact with Patients Is Important

Original Article: Cancer Screening in Older Patients

Issue Date: April 15, 2016

Available online at: http://www.aafp.org/afp/2016/0415/p659.html

TO THE EDITOR: Applause for the cover photo on the April 15, 2016, issue of *American Family Physician,* showing a physician making eye contact with the patient while making a few notes on paper.

As I have added years to my stated age and new entries to my problem list, I have assembled a stable of organ-focused doctors, all of whom talk to me over their shoulders while tapping computer keys or stand behind the protection of a scribe. Only my direct primary care physician sits and looks me in the eye when we are talking.

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Corrections

Incorrect NNT calculation. The *Medicine by the Numbers* "Tap Water vs. Sterile Saline for Wound Irrigation" (August 1, 2015, online only) incorrectly calculated a number needed to treat statistic for decreasing wound infection with tap water. This error stemmed from the *Medicine by the Numbers* being inadvertently based on an uncorrected version of the Cochrane review. The box at the top should not have included the line "Number needed to treat = 36 to prevent wound infection," and under Harms it should have read "None were harmed by using tap water." In the second paragraph of the Narrative section, the sentences related to this should have read: "In adults (1,328 participants), there was a nonsignificant decrease in wound infection in the tap water group (relative risk = 0.66; 95% confidence interval [CI], 0.42 to 1.04). In children (535 participants), there was a nonsignificant increase in wound infections in the tap water group (relative risk = 1.07; 95% CI, 0.43 to 2.64)." The online version of this department has been corrected.

Incorrect SI units. The CME Quiz Questions (September 15, 2015, p. 441) contained an error in answer choice C for Quiz Question #6 from the article "Potassium Disorders: Hypokalemia and Hyperkalemia" (p. 487). The correct answer choice for Q#6, answer C should have read: "Because serum potassium concentration drops approximately 0.3 mEq per L (0.3 mmol per L) for every reduction of 100 mEq (100 mmol) in total body potassium, the deficit can be estimated in patients with abnormal losses and decreased intake." The online version of the quiz has been corrected.

Incorrect disease occurrence. The article "Diagnosing Common Benign Skin Tumors" (October 1, 2015, p. 601) contained an error in the third sentence of the Dermatofibromas section on page 604. The sentence incorrectly stated that dermatofibromas are four times more common in men, instead of women. The sentence should have read: "They are four times more common in women, and most develop between 20 and 50 years of age." The online version of the article has been corrected. ■