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13<sup>th</sup> September 2010

For the attention of the Rt Hon Andrew Lansley CBE MP, Secretary of State for Health

**Re: UKNSC Consultation regarding Prostate Cancer Screening**

Dear Mr Lansley,

As you are aware the UKNSC is currently conducting a consultation process regarding prostate cancer screening which closes on the 21<sup>st</sup> September 2010. After the consultation a workshop will be held to debate stakeholder inputs received during the consultation (assuming enough interest). Once these two exercises have been completed the UKNSC will meet on the 10<sup>th</sup> November in London with the objective of agreeing and submitting their recommendations to ministers.

To help the consultation process, the UKNSC has already reviewed the evidence from the European randomised study and has provisionally concluded that:

*The harms from prostate cancer screening using PSA are currently likely to outweigh the benefits. In this circumstance screening for prostate cancer cannot be justified on the current evidence. The main reasons are:*

- *PSA is a poor test for prostate cancer and a more specific and sensitive test is needed*
- *Currently we are unable to correctly identify those cancers which will progress and those which are indolent and may be safely watched.*
- *The data relating to incidence prevalence and treatments is poor and renders planning very difficult.*

Surprisingly, this is the same reasoning used in the UKNSC's 1997 recommendation not to screen. It seems nothing has changed in 13 years. For example, each year more than 10,000 men continue to die from the disease with around 8000+ diagnosed with incurable advanced prostate cancer.

As the new Secretary of State for Health I believe you have a great opportunity to rectify this serious health problem especially as the NHS moves towards 'outcomes' as its measure of performance.

To help you understand a different perspective from that of the health professionals (who by their association and stance on Prostate Cancer screening are probably biased), I have used a simple 'top level' comparison between Breast Cancer and Prostate Cancer 'Incidence' and 'Mortality' statistics to prove that prostate cancer screening will cause more 'good' than 'harm' (exact opposite of the UKNSC's current position).

### Comparison between Breast Cancer and Prostate Cancer

Both Cancers:

- Are hormone related cancers
- Have a high death rate
- Affect older people
- Have a high number of complications from unnecessary treatments

The only differences between the two cancers are:

- One effects women and one effects men
- Annual deaths from prostate cancer are increasing whilst deaths from breast cancer are decreasing
- Annual deaths from breast cancer were approximately 20% higher than deaths from prostate cancer in 2007, but the difference is getting less
- One has national screening and one does not

Interestingly, the health professional community are strongly divided on whether breast cancer screening does more 'good than harm' but are unanimous (very small exception) that Prostate Cancer screening does more 'harm than good', as can be seen from the provisional UKNSC conclusions above.

As mentioned previously, the top level annual incidence and mortality statistics for Breast Cancer and Prostate Cancer can be used to calculate the maximum number of complications per death as can be seen from the table below (A detailed explanation of how these figures were derived is provided as an appendix).

	Breast Cancer Pre Screening	Breast Cancer Post Screening	Prostate Cancer
<b>Maximum Complications per Death</b>	1.1	3.0	2.3

**Note:** Data derived from Cancer Research UK website statistics

From this table, the maximum number of women who could experience breast cancer treatment complications per one women's death from the disease is approximately 1.1 before screening and 3.0 after screening.

The current situation regarding Prostate Cancer indicates the maximum number of men who could experience Prostate Cancer treatment complications per one man's death from the disease is approximately 2.3.

This Prostate Cancer calculation does not consider the reduction in radical treatment possibilities as a result of the following.

- Watchful waiting
- Active surveillance
- Deaths from other causes

Men who have underlying health problems who may not survive radical treatments are often placed on watchful waiting, active surveillance or given hormone therapy to slow down their cancer growth, especially older men with a reduced life expectancy.

The most significant impact on the number of men who could receive radical treatment is death from other causes. For example, it is believed that some men die from natural causes before radical treatment commences and some men die from the side effects of hormone therapy and chemotherapy, for example, heart attacks, thrombosis, strokes and organ failure.

It is also suspected that some men with advanced prostate cancer take their own life when they reach the unbearable final stages of the disease.

As death certificates only record the actual cause of death, the underlying cause being prostate cancer, is not always recorded. These deaths from other causes would significantly reduce the maximum number of men that could undergo radical treatment. Interestingly, the fact that men with aggressive life threatening prostate cancer often die from other causes means the annual statistic of approximately 10,000 deaths is understated.

From the men that actually undergo radical treatment not all of them will suffer complications. Also, those that do suffer complications the severity of the complication and the time it lasts varies significantly.

Taking these factors into consideration it is reasonable to assume that the maximum number of men who could experience complications from radical treatment, for each man that dies of prostate cancer, is approximately one.

Most importantly, this calculation does not consider the number of aggressive "Tiger" cancers that would have been treated successfully from the radical treatment, this being the fundamental reason why Urologists and Oncologists perform these radical treatments. In other words, they perform them to save a man's life, which means saving life is more important than causing harm.

Furthermore, there are many methods and medicines to reduce and treat the effects of urinary incontinence and erectile dysfunction, these being the two main treatment complications.

However, this calculation is based on statistics reflecting the current situation and therefore does not consider the impact that national screening could have on increasing the number of radical treatments. Fortunately, the increase in radical treatments, as a consequence of national screening, will not be significant as evidenced by the three fold increase per death from the breast cancer calculation indicated in the table above.

Even though there is no 'official' screening programme in the UK at present, a form of screening already takes place for the "Privileged and Fortunate". For Example:

- Those with Health Insurance that covers screening
- Those that have a GP that screen men at risk
- Those that know they are at risk because of family genes
- Health professionals that know the symptoms and risks
- Those that are aware they can have an annual PSA test
- Those that are more generally aware of health matters

These reasons are probably why deaths from prostate cancer are not increasing as rapidly each year as they did twenty years ago, even with men living longer. This means we have an unbalanced playing field comprising the "Privileged and Fortunate" and the "Ignorant and Unfortunate". This means there would be less of an increase in the number of radical treatments if national prostate cancer screening was implemented.

Taking all these factors into consideration, it is reasonable to assume that in reality the current situation in the UK without national screening is that for every man that dies of the disease a maximum of one man could suffer complications.

If national screening was to be introduced in the UK, the maximum possible number of men with complications would be approximately three for every man that dies assuming a 50% reduction in deaths through screening.

Therefore, this begs the question: "how many men suffering complications from radical treatment is one man's life worth?" It is this fundamental question that needs to be answered in order to determine whether prostate cancer screening does more 'harm' than 'good'.

### **Options**

Based on this evidence, the Department of Health has three basic choices being:

- Implement Prostate Cancer Screening
- Stop Breast Cancer Screening
- Do Nothing

The implications regarding each of these options are:

- Implementing Prostate Cancer screening will stretch NHS resources and increase NHS costs
- Stopping Breast Cancer screening will cause a public uproar but will free up NHS resources and reduced costs
- Doing nothing could trigger a legal challenge under the Human Rights Act

**Important:** Saving lives through screening has not been mentioned as there is sufficient evidence now available to clearly indicate that it does.

From the information provided I believe it would be advantageous if you as the Secretary of State for Health could become actively involved (if not already) in having your team scrutinise the work and process being carried out by the UKNSC as well as reviewing all inputs submitted during the consultation, not just registered stakeholders, but all inputs regarding this important health issue.

If you require any further information regarding this matter please do not hesitate to contact me.

Yours sincerely

Doug Gray (Mr)

Enc. Appendix

## APPENDIX

A detailed Explanation on how Breast Cancer and Prostate Cancer 'Incidence' and 'Mortality' statistics can be used to calculate the maximum number of treatment complications per death.

### Rationale:

As the number of deaths from either breast or prostate cancer must come from the number diagnosed with the disease the maximum number of men/women who could undergo treatment resulting in possible unnecessary complications is simply the number diagnosed minus the number of deaths totalled over a given period of time. Those men/women who die are excluded from the calculation as their treatment is necessary and as such any complication are irrelevant.

### Methodology:

1. Obtain reputable Breast Cancer 'Incidence' and 'Mortality' statistics covering the ten years leading up to the year breast cancer screening started
2. Obtain reputable Breast Cancer 'Incidence' and 'Mortality' statistics covering at least ten years after breast cancer screening started
3. Obtain reputable Prostate Cancer 'Incidence' and 'Mortality' statistics covering at least the last ten years
4. Subtract the ten year mortality total from the ten year incidence total to calculate the maximum number of men/women who could undergo treatment resulting in possible unnecessary complications for:
  - a. breast cancer before screening started (1)
  - b. breast cancer after screening started (2)
  - c. prostate cancer (3)
5. Divide the 4.a., 4.b., and 4.c figures above with the respective mortality figures to calculate the maximum number of men/women who could suffer complications per one death.

### Calculations:

<b>BC (Pre)</b>	<b>1980</b>	<b>1981</b>	<b>1982</b>	<b>1983</b>	<b>1984</b>	<b>1985</b>	<b>1986</b>	<b>1987</b>	<b>1988</b>	<b>1989</b>	<b>Totals</b>
incidence	79.0	78.4	80.6	80.0	79.8	86.3	86.2	88.7	89.3	94.8	843.2
mortality	39.6	40.2	39.9	40.3	41.5	41.4	41.9	41.4	41.2	41.8	409.2
<b>BC (Post)</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>Totals</b>
incidence	114.7	119.9	116.8	117.4	117.3	122.9	123.3	124.2	123.1	120.3	1199.8
mortality	32.7	31.8	31.0	30.8	30.1	29.4	28.4	28.3	27.7	26.7	297.0
<b>PCa (Pre)</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>Totals</b>
incidence	70.7	71.3	77.5	83.8	93.5	94.1	94.7	101.5	96.6	97.1	880.8
mortality	27.7	27.4	27.2	26.1	27.3	27.0	27.2	26.7	25.5	24.9	266.8

Source: Cancer Research UK website

	Breast Cancer Pre Screening	Breast Cancer Post Screening	Prostate Cancer
<b>Incidence</b>	843.2	1199.8	880.8
<b>Mortality</b>	409.2	297.0	266.8
<b>Maximum Number of Complications</b>	434	903	614
<b>Maximum Complications per Death</b>	1.1	3.0	2.3

### Notes

1. All figures are Age standardised (European) incidence and mortality rates per 100,000 population
2. The Maximum Complications per Death number is a ratio