



Of the Derriford Prostate Support Group

**REPORT ON THE 25<sup>th</sup> MARCH 2010 PUBLIC DEBATE**

**TO ANSWER THE QUESTION**

**“SHOULD NATIONAL SCREENING  
BE  
INTRODUCED FOR PROSTATE CANCER?”**

**Date: 13<sup>th</sup> April 2010**

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## 1. Introduction

As part of the Prostate Cancer Awareness month of March, the Derriford Prostate Steering Group (PSG) organised and hosted a Public Debate on the 25<sup>th</sup> March 2010 at the Post Graduate Medical Centre, Derriford Hospital, Plymouth, to answer the question “Should National Screening be Introduced for Prostate Cancer”.

Besides creating greater awareness, another reason for organising the debate was to provide feedback to the UK National Screening Committee (NSC) which at the date of this report is in the process of reviewing its position on prostate cancer screening based on the findings of the recent European Randomised Study that claimed a 20% reduction in prostate cancer deaths by using national screening.

In addition, the Derriford PSG will also be requesting other prostate cancer support groups throughout the UK to run their own local public debates and forward their findings to the UK NSC.

The programme for the two hour debate was as follows:

- Introduction and Debate Programme
- Vote 1
- The Argument “For” National Screening
- The Argument “Against” National Screening
- Open Debate
- Vote 2
- Summary

Chairing the debate was Vice Admiral Sir Jonathan Tod. Presenting the argument for screening was Douglas Gray, a prostate cancer sufferer and leader of the Derriford PSG. Presenting the argument against screening were Consultant Urologist Mr Paul McInerney, Consultant Urologist Mr Henry Sells and Consultant Clinical Oncologist Dr Sarah Pascoe, all being consultants from Derriford hospital.

On arrival, all delegates were given a simple “tick box” questionnaire requesting details of their sex, age, affiliation and “Yes”, “No”, “Undecided” answers to the question “Should National Screening be Introduced for Prostate Cancer?” in the form of two votes, one to be taken before the debate started (Vote 1) and one to be taken at the end of the debate (Vote 2). Even though a show of hands was used during the votes, the use of questionnaires was considered necessary as they would become a formal record for reference purposes, provide more detailed information and because it was in effect a secret ballot it would allow people to reflect their own opinions without outside influence such as from a spouse/friend with prostate cancer or a Health Professional Colleague.

The debate was well promoted using posters in doctor’s surgeries, health centres, community hospitals and the main Derriford hospital complex. Also posters were placed in many large businesses, stores and supermarkets in Plymouth and the surrounding area. In addition, articles about the debate were published in two local newspapers and interviews about the debate broadcast on BBC Radio Cornwall and BBC Radio Devon.

Also, formal invite letters, along with posters promoting the debate, were sent to all GP practices in the Derriford hospital catchment area and also to local MPs and Prospective Parliamentary Candidates.

For ease of description the information provided in this report is covered under the following section headings.

2. Main Argument Points “For” Screening
3. Main Argument Points “Against” Screening
4. Questionnaire Results
5. Conclusions
6. Recommendations

In addition, a copy of the questionnaire is provided in Appendix A with a list of all questionnaire answers in Appendix B.

Also, Appendix C provides a list of debate discussion points and questions and answers.

## 2. Main Argument Points “For” Screening

The main arguments put forward in support of screening were as follows.

The following prostate cancer annual statistics were considered unacceptable.

- Number of Cases Diagnosed = 35,000 (UK)
- Number of Deaths = 10,000 (UK)
- Advanced Prostate Cancers Cases = 23% (8,000 + cases)
- Death within 1 year = 9% (England & Wales)
- Death within 5 years = 29% (England & Wales)
- Death with 10 years = 45% (England & Wales)

The following conclusions from the Health Technology Assessment (HTA) reports published in 1997, which were used by the UK National Screening Committee (NSC) to justify not to implement national screening for prostate cancer, were out of date and no longer relevant.

1. Major questions remain concerning the benefits and effectiveness of treatments and until these are resolved there is **no justification** for the introduction of a screening programme.
2. Although prostate cancer is a serious public health problem, it appears to have a long natural history and it is **impossible** on current evidence to identify the tumours that will progress to be life-threatening
3. There is **no justification** for the routine use of PSA testing in primary care. GPs should be actively **discouraged** from using PSA tests for the purposes of early detection
4. There is at present **no evidence** on the number of prostate cancer deaths (**if any**) which could be averted by screening men with no symptoms

A recommendation from one of the HTA reports, being “Clinicians should explicitly record as much information as possible on stage, ideally pathological Tumour, Node, Metastasis (TNM) staging, but otherwise clinical staging as far as they can” was considered important in helping calculate how early diagnosis through screening could reduce deaths and complications. Unfortunately, for some reason, the Department of Health declined to take up this recommendation. However, since March 2009, Derriford Hospital now formally records this information.

The following assumptions were also presented in support of screening.

The earlier prostate cancer is detected the greater the:

- possibility of a cure
- life expectancy
- number of treatment options
- reduction in treatment complications

The uptake and greater use of “active surveillance” will help reduce unnecessary treatments  
New equipment and techniques will help “reduce treatment complications”

A form of Prostate Cancer Screening already takes place for the “Privileged and Fortunate Few” 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 know they can have an annual PSA test
- those that are more generally aware of health matters

Deaths are understated because only the primary cause of death is recorded

Mention was also of new diagnosis options since the Department of Health decided not to implement national screening in 1997 (13 Years ago) these being:

- Risk Assessment Profiling
- PSA Free to Total Ratio, Velocity, Doubling, Density
- Blood & Urine Markers
- Colour Imaging TRUS Biopsy

For example, Risk Assessment Profiling could use the following information using a simple computer programme to calculate a man’s risk of having prostate cancer

- Age
- Family Genes
- Ethnicity
- Diet
- BMI
- Height
- Exposure to Cadmium
- Libido

Also the following tests conducted could help identify men requiring further tests

- PSA, PSA Free to Total Ratio, PSA Velocity, PSA Doubling, PSA density
- DRE by experienced examiner

Mention was also of new treatment options since the Department of Health decided not to implement national screening in 1997 (13 Years ago) these being:

- Radical Prostatectomy using a Da Vinci Robot
- Electroscaipel (scalpel that uses heat to cut flesh and a “sniffer” to detect in “real time” whether the flesh being cut is cancerous)
- Various radiotherapy variants such as:
  - 3D Conformal Radiotherapy
  - Intensity Modulated Radiotherapy (IMR)
  - RapidArc (a proprietary enhancement to IMR)
  - Brachytherapy
  - Proton Beam Therapy (PBT)

- High Intensity Focussed Ultrasound (HIFU)
- Cryotherapy
- Photo Dynamic Therapy (PDT)

However, it was mentioned that only radical prostatectomy, radiotherapy and brachytherapy were commonly used in the NHS. Mention was also made that these treatments were only for men with localised or locally advanced prostate cancer that had been diagnosed early enough for treatment and as such did not include these men diagnosed with incurable; advanced prostate cancer.

To demonstrate that screening will reduce the number of deaths from prostate cancer a comparison between breast cancer and prostate cancer was presented as follows.

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

Mention was made that breast cancer deaths in the UK had reduced by 35% in 18 years (1989 – 2007) and that prostate cancer should not be any different.

Mention was made that cervical cancer deaths in the UK had reduced by 50% in 16 years (1991 – 2007) and that prostate cancer should not be any different.

The following experience from screening in Austria was used to show that screening actually reduced deaths,

- Screening in Tyrol (one of 7 districts in Austria) started in 1988
- Since 1988 (20 years ago) deaths have reduced by 54% in Tyrol compared with 29% in the rest of Austria
- The reduction in the rest of Austria is attributed to “self initiated screening” based on the well publicised success in Tyrol

The following statistics from the USA National Cancer Institute were used to show that by comparing UK statistics (no screening) with USA statistics (with screening) could result in a 50% reduction in deaths from prostate cancer as calculated in table 1 below.

<u>Statistics</u>	<u>UK</u> <u>(No Screening)</u>	<u>USA</u> <u>(With Screening)</u>
Population	61,000,000	308,000,000
<b>Annual Cases Diagnosed</b>	<b>35,000</b>	<b>192,000</b>
Percentage of Population Diagnosed (%)	0.057	0.062
<b>Additional UK Cases Diagnosed to Match USA Population Percentage</b>		
Difference (%)	0.005	
Additional Cases Diagnosed	<b>3,026</b>	
<b>Annual Deaths</b>	<b>10,000</b>	<b>27,000</b>
Deaths versus number Diagnosed (%)	29	14
<b>Estimated UK Deaths with Screening</b>	<b>4,922</b>	

**Table 1: UK and USA Statistics Compared**

It was also mentioned that initially, the number of cases diagnosed will rise if screening was implemented in the UK but these would fall back again over time.

Another simple calculation was presented using UK statistics, prostate cancer stages at diagnosis and death rates per stage at diagnosis to show that deaths could be reduced by 54% through national screening as per table 2 below.

<b><u>Annual Statistics</u></b>	<b>(No.)</b>				
<b>Cases Diagnosed</b>	<b>35,000</b>				
<b>Deaths</b>	<b>10,000</b>				
<b><u>Before Screening</u></b>			<b><u>After Screening</u></b>		
<b>Stage at Diagnosis</b>	<b>(%)</b>	<b>(No.)</b>	<b>Stage at Diagnosis</b>	<b>(%)</b>	<b>(No.)</b>
Localised	43	15,050	Localised	75	26,250
Locally Advanced	34	11,900	Locally Advanced	18	6,300
Advanced	23	8,050	Advanced	7	2,450
<b>Totals</b>	<b>100</b>	<b>35,000</b>	<b>Totals</b>	<b>100</b>	<b>35,000</b>
<b>Death Rate per Stage</b>			<b>Death Rate per Stage</b>		
Localised	5	753	Localised	5	1,313
Locally Advanced	17	2,023	Locally Advanced	17	1,071
Advanced	90	7,245	Advanced	90	2,205
<b>Totals</b>		<b>10,021</b>	<b>Totals</b>		<b>4,589</b>
				<b>(%)</b>	<b>(No.)</b>
			<b>Reduction in Deaths</b>	<b>54</b>	<b>5,432</b>

**Table 2: Reduction in Deaths from Screening in the UK**



The following observations were also made as part of the presentation.

- The Fundamental Reason for the DoH decision not to implement Prostate Cancer Screening was it Does More “Harm” than “Good”
- The “Harm” being the number of complications caused by over treatment
- This begs the Question: How many men with treatment complications is a man’s life worth?

To answer this question the UK annual prostate cancer statistics were used to calculate that three men (2.5 men) with complications would be the absolute maximum per one mans’ death as can be seen from table 3 below.

<b><u>Annual Statistics</u></b>	<b>(No.)</b>
Diagnosed	35,000
Deaths	10,000
Possible Treatments (Excluding Advanced Prostate Cancer)	25,000
<b>Maximum Number of Treatment Complications per Death</b>	<b>2.5</b>

**Table 3: Maximum Number of Men with Complications per One Man’s Death**

The following realistic assumptions regarding the calculation were then used to show that approximately one man with complications was equal to one mans death.

- Did not consider those who died of other causes
- Did not consider active surveillance
- Did not consider actual number of complications
- Did not consider severity of complications

**Most Important:** The calculation did not consider the number of aggressive cancers that would have been treated.

Further observations presented were:

- The “Right to LIFE” is the top “Human Right”
- Equality is a “Human Right”
  - Parity with Breast Cancer Screening
  - Parity with the “Privileged and Fortunate Few”

To summarise the presentation the following conclusions were made.

The following are unacceptable:

- 10,000 deaths a Year
- Incurable Advanced Cases of 23% at Initial Diagnosis
- Locally Advanced Cases of 34% at Initial Diagnosis
- Only 43% of Cases Diagnosed at a Localised Stage
- Death within 1 year = 9%
- Death within 5 years = 29%
- The “Greatest Harm” is to allow men to be diagnosed when it is “Too Late to be Cured”

- Screening will:
  - “Reduce Deaths by >50% within 25 Years” as Evidenced by Breast Cancer & Cervical Screening Statistics, Austria and USA Statistics and the Simple Calculation
  - “Increase Life Expectancy”
  - “Not Significant Increase the Number of Cases Diagnosed” in the long term
  - Reduce the severity of treatment complications

The solution that was presented used what was said at the National Awareness and Early Diagnosis Initiative (NAEDI) launch conference in November 2008, where Professor Michael Richards, National Cancer Director, presented his own personal view that “advanced stage at diagnosis is likely to account for at least 50-75% of avoidable cancer deaths” Professor Richards went on to say that “Promoting earlier diagnosis could save over 5,000 lives each year without needing to wait for new discoveries or technological advances. What else provides such a good opportunity?” “LETS DO IT!”

Therefore, the only solution is a well proven means of ensuring early diagnosis of prostate cancer, which resulted in the following recommendation being made

It was recommended that “All men aged 50 years (45 years if at high risk), and then each year thereafter, to be invited by the Department of Health (or other appropriate body) to attend a specific clinic on a specific time and date to complete a risk assessment questionnaire, take a PSA blood test and have a Digital Rectum Examination (DRE) after having made an informed choice to proceed. In other words “National Screening for Prostate Cancer”.

And finally, the presentation ended with the statement, Screening will do More “GOOD” than “HARM”.

### 3. Main Argument Points “Against” Screening

It was mentioned that “The Department of Health (DoH) is committed to having a national prostate cancer screening programme, and that this will only occur “if and when” screening and treatment techniques are sufficiently well developed” In Other Words:

- When there is a test that can prevent “False Negatives” and “False Positives” and differentiate between “Pussycat” and “Tiger” cancers
- When there is more “Good” than “Harm” resulting from treatment

The reported problem of “False Negatives” and “False Positives” is because the Prostate Specific Antigen (PSA) blood test, although very accurate, can be affected by several factors and not just prostate cancer, for example, a benign prostate gland enlargement, infection, sexual activity and vigorous exercise less than 48 hours before the test.

Also, a low PSA reading would normally indicate all is well but in some cases cancer could be present (false negative) and similarly a high PSA reading would normally indicate a problem but in some cases cancer may not be present (false positive).

Also, the PSA test is unable, in isolation, to differentiate between non life threatening cancers (pussycats) and life threatening cancers (tigers). This means that further tests are required to help determine if a cancer is aggressive and thus life threatening. For example, a biopsy is required which in itself can cause serious complications, such as infection resulting in death. Mention was made that 1 in 1,000 prostate biopsies result in death.

A biopsy in some cases is unable to identify if cancer is present which can result in a false negative. Also, because of this reliability problem a number of biopsies may be necessary over a period of time to exclude and/or identify if cancer is present in the prostate. Multiple biopsies also carry an increased risk of complications.

Even when cancer is detected the biopsy result may show a low Gleason score which indicates the cancer is not life threatening. However, this result may not be accurate as biopsy samples are taken from a relative small area within the prostate and therefore it could have missed other cancerous cells that may have been aggressive and thus life threatening. Because of this uncertainty, a patient often decides to seek treatment on the basis of “it is better to be safe than sorry”.

For this reason, it is believed that a significant number of procedures are carried out unnecessarily to treat non life threatening (pussycat) cancers that could result in the patient suffering serious complications such as incontinence, erectile dysfunction/impotence and bowel problems. It is this “harm” caused by overtreatment (unnecessary treatment) that is used by the DoH for its decision not to implement national screening for prostate cancer. For example, only when there is more “Good” than “Harm” will screening be considered.

In support of this DoH position, mention was made that “more men die with prostate cancer than those that die from it”. Also, a relevant part of Hippocratic Oath “To practice and prescribe to the best of my ability for the good of my patients, and to try to avoid harming them” means that the most important aspect of health care is not to cause harm.

In support of the DoH position not to screen the following points were mentioned.

- Screening is valuable if early detection improves outcome
- Screening in itself should not cause harm
- A Screening programme is only as good as its tools allow
- Radical Prostatectomy show that PSA Density and PSA Velocity do not add any improvement to outcome

- The European randomised study of Prostate Cancer Screening (ERSPC) indicated a 20% reduction in risk of death with screening
- The Prostate, Lung Colorectal & Ovarian (PLCO) study in the USA showed no significant difference in Prostate cancer mortality rates between screened and unscreened groups
- Lowering PSA threshold from 4 to 3 would expose more men to unnecessary false positive biopsies, the side effects of which are sometimes not trivial
- 1410 men need to be screened and 48 cases of Prostate Cancer need to be treated to prevent one death from Prostate cancer (Ref: BJMSU Jan 2010)
- Patients should receive information on the risks & benefits of screening & individual risk assessment
- From 3,056 men with negative biopsies on first screening, 287 were subsequently diagnosed with prostate cancer, 26 developed progressive disease and 7 died of prostate cancer

In further support, compliance ( $\checkmark$  = yes, X = no, ? = Not Known) with the Wilson and Jungner (1968) Screening Criteria was used to show why the DoH's decision not to screen was the right decision.

- The condition sought should be an important health problem for the individual and community =  $\checkmark$
- There should be an accepted treatment or useful intervention for patients with the disease =  $\checkmark$
- The natural history of the disease should be adequately understood = X
- There should be a latent or early symptomatic stage =  $\checkmark$
- There should be a suitable and acceptable screening test or examination = X
- Facilities for diagnosis and treatment should be available = X
- There should be an agreed policy on whom to treat as patients = ?
- Treatment at an early stage should be of more benefit than treatment started later = ?
- Case Finding should be a continuous process and not a once and for all project =  $\checkmark$
- The cost should be economically balanced in relation to possible expenditure on medical care as a whole = X

Answer	Number
$\checkmark$	4
X	4
?	2

Mention was made that prostate cancer screening would probably cost less breast cancer screening which currently costs £75 million per annum. The set up cost for prostate cancer screening was estimated to be approximately £100 million.

Mention was also made that screening resources could be provided for prostate cancer but other health services, such as diabetes for example, would be affected as a consequence of budget and resource limitations.

In conclusion, national screening for prostate cancer did not meet the Wilson and Jungner (1968) screening criteria.

#### 4. Questionnaire Results

##### Attendees

Approximately 70 people attended and a total of 60 questionnaires were completed. From the completed questionnaires, 40% were women and 60% were men.

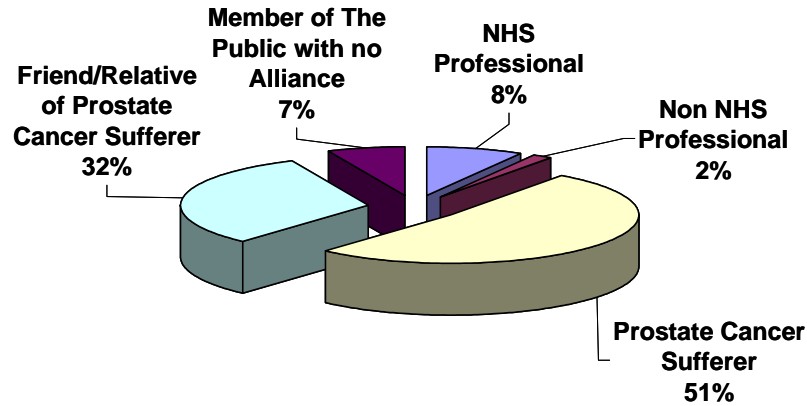


Figure 1: Attendee Breakdown

From figure 1, the largest group in attendance were men who have/have had prostate cancer followed by their spouse/family/friends. Together, these two groups represented 83% of all questionnaire respondents.

##### Overall Vote 1 and Vote 2 Results

The overall results of Vote 1 taken before the start of the debate and Vote 2 taken at the end of the debate are shown in Figure 2 and 3 respectively below.

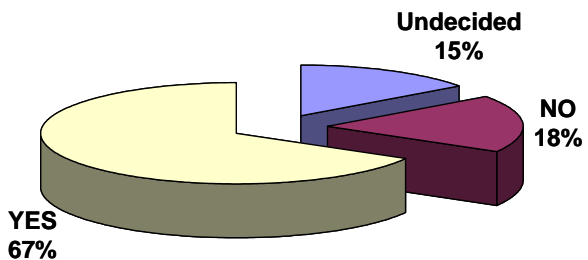


Figure 2: Vote 1 Result

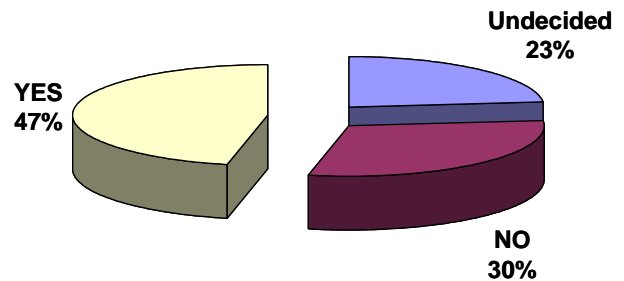


Figure 3: Vote 2 Result

At the start of the debate 67% of respondents were a favour of national screening but at the end of the debate this had dropped to 47%. This indicated a 20% movement towards not screening by the end of the debate. For example, the votes against screening increased by 12% to 30% and the undecided votes increased by 8% to 23%. However, 27 people (45%) changed their vote position by the end of the debate, which is not indicated in the pie charts.

### Vote 1 and Vote 2 Results From by Men who Have/Have Had Prostate Cancer

The results of Vote 1 and Vote 2 from by men who have/have had prostate cancer are shown in Figure 4 and 5 respectively below.

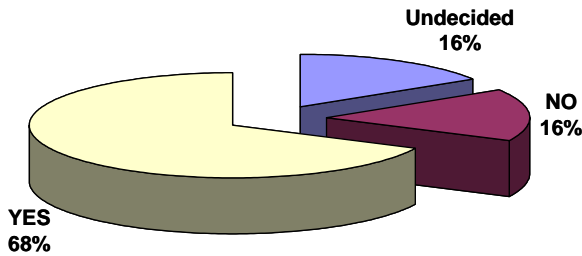


Figure 4: Vote 1 Result

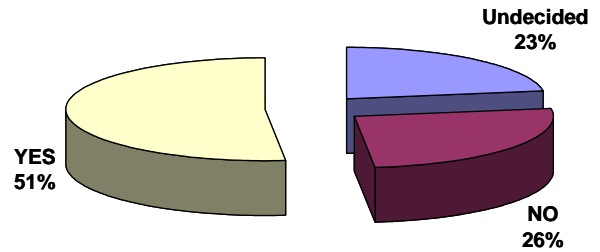


Figure 5: Vote 2 Result

At the start of the debate 68% of men who have/have had prostate cancer were a favour of national screening but at the end of the debate this had dropped to 51%. This indicated a 17% movement towards not screening by the end of the debate. For example, the votes against screening increased by 10% to 26% and the undecided votes increased by 7% to 23%. However, 11 men (36%) changed their vote position by the end of the debate, which is not indicated in the pie charts.

### Vote 1 and Vote 2 Results From Family/Friends of men who Have/Have Had Prostate Cancer

The results of Vote 1 and Vote 2 from Family/Friends of men who Have/Have Had Prostate Cancer are shown in Figure 6 and 7 respectively below.

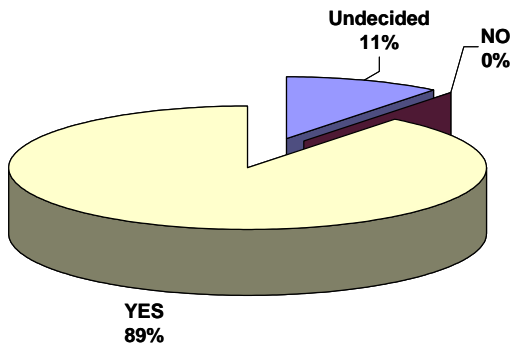


Figure 6: Vote 1 Result

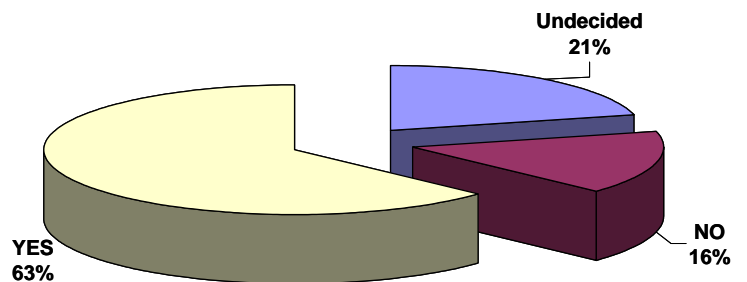


Figure 7: Vote 2 Result

At the start of the debate 89% of family/friends of men who have/have had prostate cancer were a favour of national screening but at the end of the debate this had dropped to 63%. This indicated a 20% movement towards not screening by the end of the debate. For example, the votes against screening increased from no votes to 16% and the undecided votes increased by 10% to 21%. However, 7 family/friends (37%) changed their vote position by the end of the debate, which is not indicated in the pie charts.

### **Vote 1 and Vote 2 Results From Health Professionals**

All seven health professionals voted against national screening on Vote 1 and Vote 2.

### **Vote 1 and Vote 2 Results From Members of the Public with No Alliance**

There were only three women and one man classified as members of the public with no alliance to men with prostate cancer or the NHS. Vote 1 was equally split 50/50 between “yes” and “undecided” and vote 2 was split 3 “undecided” and one “no” to screening. This indicated that two women changed their positions, one to “undecided” and one to “no” on screening by the end of the debate.

## **5. Conclusions**

As a result of the debate the following conclusions have been made.

1. Based on feedback from those attending, the debate was considered a success and a worthwhile investment by members of the Derriford PSG and the three Derriford Hospital Consultants, especially with regard to increasing awareness of prostate cancer via local media coverage.
2. Even though there was a 20% swing away from screening by the end of the debate, the final vote still indicated a majority opinion towards the need for national screening.
3. Although disappointing in several areas as mentioned below, attendance at the debate exceeded expectations, especially when considering the bad weather and difficulty in parking.
4. Attendance from health professionals was disappointing, especially as the debate was well publicised in the main Derriford Hospital Complex, Local Health Centres and Community Hospitals. In reality, only one nurse and two medical students were true NHS attendees and the remainder being the three Consultants who were on the panel and one Nurse Specialist who helped organise the debate. From the lack of response and turnout from representatives of the NHS it is concluded that prostate cancer is not a serious problem that needs to be solved.
5. It was disappointing that not one GP replied or turned up at the debate after all GP practices in the Derriford Catchment area (approximately 70 in total) were formally invited to attend. Based on the lack of response and turnout from GPs or their representatives, it is again concluded that prostate cancer is not a serious problem that needs to be solved.
6. It was also disappointing was that only one MP, Alison Seabeck, turned up, especially as all MPs and Prospective Parliamentary Candidates in the catchment area had been formally invited. Based on the poor response and turnout from Politicians or their representatives, it is again concluded that prostate cancer is not a serious problem that needs to be solved.
7. The only group of people who considered the debate to be of sufficient importance to attend were men who have and/or have had prostate cancer and their spouses, family and friends.
8. Based on the 20% swing away from screening, it is clear that the three Derriford Consultants put forward a more convincing argument not to screen than the argument for screening put forward by one prostate cancer sufferer, with no healthy professional support.
9. The vote not to screen by health professionals attending the debate is understandable as going against the Department of Health's decision in 1997 not to screen would have been unlikely, especially as the party line by senior consultants in Derriford hospital is not to screen.



## **6. Recommendations**

Based on the findings and conclusions of this report the following recommendations have been made.

1. Copies of this report to be forwarded to the following organisations
  - a. The UK National Screening Committee (NSC)
  - b. The Prostate Cancer Charity
  - c. The Prostate Cancer Support Federation
  - d. The local media
  - e. Other organisations as appropriate
2. Copies of this report to be made available as a downloadable PDF document on the Chestnut Appeal Charity Website page dedicated to the Derriford PSG
3. Formally request member organisations of the Prostate Cancer Support Federation, as well as independent Prostate Support Groups, to replicate the public debate in their local communities and feedback findings as per recommendation 1 above.
4. Produce a Guideline document comprising check lists, work programme, presentation content, media promotion, etc. to assist organisations when replicating the public debate in their areas.

## Appendix A: Questionnaire

### PUBLIC DEBATE QUESTIONNAIRE

**METHOD:** Tick/Mark Boxes as Required. Add additional comments in blank spaces

#### Personal Data

##### **Sex**

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

##### **Age**

**Please tick appropriate box below that best indicates your affiliation and/or situation**

NHS Professional	<input type="checkbox"/>	Prostate Cancer Sufferer	<input type="checkbox"/>
Non NHS Professional	<input type="checkbox"/>	Friend/Relative of Prostate Cancer Sufferer	<input type="checkbox"/>
GP	<input type="checkbox"/>	Member of The Public with no Alliance	<input type="checkbox"/>

Other (please specify)

#### **VOTE 1: To be completed by ALL Delegates before start of Debate**

		<b>Undecided</b>	<b>YES</b>	<b>NO</b>
Should National Screening be Introduced for Prostate Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### **VOTE 2: To be completed by ALL Delegates ONLY when instructed**

		<b>Undecided</b>	<b>YES</b>	<b>NO</b>
Should National Screening be Introduced for Prostate Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IMPORTANT:** Fold Twice and Post in Ballot Box when Leaving

**THANK YOU**

## Appendix B: Questionnaire Results

**Important Note:** Because of the wide age range of respondents and the relative low number of respondents it is possible to identify who the respondents are in some cases. For this reason, the ages of respondents have been deleted.

### Personal Data

Male

Female

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

### Affiliation

NHS Professional

Non NHS Professional

GP

Prostate Cancer Sufferer

Friend/Relative of Prostate Cancer Sufferer

Member of The Public with no Alliance

Other (please specify)

		1		1											
							1								
1	1		1		1	1		1	1	1	1	1	1		1
														1	

### VOTE 1

Undecided

YES

NO

1	1														
			1		1	1		1	1	1	1	1	1	1	1
		1		1				1							

### VOTE 2

Undecided

YES

NO

										1					
			1		1	1		1			1	1	1		1
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## Appendix C: Debate Discussion Points

Approximately 45 minutes debate took place directly after the two presentations. During the debate several questions were asked, some of which were personal treatment questions from men who had/and or have prostate cancer. This was expected as the three consultants on the panel collectively specialised in radical prostatectomy, radiotherapy or brachytherapy. Some of the questions of note were as follows.

1. Did the panel think that women had a better deal than men when it came to health services provided by the NHS?

**Answer:** Instead of being answered by the panel the audience were asked to vote on this question, the result being that the vast majority believed women got a better deal than men.

2. Did the UK versus the USA statistics calculation consider the 32 million people who did not have health insurance in the USA?

**Answer:** Henry Sells mentioned the health care provided by the Veterans association. Doug Gray mentioned that the USA statistics calculation did not consider the 32 million people who did not have health insurance, but taking this into consideration would have little affect on the lives that could be saved with screening.

3. Does having a prostate gland that is too large limit treatment options?

**Answer:** Paul McInerney explained that although radical prostatectomy and brachytherapy were no longer options, radiotherapy offered the same benefits and success rate.

4. If cost was removed from Wilson's screening criteria would there be more ticks in favour for screening than against it?

**Answer:** Even though there would be more ticks in favour of screening the consultants would not be in support of screening as they believed it caused unnecessary harm to patients.

5. What can cause PSA levels to be elevated?

**Answer:** Paul McInerney explained that a raised PSA level, although very accurate, can be affected by several factors and not just prostate cancer, for example, a benign prostate gland enlargement, infection, sexual activity and vigorous exercise less than 48 hours before the test.

6. Understanding that Professor Roger Kirby had openly admitted that he took PSA blood tests to screen himself for prostate cancer and that many of his colleagues did the same, have any of the male consultants had a PSA test?

**Answer:** Henry Sells has not had a PSA test. Not known whether Paul McInerney has or has not taken a PSA test.

7. Instead of councils finding ways of spending surplus budget before financial year ends, such as unnecessary road repairs, could this money be used to help offset the cost of screening?

**Answer:** Not considered a suitable question to answer and the debate was moved on by the Chairman.