

# THE 2016 SCOPE OF WORK: 2015 YEAR IN REVIEW



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<http://prostatecanceradvisorycouncil.org/>

## **I. Situation Analysis**

In 2004, state statute 381.911 established the Prostate Cancer Advisory Council (PCAC). The Council falls under the direction of the University of Florida Prostate Disease Center, (UFPDC). The UFPDC works with numerous agencies, organizations and institutions to improve public awareness of prostate cancer. Membership in the UFPDC Prostate Cancer Advisory Council is by appointment of the executive director of the UFPDC in consultation with the Department of Health's Comprehensive Cancer Control Program and the State Surgeon General to cover a geographically and institutionally diverse advisory council that consists of nine members:

- Two persons from prostate cancer survivor groups or cancer-related advocacy groups
- Four persons, one of whom is a physician licensed under chapter 458; one of whom is a physician licensed under chapter 459; one of whom is a scientist; one of whom is the executive director of the UFPDC or designee
- Three persons who are engaged in the practice of cancer-related medical specialties from health organizations committed to cancer research and control.

Many PCAC memberships are expired, and some members are unable to participate in a voting capacity. To improve PCAC's capability to act quickly on priorities laid out by the State Surgeon General, membership in PCAC will become streamlined to ensure reaching a quorum most efficiently.

## **II. Executive Summary**

PCAC is comprised of cancer specialists, physicians, expert scientists as well as patient advocates and prostate cancer survivors. PCAC is charged with advising the Legislature, Governor and Surgeon General on statewide issues regarding prostate cancer incidence and mortality as well as related health disparities for access to care and prostate-cancer treatment. The goal is to improve prostate-cancer outcomes, facilitate community engagement and improve health equity.

Prostate cancer screening, consisting of routine PSA blood testing and digital prostate exam, is controversial. Proper screening principles require a balance between cost/acceptability with a reduction in disease-specific morbidity and/or mortality. The widespread use of PSA screening in the late 1980's resulted in a 60 percent reduction of metastatic disease at diagnosis along with a 40 percent reduction in prostate cancer mortality. However, more recent large population based studies in Europe and the United States suggest a small absolute survival advantage to treatment with the inherent potential risk of complications related to treatment.

Therefore, prostate cancer screening standards have been adjusted. Numerous organizations provide variable screening criteria. These range from the American Cancer Society's recommendations for shared decision making beginning at age 50 to the United States Preventive Services Task Force (USPSTF) 2012 recommendations against routine prostate cancer screening. The USPSTF panel, which did not include an urologist or a cancer specialist, concluded that the harm of screening outweighed the benefit. As a result, 20 percent fewer patients were screened for prostate cancer in 2013 with a corresponding 30 percent reduction in prostate cancer diagnoses. Although the majority of the reduction in new prostate cancer diagnoses represented low-risk prostate cancer cases, there was a corresponding reduction of 23 percent in high-risk prostate cancer incidence. The delayed diagnosis of high-risk prostate cancer will result in eventual advanced disease presentation with limited options for meaningful survival-impacting treatment.

Standard early detection rationale for prostate cancer must address variable risk which is impacted, in part, by a positive family history for prostate cancer as well as race. African-Americans, according to the American Cancer Society, have a 60 percent greater risk than whites for diagnosis of prostate cancer and 150 percent greater risk for prostate cancer mortality. The risk disparity is thought to be a result of biological (tumor aggressiveness) and behavioral (cultural) factors which include access to care and understanding of treatment options.

Prior to routine PSA screening, nearly 34 percent of African-Americans presented with metastatic prostate cancer compared to 19 percent of whites. This translated to a five-year survival of 58.6 percent for African-Americans compared to 69.7 percent for whites. Although survival trends have improved following the introduction of routine PSA testing, the disparity in race specific survival remains. Florida specific data from the Department of Health, from 2010-12, concluded the age-adjusted prostate cancer incidence per 100,000 African-Americans rose to an all-time high of 306.8 from a low of 189.3 in 2004-06. For the same period, whites had an incidence rate of 101.2, the lowest recorded since 1993. The death rate for African-Americans from prostate cancer in Florida for 2012-14 was 36.3 per 100,000 and 16.0 for whites.

In 2015, approximately 221,000 new prostate cancer diagnoses were expected in the U.S. with 27,500 prostate cancer deaths. For men, prostate cancer is second only to non-melanoma skin cancer and lung cancer as the leading cause of cancer and cancer death, respectively, in the United States. Multiple factors determine prostate cancer survival, especially the extent or stage of the tumor at the time of diagnosis. The five-year relative survival rate among men with localized prostate cancer is nearly 100 percent compared to 31.9 percent among those diagnosed with distant metastases. Although men with advanced disease may benefit from palliative treatment, curative treatment options are unavailable. Florida Physicians and patients

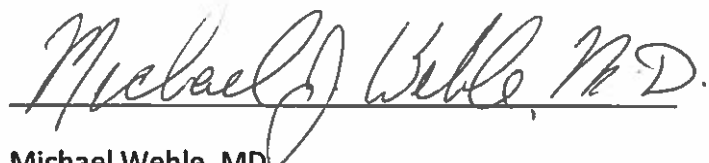
should be concerned about the potential risk of delayed diagnosis due to decreasing emphasis on early detection and the inherent increased disease morbidity and mortality.

### **III. Upcoming: 2016**

In 2016, the members of PCAC will ...

- Recommend early detection protocols and elaborate on these protocols through a sub-panel in Quarter 1 2016.
- Recommend how to address health equity and treatment standards
- Establish and disseminate statewide early detection and diagnosis standards for at-risk prostate cancer populations.
- Continue to develop evidence-based treatment standards for evolving areas of prostate cancer care/science.
- Develop evidence-based treatment standards that include collaboration with established advocacy groups, private- and academic-based referring physicians and specialists in the state.
- Update the PCAC website and speaker panels to improve community engagement, communication and outreach.
- Emphasize greater education, outreach and communication to underserved and at-risk regions of the state due to income inequality.

Submitted by

A handwritten signature in black ink that reads "Michael Wehle, MD". The signature is written in a cursive style and is positioned above a horizontal line.

**Michael Wehle, MD**  
Executive Director  
Prostate Cancer Advisory Council