El chequeo de la próstata
Perspectiva del médico de familia

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RAMCV

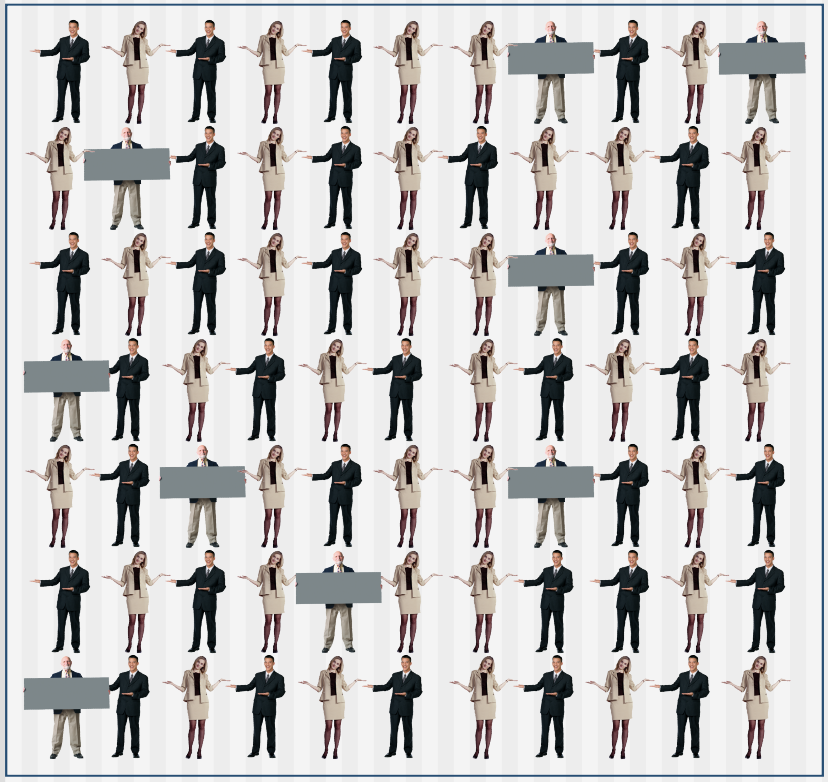
12 de diciembre de 2016

Médico de familia

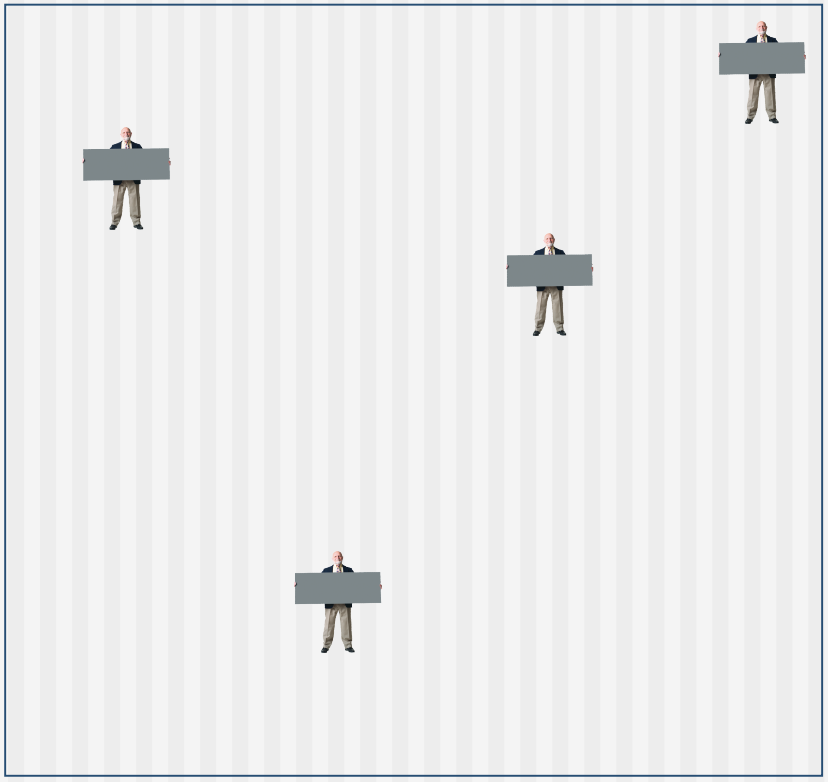
- Especialista en medicina general.
- Se ocupa de los problemas de salud de la persona desde una perspectiva global.
- Valora los problemas de salud de la población, los resuelve en una proporción importante y cuando no, los deriva al especialista.

Poblaciones diferentes

Consulta m. familia



Consulta urología

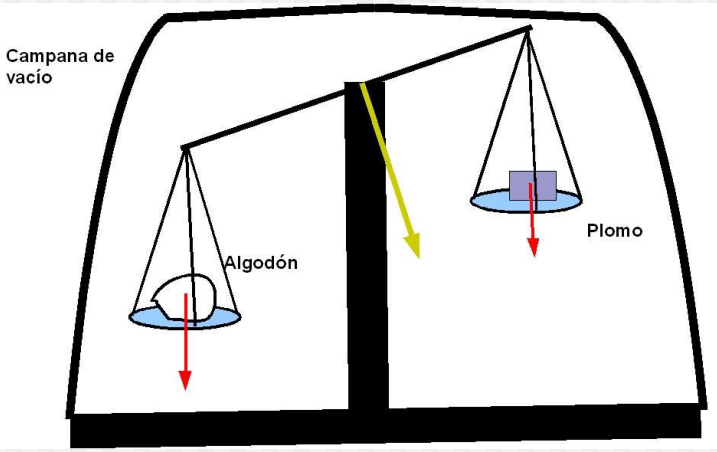


Chequeo = Cribado

- Conjunto de pruebas diagnósticas que se realizan en población que no tiene síntomas.
- Ejemplo: pedir el PSA a los hombres a partir de los 50 años de edad.

HIPÓTESIS DEL CRIBADO

- Detección precoz del cáncer de próstata.
- El beneficio principal de esta prueba podría ser la dismunición (retraso) de la mortalidad.
- Riesgos: los derivados del sobrediagnóstico y el sobretratamiento



¿Qué es el sobrediagnóstico?

Es la detección de una anormalidad o condición asintomática que:

1. Nunca progresará o de hecho puede regresar y desaparecer o
2. Si progresa lo hace tan lentamente que el paciente suele fallecer de otra causa antes de tener síntomas

¿Qué es el sobretratamiento?

- Es el tratamiento de los sobrediagnósticos.
- Al no conseguir los efectos beneficiosos del tratamiento solo podremos conseguir los efectos adversos.

Los chequeos y…

LA Hiperplasia benigna de próstata

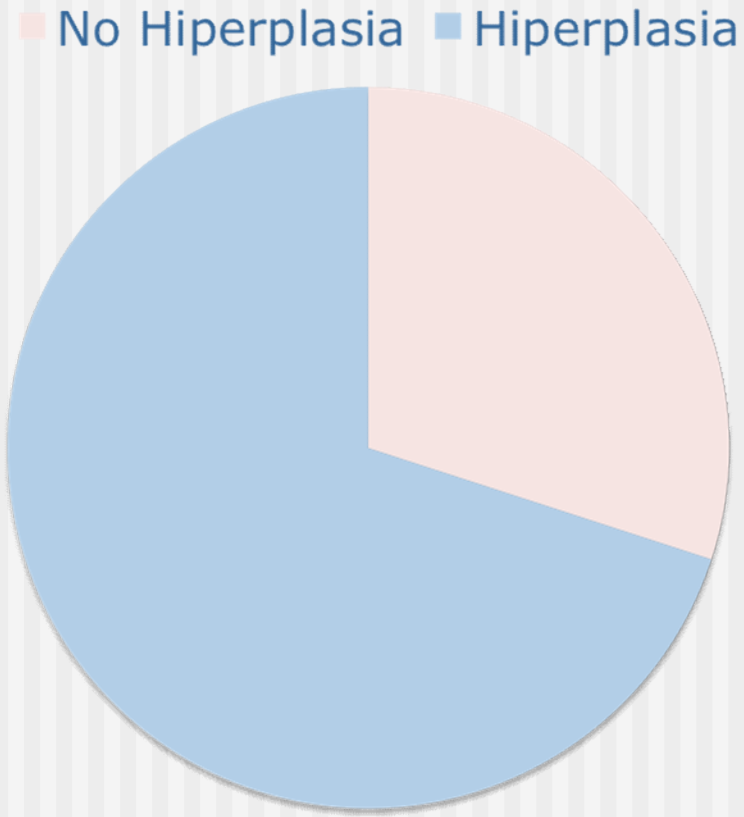
Hiperplasia Benigna Próstata

- La HBP es un término fundamentalmente histológico.

Abrams. Rev Urol 1999;1:65.

Hiperplasia Benigna Próstata

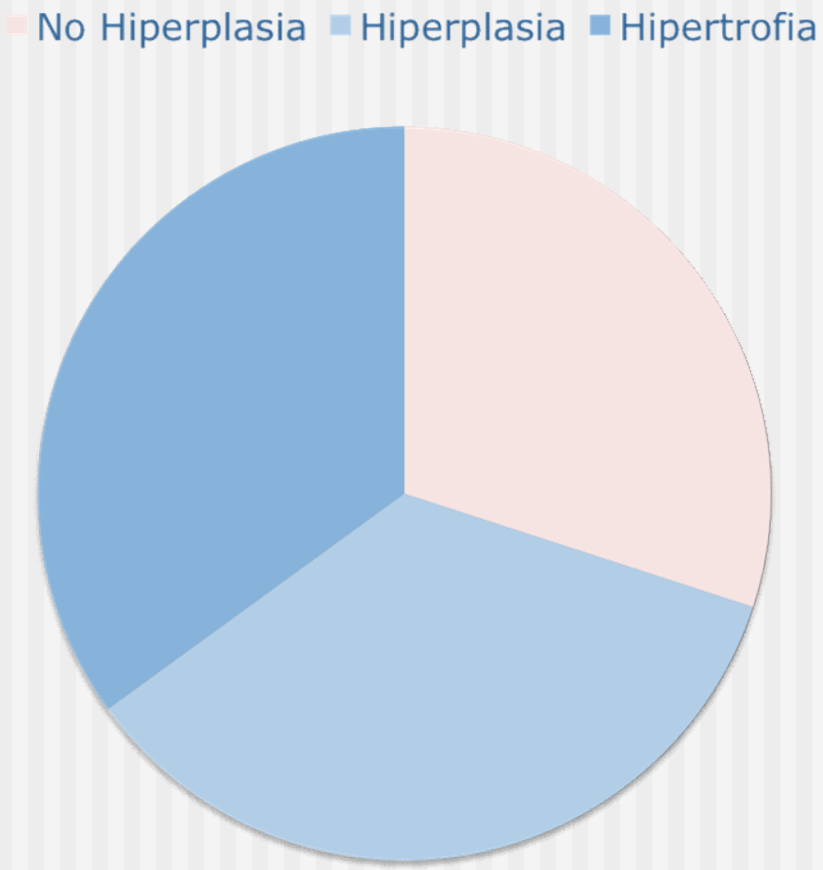
- La HBP es un término fundamentalmente histológico.
- Hacia los 70 años cerca del 70% tendrán una HBP histológica.



Abrams. Rev Urol 1999;1:65.

Hiperplasia Benigna Próstata

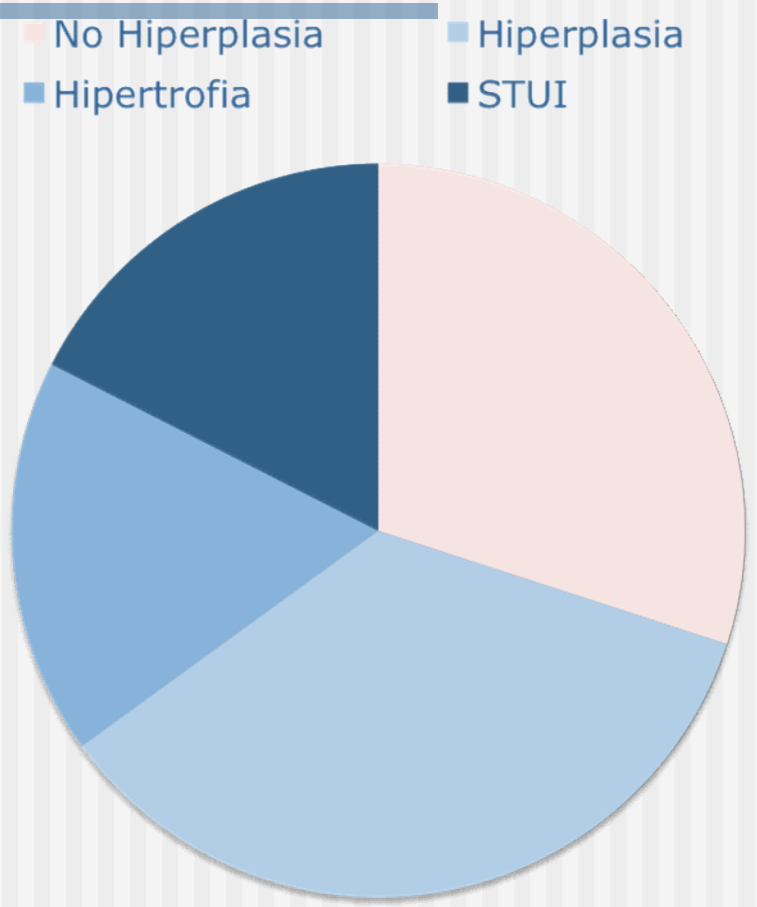
- La HBP es un término fundamentalmente histológico.
- Hacia los 70 años cerca del 70% tendrán una HBP histológica.
- De ellos el 50% tendrán próstata agrandada.

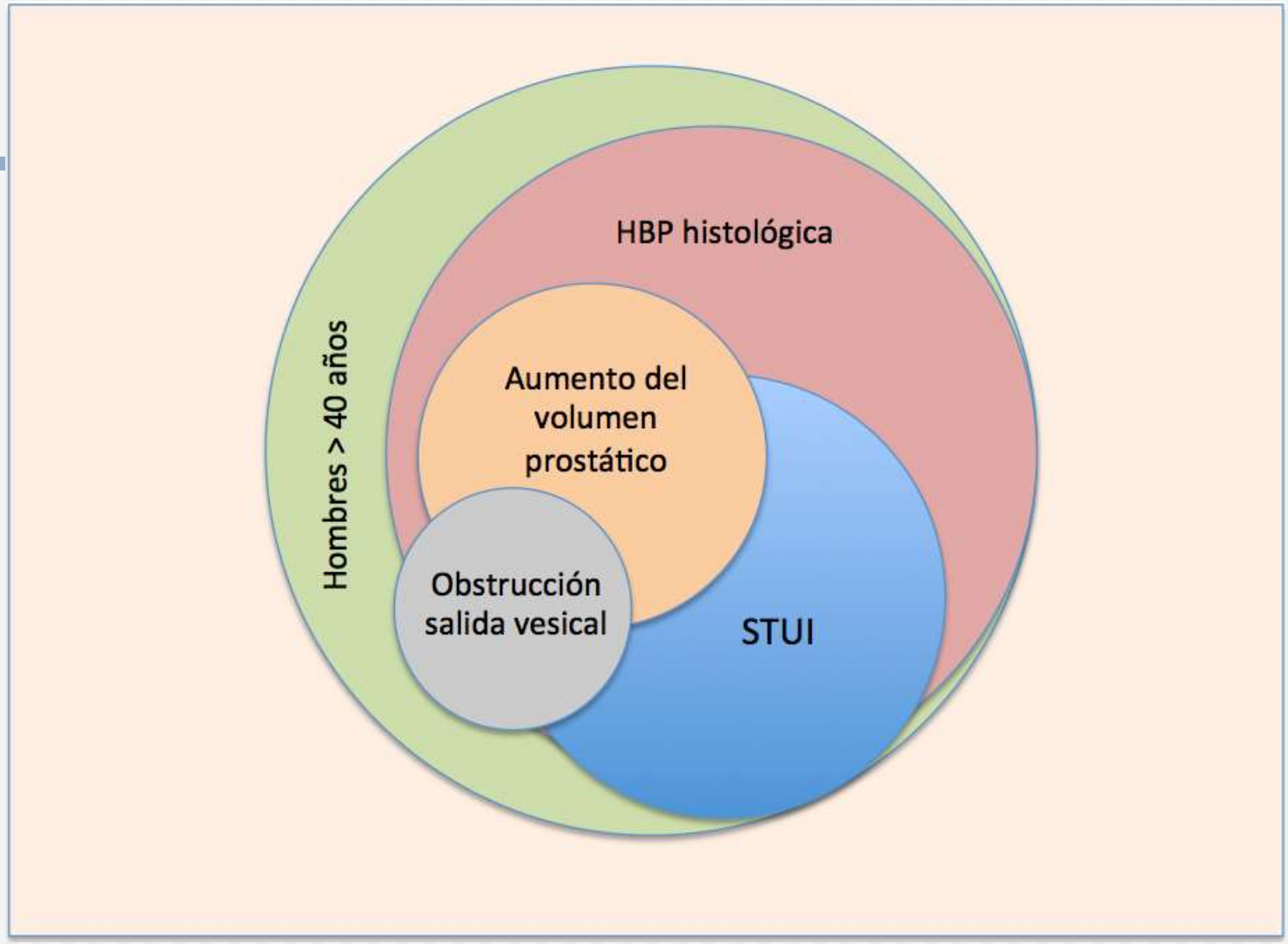


Abrams. Rev Urol 1999;1:65.

Hiperplasia Benigna Próstata

- La HBP es un término fundamentalmente histológico.
- Hacia los 70 años cerca del 70% tendrán una HBP histológica.
- De ellos el 50% tendrán próstata agrandada.
- De los últimos el 50% (aprox. 17%) tendrán síntomas y obstrucción.





Tomado de: Roehrborn CG. Benign prostatic hyperplasia: an overview. Rev Urol. 2005;7 Suppl 9:S3–S14

Síntomas del tracto urinario inferior (STUI)

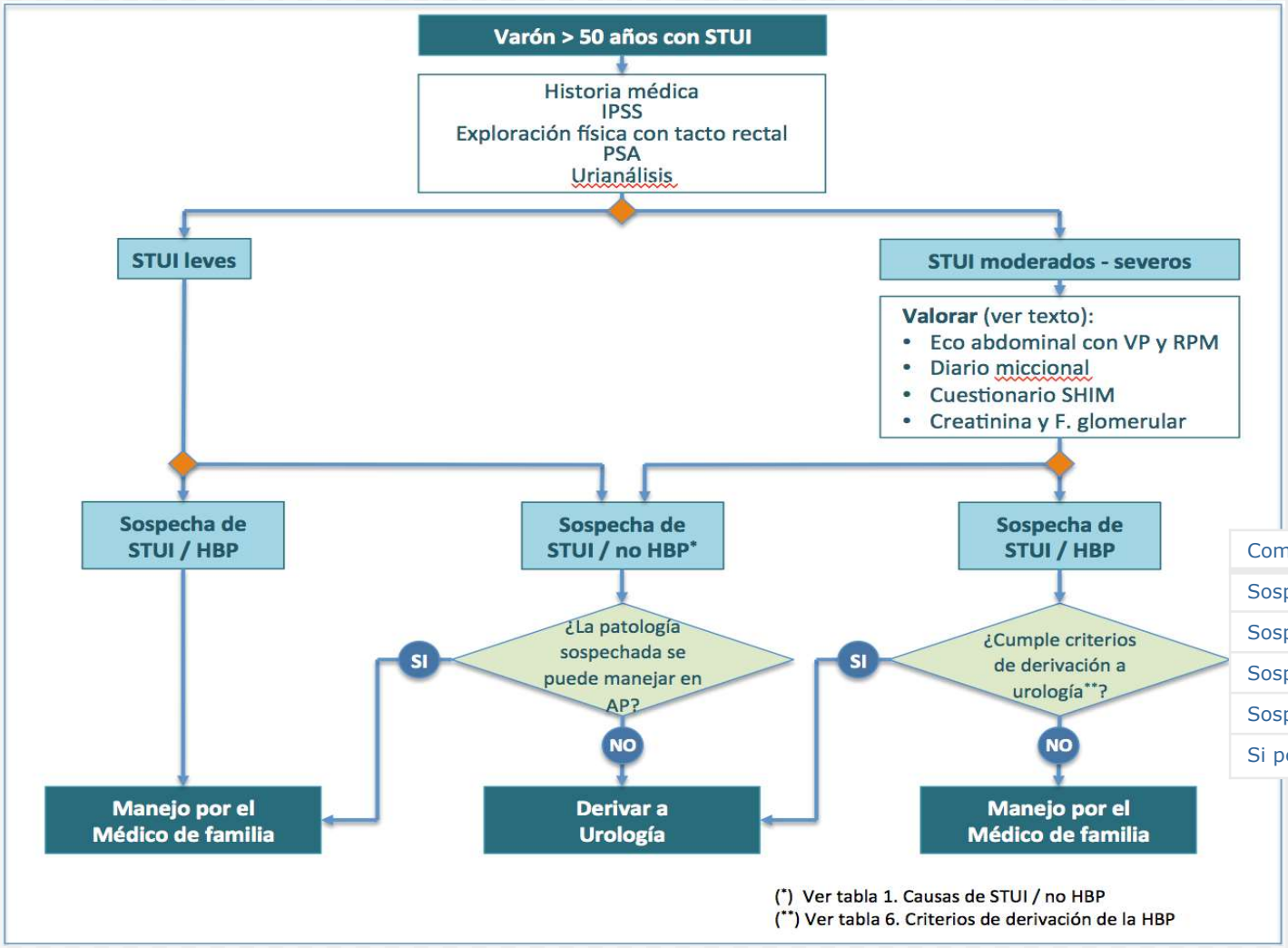
Síntomas de llenado	Síntomas de vaciado	Síntomas postmiccionales
Nocturia	Chorro débil	Sensación de vaciado incompleto
Frecuencia	Dificultad para iniciar la micción	Goteo postmiccional
Urgencia	Esfuerzo miccional	
Incontinencia	Micción intermitente	
	Goteo terminal	

Algunas cuestiones

- ¿Los pacientes con HBP tienen mayor riesgo de presentar un cáncer de próstata?.
  - NO, tienen el mismo riesgo que los que no tienen HBP[1]
- ¿Los STUI pueden ser producidos por el cáncer de próstata?
  - SÍ, aunque es muy poco frecuente

(1). Schenk JM. Am J Epidemiol. 2011 Jun 5;173(12):1419–28

Algoritmo diagnóstico



- Complicaciones de la HBP
- Sospecha de Ca. Vejiga
- Sospecha de Ca. próstata
- Sospecha de estenosis uretral
- Sospecha de vejiga neurógena
- Si persisten dudas diagnósticas

Objetivos del tratamiento en la HBP

1. Mejorar los síntomas molestos.
2. Mejorar la calidad de vida.
3. Prevenir complicaciones en los pacientes con síntomas molestos

Conclusiones HBP (I)

1. En los varones sin STUI (asintomáticos) no hay que hacer un chequeo de la próstata, ni pedir el PSA.
2. En el estudio inicial de los pacientes con STUI se debe solicitar el PSA, entre otras pruebas, para descartar un cáncer de próstata.

Conclusiones HBP (II)

3. En el seguimiento de los pacientes diagnosticados de HBP no es necesario repetir el PSA cada año.
4. Sin embargo, en pacientes tratados con finasterida o dutasterida, sí que se recomienda la monitorización anual del PSA.

Los chequeos y…

El cáncer de próstata

International Agency for Research on Cancer

World Health Organization

SPAIN

GLOBOCAN 2008

Estimated cancer Incidence, Mortality, Prevalence and Disability-adjusted life years (DALYs) Worldwide in 2008

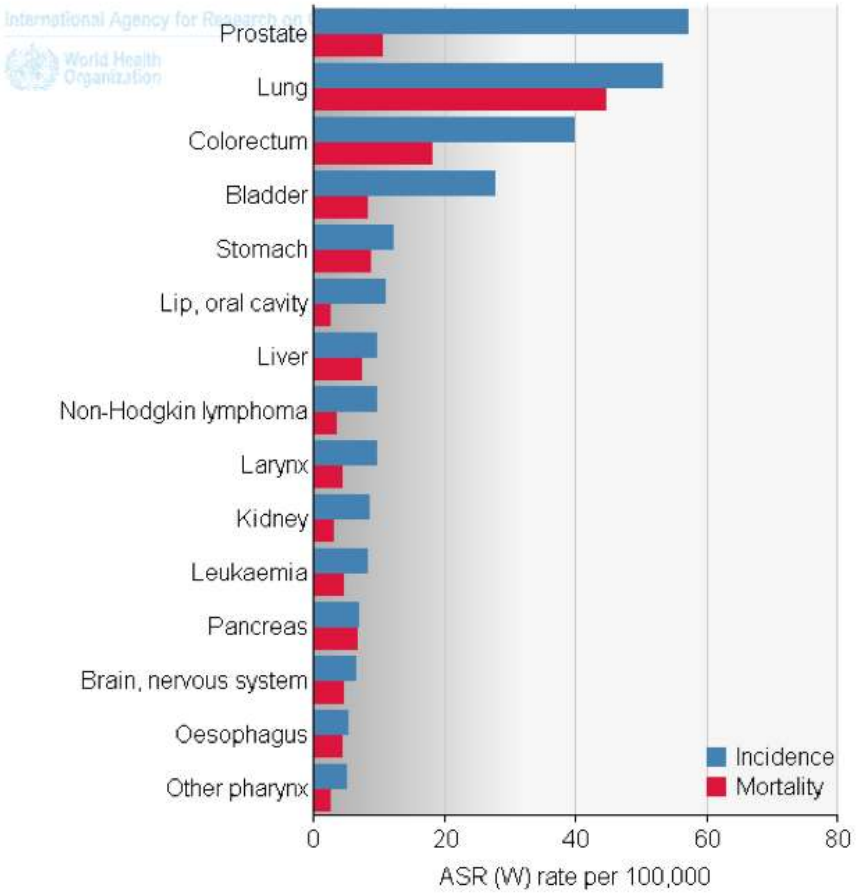
Cáncer de Próstata

-25231 nuevos casos **: 1ª causa de cáncer en hombres.**

-6062 muertes: **3ª causa de muerte por cáncer en hombres** (1ª pulmón, 2ª colon)

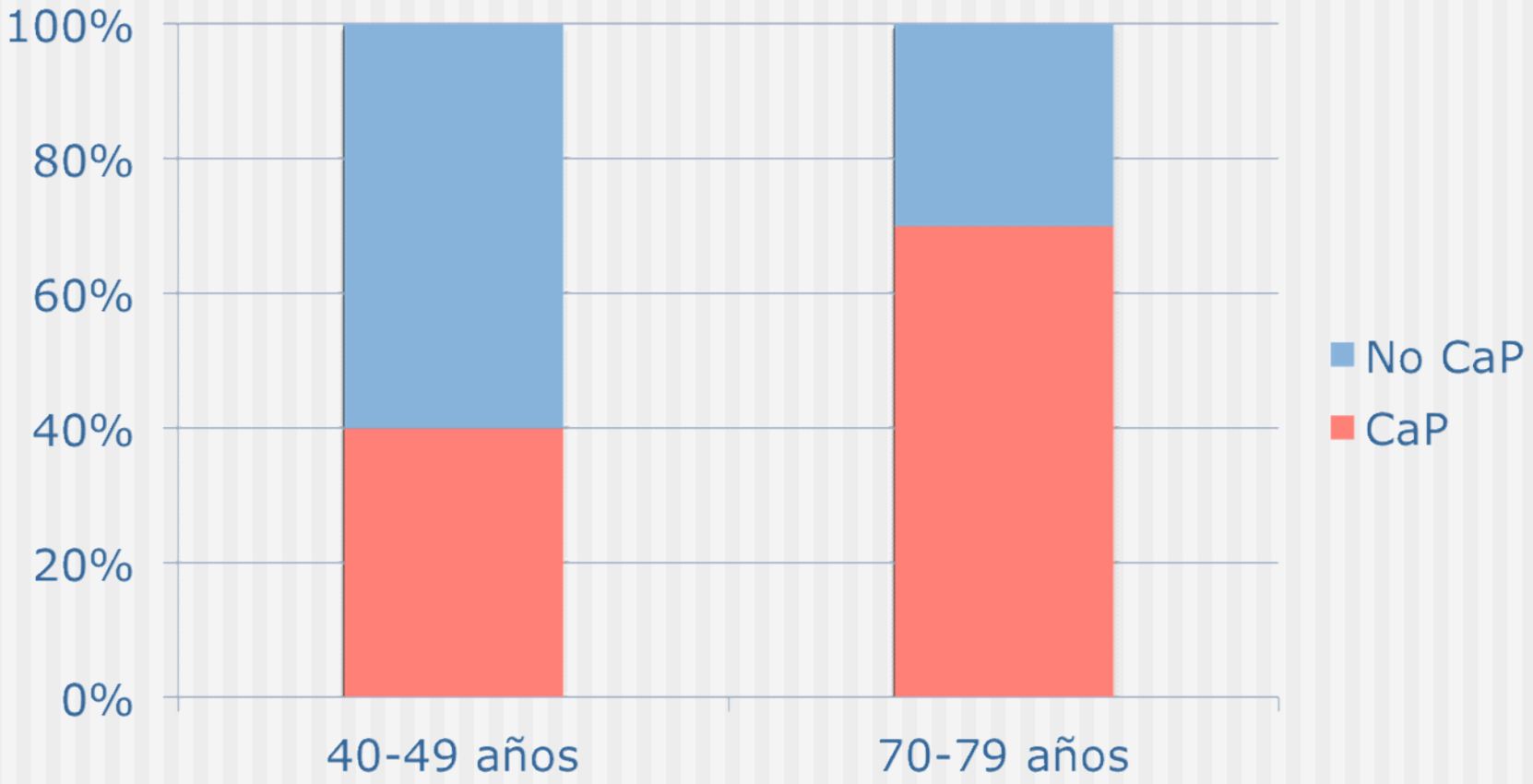
-Tendencia descendente de la mortalidad por CaP durante las últimas décadas

Estimated age-standardised incidence and mortality rates: men



GLOBOCAN 2008. Estimated cancer Incidence, Mortality, Prevalence and Disability-adjusted life years (DALYs) Worldwide in 2008 [Internet]. globocan.iarc.fr. [cited 2013 Mar 11]. Available from: http://globocan.iarc.fr/[11/03/13 00:31:04]

Cáncer e próstata y autopsias



Bell N, et al. CMAJ. 2014;186(16):1225–34

Riesgos del CaP

- Riesgo de ser diagnosticado de CaP durante la vida: **14,3%**
- Riesgo de muerte por CaP: **3,6%**
- Supervivencia a los 10 años: 95%

*Es mucho más probable morir **con** un CaP que morir **de** un CaP.*

Bell N, et al. CMAJ. 2014;186(16):1225–34

Incidencia y mortalidad por CaP

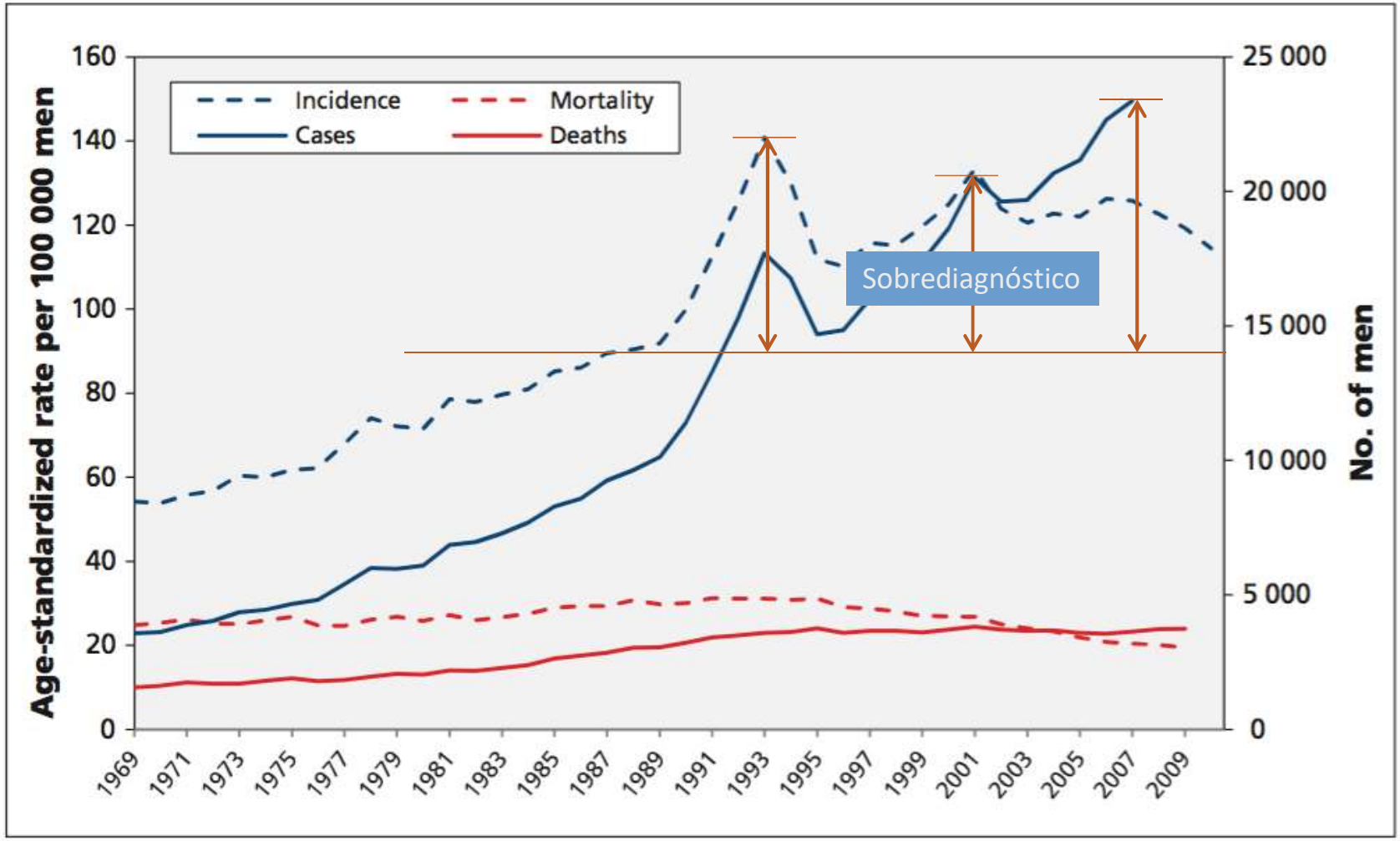


Figure 1: Cases of and deaths from prostate cancer, with associated age-standardized incidence and mortality (per 100 000 men), among Canadian men aged 45 years and older. Age was standardized to the 1991

¿qué es el PSA?

- El PSA es una kalicreína producida tanto por las células normales como por las malignas de la glándula prostática.
- Marcador prostático-específico, no cáncer específico
- Aumenta en el CaP, HBP y prostatitis.
- No hay ningún nivel de PSA que excluya o confirme el diagnóstico de CaP

PLCO

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Mortality Results from a Randomized Prostate-Cancer Screening Trial

Gerald L. Andriole, M.D., E. David Crawford, M.D., Robert L. Grubb III, M.D., Saundra S. Buys, M.D., David Chia, Ph.D., Timothy R. Church, Ph.D., Mona N. Fouad, M.D., Edward P. Gelmann, M.D., Paul A. Kvale, M.D., Douglas J. Reding, M.D., Joel L. Weissfeld, M.D., Lance A. Yokochi, M.D., Barbara O'Brien, M.P.H., Jonathan D. Clapp, B.S., Joshua M. Rathmell, M.S., Thomas L. Riley, B.S., Richard B. Hayes, Ph.D., Barnett S. Kramer, M.D., Grant Izmirlian, Ph.D., Anthony B. Miller, M.B., Paul F. Pinsky, Ph.D., Philip C. Prorok, Ph.D., John K. Gohagan, Ph.D., and Christine D. Berg, M.D., for the PLCO Project Team*

ABSTRACT

BACKGROUND

The effect of screening with prostate-specific–antigen (PSA) testing and digital rectal examination on the rate of death from prostate cancer is unknown. This is the first report from the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial on prostate-cancer mortality.

METHODS

From 1993 through 2001, we randomly assigned 76,693 men at 10 U.S. study centers to receive either annual screening (38,343 subjects) or usual care as the control (38,350 subjects). Men in the screening group were offered annual PSA testing for 6 years and digital rectal examination for 4 years. The subjects and health care providers received the results and decided on the type of follow-up evaluation. Usual care sometimes included screening, as some organizations have recommended. The numbers of all cancers and deaths and causes of death were ascertained.

RESULTS

In the screening group, rates of compliance were 85% for PSA testing and 86% for digital rectal examination. Rates of screening in the control group increased from 40% in the first year to 52% in the sixth year for PSA testing and ranged from 41 to 46% for digital rectal examination. After 7 years of follow-up, the incidence of prostate cancer per 10,000 person-years was 116 (2820 cancers) in the screening group and 95 (2322 cancers) in the control group (rate ratio, 1.22; 95% confidence interval [CI], 1.16 to 1.29). The incidence of death per 10,000 person-years was 2.0 (50 deaths) in the screening group and 1.7 (44 deaths) in the control group (rate ratio, 1.13; 95% CI, 0.75 to 1.70). The data at 10 years were 67% complete and consistent with these overall findings.

CONCLUSIONS

After 7 to 10 years of follow-up, the rate of death from prostate cancer was very low and did not differ significantly between the two study groups. (ClinicalTrials.gov number, NCT00002540.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Berg at the Division of Cancer Prevention, National Cancer Institute, National Institutes of Health, 6130 Executive Blvd., Rm. 3112, Bethesda, MD 20892-7346, or at bergc@mail.nih.gov.

*Members of the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial project team are listed in the Supplementary Appendix, available with the full text of this article at NEJM.org.

This article (10.1056/NEJMoa0810696) was published at NEJM.org on March 18, 2009.

N Engl J Med 2009;360:1310-9.

ERSPC

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Screening and Prostate-Cancer Mortality in a Randomized European Study

Fritz H. Schröder, M.D., Jonas Hugosson, M.D., Monique J. Roobol, Ph.D., Teuvo L.J. Tammela, M.D., Stefano Ciatto, M.D., Vera Nelen, M.D., Maciej Kwiatkowski, M.D., Marcos Lujan, M.D., Hans Lilja, M.D., Marco Zappa, Ph.D., Louis J. Denis, M.D., Franz Recker, M.D., Antonio Berenguer, M.D., Liisa Määttänen, Ph.D., Chris H. Bangma, M.D., Gunnar Aus, M.D., Arnauld Villers, M.D., Xavier Rebillard, M.D., Theodorus van der Kwast, M.D., Bert G. Blijenberg, Ph.D., Sue M. Moss, Ph.D., Harry J. de Koning, M.D., and Anssi Auvinen, M.D., for the ERSPC Investigators*

ABSTRACT

BACKGROUND

The European Randomized Study of Screening for Prostate Cancer was initiated in the early 1990s to evaluate the effect of screening with prostate-specific–antigen (PSA) testing on death rates from prostate cancer.

METHODS

We identified 182,000 men between the ages of 50 and 74 years through registries in seven European countries for inclusion in our study. The men were randomly assigned to a group that was offered PSA screening at an average of once every 4 years or to a control group that did not receive such screening. The predefined core age group for this study included 162,243 men between the ages of 55 and 69 years. The primary outcome was the rate of death from prostate cancer. Mortality follow-up was identical for the two study groups and ended on December 31, 2006.

RESULTS

In the screening group, 82% of men accepted at least one offer of screening. During a median follow-up of 9 years, the cumulative incidence of prostate cancer was 8.2% in the screening group and 4.8% in the control group. The rate ratio for death from prostate cancer in the screening group, as compared with the control group, was 0.80 (95% confidence interval [CI], 0.65 to 0.98; adjusted P=0.04). The absolute risk difference was 0.71 death per 1000 men. This means that 1410 men would need to be screened and 48 additional cases of prostate cancer would need to be treated to prevent one death from prostate cancer. The analysis of men who were actually screened during the first round (excluding subjects with noncompliance) provided a rate ratio for death from prostate cancer of 0.73 (95% CI, 0.56 to 0.90).

CONCLUSIONS

PSA-based screening reduced the rate of death from prostate cancer by 20% but was associated with a high risk of overdiagnosis. (Current Controlled Trials number, ISRCTN49127736.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Schröder at the Erasmus Medical Center, P.O. Box 2040, Rotterdam 3000 CA, the Netherlands, or at secr.schroder@erasmusmc.nl.

*Members of the European Randomized Study of Screening for Prostate Cancer (ERSPC) are listed in the Appendix.

This article (10.1056/NEJMoa0810084) was published at NEJM.org on March 18, 2009.

N Engl J Med 2009;360:1320-8.

RESULTADOS

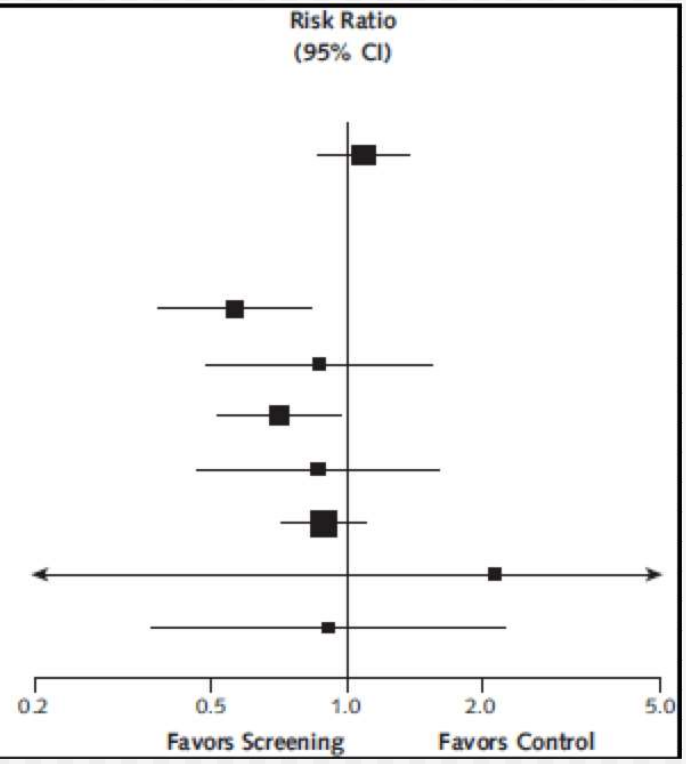
- PLCO[1]: no encontró diferencias significativas en mortalidad cáncer-específica ni en la global, entre los grupos de placebo y cribado
- ERSPC[2,3]: disminución relativa del 21% (95% IC 31% al 8%) de la mortalidad cáncer-específica en el grupo de 55-69 años de edad

	9 años	11 años	13 años
NNI	1410	979 (95% CI 594-2770)	781 (95% CI 490-1928)
NND	48	35 (95% CI 21-96)	27 (95% CI 17-66)

1. Andriole GL. Prostate Cancer Screening in the Randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: Mortality Results after 13 Years of Follow-up. J. Natl. Cancer Inst. 2012 Jan 17;104(2):125–32.
2. Schröder FH. Prostate-cancer mortality at 11 years of follow-up. N. Engl. J. Med. 2012 Mar 15;366(11):981–90.
3. Schröder FH, et al. The Lancet. 2014 Aug 6;:1–9.

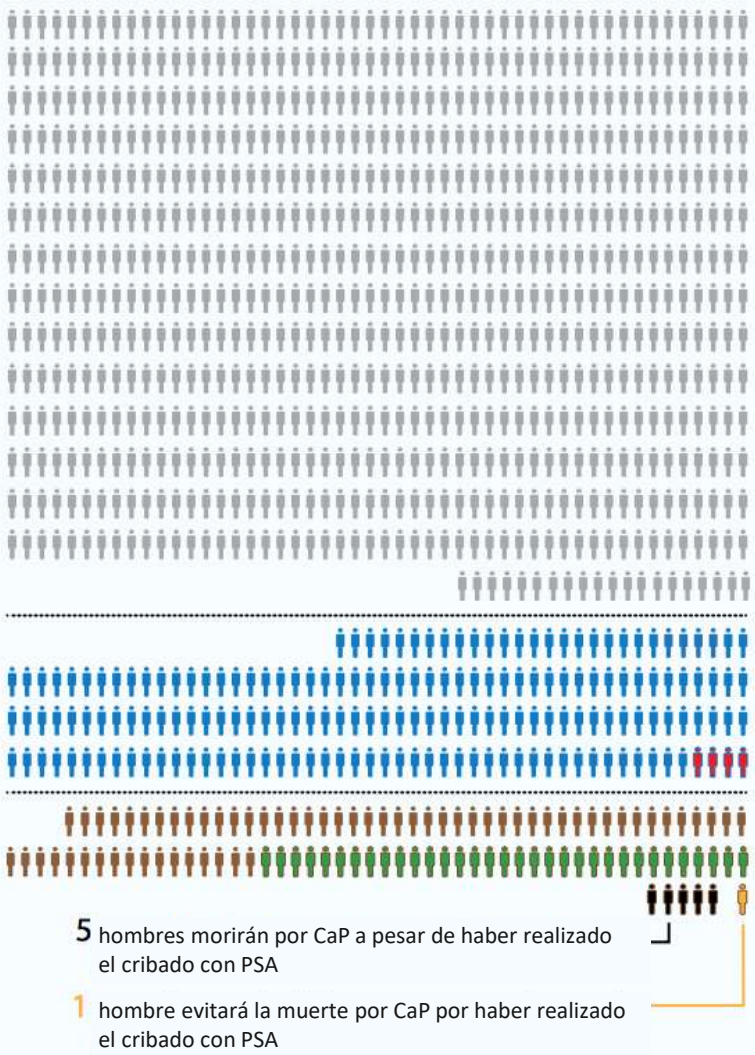
Resultados no homogéneos entre países

Country	Screened		Control		Risk Ratio (95% CI)
	Deaths	Total	Deaths	Total	
PLCO trial					
United States	158	38 340	145	38 345	1.09 (0.87–1.36)
ERSPC trial					
Sweden	39	5901	70	5951	0.56 (0.38–0.83)
Belgium	22	4307	25	4255	0.86 (0.48–1.52)
Netherlands	69	17 443	97	17 390	0.71 (0.52–0.96)
Italy	19	7266	22	7251	0.86 (0.46–1.58)
Finland	139	31 970	237	48 409	0.89 (0.72–1.09)
Spain	2	1056	1	1141	2.15 (0.20–23.77)
Switzerland	9	4948	10	4955	0.89 (0.36–2.20)



RESULTADOS DEL CRIBADO DE 1000 HOMBRES CON EL PSA

(55-69 años de edad, cribados durante 13 años y con un umbral de PSA de 3.0 ng/ml)



720 tendrán un PSA negativo

178 hombres con un PSA positivo, los estudios posteriores no identificarán un CaP

4 de estos 178 presentarán complicaciones por la biopsia como infecciones y sangrados que requieran hospitalización

102 serán diagnosticados de CaP

33 de los 102 CaP no habrían causado enfermedad o muerte

5 hombres morirán por CaP a pesar de haber realizado el cribado con PSA

1 hombre evitará la muerte por CaP por haber realizado el cribado con PSA

¿Cuáles son mis riesgos si no realizo el cribado?

- Entre los hombres cribados con el PSA, el riesgo de muerte por CaP es de 5 entre 1000
- Entre los hombres que no son cribados con el PSA, el riesgo de muerte por CaP es de 6 entre 1000

Complicaciones del tratamiento del CaP

Por cada 1000 hombres tratados por CaP:

•114-214 presentarán complicaciones a corto plazo como infecciones, cirugía adicional y transfusiones de sangre.

•127-442 sufrirán disfunción eréctil a largo plazo.

•Más de 178 sufrirán incontinencia urinaria.

•4-5 morirán por complicaciones del tratamiento

U.S. Preventive Services Task Force

Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement

Moyer VA. Ann Intern Med. 2012; 157: 120-134.

Recomendación en contra "**certeza moderada o alta que el servicio no tiene ningún beneficio neto, o que los daños superan los beneficios**", en hombres de cualquier edad.

El screening se asocia a una detección de más casos de CaP pero con una **pequeña o ninguna reducción de la mortalidad cáncer de próstata-específica después de 10 años** e importantes daños relacionados con resultados falsos positivos, posterior evaluación y terapia, incluyendo sobrediagnóstico y sobretratamiento" .

Conclusiones CaP (I)

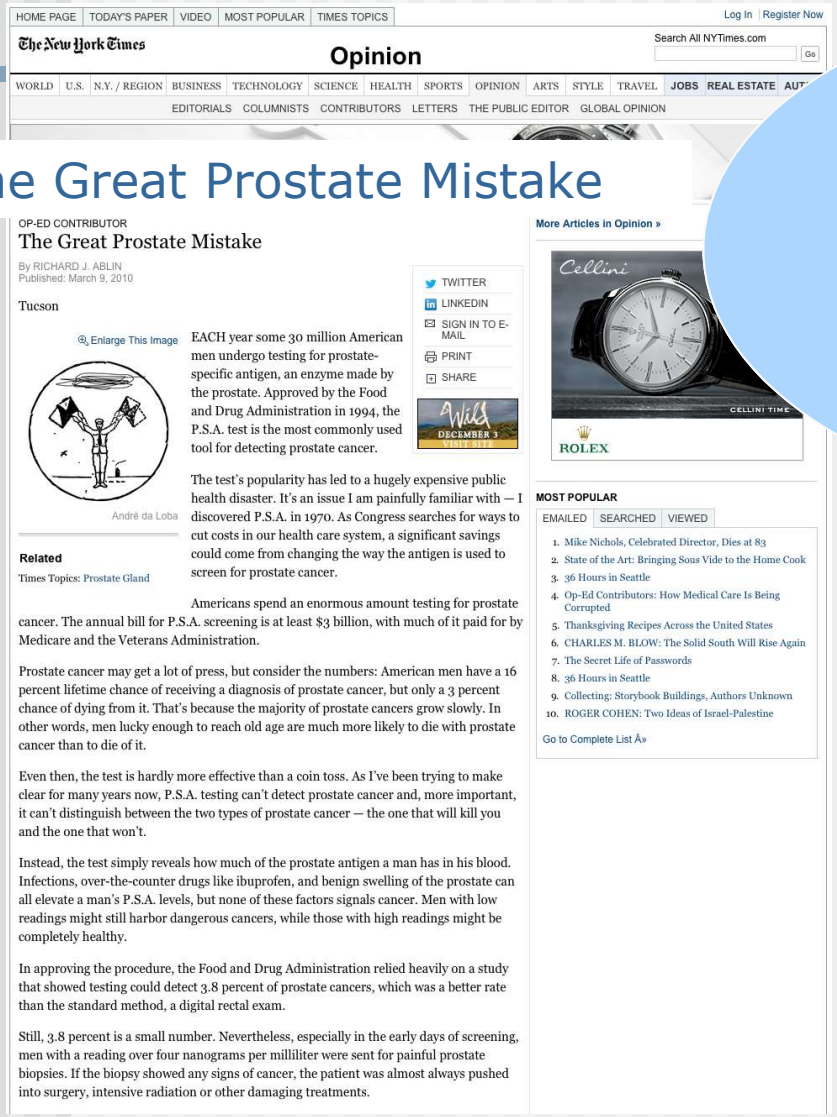
- No hay evidencias de que el cribado del CaP con PSA disminuya la mortalidad total en hombres a cualquier edad.
- Existe evidencia conflictiva que sugiere una pequeña e incierta reducción potencial de la mortalidad por CaP en hombres entre 55 y 69 años cribados con PSA.
- No hay evidencia concluyente de reducción de la mortalidad en cualquiera de los otros grupos de edad.
- Existe evidencia consistente de que el cribado y el tratamiento activo producen daños

Conclusiones CaP (II)

- **Recomendaciones**:

1. No se recomienda el cribado poblacional rutinario del CaP con el PSA.
2. En varones entre 55 y 69 años de edad que soliciten el cribado, informar de los daños y beneficios del mismo.
3. Fuera de ese rango de edad, no recomendar el cribado.
4. Aunque no existen evidencias, en general se sigue recomendando el cribado si existe un riesgo aumentado de CaP: antecedentes familiares y afroamericanos.

Richard J. Ablin… y el PSA (2010)



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The Great Prostate Mistake

OP-ED CONTRIBUTOR

The Great Prostate Mistake

By RICHARD J. ABLIN
Published: March 9, 2010

Tucson

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EACH year some 30 million American men undergo testing for prostate-specific antigen, an enzyme made by the prostate. Approved by the Food and Drug Administration in 1994, the P.S.A. test is the most commonly used tool for detecting prostate cancer.

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The test's popularity has led to a hugely expensive public health disaster. It's an issue I am painfully familiar with — I discovered P.S.A. in 1970. As Congress searches for ways to cut costs in our health care system, a significant savings could come from changing the way the antigen is used to screen for prostate cancer.

Related

Times Topics: Prostate Gland

Americans spend an enormous amount testing for prostate cancer. The annual bill for P.S.A. screening is at least $3 billion, with much of it paid for by Medicare and the Veterans Administration.

Prostate cancer may get a lot of press, but consider the numbers: American men have a 16 percent lifetime chance of receiving a diagnosis of prostate cancer, but only a 3 percent chance of dying from it. That's because the majority of prostate cancers grow slowly. In other words, men lucky enough to reach old age are much more likely to die with prostate cancer than to die of it.

Even then, the test is hardly more effective than a coin toss. As I've been trying to make clear for many years now, P.S.A. testing can't detect prostate cancer and, more important, it can't distinguish between the two types of prostate cancer — the one that will kill you and the one that won't.

Instead, the test simply reveals how much of the prostate antigen a man has in his blood. Infections, over-the-counter drugs like ibuprofen, and benign swelling of the prostate can all elevate a man's P.S.A. levels, but none of these factors signals cancer. Men with low readings might still harbor dangerous cancers, while those with high readings might be completely healthy.

In approving the procedure, the Food and Drug Administration relied heavily on a study that showed testing could detect 3.8 percent of prostate cancers, which was a better rate than the standard method, a digital rectal exam.

Still, 3.8 percent is a small number. Nevertheless, especially in the early days of screening, men with a reading over four nanograms per milliliter were sent for painful prostate biopsies. If the biopsy showed any signs of cancer, the patient was almost always pushed into surgery, intensive radiation or other damaging treatments.

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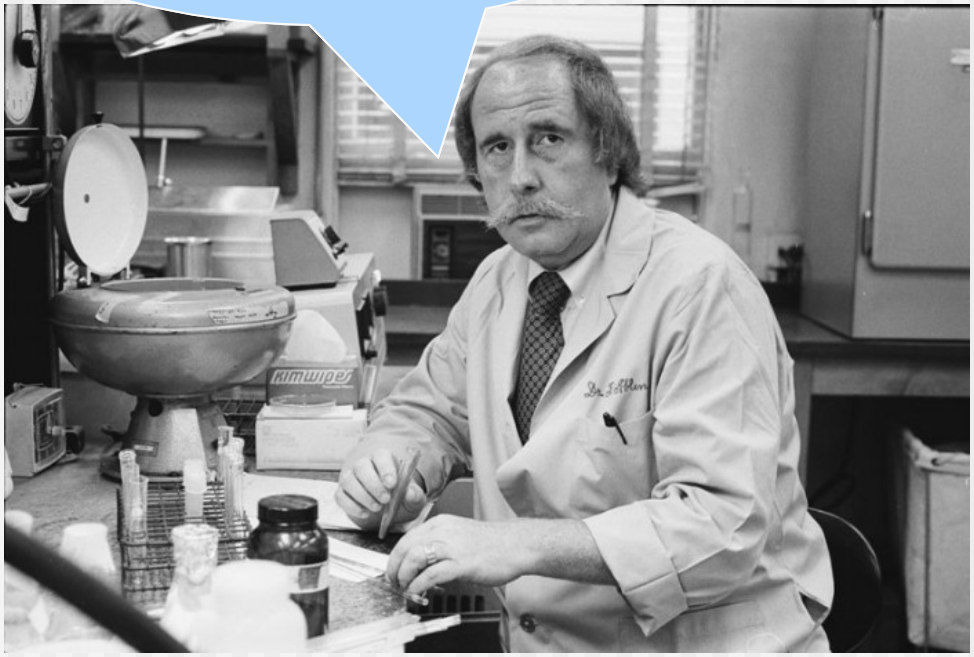
"I never dreamed that my discovery four decades ago would lead to such a profit-driven **public health disaster**".



¡Muchas gracias!