
EDITORIAL COMMENT

The authors have addressed an important issue in an appropriate manner. The PSA test has been widely used to screen men for prostate cancer (Pca). It is important to mention that the PSA test is not panacea. Most men with increased serum PSA levels have benign prostatic hyperplasia, which is a normal part of aging. Conversely, low serum concentrations of PSA do not rule out the presence of Pca. In addition nowadays it has been demonstrated that serum PSA levels can be influenced by several medical conditions such as type 2 diabetes mellitus,⁽¹⁾ dietary factors,⁽²⁾ certain clinical cardiovascular disorders⁽³⁾ and obesity.⁽⁴⁾ Even some supplemental materials such as γ linolenic acid and coenzyme Q10⁽⁵⁾ and opium consumption (a worldwide growing problem) can alter significantly serum PSA levels.^(6,7) Some scientific associations and health care providers now recommend against the use of the PSA test to screen for Pca because the benefits, if any, are small and the tribulations can be considerable. For example the U.S. Preventive Services Task Force, doesn't recommend routine PSA screening for men in the general population, regardless of age. The American Cancer Society, the American College of Preventive Medicine, the American Urological Association, and the Centers for Disease Control and Prevention, all recognize the controversy surrounding screening with the PSA test and the lack of firm evidence that screening can prevent deaths from Pca. On May 21, 2012, the U.S. Preventive Services Task Force (USPSTF) released final recommendations against PSA-based screening for Pca, asserting that there is "moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits," and discouraged the use of the test by issuing it a Grade D rating. The American Urological Association (AUA) is outraged and believes that the Task Force is doing men a great disservice by disapproving what is now the only widely available test for Pca, a potentially fatal disease. Screening for Pca needs to be an individualized decision. Physicians should discuss the benefits and risks of Pca screening by PSA testing with men especially in high-risk men. Physicians must help men make their own decisions about Pca screening, based on age, family history, life expectancy, personal preferences, and other risk factors. The American Urological Association (AUA) recommends that men talk to their doctors about getting a baseline PSA test at age 40. This could help them settle on when to screen in the future and to determine possible future risk and test results. The impacts of cardiovascular disease on serum PSA levels have been well documented,⁽³⁾ such as present study. Although the work is considered to be interesting, several substantive points need to be clarified. In present study actual values for PSA have been reported, while geometric means is a more accepted statistically method. As prostate volume has not been calculated, therefore PSA density could not be assessed and presented to see if it follows a similar or different pattern as the total PSA. Although statistically PSA was altered, longer studies are necessary to reach an appropriate conclusion. Also, studies need to be done to determine whether treatment of the coronary artery syndrome allows the PSA values to return back to pretreatment levels in long term period. PSA velocity may be an important tool for assessment; which also has not been reported.

Mohammad Reza Safarinejad
MD

Clinical Center for Urological Disease Diagnosis and Private Clinic Specialized in Urological and Andrological Genetics, Tehran, Iran.

E-mail: info@safarinejad.com

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