

15th NASPCC Annual Meeting, Wash, DC

*Prostate Cancer and African American
Men*

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Durham, NC



10/19/19

Greetings From...



We get men back in the game.

The Duke Prostate Center is dedicated to providing excellent care to men with prostate cancer and to discovering newer and better methods for detecting, treating, and preventing the disease.

Our multidisciplinary team is composed of nationally and internationally recognized surgeons, medical oncologists, radiation oncologists, basic scientists, and other medical professionals, all working together to deliver outstanding care and support to men and their families. To learn more about our services, please call 1-888-ASK-DUKE or visit us online at dukehealth.org.

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***Duke Urology-Duke Surgery- Duke Cancer Institute
Duke University
Durham, North Carolina***

Prostate Cancer used to be in the in the News in a positive way...

The central image is a newspaper clipping from the 'MEDICINE' section with the headline 'THE MAN'S CANCER'. The sub-headline reads: 'Prostate cancer is reaching epidemic levels in the U.S. This is no time for squeamishness'. The article is by SAM JOHNSON and LINDA BROWN. The main text begins: 'THREE YEARS AFTER HIS TRAUMA IN THE GULF WAR, GENERAL B. Norman Schwarzkopf was feeling testosterone. But in March 1994, uncomfortable with nagging tenderness in one knee, he stopped by the MacDill Air Force Base Hospital in Tampa, Florida. While there, he decided to visit the base urologist for an exam. "I feel something not quite right," the doctor said, after making a routine rectal exam. "But if it's cancer, it can kill 99% of the time, and I don't think so." Schwarzkopf, then 60, had reason to feel confident. He had recently undergone a PSA (prostate-specific antigen) test and registered a count of only 1.6, well below the level considered indicative of cancer.

But to play it safe, the urologist performed an ultrasound exam ("It looks like a stone," he reassured the general), took a biopsy of the prostate gland and sent it off to a pathologist. Schwarzkopf left the hospital relaxed and optimistic. But a week later, the doctor called, panicked and then said, "I don't know how to tell you this, but you have prostate cancer."

Schwarzkopf, and like most men woefully uninformed about prostate cancer, Schwarzkopf began devouring books and medical journal articles. He overcame his squeamishness and started talking to friends and experts about this disease that seems to stalk at the very core of masculinity. "For me, it was like war," he says. "First thing you do is learn about the enemy."

PHOTOGRAPHS: THESE MEN ARE FIGHTING AN ALREADY DEFENSIVE PROSTATE INDUSTRY.

Surrounding the article are portraits of several men, each with a name and age label below them:

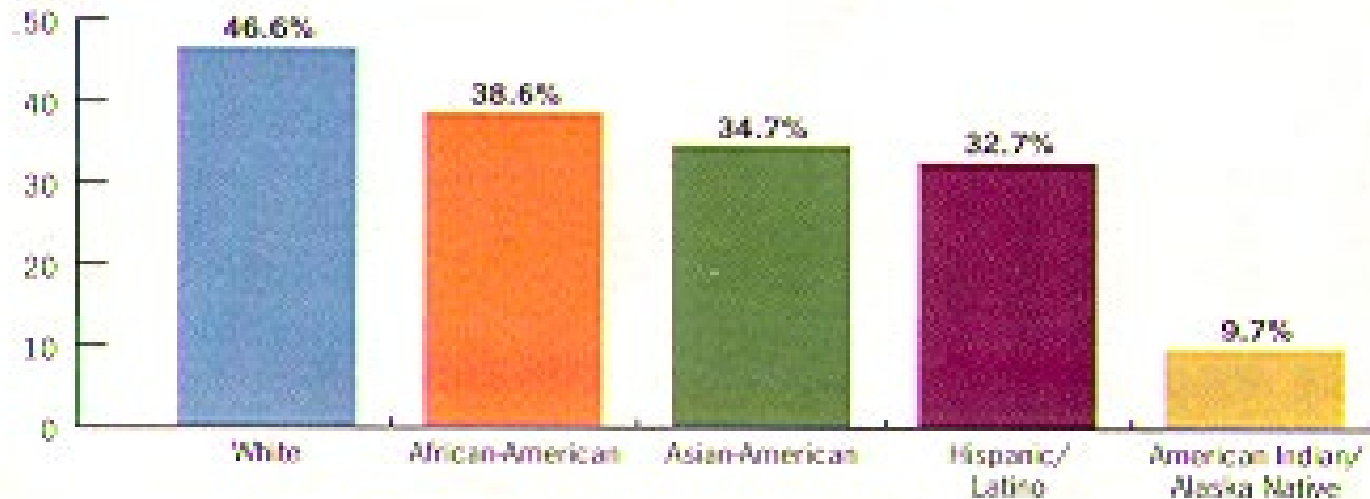
- GEN. BIRDDALL, 71
- SCOTT PETER, 61
- BOB LEWIS, 70
- WALTER LEACH, 75
- ROBERT DOULT, 62
- RICHARD PETTY, 58
- GENERAL SCHWARZKOPF, 61
- MIKE BELDEN, 67
- BOB LEE, 67
- MICHAEL EDGAR, 60
- DR. BOB HARRIS, 61
- ONG HADSON, 61
- MARSH HARTY, 60
- JUSTICE L.P. STEVEN, 75



*...but even in this era (before 2011),
the rate of screening was sub-optimal*

PSA Testing By Race/Ethnicity

Among men aged 50 years and older in the United States, American Indian and Alaska Native men are less likely than other men to undergo PSA testing, according to a report by the American Cancer Society. Shown here are the percentages of men who had PSA tests within the previous year, based on race or ethnicity.



Source: American Cancer Society, Cancer Prevention & Early Detection Facts & Figures, 2011, page 46.

...then the backlash against PSA and prostate cancer overtreatment in 2011

SPORTS SCORES INSIDE

THE NATION'S NEWSPAPER

APRIL 11, 2011 \$1.00



Tim Duncan, winning titles since 1999. By Kirby Lee, CS Presswire

Relentless Spurs

San Antonio lets others make headlines while team quietly pushes on, 1C



A GANNETT COMPANY



'Idol' down to final two

Jessica Sanchez, Phillip Phillips share their views, 3D

► What could swing votes, 3D

AP photos



Category	Value
Prostate cancer Annual cases	241,740
Prostate cancer Annual deaths	28,170

Panel discourages prostate screening

Healthy men more likely to be harmed, government advisers say. Experts explain why, 3A, 5D

Source: American Cancer Society; by Janet Loeferke, USA TODAY

Prostate Cancer – 2008-2018

- United States Preventative Services Task Force (USPSTF) erodes recommendation for screening for prostate cancer
- 2008-against screening men 70+
- 2011-prostate screening with PSA= “D-rating” (more harm than good)
- Did not even recommend screening for high risk groups
- Unclear of the long-term impact



Will the USPSTF “D-rating” from 2011-2018 disproportionately affect Black men?



22

Public health | Clinical issues | Patients

Health & Science

INSIDE THIS SECTION
HHS report warns of high vitamin levels 26

A study in black & white

DISPARITY IN CARE

- Cardiac rehabilitation
 - White: 67%
 - African-American: 40%
- Instruction on stroke alert death symptom
 - White: 72%
 - African-American: 48%
- Receiving antibiotics within six hours of hospitalization for pneumonia
 - White: 82%
 - African-American: 52%
- Cardiac bypass surgery
 - White: 45%
 - African-American: 27%
- No treatment for prostate cancer
 - White: 7%
 - African-American: 12%

AFRICAN-AMERICANS EXPERIENCE HIGHER RATES of illness and death from virtually every health condition — from asthma to diabetes to cancer. A frequently cited cause has been lack of access to quality health care. But once African-Americans enter the health system, what kind of care do they receive? A growing body of research reports that racial disparities in health status can be explained, at least in part, by racism and discrimination within the health care system itself. Blacks, for example, are less likely to receive high-tech procedures that offer the greatest chance for recovery, according to some studies. “Sadly, we are a mix of two separate health care systems,” said Henry B. Lindester, senior vice president for policy and management at the Morehouse School of Medicine, Atlanta, which recently held a symposium on health care effectiveness research. “One offers the highest quality of care while the other offers something that is clearly substandard.” The African-American death rate nationwide is 16 times that of

STORY BY DEBORAH SHELTON / ILLUSTRATION BY TERRY HUNSA

Racial disparity and Prostate Cancer

- In U.S.
 - Black men 1.5 times increased PC incidence
 - Black men 2.5 times increased PC mortality
- Mechanism likely multi-factorial
 - Biologic
 - Access to care
 - Cultural attitudes/behavior
 - Dietary
 - Other

Constant politics since 2011...

UNITED STATES PREVENTIVE SERVICES TASK FORCE: PATIENT ACCESS TO PSA SCREENING

The recent U.S. Preventive Services Task Force (USPSTF) draft decision to assign prostate-specific antigen (PSA) testing a "D" grade does a great disservice to the many men who could benefit from a PSA test. Much like the USPSTF recommendations against mammography – which were not accepted – the USPSTF's recommendations are open to debate and are ill-advised, given the evidence.

Congress should act to protect patient access to PSA screening and their right to speak with their physicians about prostate cancer treatment.

Ask Your Congressional Contacts to:

- **OPPOSE** the USPSTF recommendations against PSA screening.
- **SUPPORT** further research necessary to improve the testing and treatment process by supporting the Prostate Research, Outreach, Screening, Testing, Access and Treatment Effectiveness (PROSTATE) Act (H.R. 2159/S. 1190).
- **SUPPORT** changes to the USPSTF process that make their deliberations transparent and therefore accountable to the public by requiring:
 - 1) consultation with specialists that treat the specific diseases under review; and
 - 2) a formal response to invited public comment patterned after the rule-making process engaged in by federal agencies before they issue final recommendations.

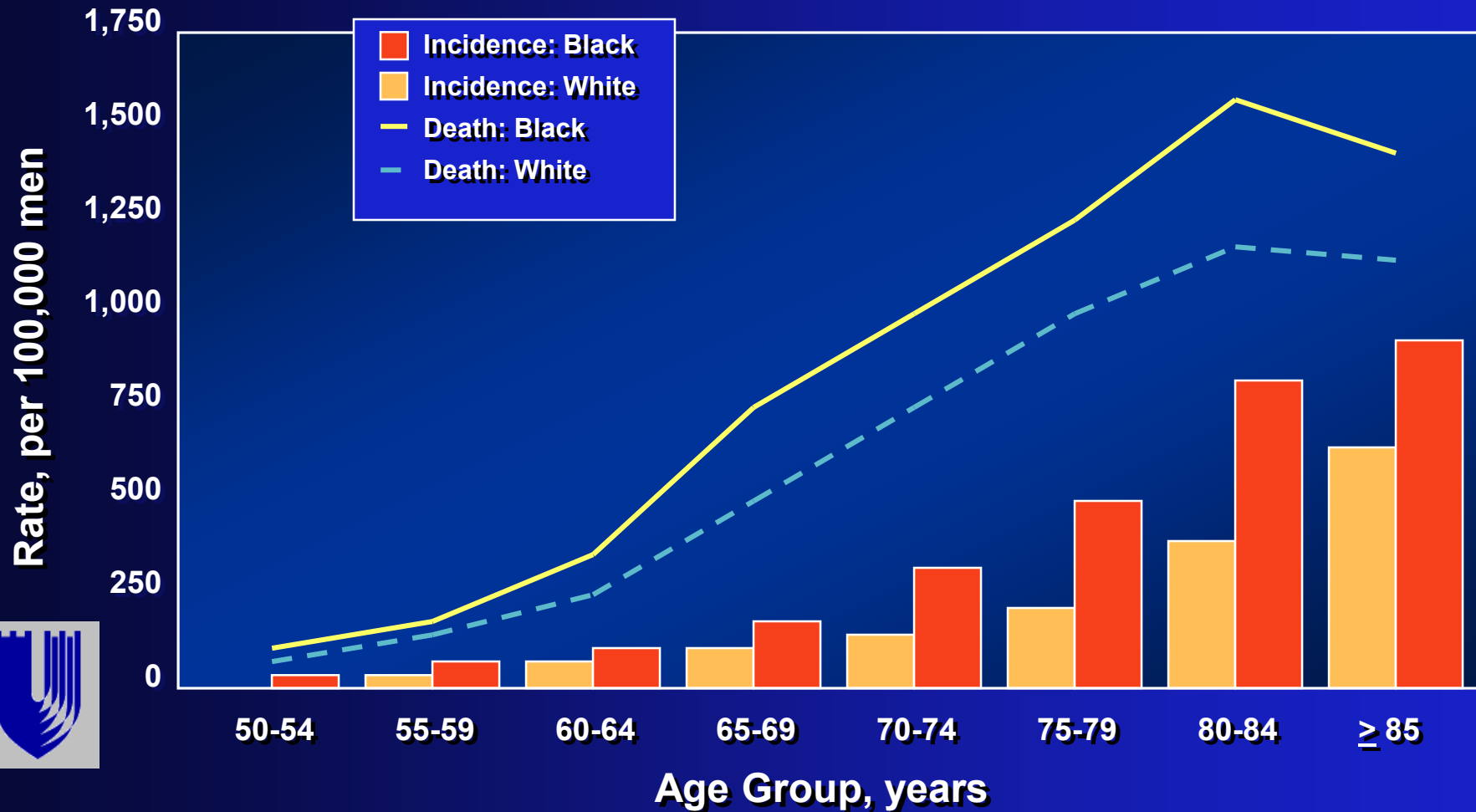
USPSTF: 4/11/17: “C-rating for PSA”

- **LEADING THE NEWS**

- **USPSTF releases draft guidelines on PSA testing**

- The [Washington Post](#) (4/11, McGinley) reports the US Preventive Services Task Force (USPSTF) “has dropped its controversial opposition to routine screening for prostate cancer, and now says that men between the ages of 55 and 69 should discuss the test’s potential benefits and harms with their” physicians “and make decisions based on their own ‘values and preferences.’” The group said in proposed new guidelines on Tuesday morning, “The decision about whether to be screened for prostate cancer should be an individual one.”
- The [New York Times](#) (4/11, Rabin, Subscription Publication) “Well” blog reports that the task force “continues to recommend that men 70 and older forgo screening altogether.”
- [USA Today](#) (4/11, Miller) reports that the USPSTF’s “2012 advice against screening said there was little evidence that PSA screening was reducing deaths.” Since that time, “PSA screening rates have declined by as much as 10%, and now fewer than one-third of US men get the tests.” Meanwhile, “fewer men are being diagnosed with early-stage disease, when it is more treatable, while more are being diagnosed with more aggressive harder-to-treat cancer.”
- The [AP](#) (4/11, Tanner) reports, “The draft prostate cancer [recommendations](#), announced online in the Journal of the American Medical Association, are open for public comment...until May 8.”

Racial Disparity in Prostate Cancer were prevalent before the D Rating



Will the disparity worsen if prostate screening is abandoned?

WEDNESDAY, JANUARY 14, 1998

The Washington Post

MIETRO

COURTLAND MILLOY

Seeking a Cure for What's Killing Black Men

MILLOY, From B1

gland; why not a comprehensive program to deal with the whole man?

Surely we need to know why black men are dying of almost everything at disproportionately high rates—including suicide, homicide and AIDS.

"We don't know why African American men are two to three times more likely to die of their prostate cancer than white men," McDonald said. "We don't know how to prevent prostate cancer . . . or even reduce risk substantially for this disease. We don't yet have the scientific data to prove conclusively that early detection of prostate cancer through screening saves lives. We don't know which are the most effective aggressive treatments."

I am no doctor, but perhaps the key to answering some of those questions lies in the answer to this one: Are black men somehow losing the will to live?

A black male born in 1995 had a life expectancy of only 65.2 years; a white male born that same year could expect to live 73.4 years. Murder isn't even among the top 10 causes of death for white men. For black males ages 15 to 24, it's the No. 1 cause of death. AIDS has been the leading killer of black men ages 25 to 44 every year since 1991.

AIDS and homicide we can do something about. But we really haven't done nearly enough.

Black men, it seems to me, have become excessively competitive with each other in recent years, and extremely suspicious of each other—murderously so in some neighborhoods.

The only resentments greater than the ones we harbor against white people are the ones we harbor

against ourselves. We can't even confide in one another.

African American men have the highest incidence of prostate cancer of any group in the world. But African men don't have this problem. What do they know that we don't?

Studies on prostate cancer have come to all sorts of conclusions: It's our diet; no, it's our income levels. It's our genes; no, it's our unwillingness to seek preventive treatment.

The fact is: Cancer death rates for black men outdistance those for white men for more than 14 types of malignant tumors, from lung cancer to cancer of the pancreas. Our first task ought to be accepting that reality, without blame or shame.

At the news conference on prostate cancer, some of us stood around drinking coffee and eating the bagels with cream cheese that were served. We thought nothing of the irony. (How nice it would have been, though, to drink some vegetable juice instead.)

Nevertheless, I applaud the new blueprint for action on prostate cancer. I think it's just what we need—but not just for that particular disease.

One suggestion, though: All the talk about what we don't know about cancer can be depressing. For a grass-roots campaign, I suggest putting more emphasis on what we think might help—even if it's only having some tomato juice and a prayer before bedtime.

Personally, I think what more black men need to know is how to live a life of love and fellowship. Who knows? Maybe we'd discover a reason for living that is in itself a potent cure.

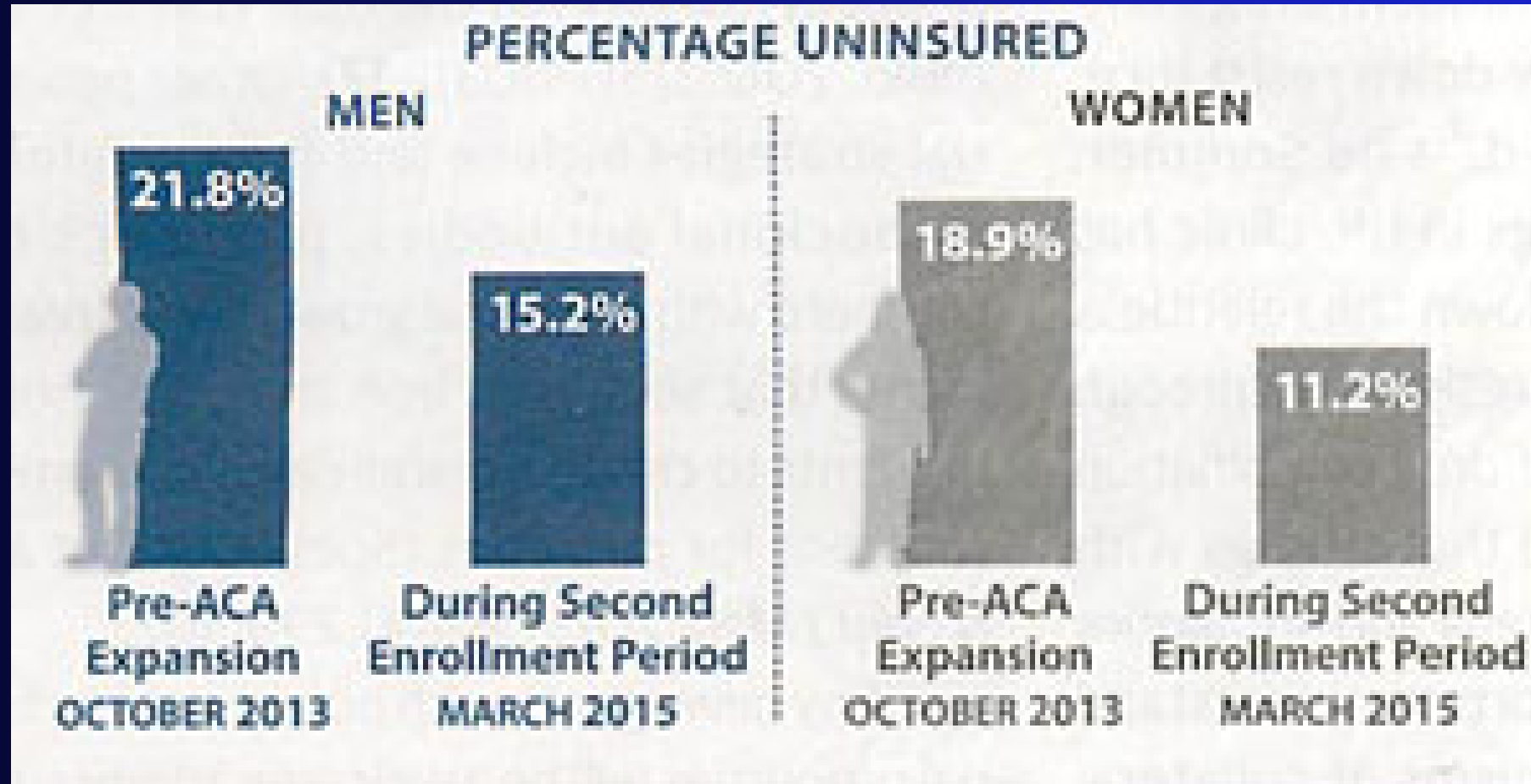


Questions

- Do black American males die more often (and more quickly) because, as a group, they have less access to care or because they seek medical treatment later, when their disease has progressed to an advanced stage?



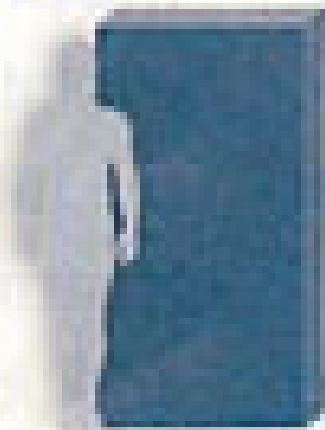
Insurance Status Pre/Post ACA



Insurance Coverage Gain 2013-15

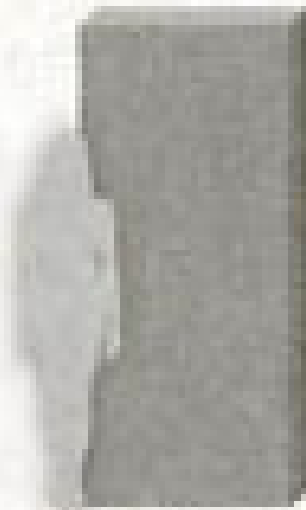
**GAIN IN COVERAGE BETWEEN
OCTOBER 2013 AND MARCH 2015**

6.5 MILLION



MEN

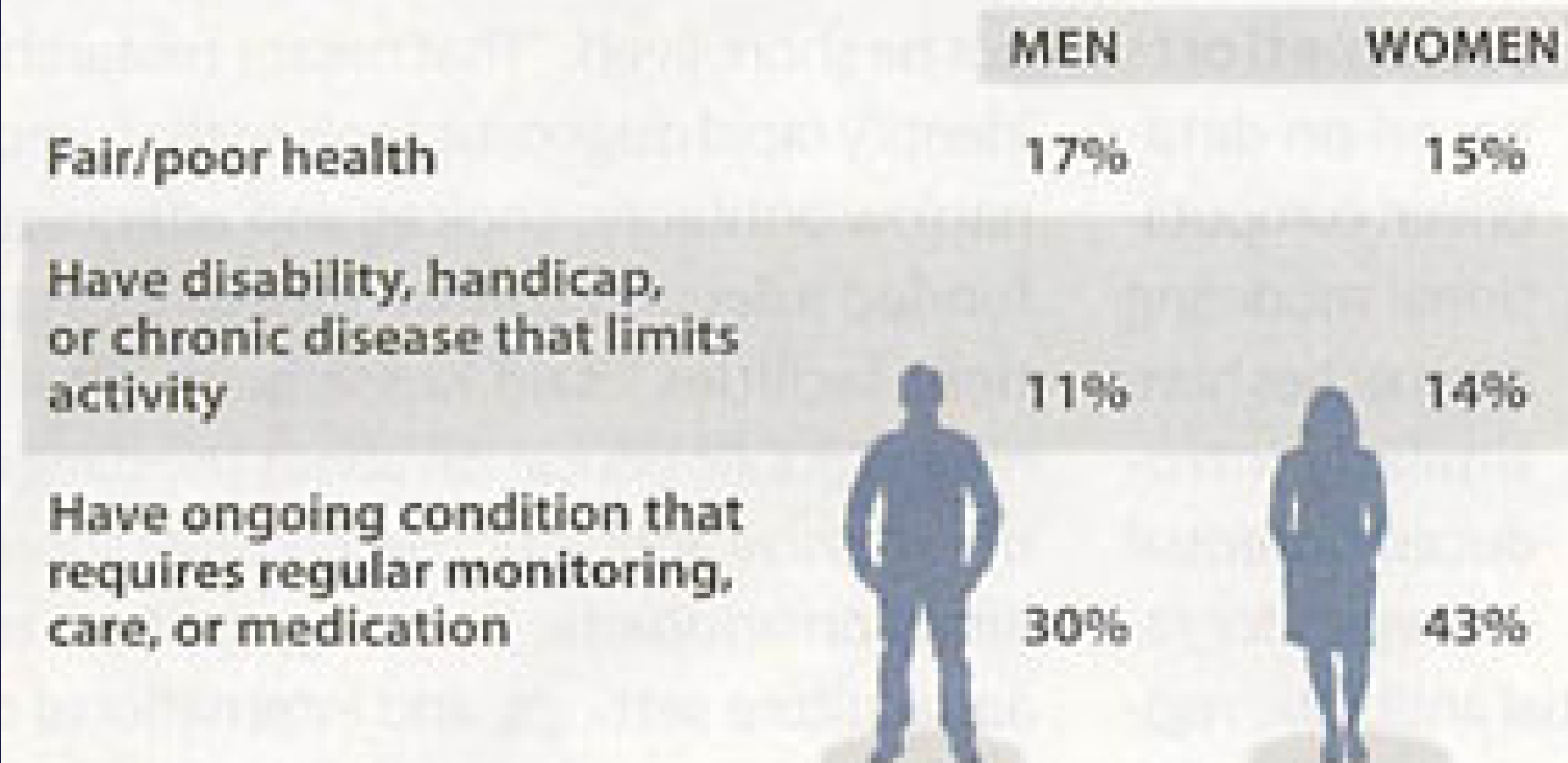
7.7 MILLION



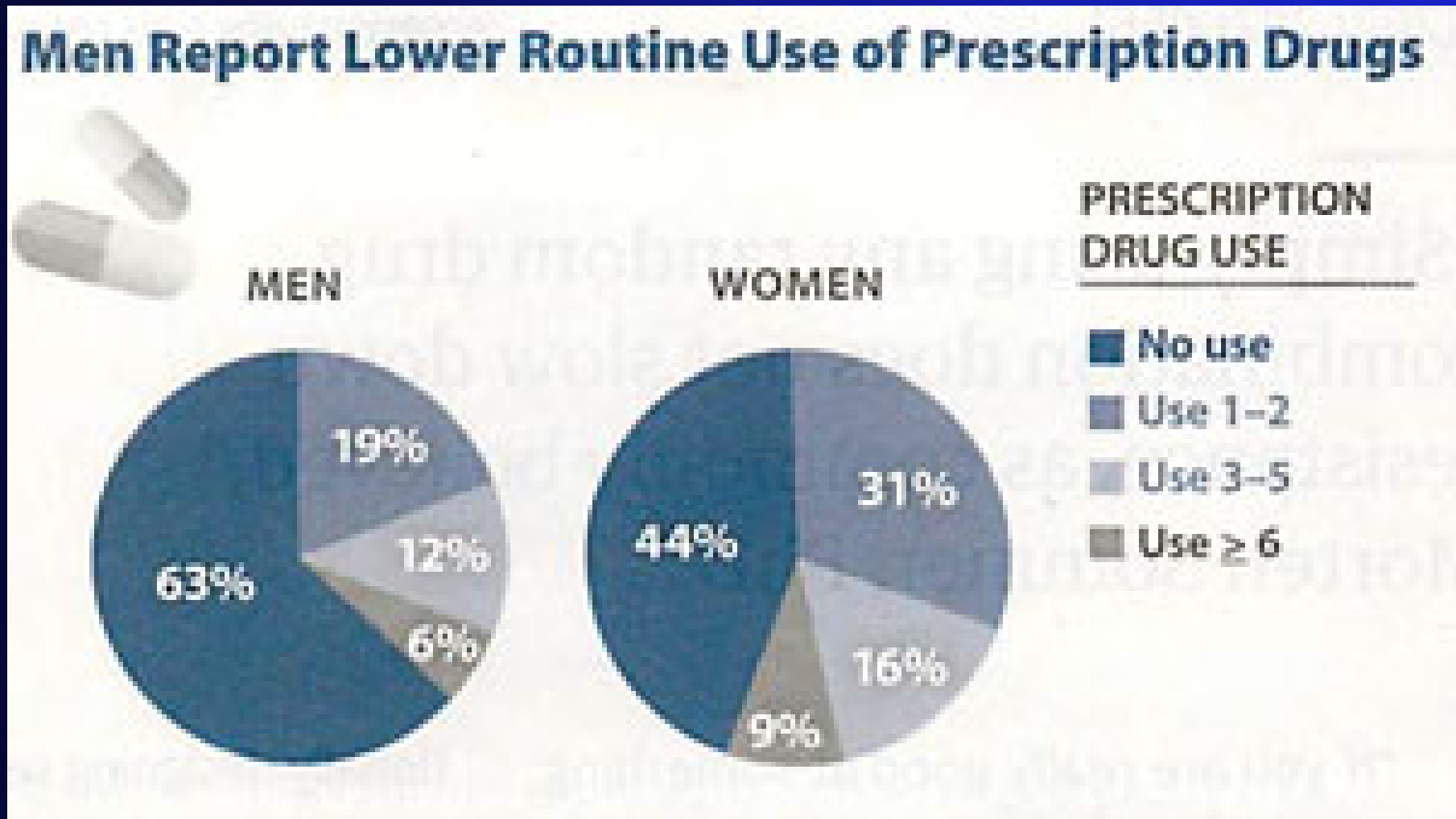
WOMEN

1 in 6 Men Rate Health Fair/Poor

One in 6 Men Rate Health as "Fair" or "Poor"



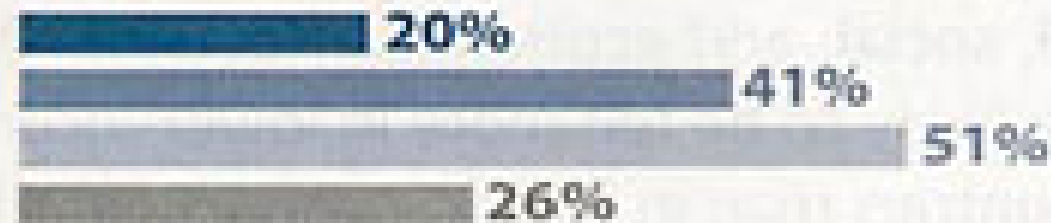
63% of men –no Rx Drugs



Cost Barriers to Care-Uninsured Men

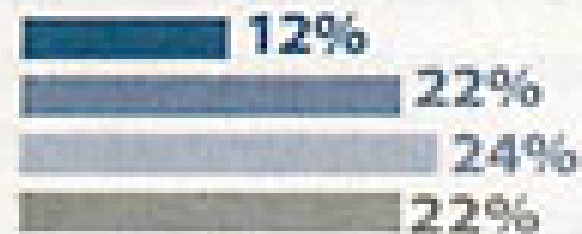
Uninsured Men Twice as Likely to Report Cost Barriers

Delayed or went without care in prior year



- Total men
- Low-income men
- Uninsured men
- Total women

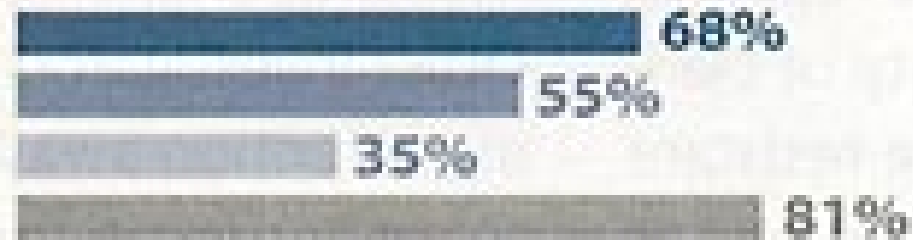
Didn't fill prescription or cut/skipped doses of medicine in prior year



Fewer men go to the doctor regularly

Men Have Weaker Ties to Clinicians

Have a regular clinician that they go to when sick or need health advice



- Total men
- Low-income men
- Uninsured men
- Total women

Have seen a health care provider in the past 2 years



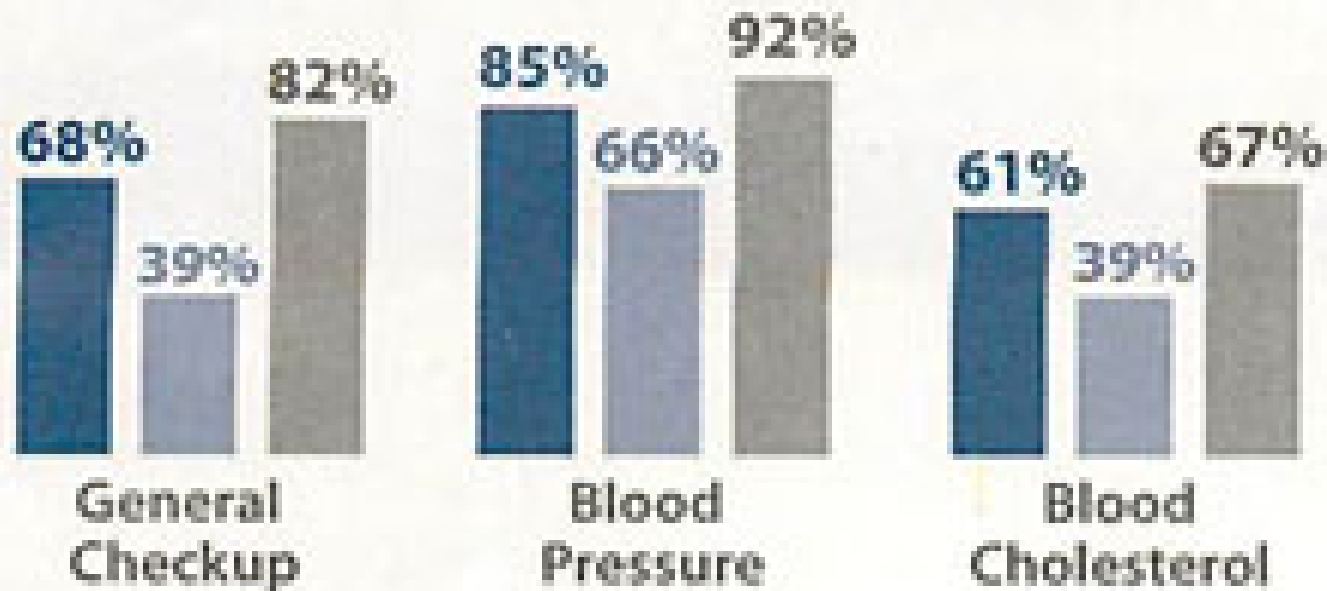
And these are for conditions where screening is recommended!

Uninsured Men Have Lower Screening Rates

RECEIVED THE FOLLOWING SERVICES
IN PRIOR 2 YEARS



■ Total men
■ Uninsured men
■ Total women



Blacks, Hispanics Overrepresented Among Uninsured Population

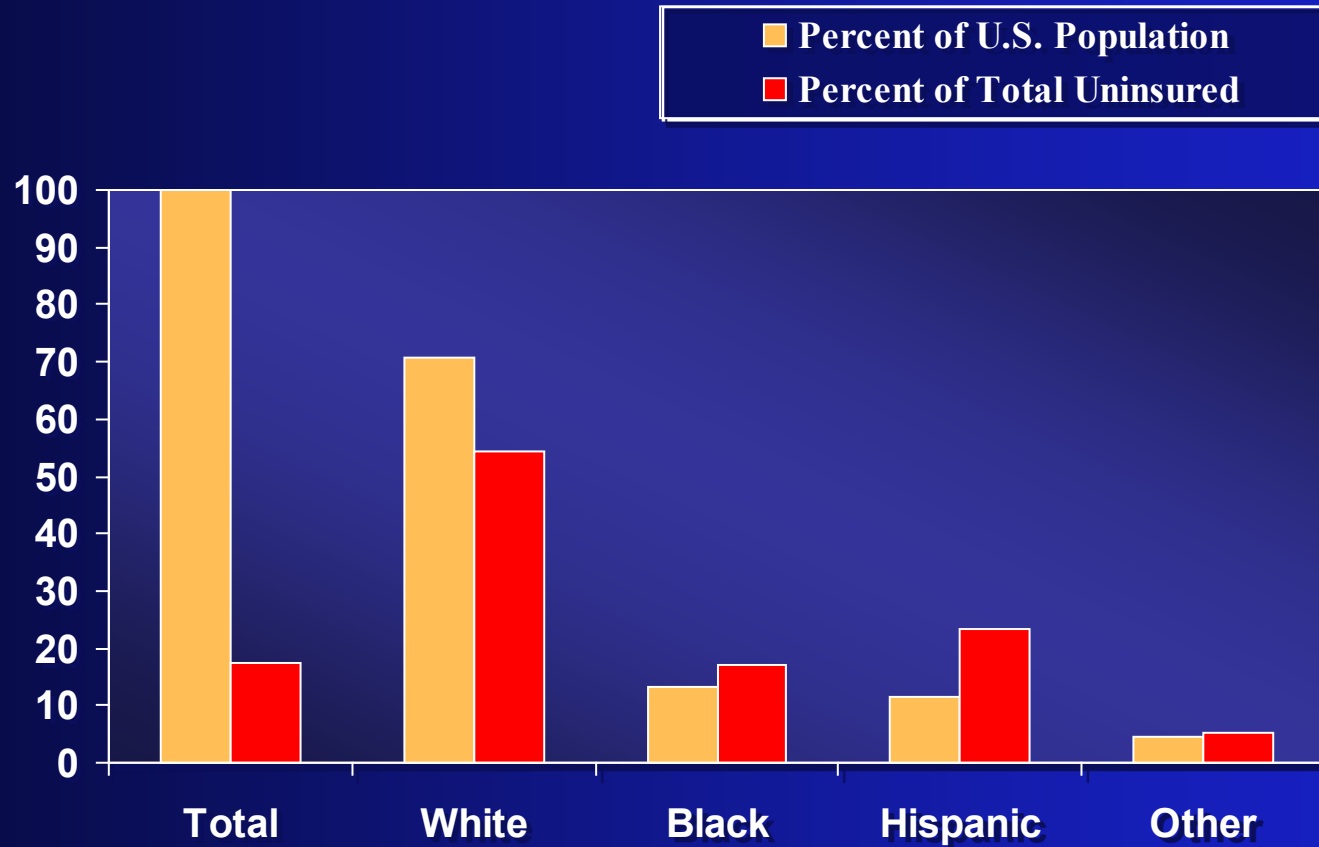


Chart Source: Bureau of Census, Current Population Survey, March 1996

Old Headline...but will repeal of ACA further deepen crisis?

Healthcare Crisis To Deepen for Blacks

By TOM MACKAY

WASHINGTON—With the latest government statistics showing a growing disparity between the health of African-Americans and whites, many analysts expect the situation to grow worse unless some solution is found.

One point made by observers is that the country needs more black physicians and other health care professionals. Out of approximately 730,000 doctors in America, only about 22,000 are black, and only 16,000 to 17,000 are in actual practice.

Nathaniel H. Murdock, M.D., president of the predominantly black National Medical Association, told *The Medical Herald* that the country should have more black medical students.

"We only represent about four percent of the doctors and four percent of the students in the medical schools," he said.

Murdock, an obstetrician-gynecologist in St. Louis, sees a need for continuing affirmative action.

"One of my themes and goals



Eli Ginsberg, Ph.D.

this year," he said, "has been edu-

cation and prevention. I've asked all the National Medical Association physicians to adopt middle schools, high schools and grammar schools.

"What I envision is them going to these schools at least on a monthly basis and talking with the students about healthy lifestyles, about immunization, about prevention of pregnancy, about not starting smoking, about deferring sexuality.

"I think that the basic thing that would help take care of the disparity between African-Americans and other minorities and the alleged mainstream of this country is education. A lot of our kids do not have nuclear families, so they don't get a chance to get this kind of information at home. So I think a surrogate parent like a physician at the school is the next best thing."

Rep. Edolphus Towns (D-Bklyn) a member of the Subcommittee on Health and the Environment of the House Commerce Committee, told *The Herald* that "there is a need for increased access to health care practitioners, such as nurse practitioners, physician assistants and physicians."

He also saw a need for increased access to public health information in the community so that patients will know what their rights are.

The quality of health insurance available to the black community has been more restricted than in the white community, he said.

Towns said there should be a comparative study of health care in the black and Hispanic communi-

ties, because the Hispanic community has a lower rate of infant mortality, but a higher poverty rate.

"There haven't been any studies," he said. "Such a study might show ways to improve the health of the African-American community."

Towns has introduced two bills to improve Medicare policies by allowing nurse practitioners, clinical nurse specialists and physician assistants to provide routine primary care and receive reimbursement at a rate of 85 percent of the physician fee schedule.

Overwhelming Problems

Eli Ginsberg, Ph.D., director of the Eisenhower Center for the Conservation of Human Resources at Columbia University says it would help to have more black physicians, but he feels other factors are more important.

"One of the few really definitive pieces of information that we have about differential quality and longevity of human life," he told *The Herald*, "is the fact that access to medical care is a minor consideration compared to the question of the basic conditions under which different groups live."

Changes that are essential, he said, include "improving inner city housing, improving the school system, getting better control over drugs and crime and having more jobs available to people who have limited education."

"There's no question that as long as their basic economic and social problems overwhelm them," he added, "their health will be no good. They'll have more illnesses, and they'll die earlier."

"It's just crystal clear. There are many things we don't know about the health care system, but that's one thing we do know.

"There is a need for better schools. School is the major escape hatch in American society. If you get decent basic education, you can go on at least to a community college. Once you get out of a community college, you can get a reasonable job with reasonable pay and your whole life is transformed."

He said this would mean an improvement in the health of the black community "by orders of magnitude."

While no one doubts that the country needs more African-American physicians, the Association of American Medical Colleges says there was an 11 percent decline in minority applicants at the country's medical schools from 1996 to 1997.

The association attributed the drop to affirmative action rollbacks in California, Texas, Louisiana and Mississippi.

Another factor is managed care, which has led to a decline in applications among both blacks and whites.

Analysts say students considering medical careers are concerned about the threat for insurance companies to dictate what physicians can and cannot do under managed care.

The comparative health statistics on black and white Americans are appalling.

Blacks suffer higher death rates from nearly all major causes. There are widening gaps between blacks and other groups in the incidence of asthma, diabetes, major infectious diseases and several forms of cancer.

The Centers for Disease Control in Atlanta has found that from 1980 to 1994 the number of diabetes cases rose 33 percent among blacks three times the increase among whites.

The CDC also said that the breast cancer death rate for all women fell 30 percent from 1990 to 1995—from 23.1 per 100,000 population to 21. But among black women the rate was 27.5 per 100,000 in both years.

Blacks typically die at about 70,



Rep. Edolphus Towns (D-Bklyn)

six or seven years earlier than whites.

The National Institute for Aging says blacks typically enjoy 56 years of reasonably good health, eight years fewer than whites and Hispanics. In a survey by the institute one-third of blacks aged 51 to 61 described their health as fair to poor, compared with only one-fifth whites of the same ages.

Said Kenneth G. Manton, director of the Center for Demographic Studies at Duke University:

"If you look at the total population, you find a significant decline in chronic disability and institutionalization for people 65 and older. But if you break it down among blacks and whites, you find almost all the improvement is among whites," said the director of the center.

A recent study in *The New England Journal of Medicine* found that 2.4 percent of white mothers in Illinois delivered underweight babies, compared with 7.4 percent of black mothers. The study covered the period from 1980 through 1995.

"To understand this thing called race," the study said, "we must turn our attention to the institutions and attitudes which perpetuate and justify unequal treatment of people on the basis of their physical appearance, language or culture."

The American Cancer Society says that since the early 1960s black men's death rate from cancer rose 62 percent, as against a 19 percent increase for all American men, and 66 percent survive for five years, compared with 81 percent of white men.

Blacks tend to suffer heart attacks, strokes and cancer at earlier ages than whites.



Localized Disease Treatment Disparity: African American men are less likely to undergo radical prostatectomy

NATIONAL
CANCER
INSTITUTE

News from NCI

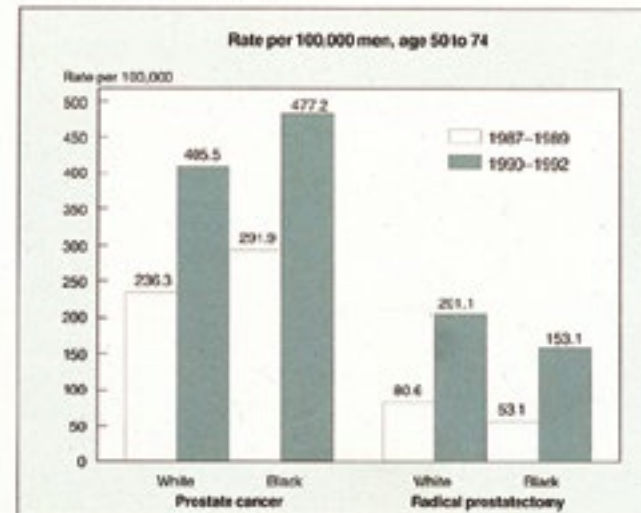
NEWS FOR PRIMARY CARE PHYSICIANS FROM THE NATIONAL CANCER INSTITUTE

JUNE 1996

Trends in prostate cancer incidence and surgery

By Ray M. Merrill, PhD

For US men age 50 to 74, the reported incidence of local and regional prostate cancer increased considerably from 1987-1989 to 1990-1992, largely as a result of widespread screening. Rates of radical prostatectomy rose even more sharply during this time. The increase in incidence was greater among white men than black men, while the increase in surgery was greater among blacks. For white men diagnosed with local or regional prostate cancer, the proportion receiving radical prostatectomy rose by 45% during this period, and for black men the proportion rose by 76%.



Source: Surveillance, Epidemiology, and End Results (SEER) Program



Localized Disease Treatment Disparity: African American Men less likely to receive definitive therapy

Racial Gap Found in PCa Treatment

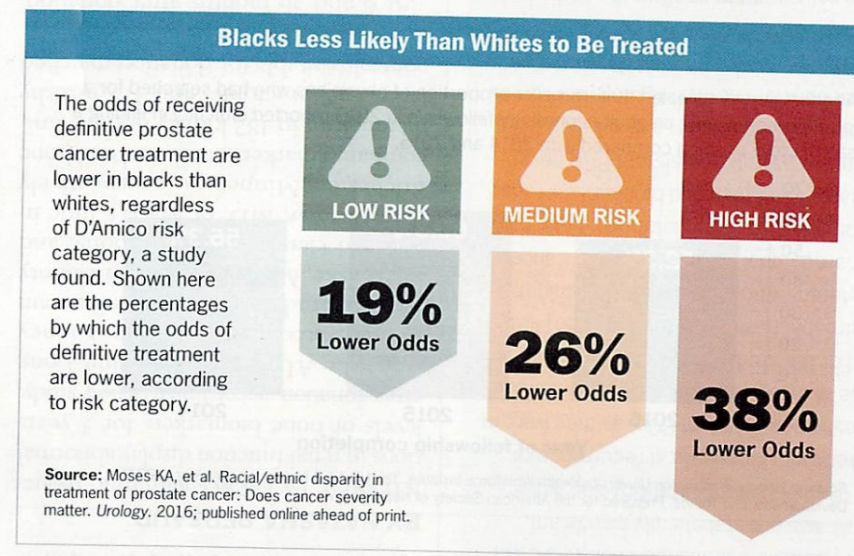
Black and Hispanic men are less likely to have radical surgery, radiotherapy, or cryotherapy than white men

BY NATASHA PERSAUD

BLACK MEN with clinically localized prostate cancer (PCa) continue to receive definitive treatment less often than white and Asian men, a new study finds. Undertreatment of Hispanic patients is another worrisome trend.

Persistent disparities in treatment for black men and emerging disparities in Hispanic men, regardless of stage at presentation, “likely represent a significant predictor of higher mortality in underserved populations,” Kelvin A. Moses, MD, PhD, of Vanderbilt University Medical Center and Vanderbilt-Ingram Cancer Center in Nashville, Tennessee, and colleagues concluded in *Urology*.

Their analysis of 327,636 patients diagnosed with localized PCa 2004 to 2011 from the SEER-17 (Surveillance, Epidemiology and End Results) database revealed that black and Hispanic patients were 27% and 5% less likely, respectively, to receive any treatment (radical prostatectomy, external beam radiation therapy, brachytherapy, or



patients in the low, medium, and high-risk categories, respectively. By Gleason score alone, black men with Gleason 7 or 8–10 cancer were undertreated compared with white men who had even lower risk disease (Gleason 6 or below). Disparities appeared in other ways.

regions with a population greater than 12,000. Dr. Moses and colleagues said they believe socioeconomic factors only partly explain the lack of access to specialty care. Neither PCa overtreatment in whites nor a higher comorbidity in blacks seemed likely.

Dr. Moses and colleagues suggested policy changes, patient education, and workforce diversification to address the disparities. On a clinical front, “the plethora of data showing that AA [African-American] men experience improved outcomes with surgery is clearly not being imparted to patients, implicating a potential lack of physician communication with patients regarding shared decision-making and discussion of benefits/risks of various treatment modalities.”

In accompanying editorial, Christopher P. Filson, MD, MS, of Emory University in Atlanta, remarked that the current study did not consider differences in insurance coverage and access to care. Noting that Dr. Moses’ team calls for an action plan “to eradicate the seemingly obstinate inequalities related to prostate cancer care based on patient race,” Dr. Filson pointed out that this already was set in motion with the passage in 2012 of the Affordable Care Act (ACA).

“It remains to be seen how racial disparities related to prostate cancer care

Duke Prostate Center

- Data was extracted from the Duke Prostate Center database regarding 10,530 patients diagnosed with prostate cancer from 1988 to 2006 (pro screening era)
- The time period was divided into 3 year groups: 1988-1994, 1995-1999, and 2000-2006.
- The cohort was divided into 2 groups: AA and non-AA.

Early PSA Era (1988-1994) Duke Prostate Cancer Cases by Race

	AA	Non-AA	p
# (%) of diagnosis	508 (16.1)	2642 (83.9)	
Median age at diagnosis	68.4	67.8	0.096
% High-risk Gleason (>7)	14.5	9.2	0.158
Median PSA at diagnosis	16.6	9.1	<0.0001
% diagnoses treated with RP	20.5	33.8	<0.0001
% of disease specific death	25.0	13.6	<0.0001

Early PSA Era (1988-1994) Duke Prostate Cancer Cases by Race

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Median age at diagnosis	68.4	67.8	0.096
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Median PSA at diagnosis	16.6	9.1	<0.0001
% diagnoses treated with RP	20.5	33.8	<0.0001
% of disease specific death	25.0	13.6	<0.0001

Middle Era (1995-1999) Duke Prostate Cancer Cases by Race

	AA	Non-AA	p
# (%) of diagnosis	674 (19.8)	2731 (80.2)	
Median age at diagnosis	66.2	67.2	0.019
% High-risk Gleason (>7)	18.4	8.7	<0.0001
Median PSA at diagnosis	7.7	6.6	0.001
% diagnoses treated with RP	28.5	44.1	<0.0001
% of disease specific death	5.9	1.7	0.017

Middle Era (1995-1999) Duke Prostate Cancer Cases by Race

	AA	Non-AA	p
# (%) of diagnosis	674 (19.8)	2731 (80.2)	
Median age at diagnosis	66.2	67.2	0.019
% High-risk Gleason (>7)	18.4	8.7	<0.0001
Median PSA at diagnosis	7.7	6.6	0.001
% diagnoses treated with RP	28.5	44.1	<0.0001
% of disease specific death	5.9	1.7	0.017

Later Era (2000-2006) Duke Prostate Cancer Cases by Race

	AA	Non-AA	p
# (%) of diagnosis	892 (22.4)	3083 (77.6)	
Median age at diagnosis	64.8	66.4	0.002
% High-risk Gleason (>7)	11.2	6.7	0.032
Median PSA at diagnosis	6.6	5.6	<0.0001
% diagnoses treated with RP	26.9	39.2	<0.0001
% of disease specific death	*	*	

Later Era (2000-2006) Duke Prostate Cancer Cases by Race

	AA	Non-AA	p
# (%) of diagnosis	892 (22.4)	3083 (77.6)	
Median age at diagnosis	64.8	66.4	0.002
% High-risk Gleason (>7)	11.2	6.7	0.032
Median PSA at diagnosis	6.6	5.6	<0.0001
% diagnoses treated with RP	26.9	39.2	<0.0001
% of disease specific death	*	*	

AA men across eras (1988-2006) Duke Prostate Cancer Cases

	1988 - 1994	1995-1999	2000 - 2006	p
# (%) of diagnosis	508 (16.1)	674 (19.8)	892 (22.4)	
Median age at diagnosis	68.4	66.2	64.8	<0.0001
% High-risk Gleason (>7)	14.5	18.4	11.2	0.007
Median PSA at diagnosis	16.6	7.7	6.6	<0.0001
% diagnoses treated with RP	20.5	28.5	26.9	0.005
% of disease specific death	25.0	5.9	*	<0.0001

Duke Radical Prostatectomy Surgery Patients 1988-1994 by Race

	AA	Non-AA	p
# (%) Radical Prostatectomy	104 (10.4)	894 (89.4)	
# (%) positive margins	27 (26.0)	169 (18.9)	0.087
# (%) PSA recurrence	82 (78.8)	506 (56.6)	<0.0001
% of pathologic stage T3 or T4	57.1	48.4	0.070

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Duke Radical Prostatectomy Surgery Patients 1995-1999 by Race

	AA	Non-AA	p
# (%) Radical Prostatectomy	192 (13.7)	1207 (86.3)	
# (%) positive margins	62 (32.3)	327 (27.1)	0.135
# (%) PSA recurrence	90 (46.9)	358 (29.7)	<0.0001
% of pathologic stage T3 or T4	48.2	39.3	0.029

Duke Radical Prostatectomy Surgery Patients 1995-1999 by Race

	AA	Non-AA	p
# (%) Radical Prostatectomy	192 (13.7)	1207 (86.3)	
# (%) positive margins	62 (32.3)	327 (27.1)	0.135
# (%) PSA recurrence	90 (46.9)	358 (29.7)	<0.0001
% of pathologic stage T3 or T4	48.2	39.3	0.029

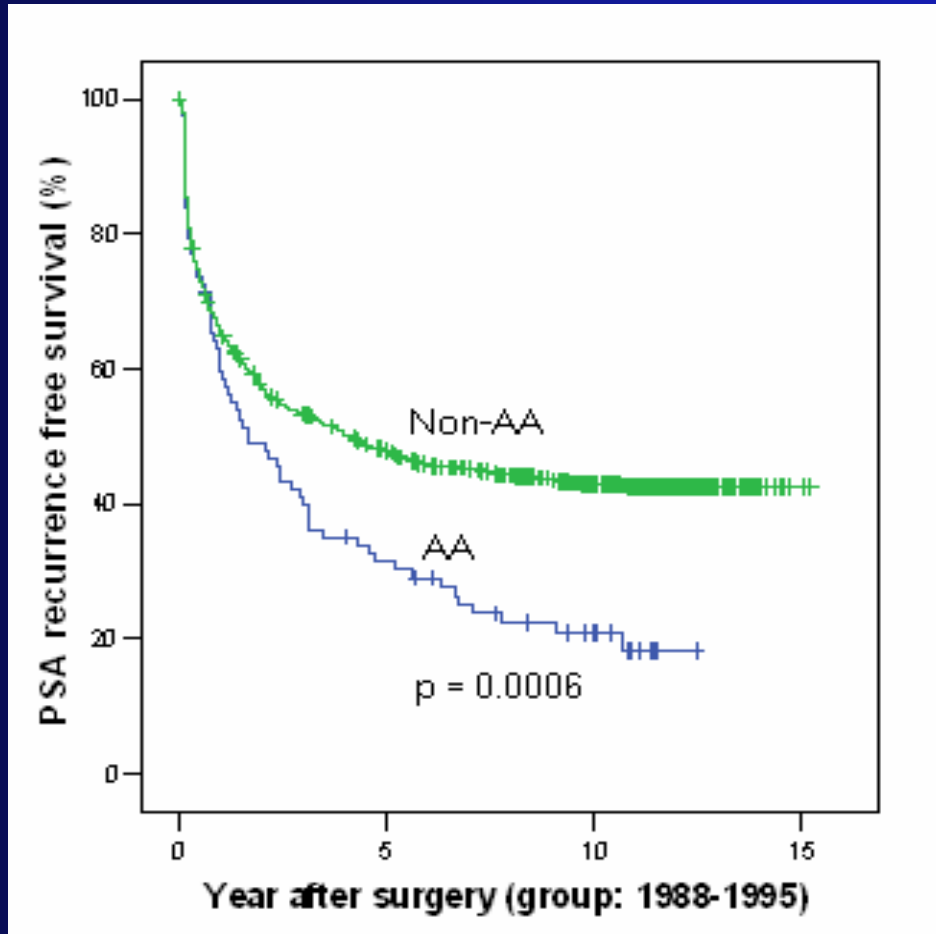
Duke Radical Prostatectomy Surgery Patients 2000-2006 by Race

	AA	Non-AA	p
# (%) Radical Prostatectomy	240 (16.6)	1209 (83.4)	
# (%) positive margins	76 (31.7)	316 (26.1)	0.078
# (%) PSA recurrence	47 (19.6)	196 (16.2)	0.202
% of pathologic stage T3 or T4	27.0	27.5	0.296

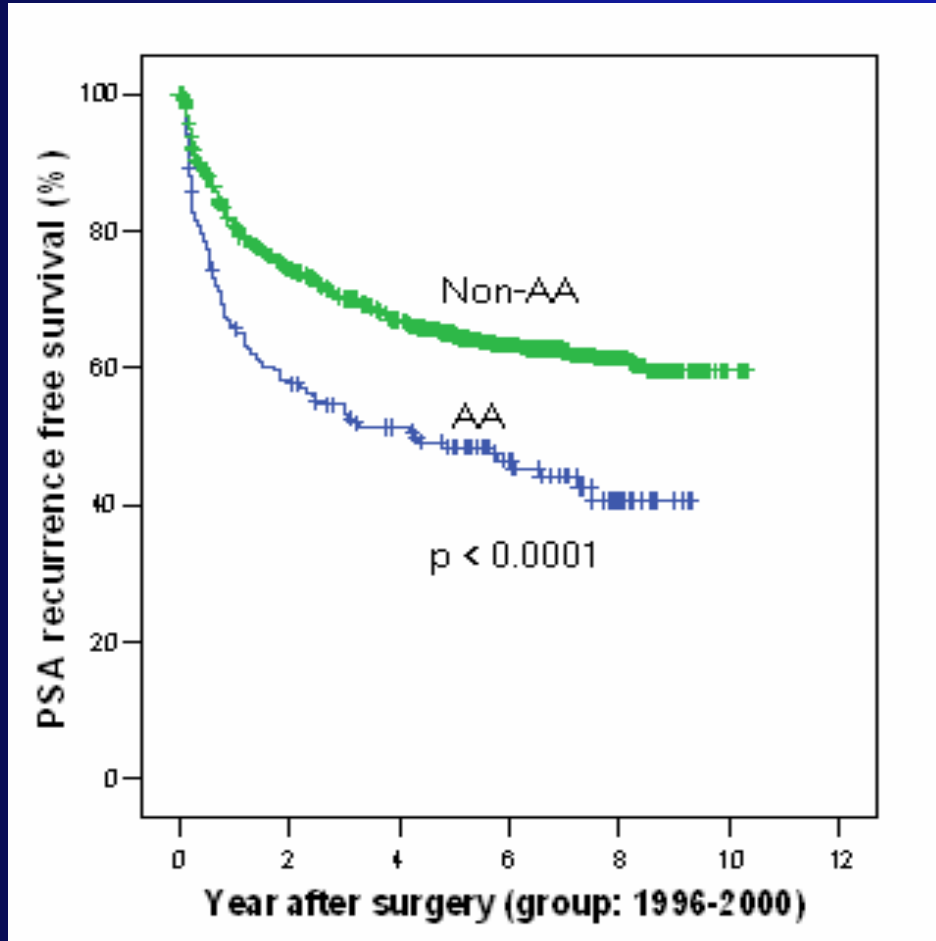
Duke AA men with Radical Prostatectomy Surgery across eras

	1988-1994	1995-1999	2000-2006	p
# (%) Radical Prostatectomy	104 (10.4)	192 (13.7)	240 (16.6)	
# (%) positive margins	27 (26.0)	62 (32.3)	76 (31.7)	0.490
# (%) PSA recurrence	82 (78.8)	90 (46.9)	47 (19.6)	<0.0001
% of pathologic stage T3 or T4	57.1	48.2	27.0	<0.0001

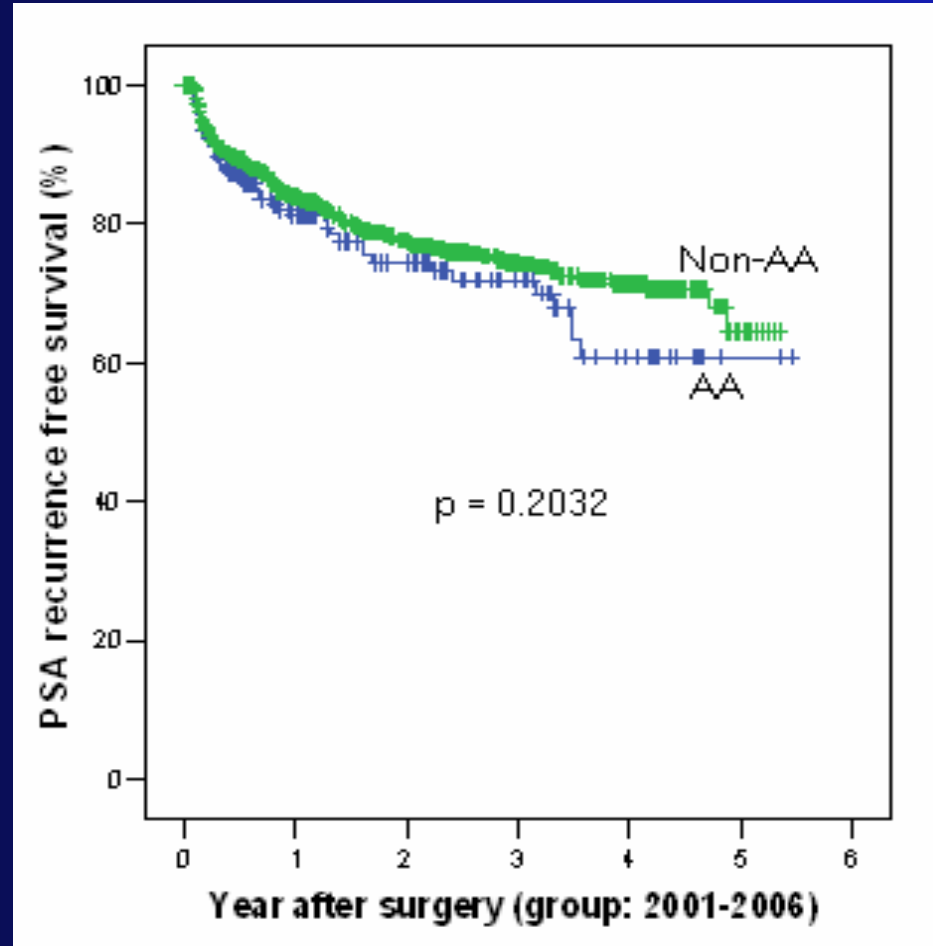
Early Era (1988-94) PSA Recurrence after Radical Prostatectomy Surgery



Middle Era (1995-99) PSA Recurrence after Radical Prostatectomy Surgery



Later Era (2000-06) PSA Recurrence after Radical Prostatectomy Surgery



Legacy of Tuskegee.....



HEALTH

Legacy of Tuskegee

Revelations about the infamous syphilis study turned many African-Americans against the U.S. health care system. More than two decades later, the repercussions persist.

The infamous Tuskegee Syphilis Study ended almost 27 years ago, but it still casts a shadow across Black America.

"It's got into a memory and present itself as a black national mourning custom. There are always at least one or two people who bring up Tuskegee as an example of who my god's real white people and that there's an element in the U.S. that would love to see black people slaughtered," said psychiatrist Carl C. Bell, MD, executive director of the Community Mental Health Council in Chicago, a nonprofit comprehensive community mental health center.

Conducted by the U.S. Public Health Service in Macon County, Ala., between 1932 and 1972, the Tuskegee study charted the progression of untreated syphilis in 600 impoverished black men, most of whom were sharecroppers on the land.

Photo illustration by Russell McGonigle

Story by Deborah L. Shelton

Overcoming Barriers to Early Detection in the African American Community

Health-Care Seeking Barriers Increase Delay Diagnosis

- Distrust
- DRE concern
- Treatment morbidity - sexual function
- Fear of cancer



Literacy/Education and Prostate Cancer...

16

FOCUS ON SOCIOECONOMICS

Low Literacy Predicts Advanced Prostate Cancer Presentation

CONTINUED FROM PAGE 3

income older men.[10] Our study population consisted of 212 English-speaking men treated at prostate cancer clinics in Chicago and Shreveport, Louisiana, over a 6-month period in 1996 and 1997.

All of the Chicago patients were treated at the Chicago VA Healthcare System/Lakeside Division, while two thirds of the Shreveport patients were treated at

the Overton-Brooke VA Medical Center, and one third received care at a university hospital that provides care to low income patients who are uninsured or who are covered by Medicaid. Both health settings are part of equal access systems, treating primarily low income patients.

We assessed patients' literacy levels with a validated instrument, the Rapid Estimate of Adult Literacy in Medicine

(REALM).[11] The REALM is an individually administered medical word recognition and pronunciation test, comprised of 66 words that patients are expected to know in order to participate effectively in their own health care. It was designed for evaluating adult reading ability in the medical setting and is an indicator of functional literacy skills.[11]

Raw REALM scores can be converted

into four reading grade levels, 0-3rd grade, 4th-6th grade, 7th-8th grade, and 9th grade and above. The REALM can be administered and scored in 1 to 5 minutes.[11] In addition to REALM scores, we obtained information from medical records on patient age, race/ethnicity, and pathologic stage.

Of the 212 men in the study, 155 were from Shreveport and 57 from Chicago. The mean age of the group was 70.8 years. Patients were almost equally divided into two racial groups: African-American and white. Patients varied in age, with 22.6% under 65 years of age, 45.8% between 65 and 74, and 31.6% age 75 or older.

Study Results

Literacy differed by stage, race, and site of care, but not by age. Men with metastatic cancer at presentation were 1.5 times more likely to have lower literacy levels (39.6% of patients with stage D disease had literacy levels of 6th grade or below vs 24.8% of stage A to C patients, $P < .001$). African-American men were

Assessment was
via REALM, a
medical word

more likely to have lower literacy levels (52.3% had levels of 6th grade or below, vs 8.7% of whites, $P < .001$).



Questions

- Is prostate cancer simply more virulent in black Americans or less responsive to therapy?



The Disparity of Prostate Cancer Between Black and White Americans

- Environmental vs. Genetic?
- SES
 - Hormonal
- Access
 - Oncogenes
- Cultural
 - TSG's
- Dietary
 - Growth Factors - Receptors



Despite controversy about causes of disparity can we make a difference?

Surviving prostate cancer

Mayor's message to black men: Screening can save your life

By Sheila Rayam
USA TODAY, 9/19/2000

When Denver Mayor Wellington Webb was diagnosed with prostate cancer in 1996, he took some time to think through his treatment options.

The what-ifs swirled through his mind, but he was certain of one thing: "Based on the fact that my father died from cancer, it wasn't something that I wanted to fool around with."

Webb had surgery in 1997, and the disease has not recurred.

The mayor points to early detection as a key reason why he is a cancer survivor.

Webb and the Prostate Cancer Education Council, based in Golden, Colo., are trying to get the word out about the importance of being screened for prostate cancer, the most common cancer in men.

This year, the American Cancer Society estimates, there will be 180,400 new cases of prostate cancer in the USA.

The organization also estimates



By Kamenko Patic, AP

Time to live: Early diagnosis saved Wellington Webb's life.

that 31,900 men will die from the disease this year.

Doctors have debated the subject of early screenings and whether the process actually benefits a majority of men. However, there is a sobering fact about prostate cancer that isn't in dispute: Black men have the highest incidence of prostate cancer.

According to the American Cancer Society, black men are at least 50% more likely to develop prostate cancer than are men in any other racial or ethnic group. They also are 50% more likely to die of prostate

cancer than men of other racial and ethnic groups.

The chairman of the Prostate Cancer Education Council, E. David Crawford, a urologist of the University of Colorado Health Sciences Center in Denver, says there are probably 10 reasons why the numbers are so high among black men, including diet and levels of care. Crawford and the council hope to reach more black men and other groups that are considered at high risk for prostate cancer.

Webb also wants to reach those men. The mayor falls into two high-risk categories: He is black, and his father died from cancer.

"The message I am trying to share with other men is: This is something that we can address," Webb says.

"Get the early detection, and it can save your life."

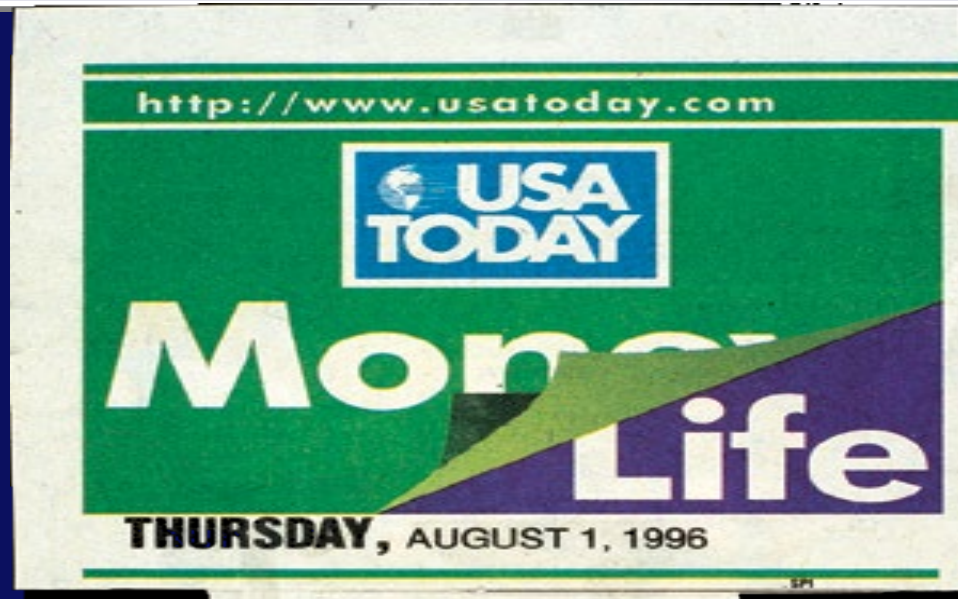
The Prostate Cancer Education Council is stressing two goals, to educate men about prostate cancer and to encourage early detection through screening, Crawford says.

"Right now, we are winning the battle through early detection," Crawford says.

This week, men can receive a free or minimal-fee prostate cancer screening at sites nationwide. To find the nearest screening location, click on www.pcaaw.com or call 888-755-7229.



DoD CPDR Study of PSA in African American men...



Finding prostate cancer in blacks

**New standards
help diagnosis**

By Tim Friend
USA TODAY



Targeted Screening For Prostate Cancer: African American Men

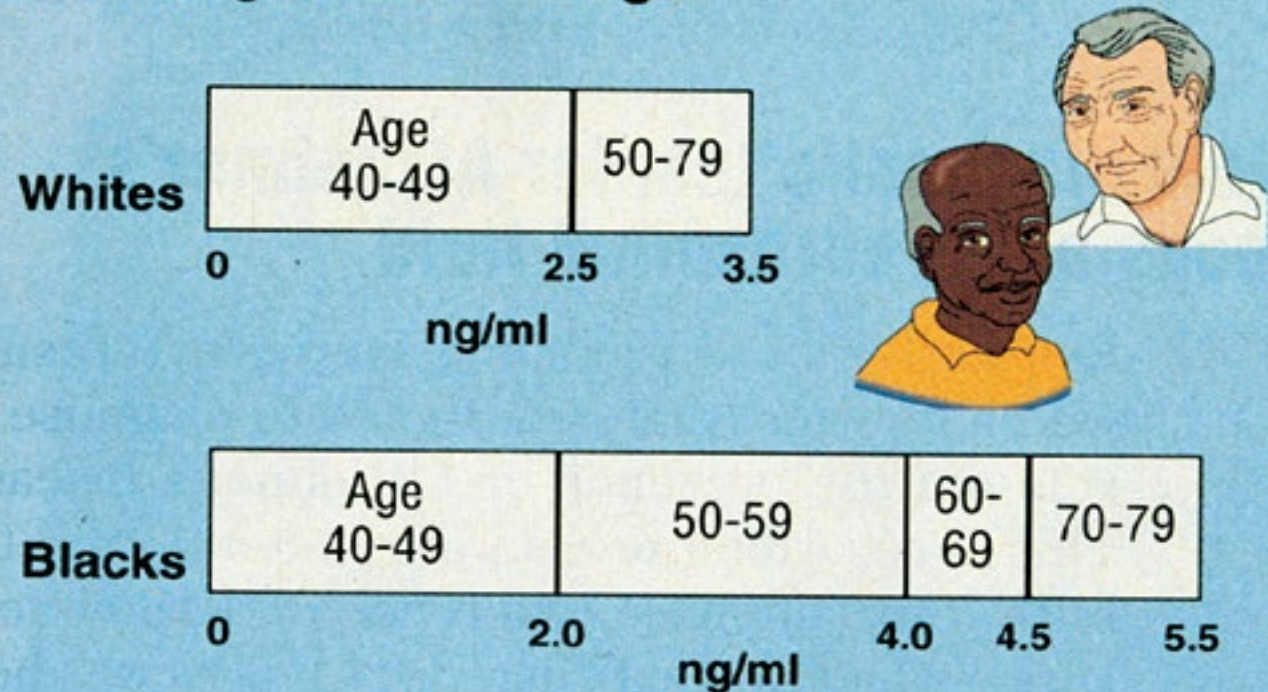
Fine-Tuning Of Screening Test Guidelines For Black Men

- Proper age to initiate screening
- Proper screening interval
- PSA guidelines



DoD CPDR PSA Guidelines-NEJM 1996

Upper limits of normal PSA values according to race and age



The Walter Reed/Center for Prostate Disease Research's age-adjusted PSA ranges for maximal cancer detection.



American Urological Association

New AUA prostate cancer guideline to address PSA testing

Annual Meeting attendees can get a sneak preview today of the AUA's new clinical guideline for the early detection of prostate cancer. H. Ballentine Carter, MD, will discuss the soon-to-be published guideline in a 10-minute presentation during Plenary II in Room 6A of the San Diego Convention Center.

"The goal of the guideline development panel was to evaluate the evidence regarding early detection of prostate cancer and develop guidelines for the practicing urologist," said Dr. Carter, Director of Adult Urology at the Brady Urological Institute and professor of Urology, Oncology at Johns Hopkins Medical Institutions.

The guideline addresses early detection of prostate cancer in asymptomatic individuals,



H. Ballentine Carter, MD

making no distinction between early detection and screening for prostate cancer as is usually practiced in the United States. The panel specifically evaluated the pre-specified outcomes of prostate cancer incidence and mortality, quality of life, test

performance and the harms of screening.

"In reviewing the evidence, the guideline panel recognized that with the exception of PSA, there was no evidence to inform interventions like digital rectal examination and other serum and urinary markers, such as

Plenary II Preview

AUA Clinical Guidelines

Detection of Prostate Cancer

Presenter: H. Ballentine Carter, MD

11:30 – 11:40 a.m. Monday

Room 6A, San Diego Convention Center

free PSA, PCA3 and TMPRSS2:ERG gene fusion markers, with respect to the outcomes of interest," Dr. Carter said.

The panel focused on PSA, the most commonly used test that's responsible for virtually all prostate cancer diagnoses.

"The panel recognizes that the use of PSA

PROSTATE CANCER GUIDELINE continued on page 34

AUA Guideline Statement 1: Age <40yrs

Recommend **against** PSA-based screening of men under age 40yrs (*Recommendation; Evidence Strength: Grade C*)

In this age group there is a low prevalence of clinically detectable prostate cancer, no evidence demonstrating a benefit for screening, and likely the same harms of screening as in other age groups

AUA Guideline Statement 2: Age 40-54yrs

Screening as a routine is not recommended in men between ages 40-54yrs at **average risk*** (*Recommendation*; Evidence Strength: Grade C)

The evidence for benefit is marginal when compared to screening beginning at age 55yrs, and the quality of evidence for harm is high

***no family Hx; not African American**

AUA Guideline Statement: Age 40-54yrs

For men younger than age 55yrs at **higher than average risk**, decisions regarding prostate cancer screening should be individualized based on personal preferences, and an informed discussion regarding the uncertainty of benefit and the harms of screening should take place prior to a decision

AUA Guideline Statement 3: Age 55-69yrs

The panel recommends *shared decision making* for men age 55-69yrs considering PSA testing, and proceeding based on a patient's values and preferences (*Standard*; Evidence Grade: B)

A decision to undergo screening must weigh the benefit of preventing 1 prostate cancer death per 1000 screened over a decade vs the harms of screening and treatment

AUA Guideline Statement 5: Age 70yrs and Above

Recommend **against** routine PSA-based screening in men age 70+ yrs, **or** in any patient with less than a 10-15yr life expectancy (*Recommendation*; Evidence Grade: C)

Some men over age 70yrs who are in excellent health may benefit from prostate cancer screening

An absolute reduction in mortality while possible is likely small, and the potential for harm high, or at least higher than benefit

Active Surveillance for Early Stage Prostate Cancer-Racial/Ethnic Issues

Black Men on AS More Likely to Harbor Higher-Risk PCa

BLACK MEN WITH clinically localized prostate cancer (PCa) initially managed with active surveillance are more likely than non-black men to have higher-risk disease at radical prostatectomy (RP), according to a new study published online ahead of print in *The Journal of Urology*.

The study findings support the hypothesis that black race itself is an influential factor in PCa progression. Previous studies offered conflicting results because race often could not be investigated apart from complicating factors such as low income and comorbidity burden.

Robert Aboussaly, MD, MS, of University Hospitals Case Medical Center in Cleveland, and colleagues queried the robust and nationally representative National Cancer Data Base, which captures 70% of new cancer diagnoses in the United States. Of 48,473 American men with clinically low-risk PCa (clinical stage T2a or below, Gleason score 6 or below, and PSA level below 10 ng/mL), 5411

(11.2%) were black. Patients transitioned from active surveillance (AS) and underwent RP from 2010 to 2013. The selected endpoints were pathologic upgrading to Gleason scores above 6 (primary) or above 7 (secondary) and/or upstaging to pathological T3 or 4 or N1 disease.

Black men had 20% greater odds of upgrading at RP to Gleason score above 6 and/or upstaging, the study found. In addition, black race independently predicted upgrading to Gleason score above 7 and/or upstaging. Results held after stratification and multivariable modeling accounting for important confounders, according to the investigators.

Black men with clinically low-risk PCa "are more likely to harbor higher-risk disease, which may lead to adverse outcomes," Dr. Aboussaly and colleagues concluded. "By itself, this finding does not preclude active surveillance; however, race should be considered as men weigh the risks and benefits of active surveillance versus treatment." ■

Duke Active Surveillance Study

Race is associated with discontinuation of active surveillance of low-risk prostate cancer: Results from the Duke Prostate Center

MR Abern, MR Bassett, M Tsivian, LL Bañez, TJ Polascik, MN Ferrandino, CN Robertson, SJ Freedland and JW Moul

Prostate Cancer and Prostatic Disease (2012), 1–6

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www.nature.com/pcan

Duke Study -Objectives

Primary:

Determine relationship between race and progression to treatment on AS

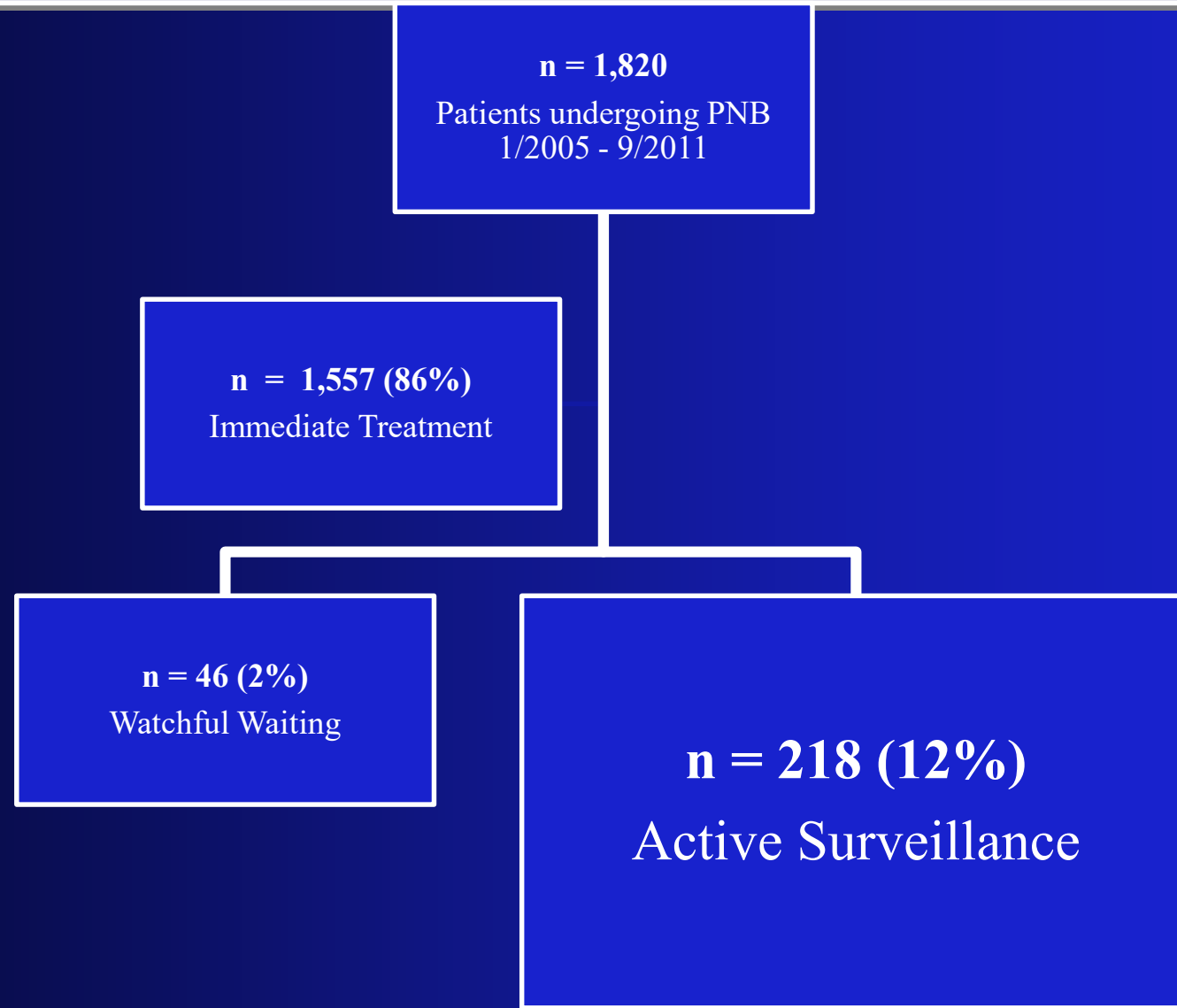
Secondary:

Demography

Intensity of follow-up

PSA kinetics

Cohort-Duke University



Methods

- Restricted to “ideal candidates”
 - PSA \leq 10 ng/ml
 - Biopsy GS \leq 6
 - \leq cT2a
 - \leq 33% cores positive
- Characteristics examined
 - PC-related: PSA, PSAV, biopsy GS, DRE, TRUS volume
 - Demographic: age, Household income, insurance status, BMI, family history
- Progression to treatment
 - Any reason
 - Disease related (PSA, DRE, biopsy, symptoms)
 - Kaplan Meier and Cox proportional hazards

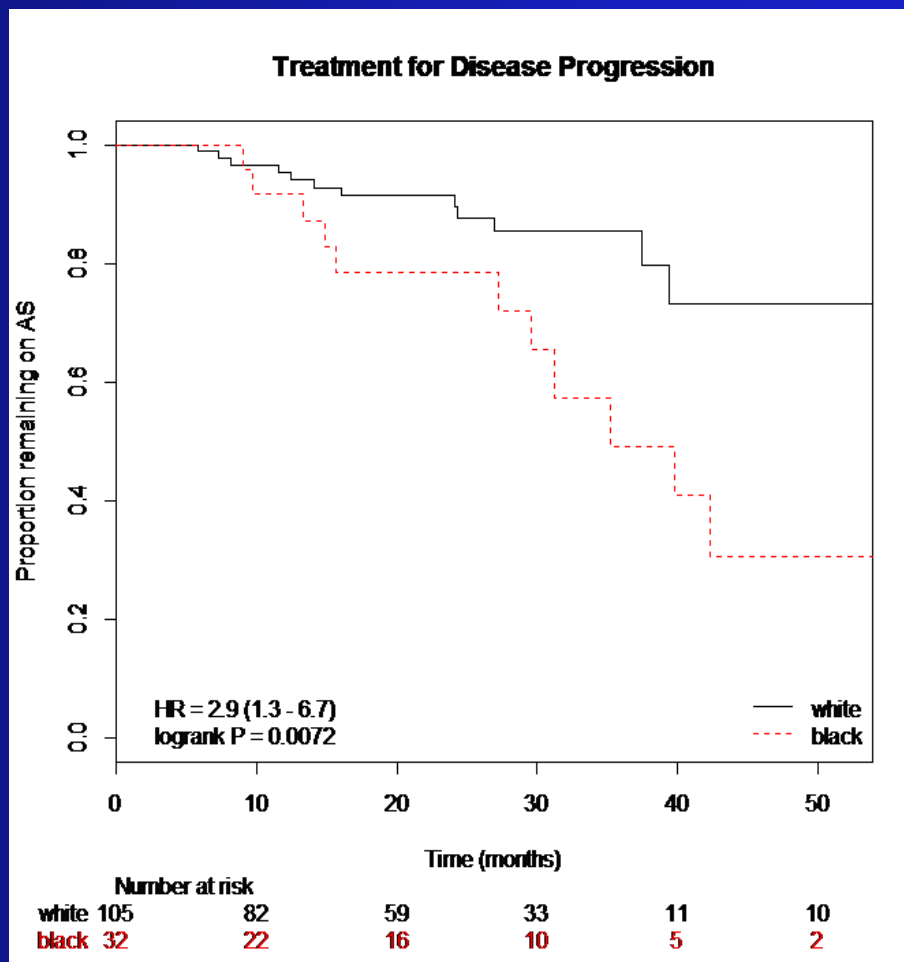
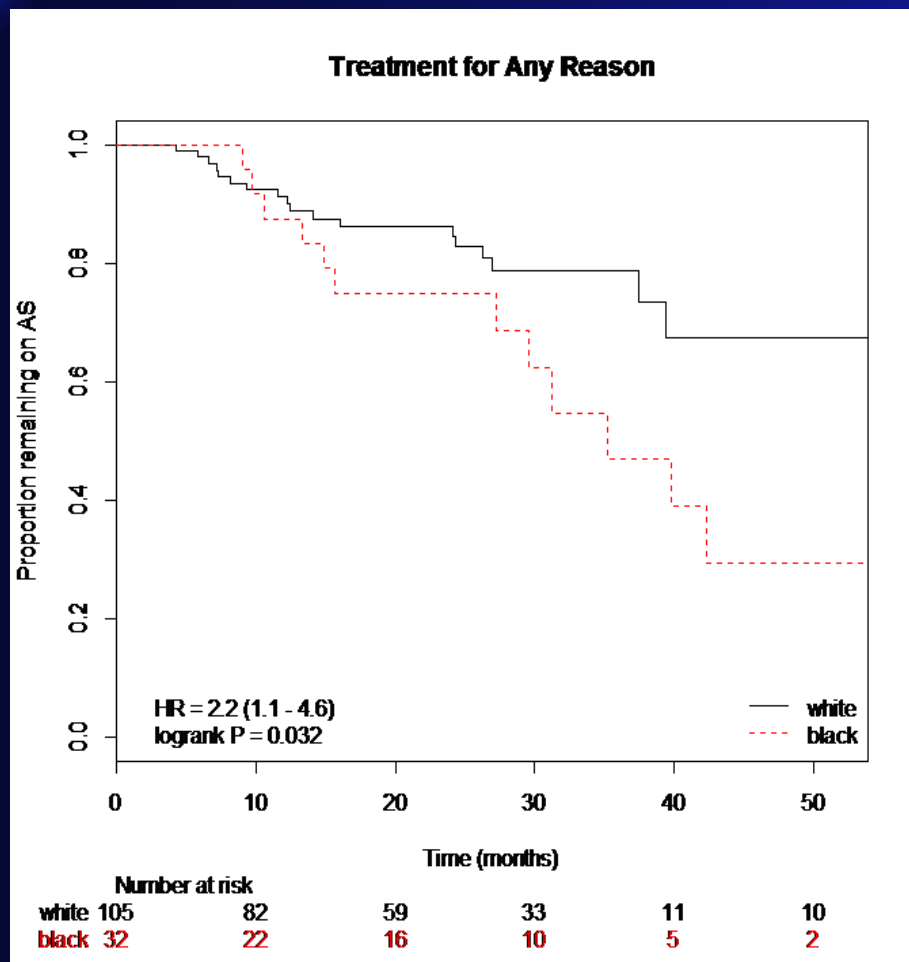
Characteristics

	White (n = 105)	Black (n = 32)	Other (n = 8)	P-value
Age (years)	65.5 (60.0–69.7)	66.5 (65.0–69.5)	67.0 (66.2–69.8)	0.39
Household income (\$k per year)	41.3 (36.8–52.4)	40.5 (31.6–48.5)	51.9 (40.0–67.6)	0.27
Insured (%)	101 (96.2%)	27 (84.4%)	8 (100%)	0.06
BMI (kg m ⁻²)	28.4 (26.3–31.6)	28.3 (24.6–30.9)	24.9 (23.0–28.4)	0.07
Positive family history (%)	24 (22.8%)	10 (31.3%)	1 (12.5%)	0.80
Positive DRE (%)	19 (18.1%)	7 (21.9%)	2 (25.0%)	0.69
PSA at diagnosis (ng ml ⁻¹)	5.1 (4.0–6.3)	5.2 (4.2–6.1)	4.8 (4.4–5.3)	0.90
<i>Initial diagnostic biopsy</i>				
TRUS volume (cc)	41.4 (28.4–55.8)	35.5 (24.1–46.3)	45.6 (31.0–46.7)	0.16
PSA density (ng ml ⁻¹ cc ⁻¹)	0.11 (0.08–0.16)	0.13 (0.10–0.20)	0.13 (0.10–0.15)	0.27
No. of cores sampled	12.0 (12.0–14.0)	13.0 (12.0–15.3)	13.0 (12.0–15.0)	0.76
No. of cores positive	1 (1–2)	1 (1–1)	1 (1–1)	0.17

Follow-up

	White (n = 105)	Black (n = 32)	Other (n = 8)	P-value
<i>AS follow-up</i>				
Duration (months)	24.2 (12.8-32.7)	19.0 (4.6-30.2)	13.9 (13.4-36.3)	0.53
PSA velocity on AS (ng ml ⁻¹ per year)	0.04 (-0.58 to 0.57)	0.46 (-0.43 to 1.17)	0.42 (-0.20 to 1.68)	0.20
No. of PSA on AS	3 (1-4)	3 (1-5)	3.5 (3-4)	0.90
PSA interval on AS (months)	7 (5-11)	7 (5-15)	3.4 (2.8-6.3)	0.13
No. of biopsies on AS	1 (0-1)	1 (0-1)	1 (0-2.5)	0.52
Biopsy interval on AS (months)	25.2 (16.7-33.0)	20.7 (15.8-22.9)	13.2 (6.9-20.0)	0.61
Remaining on AS (%)	87 (82.9%)	20 (62.5%)	5 (62.5%)	0.03

Race and AS



Multivariate analysis

	Disease progression		Any reason	
	HR (95% CI)	P-value	HR (95% CI)	P-value
Unadjusted	2.93 (1.29-6.68)	0.01	2.19 (1.05-4.56)	0.03
Adjusted for SES ^a	3.57 (1.43-8.90)	<0.01	2.43 (1.09-5.46)	0.03
Adjusted for clinical data ^b	3.05 (1.32-7.02)	<0.01	2.18 (1.04-4.54)	0.04
Adjusted final model ^c	3.08 (1.25-7.55)	0.01	2.21 (1.00-4.87)	0.05

^aModel adjusted for household income and insurance status.

^bModel adjusted for age, and PSA and number of positive biopsy cores at diagnosis.

^cModel adjusted for PSA at diagnosis and household income (the significant terms in the SES and clinical models).

Active Surveillance and Ethnicity-Summary

- Black men progress to treatment faster on AS
 - No difference in SES
 - No difference in follow-up intensity
- Suggests a biologic difference but mechanism unknown
- Attention to race when AS chosen: Consider mp-MRI; Molecular markers (Duke prospective AS trial-underway)

Prostate Cancer and African American men

- Thank you very much.
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- Twitter @JuddMoul