Reply to Borivoj Golijanin, Anthony Mega, and Dragan Golijanin's Letter to the Editor re

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Letter to the Editor

Reply to Borivoj Golijanin, Anthony Mega, and Dragan Golijanin's Letter to the Editor re: Ivo I. de Vos, Sebastiaan Remmers, Renée Hogenhout, Monique J. Roobol, ERSPC Rotterdam Study Group. Prostate Cancer Mortality Among Elderly Men After Discontinuing Organised Screening: Long-term Results from the European Randomized Study of Screening for Prostate Cancer Rotterdam. Eur Urol 2024;85:74–81

We thank Golijanin and colleagues for their kind words and comments on our study [1]. The fact that the ERSPC trial is a gift that keeps on giving is only possible through the ongoing dedication of the consortium members, who have been working together since 1993. The authors compared our results with those reported by Remmers et al [2]. It is essential to clarify that although both studies are based on ERSPC data, they differ in patient selection. One involves the ERSPC trial as a whole [2] and the other is based solely on ERSPC Rotterdam data [1].

Our study focused exclusively on participants from the Rotterdam section of the ERSPC, specifically those aged 70–74 yr with no cancer detected at previous screening visits. By contrast, Remmers et al [2] examined a younger cohort (55–69 yr) from the entire ERSPC trial (seven centers including Rotterdam). Furthermore, while Remmers et al [2] analyzed the association between PSA at first screening (baseline PSA) and future prostate cancer (PCa) detection and PCa-specific mortality (PCSM), our study specifically addressed the relationship between the last PSA screening result and the subsequent incidence of PCSM. Therefore, on comparing the findings from the two studies it becomes evident that the relationship between PSA and PCSM is significantly influenced by previous or future screening attendance and age, probably because of the inherent natural age-related increase in PSA, as also highlighted by Golijanin et al.

In addition, is it important to note that the suggestions from these ERSPC publications to discontinue PSA testing when PSA is below a specific threshold at a certain age (< 1.0 ng/ml for men aged 55–69 yr or < 3.0 ng/ml for men aged 70–74 yr) are derived from population-based screening data. In this context, it is necessary to consider the benefit/harm ratio of continued PCa screening and to acknowledge that that some aggressive or lethal cancers may go undetected via population-based screening. For instance, tumors characterized by a high Gleason score but low PSA production (< 3.0 ng/ml at diagnosis), which appear to be associated with higher PCSM risk in comparison to tumors with PSA of 4.0–10 ng/ml [3], are challenging to identify via population-based screening, where a balance between benefit (saving a few) and harm (unnecessary testing for many) is crucial. Although Golijanin et al suggest PSA velocity or PSA doubling time as a predictor for PCa detection, these metrics have so far not proven to be more effective than the absolute PSA level [4].

Nonetheless, we agree with Golijanin et al that, unlike at a population-based level, it is difficult to determine a strict screening cutoff value in the clinical setting. Within this setting, we argue for a multivariable screening approach that considers a man's individual factors, including screening history (eg, previous benign prostate biopsies), personal preferences, and, perhaps most importantly, life expectancy.

Conflicts of interest: The authors have nothing to disclose.

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