

# Congress of the United States

Washington, DC 20515

November 8, 2011

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius:

As the Chair of the CBC Health Braintrust and as a physician who practiced for over two decades before coming to Congress, I applaud the U.S. Preventive Services Task Force (USPSTF) for focusing on prostate cancer screening, early detection, treatment and outcomes, as well as for its concern about the harms to men found to have early prostate cancer based on PSA screening and tested and/or treated for prostate cancer where there may be no benefit for treatment. However, I am in total disagreement with the draft recommendations and strongly oppose them. My reasons are outlined below:

First, the USPSTF rendered a draft recommendation against the use of the PSA test for early detection screening of prostate cancer absent "symptoms that are highly suspicious for prostate cancer." This recommendation is flawed on its face because when it comes to prostate cancer, there are generally no symptoms in early prostate cancer, or even cancers that remain contained within the gland.

Consequently, if this recommendation were to be translated into a national policy or medical practice, it would likely result in a major shift from the current emphasis on the early detection of prostate cancer before it has a chance to spread and become potentially incurable and fatal. Under current medical practices, the overall mortality rate for prostate cancer has declined by approximately 40 percent since the widespread use of the PSA test for early detection. Further, National Cancer Institute models indicate that 45 to 70 percent of the prostate cancer mortality rate decline could be attributed to the impact of the PSA test.

Since symptoms are usually experienced only in advanced prostate cancer or after it has metastasized, this recommendation would reverse the gains made since PSA became routinely used, as well as increase the number of men diagnosed late and increase the number of deaths from this cancer. That alone ought to cause the Task Force to rescind the recommendations.

No one would disagree with the USPSTF assertion that it is critical to reduce the harms associated with PSA-based screening for prostate cancer. However, I also feel strongly that the known benefits of the PSA test – particularly its role in prostate cancer mortality reduction – must remain available to all men and especially those at greatest risk for prostate cancer. Some of these harms – such as the psychological stress associated with a false-positive result or a prostate biopsy – can be addressed through better education, increased research about effective treatment for prostate cancer based on specific patient age, location and size and other influencing factors as well as improved prostate cancer imaging technologies and biopsy procedures. Certainly our medical and research communities which have enabled the progress we have seen with prostate cancer and other diseases are capable and indeed motivated to further address all of the concerns raised, while still keeping early diagnosis possible, and saving lives.

As an African American whose father and several colleagues died from prostate cancer and with many friends still living with it – some many years after early diagnosis and with appropriate treatments based on age and stage – this is a major and unacceptable disservice to African-American men. While prostate cancer affects all men, numerous studies confirm that African-American men have the highest prostate cancer incidence and mortality rates in the United States. Despite this racial and ethnic disparity in prostate cancer, however, the major randomized clinical trial evidence cited by the USPSTF used for its decision against the PSA test did not include a statistically significant number of African Americans and seemingly not even men with a family history of the disease.

The USPSTF does, to its credit, acknowledge that the final decision to use the PSA test and decisions about the steps taken following PSA test results are those that should be made in partnership between the physician and the patient. However, while they fail to cite the science behind such an assertion, the USPSTF also stated that "there is no data that suggests that the net benefit of PSA-based screening is altered by race or family history." These assertions, in the absence of science, are disconcerting and I therefore am keenly interested in the USPSTF providing the evidence and assumptions used to include men "regardless of ...race and family history" within its recommendation to limit PSA testing in the absence of prostate cancer symptoms.

I am sure that the Task Force is acutely aware that if this recommendation was translated into a national policy, then the PSA test may not be classified as a preventive service or a reimbursable service – both of which would be tantamount to ignoring the disparate impact that this disease has had on African-American men who are disproportionately more likely than men from all other racial and ethnic backgrounds to die from the disease and who are generally of low income and need the test to be covered. If it is not a reimbursable service, many poor and even middle income men who need to be diagnosed will forego the test and will be diagnosed only when it is too late – despite costly attempts – to treat their cancer, and they will succumb.

I am compelled to remind you that at a hearing before the House Committee on

Energy and Commerce in the 111th Congress, I asked by one of my Republican colleagues if the Chairman of the Task Force and of MedCap felt or if they knew of any evidence that there was discrimination in medicine. Neither gave a direct or any kind of answer in the affirmative, despite the hundreds of scholarly scientific articles and reports that clearly affirm that such discrimination exists. That demonstrated an insensitivity that is reflected in this draft recommendation and I urge the Task force to increase its awareness, sensitivity and responsiveness to the unique issues of racial and ethnic minorities.

The release of these draft recommendations for prostate cancer screening may have played an instrumental role in raising greater awareness about and drawing attention to a leading cause of cancer death among men, but I am certain that it has caused far more damage in that it may have erased many of the hard fought for gains made over recent years in encouraging men to be tested.

In light of the fact that the recommendation is based on symptom-free men in a cancer with no early symptoms, and that the USPSTF recommendations for prostate cancer screening are based on limited research, particularly as it pertains to whether the recommendations would cause an increase in the risk of prostate cancer death and suffering by African Americans and other high-risk men, I reject the assumptions and the draft recommendations, and I am compelled to strongly recommend that the draft be withdrawn, that no recommendations be made at this time and that steps immediately be taken to repair the damage done by these draft recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna M. Christensen". The signature is fluid and cursive, with a long horizontal stroke at the end.

Donna M. Christensen  
Member of Congress

cc:

President Barack Obama

Virginia Moyer, MD, MPH  
Chairwoman  
United States Preventive Services Task Force