Cancer Screening: When Is the Juice Worth the Squeeze?

I learn a lot from my patients. I remember a very elderly man who often asked me rather unusual questions. Should he buy a new suit? Should he get his teeth fixed? It didn’t take me long to understand that he was trying to assess whether, given his tenuous medical condition, he would get his money’s worth from those purchases. It was simply another approach to understanding his prognosis and, being a practical man who worked hard all his life to get by, he didn’t want to spend his money foolishly.

I thought about this after reading a study in JAMA regarding cancer screening in individuals with different life expectancies. The investigators, from the University of North Carolina, used a validated mortality index specific for the National Health Interview Survey (http://www.cdc.gov/nchs/nhis/about_nhis.htm) and queried data from the same survey (2000–2010) for rates of cancer screening (for breast, prostate, cervical, and colorectal cancers) in individuals with low (≤25%), intermediate (26%–49%), high (50%–74%), and very high (≥75%) risk of 9-year mortality.

Now, although controversy exists about some forms of cancer screening and the role these play in minimizing mortality, screening for selected cancers is accepted practice and considered to be an important part of health care maintenance. But if a patient is too sick to treat the cancer you are screening for, wouldn’t you recommend against screening?

Surprisingly, the investigators found that up to 55% of patients with a very high risk of 9-year mortality had received some form of cancer screening. Even more odd, approximately one-third of women who had undergone a hysterectomy and presumably didn’t have a cervix were screened for cervical cancer. What were their doctors thinking?

I don’t know what we spend on cancer screening in the United States, but I bet it’s a lot. A prostate-specific antigen (PSA) screen doesn’t cost much in itself, but the downstream cascade of procedures (biopsies, surgeries, and other treatments) can be costly. Considering the high cost of health care in this country, it seems prudent to sit back and think these things through a bit. I admit that it can be challenging to explain to the public that at a certain age or in consideration of comorbidities, screening for cancer is no longer indicated. It could be a long discussion. But I think that with enough education and assurance that we won’t abandon individuals with symptoms of cancer, this practice could be adopted. And perhaps for the elderly or very frail public, having a few less things to worry about might be appreciated.

My elderly patient died from metastatic colon cancer a couple years after he asked me about purchasing his new suit and dental repairs. In case you were wondering, after finding out that he wanted the new suit so he would look nice for a family wedding and his teeth fixed so he could enjoy the things he liked to eat, I recommended that he do both. It seemed worth it to me. But I think that if he had asked about measuring his PSA, I would have suggested that he had more important things to worry about. And he would have agreed.

Reference


Margaret Tempero, MD

Dr. Tempero is a Professor of Medicine and Director of the UCSF Helen Diller Family Comprehensive Cancer Center. She has served as Deputy Director and Interim Director for the UCSF Helen Diller Family Comprehensive Cancer Center. She has served as Deputy Director and Interim Director for the UCSF Helen Diller Family Comprehensive Cancer Center. She has served as Deputy Director and Interim Director for the UCSF Helen Diller Family Comprehensive Cancer Center.