

Prostate cancer in Trinidad and Tobago: A response to "The epidemiology, histopathology and screening prospective of prostate cancer in Trinidad"

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SUMMARY

Prostate cancer is very common in Trinidad and Tobago but access to and uptake of screening remains limited. In this article, we respond to a recently published article on prostate cancer in Trinidad. We also highlight the state of prostate cancer research on the island.

Key words: prostate cancer, Trinidad, screening

LETTER TO THE EDITOR

Dear Editor,

We congratulate Umakanthan and colleagues on publishing their paper entitled "The epidemiology, histopathology and screening prospective of prostate cancer in Trinidad" which was recently published in your journal. However we wish to raise several points which we feel merit consideration and comment.

The authors compare the effect of a number of variables such as statin use and diet on the stage of cancer, that is, whether or not it was "confined to the prostate". However, they fail to document how they concluded whether a particular case was indeed localized solely from clinical and biopsy data. Indeed such information would require some form of imaging. Our colleagues also make statements of correlation between statin use and risk of advanced prostate cancer using descriptive statistics only, without providing us with strengths of association such as p values or what statistical methods, if any, they utilized to reach their conclusion. For clarity, they refer the reader to a table but this does not serve the intended function. They also make similar inferences about diet but do not share their questionnaire nor reveal whether it was a validated dietary questionnaire.

We find it interesting that 100% of men were found to have an "abnormal" Digital Rectal Examination (DRE). While the authors do not define what is considered to be abnormal, previous work in Trinidad has found that approximately 36 percent of men presented (non-screening detected) with a normal DRE [1]. In developed countries, with widespread screening, this number is even higher.

In addition, the authors seemed unaware of the significant local body of work that exists on prostate cancer, none of which were acknowledged [1-5]. Hosein et al. conducted a pathological evaluation of all biopsies done at a major tertiary center in Trinidad over a 2 year period. Out of 617 biopsies, 283 (51.8%) were positive for cancer, with the majority being Gleason grade 7. The ethnic disparity in our study was even more striking in our study with Afro-Trinidadians accounting for 72% of all cancers. Black men were also more likely to have higher grade and higher stage tumours [1]. We found that patients of African descent were more likely to have higher PSAs compared to their Indo-Trinidadian men. Overall, 27.5% of Afro-Trinidadians had a Prostate Specific Antigen (PSA) of more than 100 ng/mL.

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compared to 10.6% of Indo-Trinidadian men. Afro-Trinidadians were more likely to have poorly differentiated tumours, 44% compared 25% and perineural invasion was also more common among Afro-Trinidadians 11.3% vs 5.6%, although this did not reach statistical significance. Overall, men of African ancestry more likely to have D’Amico high-risk tumours.

Recently Warner and colleagues examined records of the National Cancer Registry over a 14-year period (1995-2009). He noted an age standardized incidence rate of 64.2 per 100000 as well as an increase in mortality over the study period [6]. Black men accounted for 78.4% of prostate cancer patients but were less likely to receive treatment compared to their counterparts of other races. Interestingly only 10.2% of cancers detected during the study period were detected via screening.

In Tobago, the University of Pittsburgh partnered with the government to establish a screening program in 1995. A review of their data indicated that around 60% of eligible men were screened and prostate cancer diagnosed in 11%, with Gleason grade 7 or higher accounting for 48% [5]. Among the screened men, the prostate cancer was 2.6% which was higher than among screened European cohorts. This further illustrates the magnitude of prostate cancer locally. In Trinidad, screening is widely available but largely ad hoc.

It should be apparent to the reader that prostate cancer screening is an important public health issue in Trinidad and Tobago. Which brings us to our final comment. It is unclear in this paper what proportion of their patients were screening-derived. Also, the authors have seemingly missed the opportunity for commentary on one very important finding from their study—that is, the majority of their patients presented with advanced PSAs indicating advanced disease. This, taken in the context of the high mortality rate of prostate cancer in the Caribbean [7] and its potential correlation to screening, or lack thereof. While they do mention in their abstract that men should be screened,

they seem to suggest that we limit this to men over 40 with a family history. By the authors’ own estimation, this removes 75% of men from the screening process. Most urologists in the Caribbean believe that screening should commence at 40 for black Caribbean men, regardless of family history [8]. In a survey of Caribbean urologists, 76% were in support of prostate cancer screening among Afro-Caribbean men. They believed that screening should commence at 40 years old and stop at 75 years.

Unfortunately, in Trinidad and Tobago, a number of cultural barriers exist to screening including fear of the digital rectal examination. Ocho explored perceptions of screening using focus groups and 75 men were interviewed [9]. The authors noted that while men were aware of screening services, they still unwilling to undergo screening. They displayed anxiety with respect to the digital rectal examination in particular and there were concerns over associations with homosexual activity. Additionally they were worried about obtaining a diagnosis of prostate cancer. Similar findings have been noted by other authors [10].

We hope that we have clarified our issues with this paper and provided some context as to the lay of the land in our population. Comments, queries and apparent weaknesses notwithstanding, we welcome this paper and encourage the authors to expand upon it as research on prostate cancer is sorely needed in Trinidad and Tobago. Given the prevalence of the disease locally, we have to try to enact change at the policy level in order to promote screening. The recent Harmonized guidelines for the Caribbean published by the National Comprehensive Cancer Network is a step in the right direction—PSA screening is encouraged for at-risk men beginning at age 40 [11]. Additionally, work is needed at a cultural level in order to destigmatize the process of prostate cancer screening.

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