Dépistage par PSA : à prescrire ou à proscrire ?

Cédric RAT

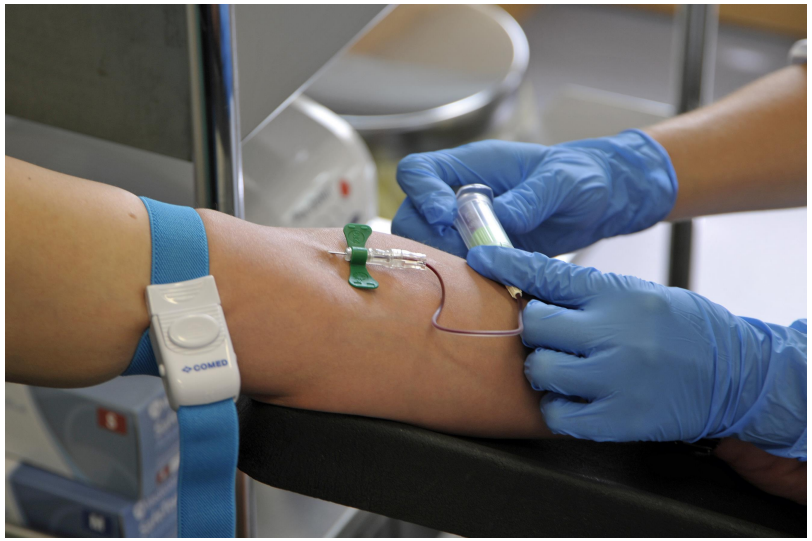
Président du Comité d'Ethique du CNGE


41.4% des hommes de 50 à 74 ans ont réalisé un dosage de PSA au cours des 2 dernières années.
COMED
* Rat C et al. JMIR Public Health Surveill. 2018 Oct 23;4(4):e10352.

COLON

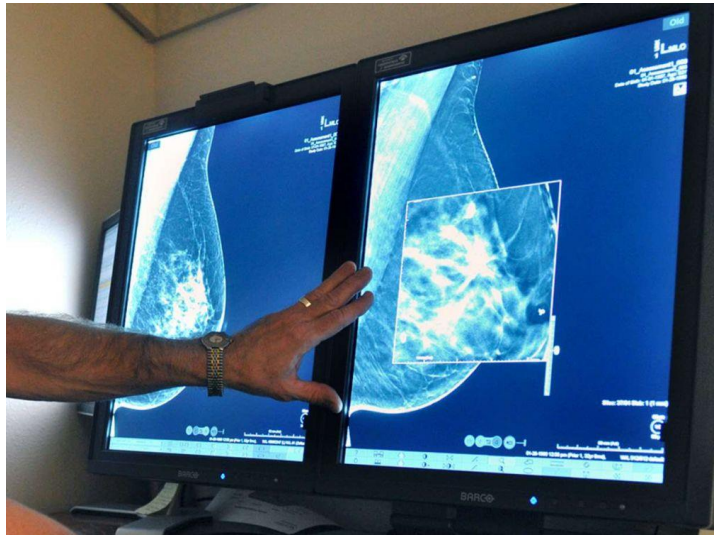
29.3%

PROSTATE



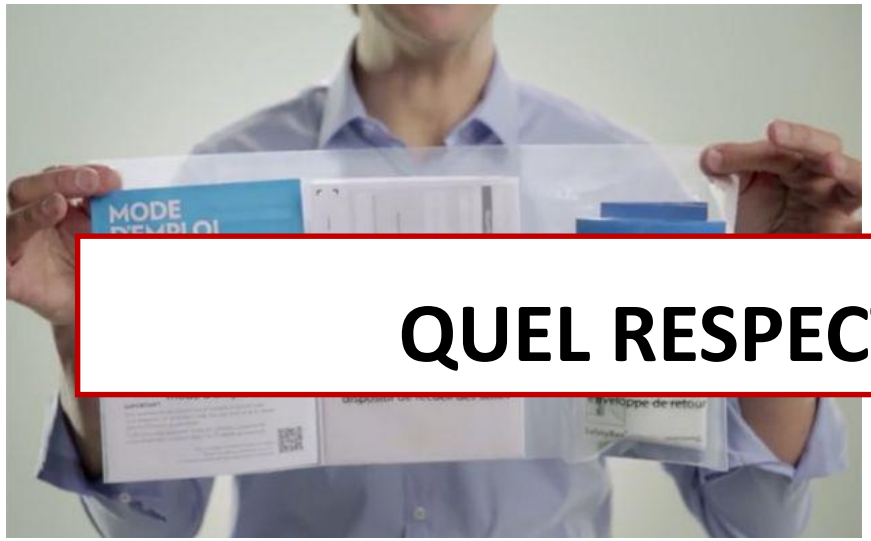
41.4%

SEIN



50.5%

COLON



29.3%

PROSTATE

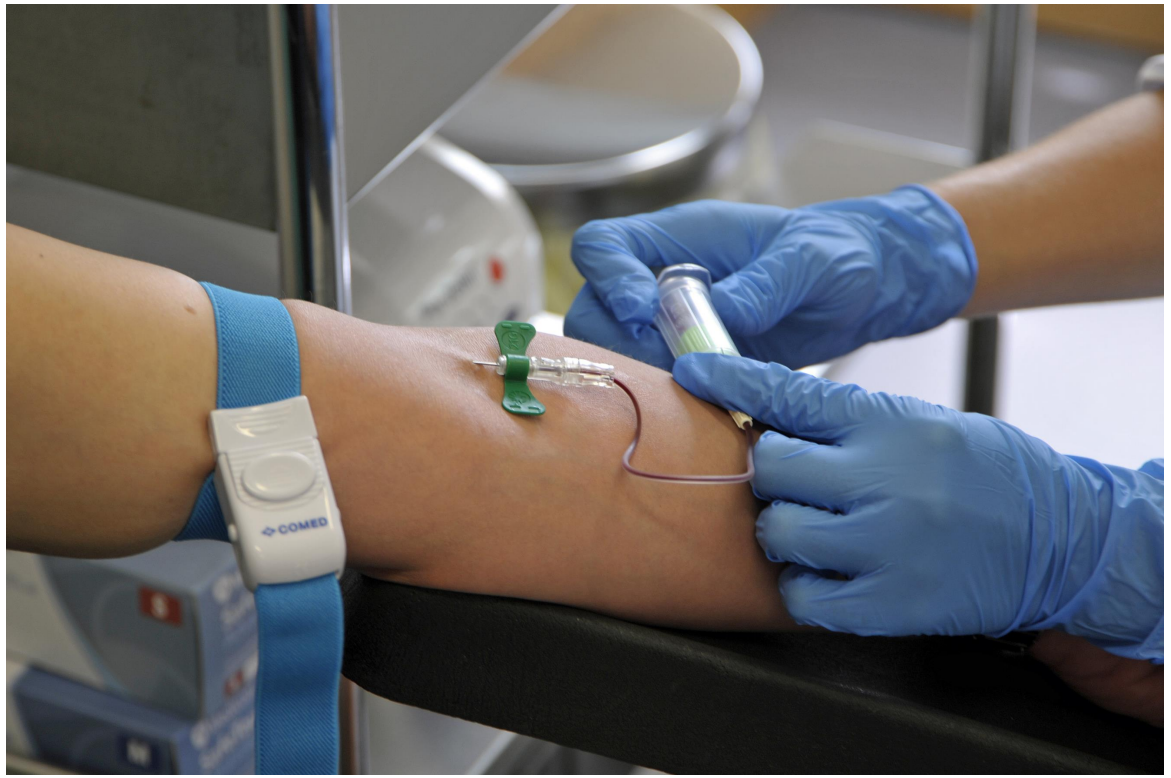
41.4%

SEIN

50.5%

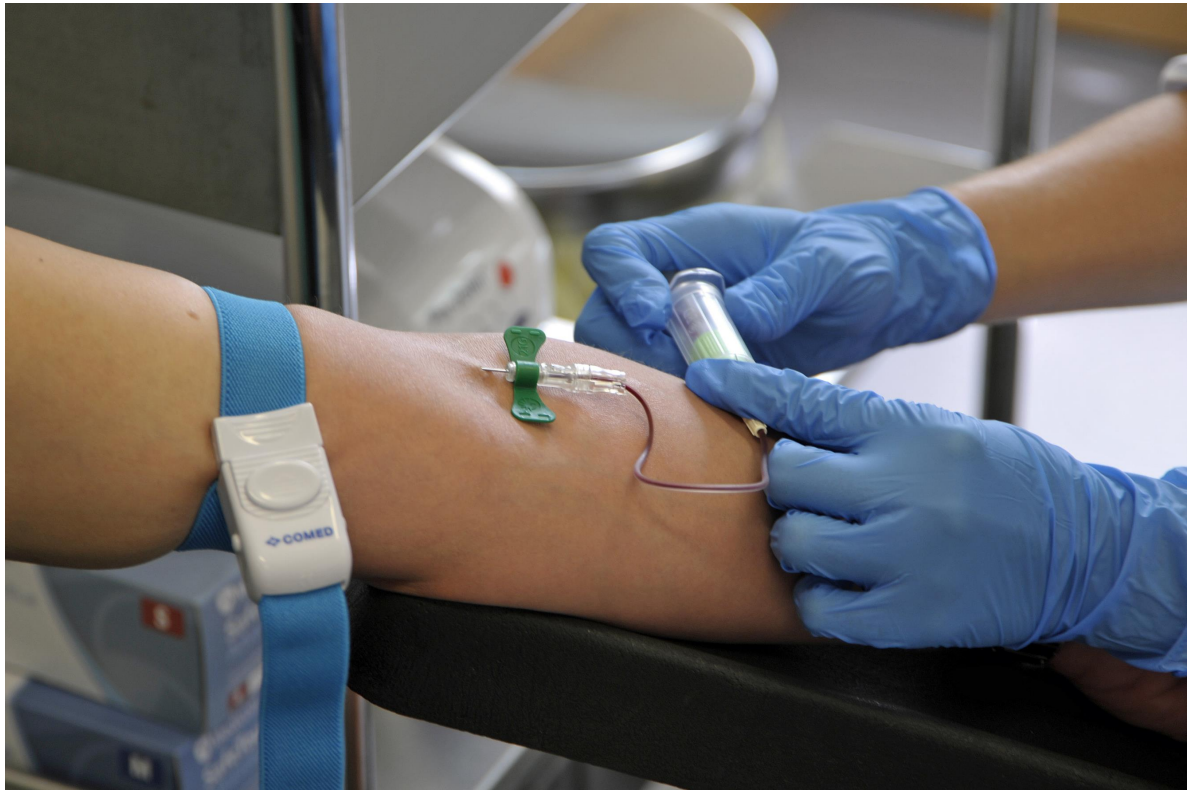
QUEL RESPECT DU PRINCIPE DE SCIENTIFICITE ?

50 - 74 ANS



41.4%

Après 74 ANS



41.1%

* *Rat C et al. JMIR Public Health Surveill. 2018 Oct 23;4(4):e10352*

50 - 74 ANS

Après 74 ANS

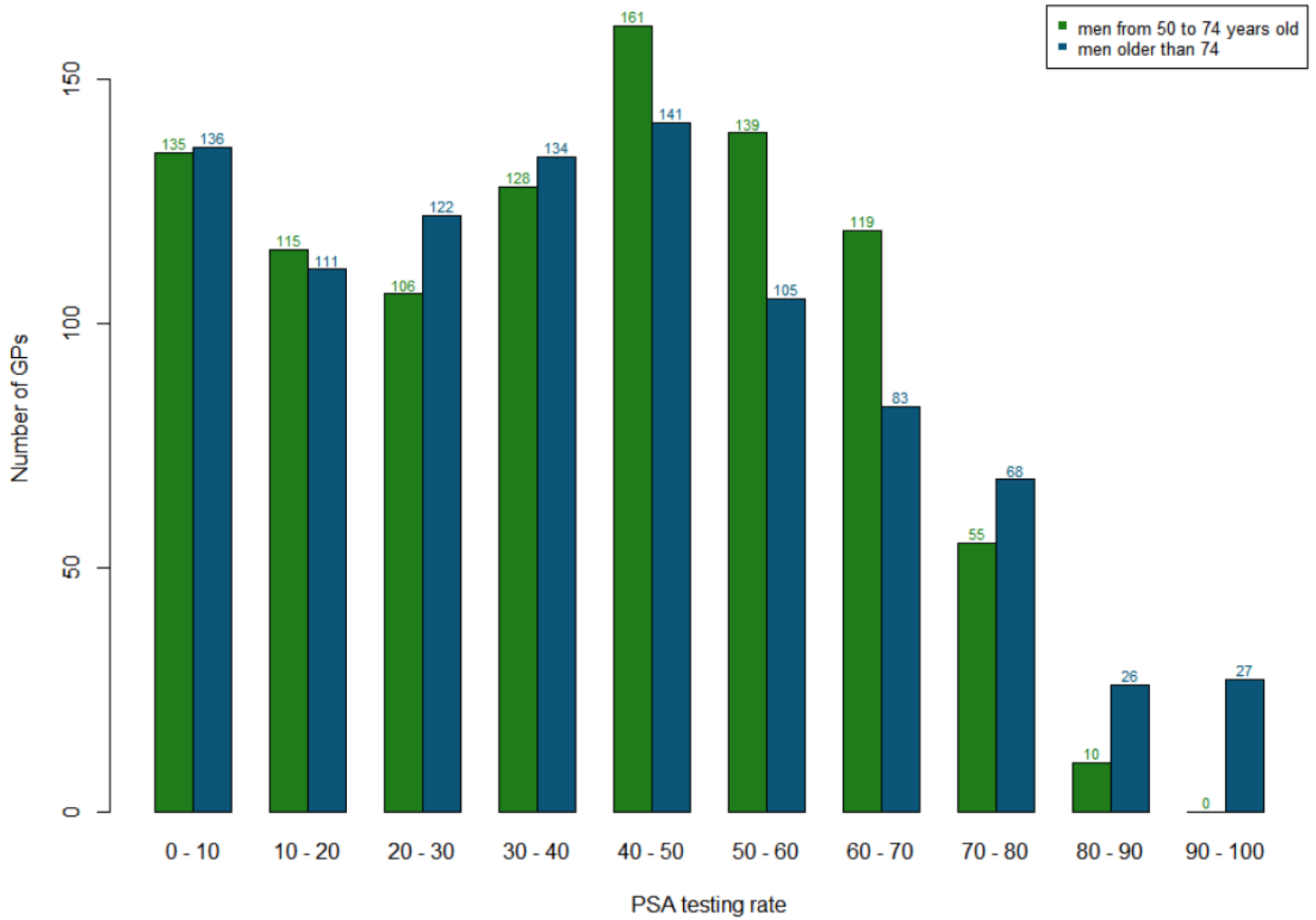
QUEL RESPECT DES PRINCIPES DE BIENFAISANCE / NON MALFAISANCE ?

41.4%

41.1%

Les pratiques des médecins généralistes sont très variables.

Figure 1. Distribution of prostate-specific antigen (PSA) testing performance rates according to general practitioner (GP; defined as the proportion of patients who underwent PSA testing in each GP's patient panel).



Rat C, Schmeltz H, Rocher S, Nanin F, Gaultier A, Nguyen JM. Factors Related to Prostate-Specific Antigen-Based Prostate Cancer Screening in Primary Care: Retrospective Cohort Study of 120,587 French Men Over the Age of 50 Years. JMIR Public Health Surveill. 2018 Oct 23;4(4):e10352.

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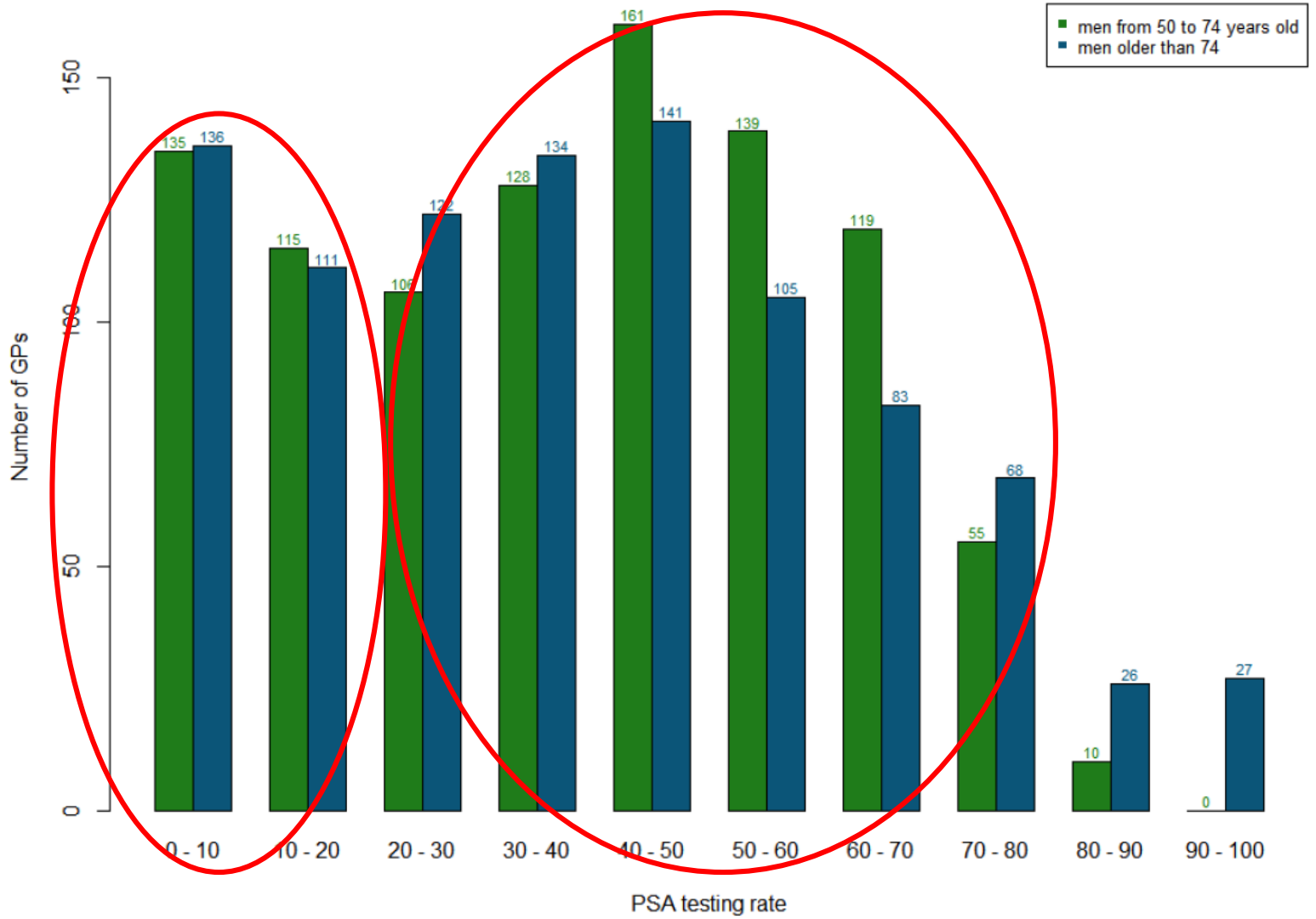

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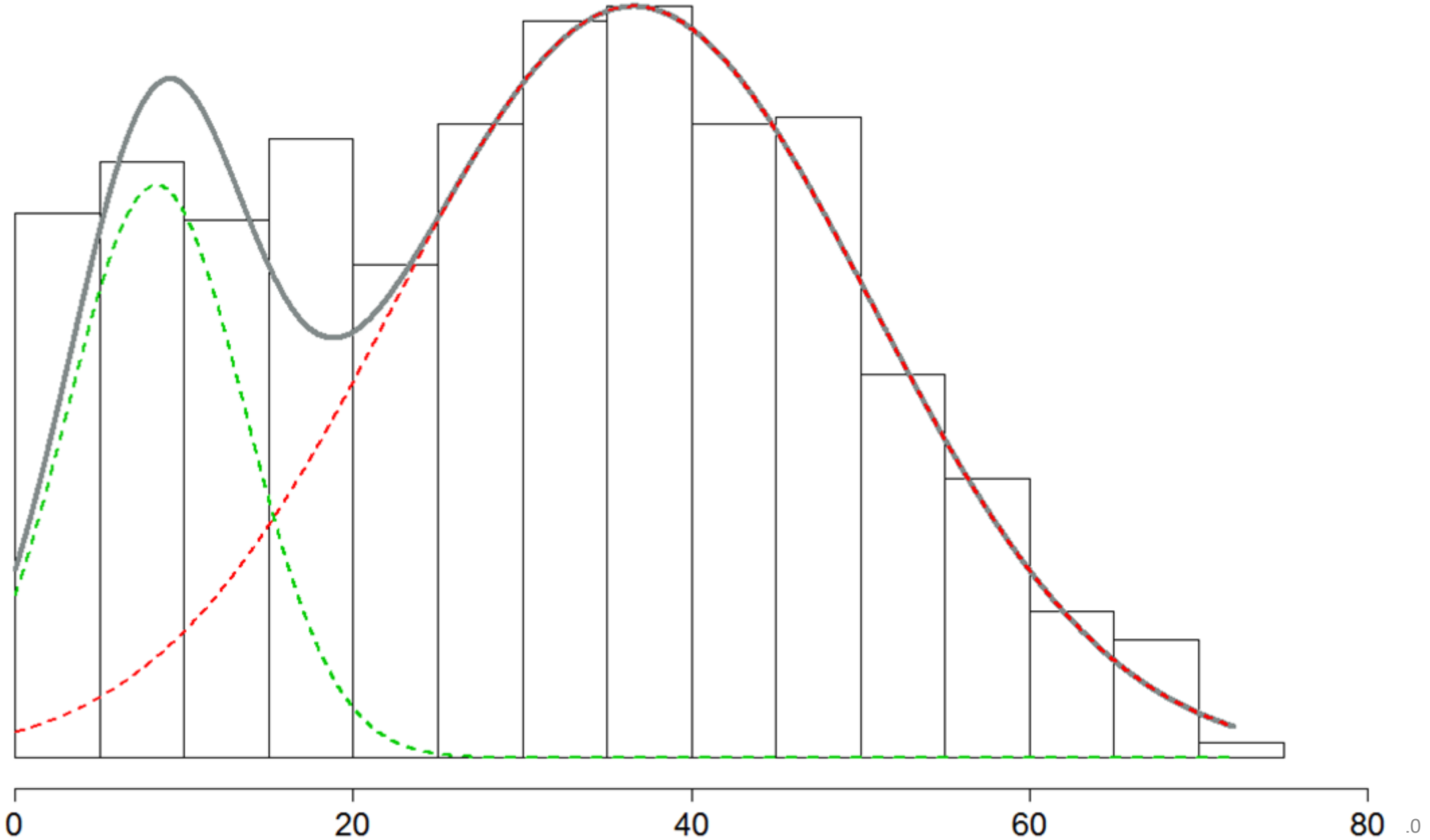

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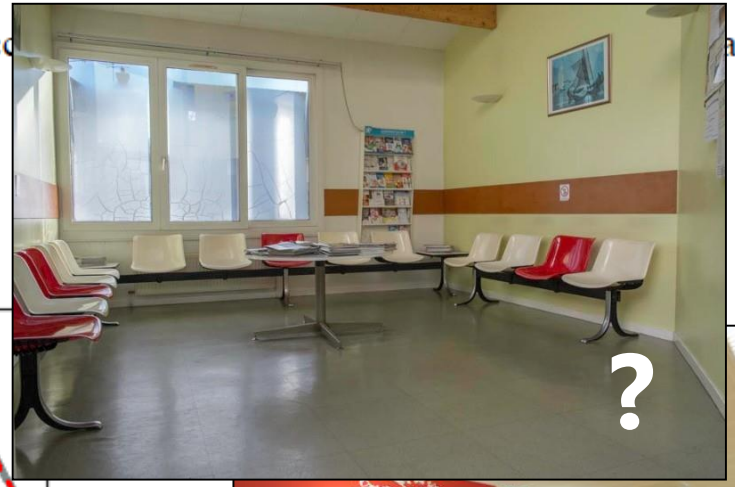

QUEL RESPECT DU PRINCIPE DE JUSTICE ?

0 20 40 60

#CI

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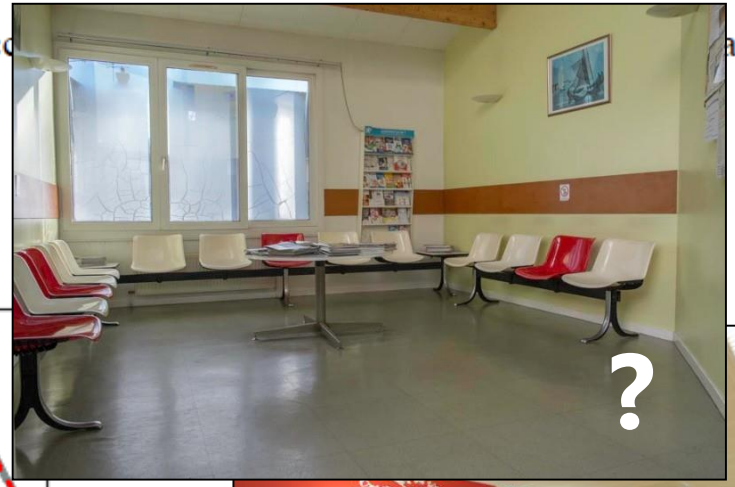
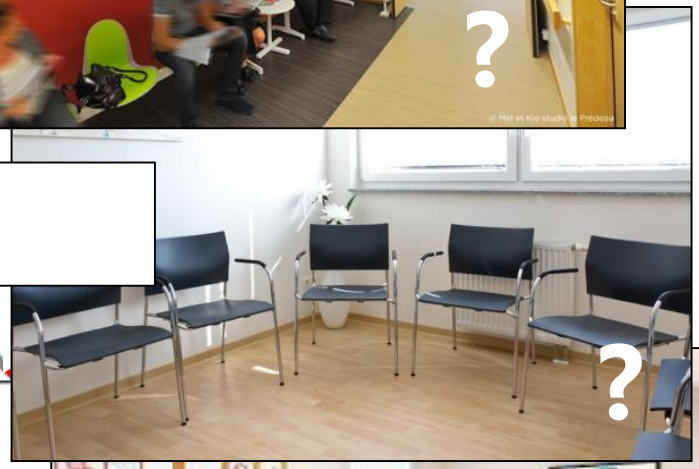


QUEL RESPECT DU PRINCIPE DE JUSTICE ?

QUEL RESPECT DE L'AUTONOMIE ?



0 20 40 60

#CI

Dépistage par PSA : à prescrire ou à proscrire ?

… entre bienfaisance et non malfaisance …


PubMed.gov


The NEW ENGLAND JOURNAL of MEDICINE
Mai 2017
US Preventive Services Task Force Recommendation Statement
Mai 2018

IJC
International Journal of Cancer

The high prevalence of undiagnosed prostate cancer at autopsy: implications for epidemiology and treatment of prostate cancer in the Prostate-specific Antigen-era

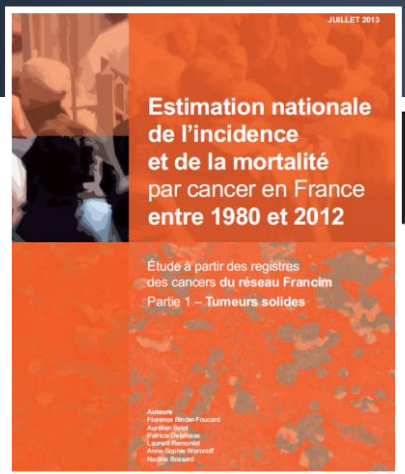
Jaquelyn L. Jahn[1,2], Edward L. Giovannucci[1,3,4] and Meir J. Stampfer[1,3,4]

[1] Channing Division of Network Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, MA
[2] Department of Social and Behavioral Sciences, Harvard School of Public Health, Boston, MA
[3] Department of Epidemiology, Harvard School of Public Health, Boston, MA
[4] Department of Nutrition, Harvard School of Public Health, Boston, MA

IJC
International Journal of Cancer

2015

36% des patients caucasiens ont des cellules cancéreuses dans la prostate à 70 ans.



Risques cumulés 0-74 ans (en %) selon la cohorte de naissance - Prostate

	Cohorte de naissance						
	1910	1915	1920	1925	1930	1935	1940
Incidence	2,74	3,43	4,50	5,73	8,32	10,71	10,74
Mortalité	1,28	1,33	1,31	1,22	1,08	0,91	0,74

36% des patients caucasiens ont des cellules cancéreuses dans la prostate à 70 ans.

Changer notre regard sur le cancer.

Revue de littérature. Effet du dépistage par PSA sur la mortalité. (Fenton et al. JAMA 2018)

Source	No. of Participants		Screening Interval, y (Planned No. of Screening Rounds)	Median Follow-up, y	RR (95% CI)
	Intervention	Control			Prostate Cancer Mortality
CAP,[15] 2018 (United Kingdom)	189 386	219 439	1 (1)	10.0	0.96 (0.85-1.08)
PLCO,[27,29] 2016 (United States)	38 340	38 343	1 (6)	13.0, 14.8[b]	1.04 (0.87-1.24)
ERSPC,[30,31] 2014[c] (Belgium, Finland, France, Italy, the Netherlands, Spain, Sweden, Switzerland)[d]	72 891	89 352	2-4 (3-10)[f]	13.0	0.79 (0.69-0.91)

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Prescrire un dosage de PSA une seule fois n'a pas d'impact sur la mortalité 10 ans plus tard.

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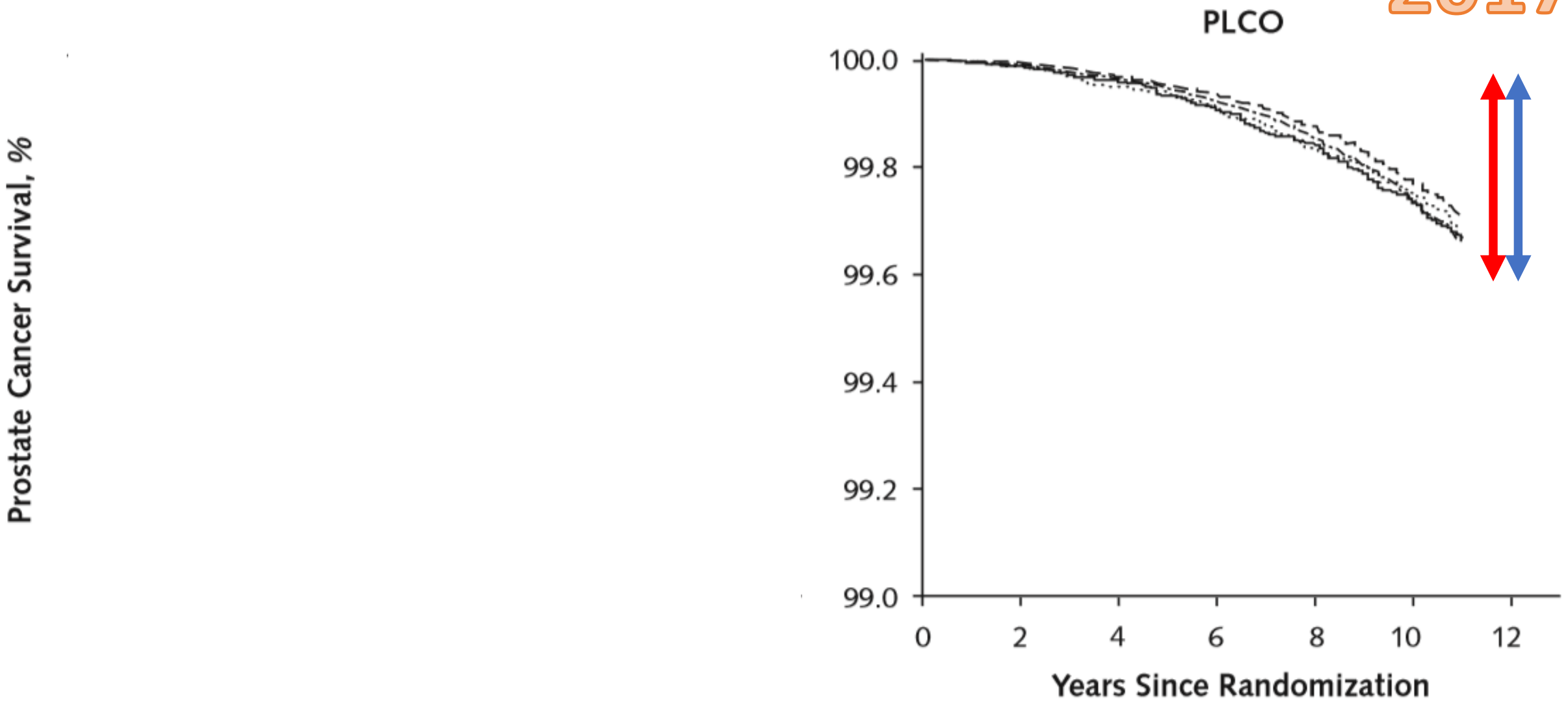
Annals of Internal Medicine

2017



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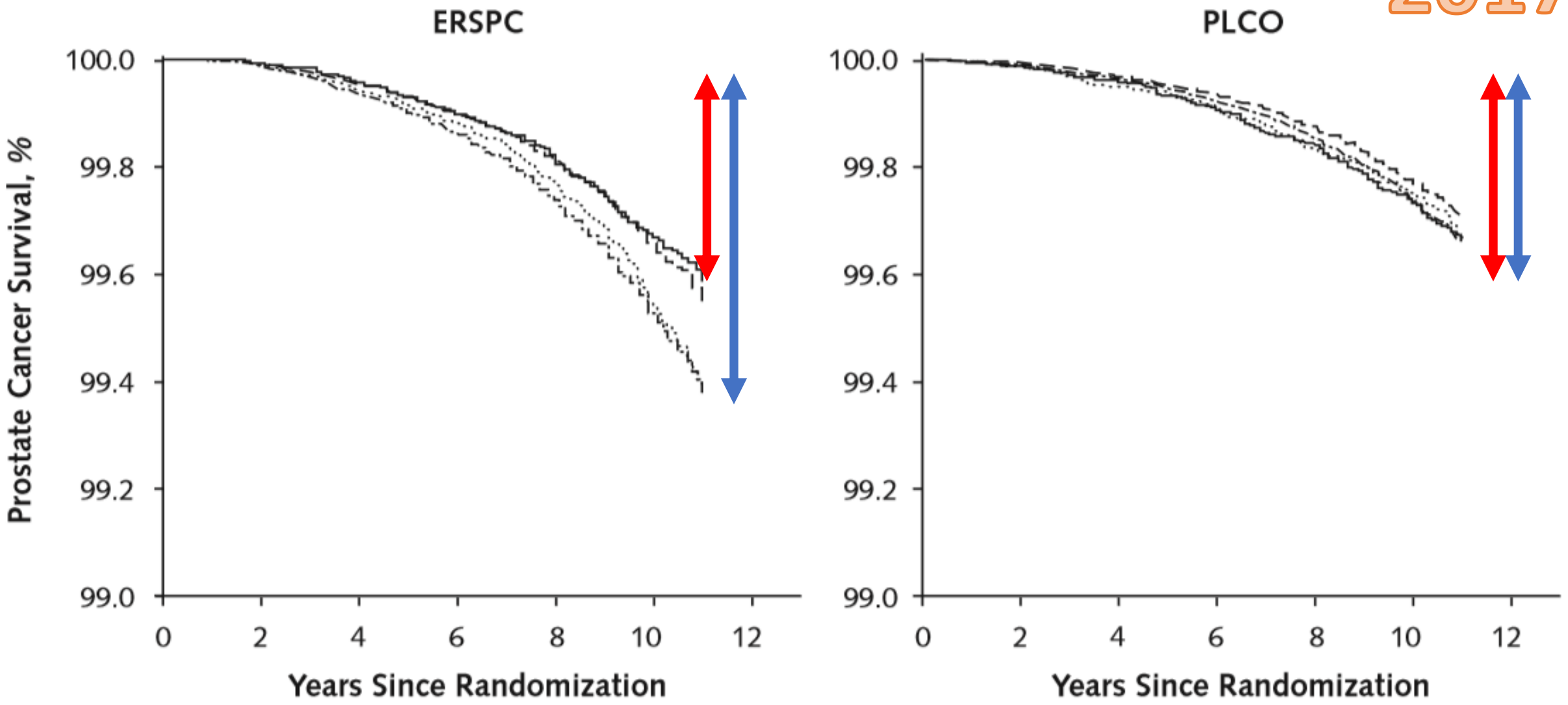

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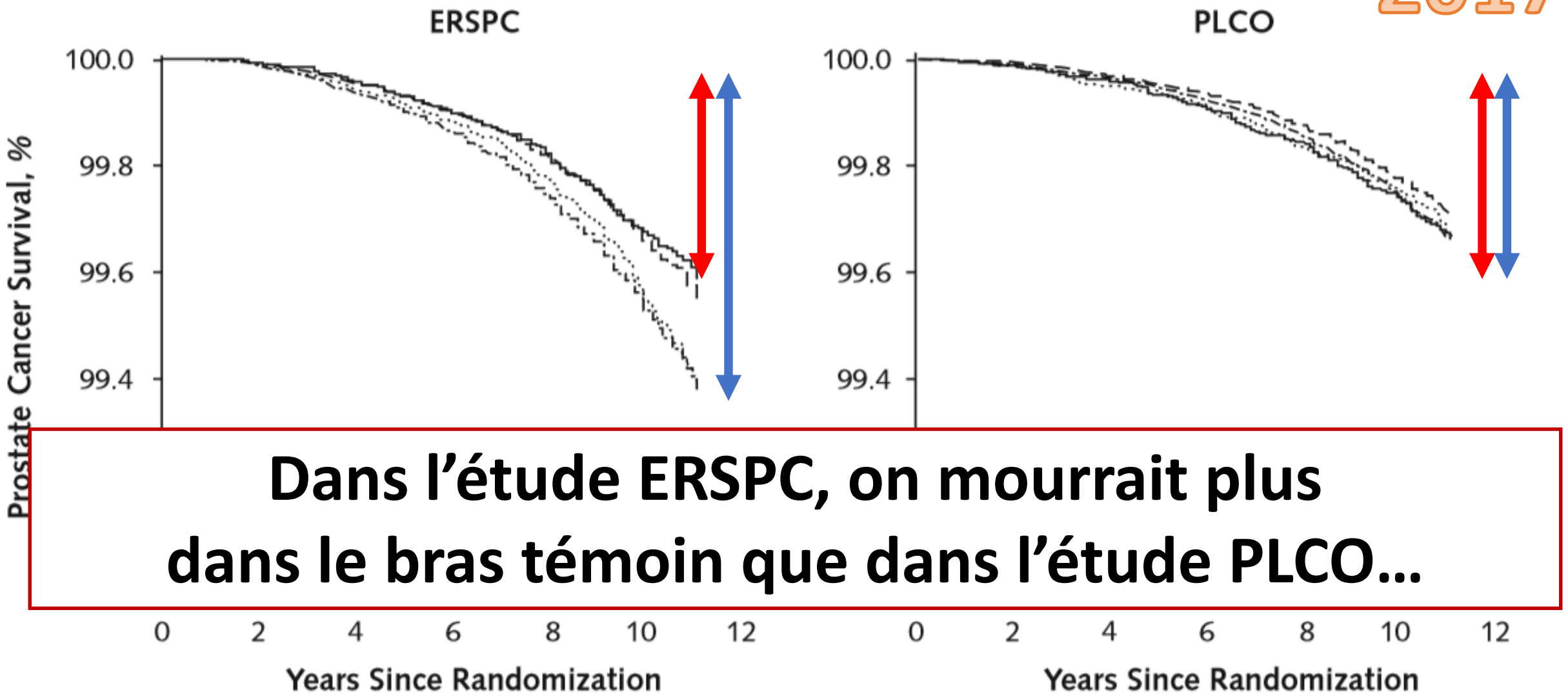

Dans l'étude ERSPC, on mourrait plus dans le bras témoin que dans l'étude PLCO…

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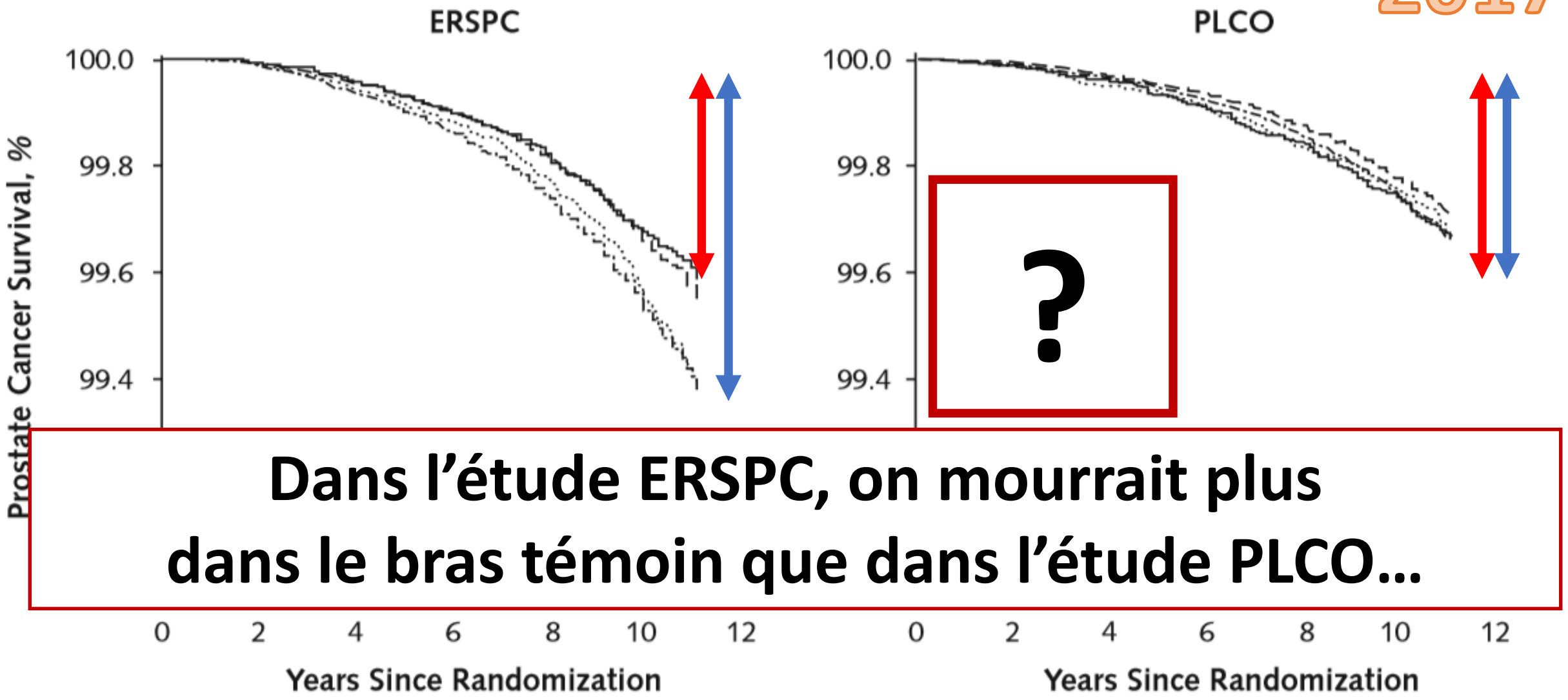

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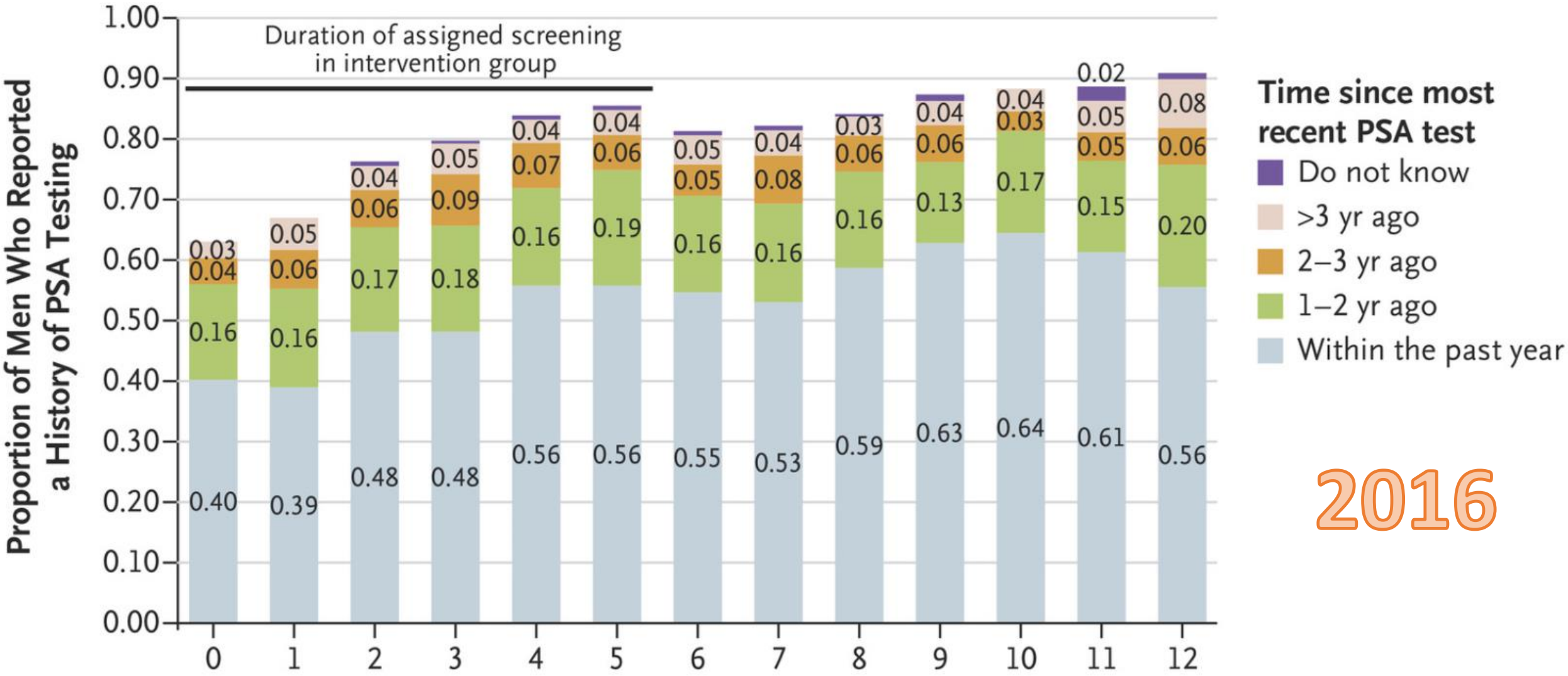
Shoag JE et al. # Reevaluating PSA Testing Rates in the PLCO Trial

The New England Journal of Medicine



2016

Shoag JE et al. # Reevaluating PSA Testing Rates in the PLCO Trial

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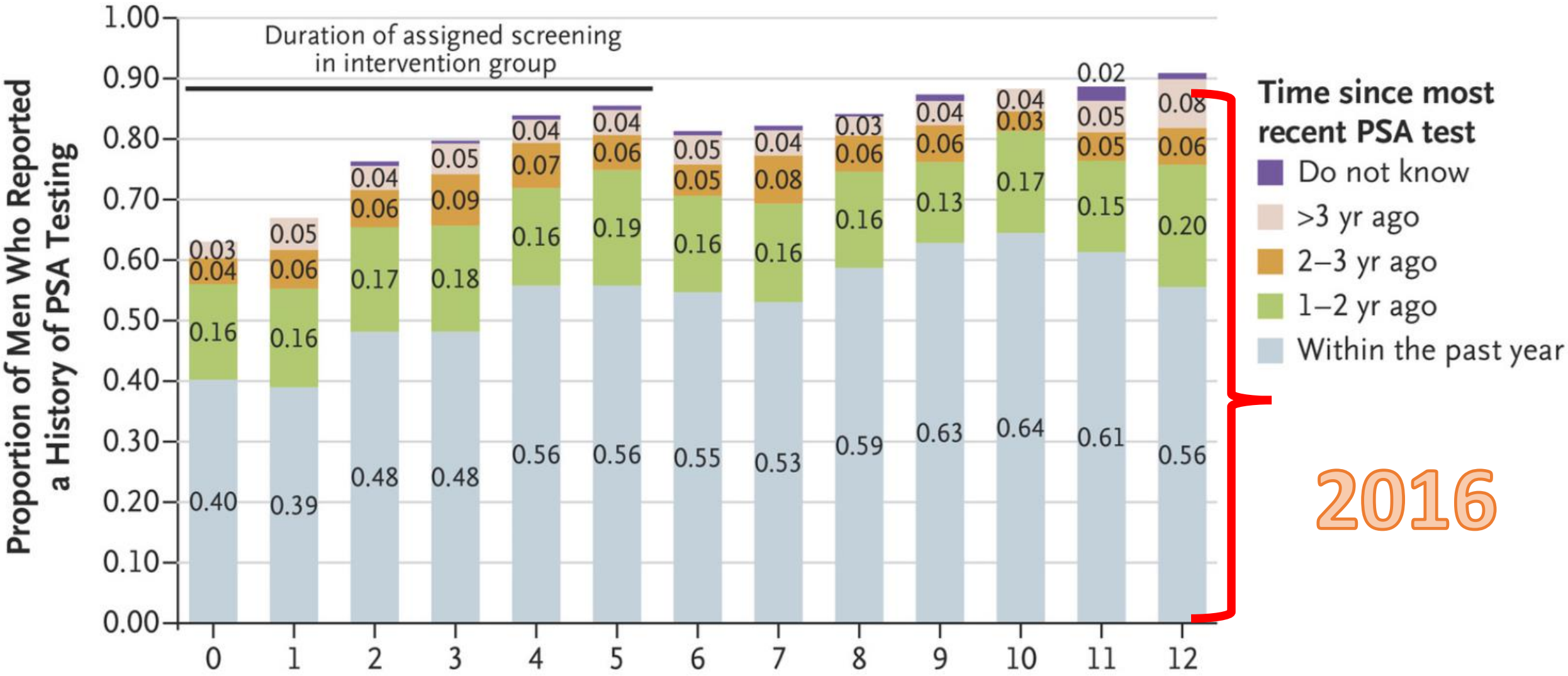
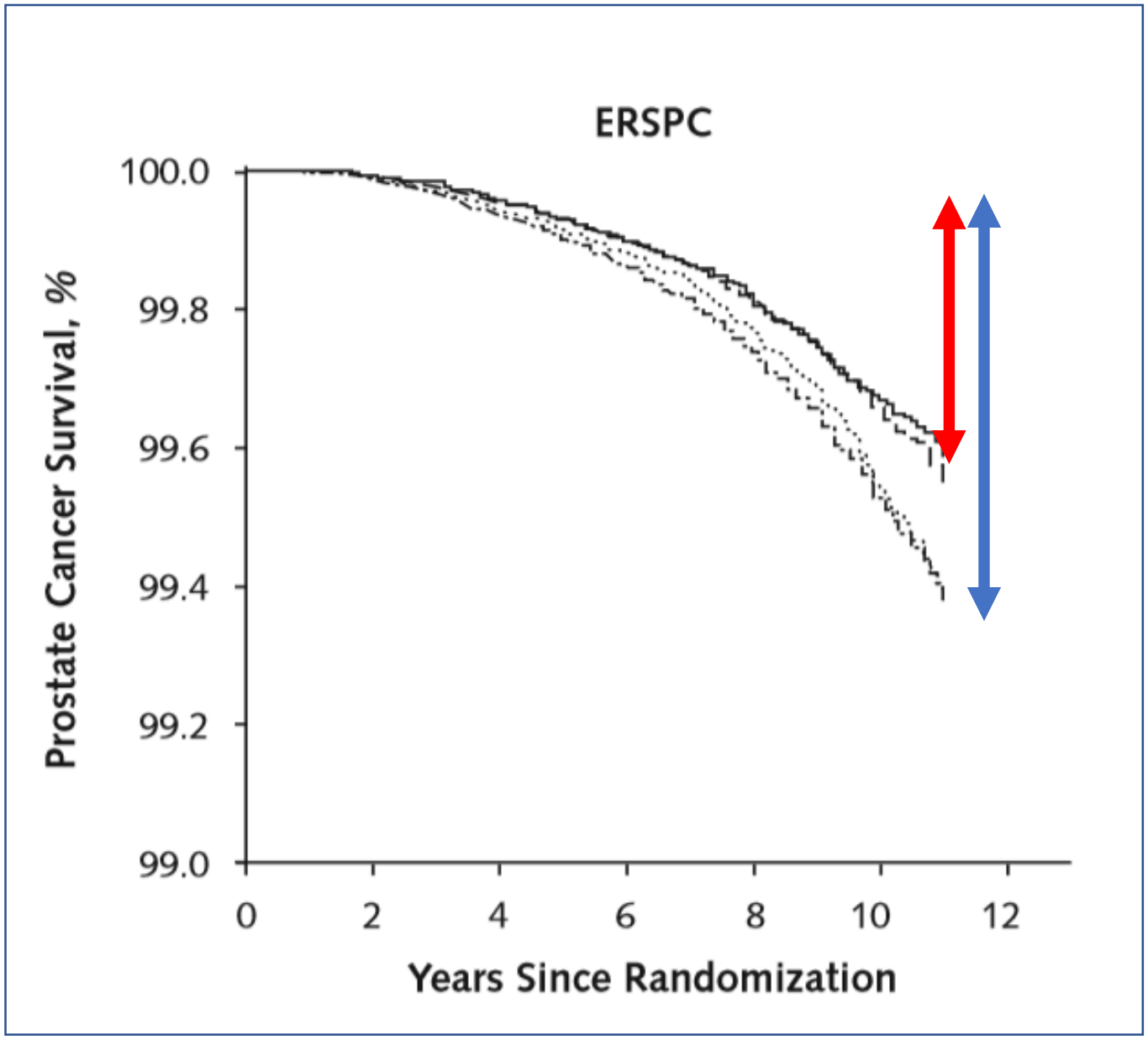


2016



Nous n'aurons jamais un essai randomisé où les patients du groupe témoin ne font pas de PSA.

Accepter l’absence de réponse scientifique.

Reconciling the Effects of Screening on Prostate Cancer Mortality in the ERSPC and PLCO Trials

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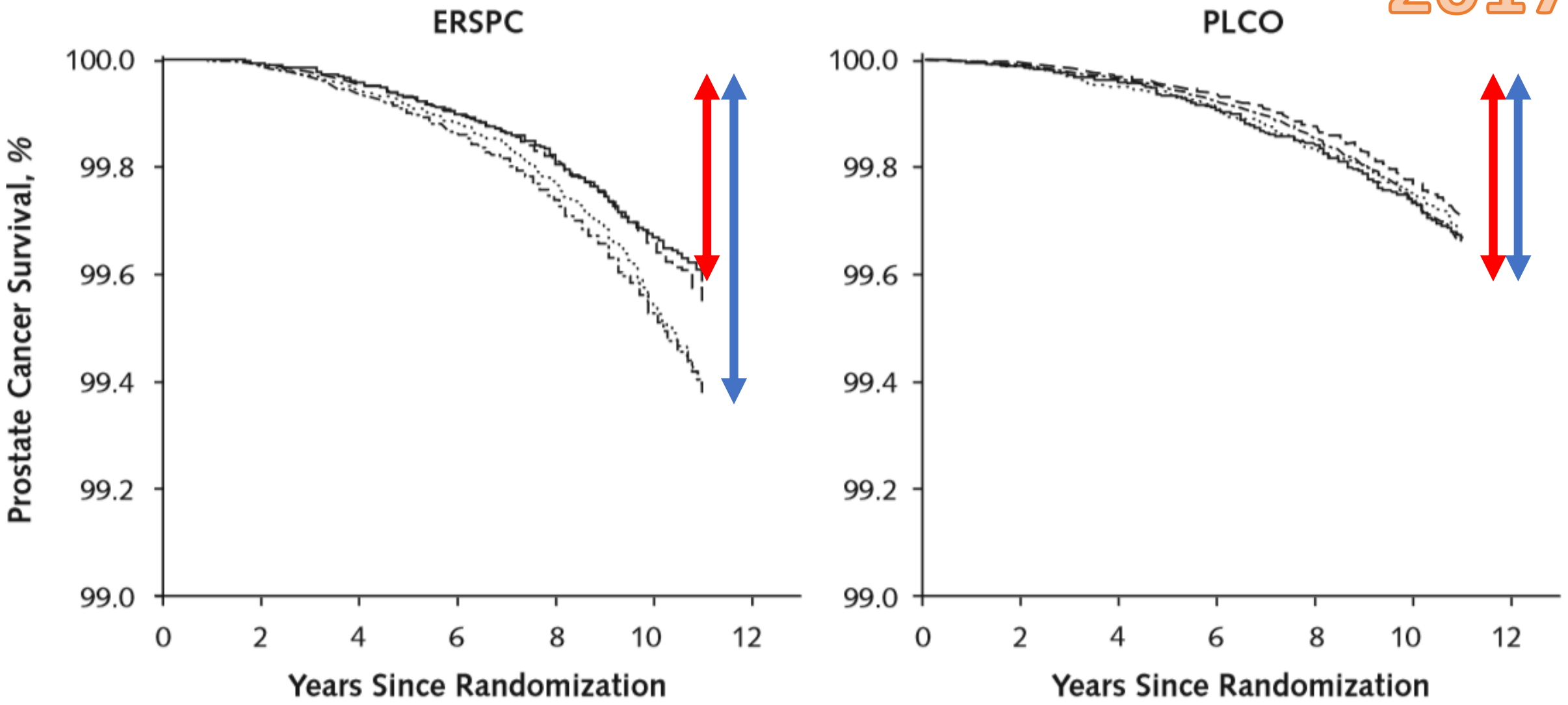

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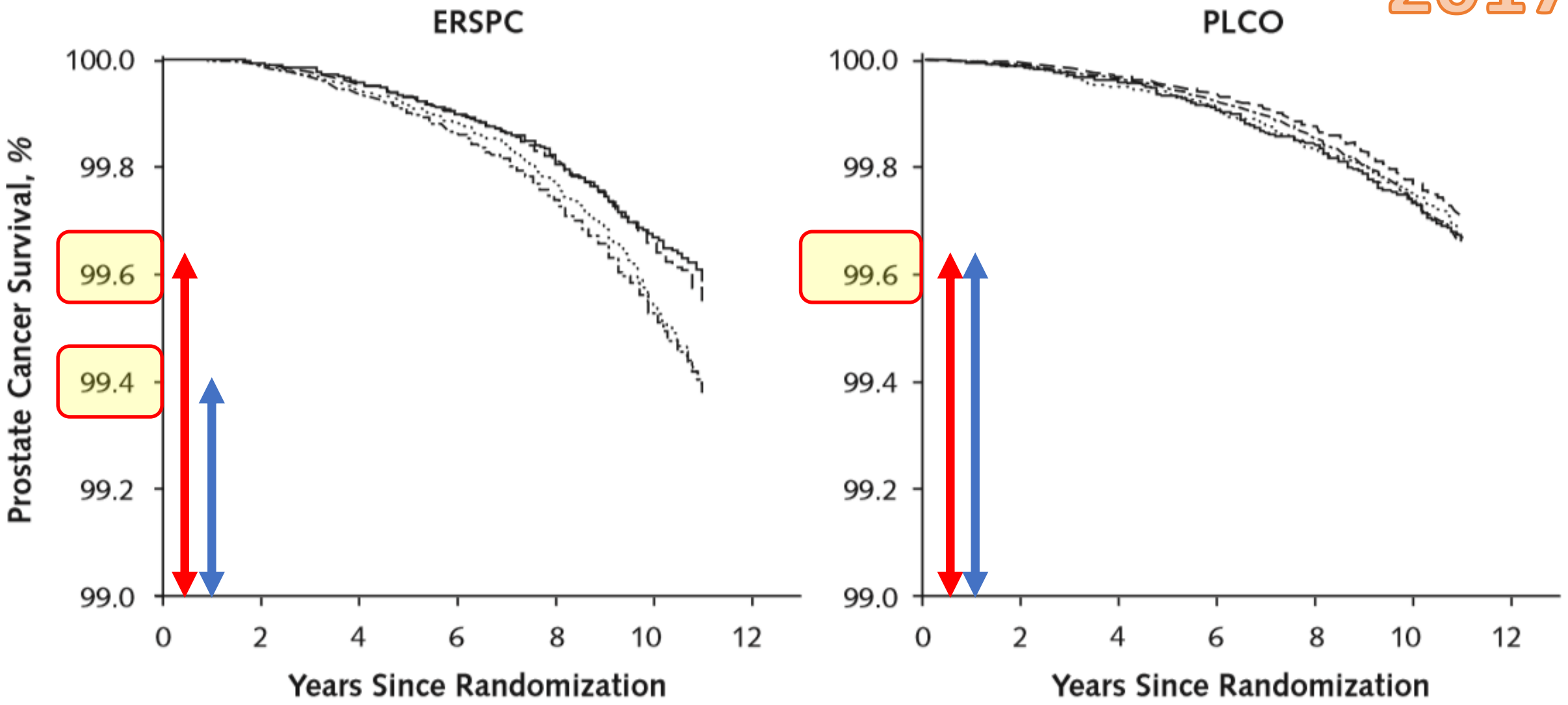


Dépister très largement pour un bénéfice très modeste.

MAI 2018

Screening for Prostate Cancer
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

Message 1. ***Le dépistage du cancer de la prostate par le recours au PSA apporte potentiellement un bénéfice modeste en terme de réduction de la mortalité par cancer de la prostate chez quelques hommes.***

MAI 2018

Screening for Prostate Cancer
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

Message 1. ***Le dépistage du cancer de la prostate par le recours au PSA apporte potentiellement un bénéfice modeste en terme de réduction de la mortalité par cancer de la prostate chez quelques hommes.***

Message 2. ***Beaucoup d'hommes vont être exposés aux effets adverses du dépistage,***

. avec des faux positifs qui vont nécessiter de répéter les tests ou de faire des biopsies prostatiques,

. avec des phénomènes de surdiagnostic et de surtraitement,

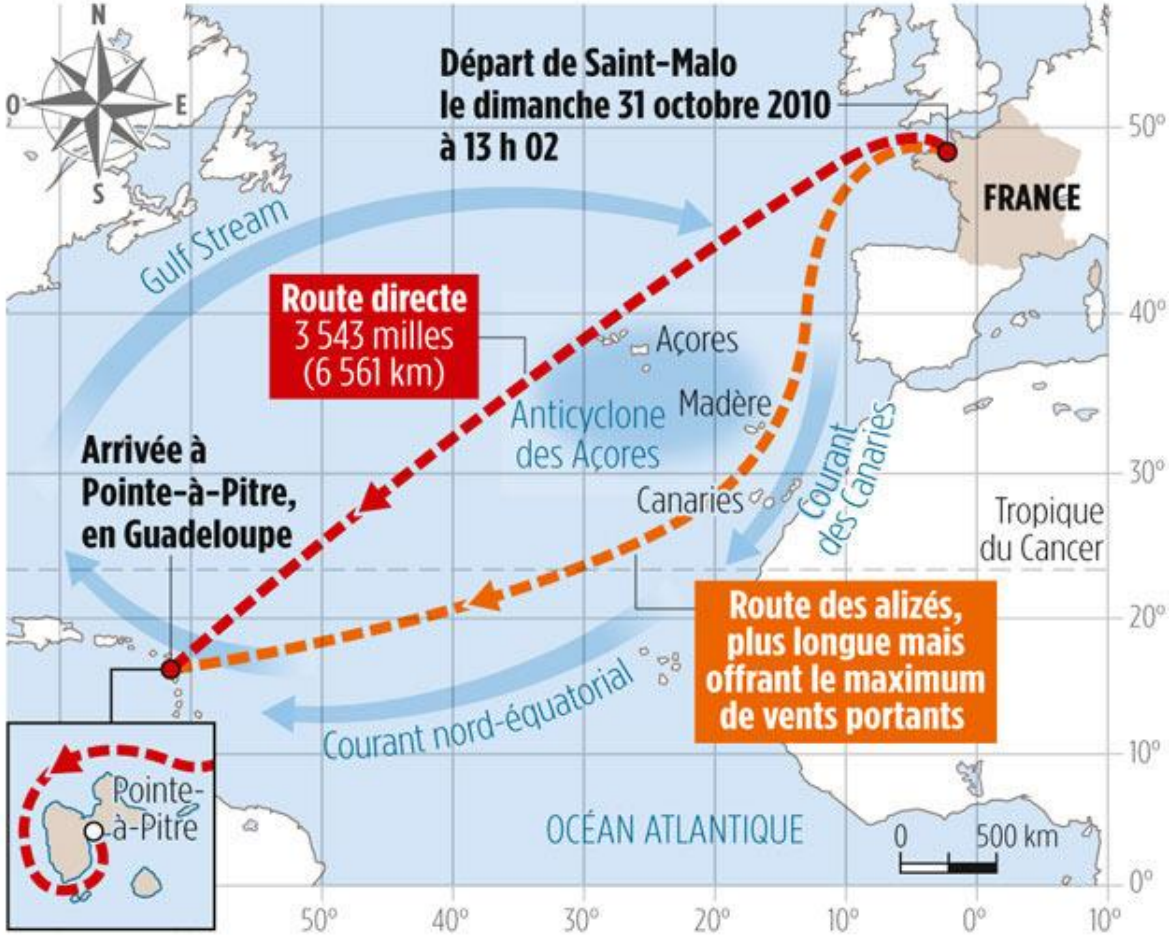
. avec des complications du traitement comme l'incontinence et les troubles de l'érection.

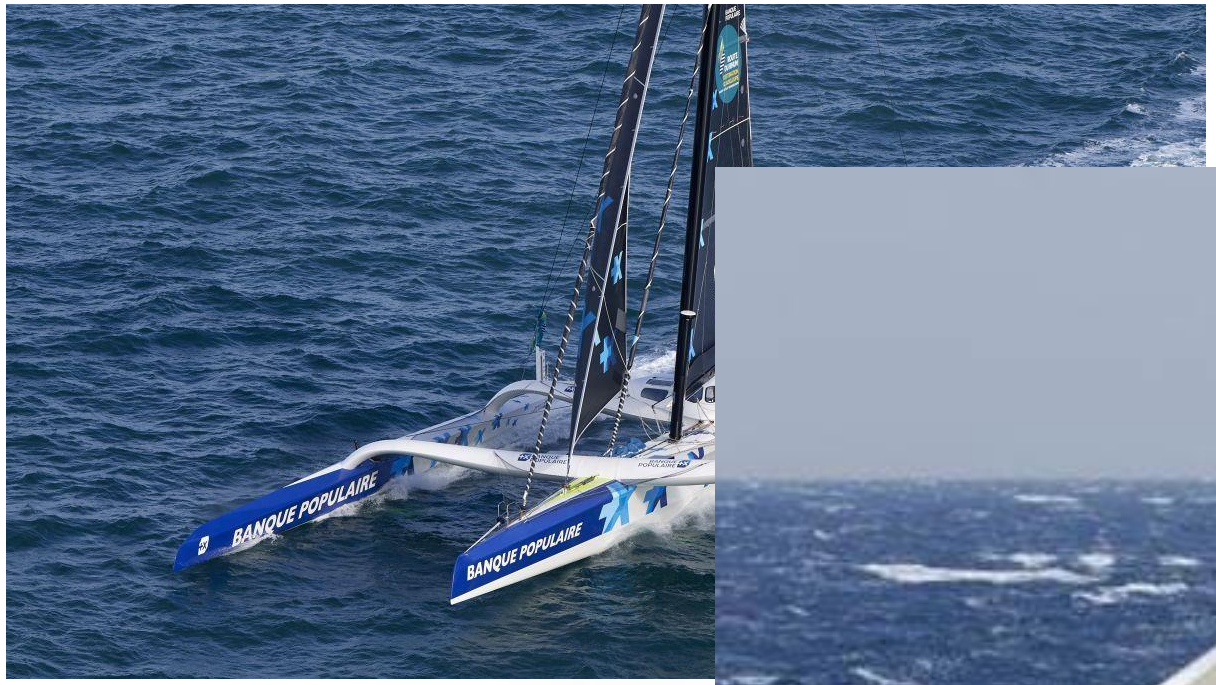
Evaluation de la balance B / R : quelle autonomie ?

Docteur, je veux faire la route du rhum

Le parcours de la Route du Rhum

En 2006, Lionel Lemonchois a battu le record de vitesse de l'épreuve en 7 jours, 17 heures, 19 minutes et 6 secondes.




BANQUE POPULAIRE
BANQUE POPULAIRE


BANQUE POPULAIRE


ECHEVIN

Traiter ?

Revue de littérature. Attitude interventionnelle ou surveillance. (Fenton et al. JAMA 2018)

Source	Study Design (Quality)[b]	No. of Participants		Prostate Cancer Mortality Deaths, No. (%)			All-Cause Mortality Deaths, No. (%)		
		Intervention	Control	Intervention	Control	RR (95% CI)	Intervention	Control	RR (95% CI)
Radical Prostatectomy									
ProtecT,[58] 2016 (United Kingdom)	RCT (good)	553	545	5 (0.9)	8 (1.5)	0.63 (0.21-1.93)[c]	55 (9.9)	59 (10.8)	0.93 (0.65-1.35)[c]
SPCG-4,[59] 2014 (Sweden, Finland, Iceland)	RCT (good)	347	348	63 (17.7)	99 (28.7)	0.56 (0.41-0.77)	200 (56.1)	247 (68.9)	0.71 (0.59-0.86)
PIVOT,[9] 2017 (United States)	RCT (good)	364	367	27 (7.4)	42 (11.4)	0.65 (0.41-1.03)	223 (61.3)	245 (66.8)	0.92 (0.82-1.02)
Barocas et al,[11] 2017 (United States)	Cohort (good)	1523	429	1 (0.1)	0	NR	18 (1.3)	12 (2.9)	NR
Ladjevardi et al,[60] 2010 (Sweden)	Cohort (fair)	12 950	12 645	NR	NR	NR	NR	NR	0.36 (0.32-0.40)[c]
Schymura et al,[61] 2010 (United States)	Cohort (fair)	1310	614	NR	NR	NR	6.3[e]	24.5[e]	NR
Stattin et al,[62] 2010 (Sweden)	Cohort (fair)	3399	2021	56 (1.7)	58 (2.9)	0.49 (0.34-0.71)	286 (8.4)	413 (20.4)	0.49 (0.41-0.57)
Zhou et al,[63] 2009 (United States)	Cohort (fair)	936	2306	NR	NR	0.25 (0.13-0.48)[c]	NR	NR	0.32 (0.25-0.41)[c]
Albertsen et al,[64] 2007 (United States)	Cohort (fair)	802	114	64 (8.0)	18 (16.0)	0.29 (0.17-0.52)[c]	216 (27.0)	65 (57.0)	NR
Wong et al,[65] 2006 (United States)	Cohort (good)	13 292	12 608	NR	NR	NR	NR	NR	0.50 (0.47-0.53)

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Table 2. Prostate Cancer and All-Cause Mortality With Radical Prostatectomy or Radiation Therapy (Intervention) Compared With Conservative Management (Control) (Key Qu

Source	Study Design (Quality)[b]	No. of Participants		Prostate Cancer Mortality			All-Cause Mortality		
				Deaths, No. (%)			Deaths, No. (%)		
		Intervention	Control	Intervention	Control	RR (95% CI)	Intervention	Control	RR (95% CI)
Radiation Therapy									
ProtecT,[58] 2016 (United Kingdom)	RCT (good)	545	545	4 (0.7)	8 (1.5)	0.51 (0.15-1.69)[c]	55 (10.1)	59 (10.8)	0.94 (0.65-1.36)[c]
Barocas et al,[11] 2017 (United States)	Cohort (good)	598	429	2 (0.3)	0	NR	21 (3.9)	12 (2.9)	NR
Ladjevardi et al,[60] 2010 (Sweden)	Cohort (fair)	6308	12 645	NR	NR	NR	NR	NR	0.54 (0.49-0.59)[c]
Schymura et al,[61] 2010 (United States)	Cohort (fair)	1037	614	NR	NR	NR	14.0[e]	24.5[e]	NR
Stattin et al,[62] 2010 (Sweden)	Cohort (fair)	1429	2021	40 (2.8)	58 (2.9)	0.70 (0.45-1.09)	196 (13.7)	413 (20.4)	0.68 (0.57-0.82)
Zhou et al,[63] 2009 (United States)	Cohort (fair)	879	2306	NR	NR	0.66 (0.41-1.04)[c]	NR	NR	0.63 (0.53-0.75)[c]
Albertsen et al,[64] 2007 (United States)	Cohort (fair)	702	114	126 (18.0)	18 (16.0)	0.65[c]	393 (55.0)	65 (57.0)	0.83 (0.67-1.11)[c]
Wong et al,[65] 2006 (United States)	Cohort (good)	18 249	12 608	NR	NR	NR	NR	NR	0.81 (0.78-0.85)[c]

Hamdy FC et al. 10-year Outcomes after Monitoring, Surgery, or Radiotherapy

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La surveillance active est une alternative.

2016

Table 1. Prostate-Cancer Mortality, Incidence of Clinical Progression and Metastatic Disease, and All-Cause Mortality, According to Randomized Treatment Group.

Variable	Active Monitoring (N=545)	Surgery (N=553)	Radiotherapy (N=545)	P Value*
Prostate-cancer mortality				
Total person-yr in follow-up	5393	5422	5339	
No. of deaths due to prostate cancer†	8	5	4	
Prostate-cancer–specific survival — % (95% CI)†				
At 5 yr	99.4 (98.3–99.8)	100	100	
At 10 yr	98.8 (97.4–99.5)	99.0 (97.2–99.6)	99.6 (98.4–99.9)	
Prostate-cancer deaths per 1000 person-yr (95% CI)†	1.5 (0.7–3.0)	0.9 (0.4–2.2)	0.7 (0.3–2.0)	0.48

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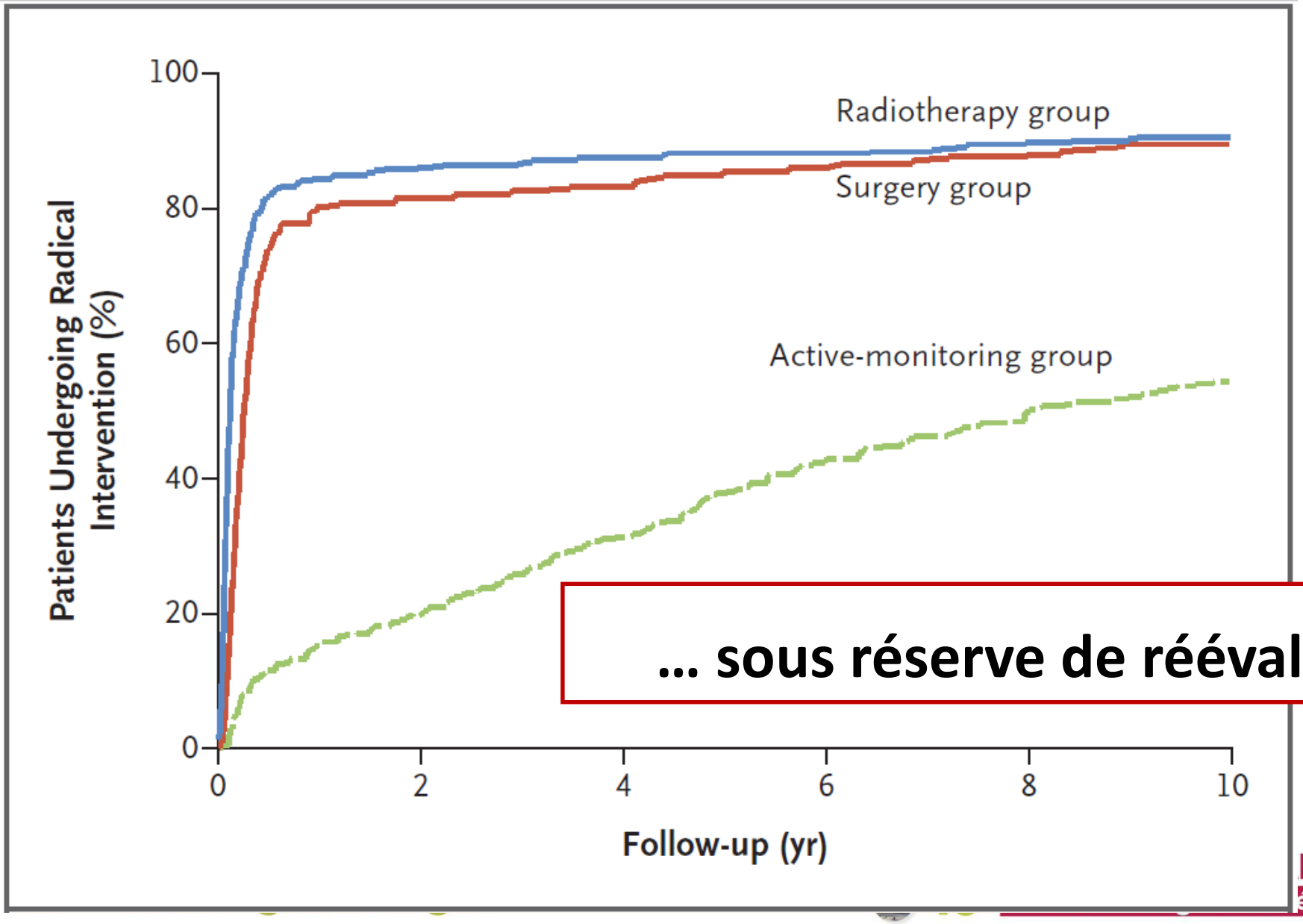
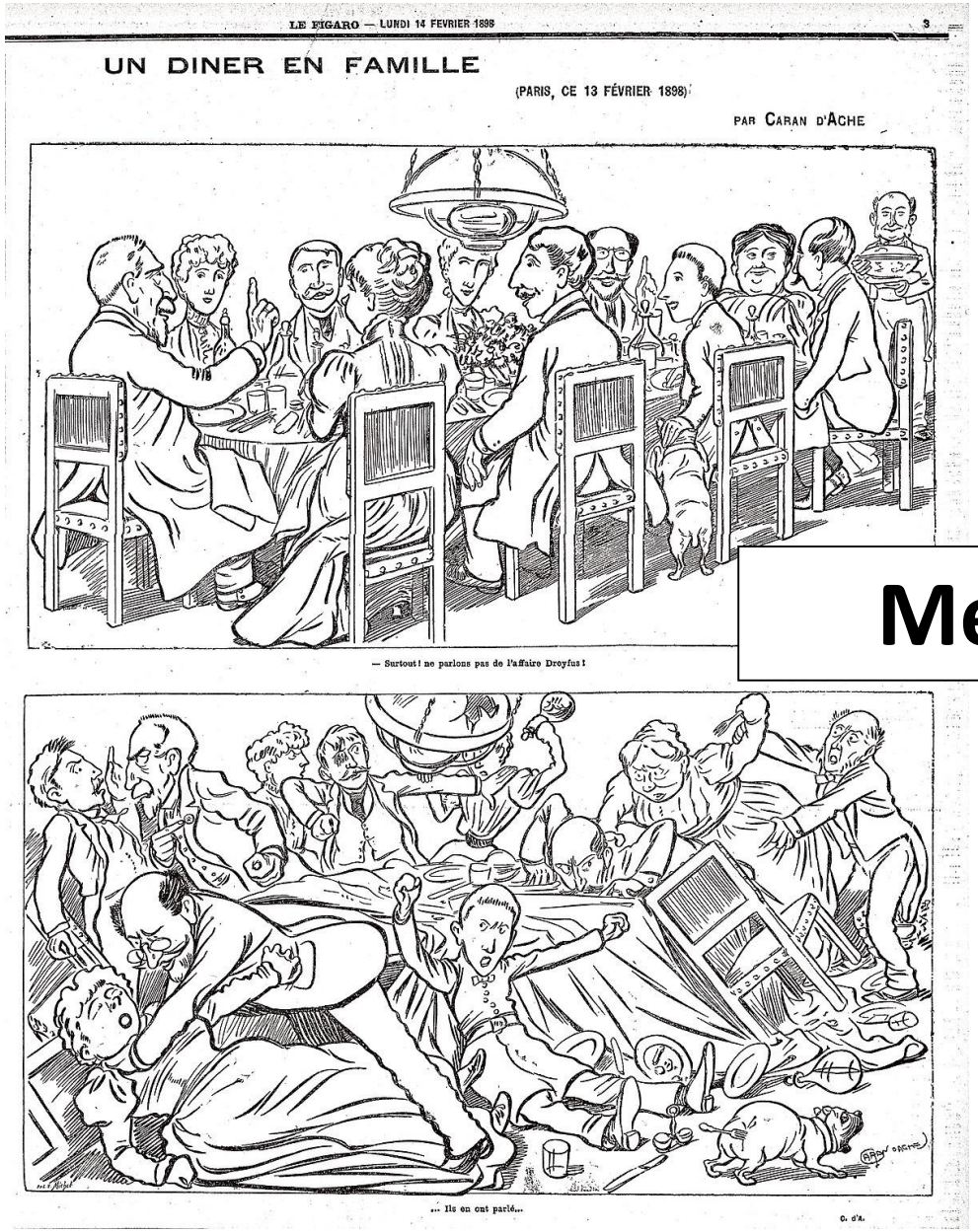
2016



… sous réserve de réévaluation.

Accepter de ne pas traiter.


LE FIGARO — LUNDI 14 FEVRIER 1898 3

UN DINER EN FAMILLE

(PARIS, CE 13 FÉVRIER 1898)

PAR CARAN D'ACHE

— Surtout ! ne parlons pas de l'affaire Dreyfus !

... Ils en ont parlé...

C. d'A.

Merci de votre attention.