The article by Powell highlights uncertainties about the relative contributions of diagnostic delay and tumor biology to racial disparities in stage at diagnosis among American men with prostate cancer, and explores a variety of factors that may discourage early cancer detection in African-American men. Observations derived from our ongoing prospective studies of prostate cancer diagnosis and treatment outcomes in black and white American veterans and from our experience with prostate cancer screening at the University of Mississippi Hospital and Clinics afford additional insights into these issues and provide a framework for this commentary.

Our investigation of race and prostate cancer diagnosis was initiated in January 1992 at the Veterans Affairs Medical Center, Jackson, Mississippi. This facility does not offer formal prostate cancer screening, and men with suspected cancer are identified in a hospital-based clinical practice. I stage the cancers, which are initially graded by staff pathologists. However, for the purpose of clinical research, the tumors are regraded in a blinded fashion by Dr. Steven A. Bigler, an experienced uropathologist.

As of July 1996, prostate cancer was diagnosed by biopsy in 343 blacks and 241 whites. Of the blacks and whites, 52% and 66%, respectively, had clinical stage T1c-2 cancer; 24% and 21%, respectively, had stage T3-4 cancer; and 24% and 12%, respectively, had metastatic cancer.

**Important Racial Differences in Pathogenesis**

A preliminary analysis of the relationship between age and Gleason score suggests important racial differences in the pathogenesis of prostate cancer, and underscores the critical need for continued investigation of variables that may predispose black men to a more malignant phenotype. Overall, 3% and 11% of the blacks and whites, respectively, had Gleason 2 to 4 tumors; Gleason 5 to 7 tumors were found in 51% and 61% of blacks and whites, respectively, and Gleason 8 to 10 tumors in 45% and 28%, respectively (P less than .0001). The unadjusted incidence of Gleason 7 to 10 tumors, which have well-documented metastatic potential and predominate in men with locally advanced and metastatic disease, was significantly higher in blacks than in whites (relative risk, 2.16; 95% confidence interval, 1.54 to 3.04), as was the age-adjusted incidence of these high-grade tumors (relative risk 2.12; 95% confidence interval, 1.50 to 2.99).

Of blacks and whites in our series with clinical stage T1c-2 cancer, 49% and 32%, respectively, had Gleason 7 to 10 lesions (P = .003). The age-adjusted incidence of Gleason 7 to 10 tumors was also higher in blacks than in whites (relative risk, 1.86; 95% confidence interval, 1.18 to 2.91). However, the crude and age-adjusted incidences of Gleason 7 to 10 tumors in blacks and whites with stage T3-4 or metastatic cancer were equivalent.

These findings suggest that the multiple malignant events that are believed to lead to biologically aggressive cancer and that are manifested by histologic dedifferentiation are more pronounced or occur more rapidly in blacks than in whites. They further suggest that the window of opportunity for detection of high-grade but potentially curable cancer may be narrower in blacks than in whites.

**Racial Disparity in Incidence of Distant Metastasis**

Public and professional interest in prostate cancer diagnosis has led to a remarkable migration in stage at diagnosis in American men, but developing evidence suggests a persistent racial disparity in the incidence of distant disease. For example, in the Detroit metropolitan area between 1990 and 1994, there was an abrupt increase in the detection of localized cancer and a 50% decline in the
incidence of metastatic cancer in men of both races.[1] However, throughout this period, the age-adjusted incidence of metastatic cancer was about three times higher in blacks than in whites. Although the trend for more aggressive cancer in blacks undoubtedly contributed to this phenomenon, wide racial differences in the utilization of health-care services may also have played a role. Thus, there is every reason to believe that prostate cancer screening programs that target African-American men will produce a further decline in distant disease at diagnosis.

**Role of the Church in Promoting the Value of Screening**

Powell has been remarkably successful in recruiting black men for prostate cancer screening, but his achievements are not representative of the national experience. He suggests that the church can have a pivotal role in promoting interest in early cancer detection, and our experience with prostate cancer screening supports the value of this recruitment strategy. We have conducted prostate cancer screening with a free digital rectal examination and prostate-specific antigen (PSA) blood test every year since 1992. The event is publicized in the newspapers and on local television and radio stations, and particular emphasis is placed on the potential benefits of screening African-American men between the ages of 40 and 60 years.

In 1995 and 1996, we sent letters to the ministers of predominantly black congregations in the greater Jackson area to ask if they would announce the program in sermons or church newsletters. We also sent a large number of informational flyers for distribution to these congregations. In 1992, 1993, and 1994, a total of 2,850 men participated in the screening program, but only 18% were black. However, in 1995 and 1996, when screening was publicized in African-American churches, 28% of 3,274 participants were black.

Finally, Powell acknowledges that the societal benefits of prostate cancer screening are unproven and controversial. Indeed, critics of screening argue that overdetection of early-stage cancer will ultimately cause more harm than good, and these individuals may interpret the data from Detroit as evidence that screening black men for prostate cancer is counterproductive. However, our experience with Gleason 7 to 10 cancers in blacks and whites with localized tumors, and the possibility that malignant alterations may be accelerated in blacks with more differentiated cancers at diagnosis, imply that this consideration is less compelling in African-American men. For this reason, and because radiation or hormonal therapy undoubtedly delays the development of debilitating metastatic disease and improves the cause-specific survival in men with locally advanced cancer, physicians who are responsible for the well-being of black men should encourage yearly PSA testing beginning at the age of 40 years.

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