

D. Robert Siemens,
MD, FRCSC

Cite as: *Can Urol Assoc J* 2012;6(5):349. <http://dx.doi.org/10.5489/cuaj.12268>

It is that time of year again when men around the world will begin to sport a moustache (with many of their significant others patiently showing solidarity) in support for men's health issues and, more specifically, prostate cancer. The Movember campaign is an enigma that has blossomed over the decade; last year it raised 41 million dollars in Canada. Through its word-of-mouth campaign, backstopped by viral social media exposure, Movember has quickly become one of the most effective forces in prostate cancer advocacy, demonstrating a public voice that many of our professional organizations have difficulty achieving. The subsequent fundraising has facilitated infrastructure development and substantial research funding with a global perspective.¹

Over a similar period, there has been a shift in our understanding of prostate cancer biology and even its definition, with significant downstream implications on diagnosis and treatment paradigms. The substantial focus on technology adoption and comparative efficacy of treatments for localized disease is a fascinating foil to the outcomes of the large randomized trials that have informed us on the potential harms of PSA screening and over-treatment of low-risk disease. This has culminated in the USPSTF recommendation on PSA screening earlier this year and fueled scrutiny and, arguably, healthy debate on the management of prostate cancer in most advanced nations. Leung and colleagues highlights yet another concern central to this conversation – the ability of clinicians to effectively identify men with sufficient life expectancy to benefit from the early diagnosis and intervention.² These results are perhaps not surprising in the face of previous reports suggesting that almost 10% of men treated in Ontario die of other causes within 10 years of definitive treatment of their disease.³

The “layers of uncertainty”⁴ that have resulted from this knowledge gap have complicated our ability to communicate and support our patients, especially those who are considering PSA testing or contemplating their preferred management for localized disease. This underscores the need to re-double our efforts to create, study and implement effective health communication for the benefit of men and their families, and not lose site of some of the gains realized over the years. This is no less true for those men with advancing disease given the complexity arising from the multiplicity of new and emerging therapies for castration resistant prostate cancer.

Prostate Cancer Canada, funded by the Movember Foundation, has announced the establishment of “A Survivorship Action Partnership” (ASAP), a multidisciplinary collaborative network that draws on healthcare professionals from various settings to help improve the lives of prostate cancer survivors, their partners and family members across Canada. ASAP aims to create strategies that will positively impact clinical practice and create supportive environments to increase self-management and improve the quality of life of men facing a diagnosis of prostate cancer. Undoubtedly this will require up-to-date, comprehensive and widely applicable solutions to effective health communication and informed treatment decision-making. This is perhaps a tall order given the rapidly changing landscape that is prostate cancer, but such endeavors do need to be lauded.

References

1. Jeffcott M, Cagiannos I, Zorn KC. Movember update: The Canadian perspective. *Can Urol Assoc J* 2012;6: E111-E114. <http://dx.doi.org/10.5489/cuaj.12037>
2. Leung KMYB, Hopman WM, Kawakami J. Challenging the 10-year rule: The accuracy of patient life expectancy predictions by physicians in relation to prostate cancer management. *Can Urol Assoc J* 2012;6: 367-73. <http://dx.doi.org/10.5489/cuaj.11161>
3. Groome PA, Rohland SL, Siemens DR, et al. Assessing the impact of comorbid illnesses on death within 10 years in prostate cancer treatment candidates. *Cancer* 2011;117:3943-52. <http://dx.doi.org/10.1002/cncr.25984>
4. Brett AS, Ablin RJ. Prostate-Cancer Screening — What the U.S. Preventive Services Task Force Left Out. *N Engl J Med* 2011;365:1949-51. <http://dx.doi.org/10.1056/NEJMp1112191>