that each of the 257 million opioid prescriptions dispensed in the United States annually contributes on average to more than 2 days of PYNMU. Coupled with continued increases in opioid pain reliever morbidity and mortality, these findings underscore the need for concerted public health and public safety action to prevent nonmedical use of these drugs. Interventions should focus on populations at greatest risk for chronic nonmedical use: men and persons aged 18 to 49 years.

Christopher M. Jones, PharmD, MPH

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Author Affiliation: Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia.

Correspondence: Dr Jones, Centers for Disease Control and Prevention, Chamblee Campus, 4770 Buford Hwy NE, MS F-62, Atlanta, GA 30341 (fjr0@c.d.c.gov).

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LESS IS MORE

Declines in Prostate Cancer Incidence After Changes in Screening Recommendations

On August 5, 2008, the US Preventive Services Task Force (USPSTF) recommended against screening men 75 years or older for prostate cancer.1 For men younger than 75 years, the USPSTF maintained its previous recommendation: “...the evidence is insufficient to recommend for or against routine screening for prostate cancer. ... (although this recommendation was changed to “do not screen” younger men in the 2011 guidelines). This study evaluates trends in prostate cancer incidence following the release of the 2008 USPSTF recommendation. If the revised recommendation led to a decline in prostate cancer screening rates, there should be a corresponding decline in the incidence of early-stage tumors among men 75 and older relative to trends in the incidence of late-stage tumors and early-stage tumors in younger men.

Methods. I measured trends in prostate cancer incidence rates by age group using the Surveillance, Epidemiology and End Results (SEER) 18 registry data, covering 28% of the US population. The SEER registries collect information on all newly diagnosed cancer cases in their respective catchment areas.

Prostate tumors were identified using International Classification of Diseases for Oncology version 3 code 619. I classified cases by stage at diagnosis using the derived American Joint Committee on Cancer summary stage variable: early (T1 or T2), late (T3 or T4), or unknown. I grouped patients into 3 age categories (30-64 years, 65-74 years, and 75 years and older). I calculated incidence rates per 100,000 persons, standardized within age categories by age (in 5-year age groups), race (white, black, American Indian, or other), and ethnicity (Hispanic or not Hispanic) to the 2009 population. I used an unpaired t test for proportions to assess the significance of differences in rates between years. The data were analyzed in Stata version 11 (StataCorp) statistical software.

Results. The data included 254,184 prostate cancer cases. There were 198,417 early-stage cases, 34,695 late-stage cases, and 21,072 cases of unknown stage. There were 109,053 cases (all stages) among men aged 30 to 64 years, 91,868 cases among men aged 65 to 74 years, and 53,263 cases among men 75 years and older.

The Figure displays the age and race/ethnicity-adjusted incidence rates of early-stage tumors among men aged 65 to 74 years (the upper line) and 75 years and older (the lower line). The trend lines generally mirror each other, but there is a sudden decrease in the incidence of early-stage tumors among men 75 and older after the release of the revised USPSTF recommendation.
Between 2007 and 2009, the adjusted incidence rate for early-stage tumors among men 75 years and older decreased from 443 to 330 per 100,000 (−25.4%; *P* < .001). The absolute number of cases declined from 8137 to 6162. The incidence of late-stage tumors decreased from 83 to 71 (−14.3%; *P* < .001), and the incidence of tumors with unknown stage decreased from 124 to 103 (−16.8%; *P* < .001). The incidence of early-stage tumors among men aged 65 to 74 years decreased from 697 to 591 (−15.2%; *P* < .001). The incidence of early-stage tumors among men aged 30 to 64 years decreased from 105 to 93 (−11%; *P* < .001). Incidence trends for all age and stage groups are given in the eTable (http://www.archinternmed.com).

Comment. There was an immediate decline in the incidence of early-stage prostate cancer tumors among men 75 years and older after the USPSTF recommended against screening this group. The magnitude of the decline was larger than the secular decline in the incidence rate for other stage and age groups. The results are consistent with the hypothesis that the revision of the USPSTF recommendations led to a small to moderate decline in prostate cancer screening rates. Many men 75 years and older may continue to receive screening tests. Some of the decline in the incidence of late-stage tumors may be attributable to decreases in screening via digital rectal examinations.

Prasad et al² reported that there was no change in self-reported prostate-specific antigen (PSA) screening rates between the 2005 and 2010 National Health Interview Surveys. Self-reported PSA testing measures have poor sensitivity and specificity.³,⁴ Small physician surveys indicate that 20% to 30% of physicians do not always discuss PSA screening with patients prior to ordering tests.⁵,⁶ Physicians who discontinued prostate cancer screening for all men 75 years and older may not have discussed the decision with patients. A snapshot of self-reported PSA testing rates may lack sensitivity to detect small to moderate changes in screening patterns. Based on trends in prostate cancer incidence rates, the impact of the revised USPSTF recommendation on screening rates merits further investigation.

David H. Howard, PhD

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Author Affiliation: Department of Health Policy and Management, Emory University, Atlanta, Georgia.

Correspondence: Dr Howard, Department of Health Policy and Management, Emory University, 1518 Clifton Rd NE, Atlanta, GA 30303 (david.howard@emory.edu).

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EDITOR’S NOTE

Time to Stop Screening for Prostate Cancer

O

ver the last decade, the evidence that screening for prostate cancer causes more harm than good has grown so much that the US Preventive Services Task Force recommended in 2008 against screening for prostate cancer in men 75 years or older, and more recently, recommended against screening men of any age. The data in the Research Letter by Howard suggest that many physicians agree with the recommendation not to screen older men. Given that the harms of screening (eg, false-positive results, increased worry, treatment-related morbidities such as incontinence and erectile dysfunction) outweigh the benefits for younger men, we hope to see a similar decrease in early prostate cancer incidence in young men.

Mitchell H. Katz, MD

COMMENTS AND OPINIONS

Advance Care Planning of the Acutely Unwell Patient

I

n a recent article, Stelfox et al¹ make an important observation that when less intensive care unit (ICU) beds are available, the decisions to change patients’ goals of care to a more conservative approach increases. This appears to be a response to the lack of ICU facilities rather than an active decision. When it is deemed unlikely to avert death, and death is imminent, our duty to provide patients with supportive care is no less important than our duty to save lives. Advance care planning and any decision to palliate should not be viewed as an option arising from the lack of resources. This requires adequate recognition and training.

The 2009 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reported that approximately half of all deaths occurring within 96 hours of admission to United Kingdom (UK) hospitals occurred in patients for whom survival was deemed unlikely. A do-not-attempt-resuscitation order was lacking in almost a