patients relating to their use. In addition, including CAM physicians in groups such as accountable care organizations can improve communication between physicians and streamline patient records. Clinical and organizational incentives that encourage patient disclosure of CAM use may facilitate better coordination of care, reduce the risk of adverse interactions between conventional medications and CAM products, and lead to better patient outcomes.

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Differences in Prostate-Specific Antigen Testing Among Urologists and Primary Care Physicians Following the 2012 USPSTF Recommendations

The use of prostate-specific antigen (PSA) testing for early detection of prostate cancer remains controversial.1 In October 2011, the US Preventive Services Task Force (USPSTF) issued a recommendation against PSA screening for all men.2 This change was associated with a decline in rates of PSA testing among men aged 50 to 74 years and a decline in cases of incident prostate cancer.3 4 Given the evidence for heterogeneity in screening practices,5 we sought to compare the use of PSA testing among urologists vs primary care physicians (PCPs) before and after the latest USPSTF guidelines, hypothesizing that the adoption of these recommendations would vary according to physician specialty.

Methods | We used the National Ambulatory Medical Care Survey to examine the use of PSA testing in 2010 (conducted between December 28, 2009, and December 26, 2010) and 2012 (conducted between December 28, 2011, and December 26, 2012). The National Ambulatory Medical Care Survey is an annual, nationally representative survey of ambulatory care in the United States that collects information about outpatient physician visits, patient demographics, diagnoses, medications, and indications for consultation. Specialty of healthcare professionals was dichotomized as urologist and PCP (general and family practice and internal medicine). We examined the frequency of PSA testing according to specialty and year to evaluate the association between the 2012 USPSTF recommendations and changes in PSA testing among men aged 50 to 74 years. Heterogeneity in testing practices between physicians was modeled by assessing the interaction term of physician specialty × survey year within a logistic regression model estimating probability of PSA testing. Results were weighted to reflect the US population based on the complex survey design. A 2-tailed level of significance was set at P < .05. The Brigham and Women’s Hospital Institutional Review Board waived approval for the study. Data analysis was conducted from July 21 to November 16, 2015.

Results | We included all visits for men aged 50 to 74 years (n = 1222) who presented to urologists (113 [9.2%]) or PCPs (1109 [90.8%]) for a preventive care visit. Men with a diagnosis of prostate cancer (n = 18), elevated PSA level (n = 1), benign prostatic hyperplasia (n = 31), prostatitis (n = 5), or other unspecified disorders of the prostate (n = 3) were excluded. This exclusion resulted in a weighted sample of 27 million eligible visits (unweighted n = 1164) in 2010 and 2012, of which 800 000 (unweighted n = 64) were provided by urologists and 26.2 million (unweighted n = 1100) by PCPs. The use of PSA testing decreased...
from 36.5% to 16.4% among PCP visits (adjusted odds ratio, 0.44; 95% CI, 0.24-0.80), whereas it decreased from 38.7% to 34.5% among urologist visits (adjusted odds ratio, 0.60; 95% CI, 0.19-1.84). The difference between physician-specific testing practices during the study years was not statistically significant ($P = .63$) (Figure).

Discussion | Despite the nonsignificance of the interaction analysis, likely the result of a small sample size, the contrasting temporal trends of PSA testing suggest a differential effect of the 2012 USPSTF recommendations on PSA testing among PCPs vs urologists. Our observations may reflect opposing perceptions among physicians on the benefit of PSA screening, conflicting guidelines (eg, the American Urological Association recommends joint decision making for men aged 55-69 years), and perhaps differences in patient demographics or expectations. Moving forward, this finding emphasizes the need to continue interdisciplinary dialogue to achieve a broader consensus on prostate cancer screening.

Certain limitations to our study must be considered. As our study relied on records of outpatient clinic visits, our findings may differ from those of other studies using self-reports of PSA testing. Second, we do not account for PSA testing outside of physician outpatient visits. Third, our findings reflect orders for PSA testing, which may differ from actual testing performed. Owing to the lack of numeric PSA values, we could not account for the definition of elevated PSA levels. Fourth, we are not able to account for PSA testing performed on a separate visit (including those by another type of physician). Finally, our findings are based on a sample of incident visits rather than a longitudinal follow-up over time.

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Correction: This article was corrected on August 15, 2016, to fix an error in reported odds ratios.

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Editor’s Note
Use of Prostate-Specific Antigen Testing Is in the Eye of the Beholder

The use of prostate-specific antigen (PSA) screening for prostate cancer is controversial. Various organizations have released conflicting messages regarding the use of the PSA