In Reply: I appreciate the time and effort taken by Zhang and Jenkins and Kurator and Jenkins in reading and responding to my article "Prostate cancer screening and the role of PSA: a UK perspective." As the final clause of this title states, my perspective is from the United Kingdom.

Kurator and Jenkins state that I falsely claim a mortality benefit. My article does not claim that PSA screening confers an overall mortality benefit, but there is clear evidence from randomised trials of a disease-specific benefit for PSA screening, which I discuss. The authors go on to state that screening causes more harm than benefit, but this is their personal judgment, not a fact. It is true that prostate cancer screening leads to the diagnosis of more insignificant tumors that would otherwise have gone undetected without screening. It is also true that treatment of these insignificant tumors causes harm and thus must be avoided. But it is not true that detection of these tumors must lead to overtreatment.

In the United Kingdom, we have centralised cancer care services and developed cancer multidisciplinary teams such that management decisions regarding insignificant and low-risk tumors are made in consensus with urologists, oncologists, nurse specialists, and others. In the United Kingdom, the rate of surgery for low-risk prostate cancer is 4%, whereas it is around 25% in the United States. Hence, diagnosing prostate cancers early in the United Kingdom does not necessarily lead to "overtreatment" with its consequent harms.

We also know that PSA screening reduces deaths from prostate cancer. If we can reduce the risk of overtreatment, as we have done in the United Kingdom, the argument in favour of screening becomes much stronger. Without screening, the number of men presenting with metastatic (incurable) prostate cancer rises sharply. The use of PSA has vastly decreased these numbers, and therefore the advent of PSA screening and ad hoc testing is responsible for saving lives.

Zhang and Jenkins in their letter state that I did not reference my "claim" that transperineal prostate biopsies curtail antibiotic resistance. I apologise for this; there are simply too many references to choose from. Sticking needles up men's rectums produces more infection than using needles that do not traverse fecal matter. Multiple studies have shown the lower infection rate with transperineal over transrectal biopsy, and again the former is advocated in specialist UK prostate cancer diagnostic practice. Clearly, having less infection means less antibiotics, which means less antibiotic resistance.

The use of multiparametric magnetic resonance imaging (MRI) before biopsy is also ubiquitous in the United Kingdom, and this strategy further improves diagnostic performance. PSA, MRI, and transperineal biopsies have revolutionized UK prostate cancer practice, with improved cancer detection of significant tumors, decreased detection of insignificant disease (due to targeted/fusion biopsies directed by prebiopsy MRI), and lower morbidity.

Improved diagnosis of significant prostate tumors with reduced morbidity, avoidance of treating insignificant cancers, and fewer deaths from prostate cancer are reasons I continue to advocate for PSA screening. Perhaps once the United States adopts prebiopsy MRI, advanced biopsy techniques, and centralisation of cancer care such that appropriate management decisions are made for patients based on need rather than financial incentives, the case for PSA screening will become more apparent to my American colleagues.

Prasanna Sooriakumaran, MD, PhD, FRCSUrol, FEBU
Cleveland Clinic London, UK

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