

Put That Finger Down! The End of the Screening Rectal Exam - Frankly Speaking EP 73

Transcript Details

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Dr. Frank Domino:

AC and DA are two providers in your office, and they're talking over lunch about new data showing that doing a rectal exam as a screening test is not beneficial. AC asks, "What am I supposed to do? Just tell patients they don't need one now? Won't they want it?" DA responds, "So what happens, if they ultimately go on to get prostate cancer? Will I be liable for missing this diagnosis?" Hello, this is Frank Domino, and welcome to Frankly Speaking on Family Medicine. Joining me today is Susan Feeney, Assistant Professor at the University of Massachusetts Medical School Graduate School of Nursing, Coordinator of the Family Nurse Practitioner Program. Welcome to the show, Susan.

Susan Feeney:

Thanks, Frank.

Dr. Domino:

So we're talking about prostate cancer screening, and more importantly, about rectal exams.

Susan Feeney:

There's been so much information lately, and a lot of it is very confusing, for not just our patients, but for us as providers. So why do we all learn to perform screening rectal exams in men?

Dr. Domino:

Well, certainly, in my training in medical school, we were taught that that was part of the physical exam, and that one of the best ways to ascertain both some stool material to test for blood, as well as to check the prostate, was to do a rectal exam on men. And gradually, over time that became, "Okay, only do it on men over the age of 50," because that's when the risk of both prostate cancer and colon cancer went up. But that was one of those assumptions we made. And it was never tested back then, but I'm curious, in the world of nurse practitioner education, what were you taught?

Susan Feeney:

Well, we're talking 20 years ago, but we also were taught that it was part of the exam, and we did rectal exam of both women and men, and for the same reason. In men, we actually, we were... I was taught to start at 40, as basically baseline information to get a baseline assessment of the prostate, and also to do an assessment of the rectal vault, and to look for fecal material, and just look for occult blood, and never really being told about what that information, how that might impact the patient.

Dr. Domino:

Yep. I think we both had very similar experiences.

Susan Feeney:

So, what does the new data tell us?

Dr. Domino:

Well, this was a very interesting study. This was a large meta-analysis. I think one of the goals in medicine right now, is to see if there is an evidence base for many of the things we do. And that was the goal of this study. They were able to find seven studies looking at 9,000 in men, who went ahead, and had both a digital rectal exam and a prostate biopsy, so we were certain whether they had prostate cancer or not. And they found that the sensitivity of doing a rectal exam, a digital rectal exam, was 50%, meaning that at least half of the time we had some finding on a rectal exam, it probably was insignificant. Certainly, with regards to cancer, the positive predictive value of a digital rectal exam is 40%. That means if you have an abnormal rectal exam, 40% of those people will actually have an abnormal prostate, and maybe some disease, but that means 60% do not.

Susan Feeney:

That's really amazing, but I don't find it surprising, do you?

Dr. Domino:

No, I don't. It's a very subjective test. We have varying degrees of sensitivity, and especially in the primary care world. Now, this study was done with a focus on primary care providers. It was not necessarily a urologist that spends 80% of their day evaluating prostates. And so I think the data showed that there's no benefit to doing this part of the exam as a screening test. And so I've been telling patients about this now for some time, and the vast majority of them respond with some degree of happiness, because they were kind of anticipating getting a rectal exam. And this is one less thing they probably have to be stressed about.

Susan Feeney:

So, what do we tell our male patients, as far as an ability to screen for prostate cancer?

Dr. Domino:

The US Preventive Services Task Force still gives prostate cancer screening a D recommendation, which means they recommend against. In 2017, they opened up a process to allow people to comment about whether they should change that D from, "Do not," to C, "Offer selectively based upon your experience and your patient preference." And I think after that process, they still have not had any conclusion that made them make that move from D to C. So the current recommendations are to not screen for prostate cancer. That being said, I still offer patients the options, and I let them know that screening and treating prostate cancer does not make you live longer. We have good 10-year data that shows it does not decrease mortality. Diagnosing and treating prostate cancer doesn't necessarily make you live longer. It does lower the risk of things like metastatic disease, but it increases the risk by a great degree in adverse outcomes like incontinence and impotence. And it can have an adverse effect insurance-wise, and so forth. It's considered one of the diseases that are commonly over-diagnosed and overtreated, and I give patients the option. If there's someone who's really anxious and wants to know everything about their health, sure. "Why don't we just obtain a PSA level on your next blood test?" But if they're okay with reporting to you any change in symptoms, and then testing, outcomes are just as good, if not better. What do you tell your patients?

Susan Feeney:

I do the same thing. It was easier back in the day, when things were very black and white, and we just tested everyone. But then again, we'd get these results and wind up chasing down rabbit holes, literally.

Dr. Domino:

Sure.

Susan Feeney:

But now, it means that we have to really need to engage our patients, talk to them about the data, in language that they understand, and make them part of the process. And I have found, actually, that most men are quite happy that they don't have to have the exam, and that they know the signs that they would need to tell us, or tell me about to be able to get the test.

Dr. Domino:

Yep, I think I find in my review of systems, I ask them about change in urinary frequency, dysuria, pain with urination, pain with defecation, any of those things. And I reassure them that if they have prostate cancer, and we find it, and treat it, that the outcomes are better. Interestingly, there was parallel data showing that doing bimanual exams in women and rectal-vaginal examinations in women as screening tests, there was no data set that found that to be beneficial. I haven't really found a discussion there yet, but I do think, as we're screening this for cervical cancer, we're gonna be doing less bimanual exams. And I have not done a screening rectal-vaginal exam in probably 20 years.

Susan Feeney:

Yeah, I haven't either, and I find that the bimanual exam though, especially for women post-menopausal, they're starting to, "Okay, I understand I don't need a pap every year, but why don't I... I should have my uterus and ovaries." And sometimes, I will tell them, "It's really a very difficult exam to do," but I offer it to them, if they want to, knowing that it's gonna give me a very low yield in most cases, if they're asymptomatic.

Dr. Domino:

Yeah, I do think what you said earlier was very important, that we make patients part of this discussion process, and I do think it's important to document that discussion in your notes. One of the big challenges people have about not doing rectal exams, is the worry about liability. And so I say, "Document that you've had this discussion offering the pros, and cons, and alternatives to screening, and making sure that the patient is aware." Will that protect you from being named in a lawsuit down the road? Probably not. Will it protect you from being found negligent or guilty of malpractice? Absolutely.

Susan Feeney:

And I think that also making sure we do the thorough review of systems, documenting that, and following up on any abnormal symptoms, that will be part of our defense as well.

Dr. Domino:

Sure.

Susan Feeney:

So, when do we do rectal exams? When would that be an appropriate thing to do?

Dr. Domino:

Sure. Well, I think that's still a really good question. I think we should do it when we have clinical symptoms that we have to evaluate. A patient comes in, a male coming in with change in urinary ability, or impotence, or dysuria, someone that you're concerned about might having a GI bleed, or someone who states they're having pain with defecation. I think a rectal exam is probably still indicated, but there it's a diagnostic procedure, rather than a screening test.

Susan Feeney:

Right. Well, I think this has been very helpful, in a topic that is very confusing for primary care providers and our patients.

Dr. Domino:

Yeah, and I hope that our patients find this to be as good news, as we as providers do.

Thanks, Susan.

Susan Feeney:

Thank you.

Dr. Domino:

Practice pointer: Have a good, informed consent discussion with your men about the need for prostate cancer screening, and in particular, the lack of data that supports doing a digital rectal exam, as part of that screening process. Join us next time, when we discuss a novel approach on treating uncomplicated urinary tract infections. And visit us at pri-med.com to stay current on many primary care topics.