

IV. PROSTATE CANCER

Prostate cancer was the most commonly diagnosed cancer in Greater Bay Area males in the years 1988 through 2018. From 2014 through 2018, NH Black males had the highest incidence rate (142.3 per 100,000 males) followed by NH White males (94.8 per 100,000), Hispanic males (80.3 per 100,000), and Asian/Pacific Islander males (55.4 per 100,000).

Prostate cancer incidence rates spiked in 1992 then steadily declined, a trend that has been attributed to the widespread adoption of prostate-specific antigen (PSA) screening (**Figure 12**) [16, 17]. However, as evidence that widespread screening did not improve survival among males older than 75 years of age, the U.S. Preventive Services Task Force recommended in 2008 against PSA-screening in this age group [18]. Furthermore, in 2012, the Task Force recommended against screening at all ages due to evidence that treatment for screening-detected prostate cancer resulted in more harm than benefit [19]. This recommendation and the associated decrease in screening, likely contributed to the national declines in prostate cancer diagnoses in recent years. In fact, in the Greater Bay Area, a significant decline in incidence occurred among males in all races/ethnicities between 1998 through 2018, at an average of -1.0% per year. However, it has recently been noted that after the decline of PSA screening, there has been an increase in late-stage disease at the national level [20-23]. The *most recent*

screening recommendation (May 2018) states that for men aged 55 to 69 years, the decision to undergo periodic PSA screening for prostate cancer should be an individual one, made with each patient's clinician, including a discussion of the potential harms and benefits of such screening [24]. Furthermore, clinical practice has shifted towards more conservative management for low risk prostate cancer through active surveillance or watchful waiting [25]. The implications of this shift in clinical practice on prostate cancer mortality is unclear; the GBACR will continue to closely monitor trends in prostate cancer mortality.

Prostate cancer mortality rates have steadily declined in males by an average of -2.2% per year from 1988 through 2018, and declines were seen across all racial/ethnic groups (**Figure 12**). Because most prostate cancers have a good prognosis even without treatment, the lifetime risk for dying of prostate cancer is very low (2.8%) [19]. From 2014 through 2018, the mortality rate was highest among NH Black males (40.2 per 100,000), whose rate was more than double the rates in NH White males (18.6 per 100,000) and Hispanic males (17.7 per 100,000), and almost five times the rate in Asian/Pacific Islander males (8.4 per 100,000). These rates were relatively similar or slightly lower than the mortality rates in California from 2014 through 2018.

Figure 12: Prostate Cancer Age-Adjusted Annual Incidence and Mortality Rates and Trends in the Greater Bay Area by Race/Ethnicity, 1988-2018

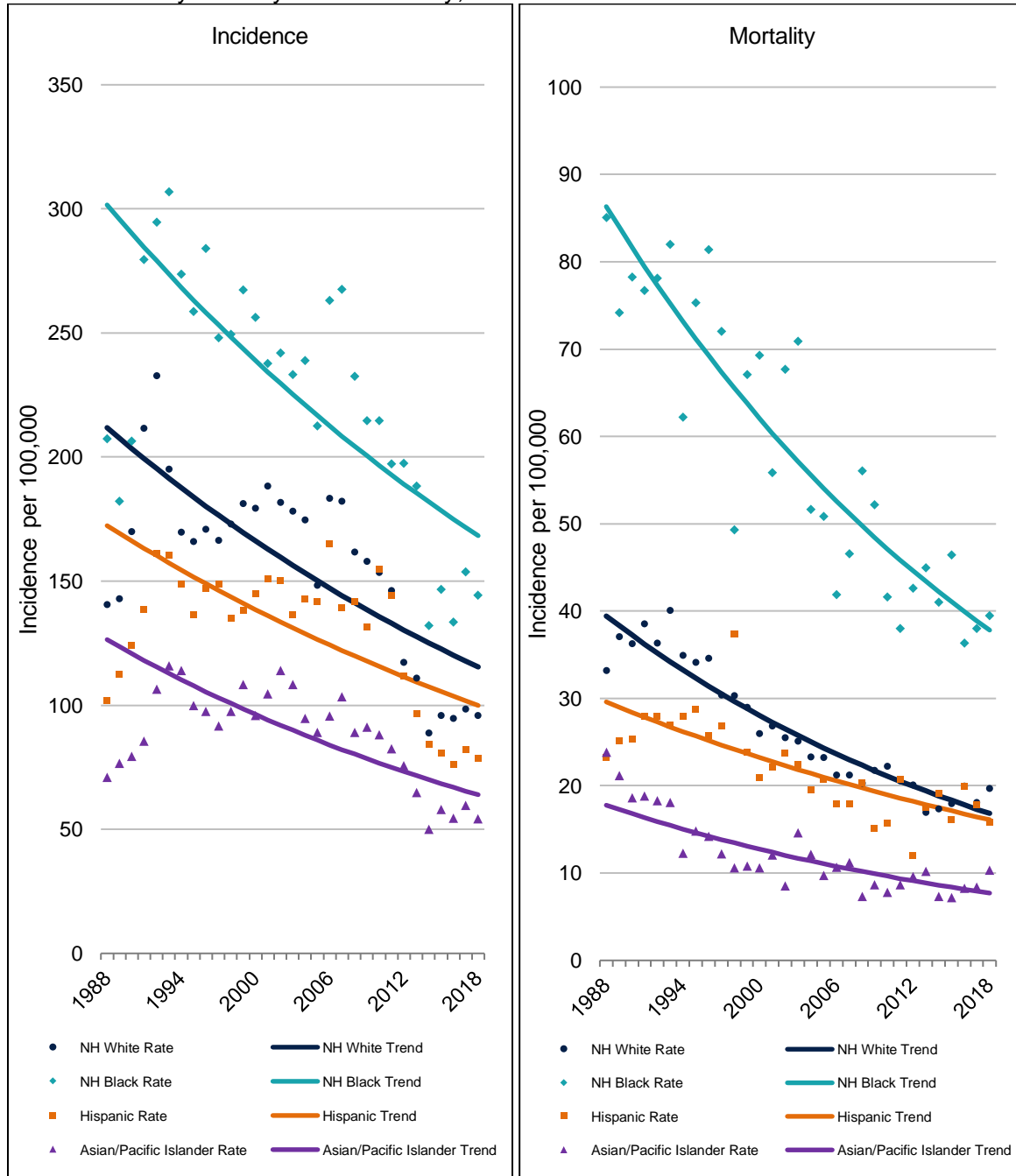


Table 4a and 4b: Prostate Cancer Age-Adjusted Incidence and Mortality Rates per 100,000 by Race/Ethnicity, and Region¹, 2014-2018

4a: Incidence

Race/Ethnicity	Greater Bay Area	California
All Racial/Ethnic Groups	90.2	93.2
NH White	94.8	94.6
NH Black	142.3	142.2
Hispanic	80.3	80.1
Asian/Pacific Islander	55.4	50.8

¹ The two regions represented include: (1) the Greater Bay Area (nine-county region) and (2) all of California (including the nine-county Greater Bay Area region).

4b: Mortality

Race/Ethnicity	Greater Bay Area	California
All Racial/Ethnic Groups	17.0	19.8
NH White	18.6	21.1
NH Black	40.2	42.7
Hispanic	17.7	17.5
Asian/Pacific Islander	8.4	9.7

¹ The two regions represented include: (1) the Greater Bay Area (nine-county region) and (2) all of California (including the nine-county Greater Bay Area region).