UNDERWRITING 201: PROSTATE CANCER
General Background

The prostate is a solid gland that surrounds the urethra at the base of the bladder in males. Prostate cancer is the most common type of non-skin cancer in males and is second only to lung cancer as the leading cause of death in American men. While the incidence of prostate cancer has increased dramatically over the past 5 to 10 years (*approximately 300,000 new cases per year*), this increase is probably because of better screening techniques.   Cancer of the prostate is usually very slow growing and it may take 10 to 15 years before a tumor can be detected by a physician during a digital exam.

THERE IS SOME GOOD NEWS: **If your client has an enlarged prostate without concern for cancer, or if he has successfully been treated for prostate cancer in the past, you can usually obtain life insurance at favorable rates.**

The presence of active prostate cancer, like any active cancer is always cause for alarm. However, the presence of a tumor in the prostate doesn't automatically make a person uninsurable. Survival and mortality rates correlate with both the *stage* and *grade* of the tumor. The higher the grade, the worse the prognosis (*tumors Grade 7 and higher have a poorer overall survival rate*).

THE STAGING OF TUMORS:

The staging of cancer refers to the extent of the tumor mass (size and/or spread). The most commonly used staging method is called TMN (T=tumor size, N=Regional lymph node spread, and M=any distant metastasis).

In the staging of prostate cancer, a number system is generally used. **Stage 1,** generally is undetected; **Stage 2**, can be felt in a digital exam and is confined to the prostate. At this level, the PSA levels can be elevated and the tumor could be in one lobe or both lobes.   **Stage 3,** is locally extended beyond capsules with or without invasion of the seminal vesicles. **Stage 4,** has shown distant spreading —into the pelvic lymph nodes, bones or distant organs. Any information gathered about staging using various scales is helpful in determining the severity of actual cancer.

Staging of tumors is done clinically by physical exam, imaging, ultrasound, bone scans, and tumor markers such as the **PSA test**. Pathological classification is much more accurate but usually involves the complete removal of the prostate gland and local lymph nodes for dissection. When the prostate is treated with non-surgical procedures (*radium seed implants, for example)* an exact pathology may not be able to be determined. In situations where surgery is not prescribed, it is normal for the doctors to do biopsies of the prostate to determine the staging and the grade.

From time to time, a person will have a very high PSA but no cancer is detected. Generally the first treatment in this case is with an anti-biotic to see if an infection might be the cause. Cases like this are hard to underwrite, but with biopsies supporting the case, we can usually get a good offer.

A large proportion of cancers detected by PSA screening may be **latent cancers**, indolent tumors that are <u>unlikely to produce clinical symptoms or affect survival</u>. Autopsy studies indicate that evidence of prostate cancer is present in about 30% of men over age 50. The reported prevalence of prostate cancer in men *without* previously known prostate cancer during their lifetimes is 10 to 42% at age 50-59, 17 to 38% at age 60- 69, 25 to 66% at age 70-79, and 18 to 100% at ages 80 and older. Because prostate cancer is slow-growing, it is sometimes not treated in older patients.

Gleason's Scores:

If a person has had prostate cancer, with successful treatment, two important factors will determine his rates for life insurance.

1) One factor is the <u>age at onset</u> of the cancer, with older ages being treated more favorably than younger ages.

2) The other important factor is the **Gleason's score**. The Gleason grading system uses samples obtained from a prostate biopsy. Together with other parameters, it is incorporated into a strategy of prostate cancer staging which predicts prognosis and helps guide therapy.

Using this system the most well-differentiated tumors have a Gleason score/grade of 2, and the least-differentiated tumors a score of 10. The range by definition is from 2 to 10, with architectural type being from 1 to 5 and always doubled or added together. Gleason scores are often grouped based on similar behavior: <u>Grade 2 to 4 </u>being well-differentiated neoplasm <u>Grade 5 to 6</u> intermediate-grade neoplasm <u>Grade 7</u> moderately - poorly differentiated grade neoplasm <u>Grade 8 to10</u> high-grade neoplasm.

Patients with lower scores are generally treated favorably and those with higher scores are more difficult to insure. A common Gleason score might be stated as a 3+3 with a total of 6. This would be considered a low score.

About PSA Readings:
The so-called "safe" ranges for PSA readings *(less than "4")* may not be that safe. A recent study suggests that men with PSA readings of 2.6 to 4.0 are 6 to 9 times more likely to get prostate cancer than men with PSA levels below 1.0. Another study found that men over 60 have more extensive disease than younger men with the same PSA levels. This means that older men may have a lesser chance of being cured once the prostate cancer is discovered. If your client has had prostate cancer, the PSA reading at the time of the diagnosis is important. Generally, PSA readings under 10 at the time of diagnosis can be treated more favorably, especially with a low Gleason's score.

Good News: the survival rates for men with localized prostate cancer (*confined to the gland itself*) and a low tumor grade appear to be excellent after surgical treatment. Patients in this classification generally have a 90% survival rate. (Low grade tumors are a tumor grade of 1 or perhaps 2)

An enlarged prostate gland without cancer can be underwritten at a Standard or even Preferred rate. This condition is called BPH (*Benign Prostatic Hypertrophy*).

WHAT DOES IT ALL MEAN – RATINGS WISE?

Very high PSA readings (*10 or above*) or labs tests which show the kidneys are starting to fail would be strong indicators of active prostate cancer (*probably as much as 95%*), and these cases could be declined for coverage. Some insurers will consider individuals with elevated PSA scores for life insurance if the PSA levels are between 4 and 10, but only if the client has had an evaluation from the doctor as to cause.

Some life insurance companies will look at "**free" PSA** compared to "total" PSA where the totals are in the 4 to 10 range. The theory is that the lower the "free" PSA number, the more likely cancer is present. **NOTE:** this use of "free PSA" is rather new and some of the medical data shows that the question of "free PSA" is not yet resolved and many underwriters won't treat low Free PSA as conclusive.

Underwriting Risk Classification

If your client just had their prostate removed, there are insurers who will consider him for coverage after only a few months from the date of the surgery - assuming he had good post-op studies, no metastasis or lymph node involvement, PSA readings below 10 and low Gleason's scores before removal, and current very low (*or zero*) PSA.

The rule of thumb on individuals who have had prostate cancer is that at some point they will probably get a standard rate with no flat extra charges. The key ingredient is the length of time from the treatment - the longer the better. However, start looking for coverage as soon as 2 years in most cases.

If the individual had the gland removed, that day will come sooner than it will for individuals who did not have the gland removed (*radiation seeding etc.*). BUT in time – with no re-occurrences of cancer and with a good PSA number they will be able to get life insurance.

Each case will be considered on an individual basis. **CLICK HERE** and get our prostate cancer questionnaire. Call your prospect and ask them the questions then email or fax (1-888-543-0886) the form to us.

Thank you for your business!

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1-800-543-0886