The study by Fletcher et al. sought to determine whether the reported racial differences in prostate cancer survival vary geographically within the United States. Using 17 geographic registries of the Surveillance, Epidemiology, and End Results (SEER) database from 2007 to 2014, they reported that black men had a higher risk of mortality overall, and in the stratified analysis, this finding was greatest among men with Gleason grade group 1 disease (defined as Gleason score \(<6\)) in the Atlanta, Georgia; Greater Georgia; Louisiana; and New Jersey SEER registries. The racial disparity in survival among men diagnosed with Gleason grade groups 2 through 5 (defined as Gleason score \(7-10\)) was of lower magnitude but still statistically significant in these same SEER registries. To place this study’s findings in context, I reviewed what is known or understood about nonbiological causes of racial disparity in prostate cancer mortality. Within the US, prostate cancer is consistently the most common noncutaneous cancer in men, accounting for 20% of cancers in men, and the second most common cause of cancer deaths in men, accounting for approximately 10% of cancer deaths in men. Compared with white men, black men consistently have a higher prostate cancer incidence, with approximately 31% of cancers among black men being prostate cancers, and mortality, with prostate cancer accounting for approximately 12% of the cancer deaths in black men. Similarly, black men have higher lifetime probability of developing prostate cancer than white men (1 in 6 vs 1 in 8) and of dying of prostate cancer (1 in 23 vs 1 in 42). Additionally, compared with white men, black men are less likely to receive definitive treatment (especially for high-risk disease), and when they do receive definitive treatment, black men are less likely to receive a radical prostatectomy. To add to this, when black men receive a radical prostatectomy, they are less likely than white men to receive a pelvic lymph node dissection, particularly when diagnosed with high-risk disease. It could be argued that the aforementioned reported findings account for a great deal of the disparity in prostate cancer mortality among black vs white men. Prior studies have shown that socioeconomic status (now commonly described as social determinants of health) and racial disparities in treatment can account for most, if not all, of the disparity in prostate cancer mortality among black vs white men, yet the search for a biological cause continues. The study by Fletcher et al. contributes to the literature that nonbiological factors are likely associated with the significant disparity in prostate cancer mortality among black vs white men, thus contributing to the discussion that increased prostate cancer mortality among black men compared with white men is unnecessary and preventable.

Fletcher et al. reported that the magnitude of the racial disparity in survival among men diagnosed with Gleason grade groups 2 through 5 disease was lower than among men with Gleason grade group 1 disease. The question remains whether society can eliminate the race-based prostate cancer mortality disparity and by doing so create a formula that will reduce the prostate cancer mortality rate for all men.

Yes, we can eliminate the race-based prostate cancer mortality disparity. There is still a large effort to prove that the race-based prostate cancer mortality disparity is a genetic phenomenon, leading to the belief that nothing can be done to positively affect it until we have Star Trek-type technology to rewire phenotypical gene expression. The findings reported by Fletcher et al. along with many others, suggest that we have the power to make a positive change now by addressing several contemporary and relevant factors.
One issue is racial differences in clinical TNM staging at diagnosis. A potential solution is to detect prostate cancer early and treat it aggressively. Clinicians need better tools to detect prostate cancer as early as possible. If fear of treatment adverse effects influence treatment decision-making, then it is the duty of health care researchers and practitioners to improve treatments and reduce adverse effects. If there is a genetic cause for black men presenting with more advanced disease at diagnosis, the important question is whether this genetic cause can be overcome by early detection and appropriate treatment.

A second issue is racial disparities in the receipt of definitive treatment. The idea that black men, who have the greatest risk of dying from prostate cancer, are less likely to receive definitive treatment, especially when diagnosed with high-risk prostate cancer, is perplexing. A 1995 study found that a significant proportion of the racial disparity in prostate cancer mortality is secondary to the racial treatment disparity. If clinicians believe that treatments have the potential to cure or prolong life long enough for a man to die from another cause, it is the duty of health care researchers and practitioners to make these treatments as safe, effective, and affordable as possible. Treatments must be attainable for all men, regardless of race. I am certain that equal treatment for equal disease regardless of race is possible in the US. As clinicians, we can and must eliminate unwarranted variations in care.

Third, racial difference in income, education, insurance status, and geographic region are likely contributing to these racial disparities in prostate cancer mortality. A person's income, education, insurance status, or geographic region should never be the reason one person lives and another person dies of a disease, especially in a nation as wealthy and powerful as the US.

This study by Fletcher et al should be added to the increasing discussion regarding the causal factors for the reported racial disparities in prostate cancer mortality. Future research is needed to better understand the factors associated with the racial differences in survival among men with Gleason grade group 1 prostate cancer in the Atlanta, Greater Georgia, Louisiana, and New Jersey SEER registries. There has to be an explanation for the findings reported by Fletcher et al. Overall, I believe this is another excellent population-based study that contributes to the literature that the race-based prostate cancer mortality disparity is a social phenomenon and not a genetic one.

ARTICLE INFORMATION
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