Tailoring Prostate-Specific Antigen (PSA) Screening for Prostate Cancer

Patient and clinician engage in shared decision-making (SDM) regarding PSA screening

Age 45-49 years*

- **PSA < 2.5 ng/mL** → **Resume screening at age 50**
- **PSA ≥ 2.5 ng/mL** → Refer to urology following confirmatory PSA

Age 50-69 years

- **PSA ≥ 3.5 ng/mL** → Refer to urology following confirmatory PSA
- **PSA < 3.5 ng/mL** → **Continue biannual screening**
  Patients and clinicians should engage in SDM to determine if screening intervals can be extended beyond two years up to four years in this population.

Age 70+ years

- **PSA ≥ 6.5 ng/mL,** Life expectancy ≥ 10 years → Refer to urology following confirmatory PSA
- **PSA < 6.5ng/mL,** Life expectancy ≥ 10 years → **Discontinue or lengthen screening**
- Life expectancy[a] < 10 years → **Discontinue screening**

***High-Risk Patients**

High-risk patients may choose to **initiate biannual screening at age 40.** High-risk is defined by:

- Black ancestry OR
- A germline mutation OR
- A strong family history of prostate cancer

Risk calculators are available to aid in risk assessment and inform SDM.

American Urological Association/ Society of Urologic Oncology Early Detection of Prostate Cancer Guideline (2023):

Refer to urology following confirmatory PSA

Confirmatory PSA

In patients with a newly elevated PSA, clinicians should **repeat the PSA prior to proceeding with further workup** to confirm elevation. The AUA recommends conducting a repeat PSA within a few months, though the time period can be shortened or lengthened depending on other clinical factors. Digital rectal exam (DRE) should not be used as an initial screening mechanism but may provide value in patients with confirmed PSA elevation. Empiric antibiotics should not be utilized to treat an elevated PSA in an asymptomatic patient.

Next Steps/Biopsy Discussion

Clinicians should engage patients in SDM when deciding about next steps (magnetic resonance imaging (MRI), additional lab tests, and/or biopsy).

With the goal of detecting **clinically significant cancer**, clinicians may utilize additional tools (e.g., urine or serum markers, imaging) to provide further information to inform the prostate biopsy discussion. Validated risk calculators, such as the Prostate Cancer Prevention Trial (PCPT) risk calculator (https://riskcalc.org/PCPTRC/), may incorporate patient information and provide value in determining whether to proceed with biopsy or rescreen at a later date.

SHARE Approach for SDM

- **SEEK** patient participation
- **HELP** the patient explore and compare options
- **ASSESS** patient values and preferences
- **REACH** a decision together with the patient
- **EVALUATE** the patient's decision

The SHARE Approach. Content last reviewed March 2023. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html

[a]Estimates of life expectancy may be ascertained using Social Security Administration Life Tables or online calculators.

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Diagnostic excellence is defined as *"an optimal process to attain an accurate and precise explanation about a patient's condition. An optimal process would be timely, cost-effective, convenient, and understandable to the patient. An accurate and precise diagnosis gains clinical value insofar as it leads to better choices in treatment."*[15] The AUA highlighted "enhancing diagnostic excellence" as a top priority in its *National Quality Agenda and Strategies for Urologic Practice*, emphasizing its importance in improving urologic health and urologic health care.

For additional information, visit **AUAnet.org**

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American Urological Association

ADVANCING DIAGNOSTIC EXCELLENCE AND HEALTH EQUITY:

The Role of PSA Screening in Early Detection of Prostate Cancer

Prostate Cancer Disparities

1 IN 8

MEN

IN THE U.S. OVERALL

WILL BE

DIAGNOSED WITH PROSTATE CANCER

IN THEIR LIFETIME.[1]

1 IN 6

BLACK MEN

IN THE U.S. OVERALL

WILL BE

DIAGNOSED WITH PROSTATE CANCER

IN THEIR LIFETIME.[2]

Black men are **1.8x** more likely to be diagnosed compared to their White counterparts.[3,4]

Black men are **2.1x** more likely to die from prostate cancer than their White counterparts.[3]

Black men are **44-75%** more likely than the general population to have advanced disease at the time of diagnosis.[5]

Prostate Cancer Screening

Since the introduction of Prostate-Specific Antigen (PSA) screening, there has been a **72%** reduction in the number of men with metastatic disease at the time of diagnosis.[6]

In 2012, the U.S. Preventive Services Task Force (USPSTF) recommended against PSA screening for men of all ages.[7]

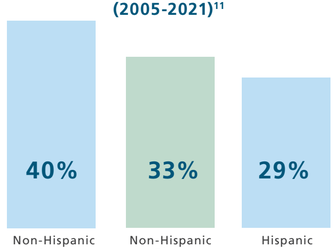
In the years immediately following this recommendation, **rates of PSA screening decreased,** and the diagnosis of **advanced prostate cancer increased.**[8]

In 2018, the USPSTF recommended that clinicians inform Black men about their increased risk of developing and dying from prostate cancer.[9]

In 2022, **only 30%** of family physicians report **routinely informing Black men of their increased prostate cancer risk.**[10]

Even though Black men are **more than twice as likely to die** from prostate cancer, they are **screened at lower rates** than their White counterparts.

% OF MEN AGED 55-69 WHO HAD A PSA TEST WITHIN THE PAST YEAR (2005-2021)[11]



Some studies recommend starting PSA screening **3-9 years earlier** in Black men.[5]

Due to the increased prostate cancer risk, the American Urological Association (AUA) recommends that clinicians offer prostate cancer screening to Black men beginning at **age 40-45.**[12]

Risks and Benefits of PSA Screening

The AUA recommends engaging in shared decision-making with people considering prostate cancer screening, so they can make an informed choice.

PSA screening may help to detect the cancer **early.**	Some prostate cancers are **slow-growing** and unlikely to cause harm (overdiagnosis).
If caught early, it is **easier to treat** and more likely to be cured.	There can be **side effects** associated with treatment, and not all prostate cancers require treatment (overtreatment).
Some patients prefer to have **more information** about their health.	An elevated PSA can be **anxiety-provoking** for some patients.

Reducing the Harms of Diagnosis and Treatment

Strategies to mitigate the harm associated with unnecessary biopsies and the overdiagnosis and overtreatment of prostate cancer:

TOOLS TO AID IN THE DETECTION OF CLINICALLY SIGNIFICANT PROSTATE CANCER:

Conducting **confirmatory PSA tests** and using **age-specific PSA cutoffs** can help reduce the number of unnecessary biopsies.

Prostate magnetic resonance imaging (MRI), prostate cancer **risk calculators,** other tests, and **digital rectal exam** (DRE) may be used to determine appropriate candidates for biopsy.

MANAGEMENT STRATEGIES TO PREVENT OVERTREATMENT OF PROSTATE CANCER:

Active surveillance is the recommended management strategy for low-risk disease. Active surveillance rates in low-risk prostate cancer increased from 27% in 2014 to 60% in 2021.[13]

Watchful waiting is the recommended management strategy for men with asymptomatic prostate cancer and a limited life expectancy.[14]