



PSA Screening: Primary Care Practitioner FAQ



The recommendations apply to all men not previously diagnosed with prostate cancer

- For men aged less than 55 years, we recommend not screening for prostate cancer with the prostate-specific antigen test. (*Strong recommendation; low quality evidence**)
- For men aged 55-69 years, we recommend not screening for prostate cancer with the prostate-specific antigen test. (*Weak recommendation; moderate quality evidence*)
- For men 70 years of age and older, we recommend not screening for prostate cancer with the prostate-specific antigen test. (*Strong recommendation; low quality evidence*).

1. Why are there different recommendations for different age groups?

There is no evidence that PSA screening reduces overall mortality for men of any age and consistent evidence that screening and active treatment lead to harm. However there is conflicting evidence suggesting a small and very uncertain potential reduction in prostate cancer mortality in men aged 55-69 years and no convincing evidence of a reduction in prostate cancer mortality for any other age group.

2. Do these guidelines include high-risk groups such as those of black race/ancestry or those with a family history of prostate cancer?

Yes. There was no evidence indicating that men of black race/ancestry or those with a family history of prostate cancer (one or more affected first-degree relatives) should be screened differently from the average-risk population.

3. Does this guideline include screening with digital rectal examination (DRE)?

This guideline recommends not screening with the PSA test, regardless of whether DRE is performed. Although DRE has been used in clinical practice to screen for prostate cancer, there was no evidence showing that DRE reduces prostate cancer mortality when used on its own or with the PSA test.

4. Is it necessary for primary care practitioners to discuss the benefits and harms of screening with their patients?

If patients raise the issue of PSA screening, physicians should discuss the benefits and harms associated with screening. Men should understand that undergoing a PSA test can lead to additional testing if the PSA level is raised. Tools outlining the harms and benefits of screening are available at www.canadiantaskforce.ca

5. Why does the CTFPHC recommend against prostate cancer screening when the death rate has fallen since the introduction of the PSA test?

There is no conclusive evidence to indicate what proportion of the decline in prostate cancer mortality is due to screening, improved treatment, or other factors; it is likely that both screening and treatment have contributed.

However, the CTFPHC found that the potential small benefit that can result from PSA screening is outweighed by potential significant harms of PSA screening and associated follow-up treatment.

KEY POINTS

- The prevalence of undiagnosed prostate cancer at autopsy is high and increases with age (over 40% in men aged 40-49 years to over 70% in men aged 70 to 79 years).
- Only a small proportion of prostate cancer causes symptomatic disease or death whereas the majority is slowly progressive and not life threatening.
- Screening with PSA may lead to a small reduction in prostate cancer mortality but does not reduce overall mortality
- PSA thresholds of 2.5ng/ml to 4.0ng/ml are commonly used for screening, with lower thresholds increasing the probability of false positive results and overdiagnosis, but no value completely excludes prostate cancer
- Harms (such as bleeding, infection, urinary incontinence, false positives and overdiagnosis) are common following PSA screening
- PSA should not be used for screening without prior informed discussion, ideally using decision aids to facilitate comprehension.

*Recommendations are graded according to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. For explanation of GRADE recommenda-