Guidelines for Prostate Cancer: Frequently Asked Questions

What Has Not Changed:

- Health care professionals should discuss the potential benefits and limitations of prostate cancer early detection testing with men before any testing begins
- Discussion about screening should start at age 50 for men at average risk and earlier for high-risk men
- Men with less than a 10-year life expectancy should not be screened
- Guidelines do not support routine testing for prostate cancer

What has changed:

- Greater emphasis on informed & shared decision making
- Provides detailed recommendations on information to be discussed
- Promotes the use of decision aids
- Screening should be at a provider's discretion for men who are unable to decide
- New guidance for community-based screening programs
- Revised recommendations for providers whose patients choose to be tested

Why was an update needed?

American Cancer Society experts continually monitor the scientific literature for new findings related to cancer prevention and early detection. American Cancer Society guidelines are updated when new information becomes available that indicates there should be a change in the Society's recommendations. In the case of prostate cancer screening, results from two randomized controlled trials of screening were reported in early 2009. The findings from these studies, combined with other advances in the knowledge related to prostate cancer screening, necessitated this guideline update.

What does the new evidence tell us about prostate cancer screening?

One trial, known as the European Randomized Study of Screening for Prostate Cancer (ERSPC), found that screening reduced the rate of prostate cancer death by 20 percent. The study also found that a large number of men with prostate cancer would need to be treated to prevent one death from prostate cancer. The large number of men requiring treatment, and the risks associated with treatment for prostate cancer – incontinence, impotence, pain, and bleeding among others — reinforced longstanding concerns regarding the balance between benefits and harms associated with prostate cancer early detection.

The other study, the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, a 17-year project of the National Cancer Institute (NCI) did not observe a reduction in the rate of prostate cancer death associated with screening after an average of 7years of follow-up.

Based on these findings a shared decision-making approach to PSA screening, as recommended by the guidelines of nearly all major medical organizations, seems more appropriate than ever.

What changes were made to the guidelines?

These 2010 guidelines for the early detection of prostate cancer are very similar to the corresponding ACS guidelines of 1997 and 2001. With this update, the guidelines acknowledge that new studies further legitimize the questions and uncertainties that have been addressed in previous guidelines. As it has since 1997, the American

Cancer Society advises against a general recommendation for men to undergo screening, instead saying testing should only occur when a man is provided the opportunity to learn about the limitations and potential benefits of screening and treatment.

For the first time the guidelines include specific topics that should be part of the informed decision-making discussion. The guidelines now outline the uncertainties regarding the balance of benefits and harms associated with screening. They clearly state that every man should be told of the uncertainties, risks and potential benefits of screening, and that no man should be tested without receiving this information. And while the guidelines previously recommended that a man be tested if he cannot decide what to do, they now recommend that in such instances the screening decision can be left to the discretion of the health care provider, who should factor into the decision his or her knowledge of the patient's general health preferences and values.

The guidelines also include updated clinical recommendations regarding screening intervals and follow up of abnormal results for those men who choose to be screened. Annual screening is recommended for men whose PSA level is 2.5 ng/ml or higher, but screening intervals can be safely extended to every two years for men whose PSA is less than 2.5 ng/ml. A PSA level of 4.0 ng/ml or higher remains a reasonable threshold to recommend referral for further evaluation or biopsy for men at average risk of developing prostate cancer; for PSA levels between 2.5 and 4.0 ng/ml, health care providers should consider an individualized risk assessment that incorporates other risk factors for prostate cancer in the referral decision.

Is the American Cancer Society against all prostate cancer screening?

The American Cancer Society is not against screening. As with previous recommendations, this update emphasizes that men should learn about the limitations and potential benefits of screening and treatment and then decide whether or not to be screened. The guidelines do not support screening without a detailed discussion of the potential benefits and harms of screening and treatment before screening occurs.

How can a simple blood test have risks?

The PSA blood test itself has minimal risk. However, significant harms can arise from the diagnostic and treatment cascade that is often triggered by screening. No screening test is perfect, but the degree of over-diagnosis and associated overtreatment appears to be greater for prostate cancer screening than for any other of the cancers for which routine screening currently occurs. The adverse effects from treatment of prostate cancer are serious and potentially life altering. There is a high risk of sexual, urinary, or bowel-related symptoms, depending on the type of treatment selected. While in some men these problems may be minimal and/or temporary, for others these problems can be severe and long-lasting or even permanent.

What about community screening events?

The American Cancer Society discourages participation in community-based prostate cancer screening programs unless those can adequately provide for an informed decision-making process and appropriate follow-up. For men who have limited or no access to other sources of care, community-based screening programs may provide the only opportunity to make an informed decision about testing. Men who are contemplating screening through these programs should first receive high-quality objective informed decision-making, either through interaction with trained personnel, or through the use of validated, high-quality decision aids, appropriate to the target population. Since virtually all men age 65 years and older have health insurance through Medicare, they should be discouraged from participating in community-based screening programs, and should be referred to a primary care provider.