ACS Recommendations on Prostate Cancer Screening

CARRIE ARMSTRONG

Guideline source: American Cancer Society

Literature search described? Yes

Evidence rating system used? No

Published source: *CA: A Cancer Journal for Clinicians*, March/April 2010

Available at: http://caonline.amcancersoc.org/cgi/content/full/60/2/70#SEC3

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

Although there have been substantive advances in the understanding of prostate cancer screening since the previous American Cancer Society (ACS) guideline update in 2001, there are still uncertainties about the overall value of early detection. Evidence that periodic prostate-specific antigen (PSA) testing may reduce the risk of prostate cancer–related mortality must be weighed against the risks associated with early detection and treatment, particularly against the risk of treating men who would not have adverse effects if their cancer had not been detected.

The ACS recommends that asymptomatic men who have a life expectancy of at least 10 years be allowed to make an informed decision about whether to be screened for prostate cancer. Physicians should provide information about the uncertainties, risks, and potential benefits associated with prostate cancer screening. Men at average risk should receive this information beginning at 50 years of age. Men at higher risk, including black men and those with a first-degree relative who was diagnosed with prostate cancer before 65 years of age, should receive this information beginning at 45 years of age. Men who have multiple family members who were diagnosed with prostate cancer before 65 years of age should receive this information beginning at 40 years of age.

For men who are unable to decide whether to be screened, the decision can be made by the physician. However, the physician should consider the patient's general health preferences and values.

Asymptomatic men who have less than a 10-year life expectancy should not be offered prostate cancer screening. By 75 years of age, only about one half of men have a life expectancy of 10 years or more. Men in this age group with serious comorbidities, as well as younger men with life-limiting comorbid conditions, are not likely to benefit from screening. Life-limiting comorbid conditions become more common as men age; therefore, it is important to consider overall health status—not age alone—when making decisions about screening.

Core elements of the information that should be provided to men to assist with their decision include the following:

- Screening with the PSA blood test, alone or in combination with digital rectal examination, can detect cancer at an earlier stage than if no screening is performed.
- Prostate cancer screening may be associated with a reduced risk of death from prostate cancer; however, evidence is conflicting and experts disagree about the value of screening.
- It is not possible to predict which men with prostate cancer are likely to benefit from treatment. Some men who are treated may avoid death and disability from prostate cancer, whereas others who are treated would have died from unrelated causes before their cancer became serious enough to affect their health or shorten their lives.
- Depending on the treatment selected, prostate cancer therapy can lead to urinary, bowel, sexual, and other health problems. These problems may be severe or minimal, permanent or temporary.
- PSA testing and digital rectal examination ▶

may yield false-positive or false-negative results, which can result in unnecessary additional testing or missed cancers. False-positive results can also cause anxiety about prostate cancer risk.

• Abnormal results from PSA testing or digital rectal examination require prostate biopsies to determine whether the abnormal findings are cancer. Biopsies can be painful, can lead to complications such as infection or bleeding, and can miss clinically important cancer.

• Not all men whose prostate cancer is detected through screening require immediate treatment, but they may require periodic blood tests and prostate biopsies to determine the need for future treatment.

Once a screening decision has been made, the decision should be readdressed periodically whenever new research becomes available that changes the balance between the benefits and risks of early detection of prostate cancer. In the absence of new information, the decision still should be readdressed periodically, because a man's health status, values, and preferences may change.

Screening recommendations for men who have considered the potential benefits and risks include the following:

• Screening is recommended with PSA testing, with or without digital rectal examination.

• Screening should be conducted yearly for men whose PSA level is at least 2.5 ng per mL (2.50 mcg per L).

• In men whose PSA level is less than 2.5 ng per mL, screening can be performed every two years.

• Referral for further evaluation or biopsy is reasonable in men at average risk of prostate cancer who have a PSA level of at least 4.0 ng per mL (4.00 mcg per L).

• In men with PSA levels between 2.5 ng per mL and 4.0 ng per mL, physicians should consider an individualized risk assessment that incorporates other risk factors for prostate cancer (e.g., black race, family history of prostate cancer, older age, abnormal digital rectal examination findings). This assessment can be used to recommend biopsy. ■

Answers to This Issue's CME Quiz

Q1. D	**Q6.** A, B, C, D	**Q10.** C
Q2. B, C	**Q7.** A	**Q11.** B
Q3. A, B, C	**Q8.** B	**Q12.** A, B, D
Q4. A	**Q9.** B, C	**Q13.** A
Q5. D		