



Body System: Men's Health		
Session Topic: Diagnosis of Male Genital Tract Cancers		
Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>
Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
<ul style="list-style-type: none"> • New grade group system for risk stratification of prostate cancer. • New guidelines for active surveillance for patients with low risk, localized prostate cancer. • Physicians are not knowledgeable or confident in their use of validated screening tools and guidelines to assess the risk for and manage prostate cancer. • Prescreening discussions are under-utilized for prostate cancer due to perceived controversy over their usefulness in reducing mortality. • Patients diagnosed with prostate cancer frequently do not understand the risks and benefits of treatment options. • Physicians need to better understand and implement cancer survivorship 	<ol style="list-style-type: none"> 1. Examine scrotal masses to determine whether they are likely benign or malignant, and recommend ultrasound and prompt biopsy when appropriate in order to ensure an early diagnosis and effective treatment of testicular cancer. 2. Examine penile lesions to determine whether they are likely benign or malignant, and recommend prompt biopsy when appropriate in order to ensure an early diagnosis and effective treatment of penile cancer. 3. Counsel patients, using shared decision making resources, regarding the risks and benefits of prostate cancer screening. 4. Counsel patients about the value and limitations of various assessments used for diagnosis and risk stratification of prostate cancer, including PSA values, digital rectal examination, ultrasound and MRI imaging, and biopsy results (including explaining Gleason score and the ISUP Grade Group Classification System). 	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.



<p>guidelines, surveillance strategies, access to community and web-based resources, and strategies to improve communication and coordinate care with oncology, surgical, and other health care providers.</p> <ul style="list-style-type: none">• Physicians may require additional education and training to increase their skills confidence in testing for recurrence of cancer using recommended laboratory tests and ancillary procedures.• Most men with localized prostate cancer (LPC) underestimate their life expectancy without treatment and overestimate their potential gain in life expectancy with surgery or radiation.• Nearly 1 in 5 family physicians would like additional training in ultrasonography• Knowledge and practice gaps with regard to differential diagnosis of scrotal masses and testicular pain; evidence-based recommendations for ordering diagnostic tests; management of testicular torsion (e.g. manual detorsion); diagnosis of testicular cancer.• The diagnosis and management of penile cutaneous lesions can be challenging for some	<p>5. Examine men at risk for prostate cancer, order appropriate testing, and when appropriate refer them to a urologist for biopsy.</p>	
--	--	--



physicians because of a lack of familiarity and patient embarrassment.			
ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge	X	Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice
Faculty Instructional Goals			
<p>Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.</p> <ul style="list-style-type: none"> • Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations • Facilitate learner engagement during the session • Address related practice barriers to foster optimal patient management • Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the <u>References</u> section below are a good place to start <ul style="list-style-type: none"> ○ Visit http://www.aafp.org/journals for additional resources ○ Visit http://familydoctor.org for patient education and resources • Provide an overview of relevant clinical guidelines for prostate cancer screening, treatment, and management, and recommend practical ways to apply them in practice. • Provide strategies and resources for counseling patients on the risks and benefits of prostate cancer screening using shared decision making tools. • Provide strategies and resources for counseling patients with diagnosed prostate cancer about the risks and benefits of their treatments options, using a standardized clinical decision aid. • Provide strategies and resources for collaborating with other health providers (e.g. urologists and oncologists) to construct a coordinated referral process for men requiring prostate cancer treatment. • Provide strategies and resources on the appropriate and current resources for prostate cancer survivors and their family members on the psychosocial effects of cancer. • Provide an overview of current evidence for and recommendations regarding new treatment options. • Provide information regarding guidelines for Medicare reimbursement. • Provide recommendations to maximize office efficiency and guideline adherence pertinent to the diagnosis and management of prostate cancer. • Provide recommendations for examining and evaluating scrotal masses to determine whether they are benign or malignant and suggest the next steps in treatment. 			



- Provide strategies for evaluating acute, subacute and chronic testicular pain, identifying emergent causes such as testicular torsion based on symptoms and risk factors, and treating the condition in a timely manner.
- Provide recommendations for counseling patients the importance of receiving timely and appropriate medical attention for scrotal masses.
- Provide recommendations for identifying possible symptoms of testicular cancer and recommend further testing, such as ultrasound and biopsy, to ensure an early diagnosis and effective treatment.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of scrotal masses and testicular pain.

***Note** – Focus of the session should be about 85% of time spent on prostate cancer, 10% on testicular cancer including role of imaging, and 5% on penile cancer

Needs Assessment:

Prostate Cancer

PSA Screening

The estimated number of new cases of prostate cancer in the United States in 2017 will be 161,360, and the estimated number of deaths from prostate cancer will be 26,730.^{1,2} Prostate cancer occurs mainly in older men, and is the third leading cause of cancer death in American men.^{1,2}

The 2013 National Ambulatory Medical Survey reveals that ambulatory care physicians ordered nearly 14.6 million prostate specific antigen (PSA) tests.³ A meta-analysis of prostate cancer screening in a 2013 Cochrane Review of more than 340,000 men, concluded that there was no significant decrease in prostate cancer specific mortality, and that both over-diagnosis and overtreatment are common and associated with harm.⁴

A 2012 American Academy of Family Physicians (AAFP) Needs Assessment Survey indicates a statistically significant and meaningful difference between family physicians' medical knowledge about prostate cancer and their skill level at managing patients with prostate cancer.⁴ A more recent 2016 AAFP CME Training Needs Survey indicates that physicians need more education regarding disease management of prostate cancer.⁵ More specifically, CME outcomes data from 2012, 2015 and 2016 AAFP FMX (formerly Assembly): *Prostate Cancer* sessions suggest that physicians have knowledge and practice gaps with regard to appropriate PSA screening; educating patients on lifestyle modifications; follow up and monitoring; appropriate use of Dual-energy X-Ray absorptiometry (DEXA) for patients on androgen suppression therapy; and having shared decision making conversations with patients about the risks and benefits of PSA screening and results of screening.⁶⁻⁸

Despite increasing survival rates since the advent of PSA testing, decisions regarding screening for prostate cancer are complicated. Much of the debate stems from a lack of evidence supporting a role for screening in reducing mortality, as well as concerns about over-diagnosis and subsequent overtreatment of prostate cancer.⁹⁻¹¹ Both the AAFP and the US Preventive



Services Task Force (USPSTF) recommend against routine PSA testing or digital rectal exam testing for prostate cancer screening.^{12,13}

In 2013, the American Urological Association (AUA) released a guideline on early detection of prostate cancer in asymptomatic men, intended to reduce prostate cancer mortality, summarized as follows:¹⁴

- The AUA *recommends against* PSA screening of men younger than 40 years
- The AUA *recommends against* routine PSA screening of men 40 to 54 years of age
- The AUA *strongly recommends* shared decision making in men 55 to 69 years of age who are considering PSA screening, with the decision being based on the patient's values and preferences.
- The AUA *does not recommend* routine PSA screening in men 70 years and older, or in men with a life expectancy less than 10 to 15 years.

The American Cancer Society's (ACS's) 2010 guideline for early detection of prostate cancer recommends that asymptomatic men with ≥ 10 -year life expectancy have the opportunity to make an "informed decision," together with their physician, about screening for prostate cancer, but only after they receive information about the uncertainties, risks, and potential benefits associated with screening. ACS guidelines state that prostate cancer screening be supported by an informed decision-making (IDM) process, and recommend that men at average or higher risk for prostate cancer receive this information beginning at age 50, and men in higher risk groups receive it before age 50.¹⁵ In addition, the guidelines state that men should either receive this information directly from their healthcare providers, or be appropriately referred. Despite these recommendations, two recent studies of IDM practices (defined as "prescreening discussions") among primary care physicians showed that more than 20% did not routinely use such discussions and found variation in the routine use and role of the physician.^{16,17} For physicians in primary care and family practice, these developments signal a need for education that:

- Clarifies definitions of high and average prostate cancer risk
- Identifies which patients will benefit most from screening, and
- Provides guidance and patient decision aids that help implement IDM.

Physicians should also be familiar with a new grade group system for risk stratification of prostate cancer, which may provide more accurate risk stratification than the current composite Gleason score.¹⁸ The 2014 International Society of Urological Pathology Consensus Conference adopted an alternative grade grouping system based upon the Gleason grade, and this alternative grade group system has been adopted in the 2016 World Health Organization classification of genitourinary tumors.^{19,20}

Prostate Cancer Diagnosis

Diagnosis of prostate cancer is complicated by wide variations in symptoms and overlap with symptoms of other prostate diseases, such as difficulty passing urine, painful urination, and/or painful ejaculation. Diagnosis also requires ruling out non-prostate-related conditions, including bladder cancer, interstitial cystitis, and lower urinary tract infections.²¹⁻²³ When PSA testing and/or DRE indicates possible prostate cancer, a biopsy of prostate tissue is needed for confirmation, which requires referral to an urologist. Magnetic resonance imaging of the prostate



is also increasingly used together with ultrasound to guide prostate biopsy, called “fusion biopsy.”²⁴ Fusion-biopsy is a relatively new concept that family physicians should be aware of. When cancer is confirmed, PSA test and imaging results, together with biopsy findings and other evaluations, are used to determine the stage of the cancer. Staging helps to determine patient prognosis and guides further evaluation, with higher stages indicating the need for imaging studies to assess the presence and location of any metastatic disease.²⁵ These steps are typically performed by an urologist, but close communication with the referring family physician is needed. An important role for the family physician in this process is to provide education and counseling that reassures patients with a diagnosis of prostate cancer and allays patient fears regarding prognosis, treatment, and treatment-related morbidity. Physicians can improve patient satisfaction with the referral process by improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.^{26,27}

Scrotal Masses/Testicular Cancer/Penile Cancer

Scrotal masses are a common presentation in primary care, and a painful scrotum accounts for 1% of emergency department visits.²⁸ Patients may also present with a painless testicular mass, scrotal heaviness, a dull ache, or acute pain. Physicians should understand the risk factors for testicular cancer, and how to diagnose the conditions, as this condition is the most common malignancy in men 20 to 35 years of age with an annual incidence of four per 100,000.²⁹ However, scrotal complaints can be challenging to diagnose because of overlapping signs and symptoms among various presentations.³⁰ The diagnosis and management of penile cutaneous lesions can be challenging for some physicians because of a lack of familiarity and patient embarrassment.³¹

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal management of neoplastic conditions of the male genital tract, testicular disease, testicular torsion, and testicular cancer.³² More specifically, CME outcomes data from 2012 and 2013 AAFP Assembly (currently FMX) *Neoplastic Disease of the Male Genital Tract* sessions, suggest that physicians have knowledge and practice gaps with regard to differential diagnosis of scrotal mass, or testicular pain; evidence-based recommendations for ordering diagnostic tests; management of testicular torsion (e.g. manual detorsion); and diagnosis of testicular and penile cancer.^{6,33}

Physicians may improve their care of patients presenting with scrotal (i.e. acute, subacute and chronic) pain or a scrotal mass by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:^{29,31,34-38}

- Epididymitis/orchitis should be suspected in patients with testicular pain and a C-reactive protein level of more than 24 mg per L (228.6 nmol per L).
- Any patient presenting with acute scrotal pain suspicious for testicular torsion should be rapidly evaluated (using ultrasound if necessary) , detorsed if possible, and referred for immediate surgical management.



- Scrotal Doppler ultrasonography is the imaging study of choice to aid in the diagnosis of testicular torsion; however, prompt referral should not be delayed to perform this study.
- The AAFP recommends against screening for testicular cancer in asymptomatic adolescent or adult males.
- The U.S. Preventive Services Task Force (USPSTF) recommends against screening for testicular cancer in adolescent or adult males. (D recommendation.)
- Routine physician screening and monthly self-examinations to detect testicular cancer are not recommended in asymptomatic patients.
- Scrotal ultrasonography should be the first diagnostic test in patients with a testicular mass.
- An intratesticular mass should be considered testicular cancer until proved otherwise.
- After definitive treatment for testicular cancer, the primary care physician should monitor the patient for recurrence, infertility, second malignancy, and cardiac disease.
- Because of the risk of infertility, patients should be encouraged to bank sperm, if possible, before undergoing treatment for testicular cancer.
- Lichen sclerosus (balanitis xerotica obliterans) requires long-term follow-up to monitor for malignant transformation.
- Observational studies and expert opinion
- Biopsy is appropriate for a penile lesion if the diagnosis is unclear, or if carcinoma in situ or squamous cell carcinoma are possible.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

While ultrasonography is the imaging study of choice, physicians do have some knowledge gaps regarding the optimal use of this diagnostic tool. In a recent AAFP CME Needs Assessment Survey of Common Medical Procedures, nearly 1 in 5 family physicians would like additional training in ultrasonography.³⁹

Cancer Survivorship

Data from a recent American Academy of Family Physicians (AAFP) CME Needs assessment survey indicate that family physicians have significant knowledge gaps regarding the care of cancer survivors.³² More specifically, CME outcomes data from the 2013 AAFP Assembly: *Care of Cancer Survivors*, and 2014 AAFP Assembly: *Prostate Cancer and Prostate Specific Antigen (PSA) Screening* sessions indicate that family physicians require additional continuing medical education regarding PSA screening guidelines; how to counsel men regarding PSA screening, and treatment options, including risks and benefits; surveillance strategies; access to community



and web-based resources; understand and implement cancer survivorship guidelines; and strategies to improve communication and coordinate care with oncology, surgical, and other health care providers.^{33,40}

Family physicians are often overburdened by an aging population with multiple chronic conditions and may not be adequately prepared to care for prostate cancer survivors due to perceived knowledge gaps about the individualized needs, risks, and surveillance plans for cancer survivors.⁴¹⁻⁴⁴ Additionally, there is often a lack of inter-professional communication and clarity about responsibilities in the coordination of care between oncology professionals and primary care providers.^{42,43,45} In fact, patients are often unaware that a transition back to their family physician, from their oncology provider, is an option. Cancer survivors are at increased risk for recurrence of the original cancer and development of second primary malignancies as a result of cancer therapy and other risk factors.⁴⁶ Additionally, recent studies suggest that men with prostate cancer, who were receiving androgen deprivation therapy, are at increased risk of venous thromboembolic disease.⁴⁷

Family physicians are integral to the care of their patients with cancer, with the most involvement occurring at the time of diagnosis and during end-of-life care.⁴⁸ One challenge is to integrate family physicians into the continuum of providing care for cancer survivors.⁴⁹ The Patient-Centered Medical Home is one approach that supports patients and their families by providing a patient-centered orientation and coordinated care between medical specialties.^{50,51} In data from a 2011 survey of a sample group of active AAFP physician members, 76.8% of respondents indicated they were currently treating patients with cancer. Of these respondents, only 32% indicated that they were either moderately comfortable or comfortable in managing the care of patients with cancer. In addition, 51% of these respondents voiced they would be moderately likely or extremely likely to engage in CME on this topic. These data demonstrate a self-identified need by family physicians for CME on the management of patients with cancer.⁵²

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- (AAFP) Prostate Cancer. Clinical Preventive Service Recommendation¹²
- AUA Guideline: Early detection of prostate cancer¹⁴
- American Cancer Society guideline for the early detection of prostate cancer¹⁵
- Diagnosis and management of benign prostatic hyperplasia²³
- Testicular torsion: diagnosis, evaluation, and management³⁵
- Evaluation of scrotal masses³⁶
- Evaluation and management of scrotal pain
- Diagnosis and treatment of testicular cancer²⁹
- Noninfectious penile lesions³¹
- Primary Care of the Prostate Cancer Survivor⁵³
- Prostate cancer screening: the continuing controversy¹¹
- Care of cancer survivors⁴⁶
- Simple tools to increase patient satisfaction with the referral process²⁶
- FamilyDoctor.org. Prostate Cancer | Overview (patient education)⁵⁴
- Engaging Patients in Collaborative Care Plans⁵⁵



- The benefits of using care coordinators in primary care: a case study⁵⁶
- Managing difficult encounters: understanding physician, patient, and situational factors⁵⁷
- Adding health education specialists to your practice⁵⁸
- Thinking on paper: documenting decision making⁵⁹
- Clinical decision support: using technology to identify patients' unmet needs⁶⁰
- Exam documentation: charting within the guidelines.⁶¹
- Testicular Cancer | Overview (patient education)⁶²

References

1. Centers for Disease Control and Prevention. Prostate Cancer Statistics. 2017;
2. American Cancer Society. Cancer Facts & Figures. 2017;
3. Hing E, Rui P, Palso K. National Ambulatory Medical Care Survey: 2013 State and National Summary Tables. 2013;
4. Ilic D, Neuberger Molly M, Djulbegovic M, Dahm P. Screening for prostate cancer. *Cochrane Database of Systematic Reviews*. 2013(1).
5. CME Training Session Needs Survey. Leawood KS: AAFP; 2016.
6. American Academy of Family Physicians (AAFP). 2012 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2012.
7. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.
8. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2016.
9. Welch HG, Albertsen PC. Prostate cancer diagnosis and treatment after the introduction of prostate-specific antigen screening: 1986-2005. *Journal of the National Cancer Institute*. 2009;101(19):1325-1329.
10. Matrana MR, Atkinson B. Screening for prostate cancer: the debate continues. *Journal of the advanced practitioner in oncology*. 2013;4(1):16-21.
11. Wilbur J. Prostate cancer screening: the continuing controversy. *American family physician*. 2008;78(12):1377-1384.
12. American Academy of Family Physicians (AAFP). Prostate Cancer. *Clinical Preventive Service Recommendation 2012*;
13. American Academy of Family Physicians (AAFP). Prostate Cancer Screening Using a Prostate-specific Antigen (PSA) Test or Digital Rectal Exam *Choosing Wisely 2014*;
14. Carter HB, Albertsen PC, Barry MJ, et al. Early detection of prostate cancer: AUA Guideline. *The Journal of urology*. 2013;190(2):419-426.
15. Wolf AM, Wender RC, Etzioni RB, et al. American Cancer Society guideline for the early detection of prostate cancer: update 2010. *CA: a cancer journal for clinicians*. 2010;60(2):70-98.
16. Linder SK, Hawley ST, Cooper CP, Scholl LE, Jibaja-Weiss M, Volk RJ. Primary care physicians' reported use of pre-screening discussions for prostate cancer screening: a cross-sectional survey. *BMC family practice*. 2009;10:19.



17. Volk RJ, Linder SK, Kallen MA, et al. Primary care physicians' use of an informed decision-making process for prostate cancer screening. *Annals of family medicine*. 2013;11(1):67-74.
18. Epstein JI, Zelefsky MJ, Sjoberg DD, et al. A Contemporary Prostate Cancer Grading System: A Validated Alternative to the Gleason Score. *European urology*. 2016;69(3):428-435.
19. Moch H, Cubilla AL, Humphrey PA, Reuter VE, Ulbright TM. The 2016 WHO Classification of Tumours of the Urinary System and Male Genital Organs—Part A: Renal, Penile, and Testicular Tumours. *European urology*. 2016;70(1):93-105.
20. Epstein JI, Egevad L, Amin MB, et al. The 2014 International Society of Urological Pathology (ISUP) Consensus Conference on Gleason Grading of Prostatic Carcinoma: Definition of Grading Patterns and Proposal for a New Grading System. *The American journal of surgical pathology*. 2016;40(2):244-252.
21. Rosenberg MT, Staskin DR, Kaplan SA, MacDiarmid SA, Newman DK, Ohl DA. A practical guide to the evaluation and treatment of male lower urinary tract symptoms in the primary care setting. *International journal of clinical practice*. 2007;61(9):1535-1546.
22. Tanguay S, Awde M, Brock G, et al. Diagnosis and management of benign prostatic hyperplasia in primary care. *Canadian Urological Association journal = Journal de l'Association des urologues du Canada*. 2009;3(3 Suppl 2):S92-S100.
23. Edwards JL. Diagnosis and management of benign prostatic hyperplasia. *American family physician*. 2008;77(10):1403-1410.
24. Moore CM, Robertson NL, Arsanious N, et al. Image-guided prostate biopsy using magnetic resonance imaging-derived targets: a systematic review. *European urology*. 2013;63(1):125-140.
25. Mohan R, Schellhammer PF. Treatment options for localized prostate cancer. *American family physician*. 2011;84(4):413-420.
26. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management*. 2011;18(6):9-14.
27. American Academy of Family Physicians (AAFP). FPM Toolbox: Referral Management. 2013;
28. Davis JE, Silverman M. Scrotal emergencies. *Emergency medicine clinics of North America*. 2011;29(3):469-484.
29. Shaw J. Diagnosis and treatment of testicular cancer. *American family physician*. 2008;77(4):469-474.
30. O'Reilly P, Le J, Sinyavskaya A, Mandel ED. Evaluating scrotal masses. *Journal of the American Academy of Physician Assistants*. 2016;29(2):26-32.
31. Teichman JM, Sea J, Thompson IM, Elston DM. Noninfectious penile lesions. *American family physician*. 2010;81(2):167-174.
32. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.
33. American Academy of Family Physicians (AAFP). 2013 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2013.
34. American Academy of Family Physicians (AAFP). Testicular Cancer. *Clinical Preventive Service Recommendation* 2011;



35. Sharp VJ, Kieran K, Arlen AM. Testicular torsion: diagnosis, evaluation, and management. *American family physician*. 2013;88(12):835-840.
36. Crawford P, Crop JA. Evaluation of scrotal masses. *American family physician*. 2014;89(9):723-727.
37. Sommers D, Winter T. Ultrasonography evaluation of scrotal masses. *Radiologic Clinics of North America*. 2014;52(6):1265-1281.
38. Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement. *Annals of internal medicine*. 2011;154(7):483-486.
39. American Academy of Family Physicians (AAFP). CME Needs Assessment: Common Medical Procedures. *Market Research In Brief*. Leawood KS: AAFP; 2014.
40. American Academy of Family Physicians (AAFP). AAFP Assembly CME Outcomes Report. Leawood KS: AAFP; 2014.
41. Hudson SV, Miller Sm Fau - Hemler J, Hemler J Fau - Ferrante JM, et al. Adult cancer survivors discuss follow-up in primary care: 'not what i want, but maybe what i need'. *Ann Fam Med*. Vol 102012:418-427. doi: 410.1370/afm.1379.
42. Kantsiper M, McDonald EL, Geller G, Shockney L, Snyder C, Wolff AC. Transitioning to breast cancer survivorship: perspectives of patients, cancer specialists, and primary care providers. *Journal of general internal medicine*. 2009;24 Suppl 2:S459-466.
43. Ganz PA. Survivorship: adult cancer survivors. *Primary care*. 2009;36(4):721-741.
44. Seehusen DA, Baird D, Bode D. Primary care of adult survivors of childhood cancer. *American family physician*. 2010;81(10):1250-1255.
45. Blanch-Hartigan D, Forsythe LP, Alfano CM, et al. Provision and discussion of survivorship care plans among cancer survivors: results of a nationally representative survey of oncologists and primary care physicians. *Journal of clinical oncology : official journal of the American Society of Clinical Oncology*. 2014;32(15):1578-1585.
46. Sunga AY, Eberl MM, Oeffinger KC, Hudson MM, Mahoney MC. Care of cancer survivors. *American family physician*. 2005;71(4):699-706.
47. Klil-Drori AJ, Yin H, Tagalakis V, Aprikian A, Azoulay L. Androgen Deprivation Therapy for Prostate Cancer and the Risk of Venous Thromboembolism. *European urology*. 2016;70(1):56-61.
48. Hickner J, Kent S, Naragon P, Hunt L. Physicians' and patients' views of cancer care by family physicians: a report from the American Academy of Family Physicians National Research Network. *Family medicine*. 2007;39(2):126-131.
49. Aubin M, Vezina L, Verreault R, et al. Family physician involvement in cancer care follow-up: the experience of a cohort of patients with lung cancer. *Ann Fam Med*. 2010;8(6):526-532.
50. Holge-Hazelton B, Blake-Gumbs L, Miedema B, van Rijswijk E. Primary care for young adult cancer survivors: an international perspective. *Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer*. 2010;18(10):1359-1363.
51. Peikes D, Genevro J, Scholle S, Torda P. The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care. *AHRQ Vol Publication NO. 11-0029*. Rockville, MD: Agency for Healthcare Research and Quality; 2011.
52. AAFP. AAFP Market Research Report. July 2011.
53. Noonan EM, Farrell TW. Primary Care of the Prostate Cancer Survivor. *American family physician*. 2016;93(9):764-770.



54. FamilyDoctor.org. Prostate Cancer | Overview. 1999;
55. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management*. 2013;20(3):35-39.
56. Mullins A, Mooney J, Fowler R. The benefits of using care coordinators in primary care: a case study. *Family practice management*. 2013;20(6):18-21.
57. Cannarella Lorenzetti R, Jacques CH, Donovan C, Cottrell S, Buck J. Managing difficult encounters: understanding physician, patient, and situational factors. *American family physician*. 2013;87(6):419-425.
58. Chambliss ML, Lineberry S, Evans WM, Bibeau DL. Adding health education specialists to your practice. *Family practice management*. 2014;21(2):10-15.
59. Edsall RL, Moore KJ. Thinking on paper: documenting decision making. *Family practice management*. 2010;17(4):10-15.
60. McLeod W, Eidus R, Stewart EE. Clinical decision support: using technology to identify patients' unmet needs. *Family practice management*. 2012;19(2):22-28.
61. Moore KJ. Exam documentation: charting within the guidelines. *Family practice management*. 2010;17(3):24-29.
62. FamilyDoctor.org. Testicular Cancer | Overview. 1999;