PSA TESTING AND EARLY MANAGEMENT OF TEST-DETECTED PROSTATE CANCER-
CONSENSUS AT LAST

Urologists have long argued for sensible guidelines regarding PSA testing and acting upon its results in men wishing to undergo screening for prostate cancer. Confusion has been commonplace given that so many guidelines and opinions exist. Once data was available, Urologists in our region were quick to embrace active surveillance of low-risk disease and defer inappropriate testing in the hope of reducing overtreatment with its potential harms and overdetection.\textsuperscript{1, 2} yet this approach was previously never considered in the most publicised guidelines.

The new Australian guidelines, \textit{PSA Testing and Early Management of Test-detected Prostate Cancer: Guidelines for health professionals}, have now been approved by the National Health and Medical Research Council (NHMRC). A thoughtful and pioneering approach was utilised. The guidelines were developed through a partnership of the Prostate Cancer Foundation of Australia (PCFA) and Cancer Council Australia. For those involved in their creation they had to have demonstrated clinical experience in detecting, diagnosing and/or managing prostate cancer or have relevant epidemiological experience. Importantly, general practitioners and other health practitioners involved in detecting, diagnosing and/or managing prostate cancer. There were also consumer representatives and an Aboriginal and Torres Strait Islander representative.

Unsurprisingly, the guideline does not recommend a population-based screening program for prostate cancer (a program that offers testing to all men in a certain age group who do not have prostate cancer or symptoms that suggest prostate cancer). Everyone agrees that current evidence does not support such a program. The twelve key questions being addressed across Prostate Cancer Risk (1), Testing (5), Multiparametric MRI and prostate Biopsy (2), Active Surveillance (2) and Watchful
Waiting (2). The guidelines provide evidence-based recommendations to health professionals involved in localised prostate cancer risk assessment, surveillance and treatment. They are now being presented to USANZ and other bodies for endorsement.

For the purpose of the review the evidence fell into three categories of recommendation: 1) Evidence-based recommendation (EBR): a recommendation based on the best available evidence identified by a systematic review of evidence. If fitting this category of EBR, it then followed a Grade of recommendation being A (trusted) through D (Weak). 2) Consensus-based recommendation (CBR): a recommendation based on clinical expertise, expert opinion and available evidence, and formulated using a consensus process, after a systematic review of the evidence found insufficient evidence on which to base a recommendation. Finally 3) Practice points were made: a point of guidance to support the evidence-based recommendations, based on expert opinion and formulated by a consensus process, on a subject outside the scope of the systematic reviews.

The key recommendations are to offer evidence-based decisional support to men considering whether or not to have a PSA test accounting for benefits and harms. Offer PSA testing every 2 years from age 50 to age 69, and offer further investigation if total PSA is greater than 3.0ng/mL (EBR; Grade C). For men younger than 50 years offer testing every 2 years from age 45 to age 69 years. After aged 70 years men should be aware the risks of screening might outweigh the benefits. Throughout a lifespan of less than 7 years should preclude screening (EBR, Grade C). They recommended to not offer PSA testing at age 40 years to predict risk of prostate cancer death (CBR). The guidelines also sensibly allow clinicians to be more forceful should a patient’s risk be magnified by family history. Finally regarding testing, as a practice point, a digital rectal exam (DRE) was not recommended as a routine test for men who, after advice, wish to be tested for the presence of prostate cancer. They emphasized it will still be an important part of the man’s assessment on referral to a urologist or other specialist for further assessment prior to consideration for biopsy.
As always, the devil is in the detail. There are some clarifications particularly regarding active surveillance that need to be made and this would be anticipated with any complex guidelines. They recommend to: “Offer active surveillance to men with prostate cancer if all the following criteria are met: PSA ≤20ng/mL; clinical stage T1–2; Gleason score 6. Of course in isolation this may seem reasonable but in a younger man with multiple cores positive and possible a suspicious lesion on multiparametric MRI then one would modify this recommendation (which was only EBR; Grade C in any case). Of course that is what guidelines are- to guide, not rule. Similarly some will feel uncomfortable with the recommendation to “Consider offering active surveillance to men with prostate cancer if all the following criteria are met: PSA ≤10 ng/mL; clinical stage T1–2a; Gleason score ≤ (3 + 4 = 7) and pattern 4 component <10% after pathological review (CBR). For men aged less than 60 years, consider offering active surveillance based on the above criteria, provided that the man understands that treatment in these circumstances may be delayed rather than avoided. Again, neither the volume of disease nor MRI findings has been considered. Certainly, there is still considerable debate on whether pattern 4 disease should be surveilled- particularly in men under 60 years. So further clarification is needed but again the guidelines do have “wriggle room”.

Finally, omitting DRE may miss a small proportion of prostate cancer where a man has a PSA in the normal range. This must be balanced against greater serum testing-so greater good will hopefully prevail and those practitioners comfortable with DRE will continue to perform it.

The area is complex and some may say so too the guidelines. The evidence remains fairly thin with Grade C recommendations abounding. Yes, we certainly need better data but for the first time, health professionals have access to evidence-based recommendations for using serum PSA to assess prostate cancer risk and manage test-detected patients. Overall the messages to our fellow clinicians are simple and unified- PSA testing may be offered in men provided they are well informed and well
selected. This is a good clear message and one that as urologists we should promote, both in Australia and New Zealand.

Disclosure
The author completed was a contributor as an expert advisor to some aspects of the NHMRC Prostate Cancer Guidelines referred to in this editorial

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References


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