

## Prostate Cancer Screening Recommendation

# Frequently Asked Questions



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### About the 2018 recommendation

#### What is the Task Force's prostate cancer screening recommendation?

After a review of the evidence, the Task Force determined that men ages 55 to 69 should make an individual decision about whether to be screened after a conversation with their doctor about the potential benefits and harms. The final recommendation applies to adult men who have not been previously diagnosed with prostate cancer and have no signs or symptoms of the disease.

This recommendation applies to men who are at increased risk for prostate cancer as well, and the Task Force provides additional information to help them make decisions about screening. Doctors should inform their African American patients about their increased risk of developing and dying from prostate cancer, as well as the potential benefits and harms of screening. Doctors should also inform patients with a family history of prostate cancer about their increased risk of developing the disease.

The Task Force does not recommend screening for prostate cancer in men who are older than 70, including African American men and men with a family history of prostate cancer, because the potential benefits do not outweigh the expected harms.

#### What is the difference between this recommendation and the 2012 final recommendation?

Through this final recommendation statement, the Task Force is providing doctors and their patients with important new information about the benefits and harms of screening for prostate cancer.

To update this recommendation statement, the Task Force looked at new evidence that helps us better understand the potential benefits of prostate cancer screening. The Task Force also reviewed new evidence about the potential benefits of active surveillance.

Active surveillance has become a more common treatment choice for men with localized, low-grade prostate cancer over the past several years and may reduce the potential harms of screening in low-risk men who choose this option.

The new evidence and increased use of active surveillance convinced the Task Force to revise its recommendation for men ages 55 to 69. Now, the Task Force recommends that men consider both the potential benefits and harms and make an individual decision about whether to be screened, based on their values and individual circumstances.

The evidence continues to show that the potential benefits do not outweigh the harms of screening in men age 70 years and older. The Task Force recommends against routinely screening for prostate cancer in these men.

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### What is the difference between this recommendation and the 2017 draft recommendation?

Based on the public comments it received, the Task Force added more information to the final recommendation statement about the potential harms of screening and treatment, including psychological harms and harms from active surveillance. In addition, a new study was published since the 2017 draft recommendation on prostate cancer screening; information on this study was added to the final statement. Within the final recommendation statement, there is a section that provides an overview of the themes of the public comments received and how the Task Force responded to them.

### How to interpret the recommendation

#### What is the PSA test?

The PSA test measures the amount of prostate-specific antigen, a type of protein, in a man's blood. When a man has an elevated PSA level, it may be caused by prostate cancer, but it could also be caused by other conditions such as an enlarged prostate or inflammation of the prostate. If a man has a positive test result, he may have a biopsy to check for prostate cancer. The PSA test and follow-up prostate biopsies can't tell for sure which cancers will likely be aggressive and spread and which will not—or which cancers will grow so slowly that they will never cause symptoms. This means some men will benefit from treating screen-detected prostate cancer but many more will not. Unfortunately, treatments are associated with common harms like urinary incontinence and erectile dysfunction.

Until we have better screening tests to distinguish men who will have cancers that spread from those who won't, it's important for men who are considering screening to understand both the potential benefits and harms.

#### Who does the recommendation apply to?

The final recommendation applies to adult men who have not been previously diagnosed with prostate cancer and have no signs or symptoms of the disease. It also applies to men who are at increased risk for prostate cancer, including African American men and men with a family history of prostate cancer.

### What about men younger than 55?

There is very little evidence regarding the potential benefits of starting screening before age 55 or of having a one-time “baseline” PSA test. If younger men have questions about their risk for prostate cancer, we encourage them to speak with their doctor about what is right for them, based on their values and individual circumstances.

### Is a C grade a recommendation against screening?

No, the Task Force is not recommending against screening all men ages 55 to 69. Men should discuss the benefits and harms of screening with their doctor, so they can make the best choice for themselves based on their values and individual circumstances. For men who are more willing to accept the potential harms, screening may be the right choice for them. Men who are more interested in avoiding the potential harms may choose not to be screened.

### How often does the Task Force recommend that men have this discussion about screening with their doctor?

The final recommendation does not contain specific guidance on how often men should be screened. However, we encourage men to continue to have conversations about screening with their doctor over the years, as their values about screening may change over time as they age or develop other health issues.

We do not recommend that men age 70 years and older be screened for prostate cancer routinely because evidence shows that the potential benefits do not outweigh the expected harms for men in this age group.

### What does the Task Force mean when they refer to men's “values”?

Each of us has different values when it comes to what we're willing to do to stay healthy and prevent disease. For example, some men may prefer to avoid a test that can cause anxiety or lead to a hospital visit. These men may choose not to be screened for prostate cancer. Others may be more willing to accept the harms of screening and treatment in exchange for possible benefit, and a PSA test may be the right choice for them.



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The Task Force is providing men with the science about those benefits and harms, so they can make the right choice for themselves, together with their doctor.

### Isn't early detection and treatment of cancer a good thing?

We understand that when someone learns they have cancer, there is a strong desire to treat or remove the cancer, regardless of the potential harms of treatment. For many men, prostate cancer will not cause any problems in their lifetime. For these men, active treatment has no benefit and puts them at risk for significant harms. Research suggests that 20 to 50 percent of men diagnosed with prostate cancer after screening may be overdiagnosed (that is, diagnosed with cancer that won't affect their health during their lifetime).

The discovery of an overdiagnosed cancer can result in overtreatment, including invasive procedures, chemotherapy, and radiation, which can have significant harms. Treating these cancers early may not alter their course, and the cancer may not cause any problems in a man's lifetime. There are also aggressive cancers that do not respond well to current treatments.

### What does the science say about prostate cancer treatment?

This recommendation reflects new evidence about prostate cancer treatment, including the use of active surveillance in men with localized, low-grade prostate cancer. Active surveillance is a way of monitoring prostate cancer that hasn't spread outside the prostate, rather than treating it immediately with surgery or radiation. Active surveillance has become a more common treatment choice over the past several years among men with localized, low-grade prostate cancer and reduces the chance of overtreatment. This surveillance includes regular, repeated PSA testing and often repeated digital rectal examination and prostate biopsy. Men whose cancer progresses during active surveillance are offered surgery or radiation treatment.

The main benefit of treating prostate cancer is that it reduces a man's risk of developing metastatic cancer (spread of cancer cells to new areas of the body) and reduces a man's risk of dying from the disease. This reduction in risk is small, however.

The Task Force found that there are a number of harms associated with treatment, such as erectile dysfunction and urinary incontinence. The benefits of screening are often realized years after treatment, while the harms may occur often and consistently throughout a man's life. More than 2 out of 3 men treated for prostate cancer with surgery to remove the prostate gland develop long-term erectile dysfunction and more than half of men treated with radiation develop long-term erectile dysfunction.

## The benefits and harms of screening

### What's the latest evidence on the benefits of screening?

The evidence the Task Force reviewed indicates the benefits of screening in men between the ages of 55 and 69 include reducing the risk of metastatic cancer (spread of cancer cells to new areas of the body) and reducing the chance of dying from prostate cancer. Although screening men ages 55 to 69 may provide these important benefits, the benefits usually emerge years or even decades after screening and occur in a small number of men.

Studies show that the potential benefits do not outweigh the expected harms of routinely screening men age 70 years and older.

### What new evidence was reviewed since the draft recommendation posted?

The Task Force reviewed new evidence from two studies: the U.S.-based Prostate Cancer Intervention Versus Observation Trial (PIVOT) and the Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP). This new evidence did not change the results of the Task Force's recommendation.

### What's the harm in getting a PSA test?

One of the most important harms is frequent false-positive results. The limitations of the PSA test can often result in false positives, which often lead to immediate additional testing and years of additional close follow-up, including repeated blood tests and biopsies.



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Another important harm is overdiagnosis, which happens when screening leads to the diagnosis of prostate cancer in men who would not have experienced symptoms from cancer during their lifetime. Thus, treatment of these men provides them with no benefit and leads to harmful outcomes. Common harms associated with treatment include erectile dysfunction and urinary incontinence.

### What is overdiagnosis and why is it a serious harm?

Overdiagnosis happens when screening leads to the diagnosis of prostate cancer in men who would not have experienced symptoms from cancer during their lifetime. Thus, treatment of these men provides them with no benefit and leads to harmful outcomes. Common harms associated with treatment include erectile dysfunction and urinary incontinence.

### What is active surveillance?

Active surveillance is a way of monitoring prostate cancer that has not spread outside the prostate, rather than treating it immediately with surgery or radiation. Active surveillance has become a more common treatment choice over the past several years among men with localized, low-grade prostate cancer and may reduce the chance of overtreatment. It includes regular, repeated PSA testing and often repeated digital rectal examination and prostate biopsy. Active surveillance may also offer men with localized, low-grade cancer the opportunity to delay active treatment and complications—or avoid active treatment completely. Men whose cancer progresses during active surveillance are offered surgery or radiation treatment.

## Guidance for men at increased risk

### How do I know if I am at increased risk for prostate cancer?

African American men are more likely to develop prostate cancer than white men. They're also more than twice as likely as white men to die of prostate cancer. This is due in part to African American men having higher rates of more aggressive cancer and the fact that African American men tend to be diagnosed when their cancer is more advanced. The higher rates of death from prostate cancer may also reflect that African American men have lower rates of receiving high-quality care.

Men with a father or brother who has had prostate cancer are also at increased risk for developing the disease. This is particularly important for men whose father or brother have been diagnosed at a younger age or who died from prostate cancer. Men with three first-degree relatives (father, brother, and son) with prostate cancer or two close relatives on the same side of the family with prostate cancer who were diagnosed before age 55 may have an inheritable form of prostate cancer associated with genetic changes that are passed down from one generation to the next.

### What does the Task Force recommend for men at increased risk?

Doctors should talk with their African American patients about their increased risk of developing and dying from prostate cancer, as well as the potential benefits and harms of screening. Doctors should also inform patients with a family history of prostate cancer about their increased risk of developing the disease. This is particularly important for men whose father or brother died from prostate cancer or were diagnosed at a younger age.

The Task Force does not recommend routine screening for prostate cancer in men who are older than age 70 years and older, including African American men and men with a family history of prostate cancer.

The recommendation statement contains a specific section for men at increased risk and includes more information for these men and their doctors to consider as they make decisions about screening.