ALTHOUGH there may be no aspect of men’s healthcare more controversial than prostate cancer screening, for the most part, routine prostate cancer screening is no longer recommended for all men — rather, experts advocate engaging in shared decision-making with your physician, carefully reviewing the pros and cons of prostate cancer screening before saying yes or no, says the July 2015 issue of the Cleveland Clinic *Men’s Health Advisor*.

Proponents say screening with prostate-specific antigen (PSA) blood tests and other methods saves lives because it detects prostate cancer at an earlier, more curable stage.

On the other hand, opponents note that screening can lead to complications from invasive biopsies and treatment of tumors that may never threaten a man’s life.

The following recommendations about prostate cancer screening come from experts, which include the:

- American Cancer Society — a) Average-risk men with at least a 10-year life expectancy should begin discussions about prostate cancer screening at age 50 (younger for higher-risk men); and b) Men with PSA less than 2.5 ng/mL may be retested every two years, while men with PSA greater than 2.5 ng/mL should be screened annually.
New prostate cancer screening recommendations by experts

Written by meg sibal, m.d.
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- American College of Physicians — a) Men ages 50-69 should discuss the risks and benefits of screening with their doctors; and b) Average-risk men younger than age 50 and older than 69, or any man with a life expectancy less than 10-15 years, should not be screened.

- American Urological Association — a) Men ages 55-69 should discuss the risks and benefits of screening with their doctors; b) Screening is not recommended for men younger than age 55, older than age 70, or anyone with a life expectancy of less than 10-15 years; and c) Screening may be done every two years or less frequently, rather than annually.

- National Comprehensive Cancer Network — a) Men with at least a 10-year life expectancy should begin discussions about screening at age 45; b) Screening remains an option for very healthy men over age 70; c) Men ages 45-49 with PSA greater than 1.0 ng/mL and men age 50 and older with PSA less than 3.0 ng/mL and no other indications for biopsy should repeat testing every one to two years; d) Men ages 45-49 with PSA below 1.0 ng/mL should be rescreened at age 50.

- U.S. Preventive Task Force — a) Regardless of age, men without prostate cancer symptoms should not be screened for prostate cancer.

- Dr. Eric A. Klein says, “Based on the available evidence, I recommend a baseline PSA for men starting at around age 50, with the timing of follow-up PSAs based on the initial level and individual risk factors (such as family history). I also recommend that men who reach age 60 with a PSA of less than 2 ng/mL no longer need to be screened."

A Cleveland Clinic expert recommends discussing newer tests that may augment PSA’s predictive power, refine screening and help guide subsequent decisions about biopsy and (if necessary) treatment.

“Talk to your doctor about screening, and if you decide to be screened, ask about these other tests,” says Eric A. Klein, M.D., chairman of Cleveland Clinic’s Glickman Urological & Kidney Institute.
Since elevated PSA levels may result from prostate cancer or non-cancerous conditions, such as benign prostate enlargements or infection, the PSA test cannot accurately predict which men have prostate cancer, nor can it distinguish fast-growing, aggressive tumors from those that may not require treatment.

Thus, researchers have developed tests to complement the PSA and better predict which men will have clinically significant prostate cancer, potentially reducing the number of unnecessary biopsies and treatment.

These tests that aid biopsy decisions include the:

• Prostate Health Index (PHI) — This test measures a PSA precursor protein known as [-2] pro-PSA along with other PSA types. The PHI blood test is indicated for men with a PSA level of 4 to 10 ng/mL, a prognostic gray area that may prompt many doctors to consider recommending a prostate biopsy.

• PCA3 Assay — A urine-based test, it measures prostate cancer antigen 3 (PCA3), a gene specific to prostate cancer. The PCA3 assay is indicated for men who have had a negative biopsy but still have elevated PSA levels — but research suggests that PSA3 also may be useful in guiding decisions about an initial biopsy. “We use PCA3 for patients who come in before an initial biopsy with worrisome PSA levels, in the 3 to 7 [ng/mL] range, when we’re not sure whether that indicates non-cancerous prostate enlargement or prostate cancer,” says Dr. Klein. “If the PCA3 is low, we generally don’t biopsy them. If the PCA3 is higher, we would proceed with biopsy.”

• 4K Score Test — Used by Dr. Klein and colleagues, the 4K Score measures PSA and other prostate-derived proteins and combines them with other patient characteristics to calculate the likelihood of finding high-grade prostate cancer on biopsy. “4K can give a more precise estimate about whether you’re likely to harbor a Gleason 7 or higher cancer,” Dr. Klein says. “If you are, that would justify doing a biopsy.”

To provide physicians with a tool to help decide which men diagnosed with prostate cancer require curative treatment or can be safely monitored with active surveillance, these tests are offered:
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• 4K Score — This test can help physicians decide which patients diagnosed with prostate cancer would require curative treatment or can be safely monitored with active surveillance.

• Genomic Prostate Score — Developed with assistance by Dr. Klein and colleagues at Cleveland Clinic, this genetic test checks biopsy specimens for biologic characteristics associated with aggressive prostate cancer and can predict the likelihood that a cancer will grow and spread.

• Prolaris and Promark — These tests combine traditional risk factors with genetic testing of biopsy samples to estimate a cancer’s aggressiveness.

While active surveillance is now recognized as a viable management strategy for low-risk and some intermediate-risk prostate cancer, some men on surveillance still develop metastatic prostate cancer or die from the disease.

“What that tells you is there’s a real need for these tests,” Dr. Klein says.

“...Many physicians understand that active surveillance is appropriate for many patients, but they still don’t have confidence about how to pick the correct patients. The idea that these tests can help fill that void is gaining wide traction now,” concludes Dr. Klein.