U.S. Preventive Services TASK FORCE

USPSTF Bulletin

An independent, volunteer panel of national experts in prevention and evidence-based medicine

U.S. Preventive Services Task Force Seeks Comments on Draft Recommendation Statement on Screening for Prostate Cancer

Task Force encourages men ages 55 to 69 to make an individualized decision about prostate cancer screening with their clinician; recommends against screening men age 70 years and older

WASHINGTON, D.C. – APRIL 11, 2017 – The U.S. Preventive Services Task Force today posted for public comment a draft recommendation statement and three draft evidence reviews on screening for prostate cancer. Through this draft recommendation, the Task Force is providing clinicians and their patients with information to help guide decisions about screening for prostate cancer.

Through its systematic review of the evidence, the Task Force determined that the potential benefits and harms of prostate-specific antigen (PSA)-based screening are closely balanced in men ages 55 to 69, and that the decision about whether to be screened should be an individual one. Clinicians should talk to men ages 55 to 69 about the potential benefits and harms of screening. This is a **C recommendation.** For men ages 70 years and older, the potential benefits of PSA-based screening do not outweigh the harms, and these men should not be screened for prostate cancer. This is a **D recommendation**.

Draft Recommendation by Age:

55–69: Recommends informed, individualized decisionmaking based on a man's values and preferences.

(C recommendation)

70 and older: Not recommended.

(D recommendation)

Visit www.screeningforprostatecancer.org for more information

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

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, it may be caused by prostate cancer, but it could also be caused by other conditions, such as an enlarged prostate or an inflammation of the prostate. PSA-based screening and follow-up prostate biopsies cannot tell for sure which cancers are likely to be aggressive and spread, and which will not—or will grow so slowly that they will never cause symptoms. Because there is no good way to distinguish men who will have high-risk cancers from those who won't, most men receive surgery or radiation to treat prostate cancer, including many men who do not benefit at all. It's important for men who are considering screening to understand that screening has both potential benefits and harms.

The Task Force reviewed new evidence that increases confidence in the benefits of screening, which includes reducing the chance of dying from prostate cancer. Another important benefit of screening is reducing the risk of metastatic cancer. Metastatic cancer is the spread of cancer cells to new areas of the body. Because prostate cancer often grows slowly, the benefits of screening are generally realized years, even more than a decade, after diagnosis and treatment. The potential harms from screening and treatment, however, may occur immediately. The harms of screening include frequent false-

positive results, which often lead to immediate, additional testing and years of additional close follow-up, including repeated blood tests and biopsies. The harms associated with treatment commonly include sexual impotence and urinary incontinence. Many more men are expected to experience the harms of screening and treatment than will experience benefit.

“Prostate cancer is one of the most common cancers to affect men, and the decision about whether to begin screening using PSA-based testing is complex. 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,” says Task Force member Alex H. Krist, M.D., M.P.H. “In the end, men who are considering screening deserve to be aware of what the science says, so they can make the best choice for themselves, together with their doctor.”

The draft recommendation is also based in part on new evidence on the use of active surveillance, which includes regular, repeated PSA testing and often repeated digital rectal examination and prostate biopsy. Active surveillance has become a more common treatment choice for men with lower-risk prostate cancer over the past several years, and may reduce the chance of overtreatment. It may also offer men the opportunity to delay active treatment and complications—or avoid active treatment completely.

Further, the Task Force reviewed evidence on the benefits and harms of screening for men at higher risk for prostate cancer, such as African American men and those with a family history. This draft recommendation provides additional information to help support these men in making decisions about screening.

“Clinicians should speak 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,” says Task Force chair Kirsten Bibbins-Domingo, Ph.D., M.D., M.A.S. “This recommendation applies to African American men, but we remain particularly concerned about the striking absence of evidence to guide these high-risk men specifically as they make decisions about screening. Additional research on prostate cancer in African American men should be a national priority.”

The Task Force also recommends that clinicians talk with patients who have a family history of prostate cancer, particularly those with a father or brother diagnosed with prostate cancer, about their increased risk of developing the disease. The Task Force calls for more research on the potential benefits and harms of screening for prostate cancer among men with a family history of prostate cancer.

The Task Force’s draft recommendation statement and draft evidence reviews have been posted for public comment on the Task Force Web site at www.screeningforprostatecancer.org from April 11 to May 8. All public comments will be considered as the Task Force develops its final recommendation and final evidence review. Supplemental materials including frequently asked questions, an infographic, and a consumer fact sheet are also available on the Web site.

The Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine that works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.

Dr. Krist is an associate professor of family medicine and population health at Virginia Commonwealth University and an active clinician and teacher at the Fairfax Family Practice Residency. He is codirector of the Virginia Ambulatory Care Outcomes Research Network and director of community-engaged research at the Center for Clinical and Translational Research.

Dr. Bibbins-Domingo is the Lee Goldman, MD endowed chair in medicine and professor of medicine and of epidemiology and biostatistics at the University of California, San Francisco (UCSF). She is a general internist and attending physician at Zuckerberg San Francisco General Hospital and the director of the UCSF Center for Vulnerable Populations at Zuckerberg San Francisco General Hospital.

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