

# Prostate Cancer UK policy position on the PSA test

March 2016

**Until we develop a better test, the prostate specific antigen (PSA) test is our best means of achieving early detection of prostate cancer in men without symptoms, especially those at higher than average risk of the disease**

We believe that any man aged 50 or over who wants a PSA test should have one. We want primary health professionals to follow the national guidance that recommends this (1) and do not want them turning away any man aged 50 or over who asks for a PSA test.

We also agree with the evidence-based recommendation in the national guidance, which states that using the PSA test as a population-wide screening programme will offer more harm than benefit to the general population (1,2).

However, until we have a test that can enable effective risk-based screening, we believe we must change the way the PSA test is currently used if we are to drive improvements in the early detection of prostate cancer in men without symptoms. This includes testing some men younger than 50.

To achieve this change, we have worked with a broad range of clinical experts to reach a consensus on the ways primary health professionals can better use the PSA test. An approach of this kind is often used by organisations to develop guidelines for clinical practice and we have used it to produce four core recommendations (the full consensus guideline for health professionals, which contains 13 statements, is available [here](#) and a lay version is available [here](#)):

- **The choice of a PSA test should be made available to men with a higher than average risk of prostate cancer from the age of 45.**

This includes Black men and men with a family history of the disease. We want these men to be referred for further investigations if their PSA level is higher than 2.5 nanograms per milliliter.

- **Men over 40 without prostate cancer symptoms should consider a 'baseline' PSA test to predict their risk of getting prostate cancer in later life.**

If the PSA level is above the age-specific median value, they should be considered at higher than average risk of prostate cancer and should be encouraged to be re-tested in the future.

In addition:

- **All men should be able to be re-tested in the future, if their PSA test result is 'normal'.**

We recommend primary health professionals take prostate cancer risk factors into account to develop appropriate re-testing intervals, as well as each how often each man prefers to be tested.

- **Men without symptoms who clearly have less than 10 years to live should be recommended against an initial or repeat PSA test, as they are unlikely to benefit.**

We believe it is vital we encourage better use of the PSA test in these ways, while we continue to work with others to [develop a tool that can predict a man's risk of significant prostate cancer](#).

Our aim over the next few years is to be able to only diagnose prostate cancers that need to be treated and not treat clinically insignificant cancers. The risk assessment tool we are developing will achieve this.

Until then, we want primary health professionals to be prepared to discuss the pros and cons of the PSA test with [any man](#) that requests one or that they identify is at higher than average risk of prostate cancer.

## Q & A

### How have we developed this position and why?

We have worked collaboratively with a wide range of health professionals to improve use of the PSA test with men that have no symptoms of prostate cancer. This included primary health professionals.

Currently any man in the UK aged 50 and over who asks for a PSA test and carefully considers the implications with their GP should be given one (1).

But for those men at higher than average risk of the disease, this could be too late. We want these men to have the potential for prostate cancer to be detected early, before they develop symptoms and the disease is advanced and likely to be more difficult to treat.

We also want to make sure that no man is left unmonitored because the first PSA test result is 'normal' and considered to be of no cause for concern.

### Do our recommendations represent a population-wide screening programme?

Our recommendations do not represent a population-wide screening programme because they are focused on specific groups of men - those at higher than average risk of the disease, men under 50 who want a test and men who have a test but have a 'normal' result.

### Why is the PSA test NOT used in a population-wide screening programme?

In January 2016, the UK National Screening Committee once again recommended against a systematic population screening programme for prostate cancer, as the PSA test is not accurate enough to justify a national screening programme (2).

To save one life from prostate cancer, 781 men would need to be screened. Of these, 27 men would have unnecessary treatments (3) – risking life changing side-effects that include erectile dysfunction, urinary incontinence and bowel problems.

Screening all men in the UK with the PSA test would also lead to numerous men having unnecessary biopsies which, for up to 3 in 50 men (6%), can cause a serious infection that can on occasion lead to hospitalization (4).

This evidence demonstrates that a population-wide screening programme, using the PSA test, would result in more harm than benefit and until this changes we will not support the use of the PSA test in this way.

### Why does the PSA test produce these outcomes?

The PSA test is often unreliable. Many men receive 'false positive' or 'false negative' results, which can cause unnecessary anxiety or false reassurance.

- Around three quarters of men (76%) with a raised PSA level do not have prostate cancer (5).
- Almost 1 in 7 men (15%) with a 'normal' PSA level have prostate cancer (6).
- Around 1 in 50 men (2%) with a 'normal' PSA level have aggressive fast-growing prostate cancer (6).

The PSA test and the tests that follow it, for example biopsy, are currently insufficiently sophisticated to accurately distinguish between the aggressive fast-growing forms of prostate cancer and the 'harmless' slow-growing forms (3). This means that some men choose treatment for a type of prostate cancer that would not have caused them any problems or shortened their life and can be left with often life-changing side-effects, such as urinary and bowel problems and problems getting and keeping an erection.

### Where do our recommendations fit now and in the future?

Our recommendations will be promoted to primary health professionals alongside the PCRMP guidance. This will give health professionals both the evidence-based recommendations of national guidance and practical day-to-day guidance developed by the consensus of clinical experts.

We believe that until we have a better test, combining these two forms of guidance will improve the use of the PSA test for men and reduce variation in its use.

## What are we doing to make sure we have a better test?

We are currently working with others to [develop a tool that can predict a man's risk of significant prostate cancer](#).

Our aim over the next few years is to be able to only diagnose prostate cancers that need to be treated and not treat clinically insignificant cancers. The risk assessment tool we are developing will achieve this and enable effective risk-based screening.

## References

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