

The American Urological Association (AUA) today issued new clinical guidance about prostate cancer screening. The guidelines were announced at the association's annual meeting by Peter Carroll, chair of the panel that developed the Statement. The AUA states that its guidelines directly contrast with recent recommendations issued by other major groups.

AUA advises that the prostate-specific antigen (PSA) test should be offered to well-informed men aged 40 years or older who have a life expectancy of at least 10 years.

AUA's statement on the guidelines continues: "The PSA test, as well as how it is used to guide patient care (e.g., at what age men should begin regular testing, intervals at which the test should be repeated, at what point a biopsy is necessary) is highly controversial; however, the AUA believes that when offered and interpreted appropriately, the PSA test may provide essential information for the diagnosis, pre-treatment staging or risk assessment and post-treatment monitoring of prostate cancer."

Major changes to the new AUA guidelines include new recommendations about who should be considered for PSA testing, as well as when a biopsy is indicated following an abnormal PSA reading.

The AUA advises that early detection and risk assessment of prostate cancer should be offered to well-informed men 40 years of age or older who have a life expectancy of at least 10 years.

"The future risk of prostate cancer is closely related to a man's PSA score," the statement continues: "a baseline PSA level above the median for age 40 is a strong predictor of prostate cancer. Such testing may not only allow for earlier detection of more curable cancers, but may also allow for more efficient, less frequent testing. Men who wish to be screened for prostate cancer should have both a PSA test and a digital rectal exam (DRE)."

The Statement also notes that other factors such as family history, age, overall health and ethnicity should be combined with the results of PSA testing and physical examination in order to better determine the risk of prostate cancer. The Statement recommends that the benefits and risks of screening of prostate cancer should be discussed, including the risk of

over-detection (detecting some cancers which may not need immediate treatment).

"The single most important message of this statement is that prostate cancer testing is an individual decision that patients of any age should make in conjunction with their physicians and urologists. There is no single standard that applies to all men, nor should there be at this time," Dr. Carroll said. He also noted that "the panel carefully reviewed the most recently reported trials of PSA testing in both the United States and Europe before finalizing their guidelines. The strengths and limitations of these trials are reviewed in the guideline."

In regard to biopsy, a continuum of risk exists at all values, and major studies have demonstrated that there is no safe PSA value below which a man may be reassured that he does not have biopsy-detectable prostate cancer. Therefore, the AUA does not recommend a single PSA threshold at which a biopsy should be obtained. Rather, the decision to biopsy should take into account additional factors, including free and total PSA, PSA velocity and density, patient age, family history, race/ethnicity, previous biopsy history and co-morbidities.

The AUA statement emphasizes that not all prostate cancers require active treatment and that not all prostate cancers are life-threatening. The decision to proceed to active treatments is one that men should discuss in detail with their urologists to determine whether active treatment is necessary, or whether surveillance may be an option for their prostate cancer. "Prostate cancer comes in many forms, some aggressive and some not," Dr. Carroll said. "But the bottom line about prostate cancer testing is that we cannot counsel patients about next steps for cancer that we do not know exist." He also notes that "the AUA is committed to the timely, expert and appropriate care for men either with or at risk of getting prostate cancer and is prepared to revise these guidelines continuously as new information becomes available."

Additionally, the Best Practice Statement clarifies a number of key points about the use of PSA in treatment selection and post-treatment follow up of prostate cancer patients:

- Serum PSA predicts the response of prostate cancer to local therapy.
- Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA level is equal to or less than 20.0 ng/mL.
- Computed tomography or magnetic resonance imaging scans may be considered for the staging of men with high-risk clinically localized prostate cancer when the PSA is greater than 20.0 ng/mL or when locally advanced or when the Gleason score is greater than or equal to 8.
- Pelvic lymph node dissection for clinically localized prostate cancer may not be necessary if the PSA is less than 10.0 ng/mL and the Gleason score is less than or equal to 6.
- Periodic PSA determinations should be offered to detect disease recurrence.
- Serum PSA should decrease and remain at undetectable levels after radical prostatectomy.
- Serum PSA should fall to a low level following radiation therapy, high intensity focused

ultrasound and cryotherapy and should not rise on successive occasions.

- PSA nadir (low point) after androgen suppression therapy predicts mortality.
- Bone scans are indicated for the detection of metastases following initial treatment for localized disease, but the PSA level that should prompt a bone scan is uncertain. Additional important prognostic information can be obtained by evaluation of PSA kinetics (velocity).
- The kinetics of PSA rise after local therapy for prostate cancer can help distinguish between local and distant recurrence.

The new AUA statement is based on panel review of all available professional literature, members' clinical experience and expert opinion. The AUA Foundation will be issuing an official Patient Guide outlining what men need to know when it comes to prostate cancer testing. The new Best Practice Statement updates the AUA's previous guidance, which was issued in 2000.

Edited by J. Strax from the AUA statement.