



FREQUENTLY ASKED QUESTIONS:

2013 AUA Guideline on the Early Detection of Prostate Cancer

Prostate cancer is the most common non-skin-related cancer among men, and the second leading cause of cancer death in men. In May 2013, the American Urological Association (AUA) released new clinical guidance on the early detection of prostate cancer. This new clinical practice guideline updated the Association's Best Practice Statement on Prostate-Specific Antigen, originally released in 2009. Unlike a best practice statement, which may be based largely on consensus, AUA clinical practice guidelines are developed through a rigorous, systematic review of published literature (including data extraction and analysis), in accordance with the Institute of Medicine's standards for the development of trustworthy guidelines.

Q *It sounds like the AUA is doing an "about face" on its previous recommendations for prostate cancer screening.*

A: This new guidance is significantly different than the document we released four years ago. It is important to note that the AUA's 2009 document was a best practice statement, not a guideline. Guidelines are developed through a rigorous, systematic review of published literature (including data extraction and analysis). The AUA's 2009 best practice statement is a different kind of document – best practice statements are generally consensus-based. In 2009, there wasn't enough evidence to create a guideline. But the randomized controlled trials are more mature at this point, and there is more data available today than there was in 2009.

Q *So is the AUA saying that prostate cancer screening should only be offered to men ages 55 to 69 and no one outside that age range?*

A: What we are saying is that the highest quality evidence for benefit (lower prostate cancer mortality) was found in men ages 55 to 69 screened at two- to four-year intervals, and that the evidence demonstrated that one man per 1,000 screened will avert a prostate cancer death over a decade. However, over a lifetime, this benefit could be much greater. Men younger than 55 or older than 69 who are worried about their personal risk factors should talk with their physicians to determine whether PSA testing is best for them. It is also important to note that this guideline does not apply to symptomatic men or those at high risk for disease. These men are encouraged to discuss their individual case with their doctor, regardless of their age.



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Q Is the AUA continuing to support the use of the PSA test?

A: Yes. There is general agreement that early detection, including PSA screening, has played a key part in decreasing prostate cancer mortality. However, PSA-based screening without clearly targeting those who are most likely to benefit from testing does result in harms, including overdiagnosis and overtreatment. We have to take a more targeted approach to minimize these harms.

Q Is the AUA worried that these new guidelines could result in an increased incidence of men over 55 presenting with advanced disease? Are you turning back the clock?

A: Based on the best available evidence, there is no evidence that this will be the case. In fact, the evidence suggests that this guideline will lead to an improved benefit-to-harm ratio.

Q Does this mean that the AUA is moving more in line with the 2012 U.S. Preventive Services Task Force recommendations on PSA testing?

A: Our new guideline supports the use of the PSA test in a more targeted manner, whereas the USPSTF recommendations do not recommend its use in men of any age. We feel that men ages 55 to 69 who are in good health and have more than a 10- to 15-year life expectancy should have the choice to be tested and not discouraged from doing so.

Additionally, the USPSTF panel that developed the 2012 recommendations did not include representation from the urology community. As the physicians most experienced in the diagnosis and treatment of prostate cancer, we feel that urologists should be involved in the development of prostate cancer screening recommendations to ensure that the guidance is evidence-based and also targets the preferences of individual patients.

The AUA strongly supports the inclusion of specialists on the USPSTF (as outlined in the USPSTF Transparency and Accountability Act) and other bodies that develop recommendations that impact patient care.

Q The AUA was very extreme in responding to the USPSTF's 2012 recommendations against the use of PSA. How do you explain the organization's shift in opinion?

A: The AUA remains in disagreement with the USPSTF in its general statements against the use of PSA testing in all men. We support a man's right to be tested for prostate cancer – and to have his insurance pay for it, if medically necessary – if, in fact, he decides to do so following a detailed conversation with his physician about the benefits and harms of screening. What we're saying in our guideline is that screening as a routine is not recommended in all men.

Q Did the AUA update its PSA recommendations in response to the USPSTF recommendations? What about the recent guidance from ACP?

A: No. The AUA reviews and updates all of its guidelines on a regular basis. Our guidelines on the early detection of prostate cancer were well underway when the USPSTF released their recommendations in 2012. The recently publicized ACP guidance was also originally approved in 2012 and published in 2013.

Q Should I be proactive in communicating the new guidelines with primary care providers in my area?

A: Yes. The AUA is in the process of preparing supplemental materials that urologists can share with primary care providers in their communities. More information about these tools will be available in late May; the toolkit will be available on AUAnet.org.



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