**PROSTATE CANCER SCREENING UPDATE**

**European Association of Urology (EAU), 2019**

The EAU’s Position Paper, published in the journal European Urology\*, represents the conclusions of probably the most expert, unbiased body so far to report on Prostate Cancer (PCa) Screening. This is timely as the UK’s annual toll of deaths from PCa continues to rise, now topping 12,000, with deaths exceeding those from breast cancer. Whilst rapid advances have been made in the diagnosis and treatment of early, curable PCa, 50% of UK men still present with advanced, incurable PCa. Furthermore, there has been no updating of NHS guidance since the National Screening Committee counselled against population-based PCa screening in 2016.

The EAU report is based on over 80 references to articles in peer-reviewed journals published mostly since 2016. At its core are long term studies on PSA screening running out to 20 years and demonstrating a 50% reduction in the death rate from PCa compared with unscreened men. Supporting this are the reports on second line “reflex” tests and MRI scanning which have reduced by a third the number of men who require prostatic biopsies. This in turn has reduced the number of men diagnosed with non-aggressive, clinically insignificant cancer. For those men who are nevertheless diagnosed with clinically insignificant cancer, recent studies have demonstrated the safety of Active Surveillance for their management. Specialist urological practice has thus comprehensively demonstrated that it has overcome the two principal disadvantages of screening, namely “over-diagnosis” and “over-treatment”.

The report provides early detection strategies that avoid over-diagnosis and over-treatment whilst targeting men at risk. A family history of prostate cancer or breast cancer and black African/Caribbean/American ethnicity are well recognised, but the report emphasizes the value of an early PSA in a man’s 40s; a PSA above 1.00ng/ml at this age or above 2.00ng/ml in a man’s 50s are the most powerful tools to identify the risk of developing aggressive PCa. Screening frequency can then be adjusted according to risk: 1-2 yearly for men at high risk and 5 yearly at least for men at low risk.

The report highlights the role of MRI and novel biomarkers as well as providing a screening algorithm commencing at age 45. The report concludes as follows:

“Organised, population-based PSA screening programmes should be implemented at a European level to reduce PCa mortality. A risk-adapted strategy based on PSA values at the age of 45 years should be offered to well-informed men, in whom screening intervals should be individualised according to baseline PSA levels. PSA testing should be stopped in men with life expectancy of <10 years to minimise the risk of over-diagnosis.”

If the wisdom of this report is accepted in the UK, the questions that arise are how best to inform UK men and how effective screening could be implemented, given the current structure of Primary Care.

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