

*Figure.* Screening for prostate cancer: clinical summary of a U.S. Preventive Services Task Force (USPSTF) recommendation.

## Annals of Internal Medicine



### Screening for Prostate Cancer: Clinical Summary of a U.S. Preventive Services Task Force Recommendation

Population	Men Younger than Age 75 Years	Men Age 75 Years or Older
Recommendation	<b>No recommendation Grade: I (Insufficient Evidence)</b>	<b>Do not screen Grade: D</b>
Risk assessment	Prostate cancer is more common in older men, African Americans, and men with a family history of prostate cancer. The same uncertainties about the effects of screening that apply to other men also apply to these higher-risk men.	
Screening tests	The prostate-specific antigen (PSA) test is more sensitive than the digital rectal examination (DRE). The conventional PSA test cut-point of 4.0 µg/L misses some early cancer. However, lowering the cut-point would increase the rate of false-positive results. Variations of PSA screening have not yet been demonstrated to improve health outcomes.	
Screening intervals	If PSA screening reduces mortality, screening every 4 years may be as beneficial as annual screening.	
Interventions	Management strategies for localized prostate cancer include watchful waiting, active surveillance, surgery, and radiation therapy. There is no consensus regarding optimal treatment.	
Balance of harms and benefits	<ul style="list-style-type: none"> <li>The harms of screening include the discomfort of prostate biopsy and the psychological harm of false-positive test results.</li> <li>Harms of treatment include erectile dysfunction, urinary incontinence, bowel dysfunction, and death. A proportion of those treated, and possibly harmed, would never have developed cancer symptoms during their lifetime.</li> </ul>	
	For men younger than age 75 years, evidence is inadequate to determine whether screening improves health outcomes.  Therefore, the balance of harms and benefits cannot be determined.	For men age 75 years or older and for those whose life expectancy is 10 years or fewer, the incremental benefit from treatment of prostate cancer detected by screening is small to none.  Therefore, harms outweigh benefits.
Suggestions for practice	Clinicians should discuss the potential benefits and known harms of PSA screening with their patients younger than age 75 years. Men in this age group should be informed of the gaps in the evidence, and their personal preferences should guide the decision of whether to order the test.	
Other relevant recommendations from the USPSTF	A list of USPSTF recommendations on cancer screening can be found at <a href="http://www.preventiveservices.ahrq.gov">www.preventiveservices.ahrq.gov</a> .	

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement (including a summary of research gaps), and supporting documents, please go to [www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov).

**Table 1. What the USPSTF Grades Mean and Suggestions for Practice**

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer/provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF = U.S. Preventive Services Task Force.

**Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit**

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings that are not generalizable to routine primary care practice a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

\*The U.S. Preventive Services Task Force (USPSTF) defines *certainty* as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.