



Complete Summary

GUIDELINE TITLE

Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2008 Aug 5;149(3):185-91. [19 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

It updates a previously published version: Screening for prostate cancer: recommendations and rationale. *Ann Intern Med* 2002 Dec 3;137(11):915-6. [8 references] [PubMed](#).

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
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SCOPE

DISEASE/CONDITION(S)

Prostate cancer

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Preventive Medicine
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for prostate cancer
- To update the 2002 USPSTF recommendations on screening for prostate cancer

TARGET POPULATION

Adult males

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for prostate cancer using prostate-specific antigen (PSA)

MAJOR OUTCOMES CONSIDERED

Key Question 1: Does screening for prostate cancer with prostate-specific antigen (PSA), as a single-threshold test or as a function of multiple tests over time, decrease morbidity or mortality?

Key Question 2: What are the magnitude and nature of harms associated with prostate cancer screening other than overtreatment?

Key Question 3: What is the natural history of PSA-detected, non-palpable, localized prostate cancer?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted evidence review was prepared by the Agency for Healthcare Research and Quality (AHRQ) staff for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

In 2002, the USPSTF found insufficient evidence to recommend for or against routine screening for prostate cancer. The USPSTF found good evidence that prostate-specific antigen (PSA) screening can detect early-stage prostate cancer but found mixed and inconclusive evidence that screening and early detection improve health outcomes. Consequently, the USPSTF was unable to determine the balance between benefits and harms of periodic screening for prostate cancer.

The analytic framework that guided the previous USPSTF evidence review (see Figure in the Evidence Update [see the "Availability of Companion Documents" field]) included 8 key questions about benefits and harms of prostate cancer screening and treatment. This evidence update focuses on critical gaps in the evidence that the Task Force identified in the previous review: the lack of good-quality studies linking screening to improved health outcomes; limited information about harms of screening; and a paucity of knowledge about the natural history of PSA-detected, nonpalpable, localized prostate cancer (the most common type of prostate cancer detected today). These evidence gaps produced 3 new key questions for this update:

1. Does screening for prostate cancer with PSA, as a single-threshold test or as a function of multiple tests over time, decrease morbidity or mortality?
2. What are the magnitude and nature of harms associated with prostate cancer screening other than overtreatment?
3. What is the natural history of PSA-detected, nonpalpable, localized prostate cancer?

After consultation with USPSTF liaisons and content experts, AHRQ staff chose a broad definition of PSA screening that included evolving prognostic measures, such as PSA velocity and doubling time. However, a comparison of the performance characteristics of such measures with traditional single-threshold PSA testing is outside the scope of this review.

Data Sources

For evidence on health outcomes associated with PSA screening, PubMed was searched for English-language articles indexed between 1 January 2002 and 12 July 2007 by using combinations of the Medical Subject Heading (MeSH) terms and keywords *prostate neoplasms*, *screening*, *prostate-specific antigen*, *early diagnosis*, *PSA velocity*, *PSA doubling time*, and *prostate specific antigen doubling*.

For evidence on the harms of screening for prostate cancer, PubMed was searched for English-language articles indexed between 1 January 2002, and 12 July 2007 by using combinations of the MeSH terms and keywords *prostate neoplasms*; *screening*; *false positive reactions*; *adverse effects*; *mass screening/adverse effects*; *mass screening/psychology*; *anxiety*; *quality of life*; and *health knowledge*, *attitudes*, *practice*.

For evidence on the natural history of PSA-detected, nonpalpable, localized prostate cancer, PubMed was searched for English-language articles indexed between 1 January 2002 and 23 August 2007 by using combinations of the MeSH terms and keywords *prostatic neoplasms, natural history, epidemiology, disease progression, survival analysis, watchful waiting, active surveillance, population surveillance, expectant management, and conservative management*.

Additional articles were identified through a search of the Cochrane Library, recommendations of experts, and a hand search of reference lists from major review articles and studies.

Study Selection

Two reviewers independently reviewed the title lists, abstracts, and full articles by using predetermined inclusion and exclusion criteria. Articles selected by at least 1 reviewer advanced to the next stage of review.

For key question 1, eligible studies were randomized, controlled trials (RCTs), meta-analyses, and systematic reviews that compared screening with no screening (or usual care) in general primary care populations and reported morbidity or mortality outcomes. Although the 2002 USPSTF review considered case-control studies and ecological data related to this key question, these study types were excluded from this part of the evidence update to avoid potential sources of confounding that are inherent in nonrandomized studies.

For key question 2, eligible studies were randomized or nonrandomized comparative studies that reported quantitative health or quality-of-life outcomes related to a false-positive screening result. Studies that reported only harms resulting from prostate cancer treatment were excluded.

For key question 3, eligible studies were RCTs and cohort studies that reported health outcomes of patients with stage T1c (nonpalpable, localized, PSA-detected) prostate cancer who did not receive active treatment (including patients assigned to watchful waiting or active surveillance protocols). To ensure that the most applicable information on natural history was retrieved, studies that predominantly involved patients with non-PSA-detected cancer (defined as comprising $\geq 80\%$ of the study population), were too small to draw reliable conclusions about health outcomes (defined as < 50 patients in the watchful waiting or surveillance group), or did not provide separate data on patients with stage T1c prostate cancer were excluded.

NUMBER OF SOURCE DOCUMENTS

10 articles met inclusion criteria for this evidence update.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted evidence review was prepared by the Agency for Healthcare Research and Quality (AHRQ) staff for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction and Quality Assessment

For all citations that met the initial eligibility criteria, 2 reviewers reviewed the full articles and independently rated their quality by using previously published USPSTF criteria. Disagreements between reviewers regarding article inclusion and quality rating were resolved through a consensus process. The quality of randomized controlled trials (RCTs) and cohort studies were assessed on the following items: initial assembly and maintenance of comparable groups; absence of important differential loss to follow-up or overall high loss to followup; use of equal, valid, and reliable outcome measurements; clear definition of interventions; and appropriateness of outcomes. Systematic reviews and meta-analyses were evaluated on the following items: comprehensiveness of sources considered, appropriateness of search strategy, standard appraisal of included studies, validity of conclusions, recency, and relevance. The Appendix Table (available at <http://www.ahrq.gov/clinic/uspstf/uspsprca.htm>) describes more thoroughly the criteria and definitions for USPSTF quality ratings.

Data Synthesis and Analysis

The data were synthesized qualitatively by key question in tabular and narrative formats. Data from the 2002 USPSTF review relevant to key questions 1 and 2 are included to facilitate an overall assessment of the body of evidence. Qualitative synthesis was not performed because of the paucity and heterogeneity of included studies.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its

recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

*A, B, C, D, and I (*Insufficient*) represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose-response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study

quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med.* 2007;147:871-875 [5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or 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 or 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 there are other considerations in support of the offering/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 (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force 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.

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 factors such as: <ul style="list-style-type: none"> • The number, size, or quality of individual studies

Level of Certainty	Description
	<ul style="list-style-type: none"> • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence <p>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.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • 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 not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
 External Peer Review
 Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for screening for prostate cancer from the following groups were discussed: the American Academy of Family Physicians, the American College of Physicians, the American College of Preventive Medicine, the American Medical Association, the American Cancer Society, and the American Urological Association.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years. **This is an I statement.**
- The USPSTF recommends against screening for prostate cancer in men age 75 years or older. **This is a grade D recommendation.**

Clinical Considerations

Patient Population under Consideration

This recommendation applies to men in the general U.S. population.

Risk Assessment

Older men, African-American men, and men with a family history of prostate cancer are at increased risk for diagnosis and death from prostate cancer. Unfortunately, the previously described gaps in the evidence regarding potential benefits of screening also apply to these men.

Screening Tests

The prostate-specific antigen (PSA) test is more sensitive than the digital rectal examination for detecting prostate cancer. The conventional PSA screening cut-point of 4.0 micrograms/L detects many prostate cancer cases; however, some early cases of prostate cancer will be missed by this cut-point. Using a lower cut-point to define an abnormal PSA detects more cases of cancer.

The proportion of cancer cases detected by lower cutpoints that would ever become clinically apparent is unknown; lower cut-points would label many more men as potentially having cancer. For example, lowering the PSA cut-point to 2.5 micrograms/L would more than double the number of U.S. men between 40 and 69 years of age with abnormal results.

Variations of PSA screening, including the use of age-adjusted PSA cut-points, free PSA, PSA density, PSA velocity, PSA slope, and PSA doubling time, have been proposed to improve detection of "clinically important" prostate cancer cases. However, no evidence suggests that any of these testing strategies improves health outcomes.

Suggestions for Practice

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

Treatment

Because of the uncertainty about the benefits of treating prostate cancer detected by screening men younger than age 75 years, there is no consensus regarding optimal treatment. Current management strategies for localized prostate cancer include watchful waiting (observation with palliative treatment for symptoms only), active surveillance (periodic biochemical monitoring with conversion to curative treatment for signs of disease progression), radical prostatectomy, external-beam radiation therapy, and brachytherapy (or radioactive seed implantation therapy).

If treatment for prostate cancer detected by screening improves health outcomes, the population most likely to benefit from screening will be men age 50 to 74 years. Even if prostate cancer screening is determined to be effective, the length of time required to experience a mortality benefit is greater than 10 years. Because a 75-year-old man has an average life expectancy of about 10 years, very few men age 75 years or older would experience a mortality benefit. Similarly, men younger than age 75 years who have chronic medical problems and a life expectancy of fewer than 10 years are also unlikely to benefit from screening and treatment.

Screening Intervals

The yield of screening in terms of cancer cases detected declines rapidly with repeated annual testing. If screening were to reduce deaths, PSA screening as infrequent as every 4 years could yield as much of a benefit as annual screening.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

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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 (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

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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 factors such as: <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice

Level of Certainty	Description
	<ul style="list-style-type: none"> • Lack of coherence in the chain of evidence <p>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.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • 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 not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

- In men younger than age 75 years, the U.S. Preventive Services Task Force (USPSTF) found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes, compared with treatment after clinical detection.
- In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits from treatment for prostate cancer detected by screening are small to none.

POTENTIAL HARMS

Harms of Detection and Early Treatment

- The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate- to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.
- There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision-making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print

formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

- Patient Resources
- Personal Digital Assistant (PDA) Downloads
- Pocket Guide/Reference Cards
- Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

- Staying Healthy

IOM DOMAIN

- Effectiveness
- Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2008 Aug 5;149(3):185-91. [19 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2008 Aug)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

It updates a previously published version: Screening for prostate cancer: recommendations and rationale. *Ann Intern Med* 2002 Dec 3;137(11):915-6. [8 references] [PubMed](#).

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#) and the [Annals of Internal Medicine Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Lin K, Lipsitz R, Miller T, Janakiraman S. Benefits and harms of prostate-specific antigen screening for prostate cancer: an evidence update for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2008;149:1-8. Available from [Annals of Internal Medicine Online](#).
- Screening for prostate cancer: clinical summary of U.S. Preventive Services Task Force recommendation. 2008. Available in Portable Document Format (PDF) from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).
- Harris RP, Lohr KN, Beck R, Fink K, Godley P, Bunton A. Screening for Prostate Cancer. Rockville (MD); Agency for Healthcare Research and Quality; 2002 Oct. (Systematic evidence review, No. 16). Available in Portable Document Format (PDF) from the [Agency for Healthcare Research and Quality \(AHRQ\) Web site](#).
- A continuing medical education (CME) activity is available from the [Annals of Internal Medicine Web site](#).

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. *Ann Intern Med.* 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. *Ann Intern Med.* 2007;147:117-122. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med.* 2007;147:871-875. [5 references].

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following is also available:

- The guide to clinical preventive services, 2007. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2007. 228 p. Electronic copies available from the [AHRQ Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following is available:

- Summaries for patients. Screening for prostate cancer with prostate-specific antigen testing: U.S. Preventive Services Task Force recommendations. *Ann Intern Med.* 2008 Aug 5;149(3):I-37. Available from the [Annals of Internal Medicine Web site](#).
- Men: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the [USPSTF Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

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NGC STATUS

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