Cancer Group Shifts Toward More Prostate Screening

New guidance says PSA blood tests should be offered more proactively, reviving a debate over benefits, harms and equity.



A blood-test vial and medical gloves sit on an exam room counter to represent prostate cancer screening.

The American **Cancer** Society has changed its advice on **prostate** cancer **screening**, moving from a more cautious "talk it over first" approach to a more proactive recommendation for PSA blood tests for many people in their 50s and 60s. In an article for The Conversation, Dr. Andrew Wolf of the University of Virginia, one of the lead authors of the new **guidelines**, explained that the group now recommends screening every two years from ages 50 through 69 for people at average risk.

The PSA test measures prostate-specific **antigen**, a protein made by prostate cells that can rise when cancer is present, though it can also rise for other reasons. The prostate is a gland that some people have, and cancer in it is one of the major cancer concerns for men as they age. Screening means testing people who do not necessarily have symptoms, with the goal of finding disease early enough to treat it more successfully.

The new guidelines are not the same for everyone. The American Cancer Society says people at higher risk, including Black men and men with a strong family history of prostate cancer, should begin annual PSA screening at age 45 and continue through age 69. A strong family history means a close family member was diagnosed before age 65, or multiple family members were diagnosed at any age. People with just one family member diagnosed at age 65 or older are advised to start at 45 but screen every two years.

For ages 70 to 74, the group recommends a discussion with a health care provider rather than a blanket rule, because the balance between benefit and harm is less certain. For people over 74, the group recommends against screening, saying the likely harms are greater than the likely benefits. The guidelines also recommend against using a digital rectal exam as the screening test, because the PSA blood test is more effective for that purpose, though the exam may still be used when doctors are checking symptoms or following up on an abnormal PSA result.

The important tension is that screening can save lives, but it can also cause harm. A false positive result means a test looks concerning even though cancer is not actually present, which can lead to anxiety and additional medical procedures. Screening can also find tumors that might never have harmed a person during their lifetime. Once cancer is found, patients and doctors may face pressure to treat it, and **treatment** can bring side effects. That

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is why prostate cancer screening has been debated for years.

Wolf argues that the **evidence** has shifted. According to his explanation in The Conversation, newer understanding suggests that PSA screening reduces the risk of dying from prostate cancer and the risk of **metastatic** disease, which means cancer that has spread to other parts of the body, more than researchers once believed. At the same time, he says doctors have become better at reducing the downsides of screening, including unnecessary treatment of tumors that are unlikely to cause long-term harm.

Part of the shift comes from rethinking older studies. Two large screening trials published in 2009 shaped medical opinion for years. One U.S. study found no benefit from screening, while a European study found only a small benefit. But Wolf says the U.S. study had a major problem: many men in the control group, the group that was not supposed to receive screening, actually did get screened. That made it hard to compare screened people with truly unscreened people. In the European study, by contrast, most people assigned to no testing did not get PSA tests, making it a cleaner comparison.

With more than two decades of follow-up in the European study, screening was linked to a 13% reduction in the risk of dying from prostate cancer. About 500 men needed to be screened to prevent one prostate cancer death. Wolf notes that this may sound modest, but he compares it to other cancer screenings that are routinely offered, such as mammography for breast cancer.

The guidelines also put health disparities at the center of the decision. Black men, according to the article, have about a two-thirds higher risk of developing prostate cancer than white men and are also more likely to have advanced disease when diagnosed. Wolf points to a mix of possible reasons, including genetic, environmental, social and health care access factors. That makes the screening debate not only a medical question, but also an equity question: if one group faces higher risk and later **diagnosis**, should guidelines push harder for earlier testing?

Not every major medical group is in the same place. The U.S. Preventive Services Task Force, an influential panel that reviews evidence on preventive care, currently says clinicians should not screen for prostate cancer unless a patient chooses it after discussing the issue. Its last update was in 2018, when it judged the benefits and harms to be closely balanced. The task force has been updating its guidance, and Wolf says it may move closer to the American Cancer Society's position.

That difference shows why guidelines are not just lists of medical facts. They are judgments about what risks are acceptable, how much uncertainty society can tolerate, and whether avoiding unnecessary treatment should matter more or less than catching dangerous cancers earlier. The new American Cancer Society guidelines do not end that debate, but they do move one major organization toward saying that, for many people in midlife, the chance to detect prostate cancer earlier is worth a more active screening approach.

Written from reporting by The Conversation.

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THINK IT THROUGH

1. When evidence shows a screening test can save some lives but also lead to unnecessary procedures, who should decide whether the trade-off is worth it: medical organizations, individual patients, doctors, or some combination?

2. Should groups at higher risk receive different screening recommendations, or does that risk creating unfair or confusing medical standards?

3. What kind of evidence would you want before changing a long-standing medical guideline: new studies, longer follow-up, fewer side effects, better technology, or something else?

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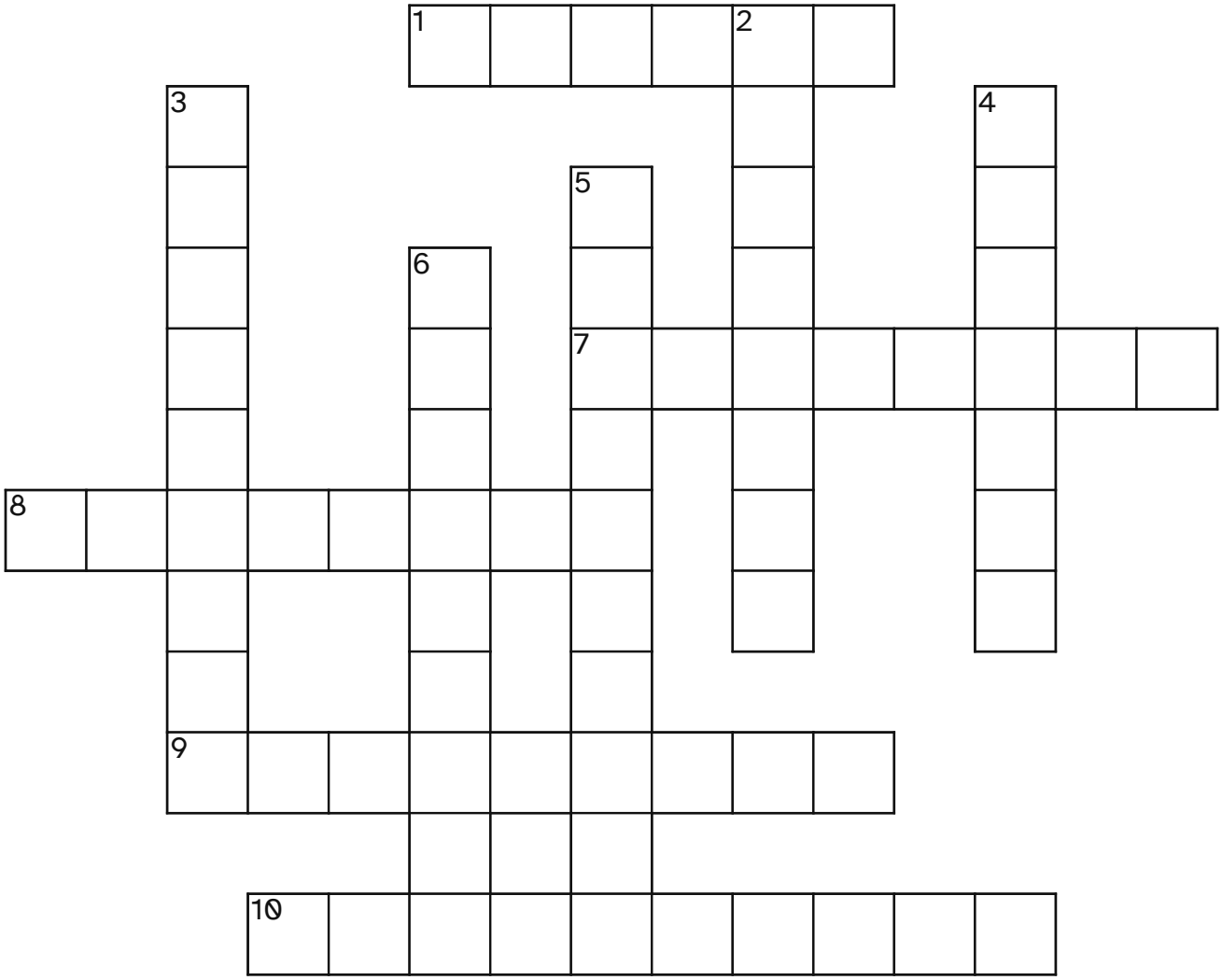
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INEQUITY METASTATIC PROSTATE SCREENING TREATMENT

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ACROSS

1 Disease marked by uncontrolled cell growth that can spread

7 Unfair gap in opportunities, care, or health outcomes

8 Gland beneath the bladder that adds fluid to semen

9 Early testing for illness in people without warning signs

10 Having spread from an original body site to other areas

DOWN

2 Facts and research findings supporting a health recommendation

3 Finding a condition using tests, signs, and medical details

4 Measurable protein in blood made by certain cells

5 Recommended standards for professional care decisions

6 Medical care to cure, manage, or lessen effects of illness

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Where this came from

This article was written for 3andB from the reporting below. It is not a reprint — the wording is ours and the facts are theirs.

The Conversation

"Prostate cancer testing now urged for men in their 50s and 60s – a lead author of the new screening guidelines explains why"

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https://theconversation.com/prostate-cancer-testing-now-urged-for-men-in-their-50s-and-60s-a-lead-author-of-the-new-screening-guidelines-explains-why-296645

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