Prostate Specific Antigen (PSA) testing

1. Never check PSA without counselling the patient, discussing the need for further investigation including biopsy, and gaining informed consent.

Information about these tests for patients is available at: cancerscreening.nhs.uk/prostate/prcm-aim.html or macmillan.org.uk/Cancerinformation/Testsscreening/ThePSTest or prostatecanceruk.org/information/diagnosis/diagnosis-tests/psa-test

An on-line decision aid is available at: sdm.rightcare.nhs.uk/pda/psa-testing

2. Prostate cancer detected after PSA testing is diagnosed about six years earlier, but it is uncertain whether there is survival benefit.

3. Normal PSA does not exclude prostate cancer. Approximately 15% of people with prostate cancer will have normal PSA. Some aggressive tumours do not raise PSA. If digital rectal examination (DRE) is suspicious refer regardless of PSA.

4. PSA is prostate specific, not cancer specific.

5. Approximately 65% of raised PSA values are not due to prostate cancer. Benign prostatic hypertrophy (BPH), prostatitis and urinary infection can raise PSA values.

6. If a single PSA is raised (without probable explanation) further investigation is needed. Don’t delay – refer immediately.

7. Even slight rises beyond the normal for age in PSA are associated with 15%–20% risk of prostate cancer.

8. Never manage a patient with a raised PSA by watchful waiting until the diagnosis has been established.

9. If there is probable explanation for a slight rise in PSA without abnormal examination, repeat the test in 3–4 weeks. Refer if value remains raised. PSA may be increased by:
   - UTI (one month)
   - ejaculation (48 hours)
   - DRE and cycling (possibly)
   - instrumentation, catheterisation or biopsy (six weeks).

10. Alternatives to PSA are under development but not yet recommended. These include PSA velocity, PSAD, PCA3 and combination scores eg ProstateCheck.