



HRSA
Health Resources & Services Administration

Going Beyond "Grade C"

An Updated Rubric for Prostate Cancer Screening in the Primary Care Setting

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Vision: Healthy Communities, Healthy People



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Meet Our Presenter



David Einstein, MD

Disease Group Leader, Beth Israel Deaconess Medical Center
Assistant Professor, Harvard Medical School

Clinical leadership: Academic medical oncologist specializing in genitourinary (GU) cancers; leads the BIDMC GU Medical Oncology program and co-chairs the Harvard Cancer Center prostate working group.

Recognition: Named a top prostate cancer oncologist by Newsweek (2024) and a top Boston medical oncologist by Boston Magazine (2025, 2026).

Research: Patient-centered endpoints, immunotherapy, and radioligand therapy in prostate and kidney cancers.

Acknowledgements and COI

This presentation is based on a prior version available for CME through the Massachusetts Department of Public Health and Massachusetts Medical Society:

Online CME course from the Massachusetts Medical Society discussing updated approaches to prostate cancer screening and decision-making in primary care settings.

My Disclosures

None relevant to this presentation
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Honoraria/consulting: Bayer, J&J, Nimbus, Xilio, DAVA Oncology

Learning Objectives

Upon completion of this activity, participants will be able to:

- Understanding common myths about prostate cancer, diagnoses and treatment.
- Describe modern paradigms that reduce over-diagnosis and over-treatment in prostate cancer screening, including MRI-based biopsy triage and active surveillance for low-risk disease.
- Interpret PSA values in the clinical context of prostate size, benign prostatic hyperplasia (BPH), and other benign causes of PSA elevation to guide appropriate evaluation and referral.
- Summarize updated evidence from major prostate cancer screening trials, including the risks and benefits of screening.
- Apply practical strategies to communicate nuanced risks and benefits of prostate cancer screening and management options, with patients.

Communicating about Prostate Cancer Testing and Treatment

“Shared Decision-Making" Isn’t Enough
We Play an Active Role in Shaping Patient Preferences

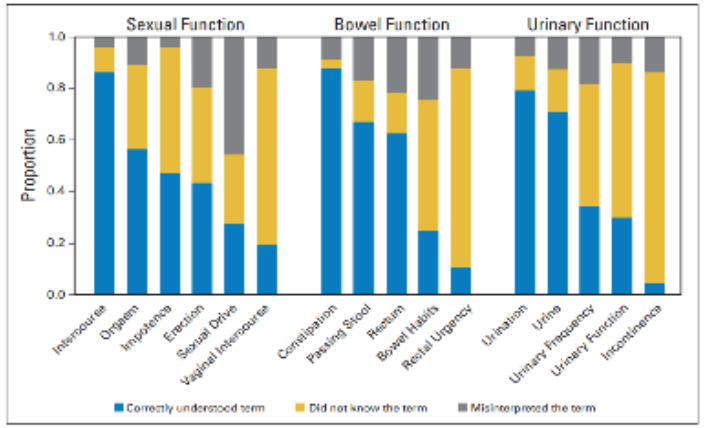
Patients pick up on:

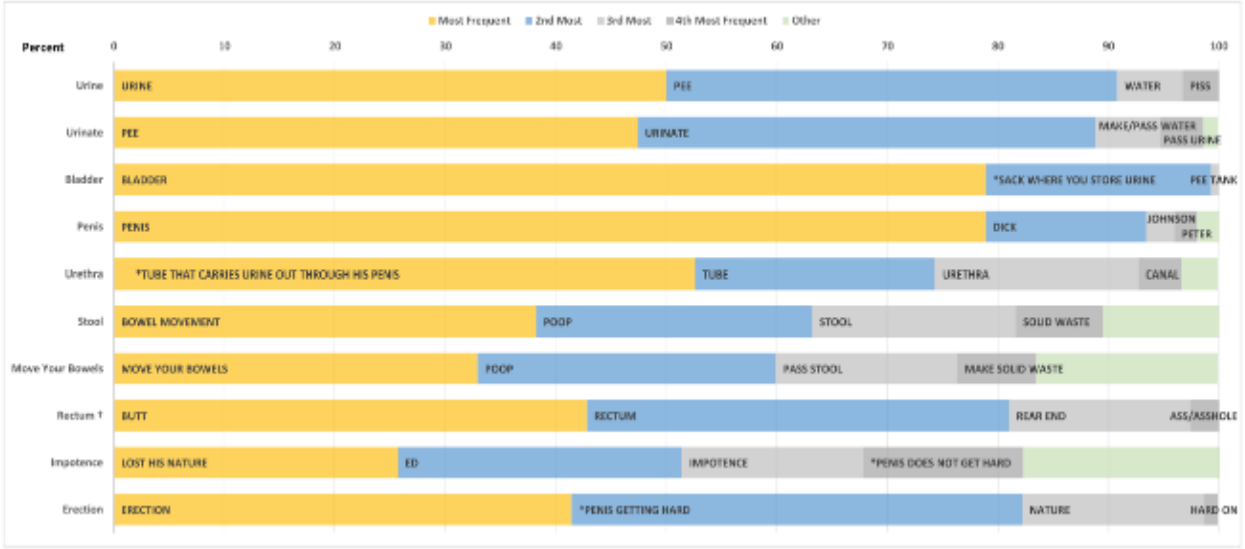
- How much time we spend on a given topic
- How much we return to a given topic
- Subtle differences in phrasing
- What we present as the “default”

Patients factor in:

- “Salience”: how much of a concern is a theoretical future risk versus immediate concerns (pain, financial/housing stressors, etc.)
- What they’ve heard from friends, family and trusted community members

Patients don’t necessarily use the same language we do





Kilbridge K et al., JCO 2009 & Kilbridge K et al., Cancer 2024

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Common Myths About Prostate Cancer

These are worth acknowledging up front!

1. Prostate cancer is common, but it's over diagnosed.
2. No one / Everyone should get screened for prostate cancer.
3. If I get tested for prostate cancer, then I'll have to get biopsies, surgery, radiation, etc. And that will just lead to urinary leakage, erectile dysfunction, and worse.
4. A blood test can clearly tell who does and doesn't have prostate cancer.
5. Prostate cancer is a death sentence. (Or, once it has spread, it is not treatable.)
6. I have no pain, so I can't have cancer.
7. If I eat right and exercise, I can prevent prostate cancer.
8. Natural supplements will do a better job treating cancer and with fewer side effects than surgery, radiation, and doctor-prescribed medications.
9. If I get prostate cancer treatment, I won't be able to work, and I'll become a financial burden.
10. Clinical trials aren't right for me.

Myth 1: Prostate Cancer is Common, but It's Over Diagnosed

Male		
Prostate	313,780	30%
Lung & bronchus	110,680	11%
Colon & rectum	82,460	8%
Urinary bladder	65,080	6%
Melanoma of the skin	60,550	6%
Kidney & renal pelvis	52,410	5%
Non-Hodgkin lymphoma	45,140	4%
Oral cavity & pharynx	42,500	4%
Leukemia	38,720	4%
Pancreas	34,950	3%
All sites	**1,053,250**	



Male		
Lung & bronchus	64,190	20%
Prostate	35,770	11%
Colon & rectum	28,900	9%
Pancreas	27,050	8%
Liver & intrahepatic bile duct	19,250	6%
Leukemia	13,500	4%
Esophagus	12,940	4%
Urinary bladder	12,640	4%
Non-Hodgkin lymphoma	11,060	3%
Brain & other nervous system	10,170	3%
All sites	**323,900**	



Myth 2a: No One Should Get Screened for Prostate Cancer

Why has prostate cancer screening been so controversial?

- Cancer screening studies are too hard to do!
- Trials have not always shown that screening clearly reduces deaths overall or deaths from prostate cancer.
  - ✓ Because screening only picks up the lower-risk cancers and not the higher-risk ones?
  - ✓ Because older men are less likely to benefit?
  - ✓ Because the patients who "didn't get screening" did?
  - ✓ Because we need smarter strategies?
- Is reducing death the only thing that matters?
- By the time we have the old data, the diagnosis and treatment approaches have already changed.

European Study of Prostate Cancer Screening (ERSPC) 23-Year Follow-Up Results

With 23 years of follow-up…

- **Benefits**
  - ✓ One death from prostate cancer is prevented for every 456 men invited to do screening
  - ✓ **One death from prostate cancer is prevented for every 12 men diagnosed with prostate cancer**
- **Potential harms**
  - ✓ 27 extra cases are diagnosed per 1000 men (did all of them need to be diagnosed?)
  - ✓ Double the rate of low-grade cancers diagnosed
- **Results are getting better with longer follow-up**
- **These are probably *worst-case* results**
  - ✓ Started too late (55-69)
  - ✓ Study population was predominately White and European
  - ✓ Outdated diagnosis and treatment approaches

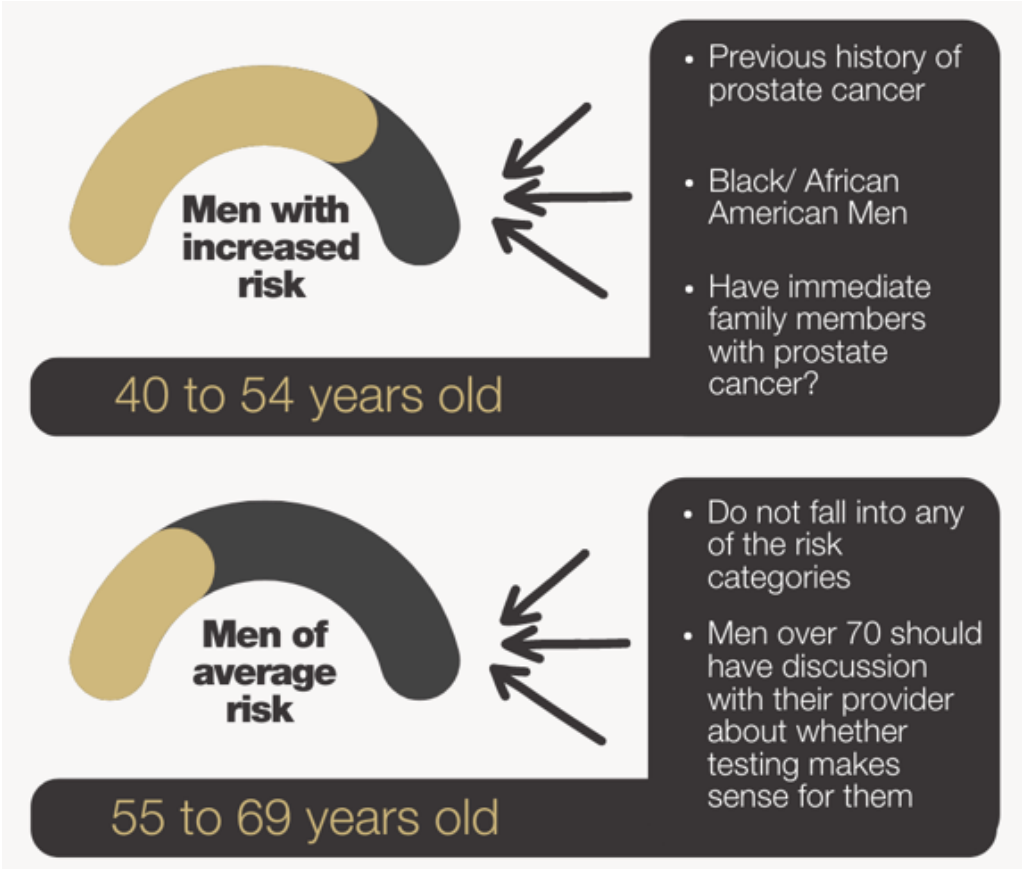
Roobol MJ et al., New England Journal of Medicine, October 30, 2025

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Myth 2b: Everyone Should Get Screened for Prostate Cancer

Recommendation Summary

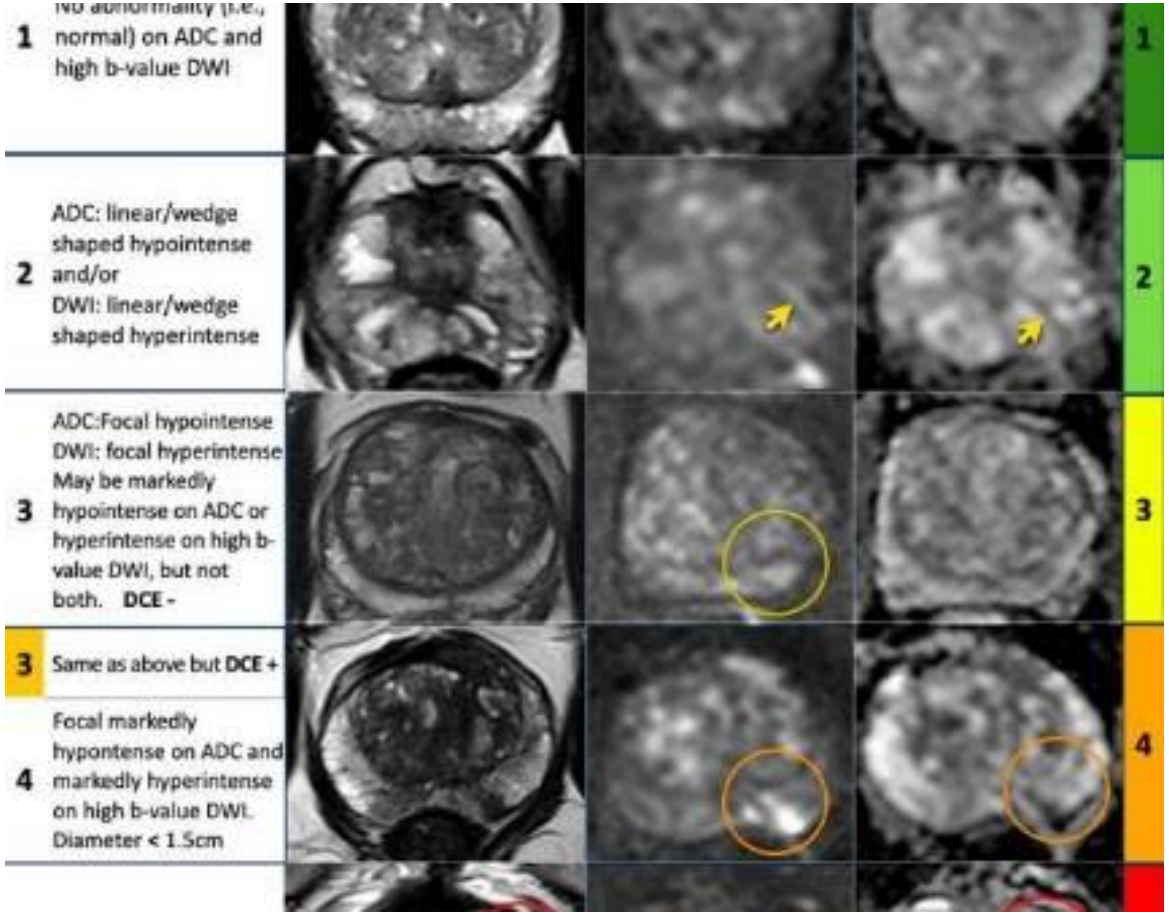
Population	Recommendation
Men aged 55 to 69 years	For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision. Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening.
Men aged 70 years and older	The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older.

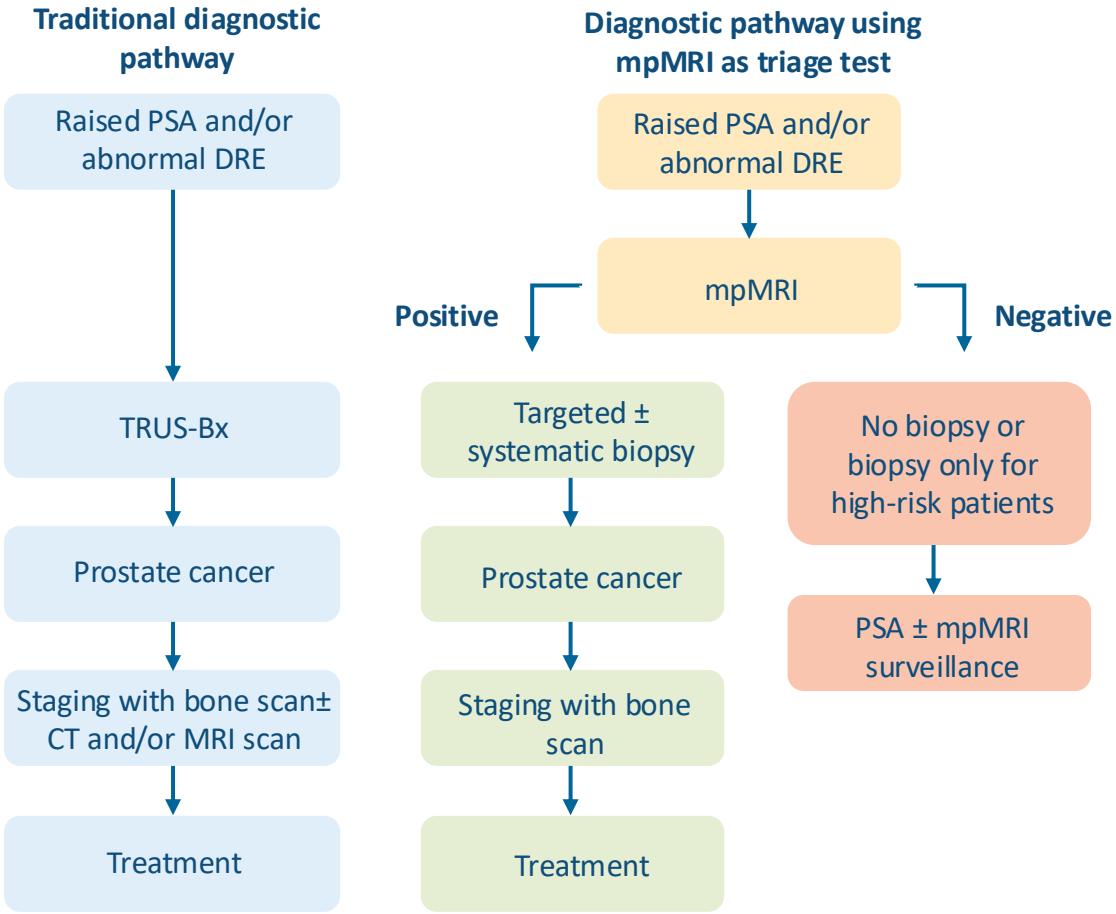


https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening

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Myth 3: If I Get Tested for Prostate Cancer, Then I'll Have to Get Biopsies, Surgery, Radiation, Etc. And That Will Just Lead to Urinary Leakage, Erectile Dysfunction, and Worse.

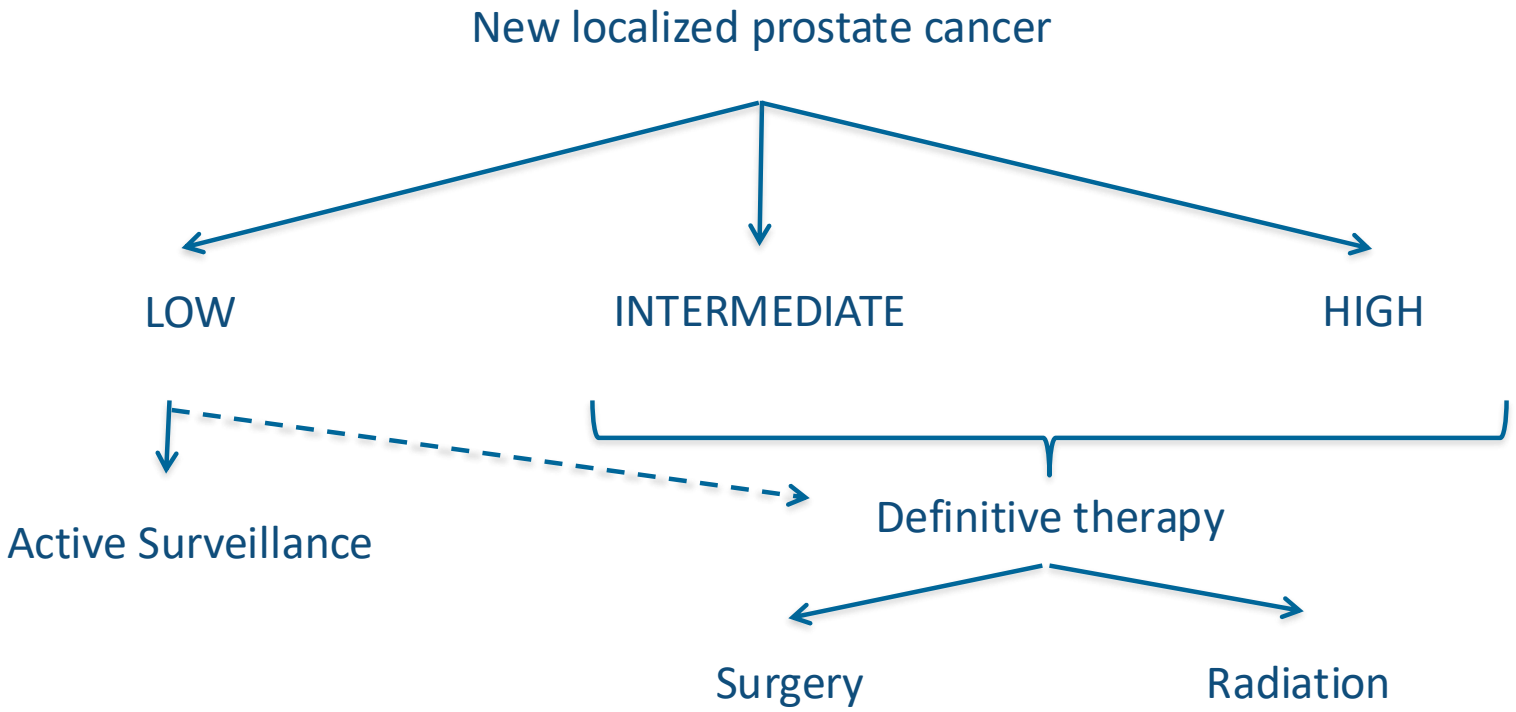




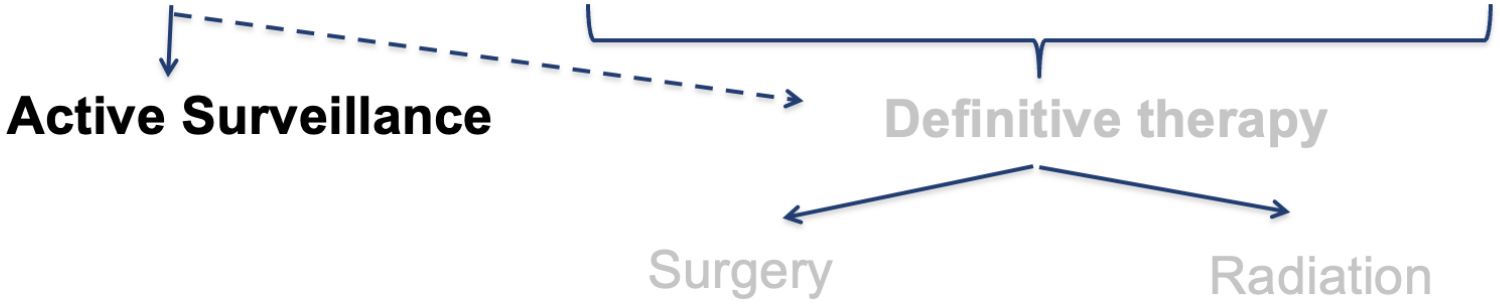
Left: https://radiologyassistant.nl/abdomen/prostate/prostate-cancer-pi-rads-v2-1
Right: A Stabile et al., Nature Reviews Urology 2020

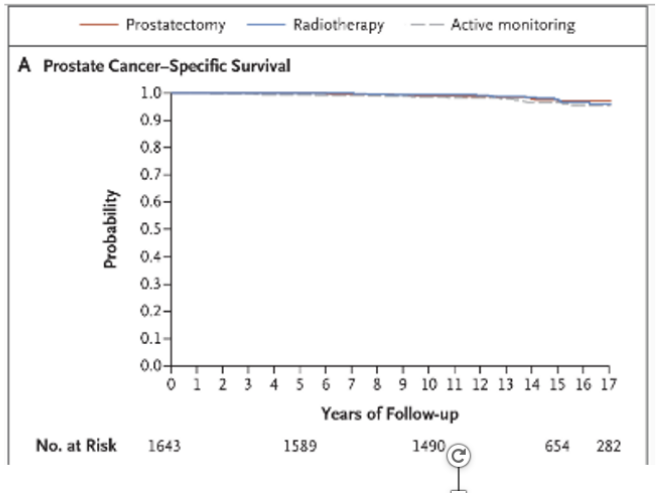
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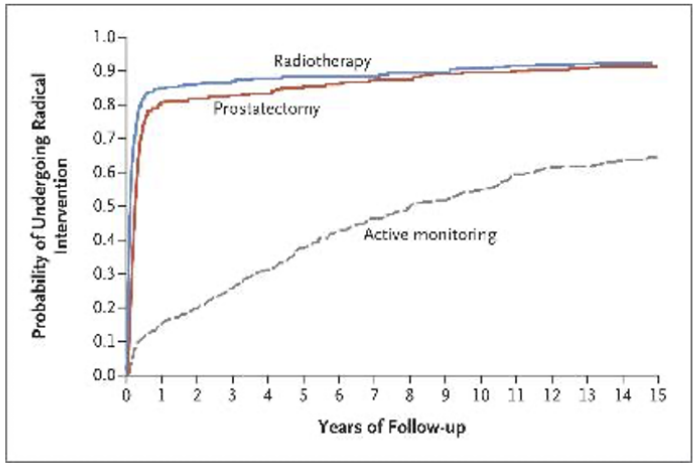
If I Get Tested for Prostate Cancer, Then I'll Have to Get Biopsies, Surgery, Radiation, Etc. And That Will Just Lead to Urinary Leakage, Erectile Dysfunction, and Worse.



If I Get Tested for Prostate Cancer, Then I'll Have to Get Biopsies, Surgery, Radiation, Etc. And That Will Just Lead to Urinary Leakage, Erectile Dysfunction, and Worse. (1)



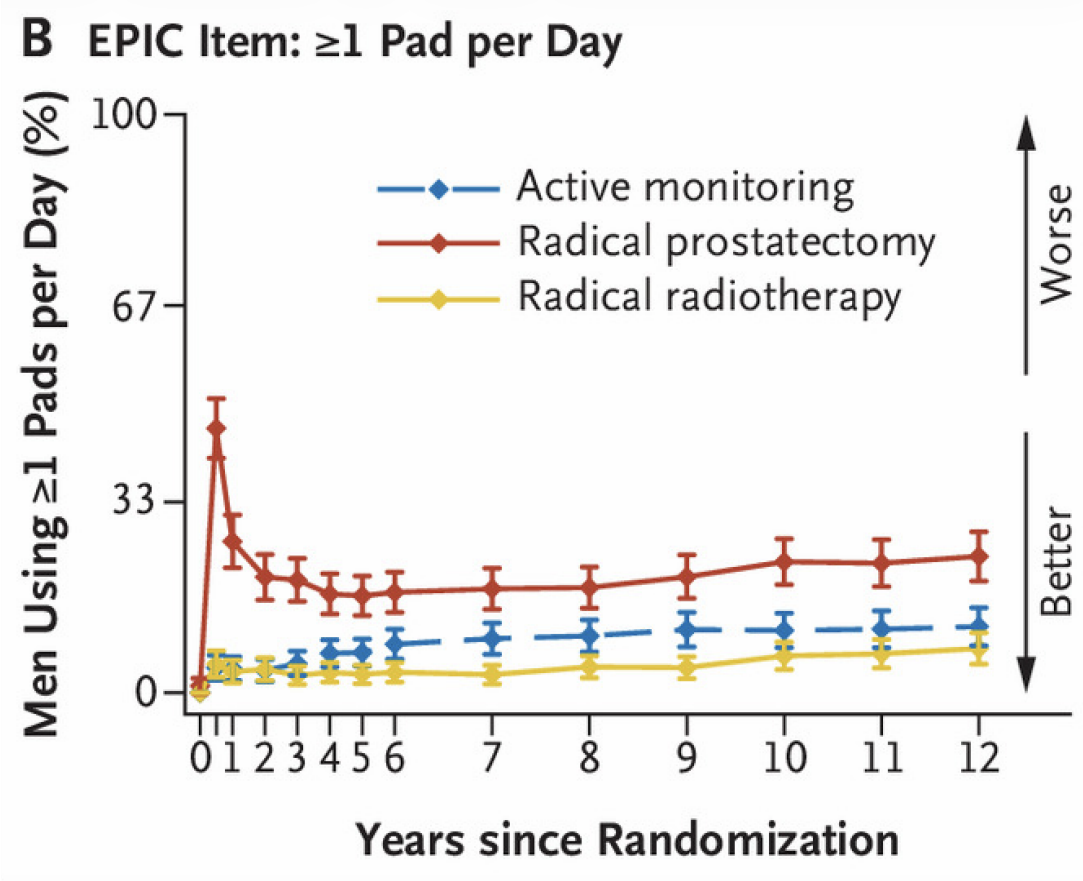




ProtecT Trial (Hamdy F et al., NEJM 2023)

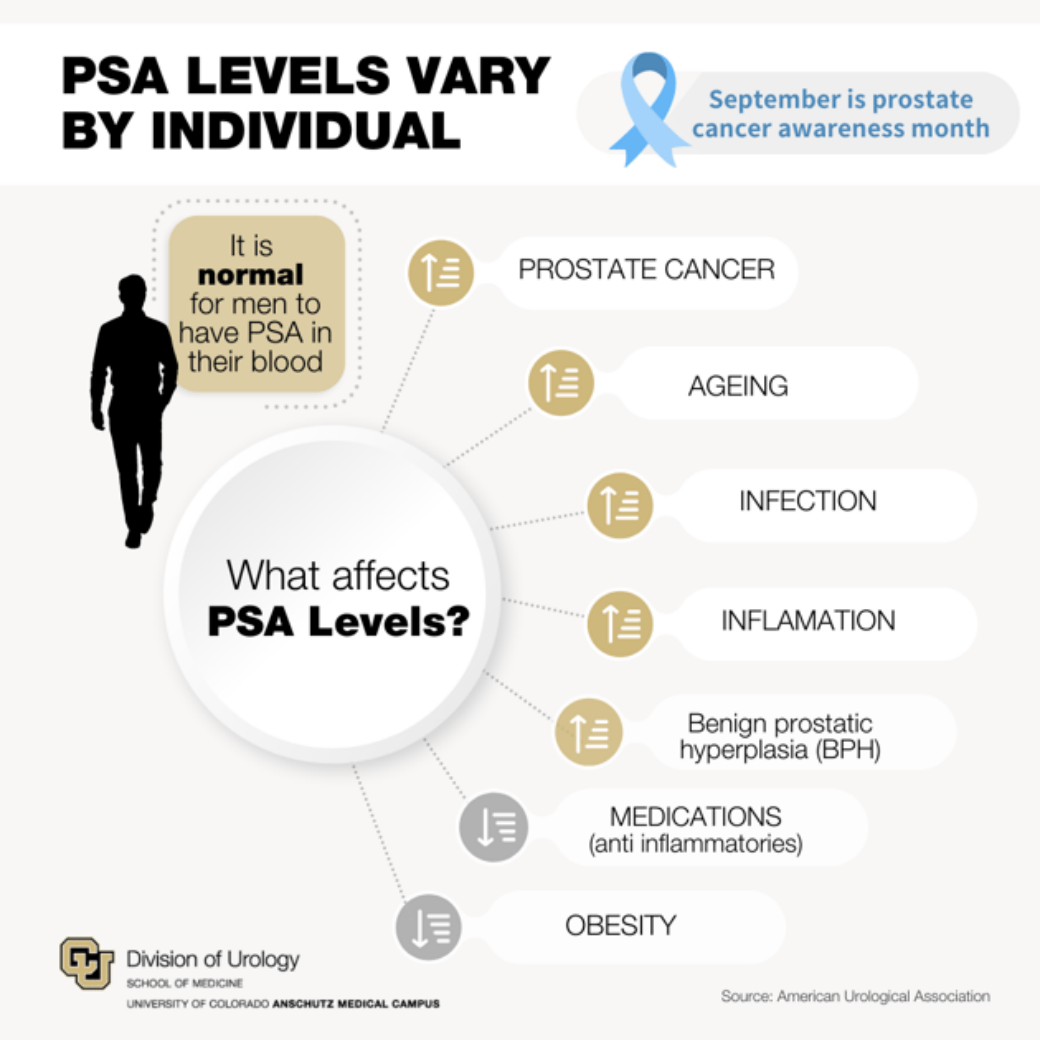
If I Get Tested for Prostate Cancer, Then I'll Have to Get Biopsies, Surgery, Radiation, Etc. And That Will Just Lead to Urinary Leakage, Erectile Dysfunction, and Worse. (2)

- Quality of life is typically good, especially with more modern techniques
- Quality of life changes over time
  - Short-term impacts of surgery are often reversible
- For patients who have persistent issues, all is not lost!
  - Incontinence: artificial sphincter
  - Urinary frequency: bladder retraining, medication
  - Erectile Dysfunction (ED): PDE-5 inhibitors, intracorporeal injections, penile prostheses, and other treatments, etc.

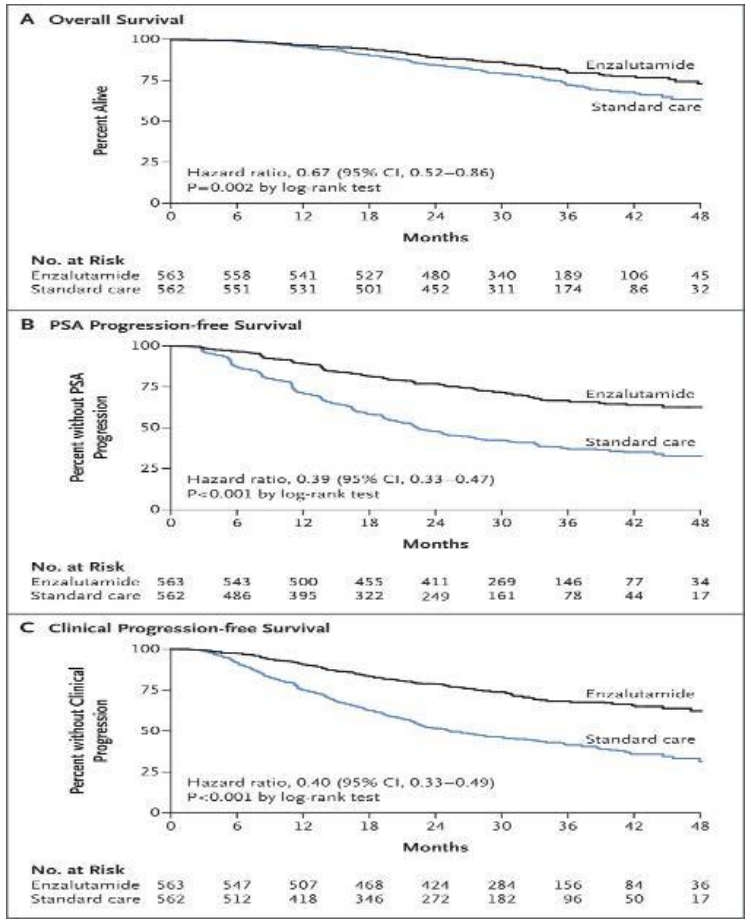


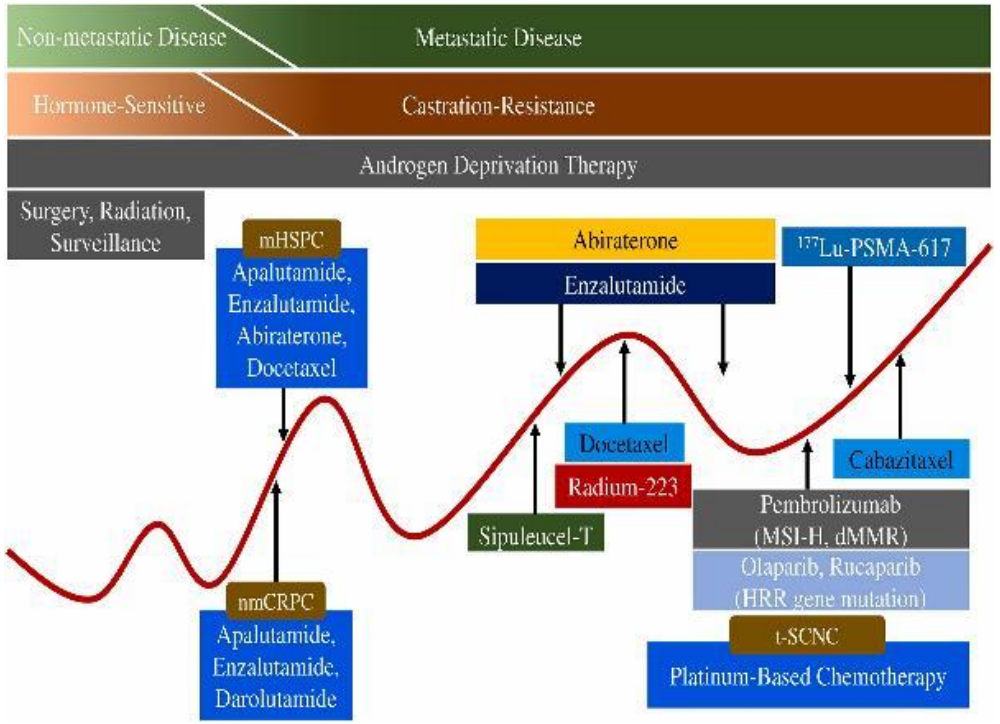
ProtecT Trial (Donovan JL et al., NEJM 2023)

Myth 4: A Blood Test Can Clearly Tell Who Does and Doesn't Have Prostate Cancer



Myth 5: Prostate Cancer is a Death Sentence





Davis I et al., ENZAMET, NEJM 2019; Yamada Y & Beltran H, Cancer Letters 2021

Myth 6: I Have No Pain, so I Can't Have Cancer

Most common symptoms:

- Nothing
- Urinary issues- but not necessarily symptoms caused by cancer

Much less common:

- Pain
- Weight loss
- Anemia
- Kidney failure
- Fracture

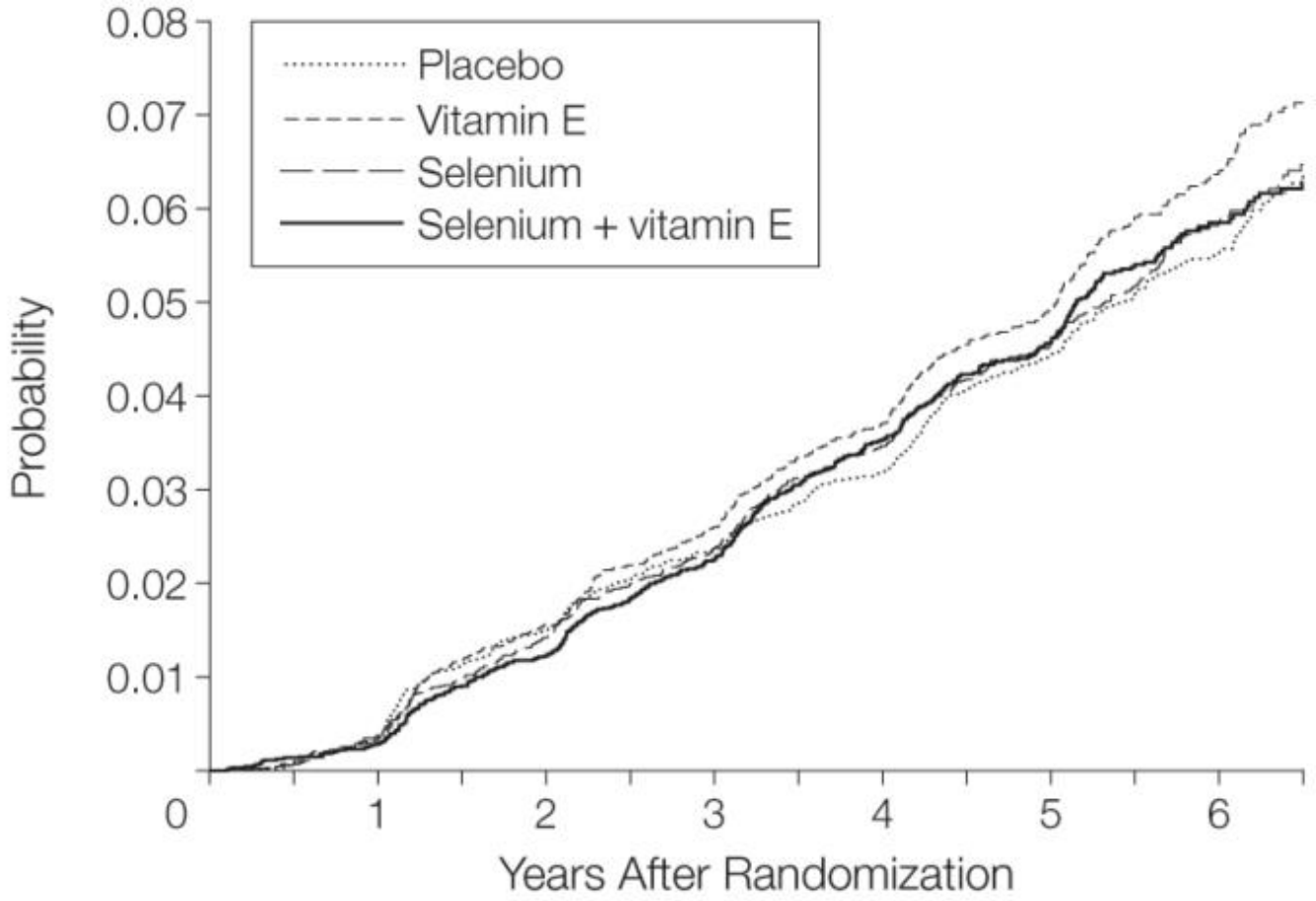
Myth 7: If I Eat Right and Exercise, I Can Prevent Prostate Cancer

Prostate cancer is not someone's fault for not eating or doing the right things. It is mostly caused by bad luck and aging.

How can diet and physical activity help:

- May help decrease risk of developing aggressive prostate cancer
- May help decrease risk of less aggressive prostate cancer becoming more aggressive
- Likely helps patients get through treatment better
- Helps patients prevent cardiovascular disease

Myth 8: Natural Supplements Will Do a Better Job Treating Cancer and With Fewer Side Effects than surgery, Radiation, and Doctor-Prescribed Medications



Klein EA et al., SELECT Trial, JAMA 2011

Myth 9: If I Get Prostate Cancer Treatment, I Won't Be Able to Work, and I'll Become a Financial Burden

Most patients don't have to take significant time off work for treatment

- Surgery involves ~6 weeks of no heavy lifting, then gradual increase
- Radiation involves brief daily visits during treatment (5-25 days, Monday-Friday)
- Hormonal therapy and radiation don't carry any work restrictions

Financial concerns

- This is real!
- Biggest issue is oral drugs for advanced prostate cancer
- Patient assistance programs and pharmacy teams may help patients address medication costs

Myth 10: Clinical Trials Aren't Right For Me

False Narratives:

- Clinical trials are only for when all else has failed ("end of the line")
- Clinical trials are an option at any time
- Clinical trials always test new experimental drugs that are unproven
- Clinical trials always involve a sugar pill (placebo)
- Clinical trials always involve blinding ("don't know what I'm getting")
- Clinical trials always involve randomization

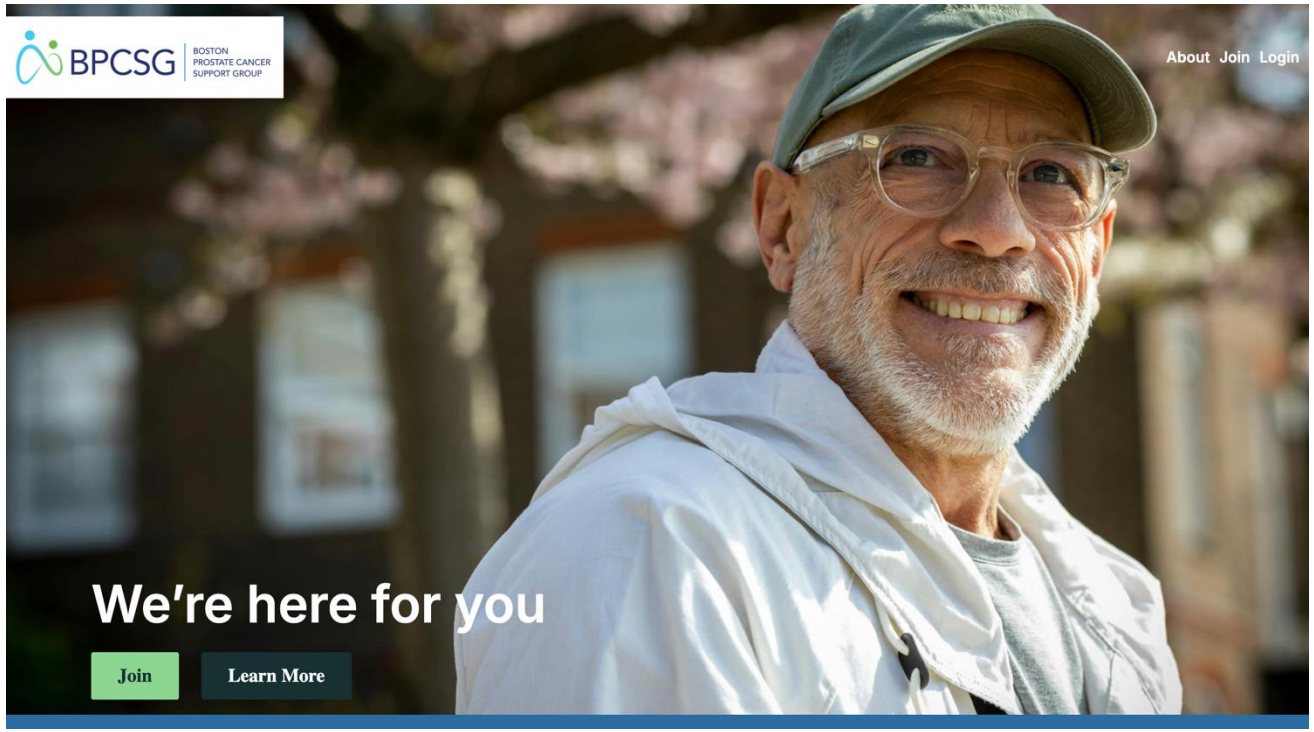
Where Can Patients Turn for Support?

- Many men aren't used to reaching out to others for support, or talking about their personal issues

- Online support groups can be very useful
  - E.g.
    - Boston Prostate Cancer Support Group

      Bostonprostatecancer.org
    - Prostate Health Education Network (PHEN)

      prostatehealthed.org



Where Can a Busy Primary Care Provider Turn To For Help?

- Prostate Cancer Screening: A Conversation Guide for Health Care Providers (MA DPH): https://massclearinghouse.ehs.state.ma.us/product/CA8002kit.html
- Prostate Cancer Risk Assessment and Screening for Clinician (ACS): https://npcrt.org/event/webinar-prostate-cancer-risk-assessment-and-screening-for-clinicians/
- What to do after an abnormal PSA test (ACS): https://npcrt.org/event/webinar-what-to-do-after-an-abnormal-psa-test-mri-biopsy-and-beyond/
- ACS interactive tool to talk about prostate cancer risk and screening: https://npcrt.org/resource/talk-to-someone-about-prostate-cancer-screening/
- Prostate Cancer Screening Booklet (MGH): prostate screening booklet
- Does an Elevated PSA Level Mean I Have Prostate Cancer? (DFCI) https://blog.dana-farber.org/insight/2019/01/does-an-elevated-psa-level-mean-i-have-prostate-cancer-2/

Prevalence of Prostate Cancer

Men with lower urinary tract symptoms and a Prostate-Specific Antigen (PSA) level of ≥3 are LESS

likely to have prostate cancer than to have benign hypertrophy

HOWEVER!!

If a patient has worsening lower urinary tract symptoms,
you need to add prostate cancer to the differential

Mindset Shift:

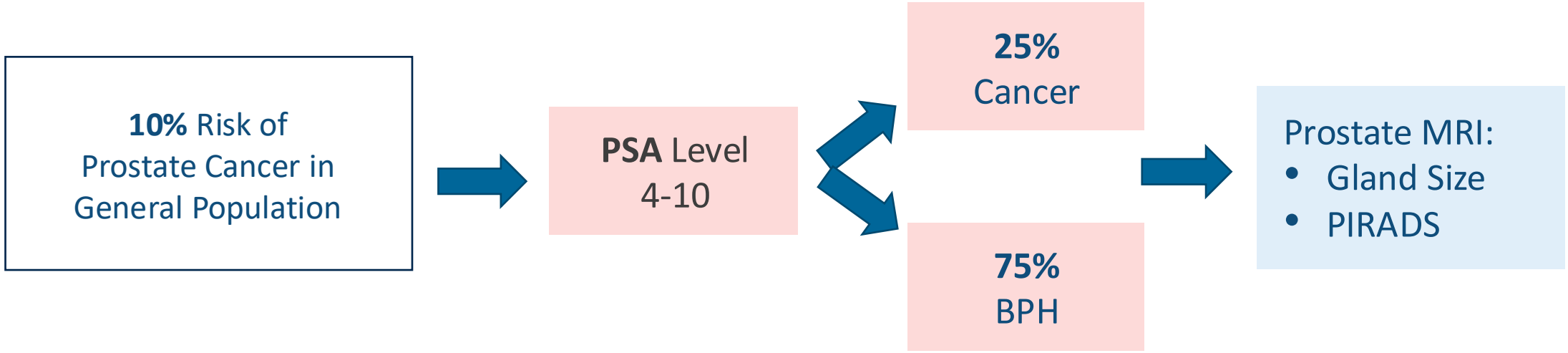
Asymptomatic → screening paradigm

Symptomatic → diagnostic workup

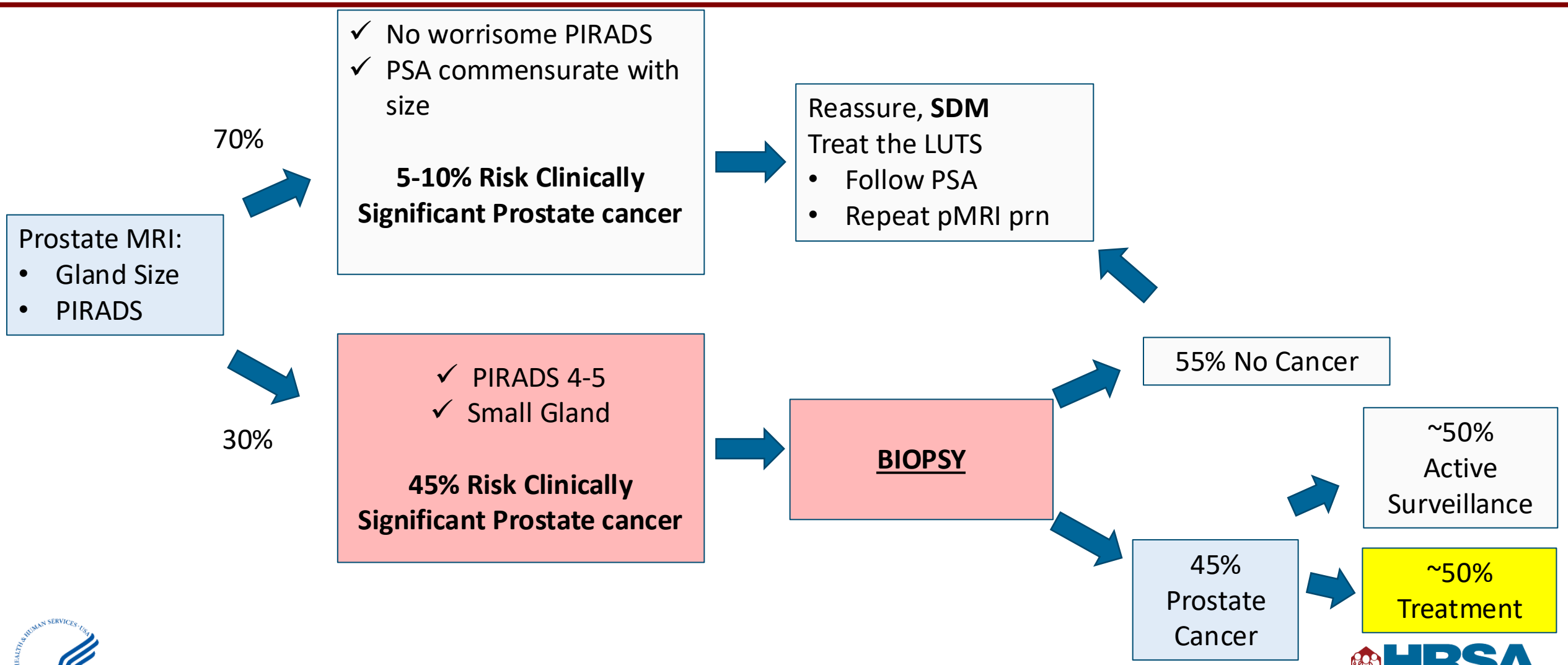
Collin SM, et al. BJU Int. 2008

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Prostate Cancer Diagnosis Algorithm-Traditional Approach



Modern Algorithm



Patient: Mr. Hogan

60-year-old Male seen with lower urinary tract symptoms:

- Urinating 2-3x per night
- Daytime frequency (every 2 hours during day)
- Weakened stream

PSA 6.3

- No family history of Prostate/Breast/Ovarian cancer.
  - Father had TURP at age 80, incidental prostate cancer on pathology, monitored without problems
- Enlarged prostate on digital rectal exam with asymmetry, but no worrisome induration

Patient: Mr. Hogan (Cont.)

60-year-old Male seen with lower urinary tract symptoms:

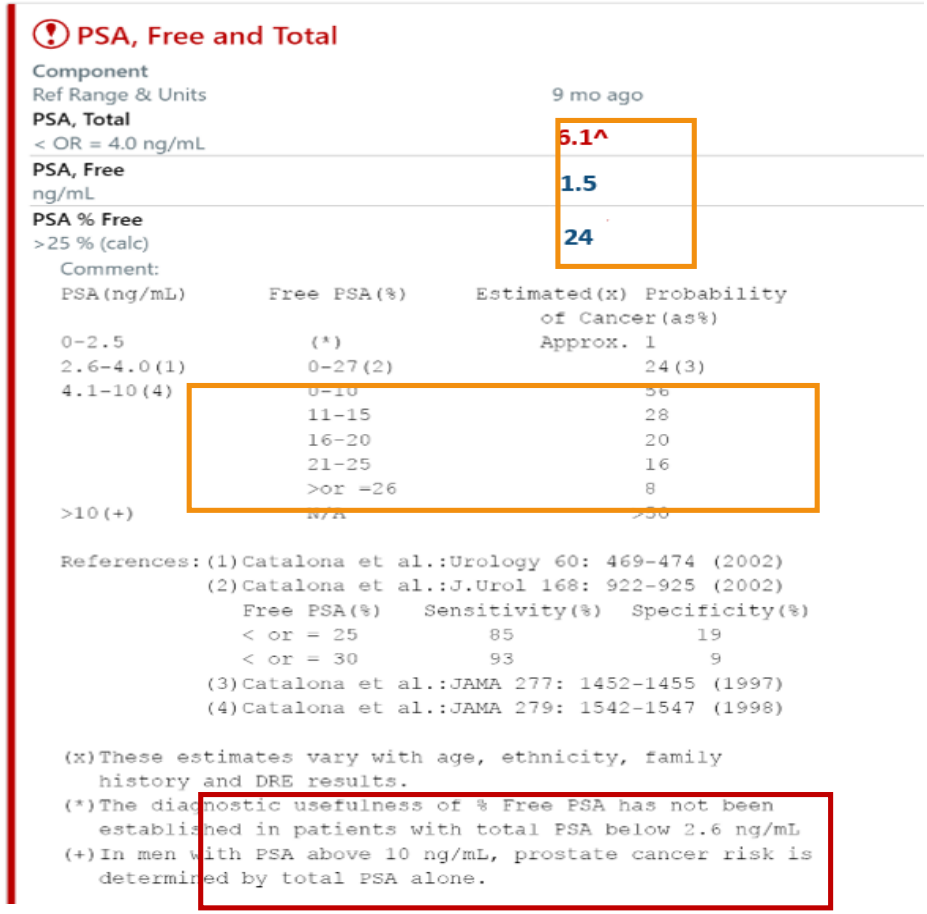
Same rubric:

- Started on Tamsulosin 0.4 mg daily
- Discussed “Bladder Retraining” – work to hold longer during day which improves bladder capacity
- Plan Recheck PSA with **FREE PSA** after Tamsulosin x 4 week

GUIDELINE STATEMENT 3

For people with a newly elevated PSA, clinicians should repeat the PSA prior to a secondary biomarker, imaging, or biopsy. (Expert Opinion)

Patient: Mr. Hogan (Cont.)



PSA, Free and Total

Component Ref Range & Units	9 mo ago
PSA, Total < OR = 4.0 ng/mL	5.1^
PSA, Free ng/mL	1.5
PSA % Free >25 % (calc)	24

Comment:

PSA(ng/mL)	Free PSA(%)	Estimated(x) Probability of Cancer(as%)
0-2.5	(*)	Approx. 1
2.6-4.0(1)	0-27(2)	24(3)
4.1-10(4)	0-10	56
	11-15	28
	16-20	20
	21-25	16
	>or =26	8
>10(+)	N/A	>56

References:
(1)Catalona et al.:Urology 60: 469-474 (2002)
(2)Catalona et al.:J.Urol 168: 922-925 (2002)

Free PSA(%)	Sensitivity(%)	Specificity(%)
< or = 25	85	19
< or = 30	93	9

(3)Catalona et al.:JAMA 277: 1452-1455 (1997)
(4)Catalona et al.:JAMA 279: 1542-1547 (1998)

(x)These estimates vary with age, ethnicity, family history and DRE results.
(*)The diagnostic usefulness of % Free PSA has not been established in patients with total PSA below 2.6 ng/mL
(+)In men with PSA above 10 ng/mL, prostate cancer risk is determined by total PSA alone.

*Free PSA validated for PSA 4-10

Patient: Mr. Hogan, 60 Year Old (Father With Late Onset, Non-Aggressive Prostate Cancer)

On Tamsulosin:

- Urination2x per night (from prior 2-3)
- Daytime frequency every 3 hours (from prior every 2 hours during day)
- Slightly stronger stream, but still bothered

<u>Prostate Cancer Screening Considerations:</u>

- PSA 6.3 -> 6.1, reassuring Free PSA
- **Young**, (Slight Family History)

Plan: Prostate MRI

- Current trend is that PCPs are sending us the patients with prostate MRI already completed!
- Allows us to expedite more worrisome patients to be seen sooner

Patient: Mr. Hogan (Cont. 1)

Prostate MRI:

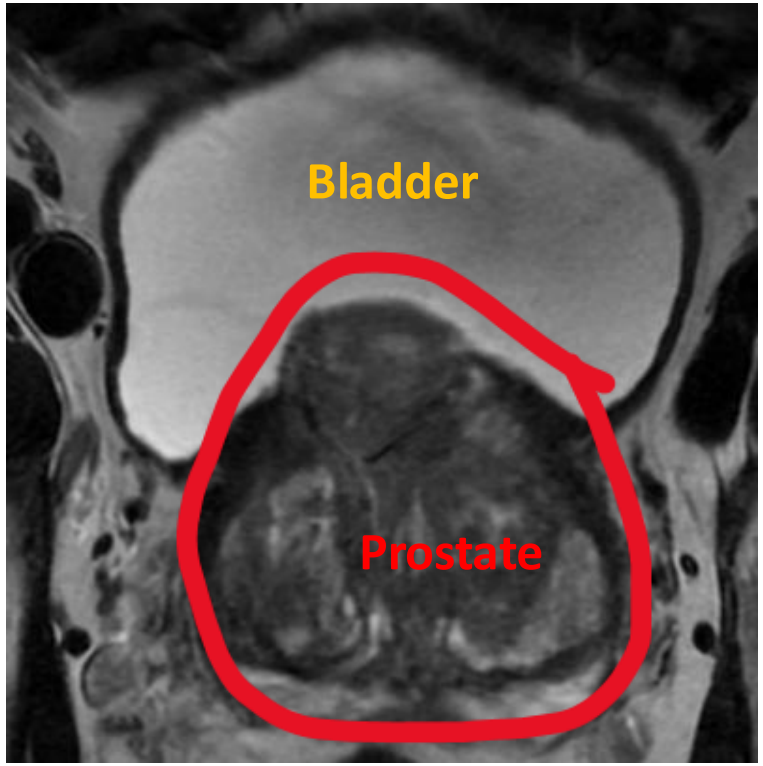
No region of concern (No PIRADS lesions)

115 gram gland

Likelihood of **CLINICALLY SIGNIFICANT (Gleason 7)** Prostate Cancer	
PIRADS 1 **PIRADS 2**	**7%**
PIRADS 3	**11%**
PIRADS 4	**37%**
PIRADS 5	**70%**

Follow

SDM Biopsy?



Patient: Mr. Hogan (Cont. 2)

Prostate MRI:

No region of concern (No PIRADS lesions)

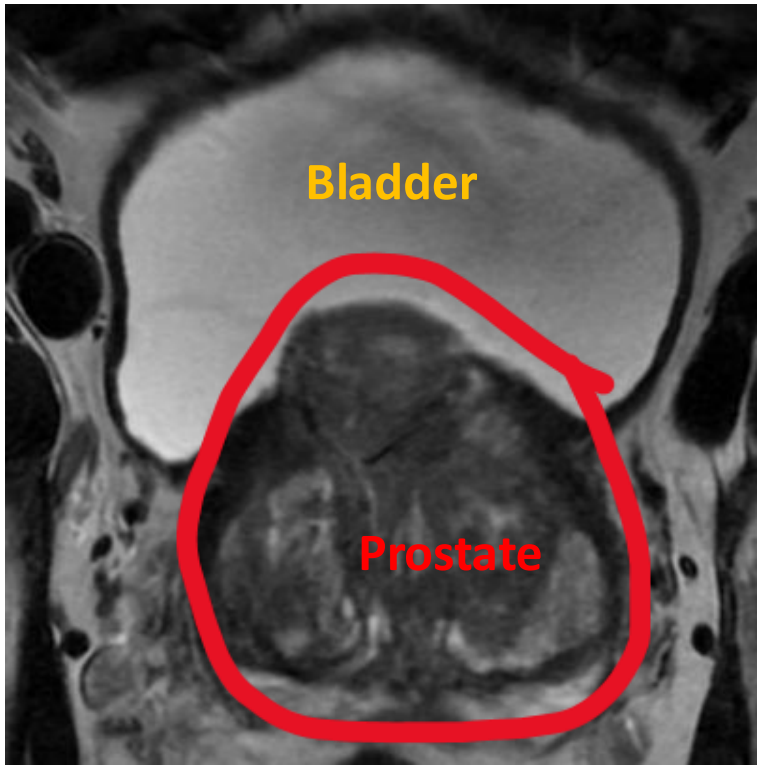
115 gram gland

Reassuring PSA DENSITY:

PSA ÷ Prostate Volume = PSA Density

Table 5: PSA Density and Increased Cancer Risk (7)

PSAD Density (ng/ml per cm3)	Interpretation
<0.1	BPH
0.1-0.15	Suspicious
>0.15	Suggestive of cancer



learnoncology.ca/modules/prostate-cancer

Patient: Mr. H. Hogan (Cont. 3)

60-year-old Male with continued lower urinary tract symptoms despite tamsulosin

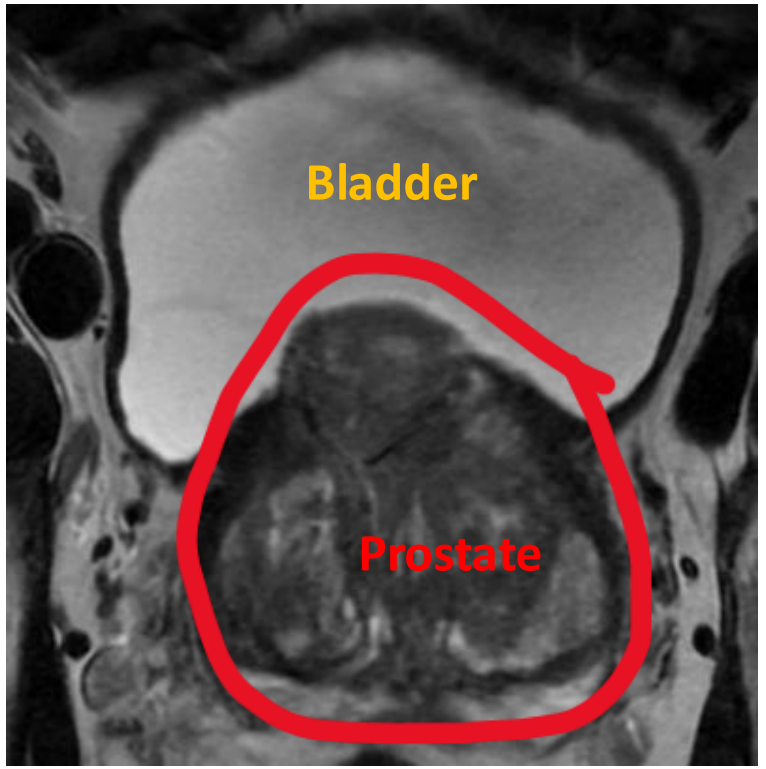
PSA 6.1 with reassuring free PSA, prostate MRI, PSA density.

Shared Decision-Making on Biopsy- (Urology would recommend observation)

Patient elects observation of PSA.

Next steps?

1. Increase tamsulosin to BID?
2. Trial tadalafil?
3. Trial finasteride?



Patient: Mr. H. Hogan (Cont. 4)

Trial finasteride:

- **Shrink Prostate**



6 months later:

- Very happy with urination
- Wakes 0x per night to urinate
- PSA 3.1 (Corrected for Finasteride: ~6.2)

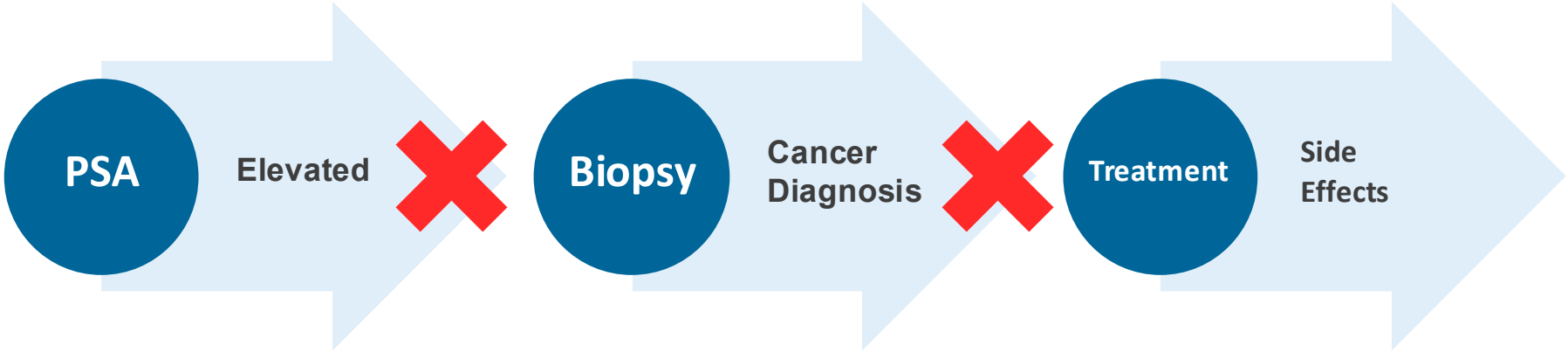
In Conclusion…

Screening = Asymptomatic

Symptomatic ≠ Screening

Symptomatic = Diagnostic Work-Up

Conclusion


PSA
Elevated
Biopsy
Cancer Diagnosis
Treatment
Side Effects

Thank You!

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HRSA Health Center Program

Free Technical Assistance for Health Centers

FREE, customized Technical Assistance is available to HRSA-funded health centers to strengthen cancer screening, improve workflows, and increase timely screening and follow-up care- virtual or on-site, tailored to your needs.

Our Technical Assistance Topics

- Workforce Strengthening & Leadership
- Screening, Navigation & Patient Engagement
- Leading Your Program Through Rapid Change
- Referral Pathways & Specialty Partnerships
- Quality Improvement & Operational Excellence
- Building Effective Outreach Teams
- Workflow Redesign to Improve Screening Rates
- Lean Yellow Belt Training (Healthcare-Focused)

Ready to Get Started?

1. Visit our website and complete the TA Inquiry Form.

2. A TA Coordinator will contact you within 5 business days.

Email:
hrsa_cancerta@veritasmanagementgroup.com

Website:
portal.veritasmanagementgroup.com

HRSA Health Center Program

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www.HRSA.gov

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