FREQUENTLY ASKED QUESTIONS with Dr Simone Gonzo

Q: Should GPs perform digital rectal examinations (DREs) as part of routine prostate testing?
A: DRE is not recommended as a routine component of PSA testing in primary care. It may form part of the specialist assessment when further investigation is required.

Q: Should a patient under 45 with LUTS and a strong family history of prostate cancer be offered a PSA test?
A: Although routine early detection testing is not recommended below 45, individual circumstances and clinical judgement should guide decision-making. For a younger patient with LUTS and a strong family history, discuss the risks and benefits of testing and consider PSA testing. Further investigation may include an ultrasound KUB, alongside assessment for other possible causes.

Q: Does the approach differ for symptomatic and asymptomatic patients?
A: Yes. The early detection guidelines primarily address asymptomatic patients. Patients presenting with LUTS require symptom-led assessment, which may include an ultrasound KUB to assess the prostate and bladder, urine testing, STI screening where indicated, and investigation of other possible causes. Clinical history and examination should guide the work-up.

Q: What should GPs discuss with patients before requesting a PSA test?
A: Explore why the patient wants testing and whether they have any symptoms or particular concerns. Assess their individual risk factors and explain the potential benefits and harms of testing, including the possibility of further investigations and treatment. Use the guideline flowcharts and decision-support resources to support shared decision-making.

Q: For men aged 50–69, which PSA threshold applies: 2 or 3 µg/L?
A: The threshold depends on the patient's risk category:

- Not at higher risk: >3 µg/L.
- At higher risk: >2 µg/L.

These thresholds apply to separate pathways, so it is important to establish the patient's risk category before interpreting the result.

Q: Can a prostate MRI be arranged before the patient sees a urologist?
A: Yes. This depends on the patient's circumstances, local specialist waiting times, and preference. If a urologist can see the patient within two to three weeks, referral first is reasonable, allowing the specialist to arrange an MRI if appropriate. If the wait is several months, discuss the option of arranging an MRI earlier, including any out-of-pocket costs.

Q: Should GPs arrange an MRI at the same time as referring to urology?
A: This is a matter of clinical judgement and shared decision-making. If specialist access is delayed, arranging an MRI before the consultation may help progress the assessment. A well-documented referral may also allow the urologist to arrange imaging before the first appointment.

Q: Should free-to-total PSA be requested when repeating an elevated PSA?
A: Free-to-total PSA is not a central component of the updated guideline pathways. The recommended approach in primary care is to follow the total PSA thresholds and repeat-testing intervals. Free-to-total PSA may form part of the urologist's subsequent assessment.

Q: Which guidelines should GPs follow when the RACGP preventive guidelines differ from the updated prostate cancer recommendations?
A: Follow the *2026 Guidelines for the Early Detection of Prostate Cancer in Australia* as these are the most current. The RACGP preventive guidelines are expected to be updated to reflect the new recommendations, with further resources also being developed.