PRACTICE SUMMARY

Prostate testing recommendations

Key changes at a glance

- **Early detection, not population screening:** An individualised, risk-adapted approach based on patient preferences, risk factors, age, comorbidities, and life expectancy.
- **No routine DRE in general practice:** Digital rectal examination is no longer recommended as a routine addition to PSA testing and risk assessment. It remains part of specialist assessment.
- **Risk-stratified PSA thresholds:** Different PSA thresholds apply according to age and risk category.
- **Repeat before referring:** An elevated PSA should generally be repeated within 1–3 months. Refer to urology if it remains elevated.
- **Greater emphasis on harm minimisation:** Reduce unnecessary investigations, biopsies, overdiagnosis, and overtreatment.

Who is considered at higher risk?

Higher risk is defined as at least double the risk of clinically significant prostate cancer or prostate cancer death compared with the overall Australian male population.

Risk factors include:

- A brother diagnosed with prostate cancer.
- A father diagnosed with prostate cancer before age 65.
- Two or more second-degree relatives who died from prostate cancer, regardless of age.
- Black men of Sub-Saharan African ancestry.
- Confirmed BRCA2 mutation.
- Hereditary breast and ovarian cancer syndrome or Lynch syndrome.

Clinically significant prostate cancer is defined as ISUP Grade Group 2 or higher.

PSA testing pathways

Patient group	Testing recommendation	PSA threshold and action
45–49, higher risk	Offer testing every 2 years following discussion of benefits and harms.	PSA ≥1.0 µg/L: repeat in 1–3 months. If persistently elevated, refer to urology.
45–49, not higher risk	No routine testing. If interested, discuss benefits and harms and offer an initial baseline PSA.	PSA ≥1.0 µg/L: repeat in 1–3 months. If persistently elevated, refer. If <1.0, no further testing until age 50.
50–69, higher risk	Offer testing every 2 years following shared decision-making.	PSA ≥2.0 µg/L: repeat in 1–3 months. If persistently elevated, refer to urology.
50–69, not higher risk	Offer testing every 2 years following discussion of benefits and harms.	PSA ≥3.0 µg/L: repeat in 1–3 months. If persistently elevated, refer to urology.
70 and over	Consider testing every 2 years following clinical assessment and shared decision-making. Life expectancy should generally exceed 7 years.	PSA ≥5.5 µg/L: repeat in 1–3 months. If persistently elevated, refer. If <5.5, further testing may be discontinued.

Note: Higher-risk patients have a separate pathway.

Key takeaways

Assess individual risk

Consider family history, genetic factors, and age.

Use shared decision-making

Discuss the benefits and potential harms of PSA testing.

Repeat before referring

Confirm elevated PSA results within 1–3 months.

Avoid over-investigation

MRI and biopsy decisions should be guided by specialist assessment.

Practice tip

Make follow-up part of the initial PSA request.

When PSA is elevated:

1. Explain that the result needs confirmation before referral.
2. Arrange a repeat PSA within 1–3 months.
3. Enter a recall or reminder in your practice software.
4. Give the patient a clear repeat-testing date and arrange a results review.
5. If referring, include relevant comorbidities and estimated life expectancy.

Useful referral investigations:

- Urine MCS to exclude UTI as a cause of elevated PSA.
- Ultrasound KUB if the patient has lower urinary tract symptoms (LUTS).

Important clinical reminders

> PSA testing is not a diagnosis. Persistently elevated PSA warrants urology assessment, not automatic biopsy.
>
> Watchful waiting and active surveillance are not doing nothing. Appropriate monitoring and recall systems are essential.
>
> Consider PSA interpretation carefully in patients taking medications or receiving gender-affirming hormones that may affect PSA levels.