# key points

SELECTED BY

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**Prostate cancer is the most common cancer in men in** the UK; each year around 52,254 men are diagnosed with the condition. The following symptoms that lead men to present to their GP should stimulate a discussion about prostate cancer risk: problems with urination; blood in the urine or semen; erectile dysfunction; pain in the hips, back, or bones; weakness or numbness in the lower limbs or loss of bladder control. It is crucial to explore the patient's reasons for attending as well as his fears and understanding of prostate cancer risk even if you suspect that any LUTS reported are due to another cause.

**The risk of prostate cancer increases with age, most** patients are aged over 50 at diagnosis. Black men have a lifetime risk of 1 in 4 compared with the estimated 1 in 8 risk faced by the general population. Prostate cancer risk is 2.1-2.4 times higher in men whose father has/had the disease and 2.9-3.3 times higher in men whose brother has/had the disease. Overweight men are at increased risk of being diagnosed with advanced prostate cancer.

**An assessment of LUTS, relevant risk factors and past** medical history are essential. NICE recommends performing a DRE; this will give an impression of prostate size. If the prostate feels malignant on DRE this should trigger a fast-track referral to secondary care, via a suspected cancer pathway referral even if the PSA is normal. A PSA test should also be offered to men with LUTS or an abnormal DRE.

**Men who would be eligible for curative treatment will** be offered an MP-MRI scan. This can identify abnormal areas in the prostate, consistent with significant prostate cancer which merit further investigation, better than untargeted prostate biopsies alone. If MP-MRI is performed first and abnormal lesions are identified, targeted biopsies of these lesions improve the detection of clinically significant prostate cancer. Men investigated using this pathway who are at low risk of having a significant prostate cancer will receive counselling and be discharged back to primary care for follow-up with triggers for re-referral. In general, men will be advised to get their PSA checked at 6 months and then annually with a trigger based on either PSA density or velocity. A tissue diagnosis is usually mandated for curative treatment options to be considered.

**Radical prostatectomy aims to cure prostate cancer** by removing the prostate gland in its entirety. Following radical prostatectomy, successful treatment should result in a PSA which is either undetectable or < 0.1 ng/ml. A PSA rise to > 0.2 ng/ml is considered indicative of recurrent disease and should trigger an urgent referral for specialist review. Following radiotherapy, successful treatment should result in the PSA being very low. Biochemical evidence of disease recurrence after treatment is defined as a rise of 2 ng/ml or more above the lowest PSA value after treatment. A rise above this level should trigger an urgent referral for specialist review so that salvage treatments may be considered if appropriate.