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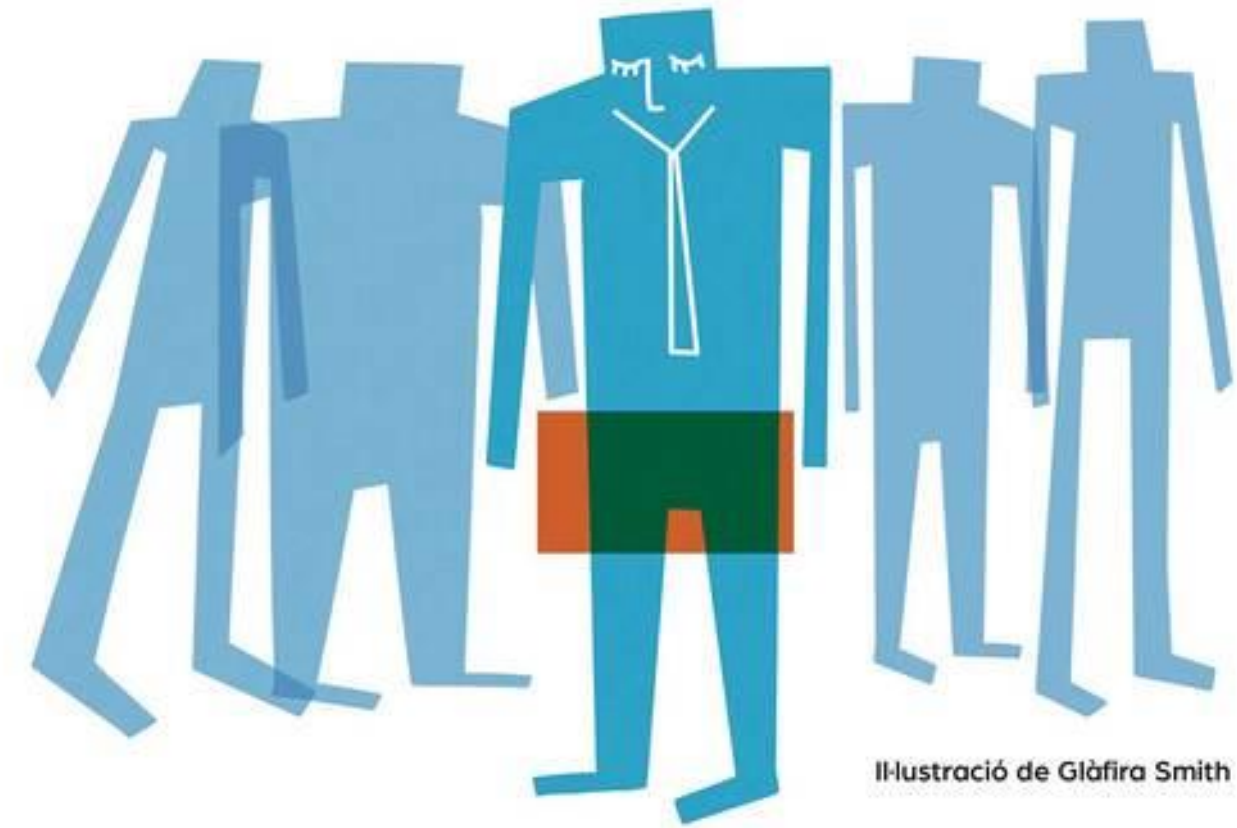


# ENORMEMENT INVISIBLE

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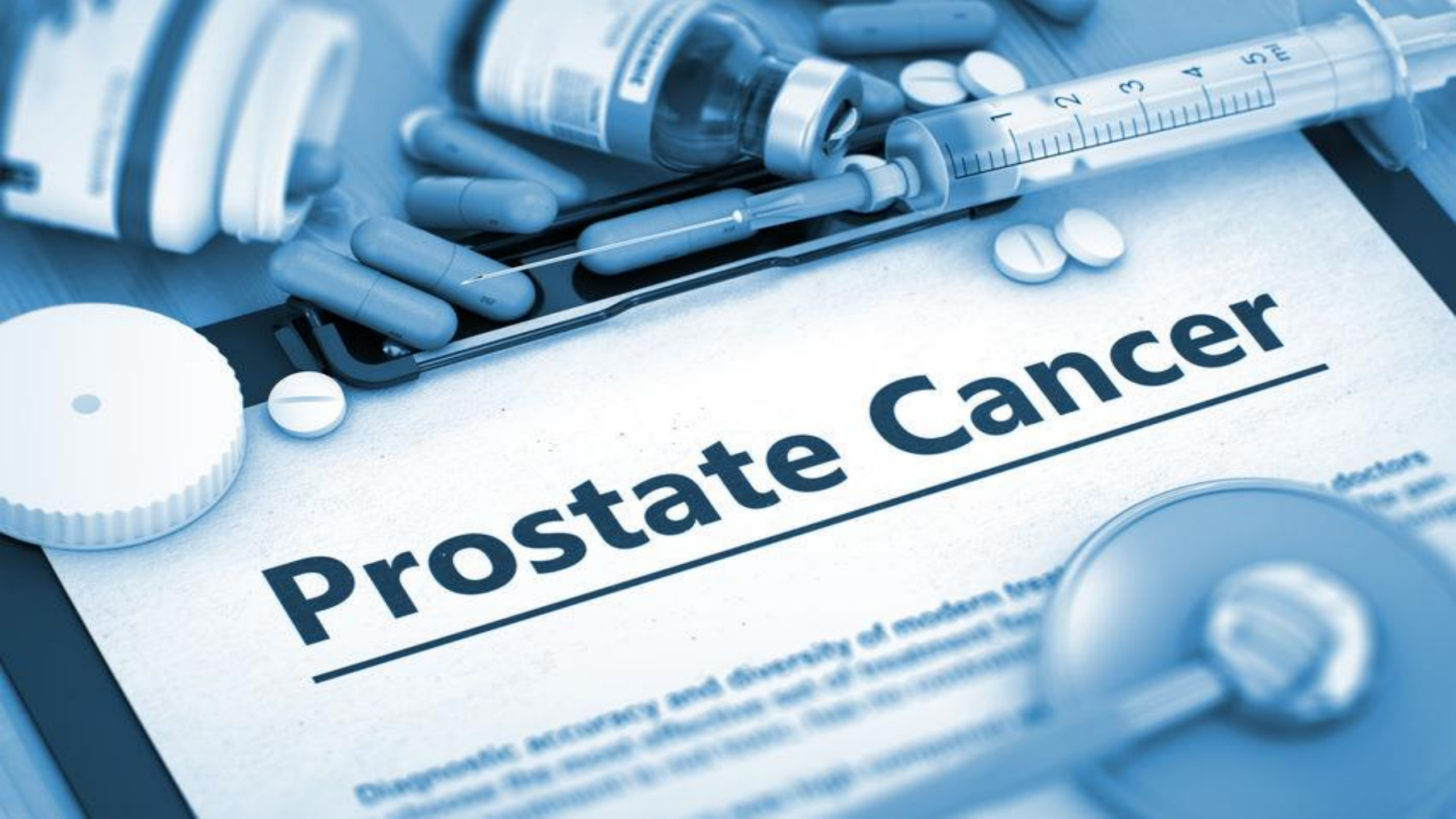
Johnson & Johnson

# Com incideixen a l’empresa els darreres avenços científics per prevenir el càncer de pròstata?

**Dr Juan M. Corral Molina**

**Consultor Urología**

**Hospital Clínic de Barcelona**


Prostate Cancer

# Cancer statistics, 2022

Rebecca L. Siegel, MPH ; Kimberly D. Miller, MPH ; Hannah E. Fuchs, BS; Ahmedin Jemal, DVM, PhD

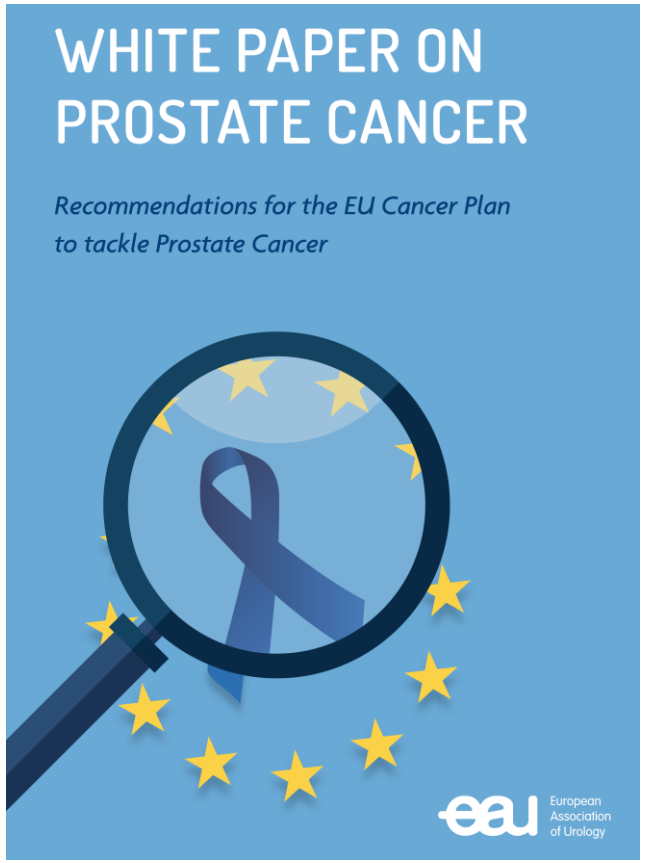
## Estimated New Cases

| | Males | |
|---|---|---|
| Prostate | 268,490 | 27% |
| Lung & bronchus | 117,910 | 12% |
| Colon & rectum | 80,690 | 8% |
| Urinary bladder | 61,700 | 6% |
| Melanoma of the skin | 57,180 | 6% |
| Kidney & renal pelvis | 50,290 | 5% |
| Non-Hodgkin lymphoma | 44,120 | 4% |
| Oral cavity & pharynx | 38,700 | 4% |
| Leukemia | 35,810 | 4% |
| Pancreas | 32,970 | 3% |
| **All Sites** | **983,160** | **100%** |

## Estimated Deaths

| | Males | |
|---|---|---|
| Lung & bronchus | 68,820 | 21% |
| Prostate | 34,500 | 11% |
| Colon & rectum | 28,400 | 9% |
| Pancreas | 25,970 | 8% |
| Liver & intrahepatic bile duct | 20,420 | 6% |
| Leukemia | 14,020 | 4% |
| Esophagus | 13,250 | 4% |
| Urinary bladder | 12,120 | 4% |
| Non-Hodgkin lymphoma | 11,700 | 4% |
| Brain & other nervous system | 10,710 | 3% |
| **All Sites** | **322,090** | **100%** |

*CA Cancer J Clin 2022;72:7-33. doi: 10.3322/caac.21708*




## PROSTATE CANCER

450,000

INCIDENCE
450,000 men in Europe are diagnosed with prostate cancer every year.

2,500,000

PREVALENCE
More than two million European men are living with prostate cancer.

1 → 7

AGE
1 in 7 men in Europe will develop prostate cancer before the age of 85.

107,000

MORTALITY
107,000 European men die of prostate cancer each year.

€9 billion

COSTS
€9 billion with healthcare accounting for €5.8 billion.

CLINICAL GUIDELINE

Annals of Internal Medicine

# Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement

**Virginia A. Moyer, MD, PhD, on behalf of the U.S. Preventive Services Task Force***

**Description:** Update of the 2008 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for prostate cancer.

**Methods:** The USPSTF reviewed new evidence on the benefits and harms of prostate-specific antigen (PSA)–based screening for prostate cancer, as well as the benefits and harms of treatment of localized prostate cancer.

**Recommendation:** The USPSTF recommends against PSA-based screening for prostate cancer (grade D recommendation).

This recommendation applies to men in the general U.S. population, regardless of age. This recommendation does not include the use of the PSA test for surveillance after diagnosis or treatment of prostate cancer; the use of the PSA test for this indication is outside the scope of the USPSTF.

*Ann Intern Med.* 2012;157:120-134. www.annals.org

For author affiliation, see end of text.

* For a list of the members of the USPSTF, see **Appendix 1** (available at www.annals.org).

This article was published at www.annals.org on 22 May 2012.

| Grade | Definition | Suggestions for Practice |
|---|---|---|
| A | The USPSTF recommends the service. There is high certainty that the net benefit is substantial. | Offer or provide this service. |
| B | The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. | Offer or provide this service. |
| C | The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | Offer or provide this service for selected patients depending on individual circumstances. |
| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I Statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |

U.S. Preventive Services TASK FORCE

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You are here: Home » Recommendations for Primary Care Practice » Archived Topic Recommendation Listing » Archived Recommendation Summary » **Final Update Summary : Final Update Summary**

## Archived: Prostate Cancer: Screening

Original Release Date: May 2012

*This version of this topic is currently archived and inactive. It should be used for historical purposes only.*

Go to the current version >>

Choose another version >>

### Archived: Recommendation Summary

| Population | Recommendation | Grade (What's This?) |
|---|---|---|
| Men | The U.S. Preventive Services Task Force (USPSTF) recommends against prostate-specific antigen (PSA)–based screening for prostate cancer. | D |

Read the Full Recommendation Statement

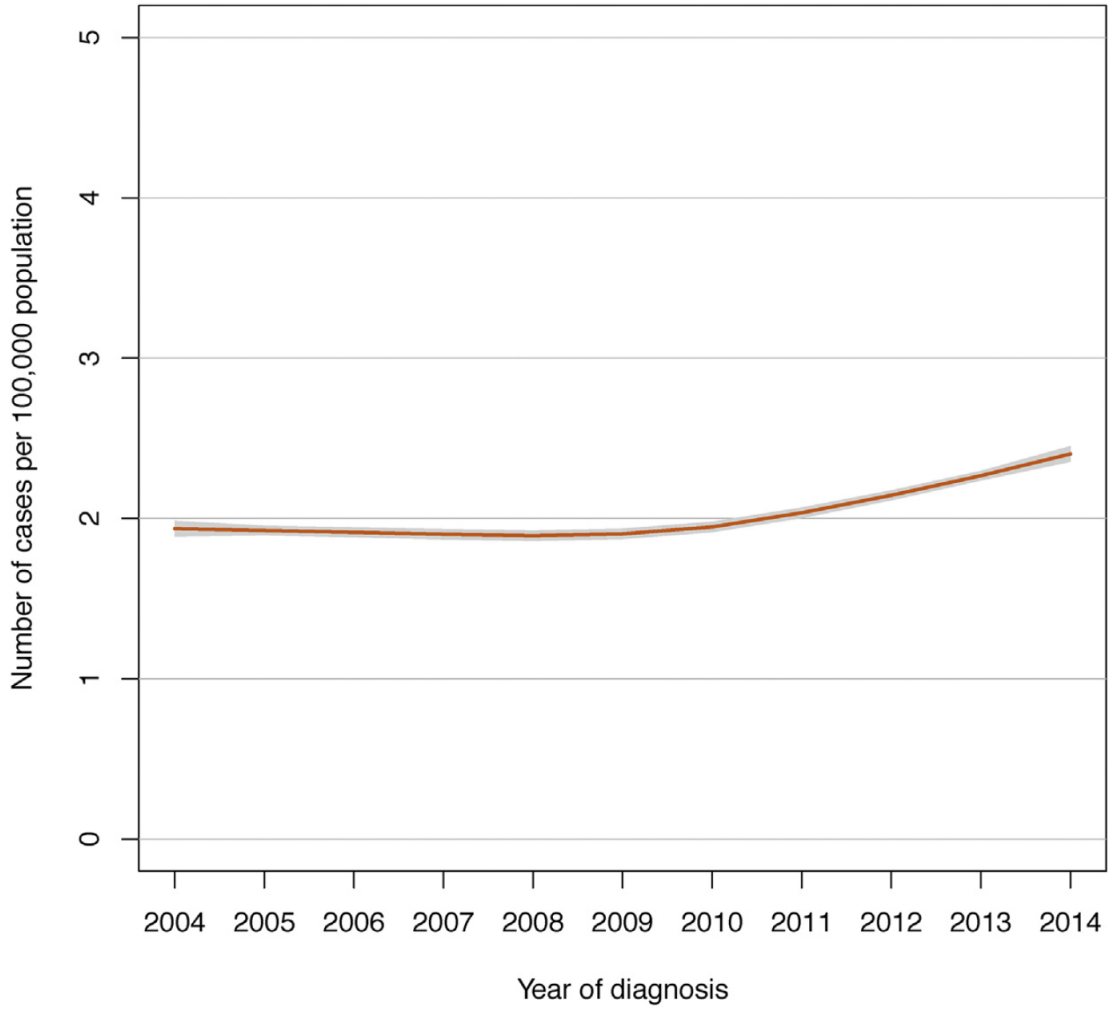
### Archived: Supporting Documents

- Final Evidence Review: Screening for Prostate Cancer
  PDF Version (PDF Help)


2012

*Editorial by Christopher J.D. Wallis and Zachary Klaassen on pp. 321–322 of this issue*

# Increase in the Annual Rate of Newly Diagnosed Metastatic Prostate Cancer: A Contemporary Analysis of the Surveillance, Epidemiology and End Results Database




*The rate of newly diagnosed mPCa increased by 25% over the past decade and the age at initial presentation with mPCa decreased. Indicative of diagnostic delays related to less frequent PSA screening*

Release Date: May 2018

## Recommendation Summary

| Population | Recommendation | Grade (What's This?) |
|---|---|---|
| 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. | C |
| Men 70 years and older | The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older. | D |

Read the Full Recommendation Statement

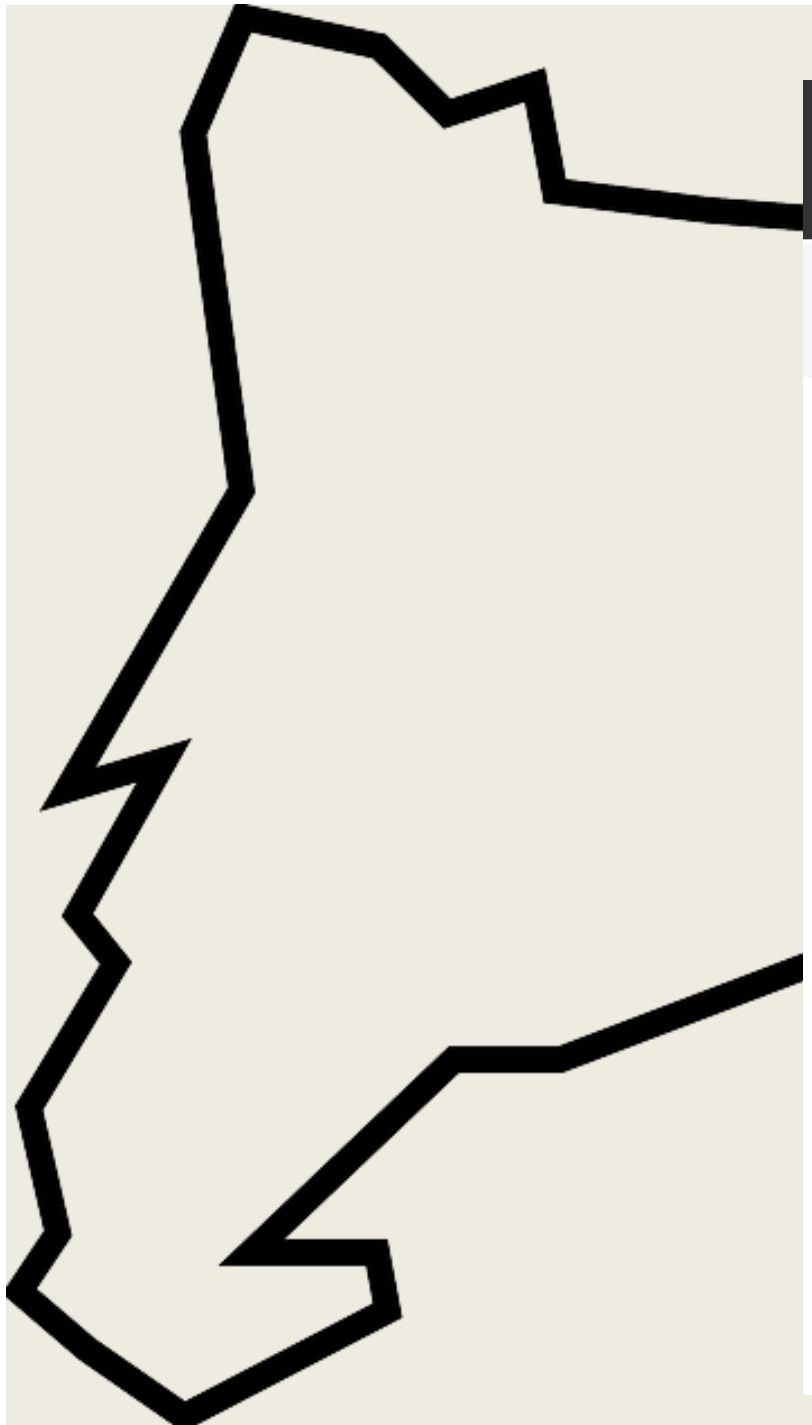
## Supporting Documents

- **Final Research Plan**
- **Final Evidence Review**
  PDF Version (PDF Help)
- **Contextual Review: Overdiagnosis in Prostate Cancer Screening Decision Models**
  PDF Version (PDF Help)
- **Contextual Review: Overview of Prostate Cancer Screening Decision Models**
  PDF Version (PDF Help)
- **Evidence Summary**
  PDF Version (PDF Help)

## Clinical Summary

Clinical summaries are one-page documents that provide guidance to primary care clinicians for using recommendations in practice.

This summary is intended for use by



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## Essencial

Inici | Què és Essencial | Recomanacions | Pràctica clínica | Pacients | Multimèdia | Participeu-hi | Actualitat

Inici > PSA en el cribratge del càncer ...

# PSA en el cribratge del càncer de pròstata

Torna


La determinació del PSA com a cribratge poblacional de càncer de pròstata no s'hauria de realitzar en no aportar beneficis en termes de reducció de mortalitat.


La determinació del PSA és apropiada en homes amb un risc per damunt del risc poblacional (antecedents familiars), davant d'una exploració sospitosa i en el seguiment del càncer de pròstata.

- A Catalunya 1 de cada 6 homes podria desenvolupar un càncer de pròstata al llarg de la seva vida. No obstant això, la mortalitat per aquest tipus de tumor se situa en un percentatge lleugerament inferior al 3% de les persones afectades.
- Un nivell elevat de concentració en sang de la proteïna PSA pot ser un indicador d'alerta sobre el risc de tenir un tumor prostàtic. L'estimació del nivell de concentració del PSA s'obté mitjançant una prova diagnòstica de laboratori.
- El nombre de complicacions i efectes adversos sobre la qualitat de vida dels pacients, en relació amb els beneficis que aquest prova pot ocasionar, ha fet que la majoria de les societats científiques i professionals no recolzin la seva utilització a nivell poblacional, fora dels casos específics de persones que presenten un risc més elevat (antecedents familiars, davant símptomes o signes, o com a seguiment de pacients que ja hagin patit aquest tumor).
- Per aquests motius es recomana no utilitzar la prova de determinació del PSA en sang com a mètode de cribratge poblacional per detectar precoçment el càncer de pròstata en no aportar beneficis en termes de reducció de la mortalitat.
- En qualsevol cas, a causa dels possibles beneficis i perjudicis associats a aquesta prova, la seva realització sempre s'hauria de dur a terme després d'informar-ne al pacient de manera exhaustiva i detallada.

## 2010-2014

ASOCIACIÓN ESPAÑOLA DE UROLOGÍA

LXXIX Congreso Nacional de Urología
TENERIFE
De 11 a 14 de junio • 2014

**En el marco del *LXXIX Congreso Nacional de Urología* que hoy se inaugura en Tenerife y coincidiendo con la celebración del**

**Día Mundial del Cáncer de Próstata**

**La AEU presenta datos actualizados del**

***Registro Nacional de Cáncer de Próstata***

**Se trata de la primera investigación que hace un retrato de esta enfermedad en nuestro país, en la que han participado 25 hospitales y más de 4.000 pacientes**

**SÓLO UN 5% DE LOS TUMORES DE PRÓSTATA SE DETECTA EN FASE AVANZADA**

## 2017

| | |
|---|---|
| PSA medio | 785 (10-7500) |
| Edad media | 67 (52-83) |
| Gleason | 9 (7-9 -5+4) |
| M1/dxo CaP | **9%** |
| M1 inicial | 80% |

**El 100% de los pacientes presentaban M1 óseas al diagnóstico asociadas o no a ganglionares, viscerales.**


BREAKING
NEWS

European Commission - Press release

# European Health Union: Commission welcomes adoption of new EU cancer screening recommendations

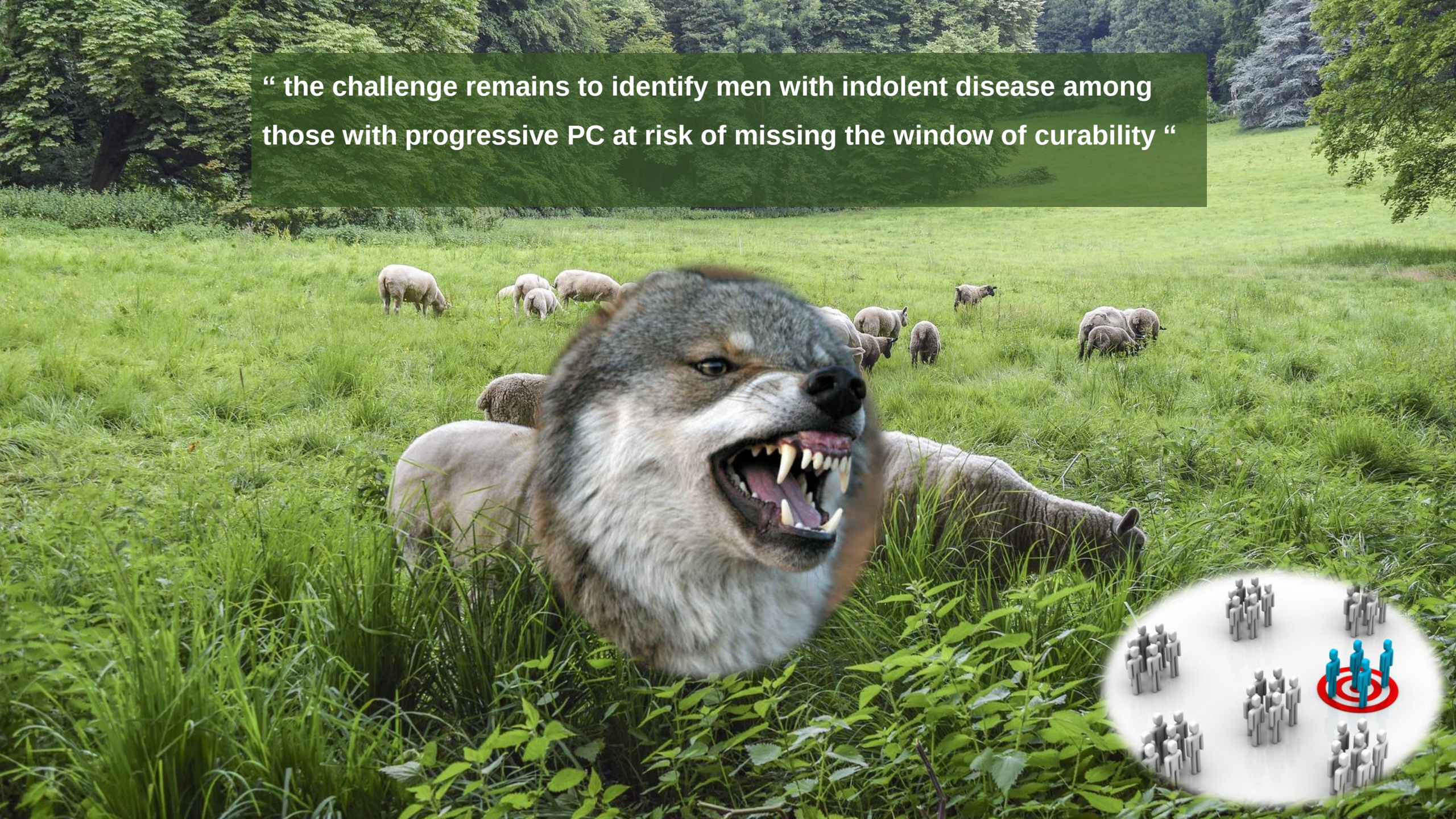
Brussels, 9 December 2022

Today, following the Commission's proposal to strengthen cancer prevention through early detection, the Council of the European Union has adopted a new approach on cancer screening. This is an important step to improve early detection throughout the EU, an important goal of the Europe's Beating Cancer Plan.

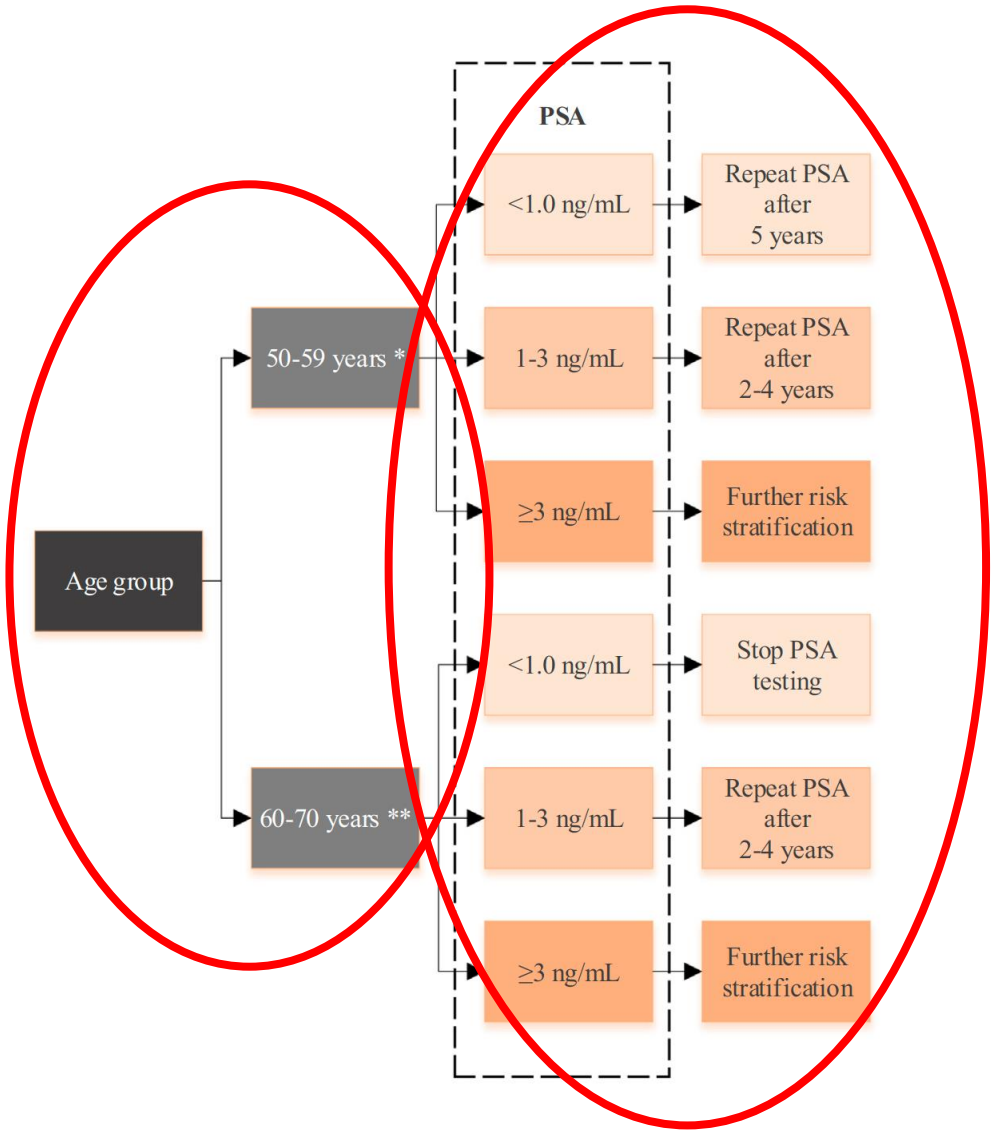
For lung, prostate, and gastric cancers, the Recommendation invites Member States on the basis of further research to:

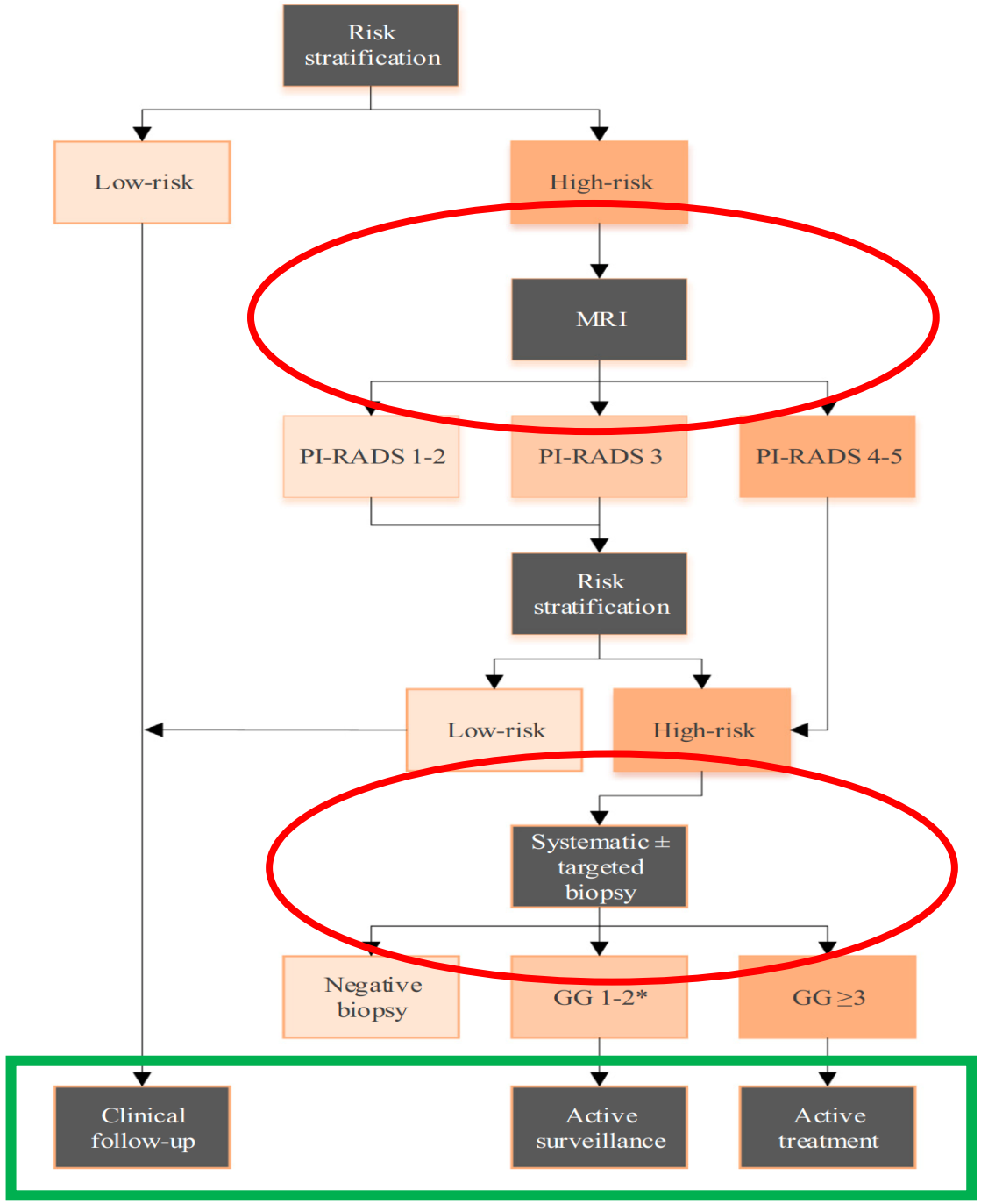
- explore the feasibility and effectiveness of low-dose computed tomography to screen individuals at high risk for **lung cancer**, including heavy smokers and ex-smokers, and link screening with primary and secondary prevention approaches
- evaluate the feasibility and effectiveness of organised **prostate cancer** screening for men, on the basis of prostate-specific antigen (PSA) testing in combination with magnetic resonance imaging (MRI) scanning as follow-up
- Follow screen-and-test strategies for Helicobacter pylori (a bacterium that can causes gastric cancer) for countries and regions with high **gastric cancer** incidence and mortality

“ the challenge remains to identify men with indolent disease among those with progressive PC at risk of missing the window of curability “



“ The harms of screening can now be reduced by risk-adapted and personalized strategies, while maintaining the reduction in metastasis and death ”



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MAY 10, 2018 VOL. 378 NO. 19

# MRI-Targeted or Standard Biopsy for Prostate-Cancer Diagnosis

V. Kasivisvanathan, A.S. Rannikko, M. Borghi, V. Panebianco, L.A. Mynderse, M.H. Vaarala, A. Briganti, L. Budäus, G. Hellawell, R.G. Hindley, M.J. Roobol, S. Eggener, M. Ghei, A. Villers, F. Bladou, G.M. Villeirs, J. Virdi, S. Boxler, G. Robert, P.B. Singh, W. Venderink, B.A. Hadaschik, A. Ruffion, J.C. Hu, D. Margolis, S. Crouzet, L. Klotz, S.S. Taneja, P. Pinto, I. Gill, C. Allen, F. Giganti, A. Freeman, S. Morris, S. Punwani, N.R. Williams, C. Brew-Graves, J. Deeks, Y. Takwoingi, M. Emberton, and C.M. Moore, for the PRECISION Study Group Collaborators*

THE LANCET

# Use of prostate systematic and targeted biopsy on the basis of multiparametric MRI in biopsy-naive patients (MRI-FIRST): a prospective, multicentre, paired diagnostic study

*Olivier Rouvière, Philippe Puech, Raphaële Renard-Penna, Michel Claudon, Catherine Roy, Florence Mège-Lechevallier, Myriam Decaussin-Petrucci, Marine Dubreuil-Chambardel, Laurent Magaud, Laurent Remontet, Alain Ruffion, Marc Colombel, Sébastien Crouzet, Anne-Marie Schott, Laurent Lemaitre, Muriel Rabilloud, Nicolas Grenier, for the MRI-FIRST Investigators**

EUROPEAN UROLOGY 75 (2019) 570–578

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Platinum Priority – Prostate Cancer – Editor's Choice

*Editorial by Derek J. Rosario, Thomas J. Walton and Steven J. Kennish on pp. 579–581 of this issue*

# Head-to-head Comparison of Transrectal Ultrasound-guided Prostate Biopsy Versus Multiparametric Prostate Resonance Imaging with Subsequent Magnetic Resonance-guided Biopsy in Biopsy-naïve Men with Elevated Prostate-specific Antigen: A Large Prospective Multicenter Clinical Study

*Marloes van der Leest[a], Erik Cornel[b], Bas Israël[a], Rianne Hendriks[c], Anwar R. Padhani[d], Martijn Hoogenboom[a], Patrik Zamecnik[a], Dirk Bakker[b], Anglita Yanti Setiasti[e], Jeroen Veltman[f], Huib van den Hout[f], Hans van der Lelij[g], Inge van Oort[c], Sjoerd Klaver[h], Frans Debruyne[i], Michiel Sedelaar[c], Gerjon Hannink[j], Maroeska Rovers[j], Christina Hulsbergen-van de Kaa[e,†], Jelle O. Barentsz[a,†,*]*

# Diagnostic accuracy of multi-parametric MRI and TRUS biopsy in prostate cancer (PROMIS): a paired validating confirmatory study

*Hashim U Ahmed*, Ahmed El-Shater Bosaily*, Louise C Brown*, Rhian Gabe, Richard Kaplan, Mahesh K Parmar, Yolanda Collaco-Moraes, Katie Ward, Richard G Hindley, Alex Freeman, Alex P Kirkham, Robert Oldroyd, Chris Parker, Mark Emberton, and the PROMIS study group†*

- Multicentre, paired-cohort, confirmatory study to test diagnostic accuracy of MP-MRI and TRUS-biopsy against a reference test (template prostate mapping biopsy (TPM-biopsy)
- Men with >15 ng/mL, with no previous biopsy, underwent MP-MRI + TRUS-biopsy and TPM-biopsy
- MP-MRI allow 27% of patients avoid a primary biopsy and diagnosis of 5% fewer clinically insignificant cancers.
- Re-biopsies directed by MP-MRI: 18% more cases of clinically significant cancer might be detected compared with the standard pathway of TRUS-biopsy
- MP-MRI, used before first prostate biopsy, reduce biopsies 25%
- MP-MRI can also reduce over-diagnosis of cnsPCa
- In conclusion, TRUS-biopsy performs poorly as a diagnostic test for clinically significant prostate cancer. MP-MRI, used as a triage test before first prostate biopsy, could identify a quarter of men who might safely avoid an unnecessary biopsy and might improve the detection of clinically significant cáncer

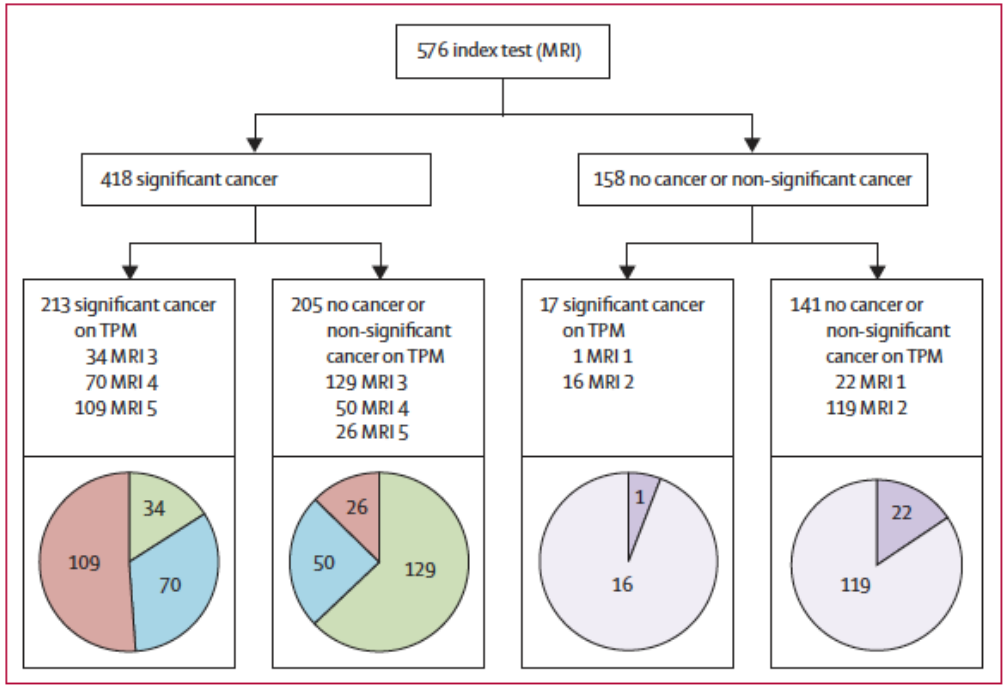



***Figure 2:*** **Diagnostic accuracy for detection of clinically significant cancer (primary definition) between MP-MRI and TPM-biopsy**

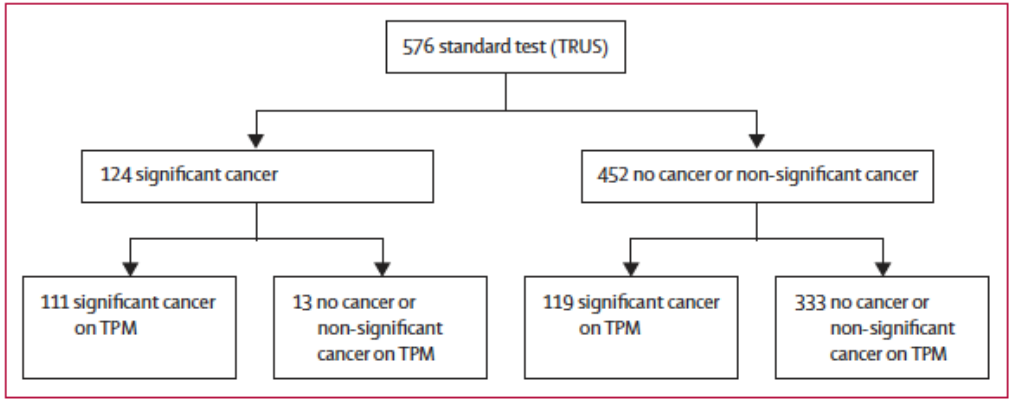



***Figure 3:*** **Diagnostic accuracy for detection of clinically significant cancer (primary definition) between TRUS-biopsy and TPM-biopsy**

*Lancet 2017; 389: 815–22*

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MAY 10, 2018 VOL. 378 NO. 19

# MRI-Targeted or Standard Biopsy for Prostate-Cancer Diagnosis

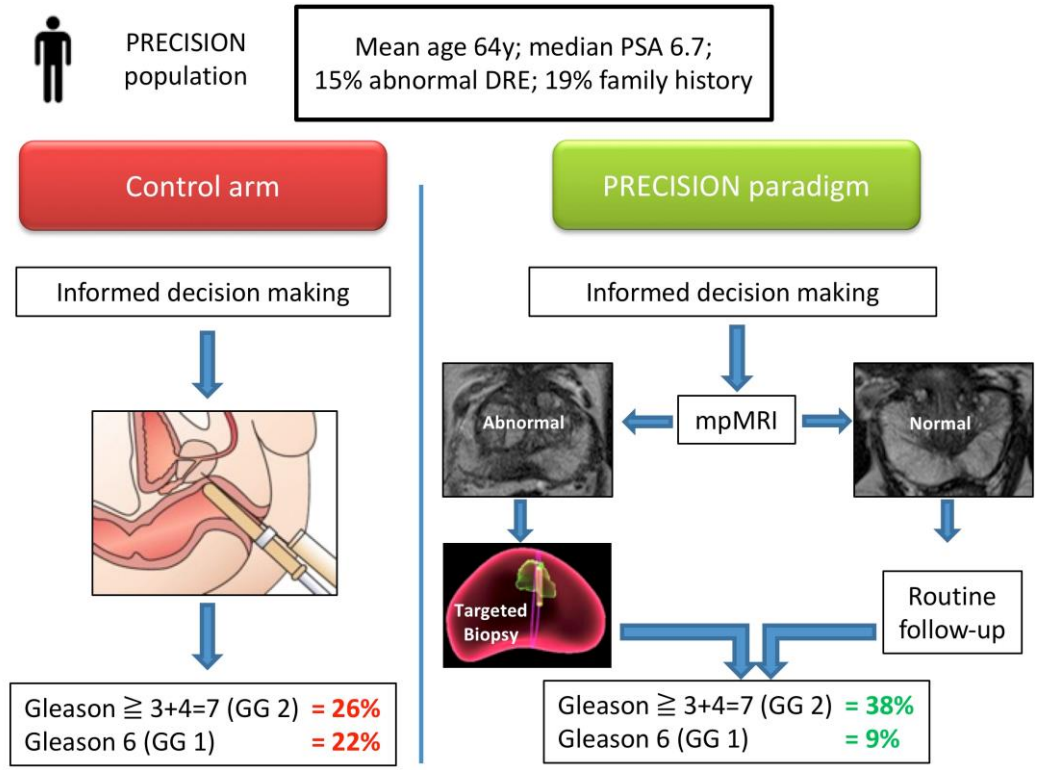
V. Kasivisvanathan, A.S. Rannikko, M. Borghi, V. Panebianco, L.A. Mynderse, M.H. Vaarala, A. Briganti, L. Budäus, G. Hellawell, R.G. Hindley, M.J. Roobol, S. Eggener, M. Ghei, A. Villers, F. Bladou, G.M. Villeirs, J. Virdi, S. Boxler, G. Robert, P.B. Singh, W. Venderink, B.A. Hadaschik, A. Ruffion, J.C. Hu, D. Margolis, S. Crouzet, L. Klotz,

Table 2. Comparison of Cancer Detection between Groups.*

| Outcome | MRI-Targeted Biopsy Group (N=252) | Standard-Biopsy Group (N=248) | Difference† | P Value |
|---|---|---|---|---|
| Biopsy outcome — no. (%) | | | — | — |
| No biopsy because of negative result on MRI | 71 (28) | 0 | | |
| Benign tissue | 52 (21) | 98 (40) | | |
| 4+5 | 7 (3) | 2 (1) | | |
| 5+5 | 3 (1) | 1 (<1) | | |
| No biopsy‡ | 4 (2) | 3 (1) | | |
| Withdrawal from trial§ | 3 (1) | 13 (5) | | |
| Clinically significant cancer¶ | | | | |
| Intention-to-treat analysis — no. (%) | 95 (38) | 64 (26) | 12 (4 to 20) | 0.005 |
| Modified intention-to-treat analysis — no./total no. (%) | 95/245 (39) | 64/235 (27) | 12 (3 to 20) | 0.007 |
| Per-protocol analysis — no./total no. (%) | 92/235 (39) | 62/227 (27) | 12 (3 to 20) | 0.007 |
| Clinically insignificant cancer — no. (%) | 23 (9) | 55 (22) | −13 (−19 to −7) | <0.001 |
| Maximum cancer core length — mm | 7.8±4.1 | 6.5±4.5 | 1.0 (0.0 to 2.1) | 0.053 |
| Core positive for cancer — no./total no. of cores (%) | 422/967 (44) | 515/2788 (18) | — | — |
| Men who did not undergo biopsy — no. (%)‖ | 78 (31) | 16 (6) | — | — |

**CONCLUSIONS**

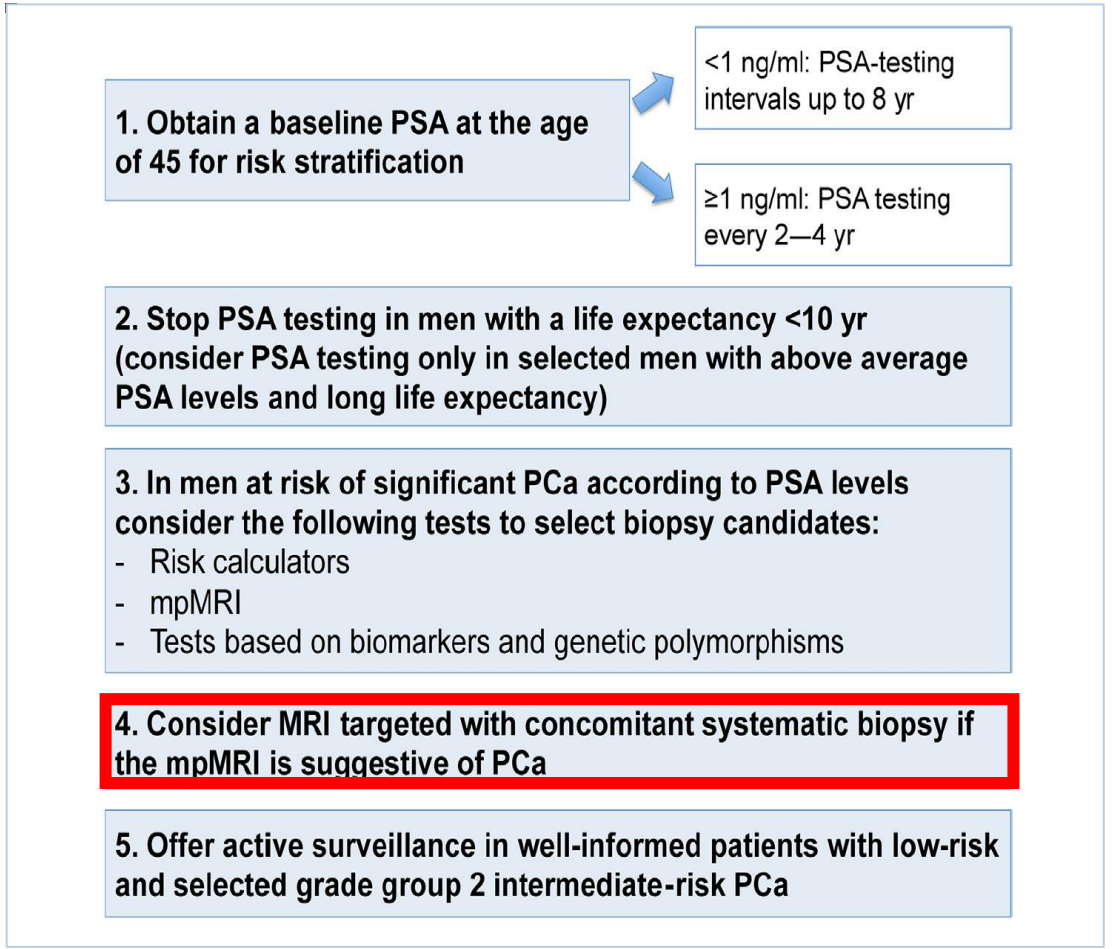
The use of risk assessment with MRI before biopsy and MRI-targeted biopsy was superior to standard transrectal ultrasonography–guided biopsy in men at clinical risk for prostate cancer who had not undergone biopsy previously. (Funded by the National Institute for Health Research and the European Association of Urology Research Foundation; PRECISION ClinicalTrials.gov number, NCT02380027.)




- A total of 78 of 252 participants **(28%)** : **DID NOT undergo biopsy**
- MRI should be included in the early detection pathway as a triage test to safely improve selection of men for prostate biopsy
- Increases 12% csPca
- detection rate of ISUP grade 1 patients was significantly lower in the MRI-TBx group as compared to systematic biopsy (9% vs. 22%)

**Proposed flowchart to reduce the risk of overdiagnosis and overtreatment in men receiving PSA-based screening**

# 2019




- At almost 20-yr follow-up, the number of **patients needed to be screened and diagnosed to prevent one PCa death were 101 and 13**, respectively, and is < breast & colon

EUROPEAN UROLOGY 76 (2019) 142–150

# Summary of evidence and practical considerations on pre-biopsy mpMRI

| Summary of evidence | LE |
|---|---|
| Systematic biopsy is an acceptable approach if mpMRI is unavailable. | 3 |

| Recommendations for all patients | LE | Strength rating |
|---|---|---|
| Do not use mpMRI as an initial screening tool. | 3 | Strong |
| Adhere to PI-RADS guidelines for mpMRI acquisition and interpretation. | 3 | Strong |

| Recommendations in biopsy naïve patients | LE | Strength rating |
|---|---|---|
| Perform mpMRI before prostate biopsy. | 1a | Weak |
| When mpMRI is positive (i.e. PI-RADS $\geq$ 3), combine targeted and systematic biopsy. | 2a | Strong |
| When mpMRI is negative (i.e. PI-RADS $\leq$ 2), and clinical suspicion of prostate cancer is low, omit biopsy based on shared decision making with the patient. | 2a | Weak |

| Recommendations in patients with prior negative biopsy | LE | Strength rating |
|---|---|---|
| Perform mpMRI before prostate biopsy. | 1a | Strong |
| When mpMRI is positive (i.e. PI-RADS $\geq$ 3), perform targeted biopsy only. | 2a | Weak |
| When mpMRI is negative (i.e. PI-RADS $\leq$ 2), and clinical suspicion of prostate cancer is high, perform systematic biopsy based on shared decision making with the patient. | 2a | Strong |


PRESENT
FUTURE
PAST

Platinum Opinion

# Early Detection of Prostate Cancer in 2020 and Beyond: Facts and Recommendations for the European Union and the European Commission

*Hendrik Van Poppel*[a,†,*], *Renée Hogenhout*[b,†], *Peter Albers*[c,d], *Roderick C.N. van den Bergh*[e], *Jelle O. Barentsz*[f,‡], *Monique J. Roobol*[b,‡]

**Table 1 – Expected harm and benefit of various hypothetical screening strategies.**

| | Overdiagnosis | Overtreatment | PCa mortality reduction | LYs[a] | QALYs[a] |
|---|---|---|---|---|---|
| Opportunistic screening: unorganized. | Significant | Significant | No | – | – |
| Organized PSA-based screening program (ERSPC): fixed PSA threshold for biopsy indication, treatment for all diagnoses. | Significant | Significant | Yes | 73 | 56 |
| Organized HR-based screening program, inviting only high-risk cases (eg, *BRCA2* mutation, positive family history, African descent).[b] | Lower (fewer men invited) | Lower (fewer men invited) | Yes, but only for invited HR subgroup | 73 | 56 |
| Screening 2.0: risk-based screening interval, risk-based biopsy indication using RCs and MRI, encourage AS in patients with low- and favorable intermediate-risk PCa. | Lower | Lower | Yes | 73 | >74 [10] |

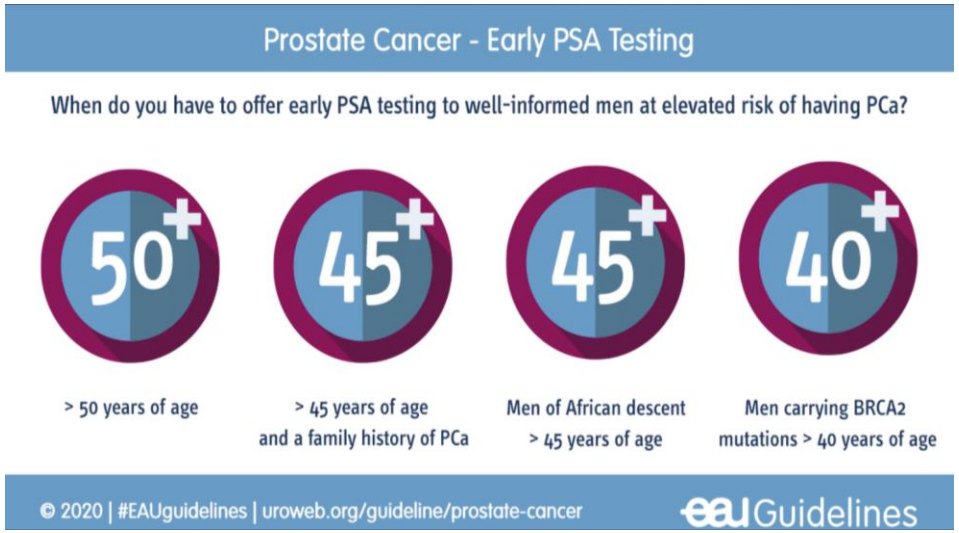
PCa = prostate cancer; PSA = prostate-specific antigen; AS = active surveillance; ERSPC = European Randomized Study of Screening for Prostate Cancer; HR = high risk; LYs = life-years; QALYs = quality-adjusted life-years; RCs = risk calculators; MRI = magnetic resonance imaging.

[a] Based on Carlsson et al [9]. The numbers refer to QALYs gained over a population of 1000 men.

[b] If the lifetime risk of diagnosis and death are both twice as high, the harm-to-benefit ratio of screening will remain unchanged [8].

# Guidelines for screening and individual early detection

| Recommendations | Strength rating |
|---|---|
| Do not subject men to prostate-specific antigen (PSA) testing without counselling them on the potential risks and benefits. | Strong |
| Offer an individualised risk-adapted strategy for early detection to a well-informed man with a life-expectancy of at least 10 to 15 years. | Weak |
| Offer early PSA testing to well-informed men at elevated risk of having PCa:<br>• men from 50 years of age;<br>• men from 45 years of age and a family history of PCa;<br>• men of African descent from 45 years of age;<br>• men carrying *BRCA2* mutations from 40 years of age. | Strong |



European Association of Urology

# Guidelines for screening and early detection

| Recommendations | Strength rating |
|---|---|
| Do not subject men to prostate-specific antigen (PSA) testing without counselling them on the potential risks and benefits. | Strong |
| Offer an individualised risk-adapted strategy for early detection to a well-informed man and a life-expectancy of at least 10 to 15 years. | Weak |
| Offer early PSA testing to well-informed men at elevated risk of having PCa:<br>• men from 50 years of age;<br>• men from 45 years of age and a family history of PCa;<br>• men of African descent from 45 years of age;<br>• men carrying *BRCA2* mutations from 40 years of age. | Strong |
| Offer a risk-adapted strategy (based on initial PSA level), with follow-up intervals of 2 years for those initially at risk:<br>• men with a PSA level of > 1 ng/mL at 40 years of age;<br>• men with a PSA level of > 2 ng/mL at 60 years of age;<br>Postpone follow-up to 8 years in those not at risk. | Weak |
| Stop early diagnosis of PCa based on life expectancy and performance status; men who have a life-expectancy of < 15 years are unlikely to benefit. | Strong |

| Recommendations | Strength rating |
|---|---|
| In asymptomatic men with a prostate-specific antigen level between 2–10 ng/mL and a normal digital rectal examination, use one of the following tools for biopsy indication:<br>• risk-calculator;<br>• imaging; | Strong |
| • an additional serum, urine or tissue-based test. | Weak |

# SCREENING CÁNCER DE PRÓSTATA

Data elaboració: 2022 / Propera revisió: 2024

Àrea Integral de Salut Barcelona Esquerra

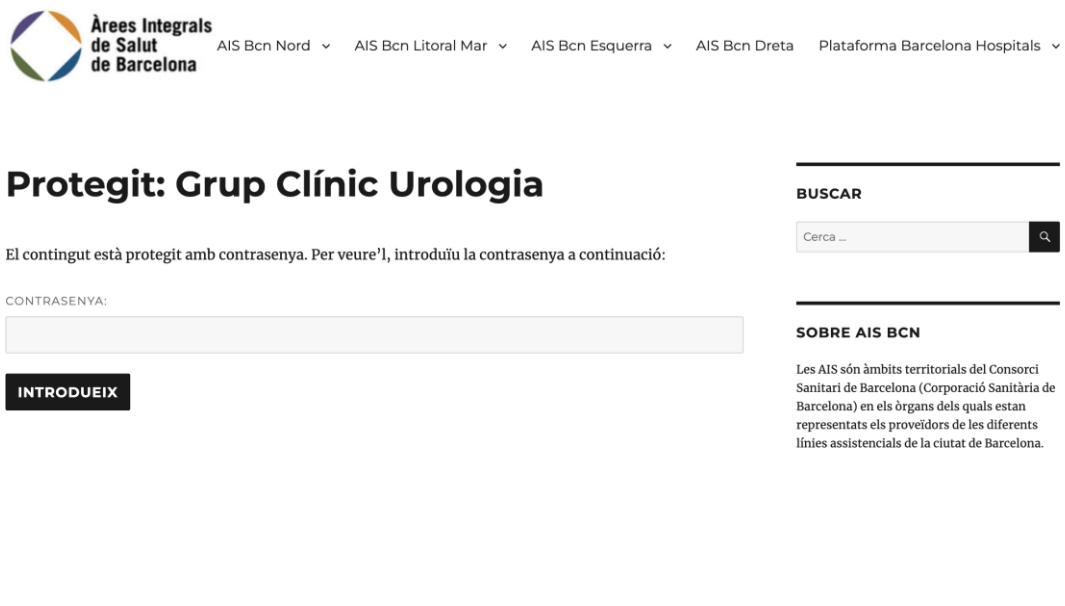
**Grup Clínic d'Urologia AISBE**

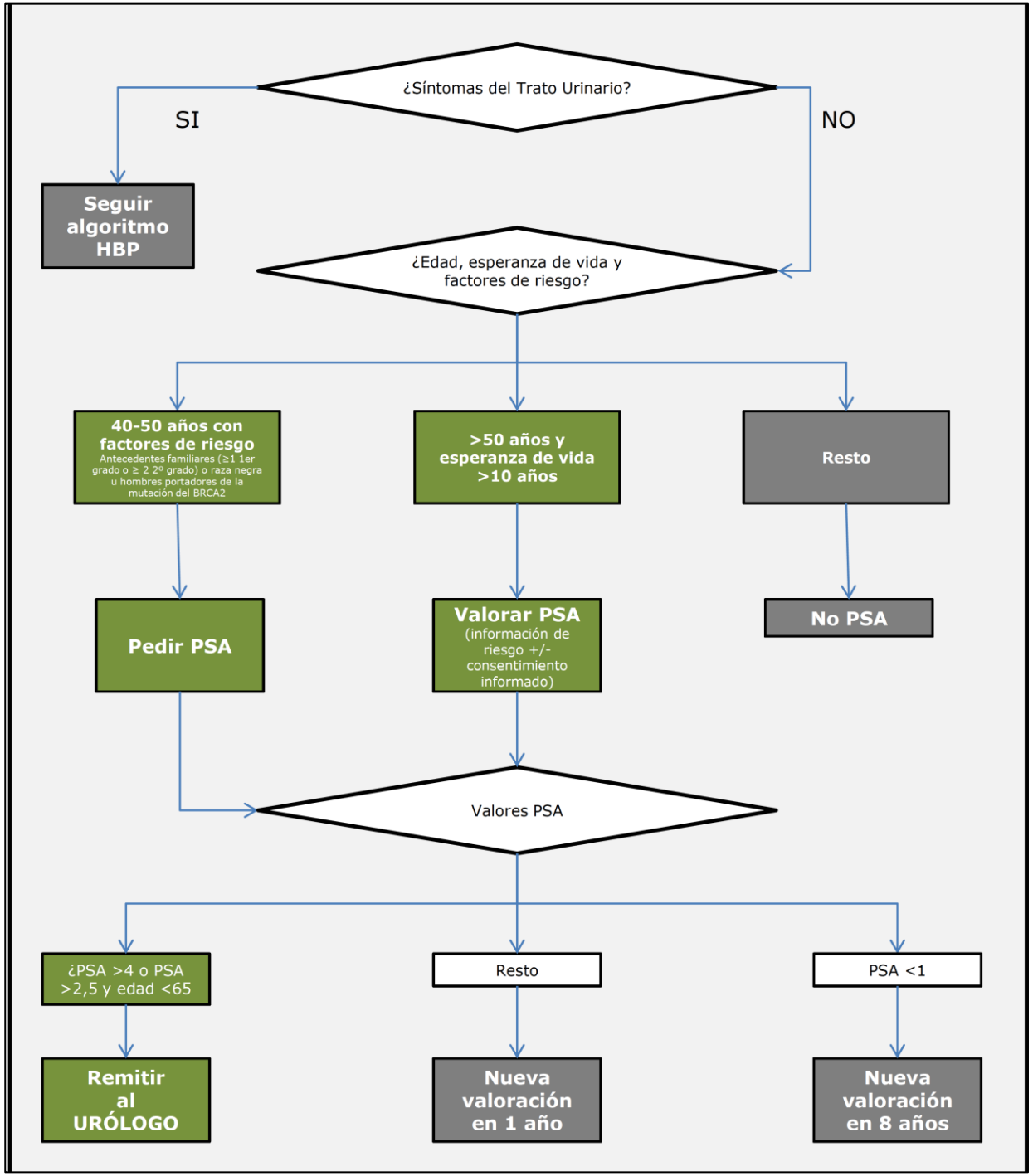
Consorci Sanitari de Barcelona

Ens públic de la Generalitat de Catalunya i l'Ajuntament de Barcelona adscrit al Servei Català de la Salut

Corporació Sanitària de Barcelona

http://www.aisbcn.cat/grup-clinic-urologia/



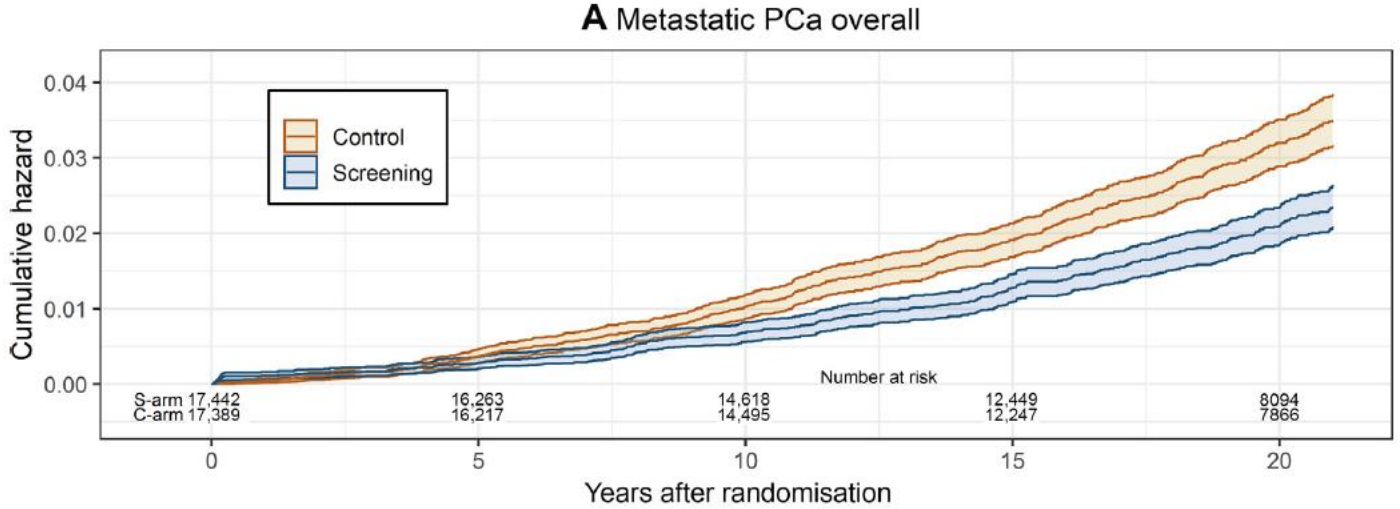



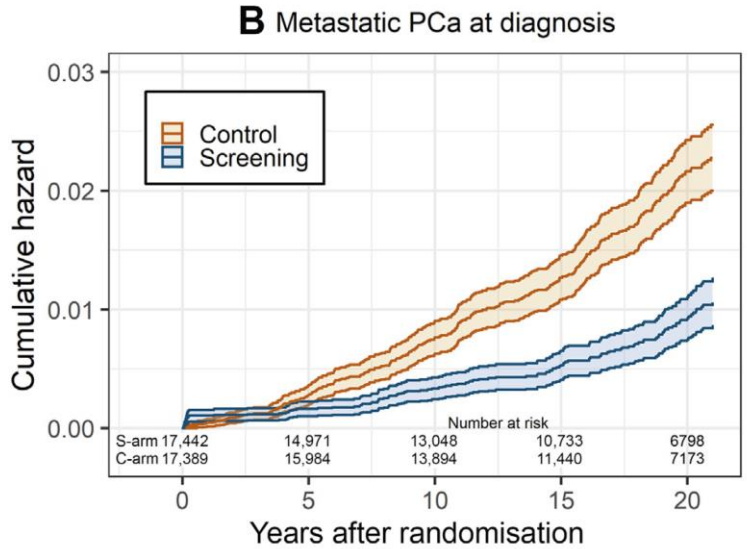

THE PAST

# A Detailed Evaluation of the Effect of Prostate-specific Antigen–based Screening on Morbidity and Mortality of Prostate Cancer: 21-year Follow-up Results of the Rotterdam Section of the European Randomised Study of Screening for Prostate Cancer

*Ivo I. de Vos*[†,*], *Annick Meertens*[†], *Renée Hogenhout, Sebastiaan Remmers, Monique J. Roobol, on behalf of the ERSPC Rotterdam Study Group*

*Erasmus MC Cancer Institute, University Medical Center Rotterdam, Rotterdam, The N*




https://doi.org/10.1016/j.eururo.2023.03.016

# Praise u

SMART EARLY DETECTION OF PROSTATE CANCER

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SMART EARLY DETECTION OF PROSTATE CANCER

# Aims and Intentions

The PRAISE-U project aims to reduce morbidity and mortality caused by prostate cancer in EU Member States through smart early detection. In partnership with the consortium, PRAISE-U works to encourage early detection and diagnosis of prostate cancer through customised and risk-based screening programmes. The goal is to align protocols and guidelines across Member States and enable the collection and distribution of relevant data to reduce prostate cancer morbidity and mortality rates in Europe.

# Methodology

The ultimate aim of the PRAISE-U consortium is to decrease morbidity and mortality due to prostate cancer across European countries. The EAU and its partners have been politically active in advocating for the early detection and diagnosis of prostate cancer in Europe through population-based screening programmes that are patient-tailored and that use a risk-based approach. These efforts are complemented by a partnership in iPAAC. The EU has already provided guidance on screening for breast, cervical and colorectal cancer, as showcased in the consortium's efforts within projects such as CanScreen 5 and EU-TOPIA. The PRAISE-U consortium aims to build on the knowledge from these other cancer indications, including using tools such as the systematic methodology of quality assurance composed by the Joint Research Centre (JRC), and expand this to prostate cancer. Additionally the consortium will benefit from the wisdom gained from ongoing EU-wide projects such as PIONEER, OPTIMA and EU-Topia, and the experiences of EMC and ERSPC. Our goal is to align the protocol and guidelines among members states within the European Union, enable faster knowledge transfer and fill knowledge gaps.

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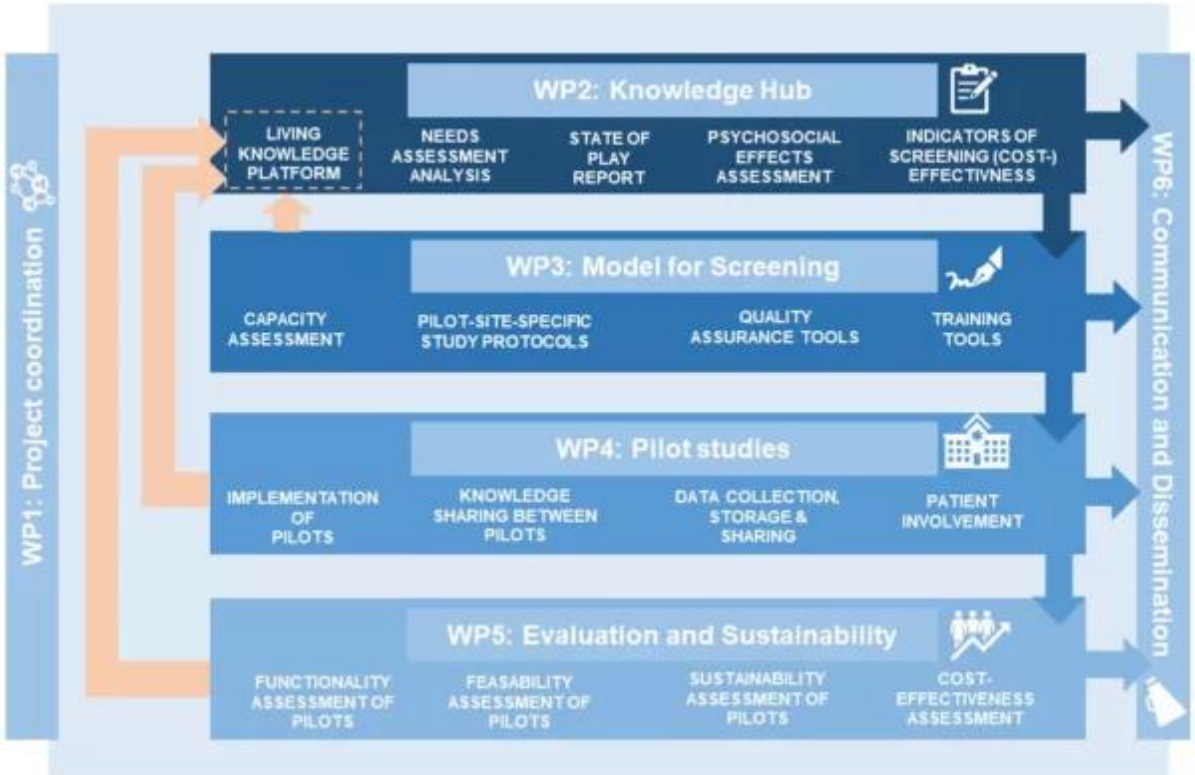


## Pilot Sites

1. *Poland*
   The Polish pilot focuses on exploring the needs of setting up a screening programme where little infrastructure currently exists.
2. *Ireland*
   The Irish pilot focuses on streamlining opportunistic testing within suggested screening interval.
3. *Spain (Galicia region)*
   Galician pilot focuses on the feasibility of the risk-based approach, including psychosocial effects.
4. *Spain (Manresa)*
   The focus of the Manresa pilot is on assessing compliance, particularly when primary HCPs are involved in the invitation process.
5. *Lithuania*
   The focus of the Lithuania pilot is, with a PSA-based population screening with certain risk-stratification in place, to align the algorithms with the one proposed by the PRAISE-U project and formalizing the invitation system.


Gracias