PROSTATE CANCER

RISK FACTORS:

- Prostate cancer mainly affects men over 50, and risk increases with age. The average age of diagnosis is between 70 and 74 years
- Family history of prostate cancer in father or brother risk increases 2.5 fold; risk increases further if father or brother were less than 60 years old when diagnosed. Increased risk if mother or sister has had breast cancer, particularly less than 60 years old or BRCA1/2 carriers
- Afro-Caribbean ('Black African', 'Black Caribbean' and 'Black Other') men have an increased risk; **1 in 4 Afro-Caribbean men will have prostate cancer in their lifetime.**

PROSTATE CANCER – PROSTATE SPECIFIC ANTIGEN (PSA) TEST

After appropriate counselling, consider a prostate specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in patients with:

- Any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention
- Erectile dysfunction
- Visible haematuria

A referral using a suspected cancer pathway (for an appointment within 2 weeks) is recommended for all men with a PSA above the age-specific threshold even in the presence of a urinary infection. For patients with an increasing PSA level that remains below the British Association of Urological Surgeons (BAUS) age-specific threshold there is no evidence that a suspected cancer referral is required. Where the result is just below the age-specific threshold, you should consider repeating the PSA test after one month. A number of decision support tools are available to assist patients in deciding whether to proceed with a PSA test (see references).

BAUS PSA AGE-SPECIFIC THRESHOLDS	
AGE (years)	**PSA VALUE (ng/ml)**
40-49	**2.7**
50-59	**3.9**
60-69	**5**
70-79	**7.2**
80-84	**10**
85+	**20**

When GP direct access investigations are performed the GP has clinical responsibility for ensuring appropriate follow up and onward referral is arranged. In many cases positive results may be forwarded directly to the cancer team but the GP must ensure a referral has been made and that appropriate safety-netting arrangements are in place.

PSA may be raised in the presence of urinary infection, prostatitis or benign prostatic hypertrophy, and may also be elevated following vigorous exercise, ejaculation or prostate stimulation (e.g. prostate biopsy, digital rectal examination, anal intercourse).

The GP should ensure that **up to date (within 3 months) eGFR / renal function,** imaging reports and other relevant investigations are available for the specialist when the patient is seen. This will enable the urology team to triage the patient **straight to test** if appropriate.

TESTICULAR CANCER

GPs should consider a direct access ultrasound scan for testicular cancer in men with UNEXPLAINED or persistent testicular symptoms

PLEASE NOTE: A suspected cancer referral (for an appointment within 2 weeks) is preferred to a direct access ultrasound if the GP has a high index of suspicion or is concerned there may be a delay to diagnosis in waiting for a direct access ultrasound scan.

BLADDER CANCER

GPs should consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent UNEXPLAINED urinary tract infection. 'Non-visible' or 'trace' haematuria is determined by dipstick urinalysis of a fresh urine sample. Dipstick testing is preferable to microscopy as it is more reliable and not compromised by haemolysis; the test should be repeated twice.

Pan-London Suspected Cancer Referral Guide - Urology

PROSTATE CANCER

Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if:

- Prostate feels malignant on digital rectal examination
- PSA levels are above the age-specific reference range (see table above). For patients with a slightly elevated PSA, a suspected cancer referral is still recommended.

TESTICULAR CANCER

Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for testicular cancer if they have:

- A solid intra-testicular lump
- Non-painful enlargement or change in shape or texture of the testis
- Abnormal ultrasound scan suggestive of testicular cancer

PLEASE NOTE: A suspected cancer referral (for an appointment within 2 weeks) is preferred to a direct access ultrasound if the GP has a high index of suspicion or is concerned there may be a delay to diagnosis in waiting for a direct access ultrasound scan.

Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP MUST give full clinical details in the 'additional clinical information' box at the time of referral)

BLADDER CANCER

Refer using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if

- Adults aged ≥ 45 with:
  - UNEXPLAINED visible haematuria without urinary tract infection
  - Visible haematuria that persists or recurs after successful treatment of urinary tract infection
- Adults aged ≥ 60 with:
  - UNEXPLAINED non-visible haematuria and either dysuria or a raised white cell count

RENAL CANCER

Refer patients using a suspected cancer pathway referral (for an appointment within 2 weeks) for renal cancer if:

- Abnormal ultrasound scan suggestive of renal cancer
- Adults ≥ 45 with:
  - UNEXPLAINED visible haematuria without urinary tract infection
  - Visible haematuria that persists or recurs after successful treatment of urinary tract infection

Asymptomatic renal cysts described as simple in the radiology report do not require referral.

PENILE CANCER

Refer using a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer if:

- Penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded as a cause
- Persistent penile lesion after treatment for a sexually transmitted infection has been completed
- Unexplained or persistent symptoms affecting the foreskin or glans

Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP MUST give full

SUSPECTED UROLOGY CANCER REFERRAL

RESOURCES:

1. Suspected cancer: recognition and referral, NG12 (2015) http://www.nice.org.uk/guidance/ng12
2. PSA Options Grid Shared Decision Making http://patient.info/decision-aids/prostate-specific-antigen-psa-test-yes-or-no and http://optiongrid.org/option-grids/grid-landing/61
3. RCGP Prostate Cancer: Early Diagnosis in General Practice http://elearning.rcgp.org.uk/course/view.php?id=132
4. BMJ Learning Prostate cancer: a guide for GPs and non-specialists: putting NICE guidelines into practice http://learning.bmj.com/learning/module-intro/prostate-cancer--a-guide-for-gps-and-non-specialists---in-association-with-nice-.html?moduleId=10032255
5. Prostate Cancer UK Professional resources http://prostatecanceruk.org/for-health-professionals/guidelines