Prostate Cancer Foundation of Australia

RESEARCH AWARENESS SUPPORT

Public Consultation Report

DRAFT 2025 Guidelines for the Early Detection of Prostate Cancer in Australia

18 June 2025

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In the spirit of reconciliation, we would like to acknowledge the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respects to their Elders, past and present, and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

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Executive Summary

The development of the DRAFT 2025 Guidelines for the for the Early Detection of Prostate Cancer in Australia ('DRAFT 2025 Guidelines'), was strongly informed by two Public Consultations.

Public Consultation 1

Public Consultation 1 explored consumer perceptions of the 2016 Guidelines in relation to effectiveness, usability, opportunities to strengthen the Guidelines in the context of this review, and personal experiences in relation to the Guidelines to inform the DRAFT 2025 Guidelines. Findings are summarised in Appendix 1: Public consultation 1 and reported in full here.[1]

Public Consultation 2

Public Consultation 2 sought wide ranging stakeholder feedback on the DRAFT 2025 Guidelines and aimed to identify any content requiring revision, review language for clarity and readability, and ensure that guidelines are feasible and acceptable to end-users/recipients.

Two approaches were used for Public Consultation 2: An open call for submissions to anyone with an interest in the early detection of prostate cancer; and targeted consultation with over 300 peak bodies, professional organisations, consumer and support groups.

A total 203 submission were received providing 1,317 individual points of feedback in Public Consultation 2. The feedback, while overwhelmingly supportive of the Guidelines' approach to the early detection and management of prostate cancer in Australia, has shaped important changes in the Guidelines and has strengthened the DRAFT 2025 Guidelines as a whole.

By far the largest proportion of responses related to Guideline implementation (46%, n=599). Of the 1,317 individual feedback items, 499 advocated for specific implementation priorities. A further 105 feedback items proposed implementation priorities in the context of individual sections of the clinical practice Guidelines themselves, e.g., strategies to support proactive PSA testing such as consumer and clinician resources and targeted awareness campaigns.

[1] Heneka N, Heathcote P, Malouf P, Chambers S, Smith D, Dunn J. Lessons from the implementation of the Australian 2016 Prostate Specific Antigen Testing Clinical Practice Guidelines: A descriptive study. ANZ Journal of Surgery. 2025; ePub ahead of print, 4 April 2025. DOI:10.1111/ans.70136

Introduction

This Public Consultation Report fulfils the National Health and Medical Research Council (NHMRC) *Procedures and requirements for meeting the NHMRC standards for clinical practice guideline* recommendations[2] for documenting details of Public Consultation submissions and guideline developer responses, relating to the process of development of the DRAFT 2025 Guidelines for the for the Early Detection of Prostate Cancer in Australia ('DRAFT 2025 Guidelines'), specifically:

F.2 Details of submissions received during Public Consultation and the response of the guideline development working group to the submissions (including whether, why and how the guideline was altered) are provided as a separate document to the NHMRC.

F.3 During the Public Consultation period, the developer has undertaken and documented consultation with:

- the Director-General, Chief Executive or Secretary of each state, territory and Commonwealth health department;
- other relevant government departments as appropriate to the guideline topic.

F.4 The developer has identified and consulted with key professional organisations (such as specialty colleges) and consumer organisations that will be involved in, or affected by, the implementation of the clinical recommendations of the guideline.

Note that following Guideline approval, a version of the Public Consultation submissions summary will be made publicly available via the PCFA website, with submissions de-identified. (*F.2.1 – Desirable*).

Terminology

The DRAFT 2025 Guidelines' were developed using a rigorous, multi-step, systematic method involving a Guideline Review team which was made up of a Project Steering Committee, two Advisory Groups, an Expert Advisory Panel, 12 Expert Advisory Panel Working Groups and an Executive Committee. When referencing the collective input of the Guideline Review team we have used '**Review'** as a collective term to refer to all processes and people involved in development of the Guidelines such as systematic reviews, Working Group discussions or other elements used to generate recommendations.

[2] National Health and Medical Research Council. Procedures and requirements for meeting the NHMRC standards for clinical practice guidelines (August 2022 version 1.2). Melbourne: National Health and Medical Research Council; 2020.

Background

Two Public Consultations were conducted in the development of the DRAFT 2025 Guidelines

1. Public Consultation 1 - Public feedback on the 2016 PSA Guidelines

In April 2024, the Prostate Cancer Foundation of Australia (PCFA) released a Call for Submissions ('the Call') inviting Australians with an interest in PSA testing for prostate cancer to share their views on the 2016 Guidelines. The objective of this call was to identify perceptions of the 2016 Guidelines in relation to effectiveness, usability, opportunities to strengthen the Guidelines in the context of this review, and personal experiences in relation to the Guidelines.

Full findings from Public Consultation 1 are available in Appendix 1: Public feedback on the 2016 PSA Guidelines, and have been published in the Australia New Zealand Journal of Surgery:

> *Heneka N, Heathcote P, Malouf P, Chambers S, Smith D, Dunn J. Lessons from the implementation of the Australian 2016 Prostate Specific Antigen Testing Clinical Practice Guidelines: A descriptive study. ANZ Journal of Surgery. 2025; ePub ahead of print, 4 April 2025. DOI:10.1111/ans.70136*

2. Public Consultation on the DRAFT 2025 Guidelines

From 14 April to 25 May (inclusive), 2025, the PCFA released a second Call for Submissions inviting Australians with an interest in prostate cancer to review and provide feedback on the DRAFT 2025 Guidelines. The aim of this Public Consultation was to provide stakeholders including consumers, clinicians and other end-users to review the content, quality, legitimacy and acceptability of the DRAFT 2025 Guidelines. The Public Consultation aimed to elicit a wide range of views from end-users, identify any content requiring revision, review language for clarity and readability, and ensure that guidelines are feasible and acceptable to end-users.

Two approaches were used for Public Consultation. An open call for submissions was made to anyone with an interest in the early detection of prostate cancer, including consumers, clinicians, organisations or professional bodies. This ensured that all stakeholders, including those who may not have been expected to make a submission, had an opportunity to provide feedback.

In addition to this, consultation targeted over 300 peak bodies, professional organisations, consumer and support groups, and organisations that represent priority populations such as Aboriginal and Torres Strait Islander peoples, LGBTIQA+ communities, culturally and linguistically diverse communities, men of sub-Saharan African descent and rural and remote populations (refer Appendix 2: Key stakeholders contacted for feedback).

This report details the procedures and findings of Public Consultation 2 in accordance with the National Health and Medical Research Council (NHMRC) Guidelines for Guidelines Handbook.[2]

Public Consultation was conducted in accordance with the steps for Public Consultation in the Guidelines for Guidelines Handbook[2]:

1. Plan for Public Consultation
2. Define parameters for the consultation
3. Notify the public
4. Request information
5. Prepare submissions for consideration
6. Consider submissions
7. Write a consultation report
8. Feedback on the Public Consultation process
9. Acknowledge submissions

Details of how each step was undertaken are provided below.

1. Plan for Public Consultation

Planning for the Call was undertaken from April 2025. The Call was scheduled to open for six weeks from Monday 14 April to Sunday 25 May (inclusive), 2025.

A Communication Strategy was prepared to plan for Public Consultation.

Task	Action
Identify key objectives and messages in the draft Guidelines	Key objectives and messages were identified to inform development of Public Consultation questions
Determine specific topic areas of interest on which to seek specific feedback	Executive Advisory Panel and Project Steering Committee were consulted regarding points of interest to seek specific feedback
Formulate the structure and form of Public Consultation questions	Develop Public Consultation questions that are accessible to all stakeholders and allow for general feedback, in addition to perspectives on topics selected by the Review group
Plan the modes of submission	Options for modes of submission were considered to ensure that the broadest range of stakeholders would be able to provide a submission
Create workflows to process incoming data	Procedures and documents for managing incoming data from selected modes of submission were developed; including allocation of identification numbers, assessment of eligibility, and preparation of feedback for review in weekly meetings
Identify any key stakeholders for targeted consultation	Advice was sought from Executive Advisory Panel and Project Steering Committee to identify key stakeholders from whom feedback should be requested
Decide how to notify the public	A multi-platform media strategy was developed by the PCFA to publicise the call for submissions
Plan to pre-emptively alert organisations of the upcoming consultation	Timeline and content for notifications about the upcoming Public Consultation for key stakeholders were agreed
Brief organisations, agencies and stakeholders that might respond to submissions	Content was prepared to explain the purpose and nature of the Public Consultation for organisations, agencies and stakeholders

Planning was undertaken by the Executive Committee in consultation with the Executive Advisory Panel and the Project Steering Committee. The detailed parameters of Public Consultation were then considered.

Key objectives and messages

The purpose and scope of both the Guidelines and the consultation process were clearly articulated in the DRAFT 2025 Guidelines document, and the 'How to make a submission' document available to the public on the online submission portal landing page.

To ensure potential respondents understood the Guidelines and associated documents were draft versions, this was clearly noted in all document titles, footers, watermarks, and in all in-text references. It was further stated on the landing page, and in any public-facing documents, such as the 'How to make a submission' document.

2. Define parameters for the consultation

2.1. Development of questions

The Project Steering Committee approved 18 questions that were posed to all respondents, covering sections of the DRAFT Guidelines, in addition to specific questions regarding topics of interest. Refer Appendix 3: Public Consultation 2 Questions for a full list of questions.

The Public Consultation invited feedback on any section of the DRAFT 2025 Guidelines.

- Introduction
- Executive Summary
- Section A: Risk assessment
- Section B: Decision support
- Section C: Priority populations
- Section D: Early detection
- Section E: Management
- Section F: Guideline implementation and monitoring
- Section G: Emerging evidence and future research priorities
- Appendices
- Resources and useful links

Additionally, seven questions sought feedback on specific aspects of the DRAFT 2025 Guidelines, including:

- approaches to early detection of prostate cancer in Aboriginal and Torres Strait Islander males
- use of language
- additional suggestions to promote uptake of Guidelines
- additional areas of emerging evidence/future research
- clarity of Guidelines
- further considerations
- any further comments participants wished to make.

Participants were informed that they did not have to provide feedback on all sections of the DRAFT 2025 Guidelines or subsequent questions. Participants were invited to focus on topics that were of most relevance or interest to them.

2.1.1. Eligible feedback and responses

In addition to comments from stakeholders, documents such as journal articles, guidelines, and policies that may provide relevant information were considered. Other forms of submission would be considered at the discretion of Executive Committee, for example face-to-face meetings and discussions. If a relevant systematic review, meta-analysis or study was provided, the recommendations in relevant sections would be reviewed and new evidence incorporated (refer 2.12 Incorporation of new evidence).

Feedback that was related to issues outside of the scope of the Guidelines was not considered for integration into the recommendations but, as applicable, could be integrated into Research Priorities (refer Dissemination Report).

2.1.2. Incorporation of new evidence

Additional studies provided by the public during the consultation would be considered if they met the same requirements for studies included in the systematic reviews conducted by the Technical team (Refer Technical Report for detailed inclusion criteria) and were in line with the NH&MRC guidance. Briefly, these included a high quality systematic review, meta-analysis, randomised controlled trial, or intervention, cohort, or observational study, but not an editorial or opinion piece, provided that the:

- outcome of the study related to the early detection of prostate cancer, testing and management;
- study results could be generalised to the Australian population.

Where a relevant systematic review or meta-analysis was provided, the recommendations in question may be revisited to incorporate the new evidence. If relevant high quality studies of other types were provided (according to the parameters above) the new evidence would be considered for incorporation into the text supporting the recommendations.

Timeframe and structure

Mode of submissions

Submissions could be made via: i) an online form; ii) direct email to the PCFA. Submissions provided via email did not need to conform to the list of questions used in the online portal. Late submissions were accepted at the discretion of the Executive Committee.

3. Notify the public

F.3 During the Public Consultation period, the developer has undertaken and documented consultation with:

- *the Director-General, Chief Executive or Secretary of each state, territory and Commonwealth health department*
- *other relevant government departments as appropriate to your guideline topic*
- *relevant authority/ies, when a guideline makes any recommendation/s specifying interventions that are not available or restricted in Australia (see Requirement D.10)*

F.4 The developer has identified and consulted with key professional organisations (such as specialty colleges) and consumer organisations that will be involved in, or affected by, the implementation of the clinical recommendations of the guideline.

Identifying and notifying key stakeholders

Key stakeholders for Public Consultation were systematically identified using the relevant domains and constructs of the Consolidated Framework for Implementation Research[3] (Refer Appendix 2: Key stakeholders contacted for feedback). This determinant framework has been applied since the start of Guideline review to: identify and address potential intrinsic factors that may affect guideline implementability, predict barriers and facilitators to implementation effectiveness, and provide a validated implementation framework to guide recommendations for national implementation strategies upon release of the updated guidelines.

The Consolidated Framework for Implementation Research comprises a series of domains that span multiple implementation settings (outer, inner, individual) and corresponding constructs to help identify key stakeholders in each setting to support effective implementation. We have systematically identified stakeholders from each relevant framework domain and construct to ensure broad representation of government, professional and consumer organisations throughout Public Consultation. An overview of domain and construct definitions used to categorise stakeholders is provided in Table 1.

To enable key organisational stakeholders time to prepare for internal consultation and formulation of a response, pre-emptive notifications regarding the upcoming Public Consultation period were distributed. Stakeholders were notified of the pending Public Consultation period on 21 March 2025, and contacted again on 14 April 2025 upon opening of Public Consultation.

[3] Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. Implementation Science. 2022;17(1):75.

Table 1: Consolidated Framework for Implementation Research domain and construct definitions

Domain/*Construct*	Definition
Outer Setting	The setting in which the 'Inner Setting' exists. The Outer Setting is designed to capture macro-level (e.g., government), meso-level (e.g., cancer councils, professional associations) and microsystem-level factors (e.g., individual health services) that impact the inner setting. For the purposes of this Guideline review the Outer Setting encompasses the **Australian Health System**.
Outer setting Construct 1: ***Partnerships & Connections***	External entities including referral networks, health services, academic/research affiliations, and professional organisations that network with the Inner Setting to support and promote implementation of the updated Guidelines.
Outer setting Construct 2: ***Policies & Laws***	Organisations representing relevant legislation, regulations, professional group guidelines/recommendations, or accreditation standards that support implementation and/or delivery of the updated Guidelines. This includes cancer councils, professional associations specific to general practice, urological practice and cancer more broadly.
Inner Setting	The setting in which the updated Guidelines will be implemented. For the purposes of this Guideline review the Inner Setting comprises **primary health care** and **specialist urological practice settings**.
Individual Setting	Those who are directly or indirectly involved with delivering updated Guidelines (e.g., health professionals and health services) or are the recipients of the updated Guidelines (consumers).
Individual setting Construct 1: ***Innovation Deliverers - Indirect***	In addition to those stakeholders listed in the Inner Setting Domain, the indirect innovation deliverers represent supporting health professionals/services involved in Guideline implementation, e.g., pathology and radiology services.
Individual setting Construct 2: ***Innovation Recipients***	Innovation recipients are the consumers to whom the updated Guidelines apply: Australian men eligible for testing for the early detection of prostate cancer. This includes those considered at-risk groups (black males of sub-Saharan African ancestry) and priority populations such as Aboriginal and Torres Strait Islander males, culturally and linguistically diverse populations, and rural and remote populations.

Public notification

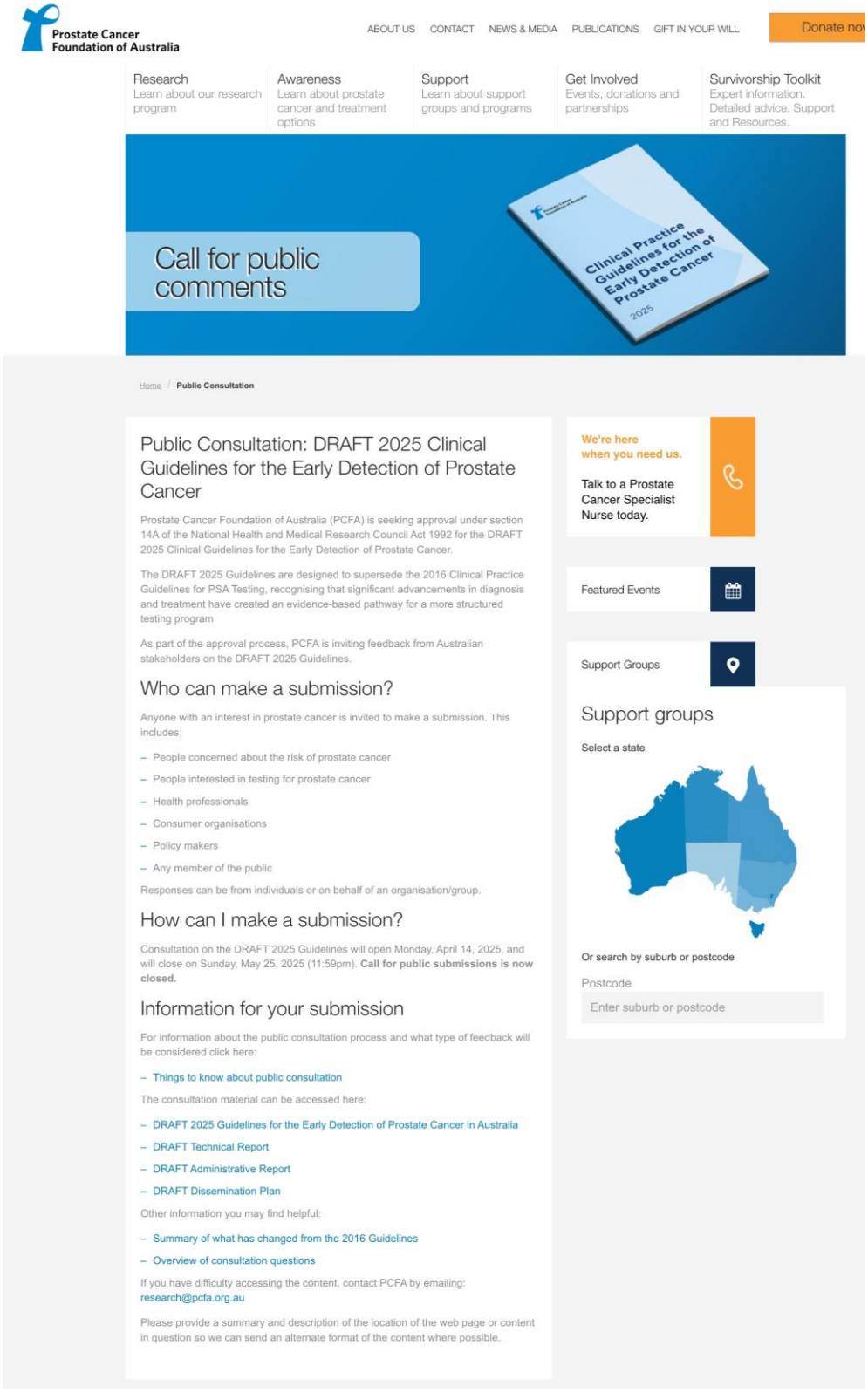
A coordinated public notification approach was implemented from 7 April 2025 using the multi-platform strategy developed during planning of Public Consultation. Refer Appendix 4: Communication strategy for the complete strategy.

Briefly, modes of notification were chosen to ensure broad reach and dissemination of the call for Public Consultation. This included traditional print media (articles and advertisements), radio interviews, television news segments, social media posts, press releases, blog posts and distribution via the PCFA network and website. Notifications were made periodically before and during Public Consultation to support stakeholder awareness. A sample of media generated from the strategy is available online.

Submission platform landing page

All potential respondents were initially directed to the online form which included a link with detailed information about the Call, a link to access the DRAFT 2025 Guidelines, information on the two methods to submit a response, and the timeframe for receipt of submissions. (Figure 1)

Figure 1. Submission platform landing page



4. Request information

Respondents were asked to provide demographic information prior to providing feedback on the DRAFT 2025 Guidelines.

Demographic information
First Name
Last Name
Email
Does this submission reflect the views of an individual, organisation or group?
Individual: • Postcode • Individual background
Organisation: • Postcode • Type of organisation • Name of organisation • Description of organisation • State/Territory where organisation is based
Prostate cancer support group: • Postcode Name of support group
Postcode
Gender
Do you identify with any of the following? • Aboriginal and Torres Strait Islander person • LGBTIQA+ • People from culturally and linguistically diverse backgrounds • People living in a rural or remote area • People of African ancestry • Prefer not to say • None of the above

5. Prepare submissions for consideration

Data export and cleaning

Throughout the Public Consultation period, submissions were regularly exported from the online portal and collated in an Excel spreadsheet. Direct submissions were manually entered into the spreadsheet. Prior to any processing or data cleaning, all submissions were read in full.

The spreadsheet was checked for blank or duplicate submissions. Feedback in progress that had not been submitted and duplicate submissions were not considered. However, completed submissions that did not contain content were allocated an ID and retained.

Feedback from individuals or organisations that provided more than one submission, either via the online portal only, or the online portal and a direct email communication, were retained if they were not identical and allocated a single ID number.

All responses were retained in full in a single spreadsheet.

Preliminary demographic information

Feedback was initially coded with the demographic information provided, such as converting postcode into Modified Monash Model of geographical classification.

Preparing for categorisation

Feedback was then transferred into a spreadsheet for categorisation and response. Where feedback provided for a question included multiple comments or topics, these were divided into individual comments for detailed categorisation.

6. Consider submissions

All submissions were checked to ensure they fit the pre-determined parameters of the Public Consultation.

Initial review of feedback

In the first instance, all submissions were considered in full by the Executive Committee. During this process, feedback was screened for potential conflicts of interest, whether the content was within scope and if any additional evidence provided was eligible for consideration.

1. Potential conflicts of interest

The process for potential conflicts was assessed by the Executive Committee on a case-by-case basis according to whether they were likely to produce substantial bias in the submission provided. If a potential conflict of interest was identified as likely to produce bias, the submission content was reviewed by the Executive Committee. If the submission's content was deemed to contain substantial bias, the submission was ineligible for inclusion.

Where feedback was deemed ineligible for inclusion, this was noted and the reason for exclusion documented. Excluded feedback was retained and provided in addition to eligible feedback for transparency.

No feedback was excluded on the basis of declared conflicts of interest.

2. Scope of Public Consultation

During the initial review of feedback, submissions were also screened to identify any comments that were beyond the scope of Public Consultation. Scope was defined as feedback and suggestions related to the content and presentation of the Draft 2025 Guidelines. All feedback was considered. However, if feedback was deemed to be out of scope this was noted in the response in addition to the reason why.

3. Considering new evidence

Evidence provided by participants was collated and provided to the technical team for assessment. Evidence was screened for eligibility using the pre-determined parameters described in Section 2.1.1. Eligible feedback and responses. Where eligible, newly identified evidence was incorporated into evidence summaries supporting recommendations, and/or associated documents, such as the Dissemination Plan.

Feedback categorisation

After initial processing and eligibility screening, comments were categorised by relevant section of the Guidelines (for example, comments related to research topics were allocated to Section G: Emerging evidence and future research), or question (for example, comments on the overall clarity of the Guidelines were allocated to Question 16: Guideline clarity), regardless of the field in which they were originally submitted.

This allowed comments about particular aspects of the DRAFT 2025 Guidelines to be collected by topic and the overall sentiment to be analysed to inform any necessary amendments to the Guidelines.

Consideration of submissions

From the commencement of the Public Consultation period, ongoing review of feedback was undertaken during weekly meetings of the Executive Committee. A weekly summary document was prepared, detailing:

- a table of all feedback including respondent ID, relevant section of guideline, and respondent's comment
- summaries of key points arising from consultation to be discussed
- additional documents such as journal articles, guidelines and policies submitted by respondents for review and consideration of integration into the DRAFT 2025 Guidelines
- actions required to address feedback including amendment to the DRAFT 2025 Guidelines
- a template for recording the guideline development group's responses and actions taken for each respondent comment

When considering submissions, all feedback was reviewed and discussed by the Executive Committee. Feedback was also provided to relevant Working Groups where necessary.

During this process, points raised in recent feedback were identified and compared to prior feedback on the same topic, if any. Patterns of responses or sentiment were noted and the overall sentiment of feedback to date was assessed. Any evidence provided as part of submissions was reviewed by the technical team.

Suggested changes to the Guidelines were assessed by the Executive Committee and drafted, if warranted. Further changes were also made to support clarity and readability. All changes were documented for review.

Developing responses and making changes

The Review group responded to each comment provided in submissions for Public Consultation.

Responses to feedback and changes to the DRAFT 2025 Guidelines were developed iteratively throughout the Public Consultation period. These were reviewed by the Executive Committee, before being considered by respective Working Groups, the Expert Advisory Panel through to and the Project Steering Committee..

7. Preparation of Public Consultation report

F.2 Details of submissions received during Public Consultation and the response of the guideline development working group to the submissions (including whether, why and how the guideline was altered) are provided as a separate document to the NHMRC.

F.2.1 A version of the Public Consultation submissions summary is publicly available, with submissions de-identified.

After the Public Consultation concluded, summary documents were prepared for the Expert Advisory Panel and Project Steering Committee.

These included:

- a summary of public feedback and changes made to the DRAFT 2025 Guidelines as a result of Public Consultation, and
- revised sections of the Guidelines.

The summary documents were prepared and presented to the Expert Advisory Panel (2 June 2025) and the Project Steering Committee (10 June 2025) by the UniSQ CSRG. After discussion at meetings, subsequent amendments were reviewed and agreed upon via email circular. Both groups reached consensus regarding proposed changes to the DRAFT 2025 Guidelines and responses to feedback.

8. Feedback on the Public Consultation process

A document containing all submissions was provided to the NHMRC in accordance with guideline development processes. A separate document was prepared for public dissemination, containing submissions from individuals and organisations that had consented to having their responses published. These submissions were deidentified by removing any names, postcode/location, contact information, and other personal information that may be inadvertently identifiable.

Upon publication of the Guidelines, these submissions were published as a supporting document.

9. Acknowledge submissions

All submissions via the PCFA portal received a confirmation that their submission had been received, a copy of their submission, and were thanked for their time. Submissions received via email received an acknowledgement of receipt, and were thanked for their time.

Subsequent to approval of the Guidelines, a de-identified version of the Public Consultation Report will be published on the PCFA website. This report acknowledges the generous and useful contribution of stakeholders and organisations that provided feedback during the Public Consultation process.

10. Key findings

Respondents

A total of 203 submissions were received. Six organisations or individuals provided two submissions which were each consolidated under a single ID number per organisation/individual.

No duplicate submissions were identified, and all complete submissions were deemed eligible for consideration.

Individual respondents

All Australian States and Territories were represented, with an additional two international submissions provided. Of Australian submissions, 64.9% of respondents resided in metropolitan regions. Most participants responded as individuals (74.1%, n=149), were male (78.5%, n=116) and were prostate cancer consumers (52.3%, n=78) (refer Table 1).

Three individuals disclosed potential conflicts of interest. After discussion by the Executive Committee, it was decided that the declared interests were not likely to produce substantial bias, and all responses were retained.

Table 1: Public Consultation 2 (Draft 2025 Guidelines) Respondent Demographics

		N=149	(%)
Gender	Male	116	(78.5)
	Female	17	(11.4)
	Non-binary	1	(0.7)
	Prefer not to say	1	(0.7)
	Did not answer	13	(8.7)
Regionality^	MM1 Metropolitan	95	64.9
	MM2 Regional centre	19	12.8
	MM5 Small rural town	13	8.8
	MM3 Large rural town	10	6.8
	MM6 Remote communities	3	2.0
	MM4 Medium rural town	2	1.4
	Unknown	5	3.4
State or Territory^	NSW	41	27.7
	VIC	35	23.6
	QLD	26	18.2
	SA	14	9.5
	WA	13	8.8
	ACT	8	5.4
	NT	3	2.0
	TAS	2	1.4
	Unknown	5	3.4

Identifies as	Living in rural or remote area	13	(8.7)
	Aboriginal and Torres Strait Islander	3	(2)
	LGBTIQA+	3	(2)
	CALD	3	(2)
	Men of sub-Saharan African descent	1	(0.7)
Individual background	Consumer	78	52.3
	Partner/Family/Friend	19	12.8
	General practitioner	16	10.7
	Public	15	10.1
	Urologist	7	4.7
	Academic	6	4.0
	Medical Oncologist	2	1.3
	Allied health professional	1	0.7
	Prostate cancer nurse	1	0.7
	Palliative Medicine	1	0.7
	Cancer Genetics	1	0.7
	General Surgeon	1	0.7
	Other health professional	1	0.7

^ N=148, one international respondent.

Organisations and Consumer groups

Submissions were provided by 48 organisations, of which 46 were based in Australia (Table 2). Prostate cancer support groups provided a further six submissions.

Four organisations declared potential conflicts of interest on behalf of those participating in the development of the submission, including organisational members who had recused themselves from this process. After discussion by the Executive Committee, it was decided that the declared interests were not likely to produce substantial bias or measures such as recusal had appropriately addressed conflicts. All responses were retained.

Table 2. Organisations and Consumer groups that made a submission

Organisations and Consumer groups
Government departments and agencies
Australian Capital Territory Government – Chief Medical Officer
Australian Capital Territory Government - Health Directorate
Australian Government – Cancer Australia
Australian Government – Department of Health, Disability and Ageing
Northern Territory Government – Northern Territory Health
Northern Territory Government - Torres and Cape Hospital and Health Service

New South Wales Government – Cancer Institute NSW
Queensland Government – Queensland Health
Victorian Government - Safer Care Victoria
Tasmanian Government – Department of Health
Professional, medical and academic organisations
Australian College of Nurse Practitioners
Australian College of Nursing
Australian New Zealand Urological Nurses Society
Public Health Association of Australia
Cancer Council Australia
Royal Australasian College of Surgeons Surgical Oncology Section
Royal Australian and New Zealand College of Radiologists
Royal Australian College of General Practitioners
The University of Melbourne
Urological Society of Australia And New Zealand
Aboriginal and Torres Strait Islander people
Aboriginal Health Council of South Australia Ltd.
Aboriginal Health Council of Western Australia
Australian Indigenous Health*Info*Net
National Aboriginal Community Controlled Health Organisation
Victorian Aboriginal Community Controlled Health Organisation
LGBTIQA+ communities
ACON
LGBTIQ+ Health Australia
Culturally and linguistically diverse communities
Multicultural Communities Council of South Australia
Migrant and Refugee Health Partnership and Social Policy Group (combined)
Sri Lankan Doctors' Association of Victoria
Rural and remote populations
National Rural Health Alliance

Rural Doctors Association of Australia
The Regional Men's Health Initiative
Commercial companies
AstraZeneca Australia
Avant Mutual
Bayer
GenesisCare
GPEx
Health providers
Icon Cancer Centre
St Vincent's Health Network Sydney, Public Division
Sullivan Nicolaides Pathology
Victorian Comprehensive Cancer Centre Alliance
Advocacy organisations
Healthy Male
Movember
Oncothera Advocacy
Prostate Cancer UK
The Prostate Zone
Prostate cancer support groups
Geelong Prostate cancer support group
Limestone Coast Prostate cancer support group
Ocean Reef Prostate cancer support group
Pals
ACT Prostate cancer support group
Sunshine Coast Prostate cancer support group

Overview of feedback

1. Feedback on the clinical practice Guidelines Sections A-E

There were 823 comments for sections A-E (refer Table X). Notably 186 comments specifically noted support for the Guidelines approach to early detection and monitoring. Editorial feedback was made in 134 comments, and 105 comments gave recommendations for implementation strategies.

Section of Guidelines	Count of feedback
Executive Summary	60
Front matter	8
Introduction	29
Plain English Summary	7
Section A: Risk assessment	65
Section B: Decision support	58
Section C: Priority populations	63
Section D: Early detection - General	36
Section D: 4. Early detection - DRE	28
Section D: 5. Early detection - PSA testing	194
Section D: 6. Early detection - mpMRI	26
Section D: 7. Early detection - Biopsy	11
Section E: 8. Management - Active surveillance	42
Section E: 9. Management - Watchful waiting	17
Section E: Management	3
Appendices	9
General feedback	143
Personal experience in the context of Guidelines	24
TOTAL	**823**

2. Feedback related to implementation and research priorities

There were 494 comments related to implementation and research priorities: Sections F-G, targeted questions 14-15, and 17-18. The majority of comments (336) related to Section F: Guideline implementation and monitoring.

When coded by implementation strategies, the most common subjects were the need for clinical education and resources (n=95), a national implementation plan (n=91), and accessible information for consumers (n=64).

Row Labels	Count of Summary code
Editorial feedback	4
Emerging evidence to consider	1
Implementation priorities	
IP.1 National Implementation plan	84
IP.2 National alignment strategy	19
IP.3 Access	36
IP.4 Consumer companion and resources	64
IP.5 Support for primary care, specialists, and other health professionals	95
IP.6 Medicare Benefits Schedule alignment	33
IP.7 Health system	20
IP.8 Monitoring, evaluating and updating	20
IP.9 Prostate cancer registration	10
IP.10 Economic considerations	8
Research priorities	
RP.1 Organised testing program	9
RP.2 Emerging screening and diagnostic tools	9
RP.3 Genetic testing	13
RP.4 Priority populations	20
RP.5 Decision support	1
RP.7 Use of AI	6
RP.9 Other risk factors	3
RP.10 Emerging management and treatment strategies	1
General comment	24
Supports Guideline approach to implementation	15
Editorial feedback	4
Out of scope	3
Total	**494**

Feedback that led to change

Aboriginal and Torres Strait Islander PSA testing recommendations

A major Guideline change related to feedback regarding the recommendation for Aboriginal and Torres Strait Islander males to receive PSA testing ever two years from 40 years of age. Review evidence to support this recommendation was considered weak based on prostate cancer incidence generally and in this age group (0.5 per 100,000 for those aged under 45) unless there is increased risk, e.g., a first-degree family member with cancer diagnosed at age <60 years.

Variations in access to, and engagement with, the health system, as well as the presence of more aggressive disease, were noted as likely reasons for the differences in prostate cancer outcomes. Further, concerns were raised about potential overtesting in this population and that the potential harms of this approach have not been adequately considered. Consequently, the recommendation to commence PSA testing for Aboriginal and Torres Strait Islander males at age 40 was removed.

Similarly, evidence to reduce the PSA thresholds for Aboriginal and Torres Strait Islander men aged 50-69 as also considered weak, and feedback strongly recommended alignment of PSA thresholds for all age groups with that of the general population. Therefore, the PSA thresholds for Aboriginal and Torres Strait Islander men aged 50-69 were aligned with those of the general Australian population.

The PSA testing guidance for Aboriginal and Torres Strait Islander males is now aligned with the ages and thresholds of those for the general population. Therefore, to ensure clarity, Flowchart 6 (PSA testing for Aboriginal and Torres Strait Islander males) was removed.

Risk assessment and PSA testing in higher risk males

Section A: Risk assessment was revised to clarify that males are considered to be at higher risk if they have a risk of clinically significant prostate cancer or prostate cancer death that is at least double that of the overall risk for the Australian male population. Additionally, further clarification was provided on how risks differ for different family histories, and the notion of 'significant' family history was defined.

Subsequent to these changes, a new strong recommendation was included in Section D: Early detection - 5. Primary health care setting - PSA testing:

5.4 Strong recommendation: We recommend offering PSA testing to males who are at higher risk* and refer readers to 5.5 consensus recommendation for testing regimen.

** Males are considered to be at higher risk if they have a risk of clinically significant prostate cancer or prostate cancer death that is at least double that of the overall risk for the Australian male population. Higher risk includes, but is not restricted to, males with certain patterns of family history, Black males of sub-Saharan African ancestry and/or males with confirmed BRCA2 gene mutations.*

PSA testing recommendations 5.1-5.5 to contextualise/provide sequence

PSA testing recommendations 5.1-5.5 were reviewed and clearly linked to contextualise and provide sequence in the context of decision support, risk assessment and age of testing.

References to Organised testing program

Multiple respondents noted the Guidelines inferred an immediate transition to a population-based screening program, but were missing key criteria for the Population-Based Screening Framework such as:

- the effectiveness of the screening program: that is, screening leads to measurable reduction in cancer specific and all-cause mortality;
- that the screening program, on the basis of the reduction in risk of mortality, is cost-effective;
- that the overall benefits of screening outweigh the potential harms.

To clarify, the language related to organised testing programs is being reviewed and the term 'planned testing' is used instead.

Other changes

- Use of GRADE language in recommendations per HMRC recommendations
- New Good practice statement regarding prostate cancer risk associated with *BRCA2*
- Added definition of priority populations in terminology and clarified priority populations in the context of early detection of prostate cancer in Section C: Priority populations.
- Clarification of the role of DRE in the early detection of prostate cancer
- Additional information regarding factors that may affect PSA value aside from prostate cancer
- Statements regarding consensus about the evidence and recommendations were added
- Editorial feedback: x pieces of editorial feedback have been included throughout the Guidelines

Other considerations

Use of gendered language

Feedback on the language used in the Guidelines was explicitly sought during Public Consultation. 135 of 198 respondents either supported the Guideline language or had no suggestions to improve language and inclusiveness.

Regarding LGBTIQA+ communities, the feedback was mixed, highlighting the challenges of balance and approach. For example, LGBTIQ+ Health noted:

> *These Guidelines are the most inclusive set of national cancer screening guidelines to date for LGBTIQ+ populations. We commend the Prostate Cancer Foundation of Australia and Cancer Council Australia for acknowledging the diversity of people who may benefit from early detection and for including specific resources for LGBTIQ+ populations. With the right investment, ongoing evaluation, and collaboration with*

LGBTIQ+ community-controlled organisations, these Guidelines have the potential to set a new national benchmark for inclusive cancer care.

Alternatively, ACON noted a preference for the term "people with prostates" believing this would be inclusive. Overall, three of the 198 respondents reported specific preferences for 'men or people with a prostate' or 'people with a prostate'.

Given the extensive literature around the challenges men experience in health care including seeking care, understanding health information and accessing health services, the PSC retained a men's health approach. The evidence for the effectiveness of gender specific language and health interventions targeting cancer prevention, diagnosis, treatment and care for men is strong and more likely to lead to greater benefit for more people. This approach aligns with international prostate cancer organisations, such as Prostate Cancer UK (PCUK).

On balance, the recommendation retains the language used in Guidelines and at the same time details Implementation Priorities and specific requirements for LGBTIQA+ people and communities, including:

- Co-designed awareness and education programmes
- Co-designed consumer companion
- Educational materials for Health Professionals with regard to people in these communities
- Future research on issues and interventions to improve outcomes for people in LGBTIQA+ communities.

Key themes and comments

The Implementation section received the most comments of all sections in the Guideline. Approximately 65% of participants made at least one comment related to implementation (>500 individual comments, average almost four per person).

- Respondents overwhelmingly agreed that, in light of the 2016 Guidelines, the development and funding of a detailed implementation strategy was essential for the success of the DRAFT 2025 Guidelines. This feedback came from diverse stakeholder groups - consumers, families, friends, clinicians, priority population organisations, healthcare providers, professional colleges, demonstrating strong community sentiment.

Key themes

The most consistently mentioned themes were:

- The change in approach to early detection of prostate cancer was widely commended, as was the meaningful inclusion of priority populations.
- A national implementation plan was an essential part of bringing the DRAFT 2025 Guidelines into practice. The plan needed to include specific strategies for a range of stakeholders including men at risk of prostate cancer, their families, general practitioners, specialists:

    - Men need to be aware of the nature and risk of prostate cancer, what testing entails (blood test only), risk factors and how often they should be tested. Correcting misinformation and encouraging open discussions are critical.
    - Clinicians need to be aware that the DRAFT 2025 Guidelines have been changed, what changes have been made, and how they can access the new Guidelines.
    - Specific messaging and awareness is required for priority populations (Aboriginal and Torres Strait Islander, LGBTIQA+ , CALD, Rural and remote). To be effective, development and implementation of awareness-raising/education strategies and materials need to be co-designed and community-led. Collaborating with communities supports them to take ownership of the messaging, that it is culturally appropriate and likely to reach its intended audience.
- Men (and their families) need concise, clear information about prostate cancer and early detection. This information should come in a number of forms (pamphlets, 2-page sheet, infographics, short videos) and cater for those with low literacy.
- Comprehensive clinician education is needed to ensure that GPs understand the new recommendations, how practice should change, and feel confident to amend their practice. Resources such as clinical summaries
- The Medicare Benefits Schedule must be updated in step with the DRAFT 2025 Guidelines, particularly where repeat or follow up testing is required (PSA annual only, MRI limit 2/3 years etc) – otherwise

Consumers strongly supported the option of PSA testing from age 40, and continuing over 70 years, and the clearer focus on risk and family history. Notable consumers called for:

- annual testing
- population-based screening for prostate cancer
- alignment of MBS with updated testing Guidelines
- dedicated consumer resources to raise awareness and support decision making around testing
- awareness raising in the primary care setting of the updated Guidelines and supporting a proactive approach to PSA testing

Clinicians also called for alignment of the MBS with updated testing Guidelines and supporting resources to implement the Guidelines such as:

- Education and clinical resources to support practice change
- Integration of Guidelines/PSA testing into practice management software,
- Integration of test results into myHealth Record

11. Appendices

Appendix 1: Public Consultation 1 - Public feedback on the 2016 PSA Guidelines

Full findings from Public Consultation 1 have been published in the Australia New Zealand Journal of Surgery:

> *Heneka N, Heathcote P, Malouf P, Chambers S, Smith D, Dunn J. Lessons from the implementation of the Australian 2016 Prostate Specific Antigen Testing Clinical Practice Guidelines: A descriptive study. ANZ Journal of Surgery. 2025; ePub ahead of print, 4 April 2025. DOI:10.1111/ans.70136*

A summary of key findings is presented below.

Background

In April 2024, the Prostate Cancer Foundation of Australia (PCFA) released a Call for Submissions ('the Call') inviting Australians with an interest in PSA testing for prostate cancer to share their views on the 2016 Guidelines. The objective of this call was to identify perceptions of the 2016 Guidelines in relation to effectiveness, usability, opportunities to strengthen the DRAFT 2025 Guidelines in the context of this review, and personal experiences in relation to the DRAFT 2025 Guidelines.

Methods

The Call was conducted in accordance with the five steps for Public Consultation in the National Health and Medical Research Council (NHMRC) Guidelines for Guidelines Handbook.

1. Public Consultation plan

Planning for the Call was undertaken from early 2024. The Call was open for six weeks from Thursday, April 18 to Monday, June 3 (inclusive), 2024 to allow time for key stakeholders to undertake their own consultation process.

2. Parameters for the consultation

Submissions could be made via: i) an online form; ii) email to the PCFA using a response template (word document) or free text; or iii) post to the PCFA.

Seven questions were developed by the Project Steering Committee and posed to all respondents:

- Have the 2016 Guidelines been effective? Please explain your view.
- How can the Guidelines be strengthened to improve outcomes for people impacted by prostate cancer?
- In your experience, have the Guidelines aided decision making at the General Practice level in Australia? Please explain your view.
- Do you consider the 2016 Guidelines easy to understand? Please explain your view.

- How can we improve the effectiveness of the Guidelines for the Australian community broadly, and for marginalised communities and at-risk groups?
- Are there any other comments you would like the Guideline Steering Committee to consider?
- Please tell us more about your experience of prostate cancer, in relationship to the Guidelines and your response to the questions above.

3. Public notification

A coordinated public notification strategy was implemented from 19 April, 2024 comprising national newspaper advertisements, social media posts, press releases, blog posts, and PCFA network and website distribution. Combined reach was an audience of approximately 3.1 million people. All potential respondents were initially directed to the online form which included a link with detailed information about the Call, a link to access the 2016 Guidelines, information on the three methods to submit a response, and the timeframe for receipt of submissions.

4. Information requested

Respondents were asked to provide their residential postcode, gender, State/Territory, whether they are responding as an individual or on behalf of an organisation, whether they identify as being part of a marginalised/at-risk group, and their background in the context of prostate cancer (e.g., consumer, health professional etc.).

5. Preparation of submissions for consideration

Submissions were independently prepared by the University of Southern Queensland, Centre for Health Research, Cancer Survivorship Research Group (UniSQ CSRG). Upon closing of the Call, all submissions were extracted into a de-identified excel spreadsheet at PCFA and provided to UniSQ CSRG for analysis.

Response categorisation

The spreadsheet was checked for blank and/or duplicate responses which were removed. Three phases of categorisation were then undertaken. In Phase 1, responses were manually categorised to quantify responses for applicable questions. In Phase 2, responses were grouped into themes by question. A broader thematic analysis was undertaken in Phase 3 to identify overarching themes across all questions. A summary of findings was prepared and presented to the Project Steering Committee, Expert Advisory Panel (EAP) and EAP Working Groups (EAP WG) by the UniSQ CSRG throughout June and July, 2024.

Key Findings

Respondents

A total of 70 responses were received, 63 via the online platform and seven via direct correspondence. All Australian States and Territories were represented with 56% of respondents residing in metropolitan regions. The majority of respondents replied as men (96%, n=67), were male (90%, n=63) and were prostate cancer consumers (97%, n=68) (refer Table 1).

Table 1: Respondent Demographics

		N=70	(%)
Gender	Male	66	(94.3)
	Female	4	(5.7)
Regionality	MM1- Metropolitan	39	(55.7)
	MM5 – Small rural towns	13	(18.6)
	MM2 – Regional centres	8	(11.4)
	MM3 – Large rural towns	4	(5.7)
	MM6 – Remote communities	1	(1.4)
	MM7 – Very remote communities	1	(1.4)
	Did not answer	4	(5.7)
State or Territory	Victoria	24	(34.3)
	New South Wales	12	(17.1)
	Queensland	12	(17.1)
	Western Australia	5	(7.1)
	South Australia	5	(7.1)
	Tasmania	3	(4.3)
	Australian Capital Territory	3	(4.3)
	Northern Territory	2	(2.9)
	Did not answer	4	(5.7)
Response type	Individual	66	(94.3)
	Support or consumer group	4	(5.7)
Identifies as	Living in rural or remote area	10	(14.3)
	Aboriginal and Torres Strait Islander	1	(1.4)
	Nil	59	(84.3)
Respondent background	Man diagnosed with prostate cancer	61	(87.1)
	Partner of man diagnosed with prostate cancer	4	(5.7)
	Prostate cancer Organisation/Group response	4	(5.7)
	Friend of man diagnosed with prostate cancer	1	(1.4)

Q1. Have the 2016 Guidelines been effective? Please explain your view.

Sixty-eight percent of respondents felt the 2016 Guidelines were ineffective. This was largely due to the Guidelines' perceived focus on harms of testing, which discouraged proactive testing and subsequent early detection and monitoring. Numerous respondents reported General Practitioner (GP) refusal or reluctance to test PSA.

> **I had to basically force my doctor to have a PSA test, he said I had no symptoms even though I was 62. And the reading turned out to be very close to the problem limit, but he did nothing except say let's check it again next year. Well, when next year came around my reading was very**

high so then off to specialists for a prostatectomy, radiation, hormone therapy and a lot of anxious medical time. (ID42)

Q2. How can the Guidelines be strengthened to improve outcomes for people impacted by prostate cancer?

Respondents repeatedly called for earlier routine testing, and no testing age limits. Testing from age 40, and beyond age 70 for all men was the general recommendation, with earlier testing still for men with a family history of prostate cancer.

I had a prostatectomy at 47, so I am in the 1% club. Whilst I had clear margins at surgery, some microscopic cells have got away and I will be needing radiation in the next 2-3 years, as my PSA is rising again. It was only picked up as a result of my GP doing a PSA test when I was 46 years of age. Current Guidelines for it being for men over 50 don't cover men like me under 50 and are therefore ineffective for all. (ID17)

I think the attitude to stop regular PSA tests at age 69 is ageist and disrespectful. Many men will live active lives into their late 80s and 90s and would not like to die of prostate cancer at age 76 because testing stopped when they turned 69. (ID53)

In addition to extended testing ages, respondents suggested lowering the PSA threshold for investigation to 2.0 µg/L and looking to fluctuations in PSA as a trigger for further investigation even if PSA is under the threshold. For many respondents, it was this approach that detected their prostate cancer early.

I think that the 2016 Guidelines would not have found my Prostate Cancer. Fortunately, I had a GP who noticed that despite my PSA never being above 3, it had risen slightly, so I was referred to a urologist who found the cancer after a series of tests. The tumour had nearly escaped the prostate. No symptoms. PSA below 3. (ID45)

Q3. In your experience, have the Guidelines aided decision making at the General Practice level in Australia? Please explain your view.

Respondents perceived the Guidelines had not effectively aided clinical decision making as GP's appeared to lack awareness of the Guidelines and a knowledge of how to apply them. This included both outdated attitudes around testing (harms of testing outweigh the benefits, PSA is over tested) and prostate cancer itself.

Correcting the perception that men can live with prostate cancer, believing they will die with it but not from it. This is still very much a perception in the community. (ID37)

Also, there are still too many GP's who believe that PSA testing is too common, there is 'over testing' done & that prostate cancer is still regarded as an 'Old Man's Disease'. (ID04)

Despite a predominantly consumer cohort, respondents stressed the need for less ambiguity for GPs in the updated Guidelines and a focus on supporting proactive PSA testing and information provision by GPs. This included stronger messaging on family history and the consequences of delayed detection.

The current Guidelines give poor guidance. For the GP they are subjective and highly discretionary. They are written to avoid false positives. They are not written to promote the early detection of indicators that warrant further investigation for the early detection of prostate cancer. The lack of clarity promotes inconsistency among GPs requiring some of their patients to shop around, away from their regular practice and advice, to get a referral (for testing) from a GP. (ID07_Support Group Response)

The effectiveness of the Guidelines rests, to a large extent, on GPs and other clinicians understanding those Guidelines and following them. The Guidelines need to be more proactive - GPs should be the ones who raise the issue of testing, rather than leaving it up to men to do so. (ID42)

Respondents highlighted the need for a single uniform guideline and called specifically for active uptake of the updated Guidelines into the Royal Australian College of General Practitioners (RACGP) Red Book, which is currently perceived to offer conflicting testing guidelines which discourage proactive PSA testing.

As the 2016 Guidelines have not been incorporated into the RACGP's guidelines, considerable ambiguity has been created for GP's who seem to be discouraged from suggesting or advocating that patients get screened for prostate cancer. The RACGP needs to be fully on board with the new revised Guidelines and need to fully incorporate them into the RACGP's own guidelines. (ID56)

Q4. Do you consider the 2016 Guidelines easy to understand? Please explain your view.

Overwhelmingly respondents reported the 2016 Guidelines were not easy to understand and called for a consumer-friendly companion to the Guidelines, with clear and simple messaging that advocates for the benefits of testing (versus harms) to support decision making.

> **...the revised Guidelines should consider clearly recommending that GP's initiate discussion of PSA testing with middle-aged males and encourage regular PSA testing. The current RACGP guidelines specifically recommend GPs against this. The Guidelines are written for GPs and health professionals rather than the general public. They are not easy to interpret. While the shorter Overview of the Recommendations provides a useful (though limited) summary for both health professionals and the general public, an education source in plain English is sorely needed to explain the new Guidelines and what blokes can expect their GPs to provide. (ID70)**

Q5. How can we improve the effectiveness of the Guidelines for the Australian community broadly, and for marginalised communities and at-risk groups?

Respondents strongly advocated for a national guideline awareness program to facilitate uptake of the updated Guidelines. Awareness should extend to prostate cancer more broadly, in addition to dedicated campaigns to promote the updated Guidelines.

> **Is it possible for a national advertising/education campaign to be considered so that the message about Prostate Cancer reaches the general population more? There seems to be national adverts about breast cancer, bowel cancer, skin cancer etc. but NOTHING about Prostate Cancer (I sometimes feel that Prostate Cancer is the 'forgotten' cancer because it is only males that experience it). (ID04)**

> **Men are often not aware of the option for prostate cancer screening. Because the Guidelines have not been clear in the past, many GPs may not raise the option of screening with the patient. (ID02)**

For marginalised communities and at-risk groups, respondents suggested targeted awareness raising strategies with strong involvement of community leaders, and which included culturally and linguistically appropriate resources. Targeted education and awareness raising for GPs to support proactive PSA testing and dispel still commonly held attitudes around prostate cancer and testing was also considered an essential strategy for future guideline implementation.

An absence of quality of life and survivorship support considerations was noted in the 2016 Guidelines and respondents urged inclusion of both in the updated Guidelines. Early involvement of prostate cancer specialist nurses was identified as a key conduit to survivorship care.

> **I attend a prostate cancer support group and have met quite a few men whose cancers were detected too late for a cure and now have a vastly reduced quality of life due to ongoing treatment and/or mental health issues. There should be more emphasis placed on maintaining quality of life rather than concentrating on mortality. Although the current survival rate is very good, many men are suffering through their later years because their cancer was not detected while it was curable but left until it was treatable but incurable. (ID06)**

> **Also, the urologist that did my robotic did not deal with the management of sexual rehabilitation at all and there is a need for staff experienced in discussing this with patients, rather than doctors who lack personal skills. (ID39)**

Importantly, timely and regular review of the Guidelines was considered essential going forward to reflect and align with rapidly evolving, less invasive, diagnostic technologies.

> **The Guidelines were made and have been treated as a set and forget strategy with no regular review period or outlines of what would prompt subsequent reviews. The Guidelines need to be revised more regularly, a combination of set time periods or be instigated by changes in trends in Australia or overseas and when new diagnosis technologies become available. (ID41)**

Q6. Are there any other comments you would like the Guidelines Steering Committee to consider?

Accessibility to, and affordability of, PSA testing was noted as a priority alongside the release of the revised Guidelines and any changes to testing parameters.

> **My only comment as a man over 75 years of age is a purely practical one. At my age a regular (say annual) PSA test would seem to be a 'no brainer'. But to get a PSA test I must visit a GP to get a referral, then go to a pathologist to get the PSA test done and then have another GP consultation to get the result. That's two GP visits which add no value at all but impose an extra burden on an already stretched medical system not to mention my time and Medicare. (ID11)**

The desire for a national reminder/screening program, akin to existing programs for breast, bowel and cervical cancers, was also high.

> **A National Prostate cancer scheme like Breast Cancer, Colon cancer, and Cervical cancer screening schemes would be a very beneficial way to detect prostate cancer early giving better outcomes for the patient. (ID30)**

> **Bowel cancer and breast cancer mail out to all men either the information or test kit once in the respective age group. Funding needs to be sought from the government to do a similar mail out once a male attains the correct age – which I suggest would be 40. This being more important that we now know that prostate cancer is the highest diagnosed cancer in Australia and the second higher cancer killer of men. Prostate cancer kills more men that bowel cancer and breast cancer for women. (ID69)**

Q7. Please tell us more about your experience of prostate cancer, in relationship to the Guidelines and your response to the questions above.

Two contrasting experiences were clear across the submissions: those whose prostate cancer was diagnosed early as a result of proactive testing and monitoring by their general practitioner, and often outside the 2016 Guidelines recommendations; and those who were denied or advised against initial/further testing as they did not meet age or PSA thresholds set out by the Guidelines and were subsequently diagnosed with advanced prostate cancer that is incurable.

> **I was fortunate to have a practitioner who noted a rise in my PSA from 3.2 to 4.2 at age 62 and advised I see a urologist even though I had no other signs of a problem. The urologist decided to do a biopsy even though he was unable to determine any other signs of prostate disease and the biopsy showed I had a highly malignant tumour. After other tests I underwent a radical prostatectomy and now 17 years later I have not had any reoccurrence of the cancer. This experience is so unlike many of my friends who did not have PSA tests and have since died of the disease. I'm sure deaths which could have been prevented with regular routine testing of their PSA. (ID43)**

> **I am now 69 years old and was diagnosed with de-novo metastatic prostate cancer after my very first PSA test (at age 66). Previously, I had queried my GPs on whether I should be doing a test for prostate cancer - initially soon after I turned 50, and again (with a different GP) soon after turning 60. On both occasions I was informed that testing was not recommended unless there was a family history or symptoms. There was no further discussion entered into or pamphlet or websites given. After my brother was diagnosed with prostate cancer, my GP did refer me for a**

PSA test. It came back over 70 µg/L, so I was referred for further testing and to a Urologist. Distant metastases were identified and systemic treatments are ongoing to slow the incurable cancer. I sought and followed my health professional's specific advice (a reasonable action for a non-medical person) and did not get screened for PC. I now have incurable stage 4 cancer, a poor prognosis and ongoing treatment side effects. (ID56)

Conclusions

Respondents reported the 2016 Guidelines as ineffective based on negative message framing, lack of uptake of the Guidelines by key primary care groups, and low community awareness. Although a small number of respondents reported that they were able to access early detection and subsequent curative treatment, the majority reported missed opportunities for testing resulting in diagnoses with late-stage disease. Suggestions for future successful implementation included a consumer companion to the Guidelines, regular guideline review, a national education and awareness program, and targeted education for health professionals.

Appendix 2: Key stakeholders contacted for feedback

GOVERNMENT DEPARTMENTS AND AGENCIES:

Organisation	Position	Response
Australian Capital Territory Government	Chief Allied Health Officer	Submission received on behalf of the Australian Capital Territory Government from • ACT Health Directorate
Australian Capital Territory Government	Minister for Health	
Australian Capital Territory Government	Minister for Mental Health Minister for Population Health Minister for Justice Health	
Australian Capital Territory Government - ACT Health Directorate	Chief Medical Officer	
Australian Capital Territory Government - Canberra Health Services	CEO	
Australian Government	Acting Assistant Secretary	Submission received on behalf of Australian Government from: • Department of Health, Disability and Ageing
Australian Government	Assistant Minister for Health and Aged Care Assistant Minister for Indigenous Health	
Australian Government	Assistant Minister Rural and Regional Health Assistant Minister for Mental Health and Suicide Prevention	
Australian Government	Minister for Aged Care Minister for Sport	
Australian Government	Minister for Health and Aged Care	
Australian Government - Department of Health, Disability and Ageing	Chief Medical Officer	
Australian Government - National Health and Medical Research Council (NH&MRC)	CEO	
Australian Government - Services Australia - Medicare	CEO	
Darling Downs and West Moreton Primary Health Network	CEO	No response submitted

Organisation	Position	Response
Government of South Australia	Chief Aboriginal Health Officer	No response submitted
Government of South Australia	Chief Allied and Scientific Health Officer, SA Health	
Government of South Australia	Chief Executive, Dept for Health and Wellbeing	
Government of South Australia	Chief Public Health Officer	
Government of South Australia	Minister for Health and Wellbeing	
Government of Western Australia	Minister for Health and Mental Health	Acknowledged
Government of Western Australia	Assistant Director General	No response submitted
Government of Western Australia	Chief Health Officer	
Government of Western Australia	Director General, The Department of Health	
Government of Western Australia	Minister for Preventative Health	
New South Wales Government	Minster for Health, Minister for Regional Health	Submission received on behalf of New South Wales Government from: • Cancer Institute NSW
New South Wales Government	Deputy Secretary Clinical Innovation and Research Chief Executive Agency for Clinical Innovation	
New South Wales Government	Minister for Medical Research	
New South Wales Government - Bureau of Health Information	CEO	
New South Wales Government - Cancer Institute NSW	CEO	
New South Wales Government - Central Coast Local Health District	A/Chief Executive	
New South Wales Government – eHealthNSW	Acting Chief Executive	

Organisation	Position	Response
New South Wales Government - Far West Local Health District	Acting Chief Executive	
New South Wales Government - Health Education & Training	Chief Executive	
New South Wales Government - Hunter New England Local Health District	Chief Executive	
New South Wales Government - Illawarra Shoalhaven Local Health District	Chief Executive	
New South Wales Government - Mid North Coast Local Health District	Chief Executive	
New South Wales Government - Murrumbidgee Local Health District	Chief Executive	
New South Wales Government - Nepean Blue Mountains Local Health District	Chief Executive	
New South Wales Government - Northern NSW Local Health District	Chief Executive	
New South Wales Government - Northern Sydney Local Health District	Chief Executive	
New South Wales Government - NSW Health	Secretary	
New South Wales Government - NSW Health Pathology	Chief Executive	
New South Wales Government - Office for Health and Medical Research	Executive Director	
New South Wales Government - Population and Public Health	Chief Health Officer Deputy Secretary	
New South Wales Government - Rural and Regional Health	Deputy Secretary	

Organisation	Position	Response
New South Wales Government - South Eastern Sydney Local Health District	Chief Executive	
New South Wales Government - Southern NSW Local Health District	Chief Executive	
New South Wales Government - Southern Western Sydney Local Health District	A/Chief Executive	
New South Wales Government - Sydney Local Health District	Chief Executive	
New South Wales Government - Western NSW Local Health District	Chief Executive	
New South Wales Government - Western Sydney Local Health District	Chief Executive	
New South Wales Government Health Share NSW	Chief Executive	
Northern Territory Government	Attorney-General	Submission received on behalf of Northern Territory Government from: • NT Health
Northern Territory Government - Northern Territory Health	Chief Allied Health Officer	
Northern Territory Government	Chief Health Officer	
Northern Territory Government - Department of Health	CEO	
Northern Territory Government - Northern Territory Prevocational Medical Assurance Services (NT PMAS)	A/Manager	
Queensland Government	Chief Health Officer	Submission received on behalf of Queensland Government from: • QLD Health, Torres and Cape Hospital and Health Service
Queensland Government	Health Service Chief Executive - North West	
Queensland Government	Health Service Chief Executive - South West	

Organisation	Position	Response
Queensland Government	Health Service Chief Executive - Sunshine Coast	
Queensland Government	Health Service Chief Executive - Townsville	
Queensland Government	Health Service Chief Executive - West Moreton	
Queensland Government	Health Service Chief Executive - Wide Bay	
Queensland Government	Minster for Health and Ambulance Services	
Queensland Government - Cairns and Hinterland	Health Service Chief Executive	
Queensland Government - Central QLD	Health Service Chief Executive	
Queensland Government - Central West	Health Service Chief Executive	
Queensland Government - Darling Downs	Health Service Chief Executive	
Queensland Government - Gold Coast	Health Service Chief Executive	
Queensland Government - Mackay	Health Service Chief Executive	
Queensland Government - Metro North	Health Service Chief Executive	
Queensland Government - Metro North	Health Service Chief Executive	
Queensland Government - Queensland Health	Director General	
Queensland Government - Torres and Cape Hospital and Health Service	Health Service Chief Executive	
Queensland Government - Health and Wellbeing QLD	CEO	
Queensland Government – QLD Cancer Clinical Network	Principal Project Officer & Coordinator	
Tasmanian Government - Department of Health	Secretary	Submission received

Organisation	Position	Response
Victoria Government	Minister for Health Minister for Health Infrastructure Minister for Ambulance Services Leader of the House	Submissions received on behalf of Victorian Government from: • Minister for Health • Governance and Statewide Programs Hospitals and Health Services • Safer Care Victoria
Victoria Government	Chief Advisor on Cancer	
Victoria Government	Chief Allied Health Officer	
Victoria Government	Senior Project Officer - Clinical Guidance	
Victoria Government	Chief Digital Health Officer	
Victoria Government	Chief General Practice Advisor	
Victoria Government	Chief Health Officer	
Victoria Government	Chief Medical Officer	
Victoria Government	Deputy Chief Medical Officer	
Victoria Government - Department of Health	Secretary	
Victoria Government - Governance and Statewide Programs Hospitals and Health Services	Executive Director	
Victoria Government - Safer Care Victoria	Director of Surgery	

PROFESSIONAL, MEDICAL AND ACADEMIC ORGANISATIONS:

Organisation	Position	Response
Australia and New Zealand Urological Nurses Society (ANZUNS)	President	Submission received on behalf of ANZUNS
Australia and New Zealand Urological Nurses Society (ANZUNS)	Vice-President	
Australian Catholic University	Vice-Chancellor & President	No submission received
Australian Centre for Health Services Innovation (AusHSI) – Implementation, QUT	Centre Director	No submission received
Australian College of Nurse Practitioners	President	Submission received
Australian College of Nursing	President	Submission received

Organisation	Position	Response
Australian Health Promotion Association	National President	No submission received
Australian Nursing and Midwifery Federation	Federal President	No submission received
Australian Primary Health Care Nurses Association (APNA)	CEO	No submission received
Australian Private Hospitals Association (APHA)	CEO	No submission received
Australian Prostate Cancer Research Centre–Queensland (APCRC-Q)	Executive Director & Founder	No submission received
Australian Prostate Centre	CEO	No submission received
Australian Urology Associates Pty Ltd	Urologist	No submission received
Bond University - Institute for Evidence Based Healthcare	Vice-Chancellor & President	No submission received
Brisbane Urology Clinic	Managing Director	No submission received
Cancer Australia	CEO	Submission received
Cancer Council Australia	CEO	Submission received from Cancer Council Australia on behalf of State and Territory Councils.
Cancer Council ACT	CEO	
Cancer Council NSW	CEO	
Cancer Council NT	CEO	
Cancer Council QLD	CEO	
Cancer Council SA	CEO	
Cancer Council TAS	CEO	
Cancer Council VIC	CEO	
Cancer Council WA	CEO	
Cancer Nurses Society of Australia	CEO	No submission received
Clinical Oncology Society of Australia (COSA)	CEO	No submission received
Clinical Oncology Society of Australia (COSA)	President	No submission received
Continence Nurses Society of Australia	President & Director	No submission received
Edith Cowan University	Vice Chancellor	No submission received

Organisation	Position	Response
Flinders Prostate Cancer Research Group	Lead	No submission received
Flinders University - Flinders Centre for Innovation	President & Vice Chancellor	No submission received
Freemasons Centre for Men's Health Discipline of Medicine (FCMHW)	Director	No submission received
Garvan Institute of Medical Research	Executive Director	No submission received
Griffith University	Vice Chancellor & President	No submission received
Harry Perkins Institute of Medical Research	CEO	No submission received
Macquarie University	Vice Chanceller & President	No submission received
Medical Oncology Group of Australia (MOGA)	Chair	No submission received
Monash Prostate Cancer Research Group	Co-Directors	No submission received
Monash University	Vice Chancellor and President	No submission received
Public Health Association of Australia (PHAA)	CEO	Submission received
Royal Australasian College of Physicians (RACP)	CEO	No submission received
Royal Australasian College of Physicians (RACP)	President & Chair	No submission received
Royal Australasian College of Surgeons (RACS)	CEO	Submission received on behalf of RACS from Surgical Oncology Section
Royal Australian and New Zealand College of Radiologists (RANZCR)	CEO	Submission received on behalf of RANZCR
Royal Australian and New Zealand College of Radiologists (RANZCR)	President	
South Australian Health and Medical Research Institute (SAHMRI)	Executive Director	No submission received
South Australian Prostate Cancer Clinical Outcomes Collaborative (SA-PCCOC)	Executive Officer	No submission received

Organisation	Position	Response
The Association of Australian General Practitioners (AAGP)	CEO	No submission received
The Australian General Practice Network (AGPN)	CEO	No submission received
The Australian General Practitioners Alliance (AGPA)	Chair	No submission received
The Australian Medical Association (AMA)	Secretary General and Group CEO	No submission received
The Australian Prostate Cancer BioResource	Executive Member	No submission received
The National Association of Testing Authorities Australia (NATA)	CEO	No submission received
The Royal College of Pathologists of Australasia	CEO	No submission received
The Royal College of Pathologists of Australasia	President	No submission received
The University of Melbourne - Department of General Practice and Primary Care	Associate Professor	Submission received
The University of Queensland	Vice Chancellor and President	No submission received
The University of Western Australia	Chancellor	No submission received
UnitingCare Australia	CEO	No submission received
University of Adelaide	Vice Chancellor	Acknowledged
University of NSW	Vice Chancellor and President	Acknowledged
University of NSW	Dean of Medicine	No submission received
University of Sydney	Vice Chancellor and President	No submission received
UQ Centre for Clinical Research	Director	No submission received
Urological Society of Australia And New Zealand (USANZ)	CEO	Submission received on behalf of USANZ
Urological Society of Australia and New Zealand (USANZ)	President	

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE:

Organisation	Position	Response
Aboriginal Education Consultative Group NSW (AECG)	President	No submission received
Aboriginal Engagement Directorate		No submission received
Aboriginal Health Council of South Australia	CEO	Submission received on behalf of the Aboriginal Health Council of South Australia
Aboriginal Health Council of South Australia & Director NACCHO	Secretary	
Aboriginal Health Council of South Australia Nunyara Aboriginal Health Service Inc & Director NACCHO	Chair	
Aboriginal Health Council of Western Australia	CEO	Submission received
Australian Indigenous HealthInfoNet	Director	Submission received
Aboriginal Medical Services Alliance NT (AMSANT)	CEO	No submission received
Croakey Health Media	Editor in Chief	No submission received
Gujaga Foundation	CEO	No submission received
National Aboriginal Community Controlled Health Organisation (NACCHO)	CEO	Submission received on behalf of NACCHO
National Aboriginal Community Controlled Health Organisation (NACCHO)	Chair of the Board	
Anyinginyi Health Aboriginal Corporation & Director NACCHO & Deputy Director First Nations Engagement and Research Strategy Charles Darwin University	CEO	

Organisation	Position	Response
Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) & Director NACCHO	CEO	
Bendigo and District Aboriginal Co-operative & Director NACCHO	CEO	
Charleville & Western Areas Aboriginal Torres Strait Islanders Community Health Ltd (CWAATSICH) & Director NACCHO	CEO	
Danila Dilba Health Service & Director NACCHO & Deputy Chair Aboriginal Medical Services Alliance NT (AMSANT)	CEO	
Dubbo, Coonamble and Gilgandra Aboriginal Health Services & Director NACCHO	CEO	
Illawarra Aboriginal Medical Service & Director NACCHO	CEO	
Kimberley Aboriginal Medical Services Ltd & Director NACCHO & Council Member of Coalition of Peaks	CEO	
Ngaayatjarra Group and Chair Kanpa Community Council & Director NACCHO	Deputy Chair	
Palm Island Community Company & Director NACCHO	CEO	
Tasmanian Aboriginal Centre (TAC) & Director NACCHO	COO	No submission received
National Indigenous Australians Agency	CEO	No submission received
Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA)	Acting CEO	No submission received
New South Wales Government - Aboriginal Health and Primary Partnerships (Mid North Coast Local Health District)	Director	Submission received on behalf of New South Wales Government from: Cancer Institute NSW

Organisation	Position	Response
New South Wales Government - Aboriginal Health and Wellbeing, Western NSW Local Health District	Executive Director	
New South Wales Government - Aboriginal Health Strategy. Western Sydney Local Health District	Aboriginal Health Hub-Director	
New South Wales Government - Aboriginal Health, Murrumbidgee Local Health District	Director	
New South Wales Government - Aboriginal Health, Oral Health & Health Promotion	Acting District Director	
New South Wales Government - Aboriginal Health, Southern NSW Local Health District	Director	
Northern Territory Government - Department of Health	Minister for Health Minister for Mental Health Minster for Alcohol Policy Minster for Aboriginal Affairs Minister for Housing, Local Government and Community Development Minister for Essential Servi	Submission received
Queensland Aboriginal and Islander Health Council (QAIHC)	Acting CEO	No submission received
SA Aboriginal Education and Training Consultative Council	General Manager	No submission received
Torres Health Indigenous Corporation	CEO	No submission received
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	CEO	Submission received on behalf of VACCHO

Organisation	Position	Response
Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Director NACCHO & CEO Victorian Aboriginal Health Service (VAHS)	Chair	

LGBTIQA+ COMMUNITIES:

Organisation	Position	Response
ACON	Manager Cancer Programs	Submission received
Australian Professional Association for Trans Health	CEO	No submission received
Diversity Council Australia	CEO	No submission received
Diversity Council Australia	Chair	No submission received
LGBTIQ+ Health Australia	CEO	Submission received
Pride Foundation Australia	Chair	No submission received
Rainbow Health	CEO	No submission received
Transgender Victoria	Chair	No submission received

CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES (CALD):

Organisation	Position	Response
Australian Institute of Interpreters and Translators (AUSIT)	National President	Acknowledged
Australian Multicultural Foundation	Executive Director	No submission received
Australian Multicultural Health Collaborative	Communications Director	No submission received
Culturally and Linguistically Diverse Communities Health Advisory Group	Chair	No submission received
Federation of Ethnic Communities' Councils of Australia (FECCA)	CEO	No submission received
Migrant & Refugee Health Partnership (MRHP)	Chair	Submission received

Organisation	Position	Response
Multicultural Communities Council of South Australia (MCCSA)	CEO	Submission received on behalf of MCCSA
Multicultural Communities Council of South Australia (MCCSA) - Men's Council	Project Officer	
Partners in Culturally Appropriate Care (PICAC)	CEO	No submission received
Refugee Council of Australia	CEO	No submission received
The Centre for Culture, Ethnicity and Health (CEH)	Manager	No submission received
The Centre for Migrant and Refugee Health (CMRH)	Founder, Director and CEO	Submission received

RURAL AND REMOTE POPULATIONS:

Organisation	Position	Response
Australian Government - National Rural Health	Commissioner	No submission received
CRANAplus	CEO	No submission received
National Rural Health Alliance	CEO	Submission received
Rural Doctors Association of Australia (RDAA)	CEO	Submission received
Rural Medical Education Australia	CEO	No submission received
The Royal Australian College of Remote and Rural Medicine (ACRRM)	President	No submission received

AUSTRALIAN MEN OF AFRICAN DESCENT:

Organisation	Position	Response
Afri-Aus Care Inc	CEO	No submission received
African Australian Advocacy Centre	Founder & Chairman	No submission received
African Australian Network Alliance Ltd	CEO	No submission received

Organisation	Position	Response
African Communities Foundation Australia	Public Officer	No submission received
African Family Services	Co-Founder and Director	No submission received
Community Abundance Inc	Program Director & Board Member	No submission received
OCI Foundation	President	No submission received
QLD African Communities Council (QACC)	President	No submission received
The Australian African Foundation for Retention and Opportunity (AAFRO)	CEO & Managing Director	No submission received
UMUNTU NGABANTU Ltd		No submission received

DEFENCE, FIREFIGHTERS, DISABILITY, PRISON & OTHER

Organisation	Position	Response
Australian Council of Social Service	CEO	Acknowledged
Australasian Fire and Emergency Service Authorities Council/Australian Fire Authorities Council	CEO	No submission received
Australian Federation of Disability Organisations	CEO	No submission received
Council of Australian Volunteer Fire Associations	Chairperson	No submission received
Country Fire Authority VIC	CEO	No submission received
Country Fire Service SA	CEO	No submission received
Dept of Fire and Emergency Services WA (DFES)	Commissioner	No submission received
Department of Veterans' Affairs	Secretary	No submission received
First Peoples Disability Network Australia	CEO	No submission received
Government of WA – Prison Health	Clinical Nurse Manager	No submission received

Organisation	Position	Response
Justice Health NSW	Executive Director of Nursing, Midwifery and Clinical Governance	No submission received
Justice Health NSW	Manager Palliative Care, Cancer, Aged & Chronic Care	No submission received
Justice Health - VIC	Executive Director	No submission received
Medical Protection Society	CEO	No submission received
Military and Emergency Services Health Australia	Program Director	No submission received
National Aerial Firefighting Centre	CEO	No submission received
National Centre for Veteran's Healthcare	Medical Director	No submission received
NSW Rural Fire Service	Commissioner	No submission received
People with a Disability Australia	CEO	No submission received
QLD Health - Prison Health and Wellbeing	Director of the Office	No submission received
Rural Fire Service - QLD	Acting CEO	Acknowledged
SA Prison Health Service		No submission received
United Firefighters Union Australia	President	No submission received
Veteran Health Association	Secretary	No submission received

COMMERCIAL COMPANIES:

Organisation	Position	Response
AstraZeneca Australia	Senior Manager Corporate Affairs	Submission received
Avant Mutual	CEO	Submission received
Bayer	Patient Engagement Associate	Submission received
Financial Review	Health Editor	No submission received
GenesisCare	CEO	Submission received on behalf of GenesisCare
GenesisCare	General Manager	
GPEx	CEO	Submission received

HEALTH PROVIDERS:

Organisation	Position	Response
Alfred Health	Chief Executive	No submission received
AndroUrology Centre	Urologist	No submission received
Australian Clinical Lab	CEO & Managing Director	No submission received
Australian Clinical Lab - NSW and ACT	CEO	No submission received
Australian Clinical Lab - QLD	CEO & Executive Director	No submission received
Australian Clinical Lab - VIC	CEO	No submission received
Australian Clinical Lab - WA	CEO WA, SA and NT	No submission received
Chatswood Private Hospital	CEO	No submission received
Epworth Healthcare	Group Chief Executive	No submission received
General Practice Supervisors Australia (GPSA)	CEO	No submission received
Greenslopes Private Hospital	CEO	No submission received
Healthscope	CEO	No submission received
Holmesglen Institute / Holmesglen Private Hospital	CEO	No submission received
Icon Cancer Centre	CEO Cancer Care	Submission received on behalf of Icon Cancer Centre
Icon Group	Group CEO	
Mater Health	Interim CEO	No submission received
Melbourne Pathology	CEO	No submission received
Mulgrave Private Hospital	CEO	No submission received
Nexus Hospital Group	Interim CEO	No submission received
Noosa & Nambour Private Hospitals	CEO	No submission received
NSW Health Pathology	Chief Executive	No submission received
Pathology QLD	Executive Director	No submission received
PathWest Laboratory Medicine WA	CEO	No submission received
PathWest Laboratory Medicine WA	Lead Pathologist	No submission received
Peter MacCallum Cancer Centre	Chief Executive	No submission received
QLD X-Ray	CEO	No submission received
Queen Elizabeth II Jubilee Hospital (QEII)	Director of Urology	No submission received

Organisation	Position	Response
Radiology SA	CEO	No submission received
Radiology VIC	Clinical Leadership	No submission received
Ramsay Health Care	CEO	No submission received
Real Men's Health & St Vincent's Hospital in Sydney	Men's Health Clinical Nurse Consultant	No submission received
Royal Brisbane and Women's Hospital (RBWH)	Director of Urology	No submission received
SA Pathology	Clinical Service Director	No submission received
Sir Charles Gairdner Hospital - Urology Department	Head of Department	No submission received
SMS Healthcare	CEO	No submission received
Sonic Healthcare	CEO & Managing Director	No submission received
South West Healthcare	CEO	No submission received
St Andrews War Memorial Hospital	General Manager	No submission received
St Vincent's Hospital-BRISBANE	CEO	No submission received
St Vincent's Hospital-MELBOURNE	CEO	No submission received
St Vincent's Hospital - SYDNEY	CEO	Submission received on behalf of St Vincent's Hospital Sydney
St Vincent's Hospital - SYDNEY, St Vincent's Health Network, Public Division	Improvement Lead-Sub-Acute, Ambulatory Care and Community Services (SACS)	
Sullivan Nicolaides Pathology	Managing Partner	Submission received
Sunshine Coast University Private Hospital	CEO	No submission received
Territory Pathology	CEO	No submission received
The Bays Healthcare Group	CEO	No submission received
The Urological Cancer Centre	Director	No submission received
The Wesley Hospital	General Manager	No submission received
Urology SA	Director	No submission received

ADVOCACY ORGANISATIONS:

Organisation	Position	Response
Australian Men's Health Forum (AMHF)	CEO	No submission received

Organisation	Position	Response
Australian Men's Shed Association (AMSA)	Chairman	No submission received
ehealthmatch		No submission received
Global Action on Men's Health	Director	No submission received
Healthy Male	CEO & Director	Submission received on behalf of Healthy Male
Healthy Male	Chair	
Men's Health Australia	Head of Content	No submission received
Men's Health Melbourne	Director	No submission received
Men's Wellbeing	President	No submission received
Movember	Global Director, Prostate Cancer	Submission received
Prostate Cancer Scotland	Communications and Supporter Care Manager	No submission received
Prostate Cancer UK	Director of Health Services, Equity & Improvement	Submission received on behalf of Prostate Cancer UK
Prostate Cancer UK	Assistant Director of Health Improvement	
SA Brothers	Founder/President	No submission received
The Australian Men's Health Forum (AMHF)	CEO	No submission received
The Australian Men's Health Forum (AMHF)	Content Manager	No submission received
Wodonga Mens Shed	Mens Shed Representative	Submission received

PROSTATE CANCER SUPPORT GROUPS:

Organisation	Position	Response
Prostate Cancer Support Group - Limestone Coast	Prostate Cancer Support Group Representative	Submission received
Prostate Support Group - Geelong	Prostate Cancer Support Group Representative	Submission received
Prostate Cancer Support Group - Ocean Reef for Perth's Northern Suburbs	Prostate Cancer Support Group Representative	Submission received
Prostate Cancer Support Group - ACT Region	Prostate Cancer Support Group Representative	Submission received
Prostate Cancer Support Group - Prosper - Darwin	Prostate Cancer Support Group Representative	Submission received

Organisation	Position	Response
Prostate Cancer Support Group - Sunshine Coast	Prostate Cancer Support Group Representative	Submission received

PRIVATE HEALTH INSURERS:

Organisation	Position	Response
Bupa Asia Pacific	Acting CEO	No submission received
Doctor's Health Fund	CEO	No submission received
Medibank Australia	CEO	No submission received
NIB	Managing Director & CEO	Acknowledged
Private Health Care Australia	CEO	No submission received

Appendix 3: Public Consultation 2 Questions

The Public Consultation invites feedback on any section of the DRAFT 2025 Guidelines.

Questions by Section of DRAFT 2025 Guidelines
1. Do you have any feedback on the Guideline Introduction?
2. Do you have any feedback on the Executive Summary?
3. Do you have any feedback on Section A: Risk assessment?
4. Do you have any feedback on Section B: Decision support?
5. Do you have any feedback on Section C: Priority populations?
6. Do you have any feedback on Section D? • Digital rectal examination • PSA testing • mpMRI • Biopsy
7. Do you have any feedback on Section E: Management, Active surveillance?
8. Do you have any feedback on Section E: Management, Watchful waiting?
9. Do you have any feedback on Section F: Guideline implementation and monitoring?
10. Do you have any feedback on Section G: Emerging evidence and future research priorities?
11. Do you have any feedback on the Appendices, References or Resources and useful links?

Additionally, there are seven questions that seek feedback on specific aspects of the DRAFT 2025 Guidelines.

Questions related to specific aspects of DRAFT 2025 Guidelines
12. Do you have any specific feedback on the approaches to early detection of prostate cancer for Aboriginal and Torres Strait Islander males outlined in the DRAFT 2025 Guidelines?
13. Throughout these Guidelines we have endeavoured to use culturally appropriate, respectful and inclusive language that reflects the diverse Australian community and is accessible to all. Do you have any specific feedback on the language used in these G
14. Do you have any additional suggestions for how we can ensure these Guidelines are as widely used as possible?

15. Are there any additional areas of emerging evidence and/or future research priorities that should be considered?

16. Are the DRAFT 2025 Guidelines clear and easy to understand?

17. Is there anything further that needs to be considered for the Guidelines?

18. Are there any other comments you would like to make about the DRAFT 2025 Guidelines?

Appendix 4: Communication Strategy - Public Consultation for the DRAFT 2025 Guidelines

Public Consultation on the DRAFT 2025 Clinical Practice Guidelines for the Early Detection of Prostate Cancer took place between Monday, 14 April and Sunday, 25 May.

Note: Extensive social, print and electronic media continued throughout the consultation period which is not all captured in this schedule. Secondary communication about the Public Consultation through stakeholder channels such as professional/organisational newsletters and meetings, was also extensive and is not captured.

Date	Action
Monday 7 April One week prior to Public Consultation	Save the date invitation sent to PCFA Support Groups for a Virtual Town Hall to discuss the draft Guidelines with the committee.
Monday 14 April Public Consultation opens	
Monday 14 April Week 1	***Media***: • Press release pitched into national print and radio and outlets resulting in coverage in national coverage in The Australian, national radio coverage on ABC and outlets including 2GB, and 6PR, and national TV coverage across Channel 7 and Channel 9. • Editorial from Prof Jeff Dunn AO published in the Canberra Times. • 1/8 page ad published in The Australian, The Daily Telegraph, Herald Sun, The Courier Mail, The Advertiser, Hobart Mercury ***Communications***: • Submissions landing page set up on pcfa.org.au • Press release and Editorial added to PCFA website and listed on homepage • Email sent to all PCFA stakeholders announcing the new draft Guidelines • Social media posts across LinkedIn, Instagram, X (Twitter) and Facebook
Thursday 17 April Week 1	• Call for submissions included in PCFA's Support Group Newsletter • PCFA Webinar pre-recorded with Prof Jeff Dunn, David Smith, Peter Heathcote

Tuesday 22 April Week 2	• Virtual Town Hall Q&A held for PCFA Support Groups to discuss the changes
Thursday 30 April Week 3	• Release of PCFA Webinar across all channels • Call for submissions included in Blue Sky Horizons Newsletter (107,000 contacts)
May (throughout)	• Continued media coverage in publications like National Seniors Magazine, and interviews on key radio stations including 3AW, 2GB, and ABC.
Thursday 8 May Week 4	• Call for submissions included in PCFA's Fundraising Newsletter
Friday 16 May Week 5	• Call for submissions included in PCFA's Support Group Newsletter • Second Virtual Town Hall Q&A held for PCFA Support Groups to discuss the changes
Thursday 22 May Week 6	• Social media posts across PCFA channels reminding people to get their submissions in
Friday 23 May Week 6	• National email to PCFA Supporters reminding them to get their submissions in before May 25
	Sunday 25 May, 11:59pm Public Consultation closes