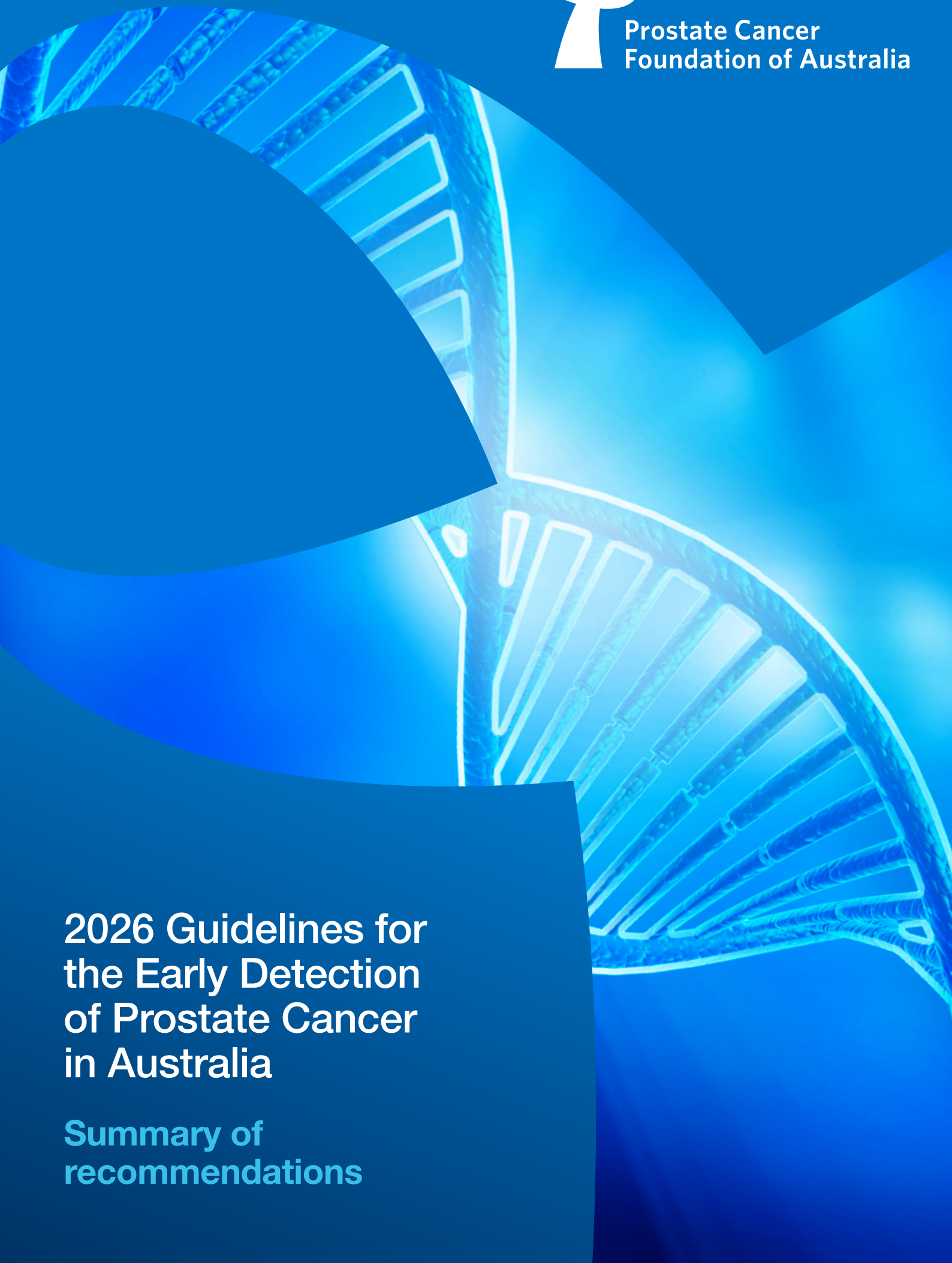
Prostate Cancer Foundation of Australia



2026 Guidelines for the Early Detection of Prostate Cancer in Australia

Summary of recommendations

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Publication Approval

Australian Government
Department of Health, Disability and Ageing

The guideline recommendations were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 18 May 2026 under section 14A of the National Health and Medical Research Council Act 1992. In approving the guideline recommendations, NHMRC considers that they meet the NHMRC standard for clinical practice guidelines.

The recommendations in Chapters 1 to 4 and 6 to 9 are approved for a period of five years, expiring on 17 May 2031.

The recommendations in Chapter 5 are approved for a period of two years, expiring on 17 May 2028.

NHMRC is satisfied that the guideline recommendations are systematically derived, based on the identification and synthesis of the best available scientific evidence, and developed for health professionals practising in an Australian health care setting.

This publication reflects the views of the authors and not necessarily the views of the Australian Government.

Contents

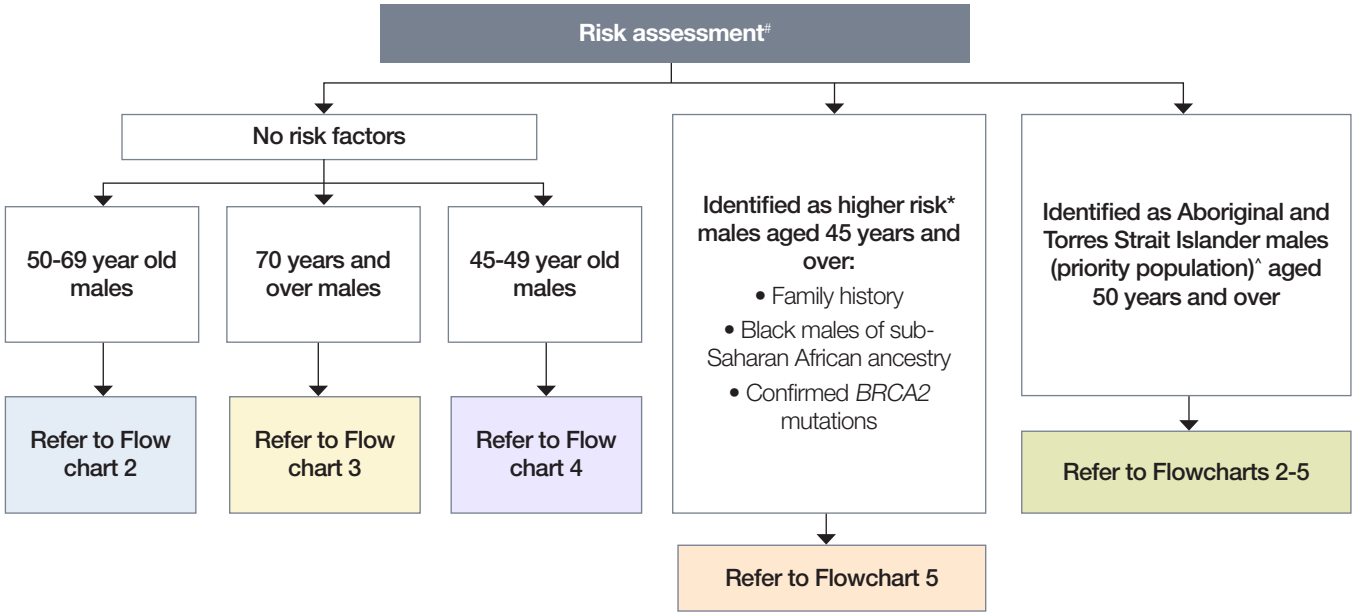
Section A: Risk assessment

Risk assessment flowchart

Flowcharts reflecting the PSA testing recommendations have been developed to aid clinical decision making.

This flowchart, and all flowcharts contained in this Guideline, include recommendations for those males who, after informed decision making, choose to have testing. Any individual may choose to opt out or opt back in at any time.

Flowchart 1: Risk assessment for the early detection of prostate cancer in Australia



#Refer Section A: Risk assessment.

**For the purposes of this review, 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. This includes:*

- *Males with a significant family history*
  - *a brother diagnosed with prostate cancer*
  - *a father diagnosed with prostate cancer before the age of 65*
  - *two or more second-degree relatives who died of prostate cancer.*
- *Black males of sub-Saharan African ancestry*
- *Males with a BRCA2 mutation*

Note: For the technical review, clinically significant prostate cancer is prostate cancer that is ISUP grade group 2 or more. For clinicians this means prostate cancers that are more likely to impact quality or quantity of life.

Familial syndromes such as hereditary breast and ovarian cancer and Lynch syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

^PSA testing recommendations for Aboriginal and Torres Strait Islander males are the same as for the general population. Refer Section C: Priority populations for further considerations.

1.1 Family history of prostate cancer

Strong recommendation

1.1.1 We recommend that males are considered as being at higher risk of prostate cancer mortality for the purposes of PSA testing in the primary care setting if they have significant family history:

- A brother diagnosed with prostate cancer
- Their father was diagnosed with prostate cancer before the age of 65
- Two or more second-degree relatives who died of prostate cancer.

In this population the risk of dying from prostate cancer is at least double that of non-higher risk males.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

Conditional recommendation

1.1.2 We suggest that males should be considered at higher risk of prostate cancer mortality for the purposes of PSA testing if their father was diagnosed with prostate cancer at any age.

In this population the risk of dying from prostate cancer is likely to be more than double that of non-higher risk males.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

Consensus recommendation

1.1.3 We propose that males should be considered at higher risk of prostate cancer mortality for the purposes of PSA testing if two or more second-degree relatives (uncle, grandfather, etc.) were diagnosed with prostate cancer.

In this population the risk of dying from prostate cancer is likely to be more than double that of non-higher risk males.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

1.2 Black males of sub-Saharan African ancestry living in Australia

Consensus recommendation

1.2.1 We propose that Black males of sub-Saharan African ancestry be considered at higher risk of clinically significant prostate cancer.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

Key message

1.2.2 To best support clinicians and Black males of sub-Saharan African ancestry, development and implementation of targeted, culturally appropriate health education/information resources for use in the clinical setting are needed.

Review by 17 May 2031, subject to emerging evidence

1.3 Germline mutations

Good practice statement

1.3.1 Consider males with a BRCA2 gene mutation as higher risk.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

1.4 Other risk factors

Good practice statement

1.4.1 Familial syndromes such as hereditary breast and ovarian cancer and Lynch Syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

Refer Flowcharts 1 and 5

For PSA testing recommendations in this population, refer to Consensus Recommendation 5.4.

Review by 17 May 2031, subject to emerging evidence

Section B: Decision support

2. Decision Support

Good practice statement

2.1 Offer decision support in accordance with current best practice. Approaches to decision support should take into account personal preferences and circumstances.

Decision support is more likely to be required in circumstances where there are alternative management options.

Decision support approaches can include:

- Informal discussions phrased in terms of options and potentially a recommendation
- In-depth discussions explaining benefits, potential harms and timelines of testing
- Provision of general written information, and/or provision of decision support tools
- Referral to digital resources such as websites or apps from reputable organisations.

Review by 17 May 2031, subject to emerging evidence

Section C: Priority populations

3.1 Aboriginal and Torres Strait Islander males

Key messages

3.1.1 Early detection should be embedded into the Aboriginal and Torres Strait Islander annual health assessment program.

3.1.2 Through programs such as the Medical Specialist Outreach Assistance Program (MSOAP), existing telehealth infrastructure, and point of care testing for PSA in Aboriginal Community Controlled Health Organisations, Aboriginal and Torres Strait Islander males, particularly in rural and remote communities, have facilitated access to specialist diagnostic and management services once they are identified as at-risk. These existing infrastructures can be utilised to support males undergoing PSA testing who require further testing/care.

3.1.3 To best support clinicians and Aboriginal and Torres Strait Islander males, development and implementation of targeted, culturally appropriate health education/information resources for use in the clinical setting are needed.

Refer Flowcharts 1 to 5

Review by 17 May 2031, subject to emerging evidence

3.2 Other priority populations

Background

There are multiple other factors associated with risk of clinically significant prostate cancer or death from prostate cancer including but not limited to: industrial exposure; smoking; rural and remote place of residence and; socioeconomic status. Further, baseline PSA values for transgender women on gender-affirming hormones may be artificially lower, necessitating extra care when interpreting PSA. Currently, however, evidence for these priority groups in Australia is limited and further research is outside the scope of this review.

While there is emerging evidence regarding risks of clinically significant prostate cancer or prostate cancer death in priority populations, data are not available to make specific testing recommendations. For recommendations on further research for priority populations including: rural and remote communities; migrant groups; culturally and linguistically diverse (CALD) communities; LGBTIQA+ populations; people with disability; military veterans and prisoners refer to Appendix 3: Literature Review - Social determinants of prostate cancer and early detection of prostate cancer in Australia.

Further information can be found in Section F: Guideline implementation and monitoring and for research priorities refer to Dissemination Plan.

Section D: Early detection

4. Digital Rectal Examination (DRE)

Conditional recommendation against

4.1 We suggest that digital rectal examination not be offered in the primary care setting as a routine addition to PSA testing and risk assessment.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

4.2 Although DRE is not recommended as a routine test for men who, after advice, wish to be tested for the presence of prostate cancer, it will still be an important part of the man's assessment on referral to a urologist or other specialist for further assessment prior to consideration for biopsy.

Review by 17 May 2031, subject to emerging evidence

5. Primary health care setting - PSA testing

Good practice statement

5.1 For males aged 50 years and over, initiate a discussion regarding risk factors for prostate cancer and the possible benefits and harms of testing for the early detection of prostate cancer*.

For males aged 45 to 49 years, assess whether they are at higher risk** of prostate cancer than the general population and, if so, initiate a discussion regarding risk factors for prostate cancer and the possible benefits and harms of testing for the early detection of prostate cancer*.

For males aged 45 to 49 years who are assessed as not at higher risk, but who enquire about their prostate health, it is reasonable to discuss the possible benefits and harms of testing for the early detection of prostate cancer*.

Refer Section B: Decision support for approaches to decision support.

**Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

***For the purposes of this review, 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. This includes:*

- *Males with a significant family history*
  - *a brother diagnosed with prostate cancer*
  - *a father diagnosed with prostate cancer before the age of 65*
  - *two or more second-degree relatives who died of prostate cancer.*
- *Black males of sub-Saharan African ancestry*
- *Males with a BRCA2 mutation*

Note: For the technical review, clinically significant prostate cancer is prostate cancer that is ISUP grade group 2 or more. For clinicians this means prostate cancers that are more likely to impact quality or quantity of life.

Familial syndromes such as hereditary breast and ovarian cancer and Lynch syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

Refer Flowcharts 1, 2, 4 and 5

Review by 17 May 2028, subject to emerging evidence

Good practice statement

5.2 The early detection of clinically significant prostate cancer requires an individualised, risk-adapted, harm-minimisation approach which may include decision support, PSA testing and multiparametric magnetic resonance imaging (mpMRI) in conjunction with:

- Digital rectal examination in the specialist setting (refer Digital rectal examination).
- Harm-minimisation strategies including prostate biopsy techniques (refer 6. Specialist setting-Multiparametric magnetic resonance imaging and 7. Specialist setting - Prostate biopsy).
- Management strategies including active surveillance (refer 8. Active surveillance).

This coordinated approach is consistent with a harm minimisation imperative and leads to a reduction in over-treatment.

Refer 5.1 Good practice statement
Refer 5.3 Conditional recommendation

Review by 17 May 2028, subject to emerging evidence

Conditional recommendation

5.3 We suggest offering PSA testing every two years to males aged 50-69 who decide to undergo testing, following a discussion of possible benefits and harms*.

If total PSA is 3.0 µg/L or greater repeat the test within 1-3 months and, if confirmed, offer referral for further investigation.

**Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

Refer Flowcharts 1 and 2

Review by 17 May 2028, subject to emerging evidence

Consensus recommendation

5.4 We propose offering PSA testing every two years from age 45 to males who are at higher risk* and decide to undergo testing, following a discussion of possible benefits and harms**.

For males at higher risk aged 45 to 49 years, if total PSA is 1.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.

For males at higher risk aged 50 to 69 years, if total PSA is 2.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.

**For the purposes of this review, 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. This includes:*

- *Males with a significant family history*
  - *a brother diagnosed with prostate cancer*
  - *a father diagnosed with prostate cancer before the age of 65*
  - *two or more second-degree relatives who died of prostate cancer.*
- *Black males of sub-Saharan African ancestry*
- *Males with a BRCA2 mutation*

Note: For the technical review, clinically significant prostate cancer is prostate cancer that is ISUP grade group 2 or more. For clinicians this means prostate cancers that are more likely to impact quality or quantity of life.

Familial syndromes such as hereditary breast and ovarian cancer and Lynch syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

***Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

Refer Flowcharts 1 and 5

Review by 17 May 2028, subject to emerging evidence

Consensus recommendation

5.5 Note that PSA testing recommendations for Aboriginal and Torres Strait Islander males are the same as for the general population.

- We suggest offering PSA testing every two years to Aboriginal and Torres Strait Islander males aged 50 to 69 years who decide to undergo testing, following a discussion of possible benefits and harms*. If total PSA is 3.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, offer referral and further investigation.
- We propose offering PSA testing every two years from age 45 to Aboriginal and Torres Strait Islander males who are at higher risk** and decide to undergo testing, following a discussion of possible benefits and harms*.
  - For Aboriginal and Torres Strait Islander males at higher risk aged 45 to 49 years, if total PSA is 1.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.
  - For Aboriginal and Torres Strait Islander males at higher risk aged 50 to 69 years, if total PSA is 2.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.
- We propose offering an initial PSA test from age 45 years to Aboriginal and Torres Strait Islander males who are not at a higher risk** and who are interested in their prostate health, and decide to undergo testing, following a discussion of possible benefits and harms*.
- In those interested Aboriginal and Torres Strait Islander males aged 45 to 49 years, if total PSA is:
  - 1.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.
  - less than 1.0 µg/L, no further PSA testing is recommended until age 50 years.

  We do not propose routine PSA testing for Aboriginal and Torres Strait Islander males aged 45 to 49 who are not at higher risk.
- We propose offering PSA testing every two years to Aboriginal and Torres Strait Islander males aged 70 years and over who decide to undergo testing, following a discussion of possible benefits and harms* and a clinical assessment. The decision to test should be based on clinical assessment, which should include:
  - life expectancy (testing is not recommended if life expectancy is 7 years or less)
  - comorbidities
  - patient values and preferences.

If total PSA is 5.5 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.

Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

- Aboriginal and Torres Strait Islander males over 70 years whose PSA is less than 5.5 µg/L may discontinue further testing.
- If they elect to continue testing, PSA testing should be offered after an informed discussion about potential benefits and harms* and an individualised clinical assessment which should include:
  - life expectancy (testing is not recommended if life expectancy is 7 years or less)
  - comorbidities
  - patient values and preferences.

  Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

**Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

***For the purposes of this review, 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. This includes:*

- *Males with a significant family history*
  - *a brother diagnosed with prostate cancer*
  - *a father diagnosed with prostate cancer before the age of 65*
  - *two or more second-degree relatives who died of prostate cancer.*
- *Black males of sub-Saharan African ancestry*
- *Males with a BRCA2 mutation*

Note: For the technical review, clinically significant prostate cancer is prostate cancer that is ISUP grade group 2 or more. For clinicians this means prostate cancers that are more likely to impact quality or quantity of life.

Familial syndromes such as hereditary breast and ovarian cancer and Lynch syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

For further details, refer to Section C: Priority populations

Refer Flowcharts 1 to 5

Review by 17 May 2028, subject to emerging evidence

Conditional recommendation

5.6 We suggest offering PSA testing only to males whose life expectancy is greater than seven years.

Refer Flowcharts 1 to 3

Review by 17 May 2028, subject to emerging evidence

Consensus recommendation

5.7 We propose offering an initial PSA test from age 45 years to males who are not at a higher risk and who are interested in their prostate health, and decide to undergo testing, following a discussion of possible benefits and harms*.

In those interested males aged 45 to 49 years, if total PSA is:

- 1.0 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.
- less than 1.0 µg/L, no further PSA testing is recommended until age 50 years.

We do not propose routine PSA testing for males aged 45 to 49 who are not at higher risk.

**Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

Refer Flowcharts 1 and 4

Review by 17 May 2028, subject to emerging evidence

Consensus recommendation

5.8 We propose offering PSA testing every two years to males aged 70 years and over who decide to undergo testing, following a discussion of possible benefits and harms* and a clinical assessment. The decision to test should be based on clinical assessment, which should include:

- life expectancy (testing is not recommended if life expectancy is 7 years or less)
- comorbidities
- patient values and preferences.

If total PSA is 5.5 µg/L or greater repeat the test within 1-3 months, and, if confirmed, consider referral and further investigation.

Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

**Informed discussion of the possible benefits and harms of PSA testing with shared decision making and patient choice is key to good clinical practice.*

Refer Flowcharts 1, 3 and 5

Review by 17 May 2028, subject to emerging evidence

Good practice statement

5.9 Males over 70 years whose PSA is less than 5.5 µg/L may discontinue further testing.

If they elect to continue testing, PSA testing should be offered after an informed discussion about potential benefits and harms and an individualised clinical assessment which should include:

- life expectancy (testing is not recommended if life expectancy is 7 years or less)
- comorbidities
- patient values and preferences.

Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

Refer Flowchart 3

Review by 17 May 2028, subject to emerging evidence

Key message

5.10 For clinicians to best support consumer awareness and understanding of prostate cancer risk factors for males aged 45 years and above, appropriate health education/information resources for use in the clinical setting are needed.

Review by 17 May 2028, subject to emerging evidence

Flowcharts for PSA testing

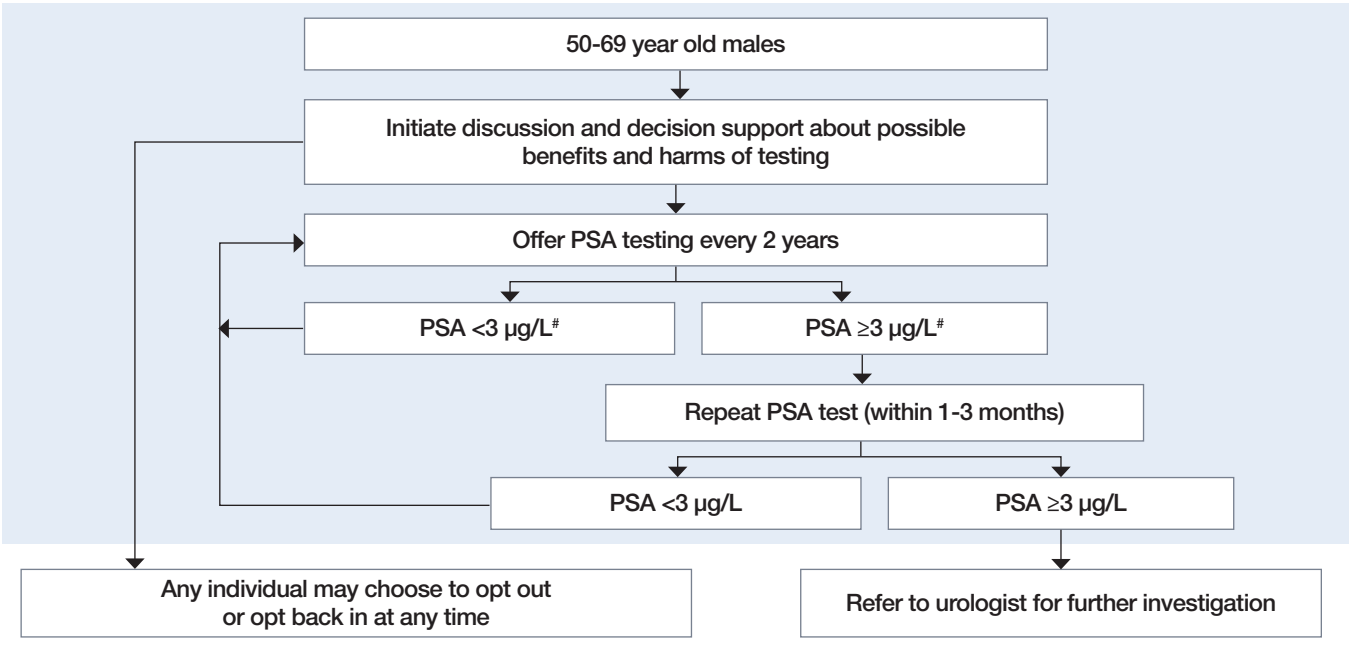
Flowcharts reflecting the PSA testing recommendations have been developed to aid clinical decision making. Flowchart 1 in Section A: Risk assessment describes risk assessment for the early detection of prostate cancer in Australia.

This flowchart, and all flowcharts contained in this Guideline, include recommendations for those males who, after informed decision making, choose to have testing. Any individual may choose to opt out or opt back in at any time.

The following flowcharts describe PSA testing in the primary care setting for:

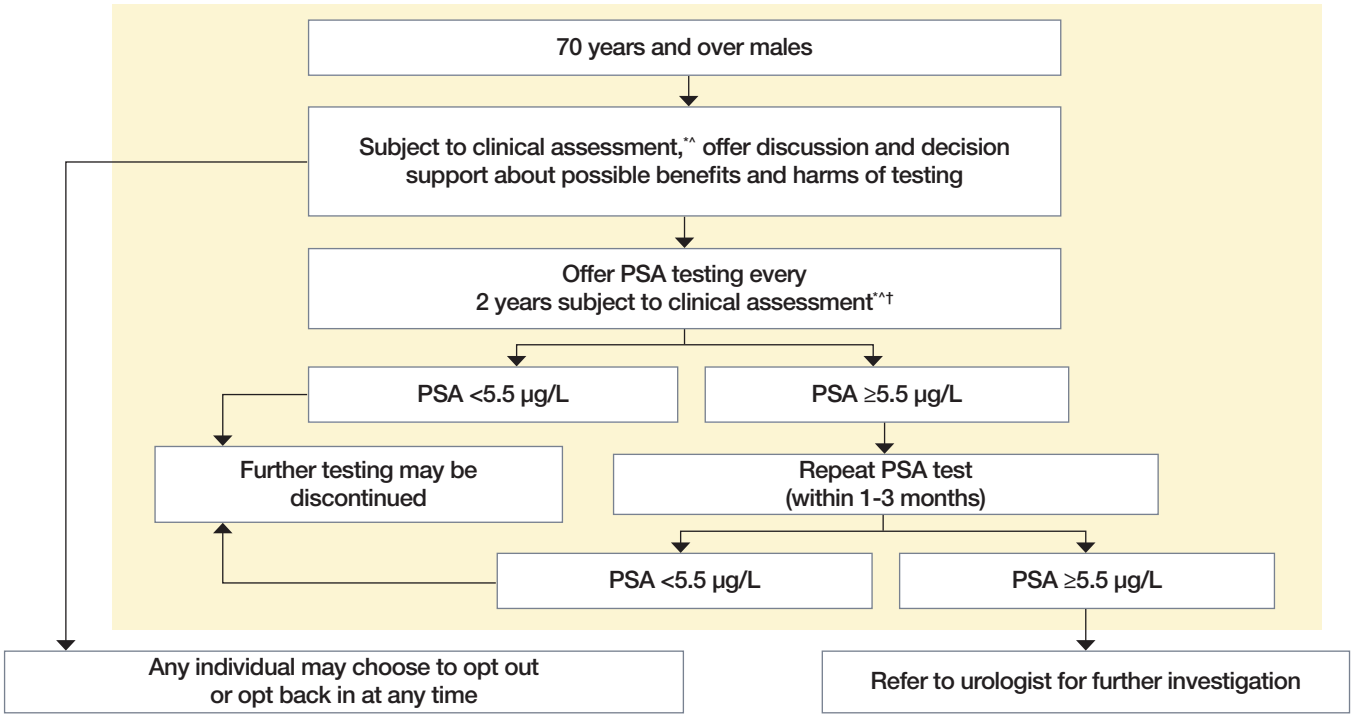
- 50 to 69 year old males (Flowchart 2)
- Males 70 years and over (Flowchart 3)
- 45 to 49 year old males (Flowchart 4)
- Males at higher risk (Flowchart 5)

Flowchart 2: PSA testing of 50 to 69 year old males, not at higher risk, in the primary care setting



#PSA ≥2 µg/L if higher risk (refer Flowcharts 1 and 5)

Flowchart 3: PSA testing of males 70 years and over, not at higher risk, in the primary care setting.

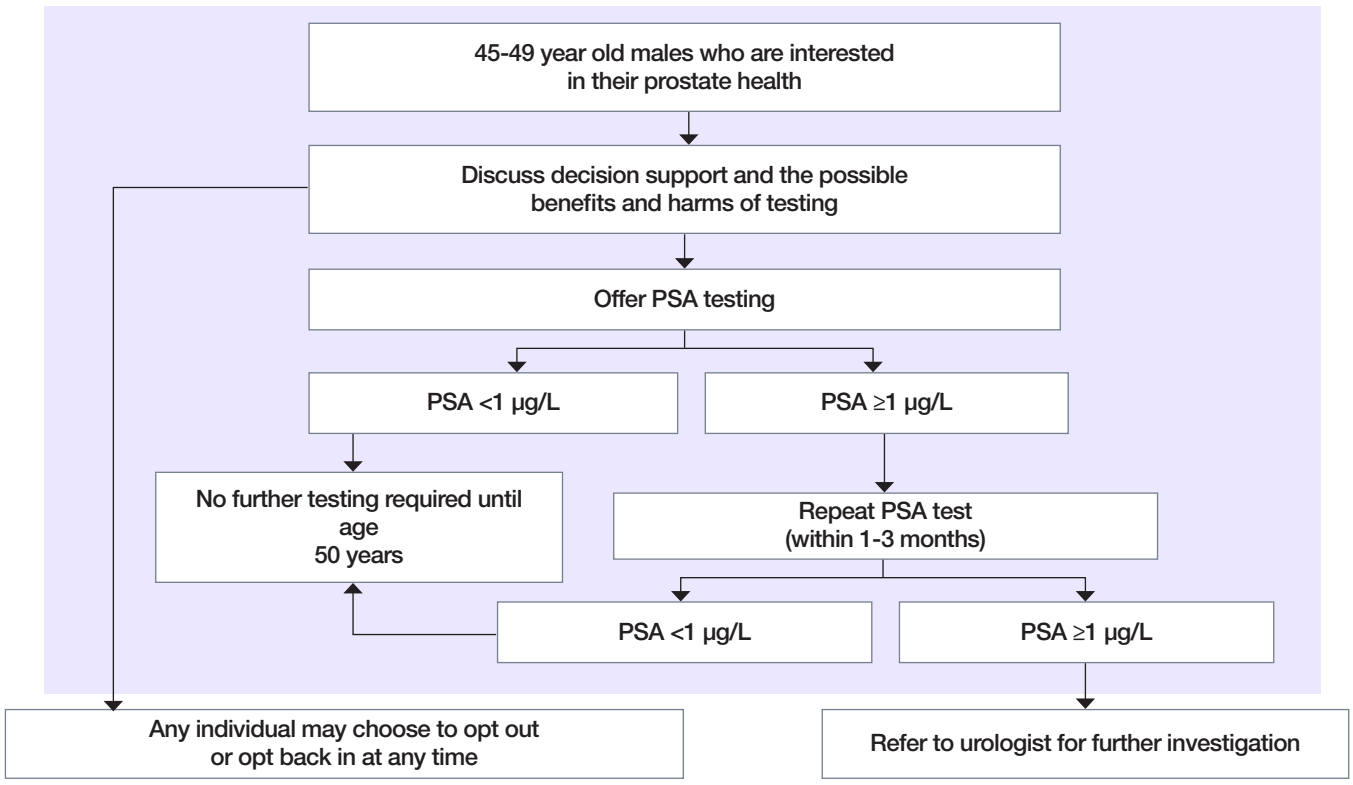


** Only offer testing if life expectancy is greater than 7 years.*

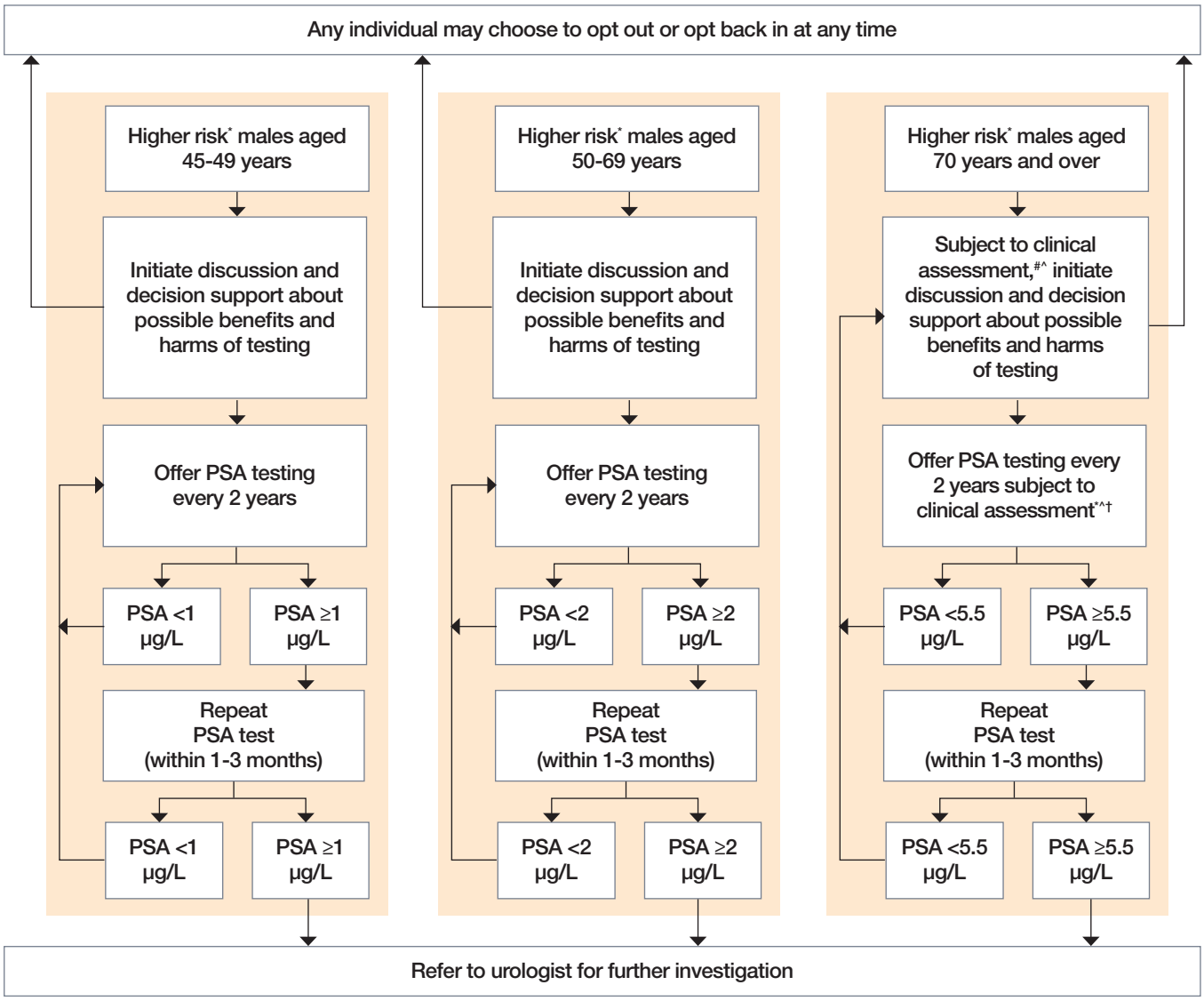
^ Clinical assessment should include consideration of life expectancy, comorbidities, and patient values and preferences.

† Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

Flowchart 4: PSA testing of 45 to 49 year old males, not at higher risk, in the primary care setting



Flowchart 5: PSA testing of males at higher risk in the primary care setting



**For the purposes of this review, 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. This includes:*

- *Males with a significant family history*
  - *a brother diagnosed with prostate cancer*
  - *a father diagnosed with prostate cancer before the age of 65*
  - *two or more second-degree relatives who died of prostate cancer.*
- *Black males of sub-Saharan African ancestry*
- *Males with a BRCA2 mutation*

Note: For the technical review, clinically significant prostate cancer is prostate cancer that is ISUP grade group 2 or more. For clinicians this means prostate cancers that are more likely to impact quality or quantity of life.

Familial syndromes such as hereditary breast and ovarian cancer and Lynch syndrome are also associated with increased risk of clinically significant prostate cancer compared to the general population.

 # Only offer testing if life expectancy is greater than 7 years.

^ Clinical assessment should include consideration of life expectancy, comorbidities, and patient values and preferences.

† Cease PSA testing when life expectancy is limited or when comorbidities make prostate cancer treatment unlikely to improve quality or length of life.

6. Specialist setting - Multiparametric magnetic resonance imaging

Good practice statement

6.1 For males requiring further investigation on the basis of their PSA, an mpMRI is recommended as their next diagnostic test to determine if a biopsy is indicated.

Review by 17 May 2031, subject to emerging evidence

Conditional recommendation

6.2 We suggest offering prostate biopsy to males with an mpMRI suspicious of prostate cancer (Prostate Imaging Reporting and Data System [PI-RADS] 4-5).

We suggest offering prostate biopsy to males with an equivocal PI-RADS 3 mpMRI and PSA density (PSAD) ≥ 0.15 µg/L/mL.

Review by 17 May 2031, subject to emerging evidence

Conditional recommendation

6.3 We suggest that males with an equivocal PI-RADS 3 mpMRI and PSAD < 0.15 µg/L/mL may not require prostate biopsy subject to clinical assessment.

We suggest that males with an mpMRI not suspicious of prostate cancer (PI-RADS 1-2) may not require prostate biopsy subject to clinical assessment.

**For males who do not require biopsy, refer 6.4 Consensus recommendation.*

Review by 17 May 2031, subject to emerging evidence

Consensus recommendation

6.4 We propose that for males with elevated PSA who do not require biopsy based on the 6.3 Conditional recommendation subsequent management will vary according to their degree of clinical risk. This should include discussion of individual preferences.

A repeat PSA and specialist review should guide subsequent management. For males with additional risk factors for cancer and those more concerned about missing a diagnosis, further management options may include a repeat PSA within 6 months, a prostate specific membrane antigen positron emission tomography with computer tomography (PSMA PET/CT) scan or undergoing a transperineal systematic biopsy.

Refer 7.3 Good practice statement

Review by 17 May 2031, subject to emerging evidence

Good practice statement

6.5 In rare circumstances where for medical reasons males cannot have an mpMRI they may be offered either a transperineal biopsy or PSMA PET/CT.

mpMRI acquisition should include T2-weighted, diffusion-weighted and dynamic contrast-enhanced series.

mpMRI reports should include the PI-RADS score for each suspicious lesion, the prostate volume, and the PSAD calculation.

The PSAD calculation should be based on the most recent PSA result prior to the mpMRI.

Review by 17 May 2031, subject to emerging evidence

7. Specialist setting - Prostate biopsy

Conditional recommendation

7.1 We suggest that for patients with a Prostate Imaging Reporting and Data System (PI-RADS) 4-5 lesion, multiparametric magnetic resonance imaging (mpMRI) targeted plus systematic biopsies should be undertaken.

Review by 17 May 2031, subject to emerging evidence

Conditional recommendation

7.2 We suggest that for patients with a PI-RADS 3 lesion who require biopsy, mpMRI-targeted biopsies plus systematic biopsies should be undertaken.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

7.3 If the mpMRI is not suspicious of prostate cancer (PI-RADS 1 or 2), we propose systematic biopsies may still be performed if there is clinical concern, such as a digital rectal examination suspicious of prostate cancer, or a high risk of clinically significant prostate cancer.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

7.4 When performing prostate biopsy for the early detection of prostate cancer, an ultrasound-guided transperineal approach is preferred as there is less risk of post-biopsy infection. In addition, the ultrasound images are in the axial plane as are the MRI images which facilitate more accurate target biopsies.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

7.5 In most circumstances, prior to considering prostate biopsy for the early detection of prostate cancer, patients should have had a urological consultation which may include a history, discussion of benefits and possible harms of diagnosis, clinical examination, PSA testing and mpMRI.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

7.6 The optimal number of cores for targeted biopsy should be at least 3-4.

As the number of systematic biopsy cores increases, the rate of diagnosis of clinically significant and insignificant prostate cancers rises. In addition, increased number of systematic cores may also increase the risk of complications arising such as bleeding, urinary retention, erectile dysfunction, and/or urinary infection.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

7.7 In patients whose biopsies are benign, subsequent management will vary according to their risk profile. A discussion of their individual preferences is advised.

Options for ongoing management may include resumption of their previous PSA testing protocol, repeat imaging or repeat biopsy at varying intervals depending on their risk profile.

Review by 17 May 2031, subject to emerging evidence

Section E: Management

8. Active surveillance

8.1 Criteria for choosing active surveillance

Good practice statement

8.1.1 The definition of active surveillance is a monitoring strategy for patients with clinically localised prostate cancer. The intention of active surveillance is to minimise treatment-related toxicity without compromising survival by achieving correct timing for curative treatment for those who may eventually require it.

Review by 17 May 2031, subject to emerging evidence

Consensus recommendation

8.1.2 We propose that active surveillance be offered to patients with low-risk prostate cancer and may be offered to some patients with intermediate risk prostate cancer as below.

In patients diagnosed with prostate cancer, if all the following criteria are met*:

- PSA<10 µg/L
- Clinical stage T1-T2a
- Multiparametric magnetic resonance imaging (mpMRI) Prostate Imaging Reporting and Data System (PI-RADS) 3 or less
- PSA density (PSAD) 0.15 µg/L/mL or less.

Then,

1. Offer active surveillance to patients with International Society of Urological Pathology (ISUP) Grade Group 1
2. Consider offering active surveillance to patients with ISUP Grade Group 2 with less than or equal to 10% of Gleason pattern 4.

**Note that in selected cases, subject to a patient's individual circumstances, active surveillance may still be offered if PSA is >10 µg/L, or clinical stage is T2b or T2c, or mpMRI PI-RADS >3, or PSAD >0.15 µg/L/mL.*

Review by 17 May 2031, subject to emerging evidence

Good practice statement

8.1.3 When considering active surveillance, take into account other factors that may be associated with the risk of future pathological progression such as total cancer length or percentage core involvement at biopsy and tumour volume.

Active surveillance is not advised in patients with:

- Variant histology, including sarcomatoid, small cell, cribriform
- Histologic features, including intraduct, extra-prostatic extension, lymphovascular invasion and perineural invasion.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

8.1.4 Perform mpMRI if no MRI has been performed before the initial biopsy.

Review by 17 May 2031, subject to emerging evidence

8.2 Monitoring protocols for active surveillance

Consensus recommendation

8.2.1 We propose for patients with prostate cancer who are being managed by active surveillance offer:

- Initial three to six-monthly PSA measurements
- Digital rectal examination periodically
- Repeat multiparametric magnetic resonance imaging (mpMRI) may be offered after 12 to 24 months and again at three years, or earlier, if clinically indicated
- Repeat the prostate biopsy in the first 12 months at clinician's discretion e.g., where there is uncertainty regarding initial diagnostic biopsy, changes in PSA, digital rectal examination or mpMRI.

Subsequent repeat prostate biopsies are usually not required in less than three years unless there are changes in PSA, digital rectal examination or mpMRI.

Review by 17 May 2031, subject to emerging evidence

Consensus recommendation

8.2.2 We propose that for patients being managed by active surveillance, offer definitive treatment if:

- Pathological progression is detected on biopsy
- Patient preference.

Note: Progression on mpMRI is not an indication for definitive treatment but will likely prompt the need for repeat biopsies.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

8.2.3 Avoid a change in treatment on an increase in PSA alone.

Perform repeat mpMRI preferably before repeat biopsy if PSA is increasing (PSA doubling time < 3 years). Repeat biopsy may still have value even with an unchanged mpMRI.

Review by 17 May 2031, subject to emerging evidence

Good practice statement

8.2.4 Males with ultralow volume, low risk prostate cancer may be excused from more rigorous surveillance protocols.

Review by 17 May 2031, subject to emerging evidence

9. Watchful waiting

Good practice statement

9.1 The practice of watchful waiting is a patient-centred conservative strategy for managing prostate cancer when cure is not the goal. The aim is to maximise the patient's quality of life in alignment with their initial and evolving stated goals of care.

A comprehensive approach to managing prostate cancer involves the following general principles of monitoring and management options:

- Identify the patient's goals of care
- Tailor plans to the patient's wishes and needs
- Plan should include continuing clinical review, even if no investigations are to be done
- Ensure clear ongoing communication with the patient and their carers/families
- Allow for the possibility that the patient might want to change goals of care and approach to care.

Multidisciplinary management is recommended, involving the patient, primary health care and specialist settings, and other relevant health professionals.

Review by 17 May 2031, subject to emerging evidence

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