This submission has been prepared by and made on behalf of **Alan White and Fiona White** from **www.theprostatezone.com**.

Public Consultation Feedback

Draft 2025 Guidelines for the Early Detection of Prostate Cancer in Australia:

Clinical Practice Guidelines for Health Professionals

Feedback on the Draft Guidelines:

We have completed the online feedback submission. The following comments (and attachment) represent our key points, recommendations, rationale and questions.

WHO ARE THE GUIDELINES FOR?

- As we understand that urologists (and rad oncologists?) use the EAU Guidelines for Prostate Cancer (https://uroweb.org/guidelines/prostate-cancer), are the 2025 Guidelines really intended for anyone other than GPs?

EARLY DETECTION OF PROSTATE CANCER

Our Recommendations –

1. **Annual** testing for **all** men between the ages of **40 and 80.**
2. All PSA blood tests to include **free-to-total PSA tests** at the same time.

Our Rationale –

- Early detection leads to better health outcomes for men.
- Early detection leads to significantly lower cost to men and the healthcare system.
- More men are being diagnosed with prostate cancer in their 40s.

- More men are living longer, healthier lives – past the age of 70. Late diagnosis for these men will lead to poor quality of life outcomes and greater cost to them and the medical system.

- Many men report that their PSA levels rose significantly over short timeframes – annual testing is far safer in this instance.

- During the COVID period, many men reported that their prostate cancer became metastatic in between tests – again, annual testing is a far better way to achieve early detection and keep costs lower.

- Men with low PSA levels that do not meet the threshold of 3 ng/ml can still have aggressive prostate cancer.

- Free-to-total PSA blood testing can pick up these "outliers" and lead to these men being referred for specialist appraisal.

- mpMRI is a very valuable tool, but it is far more expensive than a free-to-total PSA blood test.

- A free-to-total PSA blood test costs around **$40**, whereas an mpMRI costs around **$492.65**

- mpMRI is also a technology that is less readily available to men in rural, regional or remote locations.

Risk Assessment

Our Recommendations –

3. Offer annual PSA tests to **all men** aged between 40 and 80 years of age.

Our Rationale –

- As genuine risk assessment is currently of limited benefit, simply offer the testing to all men over the age of 40.

- Our recent survey (see attached results) showed that many men knew nothing about their family health history.

- Our survey also showed that many men with **NO** family history still developed prostate cancer.

- These Draft Guidelines still only offer two yearly testing, even for supposedly high-risk men. This makes no sense whatsoever.

Decision Support

Our Recommendations –

4. All GPs should be provided with clear information (similar to the attached **"Spanner in the Works"** document that was created by Healthy Male). That information should be given to **all men from the age of 40 onwards**.

5. All men from the age of 40 onwards should be directed to a suitable online source of accurate and thorough information about prostate health (e.g. PCFA's website).

Our Rationale –

- Men are frustrated by the lack of easy-to-understand information that is thorough, up-to-date and accurate.

- A GP visit is the perfect opportunity to ensure that all men aged 40 onwards receive a copy of the appropriate information (see Recommendation 4, above).

- Ensure that all GPs understand that men WITHOUT symptoms can have prostate cancer, so that early detection is promoted.

- Australian men are typically less health-literate than women. They are also less likely to visit a GP. Take advantage of this opportunity to **inform and test**.

Digital Rectal Examination

Our Recommendations –

6. All GPs should be offered **additional information and/or training** regarding the DRE.

7. All men from the age of 40 onwards should be offered a DRE, after a GP has explained the purpose of the examination to them.

Our Rationale –

- Feedback we received on our survey (see attached results) showed that many men were still undergoing DREs.

- Several men commented that it was the DRE that triggered their diagnosis.

- All GPs should be supplied with up-to-date information about how to conduct the test, as well as what they should do in the event of finding something potentially

problematic (e.g. firm or lumpy gland). Those GPs who do not feel confident / competent may omit this from their assessment.

PRIMARY HEALTHCARE SETTING - PSA

Our Recommendations –

8. All GPs should receive a clear "cheat sheet" to help them explain to men all the reasons why a standard PSA test can return high PSA results.

9. All GPs should be advised to conduct free-to-total PSA blood tests at the same time as ordering standard PSA tests.

Our Rationale –

- Talk of the "harms" of PSA testing include stress regarding "false positives", etc. Clear explanations about BPH, prostatitis and stimulation of the gland prior to testing can help diminish any fear.

- Standard PSA testing is a poor method of detecting prostate cancer, but it DOES help detect changes to the gland which may require further investigation.

- "A percentage of free PSA is expressed as the percentage of a total. Generally, if the free PSA is greater than 25% there is less likelihood of prostate cancer and **when the free PSA is less than 10% there is a greater likelihood of prostate cancer**." (Prem Rashid, *Your Guide to Prostate Cancer: The disease, treatment options and outcomes*, 4th edition, page 201.

- Men with higher PSA levels in standard PSA blood tests would benefit from their GP comparing the standard test with the free-to-total PSA test (ordered at the same time). This would help identify men who may have BPH or prostatitis (or who had engaged in sexual activity prior to their blood test).

- Please see comments under Recommendation 2.

MANAGEMENT – ACTIVE SURVEILLANCE

Our Recommendations –

10. All men diagnosed with low-risk or localised prostate cancer should be given FULL information on **all treatment options** that are appropriate for them.

11. GPs and treating clinicians should be working together to ensure that all the relevant healthcare professionals know what is going on.

12. All men who opt for active surveillance should receive clear and complete information about what it involves, including the relevant intervals of testing and follow-up visits.

13. Men should receive **reminder calls, messages or emails** to ensure that they do not miss their tests, etc.

Our Rationale –

- Clear information about what active surveillance entails – tests, scans, follow-up visits – would help men understand the "active" part of their treatment choice. "Surveillance" suggests sitting and watching something, not actively undergoing regular tests.

- Active surveillance is often confused with the very unhelpful term "watchful waiting".

- We understand that there is a significant issue of men opting for active surveillance, but not actually going for their tests, scans and check-ups.

GUIDELINE IMPLEMENTATION & MONITORING

Our Recommendations –

14. RACGP's Red Book and Medicare MBS item numbers should align with all the recommendations in the final 2025 Guidelines.

15. All GPs should be advised of the changes and the new recommendations, with possible online webinars to explain the Guidelines and respond to questions.

Our Rationale –

- The previous 2016 Guidelines suffered from lack of alignment with the Red Book and Medicare MBS item numbers.

- As this is a significant (decade in the making) change to practice and procedure, it requires a concerted effort to ensure that all GPs and their clinics are notified of the changes.