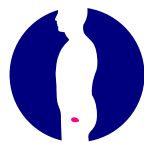




Your guide to the recognition and referral of suspected prostate cancer



Prostate cancer is the most common cancer in men in the UK [1]. This guide aims to support GPs with timely recognition and referral, whilst balancing this with the limitations of the prostate-specific antigen (PSA) test and associated risk of overdiagnosis.



Why is recognising prostate cancer challenging?

If diagnosed at stages 1 to 3, five-year survival for prostate cancer is at least 97%, but if diagnosed at stage 4, survival drops to around 46% [2]. While earlier diagnosis is important, not all prostate tumours progress and cause harm. Recognising which tumours are aggressive or likely to progress is challenging because symptoms are not always clear indicators of the disease or its progression. Often they can be non-specific and attributed to other conditions, such as benign prostatic hyperplasia.



Who is most likely to be diagnosed with prostate cancer?

Data suggests that the following groups have a higher incidence of prostate cancer, although it's unclear whether there's a higher risk of more advanced disease or death.

- Older men – incidence rates are highest in men aged 75–79 [3]
- Black men (ie men of African and African Caribbean ethnicity) – incidence is 2–3 times higher than in White men [4]
- Men with a family history of prostate cancer (68% higher risk) or breast cancer (21% higher risk) [5]
- Men with pathogenic variant in BRCA1 or 2 or with Lynch Syndrome [6,7]



What is the referral guidance?

Northern Ireland Cancer Network (NICaN) referral guidelines for suspected cancer

recommend considering a PSA test and a digital rectal examination (DRE) for people with the following symptoms:

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

An urgent suspected cancer referral (USC) should be made if:

- PSA levels exceed 20 µg/L
- PSA levels exceed the age-based threshold below at both initial testing and when repeated again between 2–4 weeks later

Age (years)	PSA level (micrograms/litre)
Below 40	Use clinical judgement
40 to 49	More than 2.5
50 to 59	More than 3.5
60 to 69	More than 4.5
70 to 79	More than 6.5
Above 79	Use clinical judgement



For a DRE suspicious of prostate cancer (hard and/or irregular), NICaN recommend requesting an urgent PSA test in parallel to making a USC referral.

Considerations prior to referral

- **For men who've had an active urinary infection, prostate biopsy, TURP, or prostatitis**, NICaN recommend delaying the PSA test by six weeks.
- **PSA levels can also be raised by other factors** such as ejaculation or vigorous exercise in the past 48 hours.
- **A normal DRE doesn't rule out prostate cancer.** A PSA test should still be requested if the patient is experiencing symptoms.

What do your patients need to know about PSA testing?

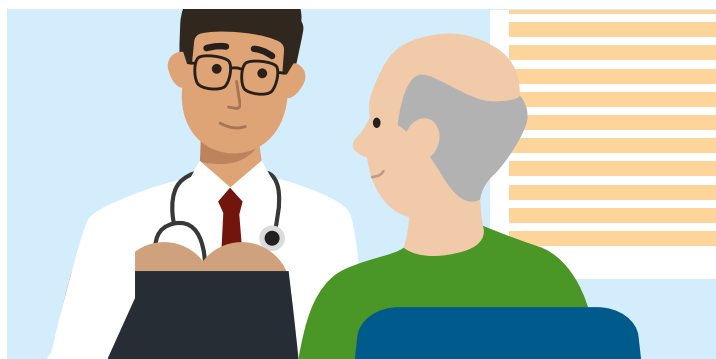
Before offering a PSA test, make sure your patients are aware of the information below so they can make an informed choice.

A PSA test can:

- help detect prostate cancer that's aggressive or likely to progress
- be inaccurate. One review of symptomatic patients found that 80% of people with elevated PSA did not have prostate cancer (false positives) and 7% of people with normal PSA had prostate cancer (false negatives) [8]
- lead to further investigations (usually an MRI* and biopsy) which could find slowgrowing tumours that may not be the cause of the symptoms or shorten life. This can lead to unnecessary diagnosis (overdiagnosis) of prostate cancer, as well as associated anxiety and unnecessary treatments (overtreatment) with adverse effects

*Although MRI may reduce patients receiving an unnecessary biopsy, there's still a risk of overdiagnosis.

Read more about PSA testing at cruk.org/psa-test



What other actions can you take to support quality referrals?



Use NICE referral guidelines in combination with clinical judgement based on patient history, examination and gut feeling, plus any local guidance and pathways.



Consider seeking out external advice, such as speaking to a urologist, to support your decision-making.



Make sure your patients understand that the referral will help to assess their symptoms, but it doesn't necessarily mean they have cancer. Provide them with clear information on next steps, ie that they'll likely be seen by a urologist who may suggest an MRI (check this is available in your area).

To support these conversations, you can use our patient information available at cruk.org/prostate and cruk.org/urgentreferrals



Whether or not they're referred for tests or specialist advice, make sure patients are monitored until their signs and symptoms are explained or resolved. **Find more guidance at cruk.org/safetynetting**

References

1. Cancer Research UK. [Cancer incidence for common cancers](#). Data is for those diagnosed between 2017 and 2019. Accessed November 2025.
2. Northern Ireland Cancer Registry, Queens University Belfast, [2020 Cancer incidence, survival, mortality and prevalence data](#) (cancers diagnosed 2012–2016, followed up to 2021). Accessed November 2025.
3. Cancer Research UK. [Prostate cancer statistics](#). Accessed November 2025.
4. [Delon et al. Br J Cancer, 2022.](#)
5. [Barber et al. Clin Cancer Res, 2018.](#)
6. [Nyberg et al. Eur Urol, 2020.](#)
7. [Bancroft EK et al. Lancet Oncol, 2021.](#)
8. [Merriel et al. BMC Med, 2022.](#)