For health professionals in the UK

CANCER RESEARCH UK

Together we are beating cancer

Primary care toolkit for assessing and managing prostate cancer risk

This guide supports UK primary care professionals to navigate the latest advice and recommendations when managing people concerned about their family history of prostate cancer.

Patient presents with concerns

Does the patient have **symptoms of suspected prostate cancer?**

Yes ↓

Check referral guidelines

Use your nation's referral guidelines:

- **England and Wales**
- **Scotland**
- **Northern Ireland**

If a PSA test is recommended, discuss the **benefits and harms of PSA testing** with the patient.

When considering PSA testing for any patient, refer to our **good practice points** for PSA testing.

No ↓

Follow **asymptomatic pathway (page 2)**.

Yes ↓

Check that a PSA test can be performed

Proceed with a PSA test after assessing the following criteria:

- 48 hours after ejaculation, vigorous exercise or receptive anal sex
- 6 weeks after an active UTI
- 1 week after digital rectal exam (DRE)

Yes ↓

No ↓

Delay the test to a suitable date.

Assess results

Does PSA test result meet the age threshold for referral?

Yes ↓

Make an urgent suspected cancer referral

No ↓

Safety net your patient appropriately. If symptoms persist or worsen, consider a DRE and repeat PSA.

Use our healthcare professional resources to support your practice:

- **PSA testing webpage**
- **GatewayC prostate course**
- **Safety netting webpage**

Produced by the Strategic Evidence team at Cancer Research UK based on advice published by the UK Cancer Genetics Group (UKCGG).

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Asymptomatic risk assessment of prostate cancer

Check *BRCA2* status

Are they a recorded carrier of a *BRCA2* gene variant?

Yes →

The UK NSC recommends targeted screening for men with *BRCA2* gene variants **and** relevant family history of cancer. Until a screening programme is implemented:

- Consider offering a PSA test for people aged 45 – 61 with a *BRCA2* gene variant
- Update patient record with any changes to personal and family history

No ↓

Check risk of hereditary gene change

- 1+ Jewish grandparent* or Whalsay (Shetland) ancestry **or**
- a close relative** with a confirmed pathogenic variant in a cancer susceptibility gene (e.g. *BRCA1, BRCA2, MLH1, MSH2, MSH6, PMS2*)

Yes →

Refer for specialist clinical genetic assessment or to direct testing via your nation or region-specific pathways.

Check our **good practice points** before referral.

No ↓

Check personal and family history

Find out if any of the following apply:

- Young onset prostate or bowel cancer (diagnosed <50), pancreatic cancer (diagnosed <60), or breast cancer (diagnosed <40 or triple negative <60)
- Young onset endometrial cancer (diagnosed <50) (excl. Scotland)
- Male breast cancer or bilateral breast cancer
- 1+ close** relative with high-grade epithelial ovarian cancer
- 2+ close** relatives with prostate, breast, ovarian, pancreatic cancer (diagnosed <60)
- 3+ close** relatives on the same side of the family with prostate, breast, ovarian, pancreatic cancer (diagnosed <70)
- 2+ close** relatives with Lynch-related cancers (e.g. colorectal, endometrial, ovarian cancer) diagnosed <70

Yes →

Due to the possibility of a hereditary cancer syndrome, **refer** for specialist clinical genetic assessment.

Check our **good practice points** and local eligibility criteria before referral.

No ↓

To assess prostate cancer risk for all other people, **complete a family history risk assessment (page 3).**

* In Wales, people who meet this criteria should only be referred if they have personal or a family history of cancer.

** Close relatives include parents, siblings, children, grandparents, aunts, uncles, nieces, nephews, half-siblings and grandchildren.

Prostate cancer family history risk assessment

1. Understand and record family history of prostate cancer

- Ask about both first-degree (parents, siblings and children) and second-degree relatives (grandparents, aunts, uncles, nieces, nephews, half-siblings and grandchildren)
- Identify the age/s at diagnosis

2. Assess risk categorisation and advised management actions

Potential high risk

- Father diagnosed ≤50 or brother diagnosed ≤55
- Any Black man with a first-degree relative diagnosed <70
- Any Black man with 2+ first- or second-degree relatives diagnosed
- 2 first-degree relatives where the average age of diagnosis was ≤65
- 2 second-degree relatives with an average age of diagnosis ≤60
- 1 first-degree and 1 second-degree relative where the average age at diagnosis was ≤65
- 3 first- or second-degree relatives with an average age at diagnosis <70
- 4+ first- or second-degree relatives diagnosed

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Refer to local family history services or specialist clinical genetic assessment depending on local pathways and service availability*.

Use our **good practice points**.

Potential moderate risk

- Father diagnosed between 50 and 70
- Brother diagnosed between 55 and 70
- 2 first-degree relatives where the average age of diagnosis was >65
- Any Black man with a second-degree relative diagnosed before <70
- 2 second-degree relatives where the average age at diagnosis was >60 and ≤65
- 1 first-degree and 1 second-degree relative where the average age of diagnosis was >65
- 3 first- or second-degree relatives with an average age at diagnosis ≥70

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Consider referral to local family history services or specialist clinical genetic assessment depending on local arrangements and service availability*. Seek advice first if family history is uncertain or if a referral could have limited clinical impact.

Use our **good practice points** and document your decision.

Near-population risk

- No affected first- or second-degree relatives
- 1 first-degree relative diagnosed ≥70
- 1 second-degree relative diagnosed at any age, or ≥70 if of Black ethnicity
- 2 second-degree relatives with an average age at diagnosis >65

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No referral required

Explain that no further investigation is needed as the potential risk of prostate cancer is similar to the general population.

If people request a PSA test, refer to our **good practice points** on PSA testing and employ shared decision-making.

*Implementation of the advice may be varied due to local constraints. Where referral capacity is not yet available, manage people in primary care.

Based on the UKCGG advice for GPs managing asymptomatic men with a relevant family history of prostate or related cancers, refer to **the UKCGG website for more information**.

Good practice points

During your consultation

- Self-reported family history of prostate cancer can be recorded using the SNOMED CT code 414205003 in England or read code 124H in Scotland.
- Signpost people to **MyCanRisk**, which can support the collection of family history information required for hereditary cancer risk assessment.
- Explain that family history can change and advise patients to contact primary care if their personal or family history changes.
- Provide symptom awareness and risk factor information to your patients such as **NHS prostate cancer information** or our **Prostate cancer awareness** leaflet.

Referrals for specialist clinical genetic assessment

- Referral capacity may vary due to local constraints. If unavailable, document family history, apply advice for near population risk groups and follow best practice for PSA testing.
- In most cases, you can seek advice from genetics services before referral. Check your local pathway and **find nation-specific advice in the UKCGG document**.
- If available, use a family history questionnaire from your local genetics or family history service and include in any referrals. In Wales, this may be posted directly to the patient after triage.
- Advise people that the youngest, affected family member should present to their GP first for referral. Note in the referral letter if this is not possible.
- Explain that referral is for specialist assessment and does not mean genetic testing will be offered. There may also be a significant wait for assessment.

Factors to consider during risk assessment and management

- Family history and specialist clinical genetic assessment services can verify ages and types of cancer diagnoses for people treated in the UK if family history is uncertain.
- People may prefer discussing their family history and risk with a specialist but note that this does not always mean referral will be accepted.

PSA testing

- Routine PSA screening is not recommended for asymptomatic men who do not meet UK NSC targeted screening eligibility criteria.
- There is limited evidence to support PSA testing more frequently than every 2 years for asymptomatic people.
- When asked about PSA testing, discuss the potential benefits, limitations and harms as part of shared decision-making.
- Signpost to our **Understanding the PSA test** leaflet which covers the challenges when using PSA to screen for prostate cancer and the benefits and harms of PSA testing to support informed choice.
- For men aged over 80, AMRC guidance advises that PSA testing should generally only be considered where there are signs of metastatic disease.

Private tests

- Established NHS assessment criteria should inform your decision-making. Use position statements on private **genetic** or **PSA** tests to inform your management.

Find further information and advice in the full **UKCGG prostate family history advice.**