Appendix 2 – Delphi survey results

Method

A web-based Delphi panel is an anonymous group technique, designed to gather individual opinions from experts and transform these into a group consensus (1). A Delphi panel was conducted to form consensus recommendations in relation to PSA testing in asymptomatic men, in areas where high quality, published evidence was lacking.

Statements for round 1 of the survey were based on international guidance from the:

Canadian Taskforce (2), Prostate Cancer Foundation of Australia/Cancer Council Australia (3), Melbourne Consensus Statement on the early detection of prostate cancer (4), NHS Prostate Cancer Risk Management Programme (5), U.S. Preventive Services Task Force (6), European Association of Urology (7), American Urological Association (8) and National Comprehensive Cancer Network (9).

Delphi participants were invited into the process through a mailshot using the following Binley's databases for the UK: 'Hospital Doctors within Urology Oncology specialty', 'Specialist Nurses within Urology Oncology specialty', 'GP Practice Managers' and 'CCG Clinical Leads'. Emails were also sent to all the HCPs in our own internal database.

The web-based Delphi process comprised three questionnaire rounds, which were delivered via the Survey Monkey® platform. Consensus in the responses was defined as an agreement of at least 70% from the respondents (after excluding the 'I'm not qualified to answer this question' responses). After each round, any questions that achieved consensus were removed from the next survey round. In cases where consensus was not gained, statement refinement was completed using information from the free-text comments provided by Delphi participants and input from the Steering Group. The free-text comments from Delphi participants were also used to generate additional questions for inclusion in subsequent survey rounds.

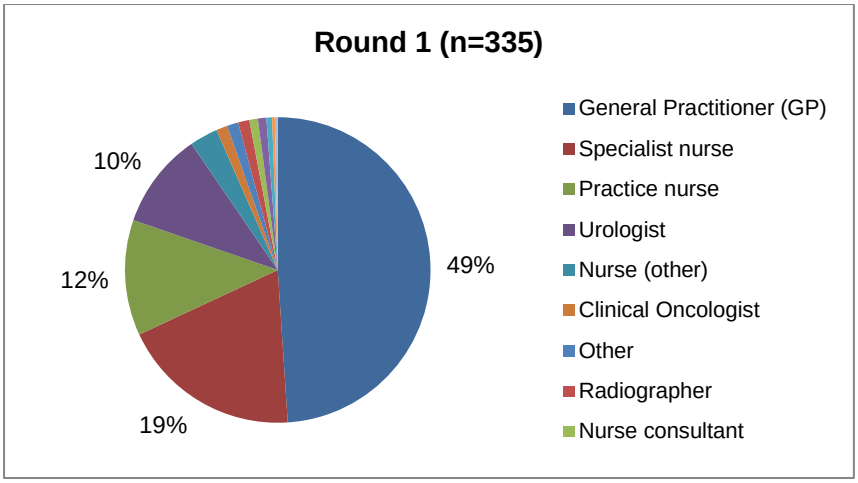
Following round 3, the resulting draft statements were discussed at the Steering Group meeting in April 2015. Following additional feedback over email from those Steering Group members who could not attend the meeting, the final statements were agreed.

Survey reference

Prostate Cancer UK. Prostate Cancer UK Delphi survey - Achieving a clinical consensus on PSA testing practice in the UK. Total sample size was 335 UK HCPs in Round 1, 121 in Round 2 and 83 in Round 3. Fieldwork was undertaken between March and April 2015. 2015.

Stage I – Delphi survey

Round I results



Topic 1 - UK population-wide screening programme

Statement 1: The PSA test alone should be used in a UK population-wide screening programme.	Count of RespondentID	Sum of RespondentID2
Agree	40	12%
Disagree	233	72%
Neutral (neither agree nor disagree)	51	16%
Grand Total	324	100%

Statement 2: The PSA test alone should be used in a UK population-wide screening programme for men within a defined age range. [If required, the age range will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	95	30%
Disagree	173	54%
Neutral (neither agree nor disagree)	53	17%
Grand Total	321	100%

Statement 3: The PSA test alone should be used in a UK population-wide screening programme for men of Black ethnicity within a defined age range. [If required, the age range will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	71	24%
Disagree	144	49%
Neutral (neither agree nor disagree)	79	27%
Grand Total	294	100%

Statement 4: The PSA test alone should be used in a UK population-wide screening programme for men with a family history of prostate cancer within a defined age range. [If required, the age range will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	169	53%
Disagree	96	30%
Neutral (neither agree nor disagree)	55	17%
Grand Total	320	100%

Topic 2 - Discussions about PSA testing

Responsibility for initiating discussions

Statement 1: The PSA test should only be offered to men with prostate cancer symptoms	Count of RespondentID	Sum of RespondentID2
Agree	92	29%
Disagree	202	63%
Neutral (neither agree nor disagree)	28	9%
Grand Total	322	100%

Statement 2: GPs should only discuss prostate health and the PSA test with asymptomatic men who raise the issue themselves.	Count of RespondentID	Sum of RespondentID2
Agree	90	28%
Disagree	189	58%
Neutral (neither agree nor disagree)	47	14%
Grand Total	326	100%

Statement 3: The issue of prostate health should be proactively discussed with asymptomatic men over 50 in a primary care setting.	Count of RespondentID	Sum of RespondentID2
Agree	212	65%
Disagree	75	23%
Neutral (neither agree nor disagree)	40	12%
Grand Total	327	100%

Statement 4: The issue of prostate health should be proactively discussed with men over the age of 50 at higher than average risk of prostate cancer due to Black ethnicity in a primary care setting.	Count of RespondentID	Sum of RespondentID2
Agree	230	74%
Disagree	33	11%
Neutral (neither agree nor disagree)	47	15%
Grand Total	310	100%

Statement 5: The issue of prostate health should be proactively discussed with men over the age of 50 at higher than average risk of prostate cancer due to a family history of prostate cancer	Count of RespondentID	Sum of RespondentID2
Agree	264	81%
Disagree	22	7%
Neutral (neither agree nor disagree)	40	12%
Grand Total	326	100%

Awareness raising

Statement 1: There is a need to raise awareness of prostate health and prostate cancer risk factors amongst men in the UK.	Count of RespondentID	Sum of RespondentID2
Agree	246	76%
Disagree	38	12%
Neutral (neither agree nor disagree)	41	13%
Grand Total	325	100%

Statement 2: Responsibility for raising awareness should primarily be the responsibility of (select one):	Count of RespondentID	Sum of RespondentID2
Charities	8	3%
GPs	39	12%
No-one, as awareness raising is not necessary	23	7%
Other (please specify below)	23	7%
The Government/Public Health Agencies	226	71%
Grand Total	319	100%

Topic 3 - Testing and referral

Age to being and end PSA testing

Statement 1: From what age should asymptomatic men (at average risk) be able to have a PSA test on the NHS, provided they have had a discussion about the pros and cons with a GP? (select one):	Count of RespondentID	Sum of RespondentID2
Age 40	61	20%
Age 45	42	14%
Age 50	124	41%
Age 55	33	11%
Not at all	25	8%
Other (please specify below)	19	6%
Grand Total	304	100%

Statement 2: Men at higher than average risk of prostate cancer due to Black ethnicity should be able to have a PSA test at a younger age than men of other ethnicities. [If required, the age will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	176	63%
Disagree	38	14%
Neutral (neither agree nor disagree)	67	24%
Grand Total	281	100%

Statement 3: Men at higher than average risk due to a family history of prostate cancer should be able to have a PSA test at a younger age than men with no family history of prostate cancer.	Count of RespondentID	Sum of RespondentID2
Agree	212	70%
Disagree	32	11%
Neutral (neither agree nor disagree)	58	19%
Grand Total	302	100%

Statement 4: Men beyond a defined age should not have a PSA test. [If required, the age will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	96	31%
Disagree	148	48%
Neutral (neither agree nor disagree)	66	21%
Grand Total	310	100%

Statement 5: Men with a life expectancy below a defined limit should not have a PSA test. [If required, the limit will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	126	41%
Disagree	116	38%
Neutral (neither agree nor disagree)	63	21%
Grand Total	305	100%

PSA referral values

Statement 1: The PSA values that trigger referral to secondary care for further investigations should be different for men in different age bands. [If required, the values will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	236	86%
Disagree	18	7%
Neutral (neither agree nor disagree)	22	8%
Grand Total	276	100%

Statement 2: The PSA values that trigger referral to secondary care for further investigations should be different for men at higher than average risk of prostate cancer due to Black ethnicity	Count of RespondentID	Sum of RespondentID2
Agree	117	47%
Disagree	70	28%
Neutral (neither agree nor disagree)	61	25%
Grand Total	248	100%

Statement 3: The PSA values that trigger referral to secondary care for further investigations should be different for men at higher than average risk of prostate cancer due to a family histor	Count of RespondentID	Sum of RespondentID2
Agree	114	45%
Disagree	80	31%
Neutral (neither agree nor disagree)	60	24%
Grand Total	254	100%

Statement 4: For men aged 40-49 who do receive a PSA test, what value should trigger referral to secondary care for further investigations? (select one):	Count of RespondentID	Sum of RespondentID2
> 5.0 ng/ml	20	11%
≥ 4.0 ng/ml	16	8%
≥ 3.0 ng/ml	81	43%
≥ 2.0 ng/ml	51	27%
The threshold should be set at a value less than 2.0ng/ml	8	4%
Other (please specify below)	12	6%
Men under the age of 50 should never be referred for further investigations for prostate cancer	1	1%
Grand Total	189	100%

Repeat PSA testing

Statement 1: All men should be able to request a repeat PSA test at a later date if their initial test result is below the referral threshold for their age. [If required, the frequency will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	201	68%
Disagree	48	16%
Neutral (neither agree nor disagree)	46	16%
Grand Total	295	100%

Statement 2: Men should be offered a repeat PSA test after a set period of time if their PSA value is slightly below their referral threshold. [If required, the frequency and value will be	Count of RespondentID	Sum of RespondentID2
Agree	192	66%
Disagree	44	15%
Neutral (neither agree nor disagree)	54	19%
Grand Total	290	100%

Statement 3: Repeat PSA testing should only be offered to men up to a defined maximum age or minimum life expectancy. [If required, the limit will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	119	40%
Disagree	112	38%
Neutral (neither agree nor disagree)	64	22%
Grand Total	295	100%

Statement 4: Repeat PSA testing should only be offered to men at higher than average risk of prostate cancer due to Black ethnicity.	Count of RespondentID	Sum of RespondentID2
Agree	39	14%
Disagree	191	67%
Neutral (neither agree nor disagree)	55	19%
Grand Total	285	100%

Statement 5: Repeat PSA testing should only be offered to men at higher than average risk of prostate cancer due to a family history of prostate cancer.	Count of RespondentID	Sum of RespondentID2
Agree	47	16%
Disagree	193	66%
Neutral (neither agree nor disagree)	52	18%
Grand Total	292	100%

Additional analyses

Statement 1: There is a role for the use of PSA dynamics (changes in PSA level over time) in addition to total PSA in determining whether to refer men to secondary care. [If required, the s	Count of RespondentID	Sum of RespondentID2
Agree	213	87%
Disagree	9	4%
Neutral (neither agree nor disagree)	22	9%
Grand Total	244	100%

Statement 2: There is a role for the use of free-to-total PSA ratio in addition to total PSA in determining whether to refer men to secondary care. [If required, the specific details will be explored in Round 2 of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	79	52%
Disagree	27	18%
Neutral (neither agree nor disagree)	45	30%
Grand Total	151	100%

Topic 4 - Role of the digital rectal examination (DRE)

Statement 1: The DRE should be used as a routine test in the primary care setting.	Count of RespondentID	Sum of RespondentID2
Agree	187	66%
Disagree	54	19%
Neutral (neither agree nor disagree)	41	15%
Grand Total	282	100%

Statement 2: The DRE should be offered in primary care alongside a PSA test to all asymptomatic men who have decided to have a PSA test following a discussion about the pros and cons.	Count of RespondentID	Sum of RespondentID2
Agree	209	74%
Disagree	46	16%
Neutral (neither agree nor disagree)	29	10%
Grand Total	284	100%

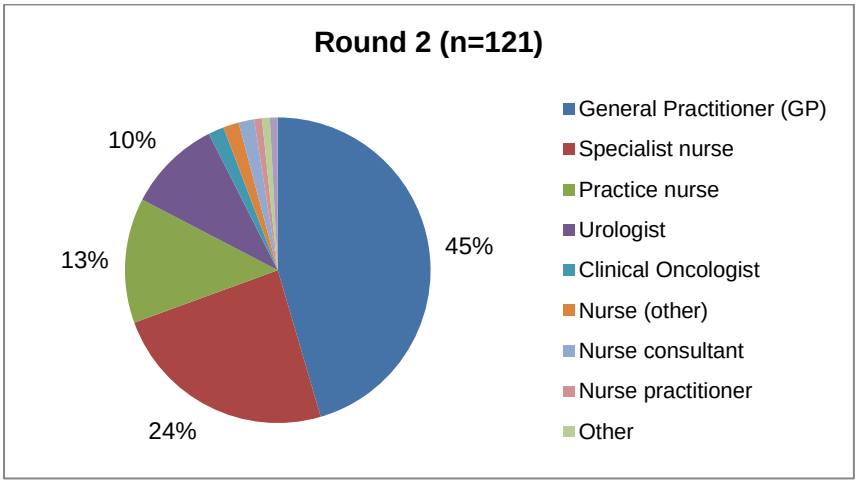
Statement 3: The DRE should only be offered in primary care to men with an elevated PSA level to inform the decision about whether to refer to secondary care for further investigations.	Count of RespondentID	Sum of RespondentID2
Agree	62	22%
Disagree	189	66%
Neutral (neither agree nor disagree)	34	12%
Grand Total	285	100%

Topic 5 - Future directions

Statement 1: A man's PSA level should be built into a validated risk assessment tool, alongside other known risk factors, to better assess a man's risk of prostate cancer.	Count of RespondentID	Sum of RespondentID2
Agree	250	87%
Disagree	10	3%
Neutral (neither agree nor disagree)	26	9%
Grand Total	286	100%

Statement 2: The PSA test should be augmented with other biological and/or genetic markers as soon as they have been independently validated and appraised for cost effectiveness.	Count of RespondentID	Sum of RespondentID2
Agree	189	81%
Disagree	13	6%
Neutral (neither agree nor disagree)	32	14%
Grand Total	234	100%

Round 2 results



Topic 1 - UK population-wide screening programme

Statement 1: The PSA test, combined with the DRE, should be used in a UK population-wide screening programme for ALL men aged 50 and over (including those who are asymptomatic).	Count of RespondentID	Sum of RespondentID2
Agree	23	20%
Disagree	67	58%
Neutral (neither agree nor disagree)	26	22%
Grand Total	116	100%

Statement 2: The PSA test, combined with the DRE, should be used in a UK population-wide screening programme for men aged 50 and over and at higher than average risk of prostate cancer due to Black ethnicity (including those who are asymptomatic).	Count of RespondentID	Sum of RespondentID2
Agree	51	46%
Disagree	35	31%
Neutral (neither agree nor disagree)	26	23%
Grand Total	112	100%

Statement 3: The PSA test, combined with the DRE, should be used in a UK population-wide screening programme for men aged 50 and over and at higher than average risk of prostate cancer due to a family history of prostate cancer (including those who are asymptomatic).	Count of RespondentID	Sum of RespondentID2
Agree	68	59%
Disagree	25	22%
Neutral (neither agree nor disagree)	22	19%
Grand Total	115	100%

Topic 2 - Discussions about PSA testing

Responsibility for initiating discussions

Statement 1: The PSA test should ONLY be offered to men with lower urinary tract symptoms (LUTS).	Count of RespondentID	Sum of RespondentID2
Agree	16	14%
Disagree	92	79%
Neutral (neither agree nor disagree)	8	7%
Grand Total	116	100%

Statement 2: Primary healthcare professionals should ONLY discuss prostate health and the PSA test with asymptomatic men who raise the issue themselves.	Count of RespondentID	Sum of RespondentID2
Agree	23	19%
Disagree	77	65%
Neutral (neither agree nor disagree)	19	16%
Grand Total	119	100%

Statement 3: Primary healthcare professionals should ONLY PROACTIVELY discuss prostate health and the PSA test with asymptomatic men over 50 if they are at higher than average risk of prostate	Count of RespondentID	Sum of RespondentID2
Agree	30	26%
Disagree	72	62%
Neutral (neither agree nor disagree)	14	12%
Grand Total	116	100%

Awareness raising

Statement 1: Governments and public health agencies have primary responsibility for raising awareness of prostate health and prostate cancer risk factors amongst men in the UK, with input from healthcare professionals and charities.	Count of RespondentID	Sum of RespondentID2
Agree	97	82%
Disagree	11	9%
Neutral (neither agree nor disagree)	10	8%
Grand Total	118	100%

Topic 3 - Testing and referral

Age to begin and end PSA testing

Statement 1: Primary healthcare professionals should consider the use of the PSA test for men aged between 45 and 50 at higher than average risk of prostate cancer due to Black ethnicity and/or a family history of prostate cancer.	Count of RespondentID	Sum of RespondentID2
Agree	79	73%
Disagree	14	13%
Neutral (neither agree nor disagree)	15	14%
Grand Total	108	100%

Statement 2: Asymptomatic men beyond a defined age should not be offered a PSA test. [If required, the age will be explored in the third and final round of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	64	58%
Disagree	29	26%
Neutral (neither agree nor disagree)	17	15%
Grand Total	110	100%

Statement 3: Asymptomatic men with a life expectancy below a defined limit should not be offered a PSA test. [If required, the limit will be explored in the third and final round of	Count of RespondentID	Sum of RespondentID2
Agree	71	61%
Disagree	22	19%
Neutral (neither agree nor disagree)	23	20%
Grand Total	116	100%

PSA referral values

For reference, the Prostate Cancer Risk Management Programme (PCRMP) currently provides the following PSA referral values for all asymptomatic men:

Age 49 and below: no guidance provided as men below 50 are not covered by the PCRMP

Age 50-59: ≥ 3.0ng/ml

Age 60-69: ≥ 4.0ng/ml

Age 70 and over: > 5.0ng/ml

Statement 1: Asymptomatic age-specific PSA referral values (see above) should be the same for all men (regardless of their ethnicity or family history).	Count of RespondentID	Sum of RespondentID2
Agree	37	43%
Disagree	35	41%
Neutral (neither agree nor disagree)	14	16%
Grand Total	86	100%

Statement 2: Amendment of the guidance to include an appropriate PSA referral value for asymptomatic men under the age of 50 would be useful for healthcare professionals.	Count of RespondentID	Sum of RespondentID2
Agree	84	76%
Disagree	12	11%
Neutral (neither agree nor disagree)	14	13%
Grand Total	110	100%

Repeat PSA testing

Statement 1: ALL asymptomatic men should be able to have a repeat PSA test after a DEFINED PERIOD OF TIME if their initial PSA value was below their age-specific referral threshold, provided they have had a discussion with a healthcare professional about the pros and cons. [If required, the defined period of time will be explored in the final round of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	76	67%
Disagree	24	21%
Neutral (neither agree nor disagree)	13	12%
Grand Total	113	100%

Statement 2: ONLY asymptomatic men at higher than average risk of prostate cancer (due to Black ethnicity and/or family history) should be able to have a repeat PSA test after a DEFINED PERIOD OF TIME if their initial PSA value was below their age-specific referral threshold, provided they have had a discussion with a healthcare professional about the pros and cons. [If required, the defined period of time will be explored in the final round of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	18	16%
Disagree	71	64%
Neutral (neither agree nor disagree)	22	20%
Grand Total	111	100%

Statement 3: ONLY men with an initial PSA value below their age-specific referral threshold whose circumstances change (e.g. start to develop symptoms) should be able to have a repeat PSA test, provided they have had a discussion with a healthcare professional about the pros and cons.	Count of RespondentID	Sum of RespondentID2
Agree	31	27%
Disagree	69	61%
Neutral (neither agree nor disagree)	14	12%
Grand Total	114	100%

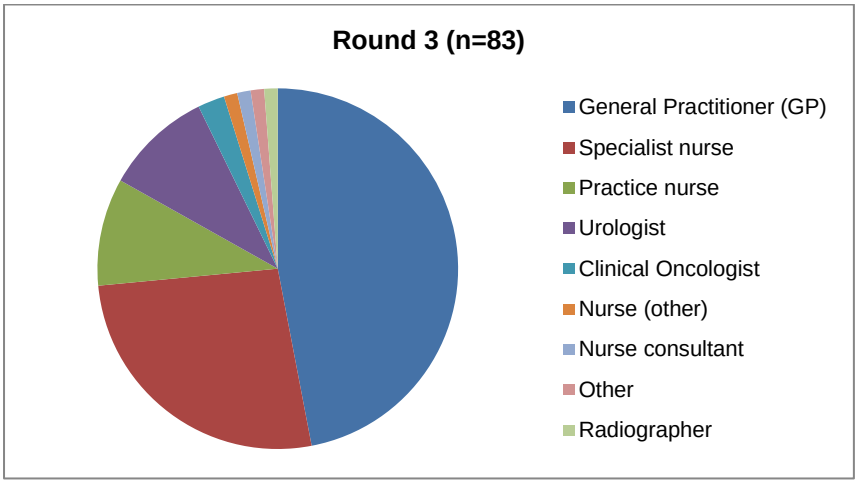
Statement 4: Repeat PSA testing should ONLY be offered to asymptomatic men up to a defined maximum age or minimum life expectancy. [If required, the limits will be explored in the final round of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	63	56%
Disagree	30	27%
Neutral (neither agree nor disagree)	19	17%
Grand Total	112	100%

Additional analyses

Statement 1: If an asymptomatic man's total PSA level is below their age-specific referral threshold, certain changes in the man's PSA level over time (doubling time) are sufficient to initiate a referral to secondary care. [If required, the changes will be explored in the final round of the survey]	Count of RespondentID	Sum of RespondentID2
Agree	65	68%
Disagree	12	12%
Neutral (neither agree nor disagree)	19	20%
Grand Total	96	100%

Statement 2: More evidence is needed before free-to-total PSA ratio should be used, in addition to total PSA, in determining whether to refer men to secondary care.	Count of RespondentID	Sum of RespondentID2
Agree	58	84%
Disagree	5	7%
Neutral (neither agree nor disagree)	6	9%
Grand Total	69	100%

Round 3 results



Topic 1 - Discussions about PSA testing

Responsibility for initiating discussions

Statement 1: Primary healthcare professionals should NOT PROACTIVELY discuss prostate health and the PSA test with asymptomatic men over 50 UNLESS they are at higher than average risk of prostate cancer due to Black ethnicity and/or a family history of prostate cancer.	Count of RespondentID	Sum of RespondentID2
Agree	28	34%
Disagree	40	48%
Neutral (neither agree nor disagree)	15	18%
Grand Total	83	100%

Topic 2 - Testing and referral

Statement 1: Asymptomatic men should not be offered a PSA test if they are unlikely to live another (choose one):	Count of RespondentID	Sum of RespondentID2
20 years	1	1%
15 years	4	5%
10 years	25	32%
7 years	7	9%
Other amount (please specify below)	7	9%
I disagree - life expectancy should not be a factor	35	44%
Grand Total	79	100%

Repeat PSA testing

Statement 1: For men with an initial PSA value below their age-specific referral threshold, a repeat PSA test should ONLY be offered when their circumstances change (e.g. start to develop symptoms suggestive of prostate cancer).	Count of RespondentID	Sum of RespondentID2
Agree	26	35%
Disagree	36	49%
Neutral (neither agree nor disagree)	12	16%
Grand Total	74	100%

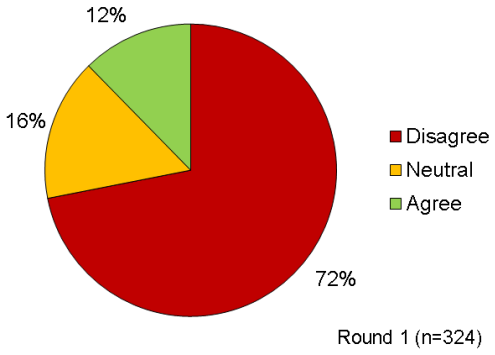
Statement 2: ALL asymptomatic men over the age of 50 whose initial PSA value was below their age-specific referral threshold, provided they have had a discussion with a healthcare professional about the pros and cons, should be offered a repeat PSA test (choose one):	Count of RespondentID	Sum of RespondentID2
Every year	16	23%
Every two years	10	14%
Every three years	16	23%
I disagree - they should not be offered a repeat PSA test	27	39%
Grand Total	69	100%

Statement 3: For an asymptomatic man who has a repeat PSA test (when previous test(s) showed a PSA level below his age-specific referral threshold), referral to secondary care should ONLY be triggered when his PSA level rises above his age-specific referral threshold (i.e. changes in PSA velocity/doubling time should NOT be taken into account).	Count of RespondentID	Sum of RespondentID2
Agree	18	30%
Disagree	33	55%
Neutral (neither agree nor disagree)	9	15%
Grand Total	60	100%

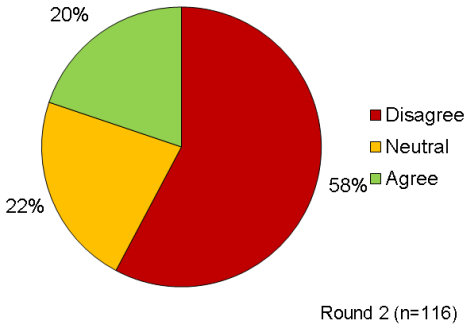
Stage 2 - Draft statements discussed by the Steering Group (with relevant Delphi survey results)

Statement 1: The PSA test, even when combined with the DRE, should not be used in a UK population-wide screening programme for asymptomatic men over 50.

The PSA test alone should be used in a UK population-wide screening programme:

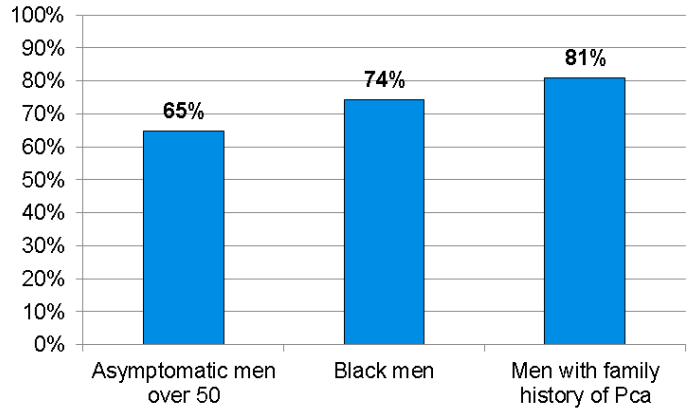


The PSA test, combined with the DRE, should be used in a UK population-wide screening programme for all men aged 50 and over (including those who are asymptomatic):



Statement 2: Primary healthcare professionals should be having proactive conversations about prostate cancer risk and the PSA test with all asymptomatic men aged over 50 and younger men at higher than average risk of prostate cancer (due to Black ethnicity or a family history of prostate cancer).

The issue of prostate health should be proactively discussed with who in a primary care setting:



% agree, with neutrals included. Round 1 (n=327)

Who thought what for all men over 50?

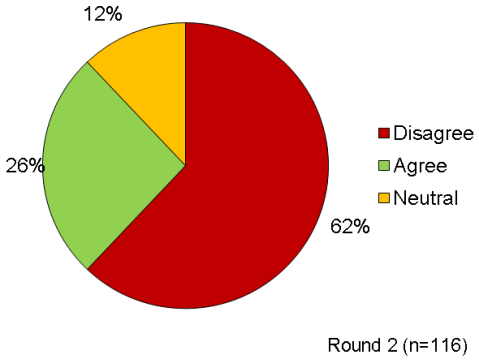
GPs (n=164): 46% agree, 35% disagree, 18% neutral

Practice nurses (n=39): 97% agree, 3% disagree

Urologists (n=34): 62% agree, 24% disagree, 7% neutral

Specialist nurses (n=61): 84% agree, 10% disagree, 7% neutral

Primary healthcare professionals should only proactively discuss prostate health and the PSA test with asymptomatic men over 50 if they are at higher than average risk of prostate cancer due to Black ethnicity and/or a family history of prostate cancer:

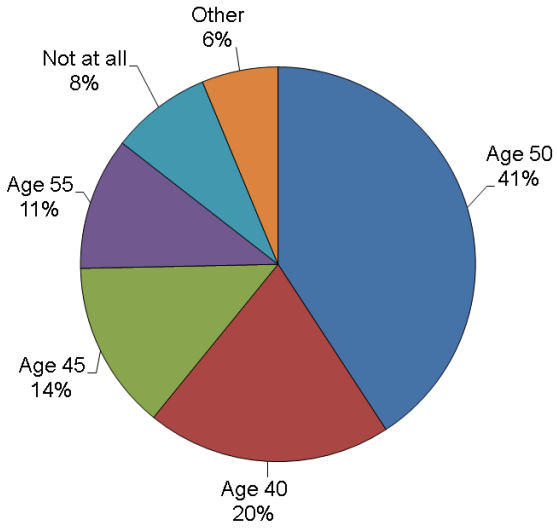


Round 2 (n=116)

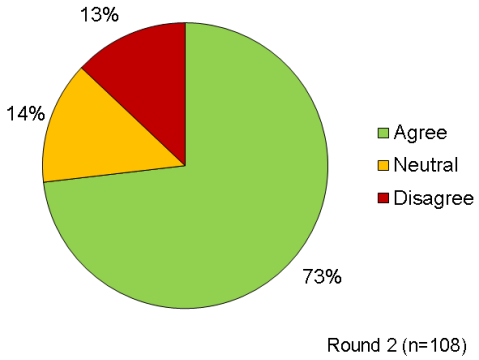
Statement 3: Primary healthcare professionals should provide balanced information on the pros and cons of the PSA test in order to allow the man to make up his own mind on whether to have the test.

Statement 4: All men should be able to access the PSA test from the age of 50, but Black men and men with a family history of prostate cancer should be able to access the PSA test from the age of 45.

From what age should asymptomatic men (at average risk) be able to have a PSA test on the NHS, provided they have had a discussion about the pros and cons with a GP?:

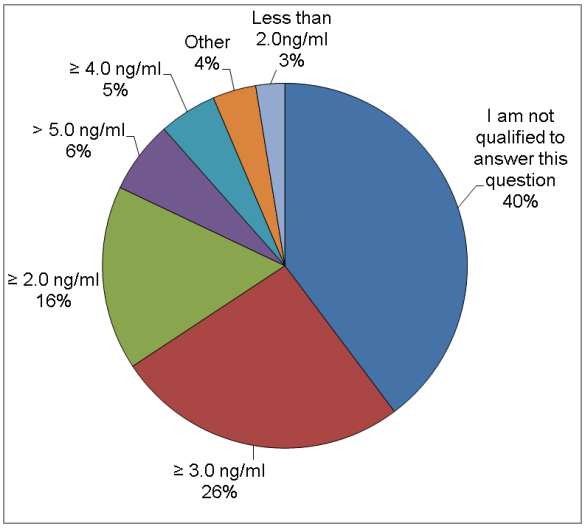


Primary healthcare professionals should consider the use of the PSA test for men aged between 45 and 50 at higher than average risk of prostate cancer due to Black ethnicity and/or a family history of prostate cancer:

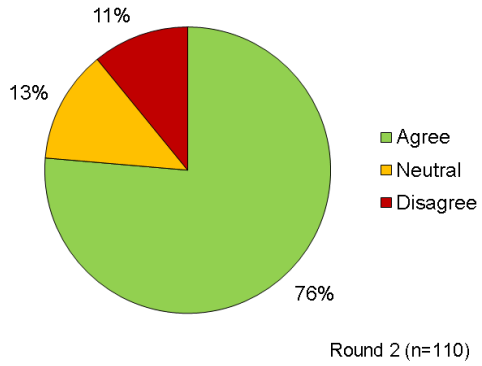


Statement 5: Asymptomatic Black men, and men with a family history of prostate cancer, who are tested between the ages of 45 and 49 should be referred for further investigations if their PSA level is higher than Xng/ml.

For men aged 40-49 who do receive a PSA test, what value should trigger referral to secondary care for further investigations?:



Amendment of the guidance to include an appropriate PSA referral value for asymptomatic men under the age of 50 would be useful for healthcare professionals:



Statement 6: Asymptomatic men over 50 who have a PSA level below the threshold referral value for their age should be recommended to come back for repeat testing every X years.

Current referral values from the PCRMP:

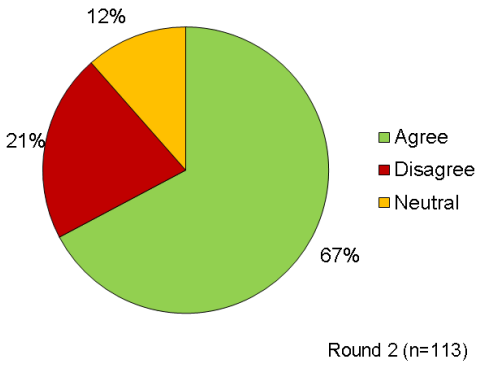
Age 49 and below: no guidance provided as men below 50 are not covered by the PCRMP

Age 50-59: ≥ 3.0ng/ml

Age 60-69: ≥ 4.0ng/ml

Age 70 and over: > 5.0ng/ml

All asymptomatic men should be able to have a repeat PSA test after a defined period of time if their initial PSA value was below their age-specific referral threshold, provided they have had a discussion with a healthcare professional about the pros and cons:

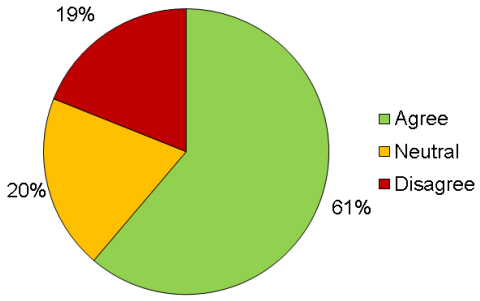


Round 2 (n=113)

Statement 7: Asymptomatic men should consider a "baseline" PSA test between the ages of 45 and 49. Men with a PSA level of Xng/ml should have a repeat test after X years.

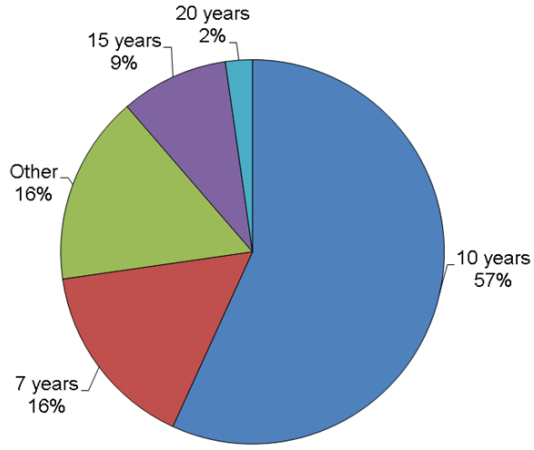
Statement 8: Asymptomatic men whose life expectancy is less than 10 years should not be offered an initial or repeat PSA test

Asymptomatic men with a life expectancy below a defined limit should not be offered a PSA test:



Round 2 (n=116)

Asymptomatic men should not be offered a PSA test if they are unlikely to live another:



Round 3 (n=44)

Statement 9: GPs should offer a DRE to all asymptomatic men who have decided to have a PSA test following a discussion about the pros and cons.

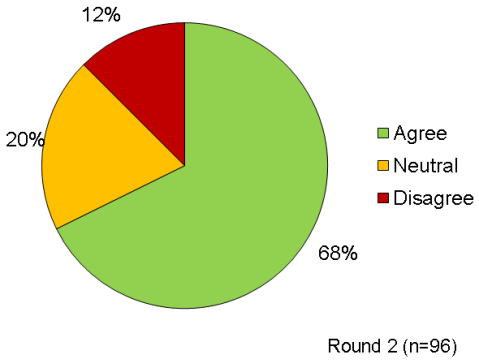
- Consensus reached (72% agreed)

Statement 10: Free-to-total PSA ratio should not be used to guide referral decisions.

- 50% “I’m not qualified to answer” when asked if it should be used to guide referral decisions (Round 1, n=304)
- 84% agreed more evidence is needed (Round 2, n=69)

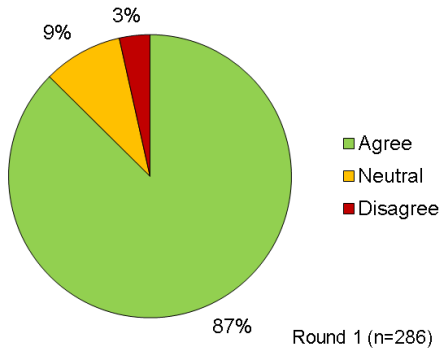
Statement 11: PSA velocity should be used to guide referral decisions.

If an asymptomatic man’s total PSA level is below their age-specific referral threshold, certain changes in the man’s PSA level over time (doubling time) are sufficient to initiate a referral to secondary care:

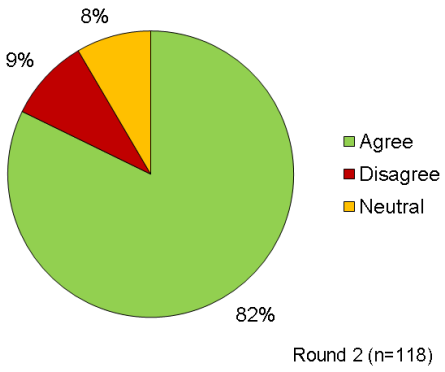


Round 2 (n=96)

Statement 12: A man's PSA level should be built into a validated risk assessment tool alongside other known risk factors to better assess a man's risk of prostate cancer and aid in the decision-making process.



Statement 13: Governments and public health agencies have primary responsibility for raising awareness of prostate health and prostate cancer risk factors amongst men in the UK, with input from healthcare professionals and charities.



Stage 3 - Final statements

Following additional feedback over email from those Steering Group members who could not attend the meeting, the final statements were agreed.

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