EARLY DIAGNOSIS AND SCREENING FOR PROSTATE CANCER

A Practical Solution to the Screening Conundrum

The facts are well known. In the UK 63,000 men are diagnosed with prostate cancer (PCa) every year. Almost half have late stage, incurable cancer at presentation which largely accounts for an annual 13,000 death toll and high mortality rate compared with other European countries.

In 2022, on the basis of scientific evidence, the EU Council accepted the case for PCa screening and EU countries are pushing ahead with national screening projects.

Meanwhile, in the face of mounting evidence, the UK National Screening Committee (NSC) has again rejected a national screening programme for disputed and highly controversial reasons.

How on earth have we arrived at this position?

In November 2025 the NSC eventually reviewed a range of screening proposals originally submitted in December 2022, but recommended screening **only** men carrying BRCA gene variants…

… estimated at 3 in 1,000 compared with 1 in 8 white men and 1 in 4 black men or men with a family history!

A public consultation followed but due to the furore surrounding this recommendation, the Secretary of State Wes Streeting held a round table meeting of experts and stakeholders in January 2026.

The criticisms made were:

1. Prostate Cancer Research commissioned the experienced York Health Economics Consortium (YHEC) to run an appraisal of the Sheffield Centre for Health and Related Research (SCHARR) Report upon which the NSC based its controversial recommendation. YHEC rated the SCHARR Report "*not fit for purpose*" due to reliance on outdated data, flawed modelling and insufficient clinical input.

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2. High risk black men and men with a family history were ignored.
3. The current problems around opportunistic and inappropriate PSA testing were ignored.
4. The TRANSFORM trial will take too long to report.

The meeting concluded with an informal vote on whether to introduce population-based screening. There was a small majority against.

May '26: NSC publishes final screening recommendations:

1. Screening for men with BRCA gene variants.
2. Black men now to be included in TRANSFORM trial – no doubt a response to the inequity furore during the public consultation.

- June '26: New S of S announces acceptance of the NSC recommendation.

This precipitate decision leaves the following problems:

- Failure to address the chaos and inequity surrounding random, "opportunistic" PSA testing that is inefficient, costly, un-programmed and does not significantly lower our high PCa death rate. The vacuum created by refusal of many GPs to provide PSA tests is being filled with off-the-shelf PSA kits of unproven efficacy and available to anyone, whether appropriate or not.

- Failure to deal with an estimated 25% inappropriate urgent suspected PCa referrals to Secondary Care creating backlogs for MRI scans and appointments. Currently, a third of men seeking PSA tests for PCa screening actually have untreated benign prostatic obstruction (BPO) that requires investigation and treatment down an entirely separate pathway from asymptomatic men who require PCa screening.

The status quo is unacceptable. We cannot allow introduction of successful screening alternatives to be stifled waiting for the TRANSFORM trial, with no guarantee of success, while men die unnecessarily every year.

The separation of Primary from Secondary Care prevents an integrated pathway management of prostatic disease.

However, the new Community Diagnostic Hubs provide an opportunity to introduce community-based, front-line diagnostics and integrated care pathways for prostatic disease with the following advantages:

- Community-based investigation and management of symptomatic men most likely suffering from BPO by urological clinical nurse specialists.
- Access to risk-based, programmed PCa screening **only** for eligible men who have been fully counselled on the pros and cons of screening.

Successful implementation of this was achieved over 20 years ago by a number of urology departments under an NHS Modernisation Agency programme and the

benefits were numerous.

This rationalisation of pathways and reduction in service variation with appropriate care being provided in the appropriate place by the appropriate healthcare professional now provides a real opportunity for a major improvement in a substantial area of suboptimal care.

The concept is supported in outline by both the British Association of Urological Surgeons and the British Association of Urological Nurses, the two organisations with the expertise essential for a resource-based, phased implementation.

In conclusion, we should not be delaying in pursuit of further trial evidence but implementing a solution that will prevent unnecessary deaths now.

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