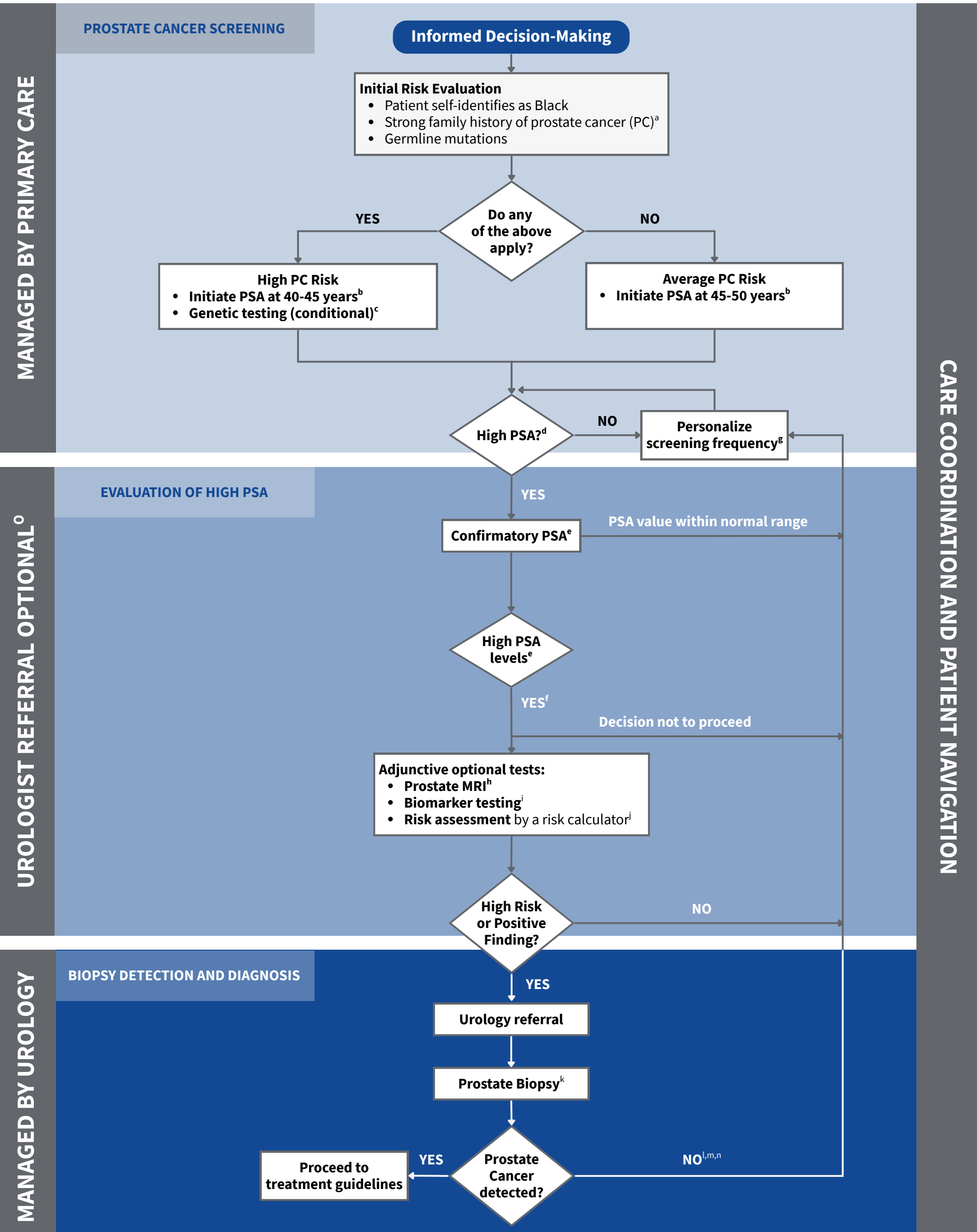
Prostate Cancer Screening and Diagnosis Workflow

This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support primary care clinicians in conducting prostate cancer screening. This flowchart illustrates a typical clinic workflow for prostate cancer screening and follow-up, highlighting key decision points around risk assessment, screening, evaluation of high PSA, urologist referral, and biopsy decision. The screening goal is the detection of clinically significant prostate cancer [Grade Group 2 or higher (GG2+)].[1]

See the digital toolkit for more prostate cancer screening resources.



Footnotes

a Patients with a strong family history (a first-degree relative diagnosed with PC before age 65, or multiple first-degree relatives diagnosed with prostate, breast, or ovarian cancer) of PC should ideally be genotyped to determine whether this is associated with a pathogenic variant.[1]

b American Cancer Society (ACS) recommends biannual screening of individuals at average risk from ages 50-69, and annual screening of individuals at high risk from ages 45-69.[2] The United States Preventive Services Task Force (USPSTF) recommends individualized decision-making for patients aged 55–69 years (Grade C).[3]

c Patients with a family history suggestive of hereditary cancer should undergo genetic testing. If there is a known or suspected cancer susceptibility gene, referral to a cancer genetic counselor may be considered.

d Increased PSA is based on laboratory, prostate size, and age median values.[1] ACS defines abnormal PSA as 3 ng/mL or higher for men less than 70 years of age, and 6.5 ng/mL or higher for men ages 70-74.[2]

e Consider DRE as an optional complementary test.

f Informed decision making should accompany the biopsy decision. Patients should be advised that a biopsy may detect low-mortality prostate cancers that can be safely managed with active surveillance rather than immediate treatment.

g Clinicians may repeat PSA every 2-4 years (ages 50-69), personalize the screening frequency, or decide to discontinue screening, based on patient preference, age, PSA, prostate cancer risk, life expectancy, and general health following SDM.[1] Patients with no high-risk factors may lengthen the rescreening interval or discontinue screening based on SDM.[1] The USPSTF advises against PSA screening in patients ≥70 years (Grade D),[3] while the ACS guideline recommends individualized screening plans for older patients based on life expectancy.[2]

h Evidence shows that mpMRI improves detection of clinically significant prostate cancer while reducing identification of non-significant disease, an effect especially notable after a prior negative biopsy.[4] We recommend an mpMRI to aid biopsy decision.

i Urine and serum biomarkers may be used for further risk stratification when the results could influence the decision to perform a biopsy, typically in patients with a PSA between 2.5 ng/mL and 10 ng/mL and no clinical or laboratory data suggesting clear low or high-risk disease.[4]

j Some tools are used to calculate the risk of clinically significant prostate cancer (GG2+). Risk calculators may include PSA, %free PSA, other biomarkers, PI-RADS, DRE, age, race, and family history, among other features. The AUA/SUO guidelines recommend: PCPT V2 (https://riskcalc.org/PCPTRC/), Chun (There is no publicly available online calculator for Chun), ERSPC (https://www.prostatecancer-riskcalculator.com/assess-your-risk-of-prostate-cancer), and PBCG (https://riskcalc.org/PBCG/).[4] After a negative biopsy result, risk calculators incorporating biopsy results should be used.[4]

k MRI-guided biopsy approach: Patients with PI-RADS 1-2 and high risk undergo systematic biopsy; PI-RADS ≥3 lesions receive targeted biopsy with optional systematic sampling.

l Further evaluation may be warranted for multifocal high-grade prostatic intraepithelial neoplasia (HGPIN), atypical small acinar proliferation (ASAP), or atypical intraductal proliferation (AIP), whereas isolated focal HGPIN does not require immediate repeat biopsy.[4]

m Screening should not be stopped solely after a negative biopsy.[4]

n PSA alone should not guide repeat biopsy decisions. Risk calculators incorporating PSA, %free PSA, PSA density, age, race, family history, and prior biopsy/MRI may aid in risk assessment.

o Referral thresholds and workflows are system-dependent and should align with local urology capacity and practice agreements.

Abbreviations

- **PC:** prostate cancer
- **PSA:** prostate-specific antigen
- **DRE:** digital rectal examination
- **MRI:** Magnetic Resonance Imaging
- **mpMRI:** Multiparametric MRI

Sources

1. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening. J Urol. 2023;210(1):46-53. doi:10.1097/JU.0000000000003491
2. Hoffman RM, Wolf AMD, Etzioni R, et al. American Cancer Society guideline for the early detection of prostate cancer, 2026. CA Cancer J Clin. 2026; e70112. doi:10.3322/caac.70112.
3. US Preventive Services Task Force.Screening for prostate cancer: US Preventive Services Task Force recommendation statement. JAMA. 2018;319(18):1901-1913. doi:10.1001/jama.2018.3710
4. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part II: Considerations for a Prostate Biopsy. J Urol. 2023;210(1):54-63. doi:10.1097/JU.0000000000003492.

Note: AUA/SUO 2026 updates were considered for the flowchart. Lin DW, Carlsson S, Filson CP, et al. Updates to Early Detection of Prostate Cancer: AUA/SUO Guideline (2026).