Diagnosis and staging

People referred with suspected prostate cancer

- Discuss prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings, co-morbidities, risk factors, history of previous negative prostate biopsy.
- Offer multiparametric MRI as the first-line investigation to people with suspected clinically localised prostate cancer. Report MRI results using a 5-point Likert scale.
- Do not routinely offer imaging to people who are not candidates for radical treatment.
- Consider omitting prostate biopsy for people whose multiparametric-MRI Likert score is 1 or 2, but only after discussing the risks and benefits with the person and reaching a shared decision.
- Give people information, support and adequate time to make a decision. Explain the risks and benefits of biopsy.
- Do not automatically offer prostate biopsy on the basis of serum PSA level alone.
- Do not offer prostate biopsy for confirmation if the clinical suspicion of cancer is high (a high PSA and evidence of bone metastases).

Use nomograms to aid decision making, and help predict biopsy results, pathological stage and risk of treatment failure. Clearly explain the reliability, validity and limitations of the prediction.

Offer isotope bone scans to asymptomatic people on watchful waiting at high risk of developing bone complications.

Decision to proceed with biopsy
Offer multiparametric-MRI influenced prostate biopsy to:
- people whose multiparametric-MRI Likert score is 3 or more, or
- people who have lower scores and have opted for biopsy.
Only offer mapping transperineal template biopsy as part of a clinical trial.

Positive initial biopsy

- Use nomograms to aid decision making, and help predict biopsy results, pathological stage and risk of treatment failure. Clearly explain the reliability, validity and limitations of the prediction.

Repeat PSA in 3–6 months and
- offer prostate biopsy if the index of suspicion is still high
- discharge the person to primary care with advice for follow up if the level of suspicion is low

Negative initial biopsy

- Advise there is still a risk that prostate cancer is present.
- Advise the risk is slightly higher if biopsy showed High-grade prostatic intraepithelial neoplasia (HGPIN), biopsy showed atypical small acinar proliferation (ASAP), abnormal DRE.
- If there is concern after negative biopsy, discuss in MDT meeting with a view to repeating biopsy.

For people who have a raised PSA, Likert 1 or 2 and negative biopsy, repeat PSA at 3–6 months and:
- Offer repeat biopsy if there is strong suspicion of prostate cancer.
- Discharge the person to primary care if the level of suspicion is low.

Positive rebiopsy

- Do not routinely offer isotope bone scans to people with low risk localised prostate cancer.
- Do not offer CT of the pelvis to people with low or intermediate risk localised disease.
- Do not offer PET for prostate cancer in routine clinical practice.

No radical treatment intent

Radical treatment intent

Offer multiparametric MRI as the first-line investigation to people with suspected clinically localised prostate cancer. Report MRI results using a 5-point Likert scale.