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May 20, 2018

Alex H. Krist, MD, MPH
Vice Chairperson, U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Dear Dr. Krist,

On behalf of the more than 15,000 urologists, more than 200 physician assistants and 600 nurse practitioners in urology, more than 2,000 urologic nurses and associates, and hundreds of thousands of individuals impacted by prostate cancer in the United States, as well as the overwhelming majority of American men who might be at risk of developing prostate cancer, we are pleased to provide comments and feedback on the U.S. Preventive Services Task Force's (USPSTF) "Final Recommendation Statement: Prostate Cancer Screening."

The American Urological Association (AUA) and the undersigned organizations in the urologic community commend the USPSTF on the revised Recommendation Grade of C for men age 55-69 years, which recognizes the need for an individualized approach to screening, and draws from the established evidence regarding PSA screening. From a public health perspective, the acknowledgment that men age 55-69 years should make individualized decisions based on their risk factors and discuss the benefits and risks of screening with their health care providers reflects the appropriate importance of shared decision making in this context. Furthermore, the inclusion of African American men and those with a family history of prostate cancer as groups at higher risk is to be applauded.

These new recommendations are in alignment with clinical guidance from most major physician groups that advocate for shared decision making in targeted populations, including the American Cancer Society, American College of Physicians, the American Society of Clinical Oncology, the AUA, and the National Comprehensive Cancer Network.

These revised recommendations are in agreement with a large collaborative advocacy effort from the prostate cancer community including patient, physician, and research advocates who united to raise awareness about the need for an individualized screening approach for patients and the need for patients to engage in the shared decision making process.

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While we applaud these recommendations, we feel they could have been further strengthened by acknowledging that an individual patient may make an appropriate decision based not only on his age, but also factoring life expectancy and personal preferences. There is no reason to believe that potential benefits of shared decision making conferred to men age 55-69 years could not also be experienced by those age 70 and above provided they have a potential life expectancy of 15 years or more. The estimation of life expectancy (and thus of potential need for screening) would benefit from consideration of overall health status, including comorbidities, and should not be limited to age. In some cases, men age 70 years and above without comorbidities may have longer life expectancies (15+ years) than younger men with significant comorbidities.

On the lower end of the age scale, we feel that it is reasonable to consider PSA-based screening for prostate cancer in men younger than 55 years. Specifically, for men younger than age 55 years at higher risk (e.g., positive family history or African American race), decisions regarding prostate cancer screening should be individualized.

Once again, we thank you for the opportunity to comment on the final recommendations and hope that the comments above will be considered in order to best serve the many men at risk for prostate cancer.

Sincerely,



J. Brantley Thrasher, MD
President, American Urological Association



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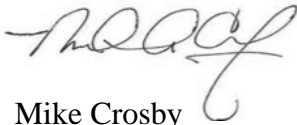
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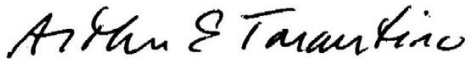
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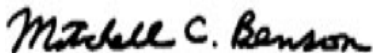
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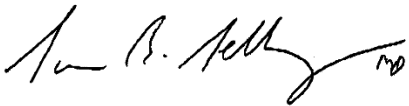
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