PSA Test Counselling Outcome Pathway

Based on Current UK NSC & NICE Clinical Evidence for Every 1,000 Men Aged 50–60 Screened

1. Negative PSA Result (900 Men)

900 out of 1,000 men will receive a normal or low PSA test reading.

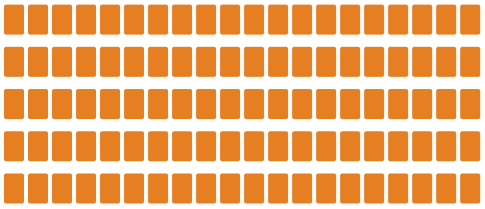
These men do not require an immediate advanced imaging referral.

90% of Screened Cohort (900 Men)

2. Raised PSA Result (100 Men)

100 out of 1,000 men present with a raised PSA reading.

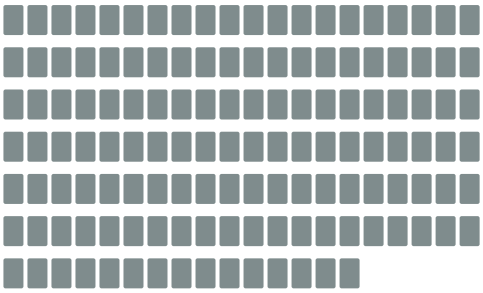
They automatically transition to pre-biopsy advanced triage.



3. False Negative Rate (PSA ≤ 4.0 ng/mL)

In men aged 55+ with PSA ≤ 4.0 ng/mL and a normal DRE, around 15 in 100 may still have prostate cancer.

Out of your 900 negative men, this equates to **135 men** whose cancers remain unpicked up behind conventional markers.



4. Advanced Triage (mpMRI)

From the 100 men with high PSA, modern mpMRI scans verify that **only 34 men** show highly abnormal tissue requiring biopsy.

The alternative 66 men safely avoid needles entirely.

5. Final Cancer Diagnosis

Following target-guided cell extraction, **28 men** are confirmed to possess prostate malignancy.

The remaining 6 men exhibit benign or localized changes.

PSA Test Counselling Outcome Pathway (Continued)

6. Clinical Management Breakdown

10 men choose **Active Surveillance** to monitor low-grade, localized cells safely.

18 men initiate **Radical Treatment** immediately (radical prostatectomy, radiotherapy, etc.).

7. Screening Trade-Off & Balance

Up to 20 men become **Overdiagnosed**. This identifies a harmless tumor that wouldn't have shortened life, resulting in roughly 12 unnecessary interventions.

Up to 2 lives are saved from terminal prostate cancer within the cohort.

Important Note: Treatment side effects can significantly affect quality of life. Almost 20% of men undergoing radical surgery experience long-term urinary incontinence, and 50% experience erectile dysfunction.

Data Sources & Clinical Context:

This modern counseling breakdown incorporates the latest UK clinical evidence updates, replacing legacy direct-to-biopsy pathways. Figures are derived from modeling by the UK National Screening Committee (UK NSC) and Cancer Research UK (CRUK), incorporating critical findings from contemporary multi-center clinical screening trials, including the Göteborg II screening study (Hugosson et al., NEJM), the CAP trial (Martin et al., JAMA), and the 23-year follow-up data from the ERSPC trial (Roobol et al., NEJM).

Educational Disclaimer: This material is created exclusively for clinical training and educational purposes for healthcare practitioners within the Bradford VTS network. It represents generalized statistical modeling compiled in May 2026 based on UK diagnostic guidance and clinical consensus. It does not replace individualized clinical judgement or patient-specific risk factor stratification.