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Editorial

Prostate Cancer Screening in Sri Lanka: Why Clinic-Based Targeting May Be Our Best First Step

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Prostate cancer is a major public health concern worldwide. The latest GLOBOCAN estimates indicate that approximately 1.55 million new cases and 419,849 deaths from prostate cancer occurred globally in 2024. It remains one of the most frequently diagnosed cancers among men and an important cause of cancer-related mortality (1). These figures highlight the need for effective strategies to detect clinically significant prostate cancer at an earlier stage.

In Sri Lanka, 1,226 new cases of prostate cancer were reported in 2022, accounting for 7.6% of male cancers, with an age-standardised incidence rate of 11.1 per 100,000 men (2). Although this reported incidence is lower than the global rate, it may not fully reflect the true disease burden. Differences in awareness, access to diagnostic facilities, and case detection can influence reported figures. This raises an important question: should Sri Lanka introduce a national prostate cancer screening programme, or would a targeted approach to early detection be more appropriate?

Prostate-specific antigen (PSA) testing is the main blood test used for the early detection of prostate cancer. However, PSA is not specific to cancer and may be elevated in benign prostatic enlargement, prostatitis, and other conditions. Screening can identify cancer at an earlier stage, but it may also lead to unnecessary investigations, overdiagnosis, anxiety, and treatment-related complications. Evidence from the European Randomized Study of Screening for Prostate Cancer, with 23 years of follow-up, demonstrated a 13% relative reduction in prostate cancer mortality among men invited for screening. However, approximately 456 men needed to be invited to prevent one prostate cancer death (3). These findings support the potential benefit of screening while emphasising the importance of careful patient selection.

Available Sri Lankan studies suggest that many men present with advanced disease. In one cohort, approximately 60% of patients had metastatic disease, 81% had a PSA level above 20 ng/mL, and only 2% were detected through screening (4). Similarly, a tertiary-centre study from northern Sri Lanka reported metastatic disease at diagnosis in 43.3% of patients, while only 30.5% had localised disease (5). Although these findings may not represent the entire country, they raise concerns about delayed diagnosis and the need to improve access to assessment.

Introducing universal PSA screening without adequate diagnostic and treatment facilities may not be appropriate at present. Limited access to PSA testing in many public-sector settings, the cost of private investigations, restricted availability of multiparametric magnetic resonance imaging (mpMRI), and delays in specialist review and biopsy are important challenges. Increasing PSA testing alone will not solve these problems. Early detection must be supported by timely investigation and access to effective treatment.

A practical first step would be to introduce a structured, risk-based early-detection pathway through selected hospital outpatient surgical departments and lower urinary tract symptom (LUTS) urology clinics. These clinics provide opportunities to assess men who are already seeking medical care. However, LUTS should not be considered a reliable indicator of prostate cancer, as these symptoms are commonly caused by benign prostatic enlargement and other conditions.

Assessment should include age, symptom history, family history of prostate cancer, relevant medical history, and digital rectal examination where appropriate. PSA testing should be offered after discussing its potential benefits, limitations, and consequences with the patient. Men with a strong family history or other recognised risk factors may require assessment at a younger age. Current European Association of Urology guidance supports an individualised, risk-adapted approach to early detection (6). An elevated PSA should not automatically lead to biopsy; repeat testing and further investigations should be guided by the overall clinical risk.

Sri Lanka should establish a prospective multicentre audit involving selected tertiary and provincial hospitals. A standardised data collection system could record the number of men assessed, PSA results, referral patterns, MRI use, biopsy rates, complications, cancer detection rates, tumour grade, stage at diagnosis, treatment received, waiting times, and costs. These findings would help determine whether targeted early detection increases the diagnosis of clinically significant, potentially curable cancer and reduces late presentation. The results could guide decisions on the feasibility, cost-effectiveness, and future expansion of a national programme.

Early detection must be accompanied by equitable access to effective treatment. Sri Lanka needs to strengthen prostate MRI, pathology services, multidisciplinary team discussions, active surveillance, radical prostatectomy, and radiotherapy. The introduction of robotic surgery offers an opportunity to develop surgical expertise and expand treatment options. However, robotic surgery alone cannot address the burden of prostate cancer; appropriate patient selection, trained teams, and access to other evidence-based treatments remain essential.

Sri Lanka needs a more organised approach to prostate cancer early detection, but immediate implementation of universal population-wide screening may not be the best starting point. A structured, risk-based pathway through existing surgical and urology clinics, supported by informed PSA testing and a prospective multicentre audit, would be a practical first step. The findings should guide the development of a sustainable national strategy that balances earlier diagnosis with the risks of overdiagnosis, unnecessary treatment, and unequal access to care. The priority should be to detect clinically significant disease earlier and ensure that every man diagnosed has access to appropriate treatment.

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