Actas Urológicas Españolas. 2011;**35(1)**:15

Actas Urológicas Españolas

www.elsevier.es/actasuro

EDITORIAL COMMENT

Comment to: "Does the criterion for prostate biopsy indication impact its accuracy? A prospective population-based outpatient clinical setting study"

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Today, the most sensitive tool for the early detection of prostate cancer is the serum PSA value; however, its main problem is its lack of specificity in intermediate values (<10 ng/ml). For this reason, alternatives have been proposed (PSA density, PSA velocity, PSA-age ranges, free PSA percentage, etc.) to improve this specificity (to reduce false positives or unnecessary biopsies). The winning alternative would have a sensitivity level as high as that offered by PSA (greater detection of cancers), but with the best possible specificity with respect to the latter. This work is an improvement in diagnostic performance with all the parameters studied, although only the addition of a digital rectal examination proves to provide a superior diagnosis (in terms of predictive value) in the multivariate analysis.[1]

According to literature, the use of derivatives such as the specific PSA ranges for age are limited due to their low sensitivity. The PSA velocity makes it necessary to have at least three separate PSA determinations in time. PSA density is hardly sensitive and precise, as the scan underestimates prostate volume by 23% and there is an intrapatient variability of over 15% As regards the percentage of free PSA, if we want to maintain an acceptable sensitivity level (>90%), we must resign ourselves to a low specificity level (20%). In short, according to literature, it can be said that there is no consistent evidence that any of these measurements improve the diagnostic validity of the PSA value in the early detection of prostate cancer.[2] On the other hand, DRE improves diagnostic performance, although potentially incurable tumours are also detected. In short, we still need tools that improve the diagnostic capacity of PSA for screening prostate cancer.

References

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