The safety and effectiveness of PSA monitoring in primary care following prostate cancer treatment

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Background

- Ageing population and increased prostate cancer diagnoses
  - >47,000 new diagnosis per year
  - 84% expected to live 10 years (CRUK)

- Discharged to GP for monitoring 2 years post treatment (NICE 2014)

- Blood test monitoring for recurrence: Prostate Specific Antigen (PSA)

- Unclear guidance on how it should be monitored (Loblaw et al 2017, Clinical Oncology)

- Yet evidence to suggest re-recurrence rate up to 50% in ‘high risk’ men (James et al 2016, JAMA Oncology)
Background

- 1500 referral annually
- Community based nurse-led follow up
- Discharge to GP at 2 years
- Uncertainty about whether monitoring is taking place
Study Aims

Overall Aim: Identify whether there is a problem with PSA monitoring in primary care and what is contributing to it

Specific Objectives
1. Describe PSA monitoring procedures in primary care
2. Identify barriers and facilitators for safe and effective PSA monitoring
3. Identify characteristics that may impact on engagement with PSA monitoring
4. Act upon shortfalls in effectiveness
Methods

**Phase 1: Retrospective case note review & audit**
- Two CCG areas in Greater Manchester
- Men discharged 2007-2017
  - Review of discharge letter
  - Review of monitoring procedures
- Patient questionnaire
  - Understanding of monitoring
  - Perception of responsibilities & confidence

**Phase 2: Semi-Structured interviews**
- Patients, GPs, Urology oncologists
- Barriers and facilitators to effective monitoring
- Solutions to problem(s)
- Thematic analysis on-going
Results Phase 1

- **N=300** cases reviewed
  - Patients discharged 4m - 16yrs post treatment

- **Disparity amongst discharge letter instructions**
  - No consensus on PSA level for re-referral: 0.1 - 50
  - No level at all in 39% letters
  - Frequency of monitoring: 3m - annual

- **Adherence to discharge letter**
  - 36% PSA monitoring as planned
  - 6% too often
  - 46% Not frequently enough
  - 6% no PSA checked post-discharge
Results – Phase 1

- Hospital data and patient reported experiences differ...
  - 222 questionnaires returned (74% response rate)
  - 90% reported PSA monitoring was as often as it should be
  - 80% identified as feeling “in control” of PSA monitoring
  - 62% had confidence that the GP was monitoring the PSA

- Re-referral
  - 21 patient records illustrated PSA levels over the re-referral threshold
  - 11 were re-referred. 10 weren’t
Results Phase 2

• 14 patients; 5 GPs; 5 oncologists
• Analysis on-going:

**GP** – “We’ve got technical capability on our IT systems to diarise timings of bloods and review appointments and stuff like that so it really should be very straightforward”

**Patient** – “Well, rather than me go and see him I thought that if they want to monitor me they would contact me, which they've never done. But are you saying that I could contact him and ask for a PSA test?”

**Oncologist**, on when the GP should re-refer the patient – “So I suppose it depends a little bit whether they have had surgery prior to radiotherapy or radiotherapy alone, there is a little bit of which day of the week it is and how you feel”
Results Phase 2

GP – “We don’t inform patients of their results routinely. We try to make the onus on the patient to ring and check”

Patient – “And, what happened on one occasion, was I phoned, and said, can you give me the result? And the woman on the phone gave me the result, and she read the wrong number out”

Oncologist – “I think the majority of patients can conduct their own follow ups since they get to know the PSA results and they can understand it”
Implications

• Understanding about who is responsible for monitoring is distorted
• Perceptions about quality of monitoring aren’t realistic
• Monitoring instructions are wildly variable
• Prostate cancer recurrence is potentially being missed
Conclusions and Next Steps

• Explore novel ways to give patients information
• Define roles & responsibilities
• Streamline documentation
• Gain consensus
Any Questions

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