Royal College of General Practitioners and Warwick Medical School
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PRESENTER'S DETAILS Session C. Audits		
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Department or organisation Warwick Medical School		
Category Audit		
Authors **Mr Harvinder Mann** **Miss Philesha Walters** **Mr Omar Ali**	**Title of Study** **Prostate Specific Antigen-How are we performing?**	

What's the problem you are tackling?
Prostate Specific Antigen (PSA) is a glycoprotein enzyme, which is secreted by the epithelial cells of the prostate gland. Clinically blood serum levels of PSA are used as a biomarker for a number of conditions.

It was suggested that PSA levels are used as a screening tool for prostate cancer, with some organisations encouraging regular screening, acting on abnormal PSA levels. However, the PSA test has some limitations, which inhibit it from becoming a National Screening Programme. The first is that detecting prostate cancer may not reduce the chance of dying from prostate cancer. The second and more important reason is that the PSA may give a false positive or false negative result.

However, despite the risk of false positives/false negatives of this test, it is the most reliable current test for this cancer. In 2002, the government launched the Prostate Cancer Risk Management Programme. This set out guidelines for health care professionals to follow in order to allow men to make informed decisions on whether to NICE recommend that when a PSA test is requested, a patient must be counselled on the implications, advantages and disadvantages of the test

It is recommended that this counselling be conducted before a patient accepts and consents to a PSA test to be conducted. However, it is suggested that this may not always occur in practice. A number of reasons are suggested for this, such as lack of time in consultations, lack of knowledge on part of the doctor and the general idea that a PSA test is similar to other blood tests. With many of the PSA tests conducted in general practice, it would be useful to conduct an audit to assess the extent to which this counselling is conducted, and whether any improvements could be made to encourage this guideline to be followed.

How did/will you do it?

Aims of the Audit:

- To assess whether or not counselling is being given to patients before a PSA test is conducted.
- To recommend changes that will help to ensure that the test is carried out after informed consent is obtained.

Standards Measured:

- 100% of patients in whom a PSA is indicated, or where a patient requests a PSA test should be counselled before the test is carried out.
- 100% of the patients should be counselled before each test is conducted, even if they have previously had a PSA test.

Data Collection:

The sample data was collected from the patient database system used by the Brookside Surgery. Data was collected retrospectively by searching for patients with the following inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
• Male patients only • Patients who have had a PSA test conducted within the last 18 months from the data collection date (December 2015). • The first PSA test conducted within the last two years of the data collection date (December 2015)	• PSA test conducted before 18 months previous to December 2015. • Repeat PSA test or PSA test conducted for monitoring purposes • Patients with a current or past history of prostate cancer.

Data Collected for Each Patient:

- Age of the patient
- Date PSA conducted
- The reason for conducting the test
- Whether counselling was offered and documented in the records
- The PSA levels
- The further outcome (if the reading was abnormal)
- Whether patients were taking Finasteride (which can be shown to alter the PSA level).

What did you find?

The results found that there were 75 patients who fell within the inclusion criteria over the time period of June 2014 to December 2015 (inclusive). Out of the 75 patients that were eligible to be considered in the audit, there were 8 patients who were found to have an abnormal PSA level. The reasons for the requisition are outlined in the table below.

The standards to be measured were that 100% of the patients in whom PSA levels were measured, should be counselled in the relevant way before the test is consented for. When analysing the data collected, it was found that of the 75 patients, only 27 patients had recorded in their computerised records, that counselling was provided. This equates to 36% of patients.

When comparing whether those with abnormal PSA levels were counselled. It was found that only 1 of the 8 patients whose results were abnormal, were counselled. The data shows that the standards for PSA counselling were not met in this practice within this time period.

Why does this matter?

The findings indicate that only 36% of patients who underwent a PSA test, when comparing this against the 100% counselling expected by the guidelines, it is clear that there may be two causes to this value. The first is that the counselling is not taking place in all consultations before PSA is tested, or that it is not being recorded. From the eight abnormal PSA tests found in this sample, only one of the patients had been counselled (according to the computerised records). This left seven patients, who had not been counselled, who were left vulnerable to the limitations of the PSA test. This is significant in the delivering of patient care, and the reason these guidelines were introduced.

This gives indication that changes are needed to improve to amount of patients that are being counselled before the PSA test is conducted, and also a record of this counselling should be kept in the notes. Ways in which this could be done is to train GPs/GP trainees to follow the guideline, to monitor each GP on the adherence to this guideline, and to reduce the barriers in conducting this counselling. It would be of value to re-audit this area 18 months after changes have been made.