PROSTATE CANCER EDUCATION COUNCIL
Position Statement | November 2026

PCEC's Position on the American Cancer Society's 2026 Prostate Cancer Screening Guideline

The Prostate Cancer Education Council (PCEC) welcomes the American Cancer Society's (ACS) updated guideline for the early detection of prostate cancer, published November 12, 2026, in CA: A Cancer Journal for Clinicians.

This is the first full update of the ACS guideline since 2010, and the first time ACS has directly recommended regular PSA-based screening. The update reflects stronger evidence that PSA screening reduces prostate cancer mortality and advanced-stage diagnoses, together with advances that can reduce screening-related harms. Long-term results from the European Randomized Study of Screening for Prostate Cancer (ERSPC) showed a relative reduction in prostate cancer deaths of approximately 20%.

For more than three decades, PCEC has been advocating for early detection, informed decision-making, and equal access to screening. We are glad to see ACS affirm what our medical advisors and community partners have long argued: early detection can save lives. PCEC agrees with most of the updated guideline. Where we differ is on when men should start screening and how a baseline PSA should guide future screening.

Where PCEC stands

Topic	ACS 2026 guideline	PCEC recommends
PSA screening	Recommends regular PSA-based screening.	**Agree.** PSA is the cornerstone of early detection.
When to start: average risk	Ages 50–69, every two years.	Begin with a baseline **PSA at age 45**. A man's first PSA can help inform his future risk and screening plan.
When to start: higher risk	Ages 45–69: annually for Black men and men with a strong family history; every two years for non-Black men with one first-degree relative diagnosed at age 65 or older.	**Age 40 for Black men and other men at higher risk,** including men with a strong family history or inherited susceptibility.
How often	Every two years for average risk; annually for Black men and men with a strong family history. Individualize decisions at ages 70–74.	**Agree.** A man's baseline PSA, family history, and other clinical factors should also guide how frequently he is followed.

Topic	ACS 2026 guideline	PCEC recommends
Elevated PSA	Repeat an elevated PSA; offer MRI and/or a validated biomarker if the elevation is confirmed to guide biopsy decisions.	**Agree.** An elevated PSA should be reassessed, with MRI and/or a validated biomarker when appropriate to better understand risk. It is not a reason for an automatic biopsy.
Low-risk cancer	Offer active surveillance as initial management for low-risk disease.	**Agree.** Not every prostate cancer needs immediate treatment.
Informed decisions	Men should understand the benefits, limits, and possible follow-up before screening.	**Agree.** Education is the foundation of PCEC's work.

Why PCEC recommends starting earlier

PCEC believes one of the most informative risk factors is one every man can have measured: his baseline PSA.

In a retrospective study of 21,502 men aged 40 or older with initial PSA values of 0–4.0 ng/mL and at least four years of follow-up, research led by PCEC Board Chairman E. David Crawford, MD, found that men with a baseline PSA of 1.5 to 4.0 ng/mL were diagnosed with prostate cancer at approximately 15 times the proportion observed in men below 1.5 ng/mL (7.85% vs. 0.51%). The association was observed in both Black and White men. These figures refer to prostate cancer diagnoses, not specifically to lethal cancer. Other studies link baseline PSA in midlife to the long-term risk of metastasis and death from prostate cancer (7).

A PSA of greater than or equal to 1.5 ng/mL alone is not an indication for biopsy nor does it mean that a man has cancer. It is an early indicator to begin risk assessment: men with a higher baseline PSA may benefit from closer follow-up. A lower PSA may support longer screening intervals but does not completely rule out cancer or eliminate the need for future screening.

A baseline PSA in a man's 40s helps him and his clinician plan future screening based on individual risk. PCEC currently recommends beginning PSA screening at age 40 for Black men and other men at higher risk, and at age 45 for men at average risk. These earlier baseline measurements can help guide individualized screening decisions over time. The optimal starting age and screening interval remain individualized; randomized evidence of a mortality benefit from starting routine screening before age 45 in average-risk men is limited.

What this means for men

- All men should have a PSA at age 45. Black men and other me at higher risk at age 40.
- Know your number and keep track of your results over time. Discuss your results with your clinician.
- A PSA at or above 1.5 ng/mL is not a cancer diagnosis and, by itself, does not mean you need a biopsy. It is a signal to discuss your individual risk and follow-up plan with your clinician.
- If your PSA is elevated, your clinician should recheck it. If it stays elevated, your clinician may recommend an MRI and/or a specialized lab test to help decide whether a biopsy is needed.

Early detection must reach every community

The updated ACS guideline rightly recognizes the heavier burden of prostate cancer among Black men, who have approximately 67% higher incidence and nearly twice the prostate cancer mortality rate of White men (4). Men living in rural areas, on average, die four years younger from prostate cancer than men in urban areas (5); and low-income men are 31% more likely to die from prostate cancer than those with greater resources (6).

But guidelines alone do not close gaps. Many men still face barriers to preventive care: no regular primary care provider, perceived inability to cover cost, long distances from health centers, and limited awareness of their own risk. For these men, the question is not only when screening should begin, but whether they will be screened at all.

Through community-based screening, partnerships with health systems, and prostate health education, PCEC brings early detection to me where they live, work, and worship, and turns national recommendations into real opportunities to be tested.

Smarter screening, not simply more screening

PCEC supports the ACS guideline's emphasis on reassessing an elevated PSA, using MRI and/or validated biomarkers to inform biopsy decisions, and offering active surveillance for low-risk disease. An elevated PSA does not automatically mean cancer, and not every prostate cancer needs immediate treatment.

The goal of screening is to find the cancers that threaten lives early, while avoiding unnecessary biopsies and over treatment, protecting quality of life. Risk-stratified follow up built on baseline PSA screening is an important step toward that goal.

Turning recommendations into action

PCEC is expanding its Prostate Health Ambassador program, which prepares community members, including faith leaders, survivors, and local advocates, to teach men and their families about prostate cancer risk factors, the value of knowing their PSA number, and how to get screened. Trusted voices in a community can reach men that national guidelines never will. Individuals and organizations interested in becoming ambassadors or hosting a training are invited to contact Cara Clements at Cara.Clements@pcec.org or 303-999-2571 to learn more.

Early detection begins with knowledge. Its impact depends on access, individualized care, and action.

Disclosure: E. David Crawford, MD, serves as Chairman of the Board of PCEC and is an author of the baseline PSA research cited in this statement.

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