Screening for Testicular Cancer

Recommendation Statement

U.S. Preventive Services Task Force

This statement summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for testicular cancer and the supporting scientific evidence, and updates the 1996 recommendations contained in the *Guide to Clinical Preventive Services,* second edition.[1] In 1996, the USPSTF found insufficient evidence to recommend for or against routine screening of asymptomatic men in the general population for testicular cancer by physician examination or self-examination (C recommendation). Recommendations to discuss screening options with selected high-risk patients may be made on other grounds.[1]

Since then, the USPSTF criteria to rate the strength of the evidence have changed.[2] Therefore, this recommendation statement has been updated and revised based on the current USPSTF methodology and rating of the strength of the evidence. Explanations of the current Task Force ratings and of the strength of overall evidence are given in Appendix A and Appendix B, respectively.

The complete information on which this statement is based, including evidence tables and references, is available in the brief evidence update[3] on this topic, on the USPSTF Web site (www.preventiveservices.ahrq.gov). The recommendation statement and brief evidence update are also available in print from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse (call 1-800-358-9295, or e-mail ahrqpubs@ahrq.gov). The recommendation is also posted on the Web site of the National Guideline Clearinghouse™ (www.guideline.gov).

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Summary of Recommendation

The U.S. Preventive Services Task Force (USPSTF) recommends against routine screening for testicular cancer in asymptomatic adolescent and adult males. **D recommendation.**

The USPSTF found no new evidence that screening with clinical examination or testicular self-examination is effective in reducing mortality from testicular cancer. Even in the absence of screening, the current treatment interventions provide very favorable health outcomes. Given the low prevalence of testicular cancer, limited accuracy of screening tests, and no evidence for the incremental benefits of screening, the USPSTF concluded that the harms of screening exceed any potential benefits.

Clinical Considerations

- The low incidence of testicular cancer and favorable outcomes in the absence of screening make it unlikely that clinical testicular examinations would provide important health benefits. Clinical examination by a physician and self-examination are the potential screening options for testicular cancer. However, little evidence is available to assess the accuracy, yield, or benefits of screening for testicular cancer.
- Although, currently, most testicular cancers are discovered by patients themselves or their partners, either unintentionally or by self-examination, there is no evidence that teaching young men how to examine themselves for testicular cancer would improve health outcomes, even among men at

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high risk, including men with a history of undescended testes or testicular atrophy.

- Clinicians should be aware of testicular cancer as a possible diagnosis when young men present to them with suggestive signs and symptoms. There is some evidence that patients who present initially with symptoms of testicular cancer are frequently diagnosed as having epididymitis, testicular trauma, hydrocele, or other benign disorders. Efforts to promote prompt assessment and better evaluation of testicular problems may be more effective than widespread screening as a means of promoting early detection.

References

1. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd ed. Washington, DC: Office of Disease Prevention and Health Promotion; 1996.

2. Harris RP, Helfand M, Woolf SH, et al; Methods Work Group, Third U.S. Preventive Services Task Force. Current methods of the U.S. Preventive Services Task Force: a review of the process. *Am J Prev Med.* 2001;20(3S):21-35.

3. Screening for testicular cancer: a brief evidence update for the U.S. Preventive Services Task Force. Rockville, MD: Agency for Healthcare Research and Quality; February 2004. Available at: http://www.ahrq.gov/clinic/3rduspstf/testicular/testiculup.htm.

Appendix A
U.S. Preventive Services Task Force—Recommendations and Ratings

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A. The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The* USPSTF *found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.*

B. The USPSTF recommends that clinicians provide [the service] to eligible patients. *The* USPSTF *found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*

C. The USPSTF makes no recommendation for or against routine provision of [the service]. *The* USPSTF *found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.*

D. The USPSTF recommends against routinely providing [the service] to asymptomatic patients. *The* USPSTF *found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.*

I. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. *Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.*

Appendix B
U.S. Preventive Services Task Force—Strength of Overall Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

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