

The digital rectal prostate exam: from useful to useless to controversial

As a general surgery resident, our Chair would famously state: “The more often you put finger or instrument in a body orifice, the less often you put a foot in your mouth”. Focusing on the digital (i.e., finger) rectal exam or DRE, in males, this physical exam component can provide information on a wide variety of diseases beyond assessing the prostate for size, tenderness and irregularities usually referred to as prostate nodules. Other common conditions such as ano-rectal cancer, hemorrhoids, anal condyloma, and assessing anal sphincter tone as part of a neurologic evaluation are also evaluated by the DRE.

The DRE has long been considered a mainstay in the men’s health physical exam evaluation with the role of the DRE for the detection of prostate cancer evolving over the last 40 years. Once considered essential and useful, many consider the DRE to be a useless tool for prostate cancer screening today.

For most of the 20th century and long before the development of PSA testing, the digital rectal exam of the prostate was the primary method to detect prostate cancer. According to the 4th Edition of “Campbell’s Urology” published in 1978, the abnormal DRE was 50%-75% accurate in the biopsy confirmed detection of prostate cancer. The needle biopsy of the prostate, usually due to a palpable nodule, was performed using a digitally directed transperineal or transrectal technique. Transrectal ultrasound biopsy guidance did not become common until the 1990’s.

Currently, the DRE in the screening, detection and in some management decisions in prostate cancer is no longer considered mandatory. Most cancers today are discovered due to an elevated serum PSA and not due to a palpable abnormality. The American Cancer Society notes that DRE is less effective than the PSA blood test in finding prostate cancer. The Society’s recommendations are that while the DRE can sometimes find cancers in men with a normal PSA, it “*might be included*” as a part of prostate cancer screening and is no longer a requirement. Similarly, the latest 2023 American Urological Association/Society of Urologic Oncology guidelines states that clinicians “*may use the DRE alongside PSA*” for prostate cancer screening and give the DRE an evidence level of only a Grade C, meaning the impact of the intervention is uncertain.¹

In the most recent US Preventive Services Task Force (USPSTF) Prostate Cancer Screening Recommendations in men aged 55 to 69 years, the decision to be screened using PSA based screening for prostate cancer should be an individual one. They focus solely on the use of PSA and indicate there is no utility in using the DRE. “*The use of digital rectal examination as a screening modality is not recommended because there is a lack of evidence on the benefits ...*”²

Two recent papers continue to minimize the utility of the screening DRE. A 2023 European Urologic Oncology paper concludes: “*The performance of stand-alone DRE to screen for prostate cancer is poor ... Furthermore, DRE does not improve the detection of PSA-screen-detected prostate cancer.*”³ In a just released meta-analysis of published prostate cancer screening studies involving over 85,000 patients, the screening strategy combining DRE and PSA was not different to that of PSA alone in terms of cancer detection rates.⁴ The collective findings from these recent studies suggest that, in the absence of clinical symptoms and signs, the DRE could be omitted from prostate cancer screening and early detection strategies.

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The National Comprehensive Cancer Network (NCCN) 2012 Prostate Cancer Detection Guidelines discussed both PSA and DRE for screening. In the 2024 update, it states the best evidence is PSA for the early detection of prostate cancer and the DRE should not be used as stand alone test. The DRE “*may*” have utility in the setting of an elevated PSA. In the UK where MRI services are more widely available, the need to perform a routine DRE of the prostate has been questioned.⁵

An occasional publication suggests that a DRE in a symptomatic patient may be useful, but in an asymptomatic patient there is limited utility for prostate cancer detection. Some new urinary tests for the detection of prostate cancer do require a DRE before the urine sample is collected.

Outside of the use of the DRE for prostate cancer screening, once diagnosed with prostate cancer, most oncology providers will use the rectal exam to further evaluate the prostate as part of clinical staging. However, the DRE in the management of men on active surveillance has been suggested to be unnecessary. At a consensus meeting on the strategy of prostate cancer active surveillance, participants agreed that the DRE is not needed, with the prostate MRI considered a much more accurate test.⁶

Patients themselves and on-line resources have also created doubts about the use of the DRE. In a patient survey, 37% of men would not speak to their doctor about prostate worries because of the DRE. The fear of the rectal exam may be a significant factor in men not talking about prostate cancer with black men reporting significantly more cultural stigma around the rectal examination.⁵ A study of YouTube videos indicated that much of the content contained misinformation and should not be considered a reliable resource of information on DRE’s for patients.⁷

In an age where there is heightened personal and cultural sensitivity, how health care providers are taught exam skills such the rectal exam has come under review and has become somewhat controversial. Earlier this year, the U.S. Department of Health and Human Services informed teaching hospitals and medical schools that written consent must be obtained from patients before performing sensitive procedures such as pelvic and prostate exams.⁸ Compliance with these new requirements has been tied to a longstanding guideline that hospitals must obtain written informed consent for such exams as a condition for being reimbursed by Medicare and Medicaid. At least 25 states have already enacted laws requiring informed consent for student supervised pelvic exams. The issue is now being more broadly addressed to include a group of what the lay press is calling “intimate” or “sensitive” physical examinations that include pelvic, breast, rectal and prostate exams.

While in a training environment, healthcare students would sometimes perform these examinations on patients who are under anesthesia, often without consent, leading to these new regulations. What is less clear is that if the patient is under care for a condition that requires this type of exam (e.g., prostate biopsy in the operating room) and the patient academic medical center consent specifies that trainees participate in their care, is additional written consent needed? Will this new student requirement evolve to include resident trainees as well? I’ll leave this up to lawyers to weigh in on these questions. Will this new additional informed consent requirement result in many forgoing the consenting process and completely avoiding the sensitive exam teaching opportunity? Many of our academic gynecology colleagues have been proactive in this area, requiring additional informed consent for participation by students in their pelvic exams.

It should be cautiously noted by anyone who participates in medical training programs that the US Department of Justice has also taken an interest in these trainee physical exam issues. The Office of Victims of Crime (OVC) has posted: “While it is critically important that medical students receive proper training, patients should have the right to give full consent for all medical services including any training- and education-related examinations, particularly if they will be under anesthesia”.⁹

The digital rectal exam in the detection and management of prostate cancer has evolved and may not have the same prominence as in the past. However, this “sensitive” exam continues to also have a role in the evaluation of diseases beyond the prostate. Teaching the DRE and other “sensitive” aspects of the physical exam are now under rigorous review and regulation. Simulators and surrogate patient volunteers can be substitutes for these

learning opportunities. However, the subtle findings present in a variety of disease states may not be apparent unless performed on a real patient with a medical condition that derives benefit from investigations such as the digital rectal exam.

The rectal exam, as an essential part of physical examination teaching for all providers in urology, general surgery, gynecology and all primary care and medical specialties and cannot be abandoned. While it may be a burden to obtain additional informed consent for these types of exams, proper training of our future health care providers makes this another essential administrative task for health care educators to complete.

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