Discuss prostate cancer screening with your doctor

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New draft recommendations released on April 11, this year, by the US Preventive Service Task Force (USPSTF) advise men aged 55–69 years to discuss prostate-specific antigen (PSA)-based screening for prostate cancer with their physicians. The change from previous recommendations, published in 2012, that counselled against PSA-based screening in all age groups is informed by two large randomised trials: one conducted in Europe and the other in the USA. The USPSTF concludes that while many men will experience potential harms of screening (false–positive results, overdiagnosis, and overtreatment), screening 1000 men can prevent one to two prostate cancer deaths and may prevent three men from developing metastatic prostate cancer. The draft statement is open for public comment until May 8, but the USPSTF looks likely to recommend decision making on PSA-based screening according to personal risk profile and patient values and preferences.

If the guidelines are approved, the challenge for the medical community will be to develop and maintain strict adherence to a PSA-based screening programme, which screens only men at increased risk and who are appropriately informed. The trend towards offering more men diagnosed with prostate cancer active surveillance rather than more invasive options of radical prostatectomy or radiotherapy must continue. The American Urological Association reacted positively to the guidance but suggested that the change does not go far enough, indicating that while there is limited evidence for PSA-based screening in men older than 70 years, selected healthier older men could also benefit.

The draft recommendations have been widely supported, but it is clear that the detail of their implementation is crucial if US men are to realise the potential benefits and minimise iatrogenic harm. The proposed move to individualised decision making acutely highlights the current deficiencies in risk stratification for prostate cancer, and the urgent need to create accurate decision support tools for clinicians to initiate appropriate conversations with their patients. ■ *The Lancet*

For the **USPSTF draft recommendations and the opportunity to comment** see https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/prostate-cancer-screening1

Prospects for neonatal intensive care

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In today's *Lancet* we publish a clinical Series on neonatal intensive care in higher resource settings. The Series, led by Lex Doyle from The Royal Women's Hospital in Melbourne, VIC, Australia, includes new approaches to the old nemesis of bronchopulmonary dysplasia (which still affects up to 50% of infants born before 28 weeks' gestation), discusses the delicacy of fine-tuning interventions in response to evolving evidence, and explores the frontier of nutritional research by referring to preterm birth as a nutritional emergency. This Series is of wide interest not only because of the extent and rate of progress in neonatal intensive medicine, but also because management of prematurity has profound consequences for the course of cardiovascular, metabolic, neurological, and pulmonary diseases throughout life.

Peripartum asphyxia contributes to disability and to the 2·7 million children estimated to die in the neonatal period. Therefore, the first Review, *Towards evidence-based resuscitation of the newborn infant*, is of particular importance, as many interventions can be generalised. It is a reminder that contemporary attitudes to evidence had their birth in neonatal practice, epitomised by the logo of the Cochrane Collaboration that depicts the pivotal meta-analysis of antenatal corticosteroids to reduce mortality after preterm birth.

The message from the evidential underpinnings of neonatal intensive care is clear: adequately powered, generalisable trials that test today's interventions at different stages of gestation in both sexes are essential to inform tomorrow's practice. Especially important is a focus on long-term neurodevelopmental results in addition to short-term neonatal outcomes.

The emotional and ethical environment for research in neonatal intensive care units is complex, but not insurmountable. Just as good neonatal care begins before birth, so too should sound research questions, developed with parental input. The recent revision of *Would Your Child Benefit from a Clinical Trial?*, posted on the US Food and Drug Administration's consumer website, is a welcome example of outreach to expand the culture of much needed research in children of all ages, including those newly born. ■ *The Lancet*

See **Series** pages 1639, 1649, and 1660

For the **FDA update on trials in children** see https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048699.htm