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Editorial Commentary

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Since September 2018, the authors' practice has used a standardized screening process to identify prostate cancer patients meeting the Philadelphia Consensus Conference guidelines criteria for genetic testing with point-of-care swabs. The authors found that after implementation of the workflow, patients meeting criteria for genetic testing were more likely get tested, results were obtained in a shorter time frame, and the patients were more likely to follow-up after testing.

There are numerous barriers to genetic testing in clinical practice. The authors tackle 2 of those barriers: capturing men who meet criteria and ease of testing. Yet, before genetic testing is widely adopted in U.S. clinics, several additional barriers will have to be addressed. Provider knowledge gaps and lack of confidence in interpreting genetic testing results have been shown to be significant barriers to genetic testing.[1] This is further complicated by the lack of a consensus surrounding variants of unknown significance, variants that have a pathogenicity status change, and limited access to genetics specialists. Lack of standardization among laboratories performing the testing and concerns regarding the generalizability of results in men of non-European ancestry—as most genome-wide association studies were performed in men of European ancestry—are other issues often described as well.[2] Finally, many insurance and health care providers might question the utility of genetic testing in the non-metastatic setting. While the authors describe the pathogenic variants as "actionable," most of the men in their cohort likely had localized prostate cancer, and the clinical role of targeting these variants in the localized setting still needs to be investigated. Nevertheless, expanding the role for genetic testing, as the authors advocate, is imperative to generating the data necessary to answer many of these questions and overcome the barriers to widespread implementation.

References

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