

# Perceptions of Barriers Towards Active Surveillance for Low-Risk Prostate Cancer: Results From a National Survey of Radiation Oncologists and Urologists

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## ABSTRACT

**Purpose.** The reasons for low clinical adoption of active surveillance (AS) for low-risk prostate cancer (PCa) remain poorly understood. Thus, we conducted a national survey of radiation oncologists (ROs) and urologists (UROs) to elucidate perceived barriers to AS for low-risk PCa.

**Methods.** In 2017, we undertook a four-wave mail survey of 1855 ROs and UROs. The survey instrument assessed attitudes about possible barriers towards AS for low-risk PCa. We used Pearson Chi square and multivariable logistic regression analyses to identify physician characteristics associated with attitudes about AS.

**Results.** We received 691 completed surveys for an overall response rate of 37.3%. A majority of respondents indicated that they felt comfortable recommending AS (90.0%), agreed that high-level evidence supports it (82.3%), and considered AS equally effective for survival compared with surgery and radiation therapy (84.4%). UROs were less likely to agree that patients were not interested in AS for low-risk PCa compared with ROs (16.5

vs. 48.9%; adjusted odds ratio [OR] 0.18,  $p < 0.001$ ). Similarly, UROs were less likely to concur patients avoid AS because of repeat prostate biopsies than ROs (36.3 vs. 55.4%; adjusted OR 0.41,  $p < 0.001$ ). ROs and UROs were more likely to agree that patients preferred treatments delivered by the respondent's specialty.

**Conclusions.** Physician perceptions of patient lack of interest in AS, need for repeat prostate biopsies, and biases of patient treatment preferences in favor of their own specialty treatments represent key barriers to AS. Shared decision making may be a meaningful approach to engaging patients in conversations about treatment decisions.

Overdiagnosis and overtreatment of localized prostate cancer (PCa) are well-recognized quality concerns in the United States (US).<sup>1,2</sup> To more selectively treat patients who harbor clinically aggressive PCa, and reduce treatment-related quality of life (QOL) complications from urinary incontinence and erectile dysfunction, clinical practice guidelines universally recommend active surveillance (AS) in appropriately selected patients with low-risk and certain intermediate-risk (low-volume Gleason 3 + 4) PCa as a means to address overtreatment.<sup>3–6</sup> Moreover, AS

has been validated as a safe and effective disease management strategy by several multicenter clinical trials and prospective cohort studies.<sup>7–11</sup>

The national uptake of AS for patients with low-risk PCa has been slow. Population-based cohort studies have shown that the rates of AS in the appropriate subset varied from 6 to 15%, although recent studies suggest that up to 50% of eligible men are now deferring primary local therapy in some settings.<sup>12–15</sup> Several factors contribute to the use of AS in clinical practice, including patient preferences and knowledge, as well as physician perceptions and recommendations of primary therapies. Indeed, several studies examining how patients make decisions about PCa treatment choices have shown physician recommendations are one of the most critical determinants on which treatment patients select.<sup>16,17</sup> Our previous national survey demonstrated that both radiation oncologists (ROs) and urologists (UROs) considered AS effective and felt comfortable recommending it to low-risk PCa patients.<sup>18</sup> However, when presented with a clinical scenario of a healthy patient diagnosed with low-risk PCa, a majority of ROs and UROs selected a treatment delivered by their own specialty, with only approximately 20% recommending AS. As a consequence, a disconnect exists between physician attitudes about AS and their preferred treatment recommendations for low-risk PCa. Furthermore, physician treatment recommendations play a significant role in patient selection of treatment decisions for surgery, radiation therapy, and AS for localized PCa.<sup>19–21</sup> Yet, little is known about physician-perceived barriers towards AS and optimal management for low-risk PCa. Identifying and addressing these physician barriers will be critical if AS is to become more readily adopted for low-risk PCa. Against this backdrop, we performed a national survey of ROs and UROs to assess the perceived barriers to AS for low-risk PCa.

## METHODS

### *Survey*

We obtained a random sample of PCa specialists from the American Medical Association (AMA) Physician Masterfile in June of 2016. Physicians from the database were selected based on specialty restricted to either radiation oncology or urology, aged < 65 years, completed residency, primarily involved in patient care, and practiced in the US for the survey sample. Information collected from the database included date of birth, race, sex, geographic region (Northeast, Midwest, South, or West) and type of practice (small practice—solo or less than two physicians, group practice, government-based, or other/

unknown). The survey instrument also queried the average number of newly diagnosed PCa patients respondents saw per week, where each respondent could select 0, 1–2, or  $\geq 3$  patients. The Mayo Clinic and University Hospitals Cleveland Medical Center Institutional Review Boards considered our study exempt from human subjects review.

### *Survey Sample, Domains, and Implementation*

Survey development began with a pilot survey to explore further information about physician characteristics from the survey sample and to elucidate perceived barriers towards AS for low-risk PCa. We developed survey items asking about practice affiliation, compensation structure, ownership of a linear accelerator to deliver radiation therapy, and access to robotic surgery and a multidisciplinary clinic for PCa patients. We then asked, “We are interested in your expert opinion regarding AS for low-risk prostate cancer. Please consider the following clinical scenarios and answer the following questions. Please select only *one response* for each question”. There were then 11 items about AS and PCa in the pilot survey (“Appendix”). Each item asked respondents about the degree to which they agreed or disagreed with patient and physician factors and the quality of existing evidence as barriers toward AS. Respondents could select whether they agreed or disagreed with each survey item on a 4-point Likert scale (strongly agree, moderately agree, moderately disagree, or strongly disagree).

Before implementation, we reviewed survey items with practicing specialists and then sent the pilot survey from a single mail wave to a random sample of 100 ROs and 100 UROs in November of 2016. This preliminary wave of the mailing included a cover letter, cash incentive, and pilot survey. The survey was then revised and finalized upon reviewing the responses and comments from the mailed survey. We then sent a four-wave mailed survey in January through July of 2017 to 915 ROs and 940 UROs. The first wave included a cover letter, a small cash incentive (\$10), and the survey, with subsequent waves having only a cover letter and survey for non-responders.

### *Statistical Analysis*

The degree of agreement among ROs and UROs with each survey item about perceived barriers constituted the primary outcome for the study. We dichotomized all responses to agree (strongly or moderately agree) or not (moderately or strongly disagree). Pearson Chi square and multivariable logistic regression analyses were used to identify physician covariates associated with each survey item. We used Stata MP 14.0 to perform all statistical

**TABLE 1** Characteristics of respondents by specialty [*n* = 691]

	ROs [ <i>n</i> = 327]	UROs [ <i>n</i> = 364]	<i>p</i> value
Age, years			
40–49	24.5	35.7	0.006
50–59	48.3	41.5	
60–65	27.2	22.8	
Female	19.8	6.3	< 0.001
Race			
White	79.5	88.6	0.009
African-American	2.4	0.6	
Asian-American	16.7	9.3	
Other	1.4	1.5	
Type of practice			< 0.001
Small practice (solo or two physicians)	11.6	16.2	
Group practice	57.2	66.2	
Government (local, state, or federal)	25.4	12.0	
Other/unknown	5.8	6.6	
Practice affiliation			0.004
Community	74.0	79.9	
Academic	21.1	12.4	
Other	4.9	7.7	
Compensation structure			0.001
Billing	32.4	45.0	
Salary ± bonus	64.2	50.3	
Other	3.4	4.7	
Region			0.12
Northeast	16.8	23.1	
Midwest	23.8	20.6	
South	34.9	36.3	
West	24.5	20.0	
Number of prostate cancer patients per week			< 0.001
0	12.8	6.0	
1–2	61.5	79.4	
≥ 3	25.7	14.6	
Access to robotic surgery	68.5	80.2	< 0.001
Ownership of linear accelerator	62.1	23.6	< 0.001
Access to multidisciplinary clinic	16.8	12.7	0.14

Data are expressed as percentages

ROs radiation oncologists, UROs urologists

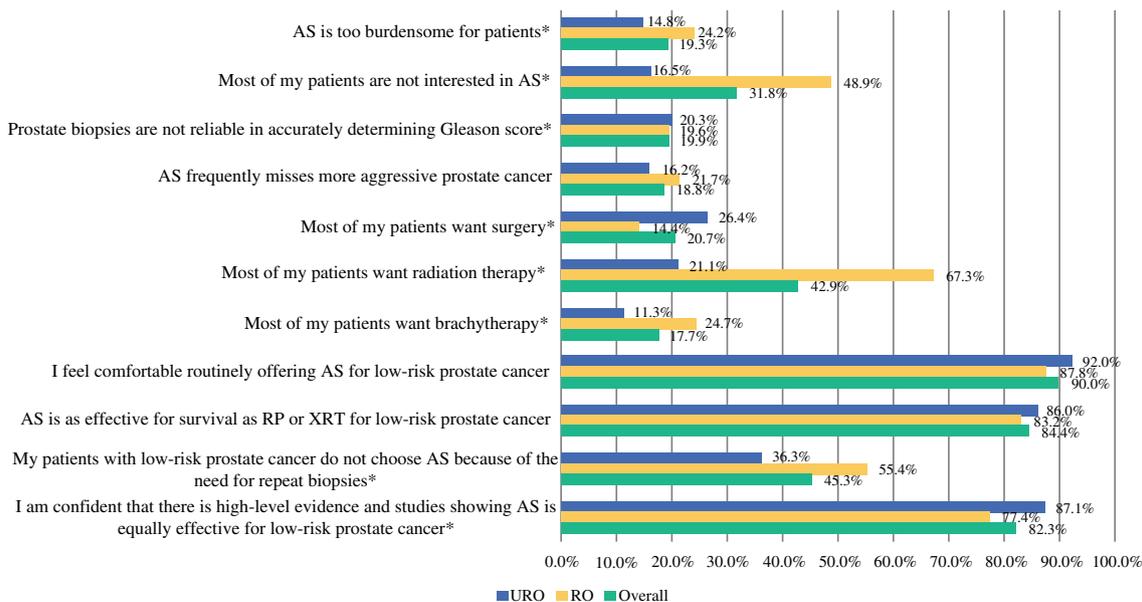
analysis (StataCorp LLC, College Station, TX, USA). A two-sided *p* value ≤ 0.05 defined statistical significance.

## RESULTS

Among the 1855 surveys sent, 691 respondents completed the survey (37.3%), with similar response rates for ROs and UROs (35.7 vs. 38.7%; *p* = 0.18). Compared with respondents specializing in urology, ROs were more likely to be older, female, and Asian–American race (all *p* < 0.05) (see Table 1). Moreover, ROs were more likely

to practice in government and academic medical settings, compensated by a salary, and own a linear accelerator, compared with UROs (all *p* < 0.05). ROs also reported less access to robotic surgery (*p* < 0.05). In addition, our survey analysis found a higher proportion of ROs self-reported seeing three or more newly diagnosed PCa patients per week than UROs (*p* < 0.001).

Figure 1 displays whether respondents agreed with the perceived barriers toward AS for low-risk PCa for all respondents and by specialty. Almost one-fifth of respondents agreed that AS is too burdensome (19.3%), although



\* $p < 0.05$

**FIG. 1** Percentage of respondents agreeing with the statements regarding different perceptions about AS for low-risk PCa by physician specialty\*. AS active surveillance, XRT external radiation therapy, RP radical prostatectomy, URO urologists, RO radiation oncologists

more ROs felt AS is burdensome compared with UROs ( $p = 0.002$ ). Similarly, almost one-fifth of respondents also agreed that prostate biopsies are not reliable in accurately determining Gleason score (19.9%), or AS frequently misses aggressive PCa (18.8%). Both specialties exhibited higher proportions in agreeing with patient-perceived opinions about AS and preferences for primary therapy. While only one-fifth of respondents agreed that most patients want surgery, more UROs agreed with this statement than ROs (26.4 vs. 14.4%;  $p < 0.001$ ). Similar trends were also observed, with a minority of respondents agreeing that patients with low-risk PCa desire some form of radiation therapy, as more ROs than UROs agreed about patients wanting brachytherapy (24.7 vs. 17.7%;  $p < 0.001$ ) or radiation therapy (67.3 vs. 21.1%;  $p < 0.001$ ) for the management of low-risk PCa. While one-third of all specialist respondents agreed that most of their patients are not interested in AS, a markedly higher number of ROs concurred than UROs (48.9 vs. 16.5%;  $p < 0.001$ ). However, most respondents agreed that they felt comfortable offering AS (92.0%), and AS is as effective for survival as surgery or radiation therapy (86.0%) for low-risk PCa patients. Although a higher percentage of UROs relative to ROs agreed that there is high-level evidence supporting AS (87.1 vs. 77.4%;  $p = 0.001$ ), overall a high proportion of respondents agreed.

On multivariable analysis, we identified several physician characteristics associated with physician attitudes (Table 2). For instance, older-age respondents were more

likely to agree that AS is too burdensome and frequently misses more aggressive PCa, but less likely to agree with feeling comfortable recommending it or agreeing high-level evidence exists supporting its use as an equally effective option compared with surgery or radiation therapy. Relative to respondents practicing in solo/small physician practices, those in government practices were less likely to believe that AS is too burdensome for patients (odds ratio [OR] 0.36;  $p = 0.01$ ), frequently misses aggressive PCa (OR 0.30;  $p = 0.005$ ), or that most patients are not interested in it (OR 0.40;  $p = 0.01$ ).

Physician specialty was also associated with perceived barriers to AS for low-risk PCa. For instance, compared with ROs in the survey, UROs demonstrated lower ORs in concurring that patients are not interested in AS (OR 0.18;  $p < 0.001$ ), and most patients want brachytherapy (OR 0.21;  $p < 0.001$ ) or radiation therapy (OR 0.09;  $p < 0.001$ ) or do not choose AS because of repeat prostate biopsies (OR 0.41;  $p < 0.001$ ). Conversely, UROs were more likely than ROs to agree that most patients want surgery (OR 2.34;  $p = 0.001$ ), and have confidence that there is high-level evidence showing AS is equally effective for survival (OR 2.10;  $p = 0.009$ ).

## DISCUSSION

Our study elucidates several key findings among specialists about perceived barriers to AS for low-risk PCa at a time when there is growing attention to reducing treatment

**TABLE 2** Multivariable logistic regression in agreeing with perceptions and barriers of AS for low-risk PCa

Covariate	OR (95% CI)	<i>p</i> value
AS is too burdensome for patients		
Age, years		
40–49	Ref.	
50–59	1.83 (1.02–3.27)	0.04
60–65	1.67 (0.84–3.31)	0.13
Race		
White	Ref.	
African-American	2.15 (0.47–9.71)	0.32
Asian-American	2.07 (1.06–4.06)	0.03
Other	3.24 (0.73–4.21)	0.12
Type of practice		
Solo or two-physician practice	Ref.	
Group practice	0.39 (0.21–0.71)	0.002
Government (local, state, or federal)	0.36 (0.16–0.79)	0.01
Most patients are not interested in AS		
Type of practice		
Solo or two-physician practice	Ref.	
Group practice	0.69 (0.39–1.24)	0.22
Government (local, state or federal)	0.39 (0.19–0.83)	0.01
Other/unknown	0.32 (0.10–1.02)	0.06
UROs (ROs)	0.18 (0.11–0.28)	<0.001
Prostate biopsies are not reliable in accurately determining Gleason score		
Access to multidisciplinary clinic	2.02 (1.14–3.58)	0.02
AS frequently misses more aggressive PCa		
Age, years		
40–40	Ref.	
50–59	1.94 (1.03–3.64)	0.03
60–65	3.93 (1.94–7.97)	<0.001
Type of practice		
Solo or two-physician practice	Ref.	
Group practice	0.57 (0.31–1.04)	0.07
Government (local, state or federal)	0.30 (0.13–0.70)	0.005
Other/unknown	0.73 (0.22–2.39)	0.61
Practice affiliation (community)		
Academic	0.69 (0.33–1.44)	0.33
Other	3.24 (1.42–7.34)	0.005
Access to multidisciplinary clinic	2.15 (1.15–3.99)	0.02
Number of prostate cancer patients per week		
0	Ref.	
1–2	5.05 (1.13–22.56)	0.03
≥ 3	7.38 (1.60–34.06)	0.01
UROs (ROs)	0.54 (0.32–0.92)	0.01
Most of my patients want surgery		
UROs (ROs)	2.25 (1.35–3.76)	0.002
Most of my patients want radiation therapy		
Type of practice		
Solo or two-physician practice	Ref.	
Group practice	0.63 (0.34–1.18)	0.13

TABLE 2 continued

Covariate	OR (95% CI)	<i>p</i> value
Government (local, state or federal)	0.35 (0.16–0.76)	0.008
Other/unknown	0.93 (0.32–2.72)	0.91
UROs (ROs)	0.10 (0.06–0.16)	<0.001
Most of my patients want brachytherapy		
Ownership of linear accelerator	0.51 (0.29–0.88)	0.01
Number of prostate cancer patients per week		
0	Ref.	
1–2	1.74 (0.65–4.67)	0.27
≥ 3	2.98 (1.06–8.35)	0.04
UROs (ROs)	0.21 (0.06–0.74)	<0.001
I feel comfortable routinely offering AS for low-risk PCa		
Age, years		
40–50	Ref.	
50–59	0.32 (0.13–0.81)	0.01
60–65	0.31 (0.11–0.90)	0.03
AS is as effective for survival as radical prostatectomy or radiation therapy for low-risk PCa		
Number of prostate cancer patients per week		
0	Ref.	
1–2	2.41 (1.07–5.42)	0.03
≥ 3	2.46 (0.98–6.25)	0.06
My patients with low-risk PCa do not choose AS because of the need for repeat prostate biopsies		
UROs (ROs)	0.44 (0.29–0.67)	<0.001
I am confident that there is high-level evidence and studies showing that AS is equally effective for low-risk PCa		
Age, years		
40–49	Ref.	
50–59	0.52 (0.26–1.02)	0.06
60–65	0.37 (0.17–0.80)	0.01
UROs (ROs)	2.01 (1.13–3.56)	0.01

AS active surveillance, PCa prostate cancer, OR odds ratio, CI confidence interval, ROs radiation oncologists, UROs urologists, Ref. referent

and facilitating greater implementation of AS. First, we found a substantive proportion of ROs and UROs perceive that many newly diagnosed low-risk PCa patients desire some form of primary therapy. Moreover, physician attitudes about perceived patient preferences regarding AS varied by specialty, with nearly half of ROs and one-third of UROs holding views that most of their patients were not interested in AS. These findings are concerning, given that physician treatment recommendations are critical to patient selection of primary therapy of localized PCa.<sup>16,22</sup> Interventions to improve physician understanding and acceptance of AS may facilitate greater adoption of AS in the US.

Second, physician specialty was significantly associated with perceived barriers toward AS. In our study, both ROs and UROs exhibited some degree of bias in perceiving that more of their patients choose treatments provided by their specific specialty. UROs also appeared to be more

supportive of AS than ROs in that they were less likely to view repeat prostate biopsies as a reason why patients do not elect AS but are more likely to acknowledge the existence of high-level evidence showing it is equally effective as surgery and radiation therapy. The current study builds on our prior work examining ways to promote AS for low-risk PCa. We have previously reported physician biases regarding perceptions toward AS and the comparative effectiveness of different primary therapies for localized PCa. In our 2013 national survey, we found support of AS in low-risk PCa, with high levels of agreement that this conservative disease management strategy is effective, and both UROs and ROs felt comfortable recommending it.<sup>18</sup> When asked for a treatment recommendation for a case presentation of a healthy patient with low-risk PCa, UROs and ROs selected surgery or radiation therapy, respectively, and only one-fifth recommended AS. Another study examining physician opinions

about comparative effectiveness of surgery and radiation therapy for survival and QOL found that each specialty tended to view their treatment as superior for cancer control and less detrimental for urinary incontinence and erectile dysfunction.<sup>23</sup> Taken together, these findings present a clear message about the importance of integrating AS for localized PCa.

Third, several physician characteristics, in particular older age and practicing at government-based practices, correlated with different perceived barriers to the routine use of AS. Identifying specific physician characteristics associated with barriers to AS are critical since several studies have shown that physician recommendations strongly impact whether patients undergo AS, surgery, or radiation therapy, along with salvage radiation therapy for biochemical recurrence following surgery.<sup>16,17</sup> To the best of our knowledge, our study is the first to report that older physicians appear to not be as receptive to AS due to concerns regarding patient burden for surveillance testing and biopsies, missing more aggressive PCa, having less comfort in recommending AS to patients, and perceive a lack of high-level evidence supporting its use for survival compared with surgery or radiation therapy. Conversely, physicians practicing in government practices viewed AS more favorably by citing fewer barriers towards AS relative to their peers in other practice contexts. In addition, physicians practicing in government clinics also differed in having less of their patients desire to be treated with radiation therapy for low-risk PCa. However, plausible factors that might lead doctors practicing in government settings to view AS more favorably include a lack of financial incentives to overtreat, institutional barriers to optimal treatments, or changing practice patterns among older physicians specifically. Nonetheless, these results provide key information into identifying which physicians and practices may be best served by implementation research in improving the use of AS in clinical practice.

Our findings highlight the importance of physician treatment recommendations in the implementation of guideline-concordant care for low-risk PCa. Implicit in clinical practice guidelines is an assumption of shared decision making (SDM) for localized PCa, where specialists work with patients to balance competing considerations of treatment-related side effects and disease control while promoting treatment decisions aligned with patient values and preferences. Several systematic reviews and clinical trials have supported the use of decision aids (DAs) in improving patient knowledge about PCa, incorporating patient preferences, and reducing decisional conflict and treatment regret.<sup>24,25</sup> For instance, Taylor et al.<sup>16</sup> developed a DA specifically for low-risk PCa that included AS as a disease management option. In this prospective, single-institution study, patients who elected for AS showed

higher PCa knowledge, greater awareness of their low-risk PCa stratification, and less uncertainty of treatment preference. In another prospective, single-arm trial of a novel web-based DA, it reduced decisional conflict when comparing the pre- and post-intervention testing for treatment decisions.<sup>26</sup> DAs can bridge the gap in patient knowledge about the natural history of low-risk PCa, and facilitate a meaningful conversation between patients and clinicians about all the available treatment options, including AS. By engaging greater use of AS, it is plausible that patients may be more willing to select and accept AS as their treatment preference for low-risk PCa. Indeed, the American Urological Association (AUA) recently published a policy position statement in support of using DAs in clinical practice in an effort to facilitate higher-quality healthcare delivery and incorporate patient preferences into complex treatment decisions.<sup>27</sup>

Widespread clinical implementation of DAs for physicians and patients diagnosed with localized PCa has been challenging for several reasons. Existing DAs vary markedly in content and ease of implementation into clinical practice, and improved patient-reported outcomes are not uniform across all tools.<sup>25,28</sup> Furthermore, a national survey demonstrated that only one-third of ROs and UROs reported using DAs for localized PCa treatment decisions.<sup>29</sup> Only a small minority of specialists were also familiar or confident with available DAs for localized PCa treatment decisions. Greater physician awareness and engagement about available DAs and the benefits of SDM are needed to promote AS.

Another consideration about the limited uptake of DAs for low-risk PCa is that while AS is emerging as the standard of care, existing DAs may not ideally fit this treatment decision.<sup>4,30,31</sup> SDM ideally places emphasis in DAs, providing patients with balanced and neutral information about different treatment options with clinical equipoise regarding benefits and risks.<sup>32</sup> Modifications to DAs and other interventions may increase patient selection and adherence to AS. Developing DAs that 'nudge' patients towards AS where this disease management option is highlighted could possibly facilitate its clinical implementation and acceptability from patients and physicians.<sup>33</sup> However, it is essential to acknowledge that tested and validated DAs that promote AS for low-risk PCa are still needed. Another possible mechanism to make AS more acceptable to physicians are targeted interventions. Ehdai et al.<sup>34</sup> recently reported a physician-directed intervention premised on framing techniques to facilitate counseling for low-risk PCa to address barriers to AS and patient perceptions and beliefs for immediate treatment. After the physician intervention that focused on addressing patient emotions and effective communication about PCa risks and treatments, approximately 80% of patients with low-risk

PCa selected AS. A key step in moving forward to promote SDM and AS for low-risk PCa is to test and develop such DAs and interventions across different clinical environments and different patient populations, particularly for minority men.

We acknowledge several limitations in our study. Our modestly lower response rate does introduce risk of bias, although it is on par with more recent specialty surveys.<sup>35</sup> However, our analysis found no differences in physician and practice characteristics between responders and non-responders in our national survey. It is also plausible that other perceived barriers may exist outside the items included in our survey. To the best of our knowledge, there are no qualitative studies completed from patients and physicians, critically examining and identifying the reasons behind the relatively lower adoption of AS, and this is an area worthy of additional research. Patient surveys could also elucidate other relevant attitudes and beliefs about PCa and AS. Addressing patient perceptions about localized PCa and primary therapy is also critical to promoting AS.

**CONCLUSIONS**

Our national survey of ROs and UROs highlights that physician attitudes about patient-perceived preferences to receive either radiation therapy or surgery, lack of interest in AS, and need for repeat prostate biopsies constitute key barriers to conservative management for low-risk PCa. Older physicians and physicians practicing in solo or small group practice represented a subgroup of respondents with higher perceived barriers as well. Increased attention in promoting AS with physician education and SDM may improve patient knowledge and decisional quality, along with facilitating AS among men diagnosed with low-risk PCa.

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**APPENDIX**

We are interested in your expert opinion regarding active surveillance for low-risk prostate cancer. For each statement indicate your degree of agreement or disagreement. Please select only one response for each item.

	Strongly agree	Moderately agree	Moderately agree	Strongly agree
Active surveillance is too burdensome for patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most patients are not interested in active surveillance.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate biopsies are not reliable in accurately in determining Gleason score.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Active surveillance frequently misses more aggressive prostate cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most of my patients want surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most of my patients want radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most of patients want brachytherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable routinely offering active surveillance for low-risk prostate cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Active surveillance is as effective for survival for radical prostatectomy or radiation therapy for low-risk prostate cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My patients with low-risk prostate cancer do not choose active surveillance because of repeat biopsies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that there is high-level evidence and studies showing that active surveillance is equally effective for low-risk prostate cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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