Introduction

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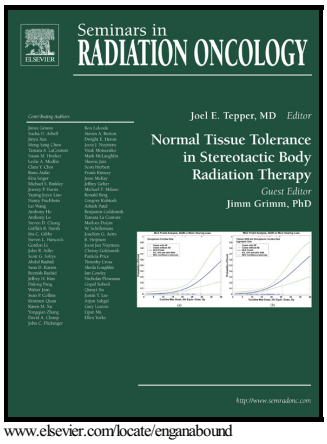

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Introduction

The landscape of prostate cancer and its management has undergone significant changes over the past decade. Notably, there has been a decrease in the utilization of PSA screening since such testing was offered a Grade D recommendation by the United States Preventative Services Task Force (USPSTF) guidelines in late 2011[1]. As a result, large observational database studies have suggested a relative decrease in incident prostate cancer and low-risk disease in the US[1]. There has also been a shift in management towards active surveillance for lower-risk disease and radical prostatectomy for higher-risk disease, seemingly at the expense of radiation[2,3]. While active surveillance helps to address the phenomenon of overtreatment and is supported by strong data for low and low-intermediate prostate cancer[4,5], the encroachment of surgery into high-risk disease has not necessarily been supported by robust evidence as much as devout beliefs[6,7]. As a consequence, many radiation oncologists have noticed that their prostate cancer practice has shifted in emphasis from treating definitive intact cases towards seeing and treating more and more patients for postoperative indications (pathologic T3, positive margins, nodal involvement and/or biochemical recurrence) when surgery has probably failed