

# Navigating a New Prostate Cancer Diagnosis

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*This document is an illustrative sample prepared with a fictitious case. All names, details, and clinical data are invented. It is intended solely to demonstrate the format, depth, and style of a typical advisory report. It does not constitute medical advice.*

CLIENT REFERENCE	ENGAGEMENT TYPE	PRIMARY CONCERN	REPORT DATE
Mr. A.V. · Age 61	Sonnet · Comprehensive Strategy	New diagnosis of localised prostate cancer; seeking orientation and second opinion pathway	May 2026 · Illustrative

## CLINICAL SITUATION

Mr. A.V. is a 61-year-old male executive in good general health whose PSA returned at 6.8 ng/mL on routine testing. Multiparametric MRI identified a PI-RADS 4 lesion in the left peripheral zone. Transperineal biopsy confirmed Gleason 3+4=7 (Grade Group 2) adenocarcinoma of the prostate, localised, with no extracapsular extension on imaging.

His urologist has presented three options: active surveillance, radical prostatectomy, and radiotherapy. Mr. A.V. wishes to understand the decision landscape clearly before his next appointment and to explore whether a second opinion at a Centre of Excellence is warranted. Concerns centre on both oncological outcomes and quality of life — specifically sexual function and urinary continence.

### ADVISOR'S FRAMING NOTE

Gleason 3+4 (Grade Group 2) is intermediate-risk, localised disease. This is not an oncological emergency. The evidence base for all three options is robust and outcomes are generally excellent. The key determinant is not survival — comparable across options — but the patient's individual risk tolerance, lifestyle priorities, and the experience of the treating team. This report equips Mr. A.V. for an informed, peer-level conversation with his specialists.

## TREATMENT OPTIONS — EVIDENCE SUMMARY

### Active Surveillance

Active surveillance (AS) is an established strategy for Grade Group 2 disease in selected patients. Current guidelines (EAU, AUA, NCCN) support AS for carefully selected intermediate-risk patients with predominantly Gleason 3 patterns and limited biopsy involvement.

- 15-year prostate cancer-specific mortality under AS in Grade Group 2: approximately 2–4% in contemporary cohorts
- Approximately 50–60% of Grade Group 2 patients on AS will require active treatment within 5 years
- No immediate impact on sexual function or continence; requires psychological comfort with uncertainty

# Radical Prostatectomy

Nerve-sparing robotic-assisted radical prostatectomy (RARP) is the reference standard for localised disease in surgically fit patients. Outcomes are highly operator-dependent; volume and experience of the surgical team are the single most important variables after tumour characteristics.

- Biochemical recurrence-free survival at 10 years for Grade Group 2: 85–90% at high-volume centres
- Erectile dysfunction: 40–70% at 12 months depending on nerve-sparing technique; recovery continues for 24 months
- Urinary incontinence: 5–15% persistent at 12 months; 1–3% severe long-term
- Advantage: definitive pathological staging; PSA becomes undetectable as clear treatment endpoint

## Radiotherapy — EBRT with or without Brachytherapy

External beam radiotherapy (EBRT), typically combined with short-course ADT for intermediate-risk disease, offers comparable oncological outcomes to surgery. SBRT protocols in 5 fractions are increasingly standard at specialist centres.

- Biochemical recurrence-free survival at 10 years: comparable to RP in randomised data
- Lower immediate risk of incontinence and erectile dysfunction vs surgery; bowel effects and late erectile dysfunction relevant at 18–24 months
- No surgical recovery period; treatment over 5–9 weeks or 1–2 weeks with SBRT

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### SECOND OPINION — RECOMMENDED PATHWAY

A second opinion at a designated Centre of Excellence is strongly advisable. The following institutions are among the highest-volume, most academically recognised centres for prostate cancer:

- 1 Martini-Klinik, Hamburg, Germany** — The highest-volume prostate cancer surgical centre in the world, with annual outcome data published. Outcomes for nerve-sparing RARP are among the best documented globally. Particularly relevant given Mr. A.V.'s European connections.
- 2 Memorial Sloan Kettering Cancer Center, New York** — Consistently ranked first or second globally for urological oncology. Remote second opinion available via the MSK International programme.
- 3 The Royal Marsden NHS Foundation Trust, London** — Premier UK centre for radiotherapy and integrated oncological care, with strong SBRT programme.
- 4 Institut Gustave Roussy, Paris** — Leading French oncology centre with strong multidisciplinary tumour board and radiotherapy expertise.

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### QUESTIONS TO BRING TO YOUR NEXT APPOINTMENT

- 1** What percentage of my biopsy cores were positive, and what was the maximum core involvement? This affects eligibility for active surveillance.
- 2** How many radical prostatectomies does this surgeon perform annually, and what are their published nerve-sparing outcomes for Grade Group 2 disease?
- 3** Is focal therapy (HIFU, focal laser ablation) an option in my case, and would you refer me to a centre with experience in this?
- 4** Has my case been reviewed by a multidisciplinary tumour board? If not, I would like to request this before a decision is made.

# AS

## ACTIVE SURVEILLANCE

Preserves quality of life immediately.  
Requires psychological resilience and rigorous follow-up. ~50% will need treatment within 5 years.

# RP

## SURGERY

Definitive. Outcome highly surgeon-dependent. Incontinence and erectile dysfunction risks real but manageable at high-volume centres.

# RT

## RADIOTHERAPY

Equivalent oncological outcomes.  
Lower immediate functional risk.  
Bowel effects and late erectile dysfunction relevant at 18–24 months.

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