Publication date: 15 June 2026

Clinical Commissioning Policy

Stereotactic ablative radiotherapy (SABR) for the treatment of localised prostate cancer (adults) [2106]

Summary

Stereotactic ablative radiotherapy (SABR) is recommended to be available as a routine commissioning treatment option for adults with low and intermediate risk[1] localised prostate cancer who do not require androgen deprivation therapy (ADT) as an alternative to moderately hypofractionated external beam radiotherapy (EBRT) within the criteria set out in this document.

The policy is restricted to adults (≥18 years old) as there is insufficient evidence to confirm safety in those age groups not included in the policy.

Committee discussion

Please see Clinical Panel reports for full details of Clinical Panel's discussion.

The Clinical Priorities Advisory Group committee papers can be accessed here: Stereotactic ablative radiotherapy for the treatment of localised prostate cancer (adults)

What we have decided

NHS England has carefully reviewed the evidence to treat low and intermediate risk localised prostate cancer who do not require ADT with SABR. We have concluded that there is enough evidence to make the treatment available as an alternative to moderately hypofractionated EBRT at this time.

The three paper summary which informs this commissioning position can be accessed here: Stereotactic ablative radiotherapy for the treatment of localised prostate cancer (adults)

Links and updates to other policies)

This document replaces Clinical Commissioning Policy:

- The use of Stereotactic Ablative Radiotherapy (SABR) in the treatment of Prostate Cancer (published on 13 July 2016)

This document should be read in conjunction with Clinical Commissioning Policy:

- Hypofractionated external beam radiotherapy in the treatment of localised prostate cancer (adults) (published on 20 October 2017)

[1] The term 'intermediate risk' in this document refers to patients who meet the criteria of 'intermediate risk' as defined in the PACE-B trial: van As, N., Griffin, C., Tree, A., Patel, J., Ostler, P., van der Voet, H., Loblaw, A., Chu, W., Ford, D., Tolan, S. and Jain, S., 2024. Phase 3 trial of stereotactic body radiotherapy in localized prostate cancer. *New England Journal of Medicine*, *391*(15), pp.1413-1425.

Plain language summary

About prostate cancer

The prostate is a small gland located at the base of the bladder. The condition usually develops very slowly meaning that there may be no signs of the cancer for many years. It is the most common cancer affecting men[2] in the UK, with 50,702 new cases diagnosed in England in 2022 (NPCA, 2023).

When prostate cancer is diagnosed it is 'staged'; this provides an indication of how large the cancer is and how far it has spread and helps to identify the best treatment for patients. Where prostate cancer is diagnosed at an early stage, which means that it is completely contained (or 'localised') within the prostate and has not spread anywhere else in the body, the chances of survival are generally good, with almost all people surviving 5 years or more after diagnosis. Since the introduction of prostate-specific antigen (PSA) testing, most prostate cancer cases are now diagnosed at an early stage (CRUK, 2023).

As well as being staged, localised prostate cancer is also risk assessed into groups; very low, low, intermediate (favourable and unfavourable), high and very high (NCCN, 2023). This is based on a combination of 3 factors: T staging, the histological aggressiveness of the cancer (Gleason score) and a PSA measurement. These risk categories also play a role in determining the best treatments and overall management plan for patients.

Low risk localised prostate cancer – is unlikely to grow or spread for many years and generally is diagnosed where patients have clinical or magnetic resonance imaging (MRI)-defined T1 or T2 disease and all of the following factors are present (NCCN, 2023):

- PSA level less than 10 ng/ml;
- Gleason score no higher than 6.

Most low-risk prostate cancers should be offered active surveillance as the preferred management strategy.

Intermediate risk localised prostate cancer is unlikely to grow or spread for a few years and is diagnosed where patients have clinical or MRI-defined T1 or T2 disease and one or more of the following factors is present:

- PSA level between 10 and 20 ng/ml;
- Gleason score of 3+4 (NOT Gleason score of 4+3);

The morbidity from the disease can include progression to locally advanced disease, which can be symptomatic, and spread to other areas of the body (metastases).

About current treatments

The primary purpose of treating localised prostate cancer is to eradicate the prostate cancer and hence improve the morbidity and mortality associated with prostate cancer progression. Management options for localised prostate cancer include different types of radiotherapy (external beam radiotherapy (EBRT), brachytherapy or brachytherapy dose escalation in combination with EBRT), surgery (called radical prostatectomy (RP)), active surveillance or watchful waiting (for those unsuitable for radical curative treatment) (NICE,

[2] Prostate cancer can also affect transgender women as the prostate is usually conserved after gender-confirming surgery. It is not clear how common prostate cancer is in this population and transgender women are able to access SABR if they meet the eligibility criteria.

2019). For low-risk prostate cancer, active surveillance should be the preferred strategy. For intermediate risk prostate cancer active surveillance, RP, EBRT, brachytherapy or brachytherapy dose escalation in combination with EBRT are options (NICE, 2019). EBRT is sometimes combined with a period of ADT (NICE, 2019).

Following discussion at the specialist prostate multi-disciplinary team meeting (MDT) meeting where the potential treatment options based on stage of cancer and overall health status are discussed and agreed, the treatment choice is then determined by individual patient preference. All prostate cancer treatments are associated with a risk of side-effects. Prostate cancer and its treatment are the leading cause of cancer years lived with disability (Soerjomataram et al., 2012) because prostate cancer is both common and has good prospects of long-term survival post diagnosis and treatment. Management plans and treatment choices are often influenced by potential treatment-related toxicities.

EBRT for low and favourable intermediate risk localised prostate cancer in the UK is given with moderately hypofractionated radiotherapy. Moderately hypofractionated EBRT for the treatment of localised prostate cancer uses fraction sizes larger than 2Gy, delivered over a shorter overall treatment time, for example 60Gy in 20 daily fractions of 3Gy over 4 weeks. Prior to the move to moderately hypofractionated EBRT for these patients' conventional fractionation was used which is delivered as daily (Monday to Friday) radiotherapy at 1.8-2 Gray per fraction for 7-8 weeks.

About stereotactic ablative radiotherapy

Stereotactic ablative radiotherapy (SABR), also called stereotactic body radiotherapy (SBRT), is a highly targeted and precise radiotherapy technique, which delivers higher overall doses of radiotherapy in a fewer number of treatments than conventional radiotherapy. SABR is delivered using one, three, five or eight treatments (or fractions) and usually delivered in an outpatient setting. The aim of treatment with SABR is to ensure that the tumour receives a high dose of radiation whilst the tissues close to the tumour receive a lower dose of radiation sparing the surrounding healthy normal tissues and reducing the risk of side effects.

SABR aims to provide one form of treatment for this condition (radiotherapy) in a shorter treatment time requiring fewer fractions (sessions) of radiotherapy and fewer visits to hospital. Typical side effects experienced after radiotherapy (both SABR and more conventionally fractionated schedules) include short and long-term gastro-intestinal side effects (such as diarrhoea, rectal bleeding, faecal urgency), genito-urinary side effects (dysuria, urgency, frequency, haematuria,) and sexual dysfunction (such as erectile dysfunction).

This clinical commissioning policy recommends the use of SABR as an alternative treatment option to moderately hypofractionated EBRT for patients who meet the criteria set out in this document.

Epidemiology and needs assessment

Prostate cancer is the most common cancer affecting men in the UK, with 55,241 new cases diagnosed in 2024 (NPCA, 2024). In 2021, approximately 32% of patients were diagnosed with low-risk (8%) and intermediate-risk (24%) disease in England (NPCA, 2024), equating to 17,677 patients with low-risk (4,419) and intermediate (13,258) risk prostate cancer. Around 92% of men with low-risk prostate cancer choose active surveillance (NPCA, 2024), equating to 354 low risk prostate cancer patients who choose radical therapy instead (radiotherapy or surgery).

Clinical consensus suggests that 60% of men with intermediate risk prostate cancer choose active surveillance, equating to 5,303 intermediate risk prostate cancer patients who choose radical therapy (either surgery or radiotherapy). Of the patients who are unsuitable for active surveillance, half will have radiotherapy, in the form of hypofractionated radiotherapy, (2828 patients: 177 low risk, 2652 intermediate risk), and half will have radical prostatectomy (2828 patients: 177 low risk, 2652 intermediate risk). Of the 2828 patients who have radical radiotherapy, half of these are expected to not require ADT equating to 1,415 patients (89 low risk, 1,326 intermediate risk).

The cohort expected to have SABR will consist of all the patients who would have had hypofractionated radiotherapy (1,415 patients) and clinical consensus estimates that 20% of patients who would have otherwise had a radical prostatectomy, would now opt for SABR (565 patients: 35 low risk, 350 intermediate risk). Clinical consensus also suggests that around 20% of patients who would otherwise be eligible for active surveillance, may refuse surveillance and opt for SABR instead. Assuming that half of these patients will require ADT, this means that 1202 patients (407 low risk, 795 intermediate risk) who would have otherwise had active surveillance will opt for SABR. Therefore, circa 3,182 patients (531 low risk, 2,651 intermediate risk) may be eligible for SABR every year. There are expected to be no existing patients, as patients would have already started another treatment option.

Implementation

All patients with prostate cancer should have their care managed by a variety of different specialists working together as part of a tumour specific cancer MDT. This may include Urologists, Clinical and Medical Oncologists, Specialist Nurses, Therapeutic Radiographers, Radiologists and Pathologists. The MDT is responsible for radiotherapy case selection and should take into consideration patient comorbidities, potential adverse events and likely outcomes of treatment.

Inclusion criteria

SABR, an alternative to moderately hypofractionated EBRT, is an option for patients with low and intermediate risk localised prostate cancer where androgen deprivation therapy (ADT) is not required and, following discussion and agreement between the patient and the clinician, are unsuitable or unwilling to consider active surveillance or radical prostatectomy. In exceptional circumstances, SABR may be considered as an alternative to moderately hypofractionated EBRT, where a patient has already commenced ADT prior to Clinical Oncology referral by the referring team.

Patients must have a diagnosis of either:

- Low risk localised prostate cancer: diagnosed where patients have clinical or MRI-defined T1 or T2 disease and **all** of the following factors are present:
    - PSA level less than 10 ng/ml;
    - Gleason score no higher than 6 (3+3);

    OR

- Intermediate risk localised prostate cancer: diagnosed where patients have clinical or MRI-defined T1 or T2 disease and **one or more** of the following factors is present:
    - PSA level between 10.1 and 20 ng/ml;
    - Gleason score of 3+4 (NOT Gleason score of 4+3).

and **ALL** of the following:

- Confirmed as suitable for radical treatment with a life expectancy of greater than ≥10 years as determined by a specialist prostate MDT[3];
- The decision to choose SABR is a result of shared decision making between the patient and clinician acknowledging the potential higher risk of grade 2 genitourinary toxicity after SABR, particularly in the first 1-2 years after SABR. The risks have been explained using the Shared Decision-Making Tool in Appendix 1;
- WHO performance status ≤ 2.

Exclusion criteria

Patients who meet **any** of the following criteria are not eligible for SABR:

- Significant urinary symptoms, e.g. International Prostate Symptom Score (IPSS) of 20 and above (in this scenario hypofractionated external beam radiotherapy delivered in 20 fractions should be preferred);
- Have National Comprehensive Cancer Network (NCCN) unfavourable intermediate (Gleason 4+3), high (including MRI T3a) or very high risk localised, regional or metastatic prostate cancer.

Patient pathway

The Service Specification for External Beam Radiotherapy Services (NHS England Reference: 170091S) describes the detail of the care pathways for this service. Radiotherapy is part of an overall cancer management and treatment pathway.

Treatment options are considered at the specialist prostate MDT, and the patient is referred to a clinical oncologist for assessment and full explanation of the advantages and side effects of treatment with adequate time for decision making. For patients who decide to undergo radiotherapy and do not require ADT, the clinical oncologist will arrange treatment planning and delivery of radiation fractions as appropriate. SABR treatment will be offered to those within the criteria set out in this document.

MRI imaging should be considered for radiotherapy treatment planning purposes to improve contouring accuracy. Each fraction of radiation is delivered on one visit, on an outpatient basis. Based on the published efficacy date, a dose of 36.25Gy in five fractions daily or alternate days, at centre discretion, should be used.

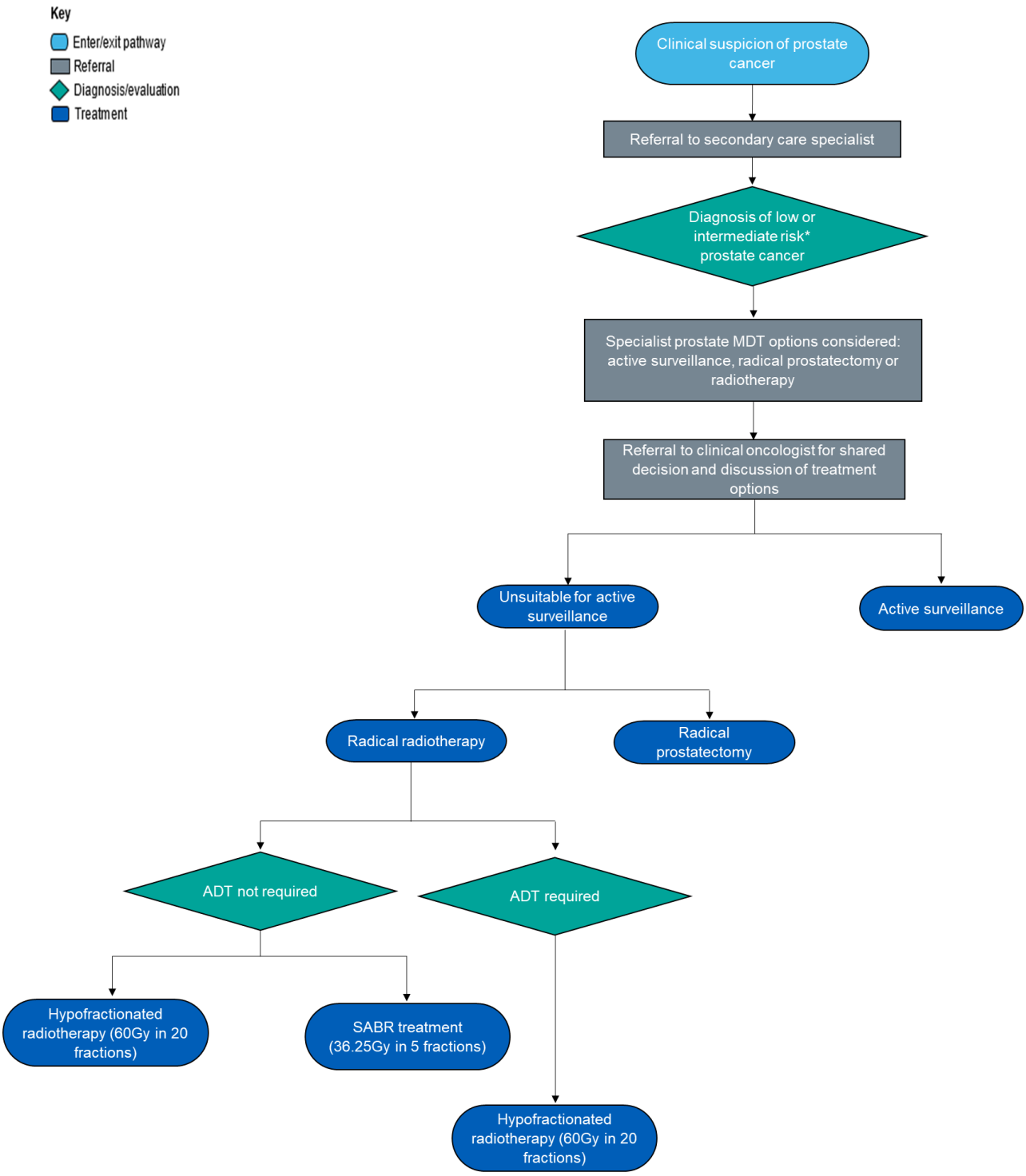
Daily image guidance to the prostate is required. During the PACE-B trial prostatic fiducial markers were recommended but there was no evidence this reduced toxicity.

As the majority of patients will be treated on a standard linear accelerator, intra-fractional motion management is not required. For those receiving treatment times longer than 3 minutes, intra-fractional motion management must be considered.

In addition, all providers of treatment with SABR must:

[3] Specialist prostate MDT includes at least a urologist, a clinical oncologist and a radiologist.

- Ensure all patients treated are subject to an MDT approach to patient selection and treatment including discussion at a specialist prostate MDT;
- Have an adequate technical multi-professional radiotherapy SABR team available and able to deliver SABR radiotherapy; and
- Have minimum of two subspecialist clinical oncologists with experience in treating prostate SABR:
- Provide oncological follow-up as per their organisation’s local protocol.



PSA: Prostate specific antigen
SABR: Stereotactic ablative radiotherapy
*The term 'intermediate risk' refers to the definition as outlined in the PACE-B trial: van As, N., Griffin, C., Tree, A., Patel, J., Ostler, P., van der Voet, H., Loblaw, A., Chu, W., Ford, D., Tolan, S. and Jain, S., 2024. Phase 3 trial of stereotactic body radiotherapy in localized prostate cancer. New England Journal of Medicine, 391(15), pp.1413-1425.

Governance arrangements

The Service Specification for External Beam Radiotherapy (NHS England Reference: 170091S) describes the governance arrangements for this service. It is imperative that the radiotherapy service is fully compliant with this Service Specification and in particular, with the The Ionising Radiation (Medical Exposure) Regulations 2017.

Clinical governance systems and policies should be in place and integrated into the organisational governance with clear lines of accountability and responsibility for all clinical governance functions. Providers should produce annual clinical governance reports as part of the NHS clinical governance reporting system. Providers must have an externally accredited quality management system (such as British Standards Institution [BSI] in place.

All providers must be compliant with Radiotherapy Quality Assurance (RTTQA) for contouring and outlining prior to offering this treatment. A national approach to regular peer review of patient eligibility and treatment plans will be required.

The current version of the SABR Consortium Guidelines provide detailed information on each indication contained within this policy.

Provider organisations must register all patients using prior approval software and ensure monitoring arrangements are in place to demonstrate compliance against the criteria as outlined.

Mechanism for funding

A new local HRG code (SABR 6) and price will be added to Annex A, tab 4 of the NHS Payment Scheme. This is anticipated to be cost neutral, but commissioners will need to work with their providers to transfer baseline funding from the fixed element of the API (service line code NCBPS01R: Radiotherapy) to the variable element.

Audit requirements

Radiotherapy providers must submit their activity to the national Radiotherapy Dataset (RTDS) on a monthly basis. Providers will collect the audit and clinical outcome data through their own collection process for all SABR. Providers should participate in national audits and National Quality Improvement Toolkits including ProKnow.

Radiotherapy services are subject to regular self-assessment by the national Specialised Commissioning Quality Surveillance. The quality system and its treatment protocols will be subject to regular clinical management and audit as part of the development of radiotherapy networks in England.

Data will be reviewed through use of prior approval forms.

Policy review date

This document will be reviewed when information is received which indicates that the policy requires revision. If a review is needed due to a new evidence base then a new Preliminary Policy Proposal needs to be submitted by contacting england.CET@nhs.net.

Our policies provide access on the basis that the prices of therapies will be at or below the prices and commercial terms submitted for consideration at the time evaluated. NHS England reserves the right to review policies where the supplier of an intervention is no longer willing to supply the treatment to the NHS at or below this price and to review policies where the supplier is unable or unwilling to match price reductions in alternative therapies.

Equality statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Definitions

Androgen deprivation therapy (ADT)	This is a medical treatment for prostate cancer that reduces male hormone (androgen) levels to slow cancer growth. This helps control the cancer but can have side effects. It is also known as androgen ablation therapy or androgen suppression therapy.
Fraction	The term that describes how the full dose of radiation is divided into a number of small doses (called fractions). The fractions are given as a series of treatment sessions which make up a radiotherapy course.
Hypofractionation	A treatment regimen that delivers high doses of radiation using a shorter number of treatments as compared to conventional treatment regimens.
Metastatic / metastases	Metastatic describes a cancer that has spread from the part of the body where it started (the primary site) to other parts of the body. Metastases is the plural form of metastasis and indicates that the cancer spread to more than one other site in the body.
Radiotherapy	The safe use of ionising radiation to destroy cancer cells with the aim of cure or effective palliation.
Stereotactic ablative radiotherapy (SABR)	Refers to the irradiation of a lesion and is associated with the use of high radiation dose delivered in a small number of fractions. The technique requires accurate positioning of the patient and imaging to confirm correct targeting. It allows sparing of the healthy normal tissues. This is also known as stereotactic body radiotherapy (SBRT).
WHO performance status	A recognised system developed by the World Health Organisation and other bodies to describe the general health and daily activity of patients. The WHO performance status classification categorises patients as: 0. Able to carry out all normal activity without restriction 1. Restricted in strenuous activity but ambulatory and able to carry out light work 2. Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours 3. Symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden 4. Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

References

Cancer Research UK Website (2023). Prostate Cancer Mortality Statistics. Available at: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer/mortality#heading-Zero.

National Comprehensive Cancer Network (NCCN) (2023). Clinical Practice Guidelines in Oncology for Prostate Cancer. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf.

National Institute for Health and Care Excellence (NICE) (2019). Prostate cancer: Diagnosis and Management (NG131). Available at: https://www.nice.org.uk/guidance/NG131.

National Cancer Audit Collaborating Centre (2024). National Prostate Cancer Audit State of the Nation Report. Available at: NPCA-State-of-the-Nation-Report-2024_v2.pdfNPCA-State-of-the-Nation-Report-2024_v2.pdf Soerjomataram I, Lortet-Tieulent J, Parkin DM, et al (2012). Global burden of cancer in 2008: a systematic analysis of disability-adjusted life-years in 12 world regions. Lancet 2012; 380: 1840–50.

Appendix 1: Shared decision-making tool – Radiotherapy options for localised prostate cancer

You and your doctor have agreed that radiotherapy is the best option to treat your prostate cancer.

How does radiotherapy work?

Radiotherapy can be given to you in different doses. Usually, the higher the dose, the more likely it is to kill the cancer cells in your prostate. However, a higher dose is also more likely to damage nearby non cancer, healthy cells. Cells in your bowel, bladder and sex organs are commonly affected. This can cause problems such as diarrhoea, difficulty passing water and problems getting an erection. Your doctor and other health professionals involved in your care have to balance giving as much radiotherapy to the cancer cells as possible whilst reducing the chances of damaging nearby healthy cells so side effects are reduced.

External beam radiotherapy (EBRT)

The standard way of giving radiotherapy for prostate cancer is called external beam radiotherapy (EBRT). Machines called linear accelerators target X-ray beams from outside the body at the cancer cells in the prostate. EBRT can be given in different doses (also called schedules). In the UK, the most common schedule gives a total dose of 60 gray (how much radiation you need) in 20 fractions (daily treatments). This means you will have to visit your radiotherapy centre every day for 4 weeks to receive the total dose (60 gray over 20 visits).

Stereotactic ablative radiotherapy (SABR)

Stereotactic ablative radiotherapy (SABR), also called stereotactic body radiotherapy (SBRT), is a highly targeted and precise radiotherapy technique, which delivers radiotherapy in a fewer number of treatments than conventional radiotherapy. SABR is delivered using five treatments (or fractions) for prostate cancer and is delivered in an outpatient setting. The aim of treatment with SABR is to ensure that the tumour receives a high dose of radiation whilst the tissues close to the tumour receive a lower dose of radiation sparing the surrounding healthy normal tissues and reducing the risk of side effects. The dose delivered is 36.25 gray in 5 fractions. This means you will have to visit your radiotherapy centre five times either daily or alternate daily.

What are the benefits and harms of SABR?

The evidence from clinical studies suggests that treating the prostate with SABR will have a similar effect to EBRT, which means with both schedules there is a low chance of the cancer coming back. There are possible additional harms with giving this type of radiation compared with EBRT as healthy tissues may react differently to lots of little doses of radiation compared to fewer, larger doses of radiation each time. You are slightly more likely to have moderate bladder side effects (problems with your waterworks) after SABR but the chance of bowel or sexual function is very similar comparing SABR and EBRT.

What does this mean for you?

You will need to think about what matters to you and weigh up the benefits and risks of SABR.

This decision aid is to help you to make up your mind on what radiotherapy option is best for you. When making this decision you should use this tool with your doctor and other health professionals who will explain anything you do not understand and help you to weigh up the choices based on what matters to you.

Different people will feel that some of these things are more important to them than others, so it is important that you make a decision that is right for you.

You may want to discuss this with friends, family or anyone else who you feel can help you to make the right decision for you. If you wanted, they can also join you when you have the discussion with your doctor.

What are my options?

	External beam radiotherapy (EBRT)	**Stereotactic ablative radiotherapy (SABR)**
What does it involve?	You will have to visit your radiotherapy centre **20 times over four weeks (Monday to Friday)** to receive the total dose of radiotherapy.	You will have to visit your radiotherapy centre **5 times over 1-2 weeks** to receive the total dose of radiotherapy.

Decision aid

The table below gives you an idea of the benefits and risks with having SABR compared with having EBRT in patients with low or favourable intermediate risk prostate cancer.

	EBRT (Treatment over 4 weeks)	**SABR** (Patients received 36.25 gray in 5 visits either daily or on alternate days)
What are the benefits?	At 5 years patients were examined to see if their cancer had progressed by measuring a blood test called PSA, looking for evidence that the cancer had recurred. There was no difference between groups (i.e. both treatments were very likely to cure the cancer)	
	At 5 years, out of 441 patients who had EBRT, **94.6%** had no sign of cancer recurrence.	Out of 433 patients who had SABR, **95.8%** had no sign of cancer recurrence.
What are the harms?	The risks associated with having EBRT and SABR include: • Urinary symptoms - examples of these include feeling the need to pass water more often, or in more of a hurry or, very rarely, needing a catheter (a tube into the bladder to help you pass water) • Bowel symptoms – increased frequency of stools, and passing small amounts of blood from your bottom • Having difficulty in getting an erection	

<table>
<tr><td></td><td colspan="2">Not everyone gets these symptoms and for most men they are mild and resolve on their own.</td></tr>
<tr><td></td><td colspan="2">Erectile dysfunction

Erectile dysfunction was measured using the CTCAE assessment tool. Any Grade 2 or higher dysfunction was recorded. Grade 2 and above refers to a decrease in erectile function where erectile intervention is needed (e.g., medication or mechanical devices such as a penile pump).

The difference between the two groups was not considered to be significantly different.</td></tr>
<tr><td></td><td>At five years follow up 29.1% of patients who had EBRT experienced erectile dysfunction.</td><td>At five years follow up 26.4% of patients who had SABR experienced erectile dysfunction.</td></tr>
<tr><td></td><td colspan="2">Genitourinary toxicity

Genitourinary (GU) toxicity refers to adverse effects in the bladder system.

Toxicity was measured using the CTCAE and RTOG assessment tool. Events graded as 2 or above were recorded. Grade 2 generally means that a medication (tablet) is needed for a symptom.

The difference in cumulative incidence up to 5 years is higher in those receiving SABR compared to EBRT. However, at 5 years there was no difference in urinary symptoms between patients who had received SABR or EBRT.</td></tr>
<tr><td></td><td>The cumulative incidence of late grade 2 or higher events up to 5 years for GU toxicity measured using RTOG was 18.3% in the EBRT group.</td><td>The cumulative incidence of late grade 2 or higher events up to 5 years for GU toxicity measured using RTOG was 26.9% in the SABR group.
This higher risk was largely seen in men with a “weak bladder” before treatment.</td></tr>
<tr><td></td><td colspan="2">Gastrointestinal toxicity

Gastrointestinal (GI) toxicity refers to adverse effects in the digestive system.

Toxicity was measured using the CTCAE and RTOG assessment tool. Events graded as 2 or above were recorded. Grade 2 generally means that a medication (tablet) is needed for a symptom.

The number of patients who reported GI toxicity was low at 5 years. The difference between the two groups was not considered to be significantly different.</td></tr>
<tr><td></td><td>The cumulative incidence of grade 2 or higher events up to 5 years for GI toxicity measured using RTOG was 10.2% in the EBRT group.</td><td>The cumulative incidence of grade 2 or higher events up to 5 years for GI toxicity measured using RTOG was 10.7% in the SBRT group.</td></tr>
</table>

Percentages display how many men out of a hundred may experience a symptom. For the symptoms listed above, the majority of men do not experience these effects, regardless of which radiotherapy option they received. It is not possible to know in advance what will happen to any individual person.

In summary

There is no clear evidence to recommend SABR over EBRT. These treatments are thought to have similar overall benefits. The decision will depend on whether you are willing to accept the potential extra bladder risks of the treatment (particularly in men with poor bladder function before treatment) for the benefits of a reduced number of radiotherapy appointments.

When making this decision you should use this tool with your doctor and other health professionals who will explain anything you do not understand and help you to weigh up the choices based on what matters to you.