Article details: 2017-0149	
Title	Reducing overtreatment of prostate cancer in eastern Ontario: population based cohort study of radical prostatectomy
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Reviewer 1	Dr. Waseem Sharieff
Institution	Dalhousie University Faculty of Medicine, Radiation Oncology, Halifax, NS
General comments (author response in bold)	1. Reference should be made to the study author rather than NCCN for prostate cancer risk categories. **We have added the relevant reference to this section. We have maintained the NCCN risk group language as we believe many readers are familiar with this and it is easier to find online for readers who are less familiar with prostate cancer risk nomograms.** 2. The authors need to provide more details on the CoP database. Who maintains it, what information is stored, how is it cross linked to other databases? **We have detail regarding the CoP database (Methods P1). It was not linked to any other databases for this study.** 3. Readers might be interested in rates of positive margin **We agree margin status may be of interest and a topic for future study, In this study our objective was to describe patients selection for surgery rather than outcomes of treatment.** 4. There is substantial missing data from the community hospitals. To assign intermediate and high risk, one needs only one out of the three factors. Is it not possible to complete the risk category assignment without introducing clinically significant and insignificant categories? **We agree that missing data from community hospitals limited some of our analyses. While we could have placed these patients into risk categories based on incomplete data, we felt analyzing patients with complete data was preferable as the trends we observe in patients with complete data were very similar between hospitals and we therefore feel it is unlikely that patients that have not been categorized would bias our results significantly. We have no reason to suspect that patients with incomplete data differ from those with complete data.** 5. A hypothesis is stated but it has not been tested. The authors may rephrase it as a question. **We have rephrased our objective and hypothesis. (Introduction P3)** 6. Power calculations need to be included in the methods section. **We do not agree that a power calculation is needed. This was a descriptive study of trends in a population. We have provided RR and 95% CI for all comparisons and we feel this is appropriate.** 7. Authors may wish to include a paragraph in the discussion section on the subset of high risk patients in whom surgery is appropriate. **We agree that appropriate patients selection for different treatments is important. This study aimed to describe treatments being used but did not assess their efficacy. Use of surgery for high risk patients is a controversial topic and evidence supporting its use in one subgroup over another is inconclusive. For this reason we would prefer to avoid a detailed discussion of this. We have acknowledged in our Limitations that we are not making inferences about treatment efficacy.**
Reviewer 2	Dr. Kirk A. Keegan
Institution	Brooke Army Medical Center, Department of Urologic Surgery, Fort Sam Houston, Tex.
General comments (author response in bold)	1) The manuscript would benefit from an expanded limitation section, most notably addressing the authors principle claim that overtreatment has decreased. To make this claim one must also address the potential secular trend of increased high risk prostate cancer, which remains controversial., In addition, the rates of EBRT and brachytherapy utilization would impact their claim that overtreatment has been reduced. **We agree with this comment and have specifically addressed this (Limitations). We did not assess other treatment modalities for our patient cohort to examine if other treatments were being chosen over surgery. We do feel that because we show a significant change in patients receiving surgery and the total number of prostatectomies did not drop significantly over time that the findings do support a change in patient selection by surgeons. This is supported by our earlier report that active surveillance rates have increased for low risk patients. Future studies should address if these changes are consistent in patients receiving radiotherapy.** 2) It would be illuminating to present the number of patients screened, biopsied, and treated as a time series, in order to better understand the exposure cohort, and changing patterns of care. [Ed note: while this would be nice to have, it may not be necessary and/or feasible] **We agree but unfortunately do not have these data available to us as part of this study and so would not be able to report this.**