Author reply Re:Kumar A, Yadav S, Krishnappa RS, Gautam G, Raghavan N, Bakshi G, *et al*. The Urological Society of India guidelines for the evaluation and management of prostate cancer (executive summary). Indian J Urol 2022;38:252-257

We thank the readers for their letter. They have raised many important points that merit clarification. We wrote this article as an executive summary to serve as general directions for the practicing urologist, especially the ones practicing privately in small community practices.

The point about the dose of radiation therapy, whether conventional or hypofractionated regimens, is well put. Radiation therapy doses are a discussion unto themselves due to the very nuanced approach that is optimized by the radiation oncologist in terms of the technology available in their department, its functioning in terms of protocols for immobilization/target delineation and planning. For example, a lack of access to image-guided radiation therapy can lead to uncertainty in the execution of some well made plans. The same uncertainty plays even more when hypofractionated regimens are used. Thus, the committee has not kept the discussion of radiation doses and techniques within its defined scope.

Ultrahypofractionated regimens (stereotactic body radiation therapy) are indeed an emerging technology and while some excellent data are available, the same technique has not matured enough to be recommended by this panel.

We agree with the authors that early salvage radiotherapy (RT) is now the norm. This has been endorsed in our guidelines. A delay in the administration of adjuvant RT has been endorsed by the team in the same section. The term delayed salvage RT is perhaps grammatically incorrect and needs correction. However, the spirit of the statement in the paper indeed endorses what the randomized trials and a meta-analysis have reported.

We agree that brachytherapy has helped numerous patients, especially in the times when modern radiation therapy facilities were not available. Brachytherapy continues to help patients in the form of boost therapy. Once again, the scope of this discussion precludes the nuanced discussion that an advisory for brachytherapy would entail. While the committee agrees that the most appropriate salvage treatment is always subject to a multitude of factors, brachytherapy for biochemical recurrence is not practiced. The authors believe in the value of radical radiation therapy as a definitive treatment and continue to recommend the same as indicated.

The scope of this first version was also limited by word limit that was required by the journal. We feel fulfilled that the overall scope for this first version, which was to lay down the most essential practice points for day-to-day understanding an possibility for any inter-specialty referral, has been fulfilled and we seek to make these guidelines more descriptive and detailed in future versions with possibly separate discussion on radiation oncology practice.

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