



Key Performance Indicators for Organised Prostate Cancer Testing (OPT), Version 2026-2

Changes

Date	Changed by	Change
2020-01-15	Anna Hedström	Described indicators in table 1 based on the work of the National OPT Group, and prepared template for further work.
2020-01-30	Ola Bratt	Added text under subheadings and modified a few indicators following discussion with Rebecka Arnsrud Godtman, Ulf Lönqvist and Anna Hedström.
2022-05-09	NAG OPT Ola Bratt	Some indicators were modified, one was removed (proportion of men undergoing repeat biopsy) and one was added (socio-economic equity).
2023-01-23	Ola Bratt	Only corrections of typos.
2023-03-11	Ola Bratt	Only corrections of typos.
2024-06-10	NAG OPT SweOPT steering group via Ola Bratt	Names and order changed.
2025-11-27	SweOPT steering group	New indicators were added, several were modified, renamed and reordered.
2026-01-26	NAG OPT SweOPT steering group	Decision on the design of the equity indicator.
2026-05-28	NAG OPT SweOPT steering group vi	Revision of indicators 3, 5 & 7. Specifications of data retrieval (by O Bratt)

Contents

List of indicators.....	4
Indicator 1 – Algorithm	6
Indicator 2 – Coverage	7
Indicator 3 – Participation	8
Indicator 4 – Test results.....	9
Indicator 5 – Testing and diagnostics outside OPT.....	10
Indicator 6 – Adherence to diagnostic investigation.....	12
Indicator 7 – Equity.....	13
Indicator 8 – Imaging.....	15
Indicator 9 – Time intervals.....	16
Indicator 10 – Cancer detection.....	17
Indicator 11 – Hospital care for infection following prostate biopsy ..	18
Indicator 12 – Advanced cancer	19
Indicator 13 – Treatment.....	21

List of indicators

The table presents the 13 main indicators for OPT established by the National OPT Working Group. Please note that some indicators have been renamed and that the numbering has changed since the previous year. The sub-indicators (a total of 29 indicators) are also presented on the next page. All indicators are described in detail on the subsequent pages.

The results for indicators 1, 2, 5a, and 11 are produced by the regions themselves, while the others are obtained from national registries. Follow-up of indicator 12 also requires input from the regions (medical record review).

No.	Name
1	Algorithm
2	Coverage
3	Participation
4	Test results
5	Testing and diagnostics outside OPT
6	Adherence to diagnostic investigation
7	Equity
8	Imaging
9	Time intervals
10	Cancer detection
11	Hospital care for infection following prostate biopsy
12	Advanced cancer
13	Treatment

The table presents the 13 main indicators for OPT, with sub-indicators (a total of 29 indicators). All are described in detail on the following pages. The results for indicators 1, 2, 5a, and 11 are produced by the regions, while the others are obtained from national registries. Follow-up of indicator 12 also requires input from the regions (medical record review).

MRI = magnetic resonance imaging of the prostate.

PSA = blood test for prostate-specific antigen.

No.	Name
1	Algorithm
2	Coverage 2a) Age groups invited to OPT 2b) Proportion of men invited to OPT
3	Participation 3a) Cumulative participation 3b) Participation within 6 months 3c) Participation after re-invitation of men with PSA ≥ 3 $\mu\text{g/l}$
4	Test results: Distribution of PSA < 1.0 / $1.0\text{--}2.9$ / ≥ 3 $\mu\text{g/l}$
5	Testing and diagnostics outside OPT 5a) Testing both outside OPT among OPT participants 5b) Prostate cancer diagnosis outside OPT among OPT participants
6	Adherence to diagnostic investigations 6a) Adherence to the first diagnostic investigation 6b) Adherence to prostate biopsy
7	Equity 7a) Participation in testing in towns, villages and rural areas 7b) Participation in diagnostic evaluation in towns, villages and rural areas 7c) Participation in diagnostic evaluation depending on neighbourhood income 7d) Participation in diagnostic evaluation depending on country of birth
8	Imaging 8a) MRI assessment 8b) Incidental findings on MRI
9	Time intervals 9a: Time from PSA test to notification of MRI 9b: Time from MRI examination to notification of biopsy results
10	Cancer detection 10a) Outcomes of prostate biopsy within OPT 10b) Proportion of diagnostic investigations resulting in a cancer diagnosis within OPT 10c) Proportion of OPT participants diagnosed with prostate cancer within OPT
11	Hospital care for infection following prostate biopsy
12	Advanced cancer 12a) Advanced interval cancer 12b) Advanced cancer diagnosed in OPT 12c) Regional incidence of advanced prostate cancer
13	Treatment 14a) Curative treatment among OPT participants 14b) Curative treatment among participants with cancer 14c) Active surveillance for low-risk cancer

Indicator 1 – Algorithm

Measure	The testing and diagnostic algorithm used by the region.
Purpose	Required to enable comparisons of outcomes between regions and within regions over time, and to evaluate changes to the algorithm and new diagnostic methods.
Direction	-
Type of indicator	Structure
Technical description	All changes to the regional algorithms are documented and dated.
Data sources	Excel file on the SweOPT Teams workspace. The urology representatives in NAG OPT are responsible for the annual review of the algorithms used in the regions within the area of responsibility of their respective RCC.
Level of reporting	By region in the SweOPT annual report. A comment is included in public reporting if a region deviates substantially from the standard algorithm.
Sources of error	Failure to document changes.

Indicator 2 – Coverage

Measure	2a) Age groups invited to OPT: Complete birth cohorts that have been invited to OPT. 2b) Proportion of men in the target population that has been invited to OPT: Proportion of men aged 50–74 years in the region who have received at least one invited to OPT.
Purpose	Describes the rate of implementation.
Comments	Corresponds to KPI 1 of PRAISE-U.
Direction	High
Type of indicator	Structure
Technical description	2a) All entire birth-year cohorts that at least once has been invited to OPT in the region, described by their age (t e.g., 50-54, 56-58 years) 2b) <i>Numerator:</i> The number of men offered OPT according to indicator 3a Cumulative participation. <i>Denominator:</i> The number of men in the region in December the year in question, collected from Statistics Sweden. The technical description must be revised when the first region completes OPT for a birth-year cohort.
Data sources	Each region produces and compiles its own data.
Level of reporting	By region in the SweOPT annual report.
Sources of error	-

Indicator 3 – Participation

Measure	3a) Cumulative participation: Number of men who have at any time provided a PSA sample within OPT, divided by the total number of men invited to OPT. 3b) Participation within 6 months: Number of men who have provided a PSA sample within OPT within 6 months from the date the invitation to OPT was sent, divided by the total number of men invited to OPT up to 6 months before the date of evaluation. 3c) Participation following re-invitation of men with PSA ≥ 3 $\mu\text{g/L}$: Number of men in the previous testing round who had PSA ≥ 3 $\mu\text{g/L}$ and were invited to the current testing round, who have provided an OPT PSA sample within 6 months from the date the re-invitation was sent, divided by the total number of re-invitations sent to this group.
Purpose	Required for estimating the cost-effectiveness of OPT and assessing adherence to the programme as a whole. Participation following re-invitation of men with PSA ≥ 3 $\mu\text{g/L}$ is chosen because these men would be actively followed up in routine healthcare.
Comments	3b) The proportion of participants in test round 2 and later is reduced by that many of the men then offered OPT were previous non-participants. For comparisons between regions, a specific age group and a specific testing round should therefore be selected. In the annual report, only the second round of invitation is presented, separately for men under and over 60 years of age. Corresponds to KPIs 2 and 4 of PRAISE-U.
Direction	High. An acceptable minimum level will be defined.
Type of indicator	Process
Technical description	Both numerator and denominator are calculated up to the end of the previous calendar year.
Data source	SweOPT
Level of reporting	Region
Sources of error	-

Indicator 4 – Test results

Measure	Proportion of men with PSA < 1, 1.0–2.9, and ≥ 3 µg/l.
Purpose	To assess the impact of using different analytical methods.
Comments	In addition to the testing method, the distribution of PSA levels depends on age and testing round. For comparisons between regions, a specific age group and a specific testing round must therefore be selected. Results are fully comparable only in the first testing round. The PSA value distribution in subsequent testing rounds is affected by that men with PSA < 1 µg/l are not re-invited until after 6 years. This means that many men who are PSA tested from round 2 and onwards had PSA ≥ 1 µg/l in the previous testing round, which skews the distribution towards higher values. In the annual report, results are presented for all men aged 50 years who have been tested for the first time within OPT, and for those who received their first invitation at age 62. Corresponds to KPI 5 of PRAISE-U.
Direction	Close to the national average.
Type of indicator	Process
Technical description	Age is defined as of 31 December.
Data sources	SweOPT
Level of reporting	Region
Sources of error	-

Indicator 5 – Testing and diagnostics outside OPT

Measure	5a) Testing outside OPT among OPT participants: Proportion of OPT participants that provided a PSA sample also outside OPT after the OPT PSA during the remaining part of the same year or the subsequent calendar year. 5b) Prostate cancer diagnosis outside OPT among OPT participants: Proportion of men who have participated in OPT but were diagnosed with localised cancer outside OPT in the interval from the PSA test within OPT to the next invitation to OPT.
Purpose	PSA testing of asymptomatic OPT participants outside OPT is not cost-effective, nor is PSA testing of asymptomatic men over 75 years of age.
Comments	A small proportion of men should undergo PSA testing in routine care due to clinical suspicion of cancer; this proportion increases with age. A small proportion of men (< 2 %) provided a PSA sample after a prostate cancer diagnosis or during medically indicated follow-up within or outside OPT. Corresponds to KPI 8 of PRAISE-U.
Direction	Low
Type of indicator	Process
Technical description	Age is defined as of 31 December the evaluated year. 5a) Numerator: The number of men who had an OPT PSA test the calendar year before the evaluated year without being diagnosed with prostate cancer within OPT and subsequently had at least one PSA test outside OPT during the remaining part of that year or the following year. Denominator: The number of men without cancer diagnosis at the date of evaluation who had an OPT PSA test the calendar year before the evaluated year. Example: If year 2025 is evaluated, men are included who had an OPT PSA test in 2024 and were not diagnosed with prostate cancer within OPT in 2024. PSA testing data outside OPT are collected from the date of the OPT PSA in 2024 until the end of 2025. 5b) Numerator: The number of OPT participants who participated 2 years prior to the evaluated year and then had PSA ≥ 1 $\mu\text{g/l}$ + the number of OPT participants who participated 6 years prior to the evaluated year and then had PSA < 1 $\mu\text{g/l}$, who were then not diagnosed with prostate cancer in OPT but were subsequently diagnosed with localised cancer (T1-2, Nx/N0, M0, PSA < 20 $\mu\text{g/l}$) outside OPT in the test interval 5b). Denominator: The number of OPT participants who participated 2 years prior to the evaluated year and then had PSA ≥ 1 $\mu\text{g/l}$ + the number of OPT participants who participated 6 years prior to the evaluated year and then had PSA < 1 $\mu\text{g/l}$, who were then not diagnosed with prostate cancer in OPT. Example: If 2026 is evaluated, the population at risk is men who in 2020 had PSA < 1 $\mu\text{g/l}$ in OPT + those who had PSA ≥ 1 $\mu\text{g/l}$ in 2024 without then being diagnosed with prostate cancer in OPT.
Data sources	5a): Each region produces its own data. 5b) SweOPT and NPCR.



REGIONAL CANCER CENTRES

Key Performance Indicators for Organised Prostate Cancer Testing (OPT), Version 2026-2 2026-02-09

Level of reporting	By region in the SweOPT annual report. 5b also publicly, with options to select calendar year, age and testing round.
Sources of error	The small number of PSA tests performed outside OPT urology visits does not affect the interpretation of the indicator (the proportion can be estimated via Indicator 6). Men may seek healthcare and provide PSA samples outside the region.

Indicator 6 – Adherence to diagnostic investigation

Measure	6a) Adherence to the first diagnostic investigation: Proportion of men who underwent MRI and/or a urology visit within OPT among men who for the first time had PSA ≥ 3 $\mu\text{g/L}$ within OPT. 6b) Adherence to prostate biopsy: Proportion of men who underwent prostate biopsy within OPT among men who for the first time had an indication for biopsy.
Purpose	Measures adherence to recommendations for diagnostic investigation.
Comments	In 2024, Region Stockholm conducted a study in which some men with PSA 3.0–9.9 $\mu\text{g/L}$ did not undergo MRI.
Direction	Very high
Type of indicator	Process
Data sources	SweOPT
Technical description	6a) Indication for biopsy is defined as PI-RADS 4–5 or PI-RADS 3 + PSA density ≥ 0.10 or PI-RADS 1–2 + PSA density ≥ 0.2. PSA density is calculated based on the first PSA taken after the invitation to OPT (PSA1). If two PSA measurements are available before MRI (PSA1 and pre-MRI PSA), density is calculated using the lower of the two values. 6b) Based on the variable "Cause for no biopsy". <i>Numerator:</i> All men with a registered value for this variable that is not "Declined further diagnostic investigation" or "Unknown". <i>Denominator:</i> All men with a registered value for this variable.
Level of reporting	Region
Sources of error	Men may have undergone diagnostic investigation outside OPT, but this proportion is likely to be very small. During 2020–2024, a repeat PSA test was performed outside OPT prior to urology visits in some regions; this was not recorded in SweOPT/ROP. If the new PSA level was lower, the indication for biopsy could disappear. This accounts for part of the difference between the proportion in 6b and 100 %. From 2025, this "PSA2" is recorded, renamed "PSAbeforeMRI" and forms the basis for determining whether a biopsy is indicated. From 2025, PSA prior to MRI is evaluated in a similar way in the regions of Jönköping County and Uppsala.

Indicator 7 – Equity

Measure

7a) Participation in testing in towns, villages and rural areas among those receiving their first invitation to OPT.

7b) Participation in diagnostic evaluation in towns, villages and rural areas: Proportion of participants with PSA ≥ 3 $\mu\text{g/L}$ and an indication for investigation who initiate investigation (MRI or urology visit) within OPT, stratified by residency.

7c) Participation in diagnostic evaluation depending on neighbourhood income: Proportion of participants with PSA ≥ 3 $\mu\text{g/L}$ and an indication for investigation who initiate investigation (MRI or urology visit) within OPT, stratified by proportion of households with low income.

7d) Participation in diagnostic evaluation depending on country of birth: Proportion of participants with PSA ≥ 3 $\mu\text{g/L}$ and an indication for investigation who initiate investigation (MRI or urology visit) within OPT, stratified by the proportion of neighbourhood residents born in versus outside Europe.

Purpose	To identify socio-economic inequalities in OPT that can be reduced through targeted interventions, so that OPT becomes as equitable as possible.
Direction	Small differences between socio-economic groups.
Type of indicator	Process
Comments	Socio-economic factors are assessed at area level; therefore, the results cannot be directly translated to the individual level. In sparsely populated areas, the defined areas studied (DeSO) have a more heterogeneous population than in metropolitan areas, where boundaries between different types of residential areas are more distinct. This results in smaller gradients in outcomes for indicator 7 in regions where a large proportion of the population lives in small towns and sparsely populated areas compared with regions dominated by large cities. Differences in participation related to income or country of birth are chosen not to be indicators. The reason is that in the absence of a national screening recommendation, not participating in OPT cannot be considered as an indication of inequity.
Technical description	We use Statistic Sweden's Demographic Statistical Area classification (Swedish abbreviation: DeSO). There are 6,160 DeSO in Sweden, delineated by shared socioeconomic characteristics, with populations of 700 to 3,000.

	7a-b) The areas' degree of urbanization is categorized as: - Urban centre: The most populated town/city in the municipality. - A smaller town or a village in the municipality with more than 200 residents. - Rural area: A village with fewer than 200 residents or in the countryside. 7c) Low household income is defined according to variable SDI1 from Statistics Sweden (proportion living in the quartile of Swedish households with the lowest disposable income). 7c-d) The outcomes are reported av quintiles. Quintile 1 (Q1) is the fifth of the areas with the lowest proportion of low-income households (i.e., the richest areas) or residents born outside Europe, Quintile 5 (Q5) the fifth of the areas with the highest proportion.
Data sources	SweOPT and Statistics Sweden (Demographic Statistical Areas, DeSO).
Level of reporting	Region
Sources of error	See Comments.

Indicator 8 – Imaging

Measure	8a) MRI assessment: Results of the first prostate MRI performed within OPT among men with PSA 3.0–9.9 µg/L. 8b) Incidental findings on MRI: Number of MRIs with a described incidental finding divided by the total number of registered MRIs.
Purpose	8a) To achieve consistent assessment of prostate MRI across Sweden. 8b) To evaluate the extent of follow-up interventions resulting from incidental findings in OPT, and how often clinically irrelevant findings are recorded, which could lead to unnecessary healthcare if the participant reads their report.
Direction	8a) Close to the national average. 8b) Very low for incidental findings without clinical relevance.
Type of indicator	Process
Comments	8a) PI-RADS 1–2 = no suspicion of prostate cancer, PI-RADS 3 = low suspicion, PI-RADS 4–5 = higher suspicion. 8a) Some regions first perform an ultrasound for calculation of PSA density in men with PSA 3.0–9.9 µg/L and refer only men with PSA density ≥ 0.10 µg/L/cm³ for MRI. Those who undergo ultrasound only (density < 0.10) are reported separately so that the proportion with suspected cancer according to MRI is comparable between regions. 8a) In 2024, Region Stockholm conducted a study in which some men with PSA 3.0–9.9 µg/L did not undergo MRI. 8b) Incidental findings are categorized as suspected other cancer (red), other finding that should trigger action (amber), and findings without clinical significance that should not trigger notification to the participant (green). 8b) Incidental findings that do not require action should, according to OPT guidelines, not be described in the report, as the individual has chosen to be screened specifically for prostate cancer only. 8a+b) For comparisons between regions, a specific age group should be selected. In the annual report, men under and over 60 years of age are reported separately. 8a) Corresponds to KPI 13 of PRAISE-U.
Data sources	SweOPT
Level of reporting	Region
Sources of error	Incidental findings may be described in the report but not registered.

Indicator 9 – Time intervals

Measure	9a) Time from PSA test to notification of MRI: Time from receipt of the PSA test in OPT-IT to when a letter/message with the MRI result indicating no need for biopsy is sent. 9b) Time from MRI examination to notification of biopsy results: Time from the MRI examination to when the man receives the biopsy result. 9c) Time from PSA test to notification of biopsy results: Time from receipt of the PSA test in OPT-IT to when the man receives the biopsy result.
Purpose	Short time intervals are important for participating men.
Comments	In regions with digital communication, men have access to the MRI results (9a) on the same day they are sent; in other regions, it takes a few days for the letter to reach the recipient. In the four northern (Norrland) regions, an ultrasound examination is performed prior to MRI, which prolongs the time to MRI. In 2024, Region Stockholm conducted a scientific study that prolonged the time to MRI in that region. Corresponds to KPI 11 of PRAISE-U.
Direction	Short
Type of indicator	Process
Technical description	-
Data sources	SweOPT
Level of reporting	Region
Sources of error	-

Indicator 10 – Cancer detection

Measure

10a) Outcomes of prostate biopsy within OPT:

Proportions of benign biopsies, cancer with Gleason score (GS) 3+3=6, GS 3+4=7, GS 4+3=7, GS 8–10, and no grade recorded (yet), plus the GS distribution among graded cancers.

10b) Proportion of diagnostic investigations resulting in a cancer diagnosis within OPT: An indication for MRI or (in the Norrland regions) an ultrasound examination for calculation of PSA density is considered an indication for diagnostic investigation.

10c) Proportion of OPT participants diagnosed with prostate cancer within OPT: All men who have provided a PSA sample within OPT are counted as participants.

Purpose	Evaluation of the algorithm and diagnostic methods.
Direction	High proportion of cancer with Gleason score ≥ 7 and low proportion of benign biopsies and Gleason score 6.
Comments	For comparisons between regions, a specific age group should be selected. In the annual report, men under and over 60 years of age are reported separately. The counts in 10a are slightly lower than in 10b because the Gleason score information becomes available a few months after the information that cancer has been detected. Corresponds to KPI 15 of PRAISE-U.
Type of indicator	Process
Technical description	Output is adapted to the region's algorithm for each calendar year.
Data sources	SweOPT and NPCR
Level of reporting	Region
Sources of error	-

Indicator 11 – Hospital care for infection following prostate biopsy

Measure	Proportion of men hospitalised for infection within 2 weeks after prostate biopsy within OPT.
Purpose	Avoiding harm is essential in screening. Infections following biopsy can be serious (sepsis). Many affected men do not have prostate cancer (false-positive screening tests), and avoiding harm in them is particularly important. Increasing antibiotic resistance may lead to a higher proportion of men developing sepsis over time.
Comments	Corresponds to KPI 10 of PRAISE-U.
Direction	Low
Type of indicator	Process
Indicator status	Development indicator at regional level.
Technical description	The outcome is defined as any inpatient care episode with one of the following diagnosis codes: A41 (sepsis), N10 (pyelonephritis), N39 (urinary tract infection), N30 (lower urinary tract infection), R65 (systemic inflammatory response, sepsis), R57.2 (septic shock), T814 (infectious complication following intervention). Alternatively, the outcome can be identified through review of medical records for all men hospitalized in the region within 2 weeks after prostate biopsy in OPT. It is desirable to record whether biopsies were performed transperineally or transrectally.
Data sources	Retrieved by the regions themselves from ROP and the regional inpatient care register.
Level of reporting	Region
Sources of error	Incorrect diagnosis code in the inpatient care registry. Care received outside the region.

Indicator 12 – Advanced cancer

Measure	12a) Advanced interval cancer: Proportion of OPT participants scheduled for re-invitation after 2 years who are diagnosed with advanced prostate cancer outside OPT before the next testing round within OPT. 12b) Advanced cancer within OPT: Proportion of OPT participants scheduled for re-invitation after 2 years who are diagnosed with advanced cancer at that time. 12c) Regional incidence of advanced prostate cancer: Age-standardised incidence of advanced prostate cancer in men under 85 years of age.
Purpose	12a/b) Evaluation of the programme's ability to diagnose cancer before it becomes advanced. 12c) Evaluation of reduced morbidity and mortality from prostate cancer following the implementation of OPT. A reduction in mortality cannot be expected until after at least 10 years of OPT with high coverage; therefore, this marker is used as a surrogate measure for reduced morbidity and mortality. It reflects the combined effect of testing, diagnostic investigation, and participation.
Comments	Advanced prostate cancer: T3–T4 and/or N1 and/or M1 and/or PSA $\geq$ 20 $\mu\text{g/L}$. Men diagnosed with advanced cancer at their first participation in OPT are not included. For comparisons between regions, a specific age group and testing round should be selected. In the annual report, cancers diagnosed between testing rounds 1 and 2 (12a) or in testing round 2 (12b) are reported. Men under and over 60 years of age are reported separately. The regions should review the medical records of all cases in 12a/b and report PSA levels, diagnostic results, and cancer characteristics at the individual level to NAG OPT. Indicators 5e and 12a/b correspond to KPI 20 of PRAISE-U. Indicator 12c is a surrogate measure for KPI 19 of PRAISE-U.
Direction	12a/b) Very low 12c) Decreasing over time

Type of indicator	Outcome
Technical description	12a/b) Denominator: Number of men with PSA ≥ 1 $\mu\text{g/L}$ within OPT up to and including the third most recent calendar year (requiring 30 months of observation) who have not been diagnosed with cancer within 6 months. Numerator: Number of men diagnosed with advanced cancer (T3–T4 and/or N1 and/or M1 and/or PSA ≥ 20 $\mu\text{g/L}$) 6–30 months after this PSA test. An individual may be counted multiple times, e.g., from round 1 to round 2 and from round 2 to round 3. 12c) Age-standardised according to the European population to enable comparisons with other countries.
Data sources	12a/b) SweOPT and NPCR. 12c) NPCR and the Population Registry
Indicator status	12c will be analysed from 2028 onwards.
Sources of error	Misclassification of diagnoses outside OPT (12a) and within OPT (12b) may occur, but is expected to be rare.

Indicator 13 – Treatment

Measure	13a) Curative-intent treatment among OPT participants: Proportion of men with prostate cancer diagnosed within OPT who are primarily planned for curative-intent treatment, among all men who have participated in OPT. 13b) Curative-intent treatment among participants with cancer: Proportion of men with prostate cancer diagnosed within OPT who are primarily planned for curative-intent treatment, among those diagnosed with cancer within OPT and with a registered primary treatment. 13c) Active surveillance for low-risk cancer: Proportion of men with Gleason score 6 prostate cancer diagnosed within OPT who are primarily planned for active surveillance, among men diagnosed with cancer within OPT and with a registered primary treatment.
Purpose	13a+b) To assess the extent to which OPT detects cancer at a stage where curative-intent treatment can be provided. 13c) To assess the extent to which overdiagnosis within OPT leads to overtreatment.
Comments	The outcome is registered planned primary treatment within 6 months in NPCR. Curative-intent treatment may include radical prostatectomy, radiotherapy, or focal therapy. 13c is an indirect measure of overtreatment. Many men with Gleason score 7 are also overtreated, and many men who initially start active surveillance are overtreated at a later stage. For comparisons between regions, a specific age group should be selected. In the annual report, men under and over 60 years of age are reported separately. Corresponds to KPIs 17 and 21 of PRAISE-U.
Direction	In line with the national average.
Type of indicator	Process
Data sources	SweOPT and NPCR
Level of reporting	Region
Sources of error	Planned treatment may change after registration in NPCR, e.g., after repeat biopsy before starting active surveillance.



Regionala cancercentrum – regionernas nationella samverkan inom cancervården.
Med patienter och närstående för hela människan, i dagens och framtidens cancervård.
www.cancercentrum.se