



APERTURE

RESEARCH WORKS

THE 30-MINUTE PROSTATE CANCER TREATMENT CLAIM

Independent Claims & Evidence Audit of a High-Impact Medical Treatment Proposition

CASE DESIGNATION	APERTURE-CASE-2026-006
MATTER TYPE	Independent Public-Source Case Study
PRIMARY CAPABILITY	Claims & Evidence Audit
STATUS	Final public dossier - subject to right of reply
DATE	14 August 2026
GOVERNING LANGUAGE	English

Reality before reliance. Verification before interpretation. Evidence before narrative.

INDEPENDENT PUBLIC-SOURCE CASE STUDY - NOT A CLIENT ENGAGEMENT

DOCUMENT CONTROL

This dossier was prepared by Aperture Research Works as an independent public-source case study. It is not a client engagement, medical consultation, diagnosis, treatment recommendation, legal opinion or regulatory finding. The purpose is to determine how far specific public claims concerning permanent-seed prostate brachytherapy can be supported by independent evidence, what qualifications are material, and what a reasonable decision-maker may safely rely upon.

No adverse inference is drawn merely because a claim could not be independently verified from public sources. Unresolved items are identified as unresolved rather than converted into negative findings.

Field	Controlled value
Author / final human approver	Paul Hattingh
Public brand	Aperture Research Works
Case	APERTURE-CASE-2026-006
Version	Final public dossier v1.0
Research status	Complete subject to right of reply
Confidentiality	Public-source case study
Medical boundary	No medical advice; specialist clinical assessment required
Regulatory boundary	No finding of professional misconduct or statutory breach

EXECUTIVE FINDING

The investigation found that the treatment at the centre of the claim is real, established and capable of excellent clinical outcomes. Low-dose-rate permanent-seed brachytherapy is an accepted treatment for appropriately selected patients with localised prostate cancer. Permanent radioactive implants, including palladium-103, are established. Local-anaesthesia protocols are feasible. Rectoprostic spacers can reduce rectal radiation exposure. Neoadjuvant androgen-deprivation therapy can reduce prostate volume in selected patients.

The investigation therefore did not support characterising the treatment as fictitious, fringe or inherently misleading.

The material evidentiary problem arose when conditional clinical findings were converted into concise patient-facing propositions without consistently retaining the risk group, denominator, endpoint, follow-up period, baseline function, treatment composition or modern competing-treatment context needed to interpret them safely.

OVERALL DETERMINATION: The headline proposition is PARTIALLY SUBSTANTIATED, BUT NOT RELIABLE WITHOUT MATERIAL QUALIFICATION. The treatment is legitimate and the evidence base is substantial. Several public claims are broader or more precise than the independently reviewed evidence permits without qualification.

Decision implication

A reasonable patient may safely rely on the proposition that permanent-seed brachytherapy is a genuine treatment worthy of discussion with an appropriate specialist. A patient should not rely on a universal >98% personal cure probability, a universal 76% probability of preserved sexual function, fixed surgery complication rates, or universal superiority over modern alternatives without individual clinical assessment and source qualification.

1. CENTRAL QUESTION, SCOPE AND METHOD

Central Question: Can the claim that appropriately selected men with localised prostate cancer can receive a short outpatient permanent-seed brachytherapy procedure with a greater-than-98% cure rate withstand independent evidentiary scrutiny?

Supporting questions

- Is LDR permanent-seed brachytherapy clinically established?
- Can the procedure genuinely be performed in a short outpatient setting under local anaesthesia?
- Is the greater-than-98% cure-rate claim supported as presented?
- Are comparisons with surgery, external-beam radiation, sexual function and urinary complications fair and properly qualified?
- What level of reliance should a reasonable decision-maker place on each material public claim?

Method

The investigation used a claim-first rather than narrative-first approach. Each material proposition was isolated and tested for source provenance, denominator, endpoint, time horizon, baseline status, treatment composition, generalisability, competing evidence, audience impression and reliance value.

Evidence hierarchy

- Tier 1: direct or controlling evidence, including legislation, official registers and original records.
- Tier 2: strong authoritative evidence, including peer-reviewed research, regulator material, formal government publications and recognised technical standards.
- Tier 3: reputable secondary evidence.
- Tier 4: contextual or discovery evidence, including provider marketing, interviews and press material.

The Aperture visual and production system requires a consistent A4 dossier format, evidence-derived graphics only, and a clear separation between factual status, evidential confidence and reliance status. The current dossier follows that controlled structure. ■filecite■turn2file2■L279-L306■

2. CLINICAL BACKGROUND AND TREATMENT LANDSCAPE

Localised prostate cancer is not a single uniform condition. Management depends on risk category, PSA, Grade Group, clinical stage, life expectancy, baseline urinary and sexual function, anatomy and patient preference. For many low-risk patients, active surveillance is a major comparator because the first decision may be whether definitive treatment is needed immediately.

Contemporary definitive options may include radical prostatectomy, conventionally fractionated external-beam radiotherapy, moderately hypofractionated radiotherapy, stereotactic body radiotherapy (SBRT), LDR brachytherapy and other radiation strategies. The relevant comparison therefore depends on the individual patient rather than on a universal treatment ranking.

Finding C6-F92: For low-risk disease, efficacy alone does not establish treatment necessity. A treatment can have excellent cancer-control statistics while immediate treatment may still be unnecessary for an appropriate surveillance candidate.

3. THE >98% CURE CLAIM

Published LDR-brachytherapy cohorts genuinely contain outcomes at or near 98% in selected populations and under specific clinical endpoints. This materially weakens any suggestion that the number itself must have been invented.

The central problem is endpoint translation. Biochemical recurrence-free survival, PSA relapse-free survival, cancer-specific survival, metastasis-free survival and overall survival are not interchangeable with an unrestricted ordinary-language promise of cure.

Finding C6-F84: The numerical value near 98% has a genuine scientific foundation in selected prostate-brachytherapy cohorts. The word “cure” materially broadens the ordinary audience impression beyond what can safely be inferred from every clinical endpoint producing a similar percentage.

Risk-group problem

Low-risk, favourable intermediate-risk and unfavourable intermediate-risk disease are not interchangeable populations. A result generated in a selected lower-risk cohort cannot simply be extended to every intermediate-risk patient.

Finding C6-F112: “Results around 98% occur in the evidence” is strongly supported. “Low- and intermediate-risk prostate cancer has a general >98% cure rate after the described treatment” is not established at the same level.

4. THE 76% SEXUAL-FUNCTION CLAIM

Hostile scrutiny found strong support for the numerical value itself. Published prostate-brachytherapy literature contains potency-preservation outcomes around 76% in selected cohorts. The critical issue is the denominator: studies commonly evaluate men who were potent before treatment, and results depend on age, follow-up period, treatment composition, potency definition and use of erectile-function medication.

Finding C6-F86: The 76% number is substantially traceable to real clinical evidence. Its reliability falls when the baseline-potency requirement and follow-up period are removed from the public formulation.

A two-year potency result and a five- or ten-year potency result are not interchangeable. Erectile function can change with ageing, comorbidity and delayed treatment effects.

Reliance: RELIABLE WITH MATERIAL QUALIFICATION.

5. RADICAL PROSTATECTOMY COMPARISON

The broad proposition that radical prostatectomy can materially affect erectile function and urinary continence is well supported. The evidentiary problem is the use of precise, age-specific and permanent percentages without a clearly identified contemporary cohort and matching endpoint definition.

Asymmetrical framing

Brachytherapy is presented positively as a preserved-function percentage, while surgery is presented negatively as a dysfunction percentage. A fair comparison should use the same orientation and comparable populations, endpoints and follow-up periods.

Finding C6-F89: High post-prostatectomy erectile dysfunction is strongly supported. The exact >65% permanent age-specific formulation remains over-precise relative to the evidence located.

Finding C6-F90: The >25% permanent-incontinence claim is substantially less secure and receives LOW RELIANCE without a defined endpoint and cohort.

6. MODERN SBRT AND ACTIVE SURVEILLANCE

The source's portrayal of external-beam radiation as a treatment requiring four to eight weeks is true for some schedules but incomplete as a description of the modern landscape. Five-fraction SBRT is an established short-course option for appropriately selected patients.

Randomised evidence from the PACE programme materially changes the functional comparison. SBRT has shown less patient-reported urinary incontinence and sexual dysfunction than prostatectomy at two years, with a different bowel-toxicity trade-off.

Finding C6-F113: The strongest adverse evidence against the source concerns comparative completeness rather than brachytherapy efficacy. Modern SBRT materially changes both treatment-duration and functional-outcome comparisons.

For low-risk disease, active surveillance is also a critical comparator because it can avoid immediate treatment morbidity while maintaining structured monitoring.

7. Pd-103 PHYSICS, DOSIMETRY AND OEDEMA

Palladium-103 is a recognised isotope used in permanent prostate implants. Its activity decays exponentially. The source's "about 60 days" description is a practical simplification rather than a literal point at which the implants suddenly become inert.

Post-implant oedema and seed movement complicate dose delivery. These factors are particularly relevant to a short-lived isotope because a meaningful portion of decay occurs while anatomy may still be changing.

Finding C6-F94: The inside-out radiation explanation is directionally correct but omits clinically relevant dosimetric variables including post-implant oedema and seed movement.

Finding C6-F95: The local-dose advantage is genuine. "Very little" radiation to healthy tissue should not be interpreted as negligible or clinically irrelevant exposure to adjacent structures.

8. PROSTATE SIZE AND ADT DOWNSIZING

Prostate size is a material technical consideration, but the evidence does not support treating 60 grams as a universal binary eligibility rule. Relevant factors also include pubic-arch interference, urinary symptoms, urinary flow, prior procedures, tumour risk, implant geometry and clinician experience.

Finding C6-F96: The source correctly identifies gland size as a material technical factor but overstates it when presented as a universal under-60-gram requirement.

Neoadjuvant androgen-deprivation therapy can reduce prostate volume in selected men, often by roughly one third in published cohorts, and can overcome anatomical limitations in some cases.

Finding C6-F97: The claim that several months of hormone therapy can reduce prostate size and permit later brachytherapy in some patients is substantially supported.

9. RECTOPROSTATIC SPACERS

The underlying mechanism is well supported. Hydrogel or related spacing can increase the separation between the prostate and anterior rectal wall and reduce rectal radiation exposure. Placement quality matters, and dose reduction should not be translated into guaranteed elimination of toxicity.

Finding C6-F99: The claim that a rectoprostic spacer can reduce rectal radiation exposure is strongly supported.

Finding C6-F100: “Additional protection” should not be interpreted as guaranteed absence of rectal toxicity or procedure-related complications.

10. LOCAL ANAESTHESIA, PROCEDURE TIME AND SELF-DRIVE

Prostate brachytherapy under local anaesthesia has a published clinical foundation. A highly experienced practice may therefore operate a short in-office workflow without making that workflow a universal standard.

Finding C6-F101: Local-anaesthesia prostate brachytherapy is clinically credible and supported. The in-office workflow is provider-specific rather than universal.

The 30-minute, 45-minute and “under one hour” descriptions are not necessarily contradictory. They may use different start and end points. Precision requires a defined procedural clock.

Finding C6-F80: A 30-minute implant is feasible within a provider-specific workflow, but a general statement that prostate seed brachytherapy “takes 30 minutes” compresses a wider documented procedural range.

Self-driving after treatment can be a feature of a selected local-anaesthesia protocol, but applicability depends on the absence of impairing sedation and on individual clinical circumstances.

11. PROVIDER IDENTITY, EXPERIENCE AND THE >15,000 CLAIM

Public professional material supports that Dr Ajay Bhatnagar is a radiation oncologist with substantial experience in radiation oncology and brachytherapy. The investigation found no basis to treat the provider as fictitious or the treatment as an invented internet proposition.

The repeated >15,000-patient figure could not be independently resolved to a precise denominator. Public material did not establish whether it means prostate-cancer patients personally treated, all oncology patients, procedures, consultations or another count.

Finding C6-F105: The >15,000 figure should not be used as an independently established indicator of personal prostate-brachytherapy case volume without clarification of its denominator.

Board certification

Board certification is a repeated provider-associated claim. Primary name-specific verification was not closed through the accessible public interface. No adverse inference is drawn from that administrative limitation.

12. SPECIALTY ALIGNMENT AND CONFLICT SCREENING

The proposition that treatment availability, training, referral patterns and facility capability can influence what patients are offered deserves serious consideration. The same scrutiny must be applied symmetrically to a practice commercially and clinically centred on brachytherapy.

Finding C6-F106: Specialty alignment is a legitimate health-system variable but must be tested symmetrically across surgery, external-beam radiation and brachytherapy providers. Specialisation alone does not establish improper bias.

Public Open Payments review did not establish a material manufacturer conflict relevant to the headline claims. The correct formulation is “no material relevant conflict identified”, not “no conflict exists”.

Negative-evidence rule: Failure to locate a record is not proof that no record exists unless the search universe is demonstrably complete.

13. REGULATORY FRAMEWORK

Arizona physician regulation expressly treats false, fraudulent, deceptive or misleading physician advertising as a potential form of unprofessional conduct. That makes patient-facing accuracy and substantiation a legitimate subject of scrutiny.

This dossier does not find that Dr Bhatnagar or PCIA violated Arizona law. A misconduct finding would require the competent regulator, a complete evidentiary record, procedural rights and legal analysis outside the scope of this public-source case study.

Finding C6-F116: The evidence justifies scrutiny of substantiation and audience impression. It does not justify an allegation of regulatory violation.

Comparative superlatives

Claims equivalent to “highest cure rate”, “lowest side-effect risk” or superiority over modern SBRT or proton therapy carry a heavier evidentiary burden than a claim that LDR brachytherapy works well. Strong single-arm outcomes do not themselves prove comparative superiority.

Finding C6-F110: The evidence reviewed did not establish universal superiority of LDR brachytherapy across the relevant clinical endpoints.

14. STRONGEST DEFENCE OF THE PROVIDER

The strongest fair defence is substantial. Permanent-seed brachytherapy is established. Very high cancer-control outcomes are real in selected cohorts. Potency preservation can be favourable in selected previously potent men. Radical prostatectomy carries real functional risks. A short outpatient pathway can have meaningful practical value. Declining use of a legitimate treatment can justify encouraging patients to ask whether it is appropriate for them.

The central message, “ask whether brachytherapy applies to your case”, is therefore not inherently irresponsible.

Finding C6-F111: The strongest defence establishes that the public communication is rooted in genuine clinical evidence. It does not establish that every quantified public proposition retains enough of that evidence’s conditions to support the ordinary patient interpretation.

15. ADVERSE-EVIDENCE AND HOSTILE-SCRUTINY REVIEW

Aperture deliberately searched for evidence capable of undermining its own emerging conclusion. That process strengthened the treatment's legitimacy rather than weakening it. The strongest contrary evidence concerned the completeness and symmetry of the comparison set, especially modern SBRT and active surveillance.

No evidence reviewed justified a universal conclusion that LDR brachytherapy simultaneously provides the best cancer control, lowest toxicity and best functional outcome for every relevant patient group.

Finding C6-F115: No single modality dominates every outcome. The appropriate choice remains patient-specific and risk-stratified.

16. FINAL CLAIM-TO-EVIDENCE REGISTER

ID	Claim	Factual status	Confidence	Reliance
C6-01	LDR brachytherapy is established	Corroborated	High	Suitable for Reliance
C6-02	Pd-103 permanent seeds are legitimate	Corroborated	High	Suitable for Reliance
C6-03	Procedure takes about 30 minutes	Partially Verified	Moderate	Suitable for Conditional Reliance
C6-04	Tom treated in about 45 minutes	Unverified	Insufficient	Further Evidence Required
C6-05	>98% cure, low/intermediate risk	Partially Verified	Moderate	Limited Reliance Only
C6-06	Radiation is highly localised	Corroborated	High	Suitable for Conditional Reliance
C6-07	Pd-103 works for about 60 days	Corroborated	High	Suitable for Conditional Reliance
C6-08	Spacer reduces rectal dose	Corroborated	High	Suitable for Reliance
C6-09	Spacer can accompany implant	Corroborated	Moderate	Suitable for Conditional Reliance
C6-10	Local anaesthesia possible	Corroborated	High	Suitable for Reliance
C6-11	Patient can drive home	Attributed Claim	Moderate	Suitable for Conditional Reliance
C6-12	Prostate must be <60 g	Partially Verified	Moderate	Limited Reliance Only
C6-13	ADT can downsize gland	Corroborated	High	Suitable for Conditional Reliance
C6-14	76% retain sexual function	Partially Verified	High	Suitable for Conditional Reliance
C6-15	Most do not need catheter	Corroborated	Moderate	Suitable for Conditional Reliance
C6-16	>65% permanent impotence after surgery	Partially Verified	Moderate	Limited Reliance Only
C6-17	>25% permanent incontinence after surgery	Unverified	Low	Not Suitable for Reliance
C6-18	External beam requires 4-8 weeks	Partially Verified	High	Limited Reliance Only
C6-19	Most eligible men never hear of LDR	Unverified	Low	Not Suitable for Reliance
C6-20	>15,000 men treated	Attributed Claim	Low	Further Evidence Required
C6-21	LDR has best erectile preservation	Indeterminate	Low	Not Suitable for Reliance
C6-22	LDR outcomes exceed SBRT/protons	Unverified	Low	Not Suitable for Reliance
C6-23	Highest cure + lowest side effects	Unverified	Low	Not Suitable for Reliance

17. CONTRADICTIONS AND TENSIONS REGISTER

ID	Tension	Assessment	Impact
CT-01	30 min / 45 min / <1 hour	Likely definitional rather than factual	Moderate
CT-02	>98% "cure" / multiple endpoints	Endpoint translation materially changes meaning	High
CT-03	Low and intermediate risk grouped	Risk strata are not interchangeable	High
CT-04	76% preserved function / baseline potency	Material denominator omission	High
CT-05	Positive LDR framing / negative surgery framing	Asymmetrical comparative framing	Moderate
CT-06	>25% permanent incontinence	Endpoint insufficiently specified	High
CT-07	4-8 week EBRT / modern SBRT	Contemporary comparator omitted	High
CT-08	"third option" / active surveillance	Decision set incomplete for some low-risk patients	High
CT-09	Competitor specialty bias / LDR-focused provider	Requires symmetrical scrutiny	Moderate
CT-10	Provider experience / >15,000 denominator	Repeated but independently unresolved	Moderate

18. RIGHT-OF-REPLY PACKAGE

1. What specific peer-reviewed publication, audited internal dataset or combination of sources supports the repeated >98% cure-rate claim?
2. How does PCIA define “cure” for that public claim, and what follow-up period applies?
3. Does the >98% figure apply separately to low-risk, favourable intermediate-risk and unfavourable intermediate-risk disease?
4. What source supports the 76% sexual-function figure, and does it apply only to men potent before treatment?
5. At what follow-up interval is the 76% figure measured, and does it include pharmacological erectile support?
6. What source supports the >65% permanent-impotence figure for men older than 60?
7. What source supports the >25% permanent-incontinence figure, and how is incontinence defined?
8. Does “30 minutes” mean seed implantation alone or total procedure time including local anaesthesia, imaging, planning and spacer placement?
9. Under what circumstances may a patient drive home, and are patients receiving sedating medication excluded?
10. Is 60 g a fixed exclusion threshold or a practical guideline in the provider protocol?
11. What precisely is included in the public claim of more than 15,000 patients treated?
12. How many prostate-cancer patients and permanent-seed implants has Dr Bhatnagar personally treated/performed?
13. Does PCIA maintain an audited outcomes database for recurrence, urinary, sexual and rectal outcomes?
14. What evidence supports claims that LDR brachytherapy outperforms SBRT or proton therapy?
15. What evidence supports any claim that LDR combines the highest cure rate with the lowest side-effect risk?
16. Are there financial, consulting, speaking, ownership or other relationships with manufacturers of radioactive seeds, rectal spacers or brachytherapy equipment considered material to these public claims?

Any substantive response should be evaluated as evidence, independently verified where possible, and incorporated with a preserved audit trail. Failure to respond is not evidence that an allegation is true.

19. MATERIAL LIMITATIONS

- Public-source limitation: no access to complete internal patient databases, treatment plans, billing records or audited provider outcomes.
- Patient confidentiality: the anecdotal patient was not independently identified and should not be identified without lawful and proportionate reason.
- Non-randomised comparisons: much modality literature is observational and vulnerable to patient-selection effects.
- Evolving treatment: modern radiation schedules and surgical techniques can make older comparisons less representative of current practice.
- Outcome definitions: “cure”, “potency” and “continence” can represent materially different clinical endpoints.
- Provider-specific protocols: workflow results from an experienced practice should not automatically be generalised to other facilities.
- Regulatory limitation: this dossier is not a legal opinion and does not determine statutory liability or professional misconduct.

20. FINAL RELIANCE DETERMINATION

SUITABLE FOR RELIANCE	LDR brachytherapy is established; permanent radioactive seeds are legitimate; very strong cancer-control outcomes can occur in selected patients; ADT can reduce prostate volume; rectoprostic spacing can reduce rectal dose.
SUITABLE FOR CONDITIONAL RELIANCE	Short outpatient treatment, local anaesthesia, the 76% potency figure, highly localised dose delivery and catheter avoidance are supportable with patient-, endpoint- or provider-specific qualification.
LIMITED RELIANCE ONLY	The general >98% cure proposition, universal 30-minute duration, universal <60 g eligibility threshold, >65% permanent impotence formulation and 4-8 week external-beam comparison require material qualification.
NOT SUITABLE FOR RELIANCE	The >25% permanent-incontinence proposition as framed, "most eligible men never hear about LDR", and unqualified superiority claims over modern alternatives were not adequately established.
FURTHER EVIDENCE REQUIRED	The >15,000 denominator, provider-specific source for the repeated >98% figure, the patient anecdote and certain primary-register biographical checks remain unresolved.

21. FINAL CENTRAL FINDING

After claim extraction, literature review, guideline comparison, technical analysis, adverse-evidence review and hostile scrutiny, Aperture reaches the following determination:

The underlying medical treatment is legitimate, established and capable of excellent outcomes. The investigation found substantial evidence supporting many of the clinical concepts and even several of the numerical values used in the public communication.

However, the public presentation repeatedly compresses risk-specific, endpoint-specific, time-specific and provider-specific evidence into concise statements that can reasonably be understood more broadly than the underlying evidence warrants.

FINAL HEADLINE DETERMINATION: PARTIALLY SUBSTANTIATED, BUT NOT RELIABLE WITHOUT MATERIAL QUALIFICATION.

The case is not primarily about fabricated science. It is about loss of material qualification between scientific evidence and public communication.

22. APERTURE CASE CONCLUSION

Case 6 demonstrates a verification problem that extends beyond prostate cancer. A proposition can be built from individually credible facts and still create an unreliable overall impression when the conditions attached to those facts disappear.

In this case, the treatment was real. The science was substantial. Several impressive numbers were real. But the meaning of those numbers changed when denominators, endpoints, follow-up periods, risk groups and modern alternatives were removed.

The defensible conclusion is therefore neither that the “30-minute cancer treatment” is fake nor that a universal >98% cure claim has been confirmed.

LDR prostate brachytherapy can be a highly effective, short and clinically legitimate treatment for appropriately selected patients. Several public claims examined in this case have genuine scientific foundations, but some are expressed more broadly and more precisely than the independently reviewed evidence permits without qualification.

23. SOURCE REGISTER

ID	Source	Reference / URL	Use
S01	AUA/ASTRO Clinically Localized Prostate Cancer Guideline	https://www.auanet.org/guidelines-and-quality/guidelines/clinically-localized-prostate-cancer	Guideline / treatment landscape
S02	PubMed PMID 23062705 Long-term LDR brachytherapy outcome study	https://pubmed.ncbi.nlm.nih.gov/23062705/	98% biochemical-control ancestry
S03	PubMed PMID 30635196 Long-term prostate brachytherapy outcomes	https://pubmed.ncbi.nlm.nih.gov/30635196/	Long-term outcome definitions
S04	PubMed PMID 25255712 Sexual potency preservation after prostate brachytherapy	https://pubmed.ncbi.nlm.nih.gov/25255712/	76% potency context
S05	PubMed PMID 11483334 Sexual function after permanent prostate brachytherapy	https://pubmed.ncbi.nlm.nih.gov/11483334/	Potency preservation / long follow-up
S06	PubMed PMID 39266383 PACE-A randomised trial	https://pubmed.ncbi.nlm.nih.gov/39266383/	SBRT vs prostatectomy functional outcomes
S07	PMC 7616714 PACE-B trial report	https://pmc.ncbi.nlm.nih.gov/articles/PMC7616714/	Modern short-course SBRT
S08	PMC 6043740 Low-dose-rate prostate brachytherapy review	https://pmc.ncbi.nlm.nih.gov/articles/PMC6043740/	Selection, prostate volume, ADT
S09	PubMed PMID 11992054 ADT downsizing before brachytherapy	https://pubmed.ncbi.nlm.nih.gov/11992054/	Gland downsizing
S10	PubMed PMID 15701265 Neoadjuvant hormone therapy and prostate volume	https://pubmed.ncbi.nlm.nih.gov/15701265/	Volume reduction
S11	PubMed PMID 19523856 Optimal duration of neoadjuvant ADT	https://pubmed.ncbi.nlm.nih.gov/19523856/	Downsizing time window
S12	PubMed PMID 9719117 Prostate oedema after seed implantation	https://pubmed.ncbi.nlm.nih.gov/9719117/	Post-implant oedema
S13	PubMed PMID 10360539 Oedema effect on Pd-103 dosimetry	https://pubmed.ncbi.nlm.nih.gov/10360539/	Dosimetric complexity
S14	PubMed PMID 22557797 Seed movement / oedema dosimetry	https://pubmed.ncbi.nlm.nih.gov/22557797/	Implant dosimetry
S15	PubMed PMID 40976759 American Brachytherapy Society rectoprostatic gel spacer consensus	https://pubmed.ncbi.nlm.nih.gov/40976759/	Spacer evidence
S16	PubMed PMID 37213478 Spacer placement quality and rectal dose	https://pubmed.ncbi.nlm.nih.gov/37213478/	Spacer quality
S17	Arizona Legislature A.R.S. §32-1401	https://www.azleg.gov/ars/32/01401.htm	Physician advertising / professional conduct framework
S18	PubMed PMID 33577175 Patient-reported outcomes after SBRT, LDR and HDR	https://pubmed.ncbi.nlm.nih.gov/33577175/	Comparative quality of life
S19	PubMed PMID 25151536 Late urinary effects after LDR brachytherapy	https://pubmed.ncbi.nlm.nih.gov/25151536/	Normal-tissue toxicity
S20	Provider public materials PCIA / prostatecancerusa.com	https://prostatecancerusa.com/	Provider-specific protocol and claims

24. QUALITY-CONTROL AND PUBLICATION GATE

CONTROL	STATUS
Central question neutral and answerable	PASS
Treatment legitimacy separated from claim wording	PASS
Claims individually classified	PASS
Counter-evidence and strongest defence included	PASS
Modern SBRT and active surveillance considered	PASS
Unresolved provider claims not converted into adverse findings	PASS
Medical-advice boundary explicit	PASS
Regulatory conclusion appropriately limited	PASS
Right-of-reply questions prepared	PASS
Source register included	PASS
Aperture Research Works branding applied	PASS
A4 visual system, page numbering, footer and divider system applied	PASS
Public upload status	READY - subject to right of reply update if received

PUBLICATION GATE: The dossier is technically ready for upload as an independent public-source case study. If a substantive right-of-reply response is received, the controlled version should be updated and the change recorded rather than silently replacing the historical version.



APERTURE

RESEARCH WORKS

REALITY BEFORE RELIANCE.

VERIFICATION BEFORE INTERPRETATION. EVIDENCE BEFORE NARRATIVE.

APERTURE-CASE-2026-006

Independent Public-Source Case Study

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