Corrigendum: Correction of the Figure

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Trends of stratified prostate cancer risk in a single Korean province from 2003 to 2021: A multicenter study conducted using regional training hospital data

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After the above paper was published, the authors realized that all the figures were presented with a specific error: they should have shown the high-, intermediate-, and low-risk rates for each year, but instead, they calculated the year's rate for each risk stratification level and then converted it back to a yearly rate. As a result, the values of the percentages for each risk stratum in the results session for those years were incorrectly displayed in Fig. 1, 2, and 3, as opposed to the values in Table 1. In Fig. 1, which shows each indicator in the aggregate, the percentages of high-risk prostate cancer increased to 79.6%, 61.7%, and 65.6% in 2003, 2019, and 2021, instead of 54.8%, 30.6%, and 35.1%, respectively. The same problem occurred with Fig. 2, which shows the proportion of high-risk cancers for each indicator in the risk classification, raising the need to revise the numerical descriptions of key information in each figure during the results session. The percentage of patients with a high prostate-specific antigen (PSA) (≥20 ng/mL) consistently decreased from 61.2% (instead of 59.4% before correction) in 2003 to 28.8% (instead of 29.6%) in 2021 (Fig. 2A). The percentage with a high Gleason score (GS) (≥8) increased from 47.8% (instead of 32.8%) in 2011 to 49.2% (instead of 34.0%) in 2021 (Fig. 2B). The percentage with a high stage (over cT2c) increased from 36.1% (instead of 26.5%) in 2011 to 46.4% (instead of 37.1%) in 2021 (Fig. 2C). Also in Fig. 3, which breaks down the risk classification of each indicator in the risk classification, we had to go through the same process to calibrate the numbers.

However, the authors emphasized that, unlike the United States, high-risk prostate cancers account for the most significant proportion of cases in Korea, even in the nearest investigation, and this was not different before and after the correction. Therefore, the authors confirm that the errors related to these figures did not significantly affect the conclusions reported in this study. The authors are grateful to the editors of Investigative and Clinical Urology for the opportunity to publish this correction. We also apologize for any inconvenience caused to readers of this journal.

Corrected Figures

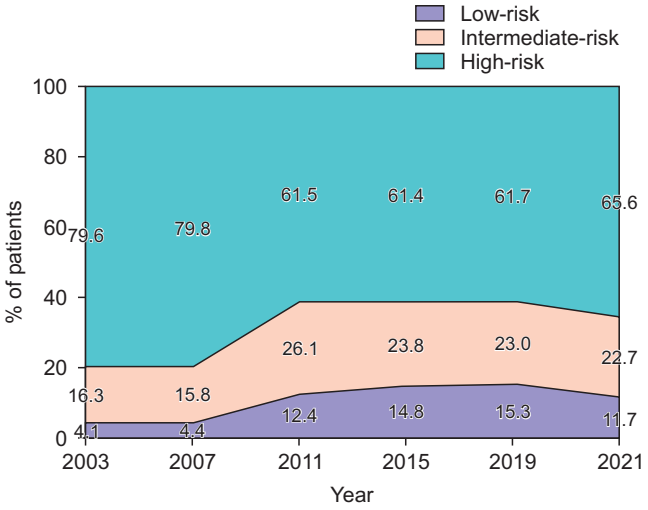

Fig. 1. Changes in prostate cancer risk-stratification during 2003–2021 based on the data of pathologically confirmed patients at seven academic hospitals in Daegu-Gyeongsangbuk province, Korea.

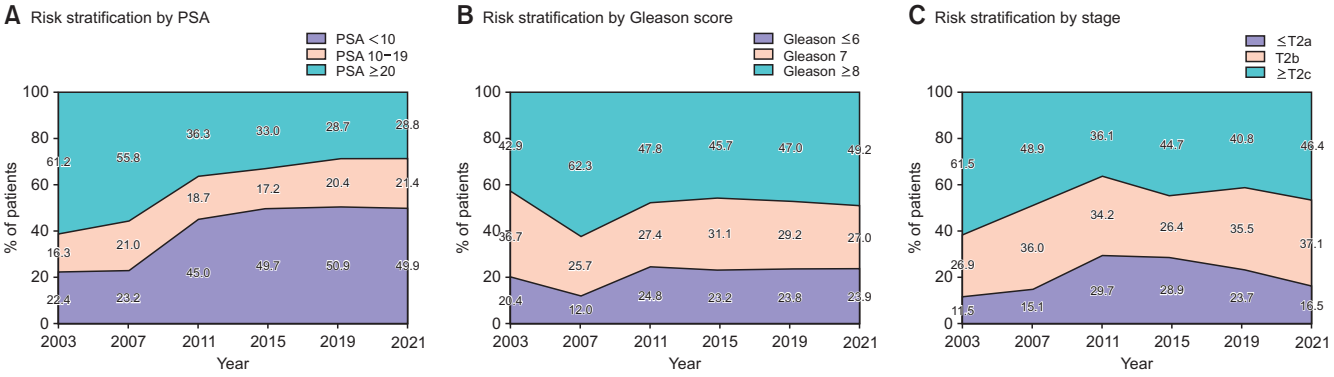

Fig. 2. Changes in prostate cancer risk-stratification during 2003–2021 in Daegu-Gyeongsangbuk province as determined by serum prostate-specific antigen (PSA) levels (A), Gleason scores (B), and clinical stages (C).

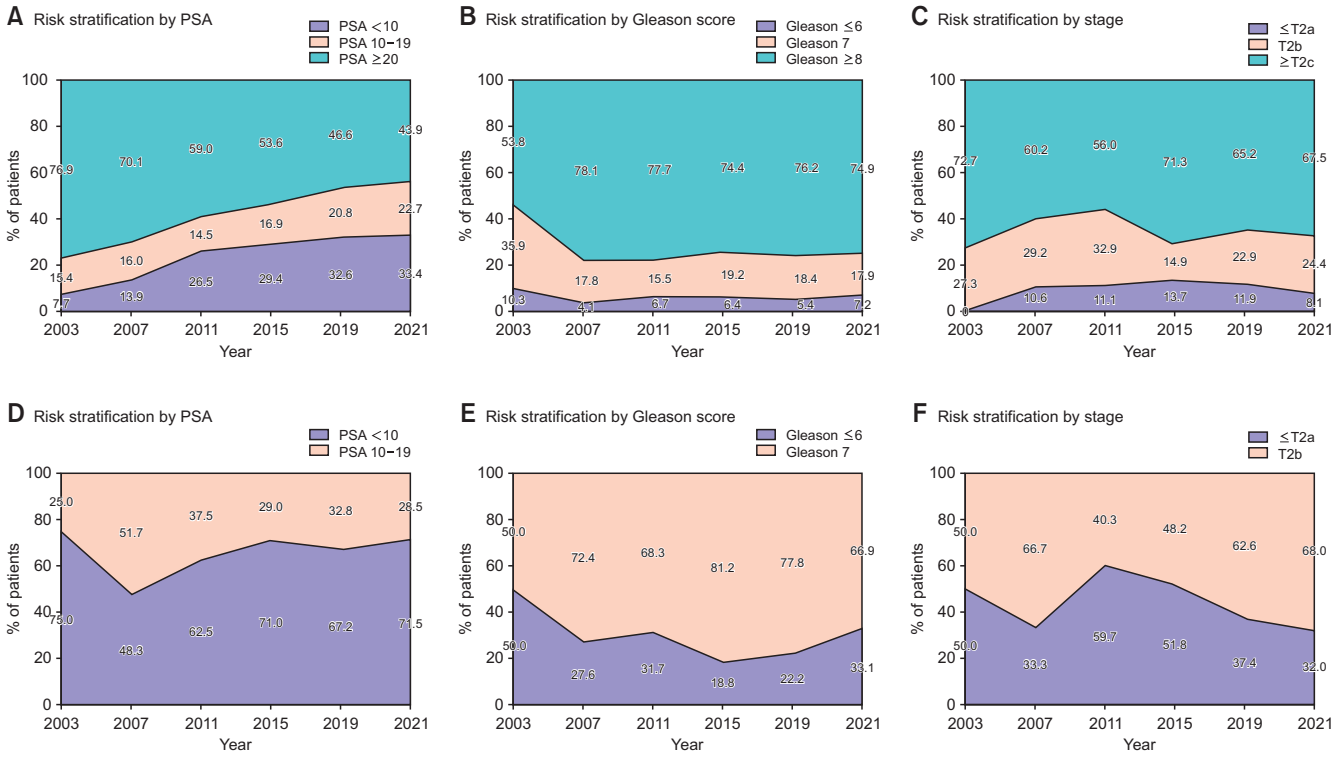

Fig. 3. Changes in prostate cancer risk-stratification during 2003–2021 in Daegu-Gyeongsangbuk province in the high-risk (A–C) and intermediate-risk (D–F) subgroups as determined by serum prostate-specific antigen (PSA) levels, Gleason scores, and clinical stages.

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