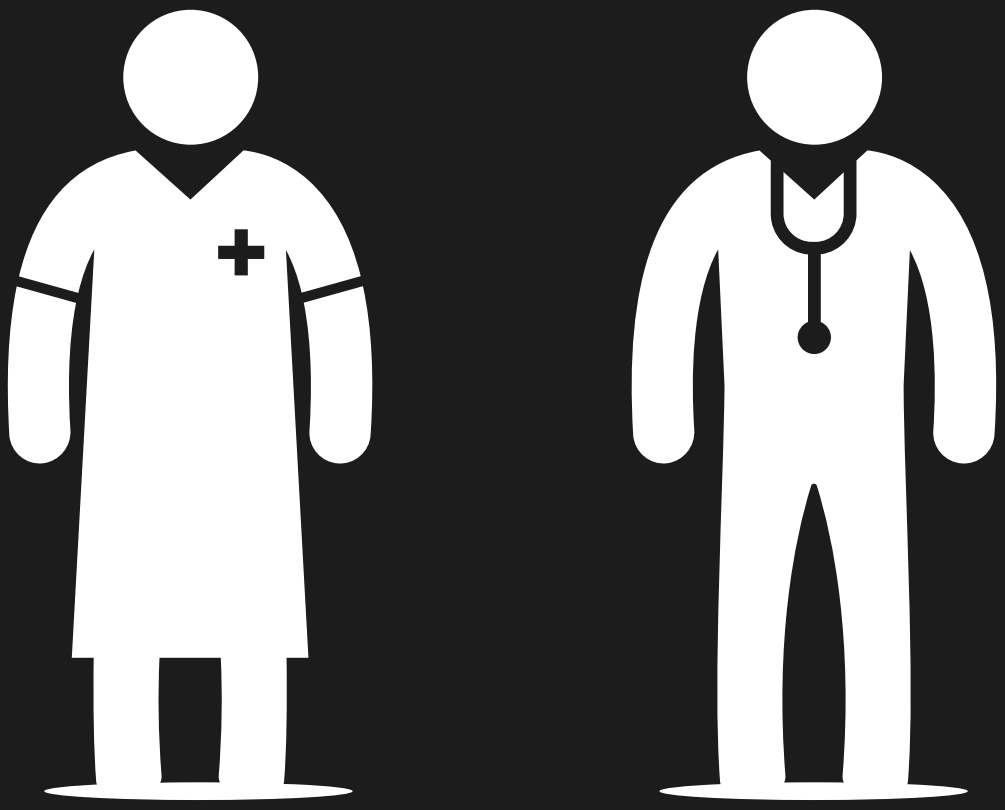
Active surveillance for CPG 1 and CPG 2:

Implementation toolkit for a risk stratified surveillance programme.



PROSTATE CANCER UK

Contents

Forward / introduction

More than 55,000 men are diagnosed with prostate cancer in the UK each year. It is estimated that up to 1 in 3 men are diagnosed with Cambridge Prognostic Group (CPG) 1 or 2 prostate cancer and are potentially suitable for active surveillance (AS) every year in England alone (approx. 20-25,000 men/year) (1).

AS is a treatment option which allows men to delay or avoid radical treatment, and the associated side-effects of those treatments. **It is an important aspect of the pathway in relation to reducing overtreatment.**

The delivery of AS is variable with heterogeneity in enrolment criteria, follow-up interval, and timing of repeat biopsy, as well as criteria for stopping or recommending treatment (2, 3, 4).

Best practice active surveillance and research priorities have been previously described (2, 3) for men diagnosed with early, localised prostate cancer. **Personalised active surveillance** is an important aspect of the pathway, as is **optimal use of NHS resources**. Therefore, the implementation of risk-adapted approaches should be a priority.

STRATCANS (STRATified CANcer Surveillance – **stratcans.com**) is an example of data driven practice with published evidence suggesting that when implemented, AS follow-up can be de-escalated for men at low-risk of disease progression. **The model has also demonstrated resource savings** (fewer clinical appointments and MRI scans which can be redirected to areas of greater need) and **high patient compliance rates (Table 1)** (5, 6).

The model has now been tested in 5-year follow up with published outcomes and has also been externally validated. The model is based on the risk of progression to CPG≥3 disease (19,20).

Table 1: Modelling scenario comparing outpatients and MRI use for the first 12 months of follow-up required by STRATCANS strategy versus UK NICE-recommended schedule. Based on NHS 2020/21 National Tariff Payment System.

Events follow-up	STRATCANS	NICE NG131 Guidelines	Difference	Estimated cost saving
Clinic visit	98	126	-22%	The estimated cost savings were £1,518 per 100 men in outpatient visits (HRG code RD101, based on £69 per follow-up) and £6027 per 100 men in MRI costs (7, 8). As repeat DRE is not part of the STRATCANS initiative, all follow-up appointments in STRATCANS were also done remotely without the need for face-to-face evaluation.
MRI	73	126	-42%	
DRE	No DRE	126	-100%	

Adapted from Thankapannair, Vineetha et al. (2023)

This toolkit, provides steps for Cancer Alliances, and NHS project leads working with secondary care, to implement risk stratified follow-up for men diagnosed with CPG1 and CPG2 prostate cancer, and aims to:

- Standardise the delivery of active surveillance on a regional basis – entry/exit criteria, follow-up, etc.
- De-escalate follow-up for men at low risk of progression on surveillance.
- Reduce and refine use of clinical resources and redirect to more “in need” parts of the disease pathway.
- Empower and enable patients to take responsibility and ownership of their AS management by providing them with personalised follow up and PSA triggers for review of their surveillance, therefore providing a safe basis on which to develop and move to remote follow-up programmes.

Although the currently available evidence is promising, we’re keen to build the evidence base for the *STRATCANS* model to support future learning and national scaling of stratified follow-up. **If you have implemented the *STRATCANS* protocol and would be happy to share your data and learnings, please contact – campaigns@prostatecanceruk.org**

Recommended online learning:

Watch our Innovation event on active surveillance and stratified follow-up - **Link.**

If you would like guidance on implementing an Active Surveillance protocol you can contact our Improvement Programmes Team at **improvement@prostatecanceruk.org**. We can offer advice on subjects such as stakeholders, navigating barriers and communication.

If you would like longer term coaching and support, we run a series of free leadership programmes that are designed to empower healthcare professionals in leading improvement projects. Please check our website for more details on our upcoming short programmes or our flagship Clinical Champions Programme **recruitment**.

Summary process

Check eligibility - informed by PSA / MRI / Biopsy test results.

Patient fully counselled on their prognosis and options using NICE guidance and resources referenced within this toolkit.

Discuss the process of surveillance with the patient - PSA / MRI / Biopsy test frequency - according to agreed stratified follow-up protocol.

Check for **psychological support needs -** patient anxiety about cancer progression. Use personalised prognosis tools to support conversations **(e.g. Predict Prostate)**.

If patient and clinical team happy, active surveillance process begins.

Establish lines of communication with clinical team so patient can ask questions.

Exit criteria: establish when a patient should move to active treatment or watchful waiting based on clinical features and patient preferences.

Context

NICE guideline, Prostate cancer: diagnosis and management (NG131), sections 1.3.8 – 1.3.12 (Table 2):

1.3.8 For people with CPG 1 localised prostate cancer:

- **offer active surveillance.**
- consider radical prostatectomy or radical radiotherapy if active surveillance is not suitable or acceptable to the person.

1.3.9 For people with CPG 2 localised prostate cancer, **offer a choice between active surveillance, radical prostatectomy, or radical radiotherapy if radical** treatment is suitable.

1.3.10 For people with CPG 3 localised prostate cancer:

- offer radical prostatectomy or radical radiotherapy and
- **consider active surveillance** for people who choose not to have immediate radical treatment.

1.3.11 **Do not offer active surveillance to people with CPG 4 and 5** localised and locally advanced prostate cancer.

1.3.12 Offer radical prostatectomy or radical radiotherapy to people with CPG 4 and 5 localised and locally advanced prostate cancer when it is likely the person's cancer can be controlled in the long term.

1.1 Information and decision support for people with prostate cancer, their partners, and carers - Link.

The **East of England Cancer Alliance** has developed a patient directed website that explains the NICE guidance in lay terms for each CPG to support active surveillance uptake - **Link.**

GIRFT, Towards better diagnosis and management of suspected prostate cancer.

- For patients where active surveillance (AS) is a management option: Active surveillance is the recommended approach for men diagnosed with Cambridge Prognostic Group (CPG) 1 & 2.
- Patients on active surveillance: Intensity of follow up will vary with the risk stratification of prostate cancer and the level of risk at which treatment will be triggered.
- **Link to GIRFT better diagnosis and management of suspected prostate cancer resource.**

Cancer Alliance Planning Pack 2024/25, Faster Diagnosis Priority Pathways – Urology:

- Lead a project with secondary care partners to implement risk stratification tools, such as Predict Prostate / Cambridge Prognostic Groups, to reduce unnecessary progression to biopsy and/or progression to treatment regimens.
- Rationale: The use of risk stratification tools will support the reduction of unnecessary investigation and over-intensive monitoring.

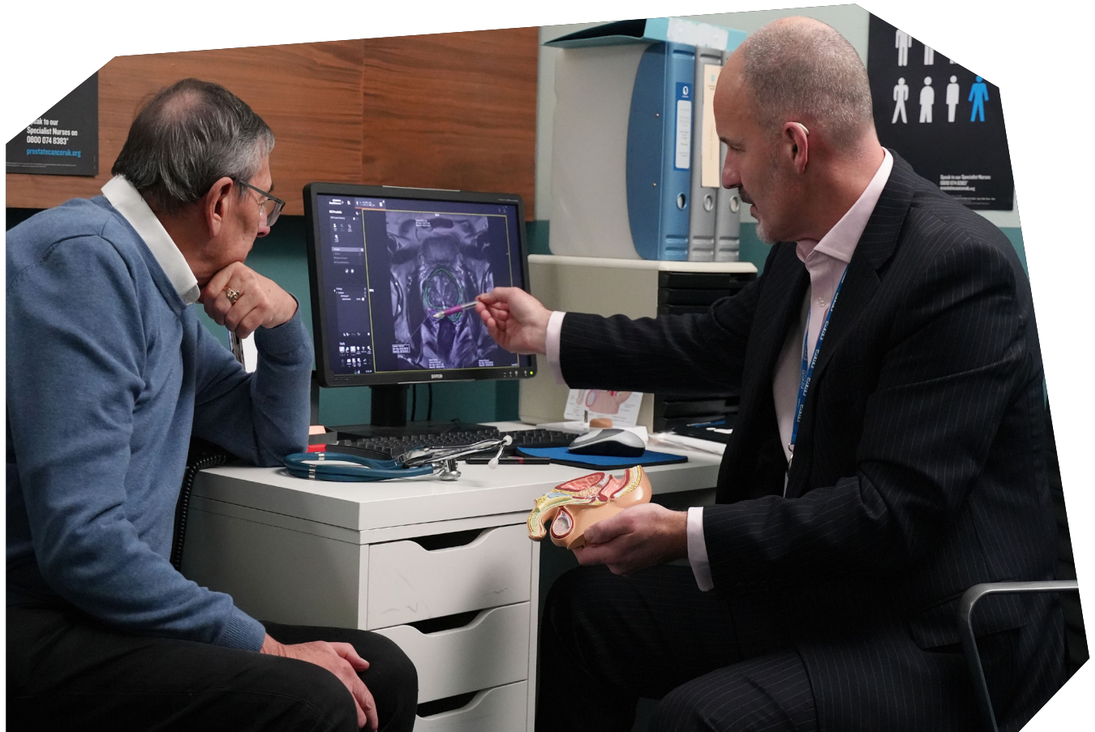
National Prostate Cancer Audit (NPCA):

- Work by the NPCA has shown Cambridge Prognostic Groups (CPGs) to be accurate in predicting outcomes and has potential for assessing the appropriateness of treatment allocation.
- **Using the Cambridge Prognostic Groups for risk stratification of prostate cancer in the National Prostate Cancer Audit: How could it impact our estimates of potential 'over-treatment'?**

Active surveillance - eligibility criteria

Table 2: Cambridge Prognostic Group and recommended management.

Cambridge Prognostic Group	Management
CPG 1	Recommend active surveillance.
CPG 2	
CPG 3	Consider active surveillance, particularly for non-MRI visible Gleason 3+4.
CPG 4	Do not recommended active surveillance
CPG 5	
Provide shared decision-making support and ensure timely review for those patients who want to explore active treatment options.	



Active surveillance stratified follow-up: Protocol development

Institutional oversight of implementation and evaluation are recommended. No additional administrative, personnel, or set-up costs are expected to arise because of implementation and evaluation however this may be different for each hospital trust.

- Enrol men with early prostate cancer (cancer still contained within the prostate, and has not spread to other parts of the body) into a prospective stratified follow-up programme.
- Using CPG to define inclusion criteria and discontinuation triggers. (6), see also **NICE NG131**.
- Men otherwise fit for curative therapy and with disease suitable for AS defined as:
    - CPG ≤2 (clinical stage T1-T2, PSA ≤20 ng/ml, and histological grade group ≤2)
- All men should have had a multiparametric MRI (mpMRI) prebiopsy, which was used to guide biopsy (sectoral and targeted), or sectoral only if there are no lesions.
- Prostate Imaging Reporting and Data System (PI-RADS)-compliant protocol performed as a multiparametric study at baseline and as a biparametric study without dynamic contrast enhancement in AS follow-up as described previously. (9 ,10)
- Estimate prostate volume by MRI measurements using the **'ellipsoid formula'**. Report changes using the Prostate Cancer Radiological Estimation of Change in Sequential Evaluation (PRECISE) criteria (11).
- At diagnosis, counsel all men on risk-benefit using the NICE CPG recommendations and individual prognosis estimates using the Predict Prostate tool **(prostate.predict.cam)**.
- Signpost men to information and support resources that can be accessed in their own time (see section – **'Supporting your patients'** for examples).
- For men new to AS, commence from day one on a risk stratified programme outlining the schedule of follow up based on their baseline characteristics as detailed below.
- Use figure 1 pathway on page 9.

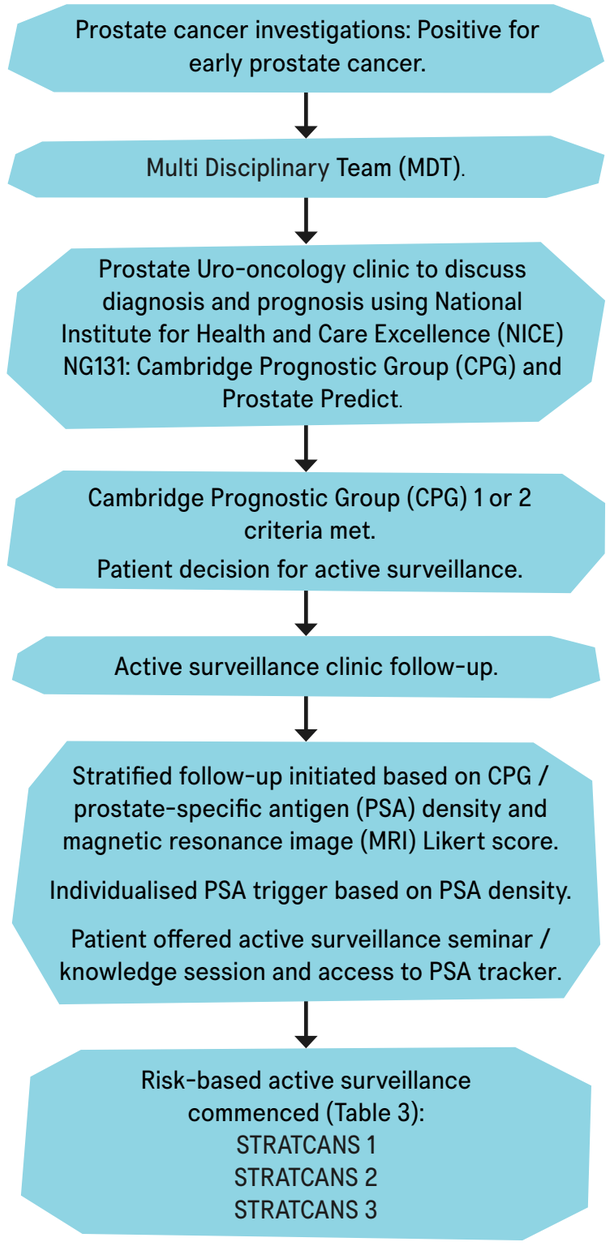


Fig. 1. Adapted from Thankapannair, Vineetha et al. (2023). Pathway of the diagnostic, risk stratification, and counselling process for men with new prostate cancer and the onward pathway for men who select active surveillance in the Stratified Cancer Surveillance (STRATCANS) programme.

- Consider offering an early, repeat biopsy to confirm the diagnostic parameters and ensure no higher-grade disease is present if surveillance is to be risk-stratified. (12)
- Based on CPG, PSA density (PSAd = PSA divided by MRI-derived prostate volume), and presence of an MRI lesion, include men into *STRATCANS*-tiered groups as outlined in Table 3 and in the ***STRATCANS*** webtool.

- Men in the lowest tier *(STRATCANS 1)*, de-escalate follow-up to 18-24 months intervals. Those in the highest tier *(STRATCANS 3)* will have 6 monthly follow-ups and those in the middle tier *(STRATCANS 2)* will have annual follow-ups.
- Repeat MRI should be risk scheduled based on the presence of no lesion (PI-RADS Likert 1–2) every 5 yr, or a positive lesion (Likert 3–5) every 24 months EXCEPT for men in STRATCANS 3 where imaging should be annual (Table 3).

  Note: For men with MRI-visible lesions (especially Likert 3–5), the STRATCANS study group advised an additional higher risk of progression within the subgroups. Conversely, they found, like others, that MRI invisibility is a favourable marker for non-progression (13).
- Use the PRECISE scoring system to compare MRI on AS. (11)
- Men in the highest-risk *STRATCANS* group should have annual MRI regardless of lesion positivity.
- A personalised PSA threshold for earlier review should be defined for each man based on their individual PSAd at the start of AS:
  - If the starting PSAd is <0.15, then a PSA level that breached 0.15 on two separate occasions 3-months apart should be used as a trigger for an early review.
  - If the PSAd is ≥0.15, then a PSAd threshold of 0.20 should be used.
  - Higher PSA thresholds can be decided on a case-by-case basis.
  - The ***STRATCANS*** webtool can be used to calculate the personalised PSA threshold.
- PSA should be repeated every 3-months regardless of the follow-up tier.

  Note: Empower and encourage men to self- monitor their PSA and be aware of their own personal PSA threshold based on the above.
- Digital rectal examination (DRE) is not required as part of the follow-up protocol and follow up can be done remotely for all clinic visits. However, for patients who cannot have MRI, DRE and in-person clinic visits are recommended.
- Protocol repeat biopsies are mandated at 3 years for STRATCANS 3, with the option for the patient to not proceed if other features were favourable (Table 3).
- For *STRATCANS* 1 and 2, a biopsy is recommended if triggered by a change in PSA or MRI.

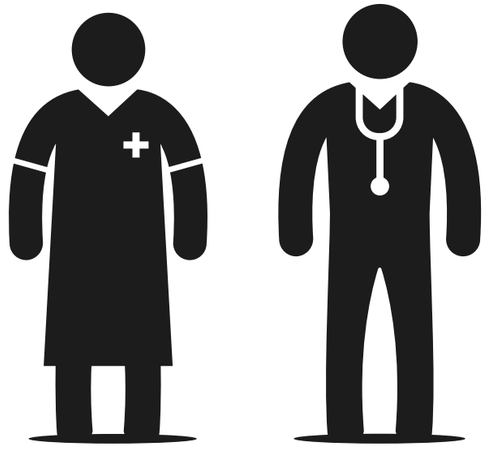


Table 3: Recommended risk-stratified follow-up schedule and intervals of outpatient appointments, prostate specific antigen (PSA) testing, magnetic resonance imaging (MRI) scans, and recommendations for biopsy.

STRATCANS group	Inclusion criteria	Follow-up schedule
1 Low Intensity	Cambridge Prognostic Group 1 **and** PSAd <0.15	3-4 monthly PSA (patient self-monitoring recommended). 18-24 monthly (telephone/in person) appointment.
		MRI Likert/PI-RADS 1-2 (no lesion) = repeat at 5 years. MRI Likert/PI-RADS 3-5 = repeat 2 yearly.
		No routine re-biopsy. Triggered re-biopsy if any change.
2 Moderate Intensity	Cambridge Prognostic Group 2 **or** PSAd ≥0.15	3-4 monthly PSA (patient self-monitoring recommended. 12- monthly (telephone/in person) appointment.
		MRI Likert/PI-RADS 1-2 (no lesion) = repeat at 5 years. MRI Likert/PI-RADS 3-5 = repeat 2 yearly.
		Triggered re-biopsies if any change.
3 High Intensity	Cambridge Prognostic Group 2 **and** PSAd ≥0.15	3-4 monthly PSA (patient self-monitoring recommended). 12 monthly (telephone/in person) appointment.
		MRI (any Likert/PI-RADS) = repeat at 12 months.
		Re-biopsy at 3 years.* Triggered re-biopsies if any change.
* Option to omit 3-year re-biopsy after discussion with patient		

Adapted from Gnanapragasam et al (2025) and stratcans.com webtool

- Prior to enrolment into *STRATCANS*, inform men of the rationale and plan of transfer to the programme by letter or other discussion.
- Ask them to contact if they have any concerns or declined to enrol. **Importantly, establish a key point of contact for patients if they have question or issues.**
- Note: the contact will normally be a Clinical Nurse Specialist (CNS) who leads the AS programme implementation or could be a consultant or delegated administrator / pathway navigator.

- Invite men (and their 'significant other' (14)) to attend an AS seminar/educational session (online or in-person) to explain how the *STRATCANS* programme will work. This could be in the form of a PowerPoint presentation which we can support with if needed.
- Signpost men to AS health information which they can read/watch beforehand, for example:
    - Prostate Cancer UK health information on active surveillance – **Link**.
    - Prostate Cancer UK webinar: An introduction to active surveillance – **Link**.
    - Active surveillance for Early Prostate Cancer, produced by the East of England Cancer Alliance – **Link**.
- Transfer men already on AS to the *STRATCANS* programme as they came up for routine review.
- *STRATCANS is proposed as a 5-year cycle with review at the end for each patient before either:*
    - Repeating the 5-year cycle.
    - Moving an individual up to closer follow up *(e.g. STRATCANS 1 to 2)*
    - Re-evaluation of the suitability of AS and/or switching to treatment as needed.

Dealing with changes during active surveillance and when to stop

- PSA changes/rises alone should not trigger a change in management. If PSA levels show a continuous trend to rise – perform a repeat MRI first. Based on the MRI consider options of repeat biopsy or continuing surveillance (15).
- MRI changes alone (not amounting to progression to T3) should be used to discuss a repeat biopsy. MRI changes alone in size should not trigger direct conversion to treatment (15).
- A change from CPG 1 to CPG 2 either through PSA rises or a change from Grade Group 1 to 2 should be discussed and the prognosis and *STRATCANS* tiers re- evaluated. AS remains a good option for ongoing management. (15)
- MRI changes to T3 or biopsy progression to Grade Group 3 and composite of CPG 3 is a trigger to discuss treatment unless the patient is no longer suitable for active treatment or has moved to watchful waiting.
- If a man moves to CPG 3 based on a PSA rise >10 and Grade Group 2 then this is outside the *STRATCANS* programme and follow up should be managed individually. These men can continue AS but should be in *STRATCANS* tier 3. However, this is an individual decision with the patient.
- Moving to watchful waiting is an individual discussion with the patient. As a guide, consider when the life expectancy is below 10 years based on the **ONS male life expectancy calculator** and co-morbidities.
- Other scenarios e.g. core number changes on re-biopsy, other pathology, and volume of disease remain uncertain and is up to centre discretion and clinician confidence.
- In any scenario above, the patient can choose to move to treatment if they wish and after having the appropriate counselling and information.

Supporting your patients

Uptake and adherence to active surveillance continues to be a challenge and many factors influence men's choice and ability to adhere to an active surveillance protocol (16). Being diagnosed and living with untreated prostate cancer can have a negative impact on men's psychological wellbeing, quality of life and adherence to active surveillance. The support and informational needs of men suitable for active surveillance have been well documented, in addition to the needs of their partners.

Men have mixed experiences on active surveillance – some are content with monitoring, others anxious and uncertain, supporting the need for personalised care for each patient. Family also plays an important, and often unrecognised, role in the decision-making process, and studies show they would benefit from more support (14).

As outlined above, when communicating with patients and their families, healthcare providers should give clear and balanced information on treatment options, to support them during the decision-making process. This should include individualised estimates of prognosis and treatment benefit balanced against competing morbidity and mortality. Simply outlining outcomes in terms of prostate cancer mortality is not sufficient. If AS is selected, this should be followed by communication with patients in the form of **a personalised care plan that empowers them to take ownership of their active surveillance journey.**

Note: Clinicians are encouraged to be conscious of how they communicate follow-up findings to their patients (i.e. PSA, MRI results) (14) (also see Figure 2).

A Prostate Cancer UK study found that some patients, notably those who were receptive to active surveillance as a treatment choice, may be reassured by the latest clinical trial results. Of relevance, HCPs are advised to refer to high-quality randomised phase III trial data, such as the Prostate Testing for Cancer and Treatment (ProtecT) trial study. We suggest referring to Box 2, p.16 – 20, NICE NG131, in addition to the Prostate Predict tool when counselling patients.

Although the number of men on active surveillance is increasing, patient information and support varies across the UK (3). Our insights into the information and support needs of men eligible for active surveillance can be found in Table 4. Suggested clinical interventions during active surveillance can be found in Figure 2.

Table 4: considerations when supporting men through decision-making about active surveillance.

Individual preferences

- Most men eligible for active surveillance feel well supported at diagnosis and during active surveillance, but some men need more help and support.

Communication

- **Regular open communication with a trusted health professional, and a personalised treatment plan** are crucial to ensuring men feel reassured on active surveillance. It can also help them avoid the adverse side effects from radical treatment.
- Encourage HCP's to signpost men towards resources for peer support, and their partners towards support groups.

Family influence

- A man's partner and loved ones can influence treatment decision making and adherence to active surveillance. Therefore it is important to provide partners and family with the appropriate health information and include them in treatment discussions.
- Encourage significant others to attend active surveillance educational programmes and support their partner's record-keeping of medical information (PSA level, etc).

Language

- **Language used during the initial consultation to 'frame diagnosis'** can determine whether men feel comfortable choosing active surveillance. For example, describing the cancer as "very small", explaining prognosis, and describing active surveillance as a "modern" and "progressive" way to manage localised prostate cancer.

Decison-making support

- Choosing active surveillance over treatment options isn't always an easy decision. Some men, their partners and family members, may feel that it goes against the instinct of wanting to treat and 'get rid of the cancer' immediately.
- Encourage HCP's to be more mindful of the impact/influence of significant others on their patient's care, maybe by supporting partners to be present in medical appointments and in discussions around clinical decision making.

Recommended online learning:

Risks Counselling and the importance of Active Surveillance, David Thurtle, Senior Urology Registrar, Cambridge University Hospitals - **Link**.

- Patient involvement and education into their own active surveillance management is key to the implementation and safety of *STRATCANS*. Encourage men to keep a record of their own PSA in paper or electronic form and having an awareness of their personal PSA thresholds e.g.
  - using the Expanded Prostate Cancer Index Composite MyChart facility; or
  - access to the patient-maintained electronic tracker **(trackmypsa.com)**, and to self-report changes in PSA if they breached preset thresholds.
  - **Prostate Cancer UK, Active Surveillance Diary.**
  - **Prostate Cancer UK, Active Surveillance Fact Sheet.**
  - **Trackmypsa.com** (a patient enabled PSA self-monitoring tool, NOT monitored by any health care professional)
- **Encourage and empower men to track that their specific intervals of PSA tests, MRI and clinic visit are achieved and to know the triggers for earlier intervention and review.**
- Include plans to conduct formal patient feedback (PREMS) to ensure the pathway and protocol are acceptable to patients and to highlight changes that could support improvements.

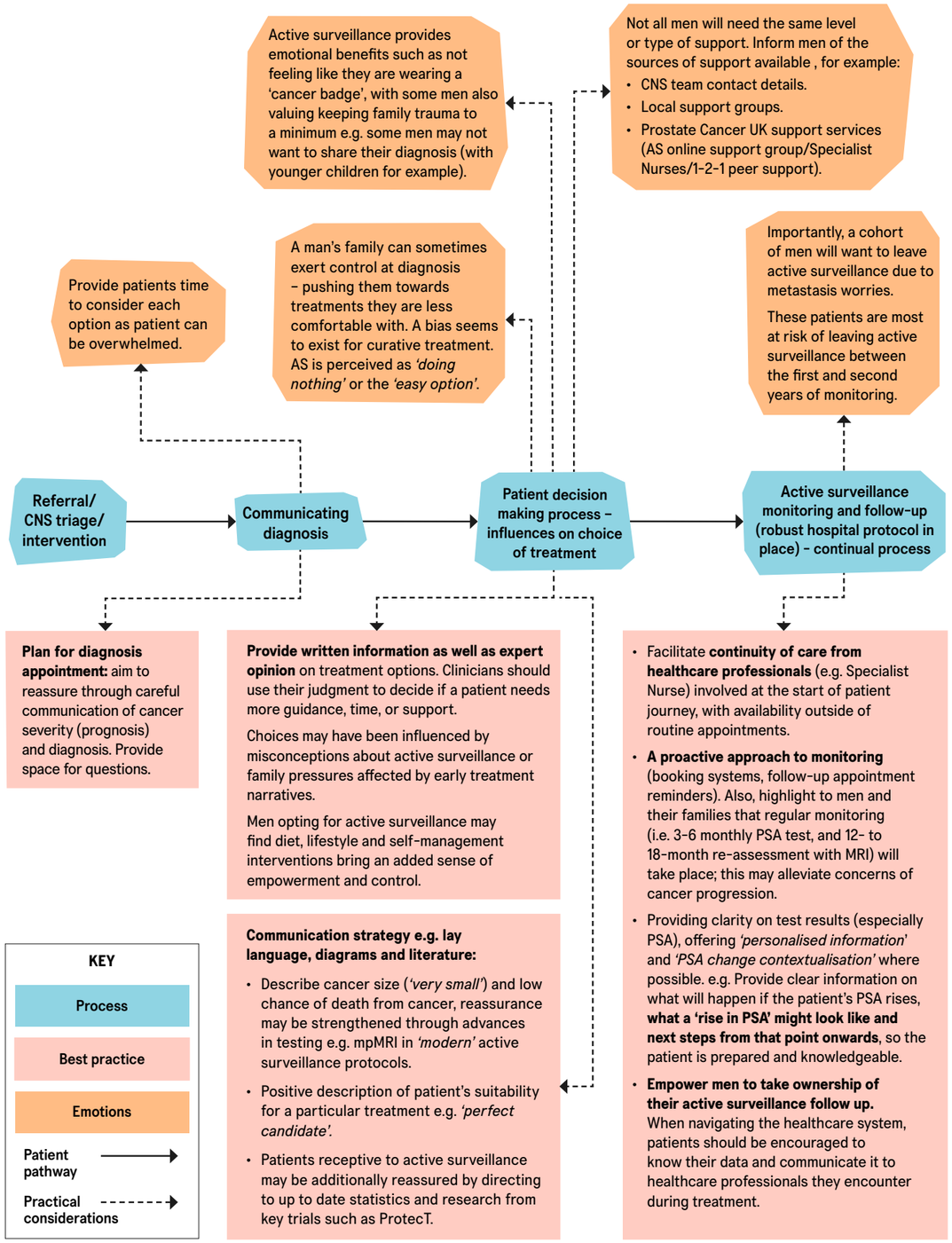
Other patient support tools:

- Prostate Cancer UK, Active Surveillance health information - **Link.**
- Prostate Cancer UK, Active Surveillance Virtual Support Group. A monthly group chat led by men who are on active surveillance who can share experiences and answer questions. The group chat happens on the 2nd Tuesday of each month from 7-8pm - **Link.**
- Common question on active surveillance in prostate cancer. Dr Sam Merriel addresses the ten most common questions on active surveillance asked by GPs and primary care health professionals - **Link.**
- East of England Cancer Alliance NICE guidance - **Link.**
- *STRATCANS* (STRATified CANcer Surveillance) webtool - **Link.**
- Predict Prostate tool - **Link.**

Figure 2:

Clinical interventions during patient's Active Surveillance journey

A summary of the initial, and ongoing, clinical interventions and key considerations for healthcare professionals (HCPs) advising and supporting eligible active surveillance candidates, diagnosed with localised CPG1 and CPG2 prostate cancer, informed by Prostate Cancer UK research.



Nurse-led active surveillance

Nurse-led active surveillance has been shown to be safe, effective and linked to high levels of patient satisfaction, where patient value flexibility, accessibility and continuity of care in particular. (17)

Recommended online learning:

Vineetha Thankappan Nair - Macmillan Lead Clinical Nurse Specialist and Urology cancer and prostate cancer Clinical Nurse Specialist - Cambridge University Hospitals – **Link**.

Patient educational seminars have been shown to halve AS drop-out rates, with men feeling more supported when provided with a single educational intervention within 3-months of treatment decision, with effectiveness of the intervention still evident at 5 years. (18)

Guidance on data capture, evaluation and outcome analysis

Regular audit and reporting of practice is important to ensure a high quality AS service. The *STRATCANS* programme is entirely based on data and evidence in follow up to develop the tiers and recommended schedules (5,6) (see ***STRATCANS*** for further information). It continues to be updated and reported as follow up accrues. In the same way implementation of the *STRATCANS* AS programme in any hospital should be robustly audited and monitored.

We recommend establishing a baseline by conducting an initial audit to look at current follow-up and resource usage for men in your active surveillance cohort.

Standardised reporting of ethnicity, family history, age, co-morbidities, length of time on AS, stage at diagnosis should be included in evaluation metrics, in addition to:

- Rates of objective progression to CPG ≥3 disease (unfavourable intermediate-risk disease), which is consistent with a change in NICE guideline recommendation to consider treatment rather than surveillance: This could be reached by upgrade on biopsy to grade group ≥3 or upstage to ≥T3.
- Rates of any progression, e.g. PSA increases only without a pathological change.
- Any other pathological progression (defined as grade group 1–2 increase, increase in core involvement, or any increase in the PRECISE score), any treatment due to progression and the type of treatment.
- Also record conversion to watchful waiting (WW), patient choice for treatment, or death from other causes or if discharged to GP.
- Conversion to WW should be decided on a case-by-case basis, though in general, this will be because of advanced age or a new significant comorbidity, making the person ineligible for any future radical treatment (see above).
- Report on event rates as percentages.

- Differences in progression rates between follow-up groups should be compared as part of quality control (QC). In addition, record compliance with follow-up protocol and any deviations and reasons.
- Formal patient feedback (Patient Reported Outcome Measures – PREMS) should be collated and assessed, importantly to understand the psychological impact men experience whilst on active surveillance.

Limitations

The *STRATCANS* group reported the following limitations of their study, at the time of publication:

a single-centre prospective and comparatively small observational cohort. Our cohort is however well characterised, with all men being diagnosed and risk assessed through a high-quality MRI-guided diagnostic pathway.

- Follow up to date is up to 5-years.
- The study did not look at all outcomes from protocol (non-triggered) biopsies, as follow-up was short, so it is possible that some progression may occur, which is not detected by PSA or MRI changes.
- They also did not look at negative biopsy rates and what factors may have allowed them to further refine selection for biopsies.

According to the STRATCANS group - All newly diagnosed men and those who select AS are now automatically included into the *STRATCANS* protocol.

Validation of the *STRATCANS* protocol

The *STRATCANS* group is updating and will be reporting on ongoing outcomes as the cohort matures. A US study (19) validated the *STRATCANS* approach by retrospectively applying the protocol to a large heterogenous US cohort of 7578 men on active surveillance. In this study the team reported the following:

i. Significant differences in biopsy upgrading to ≥CPG 3 and any biopsy upgrading ($p<0.001$) between the *STRATCANS* groups. The probability of upgrading to ≥CPG3 within 3 years of diagnosis was 13%, 33%, and 53% of men with *STRATCANS* 1, 2, and 3 criteria 3, respectively.

ii. *STRATCANS* criteria was associated with duration on AS ($p<0.001$), with 24%, 42% and 46% for patients with *STRATCANS* 1, 2, and 3 criteria undergoing treatment within 5 years, respectively.

Support with your active surveillance project

Contact **campaigns@prostatecanceruk.org**

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