Supplementary Table S1. Item-level extraction and adjudication codebook for EAU, AUA, and NCCN salvage-relevant recommendations

Item	EAU	AUA	NCCN	Final adjudication
1. BCR / PSA persistence Expected PSA status after RP and clinical meaning of a rising PSA	**Source:** Sections 6.3.6.a and 6.4.2; pp. 98, 101 **Extracted recommendation:** PSA should become undetectable after RP; persistent or subsequently rising PSA is clinically relevant. **Actionability code: 2**	**Source:** Guideline Statements 1-3; pp. 1-2 **Extracted recommendation:** Detectable and rising PSA after RP identifies a setting in which earlier salvage RT is more effective. **Actionability code: 2**	**Source:** PROS-8A; PROS-9 and footnote w **Extracted recommendation:** Distinguishes PSA persistence from recurrence after an undetectable postoperative level and routes both to risk-adapted evaluation. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None **Adjudication rationale:** All three frameworks regard failure to reach an undetectable/very low PSA or a confirmed postoperative rise as clinically meaningful.
2. BCR / PSA persistence Post-RP BCR threshold definition	**Source:** Section 6.4.2; p. 101 **Extracted recommendation:** Highlights PSA >0.4 ng/mL and rising as the threshold most predictive of later metastasis while noting concern at lower rising values. **Actionability code: 1**	**Source:** Definition of BCR and Guideline Statement 7; pp. 2-3 **Extracted recommendation:** Uses PSA ≥0.2 ng/mL with confirmation as the formal post-RP BCR definition. **Actionability code: 2**	**Source:** PROS-8A; PROS-9 footnote w **Extracted recommendation:** Uses persistence or a detectable PSA that rises on serial measurements, with an additional >0.1 ng/mL pathway trigger. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Definition heterogeneity **Adjudication rationale:** The same clinical state is recognized, but the formal biochemical thresholds and confirmation rules differ.
3. BCR / PSA persistence Use of ultrasensitive PSA and early action before classical BCR	**Source:** Section 6.4.2; p. 101 **Extracted recommendation:** Acknowledges that a rising ultrasensitive PSA below the metastasis-predictive threshold may warrant concern. **Actionability code: 1**	**Source:** Guideline Statements 6-7; p. 2 **Extracted recommendation:** Allows ultrasensitive PSA in selected high-risk patients but requires confirmation of a rising trend before therapy. **Actionability code: 1**	**Source:** PROS-8A; PROS-9 footnote w **Extracted recommendation:** Allows imaging or treatment at lower PSA levels in patients at high risk of progression. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Operational threshold uncertainty **Adjudication rationale:** All permit earlier evaluation in selected patients, but the trigger, confirmation rule, and strength of endorsement are not identical.
4. BCR / PSA persistence Phoenix definition after definitive radiotherapy	**Source:** Section 6.4.2; p. 101 **Extracted recommendation:** Uses the Phoenix biochemical-failure standard after definitive RT. **Actionability code: 2**	**Source:** Introduction/definitions; p. 3 **Extracted recommendation:** Uses the Phoenix criterion to define BCR following RT. **Actionability code: 2**	**Source:** PROS-8A; PROS-10A footnote v **Extracted recommendation:** Identifies the Phoenix criterion as the standard definition after EBRT with or without hormonal therapy. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for reporting definition **Adjudication rationale:** The three frameworks use the same conventional biochemical reporting standard after definitive RT.
5. BCR / PSA persistence Evaluation before Phoenix failure in selected salvage candidates	**Source:** Sections 6.4.4.b.2-6.4.4.d; pp. 103-104 **Extracted recommendation:** Supports imaging and biopsy-directed evaluation in patients fit for curative local salvage, without making the Phoenix threshold the sole clinical trigger. **Actionability code: 1**	**Source:** Guideline Statement 23 and introductory definitions; p. 3 **Extracted recommendation:** Evaluates suspected nonmetastatic recurrence in local-salvage candidates, but provides less explicit pre-Phoenix timing language. **Actionability code: 1**	**Source:** PROS-10; PROS-10A footnote v **Extracted recommendation:** Permits recurrence evaluation before nadir +2 ng/mL when PSA is confirmed to be rising, especially in young and fit salvage candidates. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Timing uncertainty **Adjudication rationale:** Earlier evaluation is supported in selected patients, but the timing and explicitness of the pre-Phoenix pathway differ.
6. BCR / PSA persistence Biochemical recurrence definition after HIFU, cryotherapy, or focal/ablative therapy	**Source:** Sections 6.2.4.c and 6.4.2; pp. 84-85, 101 **Extracted recommendation:** States that PSA endpoints after HIFU or cryotherapy have not been validated against clinical progression or survival. **Actionability code: 1**	**Source:** Guideline Statements 23 and 25; p. 3 **Extracted recommendation:** Provides evaluation and salvage pathways after ablative/focal therapy without defining a validated biochemical threshold. **Actionability code: 1**	**Source:** PROS-I (2 of 3 and 3 of 3) **Extracted recommendation:** Provides surveillance and recurrence-management principles but acknowledges the absence of a universally accepted follow-up protocol. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-gap zone **Adjudication rationale:** All three frameworks recognize the need to evaluate and manage recurrence after focal or ablative therapy, supporting partial agreement in overall clinical direction. However, none provides a validated universal biochemical recurrence threshold; this absence of a standardized definition supports the evidence-gap-zone qualifier.
7. PSMA PET General endorsement of PSMA PET in BCR	**Source:** Sections 6.4.4.a.3 and 6.4.4.d; pp. 102-104 **Extracted recommendation:** Recommends PSMA PET when its result is expected to influence subsequent management. **Actionability code: 2**	**Source:** Guideline Statement 8; p. 2 **Extracted recommendation:** Allows PSMA PET instead of conventional imaging or after negative conventional imaging in BCR. **Actionability code: 1**	**Source:** PROS-E (3 of 5 to 5 of 5); PROS-9; PROS-10 **Extracted recommendation:** Incorporates PSMA PET into recurrence imaging pathways and the general imaging principles. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for clinical direction **Adjudication rationale:** All three frameworks endorse PSMA PET as an appropriate imaging modality in BCR; therefore, the clinical direction is concordant. The lower AUA actionability code reflects its more conditional "may obtain" formulation in the relevant statement rather than a different or opposing clinical recommendation.
8. PSMA PET PSA threshold or timing for PSMA PET after RP	**Source:** Section 6.4.4.d; pp. 103-104 **Extracted recommendation:** Provides a PSA-based imaging threshold and requires anticipated management impact. **Actionability code: 2**	**Source:** Guideline Statements 8-9; p. 2 **Extracted recommendation:** Recommends molecular PET when salvage RT is being considered, without a single mandatory PSA threshold. **Actionability code: 2**	**Source:** PROS-9; PROS-E (3 of 5 to 5 of 5) **Extracted recommendation:** Supports PSMA imaging during recurrence workup but is less threshold-driven. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Operational timing heterogeneity **Adjudication rationale:** The modality is shared, but PSA thresholds and the point in the salvage pathway at which imaging is performed differ.
9. PSMA PET PSMA PET after primary RT in candidates for curative salvage	**Source:** Sections 6.4.4.b.2-6.4.4.d; pp. 103-104 **Extracted recommendation:** Recommends PSMA PET in patients fit for curative salvage after RT. **Actionability code: 2**	**Source:** Guideline Statements 8, 11, and 23; pp. 2-3 **Extracted recommendation:** Supports advanced imaging during BCR evaluation and local assessment in nonmetastatic salvage candidates. **Actionability code: 1**	**Source:** PROS-10; PROS-E (3 of 5 to 5 of 5) **Extracted recommendation:** Includes bone and soft-tissue imaging, with PSMA PET available through the imaging principles, before local secondary therapy. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for clinical direction **Adjudication rationale:** All support advanced imaging in appropriate post-RT salvage candidates, although wording and strength differ.
10. PSMA PET PSMA PET as an alternative to or after conventional imaging	**Source:** Sections 6.4.4.a.3-6.4.4.d; pp. 102-104 **Extracted recommendation:** Prioritizes PSMA PET when it may change management but does not frame the sequence as a rigid replacement rule. **Actionability code: 1**	**Source:** Guideline Statement 8; p. 2 **Extracted recommendation:** Explicitly permits PSMA PET in lieu of conventional imaging or after negative conventional imaging. **Actionability code: 1**	**Source:** PROS-E (3 of 5 to 5 of 5) **Extracted recommendation:** Lists PSMA PET as an alternative to conventional cross-sectional and bone imaging in relevant settings. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Sequencing heterogeneity **Adjudication rationale:** All permit PSMA PET, but its relationship to conventional imaging is expressed with different specificity.
11. Negative PSMA PET Negative PSMA PET should not preclude otherwise indicated prostate-bed SRT	**Source:** Sections 6.4.4.d and 6.4.7; pp. 103-104, 117 **Extracted recommendation:** Bases early SRT on rising PSA and treatment intent; imaging is performed only when it can affect planning, so positivity is not required. **Actionability code: 1**	**Source:** Guideline Statement 12; p. 2 **Extracted recommendation:** Explicitly states that negative PET/CT should not be used to withhold prostate-bed salvage RT. **Actionability code: 1**	**Source:** PROS-9 and PROS-9A **Extracted recommendation:** Offers prostate-bed EBRT for nonmetastatic PSA persistence/recurrence without requiring a PET-positive lesion. **Actionability code: 1**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for clinical direction **Adjudication rationale:** The operational explicitness is limited in EAU and NCCN, but no framework requires imaging positivity before otherwise indicated prostate-bed SRT.
12. Post-RP SRT Early risk-adapted SRT at low PSA	**Source:** Sections 6.4.5.a.1 and 6.4.7; pp. 104-106, 117 **Extracted recommendation:** Recommends early SRT after confirmed PSA rises and advises treatment as soon as the SRT decision has been made. **Actionability code: 2**	**Source:** Guideline Statements 1-3; pp. 1-2 **Extracted recommendation:** States that salvage RT is more effective at lower PSA and supplies low-PSA delivery thresholds. **Actionability code: 2**	**Source:** PROS-9; PROS-9A footnote w **Extracted recommendation:** Routes nonmetastatic first PSA persistence/recurrence to risk-adapted secondary EBRT, including treatment at low PSA in higher-risk patients. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for overall principle **Adjudication rationale:** All favor early, risk-adapted SRT rather than waiting for a high PSA.
13. Post-RP SRT PSA threshold for delivering SRT	**Source:** Sections 6.4.5.a.1 and 6.4.7; pp. 104-106, 117 **Extracted recommendation:** Advises against waiting for a fixed PSA threshold once SRT is selected and emphasizes prompt treatment. **Actionability code: 1**	**Source:** Guideline Statements 2-3; pp. 1-2 **Extracted recommendation:** Provides an operational ≤0.5 ng/mL threshold and permits treatment below 0.2 ng/mL in selected high-risk patients. **Actionability code: 2**	**Source:** PROS-9; PROS-9A footnote w **Extracted recommendation:** Uses low-PSA risk-adapted secondary treatment but does not apply one universal delivery threshold. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Threshold heterogeneity **Adjudication rationale:** Early treatment is shared, whereas exact delivery thresholds differ.
14. Post-RP SRT Adjuvant RT versus early SRT in adverse pathology	**Source:** Sections 6.3.5.c-6.3.5.g; pp. 94-98 **Extracted recommendation:** Does not favor routine adjuvant RT but retains it for highly selected patients with adverse pathology. **Actionability code: 1**	**Source:** Guideline Statements 1-3 and salvage-treatment scope; pp. 1-2 **Extracted recommendation:** Centers treatment on early salvage for detectable PSA; adjuvant selection is outside the principal operational scope. **Actionability code: 1**	**Source:** PROS-7A; PROS-9 and footnote hh **Extracted recommendation:** Allows postoperative treatment for selected patients with multiple adverse features while otherwise using early secondary treatment at recurrence. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Selection heterogeneity **Adjudication rationale:** Routine adjuvant RT is not the dominant strategy, but the definition of patients who may still merit adjuvant treatment differs.
15. SRT target volume Prostate-bed RT as foundational salvage field in nonmetastatic recurrence	**Source:** Section 6.4.5.a.2.a; pp. 106-110 **Extracted recommendation:** Treats the prostate bed as the core postoperative salvage field. **Actionability code: 2**	**Source:** Guideline Statements 12 and 19-20; pp. 2-3 **Extracted recommendation:** Uses prostate-bed RT as the foundation, with optional field expansion in selected patients. **Actionability code: 2**	**Source:** PROS-9; PROS-J **Extracted recommendation:** Lists postoperative EBRT as preferred local secondary treatment for nonmetastatic first recurrence. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None **Adjudication rationale:** The prostate bed is the shared foundational salvage target when distant disease is not identified.
16. SRT target volume Elective pelvic nodal RT indication	**Source:** Section 6.4.5.a.2.a; pp. 106-110 **Extracted recommendation:** Discusses pelvic nodal irradiation as a selective intensification strategy rather than a universal field. **Actionability code: 1**	**Source:** Guideline Statements 19-20; p. 3 **Extracted recommendation:** Allows regional nodal fields with salvage RT plus ADT and requires counseling about added toxicity. **Actionability code: 1**	**Source:** PROS-9; PROS-J **Extracted recommendation:** Incorporates pelvic nodal coverage according to nodal risk, prior treatment, and the broader radiation principles. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Selection uncertainty **Adjudication rationale:** All consider pelvic nodal RT selectively, but indications and routine-use framing are not uniform.
17. SRT target volume Incorporation of PET-positive pelvic nodes into the radiation plan	**Source:** Section 6.4.5.a.2.b; pp. 110-111 **Extracted recommendation:** Uses PET-detected nodal disease to guide field design and treatment intensification. **Actionability code: 2**	**Source:** Guideline Statement 10; p. 2 **Extracted recommendation:** Explicitly directs incorporation of PET-positive pelvic nodes into the radiation plan. **Actionability code: 2**	**Source:** PROS-9; PROS-J; PROS-M **Extracted recommendation:** Routes imaging-defined nodal disease through nodal and metastasis-directed pathways but is less explicit as a single statement. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Field-design heterogeneity **Adjudication rationale:** The frameworks act on PET-positive nodes, but the NCCN direction is distributed across algorithms and principles.
18. SRT target volume Nodal boost or nodal-directed strategy	**Source:** Sections 6.4.5.a.2.c and 6.4.5.a.3; p. 111 **Extracted recommendation:** Reviews elective nodal RT, nodal boost, SABR/MDT, and salvage lymph-node dissection with limited comparative evidence. **Actionability code: 1**	**Source:** Guideline Statements 10 and 26-28; pp. 2-3 **Extracted recommendation:** Supports nodal RT with ADT in regional recurrence and permits salvage lymphadenectomy with uncertainty counseling. **Actionability code: 1**	**Source:** PROS-11; PROS-13; PROS-J; PROS-M **Extracted recommendation:** Uses pathway-based nodal RT or metastasis-directed options, with the strategy dependent on disease extent and prior therapy. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** Nodal-directed treatment is recognized, but modality choice, boost use, and evidentiary thresholds differ.
19. ADT with SRT Addition of ADT to SRT	**Source:** Sections 6.4.5.a.2 and 6.4.7; pp. 104-111, 117 **Extracted recommendation:** Supports adding hormonal therapy to SRT, with weak overall recommendation strength and risk-adapted interpretation. **Actionability code: 1**	**Source:** Guideline Statements 13-14; p. 2 **Extracted recommendation:** Recommends ADT with SRT when high-risk features are present and permits RT alone without them. **Actionability code: 2**	**Source:** PROS-9; PROS-G (1 of 6) **Extracted recommendation:** Allows secondary EBRT with or without ADT according to clinical risk and nodal status. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Selection heterogeneity **Adjudication rationale:** Risk-adapted ADT is shared, but the criteria and directive strength differ.
20. ADT with SRT Selection criteria for ADT with SRT	**Source:** Section 6.4.5.a.2; pp. 104-111 **Extracted recommendation:** Uses PSA level, PSA kinetics, pathology, and recurrence risk to individualize treatment intensification. **Actionability code: 1**	**Source:** Guideline Statement 13; p. 2 **Extracted recommendation:** Lists operational high-risk features including PSA, Grade Group, short PSADT, persistent PSA, and seminal-vesicle involvement. **Actionability code: 2**	**Source:** PROS-9; PROS-G; PROS-H **Extracted recommendation:** Uses pathway-based risk stratification, pathology, PSA behavior, and nodal status to select ADT. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Risk-definition heterogeneity **Adjudication rationale:** The clinical factors overlap, but AUA provides the most explicit itemized selection rule.
21. ADT with SRT ADT duration with SRT	**Source:** Section 6.4.5.a.2; pp. 104-111 **Extracted recommendation:** Reviews short- and long-duration trial evidence without defining one universal duration for all salvage candidates. **Actionability code: 1**	**Source:** Guideline Statements 17-18; p. 3 **Extracted recommendation:** Provides a minimum 4-6 month duration and permits extension to 18-24 months in high-risk patients. **Actionability code: 1**	**Source:** PROS-G (1 of 6) **Extracted recommendation:** Uses a risk-adapted 6-24 month range when ADT accompanies secondary RT after first RP recurrence. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Duration heterogeneity **Adjudication rationale:** All support risk-adapted duration, but the operational ranges and extension criteria are not fully harmonized.
22. High-risk BCR Definition of high-risk BCR	**Source:** Section 6.4.3 and Table 6.4.1; pp. 101-102 **Extracted recommendation:** Defines EAU BCR risk groups using PSADT and pathological Grade Group after RP and interval/Grade Group after RT. **Actionability code: 2**	**Source:** Guideline Statements 5 and 13; p. 2 **Extracted recommendation:** Defines high-risk features for counseling and SRT/ADT selection using PSA, PSADT, grade, stage, margins, persistence, and SVI. **Actionability code: 2**	**Source:** PROS-12 footnote pp; PROS-H **Extracted recommendation:** Acknowledges trial-dependent high-risk BCR definitions, generally centered on short PSADT plus adverse prognostic features. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Definition heterogeneity **Adjudication rationale:** Each framework identifies high-risk BCR, but the formal criteria and intended use differ.
23. High-risk BCR PSA doubling time as an adverse feature	**Source:** Sections 6.4.1.a and 6.4.3; pp. 100-102 **Extracted recommendation:** Uses short PSADT as a central prognostic and risk-group variable. **Actionability code: 2**	**Source:** Guideline Statements 5 and 13; p. 2 **Extracted recommendation:** Uses PSADT in risk counseling and identifies very short PSADT as a high-risk feature favoring ADT intensification. **Actionability code: 2**	**Source:** PROS-10; PROS-12 footnote pp; PROS-H **Extracted recommendation:** Uses PSADT for treatment selection and high-risk BCR stratification. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None for prognostic direction **Adjudication rationale:** All three treat PSADT as a major adverse prognostic and treatment-selection variable.
24. High-risk BCR Use of Grade Group, pathological stage, margin status, and SVI in risk stratification and treatment intensification	**Source:** Sections 6.3.6.b-6.3.6.c and 6.4.3; pp. 98-102 **Extracted recommendation:** Recognizes Grade Group, stage, margins, and seminal-vesicle involvement as prognostic factors after RP. **Actionability code: 2**	**Source:** Guideline Statements 5 and 13; p. 2 **Extracted recommendation:** Uses Grade Group, stage, margin status, and SVI in progression counseling and ADT selection. **Actionability code: 2**	**Source:** PROS-7A footnote x; PROS-9; PROS-H **Extracted recommendation:** Uses adverse pathology and risk stratification to guide postoperative observation, RT, and systemic intensification. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Decision-rule and trigger heterogeneity **Adjudication rationale:** All three frameworks explicitly and actionably incorporate adverse pathological features into postoperative risk assessment, which accounts for the 2/2/2 actionability profile. However, the frameworks do not use identical combinations, thresholds, or clinical consequences: EAU integrates these variables into formal prognostic and BCR risk-group structures, AUA uses an itemized set of prognostic and treatment-intensification features, and NCCN distributes adverse-feature assessment across postoperative observation, radiotherapy, and systemic-treatment algorithms. Because these differences may alter eligibility for treatment intensification, the item was classified as partial rather than complete clinical agreement.
25. High-risk BCR Persistent PSA as an adverse feature	**Source:** Section 6.3.6; pp. 98-100 **Extracted recommendation:** Treats persistent postoperative PSA as a poor prognostic state requiring imaging and multimodal consideration. **Actionability code: 2**	**Source:** Guideline Statement 13; p. 2 **Extracted recommendation:** Lists persistently detectable postoperative PSA among high-risk features favoring ADT with SRT. **Actionability code: 2**	**Source:** PROS-8A; PROS-9 and footnote w **Extracted recommendation:** Defines PSA persistence separately and directs it to risk-adapted secondary management. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None **Adjudication rationale:** All frameworks regard persistent PSA after RP as clinically adverse.
26. Post-RT local recurrence Histological confirmation before curative-intent local salvage	**Source:** Sections 6.4.4.b.2 and 6.4.7; pp. 103, 117 **Extracted recommendation:** Requires biopsy confirmation before morbid local salvage after RT. **Actionability code: 2**	**Source:** Guideline Statement 23; p. 3 **Extracted recommendation:** Requires prostate biopsy in nonmetastatic post-RT or post-ablative candidates for local salvage. **Actionability code: 2**	**Source:** PROS-10; PROS-L (1 of 2) **Extracted recommendation:** Limits local secondary therapy after RT to biopsy-proven prostatic recurrence. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None **Adjudication rationale:** All require or strongly emphasize histological confirmation before curative-intent local salvage.
27. Post-RT local recurrence Exclusion of metastatic disease before local salvage	**Source:** Sections 6.4.4.c-6.4.4.d and 6.4.7; pp. 103-104, 117 **Extracted recommendation:** Requires distant disease to be ruled out in patients considered for local salvage after RT. **Actionability code: 2**	**Source:** Guideline Statement 23; p. 3 **Extracted recommendation:** Restricts the biopsy-and-local-salvage pathway to patients without metastatic disease. **Actionability code: 2**	**Source:** PROS-10; PROS-L (1 of 2) **Extracted recommendation:** Restricts local secondary therapy to biopsy-proven local recurrence without distant metastasis. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** None **Adjudication rationale:** All reserve curative-intent local salvage for patients without distant metastatic disease.
28. Post-RT local salvage Salvage radical prostatectomy as a local salvage option	**Source:** Sections 6.4.5.b.1 and 6.4.7; pp. 112-113, 117 **Extracted recommendation:** Offers salvage RP to highly selected patients in experienced centers. **Actionability code: 2**	**Source:** Guideline Statement 24; p. 3 **Extracted recommendation:** Includes salvage RP among options for biopsy-documented recurrence after primary RT. **Actionability code: 2**	**Source:** PROS-10; PROS-L (1 of 2) **Extracted recommendation:** Includes secondary RP among local options for appropriately selected patients. **Actionability code: 2**	**Final concordance:** Complete agreement **Evidence-status qualifier:** Selection and toxicity remain important **Adjudication rationale:** All include salvage RP as an option for carefully selected patients.
29. Post-RT local salvage Salvage brachytherapy, SBRT, or reirradiation	**Source:** Section 6.4.5.b.3 and 6.4.7; pp. 114-117 **Extracted recommendation:** Offers brachytherapy or stereotactic reirradiation to highly selected patients in experienced centers. **Actionability code: 1**	**Source:** Guideline Statement 24; p. 3 **Extracted recommendation:** Includes reirradiation as a local salvage option within shared decision-making. **Actionability code: 2**	**Source:** PROS-10; PROS-L (1 of 2) **Extracted recommendation:** Prioritizes selected reirradiation approaches supported by prospective phase II data. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** All three frameworks recognize reirradiation as a possible local salvage strategy, supporting partial agreement in overall clinical direction. However, modality preference, selection criteria, toxicity constraints, and center-experience requirements differ, and comparative outcome evidence remains insufficient to establish a preferred approach; this supports the evidence-limited-zone qualifier.
30. Post-RT local salvage Salvage HIFU, cryotherapy, or other ablative strategies	**Source:** Sections 6.4.5.b.2, 6.4.5.b.4, and 6.4.7; pp. 113-117 **Extracted recommendation:** Restricts salvage HIFU or cryoablation to trials or well-designed prospective cohorts in highly selected patients. **Actionability code: 1**	**Source:** Guideline Statement 24; p. 3 **Extracted recommendation:** Includes cryoablation and HIFU among local salvage options within shared decision-making. **Actionability code: 2**	**Source:** PROS-10; PROS-L (1 of 2) **Extracted recommendation:** Includes whole-gland ablative local secondary options, with evidence and toxicity qualifications. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** The options overlap, but EAU is more restrictive and the evidence framing differs.
31. Focal / ablative recurrence Biopsy confirmation after focal or whole-gland ablative therapy	**Source:** Sections 6.2.4.c and 6.4.2; pp. 84-85, 101 **Extracted recommendation:** Emphasizes the uncertain follow-up pathway and the role of imaging and biopsy after focal treatment, without a dedicated directive for every recurrence scenario. **Actionability code: 1**	**Source:** Guideline Statement 23; p. 3 **Extracted recommendation:** Requires biopsy when local salvage is considered after ablative therapy. **Actionability code: 2**	**Source:** PROS-I (3 of 3) **Extracted recommendation:** Directs biopsy confirmation when residual or recurrent disease is suspected after focal or whole-gland ablation. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** AUA and NCCN are explicit, whereas EAU is less directive because follow-up and recurrence definitions are less standardized.
32. Focal / ablative recurrence RP or RT as whole-gland salvage therapy for clinically significant local recurrence	**Source:** Section 6.2.4.c; pp. 84-85 **Extracted recommendation:** Reviews salvage RP and salvage RT after focal therapy but does not provide a strong dedicated recommendation. **Actionability code: 1**	**Source:** Guideline Statement 25; p. 3 **Extracted recommendation:** Recommends whole-gland RP or RT when local salvage is pursued after focal ablation. **Actionability code: 1**	**Source:** PROS-I (3 of 3) **Extracted recommendation:** Offers RP or prostate RT for clinically significant recurrence when life expectancy is appropriate. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** The whole-gland salvage direction is shared, but explicitness, evidence strength, and selection detail differ.
33. Focal / ablative recurrence Follow-up and biochemical endpoint standardization after focal/ablative therapy	**Source:** Sections 6.2.4.c and 6.4.2; pp. 84-85, 101 **Extracted recommendation:** States that the follow-up pathway and biochemical endpoints after focal/ablative therapy are not validated. **Actionability code: 1**	**Source:** Guideline Statement 25 and focal-therapy discussion; p. 3 **Extracted recommendation:** Provides a salvage-treatment direction but no validated universal biochemical endpoint or surveillance protocol. **Actionability code: 1**	**Source:** PROS-I (2 of 3 and 3 of 3) **Extracted recommendation:** Acknowledges that no universally agreed evidence-based follow-up protocol exists and that serial imaging and biopsy are often used. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-gap zone **Adjudication rationale:** All three frameworks recognize the need for surveillance and recurrence evaluation after focal or ablative therapy, supporting partial agreement in overall clinical direction. However, no validated universal biochemical endpoint or standardized follow-up protocol exists; this absence of standardization supports the evidence-gap-zone qualifier.
34. Pelvic nodal recurrence Pelvic nodal recurrence management after RP or RT	**Source:** Sections 6.4.5.a.2.c and 6.4.5.a.3; pp. 111-112 **Extracted recommendation:** Reviews elective nodal RT, nodal boost/MDT, and salvage lymph-node dissection, emphasizing the limitations of comparative evidence. **Actionability code: 1**	**Source:** Guideline Statements 26-28; p. 3 **Extracted recommendation:** Recommends nodal RT plus ADT after RP or selected post-RT recurrence and allows lymphadenectomy with uncertainty counseling. **Actionability code: 1**	**Source:** PROS-11; PROS-13; PROS-J; PROS-M **Extracted recommendation:** Routes nodal recurrence through staging, pelvic therapy, systemic treatment, and metastasis-directed pathways. **Actionability code: 1**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** The frameworks endorse active nodal management but differ in preferred modality, prior-RT contingencies, and the role of surgery/MDT.
35. Oligometastatic recurrence Metastasis-directed therapy and systemic integration for oligorecurrence	**Source:** Sections 6.6.8 and 6.6.9 recommendations; pp. 128-129 **Extracted recommendation:** Reviews MDT as a means of delaying systemic escalation but restricts routine use to trials or well-designed prospective cohorts. **Actionability code: 1**	**Source:** Guideline Statement 29; p. 3 **Extracted recommendation:** Permits SABR MDT for regional or metastatic oligorecurrence after balancing toxicity and potential benefit. **Actionability code: 1**	**Source:** PROS-13; PROS-M (1 of 3 to 3 of 3) **Extracted recommendation:** Provides an explicit MDT pathway and integrates it with observation or systemic therapy according to disease extent and timing. **Actionability code: 2**	**Final concordance:** Partial agreement **Evidence-status qualifier:** Evidence-limited zone **Adjudication rationale:** All three frameworks recognize a potential role for metastasis-directed therapy in oligorecurrence, supporting partial agreement in overall clinical direction. However, survival benefit, lesion-number definitions, patient selection, and integration with systemic therapy remain incompletely established; this unresolved comparative and outcome evidence supports the evidence-limited-zone qualifier.

Recommendations are presented as concise source-derived paraphrases rather than reproductions of copyrighted guideline text. The cited section, statement, printed page, or NCCN algorithm-page identifier enables verification against the archived source corpus. The actionability codes displayed in this table are the final consensus guideline-specific codes used in the operational inter-guideline analysis: 0 = absent or not standardized; 1 = qualified, implicit, or less standardized; and 2 = explicit and actionable. These codes describe the explicitness and operationalization of each guideline's own recommendation and do not measure similarity in clinical content across guidelines. Final clinical concordance was adjudicated separately by considering recommendation direction and potentially decision-changing differences in thresholds, timing, eligibility, treatment intensity, duration, and other clinical conditions. Therefore, identical actionability codes may coexist with partial clinical agreement, while non-identical actionability codes may coexist with complete clinical agreement. Independent pre-consensus reviewer coding used a separate four-level source-explicitness scale and was not mechanically converted into either the final actionability codes or the clinical concordance categories. Evidence status was coded as a separate, orthogonal qualifier and did not create a fourth concordance category. "Evidence-gap zone" denoted the absence of a validated common definition or standardized follow-up endpoint despite aligned recognition of the clinical problem. "Evidence-limited zone" denoted insufficient comparative or outcome evidence to establish a preferred intervention or operational rule despite broadly aligned management direction. These qualifiers were based on evidentiary limitations described in the included guideline corpus and were not derived from an independent systematic evidence grading

ADT, androgen deprivation therapy; AUA, American Urological Association; BCR, biochemical recurrence; EAU, European Association of Urology; EBRT, external-beam radiotherapy; HIFU, high-intensity focused ultrasound; MDT, metastasis-directed therapy; NCCN, National Comprehensive Cancer Network; PET, positron emission tomography; PSA, prostate-specific antigen; PSADT, PSA doubling time; PSMA, prostate-specific membrane antigen; RP, radical prostatectomy; RT, radiotherapy; SABR/SBRT, stereotactic ablative/body radiotherapy; SRT, salvage radiotherapy; SVI, seminal-vesicle invasion