on prior evidence that observation is used infrequently in men with low-risk disease,\(^5\) this study establishes that active surveillance use is low. Usage increases as the inclusion criteria for surveillance become more stringent, i.e., less likely to miss significant disease. While active surveillance is aptly applied to elderly men, its use is sporadic, confined to academic and regional hospitals, and strongly influenced by nonclinical factors, including the patient’s insurance provider. Patient preference may influence use, especially in certain demographic groups. Despite ongoing adoption, use of active surveillance must increase substantially to effectively reduce the overtreatment of screening-detected prostate cancer.\(^6\)

This study has several limitations. Selection bias related to the National Cancer Data Base’s hospital-based data set may cause potential underrepresentation of active surveillance use in the outpatient setting. Because the data set is somewhat dated, it may not accurately reflect recent urological patterns. Nonetheless, this study represents, to our knowledge, the most up-to-date analysis of active surveillance trends, and its predictors, in a large nationally diverse cohort. Uniquely, our study is generalizable to men of all ages, including younger men who may benefit more in the long term with active surveillance. Last, the treatment-specific identifier that we used minimizes misclassification bias.

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Disclaimer: The American College of Surgeons and the Commission on Cancer have not verified and are not responsible for the analytic or statistical methods that diminish their importance.\(^2\) We assess the reporting of limitations of observational studies published in major internal medicine journals and associated news stories, specifically focusing on inference of causality.

Methods | Using MEDLINE, journal websites, Eurekalert, and Factiva, we collated 81 prospective cohort and case-control studies with clinical outcomes published between January 1, 2013, and June 30, 2013, in the Annals of Internal Medicine, BMJ, JAMA, JAMA Internal Medicine, Lancet, New England Journal of Medicine, and PLoS Medicine; 48 accompanying editorials; 54 journal press releases; and 319 news stories generated within 2 months of publication. We analyzed the Abstract and Discussion sections of the source articles as separate documents. For each of the resulting 583 documents, we determined whether any study limitation was reported and whether there was an explicit statement that causality could not be inferred. If a causality limitation was reported, we determined whether it was accompanied by a disclaimer, defined as a statement that undermines or downplays the limitation. Data were extracted independently by 2 of us (M.T.M.W. and A.G.), and differences were resolved by consensus.

Results | Any study limitation was mentioned in 70 of 81 (86%) source article Discussion sections, 26 of 48 (54%) accompanying editorials, 13 of 54 (24%) journal press releases, 16 of 81 (20%) source article abstracts (of which 9 were published in the Annals of Internal Medicine), and 61 of 319 (19%) associated news stories. An explicit statement that causality could not be inferred was infrequently present: 8 of 81 (10%) source article Discussion sections, 7 of 48 (15%) editorials, 2 of 54 (4%) press releases, 3 of 81 (4%) source article abstracts, and 31 of 319 (10%) news stories contained such statements (Figure). Among the 51 source documents that included a causality limitation, 23 (45%) were accompanied by a disclaimer.

Of the 13 source articles that generated at least 1 news story containing a causality limitation, 8 (62%) contained the limitation in the Abstract or Discussion, editorial, or journal press release. In comparison, only 10 of 68 (15%) source articles that did not generate at least 1 news story with a causality limita-
Reporting of limitations of observational research published in 7 major internal medicine journals (New England Journal of Medicine [NEJM], Lancet, JAMA, BMJ, PLoS Med, Annals of Internal Medicine, and JAMA Internal Medicine) from January 1, 2013, to June 30, 2013. Data are proportions of the indicated journal documents and associated news stories that mention any study limitation (dark blue bars) or contain an explicit statement that causality cannot be inferred (light blue bars). NEJM Journal Watch articles were categorized as press releases for NEJM articles.

* Number of abstracts that report any limitation: Annals of Internal Medicine, 9 of 9; BMJ, 2 of 13; JAMA, 2 of 17; JAMA Internal Medicine, 2 of 21; PLoS Medicine, 1 of 7; NEJM, 0 of 10; and Lancet, 0 of 4. Number of abstracts that report a causality limitation: Annals of Internal Medicine, 1 of 9; BMJ, 1 of 13; JAMA, 1 of 17; JAMA Internal Medicine, 0 of 21; PLoS Medicine, 0 of 7; NEJM, 0 of 10; and Lancet, 0 of 4.

† Number of journal press releases that report any limitation: Annals of Internal Medicine, 0 of 2; BMJ, 0 of 8; JAMA, 3 of 16; JAMA Internal Medicine, 4 of 12; PLoS Medicine, 2 of 6; NEJM, 4 of 7; and Lancet, 0 of 3. Number of journal press releases that report a causality limitation: Annals of Internal Medicine, 0 of 2; BMJ, 0 of 8; JAMA, 1 of 16; JAMA Internal Medicine, 0 of 12; PLoS Medicine, 1 of 6; NEJM, 0 of 7; and Lancet, 0 of 3.

A possible consequence of inadequate reporting of limitations of observational research is that readers consider the limitations of observational research, particularly in the publication abstract and journal press releases, might temper this enthusiasm and reduce the need for subsequent reversals of practice.

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Retrieval of Inferior Vena Cava Filters With Prolonged Dwell Time: A Single-Center Experience in 648 Retrieval Procedures

Retrievable inferior vena cava filters (IVCFs) offer temporary protection from pulmonary embolism without the