

## Q & A

### Staging Symposium 9-20-17

**1. QUESTION: Case #1 path report [#2], “metastatic foci show focal micropapillary features”. Does this alter the TNM Stage?**

Reference Text excerpt from Path Report #2:

**J)** and prostate, cystoprostatectomy:

Focal urothelial atypia consistent with high grade intraepithelial neoplasia/carcinoma in situ; no residual invasive carcinoma identified. (See comment)

Edema, fibrosis, hemosiderin deposition and focal foreign body type giant cell reaction in lamina propria, suggestive of previous therapy effect.

Prostatic parenchyma, no carcinoma identified.

**K)** Perirectal, excision: Fibroadipose and fibrovascular tissue with nerve trunks, no carcinoma identified

**L,M)** Final left ureteral and final right ureteral margins, excision: Segment of ureter, no high grade dysplasia or carcinoma identified.

**Comment:**

The scarred area in the bladder is submitted entirely for histologic evaluation and no residual carcinoma is identified. **Metastatic foci show focal micropapillary features.**

**ANSWER: No, this does not alter the TNM stage.**

This comment I believe is referring to the metastatic foci within the positive lymph nodes, and the pathologist forgot to add a “see comment” in his specimen narratives for A), B) or E) which were the LNs positive for metastasis. The “see comment” statement in specimen **J)** is referencing the first sentence of the comment noting the scarred area in the bladder and there is no residual carcinoma identified.

Sometimes pathologists use the word “metastatic” in a path report to describe “mets” or extension within the organ itself or LNs. Only if a site of distant mets was biopsied or resected would the use of the word metastatic actually be describing distant mets.

**2. Case #2 Prostate case – we were told we can’t use the MRI without documentation from MD. In the bladder case we didn’t use the MD’s stage, but in prostate case we did. I don’t understand the difference.**

**ANSWER:**

I’m assuming you are asking about the clinical stage, so...

**In the prostate case** we have two physicians who have clinically staged the patient as cT2b in spite of the MRI report indicating there was extension to the right seminal vesicles.

In the AJCC prostate chapter if you read through the entire clinical stage classification section, repeatedly throughout, different imaging techniques are discussed and the common thread through it all is that imaging including MRI has not been proven to be consistently helpful in [prostate] staging. AJCC is cautioning the MDs to consider imaging findings carefully; it’s not a slam dunk.

To further clarify, they are talking about using imaging in evaluation of the “T”- the extension of the prostate cancer within the gland or extraprostatic, not the N or M. It is my understanding imaging findings of positive or negative LNs or positive or negative distant mets info can be assigned based on imaging.

Since the MDs have to weigh this so carefully, AJCC/Donna Gress has stated the registrar should not use imaging findings to assign the clinical T category (for prostate), unless there is a statement by the managing physician/urologist that (s)he interprets those findings as positive and this information was used in the staging. Otherwise, the weight of the clinical data utilizes DRE as the critical component for staging.

The consulting surgeon could have amended his stage to include the MRI findings and changed this to a cT3b, but he did not do so. Instead he re-affirmed and concurred with the original MDs stage cT2b which is supported by the DRE findings.

**With regards to Case #1 Bladder**, there was no documented physician clinical stage for the bladder case. PTA the patient was diagnosed with an invasive bladder tumor and the TURBT pathology showed invasion of the muscularis propria. PTA the patient had a CT scan and the only information we have regarding the findings is a statement by the consulting MD that there was “residual bladder mass”, [after the TUBRT] but no further documentation of [bladder wall] extension, and his statement the “original read did not notice any adenopathy”. For clinical staging that leaves us with T2 for muscle invasion and cN0 for no adenopathy on CT. There was no evidence of distant mets cM0

Then the patient started neoadjuvant therapy on 1/30/16 and the clock stops ticking for assigning clinical stage. cT2 cN0 cM0 Stage 2

After the patient completed neoadjuvant therapy, and saw the consulting surgeon, new scans were ordered. The 6/3/16 CT done after neoadjuvant therapy cannot be used in the clinical stage. And the MDs retrospective review of the original scans and his belief that the patient had LN mets originally can't be used in the clinical stage because this is in hindsight and the clinical staging timeframe had passed.

### 3. When is neoadjuvant therapy considered a neoadjuvant treatment?

**ANSWER: When it meets the definition of what is considered neoadjuvant therapy per NCCN or ASCO guidelines for that cancer site.**

I highly recommend viewing the new AJCC 7<sup>th</sup> Edition webinars. Both the Breast and Prostate sessions discuss this - see slide excerpts below.

These are different than the original Disease site webinars. Here is the link:

<https://cancerstaging.org/CSE/Registrar/Pages/Seventh-Edition-Webinars.aspx>

#### BREAST

- Postneoadjuvant therapy staging
  - MUST meet standard guidelines, such as NCCN or ASCO for what is considered NeoRX
  - Usually 4-6 cycles of chemo, sometimes more
  - Usually 4-6 months of endocrine therapy, may be up to 1 year
  - **Short course endocrine therapy does NOT qualify**

#### PROSTATE

- Postneoadjuvant therapy staging NOT appropriate
  - NO neoadjuvant therapy outside of clinical trials

- Neoadjuvant ADT short term (4-6 months) treatment
- Neoadjuvant ADT long term (2-3 years) treatment
- **Lupron shot prior to surgery NOT neoadjuvant treatment**

Think about the facts of neoadjuvant therapy and what makes sense in the case you're abstracting. Here is how I would approach this:

- 1.) For a breast case; look for a statement in the medical record that the treatment plan includes "neoadjuvant therapy". Physicians are usually very good about documenting that the treatment plan will include "neoadjuvant" therapy – this is important for them to document- and they will usually specify the regimen such as ACT x 4 cycles, plus Arimidex, followed by XRT to axilla, etc., which all together can take 4-6 months and sometimes up to a year- after which the patient will then have surgery.  
SO, if the MD starts hormone therapy shortly after Dx, and the plan for neoadjuvant therapy was documented, then consider this neoadjuvant therapy.
- 2.) If the patient is newly diagnosed, and there is no documentation the treatment plan will include neoadjuvant therapy, and surgery is being planned within the next few weeks or even a month or more (depending on insurance authorization, scheduling the OR, patient requested delays, etc.), and the MD prescribes or starts the patient on a hormonal agent before surgery (and no other systemic agents are initiated or mentioned such as chemotherapy), I would not consider the hormonal agent to be neoadjuvant. I would suspect the MD is doing this for some other reason such as:
  - a. Hormonal therapy started early to sooth an anxious patient.
  - b. Or, to test tolerance to the drug prior to use for adjuvant therapy after surgery.
  - c. Or, like Homework case #7 in instances when a patient already has distant disease and this gets some therapy started while further treatment planning continues.
- 3.) For prostate cancer AJCC unequivocally has stated there is no recognized neoadjuvant therapy regimen outside of a clinical trial. Therefore if the MD begins the patient on Lupron or some other ADT agent prior to surgery, we are NOT to consider that neoadjuvant therapy for the purposes of TNM staging.

While these examples are just for breast and prostate, the overall logic applies to other sites as well.

**PLEASE NOTE: This is an area where the standard setters are attempting to come up with a more defined definition of neoadjuvant therapy, but this is all we have at this time. If more information or clarifications are issued by AJCC, or other standard setters, this information will most certainly be communicated.**