Collecting Cancer Data: Prostate

2015-2016 NAACCR Webinar Series
June 2, 2016

Q&A

• Please submit all questions concerning webinar content through the Q&A panel.
• Reminder:
• If you have participants watching this webinar at your site, please collect their names and emails.
  • We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.
Fabulous Prizes

Agenda

• Anatomy
• Multiple Primary and Histology Rules
• Epi Moment
• Staging
• Treatment
**Zones of the Prostate**

- **Peripheral Zone**
  - Surrounds the distal urethra
  - 70-80% of prostate cancers
- **Central Zone**
  - Surrounds ejaculatory ducts
  - 2.5% of prostate cancers
- **Transition Zone**
  - Surrounds proximal urethra
  - Grows throughout life
  - BPH
  - 10-20% of prostate cancers
- **Anterior Zone**

**Lobes of the Prostate**

- Lateral Lobes
- Anterior Lobe
- Urethra
- Median Lobe
- Posterior Lobe
- Ejaculatory Ducts

Image Source: SEER Training Modules
Lobes and Zones

<table>
<thead>
<tr>
<th>Lobes</th>
<th>Zones</th>
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<tbody>
<tr>
<td>Anterior</td>
<td>Part of transitional zone</td>
</tr>
<tr>
<td>Posterior</td>
<td>Peripheral zone</td>
</tr>
<tr>
<td>Lateral</td>
<td>Spans all zones</td>
</tr>
<tr>
<td>Median</td>
<td>Part of central zone</td>
</tr>
</tbody>
</table>

Regional Lymph Nodes

- Pelvic, NOS
- Hypogastric
- Obturator
- Iliac
  - Internal
  - External
- Sacral
  - Lateral
  - Presacral
  - Promontory (Gerota’s)

Distant Metastasis

- Bone
- Distant Lymph Nodes
  - Aortic (para-aortic lumbar)
  - Common Iliac
  - Deep Inguinal
  - Superficial Inguinal (femoral)
  - Supraclavicular
  - Cervical
  - Scalene
  - Retroperitoneal, NOS
- Liver
- Lung

Multiple Primary and Histology Rules

Other Sites Rules
Terms and Definitions

• Equivalent Terms
  • Acinar adenocarcinoma, adenocarcinoma
    • Acinar refers to the fact that the adenocarcinoma originates in the prostatic acini.
    • 95% of all prostate cancers are (acinar) adenocarcinoma.

Other Sites Multiple Primary & Histology Rules

• Rule M3
  • Adenocarcinoma of the prostate is always a single primary
    • One per patient per lifetime

• Rule H10 and H20
  • Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma
Grade/Differentiation

Coding Grade for Prostate

- Gleason’s Grading System
  - There are 5 patterns described by Gleason's
  - Sum of Primary and Secondary patterns = Score
  - A tertiary pattern may also be defined
Grade 2014 Coding Instructions

- Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began.
- Use table to determine grade
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</table>

Questions?
And now a brief pause for...

An Epi Moment

(insert “Take it Like A Man” here…Michelle Wright version)

Epidemiology of Prostate Cancer

• Incidence
  • #1 among men US & Canada
  • 2013: 102.3 per 100,000 men
    • 26%
    • All major race/ethnic groups
    • Highest among blacks (167.6)
    • 2nd for Korean, 3rd for Vietnamese
  • More common in developed world
    • #2 worldwide
    • 15%

• Mortality
  • #2 US & Canada & #5 worldwide
  • 2013: 19.2 per 100,000 men
  • Highest among blacks (39.1)
Epidemiology of Prostate Cancer

- Prostate gland
  - Part of reproductive organ
  - Secrete prostate fluid, component of semen
- Predominately adenocarcinomas
  - Sarcomas, transitional & small cell carcinoma
- Average age at dx: 66
- No population based screening
  - USPSTF
    - 2012 D grade for PSA
    - If DRE = Abnormal texture, size, or shape
    - PSA above 4 (although some recommend lower) then biopsy
    - PSA also part of staging (Gleason)
    - Imaging to look for cancer spread
      - Transrectal ultrasound also used for diagnosis alone and to help guide needles during biopsy

Prostate Cancer Trends, 1995-2013
Symptoms of Prostate Cancer

- **Early stage asymptomatic**
- **Urinary symptoms**
  - Burning or pain during urination
  - Difficulty urinating, or trouble starting and stopping while urinating
  - More frequent urges to urinate at night
  - Loss of bladder control
  - Decreased flow or velocity of urine stream
  - Blood in urine (hematuria)
- **Other symptoms**
  - Blood in semen
  - Erectile dysfunction and painful ejaculation
  - Swelling in legs or pelvic area
  - Numbness & bone pain

### Table 1. Symptoms Assessed by International Prostate Symptoms Score (IPSS) *

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Sensation of not emptying bladder</td>
<td>0-20</td>
</tr>
<tr>
<td>Frequency of urination</td>
<td></td>
</tr>
<tr>
<td>Intermittent of urine stream</td>
<td></td>
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<tr>
<td>Difficulty postponing urination</td>
<td></td>
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<tr>
<td>Weakness of urine stream</td>
<td></td>
</tr>
<tr>
<td>Need to strung to begin urination</td>
<td></td>
</tr>
<tr>
<td>Frequency of urination overnight (nocturia)</td>
<td>0-20</td>
</tr>
</tbody>
</table>

*Symptoms are assessed by the patient from a range of not at all (0 points) to almost always (5 points). Nocturia is measured as a frequency of 0-5 or more times and receives a corresponding point value (maximum of 5). Total score: 0-7 points = mild symptoms; 8-19 points = moderate symptoms; 20-25 points = severe symptoms. Source: Reference 7.*

Risk Factors for Prostate Cancer

- **Developed countries**
  - Screening & lifestyle differences
  - Immigrants have increased risk than home countries
- **Blacks**
  - High testosterone level (therapy)
    - Testosterone stimulates growth of prostate
  - Genetic Factors and conditions
  - Father or brother 2x the risk
  - Risk increases with # of family members
  - Prostatic intraepithelial neoplasia (PIN)
  - BCRA1 & 2
- **Risks under investigation**
  - Diet (High fat)
  - Obesity
  - STDs
  - Vasectomy
  - Chemical Exposures
    - Agent Orange
- **Unlikely risks**
  - Smoking
Prostate Cancer Prognosis

Percent of Cases & 5-Year Relative Survival by Stage at Diagnosis: Prostate Cancer

- Localized (80%) Confined to Primary Site
- Regional (12%) Spread to Regional Lymph Nodes
- Distant (4%) Cancer Has Metastasized
- Unknown (4%) Unstaged

Percent of Cases by Stage

5-Year Relative Survival

SEER 18 2006–2012, All Races, Males by SEER Summary Stage 2000

PSA Cancer Screening and Incidence

U.S. Prostate Cancer Incidence

Surveillance, Epidemiology, and End Results (SEER) Program and the National Center for Health Statistics
PSA Screening and Overdiagnosis

- Annual Report to the Nation
- DX
  - Overdiagnosis
  - Biomarkers
- TX
  - Active surveillance versus immediate treatment
    - Early-stage, low grade
    - Molecularly targeted agents and vaccines
Questions?

Quiz 1

Summary Stage
1-Localized

- Confined to the prostate
  - Invasion into, but not through prostatic capsule

Source: National Cancer Institute (NCI)
Creator: NIH Medical Arts

2-Regional by direct extension only

- Direct extension beyond the prostate
  - Extracapsular extension
  - Bladder
  - Seminal vesicle(s)
  - Skeletal muscle, NOS
  - Ureter(s)
- Direct extension to bone is 7-distant mets

By Created by US government agency National Cancer Institute -
http://www.cancer.gov/cancertopics/wyntk/prostate/allpages#ab3d4f20-6ab9-4428-9717-067035d2e691, Public Domain,
https://commons.wikimedia.org/w/index.php?curid=837427
3-Regional lymph node(s) involved only

- Iliac, NOS
  - External
  - Internal (hypogastric)
  - Obturator
- Pelvic, NOS
- Periprostatic
- Sacral, NOS:
  - Lateral (laterosacral)
  - Middle (promontorial)
  - Presacral
- Regional lymph node(s), NOS


7-Distant site(s)/lymph node(s) involved

- Distant Lymph Nodes
- Direct extension or fixation to:
  - Pelvic wall or pelvic bone
  - Penis
  - Sigmoid colon
  - Other direct extension
- Discontinuous metastasis
AJCC Staging

Clinical Stage Rules for Classification

- Digital Rectal Exam (DRE)
- Transrectal Ultrasound
- MRI
- CT scans
  - Abdomen/pelvis
  - Bone
  - Liver/spleen
  - Brain
Clinically Inapparant Tumor

- Incidental finding
  - In less that 5% of tissue is c1A
  - In more than 5% of tissue is c1B

Clinically Inapparent Tumor

- Cancer is suspected, but not enough tumor is in the prostate to make it palpable on DRE or visible on TRUS.
- A biopsy confirms cancer is present c1C
Clinically Apparent Tumor

- Tumor is large enough to be felt on DRE or seen on TRUS
  - Less than half of one lobe is c2A
  - More than half of one lobe is c2B
  - Both lobes is c2C

Staging Case 1

- A patient with a PSA of 7 had a DRE that showed a firm and enlarged prostate. A needle biopsy of the showed Gleason 3+2 adenocarcinoma in 3 of 6 cores from the left lobe and Gleason 3+3 in 1 of 6 cores from the right lobe.

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
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<tr>
<td>Path</td>
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<tr>
<td>Summary Stage</td>
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</table>

Pg 467
### Staging Case 2

- A patient with a PSA of 27 had a DRE that revealed a large nodule involving both lobes of the prostate. A needle biopsy of the prostate showed Gleason 3+2 adenocarcinoma in 5 of 6 cores from the left lobe and Gleason 4+3 in 4 of 6 cores from the right lobe.

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<td>Summary Stage</td>
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</table>

### Nomograms and Predictive Models

- **Assessment of risk**
  - How likely is a cancer to be confined to the prostate?
  - How likely is the cancer to progress after treatment?

- **Predictions based on:**
  - Clinical stage
  - Biopsy Gleason grade
  - Preoperative PSA
**Partin Tables**

- PSA: 2.6-4.0
- Gleason Score: 3+4
- Clinical 2B/2C

<table>
<thead>
<tr>
<th>OC: organ confined (27)</th>
<th>EPE: extraprostatic extension (30)</th>
<th>SV+: seminal vesicle involvement (3)</th>
<th>LN+: lymph node involvement (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>44(37-51)</td>
<td>46(39-53)</td>
<td>6(3-10)</td>
<td>4(2-8)</td>
</tr>
</tbody>
</table>

Numbers represent percentage of patients with the specified PSA, clinical stage, and biopsy Gleason score who would have organ-confined disease (OC), extra-prostatic extension (EPE), cancer invading into the seminal vesicles (SV+), or cancer invading regional lymph nodes (LN+). Numbers in parentheses represent 95% confidence intervals.

http://urology.jhu.edu/prostate/partintables.php

**Extension beyond the prostate-clinically**

- Extension through the prostatic capsule, but not into adjacent structures c3A
- Extension into seminal vesicles is c3B

http://training.seer.cancer.gov/prostate/anatomy/
Extension into Adjacent Organs or Structures-Clinically

- c4 Extension to the:
  - Rectum
  - Bladder
  - Levator muscles
  - Pelvic wall
  - Other structures or organs

Pathologic Stage-Rules for Classification

- The following meet the rules for classification for pathologic T:
  - Total prostatectomy
  - Biopsy confirming extension into the rectum (T4)
  - Biopsy confirming extension into extraprostatic soft tissue (T3A)
  - Biopsy confirming extension into the seminal vesicles (T3B)
- Removal of at least one regional lymph node is required to meet the rules for classification for a pathologic N.
Staging Case 3

- A patient with an elevated PSA has a transrectal biopsy that confirms extension into the seminal vesicle. Additional imaging did not show any additional metastasis.

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<td>Clin</td>
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<tr>
<td>Path</td>
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<tr>
<td>Summary Stage</td>
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</tbody>
</table>

Staging Case 4

- A patient with an elevated PSA has a transrectal biopsy that confirms extension into the seminal vesicle. An enlarged lymph node was also biopsied and found to be positive for malignancy. Additional imagining did not show metastasis.

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<td>Clin</td>
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<tr>
<td>Path</td>
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<tr>
<td>Summary Stage</td>
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</tbody>
</table>

What if biopsy confirmed extension into the rectum (T4) and LN Mets (N1)?
We have met the criteria for pStage.
**Confined to the Prostate**

- p1A, p1B, and p1C are not valid values (will cause an edit)
- P2-Confined to the prostate
  - Less than half of one lobe p2A
  - More than half of one lobe is p2B
  - Both lobes is p2C

**Staging Case 5**

- Patient with a PSA of 7 and a normal DRE documented by physician had a needle biopsy of the prostate that identified Gleason 3+2 adenocarcinoma in 1 of 6 cores from the left lobe.
- This was followed by a retropubic prostatectomy that showed Gleason 3+2 adenocarcinoma involving the majority of 1 lobe. No extension beyond the prostate. Two pelvic lymph nodes were removed and found to be negative.

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<tr>
<td>Path</td>
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<tr>
<td>Summary Stage</td>
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</tbody>
</table>
**Extraprostatic Extension-p3**

- Extracapsular invasion p3A
  - May be unilateral or bilateral
  - Includes bladder neck invasion
  - Does not invade into any structures or organs
- Invasion of the seminal vesicles p3B

**Extraprostatic Extension-p4**

- Direct invasion into adjacent structures
  - Rectum
  - Bladder
  - Muscles
  - Pelvic wall
  - Etc.
Regional lymph node N1

- Iliac, NOS
  - External
  - Internal (hypogastric)
  - Obturator
- Pelvic, NOS
- Periprosthetic
- Sacral, NOS:
  - Lateral (laterosacral)
  - Middle (promontorial)
  - Presacral
- Regional lymph node(s), NOS


Inaccessible Site Rule - Applies to AJCC Staging

- Inaccessible lymph nodes rule for regional lymph nodes. For inaccessible lymph nodes, record CS Lymph Nodes as Code 000 (None) rather than Code 999 (Unknown) when the following three conditions are met:
  - There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration.
  - The patient has clinically low stage (T1, T2, or localized) disease.
  - The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) or is offered usual treatment but refuses it, since this presumes that there are no involved regional lymph nodes that would otherwise alter the treatment approach.
Distant Metastasis

- Bone
- Distant Lymph Nodes
  - Aortic
  - Common Iliac
  - Inguinal
  - Supraclavicular
  - Cervical
  - Scalene
  - Retroperitoneal
- Lung
- Liver

Stage Grouping - Stage I, IIA, and IIB

- Stage PSA and Gleason score impact stage grouping
- Subcategories may be required
  - If PSA is less than 20 or Gleason is less than 8, subcategories are required for stages I, IIA, and IIB

See page 461
Staging Case 6

• A patient had DRE due to an elevated PSA (5.4). The urologist felt a nodule in the left lobe. The urologist did not indicate if it was more or less than half a lobe. Biopsy confirmed adenocarcinoma Gleason 3+3. No indication of any additional disease.

Staging Table

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<th>M</th>
<th>PSA</th>
<th>Gleason</th>
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<tr>
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<td>c0</td>
<td>c0</td>
<td>5.4</td>
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See page 462 AJCC Manual
Staging Case 7

- A patient had DRE due to an elevated PSA (15.4). The urologist felt a nodule in the left lobe. The urologist did not indicate if it was more or less than half a lobe. Bx confirmed adenocarcinoma Gleason 4+4. No indication of any additional disease

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Neoadjuvant Treatment

- Androgen Deprivation Therapy
  - If given prior to surgery, it may not be considered neoadjuvant therapy.
  - Only assign code 4 in the data item Path Stage Descriptor if you have confirmation that it is being given as neoadjuvant therapy.
  - Code date therapy started in system therapy even if it is not considered neoadjuvant therapy.
  - Is considered neoadjuvant therapy if given prior to radiation. However, this would not be coded in Path Stage Descriptor.
Questions?

CS Site Specific Factors

CoC
1, 2, 3, 7, 8, 9, 10, 11, 12, 13
Prostatic Specific Antigen (PSA)

- Monitors progression of disease & response to therapy in prostate cancer
- Screening test to detect early stage prostate cancer
- PSA Lab Value is used for stage grouping in AJCC Cancer Stage for prostate

Prostatic Specific Antigen (PSA)

- SSF1: PSA Lab Value
  - Record highest PSA lab value prior to diagnostic prostate biopsy and treatment to nearest tenth in nanograms/milliliter (ng/ml)
  - Record test prior to diagnosis if there are tests prior to diagnosis and after diagnosis but before treatment
- SSF2: PSA Interpretation
  - Record the clinician’s interpretation of highest PSA lab value prior to diagnostic prostate biopsy and treatment
Code the following PSA Values

- 3.2 ng/ml 032
- 7.5 ng/ml 075
- 12 ng/ml 120
- 72.5 ng/ml 725
- 1027 ng/ml 980

SSF3: CS Extension – Pathologic Extension

- Record information from prostatectomy and autopsy
  - Includes simple prostatectomy with negative margins
  - Code info from biopsy of extraprostatic sites in CS Extension – Clinical Extension
  - Include extension information from prostatectomy for another reason (i.e., cystoprostatectomy for bladder cancer) when prostate cancer is incidentally identified
  - AJCC considers in situ carcinoma of prostate impossible and 00 maps to TX
SSF3: CS Extension – Pathologic Extension

- AJCC Cancer Stage
  - T2 NOS: Organ confined
    - SSF3 = 200, 300, 320, or 400
  - T2a: Involves ½ of 1 lobe/side or less
    - SSF3 = 210, 330, or 402
  - T2b: Involves more than ½ of 1 lobe/side but not both lobes/sides
    - SSF3 = 220, 340, or 404
  - T2c: Involves both lobes/sides
    - SSF3 = 230, 350, or 406

- SSF3: CS Extension – Pathologic Extension

- AJCC Cancer Stage
  - T3 NOS: Extraprostatic extension
    - SSF3 = 495
  - T3a: Extracapsular extension; Microscopic invasion of bladder neck
    - SSF3 = 415-483
  - T3b: Seminal vesicle invasion
    - SSF3 = 485 or 490
  - T4: Invasion of rectum, levator muscles, and/or pelvic wall
    - SSF3 = 500-750
SSF3: CS Extension – Pathologic Extension

- Summary Stage 2000
  - Localized (L): Tumor confined to prostate
    - SSF3 = 200-350
  - Regional by direct extension (RE): Extension beyond prostate
    - SSF3 = 400-520
  - Distant extension (D): Extension or fixation to pelvic wall or bone; further extension to bone, soft tissue, or other organs
    - SSF3 = 600-700

SSF3: CS Extension – Pathologic Extension

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7</th>
<th>SS20000</th>
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<tbody>
<tr>
<td>960</td>
<td>Unknown if prostatectomy done</td>
<td>TX</td>
<td>U</td>
</tr>
<tr>
<td>970</td>
<td>No prostatectomy done within 1st course treatment</td>
<td>TX</td>
<td>U</td>
</tr>
<tr>
<td>980</td>
<td>Prostatectomy done but not considered 1st course treatment</td>
<td>TX</td>
<td>U</td>
</tr>
<tr>
<td>985</td>
<td>Autopsy performed but extension unknown</td>
<td>TX</td>
<td>U</td>
</tr>
<tr>
<td>990</td>
<td>Prostatectomy done: Extension not stated; Primary tumor cannot be accessed; Not documented in patient record</td>
<td>TX</td>
<td>U</td>
</tr>
</tbody>
</table>
9/6/15 patient with PSA of 4.4 has DRE and prostate needle biopsy: Adenocarcinoma right & left lobes; T1c. Patient opted for Active surveillance.

1/5/16 Patient had first follow-up visit with physician. DRE normal and PSA 4.3.

3/19/16 PSA rising. Prostate biopsy: Adenocarcinoma. Patient referred to the oncology department for a consultation for an intermediate risk prostate carcinoma.

6/17/16 Prostatectomy: Adenocarcinoma involving seminal vesicles (pT3b).

What is the code for SSF3 (CS Extension – Pathologic Extension)?

- 230: Involves both lobes; Stated as pT2c with no other info on pathologic extension
- 300: Localized NOS
- 485: Extension to seminal vesicles; Stated as pT3b with no other info on pathologic extension
- 980: Prostatectomy performed but not considered 1st course treatment
Gleason System for Grading Prostate Cancer

- Patterns based on 5 component system
  - Primary pattern
    - Predominant
  - Secondary pattern
    - Second most predominant
  - Gleason’s score
    - Sum of primary and secondary patterns
  - Tertiary pattern
    - Small component of 3rd more aggressive pattern associated with a worse outcome

SSF7: Gleason’s Primary Pattern & Secondary Pattern Values on Needle Core Biopsy/TURP

- Record primary and secondary patterns from needle core biopsy or TURP
- Record patterns that reflect highest score if different patterns are documented on multiple biopsies
- Record patterns that reflect highest score if both biopsy and TURP performed
- Do not mix patterns from multiple specimens
- Use code 998 if biopsy/TURP not performed
SSF8: Gleason’s Score on Needle Core Biopsy/TURP

- Record Gleason’s score based on primary & secondary patterns recorded in SSF7
- Use code 998 if biopsy/TURP not performed
- Used for clinical stage grouping in AJCC Cancer Stage for prostate

SSF9: Gleason’s Primary Pattern & Secondary Pattern Values on Prostatectomy/Autopsy

- Record primary and secondary patterns from prostatectomy or autopsy
- Use code 998 if prostatectomy or autopsy not performed
- Do NOT code tertiary pattern in this SSF
SSF10: Gleason’s Score on Prostatectomy/Autopsy

- Record Gleason’s score based on primary & secondary patterns recorded in SSF9
- Use code 998 if prostatectomy or autopsy not performed
- Used for pathologic stage grouping in AJCC Cancer Stage for prostate
- Do NOT code tertiary pattern in this SSF

SSF11: Gleason’s Tertiary Pattern Value on Prostatectomy/Autopsy

- Record tertiary pattern documented on prostatectomy or autopsy
- Disregard tertiary pattern from prostate biopsy or TURP
- Use code 998 if prostatectomy or autopsy not performed
**SSF12: Number of Cores Positive**

- Record the number of prostate core biopsies positive for cancer
- If multiple core biopsy procedures are performed, record the number of cores positive for cancer from procedure with highest number of cores positive
- Use code 991 if core biopsies positive but number unknown
- Use code 998 if needle core biopsy was not performed

**SSF13: Number of Cores Examined**

- Record number of prostate core biopsies examined
- If multiple core biopsy procedures are performed, record the number of cores examined from procedure with highest number of cores positive (same procedure as used to record SSF12)
- Use code 991 if core biopsies examined but number unknown
- Use code 998 if needle core biopsy was not performed
Questions?

Treatment
Initial Diagnosis, Assessment, and Workup

- DRE
- PSA
- Gleason
- Life Expectancy
  - Less than or equal 5yrs and asymptomatic
  - No further workup or treatment until symptomatic
- Life Expectancy
  - Greater than 5yrs or symptomatic
  - Bone scan or Pelvic CT or MRI

Risk Groups

- Clinically Localized
  - Very Low
  - Low
  - Intermediate
  - High
- Locally Advanced
  - Very High
  - Metastatic
Treatment Based on Risk Group

- Very Low
  - Active Surveillance, EBRT or Brachytherapy, Radical Prostatectomy
  - Active Surveillance
  - Observation
- Low
  - Active Surveillance, EBRT or Brachytherapy, Radical Prostatectomy
  - Observation

Treatment Based on Risk Group

- Intermediate
  - Radical Prostatectomy
  - Observation
  - EBRT, Androgen Deprivation Therapy, Brachytherapy or Brachytherapy alone
Treatment Based on Risk Group

- High and Very High
  - EBRT, ADT, Brachytherapy, Docetaxel
  - Radical Prostatectomy
- Metastatic
  - Regional – EBRT, ADT
  - Distant - ADT

Active Surveillance

- Active surveillance involves actively monitoring the course of disease with the expectation to intervene with curative intent if the disease progresses.
  - PSA testing every 6 months
  - DRE as often as every 12 months
  - Repeat biopsies every 6 months
**RX Summ-Treatment Status**

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<thead>
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<th>Code</th>
<th>Definition</th>
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<tr>
<td>1</td>
<td>Treatment given</td>
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<tr>
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<td>Active surveillance</td>
</tr>
<tr>
<td>9</td>
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**Question**

- Often with low risk prostate cancer, the patient is offered XRT, surgery, or active surveillance. I have several instances where the patient initially chose watchful waiting, and then, he changes his mind (still within the 1st year of diagnosis) and wants to proceed with XRT or surgery. There is no documentation to indicate there is disease progression.
  1. Should the surgery or XRT that follows a period of AS be considered First Course or Subsequent Treatment?
  2. How would I handle the same watchful waiting patient who is re-biopsied with no mention of progression and decides to proceed with XRT or surgery?
  3. How does watchful waiting patient w/no mention of progression differ from a patient who refuses and changes their mind within the first year? or does it?
Answer

• The rule of thumb, according to Dr. Winchester, is if the change was made before the patient's first follow-up doctor's visit after the decision to use active surveillance then it is a change in first course treatment. If it occurs after that visit, the switch to surgery is second course.
  • Kathleen Thoburn CoC


Questions?
Quiz 2

Case Scenarios
Coming Up…

- Patient Outcomes
  - 7/7/2016

- Collecting Cancer Data: Bladder
  - 8/4/2016

And The Winners Are…
CE Certificate Quiz/Survey

- Phrase
- Link

Thank You!!!!

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