Prostate Q&A

Thursday, October 5, 2017

Q1: ­Can you SEER stage w/out a prostatectomy?­

A1: ­Yes...a summary stage can be assigned based on clinical information. If you a patient had a cT1c, it would be considered localized.­‑

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Q2: ­When will the errata on the histology be out?­

A2: A list of all of the new histology codes, terms, and changes to behavior should be available by 12/15/17. You can find more information on the NAACCR 2018 implementation page <https://www.naaccr.org/2018-implementation/> .

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Q3: ­AJCC website originally said there will be electronic copy of the 8th edition manual. Any news whether that is still planned? ­

A3: Donna Gress - that is why we haven't put it out yet, waiting for all the updates to be finished, but there is a way to put updates in Kindle.

Jim-News concerning the AJCC 8th edition can be found on the AJCC website <https://cancerstaging.org/About/news/Pages/Implementation-of-AJCC-8th-Edition-Cancer-Staging-System.aspx>

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Q4: Q: Please have Angela repeat the corrections for the slide pertaining to the 2018 Teaser (3 Gleason items).

A4: ­The table that you have on slide 16 distributed prior to the webinar is incorrect. The one shown during the live session is correct. We will make sure to send out the correct slides­.

­On Slide 17 the ­Gleason grade group should be 2 and not 4 for the needle core biopsies of the prostate. The Gleason grade group from the prostatectomy should be 4 and not 3.

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Q5: ­For SS2000 if a patient has no extracapsular extension but margins are involved, the stage should be regional by direct extension (2) - we've seen miscoding of this.­

A5: Great tip! You are correct.

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Q6: ­On slide 11, the survival stats quoted are for patients with NO treatment? ­

A6: ­All patients had undergone standard treatment with the chemotherapy drug docetaxel. ­

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Q7: ­On Pop Quiz 4, should the clinical T be T2c? Can you please explain why or why not?­

A7: Only 1 lobe is involved. The majority of the lobe is involved so T2b is correct.

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Q8: ­If you have a TURP with mention of elevated PSA but no DRE and then CT staging showing direct extension into bladder, do you base the clinical T stage off the TURP or imaging that followed?­

A8: I would assign the T based on the extension into the bladder. T2 is a clinically apparent tumor confined to the prostate. This tumor is not confined to the prostate so clinically apparent/not apparent does not play a role.

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Q9: ­Can you clarify how to code bladder neck involvement? We don't see anything in T3 about bladder.­

A9: The instructions are kind of buried. See page 460. The first column that starts with a bolded pT4. The final sentence in that paragraph. It is also on the first page of the chapter in the Summary of Changes.

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Q11: If DRE & PSA are not done for population based screening, how will clinically inapparent­ tumors be found before becoming symptomatic? ­

A11: They will not be found. The research is on-going, but identifying asymptomatic tumors may not confer a benefit in terms of lowered mortality and may increase risk of complications due to biopsy, treatment, or mental distress due to the diagnosis. The current evidence indicates that the benefits do not clearly outweigh the risks for most men. However, PSA may be beneficial for some men which is why men are encouraged to discuss their individual risks with their physicians. Note: the recommendation may change as new evidence emerges. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q12: ­If there is no pattern given, only a score, and pattern is needed to determine correct grade group (i.e. Gleason 7 grade group 2 vs 3), is stage group unknown?­

A12: If the grade group influences the stage group, then stage group will have to be unknown. This certainly could happen if Gleason is 7 and you don’t know if the pattern was 3+4 or 4+3.

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Q13: ­For a non-analytic case, where prostatectomy is subsequent treatment, SSF3 is 980 (prostatectomy done but not first course), is SSF9, 10, 11 coded or are they 998? ­

A13: It should be coded 998.

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Q14: ­Can you please interpret the note under the stage group table that states when either PSA or Grade Group is not available grouping should be determined by T category and/or either PSA or Grade Group as available.­

A14: From Donna Gress - ­That is for PHYSICIANS ONLY - NEVER registrars, physicians need to be able to talk to their patients about their stage & prognosis­.

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Q15: ­What is the rationale for the LN draining XRT codes? ­

A15: Now we can identify when regional lymph nodes are receiving radiation treatment.

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Q16: ­On XRT to draining LNs stated regional LNs only so for prostate you would be referring to????? Please clarify New STORE codes for this field thx­

A16: We will forward this to CoC for clarification.

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Q17: Is ­Provenge still in use for mets prostate cancer? ­

A17: ­According to the American Cancer society Provenge is a vaccine that is used to treat advanced prostate cancer that is no longer responding to hormone therapy but causing few or no sy­mptoms.‑

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Q18: F­or risk group slide, could you add the criteria for each category. Thanks!­

A18: We have created a document with a summary of the risk groups and posted it with the recording.

Please see the NCCN guidelines for detailed information on treatment recommendations based on risk groups, see the <https://www.nccn.org/professionals/physician_gls/f_guidelines.asp>

Go to page MS 33 and review the NCCN Recommendations.

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Q19: ­Which part of the Gleason Score is incorrect? ­

A19: On Prostate Quiz 1 the Gleason score was stated 6 (3+4) Gleason score should be 7­.

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Q20: ­If the path states: acinar adenocarcinoma, we now code 8140/3, and disregard the term acinar. Will this rule apply in 2018? ­

A20: Yes

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Q21: ­Are the grade groups going to be the same grade that are to be coded in the grade field?­

A21: Grade group will be coded in Clin Grade and/or Path Grade. The current Grade data item will not be collected.

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Q22: ­For scenario 1, if the patient underwent TURB and not cystoprostatectomy, staging would be clinical, right? ­

A22: No. The patient was not diagnosed until after the treatment was started. Therefore, clinical stage is blank, blank, blank, stage unknown

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Q23: ­For hormone therapy is it 88 since scenario states it is planned, no date it is given yet? ­

A23: Yes that would be correct.

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Q24: ­When would the descriptor (m) be used in prostate cancer clinically and pathologically­

A24: It could be used if it is documented that multiple tumors are present. However, multiple tumors is not a clinical factor for prostate.

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Q25: If this is an incidental finding, why wouldn't we use T1a?

A25: T1a is for cT only.

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Q27: When would we use pT1a?

A27: pT1a is not a valid value. For pT the values start at pT2.

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Q28: Why is it pT2 for 8th edition? And not pT2a?

A28: T2a, T2b and T2c are really a concept for clinical stage. The subcategories are based on what the physician feels during a DRE. They allowed them for the pT in the past just so the values were consistent between clinical and path T. In 8th edition they state that the subcategories don’t add any real value to the pT so they have been dropped. See page 720 **pT2** in 8th edition for additional clarification.

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Q29: Does hormone therapy affect grade­? ­

A29: I don’t know. I am not aware of any rule that states that grade cannot be assigned after hormone therapy.

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Q30: ­There are a lot of patients who receive hormone therapy prior to their prostatectomy. The NCCN guidelines do not consider this to be adjuvant therapy? ­

A30: Based on what I have read in the NCCN guidelines it seems they are pretty adamant that there is no benefit to giving patients hormone treatment prior to prostatectomy. I would want a clear statement from a physician stating that hormone treatment given prior to prostatectomy should be considered neoadjuvant treatment and that the neoadjuvant treatment should be reflected in the AJCC stage.

The NCCN guidelines do indicate there is some benefit for patients that get hormone therapy prior to radiation (no prostatectomy as first course tx) ­.

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Q31: ­Does a T1c imply a clinically inapparent tumor? ­

A31: Yes.

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Q32: ­Can you review pop quiz 5 and why is it not T2c?­

A32: T2c indicates the physician felt tumor in the left and right lobes of the prostate during the DRE. We know the tumor was palpable, but we don’t know if there was enough tumor that it could be felt in just on lobe or both lobes. Therefore, the best we can do is cT2. The core biopsy do not impact the subcategories for T2. The T2 category does not necessarily reflect whether tumor is present in both lobes. It reflects whether there is enough tumor to be palpable.

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Q33: ­In the last pop quiz I don't see enough that says the cancer is confined to the prostate. Why not a T1c? ­

A33: There is a statement that says no indication of any additional metastasis. For the purposes of the presentation, that has to suffice to indicate there is nothing to make the physician believe there is extension beyond the prostate.

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Q34: ­Pop quiz - we don't have info that says the cancer is confined within prostate? ­

A34: There is a statement that says no indication of any additional metastasis. For the purposes of the presentation, that has to suffice to indicate there is nothing to make the physician believe there is extension beyond the prostate.

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Q35: ­Back to Quiz 5 pt has a nodule, biopsy is positive in both lobes does this change the Clinical T in 7th Ed to a cT2c vs your code of cT2?­

A35: No. T2 reflects the tumor burden, not whether tumor is present in both lobes. A T2c indicates there is enough cancer in the prostate that tumor can be palpated in two lobes.

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Q36: ­Pop Quiz 5 again - your T2 says that the tumor is not palpable. If not palpable then shouldn't we use T1c? Also - we should likely have a path with needle biopsy and know lobe involvement?­

A36: Good point. I should have stated that nodule was identified through DRE. The needle biopsy does not impact the T value. The T2 indicates there was enough tumor in the prostate to make it palpable. The subcategories give us an idea of how much palpable tumor was present.

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Q37: ­Are suspicious core biopsies included when we count the number of positive cores? ­

A37: A definitive statement of malignancy has to be documented to count a core biopsy as positive.

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Q38: ­What terms in a DRE can be used to indicate clinically apparent? ­

A38: I found a post on the CAnswer forum that might help. It’s rather old, but I think it is still relevant.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/genitourinary-sites-chapters-40-47/821-palpable-definition-for-clinical-staging-of-prostate-ca>

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Q39: ­Is a rising PSA (2times) after Rad prostatectomy a recurrence? Is it enough to have this rising PSA?­

A39: What you are describing sounds like what is sometimes referred to as a biochemical recurrence. This has been a hot topic on the CAnswer forum. I would suggest going to the CAnswer forum. Click on the FORDS subforum and do a search on Biochemical.

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Q40: ­What is the site of recurrence with a rising PSADT? ­

A40: I found one post that might offer some clarification

<http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/data-quality-chapter-5/s5-7-commission-on-cancer-special-studies/prostate-questions/73475>

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Q41: ­What is the STORE acronym? ­

A41: ­STORE stands for Standards for Oncology Registry Entry.­

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Q42: ­Case scenario 1 - cN0 can you tell me how you determined there was no clinical LN involved prior to surgery? CT A/P was on 5/20 which is 4 days after prostatectomy which is not part of clinical staging.­

A42: Great point. That was a typo on our part. The imaging was supposed to be done prior to the prostatectomy. I am going to correct it for those that do the scenario after the live session.

If you take the imaging away, this is a tough call when it comes to the cN.

The patient had a high PSA, a fairly aggressive Gleason (4+3), and there was enough tumor in the prostate that it could be felt in both lobes. However, they did do a prostatectomy. The NCCN guidelines do not list prostatectomy as a recommended treatment for patients with N1 disease. Based on the fact they did do the prostatectomy, I would lean towards using a cN0.

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Q43: ­Scope of nodes should be 4 (1-3 removed).­

A43: I think you are correct. If additional lymph nodes had been removed, they would have been mentioned. We will make the correction to the answer sheet.

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