

## Q&A Session for Prostate 2023

April 6, 2023

#	Question	Answer
1.	We had a case where only had a biopsy of a node and no Gleason score. Can we still give it a stage IV?	Yes. PSA and Gleason grade group are not factors when calculating stage 4 disease. A stage 4 can be assigned without a PSA or Gleason.
2.	If the physician dictates cT1c in his note but does not document the rectal exam, do we need code cTX or should it be empty?	Should be empty you have to have the findings from a DRE in order to clinically stage
3.	If the physician states the stage without a DRE performed, would the T be left blank or would it be cTX?	If the physician states why the DRE was not done (i.e. patient refused), then it would be a cTX. If you don't know if a DRE was performed, then it would be cT blank.
4.	You state that we can use hard spots or soft spots on the prostate on DRE can but used as clinically apparent? My understanding was that it had to be a tumor or nodule or mass. Please review again what we can consider as apparent.	I wish we had a list of terms we can use to differentiate between when the feels a tumor in the prostate and when the physician feels something else. However, we don't have such a list. It is my understanding that AJCC prefers you leave the cT data item blank if you are unsure whether the physician is palpating a tumor or something else.
5.	"Tesla" is also known as the magnetic strength of MRI machines	Thank you!
6.	For diagnosis date, does a PIRADS 4 OR 5 qualify as a diagnosis date for a COC facility if the MRI is done BEFORE the TRUS bx and the MRI does NOT use any other ambiguous terms other than the PIRADS 4 or 5.	Per the STORE manual, the date of the biopsy would be the date of diagnosis in the scenario you describe. The SEER manual would have you make the date of the MRI as the date of diagnosis. The two standard setters have given us conflicting instructions in this scenario. Until this gets resolved, I would look at how this scenario has been handled in the past and/or what my cancer committee advises to determine the date of diagnosis.
7.	If a patient comes in and is diagnosed with prostate cancer and opts for surveillance, even though surgery and radiation was recommended. A year later patient decides to have radiation,	I would say subsequent treatment. Also, the patient participated in active surveillance for a significant amount of time. Pt was recommended treatment but refused. Physician would only offer initial surveillance for a low risk Gleason score.

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	would that still be considered first course treatment? Or would that be considered subsequent?	
8.	You have to be careful if the physician is using the bx results to say T2b which is what we have happening here.	You can't use laterality or info from the bx to clinically stage prostate cancer. You have to have physicians' statement of what they are actually feeling. The biopsy is only confirming the patient has cancer. It is not used to assign the cT 1 or 2.
9.	There should be somewhere in abstract that you can document physician's stage (especially helpful if discrepancy from registrar's stage).	Physician stage has been collected in the past. It would be up to CoC or one of the other standard setters to require it again. However, it can always be collected as a user defined field within a hospital registry.
10.	MRI says prostate cancer invading seminal vesicles. Radiation oncologist repeats this in his staging, based on the MRI. We can't use this, and it feels as though it's under-staging, or not staging when we could have.	It does feel like that and I am sure in some ways they are being under-staged. However, the physician experts that developed the chapter felt this was the best way to document clinical stage for prostate. I know Donna has mentioned tables that are used for treatment and prognosis, and they are based on a cT from a DRE. Sometimes, as registrars, we have to just take that leap of faith that even though something does not make sense to us, this is how the people that use the data want it.
11.	This is Jennifer from NCI SEER and manager of SEER Summary Stage. Summary Stage is not as strict with staging as AJCC is. You don't have to have a DRE to assign a Summary Stage. Updated notes have been included with the v23 updates, along with examples, on how Summary Stage (and EOD) can be assigned when there is no DRE and the case is clinical staging only. You cannot use imaging for EOD or Summary Stage, which of course aligns with AJCC.	Thanks Jennifer!
12.	For Summary Stage, can you use a Subtotal, segmental, or simple prostatectomy?	Yes if you have a prostatectomy you are supposed to use path info over your clinical for SS2018 if applicable.
13.	Comment: the type of prostatectomy matters, it has to be radical	That is correct...radical prostatectomy is required for pT in most cases.

14.	On quiz 3 if the physician note says he did a DRE, can't we use cT1 since it was done?	No because you don't know the results from the DRE. If not palpable then cT1c but if palpable then you move onto cT2 and higher
15.	For the last quiz about LN if the CT was suspicious but PET indicated benign you would still code cN1?	Use the CT over a PET scan when using imaging for LN status on prostates
16.	Heidi: The physician did not state that it was palpable or not. Since no results of the DRE were documented it would be cT blank. IF the physician would of stated the results as "not palpable" we would use cT1.	Correct
17.	Where is the guidance coming from that you down the clinical grade? The grade manual prostate shows you use the higher of the two grades.	I think you are referring to when she said "carry the clinical grade down". What she meant is that if you have met the rules for classification for pathologic grade, you can use information biopsy to assign the value. This is allowed if the grade from the biopsy is higher than the grade from the prostatectomy specimen. pGrade is the highest known grade after a prostatectomy is done.  This is documented in the general instructions.
18.	Does SSDI PSA and PSA for TNM AJCC staging must be same?	I believe there has been a change to the PSA collection date time frame. According to the current SSDI manual, you record the last pre-dx PSA lab value prior to diagnostic BX. NOTE: This is a change from CSv2, where the instructions stated to code the highest PSA value w/in 3 months prior to diagnostic bx.
19.	I'm a little confused. On the first Example (11-15-21), The Grade Clinical was 3 but the Grade Pathological would have been a Grade 1 (Gleason 3+3=6), correct? However, we are supposed to bring the Clinical grade down so shouldn't the Grade Clinical have been brought down to a 1 and the Grade pathological a 1?	You use the higher grade. Higher grade informs prognosis and treatment so if clinical GRD 3, you and surgical path GRD 1, you bring down the clinical grade to the pathological.
20.	Does the 3 months rule for SSDI PSA...must be applicable to TNM AJCC Staging?	Can use pre-treatment PSA to assign stage (not necessary within three months, might not be the same PSA used for SSDI). this was taken from CANswer forum..."

21.	Number of cores examined differs between the physician's report and the pathology report some times. Which takes precedence?	Take off the pathology report
22.	Could you explain the difference between this SSDI coding guideline and the one mentioned on our slide in regard to the 3-month rule?	Coding Guidelines Record the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and initiation of treatment in nanograms per milliliter (ng/ml) in the range 0.1 (.1 ng/ml) to 999.9 (999.9 ng/ml). Note: This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy.
23.	Is the EOD taken from clinical or from path?	EOD Primary Tumor is based on "clinical" information. It used to derive a cT value. EOD Prostate Pathologic Extension is used to derive a pT.
24.	If path report has tertiary listed as N/A for none found per new cap protocol would you use an x8 (N/A can this apply because of the cap protocol stating either N/A or present) or N/A, info not collected) on the SSDI ? The patient did not have tertiary 5 and no other tertiary grade listed.	X8 is only used if field is not required. X9- not documented in med record would be the correct code in the situation you describe. .
25.	Can PSA alone be used to determine cancer status, or do you need a physician statement?	Cancer Status must be based on a physician statement. However, a physician may base there statement, in part on the PSA. The physician would probably want to see a post op psa <0.05 before stating the patient was NED.
26.	I thought Cancer Forum stated that we could not use PSA to determine NED?	That is correct.
27.	Your histology? There was SEER Educate case with this same situation and they there is a specific code for acinar and ductal ca of prostate and to use that code 8552/3	You are correct!  We sent this to SEER and they stated that as of 2018 Adenocarcinoma, mixed acinar and ductal type should be coded to 8552/3.
28.	If a patient had a Thulium laser enucleation of the prostate (ThuLep) that was done for BPH and path showed prostate cancer, what do we code?	Use surgical code 25. This is a type of TURP.

29.	PT is dx on 12/2021 and comes to our facility for prostatectomy in 7/2022. On H&P and operative note there is no information if Pt chose surveillance earlier. Can we code prostatectomy at our facility as first course treatment or second course?	I would code the prostatectomy as first course. Especially with a low risk Gleason score, patients may delay start of treatment looking for doctors, choosing modality or even delaying start to a convenient time. Remember, active surveillance is an active monitoring plan. Do not assume it is being done if it is not documented.
30.	When determining between cT1a and cT1b categories of a clinically inapparent tumor, is the information about percentage of tumor in the resected sample provided only by the TURP since information from the needle Bx would be cT1c even though the needle cores quote a tumor percentage of tumor along the core length? I did not think the core Bx percentage should be considered for determining the % of tumor in the resected specimen. Please verify. Thanks.	cT1A and cT1B are based entirely on the incidental finding of cancer during a TURP. Do not use information from a needle core biopsies.
31.	Per the SEER Program Code Manual, pg 153: When there is no documentation of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment. I would say, since I am from a SEER state, that the prostatectomy would be 1st course treatment since there is only 8 months from diagnosis to the prostatectomy.	That makes sense.
32.	Wouldn't it be stage 99 because you don't know if there are mets? There's no imaging with a GG5?	Gleason Grade Group 5 is automatically Stage 4 per the stage tables.
33.	Wouldn't it be cN0 since the PET disproved the CT scan "suspicious for mets"?	No in cN prostate cancer you use a CT scan not PET-in AJCC staging manual the accepted scans to use to assign cN
34.	On the grade slide for grade pathological is there a misprint - it states grade is from specimen taken from prior to any neoadjuvant treatment. It wouldn't be considered neoadjuvant if the prostatectomy has been done right?	Neoadjuvant treatment isn't routinely done for prostate cancer so it is kind of a moot point. However, if they decided to do neoadjuvant chemotherapy prior to the prostatectomy, the grade information from the prostatectomy could not be use to assign the pathological grade.

<b>35.</b>	Prostate biopsy does not give number of cores on path, but does on op report. If I count it myself on path, and they don't match, which number of cores should I use? Op Report or my own counting on path?	You take the path, always has precedence over op report. If the total no. of cores not stated on the path report, you can add the reported no. of cores. You can use physician statement for no. of cores when no other info available.
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