Q&A Session for Prostate 2025

May 15, 2025

#	Question	Answer
1.	MRI TARGETED BYOPSY NUMBER CORES EXAMINED AND NUMBER OF CORES POSITIVE SSDI's This was briefly discussed at the SEER Symposium last week, I just want to make sure I have a correct understanding before I share the visual, I made up. But I cannot get my pictures in the Q & A but would love someone to see if these I made up are correct. Scenario 1: mpMRI Prostate shows 1 area suspicious for adenocarcinoma. Patients has MRI targeted prostate biopsy of that area where 3 out of 4 cores were positive for Adenocarcinoma. Number of Cores Positive: 01 Number of Cores Examined: 01 Scenario 2: mpMRI Prostate shows 2 areas suspicious for adenocarcinoma. Patient has MRI targeted prostate biopsy. Area 1: 3 out of 4 cores were positive for Adenocarcinoma. Area 2: 1 out 2 cores positive for denocarcimoma. Number of Cores Positive: 02 Number of Cores Examined: 02 Scenario 3: mpMRI Prostate shows 2 areas suspicious for adenocarcinoma. Patient has MRI targeted prostate biopsy. Area 1: 3 out of 4 cores positive for Adenocarcinoma. Area 2: 0 out 2 cores positive. Number of Cores Positive: 01 Number of Cores Examined: 02 HY THIS IS SO IMPORTANT Prostate NCCN Treatment Guidelines are based on Prostate Risk Levels. When we are doing NCCN guideline compliance studies, we need to base compliance on the risk level. Regardless of whether your facility does the compliance studies, there may be individuals looking at this at the VACRS, state or national levels so it is important that we are recording this SSDI correctly so this can be accurately completed. (I am not sure if our new software will have a prostate risk level field, if it does hopefully it will include all risk categories. But,	You got it! I confirmed this with Jennifer Ruhl prior to the webinar. If patient has targeted biopsies only (systemic biopsies not done), the same concept applies. Regardless of the number of biopsies, the Cores Examined for each ROI will be 01. The Cores positive for each ROI will be either 00 or 01.

	regardless, we still need to be able to calculate an accurate risk level from the registry data.) I am in no way an expert on this, but to calculate very low and very high risk, we need to know the number of cores positive so that an estimate of the tumor burden can be calculated. We need to adjust this process since the MRI targeted biopsy does not sample the whole prostate like the TRUS Prostate Biopsy, it just samples sus.	
2.	Jim, if a dr says the patient has biochemical recur and treats him, can we code the recurrence at this point? Usually they have the biochemical recurrence and are now going for Radiation +/- HRT	I'm not sure. I could see an argument either way. Do you have an actual case we could send to CANswer forum? It seems like they would have to identify tumor before they would start beam radiation.
3.	How would you code when there is Target area 1 and Target area 2?	See post #1. Each target area would count as 1 regardless of the number of cores taken.
4.	Where is this rule in the SSDI manual?	It is still a CAnswer forum post. Hopefully, it will be included in the next update.
5.	If they don't give you the percentage of ductal carcinoma in the resection. How would you code that? 8140?	If it is a clear statement of ductal carcinoma and no mention of percentages, code to ductal. If percentages are given and less than 50% is ductal, code to adenocarcinoma.
6.	Does sm cell ca initially found at DX & adenoca that turned into sm cell adenoca s/p xrt/androgen therapy have same prognosis since it's more aggressive?	It is my understanding that you would go with the histology confirmed at diagnosis. If this this does happen I would go to Ask a SEER registrar. These are typically aggressive tumors.
7.	Would you change your histology code if transforms from adenoca to sm cell at surgery after hormone cocktail?	No.
8.	I thought it was cTblank if no DRE was done?	If you are assigning it, go with blank. If the physician assigns, it can be X.
9.	If pt has a prostate bx, but no DRE documented but the physician stages as cT1c. Can you stage it as cT1c, or cTx?	For SS and EOD info can be used when it's the only info available. However, use MR info when there is disagreement between MR documentation and TNM. If there is doubt that MR documentation is complete, use the stage documented by physician. Also, we can't use imaging findings for this field, even if the physician uses it to assign cT. If you can't tell if MD used imaging findings, assume they didn't.
10.	Why does exercise 4 scenario A count as pathologic stage? It did not have a radical prostatectomy or path of distant mets.	We confirmed that scenario A would be a clinical stage 4a. The scenario does not meet the criteria for pathologic Stage 4A.

11.	I'm confused about using a cT1c when the physician says it, but no DRE is done. I was under the impression that if it's no DRE it always a cTx.	cTX means there is no information about the primary tumor. If there is no DRE AND no other info, then you can assign cTX based on the physician noting that there is no information. If you have no information yourself, including DRE, but you don't have a statement from a physician that there is no information available then leave it blank. If there is any information in the MR, including a physician statement of a cT value, you can use that, as long as the rules in the answer to question 9 (from the SS and EOD manuals) are followed.
12.	For summary stage I see we cannot use LAD to code LN involvement. Can we use the term LAD for AJCC coding of LN involvement?	AJCC does not provide guidance on which terminology represents involvement vs noninvolvement. Hopefully, the physician will make that decision and assign an N value. If that does not occur, the registrar is left to make the decision. Personally, I would want something more than just a simple statement of lymphadenopathy to assign cN1. Remember, regional node metastasis would make this stage 4A. If the physician felt like there was LN mets, it's probably documented or is reflected in the treatment. There are a couple of primary sites (penis, lymphoma) where the AJCC uses the term "lymphadenopathy" in the definitions for positive nodal involvement, otherwise, there is no real guidance on that in the staging manual related to ambiguous terms.
13.	In field Tumor Size Summary is there a hierarchy of which size to code, for example is it size at surgery only when neoadjuvant TX not given? Or is it largest size clinical or path?	SEER coding manual (pg 124-125) and STORE manual (pg 163) both give the exact same rules on this. The order is: 1) Surgical path specimen a. If differing tumor sizes in various sections of path report, code from synoptic section b. If only text report available, use final diagnosis, microscopic, or gross examination, in that order.

		2) If neoadjuvant therapy followed by surgery, don't use size on path specimen. Code largest size prior to neoadjuvant treatment; if unknown code size as 999. 3) If no resection, use largest measurement from imaging, PE, or other diagnostic procedures in this order, prior to any other form of treatment. 4) If none of these apply, use largest size from all info available within four months of date of diagnosis, in the absence of disease progression
14.	Do we code cT1a if no mention of DRE but found on TURP?	The patient must have clinically inapparent tumor to assign a cT1a, which can only be determined by DRE, so the answer is no.
15.	If no DRE, you cannot assign T1a or T1b for TURP, since it could have been a palpable tumor, but they had urinary obstruction and they did a TURP for that reason not for diagnosis	Thank you Donna!
16.	Biopsy found cases we would never use the clinician cT category without a DRE unless we knew for certain it was based on a DRE and not anything else.	That's correct. See the answer to question #9.
17.	Should all registries be coding EOD, or is this for SEER states?	I believe only SEER states are requiring EOD at this time.
18.	You wouldn't code 900 for turp, that would be lower code, right?	You would use the lower code and the specific code you would use depends on whether the tumor was apparent, % of resected tissue involved, and laterality.
19.	If using code 900 for EOD (no prostatectomy, why would you not use the surgery code of A000? Am I reading this right?	Rad prostatectomies are surgeries with codes A500-A700, so if any other surgical code is used then use code 900, except if an autopsy was done or surgery code is A000
20.	EOD Prostate Path extension instructions: Note 2 and Note 10 both state if surgery code is 99 to code 900 (note 2) or code 999 (note 10). What is a scenario in which Surgery is 99 and path ext is 900?	This question has been posted to ask a SEER registrar, which is experiencing longer than usual response times due to staffing cuts. We will let you know the answer once they have posted a response.
21.	When do we leave cT blank?	If the registrar is missing the information necessary to assign a value, leave it blank. If the physician doesn't know the stage or if the registrar knows a DRE was not done, then use cTx.

22.	Exercise 3: AJCC Staging. Just want to clarify, we can't use the biopsy info on clinical T but can use to assign path T and "add" to the resection info?	Pathological staging uses ALL clinical staging info + op findings + resected specimen path report, so you can use the biopsy in pathological staging
23.	Do you still need to have all three (DRE, PSA and Gleason Score) to stage Clinically and Pathologically?	DRE is required for cT. If the PSA or Gleason scores can change the stage group they are required. For example, PSA and Gleason can influence stage group for a cT2a cN0 cM0. PSA and Gleason do not influence the stage group if the patient has lymph node involvement or distant mets.
24.	My question is about first course treatment timing rules. I work in a Central Cancer Registry and text includes the Path report of the biopsy 3/1/2024 and the Radiation 8/15/2024. We do not have the ability to contact the physician. The hospital coded this as first course of therapy. Should we follow the Commission on Cancer rule and consider the Radiation subsequent treatment. Thank you so much.	There are a lot of unknowns in this case. We do not have access to the patient's treatment plan, and we do not have enough information to determine if a standardized treatment protocol is being followed. That leaves us with the timing rule. CoC recommends that all treatment with 4 months be considered first course treatment (in the absence of a treatment plan or standard protocol). SEER recommends treatment given within 1 year (in the absence of a treatment plan or standard protocol) be considered first course. Whether you are in a SEER registry or not, I think it is reasonable to code the radiation as first course treatment in this case.
25.	If the managing physician states that the rising PSA indicates biochemical recurrence and proceeds to treat it as such, should we code as a recurrence? Or just a new course of treatment?	This is another issue for which we do not have clear coding rules. In my opinion (Jim)it would depend on the treatment. If the patient had beam radiation or surgery, I would lean toward coding as a recurrence. If they are started (or re-started) on hormone treatment, that would not be enough for me to consider this a recurrence.
26.	Are biochemical recurrences reportable to central registries?	I am not aware that would require a reporting facility to report a case based solely on a biochemical recurrence.
27.	We don't see this level of description for cores. If we are told the number of cores 18 for example and positive 2 on the biopsy report - do, we record this? in this example are they possibly doing targeted areas?	If I didn't have any information indicating a targeted biopsy was done, then I would assume it was not done and count all cores.
28.	The majority of prostate cancers are adenocarcinoma. If you have a biopsy that is done of a metastatic site and the path report only states "metastatic prostate carcinoma", based on	Looking at the solid tumor sures it specifically states the carcinoma, nos is not equal to adenocarcinoma, nos. So I would code it to carcinoma, nos. I know it states that

	Rule H10 wouldn't the histology be coded as carcinoma, NOS 8010/3?	carcinoma and adenocarcinoma are equivalate terms but a histology needs to be stated to make that true so for example if it stated acinar carcinoma it would be equivalent to acinar adenocarcinoma
29.	If a bx of a regional LN is metastatic adenocarcinoma - is this classed as bx at site or site other than primary.	It would be coded in scope of regional lns
30.	We are seeing 'multifocal' documented on our pathology reports (and imaging) - we are under the impression that m suffix doesn't really apply for prostate cancers - is that true??	It is not necessary to assign the M suffix for prostate.
31.	So if the doctor does a DRE and mentions a nodule on the right then states this is a CT3A but does not state explicitly extra prostatic extension, what code should we use?	If all you have is that DRE (and it shows that there is an apparent tumor) and the physician statement of the clin T category (and you are sure it is not based on imaging findings), you can use the physician's statement of cT3a.
32.	Why are LN coded positive? I thought that when they are neg on Prostatectomy - they are coded negative?	Remember that path staging uses ALL clin staging info + op findings + resected specimen path report, so you can use the biopsy in path staging. If there is only imaging or physical exam findings showing lymph node involvement, that can be disproven if that specific lymph node is resected and there is no pathological involvement, but a positive biopsy is pathological proof of involvement regardless of surgical path findings.
33.	EOD Exercise 2: Why is the noted extra prostatic extension in Scenario B not clinical evidence?	Because it is based on imaging findings, and we don't use imaging findings for this field, even if MD uses it to assign cT
34.	Imaging of Bone mets, physician stage IV, with no biopsy or surgery. How are we to stage? I'm asking for EOD Primary Tumor.	If this is all the info we have and there is no evidence of the primary tumor we would use code 800. However, with imaging only and no biopsy of the bone mets, it is likely that we wouldn't know that it was from a prostate primary if there were no evidence of the primary tumor.
35.	Can you do a refresher on rounding the PSA value?	We round to the nearest tenth value (i.e. 87.46 would be 87.5)
36.	Can you give an example of when X8 would be used? (SSDI Primary & Secondary patterns)	The only time you would use X8 is if the field is not required. It is not meant to be assigned based information from the case.
37.	I'm not sure if it depends on the application, but in METRIQ, PSA would be coded as XX.X (rounded up to the 10th place, but with a decimal).	That is correct.

38.	I thought the highest clinical Gleason is used in path if clinical is a higher Gleason?	That is correct when assigning Grade.
39.	SSDI ex 1 agree with the SSDI - but the AJCC coding for Path for GG would be from the higher clinical Gleason grade - is that correct? and if so, it would that also have an influence on the AJCC stage group?	That is correct that the highest Gleason score would be recorded as the path Gleason score (in this case it is the clin Gleason score), but since in this case the clin and path grade are in the same grade group it doesn't affect the stage.
40.	That is only for grade when clinical Gleason vs path Gleason?	Correct. When assigning Grade Pathologic we can use the grade information from a biopsy if it is higher than the grade from the prostatectomy. That is not the case when assigning the SSDIs Gleason Patterns and Score Pathological.