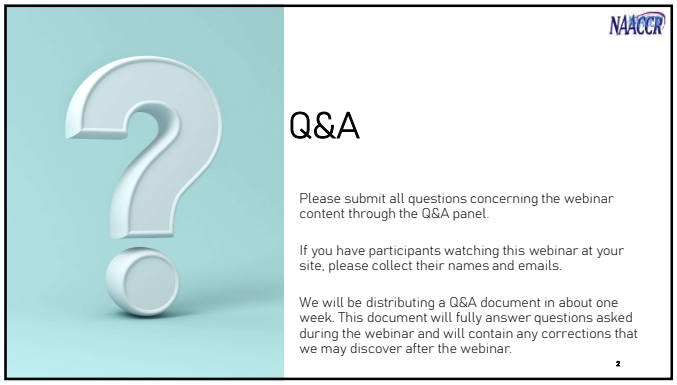

Prostate
2025
NAACCR 2024-2025 MONTHLY
WEBINAR SERIES

1


NAACCR
Q&A
Please submit all questions concerning the webinar content through the Q&A panel.
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.
2

2


Fabulous
Prizes

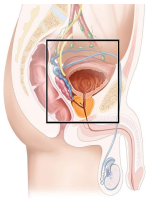
3

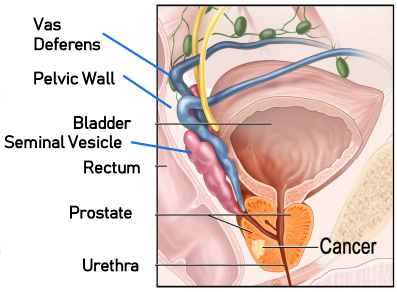
GUEST PRESENTER

Noah Reid, AS, ODS

4

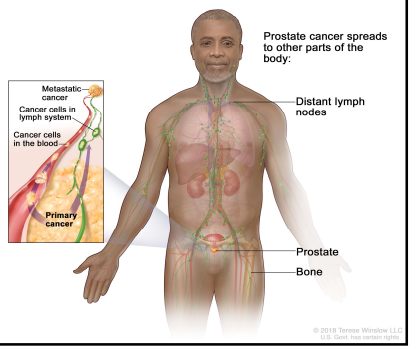
Anatomy





5

Anatomy



6

Prostate Cancer Work-Up

We only collect Total PSA

- **Prostatic specific antigen (PSA) screening**
  - AKA Total PSA
- **Free PSA**
  - The ratio of how much PSA circulates free compared to the total PSA level
- **Complexed PSA**
  - Measures the amount of PSA attached to other proteins (the "not free) PSA
- **PSA Velocity (PSA-V)**
  - Rate of rise in the PSA level
- **PSA Doubling Time (PSA-DT)**
  - The length of time it takes the PSA to double
- **PSA Density**
  - PSA level / volume of the prostate

7

Vocabulary

- **PSMA**-Prostate-Specific Membrane Antigen
  - PSMA PET
  - PSMA Targeted radiation therapy Lu177-PSMA-617 (Pluvicto)
- **Biochemical recurrence**
  - Biochemical recurrence refers to a rise in prostate-specific antigen (PSA) levels after initial treatment, indicating that the cancer may have returned, even without symptoms or visible evidence of disease
- **Active Surveillance** examples
  - PSA every 3-6 months
  - DRE annually
  - MRI every 18 months
  - Biopsies every 1-3 years

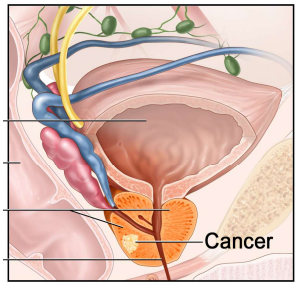
8

Diagnosis/Work-up

9

Initial Diagnosis

- PSA
- DRE
- Core Biopsy
- MRI

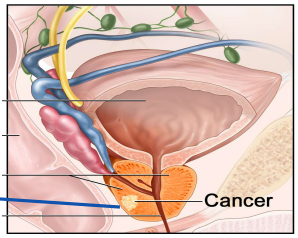


10

Prostate Cancer Work-Up

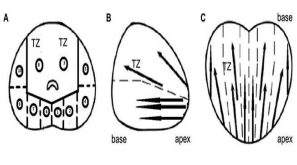
- Digital rectal exam (DRE)
  - Most prostate cancers occur in the peripheral zone
  - Whether or not a tumor is large enough to be palpable is an important clinical indicator

Is there enough cancer in the prostate that the physician can feel it during a DRE?



11

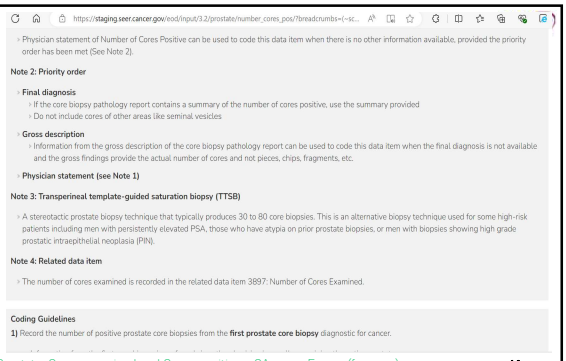
Prostate Cancer Work-up



- Transrectal needle biopsy
- Transperineal needle biopsy
- Transurethral core biopsy

12

Prostate: Needle Cores Pos/Exam-Updates



› Physician statement of Number of Cores Positive can be used to code this data item when there is no other information available, provided the priority order has been met (See Note 2).

Note 2: Priority order

› **Final diagnosis**
  › If the core biopsy pathology report contains a summary of the number of cores positive, use the summary provided
  › Do not include cores of other areas like seminal vesicles

› **Gross description**
  › Information from the gross description of the core biopsy pathology report can be used to code this data item when the final diagnosis is not available and the gross findings provide the actual number of cores and not pieces, chips, fragments, etc.

› **Physician statement (see Note 1)**

Note 3: Transperineal template-guided saturation biopsy (TTSB)

› A stereotactic prostate biopsy technique that typically produces 30 to 80 core biopsies. This is an alternative biopsy technique used for some high-risk patients including men with persistently elevated PSA, those who have atypia on prior prostate biopsies, or men with biopsies showing high grade prostatic intraepithelial neoplasia (PIN).

Note 4: Related data item

› The number of cores examined is recorded in the related data item 3897: Number of Cores Examined.

Coding Guidelines

1) Record the number of positive prostate core biopsies from the **first prostate core biopsy** diagnostic for cancer.

See also Prostate: Cores examined and Cores positive - CAnswer Forum (facs.org)

13

13

Prostate: Needle Cores Pos/Exam

- If you have a "targeted" biopsy or "region of interest (ROI)"
  - Code them as 1 core
  - These are becoming more common as physicians are using MRIs to evaluate the prostate and can see more clearly which areas may be involved
  - When they do the standard biopsy (reviewing all lobes), the physician will take additional cores from the involved area
  - More cores will be taken from that area, and probably more positive cores

Prostate - How to count MRI fusion BX targeted cores - CAnswer Forum (facs.org)
Prostate MRI Fusion BX - Target is highest gleason - CAnswer Forum (facs.org)

14

14

Even though 4 cores were taken from the ROI and 2 were positive, we count them as 1/1

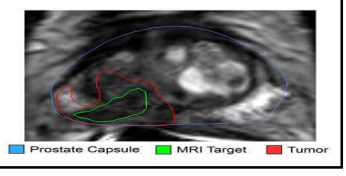
00 Systemic Cores Pos
+1 ROI
01 Cores Pos

24 Systemic Cores
+1 ROI Ex
25 Cores Pos

Pop Quiz 1 Q1

- 1/12/24 A patient presents for transrectal needle biopsies.
  - Systemic cores
    - Number of cores: 24
    - Number of cores pos: 00
  - Targeted Biopsy
    - Number of cores: 4
    - Number of cores pos: 2

Data Item	Value
Cores Positive	01
Cores Examined	25



15

Each ROI represents a single Core Examined and no more than 1 Core Positive

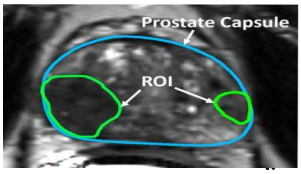
00 Systemic Cores Pos
+1 ROI Pos
+1 ROI Pos
02 Cores Pos

24 Systemic Cores
+1 ROI
+1 ROI
26 Cores Pos

Pop Quiz 1
Q2

- 1/12/24 A patient presents for transrectal needle biopsies.
  - Systemic cores
    - Number of cores: 24
    - Number of cores pos: 00
  - ROI 1
    - Number of cores: 4
    - Number of cores pos: 4
  - ROI 2
    - Number of cores: 4
    - Number of cores pos: 3

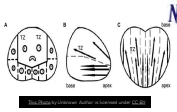
Data Item	Value
Cores Positive	02
Cores Examined	26



16

Pop Quiz 1
Q3

- 1/12/24 A patient presents for transrectal needle biopsies.
  - Systemic cores
    - Number of cores: 24
    - Number of cores pos: 01
- 2/27/24 Patient returns for biopsy of Region of Interest (ROI)
  - Systemic cores
    - Number of cores: 5
    - Number of cores pos: 4



Data Item	Value
Cores Positive	01
Cores Examined	24

Note 2: Record the number of positive prostate core biopsies from the first prostate core biopsy diagnostic for cancer.

17

Questions?

18

Solid Tumor Rules: Other Sites

https://seer.cancer.gov/tools/solidtumor/

Other Sites pg 405

19

19

2024 Revision History: Other Sites

Equivalent or Equal Terms section: Deleted: "Basal cell carcinoma; basal cell adenocarcinoma (Prostate primaries only, both are coded 8147)"

Basal cell adenocarcinoma 8147	Adenoid cystic basal cell carcinoma Adenoid cystic carcinoma Adenoid cystic carcinoma (solid pattern) Basal cell carcinoma of prostate	

20

20

Table 3: Prostate Histologies

- More common histologies for prostate
- Coding notes for Acinar adenocarcinoma subtype and variants:
  - Ductal Adenocarcinoma 8500/3
  - Intraductal Carcinoma of Prostate 8500/2
  - Mucinous Adenocarcinoma 8450/3
  - Sarcomatoid Carcinoma 8572/3
  - Signet Ring Cell-like Adenocarcinoma 8490/3

21

21

Table 3: Prostate Histologies Coding Notes

- Ductal Adenocarcinoma 8500/3
  - Ductual component >50%
  - Radical Prostatectomy specimen
- Intraductal Carcinoma of the Prostate 8500/2
  - Associated with invasive Acinar adenocarcinoma of ductal carcinoma
- Mucinous adenocarcinoma 8480/3
  - Mucinous adenocarcinoma component >25%
  - Only in Excision Specimens

22

22

Table 3: Prostate Histologies Coding Notes

- Sarcomatoid Carcinoma 8572/3
  - Rare
  - Occurs during development of high-grade adenocarcinoma after irradiation
- Signet Ring Cell-like adenocarcinoma 8490/3
  - Signet-ring-like cells must comprise >25% of tumor
  - Only in Excision Specimens

23

23

Multiple Primary Rules: Multiple Tumors

Rule M3: Acinar Adenocarcinoma (8140) of the prostate is always a single primary

- Only one acinar/adenocarcinoma of the prostate per patient lifetime
- Previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2023, it is a single primary
- This rule applies to multiple occurrences of acinar adenocarcinoma of prostate and/or subtype variants which are listed in Table 3

24

24

Multiple Primary Rules: Multiple Tumors

Rule M4: Abstract multiple primaries when the patient has a subsequent small cell carcinoma of the prostate more than 1 year following a diagnosis of acinar adenocarcinoma and/ or subtype variants which are listed in Table 3

- SmCC of prostate is rare < 1%
- 50% of SmCC of prostate cases present as de novo malignancy
- Usually occurs following androgen deprivation treatment (ADVT) and/or radiation therapy for acinar adenocarcinoma
- SmCC of the prostate are aggressive with poor clinical outcomes and survival

25

25

Histology Rules:

Single Tumor: Invasive Only (H11) and Multiple Tumors Abstracted as a Single Primary (H24)

Code 8140 (adenocarcinoma NOS) for prostate primaries when the diagnosis is

Acinar adenocarcinoma/carcinoma	Foamy gland adenocarcinoma
Adenocarcinoma	Microcystic adencarcinoma
Adenocarcinoma with ductal features	Pseudolyperplastic adenocarcionoma
Atrophic adenocarcinoma	Prostatic intraepithelial-like carcinoma

26

26

Pop Quiz 2
Q1

- Patient has a TURP in January of 2024 and is found to have adenocarcinoma. The patient returns in March of 2025 with an elevated PSA.
  - The biopsy confirms *adenocarcinoma*.
- Does the patient have a new primary?
  - Yes
  - No

27

27

Pop Quiz 2
Q2

- Patient has a TURP in January of 2024 and is found to have adenocarcinoma. The patient returns in March of 2025 with an elevated PSA.
  - The biopsy confirms *ductal adenocarcinoma (8500)*
- Does the patient have a new primary?
  - Yes
  - No

No per rule M3. Ductal is a subtype of adenocarcinoma per table 3

28

28

Pop Quiz 2
Q3

- Patient has a TURP in January of 2024 and is found to have adenocarcinoma. The patient was treated with radiation. The patient returns in March of 2025 with an elevated PSA.
  - The biopsy confirms *small cell carcinoma (8041)*
- Does the patient have a new primary?
  - Yes
  - No

Yes. Per rule M4 this is a new primary.

29

29

30

Brain Break!

Take a big deep breath and get ready to stretch out those neurons!

In what blockbuster 1988 movie did Tom Cruise star as Brian Flanagan, an ex-military man who becomes a bartender to support himself while pursuing a business degree, known for his flamboyant bartending skills and his dream of opening his own bar?

Cocktail, starring Tom Cruise, Australian actor Bryan Brown and Elisabeth Shue

31

Staging

✓AJCC

✓Summary Stage

✓Extent of Disease

The excitement is building!

32

Staging

AJCC

33

Prostate Cancer Staging

AJCC Staging

Fun Facts

- ✓80–85% arise from peripheral zone, amenable to detection by DRE
- ✓10–15% from transitional zone (anteromedial), remote from rectal surface, mostly benign
- ✓5–10% from central zone (most of base of prostate) often invaded by spread
- ✓Anterior cancers also possible, may be detected w/ biopsy or MRI
- ✓Vast majority are acinar, microacinar, or conventional type
- ✓Rarer histos like ductal, signet-ring cell and mucinous carcinomas have worse prognosis
- ✓Pathologically, prostate cancers are often multifocal

34

Prostate Cancer Staging

AJCC Staging

While enlarged LNs can occasionally be seen on imaging, fewer patients are initially discovered with clinically evident LN mets

- In lower risk patients, imaging tests have proven unhelpful

Instead, risk tables often used to determine individual patient risk of LN involvement before initiating treatment

Risk Groups

5 categories
- ✓ Very low
- ✓ Low
- ✓ Intermediate (favorable and unfavorable)
- ✓ High
- ✓ Very high

Categories based on clin/path features
- ✓ Stage
- ✓ Grade group
- ✓ PSA
- ✓ % of + tissue in biopsy
- ✓ # of + risk factors

35

Prostate Cancer Staging

AJCC Staging

- To sum up an important point, currently imaging is not very useful for staging primary tumors because of issues with:
  - Accuracy
  - Interobserver reproducibility
  - Patient selection
  - Contradictory results
- LAD found on imaging can be helpful in determining nodal involvement for high-risk patients
  - Enlarged node can be target for biopsy or selective resection
- Imaging can be especially useful in identifying mets, particularly bone mets

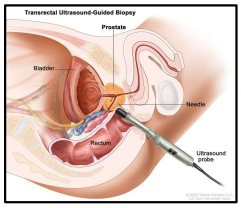
36

Prostate Cancer Staging

AJCC Staging

cT Category

- cT categories generally based on DRE findings
- cTX follows standard AJCC definition (in case of prostate this means no DRE)
- cT0 indicates that no primary tumor was found



37

Prostate Cancer Staging

AJCC Staging

cT Category

- cT1 tumors must not be palpable on DRE
  - Broken down by % of needle core/TURP involvement and laterality
- TX, T0 and T1 only available in cT category
- cT2 tumors must be palpable, subclassified by laterality
- cT3 and cT4 categories indicate progressively greater extension beyond the capsule into other tissues and structures

38

Prostate Cancer Staging

AJCC Staging

pT Category

- pT categories based on rad prostatectomy or autopsy
- N0 pT1 CATEGORY
- pT2 indicates no invasion beyond capsule
- pT3 and pT4 similar to cT3 and cT4 – represent progressively greater extension beyond capsule

Rad prostatectomy required for path stage, but path stage can be > what is on rad prostatectomy findings

Examples of exceptions:

- ✓ + rectal biopsy
- ✓ TURBT w/ prostate CA invasive into bladder
- ✓ Biopsy w/ prostate CA in extraprostatic soft tissue
- ✓ Biopsy w/ prostate CA in SV

39

Prostate Cancer Staging

AJCC Staging

N Category

- Same for clin and path classification
- Very simple, LNs either:
  - Can't be assessed (c/pNX)
  - Not involved (c/pN0) OR
  - Involved (c/pN1)

Prostate Regional LNs

- Pelvic, NOS
- Hypogastric
- Obturator
- Iliac (internal, external, NOS)
- Sacral (lateral, presacral, promontory [Gerota's], or NOS)

40

Prostate Cancer Staging

AJCC Staging

M Category

- Same for clin and path classification
- Based on extent of mets
  - LNs
  - Bone mets
  - >1 mets site

Bone mets most common non-LN mets site

Lung and liver mets typically identified late in course of disease

41

Prostate Cancer Staging

AJCC Staging

Calculating the Stage Group

- PSA and Grade required to calculate stage unless N+ or M+ disease or GG is 5
- Stage group progression is a gradient of not only increasing T, N and M, but also of PSA and grade group/Gleason score

42

Prostate Cancer Staging

AJCC Staging

Calculating the Stage Group

- Gleason grade groups not only based on the pattern, can also be based on order of scores
  - I.e. 3+4=7 is group 2, but 4+3=7 is group 3
- Stage grouping approach for prostate similar to liver, bone, and GIST in that stage III may include organ-confined disease

43

Prostate Cancer Staging

AJCC Staging In Practice

Exercise 1: Which scenario represents clin stage IIB disease?

Scenario A	Scenario B	Scenario C
DRE: None documented **CTAP:** 2.1cm prostate nodule in left side of prostate with no apparent invasion into adjacent structures, no evid of LAD or mets **PSA:** 8.0 **Core bx prostate:** Acinar adenoca, Gleason 3+3=6, Group 1	**DRE:** Palp mass in peripheral zone, center to left of prostatic urethra and extending laterally to R side **CTAP:** No evid of abdominopelvic LAD **Bone Scan:** No evid of mets **PSA:** 15.6 **Core bx prostate:** Acinar adenoca in 7/12 cores, Gleason 3+4=7, Group 2	**DRE:** No palp prostate nodules **CTAP:** 1.8cm prostate mass that appears to invade up to but not into bladder with pelvic LAD **PSA:** 29.7 **TURP:** adenoca in 25% of cores sampled

44

Prostate Cancer Staging

AJCC Staging In Practice

Exercise 2: Which scenario represents path stage IIB disease?

Scenario A	Scenario B	Scenario C
PSA: 68.2 **Rad prostatectomy:** 8cm adenoca of prostate involving majority of posterior lobe without extraprostatic invasion, LVI+, 1/3 LNs+	**PSA:** 5 **Rad prostatectomy:** 5.2cm adenoca of prostate invading into periprostatic tissue, 0/7 LNs+, Gleason 4+3=7	**PSA:** 13.8 **Rad prostatectomy:** 3cm adenoca of prostate, no invasion beyond capsule, 0/7 LNs+, LVI neg, Gleason 3+4=7

45

Prostate Cancer Staging

AJCC Staging In Practice

Exercise 3: Which scenario represents a path T3b primary tumor?

Scenario A	Scenario B	Scenario C
CTAP: No significant abdominopelvic findings **Rad prostatectomy:** 5cm prostate adenoca invading into prostatic urethra	**CTAP:** Lg soft tissue mass that appears to be centered in the prostate and invading into seminal vesicle **SV soft tissue mass bx:** Acinar adenoca of prostate infiltrating seminal vesicle smooth muscle **Rad Prostatectomy:** Multifocal acinar adenoca confined to capsule	**CTAP:** Questionable pelvic LAD **Rad Prostatectomy:** Multifocal prostate adenoca w/ invasion into adjacent bladder wall

46

Prostate Cancer Staging

AJCC Staging In Practice

Exercise 4: Which scenario represents clin stage IVA disease?

Scenario A	Scenario B	Scenario C
DRE: Enlarged prostate w/ no palp nodules **PSA:** 35 **CTAP:** Pelvic LAD w/ no evid of mets **Pelvic LNBx:** adenoca, c/w prostate origin	**DRE:** Palpable prostate nodules near apex **PSA:** 60.8 **CTAP:** Presacral LAD susp for mets w/ evid of osseous mets **Iliac bone bx:** Ca c/w mets from prostate	**DRE:** Enlarged prostate w/ multiple nodules, some of which appear to extend beyond capsule **PSA:** 148 **CTAP:** No LAD or mets **Rad prostatectomy:** Multifocal prostate adenoca invading pelvic sidewall. Gleason 4+4=8. 0/5 LNs+

47

Brain Break!

Shake out those arms, legs and brains and let's refresh ourselves with something fun.

How long did it take Gertrude Ederle, the first woman to ever swim across the English Channel, to cross the Channel on her first and only successful attempt?

A. 17 hours, 18 minutes
B. 13 hours, 32 minutes
C. 14 hours, 34 minutes

48

Staging

Summary Stage

49

Prostate Cancer Staging

Summary Stage

What's (Relatively) New?

Code 5 for "Regional, NOS" retired for 2018+ cases, still used for SS2000 cases

50

Prostate Cancer Staging

Summary Stage

Reminders

- Most basic way of categorizing how far cancer has spread from point of origin
- Use all info available within four months of diagnosis (if no disease progression) or upon completion of surgery (in 1st course of treatment), whichever is longer
- Code based on info you have, even if you don't have all info
- If there is a discrepancy between an op report and a path report, path report takes precedence

51

Prostate Cancer Staging

Summary Stage

Reminders

- T, N, and M category info can be used to assign SS, if it's all that is available
- Strongly recommended to document assessment and choice of SS in related stage text field on abstract
- If primary site is prostatic urethra (transitional cell ca), that is covered under Urethra SS chapter
  - Prostatic urethra coded to C680, so it is not treated as part of prostate for staging purposes

52

Prostate Cancer Staging

Summary Stage

Did you know?

Over the years, Summary Stage has also been known as:

- General Stage
- California Stage
- Historic stage
- SEER Stage

53

Prostate Cancer Staging

Summary Stage

Terms indicating involvement when there is no other info available:

Adherent	Fixed to another structure**	Presumed
Apparent(ly)	Impending perforation of	Probable
Appears to	Impinging upon	Protruding into (unless encapsulated)
Comparable with	Impose/imposing on	Suspected
Compatible with	Incipient invasion	Suspicious
Consistent with	Induration	To*
Contiguous/continuous with	Infringe/infringing	Up to
Encroaching upon*	Into*	
Extension to, into, onto, out onto	Intrude	
Features of	Most likely	
Fixation to structure other than primary**	Onto*	
	Overstep	

* Interpret as involvement whether the description is clinical or operative/pathological
** Interpret as involvement of other organ or tissue

54

Prostate Cancer Staging

Summary Stage

Imaging and Summary Stage

If you don't have path info and are using clin info to determine extent:

- Don't use imaging findings to determine clin extension, even if MD does
- If you can't determine whether MD used imaging findings, assume they aren't

55

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

0 – In situ

- If path report indicates in-situ tumor but there is evidence of + LNs or distant mets, code to regional nodes/mets
- In situ diagnosis can only be made microscopically

56

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

0 – In situ: Synonyms

- Behavior code '2'
- Confined to epithelium
- Intracystic, noninfiltrating (carcinoma)
- Intraductal (carcinoma)
- Intraepithelial neoplasia, Grade III
- Intraepithelial carcinoma, NOS
- Up to, but not including basement membrane
- Noninfiltrating carcinoma
- Non-invasive carcinoma
- No stromal invasion/involvement
- Papillary, noninfiltrating or intraductal carcinoma
- Pre-invasive
- Stage 0

57

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

1 – Localized

- Relatively straightforward because boundaries of prostate are well-defined
- Must be limited to prostate
  - Infiltrates into, but not beyond capsule (no extracapsular extension)
- Can be clinically apparent or inapparent
- Can involve ≥ one lobe

58

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

1 – Localized

- Use path, imaging (LNs and mets only), DRE and op reports to determine whether cancer has spread beyond boundaries; if so it's not localized
- If reports don't mention evidence of spread, assume tumor is localized

59

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

1 – Localized

If there is no info from DRE:

- If MD assigns an extent of disease, this can be used
- If TNM stage is documented, this can be used
- Important to know structures within prostate so invasion can be correctly identified

60

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

2 – Regional by Direct Extension

- Direct tumor extension beyond limits of site of origin
- Not used when there is also LN involvement
- If extraprostatic extension identified on needle biopsy, this can be used to assign code 2
- Involvement of prostatic urethra doesn't change extent of disease

61

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

2 – Regional by Direct Extension

Direct Extension can be:

- Bladder neck/ Bladder, NOS
- External sphincter
- Extraprostatic/extracapsular NOS
- Extraprostatic urethra
- Fixation, NOS
- Levator muscles
- Periprostatic tissue
- Rectovesical fascia
- Rectum
- Seminal vesicles
- Skeletal muscle
- Ureter(s)

62

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

Regional Lymph Nodes Include:

- Hypogastric
- Iliac, NOS
  - External
  - Internal (hypogastric) (obturator), NOS
- Pelvic, NOS
- Periprostatic
- Sacral, NOS
  - Lateral (laterosacral)
  - Middle (promontory) (Gerota's node)
  - Presacral
- Regional lymph node(s), NOS
  - Lymph node(s), NOS

63

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

Terms Interpreted as LN Involvement	Terms NOT Interpreted as LN Involvement*
Fixed	Palpable
Matted	Enlarged
Mass in retroperitoneum, mesentery, etc. w/ no specific info about tissue involved	Visible swelling
	Shotty
	Lymphadenopathy

*Only interpreted as no LN involvement if there is no treatment to indicate lymph node involvement

64

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

Priority order to resolve conflicting information:

1. Path report
2. Imaging (if + on imaging but neg on path, treat LNs as neg)
3. PE (if + on PE but neg on path, treat LNs as neg)

65

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

- If neoadjuvant therapy is administered, followed by surgery:
  - Code most significant LN involvement from clin and path info
- Prostate does not have accessible lymph nodes, so PE can not be used as basis for no LN involvement

66

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

- Code direct extension from primary tumor into LN as LN involvement
- If an involved LN chain is not listed in code 3, use these resources to identify regional lymph nodes:

• Appendix I	• ICD-O manual
• Anatomy textbook	• Medical dictionary

67

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

3 – Regional Lymph Nodes Only

- Can use MD statement of + N category from TNM staging as basis for LN involvement
- Be sure to check that LNs are listed as regional, otherwise they represent distant mets
- Do not use code 3 if there is LN involvement AND regional extension

68

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

4 – Regional by Direct Extension AND Regional LNs Involved

Used when criteria for code 2 and code 3 are both met, but there are no distant mets

69

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

7 – Distant

Four methods of mets spread:

1. Extension from primary organ beyond adjacent tissue into next organ
   a. If tumor grows from one organ onto/through surface of secondary organ, it's direct extension
   b. If tumor is only found in parenchyma of secondary organ – well away from primary organ, it's mets
2. Through lymph channels beyond the first drainage area
3. Blood-borne metastases
4. Fluids in a body cavity

70

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

7 – Distant

Most common sites of distant spread → **Bone, Lung, Liver**

"Frozen pelvis" means involvement of pelvic sidewall and is considered distant mets

71

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

7 – Distant

Distant Sites (incl. cont. extension)	**Distant LNs**	**Distant mets, NOS**
Bone	o Aortic (lat, para/periaortic, NOS)	o Carcinomatosis
Pelvic wall/bone/"Frozen pelvis"	o Cervical	o Distant mets w/ or w/o distant LNs
Other organs	o Common iliac	
Penis	o Inguinal (deep, NOS)	
Sigmoid colon	Node of Cloquet or	
Soft tissue other than periprostatic	Rosenmuller (highest deep inguinal)	
	Superficial (femoral)	
	o Retroperitoneal, NOS	
	o Scalene (inferior deep cervical)	
	o SCV (transverse cervical)	

72

Prostate Cancer Staging

Summary Stage

Summary Stage Categories

9 – Unknown

- Use only when no info about stage can be obtained
- Use when primary site is unknown
- Use for all death certificate only cases
- Default to code 3 when status of primary tumor is unknown, but regional LNs involved
- Default to code 7 when status of primary tumor is unknown, but there are distant mets

73

Prostate Cancer Staging

Comparison: AJCC and Summary Stage/EOD

Factor	AJCC	SS	EOD
Tumor size required*	No	No	No
# Involved lymph nodes required*	No	No	No
SSDIs	Yes	No	No
Need complete info to stage	Yes	No	Yes
Clinical and pathological stage separated into distinct categories**	Yes	No	Yes
Imaging okay to use to calculate stage	No	No	No
Distinguishes between clinically apparent or inapparent	Yes	No	Yes

*TS and # LNs are a factor for AJCC schemas for many sites, but not for prostate

**For most sites, EOD has a single clinicopathological system for recording extent of primary tumor; but prostate extent of primary tumor is separated based on clinical (EOD primary tumor) and pathological (EOD Prostate Pathological Extension) systems

74

Prostate Cancer Workup

Summary Stage Exercise 1

Which of these scenarios represents localized disease?

A. Prostatic adenoca w/ invasion of prostatic urethra
B. Intraductal prostate carcinoma
C. Prostate adenoca w/ frozen pelvis
D. Clin T3a prostate tumor

75

Prostate Cancer Workup

Summary Stage Exercise 2

Which of these scenarios would be staged as Regional by Direct Extension?

Scenario A	Scenario B	Scenario C
4/5/25 DRE: Mildly enlarged prostate w/ no palp nodules **4/6/25 PSA:** 19.7 **4/12/25 CTAP:** No pelvic LAD or mets **4/24/25 TURP:** Gleason 3+3=6 acinar adenoca **4/29/25 MD Note:** Patient elects for watchful waiting **7/29/25 Bladder wall bx:** Adenoca c/w prostate origin	**3/6/25 PSA:** 25 **3/18/25 Prostate core bx:** 3/6 L cores and 4/6 R cores + for acinar adenoca **3/26/25 Rad prostatectomy:** Multifocal acinar adenoca, Gleason 4+4=8, w/ involvement of seminal vesicle	**6/16/24 PSA:** 34.5 **6/20/24 Prostate core bx:** 2/6 L cores and 5/6 R cores + for adenoca **7/21/24 Rad prostatectomy:** Gleason 4+3=7 adenoca w/ extension into periprostatic tissue, 2/6 pelvic LNs+

76

Prostate Cancer Workup

Summary Stage Exercise 3

Which of these elements is used for AJCC staging, but not for SS?

A. DRE
B. PSA
C. Radical prostatectomy
D. Bone scan

77

Prostate Cancer Workup

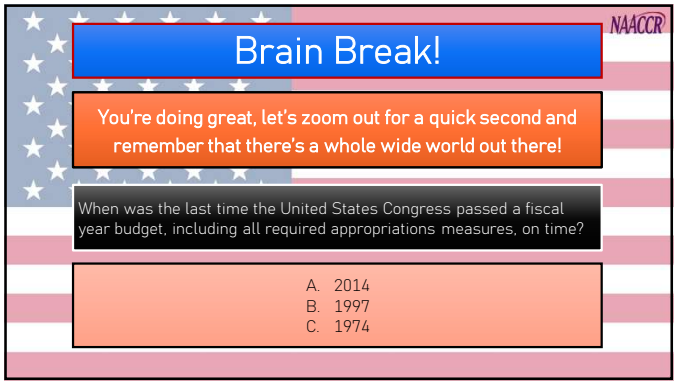
Summary Stage Exercise 4

Code 1
Localized

How would the following scenario be coded for SS?

Date	Element	Results
4/15/25	DRE	Palp prostate mass in L lobe appearing to originate from just lateral to and involving apex w/ apparent invasion into adjacent extraprostatic urethra
4/19/25	PSA	33.5
4/23/25	CTAP	Suspicious pelvic LAD
4/25/25	Prostate core bx	5/6 L cores +, 3/6 R cores + for prostate adenoca, Gleason 4+5=9; Urethra bx: Neg
4/30/25	Rad prostatectomy	3.2cm adenoca confined to prostate, 0/4 LNs+, Gleason 4+3=7

78



79

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Staging

Extent of Disease

80

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Prostate Cancer Staging

EOD Classification

Three basic elements:

EOD Primary Tumor
EOD Regional Nodes
EOD Mets

Prostate has an additional element:

EOD Prostate Pathologic Extension

81

Prostate Cancer Staging

EOD Classification

Back to the Basics: A Refresher

- Based on combined clin & op/path assessment (only LNs/mets for prostate)
- If discrepancy between path and op reports, priority given to path report
- Includes all info ≤ 4 months of diagnosis in absence of dz progression or upon completion of surgery in 1st course of treatment, whichever is longer
  - Progression that develops after initial workup excluded for EOD
- If op/path info disproves clin info, use op/path info

82

Prostate Cancer Staging

EOD Classification

Back to the Basics: A Refresher

- Autopsy reports are used just like path reports for EOD
- For death certificate only cases, code all fields as unknown
- T, N, M info can be used when it's only info available
  - Use MR info when there is disagreement between MR documentation and TNM
- If there is doubt that MR documentation is complete, use stage documented by MD

83

Prostate Cancer Staging

EOD Classification

Special Note

Usually, info from post-neoadjuvant surgery can be used for EOD Primary Tumor if EOD is greater than pre-treatment clin findings.

However, because path and clin fields are separate for prostate, this doesn't apply because surgical path results are recorded in EOD Extension Pathological field.

84

Prostate Cancer Staging

EOD Classification

EOD Primary Tumor

- Assign furthest documented progression* → Guidelines for AJCC and EOD differ:
  - AJCC requires DRE to assign cT
  - EOD can be assigned without a DRE
- Do not use imaging findings for this field, even if MD uses it to assign cT
  - If you can't tell if MD used imaging findings, assume they did not
- Strongly recommended to document assessment of tumor extension and choice of EOD Primary Tumor code in stage text field

*Blood, cartilage and bone sometimes considered connective tissues, but in EOD listed separately

85

Prostate Cancer Staging

EOD Classification

EOD Primary Tumor

In situ tumors w/ LN or mets involvement:

✓ Assign EOD Primary Tumor as in situ and code EOD Regional Nodes and/or EOD Mets appropriately

✓ Behavior code is still going to be /3

✓ This a change from previous versions of EOD and SS!

Reminder: For prostate, this field captures clin extent ONLY – there is a separate EOD field for path extension (rad prostatectomy or autopsy)

86

Prostate Cancer Staging

EOD Classification: Primary Tumor

EOD Code	Description	SS2018 Equivalent
0	In situ; noninvasive; intraepithelial	IS
100	Incidental histologic finding (for example, on TURP) In 5 percent or less of tissue resected Clinically inapparent	L
110	Incidental histologic finding (for example, on TURP) In more than 5 percent of tissue resected Clinically inapparent	L
120	Tumor identified by needle biopsy Clinically inapparent/not palpable (i.e., for elevated PSA)	L
150	Incidental histologic finding (for example, on TURP) Number of foci or percent of involved tissue not specified Clinically inapparent/not palpable	L

- Use codes 100, 110, or 150 when TURP done during clin workup and no apparent tumor (DRE neg/unk)
- Use code 150 if only TURP is done and % of cells not noted in path report
- Use code 120 when tumor is clinically inapparent (neg DRE), don't use if no info about DRE results
- Do not use ICD-10-CM code R97.20 (Elevated prostate specific antigen [PSA]) alone to code 120

87

Prostate Cancer Staging

EOD Classification: Primary Tumor

Note: Clinically inapparent tumors are tumors that are not palpable

MD documentation of DRE that does not mention a palpable "**tumor**", "**mass**", or "**nodule**" can be inferred as inapparent

Includes DRE findings of only benign prostate enlargement/hypertrophy

88

Prostate Cancer Staging

EOD Classification: Primary Tumor

EOD Code	Description	SS2018 Equivalent
200	Involves one-half of one side or less Clinically apparent/palp	L
210	More than one-half of one side but not both sides Clinically apparent/palpable	L
220	Involves both lobes/sides Clinically apparent/palpable	L
250	Confined to prostate, unknown lobe involvement Clinically apparent/palpable	L
300	Localized, NOS Not known if clinically apparent or inapparent	L

- Use codes 200-250 for clinically apparent tumors (DRE +)
- Use code 300 for localized cancers when DRE result not documented or DRE not done and no clin evidence of extraprostatic extension, or MD incorporates imaging findings into evaluation

89

Prostate Cancer Staging

EOD Classification: Primary Tumor

EOD Code	Description	SS2018 Equivalent
350	Bladder neck, microscopic invasion Extraprostatic extension Beyond prostatic capsule, unilateral, bilateral, or NOS WITHOUT invasion of seminal vesicles Extension to periprostatic tissue WITHOUT invasion of the seminal vesicles	RE
400	Tumor invades seminal vesicle(s)	RE
500	Extraprostatic tumor that is not fixed WITHOUT invasion of adjacent structures Periprostatic extension, NOS, Extraprostatic extension, NOS Unknown if seminal vesicle(s) involved Through capsule, NOS	RE
600	Bladder neck Bladder, NOS External sphincter Extraprostatic urethra (membranous urethra) Fixation, NOS Levator muscles Rectovesical (Denonvillier's) fascia Rectum Skeletal muscle Ureter(s)	RE
700	Extension to or fixation to pelvic wall or pelvic bone, "Frozen pelvis", NOS Further contiguous extension including: Other organs, Penis, Sigmoid colon, Soft tissue other than periprostatic	D

- Use 350-700 when positive extraprostatic extension by DRE or biopsy
  - Needle biopsy findings of extraprostatic extension can be used for EOD
- If no DRE or not documented as "tumor", "mass" or "nodule" but MD assigns clin extent, use that
- Involvement of prostatic urethra does not alter EOD code
- "Frozen pelvis" is clin term that means tumor extends to pelvic sidewall(s)
  - In absence of more detailed statement of involvement, assign to code 700

90

Prostate Cancer Staging

EOD Classification: Primary Tumor

EOD Code	Description	SS2018 Equivalent
800	No evidence of primary tumor	U
999	Unknown; extension not stated Primary tumor cannot be assessed/Not documented in medical record Death Certificate Only	U

- Use code 800 when incidental finding during prostatectomy for other reasons (i.e., cancer not suspected)
- Use code 999 when no documentation of prostate eval (PSA, PE/MD statement) p/t prostatectomy/autopsy

91

Prostate Cancer Staging

EOD Classification: Prostate Pathologic Extension

EOD Code	Description	SS2018 Equivalent
0	In situ; noninvasive; intraepithelial	IS
300	Invasion into (but not beyond) prostatic capsule Intracapsular involvement only No extracapsular extension Confined to prostate, NOS Localized, NOS	L

- Use code 300 when there is microscopically confirmed clin diagnosis of prostate cancer and rad prostatectomy shows no residual disease
- Only use info from rad prostatectomy or autopsy to code this field
- Limit information in this field to first course of treatment in absence of disease progression
- Information about extent of disease found incidentally during rad prostatectomy for other reasons can be used to code this field
- Involvement of prostatic urethra does not alter extension code

92

Prostate Cancer Staging

EOD Classification: Prostate Pathologic Extension

EOD Code	Description	SS2018 Equivalent
350	Bladder neck; microscopic invasion Extraprostatic extension (beyond prostatic capsule), unilateral, bilateral, or NOS WITHOUT invasion of the seminal vesicles Extension to periprostatic tissue WITHOUT invasion of the seminal vesicles	RE
400	Tumor invades seminal vesicle(s)	RE
500	Extraprostatic tumor that is not fixed WITHOUT invasion of adjacent structures Periprostatic extension, NOS or Extraprostatic extension, NOS, Unknown if seminal vesicle(s) involved Extraprostatic extension, NOS (unknown if seminal vesicle[s] involved) Through capsule, NOS	RE
600	Bladder neck, except microscopic bladder neck involvement Bladder, NOS External sphincter Extraprostatic urethra (membranous urethra) Fixation, NOS Levator muscles Rectovesical (Denonvillier's) fascia Rectum Skeletal muscle Ureter(s)	RE

93

Prostate Cancer Staging

EOD Classification: Prostate Pathologic Extension

EOD Code	Description	SS2018 Equivalent
700	Extension to or fixation to pelvic wall or pelvic bone; "Frozen pelvis", NOS Further contiguous extension including: Other organs Penis Sigmoid colon Soft tissue other than perirectal/perisigmoid	D
800	No evidence of primary tumor	U
900	No radical prostatectomy or autopsy performed	U
950	Radical prostatectomy performed but not first course of treatment For example, performed after disease progression	U
999	Unknown; extension not stated Unknown if radical prostatectomy done Primary tumor cannot be assessed/Not documented in medical record	U

- Code "Frozen pelvis" to 700 if there isn't a more detailed statement of involvement
- Use code 800 only when:
  - Clin diagnosis not microscopically confirmed (i.e., dx'd via imaging with bone mets) AND
  - Rad prostatectomy or autopsy done and no evidence of primary tumor

94

Prostate Cancer Staging

EOD Classification: Prostate Pathologic Extension

- Use code 900 when no rad prostatectomy or autopsy within 1st course of treatment
  - Rad prostatectomies are surgeries with codes A500-A700
  - If any other surgical code is used then use code 900, except if an autopsy was done or surgery code is A000
- Use code 950 when 1st course treatment is active surveillance, but rad prostatectomy is done later due to disease progression or patient changing their mind
  - When code 950 is used, make sure these SSDIs are coded as X9:
    - Gleason Patterns Pathological
    - Gleason Score Pathological
    - Gleason Tertiary
- Code 999 when
  - Rad prostatectomy performed but no information on extension
  - Surgery of Primary Site is Prostatectomy, NOS (Surgery code A800)
  - Unknown if surgery is done (Surgery code A990)

95

Prostate Cancer Staging

EOD Classification: Regional Nodes

EOD Code	Description	SS2018 Equivalent
000	No regional lymph node involvement	NONE
300	Hypogastric Iliac, NOS (External, Internal (hypogastric) (obturator), NOS) Pelvic, NOS Periprostatic Sacral, NOS (Lateral (laterosacral), Middle (promontory) (Gerota's node), Presacral)	RN
800	Regional lymph node(s), NOS/Lymph node(s), NOS	RN
999	Unknown; regional lymph node(s) not stated Regional lymph node(s) cannot be assessed Not documented in medical record Death Certificate Only	U

- Make sure you're not coding distant nodes in this field (code in EOD Mets)
- Use code 000 for "path only" cases – **only for prostate; don't apply to other primary sites**
- Use code 800 only if you know that nodes are involved but you don't know which ones

96

Prostate Cancer Staging

EOD Classification: Mets

EOD Code	Description	SS2018 Equivalent
0	No distant metastasis Unknown if distant metastasis	NONE
10	Distant lymph node(s) Aortic (lateral [lumbar], para-aortic, periaortic, NOS) Cervical Common iliac Inguinal (deep, NOS) - Node of Cloquet or Rosenmuller (highest deep inguinal) - Superficial (femoral) Retroperitoneal, NOS Scalene (inferior deep cervical) Supraclavicular (transverse cervical) Distant lymph node(s), NOS	D
30	Bone, WITH or WITHOUT distant lymph node(s)	D
50	Other specified distant mets, WITH or WITHOUT distant lymph node(s) or bone mets Carcinomatosis	D
70	Distant metastasis, NOS	D
99	Death Certificate Only	U

If mets site isn't included in codes 10, 30, or 50, assign code 50

97

Prostate Cancer Staging

EOD Exercise 1

2/19/25 65yo male diagnosed with BPH, DRE: Palpably enlarged prostate

2/25/25 TURP: Carcinoma in situ

3/14/25 CTCAP: Susp internal iliac LN

3/15/25 Internal iliac LNBx: Carcinoma c/w prostate origin

4/1/25 Rad prostatectomy: Residual ca in situ, 0/2 internal iliac LNs+, 0/4 pelvic LNs+

How would you code:

EOD Primary Tumor?	000 In situ
EOD Prostate Pathologic Extension?	000 In situ
EOD Regional Nodes?	300 Internal iliac nodes
EOD Mets?	00 No mets

98

Prostate Cancer Staging

EOD Exercise 2

Which scenario would be coded to EOD Primary Tumor code 300 (Localized NOS)?

Scenario A	Scenario B	Scenario C
8/19/24 Pt presents for difficulty urinating, DRE: No palp prostate abnormalities; PSA: 81.5 8/27/24 Prostate needle bx: 3/10 cores + for acinar adenoca, 22% of sample containing cancer, Gleason 4+4=8 9/7/24 MD Note: Discussion with pt, plan to undergo RP+XRT+ADT 10/3/24 RP: Gleason 4+5=8 acinar adenoca w/o extracapsular invasion 11/21/24 XRT+ADT initiated	5/16/24 Pt w/ urin symptoms w/ abn prostate findings PTA 6/18/24 Prostate needle bx: 2/4 left cores and 0/4 right cores + for acinar adenoca, 43% of sample containing cancer, Gleason 3+4=7 6/23/24 MD Note: Imaging performed PTA shows extraprostatic extension, making this a cT3a prostate acinar adenoca	12/4/24 Pt presents for lower back pain w/ urinary straining, DRE: Prostatomegaly; PSA: 24.0 12/19/24 Prostate needle core biopsy: 4/6 cores + for mucinous ca 1/2/25 Bone scan: Osseous mets in sacrum and proximal left ischium 1/5/25 Sacral lesion bx: Mets prost ca 1/17/25 Pall XRT to sacrum and left hip 1/29/25 ADT+docetaxel initiated

99

Prostate Cancer Staging

Staging Comparison Exercise 1

Which scenario allows coding of EOD Path Extension to 400 (Extension to SV)?

Scenario A	Scenario B	Scenario C
7/5/24 PSA: 18.4 8/19/24 RP: 1.8cm Gleason 5+5=10 acinar adenoca invading into periprostatic tissue, 0/4 pelv LNs+ 8/26/24 MD Note: pT3bN0M0 Stage 3B acinar adenoca of prostate	10/13/24 Rad Onc Note: Pt w/ prostate ca w/ RP PTA w/ path results showing regional invasion presents for adjuvant XRT+ADT 10/25/24 Med Onc Consult Note: Pt w/ stage pT3bN0M0 Stage 3B acinar adenoca of prostate presents for initiation of ADT	11/5/24 DRE: Lg palp mass at base of prostate with apparent invasion of SV 11/12/24 CTCAP: Large prostate mass centered at base of prostate that appears to invade adjacent SV 11/15/24 Prostate core bx: 6/9 cores + for acinar adenoca, Gleason 4+4=8 11/28/24 Med Onc Note: Pt w/ prostate cancer invading into SV

100

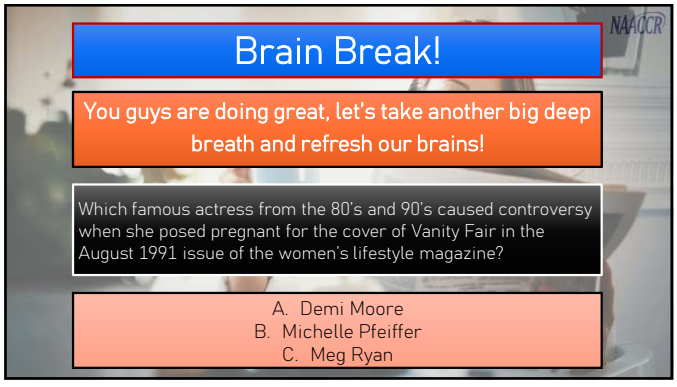
Prostate Cancer Staging

Staging Comparison Exercise 2

Which staging system(s) doesn't break out stage into clinical and pathological categories for prostate cancers?

A. EOD
B. SS
C. AJCC
D. EOD and SS

101



102

103

104

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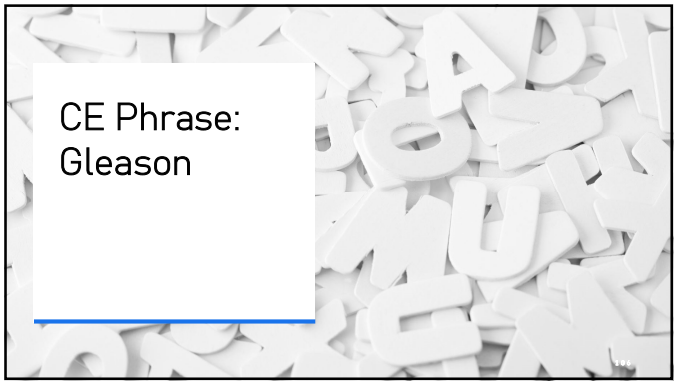
Coming Up!

- Uterus 2025
  - Janine Smith, ODS
  - 6/11/25 and 6/12/25
- Leveraging Technology to Improve Efficiently in Hospital Based Cancer Registry
  - Michelle Webb, ODS-C
  - Kelly Merriman, MPH, PhD, ODS
  - 7/09/25 and 7/10/25

105



106

107