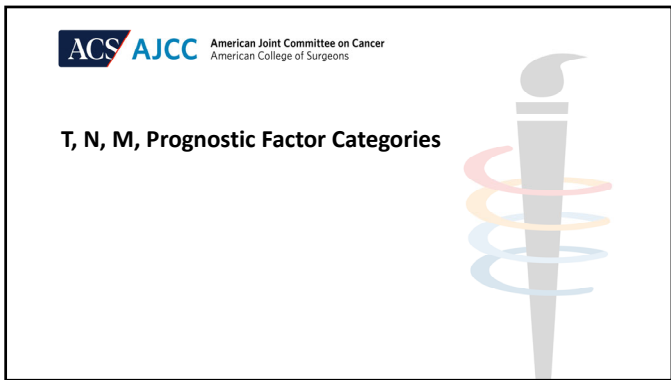
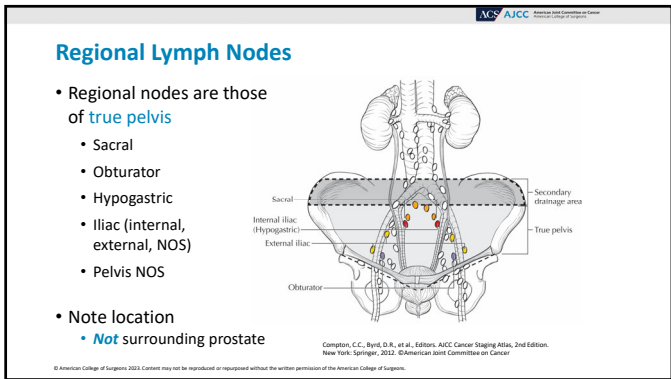


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Prognostic Cancer Staging

Clinical T Category

- DRE
 - **Required** for assigning T category – no other options!
 - **Standard of care**, included in NCCN diagnostic workup guidelines
 - Determine whether tumor inapparent (not palpable) or apparent (palpable)
- DRE
 - Used for staging as prognosis based on **palpable** tumors
 - No list of words that mean palpable
 - Determine by description, physician notes
 - Small inapparent tumors found on biopsy **do not** affect prognosis
- cTX – physician did **not** perform DRE
- cT blank – registrar does not have information

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Clinical T Category

- Biopsy reports **not** used to assign cT
 - Confirms presence of cancer
 - Does not determine T category
 - Only palpable tumors determine patient's prognosis
- Biopsies of extraprostatic tissue
 - Still need DRE information for cT assignment
 - DRE performed on all patients, standard of care
 - DRE for extracapsular extension
 - Seminal vesicles palpable if potentially involved
 - Insensitive for some extraprostatic extension
 - MR imaging may identify area to biopsy
 - Extraprostatic biopsies not random
 - Based on DRE, Grade Group, imaging

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Pathological T Category

- T2 category – confined to prostate includes
 - Invasion into prostatic apex
 - Invasion into prostatic capsule, but not beyond
- Not true capsule, usually termed extraprostatic extension
 - So called capsule only laterally and posteriorly
 - No capsule for anterior, bladder area, or apex
- Margin positivity and extraprostatic/extracapsular extension
 - Observations are **separate, cannot correlate**
 - Cannot infer one from the other
- Incidental finding during prostatectomy
 - **No** clinical stage assigned
 - **Not** cT0

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Clinical N Category

- Physician judgment may be used to assign cN0
 - Takes into account T category, PSA, Grade Group
 - Nomograms indicate probability of nodal involvement
 - Imaging only if certain criteria are met
 - ACR Appropriateness Criteria for imaging recommendations
 - NCCN guidelines on staging workup
- Imaging is not required to assign cN0

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Pathological N Category

- pN category
 - Must have microscopic assessment of at least 1 node to assign
 - No node microscopically assessed is pNX
- If *no* nodes removed with prostatectomy
 - Must assign pNX
 - If case not T4 or M1, stage group cannot be assigned

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Clinical M and Pathological M Categories

- Important to assign subcategories
 - Even though stage group not affected
 - Critical to have M1a, M1b, M1c data
 - Data may lead to different stage groups in future
- M1c: other sites with/without bone disease
 - If only one site proven microscopically, still assign pM1c
 - Important to indicate there is microscopic evidence of at least 1 site
- M category
 - Only physical exam required to assign cM0
 - If signs or symptoms then further study appropriate
 - Mets may be cM1 or pM1 with subcategories a, b, or c

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PSA

- PSA
 - Measured pre-diagnosis, prior to digital rectal exam or biopsy
 - Any manipulation of prostate may raise PSA levels
 - If **only** PSA is after DRE/biopsy, but measured pre-treatment
 - May use test results
 - Physician would have waited appropriate time before ordering
- If multiple PSA tests, use **last** pre-diagnosis test
- PSA not available
 - Common when incidental finding at time of surgery
 - May not be able to assign stage group with missing PSA

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Grade Group

- Grade Group
 - Gleason pattern and score assigned to each specimen
 - Inherent morphologic heterogeneity of prostate ca
 - This means normal to have different grades throughout tumor
 - Highest Gleason pattern/score used to assign **Grade Group**
 - Grade Group used for staging
- **Caution:** pathologist may **NOT** assign **overall highest** Grade Group
- Clinical stage Grade Group
 - Based on biopsy or TURP during that stage timeframe
- Pathological stage Grade Group
 - Based on bx, TURP, prostatectomy during that stage timeframe
 - Highest Grade Group used for staging

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Grade Group

- AJCC prostate stage group uses **highest** Grade Group
 - Prostate ca heterogeneous accounting for areas of tumor with different patterns
 - Bx cores may have different Gleason patterns/scores and Grade Groups
 - Pathologist may **not** assign **overall highest** Grade Group
- CAP requirements
 - Each core assigned Gleason score and Grade group
 - **Overall case** Gleason score and Grade group may be assigned, but **not required**
- CAP guidelines for **case level** prostate needle bx reporting
 - Recorded as highest grade, composite grade or global grade
 - Composite is aggregate that considers spatial distribution and overall involvement
 - No consensus by ISUP or GUPS on **highest vs overall grade** and **both acceptable**

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Stage Classification – Diagnostic Workup & Treatment



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Clinical and Pathological Staging

- Clinical staging
 - **DRE required** to assign T category
 - cNO may be assigned based on physician judgment and nomograms
 - Imaging performed based on risk criteria
 - PSA and Grade Group are required categories for assigning stage group
- Pathological staging
 - Total/radical prostatectomy required
 - General rules apply
 - Microscopic highest T and highest N categories may be used
 - Microscopic T3 and highest N category under certain circumstances
 - PSA and Grade Group are required categories for assigning stage group
- Rare yp staging – **No** neoadjuvant therapy outside of clinical trials
 - **Lupron is NOT** neoadjuvant

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Criteria for Clinical Classification - PreTreatment

- Patient undergoing diagnostic workup
 - Elevated PSA
 - DRE
 - Diagnostic biopsy
 - Identified on TURP due to urinary symptoms
 - Imaging in certain circumstances, see NCCN guidelines or ACR
- Incidental finding during prostatectomy
 - **No** clinical stage assigned
 - Never assign stage in retrospect, cannot go back in time

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Diagnostic vs. Treatment

- Diagnostic procedures
 - Biopsies
 - TURP
- Surgical treatment of primary site
 - Total prostatectomy
 - Radical prostatectomy
 - If nodal dissection not done, still considered treatment

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Treatment Satisfying Stage Classification


- Pathological staging
 - Total/radical prostatectomy satisfies criteria
 - Nodal dissection not required to qualify for staging
 - Rarely, biopsy of highest T **and** highest N used to qualify
 - Must have both categories biopsied
 - **Not** assigned based on just highest T category
- Postneoadjuvant therapy staging **NOT** appropriate
 - **No** neoadjuvant therapy outside of clinical trials
 - Neoadjuvant ADT short term (4-6 months) treatment
 - Neoadjuvant ADT long term (2-3 years) treatment
 - Lupron shot prior to surgery **not** neoadjuvant treatment for staging
 - Rule for staging, not for registry treatment fields

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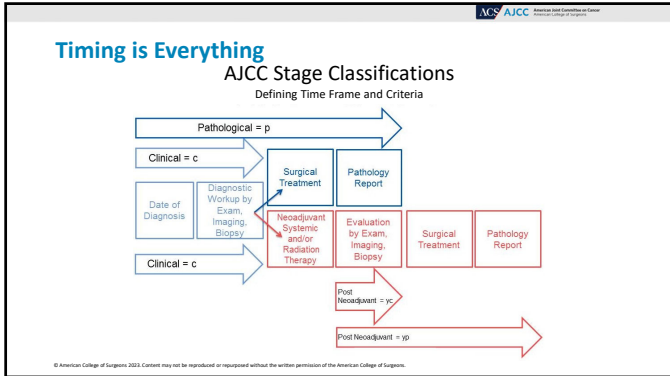
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Information and Questions on AJCC Staging



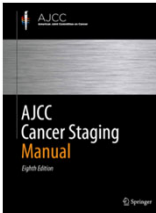
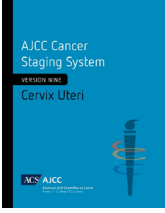
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AJCC Web Site

- <https://cancerstaging.org>
- <https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/>
- General information
 - Overview
 - Version 9
 - Cancer Staging Systems
 - AJCC 8th edition Chapter 1: Principles of Cancer Staging
 - Cancer Staging Education
 - FAQ & Resources





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CAnswer Forum

- Submit questions to AJCC Forum
 - Version 9 Forum
 - 8th Edition Forum
- Located within CAnswer Forum
- Provides information for all
- Allows tracking for educational purposes
- <http://cancerbulletin.facs.org/forums/>





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Thank You

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