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Abstract
The primary proceedings of the 2014 International Society of Urological Pathology Grading Conference were published promptly in 2015 and dealt with: (1) definition of various grading patterns of usual acinar carcinoma, (2) grading of intraductal carcinoma; and (3) support for the previously proposed new Grade Groups. The current manuscript in addition to highlighting practical issues to implement the 2014 recommendations, provides an updated perspective based on numerous studies published after the 2014 meeting. A major new recommendation that came from the 2014 Consensus Conference was to report percent pattern 4 with Gleason score 7 in both needle biopsies and radical prostatectomy (RP) specimens. This manuscript gives the options how to record percentage pattern 4 and under which situations recording this information may not be necessary. Another consensus from the 2014 meeting was to replace the term tertiary-grade pattern with minor high-grade pattern. Minor high-grade indicates that the term tertiary should not merely be just the third most common pattern but that it should be minor or limited in extent. Although a specific cutoff of 5% was not voted on in the 2014 Consensus meeting, the only quantification of minor high-grade pattern that has been used in the literature with evidence-based data correlating with outcome has been the 5% cutoff. At the 2014 Consensus Conference, there was agreement that the grading rule proposed in the 2005 Consensus Conference on needle biopsies be followed, that tertiary be not used, and that the most common and highest grade patterns be summed together as the Gleason score. Therefore, the term tertiary or minor high-grade pattern should only be used in RP specimens when there are 3 grade patterns, such as with 3+4=7 or 4+3=7 with <5% Gleason pattern 5. It was recommended at the 2014 Conference that for the foreseeable future, the new Grade Groups would be reported along with the Gleason system. The minor high-grade patterns do not change the Grade Groups, such that in current practice one would, for example, report Gleason score 3+4=7 (Grade Group 2) with minor (tertiary) pattern 5. It was discussed at the 2014 Consensus Conference how minor high-grade patterns would be handled if Grade Groups 1 to 5 eventually were to replace Gleason scores 2 to 10. In the above example, it could be reported as Grade Group 2 with minor high-grade pattern or potentially this could be
abbreviated to Grade Group 2+. The recommendation from the 2014 meeting was the same as in the 2005 consensus for grading separate cores with different grades: assign individual Gleason scores to separate cores as long as the cores were submitted in separate containers or the cores were in the same container yet specified by the urologist as to their location (ie, by different color inks). It is the practice of the majority of the authors of this manuscript that if the cores are submitted in a more specific anatomic manner than just left versus right (ie, per sextant site, MRI targets, etc.), that the grade of multiple cores in the same jar from that specific site are averaged together, given they are from the same location within the prostate. In cases with multiple fragmented cores in a jar, there was agreement to give a global Gleason score for that jar. The recommendation from the 2014 meeting was the same as in the 2005 consensus for grading separate nodules of cancer in RP specimens: one should assign a separate Gleason score to each dominant nodule(s). In the unusual occurrence of a nondominant nodule (ie, smaller nodule) that is of higher stage, one should also assign a grade to that nodule. If one of the smaller nodules is the highest grade focus within the prostate, the grade of this smaller nodule should also be recorded. An emerging issue in the studies and those published subsequent to the meeting was that cribriform morphology is associated with a worse prognosis than poorly formed or fused glands and in the future may be specifically incorporated into grading practice. We believe that the results from the 2014 Consensus Conference and the updates provided in this paper are vitally important to our specialty to promote uniformity in reporting of prostate cancer grade and in the contemporary management of prostate cancer.