Consensus guidelines for reporting prostate cancer Gleason Grade

It was with some surprise that we read of five letters to the Editor [1–5] authored by the Editors of the International Journal of Radiation Oncology Biology Physics, Urology, Urologic Oncology, BJU International, European Urology and the Journal of Urology regarding the recently defined grading system for prostate cancer [6]. For clarification the letter published in the Journal of Urology [1] is headed ‘Stage Grouping’, which would appear to be an error.

In the letters it was noted that the modification to the Gleason grading systems have been endorsed by the International Society of Urological Pathology (ISUP). In reality, this is not the case. The consensus conference held in Chicago on 1 November 2014 was convened under the auspices of the ISUP, but the attendees were selected and, unlike other ISUP consensus conferences, attendance was not open to the full membership of the Society. The modifications to the Gleason grading system published in the American Journal of Surgical Pathology have never been formally endorsed by either the Council or the Membership of the ISUP. What has been discussed is the terminology that has been applied to the grading system and the ISUP Council has unanimously endorsed the name ‘ISUP Grade’, as the meeting was coordinated under the auspices of the ISUP.

The four letters refer to the new system as Grade Groups rather than ISUP grade. This terminology appears in the latest edition of the WHO classification [7]; however, it should be noted that this was not adopted by consensus but was rather a stop-gap measure proposed by the Chair of the WHO Prostate Cancer Committee. While the final sentence of the definitive grading paper is ‘The new grading system and the terminology Grade Groups 1–5’ has also been accepted by the WHO for the 2016 edition of Pathology and Genetics. Tumours of the Urinary System and Male Genital Organs [7]. The phrase and the terminology ‘Grade Groups 1–5’ was added to the proof of the article, and was done so without the knowledge of at least some of the authors. As such, this statement is not endorsed by the ISUP. It should be noted that the term ‘Grade Group’ is entirely inappropriate as the new grading system is a combination of both Gleason scores and Gleason grades and, indeed, is primarily score based.

Interestingly, there has been much debate in the pathology literature concerning the terminology and content of the new grading system and it is clear that the grading system requires modification. We have recently outlined some of these concerns regarding both grading terminology and criteria elsewhere, including a commentary in BJU [8–11]; however, this appears to have been overlooked by the authors of the letters. Such is our concern that we have made recommendations regarding a re-working of the system [9–11].

Over the years the ISUP has endorsed recommendations regarding issues relating to prostate and renal cancer reporting [12,13]; however, these have never been the subject of a directive in the literature with respect to their implementation. We believe to do so is inappropriate and this has the effect of stifling academic debate. No such encouragement/requirement in relation to prostate cancer grading has appeared in the pathology literature and we believe that this is entirely appropriate. Free debate is the lifeblood of science and this should be actively promoted.

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Reply

We thank the authors for their letter and hope to provide some clarification from the perspective of the six journal editors. The Gleason system has endured because it aligns with clinical outcomes but is awkward for patients and physicians alike. It is misleading as it starts at six, does not discriminate between the combinations that compose Gleason seven, and does not clearly show the emerging prognostic distinctions between the high grade cancers. This has created an obstacle, not only in managing patients, but also in the consistency of scientific reports. This is particularly true when assessing patient suitability for active surveillance, and also with the nuanced treatments for higher grade tumours. The conference at which the new system was proposed was attended by several of us. The naming of the system was a contentious issue and is not yet fully resolved, as emphasized by the letter from Samaratunga et al., but there was little disagreement among participants about its value or validity.

As editors, and as practitioners caring for patients with prostate cancer, we believe that the new system for grouping of Gleason grade has clinical and pragmatic merit. Accordingly, we have encouraged our authors to use the new grouping in submitted manuscripts. This should help provide clarity and better comparative assessment of outcomes and treatment results. Nevertheless, we recognize that little in scientific publishing is static and ongoing study and novel analyses will likely result in further modifications. The exact name used for the system, while important for reference and consistency, is not within our purview to decide, and we await wider discussion in the prostate cancer community, and particularly among the pathologists, for a final consensus on that issue.

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