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UROLOGICAL ONCOLOGY

Pathology examination cannot be done without a urologist's help

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The authors of this article give us a provocative title "Should all specimens taken during surgical treatment of patients with BPH be assessed by a pathologist?" [1]. The answer in one sense is obvious – yes. For many practical and scientific reasons, there is no question that in modern hospitals where there is a pathology department, every specimen obtained from the operating theater is subjected to thorough pathologic examination. The rationale is obvious. Many, if not most, patients want to know their diagnosis and specifically if there is any cancer in the removed tissue. If the pathology report identifies cancer and the patient is not informed and treatment is not discussed, there may be medical and legal implications. Indeed, as the authors correctly discuss, the chance of a significant life threatening adenocarcinoma of the prostate (PC) being found among patients having surgery for lower urinary tract symptoms related to BPH is quite low. The percentage will vary depending on the extent of preoperative investigations which, in part, are designed to determine if the patient has PC. Thus, this will depend on the patient's age, DRE findings and PSA level. Given some preoperative investigation for men under 75 who are to have surgery for BPH, the vast majority of such prescreened patients who are found to have PC will have the equivalent of T1a (low volume GS 6 PC) disease and there is extensive data with prolonged follow up that few such patients will ever need treatment. Thus, as the authors correctly indicate, even if the overall impact of pathologic examination of specimens from TURP or open prostatectomy is relatively low, it can not be dismissed as unnecessary or unimportant. If nothing else, it identifies which patients need more careful monitoring if they have PC.

One issue related to the role of the pathologist in the diagnosis of PC relates to the material obtained from needle biopsies of the prostate in patients who have met the criteria and elected active surveillance as their initial management of PC. They, of course, have low volume GS 6 PC. These patients will have periodic repeat biopsies to monitor the presence and extent of PC. Importantly, it is not critical once they have a diagnosis of focal PC and have elected AS to detect every small focus of GS 6 PC. However, it is not infrequent that the pathologist will use immunochemistry to determine whether a small focus of abnormal appearing glands are cancer. If the urologist indicates to the pathologist that this patient already has a diagnosis of PC and has elected active surveillance, then why the need to diagnose a small focus of cancer? It will not change anything in regards to management, but will add substantial cost to the pathology charges.

References

1. Skrzypczyk MA, Dobruch J, Szostek P, Nyk Ł, Szempliński S, Borówka A. Should all specimens taken during surgical treatment of patients with benign prostatic hyperplasia be assessed by a pathologist? Cent European J Urol. 2014; 67: 227–232. ■

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