Pathology Report of Surgically Removed Prostate Gland

Compiled by Charles (Chuck) Maack – Prostate Cancer Activist/Mentor

Disclaimer: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing prostate cancer care.

If the pathology report of a surgically removed prostate gland identifies (or if the surgeon reports that he was unable to cut deeper where a tumor was extending into fatty tissue) extraprostatic extension (EPE) into periprostatic fat, this is an important determinant of the likelihood of subsequent biochemical cancer recurrence (BCR).

This was the case for me way back at original diagnosis following surgical removal of my prostate gland in December 1992. With known extension of a tumor into periprostatic fat, and despite removed lymph nodes, vas deferens, and seminal vesicles showing no evidence of cancer, I was directed to immediate salvage external beam radiation to the prostatic bed and its periphery as soon as healing from the surgery, but no mention was made of including androgen deprivation therapy (ADT) as an additional safeguard to address the likelihood that some cancer cells may have already migrated in the blood outside this periphery. With immediate prescribing of ADT those cancer cells may have been in small enough number to have been eradicated (experienced apoptosis) through the absence of testosterone fueling them. As it turned out, my cancer returned three years post completion of the salvage external beam radiation; a period for migrated cancer cells to have further developed and proliferated (divided/multiplied).

The take home message is to make sure to ask the surgeon if there was any evidence of tumor extension into fatty tissue (periprostatic fat) that he/she was unable to completely extract despite the pathology report of removed organs (identified above) showing no evidence of migrated cancer cells. The pathology

report “might” recognize this possibility if indicating such extension to “gland margins.” If there is this evidence, six months or so of immediate ADT should be considered in addition to any consideration for salvage radiation.

See: http://www.ncbi.nlm.nih.gov/pubmed/23820055