

## IMPORTANCE REGARDING GLEASON SCORE 3+3/6

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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.

This paper was compiled in view of a National Institutes of Health Consensus Development Conference Statement regarding the role of Active Surveillance in the management of men with localized prostate cancer. See:

<http://consensus.nih.gov/2011/prostate.htm>

It is extremely important that a biopsy result of 3+3/6 Gleason Score (GS), if not having been determined by a pathologist known to be a specialist in recognizing prostate cancer grade under the microscope, be sent to such a pathologist for a second opinion to insure that this is a "true" 3+3/6. Such pathologists are listed in <http://tinyurl.com/6m4fvld>.

If it has been determined that the 3+3/6 GS is absolute and there was no presence of any Gleason Grade 4 or 5 throughout the specimens, then this "true" GS is considered a very slow developing prostate cancer and surgery or radiation should be avoided. There is no logical reason to subject such patients to the side effects of erectile dysfunction and incontinence issues that that can result from surgery and proctitis, erectile dysfunction, or voiding dysfunction that can result from radiation, all of which will unnecessarily impact their future quality of life. Rather, such patients should be fully explained these side effects that can be anticipated with invasive treatment as well as the availability of Active Surveillance that will avoid those side effects. Active Surveillance should be encouraged and a protocol established between physician and patient for regular checking of diagnostics as well as PSA doubling time/velocity. That protocol, as somewhat identified in the NIH Consensus Statement with more considerations to follow, is similarly

provided here: <http://tinyurl.com/3r7mm8m>. It is likely that the majority of such patients will continue for many years without the necessity of further treatment.

On the other hand if, despite the Gleason Score 3+3/6, there is any presence of Gleason Grade 4 or 5, this changes the “status” of the patient and other treatment options should be explained with the patient having the opportunity to visit with those physicians who provide those other treatment options and come to his own conclusion as to the option he would prefer.

It is also important to realize that most biopsy samples are extracted from just one side of the prostate as well as constituting less than 0.5% of biopsy tissue even when multiple cores are sampled. With removal of a prostate gland, hidden tumours located on the top and anterior of the prostate evade traditional diagnostic procedures, including ultrasound guided needle biopsy. The following regards the anterior of the prostate:

[http://www.ncbi.nlm.nih.gov/pubmed/21341573?s\\_cid=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/21341573?s_cid=pubmed)

More in this regard: <http://www.ncbi.nlm.nih.gov/pubmed/12508755>

Following, regarding “Hidden Prostate Cancer Tumours Evade Treatment,” is found in this URL: <http://tinyurl.com/ykyqjgt>.

Both identify what should be the required procedure by all physicians when administering a biopsy in order to get a more appropriate and definitive indication of prostate cancer location and Gleason grade by extracting tissue samples from otherwise “hidden” locations. This should be the new “norm” for biopsy sampling.