Grading of the prostate carcinoma: cyto-histological correlations on 100 cases

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Summary. From January 1980 to December 1983, 154 patients underwent prostatic FNAB and histological control. The sensitivity of cytology was **85%**, the **specificity** 68% and the predictive value of positive cases 83%.

The cyto-histological correlation of the grading of the **100** prostatic carcinomas histologically confirmed (85 cytologically positive for carcinoma and 15 negative or uncertain) showed a predictive value of positive results of **58%**, ranging from 42% for G3, 50% for G1 and 69% for G2.

The usefulness of cytological grading is stressed to monitor the follow-up of those patients treated for prostatic carcinoma who, because of the advanced stage or age, were not surgically treated.

Key words: Prostate cancer - FNAB - Cytohistological grading correlation

Introduction

Cytological studies are essential in the diagnosis of prostate carcinoma (Zattoni et al., 1983). Cyto-histological statistics show that fine needle aspiration biopsy (FNAB) allows us to obtain an accurate diagnosis in 75% (VonReuter and Schuck, 1971) to 91% of cases studied (Esposti, 1982). These results are much better than those obtained with cytological studies following prostatic massage (Garret and Jassie, 1976).

In addition, FNAB permits us to grade prostate carcinoma into well, moderate and scarcely differentiated forms (Esposti, 1971, 1982). Several authors (Ekman et al.,

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1967; Alfthan et al., 1970; Epstein, 1976; Ackermann and **Muller**, 1977; Kaufman et al., 1982; Kline et al., 1982; Kline, 1985; Yatani et al., 1985; Carter et al., 1986) have referred to the possibility of obtaining a reliable cytological grade when compared **histologically**, but unfortunately they reported only a limited number of cases. For this reason, we have considered it useful to report our experience in this. field.

Materials and methods

Between January 1980 and December 1983, 154 patients underwent prostatic FNAB and histological control. FNAB was carried out with Franzen's needle (1960), performing 3-5 aspirations, not only on the suspected sites but also the rest of the gland. The aspirated material was smeared and fixed with a spray (Merckofix); the slides were then stained with Papanicolaou's method. All samples diagnosed positive for carcinoma were subsequently graded as G1, G2 or G3, according to the morphologic aspect, tendency of cells to isolate and grade of atypia (Esposti, 1971, 1982; Zattoni et al., 1983). Where cells were arranged in acinarlike aggregates and were smaller than normal, with scarce granular cytoplasm and a uniform round or oval, hyperchromatic, rarely nucleolated nucleus, a presumed diagnosis of "atypical hyperplasia" (in this work "suspicious") was accepted (Gaetani and Trentini, 1978; Helpap, 1980).

Histological material, obtained from prostatic fragments following biopsy with TRUCUT, after transuretral resection or after radical prostatectomy, was prepared and stained by the usual methods. **Cases** of carcinoma were subsequently classified according to the W.H.O. system (Mostofi et al., 1980).

The cyto-histological grading was independently diagnosed by cytologists or pathologists.

Results

In 154 patients (subjected to both types of study) who underwent both types of control, we diagnosed histologically 100 carcinomas, 45 nodular hyperplasias and 9 prostatites whereas, cytologically, 102 showed malignant cells and 52 were considered negative for carcinoma (unsatisfactory, suspicious or true negative).

Table 1 shows the cyto-histological correlation of the 154 patients: the sensitivity of cytology was 85%, the specificity 68% and the predictive value of positive cases 83%. Nevertheless, these values did not reflect the real accuracy of prostatic FNAB, since they excluded 76 patients with positive cytological diagnosis for neoplasias where no histological control had been performed. These

cases must be considered true positive, as they presented a hard fixed prostate, high serum levels of acid phosphatase and a positive bone scan for metastasis. Considering all these patients, the diagnostic accuracy increases to 90%.

Table 2 reports the correlation between the cytologic and histological grading in 100 cases of carcinomas histologically diagnosed. The distribution of the 85 cytologically positive cases was 12 G1, 61 G2 and 12 G3, respectively. The predictive value of cytologic grading was 58% when considered globally, varying from 42% for G3, 50% for G1 and 60% for G2. The table also includes 15 cytologically false negatives, which were redistributed as G1 and G2. Only one case, already classified as unsatisfactory, for the presence of numerous seminal vesicles cells, was re-evaluated as G3.



Fig. 1. Well-differentiated carcinoma, G1: microacinar formations due to fusion of single cytoplasms in a central eosinophilic "core", around which somewhat-atypical nuclei are arranged radially. Pap. x 1000



400



Fig. 3. Scarcely-differentiated carcinoma, G3: isolated cells with marked polymorphism and macronucleolated bizarre nuclei, Pap. x 400

Table 1. Cyto-histological correlation in 154 patients

	CARCINOMA	HISTOLOGY HYPERPLASIA	PROSTATITIS	TOTAL
CYTOLOGY POSITIVE	85	11	6	102
CYTOLOGY NEGATIVE*	15	34	3	52
TOTAL	100	45	9	154

 Table 2. Correlation between cytological and histological grading

	HISTOLOGY			
CYTOLOGY	(G I)	(GII)	(G III)	TOTAL
CARCINOMA G I	6	6	_	12
CARCINOMA G II	11	38	12	61
CARCINOMA G III	_	7	5	12
SUSPICIOUS	1	2	_	3
NEGATIVE	4	1	_	5
UNSATISFACTORY	2	4	1	7
TOTAL	24	58	18	100

""suspicious" considered as "negative".

Discussion

The results obtained by cyto-histological correlation were very encouraging and followed that reported in literature. Histological examination of the 17 cytologically false positive cases revealed 11 nodular hyperplasias and 6 prostatites. Since this last type of pathology is frequently associated with carcinoma and since, in these patients, radical prostatectomy was obviously not performed, they must be considered "dubious false positive", as they could be microcarcinomas not observed by biopsy. In these cases, only an adequate follow-up can give us the answer. Two cases, previously diagnosed negative by biopsy, subsequently developed an evident clinical carcinoma.

Fifteen cytologically negative cases were histologically diagnosed as "carcinomas". In fact, the limitation of FNAB, as also histology, consists in the impossibility of always obtaining samples from the suspected site, even if 3 to 5 aspirations of the same nodule are usually performed. However, in 3 out of 15 cases, the cytologic diagnosis was "suspicious". The major problem of the cytologist is to distinguish cells of a well-differentiated carcinoma from those of a hyperplasia with atypia, since the two morphological aspects can co exist (Gaetani and Trentini, 1978). The cyto-histological correlation of the grading is very difficult, as various histomorphological classifications of prostatic carcinoma have been reported in literature (Gleason, 1966, 1977; Murphy and Whitmore, 1979; Mostofi et al., 1980; Gaeta, 1981; Brawn et al., 1982). According to the authors, each of these classifications should show a correlation between tumoral differentiation and prognosis. VACURG's classification, better known as Gleason's (1966, 1977), considers only the grade of glandular differentiation and type of growth, but not the cytological grading; Gaeta's (1981) classification considers 4 different structural and cytological grades. Finally, the W.H.O. (Mostofi et al., 1980) considers 3 cytological grades independently from the histological pattern. We consider that only this last classification can be utilized for a cytohistological correlation.

Doubts on the reliability of cytological grading as a basic parameter in the prognosis of prostate carcinoma arise from this evalutation being subjective, hardly reproducible and, especially, too variable from site to site. Hovewer, we consider that the cytologist should specify if positive cells for carcinoma show scarce, intermediate or marked atypias, since the cytological grading can represent an objective and reliable parameter to evaluate medical and/or radio-therapy in non-operable patients not histologically evaluated (Kline, 1982). In these cases, therefore, prostatic FNAB is the only diagnostic method which is reliable, inexpensive, simple to perform and easily repeated, a map of the neoplastic extension being obtained when, in addition to the suspected nodule, other samples have been studied.

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