

Intraductal carcinoma of prostate (Recommended)

Intraductal carcinoma of the prostate (IDC-P) is found in approximately 17% of radical prostatectomy specimens and is usually associated with invasive prostate cancer.¹ However, occasionally isolated IDC-P is found without invasive carcinoma; this latter situation is very rare and beyond the scope of this dataset.

IDC-P has been well characterised at the histological and molecular levels over the past decade and its clinical significance is now also better understood.² The diagnosis of IDC-P is based on morphology and the key criteria include: 1) large calibre glands that are more than twice the diameter of normal non-neoplastic peripheral glands; 2) preserved (at least focally) basal cells identified on H&E staining (or with basal cell markers, such as p63, keratin 34 β E12 and keratin 5/6, however, the use of immunohistochemistry to identify basal cells is optional, rather than mandatory, for the diagnosis of IDC-P); 3) significant nuclear atypia including enlargement and anisonucleosis; and 4) comedonecrosis, which is often but not always present.^{3,4} It is important to distinguish IDC-P from high grade prostatic intraepithelial neoplasia (HGPIN): compared to IDC-P, HGPIN has less architectural and cytological atypia, and cribriform HGPIN is rare.

When present in combination with invasive carcinoma in radical prostatectomy specimens, IDC-P is strongly associated with high volume, high grade and stage (extraprostatic extension (EPE) or seminal vesicle invasion (SVI) positive)) carcinoma.⁵ Moreover the presence of IDC-P is independently associated with biochemical recurrence, regional lymph node metastasis and cancer specific survival.^{1,6,7} Hence, in radical prostatectomy specimens, the presence of IDC-P in association with invasive carcinoma should be recorded.

There was a strong consensus (82%) at the recent International Society of Urological Pathology (ISUP) consensus meeting (Chicago 2014) that IDC-P should not be assigned an ISUP or Gleason grade.⁸ It is also unnecessary to measure the extent of the IDC-P.

References

- 1 Miyai K, Divatia MK, Shen SS, Miles BJ, Ayala AG and Ro JY (2014). Heterogeneous clinicopathological features of intraductal carcinoma of the prostate: a comparison between "precursor-like" and "regular type" lesions. *Int J Clin Exp Pathol* 7(5):2518-2526.
- 2 Zhou M (2013). Intraductal carcinoma of the prostate: the whole story. *Pathology* 45(6):533-539.
- 3 Cohen RJ, Wheeler TM, Bonkhoff H and Rubin MA (2007). A proposal on the identification, histologic reporting, and implications of intraductal prostatic carcinoma. *Arch Pathol Lab Med* 131(7):1103-1109.
- 4 Guo CC and Epstein JI (2006). Intraductal carcinoma of the prostate on needle biopsy: Histologic features and clinical significance. *Mod Pathol* 19(12):1528-1535.

- 5 McNeal JE and Yemoto CE (1996). Spread of adenocarcinoma within prostatic ducts and acini. Morphologic and clinical correlations. *Am J Surg Pathol* 20(7):802-814.
- 6 Kimura K, Tsuzuki T, Kato M, Saito AM, Sassa N, Ishida R, Hirabayashi H, Yoshino Y, Hattori R and Gotoh M (2014). Prognostic value of intraductal carcinoma of the prostate in radical prostatectomy specimens. *Prostate* 74(6):680-687.
- 7 Kryvenko ON, Gupta NS, Virani N, Schultz D, Gomez J, Amin A, Lane Z and Epstein JI (2013). Gleason score 7 adenocarcinoma of the prostate with lymph node metastases: analysis of 184 radical prostatectomy specimens. *Arch Pathol Lab Med* 137(5):610-617.
- 8 Epstein JI, Egevad L, Amin MB, Delahunt B, Srigley JR and Humphrey PA (2015). The 2014 International Society of Urological Pathology (ISUP) Consensus Conference on Gleason Grading of Prostatic Carcinoma: Definition of Grading Patterns and Proposal for a New Grading System. *Am J Surg Pathol* 40(2): 244-52.