Day 2,722 — No Probability for Me

April 24, 2018 By Dan Zeller

I'm one of those people who always thinks of a snappy comeback—three days after the conversation.

Over the weekend, I reflected on my conversation with the doctor last Thursday, and one of the things that I failed to ask was what probability he would assign to the notion that my increasing PSA is attributable to benign residual prostate tissue instead of returning cancer. I sent an email that asked specifically:

> I fully understand that none of us have a crystal ball, but the one thing that I failed to ask Dr. is what he thought the probability of this being benign residual tissue was. Is it 5%? 25%? 50%? His experience gave him the insights to make the comment, so his experience may also be able to measure the likelihood as well.

To which he replied:

> I'm afraid I am not able to assign a percentage likelihood to the chance that any residual tissue is benign. I can only really extrapolate from the rate of change in the PSA. The longer it took to be detectable and the slower it rises, the more it seems likely to be a bit of benign tissue. Either way, it is those lab values and their pattern that will help to guide treatment. If it rises quickly then will treat, since a) that pattern is more likely cancer, and b) if it's not cancer it is acting like cancer and the stakes are too high to disregard even with a high % prediction at this point that the tissue is benign.
>
> Hope that helps!

His comment, "…b) if it's not cancer it is acting like cancer and the stakes are too high to disregard even with a high % prediction at this point that the tissue is benign," seems to be all over the place and contradicts his opening statement of not being "able to assign a percentage likelihood." Hmmm…

So that was an interesting little exercise. I really didn't expect him to come back with a specific number, but I thought I'd ask anyway. I don't know that his answer convincingly persuades me one way or the other, but it does allow me to throw a tad more weight behind his theory that this is benign. A tad.

Bottom line: The only thing we know with any certainty is that my PSA continues to climb. Beyond

that, it’s all a freaking guessing game.

On a related note, I’ve yet to hear from the radiation oncology department with an appointment for me. If I don’t hear from them soon, I’ll try to call to get on the calendar.

UPDATE:

About an hour after posting this, I came across this little gem of an article from 2005:

“The presence of benign prostatic glandular tissue at surgical margins does not predict PSA recurrence”

Key points:

> We conclude that the presence of benign prostatic tissue at the surgical margins is not associated with adverse prognostic features and does not have prognostic relevance; therefore, we do not advocate reporting the presence of benign prostatic tissue at the inked margins as a standard part of the surgical pathology report on prostatectomy specimens. Because benign epithelium at surgical margins is not correlated with postoperative PSA rises, postoperative PSA increases should in most cases continue to be considered “biochemical failure.”

Obviously, that’s not good news and certainly warrants more research.

This article from 2013 calls a few things into question:

“Benign Prostate Glandular Tissue at Radical Prostatectomy Surgical Margins”

Key point:

The most interesting finding of this study is the identification of Benign Glands at the Surgical Margins (BGM) after both Open Radical Prostatectomy (ORP) and Robot Assisted Laproscopic Radical Prostatectomy (RALRP) was not associated with recurrence, either biochemical or clinical, during a median follow-up interval of 49 months after ORP and 28 months after RALRP.

Extending followup further should clarify whether BGM leads to low, detectable levels of PSA that may not meet threshold for defining biochemical failure. This may be particularly relevant with the widespread availability of ultra-sensitive PSA assays. The routine use of ultra-sensitive tests after treatment has not been validated and remains controversial in clinical practice, and may be particularly true in patients at low risk of disease recurrence and potentially in those with BGM.

Within our cohort, longer follow-up may reveal detectable levels of PSA associated with BGM that may not reflect actual prostate cancer recurrence but rather a clinically benign elevation of PSA.

In other words, there’s more research to be done.

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