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ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Cracking the Code: Risk Stratification Guidelines to Identify High-Risk Patients

Announcer:

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Dr. Taplin:

This is CE on ReachMD, and I'm Dr. Mary-Ellen Taplin. Here with me today is Dr. Scott Tagawa.

Risk stratification plays a critical role in guiding treatment decisions in localized hormone-sensitive prostate cancer. So let's crack that code. Dr. Tagawa, how do you apply risk stratification guidelines in your practice to identify those at truly high risk?

Dr. Tagawa:

Yeah, thanks very much for the question. I think it's a very important one. So this is clinically localized, "this" meaning that whatever imaging modality has been used, there's no evidence of metastases, although we will allow small-volume lymph node metastasis within the pelvis, depending on the kind of the study that we're looking at.

But overall we've always had 3 major ways we've classified this. One is the T stage, what used to be the digital rectal exam. Now there's imaging that's involved, typically MRI. There is PSA, traditionally in kind of groups of 10, but now we look at 20 or 40 as kind of the high risk. And then most of it comes from the biopsy, and most of that traditionally comes from Gleason scores. Now we use Gleason grade groups. So those 3 together will bring us into a high-risk category.

If the Gleason grade group is high, the T stage is high, particularly if we feel some of the MRI shows something that appears to be extraprostatic, or maybe a little bit in terms of lymph nodes, and sometimes we see normal-size lymph nodes that light up in a PET scan. And then PSA, depending on what setting we're looking at, certainly everyone agrees that more than 40 is high risk or very high risk, and in some settings greater than 20. So, anyway, those are the overall categories.

I want to come back to some additional prognostic factors that we have that I think are in the molecular realm, but what I think is most relevant is in that setting, particularly in very high risk, we now have studies that will change what we do, give us evidence that there's better outcomes with what we do, especially in the very high-risk groups, whether we have surgery as the primary therapy or radiation as a primary therapy. And those are, I think, more specific topics for a future discussion, but I do think that is quite important.

There are additional factors that, beyond Gleason, PSA, and T stage, will give additional prognostic factors. A number of different molecular tests that are out there, I think the 2 that probably have the highest amount of data are the genomic classifier, often termed Decipher, that's the initial name for this, and then MMAI (Multimodal Artificial Intelligence) group, they're called Artera that looked at a lot

of initially radiation studies.

Those both give, I think, both patient-friendly because there's a bar that's there, as well as physician-friendly, that give the meaning of that beyond what we have with the imaging, the PSA, and the Gleason grade group. And all of that then comes back into our discussions with the patient, shared decision-making, when we're looking for often the highest chance of cure, but in the way that the patient wants to meet, in terms of how much systemic therapy are they interested in accepting or avoiding, et cetera.

Dr. Taplin:

Great. Thank you very much, Dr. Tagawa.

So a takeaway from this discussion is that when a patient is diagnosed with localized high-risk cancer, we need to take several factors into consideration. The T stage, is it T3 or T4, for instance? The level of the PSA, is it over 40, for instance? And the Gleason score, generally Gleasons 8 to 10 in the high-risk state. And when we have a patient with a high-risk disease, we use those criteria to make an optimal treatment recommendation for them.

And this has been a great review. Join us next time, and thanks for listening.

Announcer:

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