INTRODUCTION

Prostate cancer is the most common malignant tumour in men, it increases with age in men older than 50 years and it is the second most common cause of cancer death ***(Tooher et al., 2006).***

The primary prognostic factors in planning treatment for patients with newly diagnosed clinically localized prostate cancer are the biopsy Gleason Score (GS), serum prostate specific antigen (PSA), and findings on digital rectal examination ***(Rajinikanth et al., 2008).***

Several nomograms have been employed to help with counseling patients before and after treatment to predict the risk of recurrence ***(Klotz, 2002).***

Prognosis of patients with prostate cancer depends on various parameters, but histologic grading is the only one that has been confirmed by most of the relevant studies from different countries ***(Divrik et al., 2007).***

The Gleason Scoring system is the most widely used method for grading prostate cancer and is a predictor of prognosis and survival after radical prostatectomy ***(Gonzalgo et al., 2006).***

However the Gleason Score from the prostate biopsy has an inherent sampling error and often differ from the Gleason Score in the prostate after radical prostatectomy ***(Sved et al., 2004).***

Some authors have reported that the biopsy Gleason Score differs as much as 60% to 70% from the Gleason Score in the radical prostatectomy specimen ***(Rajinikanth et al., 2008).***

The diagnostic techniques as prostate biopsies, number of cores and advanced imaging equipment have increased the diagnostic yield. The biological spectrum of disease has shifted considerably, which is largely attributed to the introduction of P.S.A, there has been a significant increase in expertise among pathologists on interpretation and assignment of histological grade because of the increasing number of patients and educational efforts ***(Sengupta et al., 2006).***