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Urologic Oncology: Seminars and Original Investigations 24 (2006) 216–219

UROLOGIC ONCOLOGY

Original article

Prostate adenocarcinoma manifesting as generalized lymphadenopathy

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Received 9 March 2005; received in revised form 28 June 2005; accepted 30 June 2005

Abstract

Generalized lymphadenopathy is a rare manifestation of metastatic prostate cancer. Here, we report the case of a 65-year-old patient with supraclavicular, mediastinal, hilar, and retroperitoneal lymphadenopathy and pulmonary infiltration, which suggested the diagnosis of lymphoma. There were no urinary symptoms, and the serum prostate-specific antigen (PSA) was only mildly increased with a normal free PSA. A biopsy of the supraclavicular lymph node was compatible with adenocarcinoma, whose prostatic origin was shown by immunohistochemical staining with PSA. The origin of the primary tumor was confirmed by directed prostate biopsy. We emphasize that a suspicion of prostate cancer in men with adenocarcinoma of undetermined origin is important for an adequate diagnostic and therapeutic approach. © 2006 Elsevier Inc. All rights reserved.

Keywords: Prostate adenocarcinoma; Metastatic prostate cancer; Generalized lymphadenopathy; Prostate-specific antigen

1. Introduction

Generalized lymphadenopathy can be the initial manifestation of different diseases, with lymphomas and metastatic neoplasias being the most common in elderly individuals [1]. However, generalized lymphatic metastases are a very uncommon manifestation of prostate cancer [2]. The diagnosis of prostate adenocarcinoma with nonregional lymph node involvement might be difficult not only because this condition is uncommon but also because it can occur in the presence of normal serum prostate-specific antigen (PSA) and in the absence of urinary symptoms. Here, we report a case of prostate adenocarcinoma, which clinically manifested as generalized lymphadenopathy in the absence of urinary symptoms and in the presence of only mildly increased serum PSA with a normal free PSA, simulating lymphoma.

2. Case report

A 65-year-old man was admitted to the University Hospital, Federal University of Minas Gerais, Belo Horizonte, Brazil, with complaints of abdominal pain and a 24-kg weight loss in 3 months. There was no history of previous disease or drug intake. Upon admission, a hardened supraclavicular mass on the left and a firm abdominal mass in the right paramedial position at the height of the umbilical scar were detected by physical examination. Computerized tomography (CT) of the chest (Fig. 1) and abdomen (Fig. 2) showed extensive mediastinal, hilar, and retroperitoneal lymphadenopathy, in addition to frosted-glass opacities and pulmonary consolidations predominantly at the periphery. There were no respiratory symptoms. A biopsy of the supraclavicular mass was compatible with adenocarcinoma of undetermined origin. The patient was anti-human immunodeficiency virus negative, chorionic gonadotropin beta-subunit was <1 mU/mL (normal <5), total serum PSA was 10.1 ng/mL (normal 0−4), and free-to-total PSA ratio was 0.57 (>0.25 associated with benign prostatic hyperplasia). Digital rectal examination showed an enlarged and hardened left prostate lobe. However, there were no symptoms of prostatism. Ultrasonography revealed an enlarged prostate, weighing 46 g, with perineal invasion. A guided prostate biopsy showed Gleason score 7 (4 + 3) usual acinar type invasive prostate adenocarcinoma.

Six core biopsies were obtained, and 5 of them had cancer involving 70%, 90%, 90%, 5%, and 60% of the

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1078-1439/06/$ – see front matter © 2006 Elsevier Inc. All rights reserved.
doi:10.1016/j.urolonc.2005.06.022

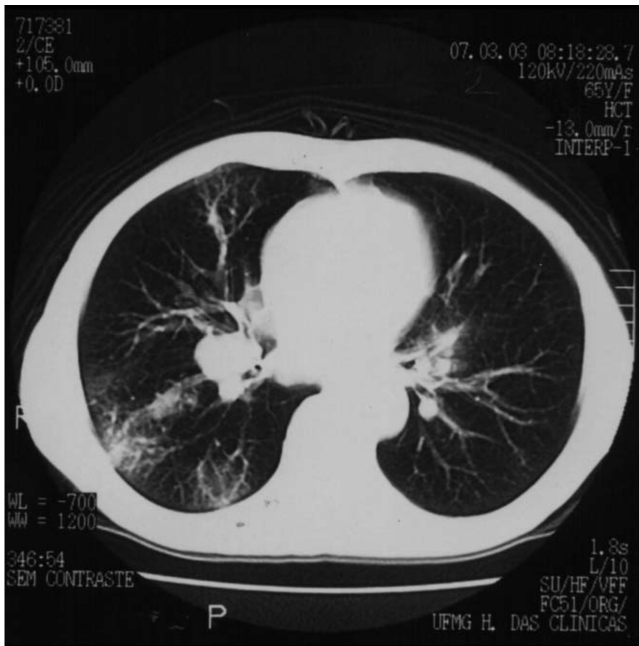


Fig. 1. CT of the thorax showing hilar lymphadenopathy and pulmonary consolidations predominantly at the periphery.

biopsies from the left apical area, mid zone of the left lobe, base of the left lobe, mid portion of the right lobe, and base of the right lobe, respectively. Only the core from the apex of the right lobe was free from cancer. The histologic picture was similar to that observed for the biopsied supraclavicular mass (Fig. 3). On this occasion, the patient reported pain in a left costal arch, and had radionuclide bone scanning that showed areas of increased uptake compatible

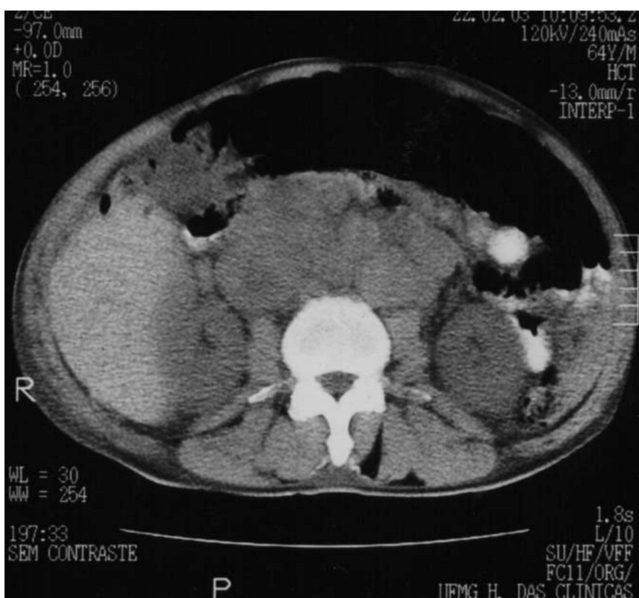
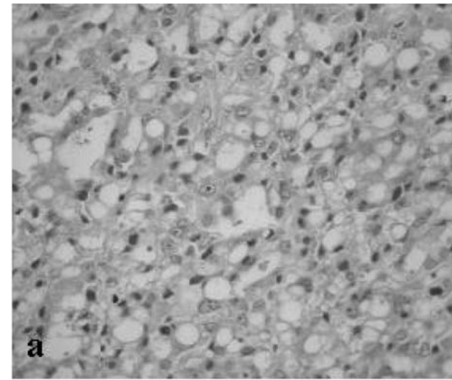


Fig. 2. CT of the abdomen showing extensive retroperitoneal lymphadenopathy.



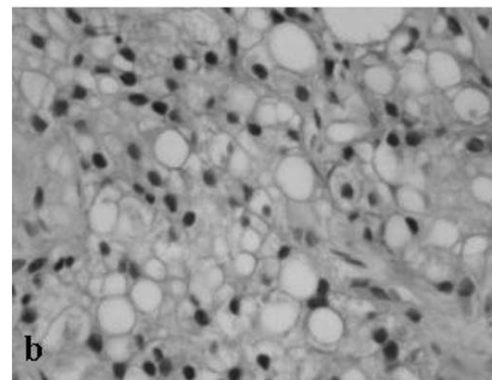


Fig. 3. Poorly differentiated metastatic prostatic adenocarcinoma with signet ring cells. Similar appearance between supraclavicular mass biopsy (A) and prostate core biopsy (B) (hematoxylin-eosin, magnification ×250 in A, ×400 in B).

with metastases in the costal arches, vertebrae, right shoulder, and left ischium. The immunohistochemical staining of the biopsy specimen obtained from the supraclavicular mass was positive for PSA, confirming its prostatic origin.

Treatment was initiated with diethylstilbestrol (DES) hormone therapy because the patient refused the proposed orchiectomy, in combination with paclitaxel chemotherapy. Soon after the third chemotherapy cycle, the patient had symptoms of intestinal obstruction, and he underwent laparotomy. During this procedure, ventricular fibrillation developed, and the patient did not respond to the resuscitation maneuvers. The death occurred on approximately the 70th day after diagnosis. An autopsy was not performed, but it is possible that the death was a consequence of a pulmonary embolism related to the cancer itself and mainly to the use of DES. It was impossible to evaluate if there was any reduction in the tumor volume in response to the treatment because the patient died before having CT, which had been scheduled between the third and fourth chemotherapy cycles.

3. Discussion

Prostate adenocarcinoma is a common neoplasia and is the second most frequent cancer among men in the United

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