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Prostate Cancer
Case report

An unusual presentation of advanced prostate cancer in a 56-year old Nigerian

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Abstract
Introduction: Advanced prostate cancer usually presents with lower urinary tract symptoms associated with features of malignancy on digital rectal examination. The bones, the liver, and the lungs are the common sites of metastasis for advanced prostate cancer.
Observation: We report an atypical case of a 56- year old Nigerian male who had bowel obstruction, multiple peripheral and intra-abdominal lymphadenopathies. The patient had a normal initial urological evaluation but his diagnostic conundrum was resolved to be prostate cancer by immuno-histochemistry of the cervical lymph node biopsy and he did well after antiandrogen monotherapy.

Introduction

Adenocarcinoma of the prostate gland is the commonest cancer in men occurring mostly in the seventh decade of life [1]. It presents with lower urinary tracts symptoms like Benign Prostatic Hyperplasia (BPH) but it is usually associated with elevated serum Prostate Specific Antigen (PSA) and malignant features on Digital Rectal Examination (DRE). Advanced prostate cancer metastasizes to the bones, liver and lungs [2]. Some atypical presentations have been published [3]. We report a case of a 56-year-old man with symptoms of intestinal obstruction, intra-abdominal masses and multiple

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lymphadenopathy suggestive of lymphoma which turned out to be prostatic adenocarcinoma.

Case report

A 56-year old man presented to the emergency department with constipation of three months and abdominal pain of two weeks duration. Abdominal pain was colicky in nature, suprapubic in location and of insiduous onset with no known precipitating, aggravating or relieving factors. Preceding history of constipation was typified mainly by infrequent passage of hard pellet-like stools. There was no vomiting, hematochezia or melena. There was however, history of significant weight loss. The patient did not have yellowness of the eye, cough, fever or drenching night sweat. There was no preceding abdominal trauma or surgery and he had no urinary symptoms.

Examination revealed an ill looking middle-aged man who had marked wasting and generalized lymphadenopathy involving the cervical, left supraclavicular, axillary and inguinal lymph nodes. The abdomen was moderately distended with multiple firm masses in the iliac fossae, suprapubic and left lumbar regions. The liver and spleen were not palpably enlarged and bowel sounds were hyperactive. Digital rectal examination revealed a firm mass bulging into the rectum on vasalva manoeuvre, the prostate was mildly enlarged with no malignant features. Other systems were essentially normal on physical examination.

An initial diagnosis of partial large bowel obstruction secondary to colorectal carcinoma to rule out lymphoma was made. The patient was initially put on NPO and parenteral nutrition for abdominal decompression while awaiting further investigations. Retroviral screening was non-reactive, full blood count and serum biochemistry were within normal limits apart from elevated urea which normalized after rehydration.

Abdominal Ultrasound Scan (USS) showed multiple masses in both iliac fossae and the pelvis, with difficulty in delineating the colon separately. The liver, the spleen and the kidneys were normal and no ascites was seen on USS. The double contrast barium enema done revealed no colonic tumour. Abdominal CT scan showed multiple para-aortic and para-iliac isodense lesions splaying the iliac and renal arteries (Fig. 1) and similar lesions were also seen within the mesentery. The CT scan also showed no ascites, mild hepatomegaly while bowel loops and other abdominal structures were unremarkable. The prostate was mildly enlarged with grossly normal urinary bladder. Multiple hilar and prevascular lymphadenopathies were seen on chest CT and sclerotic lesions were observed in L2–L5 vertebrae. The impression of the radiologist was Lymphoma with spinal metastasis.

The patient had an initial urological evaluation which did not consider prostate cancer as a result of absence of lower urinary tract symptoms in addition to normal features of the prostate gland on both DRE and CT scan. Urethrocystoscopy revealed closely apposed lateral lobes of the prostate and a normal urinary bladder.

A supraclavicular lymph node biopsy was subsequently done and histopathology returned as metastatic adenocarcinoma with unknown primary as shown in Fig. 2. This necessitated immunohistochemistry to discover the primary site. The following immuno-histochemical stains were used; Thyroid Transcription

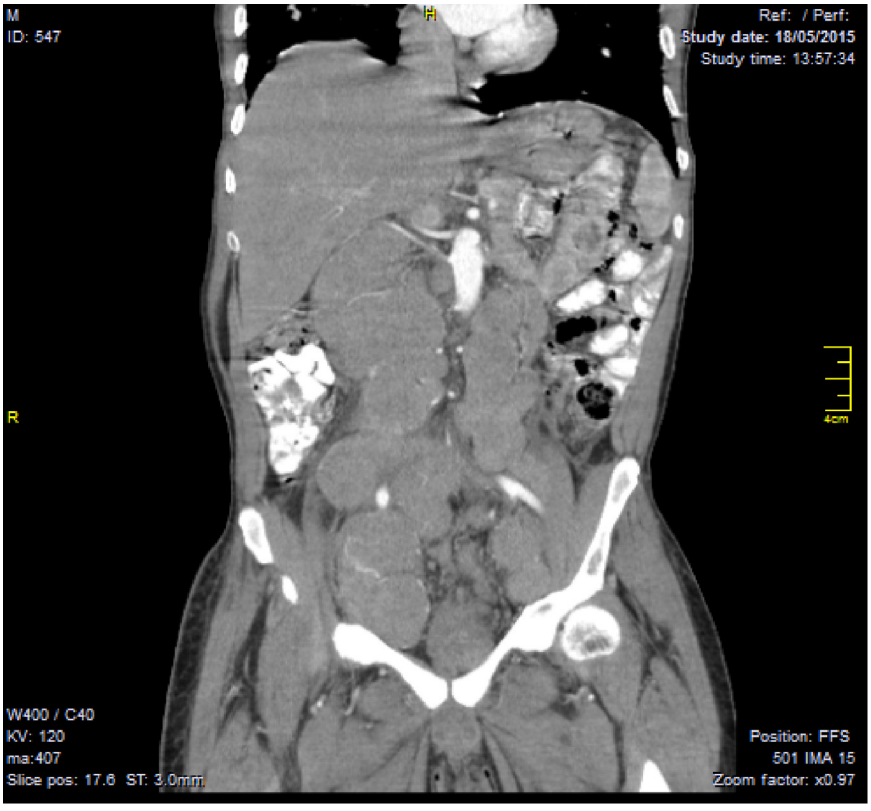

Figure 1 Abdominal CT showing multiple para-aortic and para-iliac isodense lesions splaying the iliac vessels.