Case Report

Uncommon Cause of Generalised Lymphadenopathy: A Case Report

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ABSTRACT

Prostatic adenocarcinoma is rarely manifested as generalised lymphadenopathy. Generalised lymphadenopathy in prostatic adenocarcinoma has been reported as 0.4%-1%. Generalised lymph adenopathy is explained based on the tumour emboli *via* thoracic duct. Most of the generalised lymph adenopathy occurs in the metastatic prostatic adenocarcinoma is misdiagnosed as lymphoma. Our patient initially diagnosed as lymphoma based on the clinical and radiological features. But later it was diagnosed as metastatic adenocarcinoma of prostate. This case is reported due to unfamiliar feature of prostate cancer which creates diagnostic difficulties.

Keywords: Generalised lymphadenopathy, Prostate cancer, Adenocarcinoma.

INTRODUCTION

Prostatic adenocarcinoma is rarely manifested as generalised lymphadenopathy. Generalised lymphadenopathy in prostatic adenocarcinoma has been reported as 0.4%-1%. Generalised lymph adenopathy is also explained based on the tumour emboli *via* thoracic duct [1]. Most of the generalised lymph adenopathy occurs in the metastatic prostatic adenocarcinoma is misdiagnosed as lymphoma. It is not mandatory all patient with metastatic prostate cancer should have urinary symptoms, there are case report of metastatic prostate cancer never had urinary symptoms [2].

CASE REPORT

A 67-year old male admitted with complaint of left side thigh swelling for 2 months duration. There was a history of loss of weight and loss of appetite for 2 months. Patient also said there was night sweating and fever for 2 months duration. He denied history of contact with tuberculosis. On examination patient was pale. There were multiple enlarged lymph nodes present in bilateral submandinular, submental, cervical, posterior triangle, bilateral axillary, bilateral supraclavicular and bilateral inguinal lymph node enlargement **(Figure 1).** Systemic examination showed edema in the left thigh. Abdominal examination showed no hepatosplenomegaly. Per rectal examination was normal. Provisional diagnosis made as generalised lymphadenopathy for evaluation due to lymphoma.

Investigations showed haemoglobin of 9.0 gm% and normal renal and liver function test. Ultrasound abdomen showed multiple enlarged para aortic, bilateral iliac group of lymph node, largest measuring 2.2 × 2 cm on right and 5.2 × 2.5 cm on the left side. We proceed with Computed Tomography (CT) of chest and abdomen showed cystic bronchoietatic changes are noted in bilateral

Figure 1: Multiple enlarged lymph nodes present in bilateral submandinular, submental, cervical, posterior triangle, bilateral axillary, bilateral supraclavicular and bilateral inguinal lymph node enlargement.

lung fields with bilateral enlarged mediastinal lymph nodes. No evidence of space occupying lesion in the lung. Multiple well defined enhancing nodes in bilateral supraclavicular, axillary, medistinal, peripancreatic, para aortic, bilateral external and internal iliac, inguinal region **(Figures 2-4).** CT screening of long bones was normal.

Cervical and supraclavicular lymph node excision biopsy on the

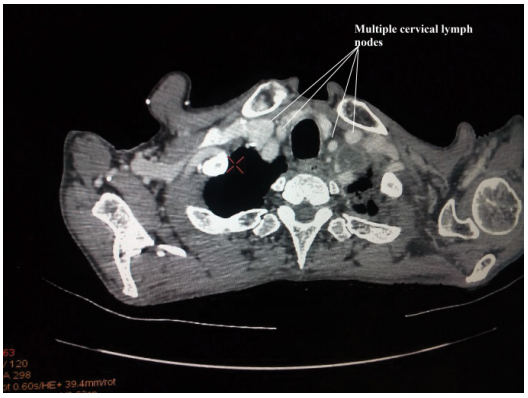

Figure 2: CT showed Multiple well defined enhancing nodes in bilateral supraclavicular, axillary region.

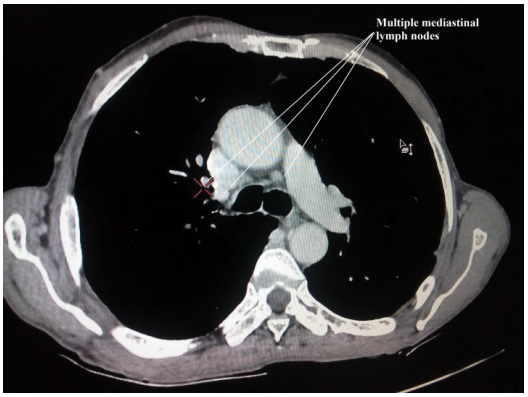

Figure 3: CT showed Multiple well defined enhancing nodes in mediastinal region.

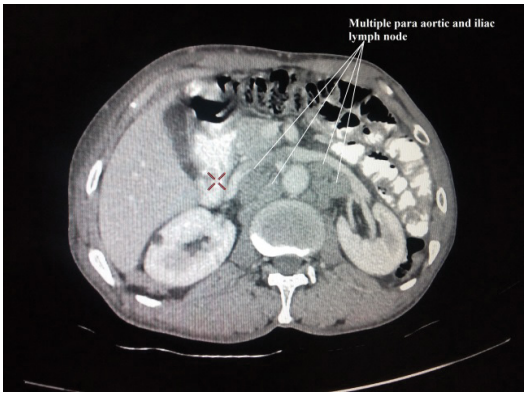

Figure 4: CT showed multiple well defined enhancing nodes in para aortic, bilateral external and internal iliac, inguinal region.

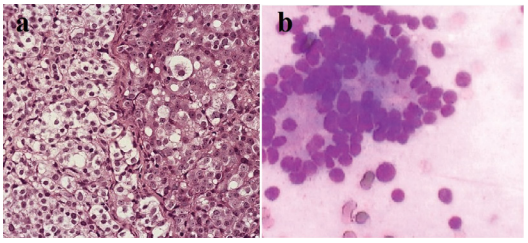

Figure 5: (a) Cervical and supraclavicular lymph node excision biopsy on the left side showed features of metastatic adenocarcinoma and (b) trucut biopsy from prostate also showed prostate adenocarcinoma.

left side showed features of metastatic adenocarcinoma **(Figure 5).** Inguinal node fine needle aspiration cytology also showed features of adenocarcinoma. After excision biopsy we searched for primary by upper gastrointestinal endoscopy, colonoscopy and ultrasound of salivary gland tumour, thyroid and breast. Every investigation for metastatic adenocarcinoma fails to identify primary lesion. Being a male patient we want to identify prostatic malignancy even there was no significant prostatomegaly. Serum PSA was 1 ng/dl (normal 0.0-4.5 ng/dl). Prostate trucut biopsy showed adenocarcinoma of prostate. As the patient diagnosed as metastatic prostatic adenocarcinoma, we proceeded with bilateral orchidectomy was done and started on bicalutamide 50 mg once in a day.

DISCUSSION

Bone is the most common site for metastasis in prostate cancer. Other common sites of metastasis include lung, liver, pleura and adrenal gland. Lymphatic metastasis in prostate cancer is very rare, compared to bony metastasis [3]. Lymph node metastasis even very rare when serum PSA (Prostatic specific antigen) level is less than 10 ng/ml. Supraclavicular, mediastinal, pulmonary, retroperitoneal metastasis rarely occur as the initial manifestation of prostatic adenocarcinoma. Mediastinal metastasis occur only 1% of prostatic adenocarcinoma [4]. There are reports of prostatic adenocarcinoma mimicking like lymphoma on FDT-PET scan [5].

Clinical diagnosis of metastatic prostate cancer presenting as lymph node enlargement mostly misdiagnosed as other condition like lymphoma [6]. All these patients undergo lymph node excision biopsy as part of primary investigation for generalised lymphadenopathy. It is better to advice trucut biopsy of prostate when excision biopsy of lymph node shows features of adenocarcinoma, but investigations failed to identify primary. Number of biopsy in prostate cancer makes big difference like 12 core prostate biopsy, had low detection rate of prostate cancer compared to 20 core prostate biopsy [7].

Management of generalised lymph adenopathy due to prostatic cancer is same as metastatic prostatic cancer. Most of the patient managed with orichidectomy with bicalutamide [8]. Prognosis of this patient is poor compared to prostatic cancer that spread to bone compared to lymph node.

5. CONCLUSION

Any male patient with generalised lymph adenopathy, consider metastatic prostatic adenocarcinoma as one of the differential diagnosis even patient showed features of B symptoms. Lymph node metastasis occurs in prostate cancer even with normal PSA level. This case is reported due to unfamiliar feature of prostate cancer which creates diagnostic difficulties.

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