

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

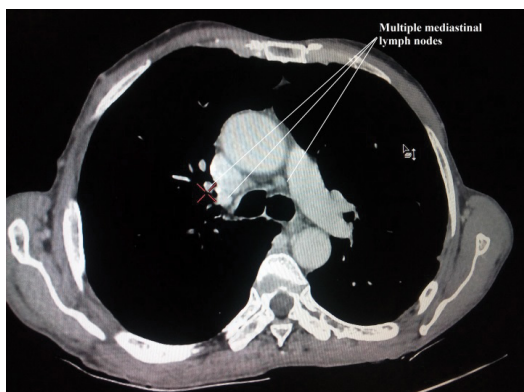


Figure 3: CT showed Multiple well defined enhancing nodes in mediastinal region.



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

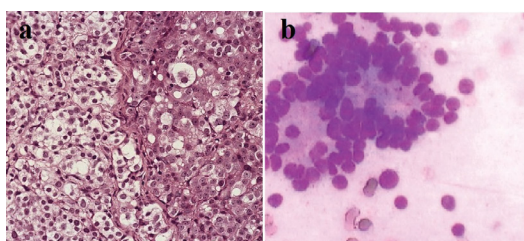


Figure 5: (a) Cervical and supraclavicular lymph node excision biopsy on the left side showed features of metastatic adenocarcinoma and (b) trucut biopsy from prostate also showed prostate adenocarcinoma.

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 orchidectomy 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.

REFERENCES

1. Chan G, Domes T. Supraclavicular lymphadenopathy as the initial presentation of metastatic prostate cancer: A case report and review of literature. *Can Urol Assoc J.* 2013; 7(5-6): E433.
2. Sepúlveda L, Gorgal T, Pires V, Rodrigues F. Prostate cancer metastatic to the cervical lymph nodes. *Case Rep Urol.* 2015.
3. López F, Rodrigo JP, Silver CE, Haigentz Jr M, Bishop JA, Strojan P, et al. Cervical lymph node metastases from remote primary tumor sites. *Head Neck.* 2016; 38(S1): E2374-85.
4. Dubhashi SP, Kumar H, Nath SR. Prostate cancer presenting as cervical lymphadenopathy. *Am J Case Rep.* 2012; 13: 206.
5. Joshi P, Lele V. Prostatic adenocarcinoma masquerading as generalized lymphadenopathy and mimicking lymphoma on FDG PET/CT: Diagnosis, staging, and evaluation of therapy response by FDG PET/CT. *Nephro-Urol Mon.* 2012; 4(2): 482.

6. Cetin B, Cetin Z, Buyukberber S, Gonul II, Sahiner I, Coskun U, et al. Generalized lymphadenopathy: Unusual presentation of prostate adenocarcinoma. *Case Rep Urol*. 2011.
7. Serefoglu EC, Altinova S, Ugras NS, Akincioglu E, Asil E, Balbay MD. How reliable is 12-core prostate biopsy procedure in the detection of prostate cancer? *Can Urol Assoc J*. 2013; 7(5-6): E293.
8. Chowdhury S, Kirby R. Advances in the treatment of metastatic prostate cancer. *The Practitioner*. 2013; 257: 15–82