

Editorial Note on Metastatic Prostate Cancer

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Editorial Note

The word 'Cancer' itself created unwanted fear among the peoples of any age group. In practice, though, most cases of prostate cancer metastasis occur in the lymph nodes and the bones. Prostate cancer metastasis occurs when cells break away from the tumor in the prostate. The cancer cells can travel through the lymphatic system or the bloodstream to other areas of the body. In theory, prostate cancer cells can spread anywhere in the body. In practice, though, most cases of prostate cancer metastasis occur in the lymph nodes and the bones.

Prostate cancer metastasis occurs when cells break away from the tumor in the prostate. The cancer cells can travel through the lymphatic system or the bloodstream to other areas of the body.

More commonly prostate cancer metastasis can occur in the:

- **Bones**
- **Lymph nodes**
- **Lungs**
- **Liver**
- **Brain**

Rare locations of prostate cancer metastasis include:

- **Adrenal glands**
- **Breasts**
- **Eyes**
- **Kidneys**
- **Muscles**
- **Pancreas**
- **Salivary glands**
- **Spleen**

Before you start any treatment, make sure you have all the information you need. It's important to think about how you would cope with the possible side effects. Speak to your doctor or nurse about this. It can help to write down any questions you want to ask at your next appointment.

could use your phone or another recording device to do this. Let your doctor or nurse know why you are doing this, as not everyone is comfortable being recorded.

A Magnetic resonance imaging (MRI) of head revealed a mass invading the left ethmoid sinus. The patient underwent left endoscopic partial ethmoidectomy and the histopathological examination suggested metastatic adenocarcinoma, with positive staining to prostatic specific antigen (PSA), and prostatic acid phosphatase (PSAP); and negative for CK7, CK20, S100, P63, Ck20, NSE, synaptophysin, neurofilament, TTF-1, GCDFP-15, CD 117, ER and Sox10. A CT scan chest abdomen and pelvis, bone scan showed enlarged prostate with diffuse metastatic lesions to the appendicular and axial skeleton. A total serum prostate specific antigen (PSA) value was 5000 ng/ml. He subsequently reported a history of rising PSA, biopsy was recommended but patient declined. Molecular profiling of tumor showed CDK12, TP53 mutation, MYC amplification, and FH (fumarate hydratase) mutation. He was treated with radiotherapy for total dose of 5040 cGy over 28 fractions and androgen deprivation with dramatic response. One year after diagnosis, the patient is alive with good quality of life.

Lastly I would like to express gratitude towards all editors, reviewers and authors for the contribution of their time and efforts towards our journal.

