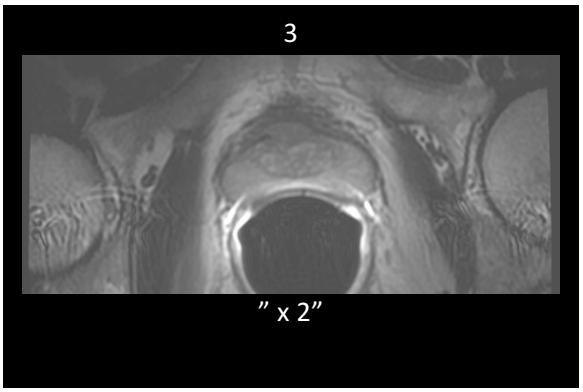
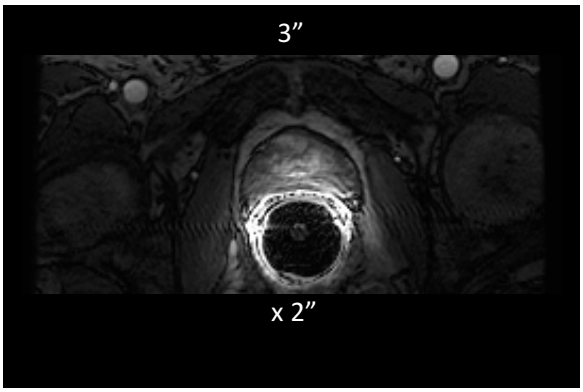
History: 58-year-old male with prostate cancer on TRUS biopsy (One core positive in the right base, GS 3+3=6. PSA of 5.3 ng/mL. He underwent a mp prostate MRI as per Active Surveillance enrollment protocol.

MpMRI **PI-RADS**

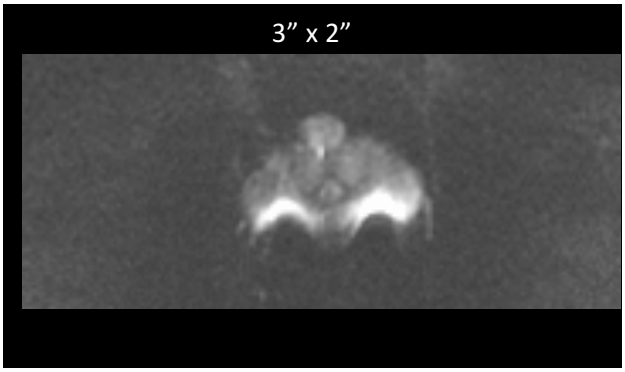
T2	5	DWI	5	DCE	Positive	Overall	5



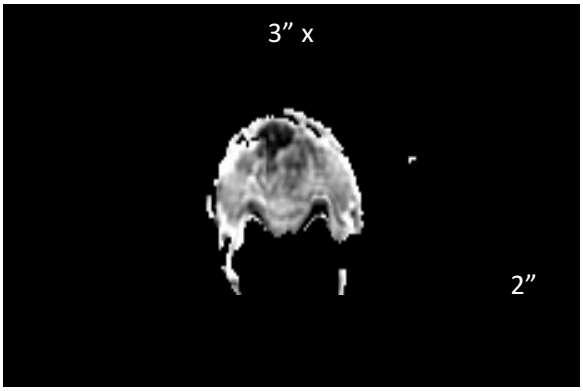
T2 3D FSE



DCE



High b value DWI



ADC map

Findings:

- T2

On the T2-weighted images, there is a 1.3cm nodular mass with diminished T2 signal mass anteriorly from base to mid gland causing anterior capsular bulge

6mm low T2 signal focus in right base laterally (not included on these films).

- DWI and ADC map

Focal restriction and bright signal on T2W lesions above.

- DCE

Dynamic enhanced contrast images demonstrate focal early enhancement in the low T2 signal foci.

Notes:

MR-TRUS fusion biopsy:

GS 7(4+3) base to mid gland far anterior , GS 6 (3+3) right base lateral on MR-TRUS fusion biopsy (not included on these films). Patient decided to undergo a robotic radical prostatectomy as per fusion biopsy results.

Radical prostatectomy:

Patient then went on to robotic radical prostatectomy that revealed as above and 6mm anterior extra prostatic extension (EPE) . However, surgical margins were negative as a wide anterior excision was performed.

Discussion:

This study nicely shows an example of an anterior capsular bulge. When reporting exams for pre-prostatectomy evaluation, anterior capsular bulge should be stated. This information is crucial for pre-operative decision to take a wide resection in sites of potential EPE. High incidence of biochemical recurrence (up to 30% in 10 years) in cases of positive surgical margins.

Teaching point:

Important to report anterior or posterior capsular bulge in staging prostate cancer.