SAR Prostate DFP interesting case
Utility of Multiparametric MRI in an exceedingly rare presentation of Metastatic Prostate Cancer

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Clinical history

• 75 yr old male with URI symptoms presented to an urgent care facility
• PMH significant for BPH
• Left supraclavicular node palpated on physical exam
• Confirmed on CT
• Biopsy non diagnostic
• FDG-PET obtained

Arrow depicts left supraclavicular node
FDG-PET selected images

• Increased uptake in right obturator region lymph node, prostate and left supraclavicular region lymph node
Additional work up

- Repeat US guided biopsy of neck node “metastatic adenocarcinoma Prostatic primary favored but radiologic correlation is recommended”
- PSA molecular marker (-)
- PSAP +
  - a tyrosine phosphatase molecular marker used by pathologists to confirm prostate origin of metastasis
- Serum PSA 5.8 No prior comparison

- mp Prostate MRI obtained
MRI Prostate: T2WI (Base to Apex):

Extensive PZ Tumor from base to apex, micropenetration thought the capsule and likely involvement of NVB
Selected images from axial diffusion weighted image ($b=1,000s/mm$) with bilateral obturator nodal involvement and the PI-RADS category 5 lesion right posterior base.
Follow up

• mpMRI helpful for determining probable prostate carcinoma
• Right external iliac lymph node core biopsy
  • Metastatic prostatic adenocarcinoma
• Bone Scan no evidence of metastatic disease
• Patient treated with androgen deprivation therapy
• 24 months later no measurable disease
Discussion

• Most commonly involved lymph nodes in metastatic prostate cancer are in the pelvis and retroperitoneum.

• The incidence of cervical lymph node involvement is reported as 0.4% and usually associated with widespread metastases as in this case.

• In one series only 5 of 9 patients with cervical metastases had elevated PSA or PSAP levels.

• Critical to perform molecular marker testing on biopsy samples to confirm prostate origin.

• mpMRI may prove helpful to confirm probable prostate carcinoma.
REFERENCES


