Celiac and perigastric lymph node metastasis of prostate cancer diagnosed with endoscopic ultrasound-guided fine-needle aspiration

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CASE PRESENTATION

An 82-year-old Caucasian man presented to his primary care physician with a 9.1 kg unintentional weight loss, decreased appetite and new-onset difficulty in voiding. Five years previously, the patient underwent suprapubic prostatectomy for benign prostatic hypertrophy, with no malignancy on transrectal ultrasound biopsies. Initial laboratory results showed abnormal levels of prostate-specific antigen (PSA) 1.57 µg/L (normal less than 0.065 µg/L), aspartate transaminase 100 U/L (normal range 5 U/L to 43 U/L), alanine transaminase 82 U/L (normal 10 U/L to 58 U/L), alkaline phosphatase 577 U/L (normal range 40 U/L to 129 U/L), total bilirubin 29.07 µmol/L (normal less than 20.52 µmol/L) and direct bilirubin 10.06 µmol/L (normal 6.84 µmol/L). The patient’s PSA level three years previously was 0.01 µg/L. An abdominal ultrasound showed normal liver parenchyma, intrahepatic biliary ductal dilation with a normal common bile duct (6 mm in diameter) without any stones or sludge within the biliary tree, a solid peripancreatic mass (1.6 cm × 2.3 cm × 1.3 cm in size) and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed tomography (CT) scan showed extensive peripancreatic and retroperitoneal adenopathy (3.4 cm in the greatest cross-sectional diameter), a dilated intrahepatic biliary tree and ascites. A subsequent computed to...
the leutenizing hormone-releasing hormone agonists leuprolide and bicalutamide. A CT scan four months after the initiation of androgen blockade therapy revealed a marked decrease in retro-peritoneal/peripancreatic adenopathy and the persistence of ascites.

DISCUSSION

The role of EUS is well-established in gastrointestinal, pancreatobiliary, and lung cancer diagnosis and staging (1). Until the introduction of EUS-FNA, only lymph node echofeatures (ie, size greater than 1 cm), echopoor appearance, distinct margins and round shape were used to predict malignant involvement of a lymph node (2). The accuracy of predicting malignant involvement of a lymph node is 80% when all four endosonographic criteria are present in a lymph node; however, only 25% of malignant lymph nodes have all four criteria (3). FNA allows for cytological evaluation of a lymph node. EUS-FNA has been found to be superior to lymph node echofeatures alone (4).

In the United States, adenocarcinoma of the prostate is the most common cause of cancer among men and the second most common cause of cancer mortality (5). Prostate cancer metastasizes hematogenously and/or lymphogenously (6). With the measurement of PSA levels and the evaluation of asymptomatic men for prostate cancer, the incidence of lymph node metastasis has decreased from 40% to 10% (7). Prostate cancer usually metastasizes to regional lymph nodes. Despite the declining incidence of lymph node metastasis, the number of patients with positive lymph nodes is still significant.

The anatomical proximity of the prostate gland to the rectum allows for the use of EUS for locoregional staging of prostate cancer (8). EUS and EUS-FNA have rarely been used to detect distant prostate cancer metastases, with only a single report of EUS-FNA of mediastinal lymph nodes (9). To our knowledge, we describe the first use of EUS-FNA to detect metastatic prostate cancer from celiac and perigastric lymphadenopathy. Celiac lymph nodes, which are located within 2 cm of the origin of the celiac trunk, may be involved with malignant (esophageal, pancreatobiliary, lung cancer and lymphoma) as well as benign diseases (pancreatitis, infections, autoimmune hepatitis and sarcoidosis). Cytology with immunohistochemical staining of FNA samples for tumour markers allowed for the correct diagnosis in the present, unusual case of metastatic prostate cancer. We recommend routine sampling of abnormal-appearing lymph nodes as well as immunohistochemical staining to reach the correct diagnosis.

REFERENCES
