developed retention of urine. Per rectal examination revealed a hard nodular prostate. USG abdomen showed cholelithiasis, multiple calcific foci in the spleen and dense calcification in the prostate with residual urine of 260 cc. Uroflowmetry showed bladder outflow tract obstruction. PSA levels were high (62.3). Prostatic biopsy revealed poorly differentiated prostatic carcinoma showing positivity for PSA on immunohistochemistry. On reassessing the pleural biopsy in the presence of prostatic carcinoma, the pleural lesion was thought to be metastatic rather than primary although PSA staining was negative on the pleural tissue. Bone scan revealed a suspicious area in the left intertrochanteric area. A final diagnosis of poorly differentiated prostatic cancer with metastatic pleural disease and bone metastasis was made. The patient was given chemotherapy along with flutamide. A bilateral orchidectomy was done. He was advised regular follow-up. Clinical and radiological improvement was seen at the time of the six months follow-up.

Prostatic cancer is known for its varied patterns of dissemination. Pulmonary metastases from prostatic carcinoma are common; however, the nodular lesions readily identified on thoracic roentgenograms are usually asymptomatic. A previous review showed that pulmonary metastases from prostate adenocarcinoma are found at autopsy in 25% to 38% of patients but are evident on chest films in only 5.5% to 6.7%. Intrathoracic involvement of metastatic adenocarcinoma of the prostate may appear on roentgenograms as parenchymal nodules (84%), mediastinal adenopathy (12%) or lymphatic spread (4%); pleural involvement is the second rarest site after the adrenals among the soft tissue metastases. Pulmonary secondaryaries secondary to prostatic carcinoma are amenable to anti-androgen therapy or orchidectomy with prolonged symptomatic remission.

Immunocytochemistry by PSA is a sensitive and specific method of detection of metastatic prostatic adenocarcinoma, but there have been case reports showing that it can be negative in some cases. Therefore, it should not be taken as a confirmatory test.

Gogia A, Agarwal PK, Vasdev N*, Sachar VP
Departments of Medicine and *Pathology, Sir Ganga Ram Hospital, Rajinder Nagar, New Delhi - 110 060, India.

Correspondence:
Atul Gogia, E-mail: atulgogs@rediffmail.com

References


PubMed ID: 15623982

Carcinomatous meningitis occurring prior to a diagnosis of large cell neuroendocrine carcinoma of the uterine cervix

Sir,

A 39-year-old lady presented with deviation of the angle of mouth to the right side, left-sided decreased hearing, dysphagia and dysarthria of three months duration associated with left-sided headache. There was no history of fever or ear discharge. On examination, optic fundi were normal. Left-sided lower motor neuron type of facial palsy, sensori-neural deafness, reduced pharyngeal sensations, impaired palatal movements and absent gag reflex were noted. The rest of the neurological examination was unremarkable.

Routine haemogram was normal and erythrocyte sedimentation rate was 130 mm/hour. Serum alkaline phosphatase was 208 U/L (normal range 40-125 U/L). Post-gadolinium magnetic resonance imaging (MRI) of the brain showed diffuse pachymeningitis (Figure 1), without parenchymal lesions. Cerebrospinal fluid (CSF) analysis showed leucocyte count of 2/cmm, protein 44 mg% and sugar 67 mg%. Bacterial and fungal cultures, TB-PCR, and smear for acanthamoebae in the CSF were negative. CSF cytology showed a few atypical cells, however, malignant cells were absent. Therefore, bone marrow examination was done, which showed metastatic carcinoma (Figure 2). Gynaecological examination done as part of the search for possible primary showed features of carcinoma cervix. Histopathological examination confirmed the cervical tumour to be large cell neuroendocrine carcinoma.

Carcinomatous meningitis (CM) occurs in 5% of all adult can-
Figure 2: Bone marrow trephine biopsy infiltrated by a tumour composed of insular clusters of cells displaying numerous mitoses and peripheral palisading of nuclei (H/E x90)

ner patients, often in the advanced stage.\(^1\) Carcinoma cervix rarely leads to CM.\(^2\) Our patient presented with multiple cranial nerve palsies, which is a relatively common neurological condition encountered in practice. MRI brain showed features of pachymeningitis, which is not specific for any particular aetiology. Diffuse meningeal enhancement on MRI can occur due to a wide variety of conditions, which include infectious (bacterial, fungal, tuberculous, etc.), inflammatory (sarcoidosis, collagen vascular diseases, etc.), carcinomatous (cancer-related), reactive (due to surgery, shunt or trauma), and chemical (due to ruptured cysts or intrathecal chemotherapy) causes.\(^3\) Though the exact aetiology can often be determined on the basis of history, clinical examination, CSF analysis and other investigations, it could be challenging at times. However, it is vital to identify the aetiology in order to institute the correct treatment. CM usually occurs in patients with known cancer. Therefore, it should be suspected in patients with a history of malignancy, who present with an isolated neurological sign or symptom. However, confirming a diagnosis of CM might prove to be difficult. Repeated CSF analysis for detecting neoplastic cells is advised, as a single lumbar puncture might yield negative results.\(^4\) Our patient did not show neoplastic cells even after three lumbar punctures. Though MRI findings are non-specific, it has been suggested that patterns of meningeal enhancement vary in different aetiologies. Infectious meningitis often results in leptomeningeal (pia and arachnoid) enhancement, when enhancement of the meninges follows the convolutions of the gyri and/or involves the meninges around the basal cisterns; whereas carcinomatous meningitis causes pachymeningeal (dura) enhancement, when the enhancement is thick and linear or nodular along the inner surface of the calvarium, falk, or tentorium without extension into the cortical gyri or basal cistern involvement.\(^5\)

Common sites of distant metastases in carcinoma cervix are liver and lung parenchyma. Brain metastases from cervical carcinoma are uncommon and occur in only 1% of all cervical carcinoma.\(^7\) The median interval between the diagnosis of cervical cancer and documentation of brain involvement is 18 months,\(^7\) however, occasionally, this can be as short as one week.\(^8\) In our patient, the detection of neurological disease preceded the diagnosis of carcinoma cervix. To the best of our knowledge, this has not been reported before.

In conclusion, the present case highlights the difficulty in diagnosing CM, especially in a patient previously not known to have a malignancy. It also emphasizes the importance of simple procedures such as bone marrow biopsy and gynaecological examination in women presenting with features suggestive of pachymeningitis, in disclosing an unknown malignancy.

Kumar S, Nair S*, Alexander M
Departments of Neurological Sciences and *Pathology, Christian Medical College, Vellore - 632004, Tamilnadu, India.

Correspondence:
Sudhir Kumar. E-mail: drsudhirkumar@yahoo.com

References

Post coital hematuria: presentation of an uncommon case

Sir,

Isolated post-coital hematuria without hemospermia is a rare clinical presentation. It is usually benign and the aetiology is often not diagnosed despite extensive investigations. We recently encountered such a case where the aetiology was diagnosed after extensive, and possibly unnecessary evaluation; and the patient was being successfully managed using the holmium laser.

A 33-year-old male presented with complaints of hematuria after coitus for the past five years. Hematuria used to occur only once after the act and recurred every few weeks. It was painless and the patient did not have any history of hemospermia. He was married 10 years back and had two children. General and systemic examinations were unremarkable. Urine, biochemical and semen examination were normal with complete absence of red blood cells in the semen. Urine cytology for malignant cells, stain for acid fast bacilli and Polymer-