LUNG AND BONE METASTASES

A 67-year-old man presented initially with complaints of longstanding backache and more recent neck pain. He gave no history of urinary or other problems. On examination he was frail. Mild rhonchi and a 3/6 ejection systolic murmur were audible in the chest. On rectal examination, he was noted to have a slightly enlarged prostate gland. The haemoglobin concentration and white cell count were normal, but the erythrocyte sedimentation rate was 76 mm/1st h. The serum creatinine level was subnormal, alkaline phosphatase was 850 U/l (normal range 30 - 115 U/l) and lactate dehydrogenase 458 U/l (normal range 100 - 350 U/l). Chest (Fig. 1, a and b) and lumbar spine (Fig. 2) radiographs were suggestive of metastatic disease. An ultrasound scan of the upper urinary tracts was normal. He then underwent an examination under anaesthetic and biopsy of a hard nodule in the right lobe of the prostate. This revealed only benign hypertrophy. Sputum examination was normal.

Six weeks later he presented with urinary retention of 1 week’s duration. At this time he was thin, with bilateral hard inguinal nodes present. The prostate gland felt firm. An ultrasound scan of the upper urinary tracts was again normal. Urea and creatinine levels were not elevated. The acid phosphatase level was 28.9 ng/ml (normal range 0 - 4 ng/ml). Cystoscopy was performed, and the left lobe of the prostate and the inguinal glands were biopsied. The prostate biopsy was highly suspicious for malignancy and the inguinal glands demonstrated adenocarcinoma, probably of prostatic origin. The patient underwent bilateral orchidectomy.

One year later he presented with bilateral lower limb weakness, with a T8 level neurologically. After investigation he was given radiotherapy to the T5 - T10 level, but remained bedridden. He was readmitted 10 months later with gross haematuria, confused and in pain, and died 2 days later.

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Fig. 1, a and b. Bilateral linear/nodular lung opacification with areas of confluence. Note bone changes, including thoracic vertebral sclerosis seen on the lateral chest radiograph.

Fig. 2. Lateral lumbar spine demonstrates widespread lytic and sclerotic foci.