Case Presentation

- Mr. S., aged 70yrs, retired teacher, came with c/o frequency of micturation and burning sensation since a week in December 2005. (Outside Hospital)
- Patient had been experiencing intermittent dysuria since 2 months.
- No other significant history
- Known hypertensive on medication

- Initial evaluation, DRE – fullness of prostatic fossa, nodule + (3x2cm). PSA = 9 ng/ml
- Patient was posted for TURP
- Initial HPE done - Moderately differentiated Adenocarcinoma. Gleason Score 3+3=6.
- Eventually was posted for b/l orchidectomy
- Was started on T. Cytomed 250mg.

  Patient consumed it for 3 months, then stopped as PSA normalised

- **Patient was on continuous f/u –**

PSA (Dec 2006) – 0.55

bone scan – normal

USG abd – prostate size – 2.6x3.8x2.6.
Prevoid urine – 278ml, postvoid – 113ml

- In Jan 2007, patient again developed c/o dysuria and frequency.
- O/E – KPS – 90,

  no pallor, icterus, pedal edema, lymphadenopathy

  P/A – soft, no organomegaly or mass p/a

  P/R – fullness in prostatic fossa – 4x3cm. No induration

  no bony tenderness

- **Investigations done revealed**

- **USG abd & pelvis – mildly enlarged prostate – 3.6x4x3.5 cm. Weight – 28gm heterogenously echogenic parenchyma with protrusion of median lobe - ? Recurrence.**

- **Patient again underwent channel TURP and BNI (Bladder Neck Incision) in Feb 2007.**

- **Started on T. Calutide 50mg daily**

- After 4 months, on f/u
- P/R – nodule of 3x4 cm in prostatic fossa. Induration +

PSA (June 2007) – 1.34 ng/ml (Dec 2006 - 0.55)

Bone scan – normal

USG Pelvis – size – 4.1x5.4x4.2 cm. wt – 48gm (↑)

Prevoid – 341ml, Postvoid urine – 63ml

with irregular outline and heterogenous parenchyma

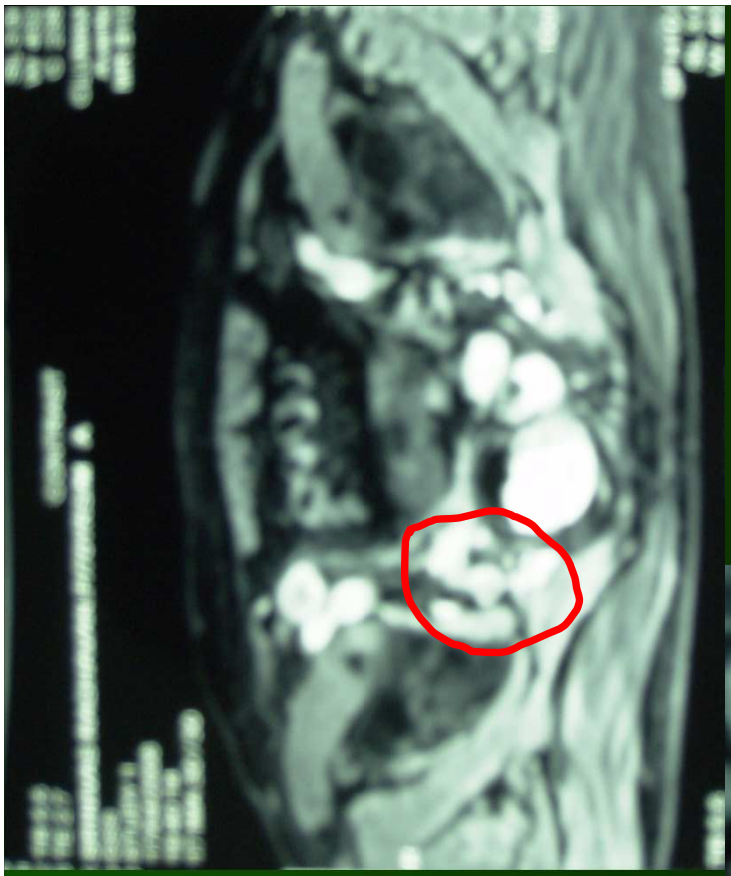
MRI –

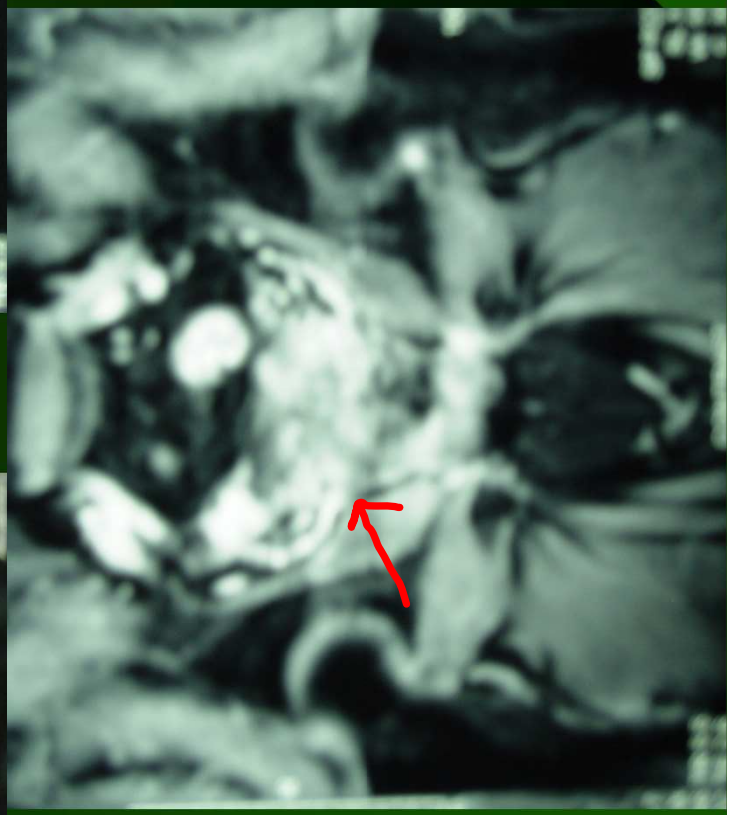
prostate mildly enlarged with lesion involving the postero right lateral portion of peripheral zone and central zone of prostate

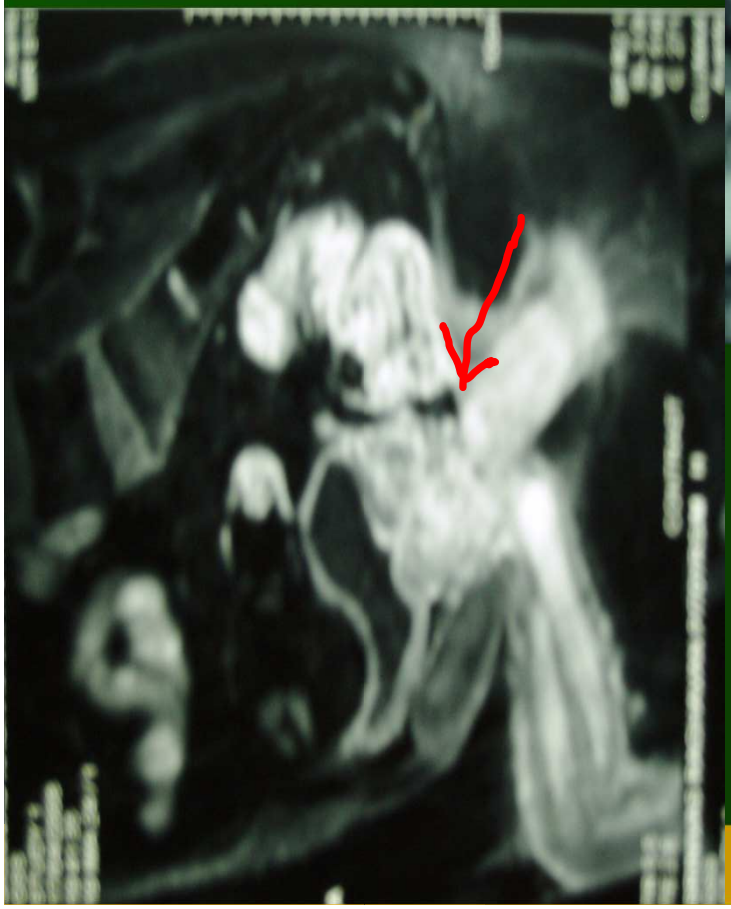
extension into periprostatic soft tissues

enlarged nodes within right external and internal iliac regions

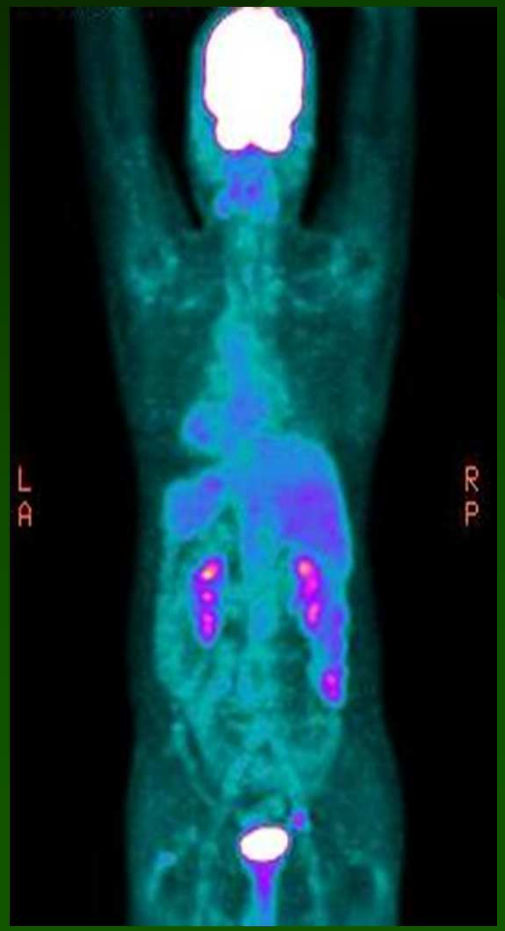
sub-centimetre sized nodes noted within left external iliac region

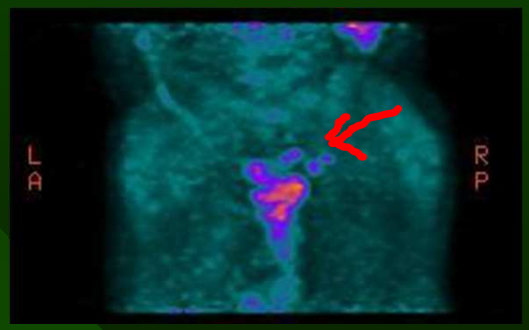


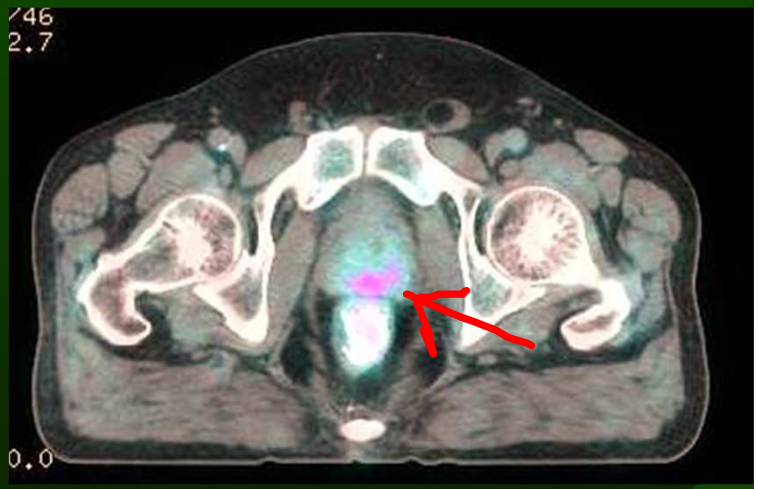


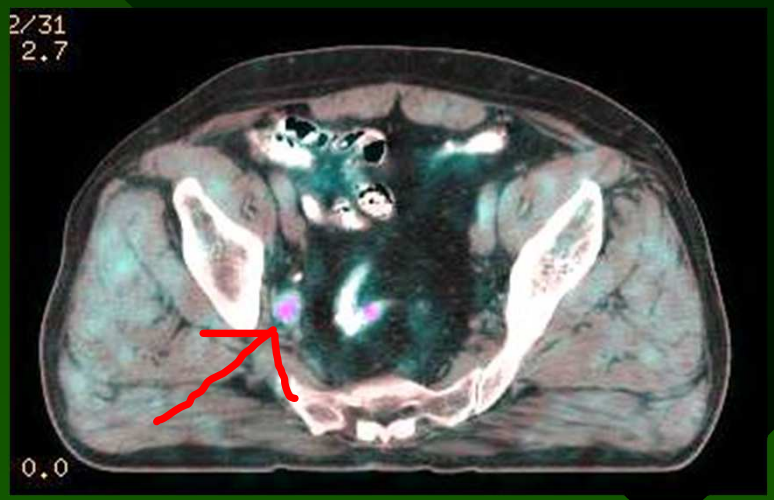


- **PET/CT –**
- **Confirmed locoregional disease with no extrapelvic extension**









Issues

- Initial management ???
- WHAT NEXT …

Risk Stratification

- Low risk – T1-2a & GS – 2 - 6 & PSA <10ng/ml
- Intermediate risk – T2a - 2b OR GS – 7 OR PSA – 10 - 20ng/ml
- High risk – T3a OR GS – 8-10 OR PSA > 20ng/ml
- Very high risk – T3b,T4 (locally advanced)
- Metastatic – Any T, N1 or Any T, Any N, M1

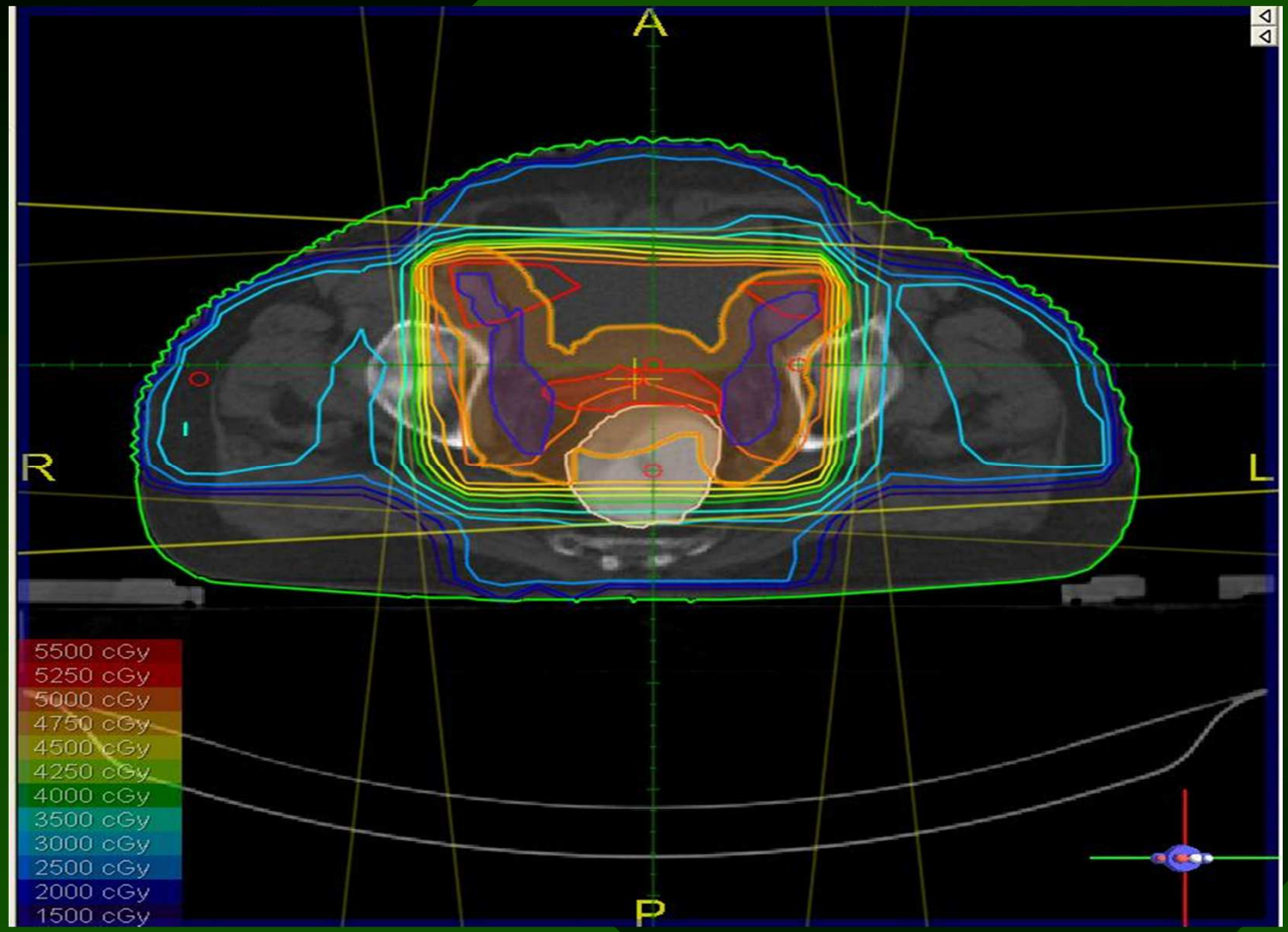
- ***High Risk*** **– ADT(2-3yr) + RT(3DCRT/IMRT) (Cat 1) or**

  RT ± neoadjuvant & concurrent short term ADT or

  Radical prostatectomy + PLND (selected low volume / no fixation cases)

- ***Nodal Metastatic*** **– ADT or**
  (Any T, N1)

  RT (3DCRT/IMRT) + ADT



- **3DCRT to a dose of 70Gy/35Fr delivered over 7 weeks with a shrinking field technique. Patient developed Grade II dermatitis in perianal region. Radiation cystitis +. No gap in treatment**

Follow Up Details

- DRE, PSA part of routine f/u at 3,6,9 months Post RT. Then every 6 mths till 3yrs. Then annually.
- Bone scan only when indicated
- CT/MRI not usually recommended during routine f/u

- PSA nadir (lowest level) might take time to achieve (sometimes 3 yrs)
- PSA nadir of 0.5ng/ml – good outcome

- PSA failure following RT (RTOG/ASTRO consensus) – 2ng/ml above post treatment nadir values
- PSADT – for local failure – 13months

  for distant failure – 3 months

- 3rd month F/U post RT –

  O/E – status Quo

  PSA – 0.469ng/ml

  USG pelvis – size – 4.3x3x1.3cm.
  Postvoid urine – 21cc

- Last f/u (April 2008) – L/E – status Quo
  PSA – 0.22ng/ml


Thank You