Three patients with prostate masses

Dr. Patrick Manshimba

Dr Dawn Balang

Dr Memory Nsingo

18 October 2016

BOTSOGO

BOTSWANA ONCOLOGY
GLOBAL OUTREACH

Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2016-2017 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.

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Statements

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This activity meets the criteria of the Massachusetts Board of Registration in Medicine for 1.0 credits of Risk Management Study

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- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey after the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
  - Click “What We Do”
  - Click “Tumor Board”
  - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- Or follow the link that was emailed to our MGH BOTSOGO email list: www.tinyurl.com/tumourboard

Case 1 history

- 68 YOM
- April 2016, noticed blood urine accompanied with dysuria for which he consulted at DRM where a urethral catheter was inserted and the patient referred to PMH.
- May 2016, patient was admitted at PMH and referred to GPH for a prostate biopsy that confirmed a prostate ?

History cont

- In June 2016, was referred to RSA for bone scan that came negative to metastasis.
- PSA done 21.68, and the patient received 2 doses zoladex + casodex.
- Currently, no catheter nor passing blood urine.

Seronegative in June 2016

- No history of cancer in their family
- history of HTN,D.M
- No known allergies
- medication: paracetamol, morphine,dulolax,antihypertensive,OAD.
- Former smoker & alcohol.
- married.

Histopathology

Features confirm an invasive prostatic adenocarcinoma corresponding to gleason score 6 (3+3)

Imagings

USS ABDOMEN &PELVIS(Late May 2016): normal liver ,GB , both Kidney. Enlarged prostate. Normal U/bladder

- Bone scan (Late June 2016) no skeletal metastases

Laboratory

PSA 11.10 Late June 2016

Examination

Stable Patient, alert, oriented. With stable vitals signs.

- Good nutritional status. No weight lost
- CVS: S1, S2 Normal,
- Chest Clear air entry bilaterally.
- HEENT :NAD
- Abdomen soft not distended no organomegaly no mass
- Breast NAD

Conclusion

68YOM RVD negative, hypertensive, diagnosed with ca prostate GS 6(3+3) high risk

Treatment

EBRT

ADT

Discussion and questions

Discuss the role of ADT in this patient

Continue antiandrogen?

Case II History

Mr. GM , 90 year old male

Former civil servant

Non smoker and occasional drinker

Blind x ~10 yrs, history of bilateral cataract surgery

Hypertension

Benign Prostatic Hyperplasia diagnosed 2013

History

Said to have been diagnosed with prostate cancer 2014 (South Africa),

Presented with

-Nocturia x 4-5 , good stream, no frank haematuria

History cont

-Elevated PSA 17.8 ng/ml

- CT scan showed “a scar in one of the lungs”

-No biopsy

Referred to Urologist

Referred to local urologist for monitoring

2013 - 2015 no significant change in PSA

April 2015- PSA 39 ng/ml

-started on Zoladex 10.8 mg sc 3mnthly + Casodex 50mg od

October 2015- PSA 0.5 ng/ml

-remained well. No change in LUTS

October 2016

Fever

Severe lower back pain

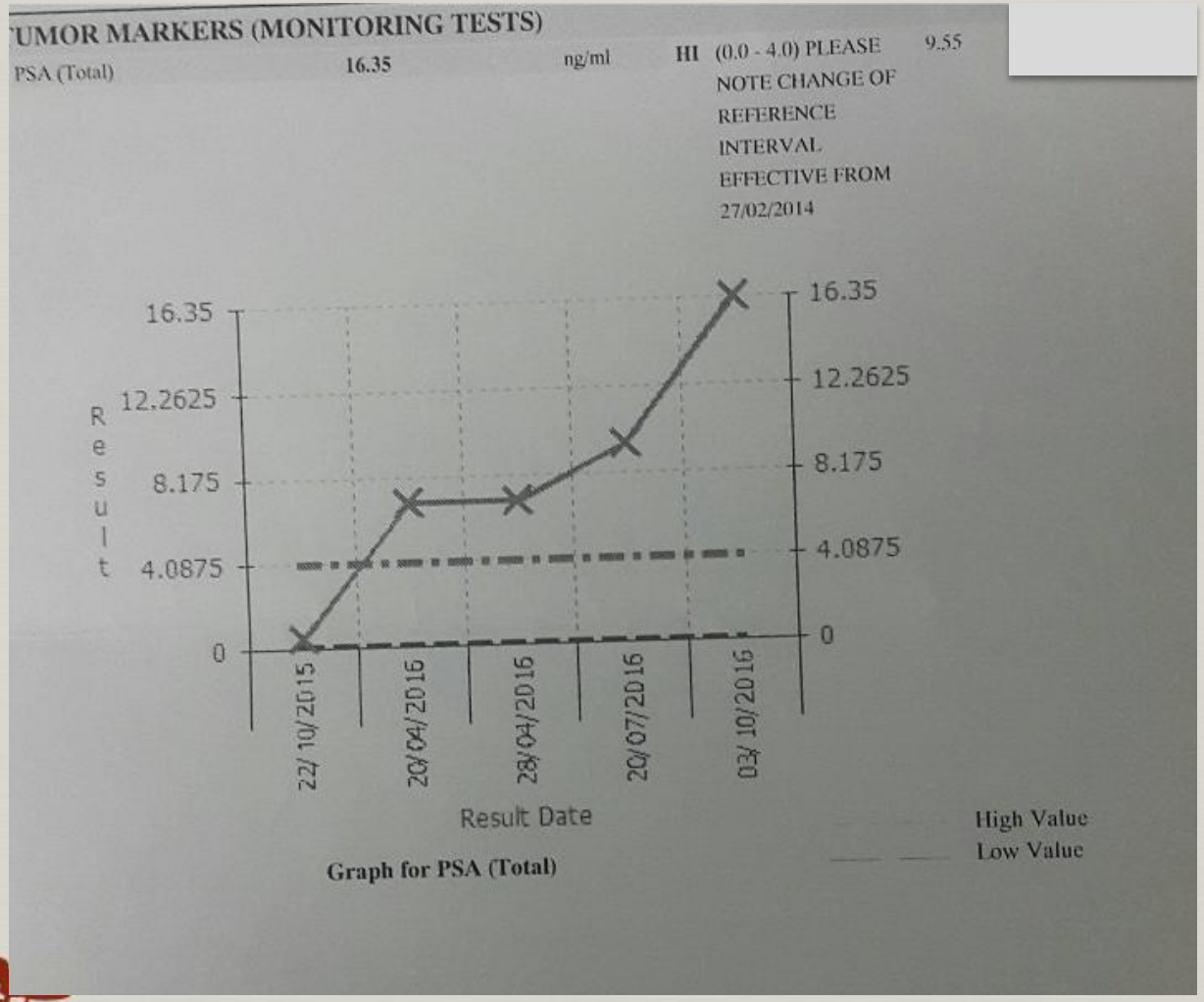
No change in LUTS

Treated with antibiotics by GP→ better

Given Zoladex 10.8 mg s/cut 02/10 ; Casodex continued

Referred to Oncologist October 2016 by urologist with ‘rising PSA ‘

Rising PSA


TUMOR MARKERS (MONITORING TESTS)
PSA (Total) 16.35 ng/ml HI (0.0 - 4.0) PLEASE NOTE CHANGE OF REFERENCE INTERVAL EFFECTIVE FROM 27/02/2014 9.55
16.35
12.2625
8.175
4.0875
0
Result
22/10/2015
20/04/2016
28/04/2016
20/07/2016
03/10/2016
Result Date
High Value
Low Value
Graph for PSA (Total)

October 2016

PSA 16.35

Physical Examination

Comfortable, pleasant elderly gentleman escorted by daughter

PS 1

No palpable adenopathy

Chest clear

Abdomen-soft , non tender

DRE- Enlarged firm prostate, smooth

- no medial furrow palpable

Medications

Medication

-Aspirin

-Doxazocin

-Enalapril

-Casodex 50 mg OD

-Zoladex 10.8 mg last given 2/10/16 prescribed by urologist

CT scan October 2016

Healed inflammatory granuloma right lung (12mm)

Severe degenerative changes and disc disease

No bone / visceral metastasis

Moderate prostatic enlargement protruding into the bladder base

Discussion

Is there a level of PSA which is ‘diagnostic’ of Ca prostate?

Which other tumours can be diagnosed based on tumour marker alone ie without biopsy?

When is it necessary to do biopsy in setting of ↑ PSA ?

Discussion

Differential diagnosis of elevated PSA

At 90, does Mr G warrant a biopsy

Should ADT be continued?

Case III: History

Mr. DD , 78 year old male

Former businessman

Non smoker and stopped drinking 1967

Presented in 2013 with symptoms of bladder outlet obstruction.

PSA was 8.

Needle biopsies confirmed ca prostate, Poorly differentiated adenocarcinoma, Gleeson 9

In 5% of volume of entire specimen.

Watchful waiting was advised

4 months later PSA 10

Referred to SA for Urologist surgical opinion

Said to be inoperable

Had bilateral orchiectomy in October 2013

PSA noted to rise in June 2016

PSA 5.26

Started on casodex 50mg daily.

Referred to Oncologist

Examination and staging

Well gentleman PS0.

Hypertensive and diet controlled diabetes

Life expectancy >10years

No significant findings on examination

No metastases

Renal function, liver function tests good

FBC normal

Still high risk with Gleeson 9

Commenced on radiation

Discussion

Who is the right candidate for watchful waiting

Gleeson score interpretation

Orchiectomy and side effects.

Role of ADT after orchiectomy