



RE: CARCINOMA OF THE PROSTATE PRESENTING AS INGUINAL ADENOPATHY

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Prostatic carcinoma disseminates by direct invasion, venous channels, and lymphatic channels. Lymphatic spread is most commonly to the pelvic nodes in general and the obturator nodes in particular.¹ Secondary spread is to the para-aortic and mediastinal nodes. The supraclavicular lymph nodes may be involved and this has been reported as the initial presentation of prostatic carcinoma.² There have been several cases of metastatic prostate cancer to an inguinal node years after diagnosis,^{3,4} but this has not, to our knowledge, been previously described as a presenting sign.

We present a rather unusual case of adenocarcinoma of the prostate presenting as inguinal adenopathy, which showed a dramatic response after orchiectomy.

A 60-year-old man first presented in March of 1984 with a two-month history of a painless left inguinal mass. A 4.0 × 4.4 × 2.0-cm mobile, nontender left inguinal node was noted. Rectal examination revealed an enlarged, firm, and fixed prostate consistent with stage C adenocarcinoma. Serum acid phosphatase level was 0.8 IU/L (normal 0.0–0.9 IU/L). A CT scan showed a left inguinal mass and no discernible pelvic adenopathy. Excisional biopsy had shown a moderately differentiated adenocarcinoma almost completely effacing the lymph node. Immunoperoxidase stains were positive for prostate-specific antigen. Prostatic biopsy confirmed moderate to poorly differentiated adenocarcinoma. Approximately 18 months later he presented with new onset of left leg edema and recurrence of inguinal adenopathy. Acid phosphatase level was now 2.9 IU/L and a CT scan showed regrowth of the left inguinal mass as well as mas-

sive left pelvic adenopathy. Palliative bilateral orchiectomy was performed. Six months later the adenopathy and edema had almost completely resolved clinically. The acid phosphatase level fell to the normal range and a CT scan in April 1987 revealed no discernible pelvic adenopathy and a very small left inguinal node. The patient has shown no evidence of relapse 18 months post-orchiectomy.

Inguinal adenopathy usually results from infections or neoplasms of the external genitalia or legs. Sexually transmitted diseases that may cause inguinal adenopathy include gonococcal urethritis, primary syphilis, herpes genitalis, chancroid, and lymphogranuloma venereum. Notably, granuloma inguinale causes granulomatous lesions, called pseudobuboes, in the inguinal area and does not primarily involve the inguinal nodes. Nonvenereal infections include streptococcal cellulitis of the lower extremities and abdominal wall, bubonic plague, brucellosis, tuberculosis, tularemia, cat-scratch disease, and infectious mononucleosis. Malignant conditions that cause inguinal adenopathy include lymphoma, melanoma, and penile, urethral, vulvar, and distal vaginal carcinoma.⁵ We add prostatic carcinoma to this list.

Inguinal lymph-node involvement from carcinoma of the prostate may be hypothesized to arise from direct spread retrograde from the pelvic nodes. The initial CT scan of the pelvis in our case revealed no pelvic adenopathy. Skip nodal metastases may account for this process but are uncommon; it is more likely that he had microscopic pelvic nodal metastases.

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