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CHOLESTATIC SYNDROME DUE TO LYMPH NODE COMPRESSION RESULTING FROM METASTATIC PROSTATE CANCER; CASE REPORT

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Abstract: Objective: to report and discuss a case of cholestatic syndrome due to lymph node compression resulting from metastatic prostate cancer. Case report: JPS, male, 74 years old, with systemic arterial hypertension and dyslipidemia, was referred for evaluation of hepatomegaly and was being treated for prostate adenocarcinoma. Discussion: Metastatic prostate cancer (MPC) can present with a variety of nonspecific symptoms or symptoms related to the site of metastatic installation. Conclusion: cholestasis due to lymphodomegaly due to metastasis is uncommon, but should be considered in the differential diagnosis.
Keywords: cholestasis; lymph node enlargement; prostate; adenocarcinoma; metastasis.

INTRODUCTION

Prostate cancer (PC) is the most common malignant tumor in men and early diagnosis of the disease is crucial for a cure. Evolution with metastasis increases mortality, and may spread to bones, lungs, liver and lymph nodes. Lymph node enlargement can cause compression of structures, including the bile duct, and extrahepatic cholestasis secondary to prostate cancer metastasis is an uncommon finding.

OBJECTIVE

Report and discuss a case of cholestatic syndrome due to lymph node metastasis of PC, treated at a tertiary hospital in Goiânia.

CASE REPORT

JPS, male, 74 years old, former farmer, from Cristalina-GO, suffering from systemic arterial hypertension and dyslipidemia, was referred to the gastroenterology outpatient clinic of the Hospital das Clínicas of the Federal University of Goiás (HC - UFMG/EBSERH) for evaluation of hepatomegaly.

He was undergoing treatment for prostate adenocarcinoma, having undergone thirty-six radiotherapy sessions (last in 2012). At the first consultation, the patient reported nodulations in the right hypochondrium, scleral jaundice, choluria, hyporexia and loss of 12 kg in two months. He denied fecal acholia, steatorrhea, or pruritus. There was a family history of prostate cancer (brother) and lung cancer (mother and sister). On physical examination: pale (+/4+), jaundiced (2+/4+), with a globular and diffusely painful abdomen.

On palpation of the right hypochondrium, a cystic point nodulation and an enlarged liver were identified, six centimeters from the right costal margin. The Courvoisier-Terrier sign was positive. Laboratory tests: total prostate specific antigen 5.13ng/mL; hemoglobin 13.1g/dL; hematocrit 37.8%; total bilirubin 8.99mg/dL; right bilirubin 6.7mg/dL; indirect bilirubin 2.29mg/dL; alkaline phosphatase 1500U/L; gamma glutamyltransferase 700U/L; aspartate aminotransferase 157U/L; alanine aminotransferase 171U/L; creatinine 1.2mg/dL. Admitted on 06/12/2019 for diagnostic clarification. During the hospitalization period, he developed increased hepatomegaly (10 cm from the costal margin), choluria, fecal acholia and a drop-in blood pressure level. Computed tomography revealed lymph node enlargement generating compression of the extrahepatic bile ducts and dilation of the intrahepatic bile ducts and gallbladder, in addition to multiple bone metastases. Patient was transferred to oncology hospital for appropriate treatment.

DISCUSSION

Metastatic prostate cancer (MPC) can present with a variety of symptoms that are nonspecific or related to the site of metastatic installation. The occurrence of obstructive jaundice as a component of CPM is not common and has been described in previous studies due to three mechanisms causing compression: lymph node enlargement, as in this case, installation of the site in the head of the pancreas and the appearance of a retroperitoneal mass. Differential diagnosis should include infectious diseases, mechanical obstruction and paraneoplastic syndrome.

CONCLUSION

Biliary obstruction due to lymph node enlargement due to prostate cancer metastasis, although uncommon, should be considered in the differential diagnosis of cholestatic syndrome in an elderly or middle-aged male patient.

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