

Supraclavicular Lymphadenopathy - Initial Manifestation of Prostatic Carcinoma

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To the Editor,

This is in reference to the article "Left cervical lymph node metastasis – An initial presentation of prostatic adenocarcinoma" published in *Journal of Cytology* volume 23,1. We wish to share our experience with a similar case.

The most common sites of metastatic spread of prostatic carcinoma are the regional lymph nodes and bones of the pelvis and axial skeleton. Enlarged lymph nodes, usually pelvic but rarely left supraclavicular or axillary can sometimes be a presenting symptom.

A fifty five year old male presented with a mass in the left side of neck present since 20 days. It measured 1.5 cm in diameter and was firm. Patient gave history of loss of weight and difficulty in evacuating bladder, which was present since 3 to 4 years.

Fine needle aspiration cytology performed from the lymph node showed cellular smears showing epithelial cells in sheets, clusters and in acinar pattern (Fig 1). The nuclear chromatin was fine and the cytoplasm moderate in amount. A diagnosis of metastatic adenocarcinoma was offered. Per-rectal examination revealed nodular hard prostate. Ultrasonography showed a nodule in the prostate. No enlarged pelvic nodes were seen. PSA levels were 642 ng/ml. Prostatic biopsy showed features of adenocarcinoma of prostate (Fig 2). A final diagnosis of prostatic adenocarcinoma with distant metastasis was made. Patient underwent bilateral orchidectomy two weeks after the biopsy and was put on hormonal treatment.

Cervical and supraclavicular lymph node involvement has been reported in 0.4% to 1% of all cases of metastatic prostate cancer.¹ However cervical lymphadenopathy as the initial presentation of prostatic carcinoma is rare. In supradiaphragmatic spread of carcinoma prostate, it has been postulated that tumour cells lodge in the nodes, which are close to the entry of thoracic duct into left subclavian vein by retrograde spread.²

Fine needle aspiration is recommended to determine the diagnosis because it has high sensitivity and specificity and can be easily performed. Possibility of prostate carcinoma should always be considered in the differential diagnosis of elderly men with cervical lymphadenopathy, even in the absence of lower urinary tract symptom. Once the diagnosis is established hormone treatment has been shown to be of benefit

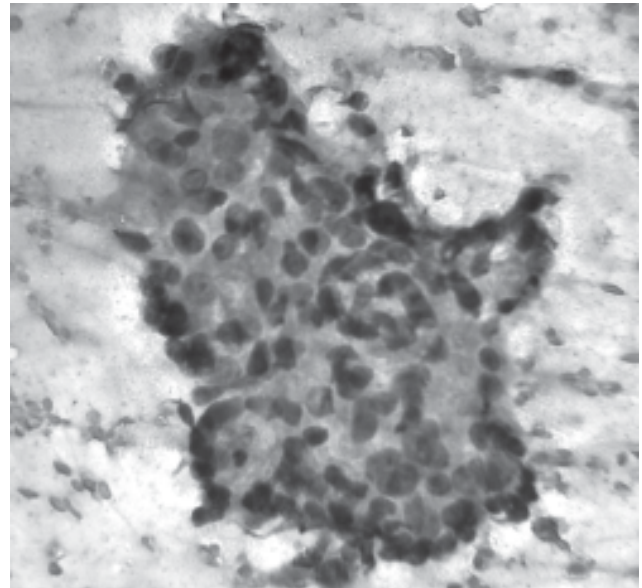


Fig. 1 : Smears show epithelial cell cluster with cells forming acini (MGG, x 400).

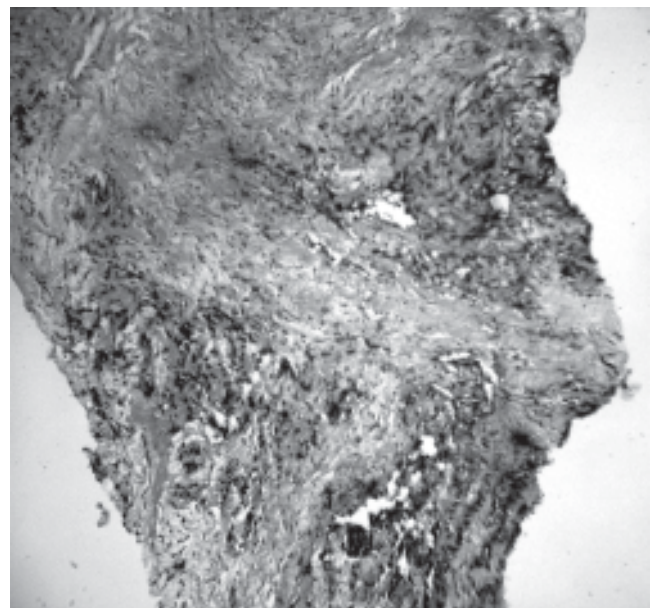


Fig. 2: Prostatic biopsy sections show features of adenocarcinoma (H&E, x 100).

even in patients in the advanced stages of the disease.³

References

1. Saitoh H, Hida M, Shimbo T, et al. Metastatic patterns of prostate cancer. *Cancer* 1984; 54:3078-84.
2. Wang HJ, Chang PH, Peng JP, Yu TJ, Yu. Presentation of prostatic carcinoma with cervical lymphadenopathy: report of three cases. *Chang Gung Med J* 2004; 27:8404.
3. Goktas S, Crawford ED. Optimal hormonal therapy for advanced prostatic carcinoma. *Semin Oncol* 1999; 26:162-73.

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Microfilariae in Cytological Smears of Hepatocellular Carcinoma Journal of Cytology 2007; 24 (3) : 158-159

To the Editor,

Filariasis is a major public health problem in tropical countries like India, with *Wuchereria bancrofti* (*W. bancrofti*) being the most common filarial infection accounting for about 95% of the total filarial infections.¹ The conventional diagnosis of filariasis rests on the presence of microfilariae in peripheral blood smear, however incidental detection of microfilariae in various cytologic specimens have also aided in the diagnosis of unsuspected cases.² Microfilariae have been reported in fine needle aspiration cytology (FNAC) of various organs, but very rarely in liver.²⁻⁴ To the best of our knowledge, not more than 4 cases of microfilariae in liver have been reported and in only one of the cases microfilariae were coexisting with the malignant neoplasm in liver.²⁻⁴ We report one more case of microfilariae coexisting with hepatocellular carcinoma detected on cytology.

A 35-year-old man presented to our hospital with history of mass in the abdomen and loss of appetite over a period of 5 months. He had continuous throbbing pain in the right hypochondriac area for the last 2 months. Physical examination revealed jaundice, pallor and tender hepatomegaly. Liver was palpable 6 cm below the right costal margin. Laboratory investigations revealed haemoglobin of 8.4 gm/dl, total leucocyte count - 10.2×10^9 /L, with 7% eosinophils. Total serum bilirubin was 14 mg/dl. Alanine aminotransferase and aspartate aminotransferase were 52 U/L and 72 U/L respectively. Alkaline phosphatase was 504 U/L, prothrombin time was prolonged, and HBsAg was negative. Ultrasound examination of the abdomen revealed a large solitary hyperechoic mass in the liver measuring 10x8x6 cm with ill defined margins, dilatation of common bile duct and minimal ascitis. Clinical and radiological diagnosis of hepatic tumour was offered and patient was referred for ultrasound guided FNAC. The aspirated material was subjected

for both wet and dry smears as well as for cell block. Microscopic examination of the smears showed pleomorphic tumour cells with few polygonal cells, arranged in loose clusters and trabecular pattern. Peripheral and transgressing endothelial cells were noted in some tumour clusters. Nuclei of the tumour cells were large and centrally placed, having unevenly distributed coarse chromatin with irregular nuclear borders. More than one prominent macronucleoli were noted in some cells. Intracytoplasmic bile pigment was noted at places. Many singly scattered stripped atypical nuclei and multinucleated tumour giant cells were noted against a hemorrhagic background. Amidst these tumour cells was noted a sheathed microfilaria of *W. bancrofti* having multiple, coarse discrete nuclei extending from head to tail, except in small terminal portion of the caudal end (Fig.1). Based on the above findings, a diagnosis of malignant tumour suggestive of hepatocellular carcinoma with microfilariae of *W. bancrofti* was offered. The peripheral blood smear did not reveal any microfilariae. Cell block section revealed features of hepatocellular carcinoma showing tumour cells in

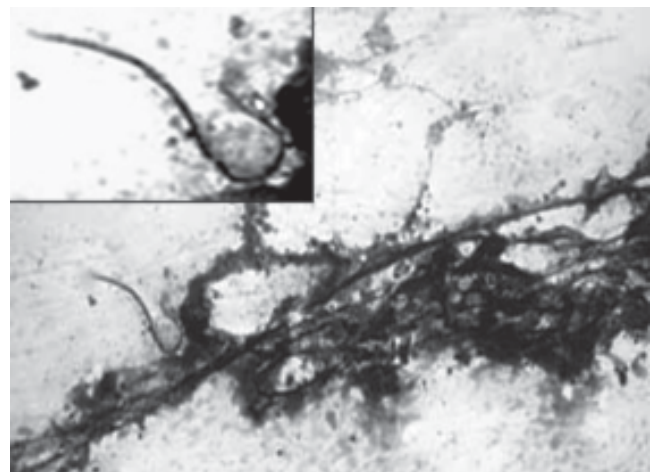


Fig.1 : Microphotograph of FNAC smear showing tumour clusters with endothelial transgressing and microfilaria (Pap, x 200). Inset showing microfilaria (Pap, x 400).