SYNCHRONOUS DOUBLE PRIMARY CANCERS CONSISTING OF BLADDER AND PROSTATIC CANCERS : A CASE REPORT

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Abstract : A 77-year-old man was referred to Honjo General Hospital for his asymptomatic hematuria. Bladder tumor was found in his urinary bladder. The screening of serum PSA level showed a gray zone data of 6.6ng/ml of EIKEN kit. No tumor was palpable on digital rectal examination and hypoechoic lesion was found on transrectal ultrasonography. Bladder tumor was resected transurethrally, and sextant systematic biopsy and hypoechoic directed biopsy were performed on his prostate. Bladder tumor was transitional cell carcinoma of grade 2, pT1b. Bladder instillation therapy was started. Moderately differentiated adenocarcinoma was exclusively found in the specimen obtained by hypoechoic directed biopsy. Hormonal therapy was started. Some discussion on primary double cancers, especially on bladder and prostate cancers, were made.

Key words : Synchronous, Double primary cancer, Bladder cancer, Prostate cancer
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INTRODUCTION

The reports on double primary cancers have been recently increased. About one hundred cases of such a category in urogenital organs were reported^{1,2)}. We reported a case of synchronous double primary cancers consisting of bladder and prostatic cancers with some discussion on detection of cancers.

CASE REPORT

A 77-year-old man was referred to Honjo General Hospital for his asymptomatic gross hematuria on November 18, 1996. On ultrasonographic and cystourethroscopic examinations, a papillary pedunculated tumor with 2 cm of diameter was detected in his urinary bladder. Prostatic urethra was smooth and was elongated by prostate hypertrophy. No nodule or induration was palpable on the surface of his prostate

on digital rectal examination. Serum prostatic specific antigen level was 6.6ng/ml by Ab Bead PSA kit (EIKEN). On transrectal ultrasonography (TRUS), hypoechoic lesion of 1.0cm×0.8cm×1.2cm was found in the right lobe (Fig. 1). On November 28, 1996, transurethral resection of bladder tumor and TRUS-guided transperineal prostatic biopsy were performed under spinal anesthesia. Bladder tumor was completely resected and was diagnosed as transitional cell carcinoma, grade 2, pT1b (Fig. 3). Seven prostatic specimens consisting of 6 sextant systematic biopsy and 1 hypoechoic directed biopsy (Fig. 2) were taken. On microscopic examination, moderately differentiated adenocarcinoma was found in a part of the directed biopsy specimen (Fig. 4). Staging evaluation on both cancers showed no metastatic lesion. Bladder instillation therapy with epirubicin hydrochloride and hormonal therapy with diethylstilbestrol diphosphate

Fig. 1 TRUS image of prostate gland.

Allows show hypoechoic lesion in the right lobe.

Fig. 2 TRUS image on hypoechoic directed biopsy.

Allows show biopsy-needle directed hypoechoic lesion.

Fig. 3 Microscopic finding of bladder tumor. HE stain. X88.

Fig. 4 Microscopic finding of directed hypoechoic biopsy specimen. HE stain. X88.

Allow shows moderately differentiated adenocarcinoma.

followed by LH-RH agonist were performed for superficial bladder cancer and prostate cancer, T1cNOMO, respectively. No tumor recurrence was found on, March 31, 1997.

DISCUSSION

The reasons for increasing of incidence of double primary malignancies are explained by elongation of life span of patients, improvement of diagnostic modality, progress in treatment modality, strict follow-up methods and so on¹⁻³⁾. In the Japanese literatures, about 100 cases were reported. Cases of triple urogenital cancers were also reported³⁾. Combination of bladder and prostate cancers as shown in our case was most frequent with about 25%. Chun⁴⁾ recently reported that the coincidence rate of bladder and prostate cancers. In his study, prostate cancer incidentally detected by cystoprostatectomy specimen and screening PSA level determined by urologists were categorized as diagnostic bias. In that sense, our case is categorized as diagnostic bias. He stated that bladder and prostate cancers coincidentally occurred than expected even if eliminating such diagnostic bias cases.

Prostate cancer in our case was detected from the hypoechoic area of the prostate on TRUS. Although the hypoechoic lesions are not specific for prostate cancer, directed biopsy is recommended in case with hypoechoic lesions⁵⁾. Considering the distribution of adenocarcinoma in obtained biopsy core, the hypoechoic lesion in this case demonstrated cancer element. Estimated cancer volume of this lesion was about 0.5 cc. Taking patient's age into consideration, we treated him with hormone therapy.

The clinical course of this case implies the importance of paying an attention to prostate gland in patient with bladder cancer, and PSA screening and TRUS are important tools for that purpose.

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