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A CASE OF OLD OPERATED CA PROSTATE WITH RECURRENCE WITH PARANEOPLASTIC SYNDROME

General Medicine

Dr Amandeep Singh Kaloti* Professor & HOD, Dept of Medicine,KCGMC, Karnal. *Corresponding Author

Dr Maninder Hariya Senior Resident, Dept of Medicine, KCGMC, Karnal.

Dr Munish Gupta Senior Resident, Dept of Medicine, KCGMC, Karnal.

ABSTRACT

Paraneoplastic syndromes (PNS) are rare disorders that are caused by the altered immune response to a neoplasm. These are non-metastatic systemic effects of malignant disease. There may be involvement of various systems. Here we present a case of prostate cancer which had been previously resected but now recurred and caused quadriplegia as a part of the PNS. The patient was was diagnosed on the basis of the onconeural antibodies which are positive in these patients and other investigations which showed the recurrence of prostate cancer. He was started on the treatment and the patient improved.

KEYWORDS

INTRODUCTION:-

The rare disorders caused by the altered immune response to a neoplasm is paraneoplastic syndromes (PNS). These are non-metastatic systemic effects of malignant disease. These are collections of symptoms which are caused by the tumour but occur at a site distant from the tumour itself. Upto 8% of the patients with cancer are estimated to be affected by paraneoplastic syndromes. Prostate cancer is the second commonest urological malignancy to be associated with PNS. The commonest is the renal cell carcinoma. PNS secondary to prostate carcinoma are a rarity. These can be associated with thye recurrence of the prostate cancer after the previous surgical resection.[1]

Case Report:-

A male aged 60 years, married, earlier worked as a guard, now retired, presented to the emergency with chief complaints of-
Weakness in the both lower limbs for the past 3 months,
Inability to walk for the past 2 months,
Weakness in the both upper limbs for the past 1 month,
Burning micturition for the past 15 days.

Patient was alright 3 months back when he started experiencing weakness in both the lower limbs which was insidious in onset and then progressed over the next few months and the patient started experiencing stiffness in both the lower limbs. The weakness in both the lower limbs progressed over time and at that time, the patient was only able to move the legs sideways a little when lying in the bed. He had not been able to walk for the past 2 months.

Patient also complained of weakness in both the upper limbs for the past 1 month. Patient had developed inability to hold the glass of water or tea cup. He also had difficulty in buttoning or unbuttoning of the shirt buttons. The patient could move the upper limbs sideways in the bed in lying position and could not lift the arms above the bed surface.

There was no history of any tingling sensation/ numbness,
There was no history of any bladder/ bowel involvement,
There was no history of fever,
There was no history of trauma to the spine,
There was no history of any cranial nerve involvement.

In the past history, the patient was an old operated case of Ca Prostate. There was no history of Diabetes Mellitus, CAD or Tuberculosis or any other chronic disease. There was a treatment history of the patient having being operated for Ca Prostate 6 months back and for Hypertension, the patient was on Tab Amlodipine. There was no family history of Diabetes Mellitus, Hypertension, CAD. In the personal history, the patient was a vegan, no addictions, bowel and bladder was normal and sleep was normal.

On general physical examination, the patient was conscious, cooperative, lying comfortably in the bed. The patient was afebrile, pulse rate of 86/min, regular. Had a respiratory rate of 16/ min, abdominothoracic. Blood pressure of 130/80 mm Hg in the right arm in the supine position. Ther was no pallor, icterus, cyanosis, clubbing, lymphadenopathy, edema. The JVP was not raised.

On CNS examination, the patient's higher mental functions were normal. Speech was normal. The Cranial Nerve examination was normal. On motor system examination, the nutrition was normal. There was clasp-knife rigidity present in all the 4 limbs. The superficial reflexes were absent, Deep tendon reflexes testing showed exaggerated reflexes on both the sides. Jaw jerk was normal. The sensory system examination was normal. Signs of meningeal irritation were absent and the spine was normal.

The investigations done showed-

Hb- 10 gm%, TLC- 8900/mm^3, Polys- 60%, Sr Ceratinine- 0.9 mg%, Bl Urea- 34 mg%, LFT- normal, RBS- 98 mg%, ECG- normal, CXR- normal, ESR- 94 mm 1st hour, Urine routine- 8-10 pus cells/hpf, Urine culture showed growth of Klebsiella sensitive to Pieracillin-tazobatum and nitrofurantoin.

MRI cervical spine showed Necrotizing Myelopathy affecting the Cervical C3, C4 level.

PET Scan showed the recurrence of the Ca Prostrate.

Onconeural Antibodies done showed positive Anti-Hu antibodies.

The diagnosis was kept as Hypertension with UTI with old operated case of Ca Prostate with recurrence with Paraneoplastic Syndrome secondary to Ca Prostate with Necrotizing Myelopathy Spinal C3,4 level with Quadriplegia(UMN type).

The patient was started on the treatment, giving IV fluids, Inj Pipeacillin tazobactam, IVIg, Corticisteroids, Amlodipine, Syp Citralka, Physiotherapy, Inj Pantoprazole.

The patient has improved with treatment and the patient has regained power and is able to walk with support at present and is awaiting re-resection of the Ca Prostate.

DISCUSSION:-

There have been reports of the involvement of the central nervous system in the PNS secondary to the recurrence of prostate cancer. These manifestations can be associated with the recurrence of the prostate cancer. The syndromes can be treated by the treatment of the underlying malignancy itself.[2] PNS are associated with the serum markers that are readily detectable which help to link the symptoms of PNS to the underlying malignancy. The histology of the prostate cancer associated with PNS frequently reveals neuroendocrine features or small cell carcinoma.[3]

Paraneoplastic neurologic syndromes can be associated with prostate cancer. It can be in the form of the paraneoplastic necrotizing myelopathy. The symptoms usually involve the cervical or the thoracic portions of the spinal cord including ascending sensory deficits, sphincter disturbances and flaccid or spastic paraplegias or quadriplegias. These symptoms may progress over weeks or months and terminate in respiratory failure or death if left untreated. MRI shows contrast enhancement within the spinal cord.[4]

CONCLUSION:-

The presence of the neurological symptoms in a case of cancer prostate should lead to proper neurological examination and localization of the lesion followed by investigations to link it to be due to PNS.

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