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SECTORAL RESEARCH XXI: CHARACTERISTICS AND FEATURES

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IMPORTANCE OF MEDICAL HISTORY AND PREVIOUS DIAGNOSIS: PROSTATE CANCER METASTASES TO THE STOMACH

According to statistics, prostate cancer is the fifth most common cause of death and the second most common cancer diagnosis in men worldwide. In the differential diagnosis, attention should be paid to the causes that could provoke the development of cancer. Risk factors that cannot be changed include race, family history and hereditary syndromes, while smoking and obesity can be avoided. Symptomatically, the disease can present in a variety of ways, so a PSA test with a possible subsequent biopsy is important in screening. Microscopically, prostate cancer is more likely to have the structure of an adenocarcinoma and less likely to be an undifferentiated cancer. Prostate cancer can spread to nearby organs and grow into the walls of the bladder, rectum and seminal vesicles. Metastasis can occur by lymphatic and haematogenous routes, which is why lymph nodes and bones are common sites. There are cases when metastases grow in completely uncharacteristic places, such as the stomach.

The aim of our work is to investigate the importance of a pathologist's detailed review of the patient's medical history and the preliminary diagnoses made by the attending physician, and the impact of the final notes on further treatment.

In the course of our work, we analysed the data provided in the articles "Prostate Cancer Metastasis to the Stomach: A Case Report and Review of Literature", "Epidemiology of Prostate Cancer", "Epidemiology and Prevention of Prostate Cancer".

There are only 15 cases of prostate cancer metastasis to the stomach in the literature, the article "Prostate Cancer Metastasis to Stomach: A Case Report and Review of Literature" discusses one of them.

A 65-year-old man with a family history of cancer (two brothers and a daughter died of cancer), an elevated PSA level, and confirmed prostate adenocarcinoma underwent therapy and radical prostatectomy. However, the patient refused radiotherapy. A year later, metastases were detected in the sacrum. Androgen deprivation therapy was used, followed by the addition of enzalutamide, which continued for several years. Although the patient's general condition was satisfactory, the PSA increased, and bone metastases were visually detected. The patient refused further treatment.

The patient reports gastrointestinal reflux disorders one year later (nine years after the initial diagnosis), including discomfort in the epigastrium, heartburn, loss of appetite, and nausea. Additionally, the patient has anaemia with a haemoglobin level of 100g/l and a PSA level of 712 ng/ml. A chest CT scan revealed small pulmonary nodules, while a CT scan of the stomach showed no changes. During endoscopy, an ulcerated area was found along the large curvature of the stomach, which is suspicious for gastric cancer. Samples were sent for biopsy with a preliminary diagnosis of 'Gastroscopy, gastric mass/cancer', but without a medical history. The pathologist made an incorrect conclusion: invasive adenocarcinoma. However, after a multidisciplinary consultation, it was recommended that an immunohistochemical examination be performed to confirm or exclude the possibility of metastatic prostate adenocarcinoma. The initial report was amended accordingly, as the immunohistochemical profile confirmed the diagnosis.

As a result, the patient was enrolled for palliative treatment to alleviate his symptoms, receiving radiotherapy (20 Gy in 5 fractions) to control gastric bleeding. However, he refused systemic treatment. The man died 9 months after the diagnosis of gastric metastasis.

Immunohistochemistry is not typically used to confirm primary tumours, but it is mandatory when metastatic disease or unusual morphological features of a tumour in an unusual location are suspected.

Therefore, based on this case, we urge clinicians to promptly submit biopsy materials to the pathology centre along with the preliminary diagnosis and medical history, including clinical differential diagnosis. This is particularly important for patients with a history of adenocarcinoma and metastases to other organs.

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