ESMO Preceptorship Programme
Prostate Cancer– Singapore – 21-22 November 2018

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Metastatic Prostate Cancer with Neuroendocrine differentiation

Disclosure of Interests

- Nil

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- Mr YWK, 66 year old gentleman with no comorbidities
- Family history – Brother has locally advanced prostate cancer
- ECOG 0
- Diagnosed with Metastatic Prostate Adenocarcinoma (multiple spine metastases) in September 2013, iPSA 57.9, Gleason Score 4+5
- Orchidectomy was done in December 2013 with a PSA nadir of 0.1 in June 2014

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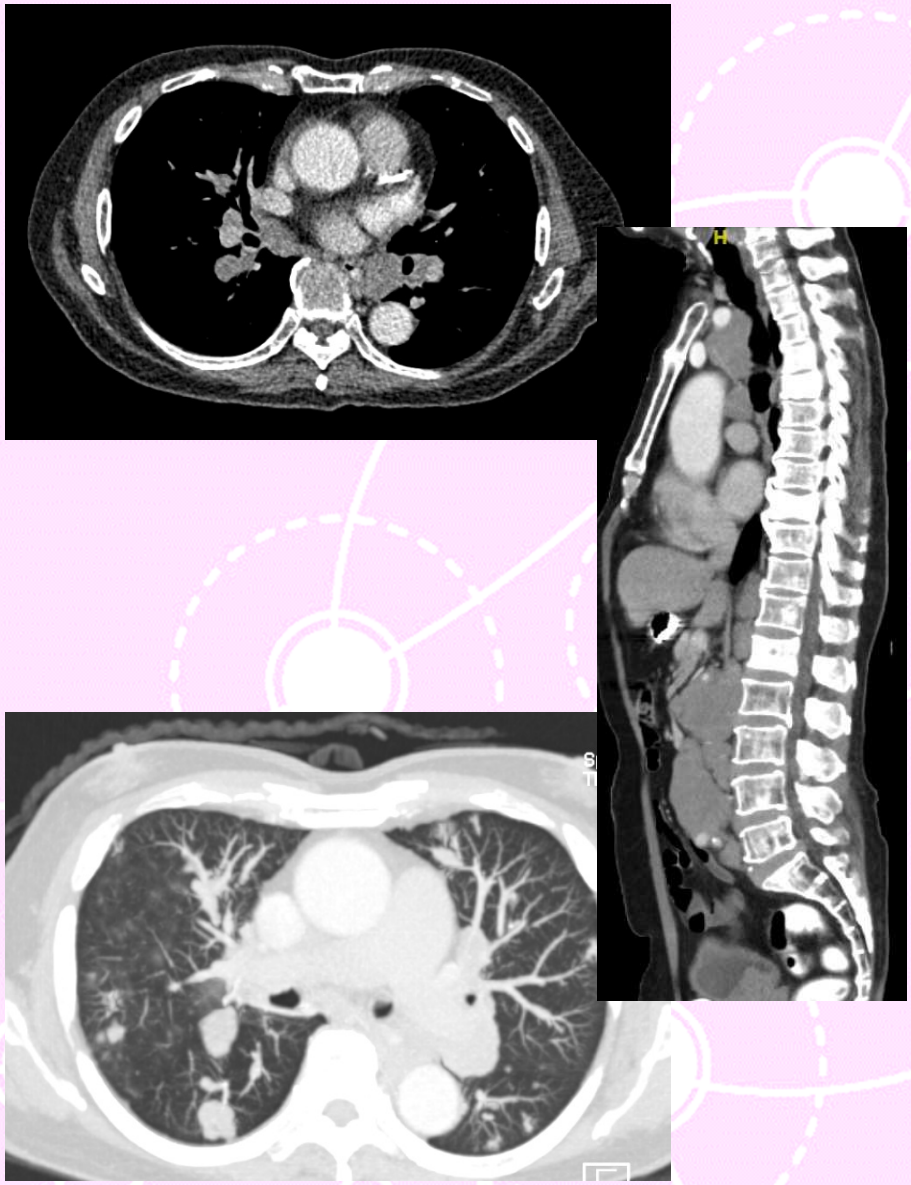
- In August 2015 PSA rose to 4.06 (doubling time ~ 6 months)
  - CT scan – worsening bone metastases + new nodal metastasis
  - Started on Bicalutamide Aug 2015 - July 2017 with fairly stable PSA
- PSA progression July 2017 to 11.04, testosterone <0.07 ng/dl pain at occipital region
  - CT Brain 13/7/17 - normal
  - CT NTAP 10/7/17 – stable paraaortic and aortocaval nodal metastases
  - Bone scan 3/7/17 - multiple bone metastasis (worsening): occipital, scapula, spine, acetabulum, ischium
- He was started on IV Docetaxel 75mg/m^2 3 weekly + oral Prednisolone and Bisphosphonates, tolerated well with some symptomatic relief

- He completed 6 cycles of Docetaxel in November 2017 with a PSA nadir of 3.45 in October 2017
- His PSA rose to 18.16 in February 2018 (doubling time < 3 months) and developed difficulty swallowing + dyspnea
- CT TAP and bone scan March 2018 showed multiple bulky nodal metastases (mediastinal, paraaortic, pelvic), multiple lung metastases, left adrenal mass, multiple worsening bone metastases



- A mediastinal node biopsy was performed.
- HPE - Consistent with metastatic prostate carcinoma with neuroendocrine differentiation >50%, positive for NSE and Synaptophysin
- He was given 6 cycles of IV Etoposide + Cisplatin with good clinical and biochemical response

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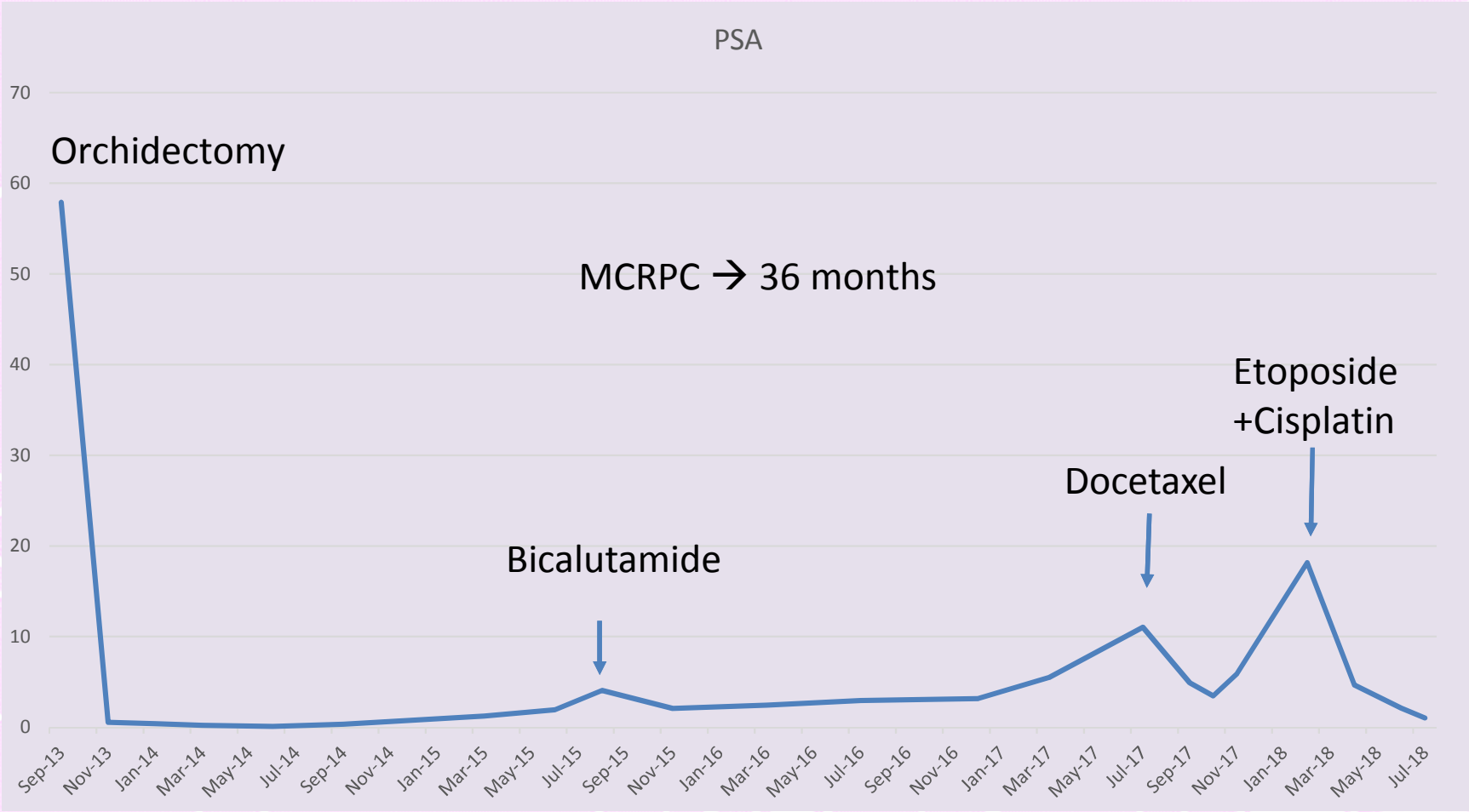

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Points for discussion

- Ideal timing of rebiopsy or clinical diagnosis alone
- Role of palliative radiotherapy in symptomatic areas
- Management approach of neuroendocrine differentiation
- Role of BRCA testing

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Thank you!