



Case Report

Prostate biopsy free system for laparoscopic radical prostatectomy in a pituitary dwarfism: a case report

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Abstract: Prostate biopsy is the gold standard for the diagnosis of prostate cancer. However, not all patients are suitable for prostate biopsy. For example, some patients have anal stenosis, some patients are too old to withstand the pain caused by puncture, patients who are unwilling to undergo prostate biopsy. We found that there was currently no literature report on a specific solution to this problem. This is the first report of a laparoscopic radical prostatectomy (LRP) in a pituitary dwarfism who didn't have a prostate biopsy before LRP due to anal stenosis. And this report added a new method to diagnose prostate cancer. We present a case of a 61-year-old pituitary dwarfism who had a prostate specific antigen (PSA) of 32.13 ng/mL by physical examination and didn't perform prostate biopsy due to anal stenosis. Preoperative prostate MRI suggests a low-signal mass on the left side of the prostate and ^{68}Ga PSMA-11 PET/CT demonstrated that Abnormally high PSMA and CHO uptake on the left side of the prostate. Therefore, combined with the patient's PSA, MRI and ^{68}Ga PSMA-11 PET/CT, our clinical diagnosis was prostate cancer. Surgery was difficult due to narrow pelvic space, but achievable through LRP. Histological analysis revealed multifocal prostate cancer, with negative surgical margins and no extraprostatic extension. Postoperative patient had no serious complications and was discharged. Based on this case, For the first time, we proposed to make full use of the results of clinical tests and imaging examinations for the diagnosis and treatment of diseases without prostate biopsy.

Keywords: Prostate cancer; prostatectomy; pituitary dwarfism; case report

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Introduction

Although the current diagnosis of prostate cancer mainly depends on prostate biopsy, there were still some special reports demonstrated that prostate biopsy might be not a significant diagnosis of prostate cancer. For example, a case report showed that a patient underwent twice prostate biopsies, and the results were all negative, and the metastatic lesion of the tumor appeared on the imaging. The biopsy of metastatic lesion finally confirmed prostate cancer (1), and another case reported that patient similarly underwent twice prostate biopsies and the results were negative, and they also showed distant metastasis on imaging. After long-

term ADT treatment, the patient's bone pain symptoms eased and PSA decreased significantly (2) which showed this patient got prostate cancer.

Therefore, there are still some special cases for the diagnosis of prostate cancer. This is the first report of laparoscopic radical prostatectomy (LRP) in pituitary dwarfism who with no preoperative prostate biopsy due to anal stenosis. We highlighted a case of significantly clinical diagnosis of prostate cancer treated with LRP, and outline surgical and anesthetic considerations before proceeding in patients with pituitary dwarfism. We present the following article in accordance with the CARE reporting checklist (available at <http://dx.doi.org/10.21037/tau-20-489>).

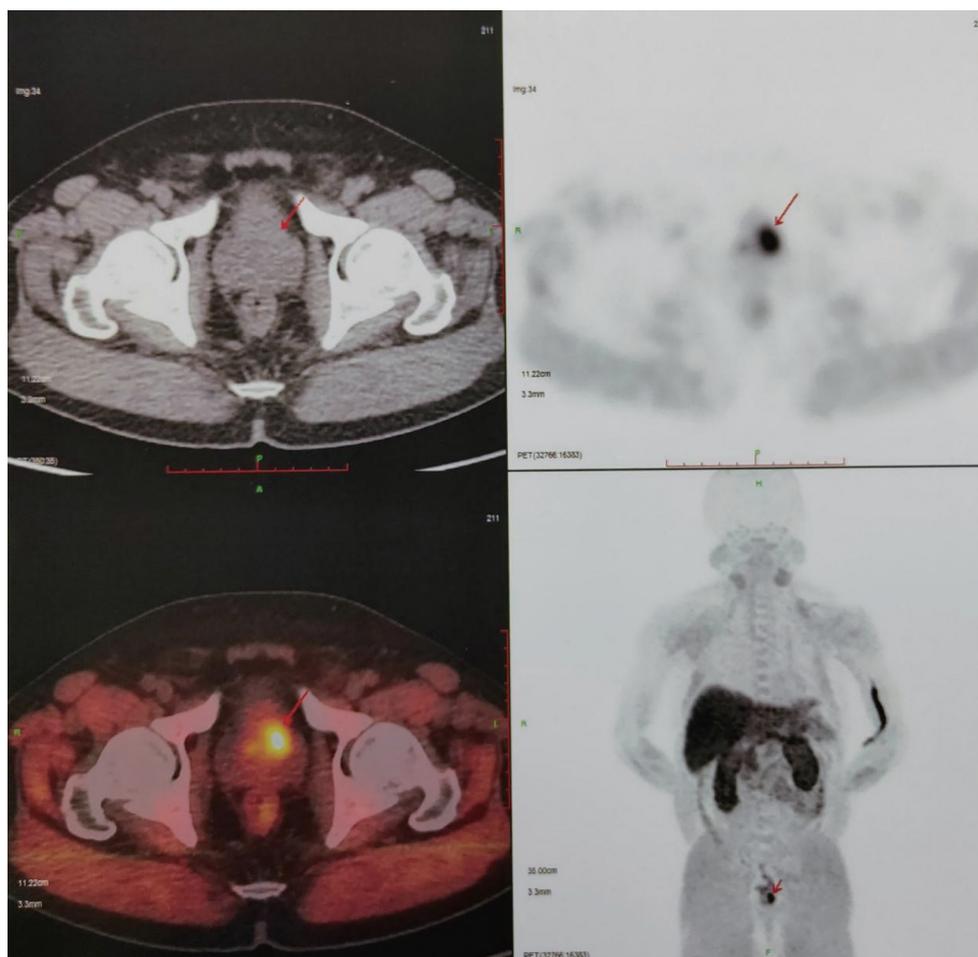


Figure 2 ^{68}Ga PSMA-11 PET/CT in the pituitary dwarfism. Red arrow indicates a prostate mass.

because of the lack of pathological diagnosis before surgery, this method was not suitable for all patients. We also found some rare case reports showing patients with bone pain and very high PSA who experienced twice prostate biopsy were negative results, and finally through the diagnosis method for bone metastases or lymph node biopsy to confirm the diagnosis (1,9,10). Compared with their cases, we found the difference that our patients did not have symptoms of bone pain, PSA was not high, and there was no tumor metastasis or lymphadenopathy on the MRI, and prostate biopsy could not be completed. Iwamura *et al.* proposed a case that a 64-year-old man with PSA level of 2,036 ng/mL underwent twice prostate biopsies, and the results were negative. And the Imaging showed bone metastases, but no metastatic lesion biopsy was performed. After ADT, the patient's bone pain was alleviated, and PSA level was reduced. Therefore, they clinically diagnosed patients with prostate cancer (2).

Therefore, for these patients with negative biopsy and high suspicion of prostate cancer with distant metastasis, we could also diagnose prostate cancer through clinical diagnosis and used tentative ADT treatment to confirm the disease. For our case, we did not find distant metastases, and tumor was inside the prostate by imaging examination and no enlarged lymph nodes were found, so there was a risk of misdiagnosis. We needed to combine the indicators of this patient to improve the accuracy of diagnosis. For localized prostate cancer, radical prostatectomy (RP) is the preferred treatment. At present, the surgical methods of RP are LRP and robotic-assisted LRP. For this patient, we used LRP to excision of prostate. Although we knew that for patients with pelvic stenosis, RALP was superior to LRP in the choice of surgery, but due to the limitations of our surgical equipment, we still decided to complete the surgery through LRP. There was no lymph node metastasis was found in



Figure 3 Timeline of examination and treatment.

the pathology of the patient, and the image did not show systemic metastasis at the same time. The postoperative pathology showed high-risk prostate cancer, so it was necessary to receive endocrine therapy and monitor PSA levels.

For this case, our diagnosis was successful, and the tumor was removed in time to improve patient survival. The strength of this case is that for patients who cannot undergo prostate biopsy and there is no metastasis and lymphadenopathy on imaging, we combined PSA, MRI, and PET-CT to make a diagnosis to avoid missing the presence of prostate malignant tumors. The biggest limitation in this case was the risk of misdiagnosis. In this case, no clear clinical information was obtained to indicate malignant tumors such as metastatic lesion or suspicious lymph nodes. we did not have specific data to enhance the accuracy of our diagnosis of prostate cancer in this case. Therefore, we hope to provide this case to solve the clinical problems. At the same time, we also hope to be able to design a scoring system to perform data analysis of laboratory data and subjective performance of different imaging studies, so that some patients can avoid unnecessary biopsy. And some patients who cannot be biopsied can also be clinically diagnosed.

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee(s) and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient.

Conclusions

Through this case, we can better use laboratory data and imaging tests to diagnose prostate cancer. Although it cannot replace prostate biopsy, for patients who are unable to perform prostate biopsy or are unwilling to perform prostate biopsy, we hope to apply the concept of prostate biopsy free in clinic.

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Footnote

Reporting Checklist: The authors have completed the CARE reporting checklist. Available at <http://dx.doi.org/10.21037/tau-20-489>

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at <http://dx.doi.org/10.21037/tau-20-489>). The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee(s) and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient.

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