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Sir,
**Decreased vision as the initial presenting symptom of
disseminated prostatic disease**

Soft tissue solitary choroidal masses of the eye as the
initial presenting symptom of disseminated metastatic
disease is rare. We present the case of a 52-year old who
presented with visual symptoms relating to a prostatic
adenocarcinoma primary, who responded clinically with
external beam radiotherapy. The presentation and
infrequency of such presentations is discussed.

Case report

A 52-year old presented with a 1-week history of a
painless decrease in visual acuity in his right eye, of
gradual onset. Past ocular history was remarkable for
anisometropic amblyopia of the left eye. Examination
revealed an unaided Snellen visual acuity of 6/60 right
and 6/18 left. Anterior segment examination was
normal. Fundal examination revealed a solitary elevated
solid mass lesion superiorly with an overlying exudative
retinal detachment, involving the macula (Figure 1). On
systems review, the patient revealed a 6-week history of
low back pain and nocturia and right-calf pain for 5 days.

B-scan ultrasound examination revealed a 5 mm
(high) × 13 mm homogenous mass with choroidal
excavation (Figure 2). A metastatic screen with CT
imaging revealed extensive systemic metastases
including a retropharyngeal mass, para-aortic adenopathy,
bilateral hydronephrosis, bony lytic secondaries in

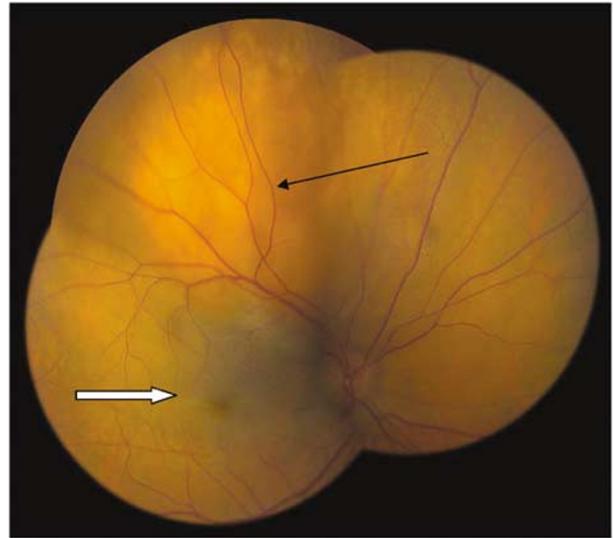


Figure 1 Superior lesion (black arrow) with overlying exudative retinal detachment involving the macula (white arrow).



Figure 2 B-scan ultrasound showing an elevated, solid, homogenous mass with choroidal excavation with calcified area in the anterior pole of the lesion.

lumbar vertebrae 3 and sacroiliac joints with an osteolytic
appearance from a presumed prostatic carcinoma
primary (Figures 3a–d). Dopplers of the right lower limb
confirmed a deep vein thrombosis secondary to pelvic
compression. Serology revealed an elevated prostate-
specific antigen (PSA) at 104 ng/dl, and renal
impairment with a creatinine of 135. Liver function tests
revealed an elevated alkaline phosphatase. Clinical
examination (urology) revealed a T4 prostatic carcinoma.
Ultrasound-guided biopsy confirmed prostatic
adenocarcinoma on histopathology, with a Gleeson
rating of 9.

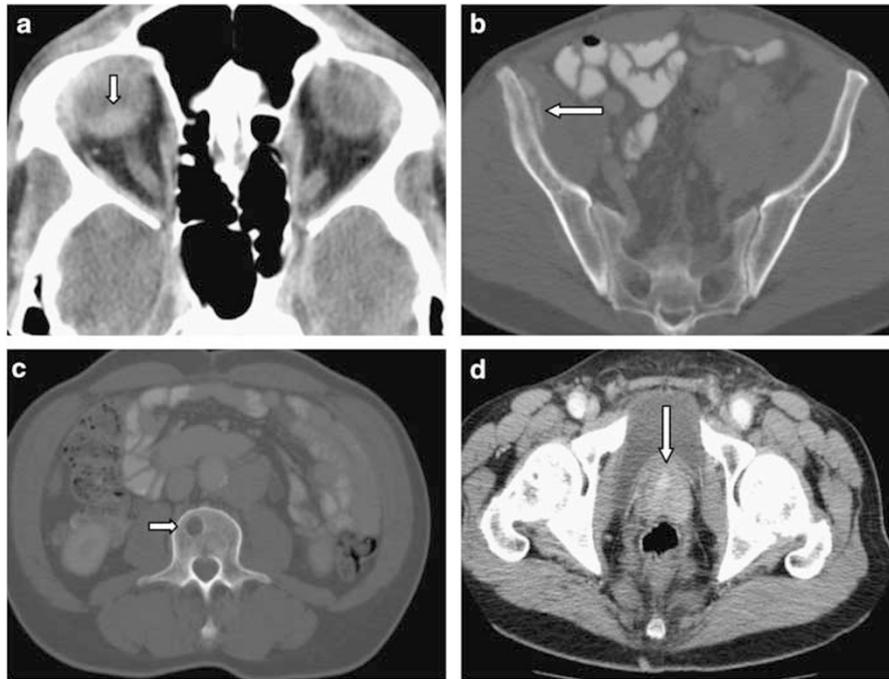


Figure 3 CT scan showing disseminated metastatic disease indicated by arrow. (a) Lesion in the posterior pole (white arrow). (b) Lesion on medial aspect of the sacroiliac joint. (c) Lytic lesion in L3. (d) Carcinomatous prostate.



Figure 4 Regressed fundal lesion with resolution of the serous detachment. Note the retinal pigment change over the radiated area (black arrow).

The treatment consisted of total androgen blockade, anticoagulation and oral dexamethasone and radiotherapy to the bony and pelvic secondaries. External beam radiotherapy of 30 Gy in 10 divided doses to the orbit lead to regression of the chorio-retinal lesion

with resolution of sub-retinal fluid and an improvement of visual acuity to 6/9 (Figure 4).

Comment

Metastatic disease from the prostate to the orbit and ocular structures is rare.¹⁻⁵ Visual symptoms as the presenting, initial feature of disseminated malignancy is rare and few case reports exist in the literature. De Potter *et al*⁴ examined 379 patients with uveal metastases and found 2% (seven patients) with prostatic carcinoma previously diagnosed. No patients had initially presented with visual symptoms. Shields *et al*¹ examined 920 patients with uveal metastases and found that 66% had previously been diagnosed with cancer, and that of the remaining 38%, none had a prostatic primary. The ocular prognosis for resolution is not dependent on the grade of the tumour and prostatic adeno-carcinoma is radiosensitive. Radiotherapy to the orbit is the standard treatment for secondary ocular neoplasms including the prostate. Transpupillary thermotherapy (TTT) may be considered and a recent report by Kiratli *et al*,⁶ demonstrated that resolution of choroidal metastases could be achieved with TTT where the primary tumours included lung, breast and prostate. They found that lesions greater than 3.5 mm high responded poorly and necessitated radiotherapy. We present a patient who presented with a solitary choroidal tumour secondary to

a previously unknown prostatic primary with a good visual outcome post treatment.

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