Sir,

A 49-year-old male, presented with dry cough for three weeks. He was febrile for ten days and was breathless for two days. He also gave history of urinary hesitancy (off and on) for the past four months. He was tachypnoeic (RR-23/min), febrile (38° C) with clinical features suggestive of right-sided pleural effusion. A clinical diagnosis of infective right-sided pleural effusion was made.

Chest radiograph showed right-sided pleural effusion with suspicious parenchymal mass in the right lower lung zone. Right-sided intercostal tube drained two litres of haemorrhagic fluid. The pleural fluid had a glucose concentration of 168 mg/dl, total protein concentration of 5.8 gm/dl and albumin level of 3.3 mg/dl. On microscopic examination the fluid demonstrated presence of 65 cells per cubic mm. These were predominantly lymphocytes. No organisms or malignant cells were seen. A contrast CT scan thorax revealed thickened pleura with nodular appearances. A CT guided fine needle aspiration of the pleural nodule was done. A diagnosis of malignant mesothelioma was offered initially. In the hospital, the patient

as monotherapy or in combination with nystatin and itraconazole, our patient responded to treatment with natamycin eye drops coupled with oral itraconazole. The value of natamycin eye drops in the treatment of C. dematium keratitis has also been emphasized in a recent publication wherein four patients responded to this treatment. The identification of this fungus may augur a favourable prognosis with antifungal therapy and this new corneal pathogen should be considered as one of the aetiological agents of mycotic keratitis.

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References


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Carcinoma prostate presenting as pleural effusion with metastatic pleural mass

Sir,

A 49-year-old male, presented with dry cough for three weeks. He was febrile for ten days and was breathless for two days. He also gave history of urinary hesitancy (off and on) for the past four months. He was tachypnoeic (RR-23/min), febrile (38° C) with clinical features suggestive of right-sided pleural effusion. A clinical diagnosis of infective right-sided pleural effusion was made.

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developed retention of urine. Per rectal examination revealed a hard nodular prostate. USG abdomen showed cholelithiasis, multiple calcific foci in the spleen and dense calcification in the prostate with residual urine of 260 cc. Uroflowmetry showed bladder outflow tract obstruction. PSA levels were high (62.3). Prostatic biopsy revealed poorly differentiated prostatic carcinoma showing positivity for PSA on immunohistochemistry. On reassessing the pleural biopsy in the presence of prostatic carcinoma, the pleural lesion was thought to be metastatic rather than primary although PSA staining was negative on the pleural tissue. Bone scan revealed a suspicious area in the left intertrochanteric area. A final diagnosis of poorly differentiated prostatic cancer with metastatic pleural disease and bone metastasis was made. The patient was given chemotherapy along with flutamide. A bilateral orchidectomy was done. He was advised regular follow-up. Clinical and radiological improvement was seen at the time of the six months follow-up.

Prostatic cancer is known for its varied patterns of dissemination. Pulmonary metastases from prostatic carcinoma are common; however, the nodular lesions readily identified on thoracic roentgenograms are usually asymptomatic. A previous review showed that pulmonary metastases from prostate adenocarcinoma are found at autopsy in 25% to 38% of patients but are evident on chest films in only 5.5% to 6.7%. Intra-thoracic involvement of metastatic adenocarcinoma of the prostate may appear on roentgenograms as parenchymal nodules (84%), mediastinal adenopathy (12%) or lymphatic spread (4%); pleural involvement is the second rarest site after the adrenals among the soft tissue metastases. Pulmonary secondaries secondary to prostatic carcinoma are amenable to anti-androgen therapy or orchidectomy with prolonged symptomatic remission.

Immunocytochemistry by PSA is a sensitive and specific method of detection of metastatic prostatic adenocarcinoma, but there have been case reports showing that it can be negative in some cases. Therefore, it should not be taken as a confirmatory test.

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References

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**Carcinomatous meningitis occurring prior to a diagnosis of large cell neuroendocrine carcinoma of the uterine cervix**

Sir,

A 39-year-old lady presented with deviation of the angle of mouth to the right side, left-sided decreased hearing, dysphagia and dysarthria of three months duration associated with left-sided headache. There was no history of fever or ear discharge. On examination, optic fundi were normal. Left-sided lower motor neuron type of facial palsy, sensori-neural deafness, reduced pharyngeal sensations, impaired palatal movements and absent gag reflex were noted. The rest of the neurological examination was unremarkable.

Routine haemogram was normal and erythrocyte sedimentation rate was 130 mm/hour. Serum alkaline phosphatase was 208 U/L (normal range 40-125 U/L). Post-gadolinium magnetic resonance imaging (MRI) of the brain showed diffuse pachymeningitis (Figure 1), without parenchymal lesions. Cerebrospinal fluid (CSF) analysis showed leucocyte count of 2/cmm, protein 44 mg% and sugar 67 mg%. Bacterial and fungal cultures, TB-PCR, and smear for acanthamoebae in the CSF were negative. CSF cytology showed a few atypical cells, however, malignant cells were absent. Therefore, bone marrow examination was done, which showed metastatic carcinoma (Figure 2). Gynaecological examination done as part of the search for possible primary showed features of carcinoma cervix. Histopathological examination confirmed the cervical tumour to be large cell neuroendocrine carcinoma.

Carcinomatous meningitis (CM) occurs in 5% of all adult can-

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Figure 1: Post-gadolinium magnetic resonance imaging of brain (coronal sequences) showing features of diffuse thickening and enhancement of meninges