A 79-year-old male admitted for poor oral intake, lack of appetite, 15 lbs. weight loss, and cramping lower abdominal pain. CT Abdomen/Pelvis was consistent with pancreatitis. He was treated with IV fluids. Given the absence of alcohol abuse, Ca 19-9 was obtained which was elevated at 6041. Gastroenterology team was consulted and an oesophagogastroduodenostomy and endoscopic ultrasound was performed which showed a hypoechoic, heterogeneous mass in the pancreatic tail which measured. Fine needle aspiration (FNA) pathology revealed an adenocarcinoma of the pancreas (Figure 1) and staging scans revealed metastasis to kidney. He started therapy with gemcitabine and paclitaxel and radiation therapy.

Three months later, the patient reported lumps on his penis and discomfort when retracting his foreskin. He subsequently noticed a lump on head of his penis and multiple lumps underneath the skin on the shaft of the penis. Genitalia exam showed an uncircumcised penis and numerous diffuse subcutaneous hard lesions of shaft of penis measuring from 2 mm to 1 cm were noted. There was a 3-mm reddened lesion on head of penis. Nodules were also noted on the shaft and deep base of penis. An MRI showed the largest mass involving the corpus cavernosum at the base of the penis, with the 2 largest lesions measuring 3 x 1.9 cm on the left and 2 x 1.4 cm on the right (Figure 2 & 3). Three weeks later, he developed urinary obstruction he underwent urethral dilation and cystoscopy; placed suprapubic urinary catheter. Biopsy showed metastatic adenocarcinoma to penis (Figure 4). The patient was offered palliative radiation to the penis but refused. He was discharged home with hospice where he died two weeks later.

Penile metastases are exceedingly rare only few hundred cases are described in the literature and most originate from either genitourinary primary or colonic primaries [1]. To the best of our knowledge this is 3rd case reported in USA. The most common metastasis of pancreatic cancer are to liver, regional lymph nodes, peritoneal cavity, lung and less commonly to brain, bone, and adrenal glands [2].

Most common metastatic mechanism is hematogenous spread through the portal venous system to the liver. Diagnosis is usually made by biopsy or fine-needle aspiration which differentiates primary from metastasis. Treatment options include radical or partial penectomy, local excision, hormonal or chemotherapy depending on the primary, and radiation therapy for palliation. Our patient experience is that penile metastasis though rare can present with masses and cause urinary obstruction.
Figure 2: MRI. Left copus cavernosam lesion

Figure 4: Metastatic adenocarcinoma to penis

References:

