

**Table 1. Blood Count**

WBC	28510	No./uL
RBC	1.43	$\times 10^6$ /uL
HGB	4.3	g/dL
HCT	13.8	%
MCV	96.8	fl
MCH	30.1	pg
MCHC	31.1	g/dL
RDW	22.2	%
Platelet	37000	No./uL
% NEUT	37.2	%
% LYM	49.5	%
% MONO	3.3	%
% EOS	0.5	%
% BASO	12.2	%

**Table 2. Biochemical Data**

Albumin	3	g/dL
Total protein	5.6	g/dL
BUN	28.5	mg/dL
Creatinine	1	mg/dL
Uric acid	6.9	mg/dL
Cholesterol	119	mg/dL
Triglyceride	59	mg/dL
GOT	107	IU/l
GPT	37	IU/l
rGT	74	IU/l
ZTT	3.9	mg/dL
D-bilirubin	0.5	mg/dL
T-bilirubin	0.9	mg/dL
ALP	772	U/l
Glucose	296	mg/dL
Iron	201	mg/dL
TIBC	249.9	mg/dL
Ferritin	572	mg/mL

was no bacterial growth in the blood or pleural effusion culture in the 7-day culture. The biochemical study of the pleural effusion is summarized in Table 3.

The aspiration cytology of the lymph node in the left neck was unsatisfactory. Bone marrow aspiration from the sternum showed few marrow cells and some scattered cancer nests. Bone marrow biopsy was not performed due to the patient's intolerance. The PSA serum level was markedly elevated (265.35 ng/mL). Under the impression of prostatic carcinoma with bone metastasis, the patient received transrectal pro-

**Table 3. Biochemical Data of Pleural Effusion**

Specific gravity	1.021	
RBC	28784	$\times 10^9$ /uL
WBC	270	$\times 10^9$ /uL
N:L	44:56	
Rivalta	negative	

static biopsy. The histological examination revealed high-grade prostatic adenocarcinoma (Gleason scoring 5+4=9). During this last admission, he also suffered from mild fever. Antibiotic and supportive treatments were continued. Orchiectomy and hormone therapies were planned. Unfortunately, his general condition continued deteriorating. Several days before his death, bloody stool and bloodstained sputum were also noted. He died 1 month after admission. An autopsy was performed.

## DIFFERENTIAL DIAGNOSIS AND DISCUSSION

According to the clinical history and clinical examinations of the patient, the anemia known 1 year before this admission might have been the first evidence of the bone metastasis by prostate cancer. In an older man, anemia can result from malignancy of the gastrointestinal system, bone metastasis, chronic inflammatory diseases, kidney diseases, liver diseases, or endocrine problems. In this patient, the serum level of iron, ferritin, and TIBC indicated that the anemia did not result from iron deficiency. The leukoerythroblastic change in the peripheral blood reminded us of the possibility of metastatic lesions or chronic granulomatous inflammation in the bone. The elevated alkaline phosphatase serum level was also an indicator of liver or bone diseases. In bone diseases, the serum level of this enzyme rises in proportion to the increase of osteoblastic activity. For example, metastatic bone diseases, osteosarcoma, Paget's disease, hyperparathyroidism, and leukemia are all associated with elevated alkaline phosphatase serum level. Coupled with the rise of prostate specific antigen, it was almost conclusive that the patient had prostatic cancer with bone metastasis. Prostatic needle biopsy confirmed the diagnosis.

The radiological examination of the patient during his last admission revealed multiple lung nodules,