Phoenix Sonogram Clinic

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Medical Director

4/11/05 RE: John Smith #6775

CLINICAL HISTORY and CONSULTATION

Mr. Smith has had a slowly progressive tPSA in elevation since 5/2003 at 5.2. He had since been diagnosed with a Gleason 7 (3,4) prostate carcinoma. Regular tPSA progression has been documented at tPSA 6.1 on 3/2006. This yields a yearly average PSAv(elocity) of 0.90 ng/ml. This progression is consistent but mildly elevated over the clinically accepted average of 0.75 ng/ml/yr PSAv. There is positive history of hesitancy and urgency symptoms reflected in an elevated AUA symptom score. This result suggests partial elevated tPSA may be caused from chronic BPH or prostatitis

SONOGRAM and COLOR DOPPLER of the PROSTATE

Overview
On 4/07/05 gray scale transrectal ultrasound of the prostate was performed following AIUM procedures. Sagittal and transverse views were imaged. The prostate and pelvic perivesical blood flow study was performed using transrectal color Power Doppler and real time examination.

Gray Scale
The prostate measures 2.21 cm x 4.60 cm x 3.40 cm. Calculated volume estimated between 36 to 40cc. The median lobe is symmetrical with a defined prostatic urethra apparent throughout the midgland.

Irregular, diffuse, and scattered regions of microcalculi/calcification were visualized focused left sagittal and mid to caudal aspect of the midgland and apex. A defined hypoechoic focal lesion was visualized at the left apex (slide 11/21) measuring 1.03 cm by 0.31 cm. This hypoechoic region further demonstrates defined extracapsular extension of approximately 0.12cm. This region was moderate in its compositional variance with well defined margins.

The seminal vesicles are visible, grossly symmetrical and appear normal. Mild post void urine was noted throughout the exam.

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Power Color Doppler

The periprostatic vasculature is well imaged with iliac arteries m/s arterial flow and the venous iliac vessels. These reveal normal flow patterns. The periphery of the prostate shows no regions of hypervascularity. The right outer gland hypoechoic region of the apex in question yielded no significant prostatic arterial flow.

IMPRESSIONS

The prostatic tumor at the left apex demonstrates defined borders (1.03cm x 0.31cm), extracapsular extension (0.12) and low significant blood flow.

CONCLUSION

Marked apical diffuse microcalculi involvement suggests the probable cause for Mr. Smith's elevated AUA values as low grade prostatitis. *The marked diffuse apical calcifications are most likely a result of a low grade chronic prostatitis*. Mr. Smith was advised to consider treatments of a pelvic lymphagogue action which could include botanical medicines and contrast hydrotherapy. These therapies secondarily may have additional function upon overall prostate health.

Proactive strategies discussed include the increase in overall positive blood flow to the pelvic region, immune system enhancement, and proper nourishment and exercise regiment. Therapies should be followed with moderate vigilance.

Due to the *extracapsular extension* follow-up *ultrasound is recommended 6 to 12 months for objective comparison*.

Thank you for allowing me to participate in the care of this patient.

Healthy Regards,

Frank Dominic Tamburri, N.M.D.