History of Present Illness

Chief Complaint/History of Present Illness: 75 y/o male presented to clinic with pain of his right ankle. 1 month prior, he suffered a minor inversion ankle sprain which improved initially then started to worsen again with increasing pain and swelling over the outside of his ankle as he tried to return to pre-injury activity. Painful to touch and with weight bearing

Past Medical History:
- Prior Achilles tendon rupture right
- Hodkins Lymphoma 8 yrs ago
- Non-Hodkins Lymphoma 4 yrs ago
- Parotid gland mass noted 7 months prior
- Several biopsies 4-8 yrs previously
- No allergies, Family and social history non-contributory

Initial Physical Exam:
- Neurovascular status intact right foot and ankle
- Pain to palpation, induration and swelling at the distal diaphyseal/metaphyseal junction of the right fibula
- Pain at this site with external rotation of the right foot
- No Ligamentous pain

Initial Diagnosis and Treatment:
- Diagnosis: Fibular stress fracture/reaction
- Recommended ankle brace
- Limit activities
- Ice, elevate
- Radiographs: mostly unchanged, some lucency at fx. site
- Treatment: weight bearing in CAM boot

2 Week Follow Up:
- Pain continues unchanged despite compliance
- Radiographs: mostly unchanged, some lucency at fx. site
- Treatment: weight bearing in CAM boot

4 Week Follow Up:
- Pain continues unchanged despite compliance
- Radiographs: see image 2
- Treatment: Continues NWB in CAM boot
- CT ordered: see image 3
- Consult to Oncology
- Consult to Ortho Oncology
- Continue protected WB with CAM boot

6 weeks From Initial Presentation:
- Diagnosis: Probable metastatic spread of lymphoma
- Bone scan: Focal uptake in the right fibula, no other lesions noted
- Treatment: Biopsy and rush rod pinning in 1 week for impending pathologic fracture by ortho-oncology, see image 4

8 Month Follow Up:
Patient returned to normal walking with out pain. His Pet/CT at 8 months from initial presentation showed decreased uptake at the fibula and inguinal canal

Discussion:

Primary metastatic tumors of the foot are very rare. Many are indistinguishable from one another on imaging alone. Conventional radiography remains the cornerstone for imaging any bony lesion with metastatic lesions typically demonstrating an appearance consistent with high biologic activity. This includes ill-defined, moth-eaten or permeative patterns of bone destruction, periosteal reaction and the presence of a soft-tissue mass. DLBCL can often be cured with chemotherapy agents but 50% of patients still die from their disease.

References