**OS 217 ONCOLOGY MODULE – Bone Metastasis CASE**

CA, 67-year-old Female, from Sta. Rosa Laguna

**Chief complaint**: Pain in the Right Arm

**History of Present Illness**

DOI: 07/31/21

TOI: 7PM

POI: Home

MOI: Non-traumatic

Patient was reaching for her medicine when she suddenly heard a crack immediately followed by pain over her right arm. Swelling developed thereafter with pain noted to be worse on movement. Temporary splint was placed on the affected extremity and patient was brought to a Local Hospital where radiographs were taken showing a non-displaced right humeral shaft fracture. A coaptation splint was placed and was advised referral to our institution for further evaluation and management.

**Review of Systems:**

**(+) Hematuria (+) Left hip pain (+) Right Breast Mass – No work up done**

(-) dysuria, polyuria

(-) other sites of bone pains, joint pains, swelling, rashes

(-) weight loss, generalized weakness, fever, snorexia

(-) headache, seizures, changes in sensorium, BOV, hearing loss, cough, dyspnea, hemoptysis

(-) hemoptysis, chest pain, easy fatigability, PND, orthopnea, edema

(-) abdominal pain, nausea, vomiting, diarrhea, constipation, hematochezia

**Past Medical History**

Allegedly had "mild stroke" 10 years ago, no CT scan done

Diagnosed with HTN also 10 years, HBP 150/100, prescribed with unrecalled medication, non-compliant after a few months - claimed to have normal BP thereafter.

No other known comorbidities.

**Family History**

(+) Bronchial asthma on paternal and maternal side

**Personal and Social History**

No vices, denies illicit drug use, food vendor

**Obstetric and Gynecologic History**

Menarche at 13 yo, regular interval, consuming 3-5 ppd, lasting for 4 days.

Menopause at 52 yo with no history of any post-menopausal spotting/bleeding.

Coitarche at Age 18. Claims to have had four sexual partners.

**Physical Examination**

At the Emergency Department, the patient was seen and examined awake, alert, follows commands, oriented and NIRD.

Reported intermittent pain over the right arm and shoulder area, including the left hip (rated 7-8/10).

BP 120/70, HR 87, RR 20, T afebrile, O2 sat of 98-99%

AS, pink PC, no CLAD/NVE/ANMs

ECE, clear breath sounds, (+) 2x2 cm round mass on the RUQ, R breast, movable, non-tender, smooth

AP, distinct HS, NRRR, no murmur

Flat abdomen, NABS, soft, nontender, no masses/organomegaly

Full pulses, CRT<2s, no edema, (+) cast over the right arm

Full and equal peripheral pulses, no edema. Pale nail beds, no jaundice.

Neurological PE unremarkable

**Laboratory Examinations at ER**

CBC: **Hgb 106 Hct 0.31** Plt 274 **WBC 12.4** N73 L17 M7 E3

Chem: BUN 10.2 Crea 113 eGFR 43 Na 145 K 3.6 Ca 2.84 (2.78) Alb 43 Mg 0.99 Cl 108 AST 39 ALT 46 ALP 139 LDH 422 **(all high except for Alb, Na, K and Mg)**

Bleeding parameters: PT 12.6/15.0/77%/1.21 PTT 30.38/27.3 **(Normal)**

NPS RT PCR swab: **Negative**

**RADIOGRAPHS:**

BILATERAL ARM AND LEFT FOREARM: There is an ill- to fairly- defined lucent region involving the mid-diaphyseal region of the right humerus, measuring approximately 7.9 cm in its craniocaudal diameter. There is an associated closed, complete, transverse fracture of the middle third of the right humerus with anterior displacement and angulation of its distal fragment.

PELVIS AP, JUDET, ILIAC OBLIQUE, OBTURATOR OBLIQUE VIEWS, LEFT HIP CROSSTABLE LATERAL: Suspicious osteopenic/osteolytic changes are seen in the lateral surface of the left iliac wing, left superior acetabular border, and left ischium.

No demonstrable fractures in the views provided. The rest of the cortical outlines are intact.

CHEST: No significant chest findings save for degenerative osseous changes

SKULL and SPINE: There are no lytic changes noted. No other remarkable findings.

PELVIS: There are no demonstrable fractures in the view provided.

BILATERAL FEMUR AND LEG: There are no lytic or sclerotic changes noted. No osseous nor joint space abnormality