5. Patella Fracture
6. Patella Avulsion Fracture

TESTS AND RESULTS:
- Initial US shows edema and fluid in the VMO region, but the quad tendon itself was intact on its most superior aspect.
- F/U US 24 hours post injury showed partial quad tendon and/or VMO tear.
- MRI results showed a vertical quad tendon tear with horizontal involvement.

FINAL DIAGNOSIS:
1. Quad Tendon Tear

TREATMENT:
1. Orthopedic consultation
2. Platelet Rich Plasma injection to tear
3. Placed in immob - initial mobilization to begin at 6 weeks
4. Sports specific rehabilitation beginning in 6 weeks

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2324 June 2, 4:35 PM - 4:55 PM
**Leg Pain - Adolescent Male Triathlete.**
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(No relationships reported)

HISTORY: 17 year old male triathlete presented for initial evaluation for right thigh pain radiating to the calf. Injury occurred when squatting with weights one week prior. He initially felt a sharp pain right groin but was able to continue. Four days later he ran 6 miles and groin/thigh pain increased. Two days later pain radiated from groin to calf. At day seventh day he presented with a limp and right leg swelling. He is recreationally training for triathlon and his weekly regimen includes 10 miles running, 50 miles on bike, 5 days of swimming.

PHYSICAL EXAMINATION: HT 195.8 cm (77.09”) WT 77.1 kg (169 lb 15.6 oz) BMI 20.11 kg/m²
On exam he ambulates with right leg externally rotated and significant limp.
There is no pelvic bony tenderness throughout. 4/5 strength right quadriceps and hamstring limited due to pain. Pain with active and passive range of motion of right ankle and knee. Tender to palpation of right thigh and right calf. Right thigh swollen and 4 cm greater than left. Right calf swollen and 2 cm greater than left. Non-pitting edema of the right ankle with 2+ posterior tibial pulse and 1+ dorsalis pedis pulse. Sensation and reflexes intact.

DIFFERENTIAL DIAGNOSIS:
- Pelvic mass/space occupying lesion
- DVT
- Stress fracture femoral neck
- Muscular strain

TEST AND RESULTS:
Radiographs of the pelvis, femur and tibia demonstrated no osseous abnormality.
Right lower extremity ultrasound demonstrated extensive occlusive venous thrombus extending from posterior tibia and peroneal veins to the level of the proximal superficial femoral vein and common femoral vein.

LAB STUDIES:
D-dimer > 50

FINAL WORKING DIAGNOSIS: Unprovoked DVT

TREATMENT AND OUTCOMES:
He had catheter placement and TPA infusion in the right lower extremity for thrombolysis. The TPA was continued for 14 hours without any event and clot in the femoral vein resolved. He was transitioned enoxaparin subcutaneous for residual clot in below the knee. At two week follow up the ultrasound demonstrated full resolution of thrombus.

SUMMARY:
Investigation for his spontaneous clot included inherited and acquired causes of thrombosis. Mildly low protein C levels were found. At 3 month follow up he remains on enoxaparin SQ, shows no signs of post-thrombotic syndrome, and is awaiting genetic testing PROC1 gene.

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2325 Chair: Benjamin Hasan. Northwest Community Hospital Medical Group, Arlington Heights, IL.
(No relationships reported)

2326 Discussant: Jeffrey M. Mjaanes, FACSM. Rush University Medical Center, Chicago, IL.
(No relationships reported)

2327 Discussant: David Smith. University of Minnesota, Minneapolis, MN.
(No relationships reported)

2328 June 2, 3:15 PM - 3:35 PM
**Malignant Ovarian Tumor In A Tennis Pro: A Case Report**
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(No relationships reported)
HISTORY: A 23 year old apparently healthy, former-Division I tennis player and current tennis pro presented for evaluation in a physical therapy scenario. She was asymptomatic, participated in fitness activities on a near-daily basis, and regularly offered tennis lessons to youth in the community. The client’s medical history was positive for an intra-abdominal procedure as a child for removal of a “cyst”.

PHYSICAL EXAMINATION: Routine screen and examination of all physiological systems revealed a palpable mass approximately 12 cm diameter across the left and right lower abdominal quadrants and extending from the symphysis pubis to 2 cm below the umbilicus; the mass was ballottable without discomfort. The abdomen was slightly rounded in the right and left lower quadrants, with a well-healed midline scar from the suprapubic region to 1 cm below the umbilicus. The client’s skin was evenly colored without lesions, telangiectasia, or venous patterns. Typical bowel sounds were auscultated in all abdominal quadrants, no bruits or venous hums were present. The abdomen was non-pulsatile, there was unusual dullness to percussion over the left and right lower quadrants, no palpable hepatosplenomegaly, and the kidneys were non-tender.

DIFFERENTIAL DIAGNOSIS:
1. Pregnancy
2. Cyst
3. Hernia
4. Tumor

TEST AND RESULTS:
1. Abnormal presentation/screening findings for an asymptomatic individual.
2. Urgent referral to client’s gynecologist (GYN), who completed an office visit the next day.
3. GYN subsequently performed diagnostic ultrasound and scheduled client for exploratory surgery.
4. Client underwent surgery within 8 days of initial evaluation in physical therapy.

FINAL WORKING DIAGNOSIS: Suspicious for abdominal tumor.

TREATMENT AND OUTCOMES: The client underwent abdominal surgery, in which a 5 kg ovarian mass with clear margins was successfully removed. Post-surgical biopsy on the mass indicated it was a malignant ovarian tumor. She returned to previous activities when released by her surgeon. Follow-up tests at 6 months (endoscopy, colonoscopy, and CT Scan) were negative and at 7 months (genetic testing) were inconclusive. This case report highlights a routine systems screen by a primary care provider that resulted in identification of pathology in an asymptomatic individual.

2329 June 2, 3:35 PM - 3:55 PM
Right Groin Pain - Basketball
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(No relationships reported)

HISTORY: A 12-year-old male presented with right groin pain that started immediately after a quick cut during basketball. He felt a pop with immediate pain, localized to the proximal adductor. Pain improved after a week of rest but increased with return to basketball. Pain was worse with hip flexion and better with rest.

PHYSICAL EXAMINATION: Right hip: There was moderate tenderness along the proximal adductor muscle extending to the lesser trochanter but no tenderness over the ASIS, AIIS, greater trochanter or pubic symphysis. There was pain with active flexion, adduction and abduction and full passive ROM with flexion, internal rotation and external rotation. Strength was 5/5, except for 4+/5 with abduction. Log roll was negative. There was anterior pain with FABER and FADIR testing.

DIFFERENTIAL DIAGNOSIS:
1. Adductor strain
2. Avulsion fracture of the lesser trochanter
3. Slipped capital femoral epiphysis
4. Acetabular labral tear
5. Avascular pubalgia
6. Avascular necrosis of the femoral head/Legg-Calvé-Perthes Disease
7. Femoral neck stress fracture
8. Biopsos bursitis

TEST AND RESULTS:
Right Hip Ultrasound:
• Small area of hypoechogenicity in the proximal adductor musculotendinous unit
Right Hip/Pelvis X-ray:
• Sclerosis of medial intertrochanteric region of the right femur
• Blurred lucent lesions within the right ischium and right proximal femoral diaphysis, no bony expansion or periosteal reaction
Whole Body Nuclear Bone Scan:
• Increased uptake in the bilateral long bones
MRI Right Hip:
• Multifocal regions of intramedullary signal abnormality involving bilateral proximal femurs
• Lobulated fluid signal lesion within the right posterior acetabular column/ischium
• No bone marrow edema, stress fracture or reaction, or soft tissue injury

FINAL WORKING DIAGNOSIS:
Right Proximal Adductor Strain with underlying Polyostotic Fibrous Dysplasia

TREATMENT AND OUTCOMES:
1. Labs showed elevated Alkaline Phosphatase, normal PTH and Calcium
2. Referral to Orthopedic Oncology
3. Biopsy confirmed Polyostotic Fibrous Dysplasia
4. MRI with and without contrast to evaluate cystic lesion
5. Endocrinology evaluation
6. Physical Therapy
Outcome - Five weeks after initial visit, patient was pain free and cleared to return to sport with Orthopedic Oncology and Endocrinology follow up.

2330 June 2, 3:55 PM - 4:15 PM
Lump on Left Leg - Runner
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(No relationships reported)

HISTORY: A 33-year-old healthy female runner presents to clinic with concerns of a lump on her left thigh. She initially noticed a small, painless lump two years ago. She saw her primary care physician who told her to observe closely and notify him if any growth or pain. She did not notice any changes until two months ago when she was unable to set her foot on the ground at a movie theatre secondary to pain in her leg. She felt her thigh and noticed the lump was larger. She had also intentionally lost ten pounds over

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