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Abstracts are listed in order by first-named author. The presenting author's name(s) is underlined.

METASTATIC MELANOMA IN A PATIENT WITH UNRESOLVING KNEE PAIN – A CASE REPORT

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Introduction: The prevalence of serious pathology in the knee is low and, as a result, physiotherapists often have a low index of suspicion regarding serious pathology such as bony tumours and infections. While these causes are relatively rare, it is imperative to discern them from more benign causes of knee pain, as they require early diagnosis and escalation of care. The following case describes the clinical reasoning employed in the triage of a patient with unresolving knee pain, that led to the timely diagnosis of metastatic melanoma.

Case Presentation: A 33-year-old female presented with a 1-month history of anteromedial knee pain, mild swelling, and instability following a twisting injury while descending stairs. Despite restricting her activity levels, these symptoms had not improved since the date of injury. Findings from the history and clinical examination were consistent with meniscal or chondral pathology. Despite manual and exercise therapy, her symptoms continued to worsen over the following month. An ongoing 5° painful loss of terminal knee extension and persisting pain and instability with short distances of walking warranted referral for radiographs and orthopedic consultation. She had no constitutional features of cancer-related pain but recalled a previous history of melanoma 4 years prior affecting her face.

Results: Radiographs were reported on and interpreted as being unremarkable both by the referring physiotherapist and upon orthopedic consultation. Magnetic resonance imaging revealed a large cystic bone lesion in the medial femoral condyle, which was subsequently characterised as metastatic melanoma by a specialist oncology team. Retrospective orthopedic review of the initial radiographs highlighted a lytic bone lesion, which was initially missed by the radiologist, specialist, and referring physiotherapist. The patient went on to develop further subcutaneous, intramuscular, and cerebral metastasis, the latter of which warranted craniotomy. At the time of publishing, the patient remains under the care of a specialised oncology team with the plan to continue immunotherapy treatment for a 2-year period.

Conclusion: Clinicians should have a high index of suspicion in patients with a prior cancer diagnosis and unresolving, worsening, or unexplained pain. The critical analysis of treatment response is an important facet of the clinical screening process and should aid clinical decision making towards appropriate escalation of investigations and care, where presumed timeframes are exceeded. The early recognition of a lack of anticipated improvement and referral to a specialist oncology team for further investigation was crucial to this patient having her cancer identified and undergoing timely intervention.