Case report 408

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Radiological studies

Fig. 1. An anteroposterior plain film roentgenogram of the area of the left hip shows a grossly destructive lesion involving the left pubic ramus and ischium. Only shreds of cortex remain.

Fig. 2 A, B. Plain film roentgenograms of the middle 2/3 of the left femoral shaft (anteroposterior and lateral projections) demonstrate an elongated, permeative, osteolytic lesion with considerable laminated periosteal reaction. The cortex is penetrated at a number of sites.

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Clinical information

This 16-year-old woman, presented with a complaint of progressively worsening pain in the left knee of two months' duration. Ten days before admission to the hospital her third pregnancy was terminated by a caesarean section due to fetal distress. However, a normal male infant was delivered.

The initial physical examination demonstrated normal vital signs, some submandibular non-tender adenopathy, and an involuting uterus with residual serosanguinous post-partum lochia. Mild edema of the extremities was present, with normal peripheral vascular pulses. Local tenderness to palpation was elicited in the anterolateral soft tissue overlying the distal end of the left femur. Laboratory findings included a hemoglobin of 9.2 gr./100., a white cell count of 8700, and an ECR of 110.

Roentgenograms of the chest were normal at the time of admission. Plain film roentgenograms of the innominate bones showed a grossly lytic lesion with very poorly defined borders in the region of the left pubic ramus and ischium (Fig. 1). A second osteolytic lesion with considerable permeation was noted in the distal 2/3 of the left femoral shaft, measuring approximately 12 cm in length (Fig. 2). Some osteosclerosis was present in this lesion, but mainly the findings were those of gross destruction with a permeative pattern. A large block of laminated periosteal reaction was present. The zone of transition was wide. No soft tissue mass was identified.

Computed tomography of the innominate bones confirmed the presence of the grossly osteolytic lesion of the ischium and pubis and suggested an extension into or edema of the adductor muscle group (Fig. 3). A $^{99m}$Tc isotope bone scan showed considerable increased uptake in both lesions (Fig. 4). Digital subtraction angiograms demonstrated that both lesions were hypovascular (Figs. 5 and 6).

Biopsy of both lesions was performed.