The patient was a 48-year-old man serving in a deployed combat setting, who was referred to a physical therapist for evaluation of progressively worsening left hip and left wrist pain. Two weeks prior to the physical therapist’s evaluation, the patient reported falling off a staircase from a height of 1.5 m and landing on his left hip and left outstretched hand. A physician had evaluated the patient the day after his fall and ordered hip radiographs, which were interpreted as negative for a fracture. The patient was diagnosed as having a left hip and left wrist sprain, prescribed a nonsteroidal anti-inflammatory medication, placed on light duty, instructed in a weight-bearing-as-tolerated gait with axillary crutches, and referred to a physical therapist.

At the time of the physical therapist’s initial evaluation, the patient had an antalgic gait, and left lower extremity edema and ecchymosis were present. Hip active range of motion was limited in all directions due to pain. The patient also had point tenderness to palpation in the anatomical snuff box of the left wrist. Due to concern for hip and wrist fractures, which are often radiographically occult initially after injury, the physical therapist ordered radiographs of the left hip and left wrist. The radiographs revealed comminuted fractures of the midneck to distal neck of the left femur and left scaphoid (FIGURES 1 and 2). Based on these findings, the patient was medially evacuated from the combat setting for comprehensive orthopaedic management. The patient was subsequently managed with open reduction internal fixation of his left hip and percutaneous screw fixation of his left scaphoid (FIGURES 3 and 4, available at www.jospt.org).

Reference

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