Introduction

Hematoma and back pain are both relatively common complaints seen in primary care with vast differential diagnoses. Often, a thorough history and physical exam can differentiate the more common benign etiologies—such as constipation and muscle spasms—from the more rare serious etiologies—such as ureteral calculi and pain caused by the secondary hyperparathyroidism caused by vitamin D deficiency. However, in some cases, despite further investigation with labs, imaging, and a specialist’s evaluation, the diagnosis remains elusive and only identifiable after death. This is one such case of a patient whose main complaints of gross hematuria and thoracic back pain were elucidated on his history as well as the diagnostic and treatment evaluation of metastatic, poorly differentiated, gastric adenocarcinoma.

Case summary

A 36-year-old male presented to the emergency department in January 2023, with a history of COPD, morbid obesity, hypothyroidism, and poorly controlled diabetes. He was admitted to the hospital on 1/13/2023 for his annual physical. During this visit, he noted a episode of gross hematuria the day prior without any associated dysuria, abdominal pain/dyscomfort, or proteinuria. He was treated conservatively. He described some chest pain related to exertion. However, his symptoms worsened and he returned to the hospital in early February 2023. He was seen again in March 2023, and then again in early April 2023. On his last visit, he was found to have a new mass in the liver.

Physical exam

Vital signs: DBP 112/71, Pulse 146, Temp 97.7°F, Weight 203.1 lb (92.2 kg) Height 67.5". Blood pressure: 103/70 mmHg. Heart rate 146 beats per minute. Respiratory rate 24 breaths per minute. Distended abdomen, maximal right upper quadrant tenderness. No ascites, hepatomegaly, or right renal mass identified. Bladder palpated but no masses palpated.

Based on the patient’s history, physical exam, and laboratory results, a diagnosis of metastatic, poorly differentiated gastric adenocarcinoma was made. The patient was referred to a gastrointestinal oncologist for further evaluation and treatment.

Discussion

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References


