Introduction:

Welcome to CUGH's bi-weekly clinical case-series, "Reasoning without Resources," by Prof. Gerald Paccione of the Albert Einstein College of Medicine. These teaching cases are based on Prof. Paccione's decades of teaching experience on the medical wards of Kisoro District Hospital in Uganda. They are designed for those practicing in low resource settings, Medicine and Family Medicine residents, and senior medical students interested in clinical global health. Each case is presented in two parts. First comes a case vignette (presenting symptoms, history, basic lab and physical exam findings) along with 6-10 discussion questions that direct clinical reasoning and/or highlight diagnostic issues. Two weeks later CUGH will post detailed instructors notes for the case along with a new case vignette. For a more detailed overview to this case-series and the teaching philosophy behind it, see Introduction to "Reasoning without Resources". Comments or question may be sent to Prof. Paccione at: gpaccion@montefiore.org

Note: If you would like to be notified when a new case is posted (along with instructor notes for the previous one), send your e-mail to Jillian Morgan at jmorgan@CUGH.org

About the Author:

Dr. Gerald Paccione is a Professor of Clinical Medicine at the Albert Einstein College of Medicine in the Bronx, New York. His career has centered on medical education for the past 35 years – as a residency Program Director in Primary Care and Social Internal Medicine at Montefiore Hospital, and director of the Global Health Education Alliance at the school. He has served on the Boards of Directors of Doctors for Global Health, Doctors of the World USA, and the Global Health Education Consortium. Dr. Paccione spends about 3 months a year in Uganda working on the Medicine wards of Kisoro District Hospital where he draws examples for the case studies.

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CASE 8 – ASCITES

A 60 year old male farmer with no past medical history of significance except for two hernia repairs, began noticing increased abdominal girth about 2-3 years ago which steadily progressed. He drinks socially only on occasion, and never had jaundice or problems with his liver. He sleeps with one pillow comfortably without waking up or difficulty breathing. He has had some shortness of breath on exertion over the past months as his abdomen grew larger, and intermittent mild ankle swelling. There has been no leg, chest or abdominal pain, no hemoptysis or cough; his appetite is good, and he has had neither fever nor notable weight loss. He was tested HIV (-) six months ago.

P.E. Short elderly man, impoverished with torn clothes, barefoot with a very protuberant abdomen.

B/P 115/75 without pulsus paradoxus; HR 107 R 18 T 98
fundi: benign without nicking, exudates, hemorrhages; A/V ratio: 4/5; no lid lag;
conjunctiva: normal, without icterus
mouth: no thrush, poor dentition
neck: Jugular venous pulsations (JVP) ↑'d to angle of the jaw sitting up, biphasic with A wave and C-V merger, regular cannon CV wave;
⊕ Kussmaul sign (↑ neck filling/pulsing with inspiration)
⊕ Hepato-jugular reflux (HJR)
thyroid palpable without enlargement;
lungs: clear to auscultation and percussion;
cardiac: no RV or LV lift/heave;
PMI 4th ICS, 1 cm lat MCL (displaced up and to the left due to huge belly)
S1, S2 no split audible; ⊕ summation gallup heard with inspiration at the left sternal border (LSB)
3/6 holosystolic murmur at the LLSB,↑'d with inspiration, radiating up sternum to 3rd rib but not to the axilla
abdomen: tense ascites with ⊕ fluid wave and shifting dullness; no venous pattern;
↑ ballottable liver, mildly tender;
large incisional hernia midline
rectal; guaiuc Θ
legs: no-trace edema
neuro: mental status intact: no asterixis; no fine tremor;
normal motor, sensory, cerebellar, gait, reflex exams

QUESTIONS

1. What is the "frame" of this case from the history and physical (i.e. the key clinical features that the final diagnosis must be consistent with)?

What is the clinical significance of each feature selected?

2. What is the significance of the Physical Exam findings?

3. What is the differential diagnosis of ascites *without* edema?

The following tests, available in a district hospital, reveal the following:

a) U/A: s. g. 1.020 Θ blood; ⊕ 2-3 protein; no rbc's, wbc's or casts seen;

b) EKG: Sinus Tachycardia at 105;
P II, III, F > 3mm tall with ↑ upright P in V1;
no RV or LV hypertrophy (voltage normal) or ST changes;

4, How do you explain the test results?

5. What is the relevant differential diagnosis in this patient, and the most cogent reasons for and against the various possibilities?

6. What is the likely specific etiology of this patient's disease?

7. What is the prognosis of this patient and how should he be managed?