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

Important note: We are developing an email distribution list of persons interested in the cases. This list will ensure that interested faculty receive timely notice of the next case and previous case instructor notes while reducing the frequency of announcements to CUGH and GHEC's full distribution lists. Please so notify Jillian Morgan at jmorgan@CUGH.org if you'd like to be on the list.

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 3

43 year old woman presents with increasing headache for the past 3 weeks. She was previously well, the mother of 5 children living in town, a shopkeeper with her husband. About a month ago, headaches first noted in the mornings, began and gradually increased in intensity and duration. The headaches began waking her at night and have been becoming less responsive to acetominophen. She has occasionally felt "hot", had no head trauma, and hasn't noted cough, sweats, or nasal discharge; she hasn't had an appetite for over a month now, has vomited intermittently, and "possibly" lost some weight (she and her husband are not sure but clothes seem looser). Her husband noted that intermittently she didn't make sense over the past week, and appeared confused. The day before admission, she began to see double.

Her husband has been healthy, and both of them tested HIV negative about 6 months ago after a close friend died of HIV.

P. E. Well-dressed, holding her head and complaining of pain
BP: 150/100 HR 55 T 99.5 p.o. R 16
skin: without rash, zoster scar, or evidence of eschars
mouth; no thrush, no dental caries or tenderness to tapping teeth
ENT: normal, without eardrum perforation or cholesteatoma
No increased pain to palpation/percussion over sinuses
fundi: benign without papilledema
eyes: left eye unable to abduct, deviated nasally; right eye full range of motion; pupils equal and reactive to light and accommodation;
neck: diffuse resistance to movement in all directions;
no lymphadenopathy; no JV pulsations at 30 degrees, or
hepato-jugular reflux observed;
lungs: clear;
cardiac: PMI in 5^{th} ICS, MCL; normal S_1 S_2,
no murmurs, gallups, rubs
abdomen soft, no hepato-splenomegaly or masses
neuro: Mental Status: alert and oriented x 2; unable to name month or day;
unable to count backwards from 10;
CN: other than above, intact:
otherwise normal: motor (5/5), sensory, cerebellar, gait

1. **What is the "frame" in this case (i.e. the key clinical features the final diagnosis must be consistent with)?**

2. **What is the diagnostic significance of the Physical Exam in this patient?**

3. **What test is foremost in *orienting* the differential diagnosis, and how does its result influence the differential diagnosis, workup, and initial therapy?**

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4. **a. What is the differential diagnosis if the patient is HIV (+) <u>AND</u> if HIV (-), and the clinical "pros and cons" vis-à-vis diagnosis for each disease mentioned?**

   b. What is the most likely diagnosis in this patient and why?