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 Katherine Unger at kunger@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.

Gerald Paccione, MD
Professor of Clinical Medicine
Albert Einstein College of Medicine
110 East 210 St., Bronx, NY 10467
Tel: 718-920-6738
Email: gpaccion@montefiore.org

CASE 42 – Feeling 400

A “400 year old” woman (her response when asked her age) is carried to the hospital by her daughters for a final opinion “before she dies”.

She has been deteriorating for 2 months with decreased appetite and marked weakness while still performing all activities of daily living. Although previously fully ambulatory and active, for the past 2 weeks she has not walked at all; is now soiling herself and incontinent of both urine and feces. Both urine and feces are of normal color with no blood. Her family thinks she’s lost significant weight but can’t quantify it.

On a full review of systems, “mild cough” and “tooth pain” have been present “for 1 week”, but there have been no fevers, sweats or other pains noted; no history of shortness of breath with exertion or cough. No other family members are sick.

The patient and her family are convinced of her imminent demise and are preparing for her death, but one of her 4 daughters wanted to have her “examined”. The patient herself is very upset at having been brought to the hospital.

Physical Exam:

Elderly woman with marked cachexia and too weak to sit

BP 80/38; HR 62; T 36 p.o.; R 22

teeth: no pain on palpation or with tapping on her 10 remaining teeth, or gums;
mouth normal except for unremarkable mild gingivitis; no thrush
neck: no lymphadenopathy; thyroid normal; no JVP/HJR
face: no pain with percussion, palpation or pressure over sinuses
lungs: increased breath sounds with crackles diffusely throughout all lung fields bilaterally; left > right, upper > lower lung fields
heart: S_1, S_2 without rubs, murmurs, or gallups
abdomen: scaphoid; loose skin; bowel sounds normal; no hepato-splenomegaly, masses, or tenderness
stool: guaiac (-), no masses
neurologic: non-focal; motor symmetric 5-/5; rectal tone normal; reflexes +2.

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 *composite* clinical significance of the 3 following observations: the extent of lung exam findings, the patient's level of distress, and the absence of respiratory difficulty by history?**

3. **What is the likely diagnosis and how was she diagnosed and treated?**

Case 42b

An 80 year old male is brought to Kisoro District Hospital by his sons for "stomach and back pain" for over a month. He has "felt sick" in an ill-defined way for 2 months, but comes to the hospital now for "burning fire" pain around right lateral rib cage increasing over the past month, exacerbated by breathing deeply. On direct questioning, his sons say he has lost some weight, "maybe 1 kilogram". The patient has not noted fevers, sweats, cough or shortness of breath; there's no history of loss of consciousness, change in color of stool or urine, blood in the stool or black stools, and he does not drink alcohol.

Physical Exam:
Extremely cachectic and weak, lying flat, with an occasional cough during the exam (which he denies having even when asked immediately following a cough)

BP 80/60 HR 70 R 22, shallow T 35

conjunctiva: no icterus or pallor
fundi: normal;
mouth: no thrush;
neck: no nodes, thyroid normal; no JVP/HJR elevation
lungs: clear to auscultation and percussion, no pleural rubs elicited with patient sitting, leaning forward, leaning to the sides;
chest wall: palpation of right ribs laterally elicits pain and wincing, over about a hand-size area without specific point tenderness
no pain elicited in the area of tenderness by simultaneous bimanual compression of spine and sternum
cor: S_1, S_2 normal, no murmurs or rubs

abd: scaphoid; no hepato-splenomegaly or masses; guaiac negative
extremities: no edema or clubbing
neurologic: cranial nerves, sensory, motor, reflexes, cerebellar – normal, without focality

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

2. What is the significance of the "cough", witnessed but denied, during the exam?

3. What general pathologies - in which tissues - are potential causes of this patient's clinical presentation of "burning fire" around his chest?

4. How does the physical exam focus the differential diagnosis in this case?

5. What diagnostic strategy/sequence is appropriate in Kisoro?

6. What is the most likely diagnosis, and what made the diagnosis "definitive"?
Why was weight loss not a significant symptom of disease noted by the family?