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 17 – MASSIVE LIVER

Two cases are presented below, compared and contrasted, and discussed.

A. A 26 year old man presents with weight loss, and increasing epigastric and right-sided belly pain for months.

He was in his usual fully functional state of health until he started losing his appetite and feeling progressive fatigue about 6 months ago. He noticed weight loss a couple of months later, ago and pain in the center and right side of his abdomen 2 months ago. The pain started as a dull continuous ache that grew more intense, and although unrelated to meals, lately has been associated with an early fullness and discomfort when eating. He's felt "hot" on and off.

He's had no prior history of significant abdominal pain, liver disease, diarrhea, change in bowel habits, or change in color of his stool, skin or urine. He's been a social drinker only, married and always monogamous with his wife of 8 years. He has 3 kids and farms rice and corn.

On exam he's cachectic, and in no acute distress. His BP is 90/60, HR 100 and T 100.2 orally. His conjunctiva are without pallor or icterus; his neck reveals normal lymph nodes, JVP and thyroid; lungs and heart are normal.
His abdomen is slightly distended, and is remarkable for a hard, tender, mass in the right upper quadrant which moves with respiration, extending 16 cm below the costal margin, spanning 23 cm, with an irregular nodular edge; a bruit can be heard over the mass. His spleen descends 2 cm below the costal margin, and there's no shifting dullness. His stool is guaiac negative. His extremities have no clubbing or edema.

B. A 46 year old woman presents with increasing weakness and a disabling itch for the last month. She was well until a year and a half ago when she noted the onset of bilateral leg swelling that at first waxed and waned but has been constantly present over the past year. Previously obese, she began to notice that she was losing weight 7 months ago. Two months ago she lost her appetite and about a month ago developed severe total body weakness and a diffuse itch without a skin rash. She's had mild abdominal pain without localization lately, no abdominal swelling, and hasn't noted a change in color of her skin or eyes, or stool or urine (uses a latrine), nor any fever, sweats, cough or chest pain.

Previously well herself, she's had 18 children, 14 of whom died between the ages of 6 and 9 years old of unknown diseases. None of the children were chronically ill before the "malaria" suddenly struck. For over 20 years she's had chest pain all day, every day.

She and her husband moved to Kampala from the Kisoro district 20 years ago to work, but the patient returned to family in Kisoro 3 days ago because of her illness.

On exam, she's of medium build, afebrile, normal vital signs. Her conjunctiva are deeply jaundiced without pallor; her skin shows excoriations without rash; mouth without thrush but icteric; she has no lymphadenopathy, thyromegaly, or JVP; her breasts are without masses; lungs and heart are normal.

Her abdomen reveals a hard, non-tender liver with an irregular edge without nodules, that descends 14 cm below the costal margin. Spleen tip is palpable; Rectal exam is without masses and guaiac (-).

There's a visible venous pattern on belly surface; no abdominal distention or shifting dullness; Edema +1-2, noted to the knees. Neurologic exam is normal, without abnormalities of mental status, or asterixis.

1. What are the common features in the "frame" of these 2 cases, and the differences?

2. a. What is the likely *pathologic process* affecting both patients? Explain.

b. Which *tests* available in a district hospital might help determine that?

3. a. Which *specific disease* is the most likely diagnosis for both patients? Explain.

b. What is(are) its cause(s) and its worldwide prevalence?

c. What are the *epidemiologic* and *clinical* differences in the disease between Africa and the U.S.?

N.B.

The hematocrit for the male patient was 39, and for the female patient, 33.

The urinalysis for the male was negative for bilirubin and urobilinogen was present, and for the female, bili was large and urobilinogen present.

The HIV test was negative.

The ultrasonogram was unavailable.

4. a. What are the clinical symptoms/signs and what is the prognosis of this disease in Africa?

b. Which of these 2 patients had the more atypical presentation?

Is it possible that that patient didn't have HCC? Does it matter?

c. What is the clinical significance of the remarkable family/social history provided by the woman?