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.

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 19 – ACUTE BEHAVIOR CHANGE

A 20 year old male from a poor family living in a village 10 kilometers from Kisoro went to Masaka near Lake Victoria to work the fields about six months ago. This was his first time away from home. About three weeks ago, he became febrile according to sparse notes from Masaka District Hospital, was admitted with "malaria" and treated with chloroquine to which sulfadoxine–pyrimethamine was added the second day. On the 3rd day, he slipped into a coma and "meningitis" was diagnosed. Sulfadoxine–pyrimethamine was continued for a day and then penicillin and chloramphenicol were started. He regained consciousness but was confused and began complaining of abdominal pain. He then became aggressive, began hallucinating and acting "strange", and refused treatment. On the 12th hospital day, he was put on a public bus bound for Kisoro by his friends/caretakers in Masaka who couldn't care for him anymore in the hospital.

On arrival in Kisoro he left the bus station and wandered about aimlessly for two days until he was recognized, his family notified, and he was taken home. At home he remained quiet and withdrawn, neither interacting with family nor eating for days. His family then brought him to the hospital.

According to his family there was no patient or family history of bizarre behavior or complaints of feeling hot, headache, belly pain or cough.

PE: The patient appeared catonic and motionless, lying on the ward floor. He suddenly jerked away terrified and screamed when touched; then became calmer but vigilant.
BP (prior nursing) 110/70 HR 85 T 99 axillary R 20
skin: no rash or scars
mouth: no thrush;
neck: supple, no lymphadenopathy, thyroid: palpable isthmus, normal size
lungs: (anteriorly) normal (posterior lungs couldn't be examined)

heart: PMI in 5th intercostal space, mid-clavicular line; no murmurs; physiologic S2
abdomen: non-focal exam, no spleen or liver palpated, but resistant to being examined with diffuse non-specific voluntary guarding,
neuro: cranial nerves, motor, etc., grossly non-focal (cooperation limited). The patient was admitted to the wards, given sedation, and an LP was attempted unsuccessfully. Thorazine was started. He remained withdrawn and intermittently aggressive, unpredictably.

1. **Which features suggest schizophrenia in this patient? Which suggest organic psychosis?**

The morning of the 3rd hospital day he seized briefly, and post-ictally his temperature was 102.

2. **What is the "frame" of this case, the clinical features that the final diagnosis must be consistent with?**

3. **What is the differential diagnosis? The *most likely* diagnosis? Explain.**

4. **What are the neurologic sequelae of this diagnosis, and how frequent are they?**