



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 22 – ABDOMINAL PAIN BACK IN TIME

55 year old woman from Kisoro town who has been told of “high sugar” in the past, presents with fever, increasing right upper quadrant (RUQ) pain for 3 weeks, and frequent urination.

Otherwise healthy without any weight loss or chronic symptoms, her problem started about 5 weeks ago with pain in the center of her belly that developed progressively over a half hour accompanied by nausea, anorexia and severe constipation. After many hours the pain moved to the right lower abdomen with severe tenderness and some vomiting (twice), without diarrhea. Her husband bought antimalarial drugs and “antibiotics” and she took both without vomiting, finishing 5 days of antibiotics. The pain in her right lower abdomen lessened but persisted. She was too weak to dig. She began to urinate a lot and drink a lot of water.

She first noticed pain, constant and progressive, in the RUQ under her ribs about a week later (3 weeks ago), with increasing fevers and has lost considerable weight. She has no appetite; hasn't vomited again, has no diarrhea, but often feels nauseated. Over the past few days she has noticed her urine is darker than usual. She and her husband are monogamous, and she hasn't noted vaginal discharge or bleeding. She knows of no others with a similar problem.

P.E. Looks older than age, and uncomfortable but in no acute distress

BP 100/70 → 80/70; 110→ 140; T 102 R 22, not deep
conjunctiva: icteric;
mouth: dry mucous membranes, no thrush
neck: no JVP lying flat; no HJR; no lymphadenopathy
lungs: clear
heart: S₁ S₂ Gr 1/6 SEM

abdomen: RLQ: firm; tender, cylindrical “mass” 7 x 3cm
RUQ: liver ↓ 2 cm, span 13 cm; edge non-tender but winces with gentle punch over the RUQ
rectal: no masses, guaiac negative brown stool
pelvic: no discharge, general discomfort but no cervical motion tenderness, right adnexal fullness/tenderness;
extremities and neurologic exam: normal

U/A: s.g. 1.025, +4 glucose, +3 bili, +3 urobilinogen, (-) protein, trace ketones, (-) leuk. esterase, (-) nitrates

- 1. What is the “frame” of this case (i.e. the key clinical features that the final diagnosis must be consistent with)?**
What are the clinical implications of each feature of the frame re-disease process?

- 2. What is the differential diagnosis of the RUQ pain in this case?**
What are the clinical “pros and cons” of each of the possibilities?
What is the most likely diagnosis?

- 3. How would you manage this patient?**