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 13 – LEFT ABDOMINAL PAIN

A 29 year old male returns to Kisoro from a farm near Kampala where he has been working the fields most months of the year for 8 years. He has been admitted to the district hospital there a few times over these 8 years for "malaria", and has had other bouts of fever treated as an outpatient with unknown medications with good response. Otherwise he's been well until the last few months when he's felt increasing fatigue and shortness of breath on exertion, along with some (mild) weight loss and a "heavy" discomfort in the left upper quadrant of his abdomen. He's felt "hot" on and off, but has not had cough, night sweats, or diarrhea, and over the years has not had any episodes of blood per rectum nor severe pain in his muscles and bones.

Over the past 2 weeks his fatigue and belly pain have intensified, and now that he's home for the holidays he's presenting to the hospital for evaluation. He's married with 3 children, and denies sexual partners other than his wife.

PE: He's a thin man, in no distress.

BP 110/60 HR 115 T 99 axillary RR 16

conjunctiva: pale, including the rim; left subconjunctival hemorrhage; non-icteric

mouth: 3 small palatal petechiae; no thrush

fundi: normal discs without papilledema, exudates or hemorrhages

neck: JVP seen 2 cm above angle of Louis; no HJR; no lymphadenopathy; no goiter

lungs: clear to auscultation and percussion

heart: tachycardia, regular at 115

PMI 1 cm lateral to mid-clavicular line, sharp and pounding;

possible RV lift at left sternal border

loud S1 split, S2; ⊕ S3 on expiration, feint;

Grade 1/6 early systolic murmur, left upper sternal border without radiation.

abd.: soft; non-tender, without guarding or rebound

liver: span 12 cm, descends 3 cm. below costal margin on inspiration;

spleen: 12 cm below costal margin and moves down/medially with inspiration; medial cleft palpable; firm; smooth; non-tender

skin: normal, no truncal scars

extremities: no edema;

neurologic: normal; no fine tremor of outstretched fingers

1. What are the key features (the "frame") of this case?

2. What problem/observation would you build your differential diagnosis around? Explain.

What is the differential diagnosis?

3. Explain the diagnostic significance of the PE signs noted, both positive and negative:

4. What easily available history, physical exam signs and laboratory tests are useful in diagnosis?

5. What is the pathophysiology of the cause of the conjunctival pallor in this syndrome?

6. What is "gold standard" of diagnosis <u>and</u> therapy for this disease?