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 31 – Chest Pain for 14 Years

A 40 year old woman presents to Kisoro District Hospital after months of progressive abdominal pain, and abdominal and leg swelling.

She first began experiencing chest pain 14 years ago after birth of the last of her 3 children. When asked to describe the "pain", she fluttered her hand and recounted transient episodes of "heart racing" lasting minutes to hours, occurring weekly to monthly. Intermittent bouts of heart racing were her main symptom until ~ 3-4 years ago when she noticed gradually progressive dyspnea on exertion and decreased energy, and, over the past year, shortness of breath at night intermittently causing her to sleep with pillows.

Three months ago, fatigue and weakness increased, accompanied now by diffuse, constant abdominal pain, and abdominal and bilateral leg swelling. There was no change with food. She recently began to cough producing scant clear-yellow sputum. She has not felt "hot". She recalls no prolonged period of pain in her joints causing functional limitation when younger.

Physical Exam: Appearing tired and thin, in no acute distress

RR 24, T: 38, BP 110/70; HR regular ~110; occasional premature contractions (PCs)

Mouth: poor dentition, no thrush

Neck: JVP to angle of the jaw; regular cannon V waves

+ hepato-jugular reflux (HJR)

no lymphadenopathy, no thyromegaly

Lungs: crackles, intermittent wheezes ↑ ½ lung fields bilaterally

Heart: Right parasternal lift;

PMI/heave: 5 cm diameter, in 2 interspaces, anterior to mid-axillary line

Right parasternal/left PMI/heave are dyssynchronous with "rocking" motion to chest wall

S_1, ↓ S_2;

⊕ S_3 in left lateral decubitus position at apex, ↑'d with expiration;

⊕ S_3, when supine, at left lateral sternal border, ↑'d with inspiration

Gr 3/6 low-medium pitched, holosytolic murmur to axilla/back

- Post- PC compensatory pause – no significant change in intensity of murmur

Gr 2/6 holosystolic murmur, LLSB to 3rd rib, ↑'d with inspiration

Abdomen: pulsatile liver; tender to percussion in RUQ

distended, ⊕ shifting dullness

Extremities: edema: 3mm to knees bilaterally

Musculo-skeletal and Neuro exams unremarkable

1. The complaint of "chest pain" can carry different meanings in Africa than in the U.S. What other symptoms might chest pain encompass in rural Africa? Why?

How should the health provider get at the root of the complaint?

2. What is the *pathophysiologic significance* of the *time course or natural history* of the patient's symptoms?

3. In patients who complain of chronic SOB and/or edema, what is a common but often overlooked cause of *abdominal pain*? How is it diagnosed?

4. What are the key findings on the PE and their pathophysiologic significance?

5. What is the most likely *specific etiology* of this patient's underlying disease?

6. What potentially reversible cause of clinical decompensation in this disease "can't be missed"?

7. How can this disease be prevented?