Introduction:

Welcome to the 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 4-10 discussion questions that direct clinical reasoning and/or highlight diagnostic issues. A month 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

About the Author:

I'm a Professor of Clinical Medicine at the Albert Einstein College of Medicine in the Bronx, New York, where my career has centered on medical education for the past 40 years – as a past residency Program Director in Primary Care and Social Internal Medicine at Montefiore Hospital, and global health advisor and program leader at the school. I've served on the Boards of Directors of Doctors for Global Health, Doctors of the World USA, and the Global Health Education Consortium. I spend about 3-4 months a year in Uganda working on the Medicine wards of Kisoro District Hospital which, like most hospitals in the world that serve most of the world's population, has (almost) no resources. "At the bedside", I teach Internal Medicine residents and medical students how to assimilate the elements of history, physical exam and epidemiologic probability into a diagnostic impression that, even without definitive testing, can lead to appropriate therapeutic strategies in the field.

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Case 63: Lumps, Worse on Treatment

A 33 year old woman presents with 1-2 months of increasing neck lumps.

The patient went for an HIV test 6 weeks ago after feeling weak and losing weight over 4 months. At the time she did not have a cough or fever. The HIV test was positive and with a CD4 count of 150, she was started on anti-retroviral therapy (ARVs) shortly thereafter.

Despite therapy, she didn’t feel much better, and noticed that the small lumps in her neck that were painless when first noted one month prior to starting ARVs, began to enlarge more rapidly and become tender. She continued to lose weight, didn’t feel “hot” but had significant sweats at night, and did not have a cough.

Physical Exam

In no distress. Thin, with temporal wasting

BP 120/60; HR 70; T 37; R 15

Skin: normal, without plaques, lesions
Mouth: no thrush, no discolorations, no lesions
Fundi: benign, no exudates or hemorrhages
Neck: left posterior cervical chain of nodes grossly enlarged, extending to the supra-clavicular area; matted together, mostly firm with some areas of fluctuance; mildly tender, non-erythematous, not warm;
left posterior chain, top down: 8x5cm, 5x3 cm, 2x2 cm,
left supraclavicular: 3x4 cm, 2x3 cm
right side nodes: all less than 1 cm;
no other nodes >1 cm in axillary, inguinal etc. regions
Lungs: clear to auscultation and percussion:
Heart: normal PMI, S1, S2; no rubs, murmurs, gallups;
Abdomen: no hepatosplenomegaly, masses or tenderness;
Neurologic: mental status, motor, sensory, cerebellum, reflexes, gait normal
1. What is the “frame” in this case from the history and physical exam (i.e. the key clinical features the final diagnosis must be consistent with)?

2. Name 6 descriptive features of palpable lymph nodes and the clinical significance of each feature?

3. What are the implications of the clinical features (from history and exam) on the underlying pathology of the lymphadenopathy (LAD) in this patient?

4. What is the differential diagnosis?

5. What is the most likely primary diagnosis, and why? What test can provide definitive diagnosis?

6. What is the likely explanation for the patient’s failure to symptomatically respond to ART therapy? What are the potential ways that therapy may have influenced the patient’s presentation?

7. a) What are the 2 principle therapy-associated syndromes in HIV-infected patients and what are the clinical criteria for diagnosis? 
   b) What is the relevant differential diagnosis of symptoms beginning after ART commences? 
   c) What is likely to have occurred in this patient and why?

8. The patient was started on appropriate therapy for the LAD diagnosis and initially responded but then seemed to relapse with continued weight loss and overt fevers appearing, and her LAD increasing in size. What may explain this new clinical deterioration?