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 64: Finally Fungating

42 year old man presents to the hospital with a large, foul-smelling mass on his right foot and inability to walk.

He was fine, married with 5 children working as a potato farmer in Kisoro his entire life, until about 4 years ago when he started noticing intermittent right foot swelling. The swelling was mild, not always present, worse at the end of the day, and associated with a feeling of leg heaviness, but not pain. He had no fever, prominent veins, skin changes or shortness of breath.

About a year ago, he noticed a solid dark painless nodule on the back of his right foot near his ankle which grew in size to about 3 centimeters over a few months, with 2 other smaller similar lesions appearing on the edges of the nodule. They became softer as they grew, and the nodules merged with each other. He went to a traditional healer who, over the course of the last few months tried various herbs both orally and directly applied to the growing lesion. Two weeks ago, the lesion formed a crater at the top, and began to ooze yellow pus and to smell bad. When walking induced pain on the top of the foot, he decided to come to the hospital. He has been monogamous, and has not had fever, anorexia, diarrhea, weight loss, or other skin conditions.

Physical Exam:

Thin but not cachectic, in no distress, unwrapping a pus-filled, soiled rag from around his right foot and ankle, filling the ward with a pungent “rotting” smell.

BP: 110/80, HR: 95, T: 98, R: 18
Skin normal, except for lower right leg (see below)
Mouth: no thrush;
Neck: no lymphadenopathy, JVP, or thyromegaly
Lungs clear,
Heart normal PMI; normal S1, S2;
Abdomen: without hepato-splenomegaly or tenderness
   Groin, right: two 1-2 cm tender lymph nodes
Neurologic: intact mental status, CN, motor, sensory, cerebellar, reflex exams
Extremities: arms and left leg, normal without edema
   Right leg: mild pedal edema
     8 cm diameter fungating, verrucous, multicolored (pink, brown-black, purple), firm-fleshy mass 5 cm tall, topped by a 2 cm diameter pus-filled ulcer;
     adherent fleshy-soft, bleeding, 1-2cm smooth broad-based polyps around the perimeter; fleshy mass is fixed to underlying tibia and non-tender; surrounded by a firm, indurated, hyperpigmented plaque base ~ 2 cm. in diameter;
1. What is the “frame” in this case (the key clinical features from the history and exam that the final diagnosis must be consistent with)?

2. What is the (rather restricted) differential diagnosis, and the pros and cons of each of the possibilities mentioned?

3. What tests should be ordered? What therapy is appropriate?