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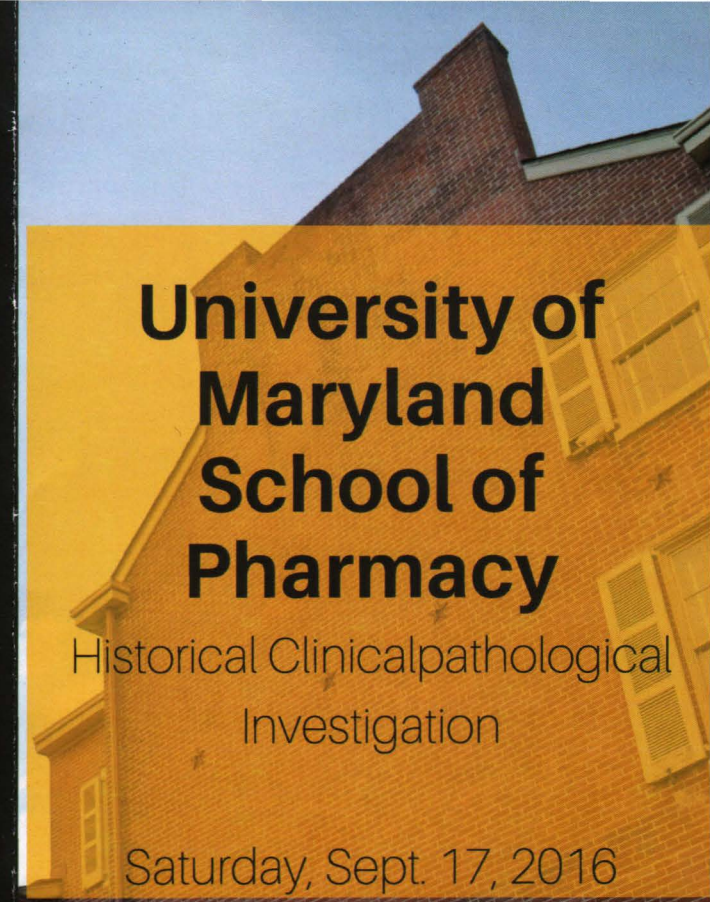


University of Maryland School of Pharmacy

Historical Clinicalpathological Investigation

Saturday, Sept. 17, 2016

Overview

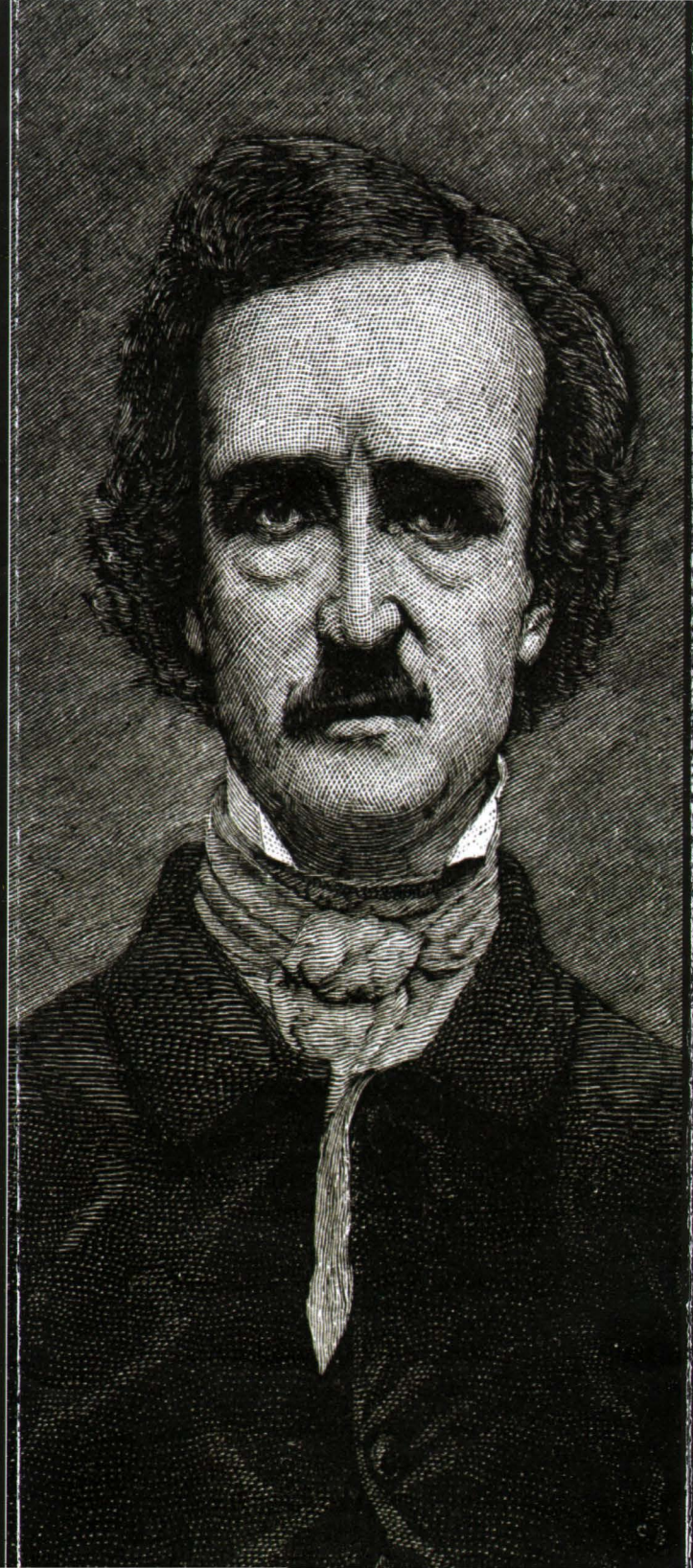
A Clinicopathologic Conference (CPC) is a clinical exercise in which the history of a patient's illness is presented to an experienced clinician for discussion in a didactic setting. The presentation of the death of a historical figure for diagnosis and discussion is a concept borrowed from our colleagues at the University of Maryland School of Medicine, which holds an annual historical CPC during its alumni reunion weekend.

In celebration of the School of Pharmacy's 175th anniversary, we present our inaugural historical CPC and have tailored the exercise to focus on pharmacological treatment, drug discovery and development, and health outcomes.

Case History

A 40-year-old man was brought to the emergency room in early October 1849 for evaluation of lethargy and confusion. He was traveling from Richmond to Philadelphia when he became ill and was found unconscious under the steps of the Baltimore Museum on Baltimore Street in the late afternoon. He was apparently well when he left Richmond at 7 a.m. There was no evidence of trauma, and the patient did not smell of alcohol.

The patient worked as a writer. He had no known allergies, coronary artery disease, diabetes, or other systemic illness, and was taking no medication. He had been diagnosed with cholera three months before his hospitalization.



In addition to a history of depression and possible opiate abuse, he had a history of alcohol abuse. However, he had abstained from drinking for the past six months and there was no reported history of seizures or delirium tremens. The patient smoked tobacco on a regular basis and was sexually active with women. There were no known pathologic work exposures.

The patient was admitted to the hospital for observation. He was initially unresponsive and remained so until approximately 3 a.m., when he developed tremulousness and delirium and began having visual hallucinations. He was noted to be drenched with perspiration and to have wide variations in his pulse rate. He remained in this state for the next 28 hours. Early in the morning on the third hospital day, he became tranquil.

Results of a physical examination showed a well-developed white male who was calm and cooperative. His skin was warm and diaphoretic. His pulse rate was in the 50s and "thready." Results of a neurologic examination showed the patient was alert, oriented, and cooperative. There was no tremor, and he followed commands appropriately.

The patient said he felt "miserable," but denied specific pain. He did complain of mild diffuse abdominal discomfort and headache. He had no recollection of how he had arrived at the hospital or of the events leading up to his illness.

Because of his improving status, he was transferred to the ward room. Here, his physicians attempted to treat him with alcohol, which he vehemently refused to drink. He soon worsened again, and by the evening of the third hospital day, his mental status became clouded. He was noted to have shallow, rapid respiration and diffuse weakness. He drank water only with great difficulty. By late evening, he was again delirious, became combative, and required restraint. He remained in this state, calling out for family and friends, until his death on the fourth hospital day.