CASE 3
WHERE IS ROBERTO?

In the gray of winter, I was called to the Emergency Room of a small local hospital to evaluate a young Hispanic man named Roberto. The nurse on the telephone simply said, "Come quick! He's been in a motorcycle accident!"

When I arrived at the Emergency Room, it was deserted. The medical doctors had the charts in a conference room where they were conducting morning rounds, the surgeons were in the surgery suite, and there was only one staff member to be seen, a harried male nurse. Before I could complete my introduction he said, "I'm from registry and I don't know any of these patients, so don't ask me." When I pressed him about Roberto's whereabouts, he waved me out into the hallway, where a hirsute, shirtless young man was wandering, fingering his skin, and laughing. A dirty splint was visible on his right leg. I could not coax him into a room so I was obliged to do my evaluation in the hall.

In his Diagnostic Examination, Roberto denied feeling sad, afraid, or angry and he denied thoughts of suicide or sensations of hearing voices. When I asked him why he was rubbing his skin, he merely fingered his arm and said, "Dirty."

On his Cognitive Examination of *attention*, Roberto's Level of Conscious fluctuated between alert and distracted. Roberto could only identify his name and his location on the Orientation test. When I called his attention to the time on a large wall clock, he commented that the clock looked like a face. His ability to hold up his hand on a test of Basic Verbal Comprehension was erratic and he failed a test of Vigilance where he was required to monitor a series of numbers to detect the numeral "5."

In *language* evaluation, Roberto's' Quality of Speech was poor—his flow of speech was halting, his words were slurred (dysarthric), and he showed strong perseveration, repeating words and phrases several times. On a test of Object and Part Naming, he could identify a watch, pen, and shoe but not their parts.

Roberto failed *memory* tests of Digit Span and Cued Delayed Memory. Although he could not remember any US presidents, he easily named several prominent members of the Mexican revolution, who he called "the streets" (because many Mexican streets are named for historical figures). He told me he had grown up in Guadalajara, and when I asked him how he liked the market in a small town nearby, he correctly told me that there was no market there. Thus, his long-term or distant memory was intact.

Roberto failed all the tests of *abstract thinking*. He was unable to perform a Simple Arithmetic test; his drawing of a Greek Cross showed only the left side of the figure; and he did not seem to be able to understand the instructions for Proverb Interpretation or Set Analysis.

Roberto also failed all the tests of *sequential thinking*. He could follow only three of the steps in a Four-Step Sequential Command and he failed Serial Sevens subtraction. In the Luria Figure Drawing Test (Appendix VII), Roberto's drawings, like his speech, were perseverative, with many repeated lines, loops, and figures. When I had exhausted Roberto, I repaired to a corner to try to make some sense out of the information I had collected.

CHALLENGE

This case illustrates the problems of trying to make an assessment with insufficient information. Using the information available, see if you can devise a tentative diagnosis for Roberto and decide what you would suggest for the next stage of his treatment. By the way, one solution would simply be to wait a day until more information was available from the chart or staff—do you want to wait?

CASE 4
MR. SMITH HAS VOODOO WORMS!

The beliefs of different cultures influence patients' understanding of the meaning of disease and clinicians' ability heal. We are trained to combat problems with knowledge and facts, whereas patients' cultural understanding can anscend the logic of our own clinical culture. When the facts are unknown or the patient cannot accept our xplanations, then the approach to the problem may become more important than the solution. This somewhat rrifying case involves the approach to a confounding medical problem and the need to make a psychological terpretation that the patient can accept.

This case took place in the Emergency Room of an East Coast hospital that serves a broad range of cultures ncluding Native American, Caribbean, and Cuban. Around 3:00 A.M., I was called to see a 32-year-old man of aribbean birth named Mr. Smith. Mr. Smith's accompanying papers vaguely listed "urinary problems" as his chief omplaint.

When I came into the cubicle where he was sitting, Mr. Smith looked up and said, "Doctor, I've been cursed." Vhen I looked confused, he explained further.

"There's a Santeria woman on my block and this man I know paid her to curse me. She has got a St. John the Conqueror root and she cursed me with it. Yesterday this curse made me fall down and today this woman has filled my ody with red worms," he said.

"Yes. And how do you know this?" I said, trying not to sound critical.

"I know it because I *see* the worms!" he said, as if I was a dunce. "They come out in my piss. I know that's not ight. When I saw them swimming out, I came right to the hospital."

I agreed with Mr. Smith that his condition certainly did not seem to be right and handed him a cup to provide a urine sample. Then I excused myself to look up more information about the patient. I could find no previous medical or psychiatric records and there was no indication that he had ever come into our Emergency Room before. His complete blood count, electrolytes, creatinine, and blood urea nitrogen were all normal.

Suddenly I heard a shout from his cubicle and I ran in to see Mr. Smith looking hysterical. He held his urine cup at arm's length as if it contained the plague. I could see that it was partially full of a clear fluid.

"Look!" he screamed, "I just peed out a worm!"

I peered over Mr. Smith's shoulder to stare down into the cup. To my horror, I saw a thin, bright red object the size of a short piece of spaghetti that was swishing around in the sample cup. It certainly looked to me like a thin, red worm swimming around in the fluid.

In his Diagnostic Examination, Mr. Smith said that his appetite, sleep, and activity were normal. He denied physical symptoms of restlessness, edginess, muscle tension, pounding or racing heart, shortness of breath, choking, chest pain, stomachache, nausea, excessive sweating, chills, hot flushes, trembling, shaking, tingling, fatigue, dizziness, lightheadedness, a sense of detachment, poor concentration, or his mind going blank. Mr. Smith denied experiencing recent elation, sadness, hopelessness, anxiety, irritability, or anger. He denied thoughts of suicide and violence and he said that he had no fears of losing control, dying, or going crazy. He denied delusions or hallucinations in any sensory modality. Mr. Smith's Cognitive Examination was normal for all tests of *attention, language, memory, abstract thinking,* and *sequential thinking*.

CHALLENGE

It would take lots of luck for you to figure out the nature of Mr. Smith's medical problem, although you are welcome to try. Your job is to develop a psychological approach to the patient that will help him cope with his frightening magical experience and still allow him to accept help from mainstream medicine.