From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 03/11/2025 07:50 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh!!

The next student CPC is scheduled on **Nov 3, 2025, in the CPD Hall, AIIMS Rishikesh,** from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link: https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m74b3d54bda78b27b0a92b72229f63967
Monday, Nov 3, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2518 425 2275
Meeting password: 031125

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine and Biomedical Informatics
AIIMS Rishikesh

Behind the Fibrosis: Tracing the True Identity of Our Blasts

Student CPC Case Summary (to be presented on 03/11/2025)
Department of Medical Oncology Hematology | AIIMS Rishikesh

Patient Name: Mrs ABC	**Age/Sex: 37**years / F	**Clinician in-charge:** Prof. Uttam Kumar Nath
Residence: Saharanpur,Uttar Pradesh	**UHID -** 20250127090	**Pathology Faculty incharge :** Prof. Neha Singh
Pathology Discussant : Dr. Lumen P Agarkar		**Clinical discussant** : Dr. Nikhil Nagpal

1.

Presenting Complaints

• Fever for 2 months
• Cough for 2 weeks at the beginning of illness
• Dragging sensation over the left upper abdomen for 2 months

2. History of Present Illness

The patient was apparently well two months ago when she developed fever, which has been persistent. Fever was low-grade (up to 100°F), occurring once daily without chills or rigors. No rash, night sweats, or weight loss. Dry cough for two weeks without expectoration or breathlessness.

She also reports a dull dragging sensation in the left upper abdomen for two months, aggravated after meals or lying on the left side. No associated pain, nausea, vomiting, or early satiety. No abdominal distension, jaundice, or altered bowel habits.

3. Past, Personal, Family & Socioeconomic History

Past History: No prior hospitalizations or similar complaints.
Personal History: Appetite and sleep normal; bowel/bladder habits regular; no addictions.

Family History: Non-contributory.
Socioeconomic History: Class IV (Modified Kuppuswamy). Husband is a labourer; lives with 5 family members.

4. General and Systemic Examination

General Examination:
• ECOG Performance Status: 3
• Pallor present; no icterus, cyanosis, clubbing, or edema
• Vitals: PR 94/min, BP 118/76 mmHg, RR 18/min, SpO_2 98% (RA)

Systemic Examination:
• CVS – S1S2 audible, no murmur
• RS – NVBS heard, no added sounds
• Abdomen – Soft; liver palpable 7 cm below right costal margin; spleen palpable 12 cm below left costal margin, firm, non-tender, moves with respiration
• CNS – No focal neurological deficit

5. Investigations

Key laboratory findings are summarized below:

Investigation	Result
Hemoglobin	7.8 g/dL
Total Leukocyte Count	107 $\times 10^9$/L
Platelet Count	402 $\times 10^9$/L
Peripheral Smear	Myeloid preponderance with blasts
Bone Marrow	Hypercellular with fibrosis
Flow cytometry	To be discussed in CPC
PCR	To be discussed in CPC
Cytogenetics	To be discussed in CPC
NGS Myeloid Panel	Sent

6. Discussion

A 37-year-old female presented with prolonged low-grade fever, hepatosplenomegaly, and marked leukocytosis. Differentials included chronic infections and myeloproliferative disorders. Progressive evaluation focused on distinguishing myeloid malignancies and assessing marrow fibrosis. The final diagnosis, revealed during CPC discussion, integrated hematologic, cytogenetic, and molecular findings.