From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 04/08/2025 11:02 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh!!

The next student CPC is scheduled on **Aug 3, 2025, in 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=ma82f3b3bf9d20bd40a3da812b4003e4c
Monday, Aug 3 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2511 359 2464
Meeting password: 040825

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

CPC Clinical Summary (4th August 2024)

UHID: 20240168530	Dept: Ophthalmology	Clinician-in-Charge: Dr. Ajai Agrawal Clinical discussant: Dr. Shalaka Waghamare
Age/ Gender : 54 y/ female Residence: Bijnor , UP	Date of admission: 07.12.24 Date of discharge: 27.12.24	Neurology Discussant: Dr. Nitesh Radiology Discussant: Dr. Nishant

Chief Complaints:

Diminution of vision in left eye (LE) for 2 months

History of present illness:

- Patient was apparently alright 2 months back when she had gradual diminution of vision in left eye which was associated with redness, swelling of upper eyelid, limitation of extra ocular movements and headache.
- No H/o ocular discharge/ watering/ fever/ rash/cough/cold recent ocular trauma/ past similar episodes
- She had taken treatment for the same elsewhere (no documents available) but had no relief.
- MRI report (30/11/2024) (elsewhere): Features of left eye orbital cellulitis with optic neuritis, orbital apex syndrome, phlebitis of cavernous sinus and altered signal intensity likely early osteomyelitis of clivus.

Past Surgical History: LE cataract surgery 6 months back (elsewhere), improved vision after surgery.

Past Medical History: H/o Hypertension since x 1 year controlled on medication

DM diagnosed 1 month back , not on medication

Personal history: Normal sleep, no addiction or allergy.

Examination:

General Physical examination: Conscious and well oriented. No pallor, edema, icterus, cyanosis, clubbing, lymphadenopathy

Systemic Examination: WNL

Ocular examination	**Right Eye**	**Left Eye**
Corrected Visual Acuity for distance	6/24	6/36
Pupil	NSNR	Mid dilated and fixed
Intraocular Pressure (mm of Hg)	15	19
Ocular adnexa	WNL	Mild ptosis and swelling of left upper eyelid
Extraocular movements	Full and free in all gazes	Limitation in all gazes
Anterior Segment	Nuclear sclerosis grade 2 with posterior subcapsular cataract	• Focal conjunctival chemosis, nasally • Well centered posterior chamber intra-ocular lens
Fundus	Media grade 1; Optic disc, retinal vessels, macula and periphery within normal limits	Media grade 1; Disc margins blurred nasally, retinal vessels, macula and periphery within normal limits
Corneal sensations	Intact	Intact
Color vision	Within normal limit	Within normal limit
Contrast sensitivity (on Pelli- Robson chart)	1.20	1.20
Regurgitation test	Negative	Negative
Ocular diagnosis	Nuclear sclerosis with posterior subcapsular cataract	Orbital infection with pseudophakia

Investigations :

Date	07.12.2024
Hemoglobin (g/dL)/ TLC/ Plt	12.9/9,600/428,000
PT/ INR	14.6/1.16

KFT (Urea/ S. Creatinine)	20/0.84
LFT (Tot Bil/Dir Bil)	0.65/ 0.17
HbA1C	6.5 %
Viral markers	Negative
Blood culture	No growth obtained
Urine culture	No growth obtained
Nasal mucosa KOH	No fungal elements
CEMRI Brain + Orbit (12/12/2024)	Enhancing thickening with central necrosis (abscess) in medial rectus and extension into orbital apex.

Course during hospital stay:

Patient was admitted on 07.12.2024. A provisional diagnosis of superior orbital fissure syndrome (likely infective) was made. She was started on broad spectrum intravenous antibiotics and anti-inflammatory medication. She was planned for CE-MRI brain and orbit. Multidisciplinary consultation including neurology, ENT, and interventional radiology team was performed. CSF findings were within normal limit. Following an initial sub-optimal recovery on antibiotics, oral corticosteroid was started. The patient showed gradual improvement of extraocular movements and other ocular symptoms.