From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 10/02/2025 07:47 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **Feb 10, 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=m737e6b8a25a3532c619ad036722ff5f5

Monday, Feb 10, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2516 261 0327

Meeting password: 100225

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

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Name : Mr. A	**Age-** 56 years	**Gende**r-Male	**CR No-** 20240179485
DOA: 31/12/24			**DOD: 06/01/25**
Clinician in-charge- Dr Lokesh Kumar Saini		**Clinical Discussant: Dr Prakhar Sharma**	
Address:		**Meerut, Uttar Pradesh**	
History- A 56-year-old male farmer with a 20 pack-year smoking history and chronic alcohol use, presented with multiple painless subcutaneous swellings over the chest and abdominal wall, progressively increasing over four weeks. He also reported blood-streaked sputum for one week and melena, occasionally mixed with frank blood. He denied history of fever, chest pain, dyspnea, weight loss, or loss of appetite.			

Examination:

Built: Well built

ECOG PS - 2

General Condition – Conscious & Oriented

Head to toe Examination:

Multiple swellings over chest wall, back and abdominal wall [total 15 in number], some showing purplish red discoloration over the overlying skin, firm, non-tender, no local rise in temperature, mobile, not fixed to underlying structures, skin not pinchable separately from the swelling.

Respiratory- Chest movement decreased in left lower areas, dull note on percussion over left ICA, MA, IAA, ISA. Breath sounds decreased in right side ICA, MA, IAA, ISA. Vocal resonance decreased on the same areas. No added sounds.

CVS - S1 S2 heard normally, no murmur present.

P/A- Soft, No palpable organomegaly, BS present.

CNS – Intact higher mental function, GCS = E4V5M6 =15/15

*No pallor, xerostomia, skin changes, rheumatoid nodules, deformities over extremities

Clinical diagnosis- Ca lung with cutaneous metastasis

Parameter	Value (SI unit)
Hemoglobin	**8.4 (gm%)**
Total Leucocyte Count	7850/ul
Platelet count	1.25 lakh/ul
Differential Count (in %) (N/L/M/E/B)	70.2/13.0/16.6/0.1/0.1
FBS/PPBS	**131/187**
HBA1C	8.3
Blood Urea	24
Serum Creatinine	0.84
Serum. Na^+	**134**
Serum K^+	4.29
Serum Cl^-	103
Serum Ca^{2+}	8.4

Viral Markers HBsAg Anti HCV antibodies Anti HIV antibodies	 Negative Non-Reactive Non-reactive
Radiology	***Will be discussed in CPC***
Course during hospital stay	The patient with above mentioned diagnosis was admitted in pulmonary ward. CXR and CECT Thorax and Upper Abdomen done outside were interpreted s/o lung lesion, and gastric lesion with multiple peritoneal lesions. Punch biopsy and FNAC was done from the swelling over chest wall. FNAC from cutaneous swelling was reported as carcinoma. Gastro medicine opinion

	was done for UGIE and evaluation of primary, which did not show any abnormality. Metastatic workup was done. MRI brain was suggestive of multiple well defined t2/flair hyperintense peripherally enhancing lesions in bilateral cerebral hemispheres bilateral cerebellar hemispheres, medulla, pons, thalamus, bilateral caudate nucleus, many shows internal areas of necrosis. Radiation oncology opinion was sought; they asked to rule out tuberculosis. MR Spectroscopy showed choline peak s/o metastasis. Medical Oncology opinion was done and they advised to send the HPE for extensive IHC panel in view of confusion regarding primary. He was discharged and asked to review with HPE reports. ***The details of HPE will be discussed in the CPC***.
Outcome	Patient received WBRT and CT on day care basis On telephonic review, relatives informed of unfortunate and sad demise of patient