From: "ROOT" <root@sctimst.ac.in>
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Date: 11/02/2025 07:55 AM
Subject: Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The CGR will be held on the **Feb 11, 2025** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM.** You can join online through the following link:

Meeting link:
https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=md392a904e5080a6d577db63a4092e49d
Tuesday, Feb 11, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2518 044 8512

Meeting password: 110225

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

CLINICAL GRAND ROUND

Department of Nephrology, 5TH FEB 2025

Name: Mr X	Age/Sex: 66/M	Residence: Dehradun,Uttarakhand
UHID: 20240089679, First OPD visit on 28/06/2024		
Case Presenter- Dr Parul (Academic Senior resident)		Consultant in charge- Dr Sharon Kandari (Associate professor)

Chief complaints-

- Facial puffiness and bilateral lower limb swelling - 4-5 months
- High grade fever - 3 days
- Cough with expectoration - 3 days
- Decrease urine output - 3 days

History of present illness-

- Not a known case of hypertension and diabetes . Patient was apparently normal five months back when he developed swelling in bilateral lower limbs which was insidious in onset and gradually progressive . It was associated with facial puffiness. Swelling became generalised with in three months .Not associated with frothuria, hematuria and decrease urine output .With these complaints patient visited nearby physician . He was managed conservatively on oral diuretics for two months .
- On investigations , patient was found to have renal dysfunction (S.creat-1.8), proteinuria (24 hours urine protein - 7.8 gram), dyslipidemia. Anti PLA2R quantitative levels were 632 RU/ml.Patient was advised for renal biopsy . Renal biopsy was done on 11/05/25 which was suggestive of membranous nephropathy with focal areas of global glomerulosclerosis . Patient was given two doses of inj Rituximab (1gram) on 24/5/24 and 11/6/24.
- He presented to nephrology OPD, AIIMS, Rishikesh on 28/06/24. He had persistent lower limb swelling ,fever , cough and decrease urine output during the time of presentation to AIIMS, Rishikesh.

Examination-

- Pallor +, Bilateral pitting pedal oedema - grade 3+
- Pulse- 104, BP- 96/60 mm hg, R/s- bilateral coarse crepitations

Investigations-

- At presentation (28/6/24)- HB- 7.5, TLC- 16.18K, PLT- 161k, Albumin- 1.3, urea/creatinine- 127/3.5, procalcitonin- (17 →1.5)
- 24 hours urine protein -6.4 gram
- Anti PLA2R antibody titre - 48.25
- CA 19-9 - 1.3, AFP - 1.3
- Xray- bilateral lower zone non-homogenous opacities
- HRCT CHEST (1/7/24)- Bilateral pleural effusion with subsegmental atelactesis
- USG KUB- RK- 10 CM, LK- 10 CM
- P-ANCA and C-ANCA - not detected, Anti GBM - negative
- RENAL BIOPSY- (10/12/24)- 17 Glomeruli**,** 4 globally sclerosed, 3 focal segmental sclerosis, uniform thickening and duplication of basement membrane .One glomerulus- segmental cellular crescent, IFTA -10-15%. IF -14 glomeruli , IgG4- 3+

Management-

Duration	**ISSUE**	**MANAGEMENT**
IST admission 28/6 - 16/7/24	Sepsis - LRTI Fluid overload Hypoaluminemia CRBSI	IV antibiotics (Piptaz + Azithromycin) Diuretics +Albumin Blood culture - Methicillin resistant staphylococcus hemolyticus line removed, antibiotics according to sensitivity given

	Anemia (iron defeciency)	1 unit PRBC transfused
2nd admission 28/11-20/12/24	Fluid overload Woresing of proteinuria Woresing of renal dysfunction Oliguria	Initiated on hemodialysis (Access - Right IJV TCC) Renal biopsy done- crescentic transformation Methylprednisolone pulse therapy given - Tb prednisolone started Injection Cyclophosphamide given
3rd admission (18/1/25)		3rd dose of cyclophosphamide given
4th admission (9/2/25)		4th dose of Cyclophosphamide given

Summary-

- Primary membranous nephropathy with atypical presentation .LRTI was managed with antibiotics. Renal Biopsy done . He was given pulse methylprednisolone , Tb prednisolone , Inj Cyclophosphamide . He was discharged on intermittent hemodialysis with Right IJV TCC.