From: "ROOT" <root@sctimst.ac.in>
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Date: 17/09/2024 09:14 AM
Subject: Invitation for CGR

From: "RRC Rishikesh (rrcrishikesh@aiimsrishikesh.edu.in)" <rrcrishikesh@aiimsrishikesh.edu.in>
To:
Cc: Meenu Singh <meenusingh4@gmail.com>
Date: Mon, 16 Sep 2024 19:21:31 +0530
Subject: [EXTERNAL MAIL] Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The CGR will be held on the **Sept 17, 2024** 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=meb9e57af7f54a497b3b31c000d2c8c4b

Tuesday, Sept 17, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2518 183 0311

Meeting password: 170924

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

Thanks & Regards

Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

CLINICAL GRAND ROUND

Department of Nephrology, 17th September 2024

Name: Mrs X	**Age/Sex: 59/F**	**Residence: Almora, Uttarakhand**
UHID: 20240110753, First OPD visit on 7.8.2024		
Case Presenter- **Dr Anshuman Biswal (Academic Senior resident)**		**Consultant in charge-** **Dr Sharon Kandari (Associate professor)**

Chief complaints-

- Generalised weakness- 1 month
- Bilateral ankle and small joints of foot pain- 20 days
- Bilateral lower limb rashes- 20 days
- Facial puffiness and bilateral lower limb oedema- 15 days
- Cough with expectoration- 12 days
- Dyspnoea at rest- 10 days

History of present illness-

- Known case of Hypothyroidism for 15 years, on thyroxine supplement. Patient was apparently normal 1 month back when she developed generalised weakness which continued for 1 month. She had pain over bilateral ankle and small joints of foot which was insidious onset and gradually progressive over 15 days. There was no other joint pain, recurrent oral ulcers, alopecia, malar rash, fever, loose stools, and dysuria. She developed bilateral lower limb rashes which was insidious onset and gradually progressive over 15 days. It was non-blanchable with no itching and pain over lesions. She developed facial puffiness and lower limb swelling, which was insidious in onset, gradually progressive in nature over 10 days. There was no history of chest pain, palpitation or yellowish discoloration of skin and sclera. She had cough with expectoration and dyspnoea at rest for 7 days. With these complains, patient visited nearby physician. On 30/7/24, Hb- 8.8, TLC- 18000, **Creatinine- 1.3.** She was given IV antibiotics for possible infection. Repeat creatinine on 3/8/24- 2.1 mg/dl. She was diagnosed to have Hypertension outside and was started on anti-hypertensive agents. She presented to nephrology OPD, AIIMS, Rishikesh on 7/8/24. She had persistent lower limb swelling and dyspnoea at rest during the time of presentation to AIIMS, Rishikesh.

Examination-

- Pallor +, Bilateral pedal oedema +, Bilateral lower limb rash +
- Pulse- 104, BP- 150/100 mm hg, R/s- bilateral coarse crepitations, **Dipstick- Protein- traces, blood- 1+**

Investigations-

- At presentation (7/8/24)- HB- 8, TLC- 24.2K, PLT- 6.1L, Albumin- 1.7, urea/creatinine- 69/2.98, procalcitonin- 36.1. Urine output day-1- 1.2 Liters
- Serum iron- 10.3, Transferrin saturation- 6.1, TSH- 56.8**,** Anti TPO- 35.3 (negative)
- Xray- bilateral lower zone non-homogenous opacities, cough sputum aerobic CS- E. coli + Klebsiella, Blood CS- sterile.
- CT CHEST (8/8/24)- Fibro-bronchiectatic changes with few centrilobular solid fibrocalcific nodules in apico-posterior segment of left upper lobe. Areas of ground glass attenuation with interstitial septal thickening in bilateral lower lobes and right upper lobe. chronic infective changes (L>R)
- USG KUB- RK- 9.3 CM, LK- 9.4 CM, 24-hour urine protein- 1.38 GM, MPO ELISA- 167.5 (<20), PR-3 ELISA- 4.44 (<20), C3/C4- 135 (90-170)/ 16.8 (12-36), Anti GBM ELISA- negative, ANA IFA- negative
- RENAL BIOPSY- (20/8/24)- 15 Glomeruli**,** 1/15 globally sclerosed, 8/15 fibro-cellular crescents, Fibrinoid necrosis in one capillary tuft, IFTA- 10-15%, DIF- Ig G- focal entrapment, c3-1+ segmental.

Management-

ISSUE	MANAGEMENT
Sepsis (LRTI)	IV antibiotics (meropenem + teicoplanin)

Acute kidney disease	Pulse methylprednisolone followed by oral steroids, Plasmapheresis (5 sessions) and IV Cyclophosphamide
Anaemia (Iron Deficiency Anaemia)	PRBC transfusion and iron supplements
Hypertension	Tablet Amlodipine
Primary hypothyroidism	Thyroxine supplement
Vascular access	Right IJV TCC

Summary-

- Rapidly progressive glomerulonephritis with LRTI at presentation. Treated with antibiotics. She was given Pulse methylprednisolone, plasmapheresis (5 sessions) and IV cyclophosphamide. She was discharged with Right IJV TCC.

Attachments:

File: CGR SUMMARY 17.9.24.docx	Size: 23k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document