From: "ROOT" <root@sctimst.ac.in>
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Date: 25/08/2026 08:04 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh!!

The next student CPC is scheduled on **Aug 24, 2026, 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=mc44d0e830a4de4f8f64af4d4c2dea4e7

Monday, Aug 24, 2026 | 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2515 209 5835
Meeting password: 240826

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

STUDENT CPC – 10/8/2026 – DEPARTMENT OF MEDICAL GASTRO, AIIMS RISHIKESH

Name : Mrs. X	**Age-** 43	**Gender-**Male	**CR No-** 20220070476
DOA: 13/05/2026		**DOD: 16/05/2026**	
Clinician in-charge : DR. ITISH PATNAIK		**Clinical Discussant: Dr SARTHAK**	
CPC DISCUSSION THEME		**Cholestatic jaundice in a patient with IBD-UC and PSC**	

Background History

- 2017: Diagnosed with IBD – ulcerative colitis and started on oral mesalamine.
- During evaluation, cholestatic jaundice was noted; ERCP with plastic CBD stent placement was performed, after which jaundice resolved (initially considered choledocholithiasis).
- Continued oral mesalamine for 1–2 years and subsequently stopped treatment while asymptomatic until 2022.
- 2022: Recurrent biliary pain; evaluated outside and diagnosed with choledocholithiasis. ERCP with CBD clearance and stent placement was performed; cholecystectomy was advised.
- At AIIMS, MRCP/ERCP with cholangiogram showed irregularity of RHD/LHD and intrahepatic biliary radicles without dominant stricture; impression was PSC without dominant stricture. UDCA was started.

History of Present Illness

- No history of blood transfusion, cola-coloured urine, abdominal lump, vomiting of stale food, high-risk sexual behaviour or IV drug abuse.
- Prior biliary instrumentation as described above; no prior surgery.
- No abdominal distension, pedal edema, altered behaviour, melena, joint pain, red eyes, skin rash, oral ulcers, photosensitivity, night blindness, bony pain, easy bruising, gait difficulty or peripheral neuropathic symptoms.
- Bowel habit: currently 1–2 stools/day, Bristol type 3–4; bladder habits and sleep-wake cycle normal.
- Family history: father had pulmonary tuberculosis 1 year previously and completed ATT.

Summary

43-year-old male patient with IBD-ulcerative colitis diagnosed since 2017 and primary sclerosing cholangitis diagnosed in 2022, with prior biliary instrumentation, presented with cholestatic jaundice for 2½ months associated with loss of appetite and weight loss. No other major constitutional symptoms or documented micro/macro-nutrient deficiency. ECOG performance status 1.

Syndromic Diagnosis

- Extrahepatic biliary obstruction.
- Malignant > benign
- Past history of biliary instrumentation.

- No history suggestive of cholangitis or gastric outlet obstruction.
- Background of IBD-ulcerative colitis with PSC.
- ECOG performance status 1.

Differential Diagnosis

Diagnosis	Points in favour	Points against
Cholangiocarcinoma	5th decade; IBD-UC with PSC; painless jaundice with loss of appetite and weight loss; biliary stricture with cholestatic jaundice.	Jaundice was non-progressive.
UC + PSC with choledocholithiasis	Prior history of choledocholithiasis; cholestatic jaundice; painless jaundice; weight/appetite loss.	Current presentation raised concern for another obstructive process.
IgG4 sclerosing cholangitis	Cholestatic jaundice; isolated biliary involvement possible.	Typically older men; isolated biliary involvement is uncommon.
Extrinsic CBD compression by lymphadenopathy (TB/lymphoma/metastatic nodes)	Cholestatic jaundice with weight/appetite loss.	No direct association with UC; absence of other constitutional symptoms, including typical TB symptoms.

Examination

- General: conscious and oriented; BP 114/78 mmHg, pulse 92/min, SpO_2 98%, temperature 98.6°F, RR 16/min.
- Icterus and grade 2 clubbing present. No pallor, cyanosis or lymphadenopathy.
- Weight 48.8 kg; height 143 cm; BMI 17.7 kg/m^2; MUAC 23 cm.
- Abdomen: left lobe of liver palpable in epigastrium, irregular margin, firm, smooth and non-tender. Spleen palpable 3 fingerbreadths below left costal margin; smooth, well-defined and non-tender with palpable splenic notch. Liver span 16 cm. No shifting dullness or abnormal mass.
- DRE: no growth palpable.
- Respiratory, cardiovascular and CNS examinations were otherwise unremarkable.

Investigations – Liver Function Tests

Parameter	29/07/22	12/11/22	17/03/26	16/04/26	03/05/26	13/05/26
OT	34	23	76	66	64	52
PT	37	32	46	35	34	25
ALP/GGT	265/-	129/-	620/158	758/218		890/340
Total/direct bilirubin	2.51/2.11	1.40/0.85	5.46/2.88	3.04/2.04	3.01/1.99	4.84/4.01
Protein/Albumin	5.83/3.33	6.1/3.2	8.78/3.01	7.2/3.45	6.1/2.6	7.38/3.2
PT/INR	13/1.07	13.2/1.09		15/1.2		15.2/1.3

Investigations – Hematology and Tumour Markers

Parameter	29/07/22	17/03/26	16/04/26	03/05/26	13/05/26
Hb	13.3	13.08	10.7	10.6	11.2
WBC	7640	10730	4320	5820	7390
Platelet	2.43 L	2.36 L	1.82 L	1.87 L	1.89 L
BUN/Serum creatinine	29/0.87	15.6/0.61	19.2/0.58	10/0.4	
Na^+/K^+	138/4.1	136/4.1	135/4.74	142/4.1	138/4.1
CEA			2 (N<10)		
CA 19-9			12 (N<37)		

Colonoscopy

Patchy loss of vascular pattern in rectum, sigmoid colon, descending colon and transverse colon. Impression: IBD-UC-E3, in endoscopic remission.

MRCP Abdomen (17/04/2026)

- Liver normal in size (~15.6 cm) with mild nodular margins and volume redistribution.
- Moderate intrahepatic biliary duct dilatation.
- Diffuse narrowing of CBD (~2.4 mm) with multifocal strictures and alternating dilated segments in CHD and intrahepatic ducts, producing a beaded appearance suggestive of PSC.

- Ill-defined enhancing soft-tissue thickening at the hepatic hilum causing abrupt narrowing of the primary biliary confluence, non-visualization of proximal left hepatic duct and extension along CBD.

PET-CT (23/04/2026)

- Chest: FDG-avid necrotic mediastinal and bilateral hilar lymphadenopathy involving pretracheal, paratracheal, AP window, prevascular, precarinal, subcarinal, bilateral hilar, supradiaphragmatic/pericardiac, posterior mediastinal and lower paraesophageal stations. Largest subcarinal conglomerate 4.7 × 3.0 × 1.7 cm; SUVmax 4.5.
- Abdomen: hepatosplenomegaly (liver 18 cm, spleen 18 cm). IHBRD with pneumobilia and dilatation of right and left hepatic ducts.
- Ill-defined mildly FDG-avid infiltrative lesion at the biliary confluence involving right and left hepatic ducts, proximal CBD and cystic duct (SUVmax 6.5), with multiple FDG-avid hepatic lesions in both lobes.
- Multiple non-FDG-avid to mildly FDG-avid abdominal lymph nodes at porta hepatis, periportal, peripancreatic, paraaortic, retrocaval, paracaval, gastrohepatic, perigastric, pericholecystic, mesenteric and bilateral external iliac stations.

EUS with FNB

- Multiple mediastinal lymph nodes at stations 9, 8, 4, 5 and 6, ranging from 8–25 mm; some were matted and one had a necrotic centre.
- FNB obtained from the largest mediastinal lymph node.
- Hilar region showed multiple lymph nodes causing compression of the CBD and portal vein.
- Pancreas was normal; no liver SOL seen. CBD and pancreatic duct were normal.
- Impression: generalized lymphadenopathy; hilar lymph nodes with CBD compression; possibility of TB or lymphoma.

HPE Report (15/05/2026)

- Features of necrotizing granulomatous inflammation.
- AFB stain negative.
- CBNAAT for tissue positive.
- Fungal culture negative.

THANK YOU