From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 30/09/2024 07:51 AM
Subject: Student CPC

From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: Mon, 30 Sep 2024 07:50:42 +0530
Subject: Fwd: [EXTERNAL MAIL] Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **Sept 30, 2024** 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=m86e800129d02aeebe89a75ef2f04b88c

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

Meeting number: 2511 345 4468

Meeting password: 300924

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

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

CPC Clinical Summary (30 September 2024)

Pt. Age/sex: 43/F	Clinician-in-Charge: Dr. Rohit Sharma	Discussant: Dr. Sahil Gupta
Dept : Medical Gastroenterology	First admission: 22/11/23 Second admission: 22/8/24	Pathology discussant: Dr Kranthi

Chief Complaints:

- Right upper quadrant pain for 6 months
- fever with chills and rigors for last 2 months.

History of present illness:

42 yr old female, non-smoker , no known comorbidities , patient was apparently normal 6 months back when she developed Right upper quadrant pain for 6 months, insidious, intermittent, moderately severe, VAS of 6/10, relieved on analgesics . patient also complains of fever with chills and rigors for last 2 months. Intermittent

initially, f/b continuous fever since 15 days, no diurnal variation. Patient also had dry cough for 6 months and had generalized weakness and fatigue. No history of jaundice, Shortness of breath, Dyspnoea on exertion, Hematemesis or melena.

Past medical history: No previous significant medical history

Past surgical History: No previous surgical history

Family history: No significant family history

Personal history: homemaker, normal sleep, no addiction or allergy

General examination: normal built, conscious, oriented,

PR- 82bpm, regular, normovolemic, BP- 110/68 mm Hg, RR- 22/min, SpO2 97%RA, Temperature 38o C

Pallor^{+}, Pedal edema^{-}, Icterus^{-}, Cyanosis^{-}, Clubbing^{-}, Lymphadenopathy^{-}

JVP not elevated

Systemic Examination:

- Chest- B/L NVBS present, no added sounds, CVS- S1S2 + No added sounds.
- CNS: E4V5M6, No motor or sensory deficit, reflexes normal
- PA: Soft, non-tender, hepatomegaly present 8 cm below the costal margin, no shifting dullness, Bowel Sounds +

Investigations:

	22/11/23	1/12/23	22/8/24	1/9/24
Hb	9.8	9.5	7.8	8.0
TLC	8230	8070	10170	9290
Platelets	323	379	246	398
Bilirubin	1.90/1.18	0.93/0.43	1.64/1.02	0.54
AST/ALT	91/59	56/36	70/26	50/39
ALP/GGT	1009/590	1427/407	2958/395	1759/1300
Total protein/albumin	8.0/3.0	7.4/2.7	5.9/1.5	4.9/1.7
Serum Urea	23	18	22	18
Serum Creatinine	0.53	0.47	1.01	0.47
Serum Na/K	135/4.11	131/4.64	140/4.4	131/4.64
INR	1.10	1.19	1.39	1.19

Nov 2023 USG - Cholelithiasis with choledocholithiasis and bilobar IHBRD	ERCP (23/11/23): No biliary obstruction.
CECT abdomen(25/11/23) Liver is enlarged in size~17 cm in span CBD stent is seen with its proximal tip in right biliary system and distal tip seen in D2 segment of duodenum. Mild central bilobar IHBRD noted Enhancing thickening with fat stranding noted in distal ileal loops for a length of 2.5 cm.	**CECT Thorax (25/11/23)** Mosaic attenuation changes with few fibro-atelectalic bands are noted in bilateral lungs. Multiple sub-centimetric mediastinal lymph nodes are noted There is no pleural or mediastinal mass, no pleural effusion.
Colonoscopy(27/11/23)- Normal study till terminal ileum. **EUS guided FNB liver was done on 30/11/23.**	**Investigations done** **Sputum (25/11/23): C/S- normal respiratory tract flora, G/S- few pus cells, few epithelial cells, no micro-organisms seen** **Sputum CBNAAT- NOT DETECTED** **S. ACE-183 nmol/mL/min**

Course And Management:

The patient had right upper quadrant pain and fever with chills and rigors with chronic history of dry cough. USG revealed Cholelithiasis with choledocholithiasis and bilobar IHBRD. ERCP was done which revealed no biliary obstruction. In view of hepatomegaly and persistent cholestasis patient was further worked up. CECT abdomen revealed hepatomegaly with generalized lymphadenopathy and mosaic attenuation pattern of lung parenchyma. EUS guided FNB liver biopsy was done. Serum ACE levels were 183 nmol/mL/min which were significantly elevated. After all the clinical examination, laboratory work up, imaging and other invasive investigations, patient was provisionally diagnosed to have hepatic sarcoidosis and started on steroids in tapering doses. Initially patient showed improved with mild resolution of symptoms but patient was then lost to follow up and self stopped treatment. Patient presented with similar complains in August,2024 and readmitted and reevaluated. CECT Thorax was suggestive of multiple pulmonary nodules- Pulmonary sarcoidosis with possibility of coexistent tubercular infection which cannot be ruled out. BAL was done and sample for CBNAAT was positive for MTB, no rifampicin resistance detected and patient was started on ATT under NTEP.

Unit's Final Diagnosis:

- Disseminated tuberculosis
- Hepatic sarcoidosis