From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 22/07/2024 07:52 AM
Subject: Invitation for Student CPC

From: "RRC Rishikesh (rrcrishikesh@aiimsrishikesh.edu.in)" <rrcrishikesh@aiimsrishikesh.edu.in>
To:
Cc: Meenu Singh <meenusingh4@gmail.com>
Date: Sun, 21 Jul 2024 13:07:29 +0530
Subject: [EXTERNAL MAIL] Invitation for Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **July 22, 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=m4bbff771b67885dbd64a297ff3edd910

Monday, July 22, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2514 664 5482

Meeting password: 220724

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

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Student CPC

(Department of Endocrinology)

Patient Name: Mr J	**Age/Sex:** years / M	**Clinician in charge:** Dr. Kalyani Sridharan
Residence: Shivalik nagar, Haridwar	**UHID** - 20190260900	**Clinical discussant (resident):** Dr. Ch jagapathi babu
Ward: Endocrinology		**Pathology discussant :**Dr Erna

Presenting Complaints: - palpitaions since 2 years

headache since 2 years

flank pain since 2 months

- **History of present illness:** Palpitations on and off since 2 years. Palpitations initially were 5-6 times per month lasted for 5-10 minutes. Headache on and off since 2 years associated with palpitations, intermittent, bitemporal lasting for 3-5 minutes, no aggravating or relieving factors. No h/o sweating .B/l flank pain since 2 months, sudden in onset gradually progressive aching in nature and continuous pain, non radiating, no aggravating and relieving factors. Initially patient was having mild pain and he was able to do his routine activities but since 15 days pain has increased, so he came to hospital. h/o hematuria 1 episode, 2 weeks back, not associated with pain .No h/o burning micturition since 1 month, no h/o fever. Patient is known hypertensive since last 1 year incidentally detected not on regular medication. Highest blood pressure readings were up to 160/90 mmhg. No h/o swelling of feet, no h/o frothy urine. No h/o swelling of face, No h/o increased appetite, no h/o weight loss, no h/o heat intolerance or preference for cold, no h/o increased sweating, no h/o nervousness, anxiety, no h/o tremors, no h/o irritability No h/o palpitations, no h/o dyspnea on exertion, No h/o increased stool frequency

Past/Treatment /Family /Addiction /drug history : H/o hypertension currently not on any medications. Never admitted with hypertensive crisis. No history diabetes, hyperthyroidism or hypothyroidism, No h/o previous surgeries, No history of UTI, No h/o renal calculi. Family history significant for brain tumor in mother and younger brother. Family history of hypertension and palpitations in son and younger brother.

Personal history: vegetarian. Normal bowel/Bladder habits.

General examination: (at the time of admission) :-

Patient is conscious, cooperative, oriented to time, place and person. GCS 15/15

No Pallor, no cyanosis, clubbing, lymphadenopathy, edema

Vitals: PR-82/min RR-20/min; BP- 160/66 mmHg

Head to toe examination - NAD

Systemic examination: ABDOMEN- soft, non-tender, flank fullness + over the both side,

CNS – E4V5M6, pupil NSNR,

planter- flexor. Tone- normal, no neck rigidity.

Sensory examination- normal

Cerebellar signs

Fundus – normal on both sides

Investigations:

- **Routine biochemistry** – CBC/ KFT/LFT – normal.
- TFT (ft/TSH) –3-4Miu/ml / 1.2ng/ml
- 24 hr urine normetanephrine - 3135 mcg
- **USG abdomen**
- A hyperechoic mass lesion in the right supra renal region measuring 9x7.2 cm with echogenic foci within abutting the inferior surface of right lobe of liver
- **CEMRI BRAIN, SPINE, ABDOMEN AND PELVIS (11/02/2020)**

  Bilateral heterogeneously enhancing adrenal lesion likely pheochromocytoma

  Multiple right renal heterogeneously enhancing lesion likely renal cell carcinoma

  Tiny small cyst in pancreatic tail region

  spondylodegenrative changes in spine

  Possibility of VHL syndrome likely

- **Genetics -** HETEROZYGOUS VHL c.499 C>T (R167W)
-

- Course and management:- Patient was on a small dose (1.25mg-1.25mg) of selective alpha 1 blocker prazosin, the dose of which was gradually increased for optimal BP control. Total fluid intake (1.5 times) and salt intake (5-7gm/day) were increased as part of pre-op preparation. Regular monitoring for any postural hypotension and paroxysmal spells was looked. Patient had hypertensive spells during the course in hospital, which were managed by dose optimization of Prazosin. Sequentially, beta blocker- Propranolol was added. Repeat CECT abdomen and pelvis was done for any progression in the size of the preexisting tumors and occurrence of any new lesions in kidney. Accordingly, he was found to have further progression in the size of bilateral pheochromocytoma and occurrence of new lesions in the right kidney and in the left kidney. Surgical oncology consult was taken. Following discussion with the radiology team and the surgical oncology team, patient was planned for right adrenalectomy, left cortical sparing adrenalectomy with radical right nephrectomy and close follow up for the left renal lesions. With the dose of Prazosin (17.5mg) and Propranolol (10mg BD), patient was asymptomatic and hypertensive spell free and then taken up for surgery with perioperative stress steroid cover. He underwent surgery on 7.10.20- Right radical Nephrectomy with adrenalectomy with Right liver Glissonian capsulectomy with left sided cortical sparing (lateral limb) adrenalectomy. Patient required ionotropic support (Nor adrenaline) for about 48 hours following which it was tapered and stopped. The stress steroid dosing was then tapered, switched to oral maintenance dose of Prednisolone.

- Unit's final diagnosis: VON-HIPPEL- LINDAU SYNDROME
- BILATERAL PHEOCHROMOCYTOMA
- RIGHT MULTIFOCAL RENAL CELL CARCINOMA
- SECONDARY HYPERTESION AND DIABETES

Outcome: After surgery, patient was started on T.prednisolone 5mg p/o od. Patient is being followed up with yearly normetanephrine levels which were normal. Patient had a left kidney upper pole bosniak IV cyst which was 1x1 cm. as size is less than 4cm it is being followed up. Patient is being followed in OPD.

Attachments:

File: CPC Endocrinology (july 24).docx	Size: 18k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document