From: "ROOT" <root@sctimst.ac.in>
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Date: 03/02/2026 02:36 PM
Subject: CPC Clinical Protocol 04.02.2026

The next Wednesday CPC of the session will be held tomorrow, **February 04, 2026** at **08.00 hours** (IST) in **Lecture Theatre 1**, Nehru Hospital, PGIMER, Chandigarh under the Chairmanship of **Prof. Sanjay Jain.**

The session will also be available on the Webex platform. Kindly follow the link below to join.

https://pgitelemed.webex.com/pgitelemed/j.php?MTID=md00288711fdbf94321a0819943e426a2

In case you join in thru WebEx, kindly **ensure that your microphone and camera are switched off** and **PLEASE DO NOT SHARE YOUR SCREEN**.

The Clinical handout of the case to be discussed is attached herewith.
The clinical protocol will be discussed by ***Dr. KT Prasad, Department of Pulmonary Medicine.*** Radiology will be presented by ***Dr. Arun Sharma*** and Immunopathology will be presented by ***Dr. Seema Chhabra.*** Autopsy pathology will be presented by ***Dr. Ritambhra Nada.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Protocol (04-Feb-2026)

Patient: Mrs. R, 53/F
CR No.: 202305395785
Admission No.: 2024068870
Units/Wards: IM2-FMW/RICU
DoA: 28-Aug-2024

Clinician-in-charge: Drs. Sanjay Jain / A. N. Aggarwal
Clinical discussant: Dr. K.T. Prasad
Radiology discussant: Dr. Arun Sharma
Pathologist: Dr. Ritambhra Nada
DoD: 23-Sep-2024

Chief complaints: Numbness and weakness of right foot and left hand, abdominal pain, vomiting, skin rash x 15 days

Background history (Dec 2023): Presented to IM2 OPD with dryness of eyes and mouth x 1 year; also had numbness of hands and bilateral parotid swelling; ANA 2+, nuclear, fine speckled; Anti Ro >240 IU/mL; anti-La 40 IU/mL; salivary scintigraphy showed poorly functioning bilateral parotid and submandibular glands; serum IgG4 normal; diagnosed with primary Sjogren's syndrome and started on methotrexate 15 mg/week and prednisolone 5 mg/d.

History of current illness: 15 days prior to admission developed progressive numbness and weakness of right foot. About a week later, developed numbness and weakness of left hand as well. She also had right hypochondriac pain along with recurrent episodes of vomiting. She had developed multiple, reddish, non-pruritic skin lesions over both legs.
Past history: Hypothyroidism on thyroxine 50 mcg/d; no diabetes or hypertension; no abortions.
Personal history: No addictions; attained menopause 5 years ago.

Clinical examination: Conscious, oriented; afebrile; PR 96; BP 140/90; RR 28; SpO2: 99% on room air
Pallor+ icterus- cyanosis- clubbing- lymphadenopathy- pedal edema- JVP-
Bilateral parotids enlarged; palpable purpura present over both shins
NS: weakness of left hand (flexion 3/5, extension 3/5, weak handgrip) and right ankle (dorsiflexion 3/5); bilateral ankle reflexes absent, other reflexes 2+; absent touch and pinprick sensation in both hands and feet
Chest: bilateral NVBS, no added sounds; CVS: S1S2 normal, no murmur; Abdomen: tender liver 2 cm below RCM

Investigations

	28/8	**31/8**	**5/9**	**8/9**	**16/9**	**17/9**	**22/9**
Hb	7.3	5.3	7.1	6.8	7.0	5.8	7.8
TLC	13,700	13,480	15,700	12,100	18,470	16,200	14,900
DLC (N/L/M)	92/5/3	96/3/1	89/5/4	-	95/2/3	97/1/2	98/1/1
Platelets (lakhs)	3.69	2.19	1.70	1.69	2.56	2.00	1.01
PT/aPTT		13/25					16/47
Urea/Creatinine	61.9/1.1	178/2.8	140/1.6	177/1.9	156/1.5	159/1.6	134/1.2
Na/K	125/5.3	132/4.2	147/4.9	144/4.1	146/4.1	132/4.8	134/4.5
Ca/P	8.4/4.6	6.8/7.5	7.9/2.6	8.6/-	7.2/5.7	7.2/5.9	-
Bilirubin (T/D)	0.7/0.4	0.5/0.4	0.5/0.3	0.5/0.1	0.3/0.1	0.2/0.1	1.1/0.8
Protein/Albumin	5.8/3.0	5.2/2.3	5.2/3.0	5.4/2.7	4.8/2.5	4.5/2.3	3.7/2.1
AST/ALT/ALP	24/11/985	56/33/485	17/23/445	34/27/-	42/55/190	41/59/173	56/63/-
Amylase/Lipase			323/440		77/58		
CK-NAC/LDH	64/197	-/552					

Peripheral smear: Normocytic, normochromic and microcytic, hypochromic RBCs; no schistocytes
Serum iron profile: iron 25 mcg/dL (50-170); TIBC 171 mcg/dL (110-370); transferrin saturation 15% (20-40); ferritin >2100 ng/mL (13-150); ***Vitamin B12***: >2000 pg/mL; ***Folate***: 7.9 ng/mL
Hemolytic workup: Coomb's test negative; serum haptoglobin normal; plasma Hb not raised; urine Hb nil
Upper GI endoscopy: small non-bleeding ulcer in gastroesophageal junction

Urinalysis: protein nil to trace; blood nil to 2+, RBC nil to 3 (?15), WBC nil, casts nil; **Urine spot PCR**: 0.9

Cryoglobulins: positive; ***C3***: 63.2 mg/dL (90-180); ***C4***: not detected (10-40 mg/dL)
HIV, anti-HCV, HBsAg, anti-HBc total: negative
RF: not available; ***ANCA***: negative (twice); ***anti-dsDNA***: negative
Serum IgG, IgA, IgM: normal; ***Serum triglycerides***: 365 mg/dL
Serum electrophoresis: no M band; ***Urine electrophoresis***: no protein band

Pro-BNP: 72,418 pg/mL (0-125); ***Troponin T***: 243 pg/mL (13-25)
2D Echo: severe MR, mild TR, RVSP = RAP + 15 mmHg; global LV hypokinesia; LVEF: 35-40%

T3: 0.25 ng/mL (0.8-2); ***T4***: 2.8 (4.8-12.7); ***TSH***: 1.8 (0.27-4.2)
AFP: 3.06 IU/mL (0-5.8), ***CA 19-9***: 3.29 IU/mL (0-27), ***CEA***: 6.4 ng/mL (0-4.7), ***CA-125***: 152.7 IU/mL (0-35)

Blood culture: sterile (30/8, 2/9, 16/9, 20/9); P. aeruginosa (10/9); E. fecalis (23/9)
ETA bacterial culture: A. baumanii & P. aeruginosa (11/9), K. pneumoniae (14/9)
ETA fungal smear: negative (twice)
Mini-BAL fluid: Gram stain, AFB smear, fungal smear negative; GeneXpert MTB detected, no rifampicin resistance; MGIT growth of MTB complex

Pleural fluid analysis: protein 1.9; albumin 0.5; glucose 137; TLC 4,392 (neutrophils 71%, mononuclear cells 29%); gram stain and fungal smear negative; bacterial culture sterile
CSF analysis: TLC 15 (all lymphocytes); protein 41; glucose 153; gram stain, india ink, AFB smear, and GeneXpert negative

CECT chest: mild bilateral pleural effusion; smooth septal thickening; consolidation left lingula
USG abdomen: liver normal; bulky head of pancreas; no collections
CECT abdomen: bulky head of pancreas with ill-defined hypodensity in the head region ?early necrosis and minimal adjacent peripancreatic fat stranding; solid-cystic lesion in presacral region (4.2 x 4.4 x 4.5 cm) with thick internal septae ?neoplastic
CT angiography of both UL: faint to non-opacification of bilateral distal radial arteries
Arterial doppler of both UL: no flow in right radial artery
NCCT head: No evidence of intracranial bleeding

Sural nerve biopsy: mild perivascular inflammation, but no definite vasculitis; myelin and axonal loss
Skin biopsy: perivascular lymphoplasmacytic inflammation, fragmentation of internal elastic lamina of vessels with thrombi; IgM 2+ and C3 1+; IgG and IgA negative; consistent with immune-complex mediated vasculitis

Course in the hospital

On D1, started on methyl prednisolone pulse (600 mg/d x 3 days). Intubated on the next day for pulmonary edema and cardiogenic shock; developed AKI (non-oliguric). Gradually improved with antibiotics and diuretics; oral prednisolone added. Extubation attempted twice; but reintubated within 24 hours on both occasions. Underwent UGI endoscopy for malena. On D10, administered 1g of rituximab. On D13, developed VAP with septic shock; treated with polymyxin. On D17, developed ecchymotic skin lesion on right forearm (near arterial cannulation site) and dry gangrene of distal fingers; manged with heparin infusion and plasma exchange. Radiological opacities and respiratory failure progressively worsened and developed shock again. On D21, mini-BAL was performed and LAMB was started. Subsequently, ATT, caspofungin, and minocycline were added. However, shock continued to deteriorate, and she succumbed to her illness on D27.

Unit's final diagnosis

Sjogren syndrome, mixed cryoglobulinemia, pulmonary TB, VAP, refractory septic shock