From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 07/08/2025 08:33 AM
Subject: CPC Clinical Protocol 06.08.2025

Dear All,
The next Wednesday CPC will be held tomorrow, **August 6, 2025** 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. Navneet Sharma, Department of Internal Medicine.*** Radiology will be presented by ***Dr. Tarvinder Singh.*** Autopsy pathology will be presented by ***Dr. Nandita Kakkar.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

STAFF CLINICOPATHOLOGIC CONFERENCE 6TH/08/2025

Mr R Age= 40 yrs CRNo- 202502442689 DOA- 3/05/2025 DOD- 17/05/2025

Unit – GE 1 (Prof U Datta/Prof V Sharma) Presenter: Prof Navneet Sharma

Prosector: Prof Nandita Kakkar

Chief Complaints: Weight Loss/night sweats × 6 mths Dry cough × 3 mths Abd Pain ×3 mths

Farmer, Alcohol use disorder and Smoker -60-70 pack yrs. Weight decrease by 15-20 kgs with loss of appetite, malaise and easy fatigability. There was H/O night sweats with chills occasionally. Dry cough since 3 mths had resolved with medications. There had been non-bilious, non-bloody vomiting following food intake, multiple times for 10-15 days into illness that had subsided. Seen at IGMC Shimla (18/02/2025 till 26/02/2025) and a biopsy carried out following he had pain in right upper abdomen. He came to PGIMER with slurring speech, swaying to one side and walking difficulty. H/O Bed Wetting, polyuria, polydipsia (two observers) & Breathlessness – MMRC class II/IV

O/E: Consc, Cooperative, mod built, poorly nourished (cachetic), **P +** I - C- C- **L-** E**+ bilateral (Gr III).** Bp-110/70, PR- 110/min, RR-16/min, JVP –, **febrile- 102º F.**

Chest/CVS/CNS – WNL

PA – Hepatomegaly – 8 cms BRCM and Splenomegaly – 4 cms BLCM **INVESTIGATIONS:**

Date	**03/05**	**04/05**	**06/05**	**08/05**	**10/05**	**12/05**	**14/05**	**16/05**	**17/05**
Hb	**6.5**	**5.8**	**7.9**	**8.4**	**9.6**	**8.4**	**7.2**	**7.3**	**8.2**
Tlc	**1.19**	**0.7**	**0.9**	**1.38**	**2.05**	**1.2**	**2.0**	**1.49**	**0.98**
Plt	**64**	**41**	**34**	**29**	**49**	**15**	**18**	**17**	**10**
DLC	51.3-14.1-0.5-**32.6**		63.2-9.9-0.3-**25.4**-1.2			65.7-11.3-0.3-**22**-0.7			
TB/DB	1.32/0.4	1.24/0.5	1.2/0.78	2.2/1.39	2.13/1.1	1.67/1.1	2.02/1.3	3.51/2.2	4.66/2.9
OT/PT/SAP	**110/186**	**174/99**	**198/109/460**	**188/98/457**	**256/119/637**	**252/117**	**267/114**	**214/88**	**203/79**
Tprot/alb	4.1/1.19	/1.6	3.52/1.88	3.23/1.96	3.83/1.96	3.11/1.64	3.6/2.02	3.4/2.05	3.28/1.82
Na/K		126/3.8	127/-	125/3.4	122/3.9	130/3.7	121/3.6	-/4.4	122/4.5
Ca/PO4	8.8/-	8.3	-/3.74	8/1.81			8.88/_	**9.67/2.39**	**10.27/2.85**
LDH			**390**	**320**	**421**			**380**	**311**
Urea/Cr	27/0.63	26/0.64	32/0.81	24/0.59	24.6/0.6	25.5/0.6	24.8/0.6	34.3/0.6	46.2.0.7
UA			4.1	3.9	2.6			2.3	2.8
TG			**213.3**						**214**
PTI/INR		**61/1.63**							**54/1.86**
PT/APTT		**18.3/42**							**20/68**

Urine R/E- normal	HbA1c- 4.4%	B12 >2000	**Folate- 2.79**
S.Iron - 16.4	**Ferritin. >2100**	PTH.- 2.09	Cortisol- 445
ACTH- 4.04	**Vit D3.- 3.00**	TSH-1.82	T3/T4 -0.71/3.87
Retic count- 3.99 (05/05)	CRC- 1.	RPI-0.97	
IgG-647	IgM- 48	IgA-52	HBV/HCV/HIV- NR

SPOT URINE PROTEIN- 16.7 24 hr urine protein -182.70, urine creatine – 709.

14/05 EBUS TBNA- **inadequate**.

Bone marrow-Bone marrow flowcytometry show 0.006% mature B cells with Kappa:Lambda ratio of 2:1. Mature T cells are 3%, with CD4:CD8 ratio of 1.9:1. NK cells are 0.5% of all viable cells. No definite abnormal B or T cells noted. **There is a paucity of mature B cells in the bone marrow.**

Trephine Biopsy No: Tx-1000/25 - Predominantly normocellular marrow spaces. Mild megakaryocytic hyperplasia with few small hypolobated megakaryocytes seen. Erythroid and granulocytic precursors are proportionately represented. No lymphoid aggregates were seen. Focal fat atrophy and stromal degeneration are seen. An ill-defined histiocytic aggregate is seen in one of the marrow spaces but no giant cells or necrosis is identified. Ziehl-Neelsen stain does not highlight acid-fast bacilli. PAS stain does not highlight any fungal hyphae. Reticulin negative. **Interpretation**: Variably cellular marrow spaces with trilineage hematopoeisis and reactive changes**.**

13/05 Blood c/s - Staphylococcus hemolyticus (S to doxy, vanco, teico)

13/05 CBNAAT- neg

Procal -0.887 (08/05),	3.06 (15/05),	4.66 (16/05)
Sr osm-284	**Urine osm- 368**	**D dimer- 2133, Fibrinogen- 1.00**
Ammonia (17/05)- 22.6		**Pro BNP- 615; Trop T- 9.53**

Ascitic fluid: TLC- 355 (N10 **L90**), T Prot/Alb- 0.68/0.28, TG- 46.2, LDH-94, Amylase -17, Glucose- 81.50 **Ascitic F malignant cytology (16/05)-** mesothelial cells, degenerated cells and lymphocytes. **AFB- Negative (08/05)**

ABG

	16/5/25	17/5/25	17/5/25
pH	7.533	7.431	6.93
Po2	111.2	48.9	37.4
Pco2	27.7	38.5	53.5
Hco3	22.8	25	11
Lactate	-	-	16.56

5/5 USG W/A: Hepatosplenomegaly with multiple hypoechoic lesions as described; abdominal lymphadenopathy, moderate ascites, cholelithiasis with edematous mural thickening. **05/05 CECT Chest + Abdomen**- Mediastinal adenopathy, HSM with numerous variable sized lesions diffusely scattered in liver and spleen with abdominal Lymphadenopathy, mild right pleural effusion and moderate ascites, a lytic 8mm lesion in L1 vertebral body, overall f/s/o lymphoma

08/05 Whole PET-CT: hepatosplenomegaly, FGD avid LN on both sides of diaphragm, liver lesions , splenic lesions, marrow based skeletal lesions, abdominopelvic ascites, pleural effusion and min pericardial effusion as described ? Tubercular ? Lymphomatous

Sx Path (14/05/2025) Liver Bx Confluent lesions with epithelial cell granulomas and necrosis. The **background lymphoid infiltrate shows a few atypical lymphocytes which have a high N/C ratio with enlarged hyperchromatic nuclei.**

COURSE AND MANAGEMENT:

40 yr old male was initially admitted for loss of weight and loss of appetite at IGMC, Shimla. He was evaluated at IGMC Shimla. A CT scan of chest and abdomen revealed multiple mediastinal lymph nodes with subcarinal lymph nodes conglomerated to form a lymph node mass 4.8x8.6x14cm, heptasplenomegaly (liver-20cm, spleen- 15.6cm) with innumerable heterogeneously enhancing hypodense lesions in liver and spleen. Transbronchial needle aspiration (TBNA) was non-yeilding with a negative MTb genexpert on bronchoalveolar lavage (BAL). He was discharged on multivitamins. He developed high grade fever with evening rise of temperature and night sweats. After admission, he was found to have pancytopenia along with febrile neutropenia. He was started on empirical antibiotics (piperacillin+tazobactam) and hematology consultation was sought. Appropriate cultures were sent. Paracentesis showed high SAAG low protein ascites with no evidence of spontaneous bacterial peritonitis (SBP). As he did not respond, antibiotics were changed to meropenem and teicoplanin. A repeat TBNA showed inadequate aspirate. A Cardiology consultation was also taken; 2D Echo just showed mild pericardial effusion with no vegetation and normal ejection fraction. The non-resolution of fever prompted addition of empirical antifungals (liposomal amphotericin B) to the anti-infective regimen. A repeat liver biopsy was performed under SDAP cover. Blood culture grew Staphylococcus hemolyticus which was sensitive to teicoplanin on which patient was already on. A repeat CT thorax was done which also did not reveal any focus of sepsis. He soon developed shock requiring vasopressors & was intubated and ventilated. With progressive deterioration, he developed a cardiac arrest from which he could not be revived and was declared dead on 27/5/25.

Final Diagnosis – Disseminated Malignancy – Lymphoma ?
TB ?
Sarcoidosis ?

Attachments:

File: CPC Clinical Protocol 06.08.2025.pdf	Size: 90k	Content Type: application/pdf