From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 06/11/2024 09:50 AM
Subject: CPC Clinical Protocol 06.11.2024

Dear All,
Season's Greetings.
The next Wednesday CPC of the session will be held on **November 06, 2024** at 08.00 hours (IST) in **Lecture Theatre 1**, Nehru Hospital, PGIMER, Chandigarh.

The session will also be available on the Webex platform. Kindly follow the link below to join.
https://telemedicine.webex.com/telemedicine/j.php?MTID=mb8f5c93d0efe86e2ec7df721b3c21227

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. Ashok Kumar Pannu, Department of Internal Medicine.*** Radiology will be discussed by ***Dr. Pankaj Gupta.*** Autopsy pathology will be presented by ***Dr. Suruthy Ammu.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC – 06/11/2024 Chairperson: Prof. Sanjay Jain

Discussants: Clinician – Dr. Ashok Kumar Pannu, Radiologist – Dr. Pankaj Gupta, Pathologist – Dr. Suruthy Ammu

Demographics: Mr. HS. 53 years. Male. Residence- Patiala, Punjab. Occupation- Policeman

CR No: 202401266168. **DOA:** 27/01/24 at 00:35; **DOD:** 27/01/24 at 14:10 (Stay ~ 14 hours)
Unit: ACEM/ EMOPD Hall A (Prof. Navneet Sharma)

Significant background history and previous evaluations

(2020, another hospital)
CKD was diagnosed**.** Basic disease- not known. No h/o diabetes or hypertension. Baseline investigations/records- NA

(2021, another hospital)
PTB - sputum positive**.** Took ATT for 6 months (? compliance) and was tested sputum negative.

(2022 Aug, another hospital)
H/o fever for 1 week, and chest pain and hemoptysis for 1 day. HRCT chest showed fibrosis, bronchiectasis and volume loss in left lung, bronchiectasis with nodular infiltrates in right lung, rib crowding on left side, mediastinal shift on the left side. Treatment records- NA**.**

(2022 Dec, PGIMER): Nephrology OPD & MMW (12-21 Dec)
One-month h/o low-grade fever, productive cough with streaky hemoptysis and dyspnea (MMRC grade 2-3). No addiction or substance use. BP-160/90, SpO2 - 98% (room air)

Hb	**6.8**	Na/ K	132/ 4.9	USG KUB	RK/LK- 7.4/7.5 cm, CMD lost	
TLC	8000	BU/ Cr	**152/ 7.8**	Urine routine	Protein 3+, blood -	
DLC (N/ L)	65/ 27	Bil (T/ C)	0.3/ 0.1	ANA	1+, nuclear, speckled	
Platelets	167 x10^3	AST/ ALT	13/ 6	ANCA	Negative	
MCV/MCH	89/ 26	ALP	126	Sputum smear for AFB & fungus, GeneXpert Ultra		Negative
PBF: RBCs	NC/NC	TP/ Alb	7.8/ **3.0**			
Serum Fe	**34 (↓)**	Ca/ P	**7.6/ 5.2**	Sputum culture		*Pseudomonas*
TIBC	196 (N)	PTH	**348** pg/ml	Blood and urine cultures		Sterile
TS (%)	**17 % (↓)**	25(OH)D3	20 ng/ml	*Aspergillus fumigatus* IgG		Neg (4.6 mgA/l)
Ferritin	113 (N)	HbA1C	5.1 %	Serum galactomannan		Neg (0.3, <0.5)
CTBA (13/12): Left lung parenchymal destruction with fibrocavitatory and bronchiectasis changes, mildly prominent right bronchial artery. CTPA (19/12): ? left pulmonary embolism.						

Course and management: Hemoptysis resolved with conservative treatment. The patient was started on medical management for CKD and hypertension and was subsequently discharged.

(2023, another hospital)- Records NA
HIV was diagnosed and started on antiretroviral therapy (? composition, ? compliance).
HCV reactive and started on antiviral treatment (? composition, ? compliance, ? duration).
Maintenance hemodialysis twice per week was started for CKD (access- brachiocephalic fistula)

Current illness (2024 Jan)

Another hospital (1 week prior)- Chief complaints: worsening dyspnea, pain abdomen, and epistaxis. The patient received four sessions of hemodialysis. However, because of altered sensorium and worsening general condition, the patient was referred to higher center.

PGI EMOPD (27/1/24)- GCS- E1V1M1, BP- 150/40 on two vasopressors, PR- 110/ min, SpO2- 85% (room air), and reduced urine output. Pallor and bilateral pedal edema present. Pupils were reactive. Bilateral crackles on lung auscultation. Cardiac & abdominal examinations- NAD.

Hb	**9.6**	Na/ K	132/ 4.2	CSF analysis	
TLC	5200	BU/ Cr	**146/ 6.9**	TLC	11
DLC (N/ L/ M)	69/ 22/ 9	Bil (T/ C)	0.6/ 0.1	DLC (N/M) %	42/ 58
Platelets	**92 x10^3**	AST/ ALT	**73**/ 31	Glucose (mg/dl)	52 (CBS- NA)
MCV/ MCH	97/ 33	TP/ Alb	6.5/ **2.6**	Protein (mg/dl)	**68** (↑)
PT	**18**	pH	**7.25**	Ascitic fluid analysis	
aPTT	**35**	pO2	147	TLC	23
PTI	**64**	pCO2	28	DLC (N/M) %	18/ 82
INR	**1.55**	HCO3	**13**	Glucose (mg/dl)	**40** (↓)
Blood culture: *Citrobacter freundii*				Protein (g/dl)	4.0
Susceptibility: S – Amikacin; IS – Cefepime, Colistin				Albumin (g/dl)	1.7
R – Piper/tazo, Carbapenem, Ceftazidime				SAAG	**0.9** (↓)
ECG: Heart rate 91/min, premature ventricular contraction, poor R wave progression, ST depression in inferior leads, ? end QRS slurring					

CXR: Left lung parenchymal destruction with ? fibro-bronchiectasis/cystic areas, ? left pleural effusion. Right middle/ lower zone airspace opacities, right upper zone fibrosis
NCCT head: No brain parenchymal lesion or hydrocephalous. Mild cerebral atrophy.
USG abdomen: Liver- 12.8 cm, normal echotexture & outline. Gall bladder, pancreas & spleen- normal. Kidneys- 6.2 & 5.8 cm, CMD lost. Gross ascites present.

Course and management: The patient was intubated and started on piperacillin-tazobactam. Vasopressors were continued and hemodialysis was planned. However, at about 2 PM, the patient had a cardiac arrest. Cardiopulmonary resuscitation was done, but he could not survive.

Unit's diagnosis: CKD, Person with HIV and HCV co-infection, Post-TB sequelae
? PTB reactivation, Encephalopathy- meningoencephalitis or sepsis, Ascites (etiology unknown) with ?? subacute intestinal obstruction.
Cause of death: Septic shock, respiratory failure, ? cardiac arrhythmia