From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 06/10/2025 01:07 PM
Subject: CPC Clinical Protocol 08.10.2025

The next Wednesday CPC will be held on **October 08, 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. Sucharita Ray, Department of Neurology.*** Radiology will be presented by ***Dr. Anuj Prabhakar.*** Autopsy pathology will be presented by ***Dr. Uma Nahar.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

CPC CLINICAL PROTOCOL 08-10-2025

Name: SS **Age/Sex:** 32 M
CR No: 202501967656
Clinician In charge: Prof Vivek Lal
Clinical Discussant: Dr Sucharita Ray
Pathology Discussant: Prof Uma Nahar
Radiology Discussant: Dr Anuj Prabhakar
Date of Admission: 31.03.2025
Date of demise: 04.04.2025

Presenting Complaints:
Intermittent Fever x 4 months
Progressive Weakness of all 4 limbs with pain and burning in soles for 4 months
Weight loss and inanition 3 months

History of present Illness –
November- December 2024: 32M worker in Dubai started to complain of intermittent fever, recorded upto 101-102F, with evening rise of temperature, associated with chills. No rashes, coryza, cough or cold. Approximately one week after fever, started to feel pain in both thighs aggravated with muscle contractions or activity. Pain was also present all around the legs, but also around both soles, associated with burning. There was associated fatigue. Pain responded initially to 650 mg of Paracetamol temporarily but recurred once effect was over.
January 2025: Increased intensity as well as continuous pain in both lower limbs not responding to analgesics. Pain and swelling in bilateral ankle joints. Pain in toes gripping slippers and turning lid of bottle. Pain in muscles during squatting, getting up as well as during walking in both ankles. Observed tremulousness of fingers at rest. Severe pain as well as burning sensation in both feet upto ankles in stocking fashion. Fever continued intermittently with loss of appetite. Continued to experience all these difficulties until ADLs affected and had to leave Dubai and return to India.
February 2025: Started to experience pain and swelling in joints of both upper limbs and small joint of both hands (distal to wrist as per file) Weakness in both distal and proximal, leading to inability to break rotis, or grip objects. Pain over both arms, aggravated by movement. Started to require one person support to ambulate and climb stairs. Needed chair to use toilet. Was admitted in a hospital at Hamirpur. (Sputum + *K pneumoniae*, CSF TLC 2/P 41/S67, ADA 6.5). Treated with antibiotics, partial recovery.
March 2025: Worsening of weakness. Needed support for most of the activities of daily living. Abnormal sensation in both feet remained constant. Cumulative weight loss 12 kilos in 3 months.

Background History:
Investigated for polyuria 3 years back when found to be diabetic. CAM intake not verified.
H/O intermittent painless oral ulcers from childhood. But no arthritis, arthralgia, photosensitivity, genital ulcers, sicca symptoms. No skin changes ever in the course of disease.
No substance abuse or high risk behavior.

Clinical Examination:
Patient alert and conscious, alert to TPP. Tachypneic at rest. Pallor + White nails
Generalized wasting temporal hollowing, upper limbs distal (B/L FDI), lower limbs B/L thighs.
Vitals: PR- 182/min, RR- 32/min, BP- 116/ 70mm Hg, Spo2: 84 % on RA à 96% on 8-10 L O_2
Respiratory system: Crepitations in right mammary, infra-axillary and infra scapular areas
Cardiovascular: Tachycardia.
Multiple bilaterally symmetrical tender small and large joints of UL and LL
Manual Muscle Test Score 101 /150
Neurological Examination:
Cranial Nerves: Fundus B/L cotton wool spots. PERRL. Remaining cranial nerves Normal
Motor: Proximal more than distal weakness, bilateral symmetrical (3/5). Generalized wasting. Reflexes preserved symmetrically except ankles. Sensory bilateral paresthesia but gross examination normal. No meningeal signs. No lateralizing deficits.

	25-26/03	27/03	31/03	01/04	02/04	03/04	
Hb	8.1	7.9	8	7.5	7.3	8.6	HHH NR
TC	2210	2620	5300	3240	3070	16270	B12 551
DC	73/14	75/13	86/5		78/11	89/3.5	Fol 7.7
PLT	229	196	179	208	230	378	D-dimer 1810
SE	131/4.5	131/4.7	132/4.4	129/4.09	135/4	134/4.81	ProBNP 9401
RFT	22/0.45	22/0.33	20/0.37	20/0.41	23/0.45	35/0.72	Trop T 203
TB/CB	0.47/0.34	0.42/0.32	0.5/0.16	0.27/0.17	0.2/0.14	0.38/0.03	Ferritin >2100
AST/ALT	454/187	361/149	199/79	153/67	116/54	171/57	Se Fe 47/Sat 25%
ALP	254	243		216	206		TSH 8.86
TP/ Alb	5.9/2.4	5.73/2.38	5.9/2.06	5.3/2	5.1/1.98	6.1/1.86	ANA ++++ (Nucleosome dsDNA + AIH Panel ANA +++ C3/C4 68/16
Ca/ PO4	7.2/4.1	7.3/3.9	8.2	7.6/4.1	7.4/3.7	7.7	
Mg				1.66	2.08	CBNAAT Neg	
ESR	72→92 →91	HbA1C 9.9% →6.1%	TC 111 TG 185 LDL 49 HDL 22			Blood C/S Sterile	AFP1.65 CA 19-9 0.6 CEA 4.08
LDH/CRP	-/10.4	INR 1.08		615/62	594/52	Urine C/S sterile	Myositis Panel: Ku +++ PM-Scl 75 + PL-7 +
CK NAC	(501) 583	616		426		Sputum C/S sterile	
Fundus: B/L temporal disc pallor, multiple cottonwool spots, No microaneurysms S/O SLE Retinopathy							

Echo: Global hypokinesia, Severe LV dysfunction. EF 25-30%, No clots
EMG (01/04/25): Fibrillations, early recruitment, polyphasic MUAPs s/o Myositis **NCS** (01/04/25): Sensory motor axonal polyneuropathy

CTPA (PG480979) (01/04/25): No PTE. Multiple centrilobular nodules with nodular & patchy areas of consolidation in B/L lungs. B/L minimal pleural effusion. ? infective etiology. Subpleural reticulations & cystic changes in B/L anterior upper lobes – CTD related ILD.

Course and management: SS was admitted with the above-mentioned complaints. He developed sudden onset dyspnea & showed mild crepitations in right lower lobe with disproportionate hypoxemia(ABG-no CO2 retention) with tachycardia- urgent CTPA ruled out PTE and CT chest showed bilateral basal consolidation with nodular opacities. HAP cover was given with colistin and vancomycin. Cardiac biomarkers showed elevated ProBNP, troponin & D-dimer and 2D Echo revealed global LV hypokinesia with EF 25-30%. Cardiology consult suggested myocarditis and prescribed diuretics. Rheumatology consult was taken for SLE-advised for IVIg due to presence of infections. Second day of these managements developed progressive cardiorespiratory failure requiring mechanical ventilation and inotropic support and developed cardiac arrest refractory to resuscitative measures.

Units Final Diagnosis:	Cause of Death:
Diagnosis: Myocarditis- Refractory cardiogenic shock Systemic Lupus Erythematosus- multiorgan involvement – Hematological/vasculitic neuropathy/ Myositis Diabetes Mellitus/ Sepsis- Hospital acquired pneumonia	**Cause of Death** : Refractory cardiogenic shock