From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 10/04/2024 09:08 AM
Subject: CPC Clinical Protocol 10.04.2024

Dear All,
The next Wednesday CPC of the session will be held on **April 10, 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=m01a828ba1bac62c24b796a8959846d27

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 presented by ***Dr. Rajesh Vijayvergia, Department of Cardiology.*** Radiology will be presented by ***Dr. Manphool Singhal***. Autopsy pathology will be presented by ***Dr. Uma Nahar.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

CK- 22-year Male, Resident of Ambala, CR No 202401392821, Adm No 2024010280

DOA:07/02/24 DOE:13/02/24 ↓ EMW/Endocrinology, Prof Dr SK Bhadada

Clinical discussant: - **Prof. Rajesh Vijayvergiya** Radiology: - **Prof. Manphool Singhal**

Pathology discussant:- **Prof . Uma Nahar**

Presenting complaints: - Fever – 1 week
Progressive shortness of breath – 4 days
Altered sensorium- 1 day

History of present illness: -

The young boy has been an IV drug abuser (Smack/heroin) for the last 1 year and on de-addition treatment at Ambala (buprenorphine-naloxone). He had a relapse about 2 weeks back and again started taking IV drugs. For the last 1 week, he has had a high-grade fever (101°) with chills, generalized body aches, and decreased urine output with dysuria. He also had shortness of breath for the last 4 days, progressively worsening with dry cough for 2 days and associated with altered sensorium from 1 day.

There is no history of orthopnea, hemoptysis, seizure, trauma, focal neurologic deficit, dysphagia, hoarseness of voice, pain in the abdomen, GI bleeding, jaundice, or haematuria.

Past/Personal History: - Occasional smoker, non-alcoholic, IVDU for last 1 year. There is no history of tuberculosis, diabetes, hypertension, epilepsy. No past hospitalization.

Clinical examination: -

The patient was conscious, disoriented, and delirious (E3,V3,M5). Pulse was 160/minute, regular, good volume. Blood pressure 150/80mmHg, RR 30/mt, SpO2 83% on room air. No pallor, icterus, clubbing, lymphadenopathy. Pedal edema is present. Red rash all over the body. Brownish spots (healed rash) on bilateral hands, red rash over bilateral legs.

CVS normal. Bilateral crepitations in lung fields. Per abdomen: tender hepatomegaly, soft abdomen, bowel sounds present. CNS- Neck rigidity +, Kernig's sign positive, bilateral reactive pupils. Planter downs, power 5/5, normal deep tendon reflexes.

Investigations: -

	Hb	MCV	TLC	DLC	Plat	Na/K⁺	Urea/Cr	TP/ALB	AST/ALT	TB/CB	CRP	PROCAL	LDH
Outside			11.8K				00/2		78/60				
07-02-24	10.7	88.4	21K	77/14	35K	136/5.39	103/2.12	6.0/2.88	66/22	0.96/0.51	298.68	14.2	
08-02-24						141/4.28	64.3/1.17	5.51/2.60	53/24	0.28/0.23	314	8.53	633
09-02-24	8.3	95.5	23.31k	70/20	76K	143/4.32	45/0.85	6.18/2.63	44/21	0.45/0.20	175		609
10-02-24						143/4.6	43/0.79	6.74/2.8	38/19.8	0.4/0.25	183		545
11-02-24	8.2		24.9k	78/14	97k	141/4.5	38/0.71	6.8/2.61	40/20	0.57/0.12			
12-02-24	7.7		24.85k	82/11	121k		34.8/0.63				96.18		658
13-02-24													

ABG

	PH	PCO2	Po2	HCO3-	Lactate		FiO2
07-02-2024	7.42	34.9	106.8	22.1		On NRM	100%
11-02-2024	7.46	30.4	88.3	21.1	2.1	CMV	35%
12-02-2024	7.391	30.2	104.8	17.9	3.48	CMV	50%
13-02-2024	7.471	23.2	163.3	16.5		CMV	70%

PT/INR on 7/2/24 - 14.4 secs/1.22

Blood culture: 7/2/24 & 10/4/24 - Staph aureus (MRSA) sensitive to Teicoplanin, vancomycin, doxycycline.

CSF (7/2/24)- 41 cells/HPF- N 36%, L 64%, Protein 53mg/dl, Sugar 38mg/dl, (RBS 85mg/dl), India Ink negative, fungal smear negative, culture sterile.

Serology: *HCV antibody reactive*, *HIV positive*, HBVs Ag non-reactive, IgM for Leptospira positive, Dengue IgM antibody negative, Cryptococcus antigen negative (10/2/24)

Urine RE (7/2/24): No cast/crystals, RBC 0-2/HPF, leucocytes-5/HPF, Epithelial cells 1-5/HPF. Outside report **(6/2/24)**- 8-10 pus cells/HPF

ECG:- Sinus tachycardia @125/mt, No RVH, no ST – T changes for ischemia

2D ECHO:- Mod TR, RVSP= RAP + 24mmhg, 1.1 X 0.5mm vegetation on TV leaflet, EF 45%, No MR, No AR, AFV 1.2m/sec.

Radiology:-
***NCCT Brain:* - Normal**
USG abdomen 7 Feb 2024- Mild hepatosplenomegaly, b/l pleural effusion, mod ascites
HRCT chest 8th Feb 2024- multiple patchy and nodular consolidation in bilateral lungs with bilateral mild pleural effusion.
CECT abdomen 11th Feb 2024:- Multiple nodules with central cavitation in b/l lung fields, b/l pleural effusion (R>L), mild hepatosplenomegaly

Course and management: -

The young boy, an IVDU, was admitted with MRSA infection, tricuspid valve infective endocarditis, septicemia, with septic embolization to both lung fields. He was treated with teicoplanin and cefepime during the entire hospital stay. Azithromycin was also given for the initial 4 days, followed by doxycycline for the next 4 days. The patient had persistent fever despite the coverage with broad-spectrum antibiotics. His respiratory distress worsened during the hospital stay- saturation was initially maintained with non-rebreathing mask (NRM)ventilation but required mechanical ventilation after 2 days, put on CMV mode with increasing Fio2 supplementation. He remained normotensive throughout the hospital stay without any requirement for inotropic support. His anaemia was treated with IV Vit. B1 and B12 supplementation. Naloxone and haloperidol were given to suppress withdrawal symptoms. One unit of platelets (RDP) was given for thrombocytopenia. The patient had sudden cardiac arrest on 13/2/24; CPR was performed but could not be revived, declared dead at 9.55 pm.

Unit Final diagnosis: - Intravenous drug user (IVDU), HIV and HCV positive, tricuspid valve infective endocarditis (MRSA positive), Type 1 Respiratory failure, septicaemia, anaemia.

Attachments:

File: CPC Clinical Protocol 10.04.2024.pdf	Size: 218k	Content Type: application/pdf