From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 10/09/2025 07:54 AM
Subject: CPC Clinical Protocol 10.09.2025

Dear All,

The next Wednesday CPC will be held tomorrow, **September 10, 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. Aditya Jandial, Department of Clinical Hematology and Medical Oncology.*** Radiology will be presented by ***Dr. Arun Sharma*** and cytology findings will be presented by ***Dr. Parikshaa Gupta.*** Autopsy pathology will be presented by ***Dr. Sunny Bharadwaj.***

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Protocol (10.9.2025)

Name: AS, 68/M **R/O:** Mohali, Punjab **CR. No:** 202404668194 **Adm No**: 2024090189 **Unit:** CHMO
DOA: 8/11/2024 **DOD:** 16/11/2024 **Hospital stay:** 9 days **Clinician Incharge:** Prof. Pankaj Malhotra
Clinical Discussant: Dr. Aditya Jandial **Pathology Discussant:** Dr. Sunny Bharadwaj
Cytology Discussant: Dr. Parikshaa Gupta **Radiology Discussant:** Dr. Arun Sharma

Presenting complaints:

Pain upper abdomen for 1 month
Scrotal swelling x 1 month
Decreased urine output x 1 week
Altered sensorium x 3 days

Course before hospitalization (19/10/24 - 6/11/24): He presented with complaints of pain in the upper abdomen, scrotal swelling, and loss of appetite for a 2-week duration to MOPD at PGIMER on 19.10.2024. Pain was of moderate intensity, non-radiating. It was associated with a significant unintentional weight loss (not documented). Examination revealed pallor and a vague epigastric mass. CECT abdomen (19/10/24) revealed a large heterogeneously enhancing mass in the retroperitoneum encasing the aorta, IVC, and left renal vessels, with infiltration into the left kidney. In addition, there were heterogeneously enhancing masses involving the prostate, seminal vesicles, left inguinal canal, and bilateral adrenal glands. USG-guided FNAC (1/11/24) from the retroperitoneal mass revealed high-grade non-Hodgkin lymphoma.

Present admission (7/11/24 – 16/11/24): Presented to AHC on 7/11/24 with worsening abdominal pain, vomiting, decreased urine output, and altered sensorium for a 1-week duration. The family members had noted a progressive decrease in his interaction with the family, followed by increased somnolence and drowsiness prior to admission. There was no h/o constipation/loose stools/jaundice/hematemesis/melena. No h/o dysuria/hematuria. No h/o fever/headache/seizure/facial deviation/limb weakness. He was admitted to EMOPD (7/11/24) and shifted to MMW on 8/11/24.

Past History: H/o TURP (details not available); on Tab. Silodosin OD. No history of TB, DM, HTN, Epilepsy, or allergies.
Personal History: Vegetarian. History of cigarette smoking for 50 years. No history of alcohol intake.
Family History: No history of similar illness or cancer in the family.

Examination (at presentation): Drowsy, E3V4M5
Vitals: PR: 107 bpm, regular; BP 100/70 mmHg; RR: 20/min; SpO2: 97% at room air; Temp: 37°C
GPE: Pallor +, Icterus-, Cyanosis-, Clubbing-, Lymphadenopathy-, Pedal edema-; Signs of dehydration +, Cachexia +
Systemic examination:
P/A: Distended, non-tender, a vague mass palpable over the epigastric region, bowel sounds +
RS: B/L normal vesicular breath sounds**; CVS**: S1 S2 normal, no added sounds
CNS: Drowsy, E3V4M5, B/L pupils equal in size and reacting to light, moving all four limbs, B/L plantar - flexor

Investigations:

	7/11/24	**8/11/24**	**9/11/24**	**11/11/24**	**12/11/24**	**14/11/24**	**15/11/24**	**16/11/24**
Hemoglobin (g/dL)	**8.5**	**7.5**	**8.3**	**8.5**	**7.3**	**7.3**	**6.4**	**6.3**
MCV (fL)	**117**	**115**	**115**	**118**	**120.9**	**120**	**117**	**123**
Retic count (%)			**6.3**					
WBC (x10^9/L)	9.9	7.1	10.9	**14.6**	**19.42**	**18.5**	**18.3**	**25.3**
DLC	P82 L11 M6	P87 L9 M2	P94 L3	P96 L1 M2	P98 L1	P98 L1	P94 L2	P94 L2 M3
ANC (x10^9/L)	8.1	6.2	10.3	**14.0**	**19.0**	**17.3**	**17.3**	**23.9**
Platelet (x10^9/L)	154	134	158	**117**	**61**	**59**	**57**	**71**
Na^+/ K^+/Cl^-	135/4.7/94	138/5.1/101	138/4.2	133/**5.7**	**126/>7.0**	**125/5.7**	**121**/4.5	**120/6.3**
Calcium/Phos		9.7/-	9.9/-	9.3/**5.3**		**6.7**/-		
LDH				**976**				
Urea/creatinine	**231/3.2**	**250/3.1**	**172/2.1**	**110/1.8**	**143/2.0**	**122/1.7**	**110/2.1**	**125/2.2**
Bilirubin T/C	1.6/0.7	1.5/0.6	1.8/0.8	1.4/1.0	1.5/0.9	1.6/0.9	1.2/0.8	1.6/0.9
T. Protein/Albumin	6.9/**2.6**	6.4/2.6	6.3/2.4	**5.2/2.3**	**4.3/1.8**	**4.5/2.2**	**4.1/1.8**	**3.8/1.7**
AST/ALT/ALP	**255/87/-**	**270/90/-**	**286/110/-**	**363/146/137**	**190/110/-**	**99/72/-**	**60/51/-**	**164/50/-**
Amylase	36							

PBF (15.11.24): Mild anisocytosis. Normocytic normochromic red cells. Macrocytic red cells. Platelets are reduced; large and giant platelets are seen. Toxic changes in neutrophils with left shift, neutrophilia. No atypical cells seen.

	11/11/24
S. Procalcitonin	4.35
S. Galactomannan (C/L post-mortem)	6.55
Blood c/s (11.11.24, 13.11.24): Sterile	
Urine c/s (11.11.24, 13.11.24): Sterile	

CSF analysis	13/11/24
TC	2 cells/mm^3
DC	N100 L0
P/S	77/164
Cytology	Traumatic tap
GS, c/s	sterile
CryptoLA	Negative
India Ink	Negative

	8/11	10/11	12/11	13/11	14/11	15/11
pH	7.39	7.33	**7.24**	**7.21**	**7.18**	**7.2**
pO2	69.3	77.6	135.5	54.0	123.7	45.1
pCO2	30.7	28.2	22.7	26.3	34.4	29.1
HCO3	18.5	16.5	9.6	10.4	12.7	11.6
O2 sat	94.1	95.6	98.3	82.2	97.7	67.7
Lactate	**5.1**	**4.9**	**5.7**	**3.3**	**3.2**	**6.1**
iCal	1.1	**1.2**		**0.69**	**0.8**	

PT/aPTT/INR/PTI (7.11.24): 14.3/30.3/1.28/78%
Urine r/e (9.11.24): Protein - nil, RBCs ++, WBCs ++
Urine r/e (12.11.24): Protein +, RBCs ++, WBCs ++
CXR (7.11.24): WNL, **CXR (13.11.24, 14.11.24):** B/L infiltrates +
NCCT Head (7.11.24): WNL, **NCCT Head 11.11.24:** WNL

HIV/HbsAg/Anti-HCV (11.11.24): Negative
ECG: sinus tachycardia, right axis deviation
2D ECHO (10.11.24): Normal LVEF (60-65%), No RWMA, Mild TR, RVSP = RAP + 26, No clot/vegetation/PE

CECT Abdomen (19.10.24, outside): A large heterogeneously enhancing mass (10.3x11x20 cm) in the retroperitoneum encasing the aorta and IVC as well as the left renal vessels with occlusion of the left renal vein, also infiltrating into the left kidney and encasing and compressing the left renal pelvis with mild left hydronephrosis. Posteriorly, the mass is infiltrating the left psoas muscle, and inferiorly, the mass is extending along the left common and external iliac arteries. A contiguous heterogeneously enhancing soft tissue mass extending into the left inguinal canal. A heterogeneously enhancing mass (4.1x3.5 cm) in the left suprarenal location involving the left adrenal gland. A large heterogeneously enhancing mass (6.2x6.8 cm) involving the prostate and bilateral seminal vesicles, reaching up to the pelvic side wall laterally and bulging into the lumen of UB anteriorly. Fat planes with the rectosigmoid colon are maintained. Heterogeneous enhancing soft tissue along the right adrenal gland (3.5 x 1.6 cm). Multiple ill-defined heterogeneously enhancing lesions in the right renal parenchyma. Liver, spleen, and pancreas grossly normal. Opacified bowel loops normal in caliber. No ascites. Impression – f/s/o disseminated malignancy.

FNAC from retroperitoneal mass (01.11.24): non-Hodgkin lymphoma, high-grade.

USG Abdomen (7.11.24): Liver 11.5 cm, normal outline and echotexture. Spleen 10 cm. Left kidney 11.7 cm, Right Kidney 9.6 cm, bilateral raised cortical echogenicity; B/L multiple heteroechoic lesions in the kidneys. A large heteroechoic retroperitoneal mass with encasement of the abdominal aorta, IVC, celiac trunk, SMA, and B/L renal arteries. Lymph nodal masses noted in the periportal, retrocaval, and aortocaval regions. One of the lymph nodal masses in the retrocaval region shows suspicious infiltration of the IVC. The prostate is enlarged and heteroechoic with extension into the base of the bladder. No ascites.

Course and management:
AS, a 68-year-old gentleman, was admitted to EMOPD on 7/11/24 with complaints of worsening abdominal pain, vomiting, decreased urine output, and altered sensorium. He was initially managed with IV fluids. Inj. Dexamethasone 16 mg IV once daily was started on 8/11/24 as pre-phase therapy for lymphoma. Hemodialysis was started in view of persistent altered sensorium and oliguria. On 11/11/24, his sensorium further deteriorated, and he developed hypoxemia and shock. He was intubated and started on intermittent positive pressure ventilation (IPPV) with an Ambu bag; Cefoperazone+sulbactam, Noradrenaline infusion, and antihyperkalemic measures were started. On 13/11/24, antibiotics were upgraded to Meropenem and Teicoplanin; Adrenaline infusion was also started for persistent shock. Intermittent episodes of hypoglycemia were noted, managed with IV dextrose boluses and DNS infusion. On 14/11/24, CXR showed a few inhomogeneous opacities in the bilateral lungs; Colistin was added. He continued to deteriorate over the next 48 hours and was declared dead at 1434 hours on 16.11.24.

Unit's Final Diagnosis: High-grade non-Hodgkin lymphoma, Sepsis with multiorgan dysfunction syndrome, Acute kidney injury, Acute respiratory distress syndrome, Shock, Encephalopathy (septic + uremic)

Cause of Death - Refractory Septic Shock

Attachments:

File: CPC Clinical Protocol 10.9.25.pdf	Size: 215k	Content Type: application/pdf