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Date: 10/02/2026 02:11 PM
Subject: CPC Clinical Protocol 11.02.2026

The next Wednesday CPC of the session will be held tomorrow, **February 11, 2026 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://pgitelemmed.webex.com/pgitelemmed/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. Mohan Kumar H, Department of Internal Medicine**. Radiology will be presented by **Dr. Abhinandan**. Autopsy pathology will be presented by **Dr. Amanjit Bal**.

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Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff Clinico-Pathological Conference (CPC) 11th February 2026

Mrs PM, 34 yr/ F	Unit/Ward: IM2/FMW	Clinician in charge: Prof Sanjay Jain	
CR No: 202404482521	Adm No: 2024079044	Clinical Discussant: Dr Mohan Kumar H	
DOA: 29/09/2024	DOD: 04/10/2024	Radiologist: Dr Abhinandan	Pathologist: Prof Amanjit Bal

Presenting Complaints:

- Fever for 25 days – high grade documented up to 105 F
- Swelling of lips and submandibular region for 10 days
- Erythematous rash over the nose and cheeks for 10 days
- Oral ulcers for 10 days
- Difficulty in getting up from bed for 1 week

No dyspnea, nasal regurgitation, dysphagia, or aspiration. No seizures, headache, or altered sensorium initially. No bleeding manifestations. No sicca symptoms or frothuria.

Past history:

- Inflammatory polyarthritis involving small and large joints for 3 months, associated with early morning stiffness, improving with activity
- History of three first-trimester spontaneous abortions (at ~1 month gestation, ~10 years back)
- No history of diabetes mellitus, hypertension, tuberculosis, or coronary artery disease

Personal and Family history: Three living children, Not Significant; **Treatment history:** Treated at local hospital with IV medications

On examination:

The patient was alert, cooperative and conscious and oriented to time, place and person

BP – 90/60 mm Hg, **PR** – 120/min, **RR** – 36/min, **SpO₂**: 96% on nasal prongs at 2L/min **Temp**: 103°F

Right axillary lymphadenopathy ~2cm, soft, mobile, non-tender. No pallor, icterus, cyanosis or clubbing

Skin: Malar rash with nasolabial sparing, oral ulcers present, palatal erosions present, white patches over the palate and uvula, swelling of both lips present, tender swelling in the submandibular region.

Respiratory system: B/L vesicular breath sounds heard, fine crackles heard in bilateral infrascapular areas, **CVS:** S1/S2 normal, no S3/murmur, **Abdomen:** Soft, non-tender, no palpable organomegaly, bowel sounds normal. **CNS** GCS – E4V5M6, Muscle power – 4+/5, neck weakness +mild

INVESTIGATIONS:

Date	23/09/24	28/09/24	30/09/24	01/10/24	02/10/24	03/10/24	04/10/24
Haemoglobin (g/dL)	7.4	8.1	8.7	7.8	6.3	5	5.4
Total Leucocyte Count	1600	900	340	720	1900	5300	2500
Differential (N/L/M)	N50 L36	N37 L51 M9		N51 L37 M11	N59 L19 M21		N84 L7 M9
Platelet count (10 ³)	70	37	22	22	48	59	87
Sodium/Potassium		130/3.5	132/3.9	132/3.9	131/3.9	135/4	138/4.2
Urea/Creatinine	-/0.69	18/0.85	24/1.1	54/1.46	68/1.58	81/1.86	119/3.8
AST/ALT/Al Phos	146/98	646/210	862/227/150	1021/222/251	1181/221	1121/203	995/164/312
Bilirubin- Tot/Direct		0.36/0.11	0.36/0.18	0.5/0.28	0.7/0.3	0.92/0.64	1.47/1.03
Total Protein/Alb	6.9/3.6	5.5/2.6	5.4/2.7	5.1/2.5	4.9/2.4	5.2/2.7	5.2/2
Calcium/Phosphate		7.6/-	7.3/4.7	6.9/4.4	7.1/-		8.9/6.5
PT/APTT		12/40	11/54				26/46
PTI/INR		99/1.01	100/0.98				44/2.35
Fibrinogen (g/L)			1.54				2.92
D dimer (ng/mL)			3319				2214
LDH (U/L)			2970	3025			4541
CK-NAC (U/L)			1030	1050			2579
C3/C4 (mg/dl)			16/42	19/41			9.4/39.5
CRP (mg/L)			36	20			134

ABG:

Date	28/09/2024	03/10/2024	03/10/2024 (8 pm)	03/10/2024 (10 pm)	04/10/2024
pH	7.442	7.11	7.17	7.064	7.227
pCO ₂	27.3	36.6	46.6	50.2	39.5
pO ₂	28.6	50.6	141.4	127.2	96.7
HCO ₃	19.1	11.4	16.9	14	16.1
Lactate		1.98		2.28	0.95

<p>Peripheral Blood Film (04/10/2024): Mild anisopoikilocytosis; normocytic normochromic red cells with microcytic hypochromic red cells and few macrocytes. Platelets are reduced.</p> <p>Serology / Infectious Workup: HIV / HBsAg / Anti-HCV – Negative; Malaria antigen – Negative; Widal test – Negative; IgM for Chikungunya – Negative; CMV IgM (01/10/2024) – non-reactive; EBV VCA IgM (01/10/2024) – non-reactive</p> <p>Inflammatory Markers: Procalcitonin (04/10/2024) – 100</p> <p>Biochemical Markers: Serum Ferritin (30/09/2024) – 48,359 ng/mL (13–150); Pro-BNP (30/09/2024) – 1001 pg/mL (0–125) Troponin-T (30/09/2024) – 20.2 pg/mL (12.7–24.9)</p> <p>Lipid Profile (30/09/2024): Total cholesterol – 90 mg/dL; LDL – 34 mg/dL; HDL – 14.5 mg/dL; Triglycerides – 177.8 mg/dL</p> <p>Thyroid & Bone Profile: T3 / T4 / TSH – 2.8 / 4.4 / 0.27; Vitamin D3 – 32.5 IU/mL; Intact PTH – 34.1</p> <p>Autoimmune Workup (30/09/2024): ANA – ++++ (nuclear fine speckled) Anti-dsDNA – Positive (130 IU/mL) [<10] ANA Immunoblot: UnRNP – +++; Sm – +++</p> <p>Antiphospholipid Antibodies (30/09/2024): Lupus anticoagulant, IgG/IgM anticardiolipin, IgG/IgM anti-β2 glycoprotein-1 – Negative</p> <p>Microbiology: Blood culture (04/10/2024) – <i>Enterococcus faecalis</i> Blood culture (04/10/2024) – <i>Escherichia coli</i> BACTEC MGIT (04/10/2024) – No growth in 42 days</p> <p>ET Aspirate Culture (03/10/2024): Gram-positive cocci</p>	<p>Urine Routine Examination: (30/09/2024) – Protein +++ (300 mg/dL), Blood +++ (04/10/2024) – Protein +++ (300 mg/dL)</p> <p>24-hour Urine Examination (30/09/2024): Protein – 762 mg/24 h; Urinary creatinine – 180 mg/24 h</p> <p>Urine Culture (04/10/2024): Sterile.</p> <p>Ultrasonography Abdomen (28/09/2024): Liver 15.1 cm; portal vein normal; Spleen 10 cm; Gallbladder wall edema present; RK 12cm, LK 11.4cm; Right ovarian functional cyst noted.</p> <p>Ultrasonography Right Axilla (02/10/2024): Diffuse subcutaneous edema in the right axilla.</p> <p>2D Echocardiography (Bedside; 01/10/2024): E > A; aortic flow velocity 1.22 m/s; trivial tricuspid regurgitation; no RWMA; LVEF 55–60%; mild pericardial effusion; no clot or vegetation.</p> <p>CECT Abdomen (Outside PGI; 27/09/2024): Enlarged heterogeneously enhancing retroperitoneal lymphadenopathy with extensive retroperitoneal fat stranding; hepatosplenomegaly; mild ascites; pericardial effusion; bilateral pleural effusion; right axillary lymphadenopathy.</p> <p>CECT Abdomen (PGI; PG370263; 29/09/2024): Mild hepatosplenomegaly with pericholecystic fluid.</p> <p>CT Pulmonary Angiography (03/10/2024): No evidence of pulmonary thromboembolism; bilateral consolidation with ground-glass opacities, ?diffuse alveolar hemorrhage/?infective etiology.</p> <p>Bone Marrow Examination (01/10/2024): Mildly hypocellular bone marrow with occasional hemophagocytosis.</p> <p>Flow Cytometry (Bone Marrow): 0.5% mature B cells, revealing a normal profile; however, surface and cytoplasmic kappa and lambda are inconclusive, with positivity for CD200.</p>
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COURSE AND MANAGEMENT:

Patient presented with a prolonged febrile illness associated with mucocutaneous manifestations, proximal muscle weakness, and a background history of inflammatory polyarthritis and recurrent first-trimester pregnancy losses. Initial evaluation revealed pancytopenia with neutropenia, markedly elevated ferritin, transaminitis, acute kidney injury, and raised inflammatory markers, suggesting an underlying autoimmune inflammatory disorder with secondary macrophage activation syndrome (MAS).

Based on this clinical suspicion, she was treated with intravenous methylprednisolone pulse therapy for three days. However, she continued to have persistent high-grade fever and worsening cytopenias, following which cyclosporine was added. Subsequent bone marrow examination demonstrated hemophagocytosis, supporting the diagnosis of MAS. During hospitalisation, she developed worsening hypoxia and altered sensorium, necessitating endotracheal intubation and mechanical ventilation. In view of severe neutropenia and clinical deterioration, she was managed as neutropenic sepsis with escalation of antibiotics to meropenem and teicoplanin.

She subsequently developed refractory shock, worsening renal dysfunction with anuria, and non-blanchable erythematous lesions over the extremities. Given her obstetric history, isolated prolongation of aPTT, and multiorgan involvement, the possibility of catastrophic antiphospholipid syndrome was considered, and intravenous immunoglobulin was administered. Despite aggressive immunosuppression, broad-spectrum antibiotics, and maximal supportive care, including vasopressor support, her condition continued to deteriorate with progressive multiorgan failure, and she ultimately suffered a cardiac arrest on 04/10/2024 and succumbed to her illness.

**Final Diagnosis: Systemic Lupus Erythematosus with Macrophage Activation Syndrome
? Lymphoma ?Disseminated tuberculosis**

Cause of Death: Refractory Septic Shock, Type 1 Respiratory Failure