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Date: 10/11/2026 12:26 PM
Subject: CPC Clinical Handout 11.11.2026

The next Wednesday CPC of the academic session will be held tomorrow, **November 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://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 aspect will be discussed by ***Dr. Atul Saroch, Department of Internal Medicine.*** Radiology will be discussed by ***Dr. Anindita Sinha*** and Nuclear medicine findings will be presented by ***Dr. Rajinder***. Autopsy pathology will be presented by ***Dr. Animesh.***

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Regional Resource Centre, North
Department of Digital Health & Telemedicine
PGIMER, Chandigarh

Staff CPC (11/11/2026)- Clinical Protocol

Name: Mrs SK	**Age/Sex:** 45 years / Female	**Clinician in charge:** Dr Sanjay Jain
Residence: Sirhind, Pb	**CR. No:** 202602244560	**Clinical discussant:** Dr Atul Saroch
Ward: MMW	**Ad. No:** 2026053322	**Radiology discussant:** Dr Anindita Sinha
DOA: 24-06-2026	**DOD:** 27-06-2026	**Pathology discussant:** Dr Animesh
		Nuclear Medicine Discussant: Dr Rajinder

Presenting Complaints:
Cough with whitish-yellow expectoration for 20 days
Fever for 7 days, high-grade, continuous without chills and rigours
Background history:
Patient was apparently well 10 months back when she started to have symptoms of inflammatory arthritis and progressive proximal muscle weakness, after which the patient became bedridden. No h/o fatigability/fasciculation/sensory symptoms. Patient complains of breathlessness for the last 6 months; for the last 1 month, she has dyspnoea at rest also. Patient has had dysphagia to both solids and liquids for 1 month. She has had loss of appetite and weight loss of around 10-15 kgs over 10 months.
Obstetric/Menstrual history: P1L1A1(Spontaneous abortion in 2003), Regular cycle
Drug History: Tablet Wysolone 50mg/kg in tapering doses from 22/04. Injection Rituximab 1 g x 2 doses (15/5 & 1/6). Tablet Tacrolimus 1mg BD (27/5-23/6). Tablet Septran DS every alternate day.
General Examination:PR:108/min, BP:100/70mmHg, **RR**:38/min **Saturation: 84% @ RA**. Afebrile. Pallor present / No Pedal oedema, icterus, cyanosis, or clubbing. JVP raised
Alopecia +, vasculitic rash over palms and soles, Active Raynaud's, inverse Gottron papules, Gottron's papule (Ulcerated) over knuckles, Shawl sign, V-sign, and poikiloderma present. Violaceous rash over both buttocks with recent ulceration and crusting. Oral candidiasis, atypical canker ulcers and a coated tongue present.
Nervous system: Power: B/L upper limbs & lower limbs 2/5. Neck and truncal weakness present. Reflexes: Upper limb 2+, lower limb absent. Sensory examination: Normal. **Musculoskeletal:** No swollen or tender joints. **Per abdomen**: Soft, non-tender, no organomegaly. **Respiratory system**: Bilateral infrascapular/infraaxillary coarse crepitations. **Cardiovascular system**: S1 Loud, P2 loud, no S3/S4
Investigation
Hemogram

Date	Hb(gm%)	TLC	DLC	Platelets	ESR	PT/PTI/INR	aPTT/D-dimer
11/04	10.5	5800	N89%, L6%	172000	**110mm/hr**.		
25/06	7.7	8030	N83%, L14%	184000			
27/06	7.7	18320	N91%, L6%	274000		12/89/1.1	38/293
PBS (27/06)		Reduced red cell density. Normocytic normochromic to macrocytic red cells. Platelets are adequate. Mild neutrophilic leucocytosis. No atypical cells are seen					

Ferritin **4325** ng/ml (N13 –150) HbA1C 5.3%, Anti-HCV: Negative HbSAg: Negative, HIV Non-Reactive
24-hour Urinary protein **422 mg** (N< 140 mg)

Biochemistry				**Autoimmune Hepatitis Screening** (06/05)
Date	06/05	25/06	27/06	Negative for all antibodies
Na^+/K^+		143/ 6	134/4.6	ANA/Anti CCP Negative
Urea / Cr		30/ 0.5	26/0.6	**Tumor Marker**
TB/CB		0.8/0.6	0.6/0.4	CEA 17ng/ml (0-4.7)
AST / ALT / ALP	738/441/**1177**	59/28/**684**	43/23/**811**	CA 125 19.6 U/ml (0-35)
GGT	**3929**			CA 19-9 **680 U/ml** (0-39)
T. Pro/ Sr. Alb.	6.7/3.6	4.9/2.2	5.8/2.5	AFP 8.41 (< 7 ng/ml)
Ca^{2+}/ PO_4^{3-}	8.1	7.4	7.9/2.3	**Cardiac Biomarker** (27/06)
Uric acid			3	Pro BNP 32892 pg/ml (N0 – 125)
LDH/CK-NAC			/46	Troponin T (Trop T) 55.2 pg/ml (N 12.7-24.9)
Chol / TG		192/425	208/591	
HDL / LDL		15/19	15/58	

Autoimmune IFA Myositis Profile, Antigen, Serum (Date 22/04)

MI-2	KU	PM-SCL 100	PM-SCL 75	JO-1	SRP	PL-7	PL-12	EJ	OJ	RO-52	Anti MDA 5 (ELISA)
+++Strong positive	-	-	-	-	-	-	-	-	-	-	-

Mammography Both Breasts: Significant B/L Axillary Lymphadenopathy

MRCP (02/05/26): Hepatosplenomegaly with diffuse hepatic fatty infiltration

FDG whole-body PET (28/04/26): Increased uptake in gluteal and shoulder muscles

CTPA+ HRCT Chest: ILD? NSIP pattern. Pneumomediastinum and Left Pneumothorax. Peripheral-based consolidation and Reticulation

Sputum Culture (27/06): Pan-resistant Acinetobacter Baumannii, Escherichia Coli Intermediate sensitive to Colistin; **Sputum Culture (26/06):** Yeast

Blood Culture (29/06): Pan-resistant Acinetobacter baumannii, intermediate sensitivity to Colistin

ECHO evaluation: Mild hypokinesia of mid-septal area, Grade I Diastolic dysfunction, EF 60%

Liver biopsy (15/06/26): Drug-induced liver injury

Course and management:

Despite intensive immunosuppressive therapy, the patient's hypoxemia continues to worsen. She developed spontaneous pneumomediastinum and pneumothorax. An intercostal drainage tube was inserted. However, despite all instituted measures, respiratory status continued to deteriorate. On 27 June 2026 at approximately 2:20 PM, the patient suddenly became unresponsive and was found to be in cardiorespiratory arrest. Despite prolonged and appropriate resuscitative efforts, return of spontaneous circulation could not be achieved.

Unit's final diagnosis: Dermatomyositis (Mi 2+)/Rapidly Progressive Interstitial Lung Disease with pneumothorax and Pneumomediastinum