From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 13/11/2024 07:58 AM
Subject: CPC Clinical Protocol 13.11.2024

Dear All,
Season's Greetings.
The next Wednesday CPC of the session will be held on **November 13, 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=mb8f5c93d0efe86e2ec7df721b3c21227

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. Jayanta Samanta , Department of Gastroenterology.*** Radiology will be discussed by ***Dr. Pankaj Gupta.*** Autopsy pathology will be presented by ***Dr. Suvradeep Mitra.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC clinical protocol (13th November 2024)

Patient: Mrs KK	**DOA: 30/9/22**	**Clinician in-charge:** Prof Usha Dutta
CR No.: 202204370558	**DOD: 10/10/22**	**Clinical Discussant**: Dr. Jayanta Samanta
Age/Sex: 45 years/female		**Radiologist:** Dr. Pankaj Gupta
Residence: Mohali, Punjab		**Pathologist:** Dr. Suvradeep Mitra

Presenting complaints: Yellow discoloration of eyes and skin: 3 months
Abdominal distension: 2 weeks
Loss of appetite: 2 weeks; generalized malaise, weakness, vomiting 2 weeks; Pedal edema: 1 week

Current admission:

The patient presented with jaundice, 3 months duration; insidious onset, gradually progressive, preceded in the last 15 days with generalized malaise, weakness, non-bilious vomiting; high colored urine; not with clay-colored stools and itching; no pain abdomen; bleeding episodes; CAM intake

Abdominal distension for 2 weeks; pedal edema for 1 week; fullness of flanks present, then pedal edema, no facial puffiness, (doubtful?) decreased urine output, no frothuria, no chest pain; no breathlessness

No history of oral ulcers, photosensitivity, malar rash, sicca symptoms, Raynauds phenomenon, heat/cold intolerance, hematemesis, melena, gluten hypersensitivity, CAM intake

Background history:

2012: underwent Lap cholecystectomy for symptomatic cholelithiasis; 2019: diagnosed with hypertension; 6/5/2019: diagnosed with CAD (dyspnea, chest pain, NHYA II); 2 vessel block; underwent PCI; dual antiplatelets given; 18/2/2020: Check angiography; stent patent

2020: developed multiple joint pains (bilateral hands, wrists, shoulders, elbows, ankle); symmetric, additive, with morning stiffness, a diagnosis of RA was made (RA factor +); started on HCQS and analgesic, never received Methotrexate and biologicals; stopped treatment for 1 month; no joint pains at presentation

2021: Exertional dyspnea; repeat CAG done; stent block; repeat PCI done

2021: diagnosed with hypothyroidism; was on tab Eltroxin 50 ug

Medication history: Tab ecosprin 75 mg; Atorvas 20 mg; diltiazem 60 mg; telma 40 mg OD; eltroxin 50 ug; received inj Iron (12/7/22) for hemoglobin 8.2 gm/dl; started on combination of telmisartan + metoprolol (40/50 mg) since 23/8/22.

In current admission: vitals stable (BP 130/70 mmHg; RR 18/min; afebrile; PR 76/min); SpO2 96% RA; BMI-26.3 kg/m^2

Examination findings: bilateral cheeks erythema noted; abdomen distended; icterus and edema noted; rest WNL

Before current admission:

Tests	7/10/21	12/7/22	16/8/22
Hemoglobin	8	8.2	9
TLC	-	7800	4100
platelet	-	216000	152000
Urea/creat	29/0.82	30/0.78	26/0.52
T/D bilirubin	-	0.85/-	6.2/3.01
AST/ALT	-	124/136	156/171
albumin	-	-	4

July 2022 (outside hospital): TSH 3.44; T3 140; T4 9.2; anti SLA 2.10 (negative); anti TTG IgA 9.86; anti SMA negative; USG whole abdomen- normal study ; chol/TG 181/116

During hospital admission:

Ascitic fluid analysis:

DATE	TLC	DLC	sugar	protein	albumin	SAAG	ADA	gram stain	malignant cytology	culture	amylase
30/9/22	154	P72; L27	137	1	0.25	1.45		neg	neg	neg	128
9/10/22	254	P65; L34	111	1.3	0.44	1.24				neg	107

Ascites (total bil) 1.05; **blood cultures (9/10/22):** *Klebsiella pneumoniae* (IS colistin; amikacin); anti CCP negative

Tests	28/9/22	1/10/22	4/10/22	5/10/22	6/10/22	8/10/22	9/10/22	10/10/22
Hb/TLC/plat	9.6	9.8	9.2		9.3			
TLC	5600	5300	6100		6000			
platelet	80,000	75000	73,000		62000			
DLC	P60; L26		p 58/ l 27		p69/L17			
MCV	91.4	91.3	92.3					
urea/creat	10/0.57	19/0.57	41/1.22	51.8/1.51	49/1.06		45/0.8	45/2.04
Na/K	124/3.87	138/3.8	125/3.78	125/3.8	123/3.6	124/3.2	125/3.58	131/6.33
total/direct bil	6.38/3.57	5.74/4.88	4.97/4.26	4.9/4.14	4.42/3.92	5.18/2.3	5.11/2/34	3.48/2.75
AST/ALT	510/186	391/137	307/103	284/96	275/94		230/68	291/71
ALP		136	123		117			123
T. Pr/albumin	6.9/1.7	7.12/1.84	6.34/1.28	6.2/1.31	6.4/1.38	5.6/1.64	5.5/1.68	4.48/1.06
PT/PTI/INR	34.5/40%/2.39					33.8/41%/2.34		
calcium/PO4			6.72/ 3.29					7.01/8.21
CRP			10.47		11.25			19.65
LDH			394		411			532

Additional tests during hospital admission: procal (4/10/22) 0.806; HbA1c 5%; HbsAg neg, anti HCV neg, HIV neg, anti HBc total neg, anti HAV IgM neg, anti HEV IgM neg, LEMDUS workup neg; TSH 3.94; T3 0.696; T4 6.66; vitamin D 4.23; PTH 44.5; Procal (3/1022) 0.741; chol 47.8; LDL 11.4; HDL 4.5; TG 74.5; Uric acid 2.9; magnesium 2.24; CK-NAC 123; blood CS neg (4/10/22); **ANA +3 (fine nuclear speckled) (1/10/22); rest of AIH markers negative; C3 (10/10/22) 23.1; C4 (10/10/22) 4.9**

Cardiac markers: pro BNP (4/10/22) 148; TROP T 11.8; **SOB kit (9/10/22):** myoglobin 245; BNP 456; D-dimer 2260; Trop I <0.05; **2D echo (9/10/22): normal EF; No AR/TR/MR;** ECG sinus tachycardia; no fresh changes

ABG	4/10/22	9/10/22 (11:20 am)	9/10/22 (6.35 pm)	9/10/22 (10.1 pm)	10/10/22 (4 am)	10/10/22 (8 am)
pH	7.42	7.45	7.42	7.44	6.9	6.8
PO2	28	34	19	78.7	90	42
PCO2	28	25	33	18.7	34	51
HCO3	18	17.6	12.8	12.6	6.6	8.4
SAO2	55.9	70.9	67.9	96.4	89.5	44
BE	-4.6	-5.6	-10	-8.5	-25.7	-26

USG abdomen (30/9/22): liver 9.2/11 cm, coarsened echotexture; irregular outline; no IHBRD; PV 9 mm, spleen 10.7 cm, SWE – 6 kpa; mod ascites; USG (1/10/22): CLD, ascites; MHV, RHV draining into IVC; USG (3/10/22): CLD, ascites; **Compression doppler B/L lower limbs** (4/10/22): no DVT

Course during hospital admission: The patient was admitted with jaundice and ascites. On admission, vitals were stable. Investigations for CLD evaluation were done. During course of hospital stay, patient developed hypotension and KFT worsened. For AKI, she was started on inj albumin and inj terlipressin for the same (suspecting HRS). Ascitic tap was attempted on 7/10/22 which was a dry tap. Thereafter, a bruise (6x6 cm) size developed at the site of AF puncture (RIF). On 9/10/22 at 1.45 pm, she developed breathlessness, chest examination revealed bilateral crepts, and she was shifted to GE-ICU in view of fluid overload. NIV was given. In the evening, the patient developed fever and sudden onset tachypnoea. ECG revealed sinus tachycardia, ABG revealed compensated metabolic acidosis with hypokalemia. At 2.30 am (10/10/22), the patient developed sudden onset breathlessness. HR 160/min (? SVT), and inj diltiazem given. Patient was started on ionotropic support. At 10.15 am, the patient developed bradycardia, and CPR was done as per protocol. At 10.48 cm, patient was declared dead.

Unit's final diagnosis: k/c/o CAD/ post PCI; Hypothyroidism; Hypertension; ? RA; Post lap cholecystectomy**;** Decompensated chronic liver disease; ascites; ALI; AKI; sepsis; shock (cardiogenic + septic)