From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 14/01/2026 09:09 AM
Subject: CPC Clinical Protocol 14.1.26

Wishing you all a very Happy Lohri.

The next Wednesday CPC of the session will be held tomorrow, **January 14, 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 protocol will be discussed by ***Dr. Jasmine Sethi, Department of Nephrology.*** Radiology will be presented by***Dr. Uma Debi*** and Hematopathology findings will be discussed by ***Dr. Narender Kumar.*** Autopsy pathology will be presented by ***Dr. Aravind S.***

Yours sincerely,

CPC CLINICAL PROTOCOL (14.01.2026)

Name: Mrs. M. **Age/Sex:** 27 Y/F **CR No:** 202404259715

Clinician In charge: Dr. Sanjay Jain **Clinical Discussant**: Dr. Jasmine Sethi

Pathology Discussant: Dr. Arvind Kumar

Hematopathology Discussant-Dr Narender Kumar **Radiology Discussant:** Dr. Uma Debi

Date of Admission: 14.09.2024 **Date of death:** 23.09.2024

Presenting Complaints: Patient Mrs M was apparently asymptomatic 2 weeks back when she developed fever of insidious onset, high-grade, with a maximum documented temperature of 103°F, intermittent in nature, and associated with chills, rigors. This was a/w with facial and periorbital swelling that was insidious onset, progressive in nature. She also had h/o oral ulcers on lips/buccal mucosa and palate for 5 days that were multiple, painful, a/w difficulty in swallowing more to solids than liquids. Some lesions had crusting with bleeding. She also gave h/o generalized weakness and difficulty in getting up from sitting posture requiring support to go to washroom. There was history of shortness of breath associated with palpitations along with cough with minimal expectoration for 1 week. There was no history of photosensitivity/ malar rash/ small joint pains/ decreased urine output/ frothuria/ numbness/ difficulty gripping objects.

Prior to current admission, patient received one unit of PRBC transfusion in IGMC Shimla in view of anemia.

Past history: Had history of similar episode of facial/periorbital swelling 2 years back that subsided in 2 weeks.
Known hypothyroidism for 2 years-not on medication. TSH 38

Personal history: Had one live birth 7 years back and 1 still birth 3 years back (8 months POG)

GENERAL EXAMINATION.	**SYSTEMIC EXAMINATION:**
Patient was concious oriented BP:120/80 mm Hg right arm in supine position PR: 96/min/RR 18/min Sp02: 96% on room air **P**+I-C-C-**L**+E-JVP- Right axillary LAP-1cm soft/mobile Oral ulcers over lips/palate Dirty exudate over buccal mucosa Whitish exudate over palate Alopecia/Frontal thinning of hair Subconjuctival hemorrhage Facial edema/periorbital puffiness +	**CVS-** S1, S2 heard, no murmurs **RS:** Normal vesicular breath sound heard bilaterally, no added sounds **Abdomen:** Soft, non-tender **Hepatomegaly 10 cm under RCM,** **Splenomegaly 4 cm under LCM** No Free fluid **CNS:** HMF-Normal. E4V5M6 Muscle power-Neck 1/5, Deltoid 6, Elbow flexion 10, Wrist extension 10, quadriceps 6, Gluteus medius 6, gluteus max 6, ankle 10. (Manual Muscle testing score-109/150) Reflexes 2+ bilateral

Urine dipstick-**Blood 3+, Albumin 2+**
Urine spot protein 141, urine spot creat 48- Ratio 2.9
24 hour urine protein **1.8 gm/day** (24 hour urine creatinine 218 mg/tv)
CKNAC 13002 (26-302)/ **Amylase 177/ Lipase 183**
Procalcitonin 0.9/CRP 54mg/l/ D Dimer 17580 (0-240)/
Pro BNP 95730 (0-125)/ Troponin T 147 (12-24)/ CK MB 155(7-25)
CMV IgM Reactive
DCT Anti IgG 3+ Positive
Ferritin >2100/ Serum iron 23/TSAT 15/TIBC 150/Fibrinogen 2.8 g/l/ Triglyceride 417
IgM Leptospira/Widal/IgM Chikungunya/IgM Dengue/ Malaria Antigen-Neg
Blood c/s (24/9)-Klebsiella P (Intermediate sensitive to colistin)
ANA/ANCA/DsDNA/ANA Blot-negative
HbsAg/Anti HCV/IgM anti HAV/IgM Anti HEV-negative
Anti TPO 630 (0-34) , 8 AM Cortisol 121, ACTH 9.8 (Normal) **TSH 34**/ T3 0.1/T4 4.7

Investigations

Date	13/09/24	14/09/24	16/9/24	21/9/24	23/9/24
Hb	5.6	4.9	8	9	7.9
TLC	2200	2500	4900 (N86L10)	7000	8700
Platelet count	10k	6k	14K	18K	42k
ESR			94		
SE	129/5.1	134/3.9	133/3.5	135/2.8	132/4.3
RFT	113/0.9	73/0.6	44/0.7	19/0.6	23/0.7
Ca/P	-	7.7/-	7.9/3.2	7.6/2.8	
OT/PT/ALP	911/228/-	1084/240/-	899/197	395/130/129	167/98/97
C3/C4/LDH			30/2.9/698		30/2.7/-
Chol/TG			136/417		
TB/CB	0.3/0.07	0.3/0.04	0.2/0.1	0.3/0.1	0.5/0.2
TP/Alb	7.2/2.4	6.4/2.2	6.8/2.5	7/2	6.6/2
PT/INR/aPTT	9/0.8/36	-	10/0.8/34		
Fibrinogen/D dimer			2.8/17850		

2D Transthoracic ECHO-(15/09/24)

Moderate pericardial effusion (2.6 cm anterior RV)

RA collapse/RV diastolic collapse.EF 50-55%

NO LV clot. NO MS/MR/TR/AR

IVC 0.8 cm,>50% collapsible

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Repeat ECHO 23/9/24

Moderate PE-1.6 cm anterior to RV

Mild global LV hypokinesia

LVEF-45-50%

RA/RV dilated

No tamponade

Electrophysiology study- Deltoid shows early recruitment s/o Myogenic pattern

ECG-Diffuse ST depression and prominent U waves

USG ABDOMEN (14/9/24): Mild pericardial effusion. Right kidney 8.3 cm/Left 9 cm/Liver 15 cm/Spleen 11 cm

USG Neck-Subcentimetric LAP in cervical stations 1b/2/3

CECT Chest+ Abdomen (16/9/24):Mild pericardial effusion. Multiple centrilobular and few random nodules in bilateral lungs/Bilateral axillary and retroperitoneal lymphadenopathy/ Moderate ascites ?Tubercular

PBF-Normocytic normochromic/mild anisocytosis/platelet reduced/No schistocytes
Bone marrow (17/9/24)-Moderate Hypocellular marrow with increased fibrosis and myxoid changes. Histiocytes appear increased. No granuloma or lymphoid aggregates seen. PAS/AFB stain negative

Course and Management- A 27-year-old female presented with a two-week history of fever, oral ulcers, generalized weakness, and facial swelling. Initial evaluation revealed a moderate pericardial effusion (NO TAMPONADE) with features suggestive of myocarditis. Based on a provisional diagnosis of systemic lupus erythematosus (SLE), she was initiated on pulse corticosteroid therapy. Electromyography demonstrated a myogenic pattern and elevated muscle enzymes suggestive of myositis, and further evaluation revealed severe cytopenias with a positive direct Coombs test and generalized lymphadenopathy. During hospitalization, she required multiple red blood cell and platelet transfusions.
Cytomegalovirus (CMV) IgM ELISA subsequently returned positive, following which intravenous ganciclovir therapy was initiated. Bone marrow examination revealed a hypocellular marrow, and CMV PCR was sent. Ophthalmologic evaluation showed no evidence of CMV retinitis.In view of persistent cytopenias, hyperinflammatory state, and multiorgan involvement, hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome was suspected, and she was treated with broad-spectrum intravenous antibiotics and intravenous immunoglobulin (IVIG), along with neutropenic prophylaxis. She was also started on thyroid hormone replacement.
During the hospital course, the patient continued to have severe transaminitis (AST > ALT), progressive hemolysis, and severe hypokalemia in the preterminal period, which was managed with intravenous potassium supplementation. Blood cultures grew pan-resistant *Klebsiella pneumoniae*, consistent with a hospital-acquired bloodstream infection. Ophthalmologic evaluation showed no evidence of CMV retinitis.
Her clinical condition deteriorated rapidly with worsening metabolic status. Preterminal arterial blood gas analysis revealed severe lactic acidosis. Non-contrast CT of the head demonstrated doubtful hypodensities in the temporal lobes. On the terminal day, she became unresponsive, required endotracheal intubation for poor sensorium, developed ventricular tachycardia requiring DC cardioversion, and progressed to refractory cardiogenic shock. Despite aggressive resuscitative measures, she suffered a cardiac arrest and succumbed to her illness.

Unit's Final Diagnosis: SLE with lupus myocarditis/Lupus nephritis/Myositis

Cause of Death: Refractory cardiogenic shock/Lupus myocarditis