From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 13/08/2024 02:56 PM
Subject: CPC Clinical Protocol 14.08.2024

Dear All,
Season's Greetings.
The next Wednesday CPC of the session will be held on **August 14, 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 presented by ***Dr. Usha Dutta, Department of Gastroenterology.***Radiology will be presented by ***Dr. Harish Bhujade***. Autopsy pathology will be presented by ***Dr. Ritambhra Nada.***

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Summary (14th August 2024)

HS, 50yr/ M	DOA: 16.06.24	Clinician Incharge: Prof. Ashish Bhalla
CR No: 202403151236	DOD: 30.06.24	Clinical discussant: Prof. Usha Dutta
R/o: Sangrur, Punjab		Pathologist: Prof. Ritambhra Nada
		Radiologist: Dr. Harish Bhujade

Chief Complaints:

- Loose stools x 4 days
- Fever x 4 days
- Dark colored urine x 2 days

History of present illness:

- Patient was apparently well 4 days prior to admission, when he developed sudden onset large volume loose watery stools 15-16 episodes per day associated with occasional mucus and urgency. There was no reported pain.
- It was associated with high grade fever at the onset, which resolved in 4-5 days with medication
- The attenders also noted darkish discoloration of urine for the last two days. Any h/o dysuria/oliguria/frothuria.
- H/o generalized body ache and generalized weakness was present.
- He was taken to a private hospital where he was found to have severe dehydration and hypotension
- He was given IV fluids, IV antibiotics, proton pump inhibitors and antacids.
- The attenders decided to take him LAMA and came to PGI EMOPD.

Past History: Recently diagnosed to have T2DM; not on any medication

- Known to have some psychiatric disorder for 20 years in the form of depressive symptoms and used to have death wishes. He used to tell "Ghost made him ill"
- He won't eat anything other than biscuits and milk for the last 2 years.
- Insidious onset of loss of appetite and weight for the last 2 years (65kg to 41kg). Evaluated for weight loss and anorexia in January 2024 and found to have ESR of 89 other investigations were WNL.

Family History: Mother died in 2009 with after an episode of diarrhea.

Personal History: Unmarried, vegetarian and decreased sleep, no addiction or allergy

General examination: Thin built, emaciated, conscious, oriented, dehydrated

- PR- 78 bpm, regular, feeble, BP- 60/40 mm Hg, RR- 22/min, SpO2 98%RA, Temperature 38°C
- Pallor^{+}, Pedal edema^{-}, Icterus^{-}, Cyanosis^{-}, Clubbing^{-}, Lymphadenopathy^{-}
- JVP not elevated, Dry tongue^{+}, Capillary refill time: 4 seconds, cold peripheries.

Systemic Examination:

- Chest- B/L NVBS present, no added sounds, CVS- S1S2 + No added sounds.
- CNS: E4V5M6, No motor or sensory deficit, DTR 2+, B/L planter flexor
- PA: Soft, non-tender, no organomegaly, no shifting dullness, BS+

Investigations:

Antibiotic Stopped 2 RDP | 2 RDP | 1 PRBC | 1 PRBC

Date	17.01	14.06	16.06	17.06	18.06	19.06	20.06	21.06	22.06	23.06	24.06	25.06	26.06	27.06	28.06	29.06	30.06
Hb	14.6	11	11.7	12.1	13.4	12.5	12.2	12.4	13.3	12.3	10	**6.7**	**8.1**	**7.9**	**7.4**	**6.3**	**6.3**
TLC	**17300**	**1900**	**1900**	**2600**	6000	5440	8300	9500	9920	9100	7780	6680	7400	6060	4640	**3100**	4300
ALC	**1038**	**247**	**200**	**300**	**500**	**470**	**600**	**500**	1020	**700**	**780**	**530**	**400**	**520**	**540**	**400**	**300**
P-L M-E				**78-11 10-3**	**88-9 2**	**86-9 4**	**87-7 5-1**	**91-5 3-1**	**83-10 5-1**	**86-7 5**	**83-10 6-3**	**86-8 6-1**	**86-5 8**	**81-8 9-2**	**75-12 13**		**32-6 10**
Platelets (X 10^9/L)	306	**100**	**73**	**82**	**55**	**42**	**27**	**31**	**24**	**8**	**16**	**21**	**65**	**88**	**105**	**108**	**128**
PCV	46.0	36.3	34.2	39.2	41.2	38.2	39.4	36.7	39.9	38.1	30.6	20.9	25.5	24.3	24.7	20	20.9
MCV	94.0	88.7	87.4	92.5	91.8	86.4	93.7	86.8	88.3	90.3	86	86.1	85.8	85.6	87.3	90	91.7
RDW	**16.3**	**16.4**	**17.5**	**19**	**18.5**	**17.9**	**20.2**	**20**	**19.2**	**18.7**	**17.6**	**17.4**	**21.2**	**21**	**21.5**	**21.7**	**22.1**

Date	16/06	18/06	19/06	20/06	21/6	22/06	23/06	24/6	26/6	28/6	29/06	30/06
Na/ K	**146/** 3.7	**149/** 3.8	**156/** 3.8	**149/** 4.2	**148/** 3.97	**151/** 3.7	**144/** 2.9	**144/** 2.93	**147/** 3.8	**149/** 4.43	**146/** 2.9	**146/** 4.0
Ca/PO4	-	-	8.5/2.2	7.3/2.9	7.7/**2.1**	8.0/**1.9**	-	7.6/**2.1**	7.9/**2.2**	7.5/2.9	-	8.2/-
Mg			**1.8**		**1.3**	**1.6**			**1.4**	**2.1**		
TP/Alb	**4.4/2.6**	**4.2/2.3**	**4.2/2.40**	**4.0/2.25**	**4.3/2.4**	**4.6/2.65**	**4.1/2.51**	**4.2/2.8**	**4.6/3.2**	**4.5/3.24**	**4.7/3.3**	**4.7/3.06**
Bil(T/C)	1.6/0.56	0.7/0.2	0.35/0.18	0.2/0.13	0.21/0.08	0.28/0.06	0.5/0.13	0.4/0.21	0.69/0.33	0.47/0.22	0.52/0.17	0.65/0.19
OT/PT/ALP	31/10/-	59/12/-	37/8/72	34/11/65	34/11/98	**50**/13/132	38/10	37/12/100	**47**/16/85	**51**/17/67	**51**/17/-	**63**/19/-
Ur/Cr	56/1.03	50/0.93	43/0.85	30/0/76	33/1.0	35.1/1.20	38/1.13	36/1.15	34/0.87	32/0.80	41/0/97	50/1.10
Uric acid	-	-	5.2	-	4.4	5.2	-	6.0	6.8	7.5	-	-
LDH	-	-	**299**	-	**365**	**443**	-	**609**	**306**	**297**	-	-
CRP	-	-	**84.35**	**51.22**	**36.25**	**22.64**	-	**12.51**	**15.11**	**22.04**	-	-
TG	-	-	138	119.3	114.2	-	-	-	-	-	-	-
T. Chol	-	-	**59.0**	**49.9**	**48.3**	-	-	-	-	-	-	-
LDL/HDL	-	-	**10/19**	**8.5/17.2**	**8.3/14**	-	-	-	-	-	-	-

Date	19/06/24	25/06/24	24/06/24	30/06/24	30/06/24
Blood C/S	Sterile	Sterile	-	Sterile	**Candida tropicalis (S to all)**
Urine C/S	Sterile	-	Sterile	-	-
Stool C/S (21/06/24)	**Salmonella Typhimurium**	**S: Gentamicin, Amikacin, Chloramphenicol, cotrimoxazole R: Amoxicillin, Cefotaxime, Ciprofloxacin, Furazolidone and Tetracycline**			
Procal	**1.65**	**1.24**	0.593	-	-
URME	Protein 1+, Ketone bodies 1+ WBC nil	-	-	-	-

Upper GI Endoscopy (26/06/24):
Esophagus- Adherent clot at lower Esophagus
Stomach- Fundus: Linear ulcers
Body: Atrophic gastritis and erosions
Antrum: Atrophic mucosa
Forrest-lll clean based ulcer
D1 & D2- Duodenopathy changes present.
Biopsy from antrum (S-18650/24): Chronic superficial gastritis
H .pylori negative

2D ECHO (7/6/24)
EF- **30-35 %**
Global hypokinesia
DCMP with moderate LV systolic dysfunction

USG Abdomen (16/06/24)- Distended gall bladder with perihepatic free fluid, thickening of jejunal loops

COLONOSCOPY:
Poor preparation. Seen till 40cm
Luminal narrowing with multiple pseudopolyps? Growth
Complete loss of vascular pattern with multiple large pseudopolyps? Growth
Mild luminal blood present
Few areas of mucosa appear pale

CECT Chest & abdomen - B/L Pleural effusion and moderate ascites with passive subsegmental atelectasis of underlying lung parenchyma. B/L renal infarcts with attenuated arteries.
Edematous mural thickening involving the large and small bowel loops with mucosal hyperenhancement? Reactive
Aorta, IVC, SMA, SPA - Normal
No significant adenopathy

Serology: Non-reactive HBsAg: Negative Anti HCV: Negative HIV: Negative VDRL: Negative	Serum osmolality- 302 mosmol/kg Urine osmolality- 379 mosmol/kg Urine Electrolytes: Potassium- 32.33 Sodium- 106.6	Pro BNP- **39763** Trop T- 477.9 CK- NAC: 99	LEMDS Work-up: Negative IgM CMV – Negative, CMV PCR – Negative IgM EBV-Negative ANA by IIF - Negative Stool RME-no pus cells, RBC, trophozoites, cyst or ova Atypical organisms- Not found
Urine Porphobilinogen - Negative	Date: 1706.24 pH- 7.332 PO2- 52.8 PCO2-40.0 HCO3-20.7 BE **-4.8** Lactate- 2.70mmol/lit(21.06)	AFP: 13.7 (0-5.8) CEA: **70.03** (0- 4.7) CA 19-9: **45.90** PSA: 4.61 (0-4.1)	Reticulocyte - **0.28%** Vitamin B_{12}- 293.7 Folate- **2.77** S. iron- 21.7 TIBC- **646.20** T Sat- **3.36** Ferritin- **1056** PNH assay: Negative
Urine myoglobin- 21.00	Widal O <1:30 H <1:30 AH <1:30 BH <1:30	PTH- 67.4 (15-65) Vit D- **5.04** (11.1-42.9) HbA1c – 5.3% ACTH- 43.5 (7.2-63.3) Cortisol- 741(171-536) TSH- 2.71	Plasma Hb- Not raised Haptoglobin- 93.3 (36-195) G6PD screening- Normal DCT: Anti-IgG & Anti-C3d- Negative ADAMTS13 levels- 65.3% Urine Hb- Nil Fibrinogen 2.57g/L D-dimer 3566ng/ml

Course And Management:

50-year-old gentlemen presented with loose stools for 4 days and dark colored urine for 2 days. He was dehydrated with hypotension. Fluid resuscitationss and inotropic support was started. Intravenous Ceftriaxone and Metronidazole were initiated considering possibility of infective etiology. Chest x-ray showed bilateral pleural effusion and 2D transthoracic echo revealed DCMP with global hypokinesia with EF of 30-35%. He was started on diuretics, his edema and shortness of breath improved, oxygen and inotrope support were tapered. Antibiotics were withheld after 7 days on resolution of loose stool episodes.

His blood investigations initially showed bicytopenia; although leucopenia improved with IV B_{12} injection but thrombocytopenia worsened further requiring multiple platelet transfusions.

One day after nadir of platelets, he had passage of blood mixed stools and clots per rectum. It was associated with significant fall in hemoglobin for which two units of PRBC were transfused. UGIE was non-contributory, but colonoscopy revealed multiple pseudo polyps with some narrowing? growth. With conservative management, his symptoms improved but on the night of 30th June, he developed gradual shortness of breath associated with fall in systolic blood pressure and became drowsy. Chest X-ray was suggestive of pleural effusion as confirmed by chest X-ray. He was initiated on noradrenaline infusion and O_2 support. Therapeutic pleural tapping was done but with gradual deterioration of general condition he was intubated and kept on mechanical ventilation. However, he had sudden cardiac arrest and could not be revived & declared dead at 2:34pm on 30.06.2024.

Unit's Final Diagnosis:

Acute gastroenteritis
Lower GI Bleed
Cardiogenic shock
Depressive disorder with episodes of dissociation

Attachments:

File: CPC Clinical Protocol 14.08.2024.pdf	Size: 315k	Content Type: application/pdf