From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 16/04/2025 09:08 AM
Subject: CPC Clinical Protocol 16.04.2025

Dear All,
The next Wednesday CPC of the session will be held tomorrow, **April 16, 2025** 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. Sudheer Kumar Devana, Department of Urology.*** Radiology will be presented by ***Dr. Abinandan.*** Autopsy pathology will be presented by ***Dr. Aravind S.***

Please note that this will be the last CPC of this academic Session. We will see you again after the summer vacations (July 16, 2025)

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Clinical Protocol Staff CPC, 16th April 2025

Mr MS, 36y/M	**Unit:** Endocrinology/ACEM	**Clinician in charge:** Dr Mohan Kumar H	
CR no: 20401100839	**Adm no:** 2024002484	**Clinical discussant:** Dr Sudheer Kumar Devana	
DOA: 9/01/2024	**DOD:** 24/01/2024	**Radiologist:** Dr Abinandan	**Pathologist:** Dr Aravind

Clinical course at GMCH, Chandigarh: (2- 9th January 2024)
Presenting complaints:

- Hematuria through suprapubic catheter (SPC) for 4 days
- Fever for 3 days
- Shortness of breath (SOB) for 3 days
- Bilateral flank pain for 3 days

Presented with hematuria through SPC for 4 days, associated with high-grade fever and bilateral flank pain. Had SOB which was progressive and associated with left chest pain and orthopnoea.
Hospital course: NCCT KUB (03/01/24) showed left renal abscess of size 7.1x6x2.3 cm, and CXR showed bilateral pleural effusion (L>R). Blood investigations: TLC – 15,300/cumm, platelet count -19,000/cumm and serum creatinine 4.5mg/dl. Pleural fluid culture was *E.Coli* and Urine culture was *Klebsiella Oxytoca*. With the diagnosis of left empyema, left renal abscess(7cm), and septic shock with AKI, He was treated with IV meropenem, vancomycin and ionotropic support. During his hospital stay, he developed blackish discoloration of his toes and was referred to PGIMER for further management.
Clinical course at PGIMER, Chandigarh (9- 24th January 2024): Presented with swelling of bilateral foot for 5 days, insidious in onset extending to legs. This was followed by blackish discoloration of the toes, which started on the left and right sides and was associated with pain. Also, c/o abdominal distension is associated with pain, gradually progressive, not associated with vomiting. There was no h/o intermittent claudication, vomiting, cough, syncope, blurring of vision, jaundice, rash, oliguria, or loose stools.
Past History: H/o RSA in July 2022, sustained Fracture right femur and urethral injury. Underwent urethroplasty at GMCH, which failed, and since then, was on SPC. H/o Seizure disorder at 15 yrs. of age was on phenytoin, discontinued for 10 years. **Family history:** Not contributory **Personal history:** Alcoholic for 10 yrs, 60-90ml/week, Smoker for 10 years., 4 cigarettes per week

Examination:
Vitals: Afebrile, HR: 110/min, RR: 30/min, SpO2: 94%, on Venti mask 6L/min, BP: 100/70 mmHg.
GPE: Conscious and oriented, no pallor, icterus, clubbing, cyanosis. Bilateral pedal edema with blackish discoloration of all toes and multiple bullae. Limb was warm, and peripheral pulses were present.
Respiratory system: Decreased bilateral air entry in lower chest, no added sounds. **Abdomen:** Distended with tenderness, guarding and rigidity present. Bowel sounds are present. **Cardiovascular system:** S1 S2 +, no murmur/gallop. **Central nervous system:** E4V5M6, HMF intact

Investigations:

	9/01/24	10/01/24	13/01/24	15/01/24	16/01/24	19/01/24	20/01/24	22/01/24	23/01/24
Haemoglobin (g/dL)	**6.6**	**6.3**	**5.9**	**8.5**	**9.2**	**8.3**	**8.6**	**8.3**	
Total Leucocyte count	**19400**	**22070**	9800	**20420**	**29320**	**20200**	**26780**	**20900**	
Differential (N/L/M)	73/13/10	77/11/8	77/10/12	86/7/6	90/5/4	70/13	66/15/9	53/26/11	
Platelet count ($x10^3$)	**14**	**19**	**105**	**94**	**97**	405	**107**	145	
Sodium/Potassium	131/4.9	136/5.7	140/4.7	141/4.2	142/3.7	145/4.2	144/4.6	141/4.8	142/**5.6**
Urea/Creatinine	**181/5.8**	**169/5.4**	**141/4.2**	**102/3.1**	**87/2.3**	**109/2.3**	**117/2.3**	**146/3.2**	**162/3.6**
AST/ALT/Alkaline Phos	**62**/17/-	**48**/13/**244**	**71**/11/-	**65**/11/**248**	**56**/9/**198**	**53**/8/**147**	**90**/13/**166**	**91**/13/**111**	**89**/13/**111**
Bilirubin- Total/Direct	**1.4/0.7**	0.9/0.7	1.2/0.6	0.36/0.3	0.3/0.2	0.29/0.23	0.4/0.3	1.2/0.5	**1.6/1.3**
Total Protein/Albumin	**5.6/1.9**	**5.7/1.9**		6.6/**1.9**	**6.1/2.0**	5.4/1.5	**5.4/1.4**	**4.6/1.7**	**4.6/1.5**
Calcium/Phosphate		**7.9/7.4**			**7.7/4.3**				**8.2/6.5**
Coag (PT/APTT)	**14/>2min**	**14/67**	**15/31**	**17/43**					**33/44**
Coag (PTI/INR)	**82/1.2**	**86/1.16**	**-/1.26**	**80/1.23**					**35/2.8**
Coag (D dimer/Fibrinogen)		**11232/4.4**	**11693/4.2**	**-/3.69**					
CRP/LDH		**291/298**	**276/269**						

	9/01/24	10/01/24	11/01/24	13/01/24	15/01/24	16/01/24	17/01/24	19/01/24	20/01/24	22/01/24
Urine output	**370**	830	1000	1100	1800	920	1050	1240	950	**430**

C3:106 mg/dl, **C4**:21.8mg/dl, **T4**:4.23µg/dl, **T3**:0.54ng/ml, **TSH**:17.8µIU/ml (12/01/24)**; ANA:** Negative (18/01/24)

AFP: 1.96IU/ml, **CA19.9**: 6.39 IU/ml, **CEA**: 0.72ng/ml (13/01/24)

HIV, HCV, HBsAg (10/01/24): Negative

Serum procalcitonin (10/01/24): **75ng/ml**

Ascitic fluid workup: (12.01.24)
Bacterial culture: ***E.Coli*** Sensitive to Piperacillin, imipenem, AFB smear: Negative; Gene Xpert: Negative; Fungal culture: Negative; LDH: 42725 U/L, TP: 3.82g/dl, Alb:1.54 g/dl, Glucose: 4.3 mg/dl, Amylase: 75 U/L, TLC:3,53,00; DLC: N92, L7.9

Pleural fluid analysis: (18/01/24)
Serum amylase: 60U/L; Serum lipase: 24.8 U/L (19/01/24)

G6PD screening: Normal (18/01/24)

USG Abdomen (9/01/24): Massive ascites with internal septations, B/L Pleural effusion R:3.9cm, L: 7.8 cm, Medical renal disease. Grade I fatty liver

DVT scan (9/01/24): No e/o DVT, Marked skin and subcutaneous edema

B/L lower limb arterial doppler (11/01/24): Bilateral triphasic flow in CFA&SFA, Biphasic flow in ATA, PTA, PA.

ECHO (12/01/24): Mild MR, No Vegetations. EF was normal

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Course and management:

At presentation the patient had bilateral pleural effusion(L>R), gross ascites, dry gangrene with severe sepsis. He was kept on O2 support on ventimask and was initially treated with IV Piperacillin Tazobactum and Vancomycin. With decreased urine output and rising creatinine and hyperkalemia, 3 sessions of Hemodialysis were given. Around 1.5 L of ascitic fluid was tapped to relieve abdominal discomfort and subsequently abdominal collections were drained by placing 10Fr pigtail catheters in the peri hepatic and perisplenic area on 12.1.24. Both PCD drained around 1 litre of fluid in 3-4 days. Wet on dry gangrene was treated with IV Heparin 5000 IU TDS along with IV antibiotics. He also received 2 units of PRBC for fall in hemoglobin. The patient clinically improved initially for 4-5 days after admission and subsequently from 15.1.24 his fever spikes increased with worsening TLC counts and septic shock. For fall in SPO2 the patient was kept on NIV initially and subsequently he was intubated on 16.1.24 and was put on CMV mode. IV antibiotics upgraded to Inj.Polymyxin B, vancomycin, imipenem and metronidazole. Accidental slippage of right PCD occurred on 17.1.24 and USG assessment showed no significant collection. From 19.1.24, fever spikes increased with worsening TLC counts with septic shock needing double ionotropic support. He had GTC seizures on 21.1.24 which were repetitive, likely hypoxia related and was treated with antiepileptics. On 22.1.24, went into vegetative state. **Pre-terminal event:** On 24.1.24 patient went into refractory septic shock leading to cardiac arrest. CPR was performed and was declared dead at 12:05 AM.

Unit's final diagnosis:

36 Yr Male who was a follow up case of traumatic urethral injury on chronic SPC with Left pyelonephritis and ruptured subcapsular renal collection with secondary peritonitis, bilateral pleural effusion with severe sepsis, DIC, AKI and bilateral peripheral limb gangrene
With seizure disorder