From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 16/10/2024 09:19 AM
Subject: CPC Clinical Protocol 16.10.2024

Dear All,
Season's Greetings.
The next Wednesday CPC of the session will be held on **October 16, 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. Vishal Sharma, Department of Gastroenterology.*** Radiology will be discussed by ***Dr. Ujjwal Gorsi.*** Autopsy pathology will be presented by ***Dr. Rakesh Holla.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Protocol 16.10.2024

Patient: Mrs R	DOA: 22-11-23	Clinician In charge: Prof Usha Dutta
CR No: 202103576215	DOD: 25-11-23	Clinical Discussant: Dr Vishal Sharma
Age/Gender: 72/F		Radiologist: Dr Ujjwal Gorsi
R/O : Yamuna Nagar, Haryana		Pathologist: Dr Rakesh Holla

Presenting complaints: Fever followed by increased frequency of stools X 5 days
Detailed history 2020: Symptoms began in November 2020 with bloody stools, received steroids and oral 5-aminosalicylates
2021: (10-11-21 to 19-11-21). Admission for flare c/w ASUC with initial stool frequency 10-12/day with blood. Improved with intravenous methylprednisolone, discharged with stool frequency of 3/day on oral steroids. Records suggest presence of malnutrition, bilateral cataract and past cholecystectomy. Sigmoidoscopy: MES: 3 and UCEIS: 5 erosions+, ulcers+, diffuse loss of vascular pattern +, Mucosal bleed
OPD follow up- Continued on tapering steroids, azathioprine started, oral and local ASA continued; Hmg: 8.9/6900/1.9 LFT: 0.9/25/37/113/4.6/2.6 ; Dental caries, adv: extraction of tooth; facial puffiness (? steroid related)
Jan 22: Sigmoidoscopy: UCEIS: 2, patchy loss of vascular pattern +, and erosions
Feb 22: Azathioprine 100 mg; Headache and neck pain. Neurology opinion: Migraine without aura- started on Ciplar; Hmg: 8.7/6600/; LFT: 0.8/20/24/123
May 2022: Inj IV Iron was advised at center of convenience
June 2022: Increased stool frequency 5-6/day; minimal blood in all; Sigmoidoscopy: UEIS: 5 Oral ASA 2.4 gram/day and 1 gram suppository, Azathioprine 100 mg/day; Ciplar-LA continued; Oral Prednisolone 30 mg/day was started; Tapering started next week
Aug 22: Stool freq 2/day; migraine +
Oct 22: Minor blood for 2 days; stool freq 2/day H/o NSAIDs for headache
Jan 23: Admission from 23-1-23 to 29-1-23; Admission was for increased stool frequency: 4-5 /day; Anaphylactic reaction with Iron isomaltoside; Colonoscopy : E3 (Extensive colitis); Right colon, Transverse colon and Descending colon: Pseudopolyps; Rectosigmoid: LOVP; Sup ulcers;
Feb 23: Stool freq 2-6/day; erratic intake of medication and irregular use of enema
March 23: Increased stool frequency; steroids started
Aug 2023: *3rd August:* Stool frequency 10-12/day; not willing for admission ; started Prednisolone 50 mg/day; *14 August:* Stool freq still high at 10/day, Tapering started and Tofacitinib 5 mg BD started; 28 Aug: Stool freq: 3/day was still on Prednisolone 40 g/day and advised to taper
Sept 23: Stool freq 1/day; tapering of steroids continued and tofacitinib continued
Oct 23: Stool frequency 5-6/day; intermittent blood; Tofacitinib 5 mg BD continued
Nov 23 (Current Admission): Admitted on 22/11/23; Fever and myalgias followed by increased stool frequency for 5 days, stool frequency of 8-12 /day along with more than 50% blood mixed stools. She visited gastroenterology department for these complaints and was admitted/
Sigmoidoscopy :(22/11/2023)Seen till 30 cm from anal verge; Diffuse loss of vascular pattern; Mucosa bleed to touch/ mild mucosal bleed; Superficial ulcers in rectum; Sigmoid colon : Deep linear ulcers; UCEIS 6/8 (2+1+3)

	22/11/23	23/11/23	24/11/23
Hb	**10.6**	**9.1**	**8.7**
TLC	9610 N78L13.4M7.7	5050 N88L8M2	**13100** N89L6M5
PLT	**135000**	**114000**	**96000**
Na	132	132.8	136
K	**3.03**	**3.48**	4.18
Urea	14	10.8	20
Creatinine	0.64	0.55	0.62
Ca	7.19	7.82	7.7

P		**2.17**	
Mg		1.83	
Bilirubin	0.47	0.35	0.5
AST	**289**	**332**	**183**
ALT	44	**57**	45
ALP		**507**	NA
Total Protein	5.1	5.45	5.3
Albumin	1.95	2.15	1.98
CRP		**17.34**	
LDH		292	
Amylase	43		
PT	14.8	14.7	
PTI	78%	79%	
INR	1.28	1.27	
aPTT	56.4	73.3	

	25-11-23 00:04 AM	25-11-23 7:22 AM
pH	6.989	7.014
pCO2	33.4	22
PO2	100.9	129
HCO3 mmol/L	7.8	5.6
BE	-22.9	-24
SaO2	90.5%	97

ECG at admission: HR: 120/min, T inversions in anterolateral leads, ST depression V5, V6, QTc: 353 ms

ECG after onset of pain: Absent P wave, Wide QRS-160 ms, Global T inversion, Ventricular rate: 66 , LBBB like pattern

CK-MB: 1.8 ng/mL, TNI: 0.23 ng/mL; Blood culture: Sterile, Urine culture: Sterile, PCT: 0.159 ng /ml, IgM Dengue Capture microELISA: Positive; TC: 53; LDL:7; HDL: 11.6; TG: 79
NCCT Brain: Diffuse cerebral atrophy, microangiopathic age related changes. ECHO: LAD Territory hypokinesia, Mild MR+, EF: 30-35%

COURSE AND MANAGEMENT: The patient admitted with an acute flare (ASUC) possibly triggered by Dengue fever. Her sigmoidoscopy was suggestive of UCEIS of 6/8. She received IV Solumedrol (Methyl prednisolone) 60 mg OD for 3 days (22/11/2023 - 24/11/2023) with improvement in stool frequency (2-3 episodes per day) with no blood and shifted to oral Prednisolone 35mg /day on Day 4. Daily abdominal X ray did not suggest any megacolon. Inj Heparin 5000 IU s/c daily and Tofacitinib 5 mg BD were continued. She was in recovery phase of dengue with platelets more than 1 Lakhs and improving aminotransferases. She had hypokalemia which was corrected with IV potassium chloride and her serum potassium on 24/11/2023 was 4.18 mmol/L. She was planned for discharge on oral steroids but on the night of 24/11/2023 she developed sudden onset chest pain followed by loss of consciousness and uprolling of the eyeballs ? Seizure and hypotension. She was intubated and mechanically ventilated in ICU and ECG was done which was suggestive of recent onset wide complex QRS - LBBB (STEMI equivalent). She was provided loading dose of ecosprin and clopidogrel. NCCT brain was done to rule out CNS bleed and then IV thrombolysis with Inj Streptokinase 1.5 million units over 1 hour was initiated. She developed ? reperfusion arrhythmias however she was hemodynamically stable. ABG was suggestive of severe Acidosis ph 6.9 and hence she was started on IV sodium bicarbonate. She developed cardiogenic shock and required ionotropic support. She developed cardiac arrest at 3 am in the morning and was revived after CPR as per ACLS protocol. She developed another cardiac arrest in the morning and couldn't be revived and death was declared at 8:58 am.

Units Final Diagnosis: Acute Severe Ulcerative colitis, E3 disease, Post Dengue Infection, Acute STEMI, Cardiogenic shock