From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 18/07/2024 07:57 AM
Subject: CPC Clinical Protocol 17.07.2024

Dear All,

Season's Greetings.

Welcome to the new Academic Session, July-December, 2024

The first Wednesday CPC of the session will be held on **July 17, 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

(Kindly note that this is a fresh WebEx link that will be used henceforth. The previous link will no longer work)

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. Neelam, Department of Cardiology.*** Radiology will be presented by ***Dr. Arun Sharma***. Autopsy pathology will be presented by ***Dr. Nandita Kakkar.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC 17.07.2024

SDB 55 years M	**DOA: 27 March 2024**
	DOD: 01 April 2024
CR Number: 2024020240821	**Chairperson : Dr. Sanjay Jain.**
Clinical Discussant: Dr. Neelam	**Pathologist: Dr. Nandita Kakkar**
Radiologist: Dr. Arun Sharma	**Clinician In Charge: Dr. Sachin Mahajan**

Presenting Complaints: Inability to move bilateral lower limb since 26th March 2024. Under went CT Chest, found to have dissection flap. Reffered to PGIMER from command Hospital Udhampur, reached on 27th March 2024.
Past History: HTN x 10 Years, Obesity. No other significant history available.
Systemic Examination: Patient was agitated, bilateral pupil were reactive to light.
Pulse Rate : 81/minute, **Blood Pressure** : 110/72 mmHg on ionotropes
Cardiovascular System: Normal
CNS : E4V5M6
Limbs: Bilateral cold clammy
Power: B/L UL : >3/5. RLL: 2/5 LLL: 1/5
B/L: Femoral, Popliteal, not palpable
Events:
27th March: Underwent CT aortogram subequenlty underwent supra coronary AA and hemiarch replacement with 26 mm PTFE tube graft. Nuerological assesmnet showed decreased power in bilateral lower limbs . Acute ischemia of B/L lower limbs was there, there was suspicion of Spinal ischemia too .
28th March: Decreased Urine output & hyperkalemia. Dual inotropes. SLED started. Had Left leg compartment syndrome with reperfusion injury. Fasciotomy of leg and thigh done. On ventilation.
30th March: Increased ionotropic support, increased lactate. Thigh abductor noncontractile.
31st March: Had Malena, pan cytopenia. Conservative management. Ventilated. Ischemic hepatitis.CVVD continued.
1st April: Died

BLOOD INVESTIGATIONS

Date	27/03/24	28/03/24	29/03/24	30/03/24	31/03/24	01/04/2024
Hb	11.8	9.5	9	8.3	8.8	7.2
PCV	39.5	29.4	28.8	24.5	26.3	24.1
TLC	16400	12960	14400	12200	3600	0.8
PLT	149 k	78 k	50 k	36 k	15 k	7 k
Na	136	142	140	142	147	148
K	5.5	5.76	6	5.48	4.07	6.9

BUN	86	105	96	141	111	
Creatinine	3.08	4.17	3.7	4.81	3.48	3.64
Total Bil.	0.69	0.77	1.32	1.58	3.26	2.61
Conju.Bil.	0.22	0.26	0.5	0.73	2.13	1.62
AST	231	1404	1736	1805	5645	4276
ALT	112	520	875	912	1949	1056
Alk Phos		41	56	77	203	
Total Protein	6.6	4.1	4	3.7	3.2	
Albumin	3.56	2.6	2.5	2.4	2.3	
CRP				8.7		44.67
PT				17.1		
PTI				69%		
INR	1.13	1.37	1.29	1.44		
APTT				28.6		
FiO2	100	90	0.7	0.7	100	
pH	7.35	7.4	7.4	7.4	7.37	
PO2	73	49	120	86	63.4	
PCO2	40	40.9	24.8	24.7	17.1	
HCO3	21.8	26	17.5	15.7	9.8	
BE	-3.3	1.5	-6.2	-8.8	-15.3	
SpO2	93.8	85	98.7	96.8	93	
Ca	0.62	1.03	1	0.9	1.28	
Lactate	4.8	5.6	5.9	8	8.9	
RBS	85	139	184	133	32	

BLOOD CULTURE.

30.04.2024 **Acinetobacter Buamannii** : Sensitive to Minocycline, and Intermediate Sensitive to Colistin & Levofloxacine.

01.04.2024 **Acinetobacter Baumannii** : Sensitive to Minocycline.

03.04.2024 **Klebsiella Pneumoniae** : Sensitive to Colistin, Levofloxacine, and Minocycline

TISSUE CULTURE.

03.04.2024 **Klebsiella Pneumoniae** : Intermediate Sensitive to Imipenem.

ELECTROCARDIOGRAM: Normal

ECHOCARDIOGRAM: Normal LV Function, Trivial AR

CT AORTOGRAM

Impression:

Type A Stanford Aortic dissection with intramural hematoma
Moderate haemopericardium.
Mild bilateral hemothorax.

AORTA BIOPSY

Gross:

Received multiple flattened irregular tissue pieces, largest measuring 3x3x0.2cm and smallest measuring 1x1x0.2cm.
Intimal surface show few atheromatous plaques. Focally, haemorrhagic areas are seen dissecting the vessel wall with
Adventitial area showing congestion and haemorrhage.

Micro:

Section examined from the aortic wall shows focal areas of haemorrhage through the wall of the vessel (medial layer) and reaching the adventitia. Other areas of myxoid degeneration are seen in the medial layer. Mild scattered Lymph mononuclear inflammation & focal neovascularization noted. No calcification noted.

HOSPITAL COURSE

This 55 years old male who was obese and had hypertension for 10 years developed weakness of bilateral lower limbs on 26th March 2024. He was referred to PGIMER and reached PGIMER on 27TH March. At Presentation he had hemodynamic compromise, was disoriented, had renal and liver dysfunction suggesting hypo perfusion syndrome. CTA aorta showed Type A aortic dissection with moderate hemo pericardium and hemothorax. He was on ventilatory support throughout his illness. He had compartment leg syndrome for which fasciotomy was done. He had Malena, for which conservative management was done. For his limb weakness, neurology opinion was taken, and possibility of spinal ischemia was kept along with acute limb ischemia .His Blood culture grew Acinetobacter and Klebsiella for which appropriate antibiotic was given. He was on dialysis throughout hospital stay. However during his stay renal and liver function continued to worsen, ventilatory support and inotropic support increased, he developed pancytopenia and hypoglycemia suggestive of severe sepsis. Eventually he succumb to his illness and died on 6th day of surgery.

UNIT DIAGNOSIS

Non A Non B Aortic Dissection
Hypoperfusion Syndrome
Post-surgery Supracoronary AA and Hemi arch replacement. Sepsis,
MODS, Normal LV Fuction. Trivial AR

Attachments:

File: CPC Clinical Protocol 17.07.2024.pdf	Size: 45k	Content Type: application/pdf