From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 22/01/2026 01:39 PM
Subject: CPC Clinical Protocol 21.01.2026

The next Wednesday CPC of the session will be held tomorrow, **January 21, 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. Charanpreet Singh, Department of Clinical Hematology and Medical Oncology.*** Radiology will be presented by ***Dr. Nidhi Prabhakar.*** 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 (21.01.2026)

Name: Mr PK, 20/M **R/O:** Yamunanagar **CR. No:** 202503310417 **Adm No:** 2025059559
DOA: 20/07/2025 **DOD:** 25/07/2025 **Unit:** RICU
Clinical Discussant: Dr Charanpreet Singh **Pathology Discussant:** Dr Rakesh Holla
Radiology Discussant: Dr Nidhi Prabhakar **Chairperson:** Prof Sanjay Jain

Presenting complaints:
Shortness of breath x 3 days
Fever x 2 days

Background History

2013: Diagnosed initially with Autoimmune Hemolytic Anemia (AIHA) (Age at that time ~8 years). Full records are not available, but was treated initially in PGI, and then moved to Delhi for treatment

2014-2023: Treated at a private hospital in Delhi and received multiple lines of therapy, including Prednisolone, Cyclosporine and MMF. Exact details of response to each agent is not available. Records mention that Hemoglobin remained between 6-7 gm/dl throughout this time. Also mentioned to have Beta Thalassemia trait. Took on and off Complementary/Alternative medicine through this time period. Details of number of transfusions received is not available.

2023: Had worsening of AIHA and received Rituximab, 4 doses given 1 week apart. Had a transient partial response to Rituximab. CBC in November 2023- 114/4.61/244

2024: Was continuing on Prednisolone. Would change dose by himself and used to stay between 30-40mg OD. CBC in March, 2024- 106/6.9/81. Noted to have ANA + (exact method, dilution, strength not mentioned). Anti LKM positive (1+).

April-May, 2025: Developed pedal edema and ascites. Was diagnosed with cirrhosis with portal hypertension. A liver biopsy was done in an outside hospital in June 2025 which was consistent with cirrhosis with siderosis with portal and lobular eosinophils ?DILI.

July, 2025: Came to PGI OPD to get an opinion from Hematology and Hepatology services. Noted to be on Prednisolone + Azathioprine at this time. CBC- 88/5.6/216. Bil- 3/1.38; OT/PT-70/70; INR- 1.28. Fibroscan revealed LSM of 24.3. Upper GI Endoscopy revealed Esophageal Candidiasis.

Present admission

The patient presented to the EMOPD with a history of progressive shortness of breath for the past 3 days. Dyspnea had progressed from Grade II to Grade IV within 2 days with no history of cough, sputum production, palpitations, postural or diurnal variations. He also complained for fever for 2 days prior to presentation which was not measured, and not associated with chills and rigors.

Examination (at presentation):
Patient was conscious and oriented to time, place and person.
Vitals: PR: 124 bpm; BP 112/74 mm Hg; SpO2: 91% at Room air
GPE: Pallor +, Icterus-, Cyanosis-, Clubbing-, Lymphadenopathy-, Edema +
Short stature, Atypical facies, Buffalo hump, Abdominal striae present; Vitiligo +; Malar rash +
Systemic examination:
RS: Bilateral Normal Vesicular breath sounds
CVS: S1 S2 normal, no added sounds
P/A: soft, non-tender, Liver palpable 3cm below right costal margin, no free fluid, bowel sounds +

Investigations:

Hemogram

	15-Jul	19-Jul	20-Jul	21-Jul	23-Jul	23-Jul	24-Jul	24-Jul	25-Jul
Hb (g/dL)	11.2	9.1	9.7	9.6	7.7	7.7	7.9	7.9	6.7
TLC ($\times 10^9$/L)	8.44	10.5	11.6	14.37	6.02	5.9	7.96	6.0	4.3
Neutrophils %	86%	95.1%	92.3%	93.1%	97%	95.4%	96.4%	94.3%	95.9%
Lymphocytes %	6.3%	1.2%	3.4%	1.8%	1.0%	2.4%	0.9%	3.3%	1.1%
Platelets ($\times 10^9$/L)	317	35	109	328	137	27	136	117	93
Reticulocyte %	–	–	–	4.2	–	–	4.3	–	–

Biochemistry

	14-Jul	19-Jul	20-Jul	21-Jul	22-Jul	23-Jul	24-Jul	25-Jul	25-Jul
Na (mmol/L)	133	141.9	136	129.4	130	138	122	118	117
K (mmol/L)	5.28	5.21	5.16	4.56	4.92	4.53	5.7	6.16	6.93
Urea (mg/dL)	36.6	23.2	36.8	37.1	47.5	51	52.4	71.5	70
Creatinine (mg/dL)	1.03	0.72	1.05	0.89	0.78	0.66	0.76	1.00	1.09
Total Protein (g/dL)	6.56	4.87	5.21	4.82	4.22	–	4.16	3.86	–
Albumin (g/dL)	3.78	2.51	2.79	2.65	2.20	–	2.38	2.27	–
T Bilirubin (mg/dL)	3.86	3.05	3.31	3.10	1.34	–	1.35	1.68	–
D Bilirubin (mg/dL)	2.02	1.85	1.94	1.74	0.97	–	1.02	1.15	–
AST (U/L)	67.2	77.3	65.0	78.4	49.9	–	59	100.1	–
ALT (U/L)	80.6	56.7	56.5	48.9	–	–	52	68.5	–
ALP (U/L)	132	–	–	165	–	–	157	145	–
LDH (U/L)	–	–	–	659	–	–	463	571	–
CRP (mg/L)	–	–	–	21.06	–	–		–	–

Coagulogram:

	14-Jul	19-Jul	20-Jul	23-Jul
PT (sec)	15.1	16.8	16.1	19.1
INR	1.35	1.50	1.44	1.71
aPTT (sec)	24.6	27.2	27.9	60.2
Fibrinogen (g/L)	–	–	–	2.15
D-Dimer (ng/mL)	–	–	–	335

Radiology

USG Abdomen (20/7/25)-Spleen 14.2cm. Normal liver and portal vein; **USG Abdomen (24/7/25)-** Mild ascites; Bilateral renal parenchymal changes; **CECT Chest (20/7/25)-** GGOs in both lungs ?infective

Additional Investigations

ECG (20/7/25)- Left axis deviation; occ VPC
Haptoglobin- 20.8 (24/7); 24.8 low (24/7)
DCT (15/7)- Anti IgG 3+
Urine Hb (25/7)- Nil
Plasma Hb (25/7)- Not raised
Pro BNP (23/7)- 443.9 (Elevated)
Trop T (23/7)- 5.81(Low)
Ceruloplasmin (17/7)- 31.3 (Normal)
IgG (15/7)- 1540 (normal)
ANCA (21/7)- Negative
AIH Panel (21/7)- Negative
ANA (21/7)- Negative

Hormonal Profile

TSH- 42.3 high(21/7) 6.69 (23/7); 15 high (25/7)
T4- 6.2 normal (21/7);4.56 low (25/7)
T3- 0.676 low (21/7); 0.71 low (25/7)
fT3- 1.12-low (23/7)
fT4- 0.96- normal (23/7)
TPO- 9.45 normal (23/7)
Cortisol- 172 normal (23/7); 125 low (25/7)
ACTH- 1.5 low (25/7)

Microbiology

Mini BAL Biofire (23/7/25)- Mycoplasma sp
Procalcitonin (21/7)- 0.554
Blood Culture (23/7)- Sterile
ET Culture (23/7)- Sterile
ET Aspirate Fungal (23/7)- Gross contamination
Mini BAL for PCP- Positive
Nasal Swab for COVID-19- Positive
Blood Culture (26/7)- Enterococcus Faecalis; Klebsiella Pneumoniae

Course and Management:

This 20 year old gentleman presented to the EMOPD with a history as described above. He was initially maintaining saturation on low flow oxygen and CT chest showed diffuse GGOs. He received iv antibiotics for his pneumonia initially but had worsening tachypnea and hypoxia for which he was shifted to the RICU and intubated and started on mechanical ventilation. In view of immunocompromised status and consistent CT picture, a possibility of severe PCP pneumonia was kept and he was started on Septran in a therapeutic dose with oral steroids. His nasal swab for COVID 19 came out to be positive, after which his prednisolone was converted to dexamethasone transiently. ET aspirate mini BAL sample showed IFA positive for PCP and biofire was positive for mycoplasma.

He developed hyponatremia with hyperkalemia on 24/7/25 for which corrections were given. He developed ventricular tachycardia on 25/7 which was refractory to amiodarone and calcium gluconate. Prior to this the patient had remained stable with no fever, prior hypotension or increased oxygen requirement. VT was persistent despite lignocaine and repeat amiodarone and developed hypotension for which inotropes were started. 2D echo revealed dilated RA/RV with a TAPSE of 16mm and D shaped LV cavity. Rhythm degenerated into PEA. CPR was started as per protocol, but the patient could not be revived and was declared dead.

Unit's Final Diagnosis: Severe pneumocystis pneumonia, Autoimmune hemolytic anemia, Chronic liver disease ? CAM-DILI> Autoimmune.

Cause of Death: Refractory ventricular arrythmia with shock with ?Pulmonary thromboembolism