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Date: 22/09/2026 04:11 PM
Subject: CPC Clinical handout, 23.09.2026

Dear All,

The next Wednesday CPC of the academic session will be held tomorrow, **September 23, 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://pgitelemmed.webex.com/pgitelemmed/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 aspect will be discussed by **Dr. Smita Subhash Divyaveer, Department of Nephrology**. Radiology will be discussed by **Dr. Uma Debi**. Autopsy pathology will be presented by **Dr. Suruthy**.

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Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Protocol 23rd^h Sept 2026

Mr. J, 44 /M, R/O : Khera, Panchkula	CR No.: 201401881368	Admission No.: 2026030348
Date of Adm: 10.04.26 at 15: 49	Date of Death: 11.04.26 at 12: 40 AM	CPC Chairman: Dr (Prof) Sanjay Jain
Clinician I/C: Dr (Prof) A N Aggarwal	Pathologist: Dr. Suruthy	Radiologist: Dr. Uma Debi
Discussant: Dr Smita Subhash Divyaveer.		

Background history: Diagnosed as a case of Systemic Lupus Erythematosus since 2014 with history of muco-cutaneous, musculoskeletal, hematological in the form of thrombocytopenia. ANA and DsDNA were positive at that time. He was given prednisolone and Hydroxychloroquin. He was started on mycophenolate in 2019 which was stopped due to diarrhea. Records mention Lupus Nephritis since 2022, underwent kidney biopsy in Jan 2023. LN Class III + V. Patient received 6 doses of intravenous Cyclophosphamide followed by Azathioprine 100mg OD. He developed cytopenia in Oct 2024 (TLC: 3330 and platelet : 1.27 L and subsequently, in November 2024, Azathioprine was switched to Mycophenolate Mofetil 2 gm/ day. Patient was on oral prednisolone, Hydroxychloroquin, Temisartan, Prazosin, Atorvastatin. In October 2025, patient has a proteinuric flare with increase in proteinuria to 2.9 gm/ day. MMF was increased to 3 gm/ day. He was started on Triple drug immunosuppression (Tacrolimus, mycophenolate and steroids) since then. Jan 2026: C0 Tacrolimus 2.0 ng/ml and CRP: 0.7 mg/L. His prior recorded follow up was on 06.03.2026 when was asymptomatic.

Available Ix prior to admission		
Date	Creatinine	Proteinuria per day
Nov 2024	1.19	2287
May 2025	1.49	2049
Sept 2025	1.19	1580
Oct 2025	1.09	2910
Nov 2025		1666
Jan 2026	1.45	328
Mar 2026	1.4	847

12.02.26: C0 Tacrolimus : 4.2 ng/ml
03.03.26: Urine routine: 4-5 PC, No RBC;
24 hour urine protein: 847 mg/ day.
T. Cholesterol: 150 mg/dl, TG: 78.7 mg/dl.
RA Factor : Negative

Chief complaints: Fever since 5 days; upto 102°F associated with chills and rigors, shortness of breath for 2 days; MMRC Grade IV and dry cough for 1 day.

HOPi: Patient presented with fever and shortness of breath to OPD on 08.04.26. There was no history of abdominal pain, pedal edema, decrease in urine output, foamy urine, syncope, palpitations, chest pain or rash. No history of sore throat, sneezing, rhinitis, headache, burning micturition. No history suggestive of orthopnoea or paroxysmal nocturnal dyspnoea. He was advised admission and referred to emergency for further work up. He is a non-smoker and non-alcoholic.

On examination: (on 08.04.26 in OPD) BP 122/ 76 mm of Hg, Pulse rate: 140/min, RR: 22/min. In EMOPD, Hall A: BP : 168/100 mm of Hg, SPO2: 65% on room air that increased to 90% on O2 by face mask. No pallor, icterus, cyanosis, lymphadenopathy. JVP: Not raised. RS examination revealed bilateral lower zone crepitations and tachycardia on CVS examination. CNS and abdomen were WNL. 10.04.2026: RR: 22/min, SPO2: 79% on NRBM. BMI: 32.4

06.04.26:	24 hour urine protein: 594 mg/ day in 1800 ml of urine	Mg: 1.74 (normal 1.6 – 2.5)
	Total Cholesterol: 166 mg/dl, TG: 104 mg/dl.	LDH: 281 (Normal 135-225)
07.04.26	C0 Tacrolimus : 1.0 ng/ml.	Viral markers (Kit): Negative
08.04.26	ABG (?VBG): pH: 7.49, PCO2: 35.2, PO2: 23.2, HCO3: 26.3, SO2: 46.1%	

09.04.26	Bactec Culture: sterile after overnight intubation	COVID-19 and influenza tests were negative
10.04.26	PS; Normocytic Normochromic with adequate platelets.	ABG (on 85% FIO2): pH: 7.43, PCO2: 29.5, PO2: 47.4, HCO3: 19.3, SO2: 84%

DATE	03.03.26 (prior to admission)	06.04.2026 (prior to admission)	08.04.26	10.04.26
Hb	13.5	14.1	12.6	12.6
TLC(/cu.mm)	7590	7600	7200	8740
Plt (lacs)	1.59	1.64	2.01	2.32
ESR	03			
Na	139	139	130	126
K	3.8	3.97	4.66	4.37
Urea	54	49.67	55	79.4
Creat	1.4	1.67	1.60	1.78
Ca		8.6	9.5	9.83
PO4		2.3		
T. bil	0.5	0.4	0.4	0.4
C.bil	0.1	0.1		0.2
AST			28	77
ALT			21	23
ALP		51.16		
T. Prot	6.5	4.8	5.03	5.5
Alb	4.1	3.28	2.98	2.64
CRP	Negative	68.5		
Uric acid	5.7	6.28		

10.04.02026	
Lung ultrasound	B/L shred sign +, B profile, lung sliding present, right side minimal pleural effusion
Echo	LVEF 50%, mild pericardial effusion, tachycardiac
IVC USG	1.8 cm distended
Venous (Extremities) Ultrasound	Negative by 2 point CUS B/L

Course and management: Patient was started on broad spectrum antibiotics along with Cotrimoxazole. Patient received in RICU with severe hypoxemic respiratory failure and needed mechanical ventilation. BP remained on the higher side; telmisartan plus amlodipine was continued till terminal event. He continued to have progressive desaturation despite all measures. He had cardiorespiratory arrest; received CPR but could not be revived.

Unit's Diagnosis:

Refractory hypoxemic respiratory failure, severe acute respiratory distress syndrome with community acquired pneumonia ?Pneumocystis jirovecii pneumonia in a case of systemic lupus erythematosus with Lupus Nephritis III/IV on triple immunosuppressants.