From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 23/09/2025 12:06 PM
Subject: CPC Clinical Protocol 24.09.2025

The next Wednesday CPC will be held tomorrow, **September 24, 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. Mandip Bhatia, Department of Internal Medicine.*** Radiology will be presented by ***Dr. Ujjwal Gorsi .*** Autopsy pathology will be presented by ***Dr. Amanjit Bal.***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Protocol (24/9/2025)

Name: Mr. D	**Age/Sex:** 28 years / M	**Clinician in charge:** Prof. A.N.Aggarwal
Resi: Rajpura	**CR. No:** 202503573248	**Clinical discussant:** Dr. Mandip Bhatia
Ward: RICU	**Adm.No:** 2025063269	**Radiology discussant:** Dr Ujjwal Gorsi
DOA: 31-07-25	**DOD:** 01-08-2025	**Pathology discussant:** Prof Amanjit

Presenting Complaints: Cough for the last month. Fever on and off for the last month. Rapidly worsening dyspnea for 1day.

History of Present Illness: One month before admission, the patient developed intermittent low-grade evening fever with cough and scant expectoration. He consulted a local physician and received unspecified medications without relief. On July 30, after defecation, he had a syncopal episode followed by sudden severe dyspnea, without chest pain or limb swelling. A local doctor noted SpO_2 85% on room air, prescribed medicines, and sent him home. Next morning (July 31), dyspnea worsened and he presented to PGIMER at 9:14 AM.

Past history: No history of DM/HTN/TB

Personal History: The patient was employed as a professional painter. His mother had a history of pulmonary tuberculosis 15 years ago, for which she completed a 6-month course of antitubercular therapy. She subsequently died in 2023 due to a respiratory illness of unspecified nature. The patient denies any history of weight loss or loss of appetite.

General Examination: Well built, BMI-23.5 kg/m^2, **PR:** 126/min; **BP:** 106/72 mmHg; **RR:** 32/min, Spo2 -58% on room air, Afebrile,

No Pallor, Icterus, Cyanosis, Clubbing, lymphadenopathy, Pedal Edema, JVP not raised

Respiratory system: Coarse crackles in the right Infraclavicular area

Cardiovascular system: S1+ S2+, no murmur, Tachycardia present

Central Nervous System: E4V5M6;

P/A: No organomegaly

Investigations:

Parameters	**31/7**	**1/8**
Hb	14.4	13.8
TLC	23300	16100
DLC	N67 L25	N67 L10
Platelets(lakhs)	202	188
Urea	16.9	15.3
Creatinine	1.10	1.21
Na	135	143
K	4.83	5.33
T Bilirubin	0.14	0.34
SGOT	31	95
SGPT	25	83
Alkaline Phosphate		
Protein/Al	4.83/2.18	4.9/2.39
LDH	398	

CRP	8.33	
Ca		7.81

Date	**31/7**	**31/7**	**1/8**
Ph	**7.1**	**7.02**	**7.053**
pCO_2	**57**	**115**	**76**
pO_2	**101**	**124**	**88**
HCO3	**20**	**29**	**20.8**
Lactate			**2.25**

D- Dimer-2650ng/ml

Troponin I- 0.49ng/ml

BNP-681pg/ml

ECG: Sinus Tachycardia with Right axis deviation, S1Q3T3, T wave inversion in V1& V3

Urine Routine- **Protein 2+**

Dengue IgM- Borderline

Igm Leptospira- Negative

Procalcitonin-0.1

HCV antibody-Non-Reactive

Anti HIV- Negative

HBsAg- Non-Reactive

Blood Culture(1)- Sterile after 5 days of Incubation

Blood Culture(2)- Sterile after 5 days of Incubation

Blood Culture (3)- Growth of Enterobacter Resistance to 3rd Generation Cephalosporins, **Blood Fungal Culture**- Negative

ET Aspirate C/S- Shows bacterial growth of no significance

ET Aspirate AFB smear – No AFB seen in the Entire Smear

PTI-93% , **INR**-1.07, **APTT**- More than 2 minutes

Chest Ultrasound- Bilateral A profile

USG B/L Lower limbs Venous & Arterial Doppler: Right Proximal Superficial femoral vein shows echogenic thrombus and is non-compressible, suggestive of thrombosis of the right proximal superficial femoral vein. The rest of the vessels are unremarkable

CXR: Right upper and middle zone heterogeneous opacities with air bronchogram

2D Echocardiography - Concentric LVH, RA& RV Dilated, D-shaped LV cavity, TAPSE-11mm, No RWMA, Visual LVEF Normal, MPA- 29mm, Non-Visualization of LPA after bifurcation. ?LPA Thrombus

Course and management: A 28-year-old male with one month of fever and cough presented with sudden severe dyspnea and syncope. Initially treated as pneumonia, he rapidly worsened, requiring intubation and vasopressors. Bedside USG and echo suggested massive pulmonary embolism; Doppler confirmed right femoral DVT. As CTPA was not feasible, heparin was started and IV streptokinase given. During thrombolysis, he developed refractory shock and cardiac arrest, and could not be revived.

Unit's final diagnosis: Massive Pulmonary Embolism with right lower leg DVT with Right upper lobe consolidation

Cause of Death: Obstructive shock