From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 27/08/2025 08:12 AM
Subject: CPC Clinical Protocol 27.08.2025

Dear All,

The next Wednesday CPC will be held tomorrow, **August 27, 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. Sudhir Kumar, Department of Clinical Hematology and Medical Oncology.*** Radiology will be presented by ***Dr. Uma.*** Autopsy pathology will be presented by ***Dr. Debajyoti Chatterjee***

Yours sincerely,

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Regional Resource Centre, North
Department of Telemedicine
PGIMER, Chandigarh

Staff CPC Clinical Protocol (27.08.2025)

Name: RN, 48/F **R/O:** Chandigarh
CR. No: 202405335539
Adm No: 2024102894
DOA: 20/12/2024 **DOD:** 30/01/2025
Unit: Clinical Haematology& Medical Oncology **(**Prof Pankaj Malhotra)
Clinical Discussant: Dr Sudhir Kumar
Pathology Discussant: Dr Debajyoti
Radiology discussant: Dr Uma
Chairperson: Prof Sanjay Jain

Presenting complaints:
Abdominal distention x 2.5 months
Bilateral pedal swelling x 2.5 months
Shortness of breath x 20 days

Background History
2004: Diagnosed with stage 4BX follicular lymphoma, grade 2. Attained complete remission after 4CHOP+2 RCHOP. On regular clinical follow up until COVID onset (AIIMS-D).
April 2023: Presented to GMCH with bilateral pedal edema. Outpatient evaluation showed, creatinine 1.8, proteinuria (2+) & Albumin 2.0. USG abdomen: liver 12.6cm, PV 10mm and raised bilateral renal cortical echogenicity. Detected HBsAg+ (HBV DNA 7.89 x 10^6). Fibroscan: Metavir F3, 8.2Kpa. Also diagnosed with hypertension & hypothyroidism. Initiated Entecavir, levothyroxine & telmisartan/amlodipine. Control status unknown.
Early December 2024: Presented to GMCH with aforementioned presenting complaints. Baseline investigations showed HB 9.9, **TLC 16.2**, Plt 325, urea/creat **100/3.6**, Bil 0.3, **Prot/Alb 4.2/1.9, AST/ALT 124/20**, Calcium **11.3**, PTH 51.2. Ascitic fluid exam showed Prot/alb/gluc 1.0/0.3/145, 250 cells (N80 L20) & ADA 0.5. USG neck was normal but USG abdomen showed liver with coarsened echotexture, a mass in left lobe & gross ascites. FNAC from liver lesion ? lymphoma.

Personal History:
She had history of reduced appetite and undocumented weight loss over last 3-4 months along with decreased urine output for 20 days. No history of altered sleep/bowel patterns and addictions.
Family History: Unremarkable.
Physical Examination:
Vitals: PR: 68 bpm, regular; BP 140/80 mm Hg; RR: 24/min; SpO2: 97% at 6L O2.
GPE: Pallor+, Bilateral pitting pedal edema till thighs, Lymphadenopathy- & no flaps.
Systemic examination:
P/A: Grossly distended, umbilicus everted, fluid thrill+, bowel sounds +, no HSM appreciated.
RS: Decreased breath sounds on right infra-scapular & infra-axillary area.
CVS: S1 S2 normal, no added sounds
CNS: E4V5M6, no focal neurological deficit.

Investigation

HIV	Non-reactive
HBsAg	Positive
HCV	Non-reactive
HBeAg	Negative
HBV DNA	Not detected

	20/12	6/1	19/1	26/1	29/1
Hb	7.2	6.3	8.2	7.0	4.7
TLC	7240	4700	11800	7700	1200
DLC	P76L7	-	-	-	-
PLT	283	58	34	11	9

	20/12	6/1	19/1	26/1	29/1
Na/K	136/4.3	133/3.9	131/4.1	126/4.9	130/3.4
U/C	132/2.8	117/2.6	173/2.5	135/3.3	123/3.0
Bil (CB)	0.4	1.0	0.8	6.3 (3.6)	6.5 (4.5)
OT/PT	45/15	28/9	32/5	89/19	103/18
ALP	490	211	-	-	78
T.P/Alb	4.3/2.2	4.9/3.1	3.6/2.2	3.4/2.5	2.3/1.7
Ca/P	7.1/4.9	8.0/-	6.7/-	7.2/-	6.7/5.6

	20/12	20/1	27/1	29/1
PT	14	12.5	18	30
aPTT	32	50	90	>120
INR	1.25	1.12	1.62	2.69
D-Dimer	-	534	689	1889
Fib	-	2.32	0.67	0.69

Ascitic fluid	20/12	02/01
TLC	269, N75L85	246, N75L25
P/G/A	0.6/183/0.2	1.1/148/0.7
TG/Chol	62/6.5	-
Culture	Enterococcus Faecium Sensitive to linezolid	sterile
M.Cytology	Neg	Neg

Pleural fluid	6/1	15/1
TLC	2011, N93	149, N47 L53
P/G/A	.5/107/.31	.6/145/.33
Gram Stain/culture	Neg	Neg
M. Cytology	Neg	Neg

Date	**28/12**	**8/1**	**17/1**	**20/1**	**25/1**
Urine RM	WNL	WNL	Protein + Blood +	WNL	WNL
Blood c/s	Sterile	Stenotrophomonas Maltophilia sensitive to Minocycline	Sterile	S. Hemolyticus Sensitive to teico,Vanco, doxycycline	Sterile
Urine c/s	Sterile	Sterile	Yeast+	Sterile	Sterile
GMI	0.28				
Procal	0.35	8.09	1.86	4.18	8.3

Date	**23/12**	**10/1**	**20/1**	**29/1**
Ferritin	1339	888.5	1121	1339

Date	**21/12**	**26/12**	**04/01**	**18/01**
CRP	45.8	19.3	120.7	133.5

Additional Investigations

- **ECG (21/12):** Normal sinus rhythm, no ST-T changes.
- **Baseline 2D-ECHO (21/12):** Mild TR, mild GLVHK, LVEF 45-50%
- **Cardiac markers (7/1):** Troponin T 269, Pro BNP 43587
- **TSH (23/12):** 12.5
- **Stool CDTA (28/1):** Positive
- **LDH (21/12):** 754 IU/l
- **Serum Uric acid (24/12):** 754

Radiology

USG Abdomen (18/12): Liver 13cm with heterogenous hypoechoic 8cm x 5cm lesion in segment 2/3.Bilateral kidneys with raised cortical echogenicity &maintained CMD. Gross ascitic with right pleural effusion. Rest WNL.

Biphasic CECT Abdomen (21/02)- Contrast extravasation from branch of LHA with tortuous & irregular outline

Triphasic CECT Abdomen (23/12)- At least 7 Heterogenous hypodense mass (all phases) lesions-largest 13 x8.6x5.2cm in segment 2,3,4a,4b of liver. Rupture of mass anterio-inferiorly (with fluid in subhepatic & paragastric location and in mesentery) with a contiguous soft tissue mass anterior to diaphragm (20mm). Branches of LHA seen coursing through the periphery of mass.

PET CT (30/12)- Same Faintly FDG avid -mass in subcapsular parenchyma (9.5x9.5x7.2cm, SUVmax 3.7), ill-defined splenic lesion (SUVmax-3.3). None to faintly FDG avid -subcentrimetric lymph nodes on both sides of diaphragm, -ometal stranding and & nodularity in peripancreatic, perigastric and perisplenic area. FDG avid (SUVmax 4.7) dense stranding with central necrosis (5.2x4.9cm) in left abdomen abutting tail of pancreas & body of stomach. Non FDG avid calcified parenchymal RUL (1.4X1.2cm) & pleural based nodule/patchy consolidation in bilateral lungs.

Histopathology

FNAC from liver SOL (GMCH): Sheets of atypical medium sized lymphoid cells with high N:C ratio ?lymphoma

FNAC from liver SOL (27/12/24): Scattered atypical lymphoid cells present suspicious of lymphoma.

PET guided biopsy from liver SOL (2/1): No evidence of malignancy.

Bone marrow aspiration and biopsy (20/1): No evidence of lymphoma infiltration.

Course and Management:

On the day of admission, patient had massive hematemesis (1.5-2L).UGIE showed nodular growth with ulceration in the body of stomach with no active bleed but clots seen. No varices. Improved with conservative management-embolization & surgery deferred . Linezolid given based on ascitic fluid culture. She received pre-phase chemotherapy (Vincristine1 mg on Day 1, Cyclophosphamide500 mg on day 2, Dexamethasone12 mg x 5 days) in view of relapse of follicular lymphoma w.e.f 23/12. On January 6, she had respiratory distress. Diagnosed with HAP induced sepsis & treated with broad spectrum antibiotics and minocycline per cultures. She required intubation next day and developed right tension pneumothorax likely PPV related. Treated with needle thoracostomy followed by ICD insertion. Posaconazole was added. She required multiple hemodialysis sessions for anuria and metabolic acidosis. Eventually extubated on January 16 but Intubated again on January 19 & 26. Patient had cardiac arrest at 7:30 am on January 20 but revived successfully. She had diarrhea with CDTA positivity (oral vancomycin and IV metronidazole). Further developed sepsis induced over DIC (ISTH 6). MAP remained <65 despite 3 inotropes. Patient passed away at 7:42 AM on 30/1/2025 following cardiac arrest.

Unit's Final Diagnosis: Refractory septic shock with multiorgan dysfunction syndrome, hospital acquired pneumonia, CLD (chronic hepatitis B), CKD with relapsed lymphoma.