20 years old lady, date of admission to PGIMER 28th August Date of demise 14th September

History

15 days: Polyuria, Polydipsia

10 days: Fever-low to moderate grade

3 days: Cough dry initially, later productive

Repeated vomiting,

Altered sensorium and

Decrease in urinary output

Admitted at A Medical College Hospital, 27.8-28.8 – Blood glucose 310mg%, TLC 20,600, P88L10M2, Serum creatinine 1.0, 1.3, 4.5mg%, Urine sugar ++, Ketones++, no pus cells Diagnosis: Diabetic Ketoacidosis, Treated with IV fluids, insulin and piperacillin-Tazobactum; No improvement- referred to PGI.

Family history: Father died of CAD-Acute MI at age of 45 years.

On admission at PGI: Soon after admission, had cardiac arrest- revived after CPR-on ventilator, cause of cardiac arrest –hypokalemia, Potassium 2.8mEq/L. IV potassium infusion started.

On examination

Status: Post cardiac arrest, E2 VT M4, Pupil: 3mm bilateral and normal reaction;

No pallor/icterus/cyanosis/lymph nodes/edema, CVP 8cm, Afebrile, Pulse 120/min, BP 110/60,

SpaO2 100% @ FiO2 .5, VT 360ml, RR 30, PEEP 7, Chest, CVS, P/A normal,CNS: no focal deficits

Course:

1. Managed for diabetic ketoacidosis-IV fluids, potassium, insulin and antibiotics

2. Received hemodialysis same night – Serum amylase was raised -? DKA??acute pancreatitis-CT abdomen did not show pancreatitis.

3. Sepsis- IV Piperacillin-Tazobactum, and azithromycin; 2D echo normal, blood culture E.fecalis, A.baumanni-teicoplanin, later linezolid and colistin added

4. Urine –Candida received caspofungin later IV amphotericin -CT abdomen: hypodense lesions bilateral kidneys? Septic? , patient was on double ionotropes and had features of DIC

5. Patient have abdominal distension-ascitic tap – 350ml, TLC 3200, DLC P90L10, Sugar 134mg%, Protein 2.7gm%, Surgical consultation-conservative management. During her entire stay in the hospital the patient was maintained on ventilator, inotropes, underwent 6

sessions of hemodialysis, supported with blood products-7FFP, 3 unit platelet concentrate and one unit packed cells. However, sepsis remained unabated and she died on 14.9 and an autopsy was done after an informed consent.

Investigations

	28/8	29/8	31/8	2/9	7/9	10/9	13/9
Hb	9.5	8.8	7.1	5.8	8.9	7.2	6.3
TLC	12200	7100	4570	6400	20300	4500	19500
DLC			P65L20M3				
Platelet	1.19L	1.17L	44000	50000	61000	19000	63000
			MCV71, RDW21				12/9
PT	15		15			21	26
PTI	86		86			62	50
PTTK	23		29			31	32
INR	1.14		1.14			1.6	1.9
Fibrinogen			4.9				
D.Dimer			+				
Na/K/Cl	145/4.2/113	142/4/110	140/4.3/111	140/4.6/108	142/3.4/99		
Urea/creat	38/2.6	74/4.4	73/4.7	91/4.5	55/2.1	91/2.5	
Bilirubin	0.6	0.7	0.7	0.7	0.7		(11/9)
OT/PT/ALP			369/180/78	153/152/99			199/70/276
Ca/Mg/PO4			11.6/1.8/1.9	8.1/1.79/1.8	7.4/2.3/4.4		7.4/2.5/7.8
Glucose	544	193	190	155	148	162	280
ABG							13/9
pH	7.02	7.33	7.4	7.4	7.3	7.3	7.37
PO2	51	205	186	199	194	99	78
PCO2	35	32	27	25	35	34	40
SO2	61	99	99	99	99	97	95
HCO3	9	16	17	16	20	90	22

LDH- 2010,1874,2019; Serum amylase -927, Serum lipase-608,355

Urine: Alb Nil to 1+, Sugar+, Ketones +, Later Negative, no pus cells Budding yeast present

Blood culture: 31.8: E. fecalis resistant to vancomycin

6.9: A.baumanni resistant to imipenem sensitive to colistin, Enterococcus, Yeast Sp.

7.9: Enterococcus, A. baumanni

Widal –ve, Weil Felix –ve, Dengue serology –ve, Plasma Hb, Urine Hemoglobin, G6PD normal,

Ascitic fluid TLC 3200, DLC P90L10, ADA 54, Pr 2.7g%, Sugar 157mg%, C/s sterile,

Radiology:

X-ray chest – Bilateral infiltrates

CT Abdomen bilateral globular kidneys showing reduced nephrogram with multiple hypodense lesions in the cortex , Circumferentially thickened, edematous small and large bowel loops, B/L pleural effusion with underlying collapse-consolidation, Mild ascites

USG Abdomen 29.8. Mild ascites , Fatty liver, pancreas obscured ,Repeat USG ABD on 14.9 few septations in the ascitic fluid