SREE SUDHEENDRA MEDICALMISSION
Chittoor Road,Ernakulam
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DISCHARGE SUMMARY

DEPARTMENT OF RHEUMATOLOGY

Consultants
Dr.PADMANABHA SHENOY MD DM
Dr.K. NARAYANAN (BRIG) MD PDCC
Dr.KAVERI K.NALIANDA MD PDF
Dr.SHANOJ K.C MD DM
Dr.PADMAJA RAGHAVAN MD PDF
Dr.SANJANA JOSEPH MD PDF
Dr.ANUROOPA VIJAYAN MD PDF
Dr.GLAXON ALEX MD PDF

Residents
Dr.NAYANTARA SHENOY DNB
Dr.PATHAK AMEYA RAMCHANDRA DNB

Name : SHAHANA A H
Address : KANAVARA HOUSE
UDYOGAMANDAL P O
ELOOR
Phone : 9645562188

Age/Sex : 27Y/ Female

OP No. : 194621
IP No. : 26536
Ward : SINGLE ROOM
Date of Admission : 24-02-2021 08:49 PM
Date of Discharge : 03-03-2021 03:50 PM

DIAGNOSIS

- **AUTOIMMUNE HEMOLYTIC ANEMIA**
- **TO R/O PRIMARY SJOGRENS SYNDROME**
- **S/P MSGB 2/3/21**
- **FIBROMYALGIA**
- **HYPOTHYROIDISM**

HISTORY

The patient is a 27-year-old female, housewife, symptomatic for the last 3 years. In her second pregnancy at 23 years of age, she had complaints of fatigue and palpitations. At that time, her ECG was normal. She was evaluated in Medical Trust Hospital. Her Hb was 6, she was transfused one unit of PRBC and she was told to have low vitamin B12 and advised dietary correction of vitamin B12 along with vitamin B12 injection for 5 days.

Again, after 2 weeks, she was noticed to have Hb of 6.1. Investigations at that time showed Hb of 6.1, MCV of 104, MCHC of 32. Peripheral smear macrocytic anemia, vitamin B12 was 286, LDH was 310.

USG abdomen showed mild splenomegaly and mild hepatomegaly. Initially, she was advised to undergo bone marrow aspiration biopsy, but she deferred. Again, one unit of PRBC was transfused. Then, she consulted hematologist at Medical Trust Hospital, Dr.Sreeraj. Investigations were done. ANA was reported as negative. DCT was strong positive.

She was diagnosed as autoimmune hemolytic anemia. She was started on tablet Wysolone 60 mg o.d., which was slowly tapered and when the dose was kept below 10 mg, she had fall in Hb.

During delivery, she was on Wysolone 10 mg o.d. In the postpartum period, she had myalgias and small joint pains of hands with early morning stiffness of 30 minutes and plantar fasciitis. She had undergone Ayurvedic oral medications along with Wysolone being continued.

Six months postpartum, she has stopped her Wysolone and started acupuncture therapy, which she has taken for 4 months. Then Hb dropped from 10-9 and later to 8 g/dL.

Then, she consulted another hematologist Dr. Ramaswamy at Aster. She was noticed to have severe pallor. Hb was around 8 and she received 4 infusions of injection rituximab 600 mg on 5/08/19, 12/08/19, 19/08/19, and 26/08/19 and later started on oral steroids 60 mg Wysolone and then started tapering.

After first two doses, she developed fever and throat pain. After the 4th injection, she had abdominal pain, headache, and constipation. So, that time, OGD scopy was done, which showed antral erosions and colonoscopy showed ileal aphthae, grade 1 internal hemorrhoids. She was given medications for that, laxative, topical applications, and ?PPIs.

She states that the Hb was in the level of around 10 post infusions. From then onwards, she is on steroids. Now, she is taking 7.5 mg on alternate days.

Six months later, after rituximab infusion, she was given cyclosporine tablet, which she took for only 2 weeks and then stopped because of abdominal discomfort, heartburn, headache, giddiness.

Since, the last 6 months, she is having generalized myalgia, pains in the small joints of the hands, muscles without any active swelling or early morning stiffness. There is increased swelling in the forearm with increased touch sensation. Pain in the fingers on straining. Numbness in the hands, feet, pain in the thigh and calf. Initially, consulted Dr. Joe Thomas at Aster, was started on tab hydroxychloroquine and Naxdom. She did not have any relief.

X-rays done was reported as normal.

A whole body skeletal scintigraphy done on 16/07/20 read as asymmetric mildly increased tracer uptake in right frontoparietal lobes with no CT detected lesion, ?significance.
Normal tracer uptake in rest of the bones and joints of axial and appendicular skeleton. She was diagnosed as FMS.

Investigations at that time, ESR was 45, CRP 11.33, CBC was normal. Hb was 11. ANA done repeatedly was normal.
She was started on tablet duloxetine 30 mg, tab flupirtine b.d., tab sulfasalazine 500 mg b.d.

Later, she developed one-sided headache with no typical history suggestive of photophobia or phonophobia. The headache, she says was continuous. Later, she consulted neurologist Dr. Sandeep at Aster. CT brain done there was normal. No reports. She was started on tab Dicorate, tab Naxdom, tab Ciplar.

She also has history of low back pain following a fall from the swing at the time of 3rd month postpartum after second pregnancy. After which, she is having increased low back pain on prolonged standing and bending down works. She also had difficulty in turning from side-to-side in bed, history of alternating buttock pain with early morning stiffness of around one hour.

Then, she had consulted interventional pain specialist at Lourdes Hospital. There, she was diagnosed as bilateral sacroiliitis, received ultrasound guided bilateral SI joint injection and USG guided trigger point release. on the left side. After which, she had relief for few days. She was advised physiotherapy and stretching exercises after that. After which, her symptomatology have become worse.

The MRI of the LS-spine and SI joints done on 15/12/20 showed reduced lordosis, Schmorl's nodes at superior end of D11 plate, normal canal and neural foramen. No canal stenosis suggested and normal appearance of sacroiliac joints. She was treated with gabapentin, amitriptylineand advised radiofrequency ablation.

After taking all these medications, she is reporting increasing lethargy and sleepiness. Also, she says her body weight has got increased dramatically from 63 kg to 73 kg. She is having difficulty in swallowing dry food. No history of ocular sicca, history of diffuse alopecia is present. She presented to CARE in December 2020 and she was diagnosed as a hypermobility syndrome along with FMS with previous history of AIHA. She was given trigger point release, stretching exercises , antineuropathic medication, psychological counsellin.

After which, she had good improvement. Two weeks back, after a journey to attend the brother's marriage, she has

history of fever for 5 consecutive days and it was managed with paracetamol. She had dry cough and sore throat at that time. COVID test done and reports as negative.

After that, she has pain in multiple joints, bilateral elbows, pain in the upper back, mechanical bilateral knee pain, mainly in the popliteal region with gel phenomenon, and early morning stiffness of around 10-20 minutes. She is unable to do all the physiotherapy because of increasing pain. She also has itchy rashes over the region of shoulders, loin, and in the groin region also. She is taking vitamin D, Symbal 30 mg b.d., Pregabalin 75 mg b.d. and prednisolone 7.5 mg on alternate days with Ultracet s.o.s.

She is para 2, live 2. No history of abortions. The younger child is 3-1/2 years. Periods are regular.
History of appendectomy 7 years ago, history of hypothyroidism for the past 8 years on tab levothyroxine 100 mcg o.d.
Sleep is disturbed. No much stressors. No family history of rheumatoid arthritis, psoriasis, or connective tissue diseases.

No history of fever at present, diarrhea, dysuria, psoriasis, dyspnea on exertion. No history of oral ulcers, photosensitivity, Raynaud's phenomenon, skin ulcers. No history of any cutaneous nodules or ulcerations.

She is having diffuse myalgias.

CLINICAL FINDINGS

- Conscious, Co-operative
- Pallor+
- BP:130/80mmHg, PR:110/mts,equally felt bilaterally
- No bruit, Afebrile
- RR-20/mts
- Temp-98.6 degree F
- spo2- 100% in room air
- No icterus, cyanosis, clubbing ,lymphadenopathy pedal oedema.
- multiple tinea rashes+ trunk
- Multiple Tender points +

Chest- NVBS heard bilateral .No added sounds
CVS- Normal S1S2 heard. No murmurs
P/A-soft non tender ,liver palpable 3 cm ,soft,min.tender,spleen 3cm below left costal margin,min tender,soft
CNS No focal neurological deficits
MSK-

- Multiple tender points+
- TJC- 5,SJC 0

Schirmers right eye-3mm,left eye 4mm

COURSE IN HOSPITAL

27 year old female ,known hypothyroid and diagnosed case of AIHA from outside was initially treated with steroids and subsequently received Inj RTX (total 4 doses weekly , last taken on 26.8.19) following which she was stable on low dose steroids (T.prednisolone 7.5 mg on alternate days) .She now reported diffuse myalgias ,polyarthralgias of small and large joints since 6 months with recent onset pruritic skin lesions .She was evaluated outside by Rheumatologist : Found to have ANA (IF) negative with normal Bone scan hence was diagnosed as Fibromyalgia and was treated with antineuropathic agents but had supboptimal response with recent onset elevated inflammatory markers hence admitted for detailed evaluation .On examination she had multiple trigger points ,peripheral pulses were palpable B/L with no bruits , schirmers positive B/L .In view of myalgias, arthralgias , sicca symptoms and positive schirmers with markedly raised inflammatory markers (ESR 95 CRP 14) ,normal CPK the possibilities considered were 1. Sjogrens syndrome however ANA was negative hence MSGB was done on 2/3/2021 which she tolerated well 2. Large vessel vasculitis hence PET done which provisionally reported no e/o vasculitis (final report awaited) 3.Metabolic bone diseases however Ca/P /ALP/PTH were normal and it could not account for elevated inflamamtory markers .Other AI work up including RF was negative while ACPA was awaited. Dermatology opinion was obtained for tinea versicolor and supportive medication was advised.For

now she was given short course of NSAID's,low dose Steroid continued ,duloxetine and pregabalin was titrated .Plan is to await final PET and MSGB report .Also to do carotid doppler to assess Intimal medial thickness on OP basis.She is discharged on the following medications.

GENERAL INVESTIGATIONS

Date	Service	Test	Result	Normal Values
25/02/2021	CRP	CRP	14 mg/L	UPTO 6
	UREA CREATINE	BLOOD UREA	35 mg/dl	10-50
		CREATININE	0.6 mg/dl	0.4-1.4
	SODIUM POTTASIUM	SODIUM	140 meq/l	137-145
		POTASSIUM	4.2 meq/l	3.5 -5.0
	LFT	BILIRUBIN TOTAL	0.9 mg%	0.2- 1.0 mg%
		BILIRUBIN DIRECT	0.2 mg%	0.2 -0.5 mg%
		PROTEIN	6.3 gm%	6-8.5
		ALBUMIN	3.6 gm%	3.2-5.5
		GLOBULIN	2.7 gm%	1.4 - 3 gm%
		AST/SGOT	21 U/L	14-36
		ALT/SGPT	22 U/L	0-35
		ALKALINE PHOSPHATASE	87 U/L	38-126
	BLOOD SUGAR F	FASTING BLOOD SUGAR	100 mg/dl	70-100
	URINE RE	REACTION	ACID	
		ALBUMIN	NIL	
		SUGAR	NIL	
		MICROSCOPY	1-3 PUSCELLS AND FEW EPITHELIAL CELLS SEEN.	
26/02/2021	RC COUNT	RECTICULOCYTE COUNT	3.3%	2.0 %
	CPK	CPK NAC	74 u/L	15-190
	LDH	L D H	86 IU/L	140-280
	TSH	TSH	0.10 ulu/ml	0.3 - 6.02
	S CALCIUM	CALCIUM	9.3 mg/dl	8.2 - 11.5
	S PHOSPHORUS	PHOSPHORUS	3.1 mg/dl	2.7 - 4.5
28/02/2021	S CREATININE	S.CREATININE	0.6 mg/dl	0.4-1.4
	SGOT & SGPT	AST/SGOT	24 U/L	14-36
		SGPT/ALT	21 U/L	0-35u/l
01/03/2021	BLOOD SUGAR F	FASTING BLOOD SUGAR	116 mg/dl	70-100
02/03/2021	BT CT	BLEEDING TIME	2 minutes	1-4
		CLOTTING TIME	12 minutes	8-18
	PTT	TEST	13 seconds	(control 13)
		CONTROL	13	
		INR	1.0	
	APTT	TEST	30 seconds	(control 13)
		CONTROL	32	
	HBS AG HIV HCV [CARDS TEST]	HIV (CARD)	NEGATIVE	
		HBSAG	NEGATIVE	
		HCV	NEGATIVE	

SPECIAL INVESTIGATIONS

25/2/2021-HB-9,TC-6.60,DC(N-3,L-1.65,E0.48)PLT-245,ESR-95

28/2/2021-HB-10,TC-8.22,DC(N-5,L-1.8,M-0.38),PLT-237,ESR-95

26/2/2021-

- ANA (IF)-negative
- CRP-14

1/3/2021- RF-negative

27/2/2021- USG ABDOMEN-

- Mild fatty infiltration of liver
- Both kidneys appear normal.
- There is no evidence of renal cysts.

ADVISE

1. C.Indomethacin 25mg 1-0-1 x 5 days
2. T.Pan D 1-0-0 B/F x 5 days
3. T.Symbal 30mg 1-0-1
4. T.Pregabalin 75mg 1-0-1
5. T.Prednisolone 7.5mg 1-0-0 on alternate days
6. T.Levothyroxine 75mcg 1-0-0 B/F
7. T.Cefuroxime 500mg 1-0-1 x 3 days
8. T. Flucan 400mg stat and repeat same dose after 2 weeks
9. Rexizole cream LA 1-0-1
10. Ketafing soap LA
11. T.Cetzine 10mg 0-0-1 x 15 days

FOLLOW UP

Pending –

- **Minor salivary gland biopsy report**
- **Anti TPO report**
- **PET CT final report**
- **ACPA**

To review after 10 days at CARE OP(Dr.Shanoj) with at CBC, ESR,CRP , SGOT, SGPT, Creat,,RBS,carotid Doppler to assess CIMT.

Dr.PADMANABHA SHENOY MD DM
(CONSULTANT RHEUMATOLOGIST)

Note: Content of the discharge summary will not be changed for any reason once the patient is discharged from the hospital. Please bring this report when you come for checkup.This Discharge summary is not a legal document or certificate.

In case of any emergency, please contact;