CHIEF COMPLAINTS: Fever x 5 days

HISTORY OF PRESENTING ILLNESS: Patient who was apparently normal 5 days back when came with c/o fever since 5 days , high grade , intermittent type , associated with fever with chills ,

no rigors, associated with bodyache and headache,

Patient also complained of dry cough since 3 days .

no h/o nausea

no h/o vomiting

no h/o abdominal pain

no h/o haematuria

For the above complaints he had been to local hospital and Dengue NS1 was sent and it was positive .

hence patient was referred here for further management.

PAST HISTORY : No history of Diabetes mellitus and Hypertension , Tuberculosis, Asthma or IHD

FAMILY HISTORY: No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY

Diet: Mixed. Appetite: Good. Sleep: Adequate. Bowel and Bladder: Regular. No substance abuse.

GENERAL EXAMINATION

Patient is consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, licterus, cyanosis, clubbing, lymphadenopathy or oedema PULSE-88bpm ,
BP-130/80 mm hg ,
RR-16/min
TEMPERATURE-98.6F

LAB INVESTIGATION

30-05-2015: Haemoglobin: 15.4g/dl, Neutrophils: 53%, Lymphocytes: 34%, Eosinophils: 01%, Monocytes: 12%, Basophils: 00%, Other Cells Method: Manual Nil, Leukocyte Count Total: 2400/cumm, Erythrocyte Sedimentation Rate: 02mm/1st hour, Platelet Count: 162000/cumm, Malarial Parasite Fluoroscent (Mp Ft) presence of parasites Negative, Serum Total Protein: 7.27g/dl, Serum Albumin: 4.66g/dl, Serum Globulin: 2.6g/dl, Serum Total Bilirubin: 0.45mg/dl, Serum Conjugated Bilirubin: 0.24mg/dl, Serum Unconjugated-Bilirubin: 0.21mg/dl, Serum Ast (Sgot): 73IU/L, Serum Alt (Sgpt): 22IU/L, Serum Alkaline Phosphatase: 85IU/L, Serum A/G Ratio: 1.8units, Dengue Rapid (Ns1, Igm, Igg) NS1 ANTIGEN POSITIVE, IgM ANTIBODY: NEGATIVE, IgG ANTIBODY: NEGATIVE, COMMENTS: This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

31-05-2015: Platelet Count: 148000/cumm, Neutrophils: 45%, Lymphocytes: 42%, Eosinophils: 01%, Monocytes: 12%, Basophils: 00%, Other Cells Method: Manual -, Leukocyte Count Total: 2800/cumm,

01-06-2015 : Haemoglobin : 16.2g/dl, Neutrophils : 55%, Lymphocytes : 32%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, Other Cells Method : Manual -, Leukocyte Count Total : 2300/cumm, Platelet Count : 136000/cumm, Packed Cell Volume : 48.7%,

02-06-2015: Haemoglobin: 15.9g/dl, Neutrophils: 55%, Lymphocytes: 42%, Eosinophils: 01%, Monocytes: 12%, Basophils: 00%, Other Cells Method: Manual-, Leukocyte Count Total: 3100/cumm, Platelet Count: 107000/cumm, Urine Blood Negative, Urine Ketone Bodies Negative, Ph 6.0, Urine Protein Negative, Urine Sugar (Qualitative) Negative, Colour Pale Yellow, Transperancy Clear, Specific Gravity 1.015, Bile Salts Negative, Bile Pigments Negative, Urine Microscopy RBCs Nil, Pus Cells: 1-2, Epithelial Cells: Occasional, Crystals: Negative, Casts: Nil, Others: NIL,

03-06-2015: Haemoglobin: 17.3g/dl, Leukocyte Count Total: 3000/cumm,

TREATMENT:
IV FLUIDS NS @ 100 ML/HR
TAB DOLO 650 MG TID
INJ PAN 40 MG TID
INJ EMESET 4 MG SOS