CHIEF COMPLAINTS

Fever since 1 day womiting since 1 day

HISTORY OF PRESENTING ILLNESS

patient was apparently normal 4 days back when he developed fever which was sudden in onset , low grade type , intermittent in nature , gradually progressive. Associated with chills and rigors.

Patient also complains of 1 episode of vomiting today morning ,non blood stained , non bile stained.

patient also complains of generalized weakness, no h/o abdominal pain /vomitting no h/o cough / breathlessness no h/o burning micturition / hematuria

GENERAL EXAMINATION

Patient is consious and cooperative, well oriented to time, place and person.

Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:90bpm
BP :120/80mmhg
RR:20/min
TEMPERATURE:99F

LAB INVESTIGATION

11-06-2015: Haemoglobin: 12.9g/dl, Neutrophils: 60%, Lymphocytes: 26%, Eosinophils: 01%, Monocytes: 13%, Basophils: 00%, Other Cells Method: Manual -, Leukocyte Count Total: 12500/cumm, Platelet Count: 51000/cumm, Mcv: 93.1fl, Mchc: 32.6g/dl, Mch: 30.3pg, Peripheral Smear Report No H/3650/15, Impression: Normocytic normochromic blood picture with severe thrombocytopenia., Whole Blood Glycated Hb (Hba1c): 7.9%,

13-06-2015: Haemoglobin: 11.2g/dl, Packed Cell Volume: 35.1%, Platelet Count: 73000/cumm, Plasma Glucose Fasting: 187mg/dl, Plasma Glucose Postprandial: 208mg/dl,

14-06-2015: Haemoglobin: 11.1g/dl, Packed Cell Volume: 35.1%, Platelet Count: 102000/cumm,

15-06-2015: Haemoglobin: 12.5g/dl, Packed Cell Volume: 39.5%, Platelet Count: 173000/cumm,

TREATMENT

IVF DNS/NS @ 75ml/hr T.Emeset 4mg SOS 1-0-1 T.Doio 650mg 1-1-1 T.Clopivas A P 0-1-0 T.Biotor 20mg 0-0-1 T.Telmiget 40mg 1-0-0 T.Euglim 1mg 1-0-0 T.Monit 2.6mg 1-0-1 Inj H.Actrapid s/c