CHIEF COMPLAINTS
Fever since 1 week

HISTORY OF PRESENTING ILLNESS
The patient was apparently normal 1 week back when he developed fever , it was high grade fever in ntensity associated with with chills and rigor , intermittent in nature and would subside on medication.During the same period patient also complains of weakness and malaise since 1 week.The patient was admitted in outside hospital and was diagnosed to have dengue fever.
No h/o bleeding manifestaions from the gums
No h/o malaena
No h/o burning micturition
No h/o difficulty in breathing
No h/o abdminal pain

PAST HISTORY
No history of Diabetes Mellitus, 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 pailor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE : 72 / min
BP : 120 / 70 mm of Hg
RR : 18 / min
TEMPERATURE : 99 F
Patient has bleedig from the canula site for a prolonged period of time

17-03-2015 : Haemoglobin : 10.8g/dl, **Neutrophils** : 49%, Lymphocytes : 38%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual Nil, Leukocyte Count Total : 2600/cumm, Packed Cell Volume : 31.8%, Platelet Count : 8000/cumm. Plasma Glucose Random :

18-03-2015 : Haemoglobin : 14.6g/dl, Leukocyte Count Total : 2700/cumm, Mchc : 34.5g/dl, Mch : 30.1pg, Mcv : 87.2fl, Packed Cell Volume : 42.4%, Platelet Count : 18000/cumm, Red Blood Cell Count : 4.86million/cumm, Neutrophils : 39%, Lymphocytes : 53%, Eosinophils : 00%, Monocytes : 03%, Basophils : 00%, **Other Cells** Method : Manual REACTIVE LYMPHOCYTES-5%, Serum Total Protein : 5.87g/dl, Serum Albumin : 3.74g/dl, Serum Globulin : 2.1g/dl, Serum Total Bilirubin : 1.55mg/dl, Serum Conjugated Bilirubin : 0.58mg/dl, Serum Unconjugated-Bilirubin : 0.97mg/dl, Serum Ast (Sgot) : 175IU/L, Serum Alt (Sgpt) : 106IU/L, Serum Alkaline Phosphatase : 58IU/L, Serum A/G Ratio : 1.8units, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph** 7.0, **Urine Protein** Positive(+), **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 : 2-3, Epithelial Cells : Occasional, Crystals : Negative, Casts : Nil, Others : NIL, Packed Cell Volume : 42.4%, **Peripheral Smear Report No** H/1733/15 , **Impression** : Normocytic normochromic blood picture with neutropenic leucopenia with reactive lymphocytes and marked thrombocytopenia. , Haemoglobin : 14.4g/dl, Packed Cell Volume : 40.9%, Platelet Count : 20000/cumm,

19-03-2015 : Haemoglobin : 13.5g/dl, Packed Cell Volume : 39.2%, Platelet Count : 40000/cumm,

20-03-2015 : Haemoglobin : 12.5g/dl, Leukocyte Count Total : 4900/cumm, Mchc : 34.2g/dl, Mch : 30.1pg, Mcv : 87.9fl, Packed Cell Volume : 36.5%, Red Blood Cell

TREATMENT
Inj.Pan 40 mg IV OD
Inj.Hydrocortisone 100 mg IV stat
T.Dolo 650 mg SOS
IVF NS at 100 ml / hr
4 units of platelet transfusion done