CHIEF COMPLAINTS
Fever since 1 day
Vomiting since 1 day

HISTORY OF PRESENTING ILLNESS
The patient was apparently normal 1 day back when she developed vomiting, multiple episodes which was followed by fever which was high grade and associated with chills and rigors. . Vomiting episodes were multiple in number and was watery, contained food particles. She was not tolerating feeds. Gives history of not passing urine since one and a half day,passed stools normally.No complaints of headache, abdominal pain

PAST HISTORY

GENERAL PHYSICAL EXAMINATION
No pallor,Icterus, Cyanosis, Clubbing, Lymphadenopathy, Edema
BP: 100/70 mm of Hg
Pulse: 102 beats/min
Temp: 100.8 * F
RR: 24 cycles/min

INVESTIGATION

11-08-2015 : Peripheral Smear Report No H/5177/15, **Impression** : Normocytic normochromic blood picture with relative neutrophilia., Haemoglobin : 12.4g/dl, Neutrophils : 87%, Lymphocytes : 05%, Eosinophils : 02%, Monocytes : 06%, Basophils : 00%, Leukocyte Count Total : 7200/cumm, Packed Cell Volume : 36.9%, Platelet Count : 167000/cumm, Serum Crp : 1.40mg/l,
12-08-2015 : Platelet Count : 130000/cumm, Packed Cell Volume : 36.7%,
13-08-2015 : Packed Cell Volume : 41.2%, Leukocyte Count Total : 3700/cumm, Platelet Count : 129000/cumm,

TREATMENT
SYRUP DOLO (250MG/5ML) 5 ML TID
INJ VEGACEF 500 MG IV BD
INJ EMESET 2MG IV TID
TAB DOLO 650 MG (1/2) 6TH HOURLY
INJ RANTAC 20 MG IV BD
IV FLUIDS