CHIEF COMPLAINTS
Fever since 4 days
Bodyache since 4 days

HISTORY OF PRESENTING ILLNESS :
Patient was apparently normal 4 days back when he developed fever which was insidious in ons
intermittent, gradually progressive, high grade associated with chills
No diurnal variations
he also complains of headache, body ache since 4 days
H/O 1 episode of loose stools semisolid non blood tinged
No H/O bleeding manifestations
No H/O pain abdomen, vomiting
No H/O cough with expectoration
No H/O burning micturition

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: reduced. Bowel : regular and Bladder: Regular.
h/o alcohol consumption present, no smoking history .

GENERAL EXAMINATION
Patient is moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:78bpm
BP:120/70mmhg

RR:18cycles/min
TEMPERATURE:98.6f

12-08-2015 : Haemoglobin : 15.1g/dl, Leukocyte Count Total : 8200/cumm, Mchc : 33.8g/dl, Mch : 31.8pg, Mcv : 94.0fl, Packed Cell Volume : 44.7%, Platelet Count : 122000/cumm, Red Blood Cell Count : 4.75million/cumm, Neutrophils : 84%, Lymphocytes : 09%, Eosinophils : 01%, Monocytes : 06%, Basophils : 00%, **Other Cells** Method : Manual Nil, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites Negative, Serum Urea : 25mg/dl, Serum Creatinine : 1.04mg/dl, **Dengue Rapid (Ns1, Igm, Igg)** NS1 ANTIGEN NEGATIVE, 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., **Urine Blood (Hb And Derivatives)** Positive (+), **Urine Ketone Bodies** Negative, **Ph** 5.0, **Urine Protein** Positive(+), **Urine Sugar** Negative, **Colour** Pale Yellow, **Transperancy** Slightly turbid, **Specific Gravity** 1.020, **Bile Salts** Negative, **Bile Pigments** Negative, **Urine Microscopy** RBCs 1-2, Pus Cells : 2-3, Epithelial Cells : 1-2, Crystals : Calcium oxalates seen, Casts : Nil, Others : NIL, Serum Total Protein : 6.77g/dl, Serum Albumin : 4.30g/dl, Serum Globulin : 2.5g/dl, Serum Total Bilirubin : 0.77mg/dl, Serum Conjugated Bilirubin : 0.25mg/dl, Serum Unconjugated-Bilirubin : 0.52mg/dl, Serum Ast (Sgot) : 73IU/L, Serum Alt (Sgpt) : 63IU/L, Serum Alkaline Phosphatase : 76IU/L, Serum A/G Ratio : 1.7units,

13-08-2015 : Haemoglobin : 14.9g/dl, Packed Cell Volume : 43.4%, Platelet Count : 103000/cumm, **Malarial Parasite Smear** Presence of parasites Negative,

14-08-2015 : Haemoglobin : 15.4g/dl, Packed Cell Volume : 45.1%, Platelet Count : 91000/cumm,

15-08-2015 : Haemoglobin : 13.9g/dl, Packed Cell Volume : 40.6%, Platelet Count : 82000/cumm, Serum Creatinine : 1.01mg/dl, Erythrocyte Sedimentation Rate : 14mm/1st hour

16-08-2015 : Platelet Count : 104000/cumm, **Urine Blood (Hb And Derivatives)** Positive (++), **Urine Ketone Bodies** Negative, **Ph** 5.0, **Urine Protein** Positive(+), **Urine Sugar** Negative, **Colour** Pale Yellow, **Transperancy** Slightly turbid, **Specific Gravity** 1.015, **Bile Salts** Negative, **Bile Pigments** Negative, **Urine Microscopy** RBCs 3-4, Pus Cells : 1-2, Epithelial Cells : Occasional, Crystals : Negative, Casts : Nil, Others : NIL,

17-08-2015 : Platelet Count : 134000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of

parasites NEGATIVE,

TREATMENT:
IVF NS/DNS
T.Calpol 500mg 1-1-1
T.Pan 40mg
Inj. Emeset 4 mg IV Q8H
inj ceftriaxone 2gm iv bd
Inj .Pan 40 mg IV OD