

**CHIEF COMPLAINTS**

FEVER- 4 DAYS

VOMITING-2 DAYS

**HISTORY OF PRESENTING ILLNESS**

Patient came with c/o fever since 4 days, intermittent ,high grade, associated with chills and rigors

h/o vomiting present,multiple episodes

no h/o nausea and headache

no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

**PAST HISTORY**

not a k/c/o htn,ptb,ba,dm

**FAMILY HISTORY**

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

**PERSONAL HISTORY**

Diet: Mixed.

Appetite: normal

Sleep: Adequate.

Bowel and Bladder: regular

**GENERAL EXAMINATION**

Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.

no pallor,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent

vitals

PULSE 80/min

BP 130/80 mm HG

RR 20/min

TEMPERATURE 101

**LAB INVESTIGATION**

**14-06-2015** : Haemoglobin : 9.3g/dl, Leukocyte Count Total : 2200/cumm, Mchc : 31.1g/dl, Mch : 23.1pg, Mcv : 74.3fl, Packed Cell Volume : 30.0%, Platelet Count : 60000/cumm, Red Blood Cell Count : 4.04million/cumm, Neutrophils : 41%, Lymphocytes : 50%, Eosinophils : 03%, Monocytes : 06%, Basophils : 00%,  
**Other Cells** Method : Manual -, **Peripheral Smear Report No** H/3701/15,  
**Impression** : Mild pancytopenia., Plasma Glucose Random : 83mg/dl, Serum Creatinine : 0.64mg/dl, Serum Total Bilirubin : 0.16mg/dl, Serum Ast (Sgot) : 68IU/L, Serum Alt (Sgpt) : 36IU/L,

**15-06-2015** : Haemoglobin : 9.9g/dl, Packed Cell Volume : 31.4%, Platelet Count : 62000/cumm,

**16-06-2015** : Haemoglobin : 9.7g/dl, Platelet Count : 66000/cumm, Packed Cell Volume : 30.6%,

**17-06-2015** : Haemoglobin : 9.9g/dl, Packed Cell Volume : 31.3%, Platelet Count : 132000/cumm,

**TREATMENT**

IVF NS @ 75ml/hr

T.Dolo 650 mg

T.Supradyn