

HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 4 days back when he developed high grade fever, intermittent in nature and associated with chills. The patient also gives history of vomiting 3-4 episodes, vomitus contained food particles. It was non projectile vomiting, non blood tinged. History of headache present. History of burning micturition present. No history of loose stools, pain abdomen, blurring of vision, altered sensorium.

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.
History of alcohol consumption present. reformed smoker.

GENERAL EXAMINATION

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

Moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema

PULSE-60 / min

BP - 110/70 mm Hg

RR- 18 / min

TEMPERATURE - afebrile

LAB INVESTIGATION

09-06-2015 : Haemoglobin : 14.2g/dl, Leukocyte Count Total : 6100/cumm, Mchc : 32.8g/dl, Mch : 27.2pg, Mcv : 82.9fl, Packed Cell Volume : 43.3%, Platelet Count : 61000/cumm. Red Blood

10-06-2015 : Haemoglobin : 14.5g/dl, Platelet Count : 58000/cumm, Packed Cell Volume : 43.7%,

11-06-2015 : Haemoglobin : 14.8g/dl, Platelet Count : 50000/cumm, Packed Cell Volume : 44.6%, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph** 7.0, **Urine Protein** Negative,

12-06-2015 : Haemoglobin : 15.1g/dl,

TREATMENT

T. Calpol 50 mg SOS

T. Pan 40 mg 1-0-0(B/F)

T. Optineuron 0-1-0

Inj. Emeset 4 mg IV BD

IVF NS /DNS at 75 ml / hr

Syp. Sucrafil 2 tsp TID