CHIEF COMPLAINTS

Fever since 1 day Vomiting since I 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

DACT 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

11-08-2015: Peripheral Smear Report No H/5177/15. normochromic blood picture with relative neutrophilia., Haemoglobin : 12.4g/dl, Impression: Normocytic

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