

CHIEF COMPLAINTS

Fever since 1 day
vomiting since 1 day

HISTORY OF PRESENTING ILLNESS

patient was apparently normal 4 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.

Patient also complains of 1 episode of vomiting today morning, non blood stained, non bile stained.

patient also complains of generalized weakness.

no h/o abdominal pain /vomitting

no h/o cough / breathlessness

no h/o burning micturition / hematuria

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:90bpm

BP :120/80mmhg

RR:20/min

TEMPERATURE:99F

LAB INVESTIGATION

11-06-2015 : Haemoglobin : 12.9g/dl, Neutrophils : 60%, Lymphocytes : 26%,
Eosinophils : 01%, Monocytes : 13%, Basophils : 00%, **Other Cells** Method : Manual
Leukocyte Count Total : 12500/cumm, Platelet Count : 51000/cumm, MCV : 93.1fl,
MCHC : 32.6g/dl, MCH : 30.3pg, **Peripheral Smear Report No** H/3650/15, **Impression**
: Normocytic normochromic blood picture with severe thrombocytopenia., Whole Blood Glycated
Hb (HbA1c) : 7.9%,

13-06-2015 : Haemoglobin : 11.2g/dl, Packed Cell Volume : 35.1%, Platelet Count :
73000/cumm, Plasma Glucose Fasting : 187mg/dl, Plasma Glucose Postprandial : 208mg/dl,

14-06-2015 : Haemoglobin : 11.1g/dl, Packed Cell Volume : 35.1%, Platelet Count :
102000/cumm,

15-06-2015 : Haemoglobin : 12.5g/dl, Packed Cell Volume : 39.5%, Platelet Count :
173000/cumm,

TREATMENT

IVF DNS/NS @ 75ml/hr

T.Emeset 4mg SOS 1-0-1

T.Dolo 650mg 1-1-1

T.Clopidas A P 0-1-0

T.Biotin 20mg 0-0-1

T.Telmiget 40mg 1-0-0

T.Euglim 1mg 1-0-0

T.Monit 2.6mg 1-0-1

Inj H.Actrapid s/c