

DIAGNOSIS

DENGUE FEVER WITH THROMBOCYTOPENIA

CHIEF COMPLAINTS

Fever with chills-1 day

Headache-1 day

Bodyache-1 day

HISTORY OF PRESENTING ILLNESS

Patient was apparently well 1 day back when he developed fever, high grade type associated with chills, intermittent in nature. Associated with headache and bodyache from past 1 day.

No h/o burning micturition.

No h/o neck pain.

No h/o any bleeding manifestations.

No h/o any skin rashes.

No H/o vomiting, loose stools or nausea.

No h/o abdominal pain.

No h/o cough, breathlessness or chest pain.

PAST HISTORY

No history of Tb, asthma, IHD, HTN, DM

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. No substance Abuse

GENERAL EXAMINATION

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

No Pallor, No icterus, No cyanosis, clubbing, lymphadenopathy or oedema.

PULSE - 88bpm

BP - 110/70mmHg

RR - 18/min

TEMPERATURE - 98.6°F

TREATMENT

T.Dolo 650 mg 1-1-1

T.Magpep 40 mg 1-0-0

T.Optineuron 0-1-0

Inj. Emeset IV 1-1-1

Inj. Vegacef 1 gm IV BD

