CHIEF COMPLAINTS Fever - 1 week

HISTORY OF PRESENTING ILLNESS

Child was admitted with complains of fever since 1 week-high grade ,intermittent type,not associated with chills and rigors. No history of vomiting, loose stools , coryza,cough or pain abdomen. She was given medications from the nearby hospital but did not subside, hence she was brought here for further management.

GENERAL PHYSICAL EXAMINATION

No Pallor, Icterus, Cyanosis, Clubbing, Lymphadenopathy, Oedema

BP:100/70mmofHg

Pulse: 102/min

Temp: 98.6'F

RR:22/min

Peripheral Smear Report No H/3669/15, Impression: Normocytic normochromic blood picture with neutropenic leukopenia and mild thrombocytopenia., Haemoglobin: 12.5g/dl, Leukocyte Count Total: 3900/cumm, Mchc: 32.2g/dl, Mch: 24.9pg, 12.5g/dl, Leukocyte Count Total: 38.9%, Platelet Count: 115000/cumm, Rdw: Mcv: 77.4fl, Packed Cell Volume: 38.9%, Platelet Count: 23%, Lymphocytes:

0.25mg/ui, Serum St. (Spr.) 14-06-2015: Packed Cell Volume: 33.9%, Platelet Count: 240000/cumm,

TREATMENT Syp.Calpol (250mg/5ml) 3.5ml-3.5ml-3.5ml ORS T.J Lanzol 15mg 1-0-0