CHIEF COMPLAINTS : Fever x 5 days

HISTORY OF PRESENTING ILLNESS : Patient who was apparently normal 5 days back when came with c/o fever since 5 days , high grade , intermittent type , associated with fever with chills ,
no rigors , associated with bodyache and headache ,
Patient also complained of dry cough since 3 days .
no h/o nausea
no h/o vomiting
no h/o abdominal pain
no h/o haematuria
For the above complaints he had been to local hospital and Dengue NS1 was sent and it was positive .
hence patient was referred here for further management .

PAST HISTORY :No history of Diabetes mellitus and 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. No substance abuse.

GENERAL EXAMINATION

Patient is consious and cooperative, well oriented to time, place and person. Moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE- 88bpm ,
BP-130/80 mm hg ,
RR-16/min
TEMPERATURE- 98.6F

LAB INVESTIGATION

30-05-2015 : Haemoglobin : 15.4g/dl, Neutrophils : 53%, Lymphocytes : 34%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual Nil, Leukocyte Count Total : 2400/cumm, Erythrocyte Sedimentation Rate : 02mm/1st hour, Platelet Count : 162000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites Negative, Serum Total Protein : 7.27g/dl, Serum Albumin : 4.66g/dl, Serum Globulin : 2.6g/dl, Serum Total Bilirubin : 0.45mg/dl, Serum Conjugated Bilirubin : 0.24mg/dl, Serum Unconjugated-Bilirubin : 0.21mg/dl, Serum Ast (Sgot) : 73IU/L, Serum Alt (Sgpt) : 22IU/L, Serum Alkaline Phosphatase : 85IU/L, Serum A/G Ratio : 1.8units, **Dengue Rapid (Ns1, Igm, Igg)** NS1 ANTIGEN POSITIVE, IgM ANTIBODY : NEGATIVE, IgG ANTIBODY : NEGATIVE, COMMENTS : This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

31-05-2015 : Platelet Count : 148000/cumm, Neutrophils : 45%, Lymphocytes : 42%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 2800/cumm,

01-06-2015 : Haemoglobin : 16.2g/dl, Neutrophils : 55%, Lymphocytes : 32%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 2300/cumm, Platelet Count : 136000/cumm, Packed Cell Volume : 48.7%,

02-06-2015 : Haemoglobin : 15.9g/dl, Neutrophils : 55%, Lymphocytes : 42%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 3100/cumm, Platelet Count : 107000/cumm, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph** 6.0, **Urine Protein** Negative, **Urine Sugar (Qualitative)** Negative, **Colour** Pale Yellow, **Transperancy** Clear, **Specific Gravity** 1.015, **Bile Salts** Negative, **Bile Pigments** Negative, **Urine Microscopy** RBCs Nil, Pus Cells : 1-2, Epithelial Cells : Occasional, Crystals : Negative, Casts : Nil, Others : NIL,

03-06-2015 : Haemoglobin : 17.3g/dl, Leukocyte Count Total : 3000/cumm,

TREATMENT:
IV FLUIDS NS @ 100 ML/HR
TAB DOLO 650 MG TID
INJ PAN 40 MG TID
INJ EMESET 4 MG SOS