CHIEF COMPLAINTS

Fever since 1 week

HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 1 week back when he developed fever, it was high grade fever in intensity associated with with chills and rigor, intermittent in nature and would subside on medication. During the same period patient also complains of weakness and malaise since 1 week. The patient was admitted in outside hospital, and was diagnosed to have dengue fever. No h/o bleeding manifestations from the gums.

No h/o malaena

No h/o burning micturition No h/o difficulty in breathing No h/o abdminal pain

PAST HISTORY

No history of Diabetes Mellitus, 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 Sieep: 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: 72 / min BP: 120 / 70 mm of Hg RR: 18 / min TEMPERATURE: 99 F

Patient has bleedig from the canula site for a prolonged period of time

17-03-2015: Haemoglobin: 10.8g/dl, Neutrophils: 49%, Lymphocytes: 38%, Eosinophils: 01%, Monocytes: 12%, Basophils: 00%, **Other Cells** Method: Manual Nil, Leukocyte Count Total: 2600/cumm, Packed Cell Volume: 31.8%, Platelet Count: 8000/cumm, Plasma Glucose Random:

18-03-2015: Haemoglobin: 14.6g/dl, Leukocyte Count Total: 2700/cumm, Mchc: 34.5g/dl, Mch: 30.1pg, Mcv: 87.2fl, Packed Cell Volume: 42.4%, Platelet Count: 18000/cumm, Red Blood Cell Count: 4.86million/cumm, Neutrophils: 39%, Lymphocytes: 53%, Eosinophils: 00%, Monocytes: 03%, Basophils: 00%, Other Cells Method: Manual REACTIVE LYMPHOCYTES-5%, Serum Total Protein: 5.87g/dl, Serum Albumin: 3.74g/dl, Serum Globulin: 2.1g/dl, Serum Total Bilirubin: 1.55mg/dl, Serum Conjugated Bilirubin: 0.58mg/dl, Serum Unconjugated-Bilirubin: 0.97mg/dl, Serum Ast (Sgot): 175IU/L, Serum Alt (Sgpt): 106IU/L, Serum Alkaline Phosphatase: 58IU/L, Serum A/G Ratio: 1.8units, Urine Blood Negative, Urine Ketone Bodies Negative, Ph 7.0, Urine Protein Positive(+), 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: 2-3, Epithelial Cells: Occasional, Crystals: Negative, Casts: Nil, Others: NIL, Packed Cell Volume: 42.4%, Peripheral Smear Report No H/1733/15, Impression: Normocytic normochromic blood picture with neutropenic leucopenia with reactive lymphocytes and marked thrombocytopenia., Haemoglobin: 14.4g/dl, Packed Cell Volume: 40.9%, Platelet Count: 20000/cumm,

19-03-2015: Haemoglobin: 13.5g/dl, Packed Cell Volume: 39.2%, Platelet Count: 40000/cumm, 20-03-2015: Haemoglobin: 12.5g/dl, Leukocyte Count Total: 4900/cumm, Mchc: 34.2g/dl, Mch: 30.1pg, Mcv: 87.9fl, Packed Cell Volume: 36.5%, Red Blood Cell

TREATMENT

Inj.Pan 40 mg IV OD Inj.Hydrocortisone 100 mg IV stat T.Dolo 650 mg SOS IVF NS at 100 ml / hr 4 units of platelet transfusion done

