HISTORY OF PRESENTING ILLNESS

Child was apparently normal 3 days back when he developed fever, high grade, intermittent, associated with chills & rigors. He also presented with joint pain since 3 days in bilateral lowerlimbs especially both knees & ankles. History of generalised weakness present. No h/o abdominal pain, bowel or bladder incontinence.

PAST HISTORY

H/o febrile seizures in the past. Last episode 3 years back.

BIRTH HISTORY

ANTENATAL HISTORY: Registered case. Inj TT, Fe and folic acid, Calcium received

NATAL HISTORY: FTNVD. BWT 2.5kg

POSTNATAL HISTORY: Recieved phototherapy in view of hyperbilirubinemia

DEVELOPMENTAL HISTORY:

Appropriate for age

IMMUNIZATION HISTORY

up to date

GENERAL EXAMINATION

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema PULSE 80/min BP 110/70mmHg RR 28/min

ANTHROPOMETRY

12-02-2015: Packed Cell Volume: 38.0%, Platelet Count: 165000/cumm, Platelet Count:

163000/cumm,

13-02-2015 : Platelet Count : 172000/cumm, Packed Cell Volume : 42.9%, 14-02-2015 : Packed Cell Volume : 40.0%, Platelet Count : 150000/cumm,

TREATMENT

Syp Calpol (250/5ml) 4ml-4ml-4ml Syp Atarax Calamine lotion