DIAGNOSIS
DENGUE FEVER WITH PANCYTOPENIA

COMPLAINTS
FEVER WITH CHILLS SINCE 1 DAY
VOMITING SINCE 1 DAY

HISTORY OF PRESENTING ILLNESS
PATIENT CAME WITH THE COMPLAINTS OF FEVER WITH CHILLS SINCE 1 DAY, HIGH GRADE, INTERMITTENT, ASSOCIATED WITH CHILLS AND RIGORS. NO DIURNAL VARIATION. SHE ALSO COMPLAINS OF GENERALISED BODY ACHE AND HEADACHE, BIFRONTAL, NON RADIATING SINCE 1 DAY. HISTORY OF VOMITING SINCE 1 DAY, 3-4 EPISODES, CONTAINED FOOD PARTICLES, NON BLOOD OR BILE STAINED, NON PROJECTILE.
NO HISTORY OF COUGH WITH EXPECTORATION
NO HISTORY OF PAIN ABDOMEN/LOOSE STOOLS
NO HISTORY OF BURNING MICTURITION/DECREASED URINE OUTPUT
NO HISTORY OF ANY DRUG INTAKE
NO HISTORY OF RASHES

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 DECREASED SLEEP DISTURBED 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, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY OR OEDEMA
BP -110/70MMHG RR -16CPM PULSE-88/MIN TEMPERATURE 101°F

TREATMENT
IVF DNS AT 80ML/HOUR
INJ. EMESET 4MG IV SOS
INJ. PANTOP 40MG IV 1-0-0
INJ. DEXA 8MG IV Q8H
T. CALPOL 500MG 1-1-1