COMPLAINTS
PAIN ABDOMEN X 1 DAY
NAUSEA X 1 DAY
FEVER X 1 DAY

HISTORY OF PRESENTING ILLNESS
PATIENT WAS APPARENTLY NORMAL 1 DAY AGO WHEN HE DEVELOPED PAIN ABDOMEN, SUDDEN ONSET, SEVERE IN INTENSITY, LOCASLISED TO THE UPPER PART OF THE ABDOMEN, RADIATING TO THE BACK, COLICKY IN NATURE. IT WAS ASSOCIATED WITH NAUSEA. NO EPISODES OF VOMITING. HE COMPLAINED OF FEVER SINCE 1 DAY, SUDDEN ONSET, MODERATE GRADE, ASSOCIATED WITH CHILLS.
HISTORY OF TRAVEL TO BANGALORE 1 MONTH BACK
NO HISTORY OF BURNING OR PAINFUL MICTURITION, INCREASED FREQUENCY OF URINE OUTPUT.
NO HISTORY OF ABDOMINAL DISTENSION, ALTERED BOWEL HABITS.
NO HISTORY OF COLD, COUGH WITH EXPECTORATION, JOINT PAINS, SKIN RASHES

PAST HISTORY
NO H/O DM , HTN OR IHD

FAMILY HISTORY
NOTHING SIGNIFICANT

PERSONAL HISTORY
SLEEP - NORMAL APPETITE - NORMAL DIET - MIXED BOWEL AND BLADDER - REGULAR

GENERAL EXAMINATION
BP 120/ 80 MM HG
PULSE 78/ MIN
TEMP 102.2 DEGREE F
RR 18/ MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED TO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
ICTERUS PRESENT
PALLOR, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

PCR IS THE CONFIRMATORY TEST., HAEMOGLOBIN : 14.7G/DL, LEUKOCYTE COUN 9700/CUMM, PACKED CELL VOLUME : 43.0%, PLATELET COUNT : 212000/CUMM,

TREATMENT
INJ. MOCEF 1 GRAM IV BD
INJ. FLAGYL 100 ML IV TID
INJ. BUSCOPAN 1 AMP IM SOS
INJ. EMESET 4 MG IV SOS
INJ. VOVERAN 1 AMP IM BD
INJ. PAN 40 MG IV OD (B/F)
T. BRUFEN 400 MG 1 SOS
T. URSACOL 300 MG TID