

CHIEF COMPLAINTS

Fever since 2 days
headache since 2 days

HISTORY OF PRESENTING ILLNESS

patient was apparently normal 2 days back following which he developed fever, intermittent in nature, high grade, associated with chills.

He also gives H/O headache - severe, throbbing in nature.

No H/o variation with posture

H/O generalised bodyache present.

No H/O vomiting, loose stools, burning micturition, blurring of vision

PAST HISTORY

K/C/O type 2 Diabetes Mellitus since 2 years, is on T.Glycophage G1 1-0-1 (not taken medication since 2 days)

No H/O Hypertension, Ischaemic Heart Disease, Asthma

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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema

PULSE = 78/min BP = 130/80mmHg RR = 12/min TEMPERATURE = afebrile

LAB INVESTIGATION

10-06-2015 : Platelet Count : 105000/cumm, Plasma Glucose Fasting : 246mg/dl, Whole Blood Glycated Hb (HbA1c) : 10.7%,

11-06-2015 : Serum Hdl Cholesterol : 15mg/dl, Serum Triglyceride : 160mg/dl, Serum Total Cholesterol : 155mg/dl, Serum Ldl Cholesterol : 101mg/dl, Serum Vldl : 32mg/dl, Haemoglobin : 14.4g/dl, Platelet Count : 114000/cumm, Packed Cell Volume : 42.3%, Urine Total Protein-Spot : 7.5mg/dl, Urine Creatinine (Spot) : 39.2mg/dl, Protein/Creatinine-Ratio : 0.2units,

12-06-2015 : Haemoglobin : 14.3g/dl, Platelet Count : 74000/cumm, Packed Cell Volume : 42.7%,

13-06-2015 : Haemoglobin : 14.6g/dl, Platelet Count : 72000/cumm, Packed Cell Volume : 44.2%,

Malarial Parasite Fluorescent (Mp Ft) presence of parasites **NEGATIVE**, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph 6.0**, **Urine Protein** Positive(+), **Urine Sugar (Qualitative)** Yellow ppt, **Colour** Pale Yellow, **Transparency** Slightly turbid, **Specific Gravity** 1.010, **Bile Salts** Negative, **Bile Pigments** Negative, **Urine Microscopy** RBCs Nil, Pus Cells : 2-3, Epithelial Cells : Occasional, Crystals : Negative, Casts : Nil, Others : NIL,

14-06-2015 : Haemoglobin : 14.2g/dl, Platelet Count : 115000/cumm, Packed Cell Volume : 43.2%,

REFERRAL

Ophthalmology Reference for funduscopy to rule out diabetic retinopathy.

TREATMENT

IV fluids

T.Rantac 150mg 1-0-1

T.Optineuron 0-1-0

T.Calpol 500mg 1-1-1

T.Glyciphage 1- 1/2 - 1/2

T.Meftal spas SOS

Inj.Emeset 4mg TID