CHIEF COMPLAINTS Fever since 4 days Bodyache since 4 days

HISTORY OF PRESENTING ILLNESS:

Patient was apparently normal 4 days back when he developed fever which was insidious in ons intermittent, gradually progressive, high grade associated with chills

No diurnal variations
he also complains of headache, body ache since 4 days
H/O 1 episode of loose stools semisolid non blood tinged
No H/O bleeding manifestations
No H/O pain abdomen, vomiting
No H/O cough with expectoration
No H/O burning micturition

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 . Sleep: reduced. Bowel : regular and Bladder: Regular. h/o alcohol consumption present, no smoking history .

GENERAL EXAMINATION

Patient is moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:78bpm

BP:120/70mmhg

RR:18cycles/min TEMPERATURE:98.6f

> 12-08-2015: Haemoglobin: 15.1g/dl, Leukocyte Count Total: 8200/cumm, Mchc: 33.8g/dl, Mch: 31.8pg, Mcv: 94.0fl, Packed Cell Volume: 44.7%, Platelet Count: 122000/cumm, Red Blood Cell Count: 4.75million/cumm, Neutrophils: 84%, Lymphocytes: 09%, Eosinophils: 01%, Monocytes: 06%, Basophils: 00%, Other Cells Method: Manual Nil, Malarial Parasite Fluoroscent (Mp Ft) presence of parasites Negative, Serum Urea: 25mg/dl, Serum Creatinine: 1.04mg/dl, Dengue Rapid (Ns1, Igm, Igg) NS1 ANTIGEN NEGATIVE, IgM ANTIBODY: NEGATIVE, IgG ANTIBODY: NEGATIVE, COMMENTS: This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA., Urine Blood (Hb And Derivatives) Positive (+), Urine Ketone Bodies Negative, Ph 5.0, Urine Protein Positive(+), Urine Sugar Negative, Colour Pale Yellow, Transperancy Slightly turbid, Specific Gravity 1.020, Bile Salts Negative, Bile Pigments Negative, Urine Microscopy RBCs 1-2, Pus Cells: 2-3, Epithelial Cells: 1-2, Crystals : Calcium oxalates seen, Casts : Nil, Others : NIL, Serum Total Protein : 6.77g/dl, Serum Albumin : 4.30g/dl, Serum Globulin : 2.5g/dl, Serum Total Bilirubin : 0.77mg/dl, Serum Conjugated Bilirubin: 0.25mg/dl, Serum Unconjugated-Bilirubin: 0.52mg/dl, Serum Ast (Sgot): 73IU/L, Serum Alt (Sgpt): 63IU/L, Serum Alkaline Phosphatase: 76IU/L, Serum A/G Ratio: 1.7units,

13-08-2015: Haemoglobin: 14.9g/dl, Packed Cell Volume: 43.4%, Platelet Count: 103000/cumm, Malarial Parasite Smear Presence of parasites Negative, 14-08-2015: Haemoglobin: 15.4g/dl, Packed Cell Volume: 45.1%, Platelet Count: 91000/cumm,

15-08-2015 : Haemoglobin : 13.9g/dl, Packed Cell Volume : 40.6%, Platelet Count : 82000/cumm, Serum Creatinine : 1.01mg/dl, Erythrocyte Sedimentation Rate : 14mm/1st hour

16-08-2015: Platelet Count: 104000/cumm, Urine Blood (Hb And Derivatives) Positive (++), Urine Ketone Bodies Negative, Ph 5.0, Urine Protein Positive(+), Urine Sugar Negative, Colour Pale Yellow, Transperancy Slightly turbid, Specific Gravity 1.015, Bile Salts Negative, Bile Pigments Negative, Urine Microscopy RBCs 3-4, Pus Cells: 1-2, Epithelial Cells: Occasional, Crystals: Negative, Casts: Nil, Others: NIL,

17-08-2015 : Platelet Count : 134000/cumm, Malarial Parasite Fluoroscent (Mp Ft) presence of

parasites NEGATIVE,

TREATMENT: IVF NS/DNS T.Calpol 500mg 1-1-1 T.Pan 40mg Inj. Emeset 4 mg IV Q8H inj ceftriaxone 2gm iv bd Inj .Pan 40 mg IV OD