HISTORY OF PRESENTING ILLNESS

Patient came with c/o fever since 7 days, intermittent, high grade, asssociated with chills and rigors
h/o vomiting present,multiple episodes
h/o nausea and headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

GENERAL EXAMINATION

Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
no pallor,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent

vitals
PULSE 80/min
BP 130/80 mm HG
RR 20/min
TEMPERATURE 101

LAB INVESTIGATION

14-06-2015 : Haemoglobin : 12.5g/dl, Leukocyte Count Total : 3200/cumm, Mchc : 32.2g/dl, Mch : 26.8pg, Mcv : 83.4fl, Packed Cell Volume : 38.8%, Platelet Count : 63000/cumm, Red Blood Cell Count : 4.66million/cumm, Neutrophils : 57%, Lymphocytes : 33%, Eosinophils : 04%, Monocytes : 06%, Basophils : 00%, **Other Cells** Method : Manual -, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites NEGATIVE, Serum Creatinine : 0.74mg/dl,

15-06-2015 : Haemoglobin : 12.6g/dl, Packed Cell Volume : 38.8%, Platelet Count : 71000/cumm,

16-06-2015 : Haemoglobin : 11.4g/dl, Packed Cell Volume : 34.7%, Platelet Count : 111000/cumm,

17-06-2015 : Haemoglobin : 10.8g/dl, Packed Cell Volume : 33.3%, Platelet Count : 143000/cumm,

TREATMENT

IVF NS @ 75ml/hr
T.Dolo 650 mg
T.Supradyn