Case presentation

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- 2nd yr PG,
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A 16 year old male

Nalgonda

Ward- General Medicine unit 4

Patient was apparently alright 3 days back then he came to the hospital with complaints of h/o High grade fever with chills and rigors since 3 days intermittent in nature ,fever occurring every 2^{nd} day.

h/o seizures (2 – 4) episodes each episode lasted for 2-3 mins associated with loss of consciousness.

h/o tongue bite present

h/o vomiting – 2 episodes, watery in consistency contain food particles, non bilious

PAST HISTORY:

History of urinary tract infection 15 days back and took herbal medicine 10 days back.

No h/o DM, HTN

No h/o similar complaints in the past

PERSONAL HISTORY:

Diet :mixed

Non –alcoholic

Not a smoker

Sleep adequate

Bowel and bladder habits – regular

General Examination

Patient conscious and coherent Glasgow Coma Scale 15/15

NO pallor, icterus, cyanosis, clubbing, edema, lymphadenopathy

VITALS:

PR – 90 bpm

BP – 110/70mm Hg

RR – 18 cycles per min

Temperature – 100 deg Fahrenheit

Systemic Examination

CNS Examination:

Higher mental functions are normal

No signs of meningeal irritation

Motor system examination normal

No focal neurological deficit

CVS Examination:

S1 S2 heard ,No murmurs

RS Examination :

Bilateral air entry present

Normal vesicular breath sounds are heard

GIT Examination: No organomegaly

PROVISIONAL DIAGNOSIS:

CLINICAL MALARIA

MENINGITIS

Investigations Done After Admission:

Hb – 12.1gm/dl

Platelet count- 2.1 lakh/ cumm

TLC – 6,400/cumm

Total Serum protein- 6.1 gm/ dl

Total bilirubin- 1.5 mg/ dl

Direct bilirubin- 0.47 mg/dl

Uric acid- 2 mg/ dl

Calcium- 8.3 mg/ dl

CUE –normal

CT brain - normal

Chest X ray- normal

USG Abdomen- normal

Malaria strip test- negative

Dengue – non reactive

Blood group – B positive

PT – 24 seconds

aPTT – 41 seconds

INR – 1.7

TRANSFUSION SUPPORT

Fresh frozen plasma (FFP):

Two units of B group FFP transfused

Transfusion of first FFP started at 1.00 pm and ended at 1.20 pm.

Transfusion of second FFP started at 1.20 pm and ended at 1.45 pm.

C/o itching all over the body at 2pm

Vitals stable

Inj Avil , Inj Hydrocortisone STAT given

Follow up showed improvement in symptoms.

Post Transfusion Investigations Of Patient :

Hb -12.2gm/dl

TLC – 6,800/ cumm

Platelet count - 1.9 lakh/cumm

PT – 16 seconds

aPTT – 32 seconds

INR – 1.1

CUE – Normal

HIV and HBsAg non reactive

Transfusion reaction work up

Transfusion reaction work up is done with the blood samples of the patient and it is proved to be mild non febrile non hemolytic transfusion reaction.(NFNHTR).

Final diagnosis

Clinical malaria with seizures with mild non febrile non hemolytic transfusion reaction.(NFNHTR).

Treatment Given:

Inj. Eptoin 900mg in 100ml NS IV STAT

Inj. Eptoin100 mg IV TID

Inj. Lorazepam 2cc IV SOS

Inj .Ceftriaxone 2gm IV BD

Inj . Falcigo 120 mg IV BD on day 1 ,once daily for 5 days

IV Fluids NS @75 ml/hr

Inj. Pantop 40 mg IV OD

Inj. Ondansetron 4mg IV SOS

Tab. Paracetamol 650mg TID

Fever subsided by day 3 , no h/o fresh episode of seizures.

Treatment continued for 5 days.

Pt was discharged on 9 th day.

Pt was advised tab Eptoin 100mg Per orally in the morning

Tab Eptoin 200mg Per orally in the night after food for 6 months.

Patient advised follow up

Thank you