Fever Profile

A few days of fever and most patients start asking, "Doctor, what is it ? Is it Typhoid or Malaria or something to worry about?" Fever may indicate an infectious, inflammatory or neoplastic disorder. The abruptness of the onset of fever, it's magnitude and pattern, appearance of the patient, and associated clinical or laboratory findings usually points to the probable cause of the fever. Main investigations, of course, depend on the symptoms, signs, organ system involved and patient's past history, but the base line investigations of CBC, ESR, Peripheral Smear, Urine Analysis and X-ray chest do provide valuable clues to either proceed with other investigation or explain to patient the futility for more investigations.

1. CBC

a. Hb - Moderate to severe anemia may indicate lowered body resistance and may explain recurrent infection. Recent drop in Hb of 1-1.5 Gm with appropriate history may suggest malaria (lysis of RBCs). This may also be visible in cases of Primaquine administration in G6PD cases

b. WBC- Total Count -Leukocytosis suggests acute infection and depending on the organ system involved, appropriate broad-spectrum antibiotic can be started. Leukopenia may be the 1st lab sign of Enteric fever. It may also indicate lowered body immunity and a not so perfect bone marrow. Lymphoma and Leukemia also present mainly as fever.

c. WBC- Differential Count -Raised count of *neutrophils* again suggests acute infection. *Lymphocytosis* may signal chronicity of an infection, but these two alone should not be given much credence and should be used in correlation with symptoms. A very high count of *Monocytes* may point to Tuberculosis, active marrow or bone marrow neoplasms.

d. PLATELETS - Low counts of platelets may suggest fulminant viral fever after iatrogenic causes are ruled out (common with Diclofenac, Ibuprofen).

e. PERIPHERAL SMEAR - should be prepared in the clinic if patient comes with rigors. We should always have EDTA bulb and slides handy so that we can collect blood for CBC and make smears rather than putting the patient to additional trouble of going to a pathologist. Two smears should be made, one thin and the other thick, for malarial parasites. While doing a smear patient should be explained the yield of the test (65%-75% even during a rigor). Presence of toxic granules indicates acute, severe infection necessitating broad-spectrum antibiotics.

2. ESR - Generally done by Westergreen method. Very important guide but rarely significant alone to diagnose. ESR finger of suspicion is most important in collagen disorders which present as fever alone. Raised ESR of Tuberculosis, (70-80 mm at the end of 1 hour); Rheumatoid and collagen disorders (100-120 mm at the end of 1 hour). In many cases we get ESR of around 40-50 mm at the end of 1 hour which may just be taken as an indicator of chronicity of some infection.

3. URINALYSIS - Very important guide again. Diagnosis of Urinary Tract Infections, In children presence of Casts, Albumin, Occult blood may point towards acute nephritis. Albumin +++ may call for quantitative estimation of protein to confirm diagnosis of Nephrotic syndrome (of course, fever is not a presenting symptom). Most cases of Malaria do show Protein + and occult blood +. Ketone bodies ++ in a known diabetic should make you rule out Diabetic keto-acidosis

4. STOOLS - In cases of Fever with diarrhoea - presence of blood - frank or occult - may suggest bacillary dysentery. Presence of reducing substance suggests Lactose intolerance telling that diarrhoea needs no specific treatment (of course, fever is not a presenting symptom). Presence of cysts of E Histolytica and G Lambia may suggest use of Metronidazole, which of course mostly is given on

Dr CH ASRANI DNB

clinical evidence only.

5. **X-RAY CHEST** - To diagnose /confirm /stage or rule out Pnuemonitis, Tuberculosis, Lung Abscess or Bronchiectasis.
6. **WIDAL TEST** - Diagnosis of Typhoid is mostly clinical. Most of us will lose the patient if still febrile after 10 days. And Widal comes positie only after day 8. We should control the impulse of ordering Widal on day 5 or 7 as a -ve Widal makes it more difficult for a patient to believe our clinical diagnosis of Typhoid. We must look for a titre of more than 1:160 in 'H' and 'O' antigen; a rising titre is also positive. The text book recommendation of waiting for a 100% rise in titers is not practical.
7. **ULTRASONOGRAPHY** – Before considering referral for diagnosis, an USG of abd/ pelvis should be asked for Hidden abscesses - Liver abscess may present with fever as the only symptom without other symptom and signs.
8. **SYSTEMATIC CLINICAL EXAMINATION** - In children, otitis media and meningitis present as child crying with fever. Quite often difficult to diagnose. Meticulous examination will save the day

All of the above form a comprehensive package when any case of fever defies diagnosis. Other investigations like USG, Culture of Urine, Stool, Blood (Clot) are to be resorted to if symptoms and clinical findings point to a particular condition. It must be borne in mind that for any culture study - patient should be without any antibiotic for a minimum of 24 hours. Again the yield (sensitivity) of culture tests in private labs is much less than in institutions. This article is repeated in this issue for comperhensive coverage. ❑

Homoeo Approach to Fever: An Overview

In order to prescribe successfully a Homoeopathic Physician should be conversant with the basic Philosophy of homoeopathy given by our great master Dr SAMUEL HAHNEMANN in his text book of ORGANON. Let us now be conversant with the essential points to be perceived in a case of fever.

The 3 fundamental points to be given due importance.

A) DATA COLLECTION

B) DATA PROCESSING

C) MANAGEMENT OF CASE

A) DATA COLLECTION

I) ACUTE CASE: ACUTE TOTALITY: L S M C

L: Location, Site, System involved.

S: Direction, Spread, Tissue affinity, Pattern, Sensation.

M: Causative modalities, Agg and Amel.

C: Concomitants like appetite, thirst, discharges etc.

II) PERIODIC / RECURRENT EXACERBATIONS: CHRONIC TOTALITY.

- o CHIEF COMPLAINTS: Fever.
- o PATIENT AS A PERSON: Predisposition, disposition, general modalities, physical generals, pathological general, physical and pathological particulars.
- o FAMILY and PAST HISTORY.

III) FEVER

ONSET: Sudden / Gradual.

- o TIME OF APPEARANCE: Morning, afternoon, evening, night.
- o PERIODICITY: Marked or absent.
- o DURATION: Continuous, intermittent, relapsing.
- o INTENSITY: Weak, mild or moderate.
- o If CHILLS are present: Extension and spread.
- o MENTAL STATE to be considered.

Dr ARDESHIR T JAGOSE, MD (Hom)
Asstt Professor, PG Yerala Hom College
Chateau Windsor, 86 Veer Nariman Road
Churchgate Mumbai 400 020.
Tel: (C+R) 2041253
E-mail: draja_osc@hotmail.com

B) Data Processing

1) Diagnosisi of Disease: Hahnemannian classification of disease, history, clinical examination & investigations.

I) Hahnemannian Classification of Disease:

- o Acute: Episodic, epidemic, relapse, acute miasm.
- o Chronic : Progressive, intermittent, alternating, one-sided, local maladies, mental disease.

II) History

- o Malaise, headache.
- o Fever with associated features as mentioned above.
- o Anorexia, nausea, vomiting.
- o Prostration or even depression.

III) Clinical Examination: Vital Parameters:
Temp, Pulse, Resp-Rate, BP.

IV) General Examination: As per the case.

V) Investigations: As per the case, to confirm or rule out the differential diagnosis.

2) Diagnosis of Patient: Mental symptoms, Physical Generals, Physical Particulars, Pathology.

3)Diagnosis of Phase:

Acute Phase: Febrile, afebrile, exacerbations, intermittent.

Chronic Phase: Recurring, relapsing, progressive.

4) Diagnosis of Maism: From the predisposition of the patient ie family history and past history.

Types: Dominant and Fundamental.
Single, mixed or complex miasm.

Tabular Representation of Miasmatic Activity

	Psora	Sycosis	Syphilitic	Tubercular
Onset	Sudden	Slow	Fast	Erratic
Pace	Fast	Slow	Moderate	Slow
Speed	Rapid	Sluggish	Mod to fast	Rapid
Intensity	Marked	Fair	Marked	Heightened
Pattern	Periodic	Slow	Fair	Erratic
Frequency	Regular	Slow	Fast	Irregular
Sensitivity	Increased	Decreased	Less	Marked

5) Diagnosis of Susceptibility
Increased or Decreased based on:
Symptom exhibited
Nature of disease
Pathology involved
Fundamental miasm
H/O suppression
Sensitivity: Mental and physical
General condition of the patient

6) Diagnosis of Remedy:
Qualitative totality according to "Law of Similars".
Reportorial totality
Differentiation
Remedy selection

2) Non-Reportorial Approach:

Key-notes	Portrait
Structure or pathology	Abstraction
Conceptual image	Symbolic

Auxillary line of Treatment: As per the case.

Follow-up And Expectations: To assess judiciously, the Follow-up criteria as per the case should be noted down.

Expectations: This depends upon the pace, speed, depth and intensity of disease which includes the pathology involved and the miasmatic activity.

The above helps us to appreciate the writings of our Master and to become true practitioners of the healing art.

C) Management of Case

Problem definition and Resolution of the patient.

1) Therapeutic Resolution

Repertorial Approach: Therapeutic Pocket Bk /Boger Boenninghausen /Kent