CLINICAL AND INVESTIGATIONAL STUDY OF “FEVER UNKNOWN ORIGIN”
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ABSTRACT: BACKGROUND AND OBJECTIVES: Classical F.U.O is in chronic fever (> 2 weeks) with no cause identified after initial investigation on two outpatient visits or three inpatient days.¹ There has been increased appreciation in recent years of the frequent occurrences and clinical importance of F.U.O.² The incident is 5–15% of cases. History taking and physical examination, remaining main stay of practice of this entity³ and absence of fever does not exclude severe infection and hypothermia may occur in severe sepsis. Many patients present with fever with no oblivion focus of infection. Inevitably, infection will account for a higher percentage of F.U.O in developing countries. And fever presents with different patterns. This study aims at the study of clinical profiles of F.U.O to spot the disease early. METHODS: The patient presenting with clinical examination of symptoms and signs. Investigational examination i.e. urine analysis, blood analysis, parasite and organism detecting from blood and imaging methods. RESULTS: Out of 50 cases, 35 cases were males and 5 cases were females. So the disease more in males because males will wander outside for their occupation and household works. The common symptoms are fever headache and malaise. The common signs are dehydration, splenomegaly, hepatosplenomegaly, toxaemia, lymph node enlargement. Common aetiology is infectious origin. Most of the cases diagnosed by blood examination. CONCLUSION: It is found that more cases are found in male sex. Common symptoms are fever, and it is low fever and often it is continuous fever. And common signs are dehydration, splenomegaly, hepatosplenomegaly, lymph node enlargement, jaundice, neck stiffness and delirium.

KEYWORDS: F.U.O, Clinical examination, Urine and blood examination, X Ray chest PA, Ultrasonography, Computed tomography (CT) and Magnetic Resonance Imaging (MRI).

INTRODUCTION: It is the frequent entity for admission in our medical wards. These present with a variety of symptoms such as fever, headache, rash (Haemorrhagic and non haemorrhagic), associated with localised lymph node enlargement and generalized lymphadenopathy, splenomegaly, hepatosplenomegaly, neck stiffness, myalgia, jaundice, polyarthritis. And had different incubation periods. Some fevers had < 10 day e.g.: Arbovirus, bacillary dysentery, some had 10-21 days e.g.: typhoid, falciparum Malaria, leptospirosis, HIV, some had long > 21 days e.g.: viral hepatitis, malaria (P. V & P.F) autoimmune disorders, amoebic liver abscess and auto immune disorder e.g.: rheumatoid arthritis, S.L.E. F.U.O’s caused by infections (30–40%), neoplasms (20–30%), collagen vascular disease (10–20%) and miscellaneous (15-20%).

AIM OF THE STUDY: The aim of the study is clinical study and investigational study.

MATERIALS AND METHODS:
Inclusion Criteria:
Patients with:
  a) Age 14 to 60 years.
  b) Fever more than 2 weeks.
  c) Fever with organomegaly, rash, weight loss, lymphadenopathy, considered.
Exclusion Criteria:
1. Fever less than 2 weeks.
2. Patients with HIV disease.

PLACE AND PERIOD: This study was done in Guntur General Hospital, Guntur from 2014 to 2015, 50 cases were taken into the study.

HISTORY AND EXAMINATION: The patients who were referred for fever symptoms to medical outpatient and other associated department or admitted patients. Patients 14 years to 60 years both males and females were included. People belongs to various socioeconomic classes were included. All patients were questioned for detailed history. In addition to general symptoms examined for other symptoms like headache, lassitude, myalgia, nausea, vomits, weight loss and observed for signs like rash (Haemorrhagic and non haemorrhagic), hepatosplenomegaly, neck stiffness, dehydration, lymph node enlargement.45 Cardiac thrills and murmurs, lungs for wheeze and crepitations. Past history taken about travel, past H/O fever, rheumatic heart disease, tuberculosis.6,7,8 And history of diabetes and polyarthralgias.9 Treatment history like surgery, previous admission and drugs.

LABARATORY: Urine tests done to check diabetes mellitus and U.T.I, blood for TC, DC, ESR, Hb, blood sugar, S creatinine, blood for malaria thick smear and thin smear, QBC, widal test, X ray chest for pneumonitis, koch’s, pl. Effusion, and ultrasonography abdomen, 2D ECHO heart to see valve leaflets, CT abdomen after ultrasonography advice, MRI not needed in this study.

OBSERVATION: Out of 50 cases, 35 were males and 15 females. So F.U.O more associated with males. Male sex more affected because they move outside for travel for their job their family needs, more exposure to environment factors and mosquito bites and more prone for diseases.

Age group analysis in our study revealed that maximum occurrence 14 to 30 years occurs 29 cases, 31 to 45 years 14 cases, 45 – 60 years 7 cases.

Detailed analysis of symptoms in our study found fever in all patients 100%, nausea 68%, vomittings 45%, myalgia 40%, lassitude 60%. Detailed analysis signs reveals splenomegaly mild to moderate 38%, heptosplenomegaly 22%, rash 12%, neck stiffness 6%, cardiac murmur 4%, joints tenderness 8%, jaundice 8%. Ultrasonography detects liver abscess 1%, abdominal lymph node enlargement 2%, sponomegaly and hepatosplenomegaly confirmed.

CONCLUSION: The Present Study Indicates:
1. Out of 50 cases 35 were males 15 were females, so it is common in males.
2. Most common symptom is fever.
3. Most common sign splenomegaly, next common is hepatosplenomegaly.
4. Most of the cases are single drug resistant malaria cases i.e. with chloroquine then treated with second line drugs.
5. Second most fevers are drug resistant enteric fever cases are treated with chloramphenical.
6. Third most cause was fever extra pulmonary koch’s.
7. Two cases of TB meningitis are observed.
8. Two cases of liver abscess are observed.
9. One case of thyrotoxicosis.
SUMMARY: It is common in males, common symptom fever, common sign splenomegaly next is hepato splenomegaly. The first cause in our study is drug resistant malaria and second cause is cephalosporins resistant enteric fever and third cause chronic hepatitis, amoebic liver abscess, auto immune disorders and drug fevers. Treatment given as per treatment guidelines.

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