INTRODUCTION:
Dengue fever (also called breakbone fever or dandy fever), is an acute febrile illness caused by bite of mosquitoes of the genus *Aedes aegypti* carrying a single-stranded RNA virus of the genus *Flavivirus* (species *Dengue virus*). It includes five different serotypes (DEN-1, DEN-2, DEN-3, and DEN-4), while fifth was announced in 2013. Dengue can be divided into: undifferentiated fever, DF (dengue fever) and DHF (dengue hemorrhagic fever).

Between 1953 and 1964, DHF was described in India, Malaysia, Philippines, Singapore, Thailand and Vietnam.1

Dengue virus infection is known to exist in India for a long time2. The first major outbreak of DHF was reported from Calcutta in 19644 followed by an epidemic in Vishakhapatnam in 1966 5. Delhi had its major outbreak of infection in 19888 and another in 19966.

Dengue fever incidence fluctuates with the seasons. It is usually associated with warmer and more humid weather. High rainfall and temperature are the conditions that promote humidity. This type of condition is conductive to breeding and survival of vector populations, associated with warmer and more humid weather. High rainfall and temperature are the conditions that promote humidity. This type of condition is conductive to breeding and survival of vector populations, especially in tropical and subtropical regions.

The diagnosis of dengue is typically made clinically, on the basis of symptoms and physical examination and this applies especially in endemic areas as the symptoms may vary according to the age and immunity of the patient. A probable diagnosis is based on the findings of fever plus two of the following: Nausea and vomiting, rash, arthralgia, bodyache, anorexia, nausea and vomiting, diarrhea, abdominal pain, respiratory symptoms, rash, hemorrhagic manifestations, altered sensorium and convulsion.

Historical background of dengue fever includes symptoms like headache, abdominal pain, retro-orbital pain, vomiting, diarrhea, rash, anorexia. Dengue fever was described in India, Malaysia, Philippines, Singapore, Thailand and Vietnam.1

METHODS:
Our study was hospital based observational study. It was carried out in tertiary care hospital in the department of General Medicine. It was carried out for a period of one year.

Patients were explained the nature of the study and on their willingness only they were included in the present study.

RESULTS:
A total of 300 patients were included in this study.

Mean Age of the study subjects was 33.12 years with over half of the subjects were below 40 years of age (Table 1). Male predominance was seen in present study with 58.7% males and 41.3% females.

Most common presenting complaints were fever (100%), nausea/vomiting (47.7%), and breathlessness (30.3%). Other presenting symptoms were headache (29%), abdominal pain (23.7%), rash (20.3%) and retro-orbital pain (19%).

Haemorrhagic manifestations were seen in 8.7% of the cases while convulsions and altered sensorium were present in 2.3% and 2.7% cases respectively. (Table 2)
Mean Hematocrit significantly increased during the admission while leucocyte and platelet count significantly decreased (p<0.01). Raised Hematocrit was seen in 32% cases while leucopenia and thrombocytopenia was seen in 59.7% and 73.3% cases respectively. (Table 3)

Liver enzymes raised (70.7% cases) significantly during the course of the study (p<0.05) while no difference was seen in S. bilirubin levels. (Table 4)

Common ultrasonography findings were gall bladder sludge and Acalculous Cholecystitis (31% each). Ascites was seen in 19% cases while hepatomegaly and splenomegaly was seen in 24.3% cases and 18.7% cases respectively. (Table 5)

**DISCUSSION:**

In this study, mean age of the study subjects was 33.12 years and male predominance was seen with 58.7% males and 41.3% females. Laul et al. in their study of 115 cases observed the mean age as 31.7 years with 64 (57%) males and 51 (44%) females. Similarly Gandhi K et al. in their study of 53 patients, observed the mean age as 34.3 years with 17 (63%) males and 10 (37%) females.

Most common presenting complaints were fever (100%), nausea/vomiting (47.7%), and breathlessness (30.3%). Other presenting symptoms were headache (29%), body ache (29.3%), abdominal pain (23.7%), rash (20.3%) and retro-orbital pain (19%). These were compared to other studies as well (Table 6). In the study by Aggarwal Anju et al., the common clinical features were fever (100%) followed by vomiting (68%) and abdominal pain (49%).

Liver enzymes raised significantly during the course of the study (p<0.05) while no difference was seen in S. bilirubin levels. Raised Liver enzymes were observed in 70.7% cases while in 23.7% cases the level raised above 3 times the normal level. The commonest abnormality detected in dengue infection has been raised liver enzymes. In the study by Narayanan M. et al., serum SGPT levels were elevated in 59.7% of the total patients in study. Serum SGPT levels were elevated in 66% of DF patients. In the study by Aggarwal Anju et al., serum SGPT levels were elevated in 57% of the patients in whom the test was performed. The elevated SGPT levels seen in all studies can be explained by the fact that liver is one of the important target organs for dengue.

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These studies (Table 7) concluded that thrombocytopenia and raised hematocrit were sufficient useful for early diagnosis of dengue hemorrhagic fever without waiting for dengue serology.

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