



**RAMSA**  
MEDICAL HEALTH CARE

Dr. SANJAY KISHORE  
MBBS, MD (MEDICINE)  
Consultant Physician  
Reg. No. -22643

Name :- Mr. Shiva Kumar  
Age :- 45 Gender :- M

Date :- 11.3.24  
Bill No. :- .....

Present Complaints :

Other Significant Diseases :-

History of Past Illness :-

Present Illness :-

Provisional Clinical Diagnosis :-

TSH 7.6  
T4 7.3  
Rx.

Low ft  
diets  
diet

Ad  
1. consult  
Endocrinologist  
for TSH & T4

Height  
Weight  
Temp.  
Resp.  
Pulse  
BP

3  
11.3.24

**Dr. Sanjay Kishore**  
MBBS, MD (Medicine)  
Reg. No.-22643



फीस 15 दिनों के लिए मान्य है, 15 दिन बाद फीस पुनः लगेगी।

Beside Yadav Timber, East of Kanti Factory More, Kankarbagh Main Road, Patna-26

Contact No# +91 6122356151 +91 9229245090 Email:- Ramsamedicalhealthcare@gmail.com



# RAMSA MEDICAL HEALTHCARE

Patient Name :- Mr.Shiva Kumar  
Bill No :- 24252825  
Refer By :- Self

Gender :-Male Age:- 49Years  
Date:- 09.03.2025

## 2D Echocardiogram Report

ECHOGENICITY :- Is Adequate.

DIMENSIONS	NORMAL	DIMENSIONS	NORMAL
AO(ed):- 2.6 cm	(2.0 – 4.0 cm )	IVS (Ed):- 1.1 cm	(0.6 – 1.1 cm)
LA(es):- 3.4 cm	(2.0 – 4.0cm )	LVPW (Ed):- 1.0 cm	(0.6 – 1.1 cm)
RVID (ed) :- 2.1 cm	(1.5 – 2.4 cm )	EF:- 60 %	(55-65%)
LVID(ed):- 4.1 cm	(3.3 – 5.4 cm)	% FD:- 32 %	(28% - 42 %)
LVID(es):- 2.6 cm	(2.0 – 4.0 cm)		

### MOROPHOLOGICAL DATA

Mitral Valve:- AML normal Interatrial septum :- Normal  
PML normal Interventricular septum :- Normal.  
Aortic Valves:- Normal Pulmonary artery :- Normal.  
Tricuspid valve :- Normal Aorta :- Normal.  
Pulmonary valve :- Normal. Right atrium :- Normal.  
Right ventricle :- Normal Left atrium :- Normal.

Left ventricle:- LV WALL MOTION ANALYSIS- No RWMA.  
Pericardium:- No echo free space.  
Doppler studies:- Normal flow across valves.  
MV – 60/70 cm/Sec PG – mmHg  
AV – 125 cm/Sec

Impression:-

**NO R.W.M.A, GRADE I LV DIASTOLIC DYSFUNCTION  
VALVES ARE NORMAL, NORMAL IVC,  
NORMAL PA PRESSURE, NO CARDIAC SHUNT  
NORMAL LV/RV SIZE & SYSTOLIC FUNCTION, LVEF=60%  
NO PE/Veg/ CLOT/Mass**

Consultant Cardiology



# RAMSA

## MEDICAL HEALTHCARE

Patient Name :- Mr. SHIVA KUMAR  
Age/Gender :- 49 Year(s)/Male  
Referred By :- SELF, ....



Bill No// :- BL/2425/2825  
Collection Date :- 09/03/2025  
Reporting Date :- 10/03/2025  
Contact No :- 7004825249

DEPARTMENT OF RADIOLOGY  
Mediwheel Full Body Annual Plus Abv 50 Male

### X-RAY CHEST- PA VIEW

Bilateral Lung fields are clear.  
Both cardiophrenic & costophrenic angles are clear.  
Cardiac size & bony cage is normal.

Greetings of good health from Ram Sa Medical Healthcare Patna. We sincerely thanks for the referral.



  
Technician

  
DR. Pawan Kumar Shah  
DMRD, Radiologist

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## DEPARTMENT OF RADIOLOGY

### Whole Abdomen

LIVER : 15.2 cm

Liver is grade I mild enlarged in size and echopattern . No focal intra-hepatic lesion detected. Intra-hepatic biliary radicals are not dilated. Fatty changes seen in liver parenchyma. Portal vein is 9.6 normal in calibre.

GALL BLADDER : Gall bladder appears echofree with normal wall thickness .

Common duct is not dilated & measures 3.9 mm.

PANCREAS : Pancreas is normal in size and echopattern.

SPLEEN : Spleen is normal in size & echopattern. Its measures 8.2 cm.

KIDNEYS :

RIGHT KIDNEY :- Measures 9.71 x 4.72 cm.

LEFT KIDNEY :- Measures 9.74 x 4.75 cm.

Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. Central sinus echoes are compact.

URINARY BLADDER : Urinary bladder is normal in wall thickness with clear contents. No significant intra or extraluminal mass seen.

PROSTATE : - Prostate is normal in size and echo-pattern. It measures 14g in weight.

PRE-VOID : - 260 cc in volume.

POST-VOID : -Nil in volume

OTHERS :- Visualized parts of retro-peritoneum do not reveal any lymphadenopathy.

No significant free fluid is detected.

**IMPRESSION:** Mild hepatomegaly grade I fatty liver.  
Adv.:- Further Workup/ Other Investigation

Greetings of good health from RAMSA Medical Healthcare Patna. We sincerely thanks for the referred

**Dr. Pawan Kumar Shah**

Technologist

D.M.R.D  
Radiologist



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### HAEMATOLOGY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
<b>Blood Group &amp; Rh Factor</b>			
Blood Group	"B"		
Rh Factor	Positive		

#### Interpretation:-

When and if following bone marrow or liver transplantation there is disagreement between the results of ABO or Rh results based on testing of RBCs ("forward" testing) and results based on testing of plasma ("reverse" testing), the discrepancy will be reported.

If baby and mother are both Rh Negative on initial testing, weak D testing should be performed on the cord sample and confirm.

#### **Erythrocyte Sedimentation Rate (Westergen Method)**

First Hour	08	mm/hr	0 - 20
Second Hour	20	mm/hr	
Ratio	9		

#### Interpretation:-

The erythrocyte sedimentation rate increases with age; the upper limit is not clearly defined for patients > 60 years old.

Technician / Technologist

  
Dr. Manish Jaipuriyar  
MD. (Pathology)



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### HAEMATOLOGY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
<b>COMPLETE BLOOD COUNT (C. B. C.)</b>			
Total Leucocyte Count (TLC)	7300	cells/Cu. mm	4000 - 11000
Differential Leucocyte Count (DLC)			
Neutrophil	65	%	60 - 75
Lymphocyte	32	%	20 - 35
Monocyte	01	%	1.0 - 6.0
Eosinophil	02	%	1.0 - 6.0
Basophil	00	%	0.0 - 1.0
Haemoglobin	14.1	gm/dl	12.0 - 17.5
Haemoglobin %	96.16	%	
Red Blood Cells (RBC) Count	5.0	million/Cu mm	4.5 - 6.0
PCV / Haematocrit (HCT)	41.7	%	40 - 50
Mean Cell Volume (MCV)	83.4	fl	80.0 - 99.0
Mean Cell Haemoglobin (MCH)	28.2	pg	26.5 - 33.5
Mean Cell Hb. Concentration (MCHC)	33.81	g/dl	32.0 - 36.0
Platelet Count	1.50	Lakh Cell/cum	1.5 - 4.5

Technician / Technologist

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### BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Blood Sugar Fasting	↑ 145	mg/dl	70 - 110
Blood Sugar Post Prandial (PP)	↑ 250	mg/dl	80 - 150

#### Interpretation:-

The Glucose Fasting test is done in the morning after an 8 to 12 hour overnight fast whereas the Glucose Postprandial test is done after a period of 2 hours from the start of the last meal. A healthcare professional will draw a blood sample from a vein in the arm.

Glycosylated Hemoglobin HbA1C	↑	7.6	%	4.0 - 7.0
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#### Interpretation:-

**Management of Diabetes:** When using HbA1c assay, the ADA recommended goal for A1c control for adult diabetic patients in general is <7%. In diabetic patients who have experienced recent blood loss, hemolysis, or have elevated reticulocyte counts for other reasons, the HgBA1c level may be lowered and may not reflect actual glycemic control. In pregnant patients with diabetes, the ADA recommends aiming for the range < 6% if it can be achieved without excessive hypoglycemia.

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### BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
<b><u>Kidney / Renal Function Test</u></b>			
Blood Urea	30	mg/dl	13.0 - 45.0
Serum Creatinine	1.0	mg/dl	0.6 - 1.4
Serum Uric Acid	6.2	mg/dl	3.4 - 7.0
Sodium (Na)	139	mEq/L	136 - 143
Potassium (K)	3.9	mEq/L	3.5 - 5.6
Chloride (Cl)	97	mEq/L	97.0 - 108.0

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### BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
<b>Liver Function Test</b>			
Bilirubin Total	0.72	mg/dl	0.0 - 1.3
Bilirubin Direct (Conjugated)	0.24	mg/dl	0.0 - 0.60
Bilirubin Indirect (Un Conjugated)	0.48	mg/dl	0.0 - 0.90
Alanine Transaminase (ALT/SGPT)	36	U/L	0.0 - 40.0
Aspartate Transaminase (AST/SGOT)	32	IU/L	0.0 - 37.0
Alkaline Phosphatase	90	U/L	41 - 137
Total Protein	6.6	g/dl	6.0 - 8.3
albumin	4.0	gm/dl	3.5 - 5.0
Globulin	2.6	gm/dl	2.3 - 3.3
A:G Ratio	1.54		0.9 - 2.0

#### Interpretation:-

**Aspartate Aminotransferase (AST)** Aspartate Aminotransferase (AST) catalyses conversion of nitrogenous portion of amino acid, essential to energy production in Krebs cycle. AST is released into serum in proportion to cellular damage and most elevated in acute phase of cellular necrosis. Useful in the detection and differential diagnosis of hepatic disease.

**Alanine Aminotransferase (ALT)** Alanine Aminotransferase catalyses reversible amine group transfer in Krebs cycle. Unlike AST, it is mainly in liver cells and is a relatively specific indicator of Hepatocellular damage. It is released early in liver damage and remain elevated for weeks.

**Gamma Glutamyl Transferase (GGT)** Gamma Glutamyl Transferase (GGT) is associated with transfer of amino acids across cell membranes. GGT is most useful when looking for Hepatocellular damage. Increased production of GGT as ductal enzymosis, with increased enzymes produced in response to Hepatocellular damage.

**Total and Direct Bilirubin** determination in Serum in used for the diagnosis, differntiation and flow-up of Jaundice & assess liver function. Elevated Unconjugated Bilirubin occur in hemolytic jaundice. The Conjugated Bilirubin is predominatly increased in obstructive jaundice due to regurgitation. Hepatic jaundice is associated with increase in both conjugated and Unconjugated Bilirubin.

**Total Protein** is increased in hypergammaglobulinemias (monoclonal or polyclonal) and hypovolemic states. It is decreased in nutritional deciciency, severe liver damage. Increased loss in Renal, GI disease, severe skin disease and blood loss. Albumin levels generally parallel total protein levels.

The liver **Alkaline Phosphatase** is increased in biliary obstruction. ALP is involved in bone calcification. So elevated level indicate liver or bone diseases or Pregnancy.



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### BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
<b>LIPID PROFILE</b>			
Total Cholesterol	190	mg/dl	110 - 240
Serum Triglycerides	146	mg/dl	60 - 160
HDL Cholesterol	47.0	mg/dl	30 - 70
LDL Cholesterol	113.8	mg/dl	60 - 130
VLDL Cholesterol	29.2	mg/dl	5 - 40
Total : HDL Cholesterol Ratio	4.04	Ratio	

#### Interpretation:-

NLA - 2014 Recommendation	Total Cholesterol	Triglyceride	LDL Cholesterol	Non HDL Cholesterol	Total : HDL Ratio
Optimal / Low Risk	< 200	< 150	< 100	< 130	3.3 - 4.4
Above Optimal / Average Risk	-	-	100 - 129	130 - 159	4.5 - 7.1
Borderline High / Moderate Risk	200 - 239	150 - 199	130 - 159	160 - 189	7.2 - 11.0
High Risk	>=240	200 - 499	160 - 189	190 - 219	>11.0
Very High Risk	> 400	>=500	>=190	>=220	

- Note:** 1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogenic lipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants)along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL
3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
4. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.
5. A variety of genetic conditions are associated with accumulation in plasma of specific class of lipoprotein particles, are critical first step, as per Frederickson classification. It is important to consider & rule out secondary causes of hypertriglyceridemia (Obesity, Type 2 DM, Alcoholism, Renal failure, Cushing's syndrome etc.) before making the diagnosis of FHTG.

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### ELISA ASSEY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Prostate Specific Antigen Total	3.8	ng/ml	0.0 - 4.0
Serum Tri-Iodothyronine (T3)	0.6	ng/ml	0.50 - 2.00
Serum Thyroxine (T4)	5.0	µg/dl	4.5 - 11
Serum Thyroid Stimulating Hormon (TSH) ↑	7.3	µIU/ml	0.28 - 6.80

#### Interpretation:-

##### Wallach's reference range for Thyroid for Male & Non Pregnant

Age	TSH (µIU/ml)		T4(µg/dl)		T3(ng/ml)	
	From	To	From	To	From	To
1-4 Days*	1.0	39.0	11.08	21.61	0.97	7.42
1-4 Weeks	1.7	9.1	8.29	17.24	1.04	3.45
1-12 Months	0.8	8.2	5.93	16.38	1.04	2.47
1-5 Years	0.7	5.7	7.33	15.04	1.04	2.66
6-10 Years	0.7	5.7	6.40	13.33	0.91	2.40
11-15 Years	0.7	5.7	5.54	11.78	0.84	2.14
15-18 Years	0.7	5.7	4.21	11.86	0.78	2.0

##### Wallach's reference range for Thyroid for Pregnant Female

Pregnancy	TSH		T4		T3	
	From	To	From	To	From	To
1 <sup>st</sup> Trimester	0.3	4.5	0.81	1.90	7.80	14.77
2 <sup>nd</sup> Trimester	0.5	4.6	1.00	2.60	7.14	19.58
3 <sup>rd</sup> Trimester	0.8	5.2	1.00	2.60	8.32	17.02

The **Tri-Iodothyronine (T3)** level may be elevated in the < 5% of hyperthyroid patients in whom the FT4 level is normal (T3 toxicosis). Measurement of T3 is of no value in the diagnosis of hypothyroidism. Total T3 can be affected by changes in thyroid binding protein levels. Measurements of Free T3 better reflect biologically active hormone levels than measurements of total T3.

**Thyroxine (T4)** is the major secretory hormone of the thyroid. Only 0.03% of T4 is unbound and free for exchange with tissues. Thyroid function may be assessed with thyroid stimulating hormone (TSH) and free T4 measured. Although free T4 is generally preferred over total T4 when monitoring thyroid function, the total T4 measurement may be preferred for monitoring of pregnant patients where total T4 reference ranges are available. The total T4 concentrations tend to be stable throughout pregnancy at 150% of the values in non-pregnant subjects and can be useful when the levels are evaluated according to pregnancy specific total T4 reference ranges which are approx. 1.5 times greater than non-pregnant ranges.

**Thyroid Stimulating Hormon (TSH)** is primarily responsible for the synthesis and release of Thyroid hormones is an early and sensitive indicator of decrease in Thyroid reserve is the diagnostic of primaryhypothyroidism. The expeted increase in TSH demonstrates the classical feedback mechanism between pituitary and thyroid gland. Additionally TSH measurement is equally important in differntiating secondary and tertiary (hypothalamic) hypothyroidism. The increase in total T4 and T3 is associated with pregnancy, oral contraceptive and estrogen therapy results into masking of abnormal thyroid function only because of alteration of TBG Concentration, Which can be monitored by Calculating Free Thyroxine Index (FTI) or Thyroid Hormone Binding Ratio (THBR).

- TSH stimulates the thyroid gland to produce the main thyroid hormones T3 and T4.
- In cases of hyperthyroidism TSH level is severely inhibited and may even be undetectable.
- In rare forms of high-origin hyperthyroidism, the TSH level is not reduced, since the NFB control of the thyroid hormones has no effect.
- In cases of primary hypothyroidism, TSH levels are always much higher than normal and thyroid hormone levels are low.
- The TSH assay aids in diagnosing thyroid or hypophysial disorders.
- The T4 assay aids in assessing thyroid function, which is characterized by a decrease in thyroxine levels and an increase in patients with hyperthyroidism.
- The T3 plays an important part in maintaining euthyroidism.
- TSH, T4 & T3 determination may be associated with other tests such as FT4 & FT3 assay, as well as with the clinical examination of the

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### URINE EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Urine Sugar Fasting	Nil		
Urine Sugar Post Prandial (PP)	Present (+++)		



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**RAMSA**  
MEDICAL HEALTH CARE

DR. AMIT SINHA  
B.D.S., M.D.S (DENTAL)  
Reg. No : BCMR-6242/A

Name :- Priya Kumar  
Age :- 49 Gender :- M

Date :- 9/3/20  
Bill No. :- .....

Advz

- uls healing to be done
- Hemorrhoid m/w count  
twice a day for  
15 days.

ofc

- loss of tooth  
structure over  
406
- Generalised  
Hem + calculus  
with Grade III



Dr. Amit Sinha  
B.D.S., M.D.S  
Reg. No.: 6242/A

Amit Sinha  
Signature

फीस 15 दिनों के लिए मान्य है, 15 दिन बाद फीस पुनः लगेगी।

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# RAM SA MEDICAL HEALTHCARE

Patient Name: Mr. SHIVA KUMAR 49/M

Resting ECG Report

March 09, 2025  
Time: 09:08:00

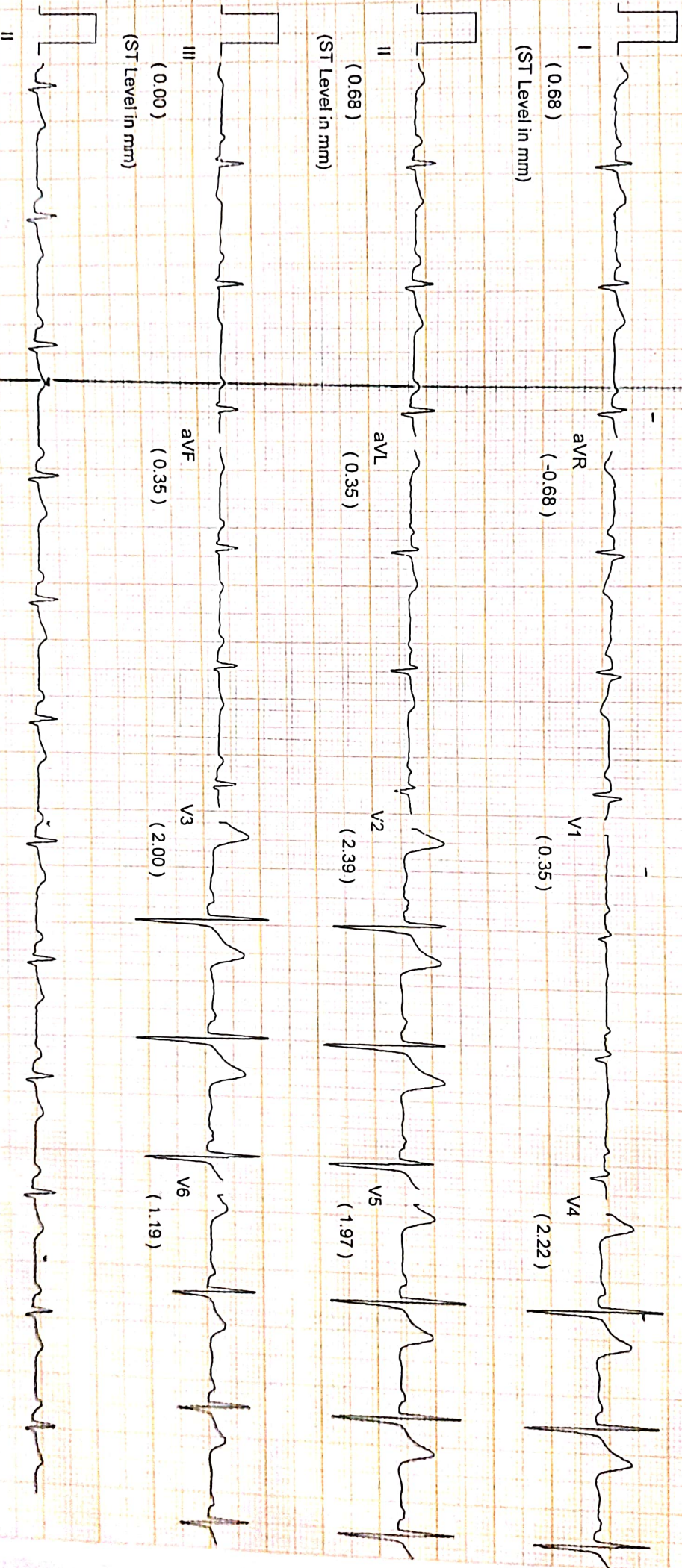
QT / QTc: 0.228 / 0.248 Sec  
P-QRS-T Axis (56) (-138) (-93) deg

PR Interval: 0.11 sec  
QRS Duration: 0.124 Sec

RR Interval: 0.80 sec

HR : 75 bpm

BP : 0 / 0 mmHg



Comments :-  
Sinus bradycardia  
Otherwise Normal ECG



**Dr. Sanjay Kishore**

MBBS, MD (Medicine)

Reg. No. 22849

DR

MBBS MD

1 Omprasti, 25m/15k, NASAN (C) Simul Q BL 4 3/72 19