CHANDAN DIAGNOSTIC CENTRE

Add: 49/19-B, Kamla Nehru Road, Katra, Prayagraj
Ph: 9235447965,0532-3559261
CIN: U85110UP2003PLC193493

Patient Name	: Mr.DIPAK KAMTI	Registered On	: 11/Mar/2025 10:16:25
Age/Gender	: 34 Y 0 M 6 D /M	Collected	: 11/Mar/2025 10:43:23
UHID/MR NO	: ALDP.0000162667	Received	: 11/Mar/2025 11:05:25
Visit ID	: ALDP0463672425	Reported	: 11/Mar/2025 12:02:16
Ref Doctor	: Dr. MEDIWHEEL-ARCOFEMI HEALTH CARE LTD -	Status	: Final Report

DEPARTMENT OF HAEMATOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Blood Group (ABO & Rh typing) , *Blood*				
Blood Group	B			ERYTHROCYTE MAGNETIZED TECHNOLOGY / TUBE AGGLUTINA
Rh (Anti-D)	POSITIVE			ERYTHROCYTE MAGNETIZED TECHNOLOGY / TUBE AGGLUTINA
Complete Blood Count (CBC) , *EDTA Whole Blood*				
Haemoglobin	14.10	g/dl	1 Day- 14.5-22.5 g/dl 1 Wk- 13.5-19.5 g/dl 1 Mo- 10.0-18.0 g/dl 3-6 Mo- 9.5-13.5 g/dl 0.5-2 Yr- 10.5-13.5 g/dl 2-6 Yr- 11.5-15.5 g/dl 6-12 Yr- 11.5-15.5 g/dl 12-18 Yr 13.0-16.0 g/dl Male- 13.5-17.5 g/dl Female- 12.0-15.5 g/dl	COLORIMETRIC METHOD (CYANIDE-FREE REAGENT)
TLC (WBC)	8,300.00	/Cu mm	4000-10000	IMPEDANCE METHOD
DLC				
Polymorphs (Neutrophils)	64.00	%	40-80	FLOW CYTOMETRY
Lymphocytes	28.00	%	20-40	FLOW CYTOMETRY
Monocytes	4.00	%	2-10	FLOW CYTOMETRY
Eosinophils	4.00	%	1-6	FLOW CYTOMETRY
Basophils	0.00	%	< 1-2	FLOW CYTOMETRY
ESR				
Observed	6.00	MM/1H	10-19 Yr 8.0 20-29 Yr 10.8 30-39 Yr 10.4 40-49 Yr 13.6 50-59 Yr 14.2 60-69 Yr 16.0 70-79 Yr 16.5 80-91 Yr 15.8	

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DEPARTMENT OF HAEMATOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
			Pregnancy Early gestation - 48 (62 if anaemic) Leter gestation - 70 (95 if anaemic)	
Corrected	-	Mm for 1st hr.	<9	
PCV (HCT)	44.00	%	40-54	CALCULATED
Platelet count				
Platelet Count	1.80	LACS/cu mm	1.5-4.0	ELECTRONIC IMPEDANCE/MICROSCOPIC
PDW (Platelet Distribution width)	16.50	fL	9-17	ELECTRONIC IMPEDANCE
P-LCR (Platelet Large Cell Ratio)	-	%	35-60	ELECTRONIC IMPEDANCE
PCT (Platelet Hematocrit)	0.23	%	0.108-0.282	ELECTRONIC IMPEDANCE
MPV (Mean Platelet Volume)	**12.80**	fL	6.5-12.0	ELECTRONIC IMPEDANCE
RBC Count				
RBC Count	5.06	Mill./cu mm	4.2-5.5	ELECTRONIC IMPEDANCE
Blood Indices (MCV, MCH, MCHC)				
MCV	88.80	fl	80-100	CALCULATED PARAMETER
MCH	27.80	pg	27-32	CALCULATED PARAMETER
MCHC	31.30	%	30-38	CALCULATED PARAMETER
RDW-CV	14.50	%	11-16	ELECTRONIC IMPEDANCE
RDW-SD	48.50	fL	35-60	ELECTRONIC IMPEDANCE
Absolute Neutrophils Count	5,312.00	/cu mm	3000-7000	
Absolute Eosinophils Count (AEC)	332.00	/cu mm	40-440	

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
GLUCOSE FASTING , *Plasma*				
Glucose Fasting	101.70	mg/dl	< 100 Normal 100-125 Pre-diabetes ≥ 126 Diabetes	GOD POD

Interpretation:

a) Kindly correlate clinically with intake of hypoglycemic agents, drug dosage variations and other drug interactions.
b) A negative test result only shows that the person does not have diabetes at the time of testing. It does not mean that the person will never get diabetics in future, which is why an Annual Health Check up is essential.
c) I.G.T = Impaired Glucose Tolerance.

CLINICAL SIGNIFICANCE:- Glucose is the major source of energy in the body . Lack of insulin or resistance to it section at the cellular level causes diabetes. Therefore, the blood glucose levels are very high. Elevated serum glucose levels are observed in diabetes mellitus and may be associated with pancreatitis, pituitary or thyroid dysfunction and liver disease. Hypoglycaemia occurs most frequently due to over dosage of insulin.

GLYCOSYLATED HAEMOGLOBIN (HBA1C) , *EDTA Whole Blood*			
Glycosylated Haemoglobin (HbA1c)	5.00	% NGSP	HPLC (NGSP)
Glycosylated Haemoglobin (HbA1c)	31.60	mmol/mol/IFCC	
Estimated Average Glucose (eAG)	98	mg/dl	

Interpretation:

NOTE:-

- eAG is directly related to A1c.
- An A1c of 7% -the goal for most people with diabetes-is the equivalent of an eAG of 154 mg/dl.
- eAG may help facilitate a better understanding of actual daily control helping you and your health care provider to make necessary changes to your diet and physical activity to improve overall diabetes mnagement.

The following ranges may be used for interpretation of results. However, factors such as duration of diabetes, adherence to therapy and the age of the patient should also be considered in assessing the degree of blood glucose control.

Haemoglobin A1C (%)NGSP	mmol/mol / IFCC Unit	eAG (mg/dl)	Degree of Glucose Control Unit
> 8	>63.9	>183	Action Suggested*
7-8	53.0 -63.9	154-183	Fair Control

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
< 7	<63.9	<154	Goal**	
6-7	42.1 -63.9	126-154	Near-normal glycemia	
< 6%	<42.1	<126	Non-diabetic level	

*High risk of developing long term complications such as Retinopathy, Nephropathy, Neuropathy, Cardiopathy, etc.
**Some danger of hypoglycemic reaction in Type 1diabetics. Some glucose intolerant individuals and "subclinical" diabetics may demonstrate HbA1C levels in this area.
N.B. : Test carried out on Automated G8 90 SL TOSOH HPLC Analyser.

Clinical Implications:
*Values are frequently increased in persons with poorly controlled or newly diagnosed diabetes.
*With optimal control, the HbA 1c moves toward normal levels.
*A diabetic patient who recently comes under good control may still show higher concentrations of glycosylated hemoglobin. This level declines gradually over several months as nearly normal glycosylated *Increases in glycosylated hemoglobin occur in the following non-diabetic conditions: a. Iron-deficiency anemia b. Splenectomy c. Alcohol toxicity d. Lead toxicity
*Decreases in A 1c occur in the following non-diabetic conditions: a. Hemolytic anemia b. chronic blood loss
*Pregnancy d. chronic renal failure. Interfering Factors:
*Presence of Hb F and H causes falsely elevated values. 2. Presence of Hb S, C, E, D, G, and Lepore (autosomal recessive mutation resulting in a hemoglobinopathy) causes falsely decreased values.

BUN (Blood Urea Nitrogen) *Sample:Serum*	9.67	mg/dL	7.0-23.0	CALCULATED

Interpretation:
Note: Elevated BUN levels can be seen in the following:

High-protein diet, Dehydration, Aging, Certain medications, Burns, Gastrointestimal (GI) bleeding.

Low BUN levels can be seen in the following:

Low-protein diet, overhydration, Liver disease.

Creatinine *Sample:Serum*	0.95	mg/dL	Male 0.7-1.3 Newborn 0.3-1.0 Infent 0.2-0.4 Child 0.3-0.7 Adolescent 0.5- 1.0	MODIFIED JAFFES

Interpretation:

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MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method

The significance of single creatinine value must be interpreted in light of the patients muscle mass. A patient with a greater muscle mass will have a higher creatinine concentration. The trend of serum creatinine concentrations over time is more important than absolute creatinine concentration. Serum creatinine concentrations may increase when an ACE inhibitor (ACE) is taken. The assay could be affected mildly and may result in anomalous values if serum samples have heterophilic antibodies, hemolyzed, icteric or lipemic.

Uric Acid *Sample:Serum*	7.09	mg/dL	3.5-7.2	URICASE

Interpretation:
Note:-
Elevated uric acid levels can be seen in the following:

Drugs, Diet (high-protein diet, alcohol), Chronic kidney disease, Hypertension, Obesity.

LFT (WITH GAMMA GT) , *Serum*

SGOT / Aspartate Aminotransferase (AST)	**65.00**	U/L	< 35	IFCC WITHOUT P5P
SGPT / Alanine Aminotransferase (ALT)	**120.50**	U/L	< 45	IFCC WITHOUT P5P
Gamma GT (GGT)	**69.90**	U/L	0-55	IFCC, KINETIC
Protein	6.74	g/dL	6.2-8.0	BIURET
Albumin	4.41	g/dL	3.4-5.4	B.C.G.
Globulin	2.33	gm/dL	1.8-3.6	CALCULATED
A:G Ratio	1.89		1.1-2.0	CALCULATED
Alkaline Phosphatase (Total)	57.52	U/L	53-128	IFCC AMP KINETIC
Bilirubin (Total)	0.69	mg/dL	Adult 0-2.0	DIAZO
Bilirubin (Direct)	**0.23**	mg/dL	< 0.20	DIAZO
Bilirubin (Indirect)	0.46	mg/dL	< 1.8	CALCULATED

Result Rechecked

LIPID PROFILE , *Serum*

Cholesterol (Total)	203.00	mg/dL	<200 Desirable 200-239 Borderline High > 240 High	CHOD-PAP
HDL Cholesterol (Good Cholesterol)	**33.70**	mg/dL	35.0-79.5	DIRECT ENZYMATIC

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Non-HDL Cholesterol	**169.30**	mg/dl	0-130	CALCULATED
LDL Cholesterol (Bad Cholesterol)	129	mg/dL	< 100 Optimal 100-129 Nr. Optimal/Above Optimal 130-159 Borderline High 160-189 High > 190 Very High	CALCULATED
VLDL	**40.02**	mg/dL	10-33	CALCULATED
TC / HDL Cholesterol Ratio	**6.02**		3-5	CALCULATED
LDL / HDL Ratio	**3.84**		< 3.0	CALCULATED
Triglycerides	**200.10**	mg/dL	< 150 Normal 150-199 Borderline High 200-499 High >500 Very High	GPO-PAP

Result Rechecked

Interpretation:

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. Lipid Association of India (LAI) recommends screening of all adults above the age of 20 years for Atherosclerotic Cardiovascular Disease (ASCVD) risk factors especially lipid profile. This should be done earlier if there is family history of premature heart disease, dyslipidemia, obesity or other risk factors
3. Triglycerides levels >150 mg/dL in fasting or >175 mg/dL in non-fasting are considered risk modifier for ASCVD risk

Treatment Goals for Lipid lowering therapy (as per Lipid Association of India 2023)

ASCVD RISK CATEGORY	TREATMENT GOAL	
	LDL-C in mg/dL (Primary target)	NON HDL-C in mg/dL (Co-Primary target)
Low	<100	<130
Moderate	<100	<130

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name		Result	Unit	Bio. Ref. Interval	Method
High	<70	<100			
Very High	<50	<80			
Extreme (A)	<50 Optional)	(<30 <80	(< 60 optional)		
Extreme (B)	<30	<60			

ASCVD Risk Stratification & Treatment goals in Indian population

Indians are at very high risk of developing ASCVD, they usually get the disease at an early age, have a more severe form of the disease and have poorer outcome as compared to the western populations. Many individuals remain asymptomatic before they get heart attack, ASCVD risk helps to identify high risk individuals even when there is no symptom related to heart disease. Risk stratification is important to guide lipid lowering therapy and to identify treatment goals.
CSI Clinical Practice guidelines (2024) recommends in the absence of formal risk calculator for Indian population, only risk factors can be used for risk assessment. Standard Risk factors are:

1. Smoking/tobacco use
2. Hypertension
3. Diabetes
4. Family h/o Premature CAD (Men <55 years and women <60 years

Risk Assessment*

Low	Moderate Risk	High Risk	Very High Risk	Extremely High Risk
		Presence of 2 or more standard factors with no manifest ASCVD	ASCVD-CAD/PVD/CeVD	ASCVD with recurrent vascular events
		DM with 1 or more risk factor	Imaging->50%lesion in any two major vessels	ASCVD with HeFH & High Lp(a)
No standard risk factor	Presence of any one standard risk factor	Heterozygous Familial Hypercholesterole- mia (HeFH) with no risk factor	DM>20 years or multiple risk factors, TOD	
		Hypertension with one or more risk factor or with Target organ damage (TOD)	HeFH-with ASCVD or RF	

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
	CKD- eGFR 30-59 ml/min	CKD-eGFR <30 ml/min		

* A more formal risk assessment may be used by clinicians according to their personal preferences and familiarity with the risk scores.

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UHID/MR NO	: ALDP.0000162667	Received	: 11/Mar/2025 12:51:39
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DEPARTMENT OF CLINICAL PATHOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
URINE EXAMINATION, ROUTINE , *Urine*				
Color	PALE YELLOW		Pale Yellow	VISUAL EXAMINATION
Specific Gravity	1.010		1.001-1.030	PRE-TREATED POLYMERIC ION EXCHANGE RESIN
Reaction PH	Acidic (6.0)		5.0-8.0	METHYL RED BROMOTHYMOLBLUE
Appearance	CLEAR			
Protein	PRESENT (+)	mg %	< 10 Absent 10-40 (+) 40-200 (++) 200-500 (+++) > 500 (++++)	TETRA BROMOPHENOL BLUE METHYLRED
Sugar	ABSENT	gms%	< 0.5 (+) 0.5-1.0 (++) 1-2 (+++) > 2 (++++)	GLUCOSE OXIDASE PEROXIDASE CHROMOGEN REACTION
Ketone	ABSENT	mg/dl	Serum-0.1-3.0 Urine-0.0-14.0	SODIUM NITROPRUSSIDE
Bile Salts	ABSENT		ABSENT	SULPHUR GRANULE
Bile Pigments	ABSENT		ABSENT	FOUCHET TEST
Bilirubin	ABSENT		ABSENT	DIAZONIUM SALT
Leucocyte Esterase	ABSENT		ABSENT	CARBOXYLIC ACID ESTER DIAZONIUM SALT
Urobilinogen(1:20 dilution)	ABSENT		ABSENT	DIAZONIUM SALT
Nitrite	ABSENT		ABSENT	SULFANANIC ACID TETRAHYDRO BENZOL
Blood	ABSENT		ABSENT	TETRA METHYL BENZIDINE
Microscopic Examination:				
Epithelial cells	0-1/h.p.f	cells/hpf	0.0-5.0	MICROSCOPIC EXAMINATION
Pus cells	0-1/h.p.f	WBC/hpf	0.0-5.0	MICROSCOPIC
RBCs	ABSENT	RBC/hpf	0.0-2.0	MICROSCOPY
Cast	ABSENT		ABSENT	MICROSCOPY

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DEPARTMENT OF CLINICAL PATHOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Crystals	ABSENT		ABSENT	MICROSCOPY
Others	ABSENT			

Urine Microscopy is done on centrifuged urine sediment.

SUGAR, FASTING STAGE , *Urine*

Sugar, Fasting stage	ABSENT	gms%	

Interpretation:

(+) < 0.5
(++) 0.5-1.0
(+++) 1-2
(++++) > 2

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DEPARTMENT OF IMMUNOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
PSA (Prostate Specific Antigen), Total *Sample:Serum*	0.37	ng/mL	<4.1	CLIA

Interpretation:

1. PSA is detected in the serum of males with normal, benign hypertrophic, and malignant prostate tissue.
2. Measurement of serum PSA levels is not recommended as a screening procedure for the diagnosis of cancer because elevated PSA levels also are observed in patients with benign prostatic hypertrophy. However, studies suggest that the measurement of PSA in conjunction with digital rectal examination (DRE) and ultrasound provide a better method of detecting prostate cancer than DRE alone.
3. PSA levels increase in men with cancer of the prostate, and after radical prostatectomy PSA levels routinely fall to the undetectable range.
4. If prostatic tissue remains after surgery or metastasis has occurred, PSA appears to be useful in detecting residual and early recurrence of tumor.
5. Therefore, serial PSA levels can help determine the success of prostatectomy, and the need for further treatment, such as radiation, endocrine or chemotherapy, and in the monitoring of the effectiveness of therapy.

THYROID PROFILE - TOTAL , *Serum*

T3, Total (tri-iodothyronine)	135.00	ng/dl	84.61–201.7	CLIA
T4, Total (Thyroxine)	6.89	ug/dl	3.2-12.6	CLIA
TSH (Thyroid Stimulating Hormone)	1.950	µIU/mL	0.4 - 4.5	CLIA

Interpretation:

0.7-27	µIU/mL	Premature	28-36 Week
2.3-13.2	µIU/mL	Cord Blood	> 37Week
1.0-39.0	µIU/mL	Child	Birth 4 Days
1.7-9.1	µIU/mL	Child	2-20 Week
0.7-6.4	µIU/mL	Child (21 wk - 20 Yrs.)	
0.4-4.5	µIU/mL	Adults	21-54 Years
0.4-4.5	µIU/mL	Adults	55-87 Years

Pregnancy

0.3-4.5	µIU/mL	First trimester
0.5-4.6	µIU/mL	Second trimester
0.8-5.2	µIU/mL	Third trimester

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DEPARTMENT OF IMMUNOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Whole blood heel puncture				
	<20.0	µIU/mL	Newborn screen	

1) Patients having low T3 and T4 levels but high TSH levels suffer from primary hypothyroidism, cretinism, juvenile myxedema or autoimmune disorders.

2) Patients having high T3 and T4 levels but low TSH levels suffer from Grave's disease, toxic adenoma or sub-acute thyroiditis.

3) Patients having either low or normal T3 and T4 levels but low TSH values suffer from iodine deficiency or secondary hypothyroidism.

4) Patients having high T3 and T4 levels but normal TSH levels may suffer from toxic multinodular goiter. This condition is mostly a symptomatic and may cause transient hyperthyroidism but no persistent symptoms.

5) Patients with high or normal T3 and T4 levels and low or normal TSH levels suffer either from T3 toxicosis or T4 toxicosis respectively.

6) In patients with non thyroidal illness abnormal test results are not necessarily indicative of thyroidism but may be due to adaptation to the catabolic state and may revert to normal when the patient recovers.

7) There are many drugs for eg. Glucocorticoids, Dopamine, Lithium, Iodides, Oral radiographic dyes, etc. which may affect the thyroid function tests.

8) Generally when total T3 and total T4 results are indecisive then Free T3 and Free T4 tests are recommended for further confirmation along with TSH levels.

Note :-

TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.

Dr.Akanksha Singh (MD Pathology)

CHANDAN DIAGNOSTIC CENTRE

Add: 49/19-B, Kamla Nehru Road, Katra, Prayagraj
Ph: 9235447965,0532-3559261
CIN: U85110UP2003PLC193493

Patient Name	: Mr.DIPAK KAMTI	Registered On	: 11/Mar/2025 10:16:28
Age/Gender	: 34 Y 0 M 6 D /M	Collected	: 2025-03-11 10:33:10
UHID/MR NO	: ALDP.0000162667	Received	: 2025-03-11 10:33:10
Visit ID	: ALDP0463672425	Reported	: 11/Mar/2025 14:04:09
Ref Doctor	: Dr. MEDIWHEEL-ARCOFEMI HEALTH CARE LTD -	Status	: Final Report

DEPARTMENT OF X-RAY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

X-RAY DIGITAL CHEST PA

X-RAY REPORT

(300 mA COMPUTERISED UNIT SPOT FILM DEVICE)

CHEST P-A VIEW

- Both lung field did not reveal any significant lesion.
- Costo-phrenic angles are bilaterally clear.
- Trachea is central in position.
- Cardiac size & contours are normal.
- Hilar shadows are normal.
- Soft tissue shadow appears normal.
- Bony cage is normal.

Please correlare clinically.

Dr. Shashikant MBBS,MD (Radiodiagnosis)

CHANDAN DIAGNOSTIC CENTRE

Add: 49/19-B, Kamla Nehru Road, Katra, Prayagraj
Ph: 9235447965,0532-3559261
CIN: U85110UP2003PLC193493

Patient Name	: Mr.DIPAK KAMTI	Registered On	: 11/Mar/2025 10:16:28
Age/Gender	: 34 Y 0 M 6 D /M	Collected	: 2025-03-11 11:40:25
UHID/MR NO	: ALDP.0000162667	Received	: 2025-03-11 11:40:25
Visit ID	: ALDP0463672425	Reported	: 11/Mar/2025 11:43:13
Ref Doctor	: Dr. MEDIWHEEL-ARCOFEMI HEALTH CARE LTD -	Status	: Final Report

DEPARTMENT OF ULTRASOUND

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

ULTRASOUND WHOLE ABDOMEN (UPPER & LOWER)

LIVER: - **Enlarged in size (15.9 cm), shape and raised echogenicity.** No focal lesion is seen. No intra hepatic biliary radicle dilation is seen.

GALL BLADDER :- Well distended. Normal wall thickness is seen. No evidence of calculus/focal mass lesion/pericholecystic fluid is seen.

CBD :- Normal in calibre at porta.

PORTAL VEIN: - Normal in calibre and colour uptake at porta.

PANCREAS: - Head is visualised, normal in size & echopattern. No evidence of ductal dilatation or calcification is seen. Rest of the pancreas is obscured by bowel gases.

SPLEEN: - Normal in size, shape and echogenicity. No evidence of mass lesion is seen.

BOTH KIDNEYS: - Normal in size, shape and position. Cortical echogenicity is normal with maintained corticomedullary differentiation. No focal lesion or calculus is seen. Pelvicalyceal system is not dilated.

URINARY BLADDER :- Is adequately distended. No evidence of wall thickening/calculus is seen.

PROSTATE :- Normal in size, shape and echo pattern.

HIGH RESOLUTION :- No evidence of bowel loop dilatation or abnormal wall thickening is seen. No significant retroperitoneal lymphadenopathy is seen.

IMPRESSION : Hepatomegaly with grade II fatty changes in liver.

Please correlate clinically.

***** End Of Report *****

Result/s to Follow:
STOOL, ROUTINE EXAMINATION, GLUCOSE PP, SUGAR, PP STAGE, ECG / EKG, Tread Mill Test (TMT)

Dr. Shashikant MBBS,MD (Radiodiagnosis)