MC-2176

Suraksha DIAGNOSTICS

Lab No.	: SG2/25-03-2023/SR7449827	**Lab Add.**	: Sevoke Road,Siliguri 734001
Patient Name	: **SOUMYAPRATIM RAY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 7 M 25 D	**Collection Date:**	25/Mar/2023 09:34AM
Gender	: M	**Report Date**	: 25/Mar/2023 02:24PM

Test Name	Result	Unit	Bio Ref. Interval	Method
ALKALINE PHOSPHATASE , *GEL SERUM*				
ALKALINE PHOSPHATASE	99	U/L	46 - 116 U/L	P-NPP,AMP BUFFER
BILIRUBIN (TOTAL) , *GEL SERUM*				
BILIRUBIN (TOTAL)	1.01	mg/dL	0.2 - 1.2 mg/dL	DIAZONIUM ION
SGPT/ALT , *GEL SERUM*				
SGPT/ALT	**85**	U/L	16 - 63 U/L	UV WITH P5P
***POTASSIUM, BLOOD ,** *GEL SERUM*				
POTASSIUM,BLOOD	4.50	mEq/L	3.5 - 5.1 mEq/L	ISE INDIRECT
***CHLORIDE, BLOOD ,** .				
CHLORIDE,BLOOD	98	mEq/L	98 - 107 mEq/L	ISE INDIRECT
CREATININE, BLOOD , *GEL SERUM*	1.06	mg/dl	0.70 - 1.30 mg/dl	ALKALINE PICRATE
GLUCOSE, FASTING , *BLOOD, NAF PLASMA*				
GLUCOSE,FASTING	97	mg/dl	70 - 100 mg/dL	Hexokinase Method
CALCIUM, BLOOD				
CALCIUM,BLOOD	9.12	mg/L	8.6-10.0 mg/dl	OCPC
TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .				
TOTAL PROTEIN	7.32	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN	4.3	g/dl	3.4 - 5.0 g/dl	BCP
GLOBULIN	3.01	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.43		1.0 - 2.5	Calculated
GLUCOSE, PP , *BLOOD, NAF PLASMA*				
GLUCOSE,PP	**149**	mg/dl	75-140	Hexokinase Method
THYROID PANEL (T3, T4, TSH) , *GEL SERUM*				
T3-TOTAL (TRI IODOTHYRONINE)	0.97	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	5.7	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	1.56	µIU/mL	0.55-4.78 µIU/mL	CLIA

BIOLOGICAL REFERENCE INTERVAL : *[ONLY FOR PREGNANT MOTHERS]*

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER : 0.10 2.50 µ IU/mL
SECOND TRIMESTER :0.20 3.00 µ IU/mL
THIRD TRIMESTER :0.30 3.00 µ IU/mL

References :

1.*Indian Thyroid Society guidelines for management of thyroid dysfunction during pregnancy. Clinical Practice Guidelines, New Delhi: Elsevier; 2012.*

2.Stagnaro-Green A, Abalovich M, Alexander E, Azizi F, Mestman J, Negro R, et al. Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum. Thyroid 2011;21:1081-25.

3.Dave A, Maru L, Tripathi M. Importance of Universal screening for thyroid disorders in first trimester of pregnancy. Indian J Endocr Metab [serial online] 2014 [cited 2014 Sep 25];18:735-8. Available from: http://www.ijem.in/text.asp? 2014/18/5/735/139221.

LIPID PROFILE , *GEL SERUM*

CHOLESTEROL-TOTAL	**212**	mg/dl	Desirable: < 200 mg/dL Borderline high: 200-239 High: > or =240 mg/dL	CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE
TRIGLYCERIDES	**239**	mg/dl	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	ENZYMATIC, END POINT
HDL CHOLESTEROL	**34**	mg/dl	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	DIRECT MEASURE-PEG
LDL CHOLESTEROL DIRECT	**130**	mg/dl	OPTIMAL : <100 mg/dL, Near optimal/ above optimal : 100-129 mg/dL, Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	DIRECT MEASURE
VLDL	**48**	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	**6.2**		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated

NOTE : Elevated Triglyceride value is to be interpreted in the light of previous 72 hrs dietary intake of lipids.Repeat estimation with 72 hrs fat restricted diet followed by 12 hrs fasting, suggested for better evaluation .

PHOSPHORUS-INORGANIC, BLOOD , *GEL SERUM*

PHOSPHORUS-INORGANIC,BLOOD	3.8	mg/dl	2.5-4.5 mg/dl	UV PHOSPHOMOLYBDATE

***SODIUM, BLOOD ,** *GEL SERUM*

SODIUM,BLOOD	138	mEq/L	136 - 145 mEq/L	ISE INDIRECT

***GLYCATED HAEMOGLOBIN (HBA1C) ,** *EDTA WHOLE BLOOD*

GLYCATED HEMOGLOBIN (HBA1C)	5.3	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	35.0	mmol/mol		HPLC

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:
Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad-VARIANT TURBO 2.0, Bio-Rad D 10
Method : HPLC Cation Exchange
HbA1C : DUAL REPORTING OF UNITS [Ref 2,3,4]
Suraksha Diagnostic Pvt. Ltd. has commenced reporting HbA1c in dual units. This is in keeping with current International recommendations to allow a transition phase from

current reporting units (%) to the eventual (IFCC) units (mmol/mol). It is anticipated that only IFCC units will be used after 2 years of dual reporting. Please note that the method of analysis has not changed. Although the two results look numerically different, they are clinically equivalent. In defining HbA1C, the unit mmol /mol was determined to be the most accurate description of what is being measured. This will make the measurement more precise and allow for better comparisons of HbA1c results from different laboratories and hospitals throughout the world.

Standardization & traceability [Ref 2,3,4]
HbA1c is standardized & traceable to IFCC methods HPLC-CE & HPLC-MS. This new unit (mmol/mol) is used as part of this standardization. This change in HbA1c calibration is to conform to national & international best practice. The initiative will mean that HbA1c is measured specifically & reproducibly. It also enables the use of international reference ranges & harmonization of medical decision or target values.

Recommendations for glycemic targets [Ref 1]
Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
Ø The timing and frequency of SMBG should be tailored based on patients individual treatment, needs, and goals.
Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
Ø If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.
Ø **For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.**
Ø Some patients may benefit from HbA1c goals that are more or less stringent.

Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B_{12}/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.

Reference: Glycated hemoglobin monitoring BMJ 2006; 333;586-8

References:
1. *Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.*
2. *Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.*
3. *Geistanger A, Arends S, Berding C, Hoshino T, Jeppsson J-O, Little R, Siebelder C and Weykamp C, on behalf of the IFCC Working Group on Standardization of HbA1c: Statistical Methods for Monitoring the Relationship between the IFCC Reference Measurement Procedure for Hemoglobin A1c ..Clin Chem 2008; 54(8): 1379-8.*
4. *International Expert Committee Report, drawn from the International Diabetes Federation (IDF), the European Association for the Study of Diabetes (EASD),American Diabetes Association (ADA), International Federation of Clinical Chemistry and Laboratory Medicine, International Society for Pediatric & Adolescent Diabetes. International Congress - IFCC, WorldLab, EuroMedLab- Berlin,2011.*

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemic targets

Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
Ø If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.
Ø **For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.**
Ø Some patients may benefit from HbA1c goals that are stringent.

Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B_{12}/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.

Reference: Glycated hemoglobin monitoring BMJ 2006; 333;586-8

References:
1. *Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.*
2. *Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.*

Lab No. : SR7449827	Name : SOUMYAPRATIM RAY		Age/G : 29 Y 7 M 25 D / M	Date : 25-03-2023
SGOT/AST , *GEL SERUM*				
SGOT/AST	**41**	U/L	15 - 37 U/L	UV WITH P5P
BILIRUBIN (DIRECT) , *GEL SERUM*				
BILIRUBIN (DIRECT)	0.16	mg/dL	< 0.2 mg/dl	DIAZOTIZATION
UREA,BLOOD	21.0	mg/dl	12.8-42.8 mg/dl	UREASE-COLORIMETRIC
URIC ACID, BLOOD , *GEL SERUM*				
URIC ACID,BLOOD	6.28	mg/dl	3.5 -- 7.2 mg/dl	URICASE ,COLORICMETRIC

DR. SANJAY KR. AGARWALA
MD CONSULTANT BIOCHEMIST

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

Lab No. : SR7449827	Name : SOUMYAPRATIM RAY	Age/G : 29 Y 7 M 25 D / M	Date : 27-03-2023

URIC ACID, URINE, SPOT URINE

URIC ACID, SPOT URINE	**8.90**	mg/dL	37-92 mg/dL	URICASE

ESTIMATED TWICE

DR. ANANNYA GHOSH
MBBS, MD (Biochemistry)
Consultant Biochemist

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

Lab No. : SR7449827 **Name : SOUMYAPRATIM RAY** **Age/G : 29 Y 7 M 25 D / M** **Date : 25-03-2023**

BLOOD GROUP ABO+RH [GEL METHOD] , *EDTA WHOLE BLOOD*

ABO	B	Gel Card
RH	POSITIVE	Gel Card

Gel technology Dia Med ID Micro typing system is the latest technology in transfusion Medicine.
It gives more reproducible and standardized test results.
It more repaid, reliable, very sensitive and objective , and hence more consistent and comparable results are obtained.
Single used cards are individualised for every patient and results can be photographed / scanned and stored for future use.
Special instruments that are used only for this technology also reduce risk of any contamination.

Ref:- WHO technical manual on transfusion medicine-Second Edition 2003

(RESULTS ALSO VERIFIED BY : FORWARD AND REVERSE GROUPING (TUBE AND SLIDE METHOD)

TECHNOLOGY USED: GEL METHOD

ADVANTAGES :

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

Historical records check not performed.

ESR (ERYTHROCYTE SEDIMENTATION RATE) , *EDTA WHOLE BLOOD*

1stHour	02	mm/hr	0.00 - 20.00 mm/hr	Westergren

CBC WITH PLATELET (THROMBOCYTE) COUNT , *EDTA WHOLE BLOOD*

HEMOGLOBIN	14.8	g/dL	13 - 17	PHOTOMETRIC
WBC	5.4	*10^3/µL	4 - 10	DC detection method
RBC	5.08	*10^6/µL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	230	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	62	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	32	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	04	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	02	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				
HEMATOCRIT / PCV	45.5	%	40 - 50 %	Calculated
MCV	89.6	fl	83 - 101 fl	Calculated
MCH	29.1	pg	27 - 32 pg	Calculated
MCHC	32.4	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	12.7	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	21.4	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	11.7		7.5 - 11.5 fl	Calculated
RBC	NORMOCYTIC NORMOCHROMIC.			
WBC.	WITHIN NORMAL LIMIT.			

PLATELET	ADEQUATE ON SMEAR.			

URINE ROUTINE ALL, ALL , *URINE*

PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION				
pH	7.0		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.010		1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	ABSENT		NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	ABSENT		NOT DETECTED	Dipstick(glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	ABSENT		NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NEGATIVE		NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE		NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE		NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE		NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	Dipstick (ester hydrolysis reaction)
MICROSCOPIC EXAMINATION				
LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/hpf	0-5	Microscopy
RED BLOOD CELLS	ABSENT	/hpf	0-2	Microscopy
CAST	ABSENT		NOT DETECTED	Microscopy
CRYSTALS	ABSENT		NOT DETECTED	Microscopy
BACTERIA	ABSENT		NOT DETECTED	Microscopy
YEAST	ABSENT		NOT DETECTED	Microscopy
OTHERS	ABSENT			

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can occur due to cell lysis.
8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria and/or yeast in the urine.

DR.BARNALI PAUL
MBBS, MD(PATH)

Suraksha DIAGNOSTICS

Lab No.	: SG2/25-03-2023/SR7449827	**Lab Add.**	:
Patient Name	: **SOUMYAPRATIM RAY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 7 M 25 D	**Collection Date:**	
Gender	: M	**Report Date**	: 25/Mar/2023 12:19PM

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

HEART RATE	:	54 /min.
RHYTHM	:	Regular sinus.
P-WAVE	:	Normal
P - R INTERVAL	:	160 ms,
QRS DURATION	:	80 ms
QRS CONFIGURATION	:	NORMAL
QRS VOLTAGE	:	R/S in V1 2/6 mm.
		R/S in V6 12/1 mm.
QRS AXIS	:	+60°
Q- Waves	:	No significant Q-wave.
QT TIME	:	Normal.
ST SEGMENT	:	Normal.
T WAVE	:	NORMAL
ROTATION	:	Normal.
OTHER FINDINGS	:	Nil.
IMPRESSION	:	**SINUS BRADYCARDIA.**

Dr. ARABINDA SAHA (MD,DM)
CONSULTANT CARDIOLOGIST

Lab No.	: SG2/25-03-2023/SR7449827	**Lab Add.**	:
Patient Name	: **SOUMYAPRATIM RAY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 7 M 25 D	**Collection Date:**	
Gender	: M	**Report Date**	: 25/Mar/2023 01:14PM

DEPARTMENT OF RADIOLOGY
X-RAY REPORT OF CHEST (PA)

FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhoutte is smoothly outlined. Shape is within normal limit.
- Lung parenchyma shows no focal lesion. No general alteration of radiographic density. Apices are clear. Bronchovascular lung markings are within normal.
- Lateral costo-phrenic angles are clear.
- Domes of diaphragm are smoothly outlined. Position is within normal limits.

IMPRESSION :
Normal study.

DR. MUKTI SARKAR MD.
CONSULTANT RADIOLOGIST

Lab No.	: SG2/25-03-2023/SR7449827	**Lab Add.**	:
Patient Name	: **SOUMYAPRATIM RAY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 7 M 25 D	**Collection Date:**	
Gender	: M	**Report Date**	: 25/Mar/2023 04:28PM

DEPARTMENT OF ULTRASONOGRAPHY
REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER
Liver is normal in size (147 mm at right MCL) **shows diffusely increased parenchymal echogenicity with maintained periportal & diaphragmatic echogenicity.** No focal parenchymal lesion is evident.Intrahepatic biliary radicles are not dilated. Branches of portal vein are normal.

PORTA
The appearance of porta is normal. Common Bile duct is normal with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal at porta.

GALL BLADDER
Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected. Sonographic Murphys sign is negative.

PANCREAS
Echogenecity appears within limits, without any focal lesion. Shape, size & position appears normal. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

SPLEEN
Spleen is normal in size (85 mm). Homogenous and smooth echotexture without any focal lesion. Splenic vein at hilum appears normal. No definite collaterals could be detected.

KIDNEYS
Both kidneys are normal in shape, size (Rt. kidney 98 mm. & Lt. kidney 93 mm) axes & position. Cortical echogenecity appears normal maintaining corticomedullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected.

URETERS
Visualised part of upper ureters are not dilated.

URINARY BLADDER
Urinary bladder is distended, wall thickness appeared normal. No intraluminal pathology (calculi / mass) could be detected.

PROSTATE
Prostate is normal in size.Echotexture appears within normal limits. No focal alteration of its echogenecity could bedetectable.

Lab No.	: SG2/25-03-2023/SR7449827	**Lab Add.**	:
Patient Name	: **SOUMYAPRATIM RAY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 7 M 25 D	**Collection Date:**	
Gender	: M	**Report Date**	: 25/Mar/2023 04:28PM

It measures : 38 x 28 x 28 mm.
Approximate weight could be around = 19 gms.

IMPRESSION

Liver shows diffusely increased parenchymal echogenicity with maintained periportal & diaphragmatic echogenicity - - Suggestive of Mild fatty change.

Please correlate clinically.

Kindly note

- *Ultrasound is not the modality of choice to rule out subtle bowel lesion.*
- *Please Intimate us for any typing mistakes and send the report for correction within 7 days.*
- *The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.*

The report and films are not valid for medico-legal purpose.

Patient Identity not verified.

DR. Ziaul Mustafa
MD, Radiodiagnosis

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com