

Dr. Vimmi Goel

MBBS, MD (Internal Medicine)
Sr. Consultant Non Invasive Cardiology
Reg. No: MMC- 2014/01/0113

C.N. 7499913052



Name: Mr. Rajkumar Khiyani Date: 01/11/23
Age: 63y Sex: M/F Weight: 62.9 kg Height: 161.7 Inc BMI: 24.1
BP: 130/70 mmHg Pulse: 95 bpm RBS: _____ mg/dl
SpO₂: 99%



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Rajkumar Khlyani	Age / Gender : 63 Y(s)/Male
Bill No/ UMR No : BIL2324052128/KH42747	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 01-Nov-23 09:30 am	Report Date : 01-Nov-23 11:44 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	10.3	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		33.8	40.0 - 50.0 %	Calculated
RBC Count		4.95	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		68	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		20.7	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		30.4	31.5 - 35.0 g/l	Calculated
RDW		20.2	11.5 - 14.0 %	Calculated
Platelet count		313	150 - 450 10 ³ /cumm	Impedance
WBC Count		6200	4000 - 11000 cells/cumm	Impedance
<u>DIFFERENTIAL COUNT</u>				
Neutrophils		61.6	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		29.0	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		6.3	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		3.1	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		3819.2	2000 - 7000 /cumm	Calculated



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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		1798	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		390.6	20 - 500 /cumm	Calculated
Absolute Monocyte Count		192.2	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<u>PERIPHERAL SMEAR</u>				
Microcytosis		Microcytosis +(Few)		
Platelets		Adequate		
ESR		18	0 - 20 mm/hr	Automated Westergren's Method
*** End Of Report ***				

Suggested Clinical Correlation * If necessary, Please discuss

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**Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. Rajkumar Khiyani	Age /Gender : 63 Y(s)/Male
Bill No/ UMR No : BIL2324052128/KH42747	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 01-Nov-23 09:29 am	Report Date : 01-Nov-23 11:19 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	103	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		145	< 140 mg/dl	GOD/POD, Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HbA1c		6.5	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

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LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	125	Enzymatic(CHE/CHO/POD)
Triglycerides		134	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		37	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		73.43	Enzymatic
VLDL Cholesterol		27	Calculated
Tot Chol/HDL Ratio		3	Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	<100
Multiple major risk factors conferring 10 yrs CHD risk >20%	>130, optional at 100-129	
Two or more additional major risk factors, 10 yrs CHD risk <20%	10 yrs risk 10-20 % >130	<130
No additional major risk or one additional major risk factor	10 yrs risk <10% >160	<160
	>190, optional at 160-189	<160

*** End Of Report ***

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Received Dt : 01-Nov-23 09:30 am	Report Date : 01-Nov-23 11:44 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
THYROID PROFILE				
T3	Serum	1.30	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.61	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.32	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence
PSA (Total)		3.55	< 4 ng/ml	Enhanced chemiluminescence

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DEPARTMENT OF BIOCHEMISTRY

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<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
RFT				
Blood Urea	Serum	23	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		0.99	0.66 - 1.25 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		85.6		Calculation by CKD-EPI 2021
Sodium		140	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.92	3.5 - 5.1 mmol/L	Direct ion selective electrode

LIVER FUNCTION TEST(LFT)

Total Bilirubin		0.63	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.21	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.42	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric
Alkaline Phosphatase		79	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		20	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		26	15 - 40 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		7.32	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.12	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.20	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.29		

URINE SUGAR

Urine Glucose

Negative

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Rajkumar Khiyani	Age /Gender : 63 Y(s)/Male
Bill No/ UMR No : BIL2324052128/KH42747	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 01-Nov-23 09:32 am	Report Date : 01-Nov-23 11:02 am

URINE MICROSCOPY

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<u>PHYSICAL EXAMINATION</u>			
Volume	Urine	20 ml	
Colour.		Pale yellow	
Appearance		Clear	
<u>CHEMICAL EXAMINATION</u>			
Reaction (pH)		5.0	4.6 - 8.0
Specific gravity		1.020	1.005 - 1.025
Urine Protein		1+ (Approx 25mg/dl)	Indicators ion concentration
Sugar		Negative	protein error of pH indicator
Bilirubin		Negative	GOD/POD
Ketone Bodies		Negative	Diazonium
Nitrate		Negative	Legal's est Principle
Urobilinogen		Normal	Ehrlich's Reaction
<u>MICROSCOPIC EXAMINATION</u>			
Epithelial Cells		0-1	
R.B.C.		Absent	0 - 4 /hpf Manual
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	



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Received Dt : 01-Nov-23 09:32 am	Report Date : 01-Nov-23 11:02 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Crystals		Absent	
*** End Of Report ***			

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mr. Rajkumar Khlyani	Age /Gender : 63 Y(s)/Male
Bill No/ UMR No : BIL2324052128/KH42747	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 01-Nov-23 09:30 am	Report Date : 01-Nov-23 12:21 pm

BLOOD GROUPING AND RH

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/Serum	" B "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	Rajkumar Khiyani	STUDY DATE	01-11-2023 10:29:17
AGE/ SEX	63Y 4M3D / M	HOSPITAL NO.	KH42747
ACCESSION NO.	BIL2324052128-17	MODALITY	DX
REPORTED ON	01-11-2023 12:39	REFERRED BY	Dr. Vimmi Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

• Hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

IMPRESSION:

No pleuro-parenchymal abnormality seen.



•
Dr. R.R. KHANDELWAL

SENIOR CONSULTANT

MD, RADIODIAGNOSIS [MMC-55870]

N.B : This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations.
Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

PATIENT NAME:	RAJKUMAR KHIYANI	AGE /SEX:	63 YRS/MALE
UMR NO:	KH42747	BILL NO:	2324052128
REF BY	DR. VIMMI GOEL	DATE:	1/11/2023

USG WHOLE ABDOMEN

Clinical history: Post partial right nephrectomy status.

LIVER is normal in size, shape and shows normal echotexture.
No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.
PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No stones or sludge seen within it.
Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in shape, size and echotexture. No focal lesion seen.

Right kidney measures 6.2 x 4.8 cm and shows normal parenchymal echotexture.
No evidence of hydronephrosis seen.

(K/c/o Partial nephrectomy).

Left kidney measures 9.6 x 4.5 cm and shows normal parenchymal echotexture.
Cortico-medullary differentiation is maintained.

No calculus or no mass lesion or hydronephrotic changes seen.

URETERS are not dilated.

BLADDER is partially filled. No calculus or mass lesion seen.

Prostate is enlarged in size (approximate vol - 31cc).

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION -

Mildly small sized right kidney – Consistent with post partial nephrectomy status.
Mild prostatomegaly.

Suggest clinical correlation / further evaluation.



Dr. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]

2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT

Patient Name : Mr. Rajkumar Khiyani
 Age : 63 years / Male
 UMR : KH42747
 Date : 01/11/2023
 Done by : Dr. Vimmi Goel
 ECG : NSR, WNL
 Blood pressure: 130/70 mm Hg (Right arm, Supline position)
 BSA : 1.68 m²

Impression: Status Post PTCA

Normal chambers dimensions
Mild left ventricular hypertrophy
No RWMA of LV at rest
Good LV systolic function, LVEF 70%
LV diastolic dysfunction, Grade II (E>A)
E/A is 1.1
E/E' is 10.5 (Borderline filling pressure)
Valves are normal
Trivial TR, No pulmonary hypertension
IVC is normal in size and collapsing well with respiration
No clots or pericardial effusion

Comments:

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views). LV size normal. Mild left ventricular hypertrophy. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 70%. LV diastolic dysfunction, Grade II (E>A). E Velocity is 98 cm/s, A Velocity is 84 cm/s. E/A is 1.1. Mitral valve deceleration time is 148 msec. Valves are normal. Trivial TR. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen.

E' at medial mitral annulus is 8.3 cm/sec & at lateral mitral annulus is 10.8 cm/sec.
 E/E' is 10.5 (Borderline filling pressure).

M Mode echocardiography and dimension:

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	30
Aortic root	20-37	7-28	29
LVIDd	35-55	8-47	41
LVIDs	23-39	6-28	25
IVS (d)	6-11	4-8	12
LVPW (d)	6-11	4-8	12
LVEF %	~ 60%	~60%	70%
Fractional Shortening			40%

P.T.O


Dr. Vimmi Goel
MD, Sr. Consultant
Non-invasive Cardiology

MR RAJKUMAR KHIYANI
Male

01-Nov-23 10:06:16 AM
KIMS-KINGSWAY HOSPITALS
PHC DEPT.

63 Years

Rate 89 . Sinus rhythm.....normal P axis, V-rate 50- 99

. Baseline wander in lead(s) V5

PR 139
QRSD 83
QT 324
QTc 395

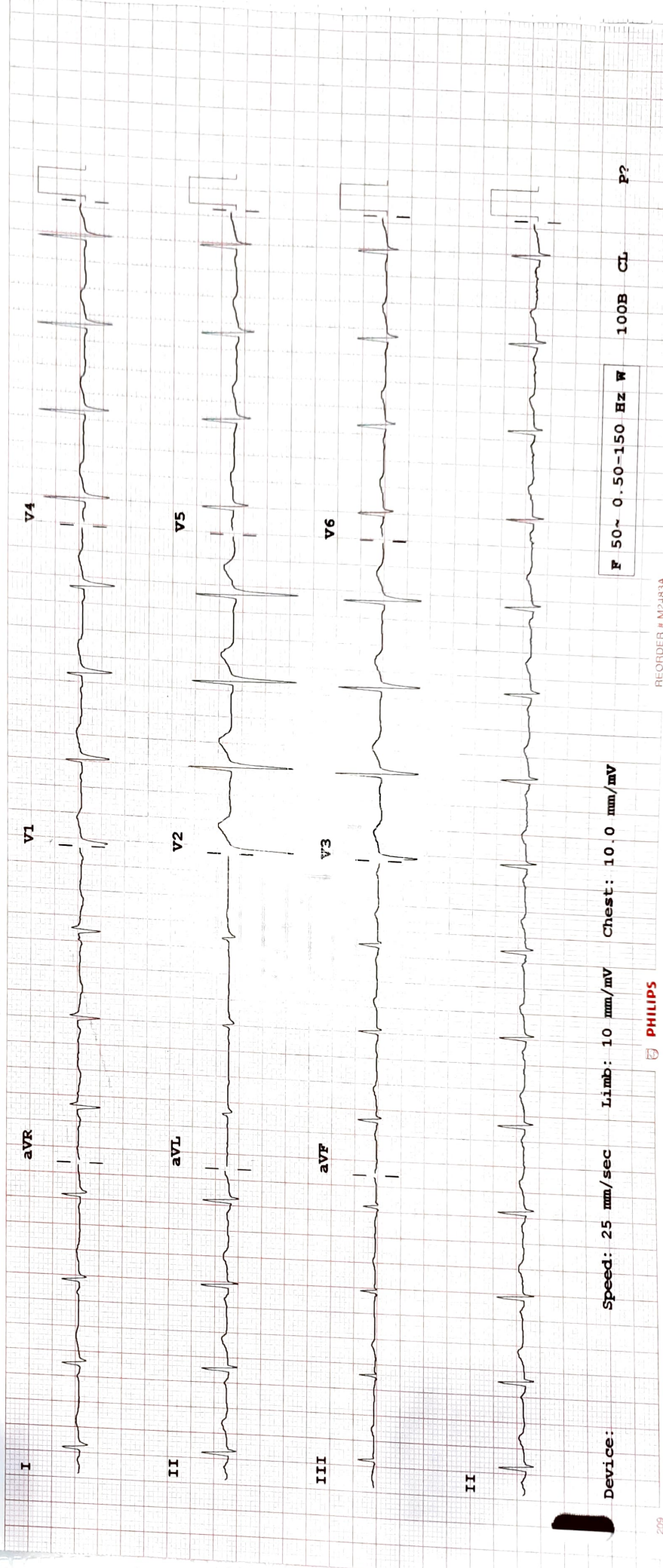
--AXIS--

P 67
QRS 60
T 56

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-150 Hz W

100B CL

P?

PHILIPS

REORDER # M2483A