Lab No.	012409140355	**Age/Gender**	37.10 YRS/MALE	**Coll. ON**	14/Sep/2024 10:48AM
NAME	Mr. PRAVIN KUMAR SINGH			**Reg. ON**	14/Sep/2024
Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 02:05PM
Rpt. Centre	undefined			**Printed ON**	14/Sep/2024 05:43PM

Test Name	Value	Unit	Biological Reference Interval
Complete Haemogram, EDTA whole blood			
Haemoglobin (Hb) *Method : Colorimetry*	15.00	gm/dl	13.0 - 17.0
RBC count *Method : Electrical impedence*	5.07	Millons/cmm	4.5 - 5.5
PCV / Haematocrit *Method : Calculated*	42.80	%	40.0 - 50.0
MCV *Method : Calculated*	84.50	fl	83.0 - 101.0
MCH *Method : Calculated*	29.60	picogram	27.0 - 32.0
MCHC *Method : Calculated*	**35.00**	%	31.5 - 34.5
RDW - CV *Method : Calculated*	13.70	%	11.6 - 14.0
Mentzer Index *Method : Calculated*	16.67		>= 13.0
The Mentzer index (MCV/ RBC count) is a useful tool for initial screening of patients with a microcytic hypochromic blood picture to rule out a thalassemia trait. If the index is less than 13, thalassemia is said to be more likely. If the result is greater than 13, then iron-deficiency anemia is said to be more likely. All patients with a low normal to low hemoglobin and a Mentzer index below 13 should be screened for thalassemia trait by HPLC.			
TLC (Total Leucocyte Count) *Method : Flowcytometry*	5,490	/cmm	4000 - 10000
DLC (Flowcytometry)			
Neutrophils	60.50	%	35.0 - 75.0
Lymphocytes	30.40	%	25.0 - 45.0
Eosinophils	3.10	%	1.0 - 5.0
Monocytes	6.00	%	1.0 - 6.0
Basophils	0.00	%	0 - 1
Absolute Leucocyte Count (Calculated)			
Absolute Neutrophil Count	3,321.45	/cmm	2000 - 7000
Absolute Lymphocyte Count	1,668.96	/cmm	1000 - 3000
Absolute Eosinophil count	170.19	/cmm	20 - 500
Absolute Monocyte count	329.40	/cmm	200 - 1000
Absolute Basophil count	0.00	/cmm	0 - 100
Platelet count *Method : Electrical impedence*	2.07	Lakh/cmm	1.5 - 4.1
ESR (Erythrocyte Sedimentation Rate) *Method : Westergren method*	5	mm/1st hr	0 - 22

Peripheral Smear

RBCs are normocytic and normochromic.
Leucocytic series is numerically and morphologically within normal limits.
Platelets are adequate in number and are normal in morphology.
No atypical cells or haemoparasites are seen.
Impression: Normal peripheral smear.

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Test Name	Value	Unit	Biological Reference Interval
Blood Group (ABO + RH)			
Blood Group *, EDTA blood* *Method : Slide agglutination (Forward & Reverse grouping)*	A		
Rh type *, EDTA blood* *Method : Slide agglutination*	Positive		

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Rpt. Centre	undefined			**Printed ON**	14/Sep/2024 05:43PM

Test Name	Value	Unit	Biological Reference Interval
Glucose Fasting, *plasma* *Method : GOD POD*	99.60	mg/dL	60 - 100

Interpretation (In accordance with the American diabetes association guidelines):

- A fasting plasma glucose level below 100 mg/dl is considered normal.
- A fasting plasma glucose level between 100-126 mg/dl is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.
- A fasting plasma glucose level of above 126 mg/dl is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dl on both the occasions is confirmatory of a diabetic state.

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Test Name	Value	Unit	Biological Reference Interval
HbA1c (Glycosylated haemoglobin), *EDTA whole blood* *Method : HPLC*	5.40	%	< 5.7
Estimated average plasma Glucose *Method : Calculated*	108.28	mg/dL	65 - 136

The test is approved by NGSP for patient sample testing.

Interpretation:

Metabolically normal patients	%	< 5.7
Pre-diabetic	%	5.7 - 6.4
Diabetic	%	> 6.4

Glycosylated hemoglobin or HbA1C is a reliable indicator of mean plasma glucose levels for a period of 8-12 weeks preceeding the date on which the test is performed and is a more reliable indicator of overall blood sugar control in known diabetic patients than blood sugar levels. A value of less than 5.7 % is usually seen in metabolically normal patients, however diabetics with very good control can also yield similar values. The HbA1c test, thus can not be used to differentiate between diabetic patients with very good control over the plasma glucose levels from metabolically normal, non-diabetic subjects as both groups may reveal very similar values in the assay.

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Rpt. Centre	undefined			**Printed ON**	14/Sep/2024 05:43PM

Test Name	Value	Unit	Biological Reference Interval
Serum Electrolytes (Na, K, Cl)			
Serum Sodium *Method : Direct measurement with ISE*	143.60	mmol/L	135 - 150
Serum Potassium *Method : Direct measurement with ISE*	4.11	mmol/L	3.5 - 5.0
Serum Chloride *Method : Direct measurement with ISE*	101.20	mmol/L	94 - 110

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Test Name	Value	Unit	Biological Reference Interval
LFT (Liver Function Test)			
Serum Bilirubin Total *Method : Diazotized Sulfanilic Acid (DSA)*	0.90	mg/dl	0.1 - 1.2
Serum Bilirubin Direct *Method : Diazotized Sulfanilic Acid (DSA)*	0.21	mg/dl	0.0 - 0.3
Serum Bilirubin Indirect *Method : Calculated*	0.69	mg/dl	0.1 - 1.1
Serum SGOT/AST *Method : IFCC without P5P*	24.00	U/l	<= 35.0
Serum SGPT/ALT *Method : IFCC without P5P*	34.40	U/l	<= 45.0
Serum Alkaline Phosphatase *Method : PNP, AMP Buffer*	73.70	U/l	30.0 - 120.0
Serum GGT (Gamma Glutamyl Transpeptidase) *Method : UV-assay according to Szasz*	28.60	U/l	11.0 - 61.0
Serum total Protein *Method : Biuret*	7.47	g/dl	6.6 - 8.3
Serum Albumin *Method : Bromo Cresol Green*	4.90	g/dl	3.5 - 5.2
Serum Globulin *Method : Calculated*	2.57	g/dl	2.0 - 3.5
Albumin / Globulin ratio *Method : Calculated*	1.91		1.5 - 2.5

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Test Name	Value	Unit	Biological Reference Interval
KFT/RFT (Kidney/Renal Function Test)			
Urea , *serum* *Method : Urease-GLDH, UV Method*	17.61	mg/dl	16.9 - 43.4
Blood Urea Nitrogen (BUN) *Method : Calculated*	8.23	mg/dl	7.8 - 20.2
Serum Creatinine *Method : Jaffe kinetic*	0.85	mg/dl	0.7 - 1.2
Serum Calcium *Method : Arsenazo III*	9.43	mg/dl	8.8 - 10.6
Serum Uric Acid *Method : Uricase-Peroxidase*	7.74	mg/dl	3.6 - 8.2
Serum total Protein *Method : Biuret*	7.47	g/dl	6.6 - 8.3
Serum Albumin *Method : Bromo Cresol Green*	4.90	g/dl	3.5 - 5.2
Serum Globulin *Method : Calculated*	2.57	g/dl	2.0 - 3.5
Albumin / Globulin ratio *Method : Calculated*	1.91		1.5 - 2.5

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Test Name	Value	Unit	Biological Reference Interval
Lipid Profile basic (direct HDL,calculated LDL)			
Total Cholesterol, *, serum* *Method : CHOD-POD*	**221.10**	mg/dl	< 200.0
Triglycerides *, serum* *Method : GPO-POD*	**199.00**	mg/dl	< 150
HDL Cholesterol *, serum* *Method : Direct measure PEG (CHE-CHO)*	**33.60**	mg/dl	> 40
VLDL Cholesterol *, serum* *Method : Calculated*	**39.80**	mg/dl	< 30
L.D.L Cholesterol *, serum* *Method : Calculated*	**147.70**	mg/dl	< 100
Cholesterol, Non HDL *, serum* *Method : Calculated*	**187.50**	mg/dl	< 130
Total Cholesterol / HDL Cholesterol Ratio *, serum* *Method : Calculated*	**6.58**		< 5.0
LDL / HDL Cholesterol ratio *, serum* *Method : Calculated*	**4.40**		< 3.5

Interpretation:

National Lipid Association Recommendation (NLA-2014)	
Total Cholesterol Desirable: <200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	**Triglycerides** Normal: <150 mg/dL Borderline high: 150-199 mg/dL High: 200-499 mg/dL Very high: > or =500 mg/dL
Non HDL Cholesterol Desirable: <130 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL	**LDL Cholesterol** Optimal: <100 mg/dL Near Optimal: 100-129 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL
HDL Cholesterol Low (Men) <40 mg/dL Low (Women) <50 mg/dL	

Phosphorus (inorganic), *serum* *Method : Phosphomolybdate Method*	3.35	mg/dl	2.5 - 4.5

Interpretation:

Eighty-eight percent of the phosphorus contained in the body is localized in bone in the form of hydroxyapatite. The remainder is involved in intermediary carbohydrate metabolism and in physiologically important substances such as phospholipids, nucleic acids, and adenosine triphosphate (ATP). Phosphorus occurs in blood in the form of inorganic phosphate and organically bound phosphoric acid. The small amount of extracellular organic phosphorus is found exclusively in the form of phospholipids. Serum phosphate concentrations are dependent on meals and variation in the secretion of hormones such as parathyroid hormone (PTH) and may vary widely.
Hypophosphatemia may have 4 general causes: shift of phosphate from extracellular to intracellular, renal phosphate wasting, loss from the gastrointestinal tract, and loss

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Test Name	Value	Unit	Biological Reference Interval

from intracellular stores.
Hyperphosphatemia is usually secondary to an inability of the kidneys to excrete phosphate. Other factors may relate to increased intake or a shift of phosphate from the tissues into the extracellular fluid.
Phosphate levels may be used in the diagnosis and management of a variety of disorders including bone, parathyroid and renal disease.
Hypophosphatemia is relatively common in hospitalized patients. Levels less than 1.5 mg/dL may result in muscle weakness, hemolysis of red cells, coma, and bone deformity and impaired bone growth.
The most acute problem associated with rapid elevations of serum phosphate levels is hypocalcemia with tetany, seizures, and hypotension. Soft tissue calcification is also an important long-term effect of high phosphorus levels.
Phosphorus levels less than 1.0 mg/dL are potentially life-threatening and are considered a critical value.
Note: Phosphorus has a very strong biphasic circadian rhythm. Values are lowest in the morning, peak first in the late afternoon and peak again in the late evening. The second peak is quite elevated and results may be outside the reference range.

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Test Name	Value	Unit	Biological Reference Interval
Urine Sugar fasting *Method : Hexokinase*	Nil		Nil

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Test Name	Value	Unit	Biological Reference Interval
Vitamin B 12, *serum* *Method : CLIA Microparticles*	212.54	pg/ml	183.0 - 822.0

Please note change in biological reference interval.

Interpretation:

Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function. In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption. The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.

Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.

Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.

Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.

A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.

The commonest cause of increased level of vitamin B12 is therapeutic intake of vitamin B12 in the form of multivitamin tablets or as intramuscular injections.

Many other conditions are known to cause an increase or decrease in the serum vitamin B12 concentration including:

Increased Serum B12	Decreased Serum B12
Ingestion of vitamin C	Pregnancy
Ingestion of estrogens	Aspirin
Ingestion of vitamin A	Anticonvulsants
Hepatocellular injury	Colchicine
Myeloproliferative disorder	Ethanol ingestion
Uremia	Contraceptive hormones
	Smoking
	Hemodialysis
	Multiple myeloma

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Test Name	Value	Unit	Biological Reference Interval
Vitamin D (25 Hydroxy), *serum* *Method : CLIA Microparticles*	**15.54**	ng/ml	30.0 - 100.0

Interpretation:

Deficiency	ng/ml	< 20
Insufficiency	ng/ml	21 - 29
Sufficiency	ng/ml	30 - 100
Intoxication	ng/ml	> 150

Vitamin D compounds are derived from dietary ergocalciferol (from plants, VitD2) or cholecalciferol (from animals, VitD3), or by conversion of 7-dihydrocholesterol to VitD3 in the skin upon ultraviolet exposure. VitD2 and VitD3 are subsequently 25-hydroxylated in the liver to 25-OH-VitD. 25-OH-VitD represents the main body reservoir and transport form of vitamin D, being stored in adipose tissue and tightly bound by a transport protein while in circulation. A fraction of circulating 25-OH-VitD is converted to its active metabolites 1,25-dihydroxy vitamin D2 and D3 (1,25-OH-VitD), mainly by the kidneys. This process is regulated by parathyroid hormone (PTH).
VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Renal calcium and phosphate reabsorption are also promoted. In addition to its effects on calcium and bone metabolism, 1,25-OH-VitD regulates the expression of a multitude of genes in many other tissues including immune cells, muscle, vasculature, and reproductive organs.
The exact 25-OH-VitD level reflecting optimal body stores remains unknown. Mild-to-modest deficiency can be associated with osteoporosis or secondary hyperparathyroidism. Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults. The consequences of vitamin D deficiency on organs other than bone are not fully known, but may include increased susceptibility to infections, muscular discomfort, and an increased risk of colon, breast, and prostate cancer.
Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in India; inadequate intake; malabsorption (eg, due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism.
Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.
Caution: Replacement therapy in deficient individuals must be monitored by periodic assessment of Vitamin D levels in order to prevent hypervitaminosis D.

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Test Name	Value	Unit	Biological Reference Interval
PSA Total, *serum* *Method : ECLIA*	0.93	ng/mL	0 - 1.4

Interpretation:

Prostate-specific antigen (PSA) is a glycoprotein that is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels.

In patients with previously diagnosed prostate cancer, PSA testing is advocated as an early indicator of tumor recurrence and as an indicator of response to therapy.

The test is also useful for initial screening for prostate cancer:

Total PSA levels < 2 ng/ml almost rule out the possibility of prostatic malignancy.

Total PSA levels between 2 and 10 ng/ml lie in the grey zone. Such values may be obtained in prostatitis, benign hyperplasia and malignancy. Further testing including a free PSA/PSA ratio and prostate biopsy is recommended for these patients for confirmation of the diagnosis.

Total PSA values >10 ng/ml are highly suspicious for prostate cancer but further testing, such as prostate biopsy, is needed to diagnose the exact pathology.

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Lab No.	012409140355	**Age/Gender**	37.10 YRS/MALE	**Coll. ON**	14/Sep/2024 10:48AM
NAME	Mr. PRAVIN KUMAR SINGH			**Reg. ON**	14/Sep/2024
Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 03:05PM
Rpt. Centre	undefined			**Printed ON**	14/Sep/2024 05:43PM

Test Name	Value	Unit	Biological Reference Interval
Thyroid Profile Total (T3, T4, TSH)			
T3, (Triiodothyronine) , *serum* *Method : ECLIA*	1.28	ng/mL	0.80 - 2.0
T4, (Thyroxine) , *serum* *Method : ECLIA*	7.14	ug/dL	5.1 - 14.1
TSH (Thyroid Stimulating Hormone) , *serum* *Method : ECLIA*	1.52	uIU/ml	0.27 - 4.2

Interpretation:

- Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values alongwith depressed TSH levels
- Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
- High T3 levels coupled with normal T4 and suppressed TSH may be seen in T3 toxicosis.

Note: Total T3 and total T4 are highly bound to plasma proteins and are amenable to fluctuations with plasma protein content as well as due to binding defects in the thyroid hormone binding proteins.

The following ranges are recommended for pregnant females:

Gestation period	TSH (uIU/ml)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

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Dr. Smita Sadwani
MD(Biochemistry)
Technical Director

Dr. Mayank Gupta
MD, DNB Pathology
Consultant Pathologist

Dr. Deepak Sadwani
MD(Pathology)
Lab Director

Dr. Moushmi Mukherjee
MBBS,MD (Pathology)
Consultant Pathologist

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NAME	Mr. PRAVIN KUMAR SINGH			**Reg. ON**	14/Sep/2024
Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 04:16PM
Rpt. Centre	undefined			**Printed ON**	14/Sep/2024 05:43PM

Test Name	Value	Unit	Biological Reference Interval
Urine Routine & Microscopic Examination			
Physical examination			
Volume	40	mL	
Colour	Pale Yellow		Pale yellow
Transparency	Clear		Clear
Specific gravity *Method : pKa change*	1.010		1.003 - 1.035
Chemical examination			
Protein *Method : error-of-indicator*	Nil		Nil
Glucose *Method : GOD-POD*	Nil		Nil
pH *Method : Double indicator*	7.5		
Bilirubin *Method : Azo-coupling reaction*	Negative		Negative
Urobilinogen *Method : Azo- coupling reaction*	Normal		Normal
Ketone *Method : Legals test*	Negative		Negative
Erythrocytes *Method : Peroxidase*	Absent		Absent
Nitrite *Method : Griess reaction*	Negative		Negative
Leukocytes *Method : Esterase activity of granulocytes*	Absent	Leu/uL	Negative
Microscopic examination			
WBC	1 - 2	/ HPF	0 - 2
RBC	Nil	/ HPF	0 - 2
Casts	Nil	/ HPF	Nil
Crystals	Nil	/ HPF	Nil
Epithelial cells	Occasional	/ HPF	0 - 15
Bacteria	Absent		Absent
Others *Method : Light microscopy*	Nil		

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MD Pathology
Consultant Pathologist

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Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 05:42PM
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Pulmonary function test (PFT)

Normal Spirometry.

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Dr. Smita Sadwani
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Director
DMC Regd. No. 48732

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Dr. Ashish Gautam
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Dr. Moushmi Mukherjee
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Consultant Pathologist

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Lab No.	012409140355	**Age/Gender**	37.10 YRS/MALE	**Coll. ON**	14/Sep/2024 10:48AM
NAME	Mr. PRAVIN KUMAR SINGH			**Reg. ON**	14/Sep/2024
Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 02:59PM
Rpt. Centre	Courier			**Printed ON**	14/Sep/2024 05:43PM

Echo-cardiography

COLOR DOPPLER ECHO-CARDIOGRAPHY

MEASUREMENTS:

Dimensions	Values	Normal Range
Aorta	30	Upto 40 mm
Left Atrium	33	Upto 40 mm
Left ventricle		
End diastolic	41	Upto 56 mm
End systolic	29	Upto 35 mm
Interventricular septal thickness		
End diastolic	11	6-12 mm
End systolic	12	
Posterior wall thickness		
End diastolic	11	6-11 mm
End systolic	11	
LV Ejection Fraction	60%	55-85 %

MITRAL VALVE: Both antero-medial and posterolateral mitral valve leaflets are normal in thickness.

There is no calcification of valve leaflets. Chordae and both papillary muscles are normal.

There is no evidence of mitral stenosis or regurgitation/prolapse of leaflets.

Mitral valve ring is normal and does not show any calcification. There are no vegetations seen.

Dr. Anil Sahoo
MD. PGDCO
Reg. No.33201

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AORTIC VALVE:

Aortic valve has three leaflets, closure line is central. There is no systolic doming of leaflets.

Aortic valve opening is normal. No calcification is seen.

No vegetations. No evidence of stenosis or regurgitation of valve.

PULMONARY VALVE:

No vegetation. No stenosis or regurgitation of the valve.

TRICUSPID VALVE:

Leaflets are normally attached. There is no vegetations. No evidence of stenosis of tricuspid valve.

DOPPLER STUDIES

Valve	Normal velocities		Gradient	Regurgitation
	Velocity m/sec	Values m/s		
Aortic	(0.7 – 1.1)	1.05		Nil
Mitral	(0.6 – 1.1) E =	0.69		Nil
	A =	0.57		
Pulmonary	(0.6 – 0.9)	0.70		Nil
Tricuspid	(0.3 – 0.6)	1.31	6	Nil

Pulmonary Artery Pressure: No pulmonary artery hypertension seen.

CHAMBERS :

LEFT VENTRICLE:

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Mild Concentric LVH.
No evidence of resting regional left ventricle hyperkinesia/ akinesia/ dyskinesia/ left ventricle aneurysm. No left ventricle clot is seen.
No intra-cavitary mass is seen. Left ventricular Ejection Fraction is : 60%

RIGHT VENTRICLE :

Right ventricle is of normal size and shape. Right ventricle contractility is normal.
No evidence of resting regional hypokinesia/ akinesia or dyskinesia of right ventricle.

INTER VENTRICULAR SEPTUM :

No evidence of inter ventricular septum rupture or ventricular septal defects.

LEFT ATRIUM :

Left atrium is of normal size. No Evidence of left atrium or left atrium appendage clots.

RIGHT ATRIUM :

Right atrium is normal in size shape and contractility. No clots or intra-cavitary mass.

INTER ATRIAL SEPTUM : No flow across inter atrial septum is seen.

AORTA :

Ascending aorta is normal in diameter. No evidence of dissection on transthoracic echo. No calcification is seen.

PUMONARY ARTERIES :

Main pulmonary artery, left and right pulmonary arteries are normal in size and do not reveal any stenosis or occlusion of lumen.

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PERICARDIUM :

Pericardium has normal thickness. There is no effusion or pericardial calcification or constriction.

LEFT VENTRICULAR SYSTOLIC FUNCTION :

Left ventricle (systolic) ejection fraction 60%.

FINAL IMPRESSION :

- Mild Concentric LVH.
- No systolic anterior motion/ Left ventricular outflow tract gradient noted
- Wall motion is normal.
- Normal mitral inflow pattern.
- Left ventricle & right ventricle systolic function is normal.
- Left ventricular Ejection Fraction – 60 %.

Kindly correlate clinically.

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Rpt. Centre	Courier			**Printed ON**	14/Sep/2024 05:43PM

MER

General Condition	Fair, no pallor, no icterus, no anemia observed
Height (cm)	169
Weight (kg)	88
Pulse (min)	73
BP (mmhg)	122/82
Far Vision (left eye)	6/6 With Glass
Far Vision (right eye)	6/6 With Glass
Near Vision (left eye)	N/6
Near Vision (right eye)	N/6
Color Vision (Both eyes)	Normal

Please note: Kindly review with clinician in view of abnormal reports (if any).

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Lab No.	012409140355	**Age/Gender**	37.10 YRS/MALE	**Coll. ON**	14/Sep/2024 10:48AM
NAME	Mr. PRAVIN KUMAR SINGH			**Reg. ON**	14/Sep/2024
Ref. Dr.	MEDIWEEL	**BarcodeNo**	01140355	**Approved ON**	14/Sep/2024 01:56PM
Rpt. Centre	Courier			**Printed ON**	14/Sep/2024 05:43PM

X-Ray Chest PA view

Trachea and mediastinum are central.

Bilateral lung fields are clear.

Bilateral hilar shadows are normal.

Bilateral costophrenic angles are clear.

Cardiac shadow is normal.

Soft tissue shadows and bony rib cage is normal.

Impression: No significant abnormality seen .

Please correlate clinically

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DR AMIT JAISWAL
MBBS,DMRD,DNB (RADIO DIAGNOSIS)
DMC No. 55709

Lab No.	012409140355	**Age/Gender**	37.10 YRS/MALE	**Coll. ON**	14/Sep/2024 10:48AM
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SONOGRAPHY OF ABDOMEN AND PELVIS

The liver is normal in size (12.2 cm) and shape. It shows a normal parenchymal echotexture. There is no evidence of any focal hepatic lesion. The hepatic and portal veins are normal. There is no intrahepatic biliary dilatation.

The gall bladder is adequately distended. There is no evidence of any calculi. There is no evidence of any wall thickening seen. The CBD is not dilated.

The pancreas is well visualized and shows a normal parenchymal echotexture. There is no evidence of any focal mass, calcification or ductal dilatation seen. There is no peripancreatic fluid collection seen.

The spleen is normal in size (11.5 cm) and shows a normal parenchymal echotexture. There is no focal lesion seen.

The right kidney measures 10.9 x 4.0 cm and the left kidney measures 11.4 x 3.6 cm. Both kidneys are normal in size and shape. The kidneys show normal echotexture with a well-maintained cortical thickness. There is no evidence of hydronephrosis or calculus in either kidney.

Right kidney show simple cortical cyst of size 24 x 22 mm at lower polar region.

Left kidney show simple cortical cyst of size 30 x 25 mm at lower polar region.

There is no evidence of any mesenteric or retroperitoneal lymph adenopathy. There is no ascites or bowel wall thickening.

The urinary bladder shows normal contours.

The prostate is not enlarged.There is no median lobe prominence.

IMPRESSION

- **No significant abnormality is seen on this examination.**

Kindly correlate clinically

*** Partial Report ***

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DR AMIT JAISWAL
MBBS,DMRD,DNB (RADIO DIAGNOSIS)
DMC No. 55709

PROGNOSIS LABORATORIES
A SUBSIDIARY OF MEDGENOME
515-516 DWARKA SEC-19 NEW DELHI-110075

Patient Information

Name : **PRAVIN SINGH**

DATE : 14-09-24 12:10:01

AGE : 37 /M ID :95

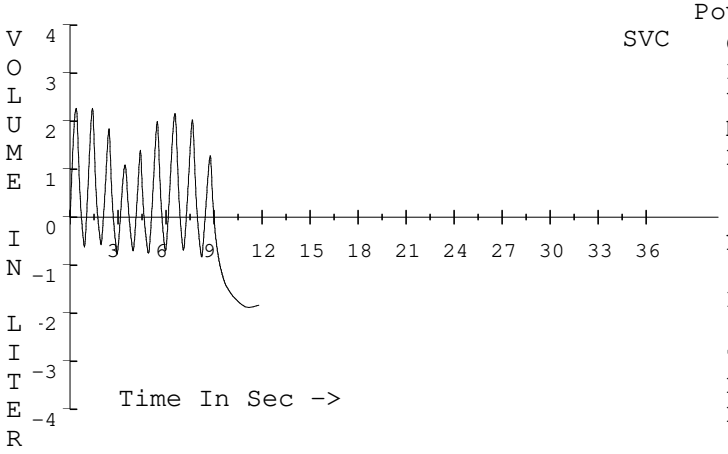
Height : 169

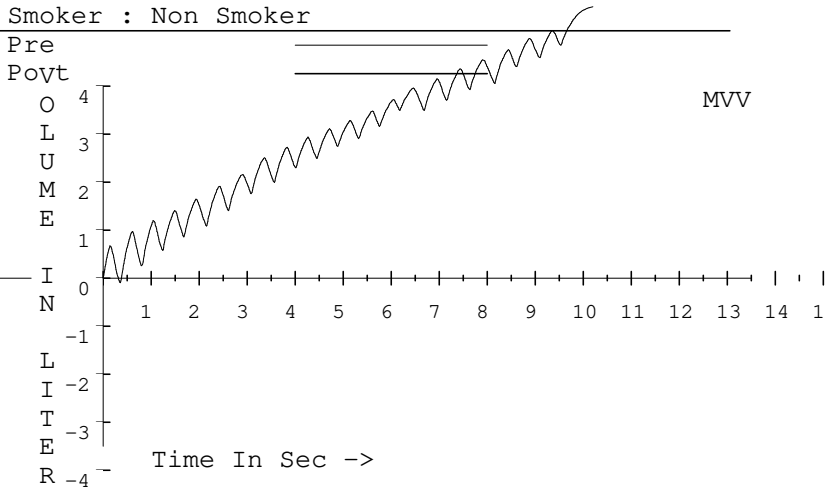
REF.BY : Dr.MEDIWEEL

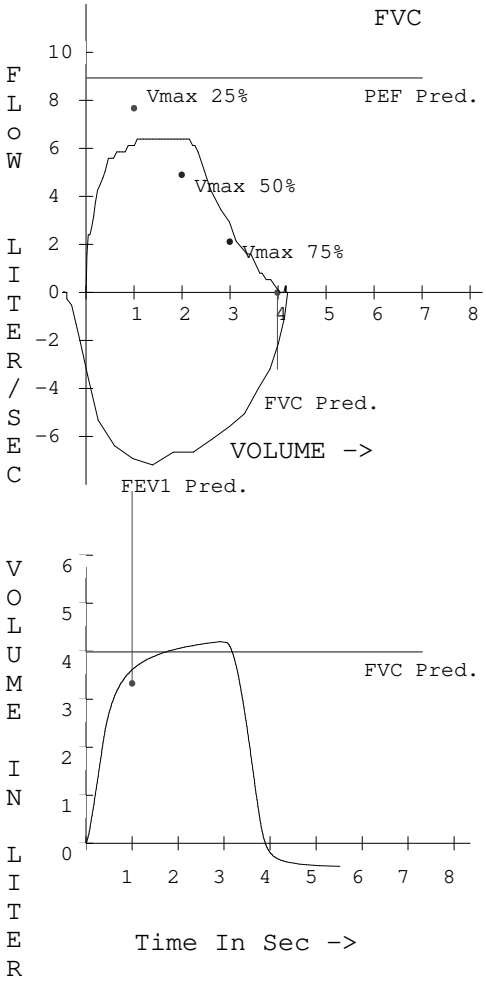
Weight : 88

Indication:

Smoker : Non Smoker





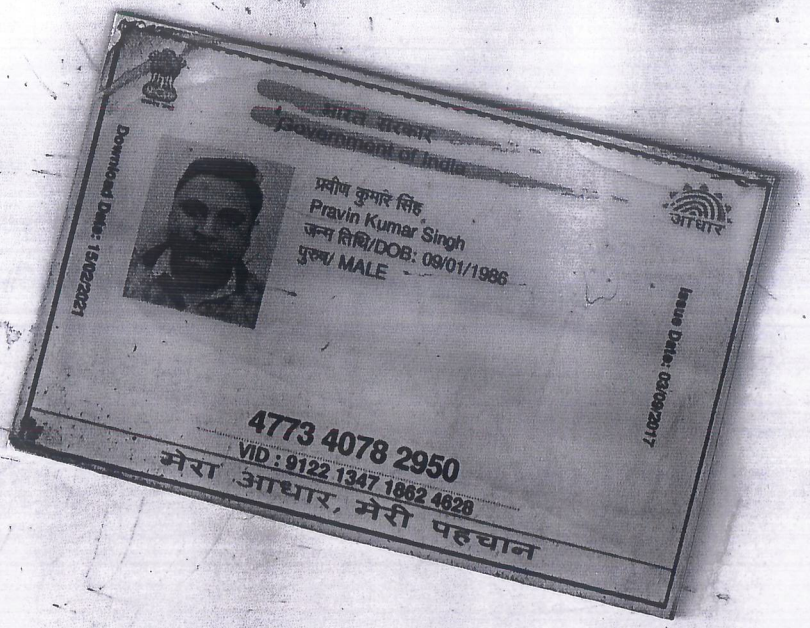


Parameter	Pred	Pre	%Pred	Post	%Pred	Dif.%
FVC (L)	3.99	4.20	105.21			
FEV0.5 (L)		2.68				
FEV1 (L)	3.33	3.61	108.18			
FEV1/FVC %	83.57	85.93	102.83			
PEF (L/S)	8.94	6.38	71.43			
PIF (L/S)		7.18				
FEF25-75%(L/S)	4.39	4.65	105.88			
VMax25 %	7.68	6.38	83.06			
VMax50 %	4.91	6.38	130.05			
VMax75 %	2.11	1.99	94.58			
FET100 %		2.92				
SVC (L)	4.16	3.13	75.17			
ERV (L)	1.26	1.20	95.01			
IRV (L)		0.88				
Rf (BrPM)		58.14				
VT (L)		2.40				
TI (s)		0.51				
TE(s)		0.52				
VE (I/M)		140.28				
VT/TI(L/S)		4.68				
TI/T.TOT		0.50				
IC		3.28				
MVV	119.67	74.82	62.53			
FEF50 %(L/S)		5.98				
FIF50 %(L/S)		6.78				
FEF50/FIF50 %		0.88				

Diagnosis :

Normal Spirometry (FVC and FEV1/FVC>80% of Predicted value)

Dr.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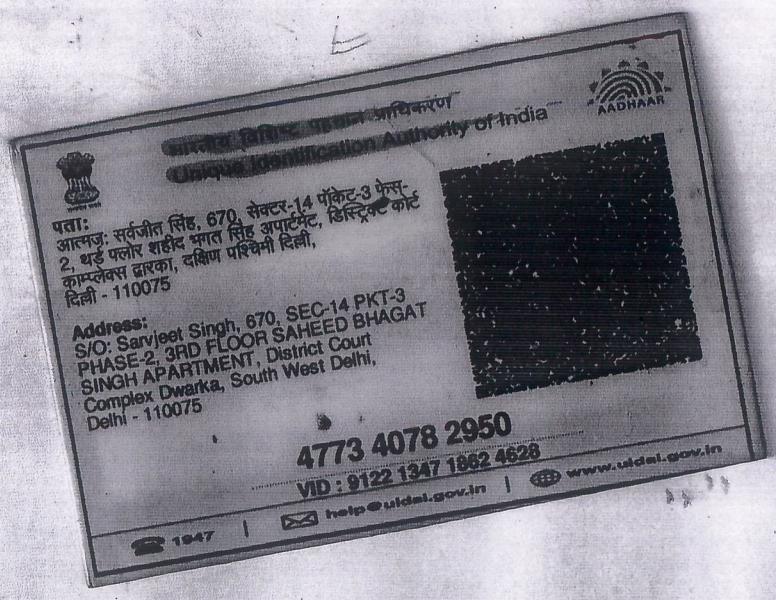
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