

LABORATORY INVESTIGATION REPORT

Patient Name : Mr. Abhinab Ravi
UHID : NMHK.2117545
Episode : OP
Ref. Doctor : NMH
Address : 3 C/1, GANGOTRI APARTMENT , KOLKATA
,Kolkata,West Bengal ,700068

Age/Sex : 32 Year(s) / Male
Order Date : 13/11/2021 09:43
Mobile No : 9968224775
Facility : NARAYAN MEMORIAL HOSPITAL

Immunology

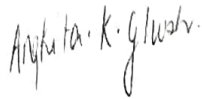
INVESTIGATION	RESULTS	UNITS	BIOLOGICAL REF RANGE
Sample No : 07H0047332	Collection Date : 13/11/21 09:44	Ack Date : 13/11/2021 12:11	Report Date : 13/11/21 17:01

BLOOD GROUPING & Rh TYPING

SAMPLE : EDTA BLOOD

BLOOD GROUP : 'O'
RH TYPE : POSITIVE

End of Report



Dr. ANGKITA K. GHOSH
MBBS, MD(PATH)
(CONSULTANT PATHOLOGIST)
RegNo: 82734
Checked By

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Hematology

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COMPLETE HAEMOGRAM (CBC)

SAMPLE : EDTA BLOOD

HAEMOGLOBIN (HB)	14.9	gm/dl	13 - 17
RBC COUNT	5.35	$\times 10^6/\text{ul}$	4.5 - 5.5
TOTAL WBC COUNT	7.5	$10^3/\text{cmm}$	4 - 10
PLATELET COUNT	260	$10^3/\text{cmm}$	150 - 410
PCV	43	%	40 - 50
MCV	81 ▼	fl	83 - 101
MCH	28	pg	27 - 32
MCHC	34	gm/dl	31.5 - 34.5
ESR	20	mm/hr	≤ 10

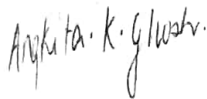
DIFFERENTIAL COUNT

NEUTROPHILS	70	%	40 - 80
LYMPHOCYTES	27	%	20 - 40
MONOCYTES	02	%	2 - 10
EOSINOPHILS	01	%	1 - 6
BASOPHILS	00	%	0 - 2

PERIPHERAL BLOOD SMEAR

RBC Normocytic normochromic

End of Report



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Biochemistry

INVESTIGATION	RESULTS	UNITS	BIOLOGICAL REF RANGE
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KIDNEY FUNCTION TEST

SERUM CREATININE

SAMPLE : SERUM

SERUM CREATININE 0.8 mg/dl 0.6 - 1.2
Method - Jaffe Gen2 Compensated

BLOOD UREA NITROGEN

BLOOD UREA NITROGEN 7.47 mg/dl 6 - 20
Method - Calculated

URIC ACID

SAMPLE : SERUM

URIC ACID 6.9 mg/dl 3.5 - 7.2
Method - Enzymatic Colorimetric

LIVER FUNCTION TEST (LFT)

SAMPLE : SERUM

TOTAL BILIRUBIN 0.4 mg/dl 0 - 2
Method - Diazo Method

DIRECT BILIRUBIN 0.1 mg/dl 0 - 0.2
Method - Diazo Method

INDIRECT BILIRUBIN 0.3 mg/dl 0.2 - 0.9
Method - Calculated

SGPT (ALT) **115 ▲** U/L 0 - 34
Method - IFCC Without Pyridoxal Phosphate

SGOT (AST) **59 ▲** U/L 0 - 31
Method - IFCC Without Pyridoxal Phosphate

ALKALINE PHOSPHATASE 115 U/L 53 - 128
Method - IFCC

TOTAL PROTEIN 7.9 g/dl 6.4 - 8.2
Method - Biuret

ALBUMIN 4.6 gm/dl 3.5 - 5.2
Method - Bromocresol Green

GLOBULIN 3.3 g/dl 2 - 3.5
Method - Calculated

ALBUMIN:GLOBULIN 1.4 - 1.1 - 2.5
Method - Calculated

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GGT 55 U/L 8 - 61
Method - Enzymatic colorimetric assay

LIPID PROFILE

SAMPLE : SERUM

TOTAL CHOLESTEROL 163 mg/dl Desirable <200 |
Borderline 200-239 |
High >=240

HDL CHOLESTEROL 35 ▼ mg/dl 40 - 60
Method - CHOD-PAP

LDL CHOLESTEROL 107 mg/dl Optimal < 100 |
Borderline 130
Method - Homogenous Enzymatic Colorimetric

VLDL 28.60 mg/dl 0 - 30
Method - CALCULATED

CHOLESTEROL-HDL RATIO 4.66 -
LDL-HDL RATIO 3.06 -
TRIGLYCERIDES 143 mg/dl Desirable <150 |
Borderline 150 - 200 |
High >200
Method - Enzymatic Colorimetric

Sample No : 07H0047332A Collection Date : 13/11/21 09:44 Ack Date : 13/11/2021 12:13 Report Date : 13/11/21 19:19

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

HBA1C 6.5 ▲ % Non-diabetic : 4-6
Method - By HPLC

- HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose.
- HbA1c has been endorsed by clinical group & American Diabetes Association guidelines 2017, for diagnosis of Diabetes using a cut-off point of 6.5%.
- Trends in HbA1c are a better indicator of diabetic control than a solitary test.
- Low HbA1c in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (Specially in Severe iron deficiency anaemia and hemolytic), chronic renal failure and liver disease. Clinical correlation suggested.
- Interference of Haemoglobinopathies in HbA1c estimation.
 - a) For HbF > 25%, an alternate platform (fructosamine) is recommended for testing of HbA1c.
 - b) Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status.

Note: Hemoglobin electrophoresis (HPLC method) is recommended for detecting hemoglobinopathy.
c) Heterozygous state detected (D10/turbo is corrected for HbS and HbC trait).
6. For known diabetic patients, following values can be considered as a tool for monitoring the glycemc control:
Excellent control:- 6 - 7%,
Fair to good control:- 7 - 8%,
Unsatisfactory control:- 8 - 10%
Poor control >10%

Sample No : 07H0047332B Collection Date : 13/11/21 09:44 Ack Date : 13/11/2021 12:14 Report Date : 13/11/21 19:02

BLOOD SUGAR(F)

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Facility : NARAYAN MEMORIAL HOSPITAL

SAMPLE : PLASMA

BLOOD SUGAR FASTING

82

mg/dl

70 - 110

Method - Hexokinase

Sample No : 07H0047382B

Collection Date : 13/11/21 14:12

Ack Date : 13/11/2021 14:46

Report Date : 15/11/21 13:09

BLOOD SUGAR(PP)

BLOOD SUGAR PP

94

mg/dl

80 - 140

Method - Hexokinase

End of Report



Dr.S. Chatterjee
MD, MBBS, FAACC
(CONSULTANT BIOCHEMIST)

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Clinical Pathology

INVESTIGATION	RESULTS	UNITS	BIOLOGICAL REF RANGE
Sample No : 07H0047332	Collection Date : 13/11/21 09:44	Ack Date : 13/11/2021 14:25	Report Date : 14/11/21 09:42

URINE FOR R/E

SAMPLE : URINE

PHYSICAL EXAMINATION

VOLUME	40	ml	
COLOUR	PALE STRAW		
APPEARANCE	CLEAR		
SPECIFIC GRAVITY	1.020		1.010 - 1.030
REACTION(pH)	ACIDIC 6.0		

CHEMICAL EXAMINATION

SUGAR	ABSENT	ABSENT
ALBUMIN.	ABSENT	ABSENT
BLOOD	ABSENT	ABSENT
KETONE	ABSENT	ABSENT
BILE SALT	ABSENT	ABSENT
BILE PIGMENTS	ABSENT	ABSENT

MICROSCOPIC EXAMINATION

PUS CELLS	2-3 / HPF	<5/HPF
EPITHELIAL CELLS	1-2 / HPF	<20/HPF
RBC	NIL	
CAST	ABSENT	ABSENT
CRYSTAL	ABSENT	ABSENT

Please correlate clinically.

End of Report

Angkita K. Ghosh

Dr. ANGKITA K. GHOSH
MBBS, MD(PATH)
(CONSULTANT PATHOLOGIST)
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Immunoassay

INVESTIGATION	RESULTS	UNITS	BIOLOGICAL REF RANGE
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THYROID FUNCTION TEST

SAMPLE : SERUM

T3	1.29	ng/ml	0.6 - 1.8
<i>Method - ECLIA</i>			
T4	7.33	ug/dL	5.4 - 11.7
<i>Method - ECLIA</i>			
TSH	1.83	uIU/ml	Adult Male – 0.27-5.50 Adult Female – 0.27-5.50 Newborns - <25 Upto 12 years – 0.3-5

Method - ECLIA

Interpretations:

- For diagnostic purposes, the result should always be assessed in conjunction with the patient's medical history, clinical examinations and other findings.
- The assay is unaffected by icterus (Bilirubin < 701 µmol/L or < 41 mg/dL), hemolysis (Hb < 0.621 mmol/L or < 1 g/dL), lipemia (Intralipid < 1500 mg/dL), biotin (<102 nmol/L or < 25 ng/ml), IgG < 2 g/dL and IgM < 0.5 g/dL)
- There is no high dose hook effect at TSH concentrations upto 1000 µmol/ml.
- TSH values may be transiently altered because of non thyroidal illness like several infections, liver disease, renal and heart failure, several burns, trauma and surgery etc. Drugs that decrease TSH values e.g. L-dopa, Glucocorticoid drugs that increase TSH values e.g. Iodine, Lithium, Amiodarone.
- The assay is unaffected by icterus (bilirubin < 633 µmol/L or < 37 mg/dl), hemolysis (Hb < 1.4 mmol/L or < 2.3 g/dl), lipemia (triglycerides < 28.5 mmol/L or 2500 mg/dl) and biotin (< 409 nmol or < 100 ng/ml).
- The assay is unaffected by icterus (bilirubin < 599 µmol/L or < 35 mg/dl), hemolysis (Hb < 1.2 mmol/L or < 2.0 g/dl), lipemia (Intralipid < 1800 mg/dl) and biotin (< 123 nmol or < 30 ng/ml).

End of Report



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DIAGNOSTICS REPORT

Patient Name	: Mr. Abhinab Ravi	Order Date	: 13/11/2021 09:43
Age/Sex	: 32 Year(s)/Male	Report Date	: 13/11/2021 19:26
UHID	: NMHK.2117545	IP No	:
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CHEST X-RAY REPORT OF PA VIEW

Lung fields are clear. No focal parenchymal opacity is seen.
No appreciable pleural thickening / calcification is noted.
Costo-phrenic angles are normal.
Cardiac shadow appears normal.
Bilateral hilar shadows are normal.
No obvious bony abnormality is seen.



Dr. MADHUSHREE RAY NASKAR ,
MBBS, DMRD

Consultant Radiologist

RegNo: 57032

DIAGNOSTICS REPORT

Patient Name	: Mr. Abhinab Ravi	Order Date	: 13/11/2021 09:43
Age/Sex	: 32 Year(s)/Male	Report Date	: 13/11/2021 16:34
UHID	: NMHK.2117545	IP No	:
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2D ECHOCARDIOGRAPHY WITH M-MODE MEASUREMENTS

2D and M-Mode :

IVS (d)	11 mm	Aorta (at sinuses)	27 mm
LVID (d)	49 mm	LA diameter	35 mm
LVPW (d)	11 mm	RVID (d) - basal	16 mm
LVID (s)	25 mm	TAPSE	24 mm
LVEF	62 %		

Estimated PASP = 19 mmHg

FINDINGS

Left Ventricle :

Cavity size : Normal.

Wall thickness : Normal.

Segmental wall motion : No abnormality found.

Global systolic function : Normal. (EF = 62 %)

Diastolic function : Normal.

Left Atrium :Normal sized; no clot in body of appendage.

Right Ventricle and Right Atrium :Normal sized; normal RV systolic function.

Mitral Valve :Normal leaflets, good excursion, normal subvalvular apparatus. No regurgitation / No MS.

Aortic valve :Structurally normal, trileaflet, normal motion, no regurgitation.

Pulmonary Valve :Normal structure, adequate opening.

Tricuspid Valve :Normal structure, normal excursion. Trivial TR. TR gradient = 14

DIAGNOSTICS REPORT

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mmHg.

Interarterial and Interventricular Septum :No breach could be seen.

Aorta :Normal sized root and proximal aorta.

Pulmonary Artery :Normal, no pulmonary arterial hypertension.

Pericardium :Normal, no effusion.

Inferior Vena Cava :IVC normal diameter, > 50% respiratory variation.

Others :No thrombus, mass, vegetation seen.

IMPRESSION:

Status of Patient :

- * No regional wall motion abnormality at rest.
- * Good LV systolic function (EF = 62 %).
- * Good RV systolic function (TAPSE = 24 mm).
- * Normal valve morphology.
- * Normal LV diastolic function.
- * No pericardial effusion.
- * No pulmonary arterial hypertension.

Dr.INDIRA BANERJEE ,
MD,DNB,MRCPCH (UK)

Board Certified Comprehensive
Echocardiographer (USA)

DIAGNOSTICS REPORT

Patient Name	: Mr. Abhinab Ravi	Order Date	: 13/11/2021 09:43
Age/Sex	: 32 Year(s)/Male	Report Date	: 13/11/2021 16:48
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ELECTROCARDIOGRAM REPORT (ECG)

HR	: 68 bpm
Rhythm	: Sinus
P wave	: Normal
PR Interval	: 130 msec
QRS axis	: Normal (28 Degree)
QRS duration	: 84 msec
QRS configuration	: Normal
T wave	: Non specific changes
ST segment	: Non specific changes
QTc	: 387 msec
QT	: 360 msec

IMPRESSION:

- Sinus rhythm. Normal QRS axis.
- Early repolarization changes.
- Non specific ST-T changes.

Clinical correlation please.



Dr.INDIRA BANERJEE ,
MD,DNB,MRCPC (UK)

Board Certified Comprehensive
Echocardiographer (USA)

RBHINRB RAUI
2117545

32 years
..... cm / kg
..... M / F

HR 68/min

Intervals:
RR 880 ms
P 78 ms
PR 130 ms
QRS 84 ms
QT 360 ms
QTc 387 ms
(Bazett)
10 mm/mV

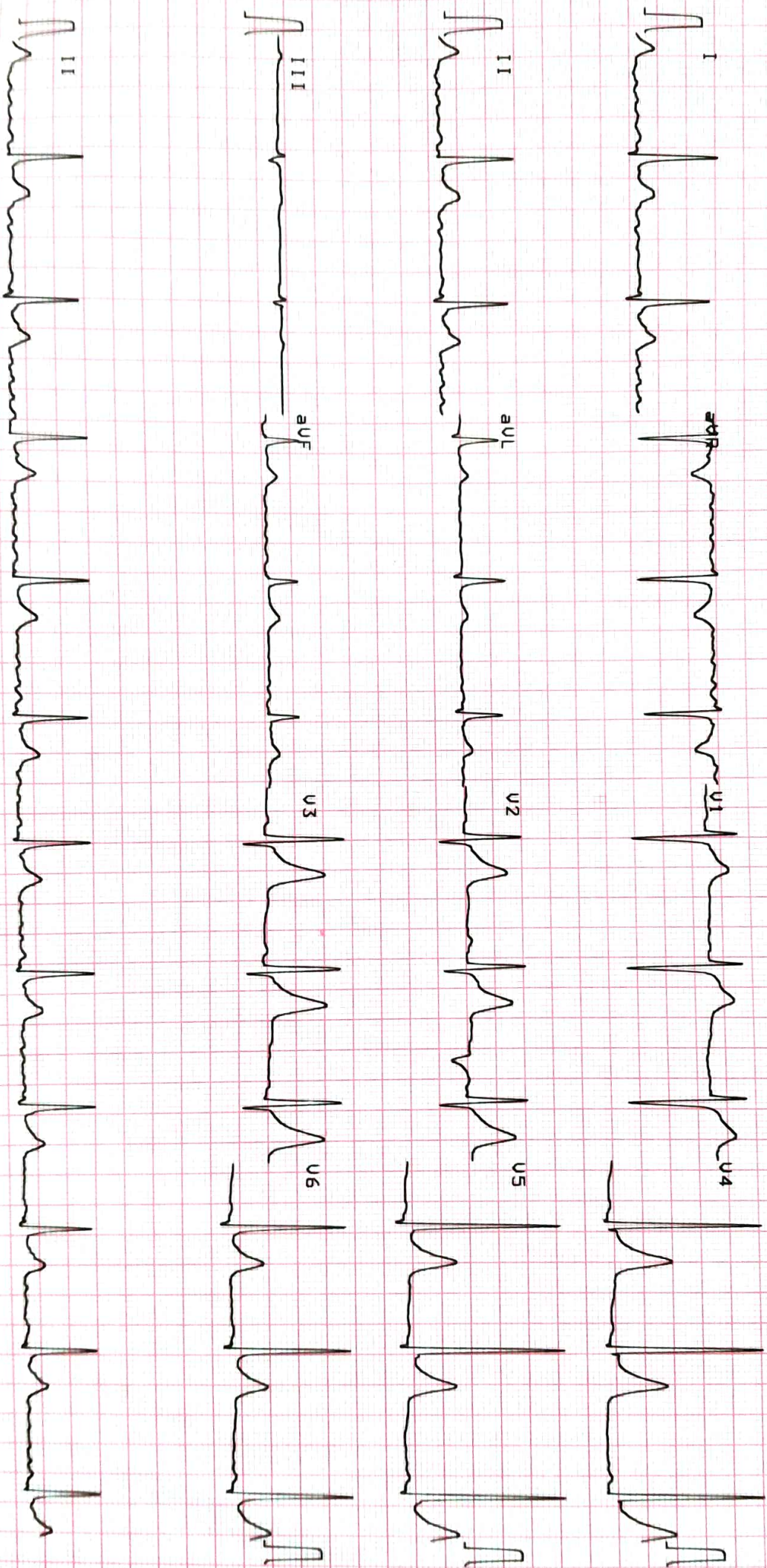
Axis:
P 36 °
QRS 28 °
T 34 °

P (II) 0.07 mV
S (V1) -1.58 mV
R (V5) 3.08 mV
Sokol. 4.65 mV

SINUS RHYTHM
OTHERWISE NORMAL ECG
6.02

UNCONFIRMED REPORT

10 mm/mV



mm/mV

MADE IN INDIA

DIAGNOSTICS REPORT

Patient Name	: Mr. Abhinab Ravi	Order Date	: 13/11/2021 09:43
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USG REPORT OF WHOLE ABDOMEN (SCREENING)

LIVER : Liver is normal in size. **Parenchymal echogenicity is raised.** Intrahepatic biliary radicles are not dilated. No focal mass lesion is seen.

PORTA :PV : Normal. PV measures 1.0 cm.

CD : Normal . CD measures 0.4 cm.

GALL BLADDER :Gall bladder is normal in size, contour, outline and position. No calculus is seen. Wall thickness is normal.

PANCREAS :Pancreas is normal in size and parenchymal echogenicity. Pancreatic duct is not dilated.

SPLEEN :Spleen is not enlarged and parenchyma shows normal homogeneous pattern.

KIDNEYS :Both kidneys are normal in size, shape, outline, position and parenchymal echogenicity. Corticomedullary differentiation maintained. No evidence of any calculus/ mass / hydronephrosis is seen. Right kidney measures : 9.8 cm & Left kidney measures : 10.2 cm.

URINARY BLADDER : Urinary bladder is normal in contour, outline and distension. No vesical lesion is seen.

PROSTATE : Prostate is normal size, outline and echotexture appear normal. No focal lesion is seen. Prostate measures 3.4 cm x 3.2 cm x 3.0 cm. It weight approx 18 gm.

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PERITONEUM : : No free fluid is noted.

RETROPERITONEUM : IVC and aorta appear normal. No lymphadenopathy is seen.

IMPRESSION : Diffuse fatty changes in liver.



Dr. MADHUSHREE RAY NASKAR ,
MBBS,DMRD

Consultant Radiologist

RegNo: 57032