

Name	BHASKAR A	ID	IND649252
Age & Gender	47Year(s)/MALE	Visit Date	4/14/2022 12:00:00 AM
Ref Doctor Name	MediWheel		

2 D ECHOCARDIOGRAPHIC STUDY

M mode measurement:

AORTA	:	2.7cms
LEFT ATRIUM	:	3.5cms
AVS	:	----
LEFT VENTRICLE (DIASTOLE)	:	4.3cms
(SYSTOLE)	:	2.9cms
VENTRICULAR SEPTUM (DIASTOLE)	:	0.9cms
(SYSTOLE)	:	1.2cms
POSTERIOR WALL (DIASTOLE)	:	0.9cms
(SYSTOLE)	:	1.4cms
EDV	:	84ml
ESV	:	33ml
FRACTIONAL SHORTENING	:	32%
EJECTION FRACTION	:	61%
EPSS	:	---
RVID	:	1.7cms

DOPPLER MEASUREMENTS:

MITRAL VALVE	:	E' 0.47 m/s	A' 0.65 m/s	NO MR
AORTIC VALVE	:	1.10 m/s		NO AR
TRICUSPID VALVE	:	E' 1.61 m/s	A' - m/s	NO TR
PULMONARY VALVE	:	0.96 m/s		NO PR

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2D ECHOCARDIOGRAPHY FINDINGS:

Left ventricle : Normal size, Normal systolic function.
No regional wall motion abnormalities.

Left Atrium : Normal.

Right Ventricle : Normal.

Right Atrium : Normal.

Mitral valve : Normal, No mitral valve prolapsed.

Aortic valve : Normal, Trileaflet.

Tricuspid valve : Normal.

Pulmonary valve : Normal.

IAS : Intact.

IVS : Intact.

Pericardium : No pericardial effusion.

IMPRESSION:

- **LV DIASTOLIC DYSFUNCTION.**
- **NORMAL SIZED CARDIAC CHAMBERS.**
- **NORMAL LV SYSTOLIC FUNCTION. EF:61 %.**
- **NO REGIONAL WALL MOTION ABNORMALITIES.**
- **NORMAL VALVES.**
- **NO CLOTS / PERICARDIAL EFFUSION / VEGETATION.**

DR. K.S. SUBRAMANI. MBBS, MD, DM (CARDIOLOGY) FESC
SENIOR CONSULTANT INTERVENTIONAL CARDIOLOGIST
Kss/da

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Note:

- * **Report to be interpreted by qualified medical professional.**
- * **To be correlated with other clinical findings.**
- * **Parameters may be subjected to inter and intra observer variations.**

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ABDOMINO-PELVIC ULTRASONOGRAPHY

LIVER is normal in size and shows diffuse mild fatty changes. No evidence of focal lesion or intrahepatic biliary ductal dilatation. Hepatic and portal vein radicals are normal.

GALL BLADDER shows normal shape and has clear contents. Gall bladder wall is of normal thickness. CBD is of normal calibre.

PANCREAS has normal shape, size and uniform echopattern. No evidence of ductal dilatation or calcification.

SPLEEN shows normal shape, size and echopattern. Spleen measures 10.5cms in long axis and 4.8cms in short axis.
No demonstrable Para -aortic lymphadenopathy.

KIDNEYS move well with respiration and have normal shape, size and echopattern. Cortico- medullary differentiations are well madeout. No evidence of calculus or hydronephrosis.

The kidney measures as follows:

	Bipolar length (cms)	Parenchymal thickness (cms)
Right Kidney	11.0	1.3
Left Kidney	10.6	1.4

URINARY BLADDER shows normal shape and wall thickness. It has clear contents. No evidence of diverticula.

PROSTATE shows normal shape, size and echopattern. It measures 3.2 x 3.2 x 3.1cms (Vol:17cc).

No evidence of ascites / pleural effusion.

IMPRESSION:

➤ **MILD FATTY CHANGES IN THE LIVER.**

DR. H.K. ANAND
CONSULTANT RADIOLOGISTS
MS/vp

DR. MEERA S

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Age & Gender	47Year(s)/MALE	Visit Date	4/14/2022 12:00:00 AM
Ref Doctor Name	MediWheel		

Name	BHASKAR A	Customer ID	IND649252
Age & Gender	47Y/M	Visit Date	Apr 14 2022 8:53AM
Ref Doctor	MediWheel		

X - RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Cardiac size is within normal limits.

Bilateral hilar regions appear normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

IMPRESSION:

No significant abnormality detected.

DR. H.K. ANAND

DR. SHWETHA S

DR. CHARUL



DR. APARNA

CONSULTANT RADIOLOGISTS

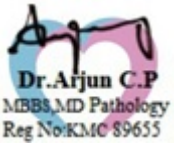
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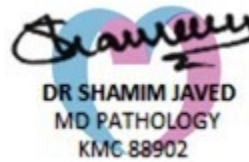
HAEMATOLOGY

Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	15.8	g/dL	13.5 - 18.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood/Derived from Impedance)	47.5	%	42 - 52
RBC Count (EDTA Blood/Impedance Variation)	4.76	mill/cu.mm	4.7 - 6.0
Mean Corpuscular Volume(MCV) (EDTA Blood/Derived from Impedance)	100.0	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood/Derived from Impedance)	33.3	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood/Derived from Impedance)	33.3	g/dL	32 - 36
RDW-CV (EDTA Blood/Derived from Impedance)	12.9	%	11.5 - 16.0
RDW-SD (EDTA Blood/Derived from Impedance)	45.15	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood/Impedance Variation)	6500	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood/Impedance Variation & Flow Cytometry)	44.3	%	40 - 75
Lymphocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	44.5	%	20 - 45



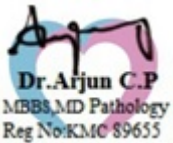
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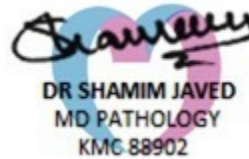
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Eosinophils (EDTA Blood/Impedance Variation & Flow Cytometry)	3.9	%	01 - 06
Monocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	6.5	%	01 - 10
Basophils (Blood/Impedance Variation & Flow Cytometry)	0.8	%	00 - 02
Absolute Neutrophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	2.88	10 ³ / μ l	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	2.89	10 ³ / μ l	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood/Impedance Variation & Flow Cytometry)	0.25	10 ³ / μ l	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.42	10 ³ / μ l	< 1.0
Absolute Basophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.05	10 ³ / μ l	< 0.2
Platelet Count (EDTA Blood/Impedance Variation)	227	10 ³ / μ l	150 - 450
MPV (EDTA Blood/Derived from Impedance)	8.7	fL	7.9 - 13.7
PCT (EDTA Blood/Automated Blood cell Counter)	0.20	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Citratd Blood/Modified Westergren)	3	mm/hr	< 15



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BIOCHEMISTRY

Liver Function Test

Bilirubin(Total) (Serum/Diazotized Sulfanilic Acid)	0.6	mg/dL	0.1 - 1.2
Bilirubin(Direct) (Serum/Diazotized Sulfanilic Acid)	0.2	mg/dL	0.0 - 0.3
Bilirubin(Indirect) (Serum/Derived)	0.4	mg/dL	0.1 - 1.0
Total Protein (Serum/Biuret)	7.4	gm/dL	6.0 - 8.0
Albumin (Serum/Bromocresol green)	5.2	gm/dL	3.5 - 5.2
Globulin (Serum/Derived)	2.2	gm/dL	2.3 - 3.6
A : G Ratio (Serum/Derived)	2.4		1.1 - 2.2
SGOT/AST (Aspartate Aminotransferase) (Serum/IFCC Kinetic)	37	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/IFCC / Kinetic)	62	U/L	5 - 41
Alkaline Phosphatase (SAP) (Serum/IFCC Kinetic)	69	U/L	53 - 128
GGT(Gamma Glutamyl Transpeptidase) (Serum/SZASZ standarised IFCC)	322	U/L	< 55



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<u>Lipid Profile</u>			
Cholesterol Total (Serum/Cholesterol oxidase/Peroxidase)	201	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/Glycerol phosphate oxidase / peroxidase)	256	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the usual circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immunoinhibition)	43	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 40 - 59 High Risk: < 40
LDL Cholesterol (Serum/Calculated)	106.8	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	51.2	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	158.0	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220



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INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.

Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	4.7		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
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Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	6		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
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LDL/HDL Cholesterol Ratio (Serum/Calculated)	2.5		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0
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<u>Glycosylated Haemoglobin (HbA1c)</u>			
HbA1C (Whole Blood/HPLC)	9.4	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5

INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %

Estimated Average Glucose 223.08 mg/dL
(Whole Blood)

INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycaemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.

Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.


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IMMUNOASSAY

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/CMIA)	0.778	ng/mL	0.7 - 2.04
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INTERPRETATION:

Comment :

Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.

T4 (Thyroxine) - Total (Serum/CMIA)	5.09	µg/dL	4.2 - 12.0
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INTERPRETATION:

Comment :

Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

TSH (Thyroid Stimulating Hormone) (Serum/Chemiluminescent Microparticle Immunoassay(CMIA))	1.78	µIU/mL	0.35 - 5.50
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INTERPRETATION:

Reference range for cord blood - upto 20

1 st trimester: 0.1-2.5

2 nd trimester 0.2-3.0

3 rd trimester : 0.3-3.0

(Indian Thyroid Society Guidelines)

Comment :

1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.

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

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.


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CLINICAL PATHOLOGY

PHYSICAL EXAMINATION

Colour (Urine)	Pale Yellow		
Appearance (Urine)	Clear		Clear
Volume (Urine)	15	mL	


CHEMICAL EXAMINATION(Automated-Urineanalyser)

pH (Urine/AUTOMATED URINANALYSER)	5.0		4.5 - 8.0
Specific Gravity (Urine)	1.030		1.002 - 1.035
Ketones (Urine)	Negative		Negative
Urobilinogen (Urine/AUTOMATED URINANALYSER)	0.2		0.2 - 1.0
Blood (Urine/AUTOMATED URINANALYSER)	Negative		Negative
Nitrite (Urine/AUTOMATED URINANALYSER)	Negative		Negative
Bilirubin (Urine/AUTOMATED URINANALYSER)	Negative		Negative
Protein (Urine)	Negative		Negative



Dr SURAJ JAEN
 Consultant Pathologist
 Reg No : 80423

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Glucose (Urine)	Trace		Negative
Leukocytes (Urine)	Negative	leuco/uL	Negative
<u>MICROSCOPY(URINE DEPOSITS)</u>			
Pus Cells (Urine/Flow cytometry)	1-2	/hpf	3-5
Epithelial Cells (Urine)	0-1	/hpf	1-2
RBCs (Urine/Flow cytometry)	Nil	/hpf	NIL
Others (Urine)	Nil		Nil
Casts (Urine/Flow cytometry)	Nil	/hpf	0 - 1
Crystals (Urine)	Nil		NIL



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IMMUNOHAEMATOLOGY

BLOOD GROUPING AND Rh TYPING (EDTA Blood/Agglutination)	'O' Positive'		
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Dr. Arjun C.P
MBBS, MD Pathology
Reg No:KMC 89655

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<u>BIOCHEMISTRY</u>			
BUN / Creatinine Ratio	8		6 - 22
Glucose Fasting (FBS) (Plasma - F/GOD - POD)	157	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose Fasting - Urine (Urine - F)	Trace		Negative
Glucose Postprandial (PPBS) (Plasma - PP/GOD - POD)	314	mg/dL	70 - 140

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti-diabetic medication during treatment for Diabetes.

Glucose Postprandial - Urine (Urine - PP)	Sample Not Given		Negative
Blood Urea Nitrogen (BUN) (Serum/Urease-GLDH)	14	mg/dL	7.0 - 21
Creatinine (Serum/Jaffe Kinetic)	1.0	mg/dL	0.9 - 1.3

INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin ,cefazolin, ACE inhibitors ,angiotensin II receptor antagonists,N-acetylcyteine , chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/Uricase/Peroxidase)	7.1	mg/dL	3.5 - 7.2
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<u>IMMUNOASSAY</u>			
Prostate specific antigen - Total(PSA) (Serum/Chemiluminescent Microparticle Immunoassay(CMIA))	0.098	ng/mL	Normal: 0.0 - 4.0 Inflammatory & Non Malignant conditions of Prostate & genitourinary system: 4.01 - 10.0 Suspicious of Malignant disease of Prostate: > 10.0

INTERPRETATION: Analytical sensitivity: 0.008 - 100 ng/mL

PSA is a tumor marker for screening of prostate cancer. Increased levels of PSA are associated with prostate cancer and benign conditions like bacterial infection, inflammation of prostate gland and benign hypertrophy of prostate/ benign prostatic hyperplasia (BPH).

Transient elevation of PSA levels are seen following digital rectal examination, rigorous physical activity like bicycle riding, ejaculation within 24 hours.

PSA levels tend to increase in all men as they age.

Clinical Utility of PSA:

ÉIn the early detection of Prostate cancer.

ÉAs an aid in discriminating between Prostate cancer and Benign Prostatic disease.

ÉTo detect cancer recurrence or disease progression.


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-- End of Report --