PARAS MRI & ULTRASOUND CENTRE

MOST ADVANCED 32 CHANNEL 3T 3D WHOLE BODY MRI

261, ASHAPURAM, OPP. DR. BASU EYE HOSPITAL, STADIUM ROAD, BAREILLY

• Helpline : 7300761761 • E-mail : parasmribly@gmail.com

REPORT

4D / 5D ULTRASOUND | COLOR DOPPLER | TVS/ TRUS | MUSCULOSKELETAL USG

Date : 11.3.2023
Name : PRAVEEN KUMAR 31Y/M
Ref.By : APPLE CARDIAC CARE

==========

ULTRASOUND WHOLE ABDOMEN

==========

LIVER - Liver is normal in size and outline. ***It shows increased echogenicity***. No obvious focal pathology is seen. The intra hepatic billary radicals are not dilated. PV –normal.

GALL BLADDER -Gall Bladder is normal in size, has normal wall thickness with no evidence of calculi. Fat planes between GB and liver are well maintained. The CBD appears normal.

PANCREAS - Pancreas is normal in size and echogenicity. Its outlines are distinct. No obvious focal lesion, calcification or ductile dilatation is seen.

SPLEEN - Spleen is normal in size and echogenicity. There is no evidence of collaterals

KIDNEYS - Both kidneys are normal in position, outline and echogenicity. **Few calculi are seen at mid pole of left kidney largest upto ~ 6mm with no associated hydronephrosis. 3-4 mm concretion seen at mid pole of right kidney.** CMD is maintained. No evidence of hydronephrosis is seen on either side.

URINARY BLADDER -Urinary Bladder is normal in size and outline. There is no evidence of any obvious intraluminal or paramedical pathology. **Wall is not thickened. Both VUJ clear.**

PROSTATE- Normal in size and echotextrue.

No evidence of ascites/pleural effusion/ adenopathy is seen. Bowel loops are not dilated. Bilateral iliac fossa appears normal

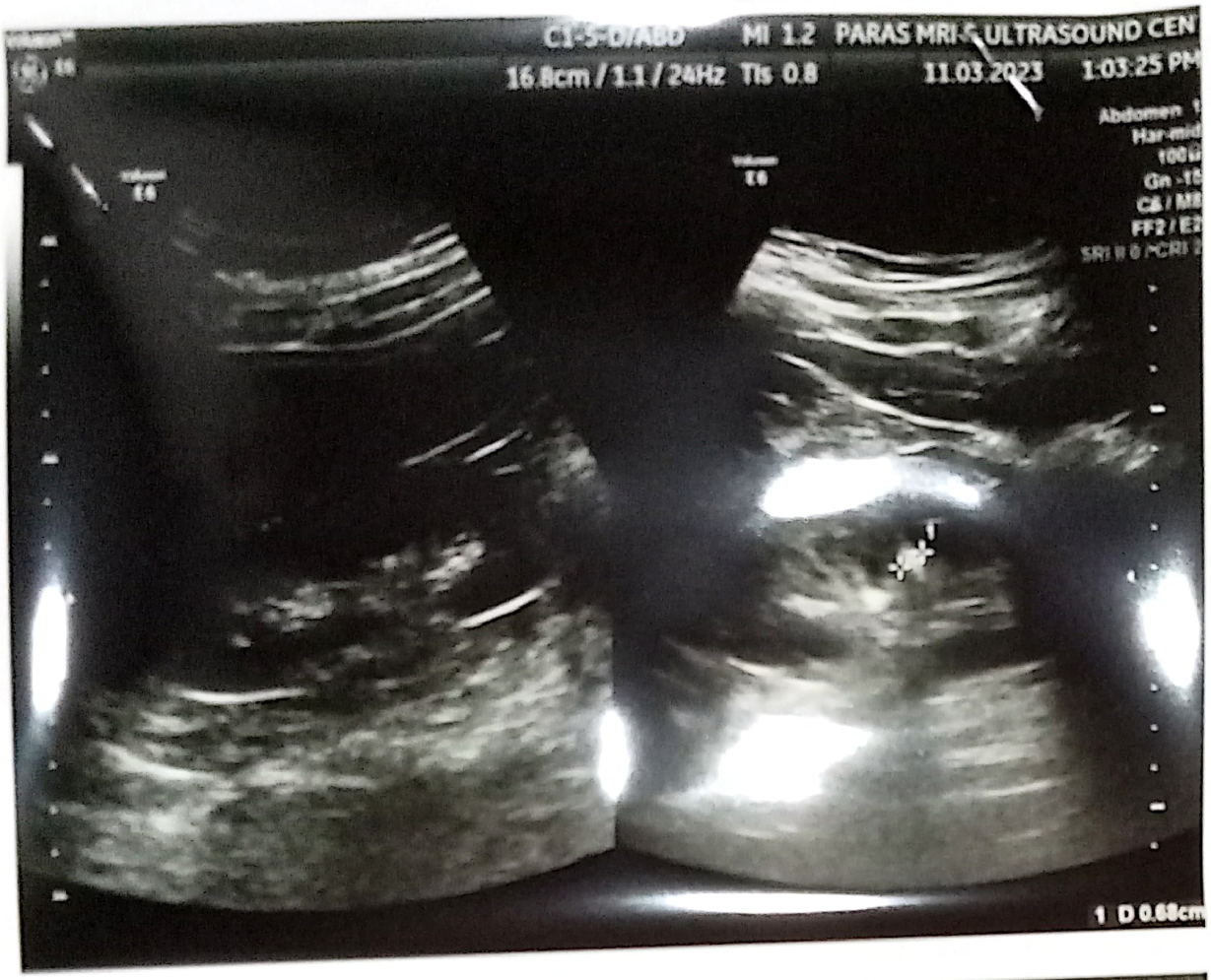
IMPRESSION:

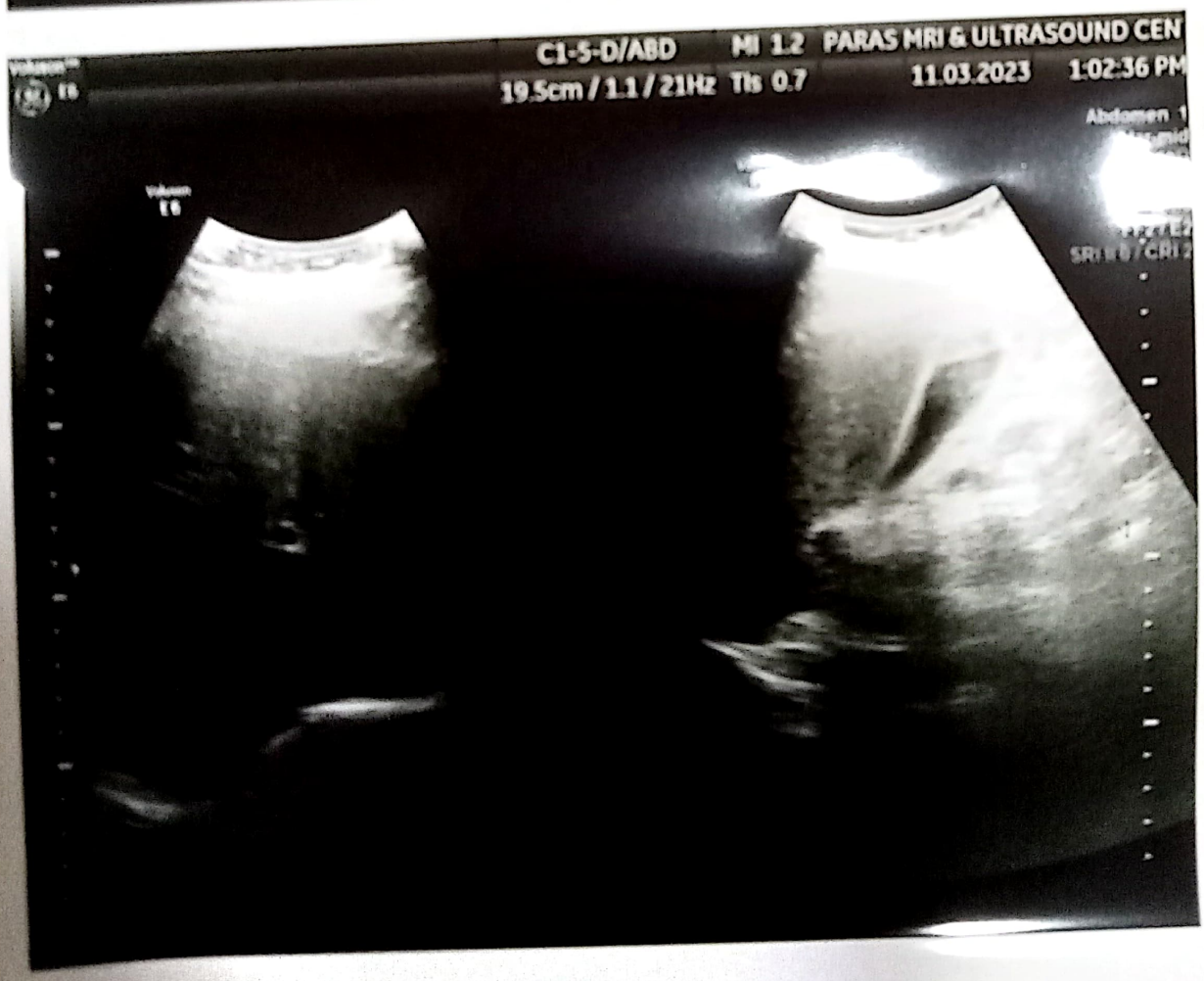
- **Left renal calculi with no associated hydronephrosis.**
- **Right renal concretions.**
- **Grade I fatty liver.**

Adv- clinical correlation.

Dr. Puja Tripathi
M.B.B.S., M.D.
MBBS, MD (Radiodiagnosis, SGPGI)

NOT VALID FOR MEDICO LEGAL PURPOSE


C1-5-D/ABD MI 1.2 PARAS MRI & ULTRASOUND CEN
16.8cm / 1.1 / 24Hz TIs 0.8 11.03.2023 1:03:25 PM
Abdomen
1 D 0.68cm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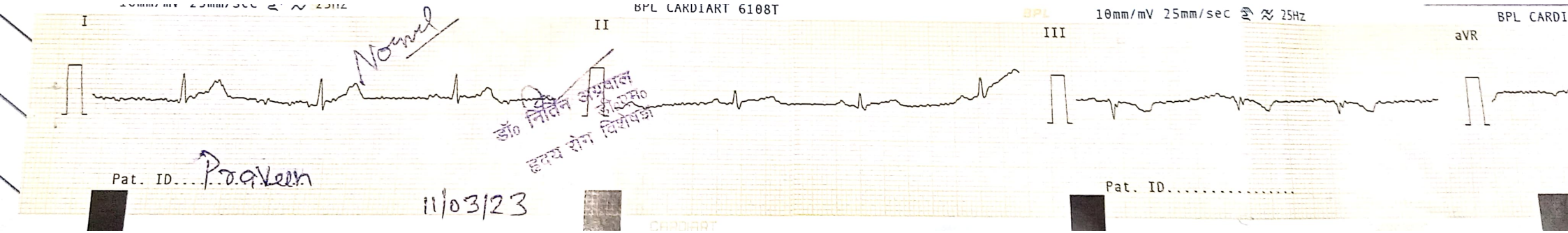
Abdomen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aVR
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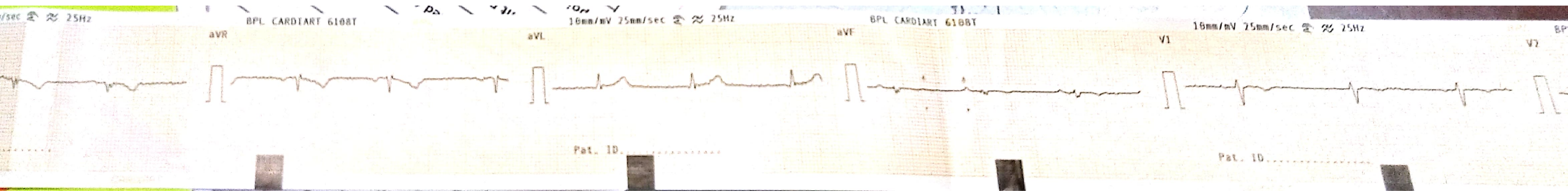
10mm/mV 25mm/sec ≈ 25Hz
BPL CARDI
Normal
डॉ० निर्दिन अग्रवाल
हृदय रोग विशेषज्ञ
Pat. ID....Praveen
11/03/23
Pat. ID.....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Pat. ID.
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10mm/mV 25mm/sec ≈ 25Hz
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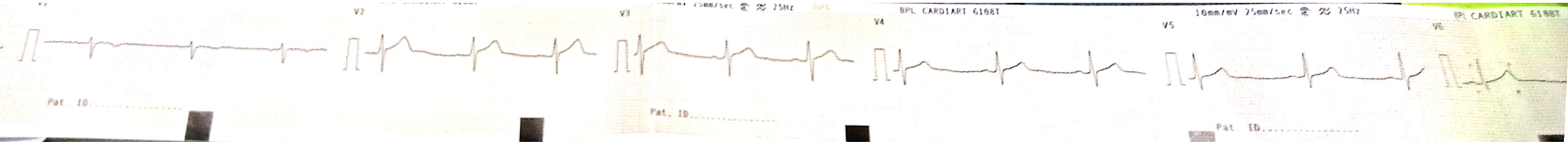
V2
Pat. ID.


V2
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BPL CARDIART 6108T
V6
Pat. ID
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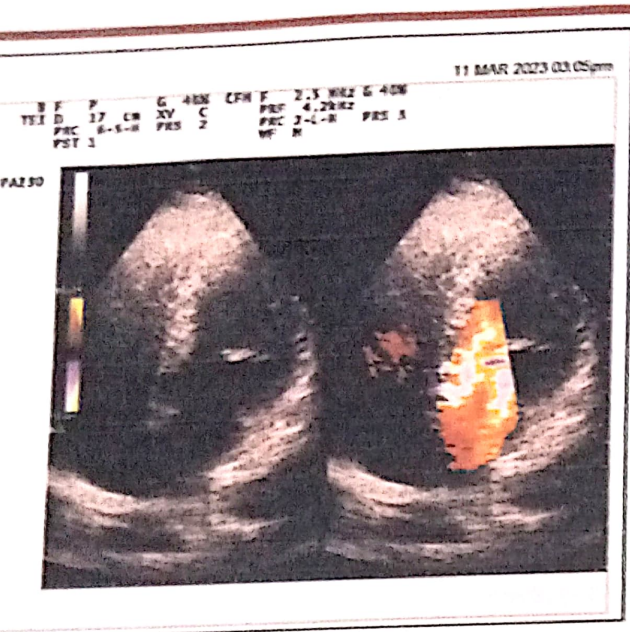
Pat. ID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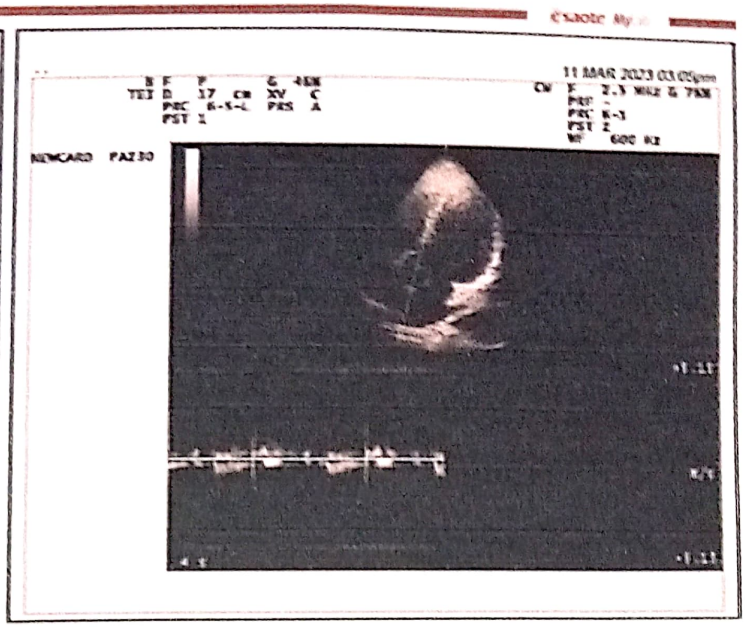
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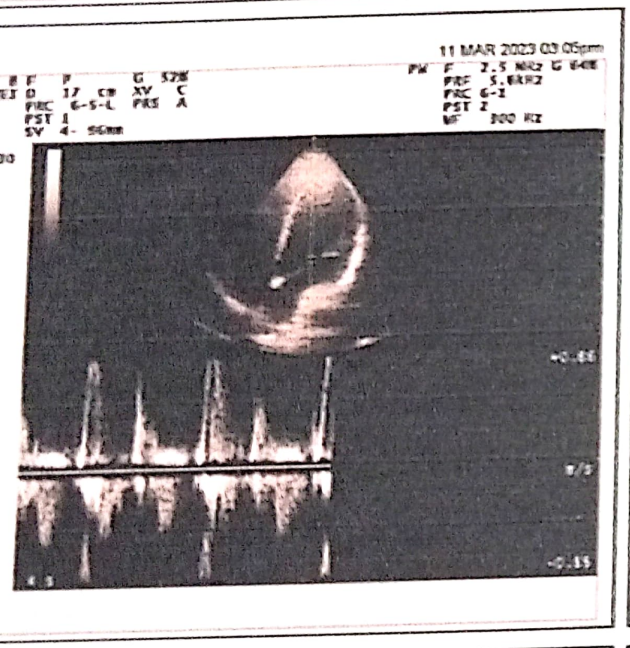
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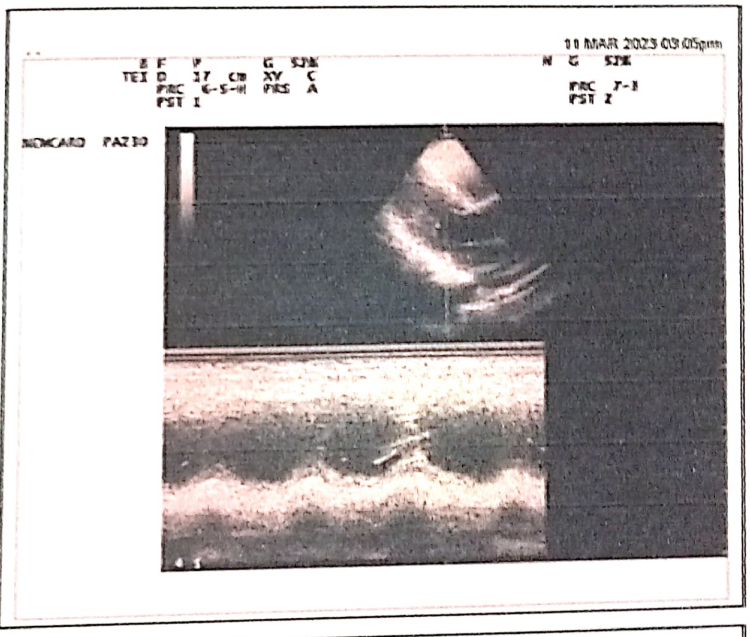
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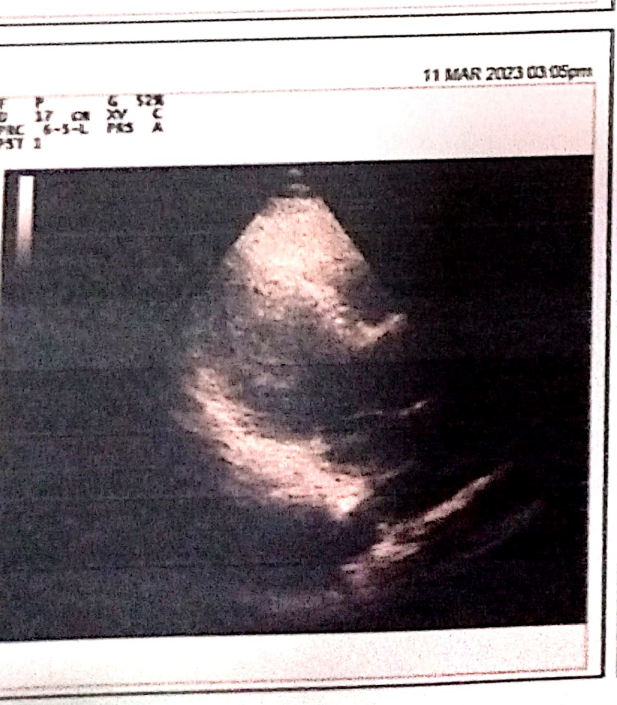
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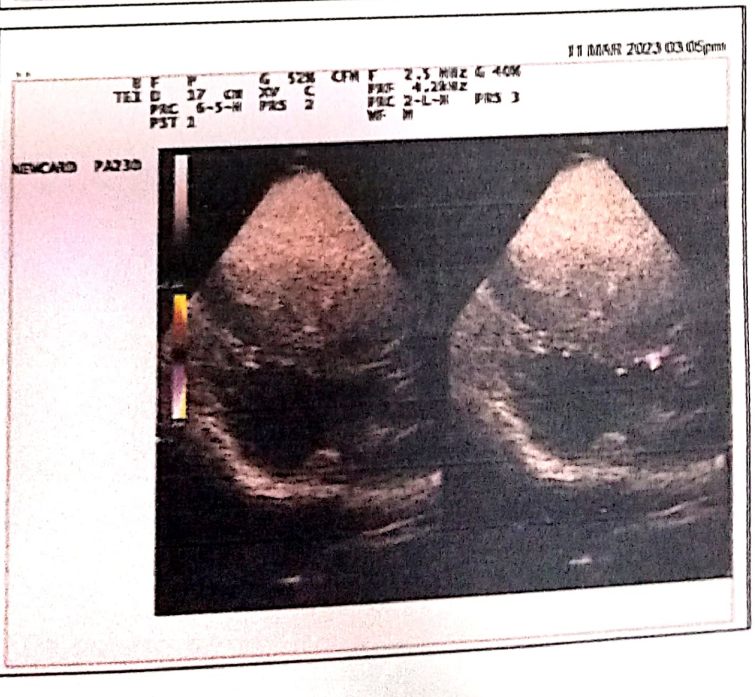
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A-3, Ekta Nagar, Stadium Road,
(Opposite Care Hospital),
Bareilly - 243 122 (U.P.) India
Tel. : 07599031977, 09458888448

APPLE
CARDIAC CARE
DR. NITIN AGARWAL'S HEART CLINIC
A UNIT OF PRIME HEART CARE

NAME	Mr. PRAVEEN KUMAR	**AGE/SEX**	31 Y/M
Reff. By	Dr. NITIN AGARWAL (DM)	**DATE**	11/03/2023

ECHOCARDIOGRAPHY AND COLOUR DOPPLER STUDY

MEASUREMENTS		VALUE	NORMAL DIMENSIONS
LVID (d)	4.5	cm	(3.7 –5.6 cm)
LVID (s)	2.5	cm	(2.2 –3.9 cm)
RVID (d)	2.4	cm	(0.7 –2.5 cm)
IVS (ed)	1.0	cm	(0.6 –1.1 cm)
LVPW (ed)	1.0	cm	(0.6 –1.1 cm)
AO	2.5	cm	(2.2 –3.7 cm)
LA	2.8	cm	(1.9 –4.0 cm)
LV FUNCTION			
EF	60	%	(54 –76 %)
FS	30	%	(25 –44 %)

LEFT VENTRICLE : No regional wall motion abnormality
No concentric left Ventricle Hypertrophy

MITRAL VALVE : Thin, PML moves posteriorly during Diastole
No SAM, No Subvalvular pathology seen.
No mitral valve prolapse calcification .

TRICUSPID VALVE : Thin, opening wells. No calcification, No doming .
No Prolapse.
Tricuspid inflow velocity= 0.7 m/sec

AORTIC VALVE : Thin, tricuspid, opening well, central closer, no flutter.
No calcification
Aortic velocity = 1.3 m/sec

PULMONARY VALVE : Thin, opening well, Pulmonary artery is normal
EF slope is normal.
Pulmonary Velocity = 0.9 m /sec

ON DOPPLER INTERROGATION THERE WAS :

- No mitral regurgitation
- No tricuspid regurgitation
- No aortic regurgitation
- No pulmonary regurgitation

MITRAL FLOW E= 0.8 m/sec A= 0.6 m/sec

ON COLOUR FLOW:

- No mitral regurgitation
- No tricuspid regurgitation
- No aortic regurgitation
- No pulmonary regurgitation

COMMENTS:

- No LA /LV clot
- No pericardial effusion
- No intracardiac mass
- IAS/IVS Intact
- Inferior vena cava – normal in size with normal respiratory variation

FINAL IMPRESSION

- NO REGIONAL WALL MOTION ABNORMALITY
- NORMAL LV DIASTOLIC FUNCTION
- NORMAL LV SYSTOLIC FUNCTION (LVEF~60%)
- NORMAL CARDIAC CHAMBER DIMENSIONS
- NORMAL VALVULAR COLOUR FLOW PATTERN

DR.NITIN AGARWAL
DM (Cardiology)
Consultant Cardiologist

This opinion is to be correlated with the clinically findings and if required, please re-evaluate / reconfirm with further investigation.

Dr. Nitin Agarwal
MD, DM (Cardiology)
Consultant Interventional Cardiologist
Cell : +91-94578 33777
Formerly at :
Escorts Heart Institute & Research Centre, Delhi
Dr. Ram Manohar Lohia Hospital, Delhi

APPLE CARDIAC CARE
DR. NITIN AGARWAL'S HEART CLINIC

A-3, EKTA NAGAR, (OPP. CARE HOSPITAL) STADIUM ROAD, NEAR DELAPEER CHAURAHA, BAREILLY - 243 122 (U.P.)
OPD Timings : 12.00 Noon to 04.00 pm, Sunday : 12.00 Noon to 3.00 pm
नम्बर लगाने के लिए फोन करें : 09458888448, 07599031977

VALID FOR 5 DAYS.

मात्र पाँच दिन के लिये मान्य

A Venture of Apple Cardiac Care
A-3, Ekta Nagar, Stadium Road,

APPLE

॥ ॐ गणेशाय नमः ॥

GANESH DIAGNOSTIC

DR. LOKESH GOYAL
MBBS (KGMC), MD (RADIOLOGY)
CONSULTANT INTERVENTIONAL RADIOLOGIST
FORMER SR. REGISTRAR - APOLLO HOSPITAL, NEW DELHI
LIFE MEMBER OF IRIA

Timings : 9:00 am to 9:00 pm, Sunday 9.00 am to 3.00 pm ☎ 8392957683, 6395228718

MR. PRAVEEN KUMAR **11-03-2023**
DR. NITIN AGARWAL, DM

REPORT

EXAMINATION PERFORMED: X-RAY CHEST

B/L lung fields are clear

Both of the CP angles are clear.

Both hila show a normal pattern .

Cardiac and mediastinal borders appear normal.

Visualized bony thorax and soft tissue of the chest wall appear normal.

IMPRESSION ---**NO SIGNIFICANT ABNORMALITY IS SEEN**

Not for medico-legal purpose

DR LOKESH GOYAL
MD
RADIODIAGNOSIS

A Venture of Apple Cardiac Care
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APPLE PATHOLOGY
TRUSTED RESULT

Reg.NO. : 115
NAME : **Mr. PRAVEEN KUMAR**
REFERRED BY : Dr.Nitin Agarwal (D M)
SAMPLE : BLOOD

DATE : **11/03/2023**
AGE : 31 Yrs.
SEX : MALE

TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
	HAEMATOLOGY		
COMPLETE BLOOD COUNT (CBC)			
HAEMOGLOBIN	13.6	gm/dl	12.0-18.0
TOTAL LEUCOCYTE COUNT	6,300	/cumm	4,000-11,000
DIFFERENTIAL LEUCOCYTE COUNT(DLC)			
Neutrophils	63	%	40-75
Lymphocytes	35	%	20-45
Eosinophils	02	%	01-08
Monocytes	00	%	01-06
Basophils	00	%	00-02
TOTAL R.B.C. COUNT	4.38	million/cumm	3.5-6.5
P.C.V./ Haematocrit value	41.2	%	35-54
M C V	94.1	fL	76-96
M C H	28.8	pg	27.00-32.00
M C H C	30.6	g/dl	30.50-34.50
PLATELET COUNT	1.76	lacs/mm3	1.50 - 4.50
E.S.R (WINTROBE METHOD)			
-in First hour	14	mm	00 - 15
	BIOCHEMISTRY		
BLOOD SUGAR F.	93	mg/dl	60-100
	HAEMATOLOGY		
Blood Group	O+		
Rh	POSITIVE		

Report is not valid for medicolegal purpose

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REFERRED BY	: Dr.Nitin Agarwal (D M)	SEX	: MALE
SAMPLE	: BLOOD		

TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
GLYCOSYLATED HAEMOGLOBIN	5.8		

EXPECTED RESULTS :

Non diabetic patients	: 4.0% to 6.0%
Good Control	: 6.0% to 7.0%
Fair Control	: 7.0% to -8%
Poor Control	: Above 8%

***ADA: American Diabetes Association**

The glycosylated hemoglobin assay has been validated as a reliable indicator of mean blood glucose levels for a period of 8-12 week period prior to HBA1C determination.ADA recommends the testing twice a year in patients with stable blood glucose, and quarterly, if treatment changes, or if blood glucose levels are unstable.

METHOD : ADVANCED IMMUNO ASSAY.

BIOCHEMISTRY

BLOOD UREA	24	mg/dL.	10-40

* Low serum urea is usually associated with status of overhydration severe hepatic failure.
* A urea level of 10-45 mg/dl indicates normal glomerular function and a level of 100-250 mg/dl indicates a serious imparement of renal function. In chronic renal failure , urea correlates better with the symptoms of uremia than does serum creatinine.
* Urine/Serum urea is more than 9 in prerenal and less than 3 in renal uremia.

SERUM CREATININE	0.8	mg/dL.	0.5-1.4
URIC ACID	7.2	mg/dl	3.5-8.0

CLINICAL SIGNIFICANCE:

Analysis of synovial fluid plays a major role in the diagnosis of joint disease.

Report is not valid for medicolegal purpose

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SEX : MALE

TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
SERUM SODIUM (Na)	137	m Eq/litre.	135 - 155
SERUM POTASSIUM (K)	4.8	m Eq/litre.	3.5 - 5.5
SERUM CALCIUM	9.0	mg/dl	8.5 - 10.5
LIVER PROFILE			
SERUM BILIRUBIN			
TOTAL	0.6	mg/dL	0.3-1.2
DIRECT	0.4	mg/dL	0.2-0.6
INDIRECT	0.2	mg/dL	0.1-0.4
SERUM PROTEINS			
Total Proteins	6.8	Gm/dL	6.4 - 8.3
Albumin	4.2	Gm/dL	3.5 - 5.5
Globulin	2.6	Gm/dL	2.3 - 3.5
A : G Ratio	1.62		0.0-2.0
SGOT	21	IU/L	0-40
SGPT	15	IU/L	0-40
SERUM ALK.PHOSPHATASE	67	IU/L	00-115

NORMAL RANGE : BILIRUBIN TOTAL

Premature infants. 0 to 1 day: <8 mg/dL **Premature infants.** 1 to 2 days: <12 mg/dL **Adults:** 0.3-1 mg/dL.
Premature infants. 3 to 5 days: <16 mg/dL **Neonates, 0 to 1 day:** 1.4-8.7 mg/dL
Neonates, 1 to 2 days: 3.4-11.5 mg/dL **Neonates, 3 to 5 days:** 1.5-12 mg/dL **Children 6 days to 18 years:** 0.3-1.2 mg/dL

COMMENTS--

Total and direct bilirubin determination in serum is used for the diagnosis,differentiation and follow -up of jaundice.Elevation of SGPT is found in liver and kidney diseases such as infectious or toxic hepatitis,IM and cirrhosis.Organs rich in SGOT are heart ,liver and skeletal muscles. When any of these organs are damaged,the serum SGOT level rises in proportion to the severity of damage.Elevation of Alkaline Phosphatase in serum or plasma is found in hepatitis ,biliary obstructions,hyperparathyroidism,steatorrhea and bone diseases.

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REFERRED BY	: Dr.Nitin Agarwal (D M)	SEX	: MALE
SAMPLE	: BLOOD		

TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
LIPID PROFILE			
SERUM CHOLESTEROL	167	mg/dL.	130 200
SERUM TRIGLYCERIDE	95	mg/dl.	30 - 160
HDL CHOLESTEROL	44	mg/dL.	30-70
VLDL CHOLESTEROL	19	mg/dL.	15 - 40
LDL CHOLESTEROL	104	mg/dL.	00-130
CHOL/HDL CHOLESTEROL RATIO	3.80	mg/dl	
LDL/HDL CHOLESTEROL RATIO	2.36	mg/dl	

INTERPRETATION

TRIGLYCERIDE level > 250mg/dL is associated with an approximately 2-fold greater risk of coronary vascular disease. Elevation of triglycerides can be seen with obesity, medication, fast less than 12 hrs., alcohol intake, diabetes melitus,and pancreatitis.

CHOLESTEROL, its fractions and triglycerides are the important plasma lipids indefining cardiovascular risk factors and in the managment of cardiovascular disease.Highest acceptable and optimum values of cholesterol values of cholesterol vary with age. Values above 220 mgm/dl are associated with increased risk of CHD regardless of HDL & LDL values.

HDL-CHOLESTEROL level <35 mg/dL is associated with an increased risk of coronary vascular disease even in the face of desirable levels of cholesterol and LDL - cholesterol.

LDL - CHOLESTEROL& TOTAL CHOLESTEROL levels can be strikingly altered by thyroid, renal and liver disease as well as hereditary factors.Based on total cholesterol, LDL- cholesterol, and total cholesterol/HDL - cholesterol ratio, patients may be divided into the three risk categories.

URINE EXAMINATION

Report is not valid for medicolegal purpose

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SAMPLE : BLOOD

DATE : **11/03/2023**
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TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
URINE EXAMINATION REPORT			
PHYSICAL EXAMINATION			
pH	6.0		
TRANSPARENCY	25	ml	
Volume	Light Yellow		
Colour	Clear		Nil
Appearence	Nil		
Sediments	1.020		1.015-1.025
Specific Gravity	Acidic		
Reaction			
BIOCHEMICAL EXAMINATION			
UROBILINOGEN	Nil		NIL
BILIRUBIN	Nil		NEGATIVE
URINE KETONE	Nil		NEGATIVE
Sugar	Nil		Nil
Albumin	Nil		Nil
Phosphates	Absent		Nil
MICROSCOPIC EXAMINATION			
Red Blood Cells	Nil	/H.P.F.	
Pus Cells	1-2	/H.P.F.	
Epithelial Cells	1-2	/H.P.F.	
Crystals	NIL		NIL
Casts	NIL	/H.P.F.	
Bacteria	NIL		
Other	NIL		

BIOCHEMICAL

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SAMPLE	: BLOOD		

TEST NAME	RESULTS	UNITS	BIOLOGICAL REF. RANGE
Prostatic Specific Antigen	2.0	ng/ml	0-4

Prostatic Specific Antigen (P.S.A)

Comment : The fact of PSA is unique to prostate tissue makes it a suitable marker for monitoring men with cancer of the prostate. PSA is also useful for determining possible recurrence after therapy. Measurement of serum PSA levels is not recommended as a screening procedure for the diagnosis of cancer because elevated PSA levels also are observed in patients with bening prostatic hypertrophy.

* Quality controlled report with external quality assurance

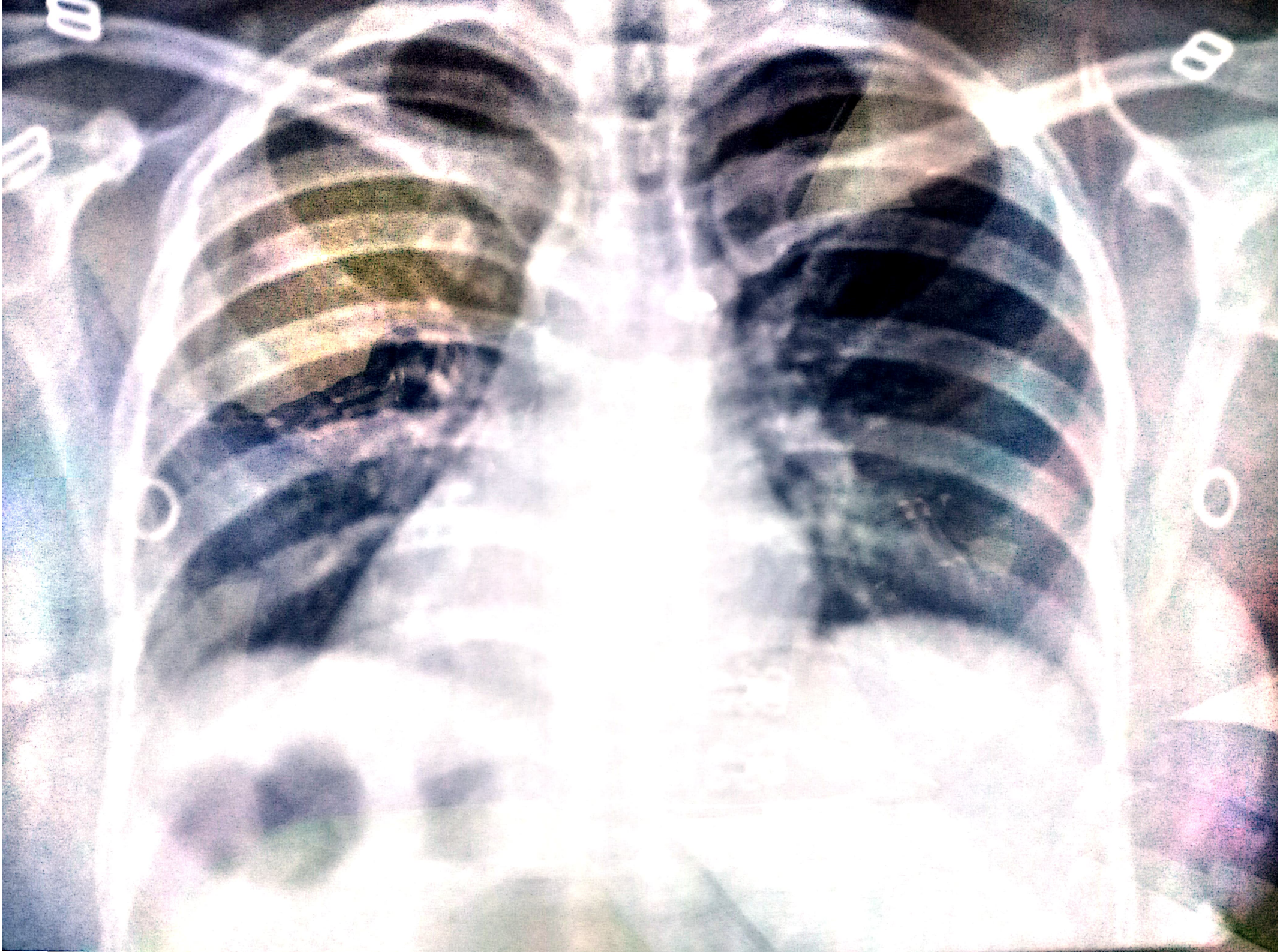
BIOCHEMISTRY

BLOOD SUGAR P.P.	**148**	mg/dl	80-160
Gamma Glutamyl Transferase (GGT)	24	U/L	7-32

--{End of Report}--

Dr. Shweta Agarwal
MD(Pathology), Apple Pathology
Bareilly (UP)

Report is not valid for medicolegal purpose



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TEST REPORT

Visit ID	**: MBAR39350**	Registration	: 11/Mar/2023 05:21PM
UHID/MR No	: ABAR.0000039338	Collected	: 11/Mar/2023 05:24PM
Patient Name	**: Mrs.PRAVEEN**	Received	: 11/Mar/2023 05:27PM
Age/Gender	: 31 Y 0 M 0 D /F	Reported	: 11/Mar/2023 07:11PM
Ref Doctor	: Dr.NITIN AGARWAL	Status	: Final Report
Client Name	: MODERN PATH SERVICES, BARELLY	Client Code	: 2423
Client Add	: 240,Sanjay Nagar Bareilly (UP)	Barcode No	: A3619625

DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,ULTRASENSITIVE TSH)				
Sample Type : SERUM				
T3	1.25	ng/ml	0.61-1.81	CLIA
T4	8.4	ug/dl	5.01-12.45	CLIA
Ultrasensitive TSH	1.059	ulU/mL	0.55-4.78	CLIA

INTERPRETATION:

1. Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
3. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
4. Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propanolol and propylthiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
6. Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.
7. Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance.
8. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.
9. **REFERENCE RANGE:**

PREGNANCY	Ultrasensitive TSH in uIU/mL
1st Trimester	0.100 – 2.500
2nd Trimester	0.200 – 3.000
3rd Trimester	0.300 – 3.000

(Reference range recommended by the American Thyroid Association)

Comments :

1. During pregnancy, Free thyroid profile (FT3, FT4 & Ultra-TSH) is recommended.
2. TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations.

*** End Of Report ***

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