



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

Hiranandani Fortis Hospital
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Fax : +91-22-3919 9220/21
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BMI CHART

Date: 20/3/23

Name: Mr. Jayaverdhan Singh Age: 35 yrs

Sex: (M) F

BP: 140/90 Height (cms): 172 cm Weight(kgs): 78 kg BMI: _____
mmHg

| WEIGHT lbs | 100 | 105 | 110 | 115 | 120 | 125 | 130 | 135 | 140 | 145 | 150 | 155 | 160 | 165 | 170 | 175 | 180 | 185 | 190 | 195 | 200 | 205 | 210 | 215 |
|---------------|-------------|------|------|------|---------|------|------|------|------------|------|------|------|-------|------|------|------|-----------------|------|------|------|------|------|------|------|
| kgs | 45.5 | 47.7 | 50.0 | 52.3 | 54.5 | 56.8 | 59.1 | 61.4 | 63.6 | 65.9 | 68.2 | 70.5 | 72.7 | 75.0 | 77.3 | 79.5 | 81.8 | 84.1 | 86.4 | 88.6 | 90.9 | 93.2 | 95.5 | 97.7 |
| HEIGHT in/cm | Underweight | | | | Healthy | | | | Overweight | | | | Obese | | | | Extremely Obese | | | | | | | |
| 5'0" - 152.4 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 |
| 5'1" - 154.9 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 | 39 | 40 |
| 5'2" - 157.4 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 33 | 34 | 35 | 36 | 37 | 38 | 39 |
| 5'3" - 160.0 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
| 5'4" - 162.5 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 31 | 32 | 33 | 34 | 35 | 36 | 37 |
| 5'5" - 165.1 | 16 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 30 | 30 | 31 | 32 | 33 | 34 | 35 | 35 |
| 5'6" - 167.6 | 16 | 17 | 17 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 34 | 34 |
| 5'7" - 170.1 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 33 |
| 5'8" - 172.7 | 15 | 16 | 16 | 17 | 18 | 19 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 32 | 32 |
| 5'9" - 176.2 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 31 |
| 5'10" - 177.8 | 14 | 15 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 30 |
| 5'11" - 180.3 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 |
| 6'0" - 182.8 | 13 | 14 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 | 29 |
| 6'1" - 185.4 | 13 | 13 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 |
| 6'2" - 187.9 | 12 | 13 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 |
| 6'3" - 190.5 | 12 | 13 | 13 | 14 | 15 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 26 |
| 6'4" - 193.0 | 12 | 12 | 13 | 14 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 23 | 24 | 25 | 25 | 26 |

Doctors Notes:



| | | | | | |
|------|-----------------------|------|------------|-----|----|
| UHID | 12362296 | Date | 20/03/2023 | | |
| Name | Mr. Jayaverdhan Singh | Sex | Male | Age | 35 |
| OPD | Ophthal 14 | | | | |

Drug allergy: → Not known
 Sys illness: → No

Clr - No

W/S - No

Unit V → R_e 6/60 (Bl)
 → L 6/60

Ref → R_e - 7.00 / - 1.00 x 180° 6/6
 → L_e - 6.75 / - 1.00 x 180° 6/6

NI → R_e N6
 → L_e N6

JOB → R_e 13.5
 → L_e 13.5

(Same as P.L.P.)

[Handwritten signature]



| | | | | | |
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| OPD | Dental 12 | | | | |

O/E

Stains +++

Calculus ++

Grossly decayed \bar{c}

Occlusal caries \bar{c}

Drug allergy:

Sys illness:

8

8 7

Treatment plan

Adv.

Scaling

Ext \bar{c}

filling \bar{c}

Dr. Tanya



| | | |
|--|---|--|
| PATIENT NAME : MR.JAYAVERDHAN SINGH | | REF. DOCTOR : SELF |
| CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001 | ACCESSION NO : 0022WC003811 PATIENT ID : FH.12362296 CLIENT PATIENT ID: UID:12362296 ABHA NO : | AGE/SEX : 35 Years Male DRAWN : 20/03/2023 08:12:00 RECEIVED : 20/03/2023 08:13:02 REPORTED : 20/03/2023 16:27:14 |

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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

| | | | |
|---|------------------|-------------|---------------|
| HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY | 16.1 | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE | 6.18 High | 4.5 - 5.5 | mil/ μ L |
| WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY | 6.15 | 4.0 - 10.0 | thou/ μ L |
| PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE | 157 | 150 - 410 | thou/ μ L |
| RBC AND PLATELET INDICES | | | |
| HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER | 48.4 | 40 - 50 | % |
| MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER | 78.3 Low | 83 - 101 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER | 26.0 Low | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER | 33.3 | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER | 14.7 High | 11.6 - 14.0 | % |
| MENTZER INDEX | 12.7 | | |
| MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER | 11.7 High | 6.8 - 10.9 | fL |
| WBC DIFFERENTIAL COUNT | | | |
| NEUTROPHILS METHOD : FLOWCYTOMETRY | 48 | 40 - 80 | % |
| LYMPHOCYTES METHOD : FLOWCYTOMETRY | 38 | 20 - 40 | % |

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Patient Ref. No. 22000000835344

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| MONOCYTES | | 8 | 2 - 10 | % |
| METHOD : FLOWCYTOMETRY | | | | |
| EOSINOPHILS | | 6 | 1 - 6 | % |
| METHOD : FLOWCYTOMETRY | | | | |
| BASOPHILS | | 0 | 0 - 2 | % |
| METHOD : FLOWCYTOMETRY | | | | |
| ABSOLUTE NEUTROPHIL COUNT | | 2.95 | 2.0 - 7.0 | thou/ μ L |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE LYMPHOCYTE COUNT | | 2.34 | 1.0 - 3.0 | thou/ μ L |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE MONOCYTE COUNT | | 0.49 | 0.2 - 1.0 | thou/ μ L |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE EOSINOPHIL COUNT | | 0.37 | 0.02 - 0.50 | thou/ μ L |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE BASOPHIL COUNT | | 0 Low | 0.02 - 0.10 | thou/ μ L |
| METHOD : CALCULATED PARAMETER | | | | |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | | 1.3 | | |
| METHOD : CALCULATED PARAMETER | | | | |
| MORPHOLOGY | | | | |
| RBC | | NORMOCHROMIC, MILD MICROCYTOSIS, MILD ANISOCYTOSIS | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| WBC | | NORMAL MORPHOLOGY | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| PLATELETS | | ADEQUATE | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |

Interpretation(s)
 RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

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Dr.Akta Dubey
 Counsultant Pathologist



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WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504. This ratio element is a calculated parameter and out of NABL scope.)

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HAEMATOLOGY**ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD**

| | | | |
|----------------------------|----|--------|------------|
| E.S.R | 02 | 0 - 14 | mm at 1 hr |
| METHOD : WESTERGREN METHOD | | | |

Interpretation(s)**ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-TEST DESCRIPTION :-**

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(52 if anemic) and in second trimester (0-70 mm/hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Polikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACCP Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

| | |
|-----------------------------|----------|
| ABO GROUP | TYPE B |
| METHOD : TUBE AGGLUTINATION | |
| RH TYPE | POSITIVE |
| METHOD : TUBE AGGLUTINATION | |

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
 Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

| | | | |
|--|-----------------|-----------|-------|
| BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF | 0.86 | 0.2 - 1.0 | mg/dL |
| BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF | 0.17 | 0.0 - 0.2 | mg/dL |
| BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER | 0.69 | 0.1 - 1.0 | mg/dL |
| TOTAL PROTEIN METHOD : BIURET | 7.2 | 6.4 - 8.2 | g/dL |
| ALBUMIN METHOD : BCP DYE BINDING | 4.2 | 3.4 - 5.0 | g/dL |
| GLOBULIN METHOD : CALCULATED PARAMETER | 3.0 | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER | 1.4 | 1.0 - 2.1 | RATIO |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P | 63 High | 15 - 37 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P | 160 High | < 45.0 | U/L |
| ALKALINE PHOSPHATASE METHOD : PNPP-ANP | 108 | 30 - 120 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANTILIDE | 102 High | 15 - 85 | U/L |
| LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE | 159 | 100 - 190 | U/L |

GLUCOSE FASTING, FLUORIDE PLASMA

| | | | |
|--|-----------------|---------|-------|
| FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE | 130 High | 74 - 99 | mg/dL |
|--|-----------------|---------|-------|

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

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| | | | | |
|--------------------------------|--|-------------------|--|-------|
| HBA1C | | 7.3 High | Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021) | % |
| METHOD : HB VARIANT (HPLC) | | | | |
| ESTIMATED AVERAGE GLUCOSE(EAG) | | 162.8 High | < 116.0 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | | |

Comments

NOTE: RESULTS OBTAINED ON REPEAT ANALYSIS (E-VARIANT WINDOW WITH RETENTION TIME 1.57 AREA 29.8%), THIS IS MOST PROBABLY DUE TO INTERFERENCE BY PRESENCE OF ABNORMAL HEMOGLOBIN VARIANTS. ADVISED HEMOGLOBIN VARIANT STUDY FOR THE SAME.

KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

| | | | | |
|----------------------|--|--------------|--------|-------|
| BLOOD UREA NITROGEN | | 5 Low | 6 - 20 | mg/dL |
| METHOD : UREASE - UV | | | | |

CREATININE EGFR- EPI

| | | | | |
|--|--|-----------------|----------------------------|---------------------------|
| CREATININE | | 0.88 Low | 0.90 - 1.30 | mg/dL |
| METHOD : ALKALINE PICRATE KINETIC JAFFES | | | | |
| AGE | | 35 | | years |
| GLOMERULAR FILTRATION RATE (MALE) | | 115.00 | Refer Interpretation Below | mL/min/1.73m ² |
| METHOD : CALCULATED PARAMETER | | | | |

BUN/CREAT RATIO

| | | | | |
|-------------------------------|--|------|--------------|--|
| BUN/CREAT RATIO | | 5.68 | 5.00 - 15.00 | |
| METHOD : CALCULATED PARAMETER | | | | |

URIC ACID, SERUM

| | | | | |
|---------------------|--|-----|-----------|-------|
| URIC ACID | | 5.8 | 3.5 - 7.2 | mg/dL |
| METHOD : URICASE UV | | | | |

TOTAL PROTEIN, SERUM

| | | | | |
|-----------------|--|-----|-----------|------|
| TOTAL PROTEIN | | 7.2 | 6.4 - 8.2 | g/dL |
| METHOD : BIURET | | | | |



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Consultant Pathologist



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MAHARASHTRA, INDIA
Tel : 022-39199222, 022-49723322,
CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000835344

PATIENT NAME : MR.JAYAVERDHAN SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WC003811
 PATIENT ID : FH.12362296
 CLIENT PATIENT ID: UID:12362296
 ABHA NO :

AGE/SEX : 35 Years Male
 DRAWN : 20/03/2023 08:12:00
 RECEIVED : 20/03/2023 08:13:02
 REPORTED : 20/03/2023 16:27:14

CLINICAL INFORMATION :

UID:12362296 REQNO-1388096
 CORP-OPD
 BILLNO-150123OPCR016213
 BILLNO-150123OPCR016213

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| ALBUMIN, SERUM | | | | |
| ALBUMIN | | 4.2 | 3.4 - 5.0 | g/dL |
| METHOD : BCP DYE BINDING | | | | |
| GLOBULIN | | | | |
| GLOBULIN | | 3.0 | 2.0 - 4.1 | g/dL |
| METHOD : CALCULATED PARAMETER | | | | |
| ELECTROLYTES (NA/K/CL), SERUM | | | | |
| SODIUM, SERUM | | 139 | 136 - 145 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| POTASSIUM, SERUM | | 3.54 | 3.50 - 5.10 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| CHLORIDE, SERUM | | 102 | 98 - 107 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| Interpretation(s) | | | | |

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels are seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and



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globulin. Higher-than-normal levels may be due to Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenström's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propanolol, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- II. Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).
- III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
- IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
 - a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy.

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-GFR- Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- A GFR of 60 or higher is in the normal range.
- A GFR below 60 may mean kidney disease.
- A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

Dubey

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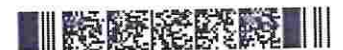
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Patient Ref. No. 2200000835344



PATIENT NAME : MR.JAYAVERDHAN SINGH

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AGE/SEX : 35 Years Male
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URIC ACID, SERUM-**Causes of Increased levels**:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome

Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis

TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenström's disease
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

| | | | |
|---|------------------|--|-------|
| CHOLESTEROL, TOTAL | 203 High | < 200 Desirable 200 - 239 Borderline High >/= 240 High | mg/dL |
| METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE | | | |
| TRIGLYCERIDES | 176 High | < 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High | mg/dL |
| METHOD : ENZYMATIC ASSAY | | | |
| HDL CHOLESTEROL | 30 Low | < 40 Low >/=60 High | mg/dL |
| METHOD : DIRECT MEASURE - PEG | | | |
| LDL CHOLESTEROL, DIRECT | 147 High | < 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High | mg/dL |
| METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT | | | |
| NON HDL CHOLESTEROL | 173 High | Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |
| VERY LOW DENSITY LIPOPROTEIN | 35.2 High | </= 30.0 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |
| CHOL/HDL RATIO | 6.8 High | 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk | |
| METHOD : CALCULATED PARAMETER | | | |
| LDL/HDL RATIO | 4.9 High | 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk | |
| METHOD : CALCULATED PARAMETER | | | |



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 Counsultant Pathologist



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| PATIENT NAME : MR.JAYAVERDHAN SINGH | | REF. DOCTOR : SELF | |
| CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001 | ACCESSION NO : 0022WC003811 | AGE/SEX : 35 Years Male | |
| | PATIENT ID : FH.12362296 | DRAWN : 20/03/2023 08:12:00 | |
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Interpretation(s)

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

| | |
|-------------------|-------------|
| COLOR | PALE YELLOW |
| METHOD : PHYSICAL | |
| APPEARANCE | CLEAR |
| METHOD : VISUAL | |

CHEMICAL EXAMINATION, URINE

| | | |
|--|--------------|---------------|
| PH | 6.0 | 4.7 - 7.5 |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD | | |
| SPECIFIC GRAVITY | 1.020 | 1.003 - 1.035 |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION) | | |
| PROTEIN | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE | | |
| GLUCOSE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD | | |
| KETONES | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE | | |
| BLOOD | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN | | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT | | |
| UROBILINOGEN | NORMAL | NORMAL |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION) | | |
| NITRITE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE | | |
| LEUKOCYTE ESTERASE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY | | |

MICROSCOPIC EXAMINATION, URINE

| | | | |
|----------------------------------|--------------|--------------|------|
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |

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Dr. Akta Dubey
Consultant Pathologist

Rekha N
Dr. Rekha Nair, MD
Microbiologist



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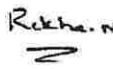
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| PUS CELL (WBC'S) | | 1-2 | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| EPITHELIAL CELLS | | 0-1 | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| CASTS | | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| CRYSTALS | | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| BACTERIA | | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| YEAST | | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| REMARKS | | URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT | | |
| Interpretation(s) | | | | |

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| CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001 | | ACCESSION NO : 0022WC003981 PATIENT ID : FH.12362296 CLIENT PATIENT ID: UID:12362296 ABHA NO : | AGE/SEX : 35 Years Male DRAWN : 20/03/2023 16:12:00 RECEIVED : 20/03/2023 16:12:12 REPORTED : 20/03/2023 17:13:50 |

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BIOCHEMISTRY

| GLUCOSE, POST-PRANDIAL, PLASMA | | | | |
|---------------------------------------|-----------------|----------|--|-------|
| PPBS(POST PRANDIAL BLOOD SUGAR) | 230 High | 70 - 139 | | mg/dL |
| METHOD : HEXOKINASE | | | | |

Interpretation(s)
 GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c
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 HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10,
 NAVI MUMBAI, 400703
 MAHARASHTRA, INDIA
 Tel : 022-39199222,022-49723322,
 CIN - U74899PB1995PLC045956
 Email : -



Patient Ref. No. 2200000835514



PATIENT NAME : MR.JAYAVERDHAN SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : **0022WC003811**
 PATIENT ID : FH.12362296
 CLIENT PATIENT ID: UID:12362296
 ABHA NO :

AGE/SEX : 35 Years Male
 DRAWN : 20/03/2023 08:12:00
 RECEIVED : 20/03/2023 08:13:02
 REPORTED : 20/03/2023 14:26:07

CLINICAL INFORMATION :

UID:12362296 REQNO-1388096
 CORP-OPD
 BILLNO-150123OPCR016213
 BILLNO-150123OPCR016213

| Test Report Status | Final | Results | Biological Reference Interval | Units |
|--------------------|-------|---------|-------------------------------|-------|
|--------------------|-------|---------|-------------------------------|-------|

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

| | | | |
|--|--------|---------------|--------|
| T3 | 119.50 | 80 - 200 | ng/dL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |
| T4 | 5.92 | 5.1 - 14.1 | µg/dL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |
| TSH (ULTRASENSITIVE) | 4.050 | 0.270 - 4.200 | µIU/mL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |

Interpretation(s)

Dr. Swapnil Sirmukaddam
 Consultant Pathologist



View Details



View Report

PERFORMED AT :

SRL Ltd
 BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4, KHARGHAR
 NAVI MUMBAI, 410210
 MAHARASHTRA, INDIA
 Tel : 9111591115,
 CIN - U74899PB1995PLC045956



Patient Ref. No. 2200000835344

| | | | |
|--|--|---------------------------------------|---------------------------------------|
| PATIENT NAME : MR.JAYAVERDHAN SINGH | | REF. DOCTOR : SELF | |
| CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001 | ACCESSION NO : 0022WC003811 | AGE/SEX : 35 Years Male | DRAWN : 20/03/2023 08:12:00 |
| | PATIENT ID : FH.12362296 | RECEIVED : 20/03/2023 08:13:02 | REPORTED : 20/03/2023 14:26:07 |
| | CLIENT PATIENT ID: UID:12362296 | | |
| | ABHA NO : | | |

CLINICAL INFORMATION :
 UID:12362296 REQNO-1388096
 CORP-OPD
 BILLNO-150123OPCR016213
 BILLNO-150123OPCR016213

| Test Report Status | Final | Results | Biological Reference Interval | Units |
|--------------------|-------|---------|-------------------------------|-------|
|--------------------|-------|---------|-------------------------------|-------|

SPECIALISED CHEMISTRY - TUMOR MARKER

| PROSTATE SPECIFIC ANTIGEN, SERUM | | | | |
|--|-------|-------|--|-------|
| PROSTATE SPECIFIC ANTIGEN | 0.440 | < 1.4 | | ng/mL |
| METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY | | | | |

Interpretation(s)
 PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
 - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
 - It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

| Age of male | Reference range (ng/ml) |
|-------------|-------------------------|
| 40-49 years | 0-2.5 |
| 50-59 years | 0-3.5 |
| 60-69 years | 0-4.5 |
| 70-79 years | 0-6.5 |

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr. Swapnil Sirmukaddam
 Consultant Pathologist



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 NAVI MUMBAI, 410210
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 Tel : 9111591115,
 CIN - U74899PB1995PLC045956



Patient Ref. No. 2200000835344

12362296
35 Years

JAYAVARDHA SINGH
Male

3/20/2023 10:48:53 AM

Hypertension (reporting)

Rate 73 . Sinus rhythm. normal P axis, V-rate 50- 99
ST elev, probable normal early repol pattern. ST elevation, age<55

PR 178
QRS 105
QT 354
QTc 390

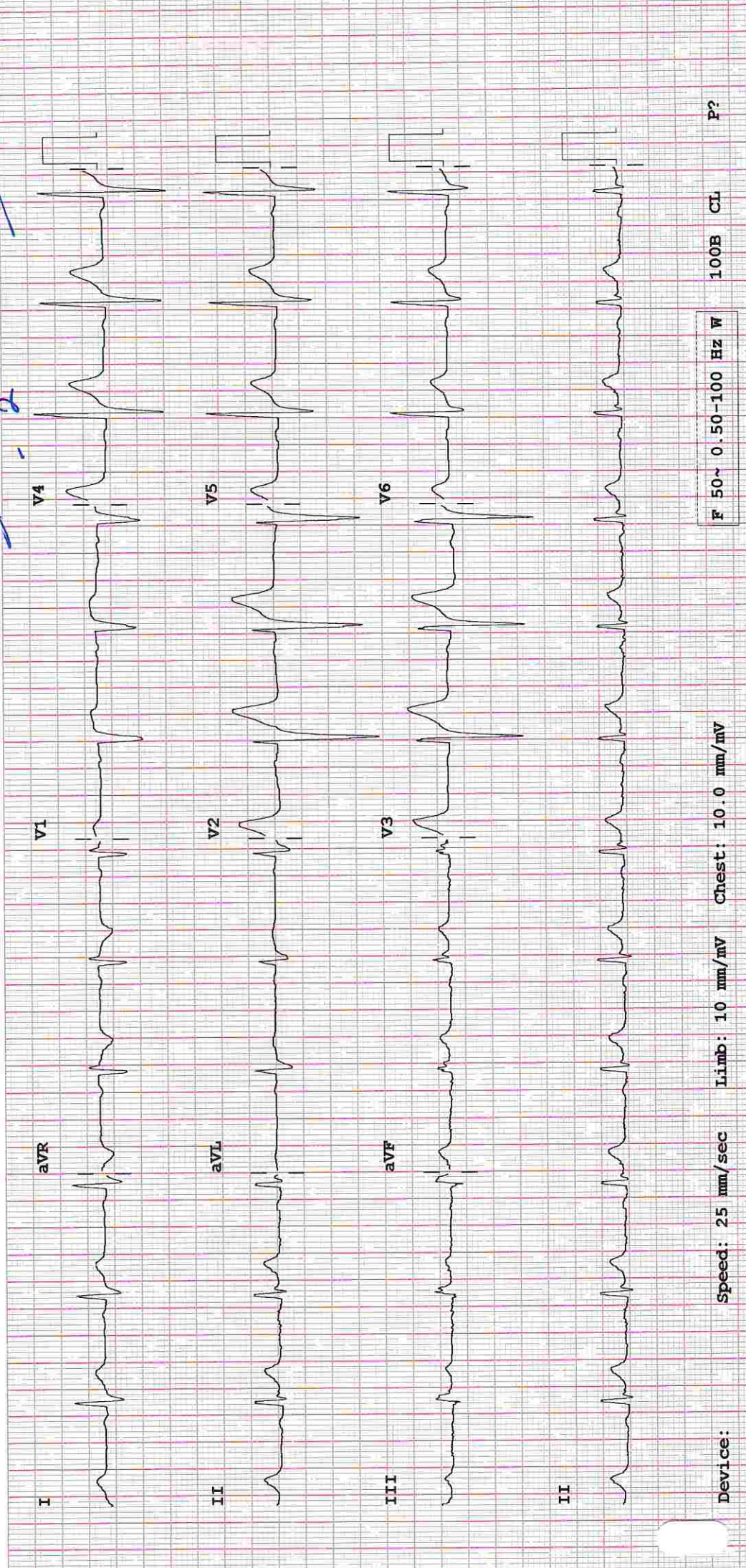
--AXIS--
P 35
QRS 69
T 51

12 Lead; Standard Placement

-- NORMAL ECG --

Unconfirmed Diagnosis: Adm - clinical AD

sinus rhythm in leads
T waves peaked
T waves peaked



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~0.50-100 Hz W 100B CL P?

**(For Billing/Reports & Discharge Summary only)****DEPARTMENT OF NIC**

Date: 21/Mar/2023

Name: Mr. Jayaverdhan Singh

UHID | Episode No : 12362296 | 16424/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/34110 | 20-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 21-Mar-2023 10:15:40

Bed Name :

Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC**FINDINGS:**

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

| | | |
|-------------|----|----|
| LA | 37 | mm |
| AO Root | 35 | mm |
| AO CUSP SEP | 24 | mm |
| LVID (s) | 25 | mm |
| LVID (d) | 49 | mm |
| IVS (d) | 10 | mm |
| LVPW (d) | 10 | mm |
| RVID (d) | 20 | mm |
| RA | 29 | mm |
| LVEF | 60 | % |



Date: 21/Mar/2023

DEPARTMENT OF NIC

Name: Mr. Jayaverdhan Singh

Age | Sex: 35 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12362296 | 16424/23/1501

Order No | Order Date: 1501/PN/OP/2303/34110 | 20-Mar-2023

Admitted On | Reporting Date : 21-Mar-2023 10:15:40

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.

A WAVE VELOCITY:0.6 m/sec

E/A RATIO:1.5

| | PEAK (mmHg) | MEAN (mmHg) | V max (m/sec) | GRADE OF REGURGITATION |
|-----------------|----------------|----------------|------------------|---------------------------|
| MITRAL VALVE | N | | | Nil |
| AORTIC VALVE | 06 | | | Nil |
| TRICUSPID VALVE | N | | | Nil |
| PULMONARY VALVE | 2.0 | | | Nil |

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

DR. PRASHANT PAWAR
DNB(MED), DNB (CARDIOLOGY)



DEPARTMENT OF RADIOLOGY

Date: 20/Mar/2023

Name: Mr. Jayaverdhan Singh

Age | Sex: 35 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12362296 | 16424/23/1501

Order No | Order Date: 1501/PN/OP/2303/34110 | 20-Mar-2023

Admitted On | Reporting Date : 20-Mar-2023 17:01:34

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Rotation+

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGESH PATHADE
(MD Radio-diagnosis)



DEPARTMENT OF RADIOLOGY

Date: 20/Mar/2023

Name: Mr. Jayaverdhan Singh

Age | Sex: 35 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12362296 | 16424/23/1501

Order No | Order Date: 1501/PN/OP/2303/34110 | 20-Mar-2023

Admitted On | Reporting Date : 20-Mar-2023 15:26:19

Order Doctor Name : Dr.SELF .

USG-WHOLE ABDOMEN

LIVER is normal in size (15.6 cm) and shows increased echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is not seen ? contracted.

SPLEEN is mildly enlarged in size (14.2 cm).

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 10.9 x 4.5 cm.

Left kidney measures 12.6 x 5.1 cm.

PANCREAS is obscured due to bowel gas.


URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

PROSTATE is normal in size & echogenicity. It measures ~ 10.4 cc in volume.

No evidence of ascites.

Impression:

- Grade I fatty infiltration of liver.
- Mild splenomegaly.


DR. YOGESH PATHADE
(MD Radio-diagnosis)