

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SHIVAM J HA	Order No	: 1000077484
UHID	: UHJ A23020475	Registered On	: 15/03/2024 09:21:36 AM
Age/Sex	: 30/Years Male	Collected On	: 15/03/2024 09:56:51 AM
Ward / Bed No	:	Reported On	: 15/03/2024 01:36:01 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230025302
Station	: At Hospital	Mobile No	: 6354790033
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	109	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	137	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	105.40	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method:C LIA)	1.01	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method:C LIA)	9.71	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method:C LIA: Ultra-sensitive)	3.18	μIU/mL	0.34-5.60
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method:CHOD-POD)	214	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method:Enzymatic GPO-POD)	174	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	52.2	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	127.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	34.79	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	4.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	2.4		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	161.8	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.1	mg/dL	3.5-7.2
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.82	mg/dL	0.9-1.3
<b>LIVER FUNCTION TEST</b>			Sample: Serum
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	3.08	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.44	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	2.65	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	7.1	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.54	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	2.55	g/dL	2.3-3.5
<b>AG RATIO</b> (Method: Calculated)	1.77		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	45	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	55	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	81	U/L	50-116
GGT (Method:IFCC)	32	U/L	< 55



**Dr. Shobha Emmanuel**  
MBBS, M.D(Pathology)  
CONSULTANT PATHOLOGIST  
KMC.66136

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HAEMATOLOGY
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	14.28	g/dL	13.5-17.5
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	44.6	%	42-52
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	6030	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	49.15	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	39.32	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	3.84	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	7.44	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.25	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	5.23	million/cum	4.5-5.9
<b>MCV</b> (Method:Derived from RBC Histogram)	85.3	fL	78-100
<b>MCH</b> (Method: Calculated)	27.3	pg	27-31
<b>MCHC</b> (Method: Calculated)	32.0	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	14.7	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	1.72	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	13.00	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.2	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	10	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Gel Method )	B		
Rh Factor (Method:Agglutination Gel Method )	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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CLINICAL PATHOLOGY

## URINE EXAMINATION, ROUTINE

Sample: Urine

## PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		1.005-1.030

## CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative

## MICROSCOPIC EXAMINATION

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
<b>URINE SUGAR, FASTING</b>	Absent		
(Method:GOD-POD)			

Verified By  
Parameshwar B

---End of Report---



**Dr. Shobha Emmanuel**  
CONSULTANT PATHOLOGIST  
KMC:66136

\*NABL renewal under process.



**EXERCISE STRESS TEST REPORT**

Patient Name: MR. SHIVAM JHA,  
 Patient ID: 20475  
 Height: 181 cm  
 Weight: 88 kg

DOB: 14.12.1993  
 Age: 30yrs  
 Gender: Male  
 Race: Indian

Study Date: 15.03.2024  
 Test Type: Treadmill Stress Test  
 Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL  
 Attending Physician: DR. RAHUL PATIL  
 Technician: YAMINI/THABITHA

**Medications:**

**Medical History:**  
 NO H/O DM & HTN

**Reason for Exercise Test:**  
 Screening for CAD

**Exercise Test Summary**

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:08	0.00	0.00	104	100/70	
	STANDING	00:12	0.00	0.00	100	100/70	
	HYPERV.	00:02	0.00	0.00	98	100/70	
	WARM-UP	00:13	0.00	0.00	100	100/70	
EXERCISE	STAGE 1	03:00	1.70	10.00	137	100/70	
	STAGE 2	03:00	2.50	12.00	155	120/80	
	STAGE 3	02:04	3.40	14.00	190	130/80	
RECOVERY		05:48	0.00	0.00	122	130/80	

The patient exercised according to the BRUCE for 8:03 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 107 bpm rose to a maximal heart rate of 190 bpm. This value represents 100 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/70 mmHg, rose to a maximum blood pressure of 130/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

**Interpretation**

Summary: Resting ECG: normal.  
 Functional Capacity: normal.  
 HR Response to Exercise: appropriate.  
 BP Response to Exercise: normal resting BP - appropriate response.  
 Chest Pain: none.  
 Arrhythmias: none.  
 ST Changes: none.  
 Overall impression: Normal stress test.

**Conclusions**

GOOD EFFORT TOLERANCE  
 NORMAL HR AND BP RESPONSE  
 NO ANGINA OR ARRHYTHMIAS NOTED  
 NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician

Technician



MR. SHIVAM JHA,  
Patient ID 20475  
15/03/2024  
11:21:44am

Male 181 cm 88 kg  
30yrs Indian  
Meds:

Test Reason: Screening for CAD  
Medical History: NO H/O DM & HTN

Ref MD: DR. RAHUL PATIL, Ordering MD: DR. RAHUL PATIL  
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test  
Comment:

BRUCE: Total Exercise Time 08:03  
Max HR: 190 bpm 100% of max predicted 190 bpm HR at rest: 107  
Max BP: 130/80 mmHg BP at rest: 100/70 Max RPP: 24310 mmHg\* bpm  
Maximum Workload: 10.10 METS  
Max ST: -0.95 mm, 0.00 mV/s in V6 EXERCISE STAGE 3 06:30  
Arrhythmia: PVC:11, PSVC:4, RUN:1, CPL:T:1  
ST/HR index: 0.75  $\mu$ V/bpm

Reasons for Termination: Target heart rate achieved

Summary: Resting ECG: normal, Functional Capacity: normal, HR Response to

Exercise: appropriate, BP Response to Exercise: normal resting BP - appropriate

response: Chest Pain: none, Arrhythmias: none, ST Changes: none, Overall

Exercise: Chest Pain: none, Arrhythmias: none, ST Changes: none, Overall

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BASELINE EXERCISE	MAX ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
102 bpm 100/70 mmHg	166 bpm 120/80 mmHg	190 bpm 130/80 mmHg	117 bpm

I	I	I	I
0.10	0.10	0.05	0.20
0.25 mm	0.35	-0.60	0.35
0.21 mV/s	1.90	0.92	0.44

0.30	0.35	-0.60	0.35
0.35	2.69	1.01	0.90
0.10	-0.35	-0.60	0.20
0.18	0.84	0.10	0.32

0.25	0.15	0.30	-0.25
1.22	-2.35	-0.94	-1.22
0.05	0.25	0.35	0.00
0.06	0.48	0.44	-0.03

0.20	-0.35	-0.65	0.30
0.26	1.82	0.56	0.65
0.05	0.25	0.35	0.00
0.06	0.48	0.44	-0.03

BASELINE EXERCISE	MAX ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
102 bpm 100/70 mmHg	166 bpm 120/80 mmHg	190 bpm 130/80 mmHg	117 bpm

V1	V1	V1	V1
0.00	0.00	0.00	0.50
-0.69	-1.48	-0.31	0.64

0.55	0.25	0.75	0.60
0.56	0.79	1.38	0.20
0.15	-0.25	0.05	0.30
0.09	-0.53	0.32	0.03

0.75	-0.05	-0.05	0.75
0.95	0.97	2.21	1.04
0.45	-0.85	-0.65	0.40
0.63	0.35	1.69	0.69

0.20	-0.95	-0.65	0.00
0.45	-0.01	1.14	0.15
0.45	-0.85	-0.65	0.40
0.63	0.35	1.69	0.69

Unconfirmed

Attending MD: DR. RAHUL PATIL



**M.R. SHIVAM JHA,**

Patient ID 20475

15.03.2024

11:21:44am

Selected Medians Report

UNITED HOSPITAL

Male 181 cm 88 kg  
30yrs Indian

Medcs:

Test Reason: Screening for CAD

Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL  
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test  
Comment:

BRUCE: Total Exercise Time: 08:03  
Max HR: 190 bpm 100% of max predicted 190 bpm HR at rest: 107  
Max BP: 130/80 mmHg BP at rest: 100/70 Max RPP: 24310 mmHg\*bpm  
Maximum Workload: 10.10 METS  
Max. ST: -0.95 mm, 0.00 mV/s in V6; EXERCISE STAGE 3 06:30  
Arrhythmia: PVC:11, PSVC:4, RUN:1, CPVT:1  
ST/HR index: 0.75  $\mu$ V/bpm

Reasons for Termination: Target heart rate achieved  
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall Impression: Normal stress test

Conclusion: GOOD EFFORT TOLERANCE  
NORMAL HR AND BP RESPONSE  
NO ANGINA OR ARRHYTHMIAS NOTED  
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA  
Location Number: \* 0 \*

E CASE V6.73 (2)

Unconfirmed

Attending MD: DR. RAHUL PATIL



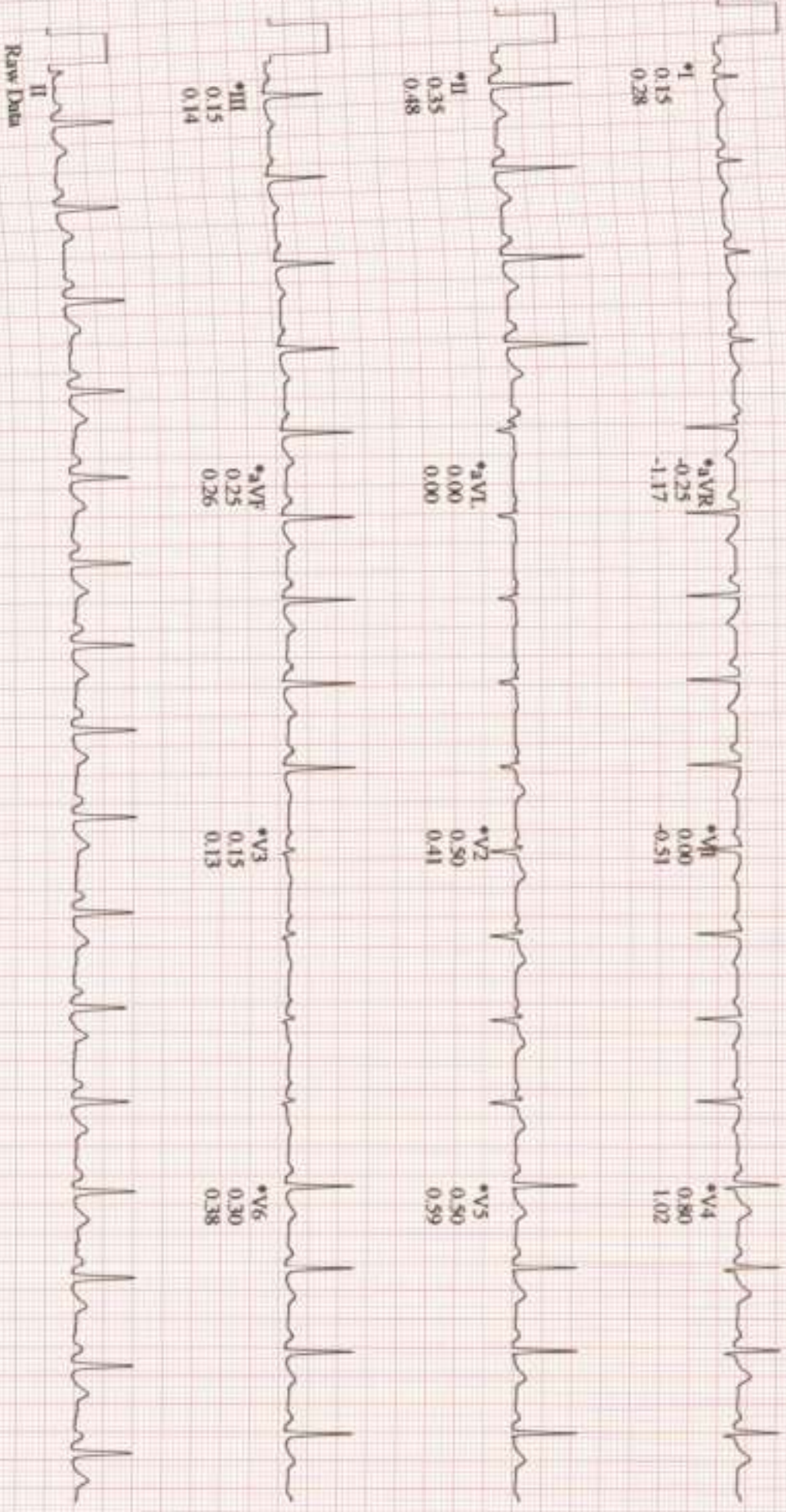
102 bpm  
100-70 mmHg

PRETEST  
STANDING  
00:17

BRUCE  
0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms



MR. SHIVAM JHA  
Patient ID: 20475  
15.03.2024  
11:22:17am

LINKED MEDIANS

UNITED HOSPITAL

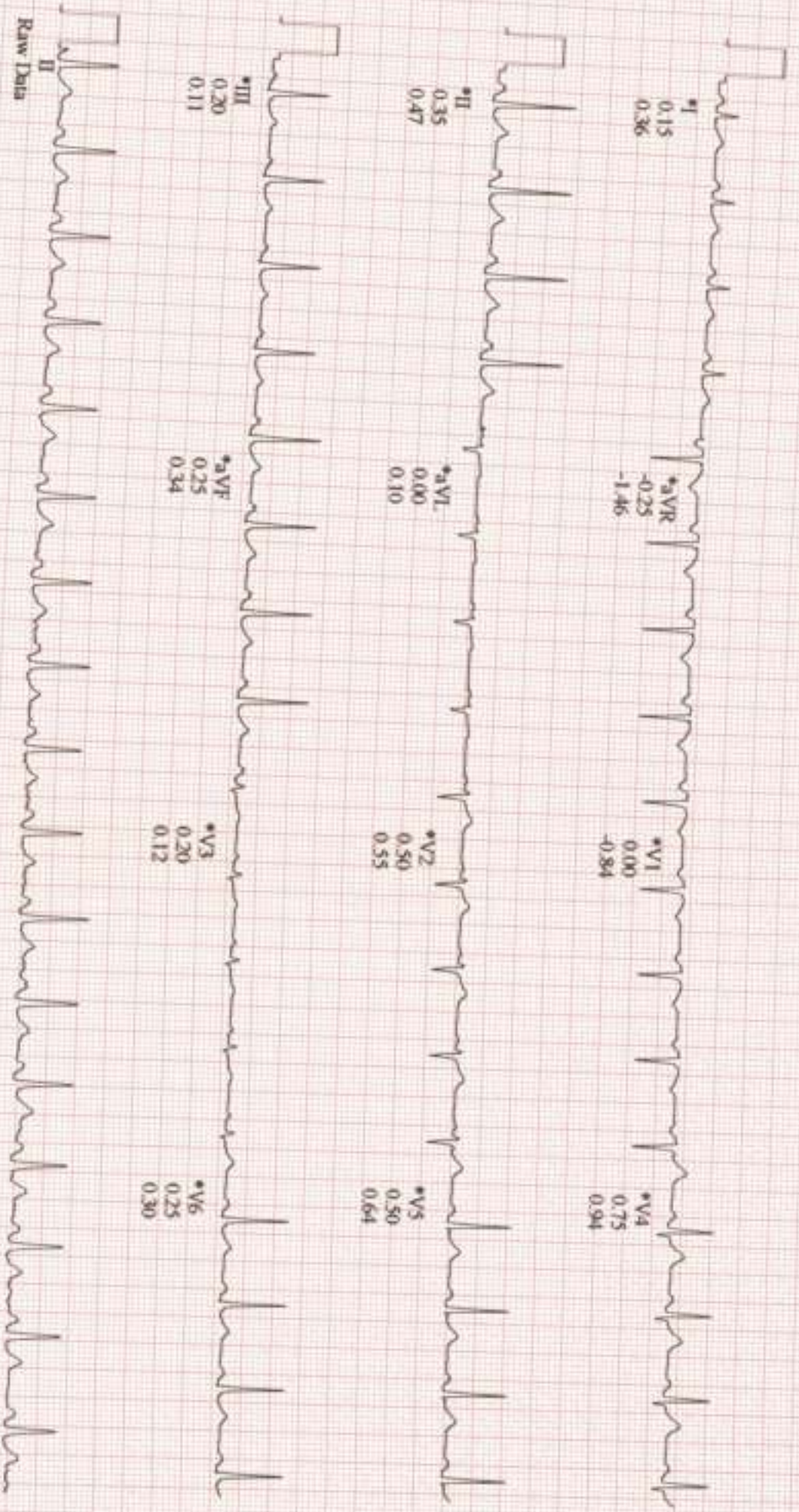
99 bpm  
100/70 mmHg

PRETEST  
WARM-UP  
00:32

BRUCE  
0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms

GE  
CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01 2015 8 11:22:17



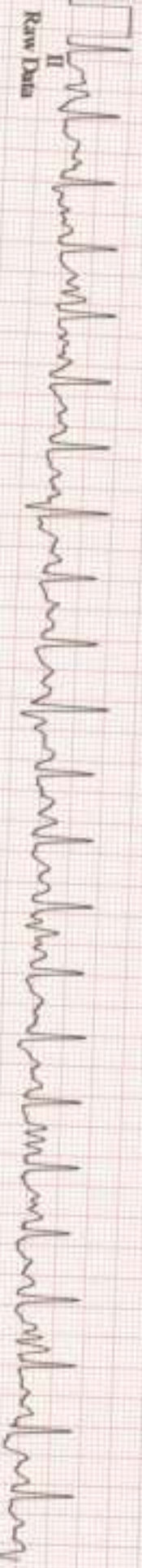
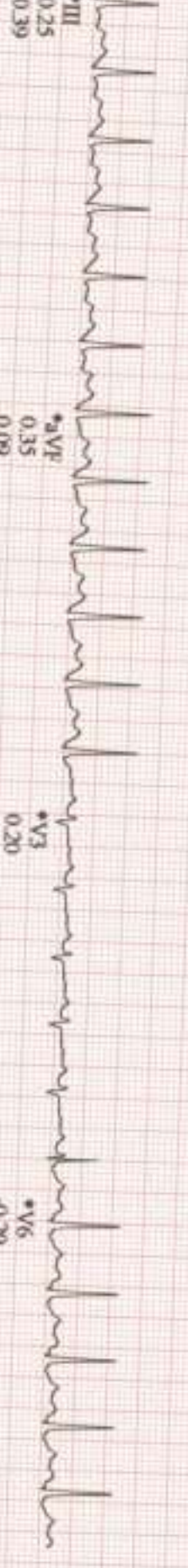
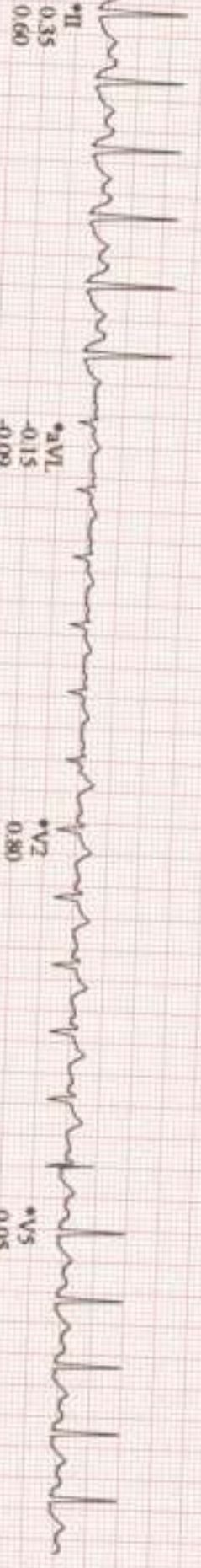
139 bpm  
100% 70 mmHg

EXERCISE  
STAGE 1  
02:50

BRUCE  
1.7 mph  
10.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



\*Computer Synthesized Rhythm



155 bpm  
EXERCISE STAGE 2  
05:50  
BRUCE  
2.5 mph  
12.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)

\*I  
-0.10  
1.27

\*aVR  
0.35  
-1.22

\*V1  
0.55  
-0.44

\*V4  
0.25  
2.29

\*II  
-0.50  
1.01

\*aVL  
0.15  
0.66

\*V2  
0.95  
1.70

\*V5  
0.10  
1.69

\*III  
-0.40  
-0.29

\*aVF  
-0.50  
0.37

\*V3  
0.25  
0.58

\*V6  
-0.20  
1.07

Raw Data

\*Computer Synthesized Rhythms



187 bpm  
130/80 mmHg

EXERCISE  
STAGE 3  
08:00

BRUCE  
3.4 mph  
14.0%

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)

\*I  
0.15  
1.55

\*aVR  
0.20  
-1.95

\*V1  
0.30  
-1.12

\*V4  
0.00  
1.72

\*II  
-0.55  
2.42

\*aVL  
0.45  
0.33

\*V2  
0.80  
1.01

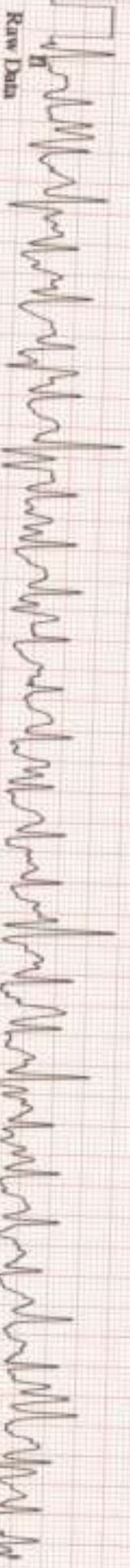
\*V5  
-0.80  
1.00

\*III  
-0.65  
0.80

\*aVF  
-0.65  
1.69

\*V3  
-0.10  
-0.44

\*V6  
-0.75  
0.72



Raw Data

\*Computer Synchronized Rhythms



157 bpm  
130/80 mmHg

RECOVERY  
#1  
01:00

BRUCE  
1.5 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

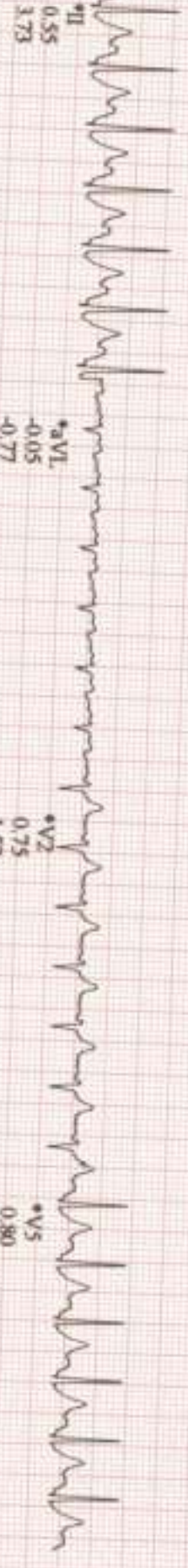
Lead  
ST Level (mm)  
ST Slope (mV/s)



\*aVR  
-0.40  
-2.53

\*aVL  
0.05  
-1.36

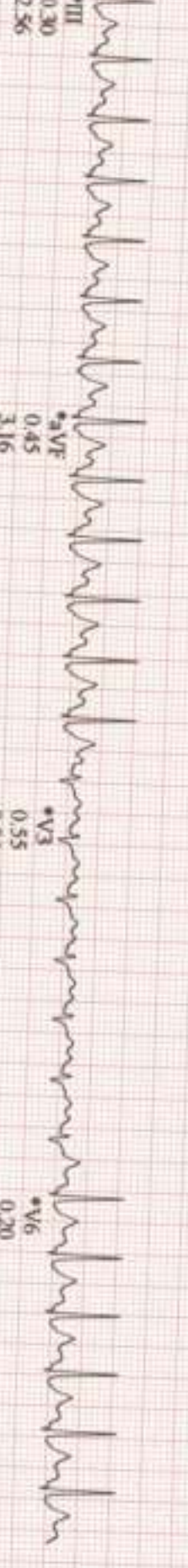
\*V4  
1.20  
3.96



\*aVL  
-0.05  
-0.77

\*V2  
0.75  
1.52

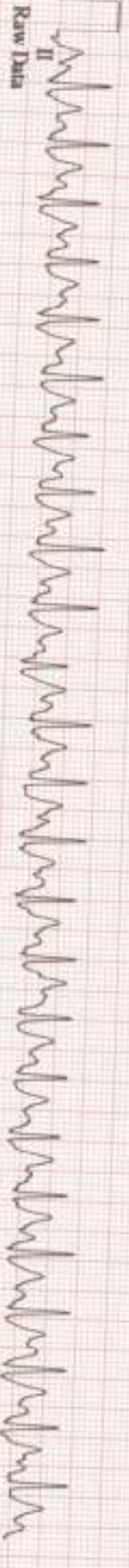
\*V5  
0.80  
3.10



\*aVF  
0.45  
3.16

\*V3  
0.55  
0.84

\*V6  
0.20  
2.02



\*Computer Synthesized Rhythms



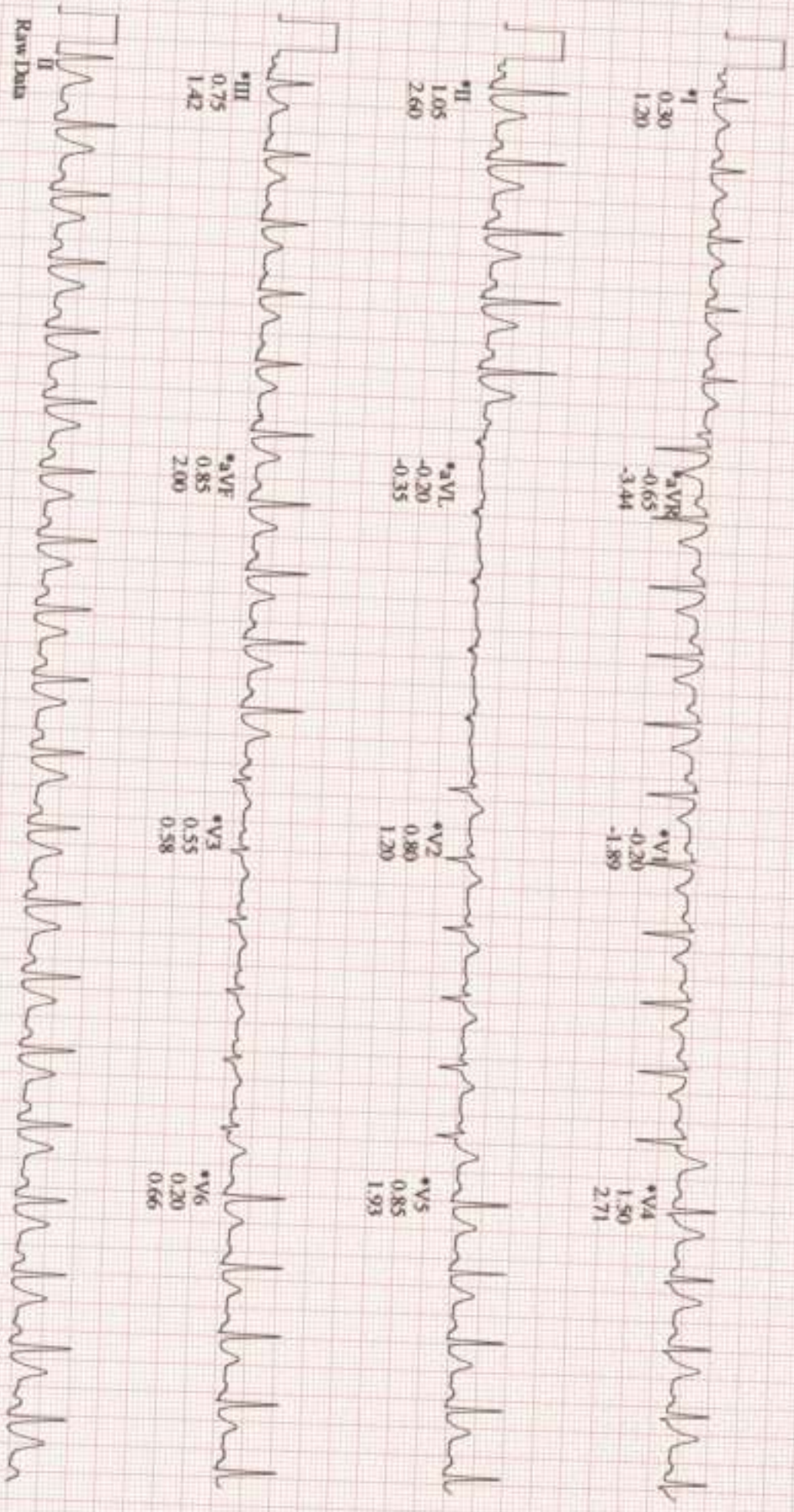
123 bpm  
130/80 mmHg

RECOVERY #1  
03:00

BRUCE  
0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)





MR. SHIVAM JHA  
Patient ID: 20475  
15.03.2024  
11:35:22am

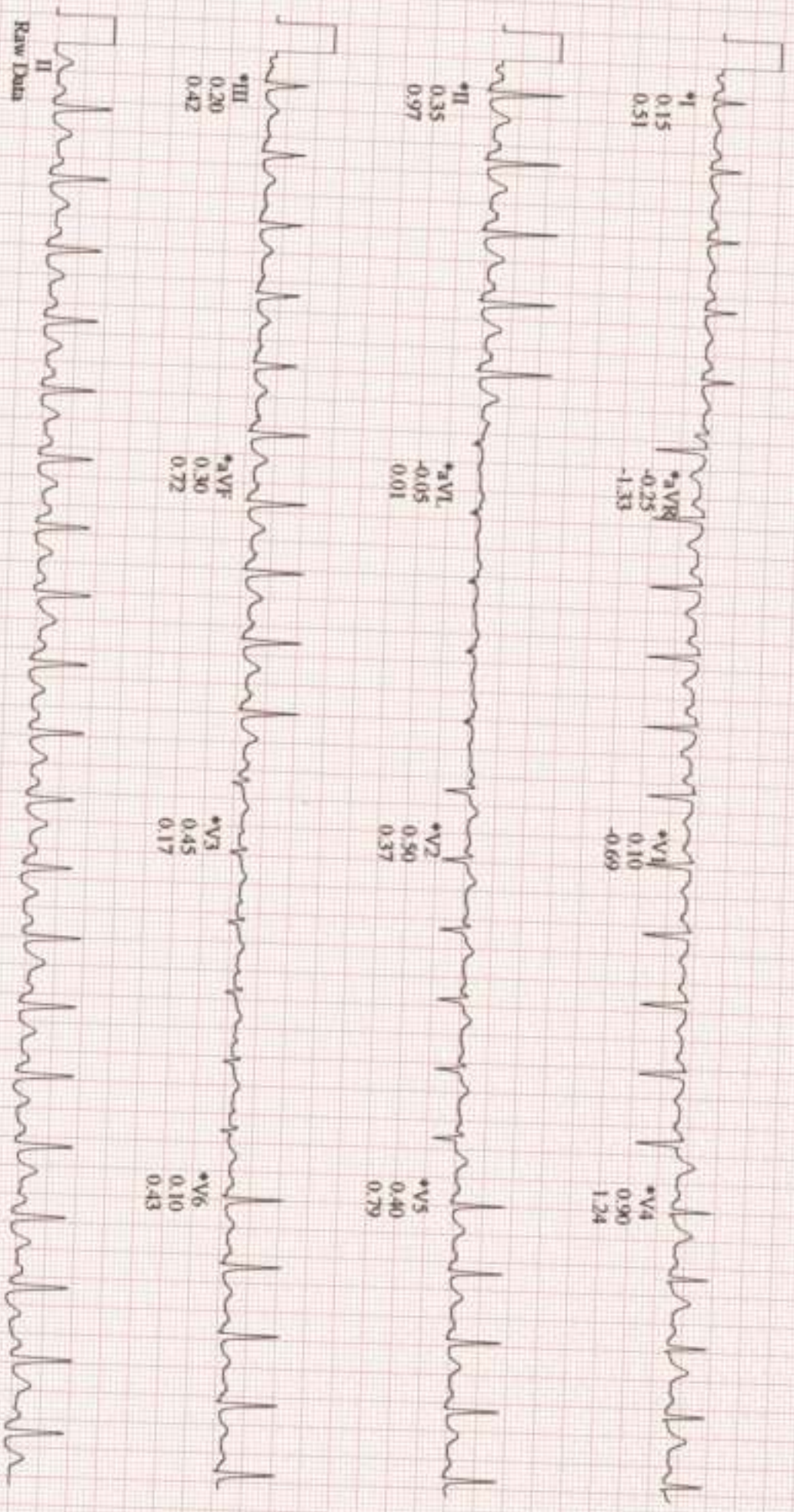
LINKED MEDICANS

UNITED HOSPITAL

122 bpm  
RECOVERY #1 05:00  
BRUCE 0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



GE  
CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HRGILV6

\*Computer Synthesized Rhythms





NABH



NABL



No.1



**UNITED HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

### Out Patient Record

Patient Name : Mr. SHIVAM JHA  
 Age / Sex : 30 Years / Male  
 Spouse / Father Name : SHASHISHEKHAR JHA  
 Address : JP nagar , , Bengaluru Urban, Karnataka,  
 INDIA.

UHID : UHJA23020475  
 OP NO/Reg Dt : 15-03-2024 09:21 AM  
 Department :  
 Referred By :  
 Consultant : Dr. Preventive Health Check Up  
 KMC No. : *Dr. Shreeha.*

#### Complaints / Findings / Observations :

*Un*  $\left\{ \begin{array}{l} 6/6 \\ 6/6 \end{array} \right\}$  *ng.*

*nil systemic*

#### Investigations:

*Alj overall*

*Fundi (well kid)*

*ov c/d to 2-3:1 FH Fr*

#### Treatment / Care of Plan / Provisional Diagnosis :

*Zh: ov only overall.*

#### Follow Up Advice :

  
 Signature of the Doctor



NABH



NABL



No.1



**UNITED  
HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	Shivam Jha	<b>Date</b>	15/03/24
<b>Age</b>	30 years	<b>Hospital ID</b>	UHJA23020475
<b>Sex</b>	Male	<b>Ref.</b>	Health check

**RADIOGRAPH OF THE CHEST (PA - VIEW)**

**FINDINGS:**

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

**IMPRESSION:**

- No radiographic abnormality.

**Dr. Elluru Santosh Kumar**  
Consultant Radiologist



Name: MR SHIVAM

30 years

1100 Sinus rhythm

4008 Nonspecific T wave abnormality [flat T or negative T (aVF, V6)]

8305 Short QTc interval [QTc int. < 360 ms]

9150 \*\* abnormal ECG \*\*

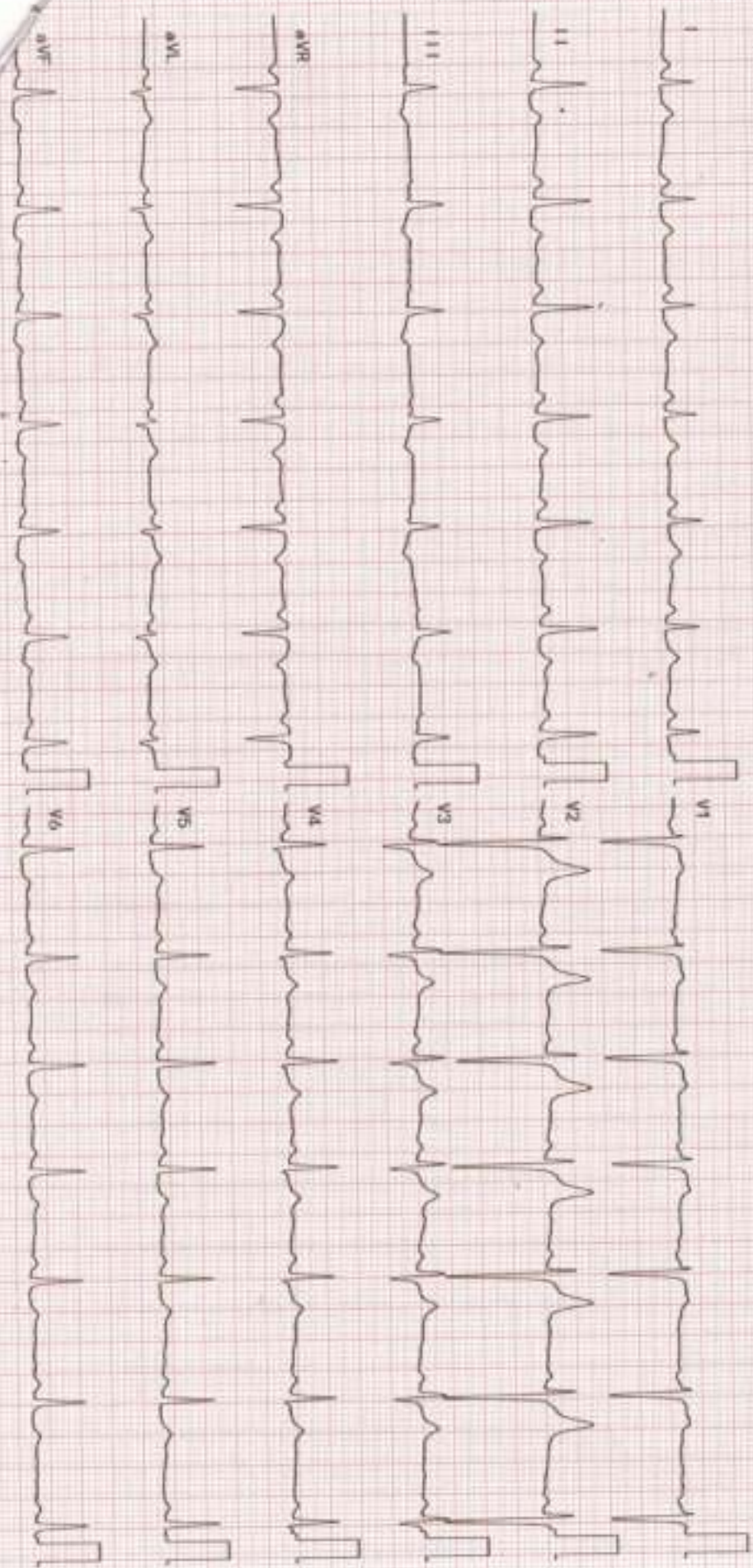
Indications:  
 symptoms:  
 history:  
 med. rate

Parameter	Value	Unit
HR	84	bpm
R int	134	ms
PR dur	80	ms
QT/QTc(E) int	304/345	ms
VQRS/T axis	21/56/16	°
VS/ST amp	1.02/1.22	mV
VS+ST amp	2.24	mV

10 mm/mV 25 mm/s Filter: H50 D 35 Hz

10 mm/mV

Unconfirmed Report  
 Reviewed by:







**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	Shivam Jha	<b>Date</b>	15/03/24
<b>Age</b>	30 years	<b>Hospital ID</b>	UHJA23020475
<b>Sex</b>	Male	<b>Ref.</b>	Health check

**ULTRASOUND ABDOMEN AND PELVIS**

**FINDINGS:**

**Liver** is normal in size and *shows mildly increased echopattern*. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

**Gall bladder** is normal without evidence of calculi, wall thickening or pericholecystic fluid.

**Pancreas** - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

**Spleen** is normal in size, shape, contour and echopattern. No focal lesion.

**Right Kidney** is normal in size (10.6 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Left Kidney** is normal in size (12.2 x 5.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Retroperitoneum** - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

**Urinary Bladder** is minimally distended.

**Prostate** is normal in echopattern and size, measures ~ 15.5 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

**IMPRESSION:**

- Mild fatty infiltration of liver (Grade I).
- No other definite sonological abnormality detected.

**Dr. Elluru Santosh Kumar**  
Consultant Radiologist