

NABH ACCREDITED

PRAKASH

EYE HOSPITAL & LASER CENTRE

Dr. AMIT GARG

M.B.B.S., D.N.B. (Oph.)

I-Lasik (Femto) Bladeless Topical Micro Phaco

& Medical Retina Specialist


Ex. Micro Phaco Surgeon

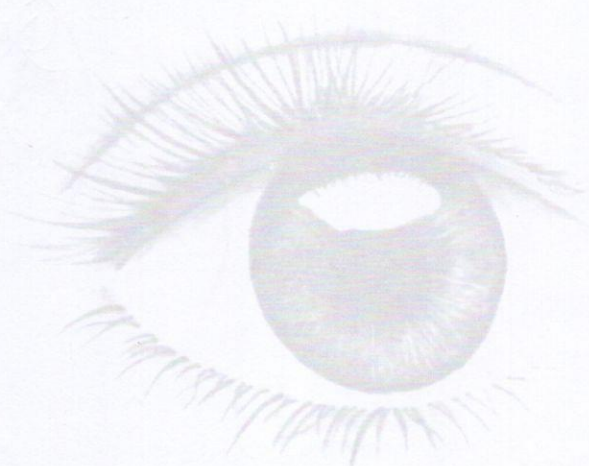
Venu Eye Institute & Research Centre, New Delhi

Name Kamal Kumar Age/Sex 54 / M C/o Date 29/Dec/22

Go Routine eye checkup

NOH/O
DM:HT


Dr. AMIT GARG
M.B.B.S., D.N.B.
Garg Pathology, Meerut



Accredited Eye Hospital Western U.P.

First NABH ECO

प्रकाश आँखों का अस्पताल एवं लेजर सेंटर



Website: www.prakasheyehospital.in
Facebook: <http://www.prakasheyehospital.in>

Counsellor 9837066186
7535832832
Manager 7895517715
OT 730222373
TPA 9837897788

Timings Morning : 9:30 am to 1:30 pm.
Evening : 5:00 pm to 7:00 pm.
Sunday : 9:30 am to 1:30 pm.
Near Nai Sarak, Garh Road, Meerut
E-mail : prakasheyehosp@gmail.com

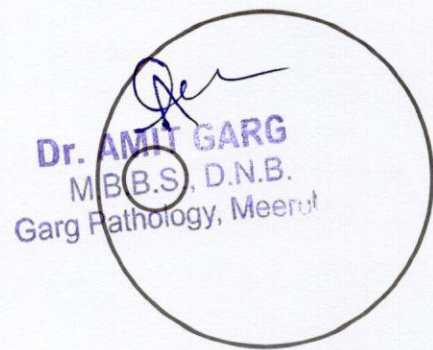
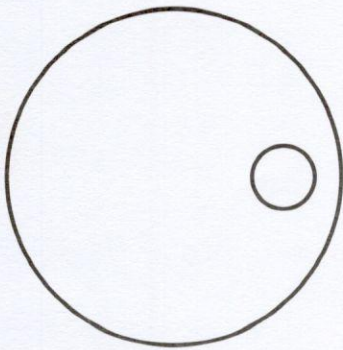
Vn R 6/9
L 6/9

PH R 6/6
L 6/6

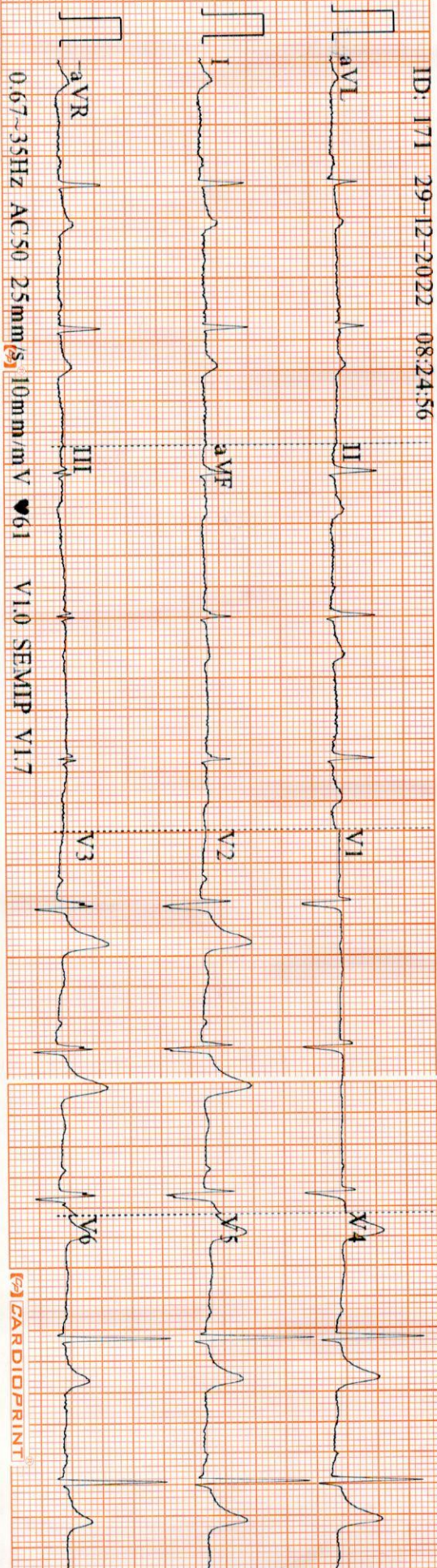
IOP R 18
L 18

Colour vision NORMAL
NORMAL

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance	+0.50	—	—	6/6	+0.50	—	—	6/6
Near								
Add RE	+2.00	—	—	4/6	+2.00	—	—	N/6.



ID: 171 29-12-2022 08:24:56



0.67-35Hz AC50 25mm/s 10mm/mV 61 V1.0 SEMIP V1.7

CARDIOPRINT

ID: 171

Male
54 Years
cm

kg

kPa

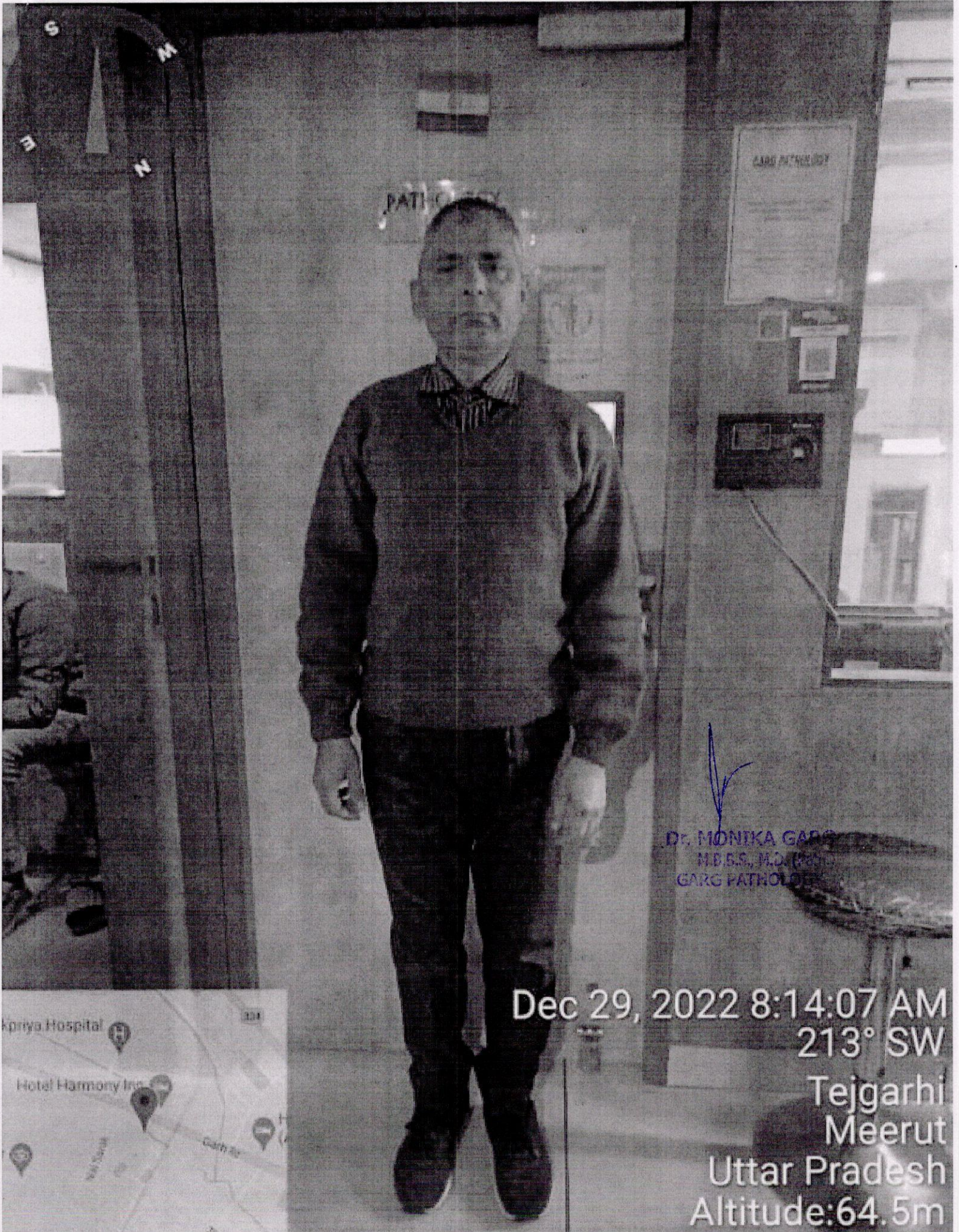
Diagnosis Information:
Sinus Rhythm
Normal ECG

Ram Kumar

HR	: 64	bpm
P	: 98	ms
PR	: 157	ms
QRS	: 83	ms
QT/QTc	: 383.396	ms
P/QRST	: 19.36/23	°
RV5/SVI	: 1.760/0.594	mV

Report Confirmed by:

Dr. MONIKA GARG
M.B.B.S., M.D. (Path.)
GARG PATHOLOGY



GARG PATHOLOGY

PATHOLOGY

Dr. MONIKA GARG
M.B.B.S., M.D. (P&D)
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Dec 29, 2022 8:14:07 AM
213° SW


Tejgarhi
Meerut
Uttar Pradesh
Altitude:64.5m
Index number: 402



Garg Pathology

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National Accreditation Board For Testing & Calibration Laboratories
ISO 9001:2008
Garden House Colony, Near Nai Sarak, Garh Road, Meerut
Ph.: 0121-2600454, 8979608687, 9837772828

DR. MONIKA GARG
M.D. (Path) Gold Medalist
Former Pathologist :
St. Stephan's Hospital, Delhi

PUID : 221229/601 **C. NO:** 601 **Collection Time** : 29-Dec-2022 8:20AM
Patient Name : Mr. KAMAL KUMAR 54Y / Male **Receiving Time** : 29-Dec-2022 8:29AM
Referred By : Dr. BANK OF BARODA **Reporting Time** : 29-Dec-2022 4:09PM
Sample By : **Centre Name** : Garg Pathology Lab - TPA
Organization : 

Investigation	Results	Units	Biological Ref-Interval
---------------	---------	-------	-------------------------

HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	12.9	gm/dl	13.0-17.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	6440	*10 ⁶ /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	55	%.	40-80
Lymphocytes	40	%.	20-40
Eosinophils	03	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	3.54	x 10 ⁹ /L	2.0-7.0(40-80%)
Absolute lymphocyte count	2.58	x 10 ⁹ /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.19	x 10 ⁹ /L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated /			
ESR (Automated Wsetergren`s)	05	mm/1st hr	0.0 - 10.0
RBC Indices			
TOTAL R.B.C. COUNT (Electric Impedence)	4.30	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	39.0	%	26-50
MCV (Calculated)	90.7	fL	80-94
MCH	30.0	pg	27-32



*THIS TEST IS NOT UNDER NABL SCOPE

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(Calculated)			
MCHC	33.1	g/dl	30-35
(Calculated)			
RDW-SD	45.9	fL	37-54
(Calculated)			
RDW-CV	12.2	%	11.5 - 14.5
(Calculated)			
Platelet Count	1.85	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	11.4	%	7.5-11.5
(Calculated)			
NLR	1.38		1-3
6-9 Mild stres			
7-9 Pathological cause			

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.
-NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
-NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).
-With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP * "O" POSITIVE \$ \$



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Organization	:				



Investigation	Results	Units	Biological Ref-Interval
GLYCATED HAEMOGLOBIN (HbA1c)*	6.9	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	151.3	mg/dl	

EXPECTED RESULTS :

-
- Non diabetic patients & Stabilized diabetics : 4.3% to 6.30%
 - Good Control of diabetes : 6.4% to 7.5%
 - Fair Control of diabetes : 7.5% to 9.0%
 - Poor Control of diabetes : 9.0 % and above

-Next due date for HBA1C test : After 3 months

-High HbF & Trig.level, iron def.anaemia result in high GHb

-Haemolytic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control.HbA1c represents average glycemia over the past six to eight weeks.Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3 Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.

As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.



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BIOCHEMISTRY (FLORIDE)

PLASMA SUGAR FASTING (GOD/POD method)	119.0	mg/dl	70 - 110
PLASMASUGAR P.P. (GOD/POD method)	263.0	mg/dl	80-140



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BIOCHEMISTRY (SERUM)

SERUM CREATININE (Enzymatic)	0.9	mg/dl	0.6-1.4
URIC ACID	5.2	mg/dL.	3.6-7.7
BLOOD UREA NITROGEN	10.30	mg/dL.	8-23



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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL (Diazo)	0.6	mg/dl	0.1-1.2
DIRECT (Diazo)	0.3	mg/dl	<0.3
INDIRECT (Calculated)	0.3	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	42.0	U/L	8-40
S.G.O.T. (IFCC method)	40.0	U/L	6-37
SERUM ALKALINE PHOSPHATASE (IFCC KINETIC)	96.0	IU/L.	50-126
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	7.2	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	4.1	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	3.1	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	1.3		1.5-2.5



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PSA*	0.929	ng/ml	
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ECLIA

NORMAL VALUE

Age (years)	Median (ng/ml)
<49	<2.0
50-59	<3.5
60-69	<4.5
70-79	<6.5



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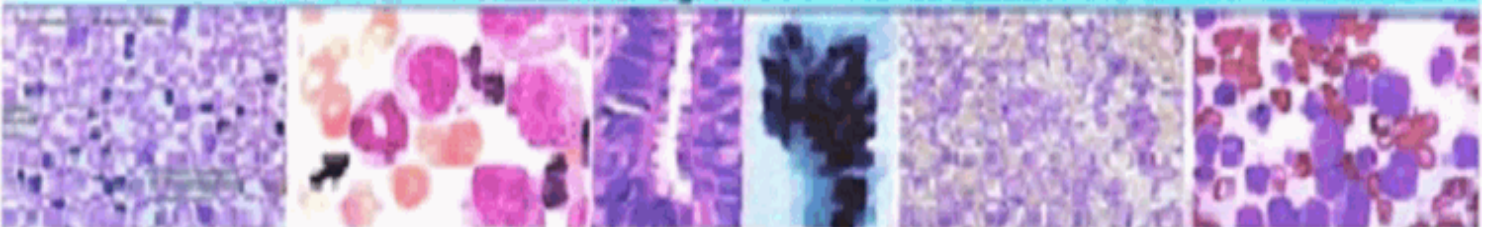
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LIPID PROFILE			
SERUM CHOLESTEROL (CHOD - PAP)	150.0	mg/dl	150-250
SERUM TRIGYCEIDE (GPO-PAP)	101.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	43.0	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	20.2	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	86.8	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	02.0	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	3.5	ratio	3.8-5.9

Interpretation :
Patient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE :
Lipid Profile Ranges As PER NCEP-ATP III :
SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated :> 240 mg/dl
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased :< 40 mg/dl
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.



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SERUM SODIUM (Na) * (ISE method) (ISE)	142.0	mEq/litre	135 - 155
THYRIOD PROFILE*			
Triiodothyronine (T3) * (ECLIA)	1.105	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	9.954	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) (ECLIA)	1.562	uIU/ml	0.38-5.30
Normal Range:- 1 TO 4 DAYS 2.7-26.5 4 TO 30 DAYS 1.2-13.1			

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disorders such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism,serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both increased and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) * (ISE method)	4.2	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	10.0	mg/dl	9.2-11.0



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URINE

PHYSICAL EXAMINATION

Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.015		1.000-1.030
PH (Reaction)	Acidic		

BIOCHEMICAL EXAMINATION

Protein	Nil		Nil
Sugar	Nil		Nil

MICROSCOPIC EXAMINATION

Red Blood Cells	Nil	/HPF	Nil
Pus cells	2-3	/HPF	0-2
Epithelial Cells	1-2	/HPF	1-3
Crystals	Nil		
Casts	Nil		

@ Special Examination

Bile Pigments	Absent
Blood	Nil
Bile Salts	Absent

-----{END OF REPORT }-----



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DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE : 29/12/2022 REFERENCE NO. : 10303
 PATIENT NAME : KAMAL KUMAR AGE/SEX : 54YRS/M
 REFERRED BY : DR. MONIKA GARG ECHOGENECITY : NORMAL
 REFERRING DIAGNOSIS : To rule out structural heart disease.

ECHOCARDIOGRAPHY REPORT

DIMENSIONS	NORMAL		NORMAL
AO (ed) 2.9 cm	(2.1 - 3.7 cm)	IVS (ed) 0.8 cm	(0.6 - 1.2 cm)
LA (es) 2.7 cm	(2.1 - 3.7 cm)	LVPW (ed) 0.8 cm	(0.6 - 1.2 cm)
RVID (ed) 1.3 cm	(1.1 - 2.5 cm)	EF 60%	(62% - 85%)
LVID (ed) 4.0 cm	(3.6 - 5.2 cm)	FS 30%	(28% - 42%)
LVID (es) 2.8 cm	(2.3 - 3.9 cm)		

MORPHOLOGICAL DATA :

Mitral Valve: AML : Normal Interatrial septum : Intact
 PML : Normal Interventricular Septum : Intact
 Aortic Valve : Normal Pulmonary Artery : Normal
 Tricuspid Valve : Normal Aorta : Normal
 Pulmonary Valve : Normal Right Atrium : Normal
 Right Ventricle : Normal Left Atrium : Normal
 Left Ventricle : Normal

Cont. Page No. 2

:: 2 ::

2-D ECHOCARDIOGRAPHY FINDINGS :

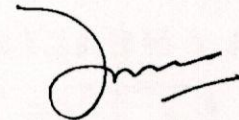
LV normal in size with normal contractions. No LV regional wall motion abnormality seen. RV normal in size with adequate contractions. LA and RA normal. All cardiac valves are structurally normal. No chamber hypertrophy/ intracardiac mass. Estimated LV ejection fraction is 60%.

DOPPLER STUDIES :

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	Trace	0.82	2.6
Tricuspid Valve	No	0.87	2.9
Pulmonary Valve	No	0.75	2.1
Aortic Valve	No	0.94	3.3

IMPRESSION :

- No RWMA.
- Normal LV Systolic Function (LVEF = 60%).
- Trace MR.



DR. HARIOM TYAGI
MD, DM (CARDIOLOGY)
(Interventional Cardiologist)
for Director, Lokpriya Heart Centre

NOTE: Echocardiography report given is that of the procedure done on that day and needs to be correlated clinically. This is not for medico legal purpose, as patient's identity is not confirmed. No record of this report is kept in the Hospital

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DATE	29.12.2022	REF. NO.	13746		
PATIENT NAME	KAMAL KUMAR	AGE	54 YRS	SEX	M
INVESTIGATION	X-RAY CHEST PA VIEW	REF. BY	GARG (PATHOLOGY)		

REPORT

- Trachea is central in position.
- Bilateral lung field show normal broncho vascular markings.
- Cardiac size is within normal limits.
- Both costophrenic angles are clear.
- Both domes of diaphragm are normal in contour and position.

IMPRESSION

Normal study

Dr. P.D. Sharma
M.B.B.S., D.M.R.D. (VIMS & RC)
Consultant Radiologist and Head

1. Impression is a professional opinion & not a diagnosis
2. All modern machines & procedures have their limitations. If there is variance clinically this examination may be repeated or reevaluated by other investigations.
Ps. All congenital anomalies are not picked upon ultrasounds.
3. Suspected typing errors should be informed back for correction immediately.
4. Not for medico-legal purpose. Identity of the patient cannot be verified.

• 1.5 Tesla MRI • 64 Slice CT • Ultrasound
• Doppler • Dexa Scan / BMD • Digital X-ray

**PRENATAL DETERMINATION OF SEX IS BANNED,
PREVENT FEMALE FOETICIDE**

Helpline Numbers : 0121-2792500, 2601901

www.lokpriyahospital.com

DATE	29.12.2022	REF. NO.	4123		
PATIENT NAME	KAMAL KUMAR	AGE	54YRS	SEX:	M
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG (PATHOLOGY)		

REPORT

Liver – appears normal in size and echotexture. No mass lesion seen. Portal vein is normal.

Gall bladder – Wall thickness is normal. No calculus / mass lesion seen. CBD is normal.

Pancreas- appears normal in size and echotexture. No mass lesion seen.

Spleen- is normal in size and echotexture.

Right Kidney - Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Left Kidney – Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Urinary bladder – appears distended. Wall thickness is normal. No calculus / mass seen.

Prostate – Normal in size (22g) & echotexture.

IMPRESSION

Essentially normal study

Dr. P.D. Sharma
 M.B.B.S., D.M.R.D. (VIMS & RC)
 Consultant Radiologist and Head

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 • Doppler • Dexa Scan / BMD • Digital X-ray

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