



BMI CHART

Date: 05/03/24

Name: Rajendra Kumar Age: 30 yrs Sex: M/F

BP: 110/80 mmHg Height (cms): 167 cm Weight(kgs): 65.4 kg BMI: _____

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
kg	45.5	47.7	50.0	52.3	54.5	56.6	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	18	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	37	38	39	40	41
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
5'9" - 175.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
5'11" - 180.3	14	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
6'1" - 185.4	13	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
6'4" - 193.0	12	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34

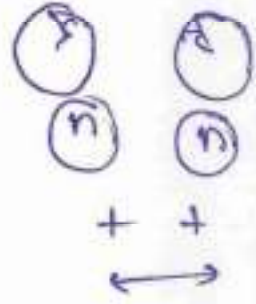
Doctors Notes:

Signature



UHID	13012865	Date	05/03/2024		
Name	Mr. Rajendra Kumar	Sex	Male	Age	36
OPD	ENT 04	Health Check Up			

Drug allergy:
Sys illness:



Nose }
Throat } NAD

Adv
Audiometry



MC-5837

PATIENT NAME : MR.RAJENDRA KUMAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022XC000878

PATIENT ID : FH.13012865

CLIENT PATIENT ID: UID:13012865

ABHA NO :

AGE/SEX : 36 Years Male

DRAWN : 05/03/2024 09:08:00

RECEIVED : 05/03/2024 09:08:20

REPORTED : 05/03/2024 13:32:38

CLINICAL INFORMATION :

UID:13012865 REQNO-1671447

CORP-OPD

BILLNO-150124OPCR012847

BILLNO-150124OPCR012847

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	13.4	13.0 - 17.0	g/dL
METHOD : SLS METHOD			
RED BLOOD CELL (RBC) COUNT	4.75	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	4.35	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	232	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	41.6	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	87.6	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.2	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.2	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.0	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	18.4		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	10.5	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

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Page 1 Of 17



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Email : -

Patient Ref. No. 2200000906785

PATIENT NAME : MR. RAJENDRA KUMAR

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NEUTROPHILS		37 Low	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		47 High	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		10	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		6	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		1.61 Low	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.04	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.44	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.26	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)		0.8		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE

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Interpretation(x)

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.

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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PATIENT NAME : MR.RAJENDRA KUMAR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000G45507		AGE/SEX :36 Years Male	
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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	05	0 - 14	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	6.0 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)	125.5 High	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA 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, Vasculitis, 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 (Paraproteinemia, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy ESR in first trimester is 0-40 mm/hr(62 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)

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REFERENCE :

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

1. 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.
2. Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, anemia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.
4. 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



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Page 5 Of 17



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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

METHOD : TUBE AGGLUTINATION

RH TYPE

NEGATIVE

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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Page 6 Of 17



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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.53	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.13	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.40	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.3	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	18	15 - 37	U/L
METHOD : UV WITH PSP			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	23	< 45.0	U/L
METHOD : UV WITH PSP			
ALKALINE PHOSPHATASE	46	30 - 120	U/L
METHOD : PAPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	33	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE	168	85 - 227	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	98	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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METHOD : HEXOKINASE



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Page 7 Of 17



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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	10	6 - 20		mg/dL
METHOD : URICASE - UV				
CREATININE EGFR- EPI				
CREATININE	0.81 Low	0.90 - 1.30		mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE	36			years
GLOMERULAR FILTRATION RATE (MALE)	117.18	Refer Interpretation Below		mL/min/1.73m2
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO	12.35	5.00 - 15.00		
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	4.9	3.5 - 7.2		mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.4	6.4 - 8.2		g/dL
METHOD : BIURET				

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 CIN - U74899PB1995PLC045956
 Email : -



Patient Ref. No. 22000000906785

PATIENT NAME : MR. RAJENDRA KUMAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022XC000878

PATIENT ID : FH.13012865

CLIENT PATIENT ID: UID:13012965

ABHA NO : 1

AGE/SEX : 36 Years Male

DRAWN : 05/03/2024 09:08:00

RECEIVED : 05/03/2024 09:08:20

REPORTED : 05/03/2024 13:32:38

CLINICAL INFORMATION :

UID:13012865 REQNO-1671447
CORP-OPD
BILLNO-150124OPCR012847
BILLNO-150124OPCR012847

Test Report Status	Final	Results	Biological Reference Interval	Units
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ALBUMIN, SERUM

ALBUMIN	4.1	3.4 - 5.0	g/dL
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METHOD : SCP DYE BINDING

GLOBULIN

GLOBULIN	3.3	2.0 - 4.1	g/dL
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METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	139	136 - 145	mmol/L
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METHOD : ISE INDIRECT

POTASSIUM, SERUM	4.08	3.50 - 5.10	mmol/L
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METHOD : ISE INDIRECT

CHLORIDE, SERUM	104	98 - 107	mmol/L
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METHOD : ISE INDIRECT

Interpretation(s)

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal hema 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.

Dr. Akshay Dhotre, MD
(Reg.no. MMC 2019/09/6377)
Consultant Pathologist



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Patient Ref. No. 22000000906783

PATIENT NAME : MR.RAJENDRA KUMAR

REF. DOCTOR :

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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, osteosarcoma, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatemia, 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.

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, Waldenstrom's disease. Lower-than-normal levels may be due to: Apoproteinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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, hemodialysis, 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 glycaemic 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 Hypoglycaemia, increased insulin response & sensitivity etc.

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, Nephrotoxicosis, Prostatism)

Causes of decreased level include: Liver disease, SIADH.

CREATININE EGFR- EPI- Kidney disease outcomes quality initiative (KDIGO) guidelines state that estimation of GFR is the best overall indices of the kidney function.

- It gives a rough measure of number of functioning nephrons. Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>50 ml/min per 1.73m²). This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).

Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.us.edu/guideline/egfr>

Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. *Kidney Med* 2022; 4:100471. 35756325

Harrison's Principle of Internal Medicine, 21st ed. pg 62 and 334

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- 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, Waldenstrom's disease.



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Patient Ref. No. 22000000906785

PATIENT NAME : MR. RAJENDRA KUMAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -5PLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022XC000878
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 CLIENT PATIENT ID: UID:13012865
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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, hemodialysis, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	168	< 200 Desirable 200 - 239 Borderline High ≥ 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	123	< 150 Normal 150 - 199 Borderline High 200 - 499 High ≥ 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	39 Low	< 40 Low ≥ 60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	108	< 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	129	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	24.6	< / = 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.3	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			

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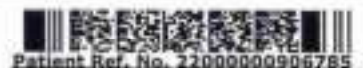
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Patient Ref. No. 22000000906785



NC-5837

PATIENT NAME : MR.RAJENDRA KUMAR

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ACCESSION NO : 0022XC000878
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AGE/SEX : 36 Years Male
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LDL/HDL RATIO	2.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
---------------	-----	--	--

METHOD : CALCULATED PARAMETER

Interpretation(s)

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Patient Ref. No. 22000000906785

PATIENT NAME : MR.RAJENDRA KUMAR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507		ACCESSION NO : 0022XC000878	
FORTIS VASHI-CHC -SPLZD		AGE/SEX : 36 Years Male	
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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	5.5	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		

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Dr. Rekha Nair, MD
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MICROSCOPIC EXAMINATION, URINE

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

PUS CELL (WBC'S)	2-3	0-5	/HPF
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METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS	0-1	0-5	/HPF
------------------	-----	-----	------

METHOD : MICROSCOPIC EXAMINATION

CASTS	NOT DETECTED		
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METHOD : MICROSCOPIC EXAMINATION

CRYSTALS	NOT DETECTED		
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METHOD : MICROSCOPIC EXAMINATION

BACTERIA	NOT DETECTED	NOT DETECTED	
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METHOD : MICROSCOPIC EXAMINATION

YEAST	NOT DETECTED	NOT DETECTED	
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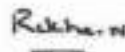
METHOD : MICROSCOPIC EXAMINATION

REMARKS URINARY MICROSCOPIC EXAMINATION DONE ON URINARY
CENTRIFUGED SEDIMENT.

Interpretation(s)



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CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022XC000878 PATIENT ID : FH.13012865 CLIENT PATIENT ID: UID:13012865 ABMA NO : :	AGE/SEX : 36 Years Male DRAWN : 05/03/2024 09:08:00 RECEIVED : 05/03/2024 09:08:20 REPORTED : 05/03/2024 13:32:38	

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UTD:13012865 REQNO-1671447
CORP-OPD
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3 METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE	118.8	80.0 - 200.0	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE	7.72	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY	1.450	0.270 - 4.200	µIU/mL

Interpretation(s)

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	1.220	0.0 - 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 patients.

- It is 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 2 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.
- Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References-

1. Burris CA, Ashwood ER, Bruns DE, Teltz. textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LH. Wallace's Interpretation of diagnostic tests. 9th edition.

End Of Report

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


Dr. Akshay Dhotre, MD
(Reg.no. MNC 2019/09/6377)
Consultant Pathologist

Page 17 Of 17



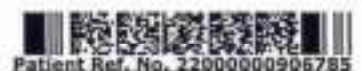
View Details



View Report

PERFORMED AT :

Agilus Diagnostics Ltd.
Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,
Navi Mumbai, 400703
Maharashtra, India
Tel : 022-39199222, 022-49723322,
CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000906785



MC-5837

PATIENT NAME : MR.RAJENDRA KUMAR

REF. DOCTOR :

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

ACCESSION NO : 0022XC000942
PATIENT ID : FH.13012865
CLIENT PATIENT ID: UID:13012865
ABHA NO : :

AGE/SEX : 36 Years Male
DRAWN : 05/03/2024 12:34:00
RECEIVED : 05/03/2024 12:42:01
REPORTED : 05/03/2024 13:35:27

CLINICAL INFORMATION :

UID:13012865 REQNO-1671447
 CORP-OPD
 BILLNO-150124OPCR012847
 BILLNO-150124OPCR012847

Test Report Status	Results	Biological Reference Interval	Units
Final			

BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 99 70 - 140 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

****End Of Report****

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Patient Ref. No. 22000000906849

36 Years

Male

HR

Rate 74 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Consider left ventricular hypertrophy.....(S V1/V2+R V5/V6) >3.50mV

Normal A

PR 141
 QRS 89
 QT 357
 QTc 396

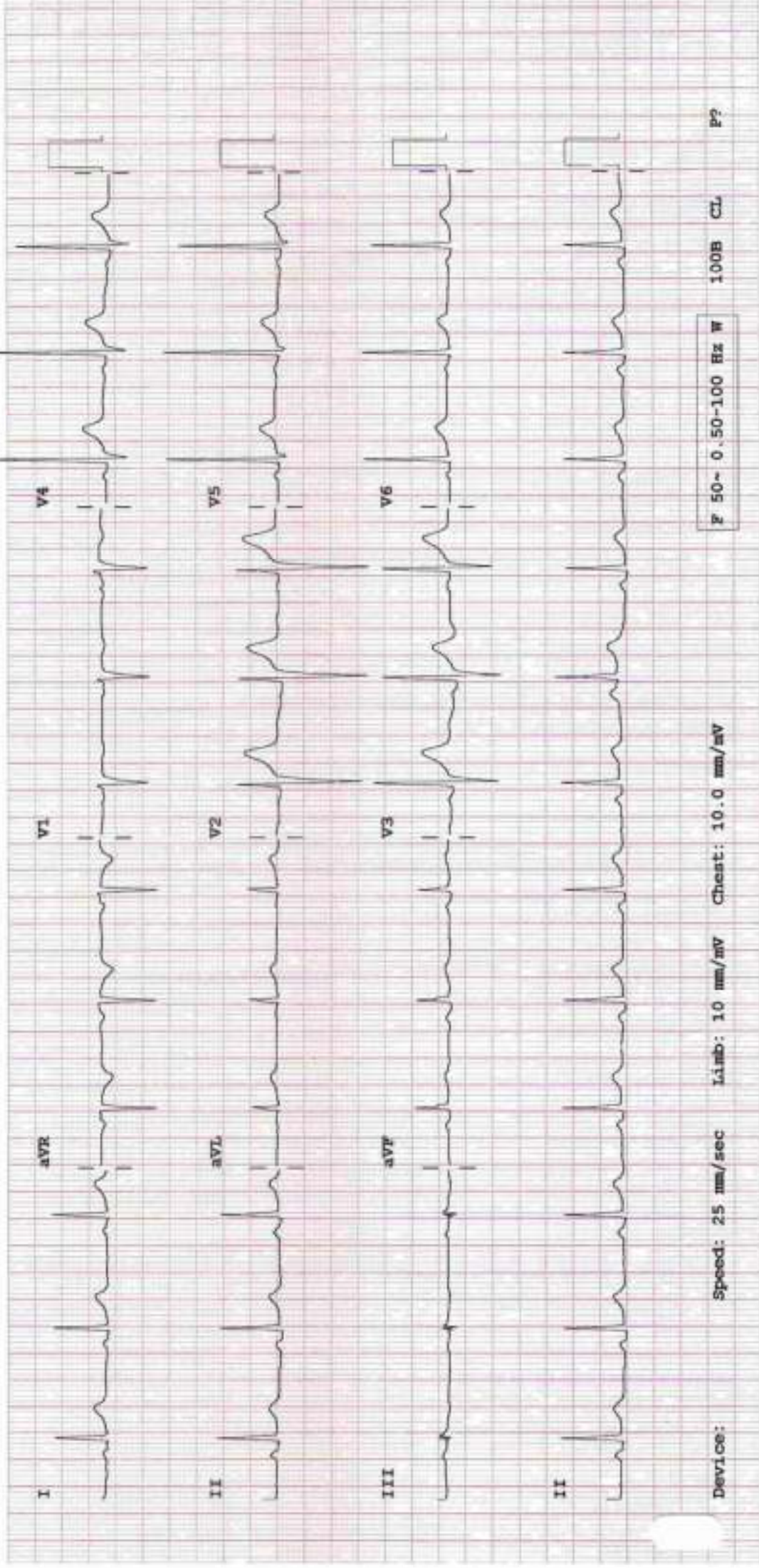
--AXIS--

P 49
 QRS 34
 T 22

12 Lead; Standard Placement

-- ABNORMAL ECG --

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50- 0.50-100 Hz W 100B CL P?



DEPARTMENT OF NIC

Date: 05/Mar/2024

Name: Mr. Rajendra Kumar
 Age | Sex: 36 YEAR(S) | Male
 Order Station : FO-OPD
 Bed Name :

UHID | Episode No : 13012865 | 13170/24/1501
 Order No | Order Date: 1501/PN/OP/2403/27315 | 05-Mar-2024
 Admitted On | Reporting Date : 05-Mar-2024 14:30:29
 Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

nor

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.
- IVC measures 12 mm with normal inspiratory collapse.

M-MODE MEASUREMENTS:

LA	30	mm
AO Root	21	mm
AO CUSP SEP	15	mm
LVID (s)	30	mm
LVID (d)	46	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	31	mm
RA	33	mm
LVEF	60	%



DEPARTMENT OF NIC

Date: 05/Mar/2024

Name: Mr. Rajendra Kumar
Age | Sex: 36 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 13012865 | 13170/24/1501
Order No | Order Date: 1501/PN/OP/2403/27315 | 05-Mar-2024
Admitted On | Reporting Date : 05-Mar-2024 14:30:29
Order Doctor Name : Dr.SELF ,


DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.
A WAVE VELOCITY: 0.4 m/sec
E/A RATIO: 1.8

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			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 (CARD)

DR. AMIT SINGH,
MD(MED), DM(CARD)

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



DEPARTMENT OF RADIOLOGY

Date: 05/Mar/2024

Name: Mr. Rajendra Kumar

Age | Sex: 36 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13012865 | 13170/24/1501

Order No | Order Date: 1501/PN/OP/2403/27315 | 05-Mar-2024

Admitted On | Reporting Date : 05-Mar-2024 12:17:41

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

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. YOGINI SHAH
DMRD., DNB. (Radiologist)



Patient Name	: Rajendra Kumar	Patient ID	: 13012865
Sex / Age	: M / 36Y 3M 3D	Accession No.	: PHC.7612649
Modality	: US	Scan DateTime	: 05-03-2024 13:22:22
IPID No	: 13170/24/1501	ReportDatetime	: 05-03-2024 13:46:03

US – WHOLE ABDOMEN

LIVER is normal in size and echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion ; seen in liver. Portal vein appears normal.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

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

Right kidney measures 11.1 x 4.7 cm.

Left kidney measures 11.5 x 5.7 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

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

PROSTATE is normal in size & echogenicity. It measures ~ 20.6 cc in volume.

No evidence of ascites.

Impression:

- No significant abnormality is detected.

DR. CHETAN KHADKE
(MD Radiologist)