



PATIENT'S NAME - Otashi shamed Ahimanyu DATE - 25/11/2023
AGE/GENDER - M
DOCTOR'S NAME - Rohmi soni

VISION SCREENING

	RE	RE	LE	LE
	Glasses	UNAIDED	Glasses	UNAIDED
DISTANT	<u>—</u>	<u>N/6</u>	<u>—</u>	<u>N/6</u>
NEAR	<u>—</u>	<u>N/6</u>	<u>—</u>	<u>N/6</u>
COLOUR	<u>Normal.</u>			
Recommendations	<u>—</u>			

VITALS

Pulse - <u>70b/m</u>	B.P- <u>110/70 mmHg</u>	SpO2 <u>98%</u> 98%
Height <u>176 cm</u>	Weight - <u>75 kg</u>	BMI- <u>24.2</u>
Waist - <u>110 cm</u>	Hip - <u>112 cm</u>	Waist/Hip Ratio- <u>0.98</u>
Chest -	Inspiration- <u>104 cm</u>	Expiration- <u>102 cm</u>

CENTRE NAME - Health Spring Aundh

SIGN & STAMP-



Patient Name : Mr. Sharad Otari
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Reg.Date / Time : 28/01/2023 / 11:46:07
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Final Test Report

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

HAEMOGLOBIN, RED CELL COUNT & INDICES

HAEMOGLOBIN (Spectrophotometry)	8.7	gm%	13-17
PCV (Electrical Impedance)	27.4	%	40 - 50
MCV (Calculated)	66.5	fL	83-101
MCH (Calculated)	21.0	pg	27.0 - 32.0
MCHC (Calculated)	31.6	g/dl	31.5-34.5
RDW-CV (Calculated)	14	%	11.6-14.0
RDW-SD (Calculated)	31	fL	36 - 46
TOTAL RBC COUNT (Electrical Impedance)	4.12	Million/cmm	4.5-5.5
TOTAL WBC COUNT (Electrical Impedance)	6880	/cumm	4000-10000

DIFFERENTIAL WBC COUNT

NEUTROPHILS (Flow cell)	57.2	%	40-80
LYMPHOCYTES (Flow cell)	34.7	%	20-40
EOSINOPHILS (Flow cell)	1.9	%	1-6
MONOCYTES (Flow cell)	6.2	%	2-10
BASOPHILS (Flow cell)	0.0	%	1-2

ABSOLUTE WBC COUNT

ABSOLUTE NEUTROPHIL COUNT (Calculated)	3930	/cumm	2000-7000
ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2380	/cumm	1000-3000

Contd ...

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HAEMATOLOGY

ABSOLUTE WBC COUNT

ABSOLUTE EOSINOPHIL COUNT (Calculated)	130	/cumm	200-500
ABSOLUTE MONOCYTE COUNT (Calculated)	430	/cumm	200-1000
ABSOLUTE BASOPHIL COUNT (Calculated)	0	/cumm	0-220
PLATELET COUNT (Electrical Impedance)	470000	/cumm	150000-410000
MPV (Calculated)	7.4	fL	6.78-13.46
PDW (Calculated)	10.8	%	11-18
PCT (Calculated)	0.346	%	0.15-0.50

PERIPHERAL BLOOD SMEAR

COMMENTS
(Microscopic) Hypochromic (+++) Microcytic (+++) Anisocytosis (++)

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Barcode : 



Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	72	mm / 1 hr	0-15
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Notes : The given result is measured at the end of first hour.

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BIOCHEMISTRY

**COMPREHENSIVE LIVER PROFILE
SERUM**

BILIRUBIN TOTAL (Diazotization)	0.94	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.24	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	0.70	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	15	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	14	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	98	U/L	40-129
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	19	U/L	<70
TOTAL PROTEIN (Colorimetric)	8.10	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.80	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	3.30	gm/dl	2.0-3.5
A/G RATIO (Calculation)	1.5		1-2

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BIOCHEMISTRY

**COMPREHENSIVE RENAL PROFILE
SERUM**

CREATININE (Jaffe Method)	0.8	mg/dl	0.6 - 1.3
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	5.3	mg/dl	6 - 20
BUN/CREATININE RATIO (Calculation)	6.6		10 - 20
URIC ACID (Uricase Enzyme)	5.7	mg/dl	3.7 - 7.7
CALCIUM (Bapta Method)	9.2	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	3.5	mg/dl	2.5-4.5

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BIOCHEMISTRY

LIPID PROFILE

SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	178	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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Notes : Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	130	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	37	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	115	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	26	mg/dl	15-40
SERUM	CHOL / HDL RATIO	4.8		3-5
SERUM	LDL /HDL RATIO (Calculation)	3.0		0 - 3.5

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BIOCHEMISTRY

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	87	mg/dl	70 - 110
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Notes : An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	115	mg/dl	70 - 140
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EDTA WHOLE BLOOD GLYCOSYLATED HAEMOGLOBIN (HbA1C)

HbA1C (High Performance Liquid Chromatography)	6.3	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
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ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	134	mg/dl	
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Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.

HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

Urine	URINE GLUCOSE FASTING (Urodip)	ABSENT		
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BIOCHEMISTRY

Urine	URINE GLUCOSE POST PRANDIAL (Urodip)	ABSENT		
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IMMUNOLOGY

THYROID PROFILE - TOTAL SERUM

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.07	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	9.08	ug/dl	4.6 - 10.5
THYROID STIMULATING HORMONE (TSH) (ECLIA)	1.550	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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CLINICAL PATHOLOGY

Urine URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		
APPEARANCE (Visual Examination)	CLEAR		

CHEMICAL EXAMINATION

SP.GRAVITY (Indicator System)	1.010		1.005 - 1.030
REACTION(pH) (Double indicator)	ACIDIC		
PROTEIN (Protein-error-of-Indicators)	ABSENT		
GLUCOSE (GOD-POD)	ABSENT		Absent
KETONES (Legal's Test)	ABSENT		Absent
OCCULT BLOOD (Peroxidase activity)	ABSENT		Absent
BILIRUBIN (Fouchets Test)	ABSENT		Absent
UROBILINOGEN (Ehrlich Reaction)	NORMAL		
NITRITE (Griess Test)	ABSENT		

MICROSCOPIC EXAMINATION

ERYTHROCYTES (Microscopy)	ABSENT	/hpf	0-2
PUS CELLS (Microscopy)	2-3	/hpf	0-5
EPITHELIAL CELLS (Microscopy)	0-1	/hpf	0-5
CASTS (Microscopy)	ABSENT		
CRYSTALS (Microscopy)	ABSENT		
ANY OTHER FINDINGS	NIL		

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SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 0 m 0 s

Stage Time : 0 m 11 s

HR: 93 bpm

Protocol: Bruce

Stage: Supine

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 120 / 80



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 0 m 0 s

Stage Time : 0 m 15 s

HR: 93 bpm

Protocol: Bruce

Stage: Standing

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 120 / 80



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 0 m 0 s

Stage Time : 0 m 1 s

HR: 89 bpm

Protocol: Bruce

Stage: Hyperventilation

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 120 / 80



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 2 m 54 s

Stage Time : 2 m 54 s

HR: 138 bpm

Protocol: Bruce

Stage: 1

Speed: 2.7 Km/h

Grade: 10 %

(THR: 159 bpm)

B.P: 120 / 80



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 5 m 54 s

Stage Time : 2 m 54 s

HR: 158 bpm

Protocol: Bruce

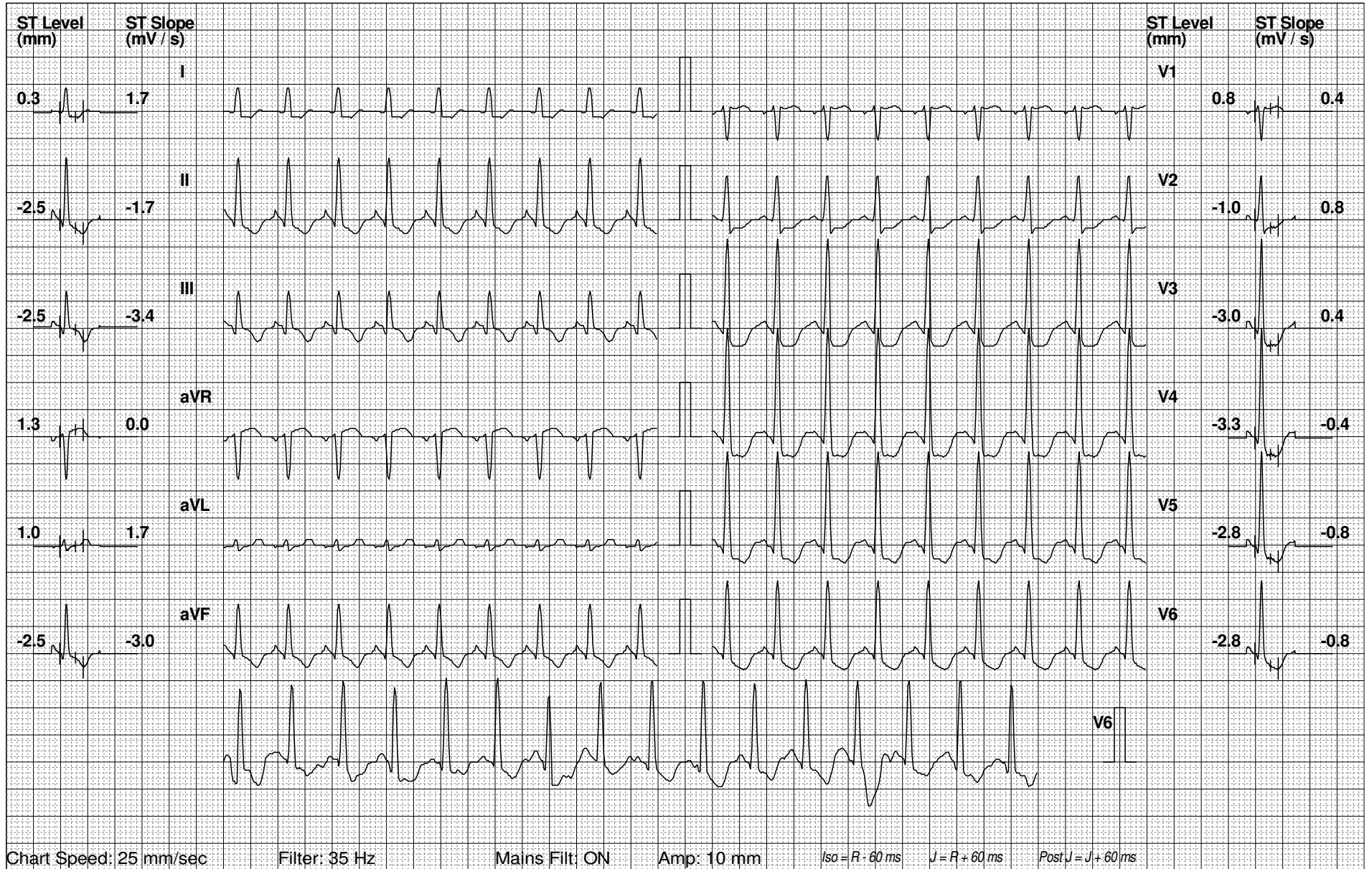
Stage: 2

Speed: 4 Km/h

Grade: 12 %

(THR: 159 bpm)

B.P: 120 / 80



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 1 s

Stage Time : 0 m 1 s

HR: 160 bpm

Protocol: Bruce

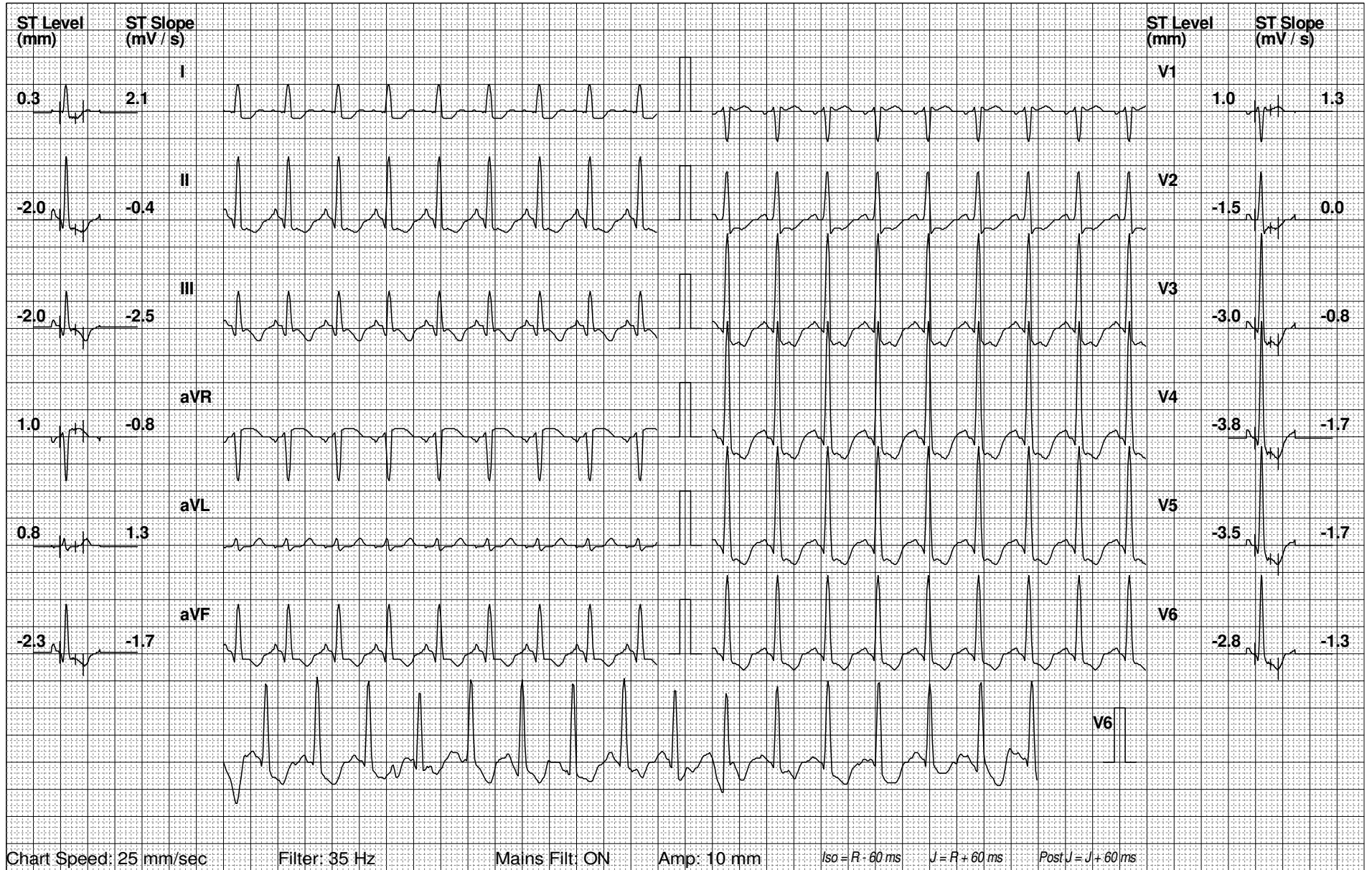
Stage: Peak Ex

Speed: 5.4 Km/h

Grade: 14 %

(THR: 159 bpm)

B.P: 140 / 90



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 7 s

Stage Time : 0 m 54 s

HR: 140 bpm

Protocol: Bruce

Stage: Recovery(1)

Speed: 1.6 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 140 / 90



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 7 s

Stage Time : 0 m 54 s

HR: 114 bpm

Protocol: Bruce

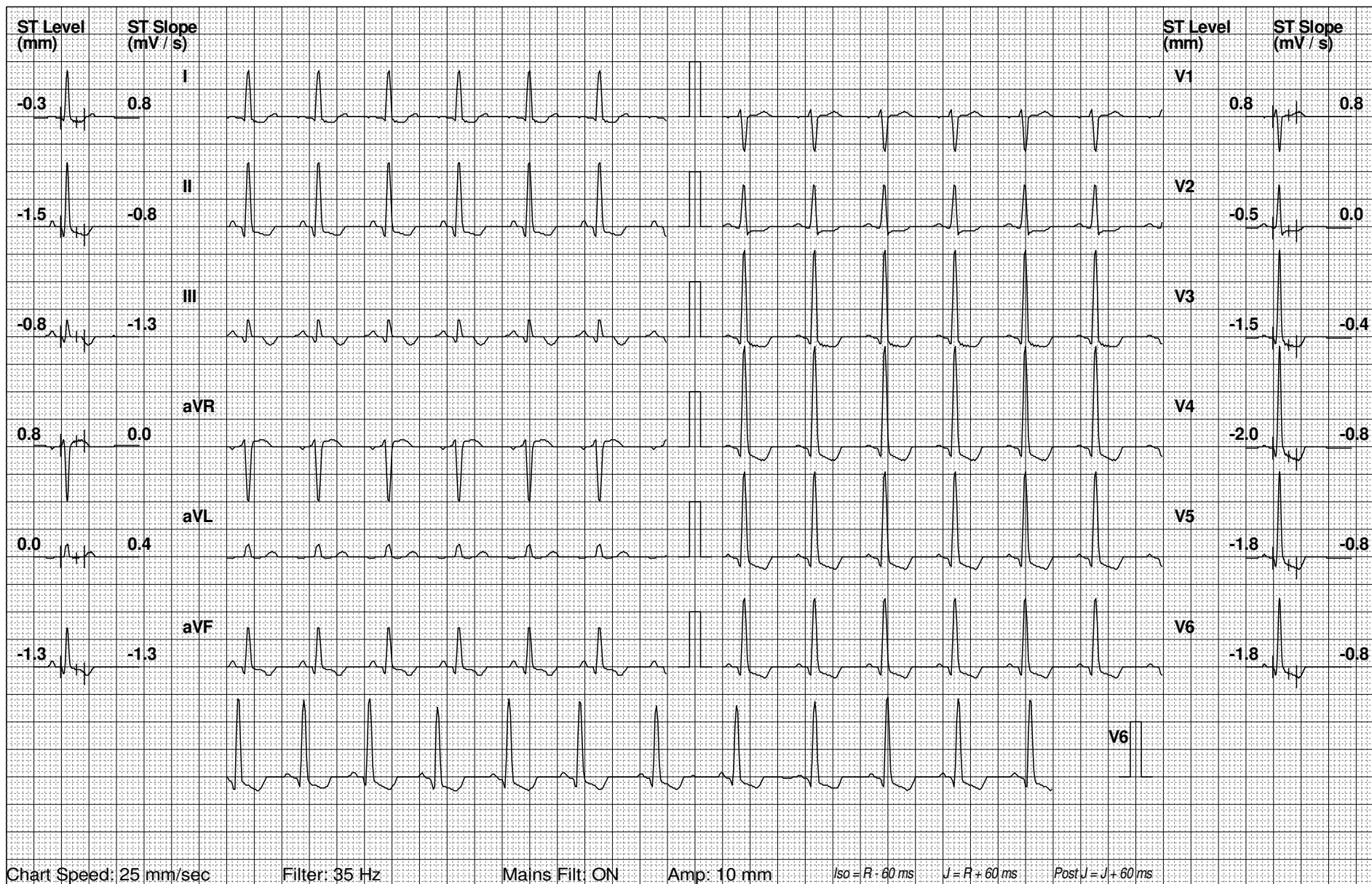
Stage: Recovery(2)

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 130 / 90



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 7 s

Stage Time : 0 m 54 s

HR: 102 bpm

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 130 / 90

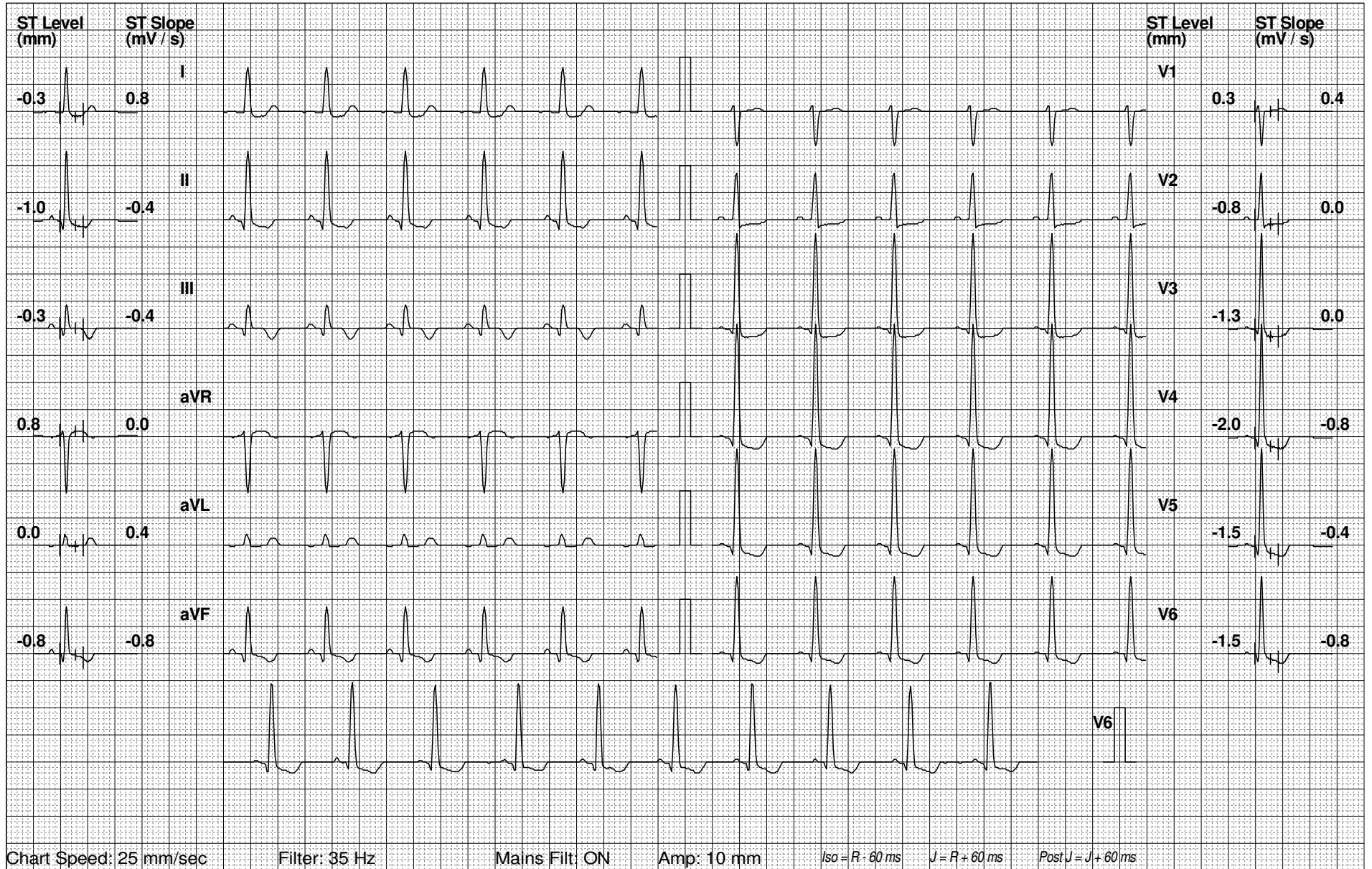


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 7 s

Stage Time : 0 m 54 s

HR: 99 bpm

Protocol: Bruce

Stage: Recovery(4)

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 130 / 90



Schiller CS-20 V 1.6

Linked Median

SHARAD OTARI (32 M)

ID: 2424561

Date: 28-Jan-23

Exec Time : 6 m 7 s

Stage Time : 0 m 5 s

HR: 102 bpm

Protocol: Bruce

Stage: Recovery(5)

Speed: 0 Km/h

Grade: 0 %

(THR: 159 bpm)

B.P: 120 / 80



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Linked Median

HEALTHSPRING HEALTHCARE AUNDH

Patient Details **Date:** 28-Jan-23 **Time:** 1:29:43 PM
Name: SHARAD OTARI ID: 2424561
Age: 32 y **Sex:** M **Height:** 176 cms. **Weight:** 75 Kg.
Clinical History: Routine Test

Medications: NO

Test Details

Protocol: Bruce **Pr.MHR:** 188 bpm **THR:** 159 (85 % of Pr.MHR) bpm
Total Exec. Time: 6 m 7 s **Max. HR:** 160 (85% of Pr.MHR)bpm **Max. Mets:** 10.20
Max. BP: 140 / 90 mmHg **Max. BP x HR:** 22400 mmHg/min **Min. BP x HR:** 7120 mmHg/min
Test Termination Criteria: Target HR attained

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (Km/h)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 : 17	1.0	0	0	90	120 / 80	-1.52 III	1.27 I
Standing	0 : 4	1.0	0	0	90	120 / 80	-0.76 V4	0.84 I
Hyperventilation	0 : 3	1.0	0	0	89	120 / 80	-0.76 II	0.84 I
1	3 : 0	4.6	2.7	10	138	120 / 80	-2.28 V3	-2.11 V4
2	3 : 0	7.0	4	12	160	120 / 80	-4.56 V4	-3.38 III
Peak Ex	0 : 7	10.2	5.4	14	160	140 / 90	-4.30 V4	-2.95 III
Recovery(1)	1 : 0	1.8	1.6	0	140	140 / 90	-3.80 V6	-3.80 V4
Recovery(2)	1 : 0	1.0	0	0	112	130 / 90	-2.78 V6	-2.95 III
Recovery(3)	1 : 0	1.0	0	0	103	130 / 90	-2.03 V5	-1.69 V5
Recovery(4)	1 : 0	1.0	0	0	101	130 / 90	-1.27 V5	-1.27 aVF
Recovery(5)	0 : 11	1.0	0	0	102	120 / 80	-1.52 III	1.27 I

Interpretation

The patient exercised according to the Bruce protocol for 6 m 7 s achieving a work level of Max. METS : 10.20. Resting heart rate initially 90 bpm, rose to a max. heart rate of 160 (85% of Pr.MHR) bpm. Resting blood Pressure 120 / 80 mmHg, rose to a maximum blood pressure of 140 / 90 mmHg.

Ref. Doctor: Dr Rashmi Soni
(Summary Report edited by user)

Doctor: DR MUKESH JHA
Schiller CS-20 V 1.6



*Members only



NAME OF THE PATIENT:	MR. SHARAD OTARI	AGE/SEX:	34 YRS/MALE
REFERRED BY DR:	HEALTHSPRING	DATE:	24/01/2023

USG OF ABDOMEN AND PELVIS

Liver

- Liver appears normal in size, shape & shows mildly raised echogenicity.
- No focal parenchymal abnormality is noted.
- IHBR & IHPR appear normal.
- Caudate lobe normal in size.
- IVC & Hepatic veins appear normal in course and calibre.

Main Portal vein-

- Main portal vein with its right and left branch appears normal in course and calibre and shows normal hepatopetal flow and velocity on colour Doppler.
- No evidence of portal hypertension in present scan.

Common bile duct

- CBD measures and appears normal in course and calibre.
- No evidence of CBD stone/ obstruction of CBD.

Gall bladder

- Gall bladder is partially distended with a normal wall thickness. No e/o mass lesion.
- No evidence of wall thickening or peri-cholecystic free fluid noted at present scan.

Pancreas

- Pancreas appears normal in size, shape and echo pattern.
- No focal lesion seen.
- No evidence of pancreatic inflammation or peri pancreatic fluid collection.

Spleen

- Spleen appears normal in size, Shape and echo pattern.
- No focal lesion seen.

Right Kidney

- Right kidney appears normal in size measures 10.8 x 4.7 cm shape and echo pattern with maintained C-M differentiation.
- Renal cortical surface appears regular.
- No obvious renal calculus or hydronephrosis.

Left Kidney

- Left kidney appears normal in size measures 11.0 x 5.2 cm. shape and echo pattern with maintained C-M differentiation.
- Renal cortical surface appears regular.
- No obvious renal calculus or hydronephrosis.



Certificate No. : MC-3200
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HEALTHSPRING

TREADMILL STRESS TEST REPORT

DATE: 28/01/2023

NAME:	SHARAD OTARI	AGE:(years)	32	SEX:	M
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PROTOCOL USED	BRUCE PROTOCOL		
ANGINA SCALE (0 – None, 1 – Non-Limiting, 2 – Limiting)	0	MAXIMUM ST DEPRESSION (mm)	0
WORKLOAD: MAXIMUM METS ACHIEVED (METS)	10.2	DOUBLE PRODUCT	22400 mm Hg/Min
DUKES SCORE (High Risk Score \leq -11, Low Risk Score \geq 5)	6		

CONCLUSION:

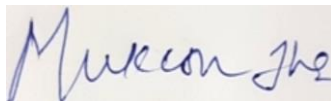
NORMAL INOTROPIC & CHRONOTROPIC RESPONSE
BASELINE ECG SHOWS ST-T CHANGES IN INFERIOR & LATERAL LEADS
NO SYMPTOMS OR ARRHYTHMIAS SEEN DURING EXERCISE
ST-T CHANGES SEEN IN INFERIOR & LATERAL LEADS DURING EXERCISE
GOOD EFFORT TOLERANCE AND FUNCTIONAL CAPACITY.

TARGET HEART RATE ACHIEVED

STRESS TEST IS INDETERMINATE FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD

IMPRESSION:

**STRESS TEST IS INDETERMINATE FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD
ADVISED- CLINICAL CORRELATION & FURTHER WORKUP**



DR. MUKESH JHA
MD (MEDICINE), DM (CARDIOLOGY)
REG NO- 2010/09/2935

NOTE-

A NEGATIVE STRESS TEST DOES NOT CONCLUSIVELY RULE OUT CORONARY ARTERY DISEASE. A POSITIVE STRESS TEST IS NOT CONCLUSIVE EVIDENCE OF CORONARY ARTERY DISEASE. THERE IS A POSSIBILITY OF THE TEST BEING FALSE POSITIVE OR FALSE NEGATIVE DUE OTHER ASSOCIATED MEDICAL CONDITIONS. THESE REPORTS ARE FOR DOCTORS & PHYSICIANS AND NOT FOR MEDICO-LEGAL PURPOSES. KINDLY CO-RELATE THE REPORT WITH CLINICAL CONDITIONS.

THIS TMT/ ECG IS REPORTED ONLINE WITHOUT INTERACTING WITH PATIENTS AND THE RESULT SHOULD BE CLINICALLY CO-RELATED AND INDEPENDENTLY REVIEWED BY THE PATIENT'S CONSULTANT DOCTOR. THE PATIENT WAS NOT SEEN BY DOCTORS PERSONALLY AND THE ABOVE REPORT HAS BEEN REVIEWED BY THE DOCTOR BASED ON THE TMT/ECG RESULT AS PROVIDED TO THE DOCTOR.



HEALTHSPRING
FAMILY HEALTH EXPERTS

NAME OF THE PATIENT:	MR. SHARAD OTARI	AGE/SEX:	34 YRS/MALE
REFERRED BY DR:	HEALTHSPRING	DATE:	24/01/2023

Urinary bladder

- Urinary bladder is minimally distended and shows normal wall thickness.
- No focal lesion seen.

Prostate

- Prostate is normal in size, shape and echo texture. No obvious focal lesion is seen on present trans-abdominal study.

Bowel loops and abdominal lymphadenopathy.

- Visualized bowel loops are non-dilated and show normal peristalsis.
- No evidence of abdominal lymphadenopathy.
- No free fluid is seen in abdomen and pelvis.

IMPRESSION: Ultrasound abdomen and pelvis reveals,

- **Grade I fatty liver.**

Suggested clinical & Pathological correlation.

Rujuta R Sawant

DR. RUJUTA.R. SAWANT
M.B.B.S., D.M.R.E.
Consultant Radiologist

(This is a professional opinion, not the final diagnosis & should be interpreted in the light of clinical background. This report is not for medico legal purposes. Always suggest a second opinion if clinically indicated.)



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