



### BMI CHART

Date: 8/3/24

Name: Shrikant Depale Age: 35 yrs Sex:  M /  F

BP: 140/90 mmHg Height (cms): 167 cm Weight(kgs): 73.6 kg BMI: \_\_\_\_\_  
SpO2: 97 % Pulse: 72 bpm

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215		
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7		
HEIGHT In/cm	<input type="checkbox"/> Underweight <input type="checkbox"/> Healthy <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Extremely Obese																									
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42		
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	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" - 162.6	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37		
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	36		
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	35		
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34		
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	33		
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32		
5'10" - 177.8	14	15	16	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	31		
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29	30		
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29		
6'1" - 185.4	13	13	14	15	15	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28		
6'2" - 187.9	12	13	14	14	15	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28		
6'3" - 190.5	12	13	13	14	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	27	28		
6'4" - 193.0	12	12	13	14	14	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26	27		

Doctors Notes:

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Signature



UHID	5635380	Date	06/03/2024		
Name	Mr Shrikant Repale	Sex	M	Age	35
OPD	Dental	Health Check-Up			

Drug allergy:  
 Sys illness:

PE - stains ++

- calculus ++

- caries  $\bar{c}$   $\frac{76}{67}$

- Ellis class I  $\bar{c}$   $\frac{2}{2}$

(chip off)

Treatment

Aid - (i) Scaling Grade II

(ii) Filling  $\bar{c}$   $\frac{76}{67}$

Dr. Trupti



UHID	5635380	Date	06/03/2024		
Name	Mr Shrikant Repale	Sex	M	Age	35
OPD	Ophthalmal	Health Check-Up			

Clas. No.

Hu No.

Drug allergy: -> Not know.  
 Sys illness: -> NO  
 Habit: -> NO

U.I.V. -> RE - 6/gp  
 -> LC - 6/gp } MV -> NO  
 -> NO

Phu -> RE - 0.75 am 6/g.  
 -> LC - 0.75 am 6/g.

MV -> RE NO  
 -> LC NO

FOP -> RE 14.8  
 -> LC 14.1 } Shms P.U.P.

*[Handwritten signature]*

**PATIENT NAME : MR.SHRIKANT P REPALE**

**REF. DOCTOR :**

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

**ACCESSION NO :** 0022XC001509  
**PATIENT ID :** FH.5635380  
**CLIENT PATIENT ID:** UID:5635380  
**ABHA NO :**

**AGE/SEX :** 35 Years Male  
**DRAWN :** 08/03/2024 11:25:00  
**RECEIVED :** 08/03/2024 11:25:38  
**REPORTED :** 08/03/2024 12:54:56

**CLINICAL INFORMATION :**

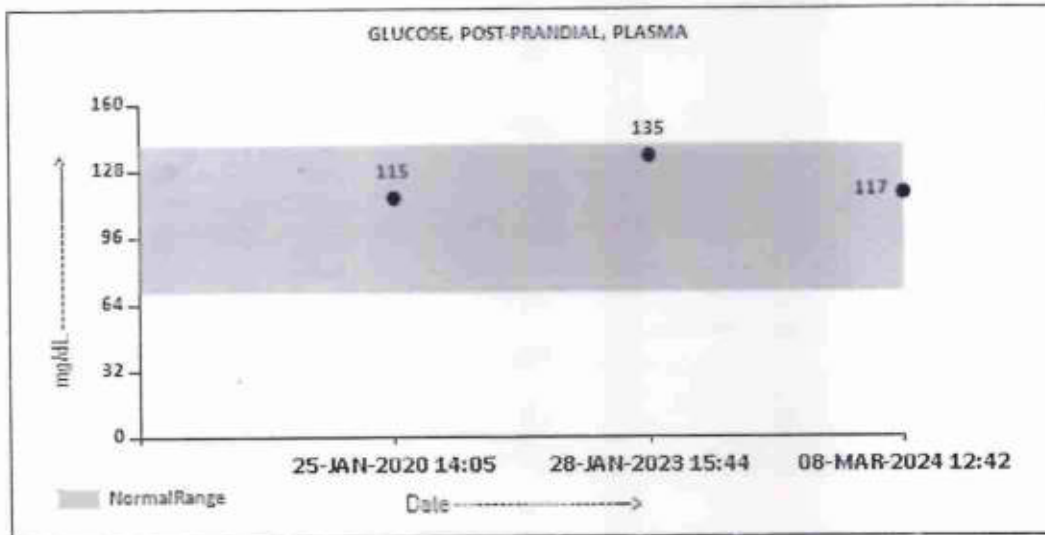
UID:5635380 REQNO-1673003  
 CORP-OPD  
 BILLNO-150124OPCR013477  
 BILLNO-150124OPCR013477

Test Report Status	Final	Results	Biological Reference Interval	Units
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**BIOCHEMISTRY**

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR) 117 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\*\***

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

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



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 Navi Mumbai, 400703  
 Maharashtra, India  
 Tel : 022-39199222,022-49723322,  
 CIN - U74899PB1995PLC045956  
 Email : -



Patient Ref. No. 22000000907416

**PATIENT NAME : MR.SHRIKANT P REPALE**
**REF. DOCTOR :**
**CODE/NAME & ADDRESS : C000045507**

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

**ACCESSION NO : 0022XC001464**
**PATIENT ID : FH.5635380**
**CLIENT PATIENT ID: UID:5635380**
**ABHA NO :**
**AGE/SEX : 35 Years Male**
**DRAWN : 08/03/2024 08:31:00**
**RECEIVED : 08/03/2024 08:34:20**
**REPORTED : 08/03/2024 13:22:13**
**CLINICAL INFORMATION :**

UID:5635380 REQNO-1673003

CORP-OPD

BILLNO-150124OPCR013477

BILLNO-150124OPCR013477

**Test Report Status Final**
**Results**
**Biological Reference Interval Units**
**HAEMATOLOGY - CBC**
**CBC-5, EDTA WHOLE BLOOD**
**BLOOD COUNTS, EDTA WHOLE BLOOD**
**HEMOGLOBIN (HB)**

METHOD : SLS METHOD

**12.0 Low**

13.0 - 17.0

g/dL

**RED BLOOD CELL (RBC) COUNT**

METHOD : HYDRODYNAMIC FOCUSING

**5.36**

4.5 - 5.5

 mil/ $\mu$ L

**WHITE BLOOD CELL (WBC) COUNT**

METHOD : FLUORESCENCE FLOW CYTOMETRY

**5.97**

4.0 - 10.0

 thou/ $\mu$ L

**PLATELET COUNT**

METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION

**288**

150 - 410

 thou/ $\mu$ L

**RBC AND PLATELET INDICES**
**HEMATOCRIT (PCV)**

METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD

**41.0**

40.0 - 50.0

%

**MEAN CORPUSCULAR VOLUME (MCV)**

METHOD : CALCULATED PARAMETER

**76.5 Low**

83.0 - 101.0

fL

**MEAN CORPUSCULAR HEMOGLOBIN (MCH)**

METHOD : CALCULATED PARAMETER

**22.4 Low**

27.0 - 32.0

pg

**MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)**

METHOD : CALCULATED PARAMETER

**29.3 Low**

31.5 - 34.5

g/dL

**RED CELL DISTRIBUTION WIDTH (RDW)**

METHOD : CALCULATED PARAMETER

**13.5**

11.6 - 14.0

%

**MENTZER INDEX**

METHOD : CALCULATED PARAMETER

**14.3**
**MEAN PLATELET VOLUME (MPV)**

METHOD : CALCULATED PARAMETER


**10.3**

6.8 - 10.9

fL

**WBC DIFFERENTIAL COUNT**

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 Email : -

  
 Patient Ref. No. 2200000907371



**PATIENT NAME : MR.SHRIKANT P REPALE**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**

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

ACCESSION NO : **0022XC001464**  
PATIENT ID : FH.5635380  
CLIENT PATIENT ID: UID:5635380  
ABHA NO :

AGE/SEX : 35 Years Male  
DRAWN : 08/03/2024 08:31:00  
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CORP-OPD  
BILLNO-150124OPCR013477  
BILLNO-150124OPCR013477

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NEUTROPHILS		55	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		35	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.28	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.09	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.42	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.18	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6		thou/ $\mu$ L
METHOD : CALCULATED				

**MORPHOLOGY**

RBC

METHOD : MICROSCOPIC EXAMINATION

MILD HYPOCHROMASIA, MILD MICROCYTOSIS, MILD ANISOCYTOSIS

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE

*(Signature)*  
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Consultant Pathologist



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FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : 0022XC001464

PATIENT ID : FH.5635380

CLIENT PATIENT ID: UID:5635380

ABHA NO :

AGE/SEX : 35 Years Male

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## Interpretation(s)

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

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504 This ratio element is a calculated parameter and out of NABL scope.



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## HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), 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	5.6	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)	%
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METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	114.0	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER


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**CODE/NAME & ADDRESS : C000045507**

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FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

**ACCESSION NO : 0022XC001464**

**PATIENT ID : FH.5635380**

**CLIENT PATIENT ID: UID:5635380**

**ABHA NO :**

**AGE/SEX : 35 Years Male**

**DRAWN : 08/03/2024 08:31:00**

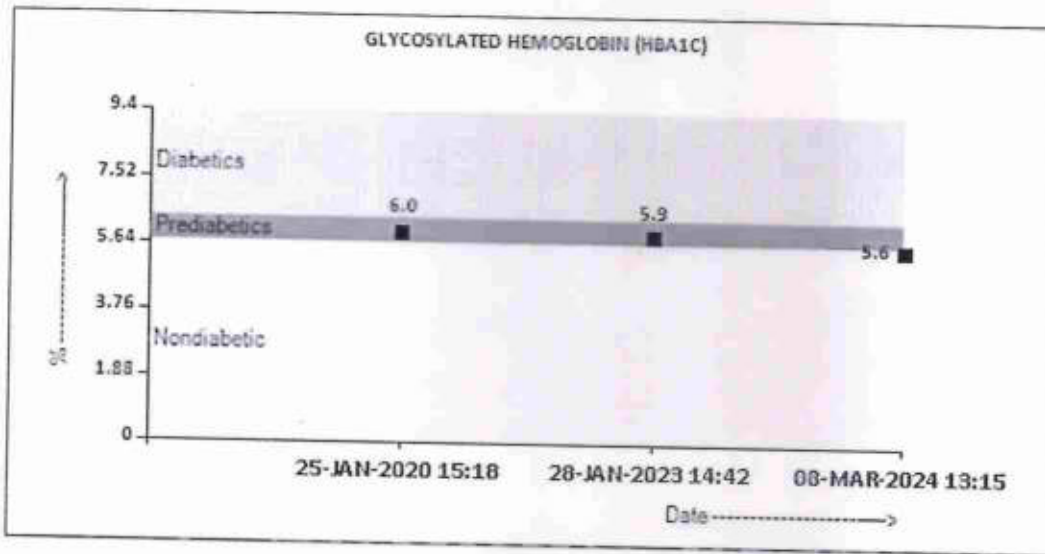
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**CLINICAL INFORMATION :**

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CORP-OPD  
BILLNO-150124OPCR013477  
BILLNO-150124OPCR013477

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

**Decreased in:** Polycythemia vera, Sickle cell anemia

**LIMITATIONS**

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

**False Decreased :** Poikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)

**REFERENCE :**

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACCPress, 7th edition. Edited by S. Soldin; 3. The reference for

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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, uremia, 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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 BILLNO-150124OPCR013477  
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**Test Report Status Final**
**Results**
**Biological Reference Interval Units**
**IMMUNOHAEMATOLOGY**
**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**
**ABO GROUP**

METHOD : TUBE AGGLUTINATION

**TYPE A**
**RH TYPE**


METHOD : TUBE AGGLUTINATION

**POSITIVE**
**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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 Navi Mumbai, 400703  
 Maharashtra, India  
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 CIN - U74899PB1995PLC045956  
 Email : -


Patient Ref. No. 22000000907371

PATIENT NAME : MR.SHRIKANT P REPALE

REF. DOCTOR :

CODE/NAME &amp; ADDRESS : C000045507

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

ACCESSION NO : 0022XC001464

PATIENT ID : FH.5635380

CLIENT PATIENT ID: UID:5635380

ABHA NO :

AGE/SEX : 35 Years Male

DRAWN : 08/03/2024 08:31:00

RECEIVED : 08/03/2024 08:34:20

REPORTED : 08/03/2024 13:22:13

## CLINICAL INFORMATION :

UID:5635380 REQNO-1673003  
CORP-OPD  
BILLNO-150124OPCR013477  
BILLNO-150124OPCR013477

Test Report Status	Final	Results	Biological Reference Interval	Units
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## BIOCHEMISTRY

## LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.33	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.11	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.22	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.3	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.4	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.2	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH PSP	15	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH PSP	20	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	61	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE	25	15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	106	85 - 227	U/L

## GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	106 High	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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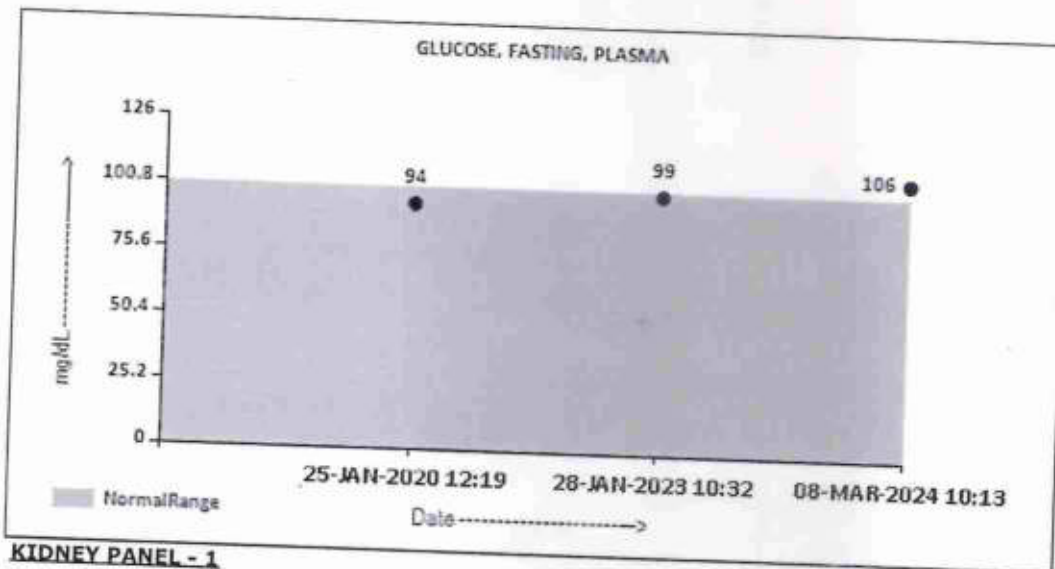
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**PATIENT ID : FH.5635380**  
**CLIENT PATIENT ID: UID:5635360**  
**ABHA NO :**

**AGE/SEX : 35 Years Male**  
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Test Report Status	Final	Results	Biological Reference Interval	Units
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**KIDNEY PANEL - 1**

**BLOOD UREA NITROGEN (BUN), SERUM**

**BLOOD UREA NITROGEN**

METHOD : UREASE - UV

11

6 - 20

mg/dL

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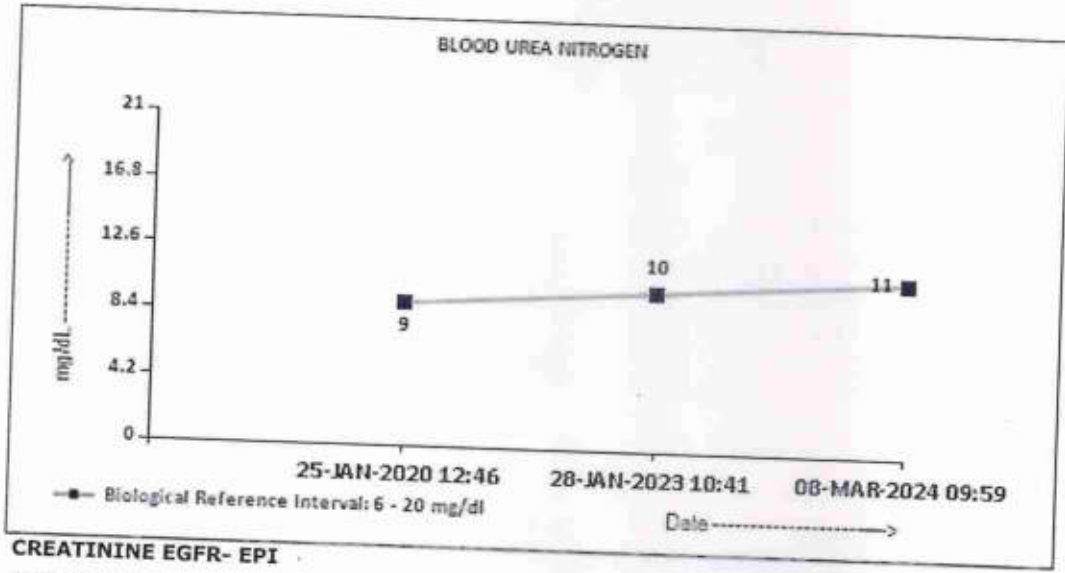
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**CREATININE EGFR- EPI**

<b>CREATININE</b> METHOD : ALKALINE PICRATE KINETIC JAFFES	<b>0.84 Low</b>	<b>0.90 - 1.30</b>	<b>mg/dL</b>
<b>AGE</b>	<b>35</b>		<b>years</b>
<b>GLOMERULAR FILTRATION RATE (MALE)</b> METHOD : CALCULATED PARAMETER	<b>116.63</b>	<b>Refer Interpretation Below</b>	<b>mL/min/1.73m2</b>

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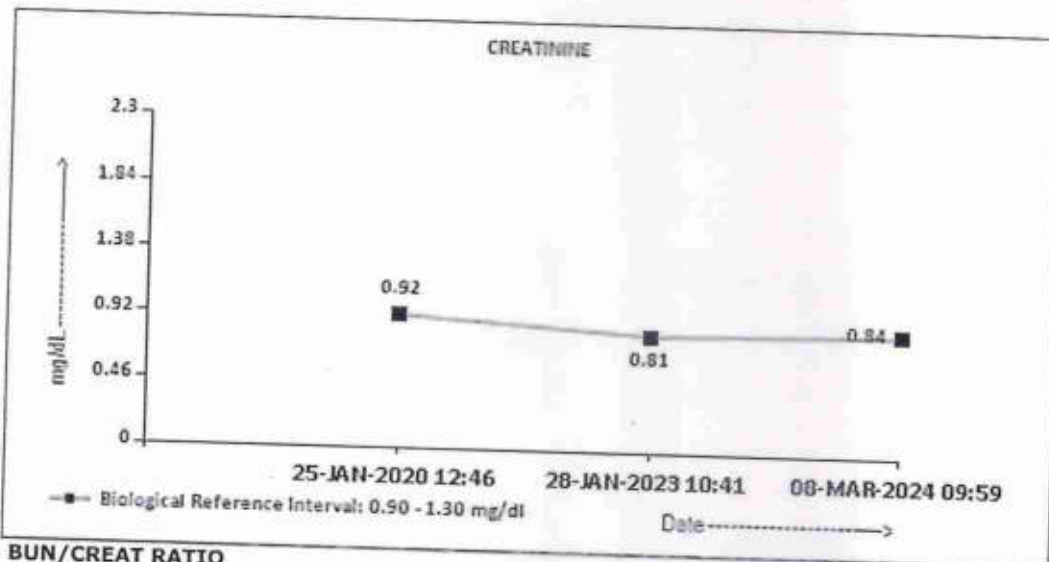
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BUN/CREAT RATIO

BUN/CREAT RATIO

METHOD : CALCULATED PARAMETER

13.10

5.00 - 15.00

URIC ACID, SERUM

URIC ACID

METHOD : URICASE UV

4.4

3.5 - 7.2

mg/dL

TOTAL PROTEIN, SERUM

TOTAL PROTEIN

METHOD : BIURET

7.3

6.4 - 8.2

g/dL

ALBUMIN, SERUM

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Test Report Status	Final	Results	Biological Reference Interval	Units
ALBUMIN		3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
LOBULIN		3.4	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM, SERUM		140	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		4.75	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM		104	98 - 107	mmol/L
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 heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. **Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions; Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

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

**ALP** is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasa, Malnutrition, Protein deficiency, Wilsons 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

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**Test Report Status Final**

**Results**

**Biological Reference Interval Units**

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, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.  
**Albumin** is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc  
**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**  
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.  
**Decreased in:** Pancreatic islet cell disease with increased insulin, Insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs-insulin, ethanol, propranolol, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.  
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.  
**BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels** include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)  
**Causes of decreased level** include Liver disease, SIADH.

**CREATININE EGFR- EPI--** Kidney disease outcomes quality initiative (KDOQI) 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 (>60 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.litmed.uw.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, Waldenstroms disease.  
**Lower-than-normal levels may be due to:** Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.  
**ALBUMIN, SERUM-** Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia)** can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

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 CORP-OPD  
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Test Report Status	Final	Results	Biological Reference Interval	Units
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**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	175	< 200 Desirable 200 - 239 Borderline High ≥ 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	53	< 150 Normal 150 - 199 Borderline High 200 - 499 High ≥ 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	47	< 40 Low ≥ 60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	117	< 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	128	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	10.6	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.7	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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**Results**

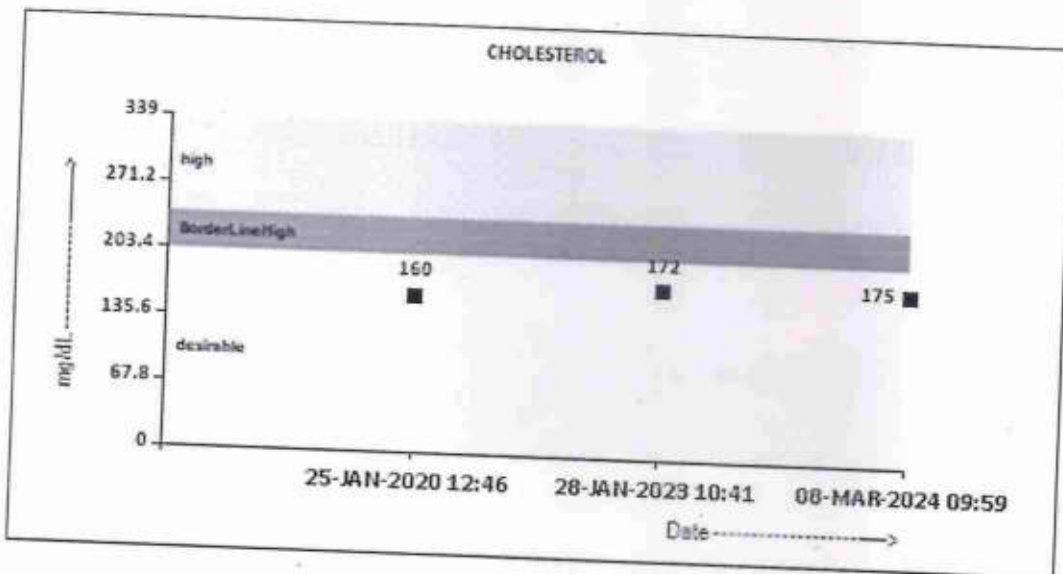
**Biological Reference Interval Units**

LDL/HDL RATIO

2.5

0.5 - 3.0 Desirable/Low Risk  
3.1 - 6.0 Borderline/Moderate Risk  
>6.0 High Risk

METHOD : CALCULATED PARAMETER



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UID:5635380 REQNO-1673003

CORP-OPD

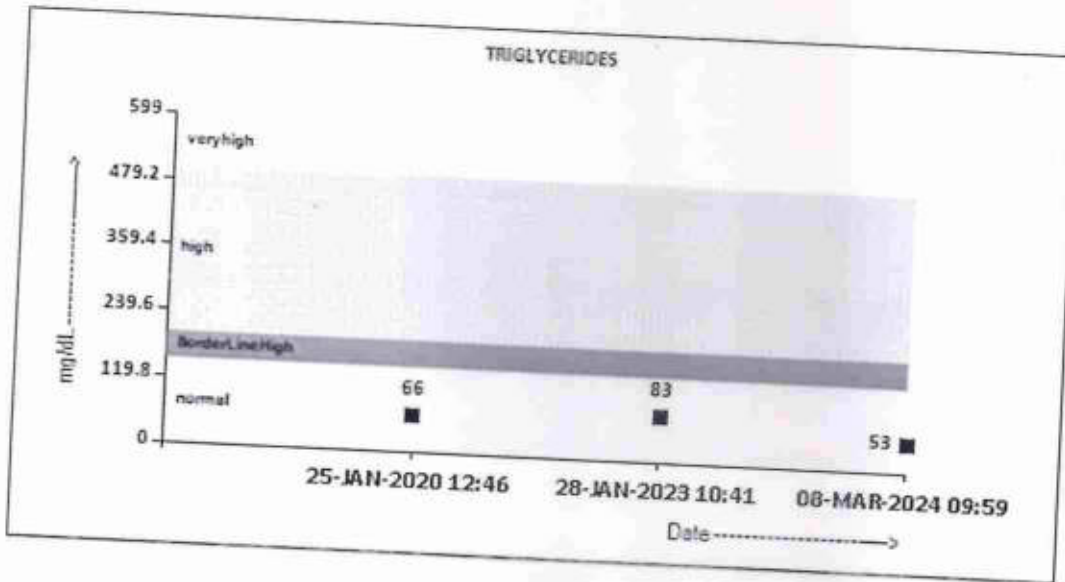
BILLNO-150124OPCR013477

BILLNO-150124OPCR013477

**Test Report Status Final**

**Results**

**Biological Reference Interval Units**



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



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 Maharashtra, India  
 Tel : 022-39199222, 022-49723322,  
 CIN - U74899PB1995PLC045956  
 Email : -

**Patient Ref. No. 2200000907371**

**PATIENT NAME : MR.SHRIKANT P REPALE**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**

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

**ACCESSION NO : 0022XC001464**

**PATIENT ID : FH.5635380**

**CLIENT PATIENT ID: UID:5635380**

**ABHA NO :**

**AGE/SEX : 35 Years Male**

**DRAWN : 08/03/2024 08:31:00**

**RECEIVED : 08/03/2024 08:34:20**

**REPORTED : 08/03/2024 13:22:13**

**CLINICAL INFORMATION :**

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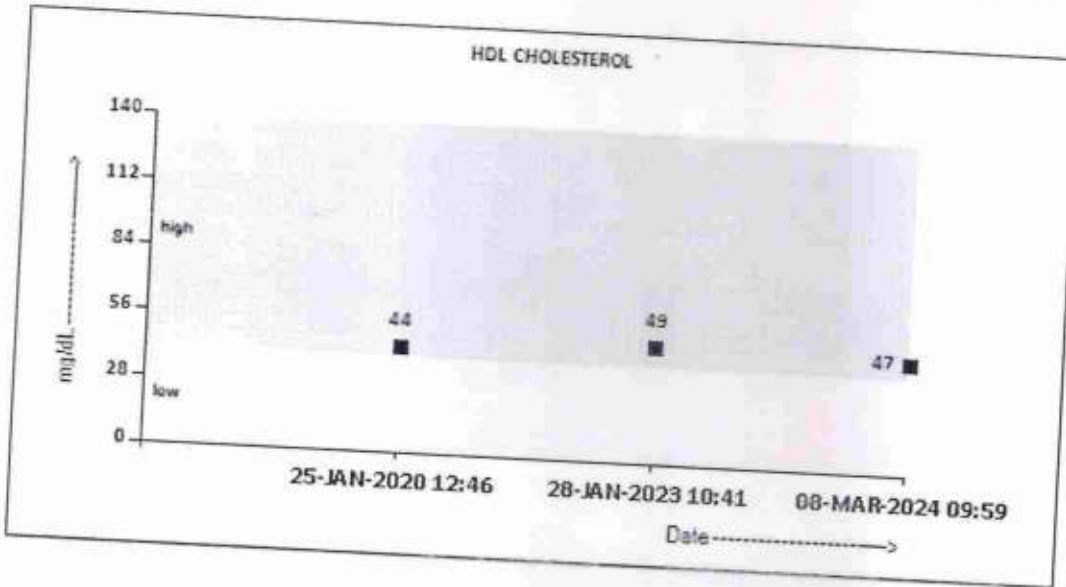
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**Biological Reference Interval Units**



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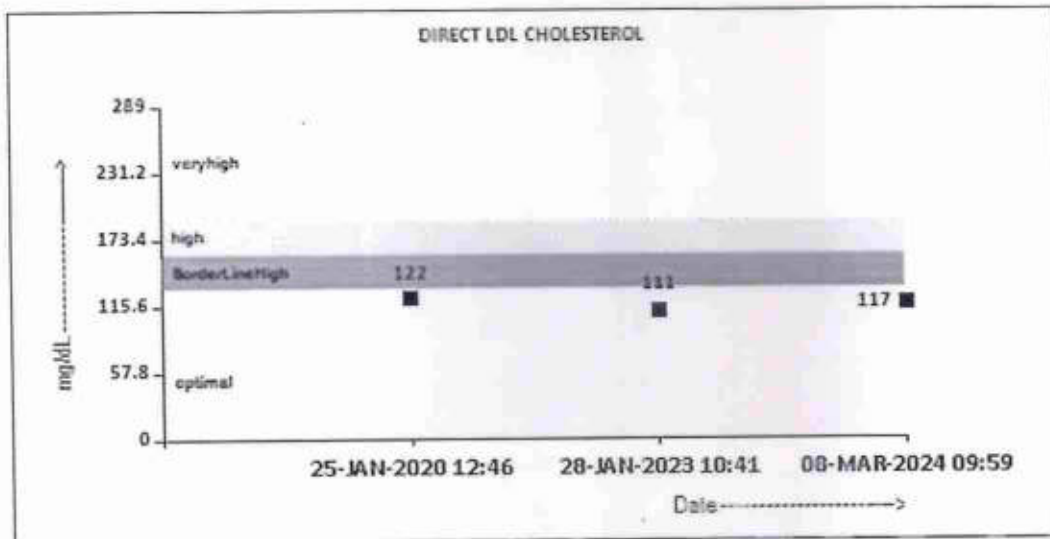
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**Interpretation(s)**

**Dr. Akshay Dhotre, MD**  
 (Reg.no. MMC 2019/09/6377)  
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**CLINICAL PATH - URINALYSIS**

**KIDNEY PANEL - 1**

**PHYSICAL EXAMINATION, URINE**

<b>COLOR</b> METHOD : PHYSICAL	PALE YELLOW
<b>APPEARANCE</b> METHOD : VISUAL	SLIGHTLY HAZY

**CHEMICAL EXAMINATION, URINE**

<b>PH</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5
<b>SPECIFIC GRAVITY</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	>=1.030	1.003 - 1.035
<b>PROTEIN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED
<b>GLUCOSE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED
<b>KETONES</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED
<b>BLOOD</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	DETECTED (+)	NOT DETECTED
<b>BILIRUBIN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED
<b>UROBILINOGEN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)	NORMAL	NORMAL
<b>NITRITE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED
<b>LEUKOCYTE ESTERASE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED

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

**Dr. Rekha Nair, MD**  
(Reg No. MMC 2001/06/2354)  
Microbiologist



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Patient Ref. No. 22000000907371


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CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022XC001464 PATIENT ID : FH.5635380 CLIENT PATIENT ID: UID:5635380 ABHA NO :	AGE/SEX : 35 Years Male DRAWN : 08/03/2024 08:31:00 RECEIVED : 08/03/2024 08:34:20 REPORTED : 08/03/2024 13:22:13	

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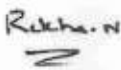
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Test Report Status	Final	Results	Biological Reference Interval	Units
<b>MICROSCOPIC EXAMINATION, URINE</b>				
RED BLOOD CELLS		2 - 3	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

## Interpretation(s)



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



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Test Report Status	Results	Biological Reference Interval	Units
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## SPECIALISED CHEMISTRY - HORMONE

## THYROID PANEL, SERUM

T3 METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE	122.5	80.0 - 200.0	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE	7.80	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY	2.370	0.270 - 4.200	µIU/mL

## Interpretation(s)



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**SPECIALISED CHEMISTRY - TUMOR MARKER**
**PROSTATE SPECIFIC ANTIGEN, SERUM**

Test Report Status	Results	Biological Reference Interval	Units
	0.198	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 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- 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. Burtis CA, Ashwood ER, Bruns DE, Teltz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

**\*\*End Of Report\*\***
**Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession**


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

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**Patient Ref. No. 22000000907371**

35 Years

Male

HC

Normal *[Signature]*

Rate 71 . Sinus rhythm.....normal P axis, V-rate 50- 99  
 . ST elev, probable normal early repol pattern.....ST elevation, age<55  
 . Baseline wander in lead(s) V1

PR 156  
 QRSD 85  
 QT 372  
 QTc 405

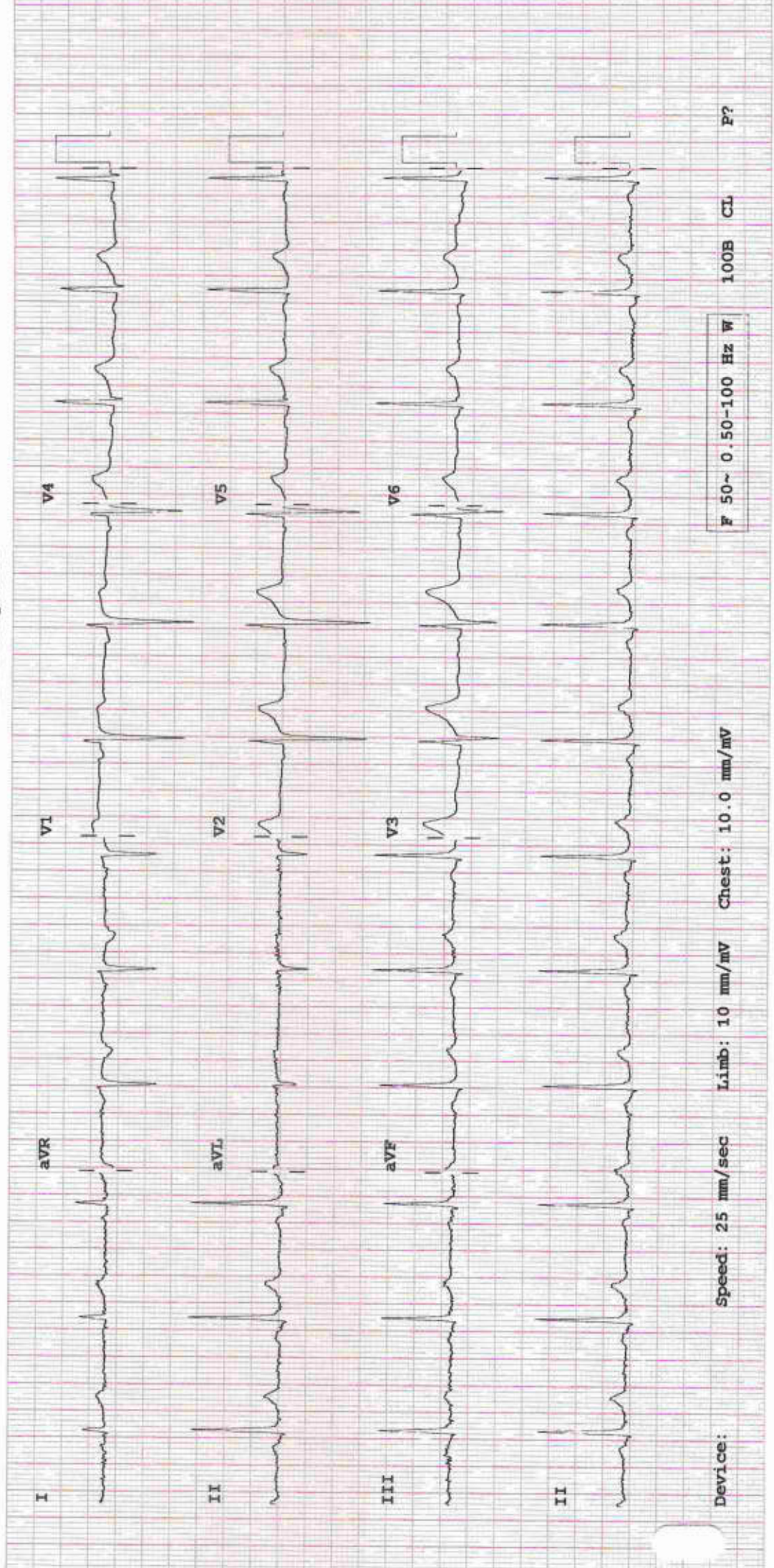
--AXIS--

P 62  
 QRS 72  
 T 51

12 Lead; Standard Placement

-- NORMAL ECG --

Unconfirmed Diagnosis





DEPARTMENT OF NIC

Date: 08/Mar/2024

Name: Mr. Shrikant P Repale  
Age | Sex: 35 YEAR(S) | Male  
Order Station : FO-OPD  
Bed Name :

UHID | Episode No : 5635380 | 13804/24/1501  
Order No | Order Date: 1501/PN/OP/2403/28643 | 08-Mar-2024  
Admitted On | Reporting Date : 08-Mar-2024 16:43:56  
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

**FINDINGS:**

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 14 mm with normal inspiratory collapse.

**M-MODE MEASUREMENTS:**

LA	25	mm
AO Root	18	mm
AO CUSP SEP	14	mm
LVID (s)	24	mm
LVID (d)	38	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	28	mm
RA	31	mm
LVEF	60	%

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www.fortishealthcare.com | vashi@fortishealthcare.com  
CIN: U85100MH2005PTC 154823  
GST IN : 27AABCH5894D1ZG  
PAN NO : AABCH5894D



DEPARTMENT OF NIC

Date: 08/Mar/2024

Name: Mr. Shrikant P Repale  
Age | Sex: 35 YEAR(S) | Male  
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UHID | Episode No : 5635380 | 13804/24/1501  
Order No | Order Date: 1501/PN/OP/2403/28643 | 08-Mar-2024  
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Order Doctor Name : Dr.SELF .


**DOPPLER STUDY:**

E WAVE VELOCITY: 0.8 m/sec.  
A WAVE VELOCITY:0.7m/sec  
E/A RATIO:1.3

	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)



DEPARTMENT OF RADIOLOGY

Name: Mr. Shrikant P Repale

Age | Sex: 35 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5635380 | 13804/24/1501

Order No | Order Date: 1501/PN/OP/2403/28643 | 08-Mar-2024

Admitted On | Reporting Date : 08-Mar-2024 11:45:56

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	: Shrikant P Repale	Patient ID	: 5635380
Sex / Age	: M / 35Y 2M 14D	Accession No.	: PHC.7633581
Modality	: US	Scan DateTime	: 08-03-2024 11:32:00
IPID No	: 13804/24/1501	ReportDatetime	: 08-03-2024 11:41:37

### USG – WHOLE ABDOMEN

**LIVER** is normal in size and echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is 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 10.3 x 4.7 cm.

Left kidney measures 10.1 x 5.4 cm.

**PANCREAS** is obscured due to bowel gas.

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

**PROSTATE** is normal in size & echogenicity. It measures ~ 8.4 cc in volume.

No evidence of ascites.

### IMPRESSION:

- No significant abnormality is detected.

**DR. CHETAN KHADKE**

MD (Radiologist)