

2468270

MR ANIL CHATRATH

7/29/2023 8:42:49 AM

65 Years

Male

Rate 61 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Nonspecific intraventricular conduction delay.....QRSd >115mS, not LBBB/RBBB
 PR 197 . Baseline wander in lead(s) V3
 QRSD 180
 QT 440
 QTc 444

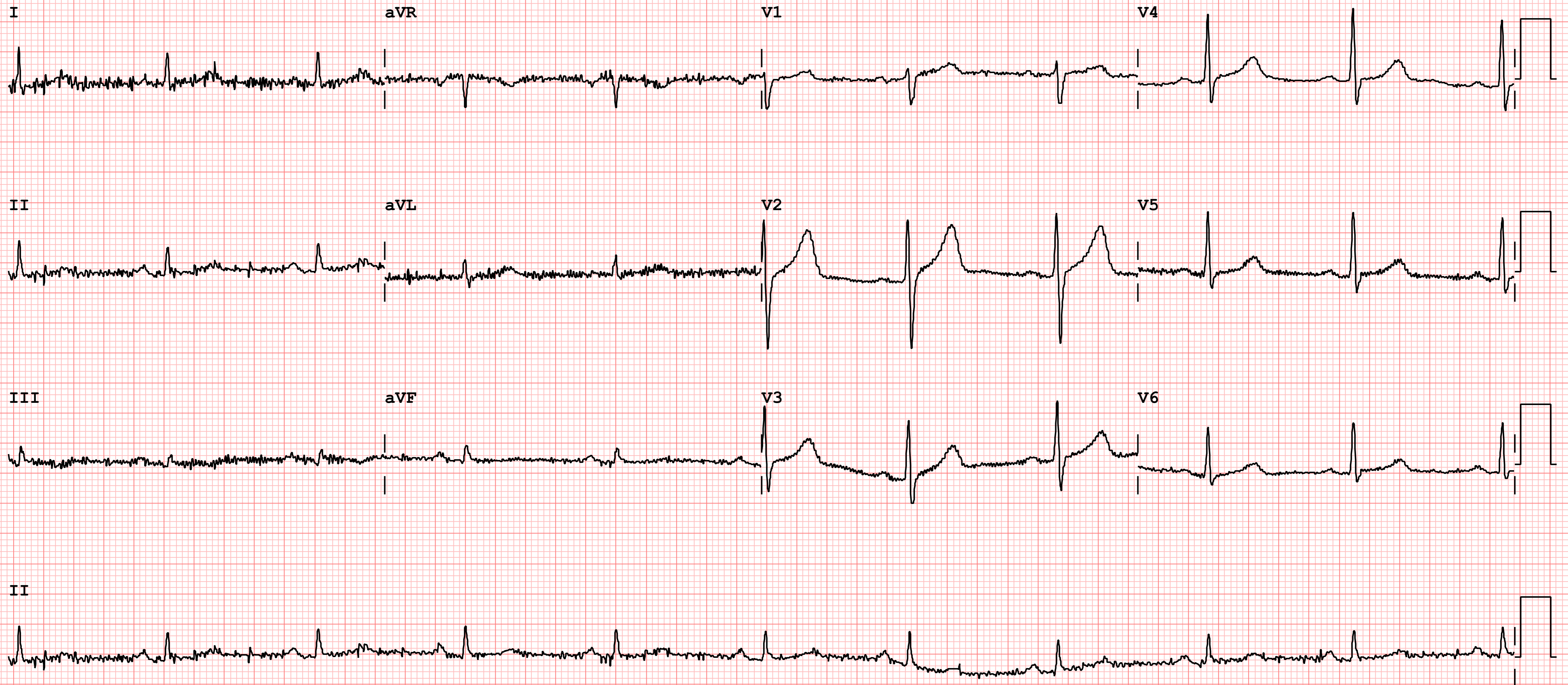
--AXIS--

P 58
 QRS 25
 T 3

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis





NAME	MR ANIL chatrath	STUDY DATE	29/07/2023 11:54AM
AGE / SEX	65 y / M	HOSPITAL NO.	MH002468270
ACCESSION NO.	NM9178266	MODALITY	US
REPORTED ON	29/07/2023 12:11PM	REFERRED BY	Health Check MHD

2D ECHOCARDIOGRAPHY REPORT

Findings:

	End diastole	End systole
IVS thickness (cm)	1.1	1.3
Left Ventricular Dimension (cm)	4.6	3.0
Left Ventricular Posterior Wall thickness (cm)	1.0	1.2
Aortic Root Diameter (cm)	3.0	
Left Atrial Dimension (cm)	3.1	
Left Ventricular Ejection Fraction (%)	55%	

LEFT VENTRICLE	:	Normal in size. No RWMA. LVEF=55%
RIGHT VENTRICLE	:	Normal in size. Normal RV function.
LEFT ATRIUM	:	Normal in size
RIGHT ATRIUM	:	Normal in size
MITRAL VALVE	:	Mild MR
AORTIC VALVE	:	Mild AR
TRICUSPID VALVE	:	Mild TR (PASP ~ 24mmHg)
PULMONARY VALVE	:	Normal
MAIN PULMONARY ARTERY & ITS BRANCHES	:	Appears normal.
INTERATRIAL SEPTUM	:	Intact.
INTERVENTRICULAR SEPTUM	:	Intact.
PERICARDIUM	:	No pericardial effusion or thickening

DOPPLER STUDY

VALVE	Peak Velocity (cm/sec)	Maximum P.G. (mmHg)	Mean P. G. (mmHg)	Regurgitation	Stenosis
MITRAL	E=69 A=91	-	-	Mild	Nil
AORTIC	131	-	-	Mild	Nil
TRICUSPID	-	N	N	Mild	Nil
PULMONARY	87	N	N	Nil	Nil

SUMMARY & INTERPRETATION:

- o No LV regional wall motion abnormality with LVEF =55%



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Human Care Medical Charitable Trust



Sector-6, Dwarka, New Delhi 110 075

GST: 07AAAAH3917LIZM

PAN NO: AAAAH3917L

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- o Normal sized RA/RV/LV/LA with no chamber hypertrophy. Normal RV function.
- o Mild AR/ Mild MR
- o Mild TR (PASP ~ 24mmHg)
- o Grade I diastolic dysfunction
- o IVC normal in size, >50% collapse with inspiration, suggestive of normal RA pressure.
- o No clot/ no vegetation/ no pericardial effusion.

Please correlate clinically.

Dr. Sarita Gulati MD, DM DMC No.22600

Senior Interventional Cardiologist

*******End Of Report*******



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Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
Registration No : MH002468270 **Lab No** : 31230701174
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 09:09
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 12:27
Receiving Date : 29 Jul 2023 10:49

Department of Transfusion Medicine (Blood Bank)

BLOOD GROUPING, RH TYPING & ANTIBODY SCREEN (TYPE & SCREEN)
Specimen-Blood

Blood Group & Rh Typing (Agglutination by gel/tube technique)

Blood Group & Rh typing A Rh(D) Positive

Antibody Screening (Microtyping in gel cards using reagent red cells)

Final Antibody Screen Result Negative

Technical Note:

ABO grouping and Rh typing is done by cell and serum grouping by microplate / gel technique. Antibody screening is done using a 3 cell panel of reagent red cells coated with Rh, Kell, Duffy, Kidd, Lewis, P, MNS, Lutheran and Xg antigens using gel technique.

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-----END OF REPORT-----

Dr Himanshu Lamba



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Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
Registration No : MH002468270 **Lab No** : 32230710877
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 09:09
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 14:11
Receiving Date : 29 Jul 2023 10:04

BIOCHEMISTRY

Specimen: EDTA Whole blood

HbA1c (Glycosylated Hemoglobin) 5.9 % As per American Diabetes Association (ADA) 2010 [4.0-6.5]
HbA1c in %
Non diabetic adults : < 5.6 %
Prediabetes (At Risk) : 5.7 % - 6.4 %
Diabetic Range : > 6.5 %
Methodology High-Performance Liquid Chromatography (HPLC)
Estimated Average Glucose (eAG) 123 mg/dl

Use :

1. Monitoring compliance and long-term blood glucose level control in patients with diabetes.
2. Index of diabetic control (direct relationship between poor control and development of complications).
3. Predicting development and progression of diabetic microvascular complications.

Limitations :

1. A1C values may be falsely elevated or decreased in those with chronic kidney disease.
2. False elevations may be due in part to analytical interference from carbamylated hemoglobin formed in the presence of elevated concentrations of urea, with some assays.
3. False decreases in measured A1C may occur with hemodialysis and altered red cell turnover, especially in the setting of erythropoietin treatment

References : Rao.L.V.,Michael snyder.L.(2021).Wallach's Interpretation of Diagnostic Tests. 11th Edition. Wolterkluwer. NaderRifai,Andrea Rita Horvath,Carl T.wittwer.

(2018)Teitz Text book

of Clinical Chemistry and Molecular Diagnostics.First edition,Elsevier,South Asia.



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Name	: MR ANIL CHATRATH	Age	: 65 Yr(s) Sex :Male
Registration No	: MH002468270	Lab No	: 32230710877
Patient Episode	: H03000055402	Collection Date	: 29 Jul 2023 09:09
Referred By	: HEALTH CHECK MHD	Reporting Date	: 29 Jul 2023 12:03
Receiving Date	: 29 Jul 2023 10:05		

BIOCHEMISTRY

THYROID PROFILE, Serum

Specimen Type : Serum

T3 - Triiodothyronine (ECLIA)	0.66 #	ng/ml	[0.70-2.04]
T4 - Thyroxine (ECLIA)	5.12	µg/dl	[4.60-12.00]
Thyroid Stimulating Hormone (ECLIA)	2.210	µIU/mL	[0.340-4.250]

Note : TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m.and at a minimum between 6-10 pm.Factors such as change of seasons hormonal fluctuations,Ca or Fe supplements,high fibre diet,stress and illness affect TSH results.

* References ranges recommended by the American Thyroid Association

1) Thyroid. 2011 Oct;21(10):1081-125.PMID .21787128

2) <http://www.thyroid-info.com/articles/tsh-fluctuating.html>

Lipid Profile (Serum)

TOTAL CHOLESTEROL (CHOD/POD)	197	mg/dl	[<200] Moderate risk:200-239 High risk:>240
TRIGLYCERIDES (GPO/POD)	113	mg/dl	[<150] Borderline high:151-199 High: 200 - 499 Very high:>500
HDL - CHOLESTEROL (Direct)	49	mg/dl	[30-60]
Methodology: Homogenous Enzymatic			
VLDL - Cholesterol (Calculated)	23	mg/dl	[10-40]
(CALCULATED) LDL- CHOLESTEROL	125 #	mg/dl	[<100] Near/Above optimal-100-129 Borderline High:130-159





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Registration No : MH002468270 **Lab No** : 32230710877
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 09:09
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 11:59
Receiving Date : 29 Jul 2023 10:05

BIOCHEMISTRY

T.Chol/HDL.Chol ratio	4.0	High Risk:160-189 <4.0 Optimal 4.0-5.0 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	2.6	<3 Optimal 3-4 Borderline >6 High Risk

Note:
 Reference ranges based on ATP III Classifications.
 Recommended to do fasting Lipid Profile after a minimum of 8 hours of overnight fasting.

Technical Notes:
 Lipid profile is a panel of blood tests that serves as initial broad medical screening tool for abnormalities in lipids, the results of these tests can identify certain genetic diseases and determine approximate risks for cardiovascular disease, certain forms of pancreatitis and other diseases.

Test Name	Result	Unit	Biological Ref. Interval
LIVER FUNCTION TEST (Serum)			
BILIRUBIN-TOTAL (mod.J Groff)**	1.05	mg/dl	[0.10-1.20]
BILIRUBIN - DIRECT (mod.J Groff)	0.31 #	mg/dl	[<0.2]
BILIRUBIN - INDIRECT (mod.J Groff)	0.74	mg/dl	[0.20-1.00]
SGOT/ AST (P5P,IFCC)	18.90	IU/L	[5.00-37.00]
SGPT/ ALT (P5P,IFCC)	19.10	IU/L	[10.00-50.00]
ALP (p-NPP,kinetic)*	77	IU/L	[45-135]
TOTAL PROTEIN (mod.Biuret)	6.9	g/dl	[6.0-8.2]
SERUM ALBUMIN (BCG-dye)	4.5	g/dl	[3.5-5.0]
SERUM GLOBULIN (Calculated)	2.4	g/dl	[1.8-3.4]
ALB/GLOB (A/G) Ratio	1.88 #		[1.10-1.80]



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BIOCHEMISTRY

Note:

**NEW BORN: Vary according to age (days), body wt & gestation of baby

*New born: 4 times the adult value

Technical Notes:

Liver function test aids in diagnosis of various pre hepatic, hepatic and post hepatic causes of dysfunction like hemolytic anemia's, viral and alcoholic hepatitis and cholestasis of obstructive causes.

Test Name	Result	Unit	Biological Ref. Interval
KIDNEY PROFILE (Serum)			
BUN (Urease/GLDH)	10.00	mg/dl	[8.00-23.00]
SERUM CREATININE (mod.Jaffe)	0.77 #	mg/dl	[0.80-1.60]
SERUM URIC ACID (mod.Uricase)	5.9	mg/dl	[3.5-7.2]
SERUM CALCIUM (NM-BAPTA)	9.6	mg/dl	[8.0-10.2]
SERUM PHOSPHORUS (Molybdate, UV)	3.6	mg/dl	[2.3-4.7]
SERUM SODIUM (ISE)	140.0	mmol/l	[134.0-145.0]
SERUM POTASSIUM (ISE)	4.35	mmol/l	[3.50-5.20]
SERUM CHLORIDE (ISE / IMT)	104.6	mmol/L	[95.0-105.0]
eGFR	95.2	ml/min/1.73sq.m	[>60.0]

Technical Note

eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to 1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis / Icterus / Lipemia.





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BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Interval
TOTAL PSA, Serum (ECLIA)	0.792	ng/mL	[<4.500]

Note : PSA is a glycoprotein that is produced by the prostate gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by BPH, prostatitis, or prostate cancer may increase circulating PSA levels.

Caution : Serum markers are not specific for malignancy, and values may vary by method.

Immediate PSA testing following digital rectal examination, ejaculation, prostate massage urethral instrumentation, prostate biopsy may increase PSA levels.

Some patients who have been exposed to animal antigens, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

-----END OF REPORT-----

Dr. Priyanka Bhatia
CONSULTANT PATHOLOGY



Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
Registration No : MH002468270 **Lab No** : 32230710878
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 12:18
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 13:59
Receiving Date : 29 Jul 2023 12:34

BIOCHEMISTRY

Specimen Type : Plasma

PLASMA GLUCOSE - PP

Plasma GLUCOSE - PP (Hexokinase) 110 mg/dl [70-140]

Note : Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying, brisk glucose absorption , post exercise

Specimen Type : Serum/Plasma

Plasma GLUCOSE-Fasting (Hexokinase) 107 # mg/dl [70-100]

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-----END OF REPORT-----

Dr. Priyanka Bhatia
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Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex : Male
Registration No : MH002468270 **Lab No** : 33230706603
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 09:10
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 12:36
Receiving Date : 29 Jul 2023 10:04

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (Automated) Specimen-Whole Blood

ESR 13.0 # mm/1sthour [0.0-12.0]

Interpretation :

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week postpartum.

ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives).

It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Test Name	Result	Unit	Biological Ref. Interval
COMPLETE BLOOD COUNT (EDTA Blood)			
WBC Count (Flow cytometry)	5160	/cu.mm	[4000-10000]
RBC Count (Impedence)	4.09 #	million/cu.mm	[4.50-5.50]
Haemoglobin (SLS Method)	12.1 #	g/dL	[13.0-17.0]
Haematocrit (PCV) (RBC Pulse Height Detector Method)	36.3 #	%	[40.0-50.0]
MCV (Calculated)	88.8	fL	[83.0-101.0]
MCH (Calculated)	29.6	pg	[25.0-32.0]
MCHC (Calculated)	33.3	g/dL	[31.5-34.5]
Platelet Count (Impedence)	217000	/cu.mm	[150000-410000]
RDW-CV (Calculated)	13.0	%	[11.6-14.0]
DIFFERENTIAL COUNT			
Neutrophils (Flowcytometry)	60.5	%	[40.0-80.0]
Lymphocytes (Flowcytometry)	27.9	%	[20.0-40.0]



Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
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HAEMATOLOGY

Monocytes (Flowcytometry)	6.2	%	[2.0-10.0]
Eosinophils (Flowcytometry)	5.0	%	[1.0-6.0]
Basophils (Flowcytometry)	0.4 #	%	[1.0-2.0]
IG	0.00	%	
Neutrophil Absolute(Flourescence flow cytometry)	3.1	/cu mm	[2.0-7.0]x10 ³
Lymphocyte Absolute(Flourescence flow cytometry)	1.4	/cu mm	[1.0-3.0]x10 ³
Monocyte Absolute(Flourescence flow cytometry)	0.3	/cu mm	[0.2-1.2]x10 ³
Eosinophil Absolute(Flourescence flow cytometry)	0.3	/cu mm	[0.0-0.5]x10 ³
Basophil Absolute(Flourescence flow cytometry)	0.0	/cu mm	[0.0-0.1]x10 ³

Complete Blood Count is used to evaluate wide range of health disorders, including anemia, infection, and leukemia. Abnormal increase or decrease in cell counts as revealed may indicate that an underlying medical condition that calls for further evaluation.

-----END OF REPORT-----

Dr.Lakshita singh



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Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
Registration No : MH002468270 **Lab No** : 38230702103
Patient Episode : H03000055402 **Collection Date** : 29 Jul 2023 09:09
Referred By : HEALTH CHECK MHD **Reporting Date** : 29 Jul 2023 15:33
Receiving Date : 29 Jul 2023 11:53

CLINICAL PATHOLOGY

Test Name	Result	Biological Ref. Interval
ROUTINE URINE ANALYSIS		
MACROSCOPIC DESCRIPTION		
Colour (Visual)	PALE YELLOW	(Pale Yellow - Yellow)
Appearance (Visual)	CLEAR	
CHEMICAL EXAMINATION		
Reaction[pH] (Reflectancephotometry(Indicator Method))	7.0	(5.0-9.0)
Specific Gravity (Reflectancephotometry(Indicator Method))	1.010	(1.003-1.035)
Bilirubin	Negative	NEGATIVE
Protein/Albumin (Reflectance photometry(Indicator Method)/Manual SSA)	Negative	(NEGATIVE-TRACE)
Glucose (Reflectance photometry (GOD-POD/Benedict Method))	NOT DETECTED	(NEGATIVE)
Ketone Bodies (Reflectance photometry(Legal's Test)/Manual Rotheras)	NOT DETECTED	(NEGATIVE)
Urobilinogen Reflectance photometry/Diazonium salt reaction	NORMAL	(NORMAL)
Nitrite	NEGATIVE	NEGATIVE
Reflectance photometry/Griess test		
Leukocytes	NIL	NEGATIVE
Reflectance photometry/Action of Esterase		
BLOOD (Reflectance photometry(peroxidase))	NIL	NEGATIVE
MICROSCOPIC EXAMINATION (Manual) Method: Light microscopy on centrifuged urine		
WBC/Pus Cells	1-2 /hpf	(4-6)
Red Blood Cells	NIL	(1-2)
Epithelial Cells	1-2 /hpf	(2-4)
Casts	NIL	(NIL)
Crystals	NIL	(NIL)
Bacteria	NIL	
Yeast cells	NIL	

Interpretation:



Name : MR ANIL CHATRATH **Age** : 65 Yr(s) Sex :Male
Registration No : MH002468270 **Lab No** : 38230702103
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CLINICAL PATHOLOGY

URINALYSIS--Routine urine analysis assists in screening and diagnosis of various metabolic , urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine.

Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine.

Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most Common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased Specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased Specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in case of hemolytic anemia.

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-----END OF REPORT-----

Dr. Asha Preethi V.S.
CONSULTANT PATHOLOGY



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NAME	MR ANIL chatrath	STUDY DATE	29/07/2023 10:13AM
AGE / SEX	65 y / M	HOSPITAL NO.	MH002468270
ACCESSION NO.	R5875765	MODALITY	US
REPORTED ON	29/07/2023 1:45PM	REFERRED BY	Health Check MHD

USG WHOLE ABDOMEN SCREENING

Liver is normal in size and shows diffuse grade I fatty change in the parenchyma. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre. Gall bladder is adequately distended and appears echofree with normal wall thickness. Common bile duct is normal in calibre.

Pancreas is normal in size and echopattern.

Spleen is normal in size and echopattern.

Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. No focal lesion or calculus seen in either kidney. Bilateral pelvicalyceal systems are not dilated.

Urinary bladder is optimally distended with normal in wall thickness and clear contents. No significant intra or extraluminal mass is seen.

Prostate is enlarged and shows heterogeneous echopattern. It weighs ~39.2 gms.

No significant free fluid is detected.

IMPRESSION: USG findings are suggestive of:-

- Grade I fatty liver.
- Mild prostatomegaly.

Kindly correlate clinically.

Dr. Simran Singh DNB, FRCR(UK) DMC N0.36404

CONSULTANT RADIOLOGIST

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NAME	MR ANIL chatrath	STUDY DATE	29/07/2023 8:54AM
AGE / SEX	65 y / M	HOSPITAL NO.	MH002468270
ACCESSION NO.	R5875766	MODALITY	CR
REPORTED ON	29/07/2023 2:45PM	REFERRED BY	Health Check MHD

X-RAY CHEST – PA VIEW

FINDINGS:

Aortic knuckle calcification is seen.
Lung fields appear normal on both sides.
Cardia appears normal.
Both costophrenic angles appear normal.
Both domes of the diaphragm appear normal.
Bony cage appear normal.

IMPRESSION:

No significant abnormality noted.
Needs correlation with clinical findings and other investigations.

Dr. Nipun Gumber MBBS, MD DMC No.90272

ASSOCIATE CONSULTANT

*******End Of Report*******



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NAME	MR UMA SHANKER PANWAR	STUDY DATE	29/07/2023 11:32AM
AGE / SEX	59 y / M	HOSPITAL NO.	MH002714090
ACCESSION NO.	R5876179	MODALITY	US
REPORTED ON	29/07/2023 3:22PM	REFERRED BY	Health Check MHD

USG WHOLE ABDOMEN SCREENING

Liver is normal in size and shows diffuse grade I fatty change in the parenchyma. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre. Gall bladder is adequately distended and appears echofree with normal wall thickness. Common bile duct is normal in calibre.

Pancreas is normal in size and echopattern.

Spleen is normal in size and echopattern.

Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. No focal lesion or calculus seen in either kidney. Bilateral pelvicalyceal systems are not dilated.

Urinary bladder is optimally distended with normal in wall thickness and clear contents. No significant intra or extraluminal mass is seen.

Prostate is enlarged and shows heterogeneous echopattern. It weighs 30 gms.

No significant free fluid is detected.

IMPRESSION: USG findings are suggestive of:-

- Grade I fatty liver.
- Mild prostatomegaly

Kindly correlate clinically.

Dr. Simran Singh DNB, FRCR(UK) DMC N0.36404

CONSULTANT RADIOLOGIST

*******End Of Report*******



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