

Dr. Vimmi Goel  
Head - Non Invasive Cardiology  
Incharge - Preventive Health Care  
MBBS, MD (Internal Medicine)  
Reg. No: MMC- 2014/01/0113



Name: Mr. Ravi Dekate Date: 26/08/23

Age: 36y Sex: (M) Weight: 83.8 kg Height: 170.3 inc BMI: 28.9

BP: 120/80 mmHg Pulse: 72/m bpm RBS: \_\_\_\_\_ mg/dl  
SpO2: 98%

36/M  
• NO addictions  
• obese

IUP°  
Ch  
Lm  
PIA/N

IW  
TG - 186  
HDL - 33  
Gd. I Fatty liver  
ECG - RPPBB

Adv.  
TMT

- Diet control
- Exercise
- weight loss
- Rpt - FLP after 3mths

Dr. VIMMI GOEL  
MBBS, MD  
Sr. Consultant-Non Invasive Cardiology  
Reg. No.: 2014/01/0113



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mr. RAVI DEKATE	<b>Age / Gender</b> : 45 Y(s)/Male
<b>MR No/ UMR No</b> : BIL2324035128/UMR2223137366	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 26-Aug-23 10:08 am	<b>Report Date</b> : 26-Aug-23 12:44 pm

**HAEMOGRAM**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Hemoglobin	Blood	14.8	13.0 - 17.0 gm%	Photometric
Hematocrit(PCV)		46.5	40.0 - 50.0 %	Calculated
RBC Count		<b>5.97</b>	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		<b>78</b>	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		<b>24.8</b>	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		31.9	31.5 - 35.0 g/l	Calculated
RDW		<b>15.6</b>	11.5 - 14.0 %	Calculated
Platelet count		294	150 - 450 10 <sup>3</sup> /cumm	Impedance
WBC Count		9300	4000 - 11000 cells/cumm	Impedance
<b><u>DIFFERENTIAL COUNT</u></b>				
Neutrophils		54.8	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		34.1	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		5.9	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		5.2	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		5096.4	2000 - 7000 /cumm	Calculated



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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		3171.3	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		<b>548.7</b>	20 - 500 /cumm	Calculated
Absolute Monocyte Count		483.6	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<b>PERIPHERAL SMEAR</b>				
RBC		Microcytosis +(Few), Hypochromia +(Few), Anisocytosis +(Few)		Light microscopy
WBC		As Above		
Platelets		Adequate		
ESR		02	0 - 15 mm/hr	Automated Westergren's Method
*** End Of Report ***				

Suggested Clinical Correlation \* If necessary, Please discuss  
 Verified By : : 11100245  
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**Dr. PURVA JAISWAL, MBBS,MD,DNB**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. RAVI DEKATE	<b>Age / Gender</b> : 45 Y(s)/Male
<b>Ill No/ UMR No</b> : BIL2324035128/UMR2223137366	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 26-Aug-23 10:07 am	<b>Report Date</b> : 26-Aug-23 11:48 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	100	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		120	< 140 mg/dl	GOD/POD, Colorimetric

**GLYCOSYLATED HAEMOGLOBIN (HBA1C)**

<u>Parameter</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
HbA1c	5.5	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

**URIC ACID**

<u>Parameter</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Uric Acid (Total)	0.511	< 4 ng/ml	Enhanced chemiluminescence

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

Suggested Clinical Correlation \* If necessary, Please Discuss

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**Dr. Anuradha Deshmukh, MBBS,MD  
CONSULTANT MICROBIOLOGIST**

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CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. RAVI DEKATE	<b>Age /Gender</b> : 45 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324035128/UMR2223137366	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 26-Aug-23 10:08 am	<b>Report Date</b> : 26-Aug-23 12:13 pm

**LIPID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>		<u>Method</u>
Total Cholesterol	Serum	138	< 200 mg/dl	Enzymatic(CHE/CHO/PO D)
Triglycerides		<b>186</b>	< 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		<b>33</b>	> 40 mg/dl	
LDL Cholesterol Direct		77.30	< 100 mg/dl	
VLDL Cholesterol		<b>37</b>	< 30 mg/dl	
Tot Chol/HDL Ratio		4	3 - 5	

<u>Intiate therapeutic</u>		<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129	<100
Multiple major risk factors conferring 10 yrs CHD risk >20%			
Two or more additional major risk factors, 10 yrs CHD risk <20%	>130	10 yrs risk 10-20 % >130 10 yrs risk <10% >160	<130
No additional major risk or one additional major risk factor	>160	>190, optional at 160-189	<160

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

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**Dr. Anuradha Deshmukh, MBBS,MD**  
**CONSULTANT MICROBIOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mr. RAVI DEKATE      **Age / Gender** : 45 Y(s)/Male  
**Patient No / UMR No** : BIL2324035128/UMR2223137366      **Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 26-Aug-23 10:08 am      **Report Date** : 26-Aug-23 12:13 pm

**THYROID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
T3	Serum	1.42	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.18	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.34	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

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

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**Dr. Anuradha Deshmukh, MBBS,MD**  
**CONSULTANT MICROBIOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

**patient Name** : Mr. RAVI DEKATE  
**Age /Gender** : 45 Y(s)/Male  
**Bill No/ UMR No** : BIL2324035128/UMR2223137366  
**Referred By** : Dr. Virmmi Goel MBBS,MD  
**Received Dt** : 26-Aug-23 10:08 am  
**Report Date** : 26-Aug-23 12:13 pm

**LIVER FUNCTION TEST(LFT)**

Parameter	Specimen	Results	Biological Reference	Method
Total Bilirubin	Serum	0.58	0.2 - 1.3 mg/dl	
Direct Bilirubin		0.39	0.1 - 0.3 mg/dl	
Indirect Bilirubin		0.19	0.1 - 1.1 mg/dl	
Alkaline Phosphatase		100	38 - 126 U/L	
SGPT/ALT		22	10 - 40 U/L	
SGOT/AST		33	15 - 40 U/L	Buret (Alkaline cupric sulphate)
Serum Total Protein		8.53	6.3 - 8.2 gm/dl	Bromocresol green Dye Binding
Albumin Serum		4.82	3.5 - 5.0 gm/dl	
Globulin		3.72	2.0 - 4.0 gm/	
AG Ratio		1.30		

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



**Dr. Anuradha Deshmukh, MBBS,MD  
CONSULTANT MICROBIOLOGIST**

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mr. RAVI DEKATE  
**Age / Gender** : 45 Y(s)/Male  
**Bill No/ UMR No** : BIL2324035128/UMR2223137366  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 26-Aug-23 10:08 am  
**Report Date** : 26-Aug-23 12:13 pm

<b>Parameter</b>	<b>Specimen</b>	<b>Result Values</b>	<b>Biological Reference</b>	<b>Method</b>
Blood Urea	Serum	15	19.0 - 43.0 mg/dl	
Creatinine		0.96	0.66 - 1.25 mg/dl	
SGFR		99.3		
Sodium		139	136 - 145 mmol/L	Direct ion selective electrode
Potassium		5.03	3.5 - 5.1 mmol/L	Direct ion selective electrode

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. Anuradha Deshmukh, MBBS,MD**  
**CONSULTANT MICROBIOLOGIST**





**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

Patient Name	: Mr. RAVI DEKATE	Age / Gender	: 45 Y(s)/Male
No/ UMR No	: BIL2324035128/UMR2223137366	Referred By	: Dr. Vimmi Goel MBBS,MD
Received Dt	: 26-Aug-23 10:31 am	Report Date	: 26-Aug-23 12:55 pm

**URINE MICROSCOPY**

Parameter	Specimen	Results	Method
<b>PHYSICAL EXAMINATION</b>			
Volume	Urine	30 ml	
Colour		Pale yellow	
Appearance		Clear	
<b>CHEMICAL EXAMINATION</b>			
Reaction (pH)		5.0	Indicators
Specific gravity		1.015	ion concentration
Urine Protein		Negative	protein error of pH indicator
Sugar		Negative	GOD/POD
Bilirubin		Negative	Diazonium
Ketone Bodies		Negative	Legal's est Principle
Nitrate		Normal	Ehrlich's Reaction
Urobilinogen			Manual
<b>MICROSCOPIC EXAMINATION</b>			
Epithelial Cells		0-1	
R.B.C.		Absent	
W.B.C.		0-1	
Crystals		Absent	



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. RAVI DEKATE Reg No/ UMR No : BIL2324035128/UMR2223137366 Received Dt : 26-Aug-23 10:31 am	Age / Gender : 45 Y(s)/Male Referred By : Dr. Vimmi Goel MBBS,MD Report Date : 26-Aug-23 12:55 pm
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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Crystals		Absent *** End Of Report ***	

Suggested Clinical Correlation \* If necessary, Please discuss

Verified By : : 11100400

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**Dr. Anuradha Deshmukh, MBBS,MD**  
**CONSULTANT MICROBIOLOGIST**

**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF IMMUNO HAEMATOLOGY**

Patient Name : Mr. RAVI DEKATE  
No/ UMR No : BIL2324035128/UMR2223137366  
Received Dt : 26-Aug-23 10:08 am

Age / Gender : 45 Y(s)/Male  
Referred By : Dr. Vimmi Goel MBBS,MD  
Report Date : 26-Aug-23 12:11 pm

**BLOOD GROUPING AND RH**

Parameter  
BLOOD GROUP.

(D) Typing.

Specimen    Results

EDTA Whole    " B "  
Blood &  
Plasma/  
Serum

Gel Card Method

" Positive "(+Ve)

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

Suggested Clinical Correlation \* If necessary, Please  
DISCUSS

Verified By : : 11100245

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**Dr. VAIDEHEE NAIK,**  
**CONSULTANT PATH**

## DEPARTMENT OF RADIOLOGY &amp; IMAGING SCIENCE

NAME	RAVI DEKATE	STUDY DATE	26-08-2023 10:57:09
AGE/SEX	45Y 7M 19D / M	HOSPITAL NO.	UMR2223137366
REGISTRATION NO.	BH.2324035128-17	MODALITY	DX
EXAM PERFORMED ON	26-08-2023 13:06	REFERRED BY	Dr. Vimmi Goel

## X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

## IMPRESSION:

pleuro-parenchymal abnormality seen.

*Ashyalia*

NAVEEN PUGALIA

S, MD [076125]

CONSULTANT RADIOLOGIST.

NAME OF PATIENT:	RAVI DEKALE	45 Y/M
PAN NO	2223137366	BILL NO: 2324035128
REF BY:	DR. VINMI GOEL	DATE: 26/08/2023

**USG ABDOMEN AND PELVIS**

**Borderline enlarged in size (15.8 cm) and shows raised echogenicity.**

**liver is borderline enlarged in size (15.8 cm) and shows raised echogenicity.**

**No evidence of any focal lesion seen. PORTAL VEIN and CBD are normal in course and caliber.**

**intrahepatic biliary radicals are not dilated. No stones or sludge seen within it.**

**GALL BLADDER is physiologically distended. No stones or sludge seen within it.**

**Wall thickness is within normal limits.**

**Visualized head and body of PANCREAS is normal in shape, size and echotexture.**

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**Visualized head and body of PANCREAS is normal in shape, size and echotexture.**

**SPLEEN is normal in size, shape and echotexture. No focal lesion seen.**

**right kidney measures – 9.5 x 4.8 cm. Left kidney measures – 10.8 x 4.2 cm.**

**Both KIDNEYS are normal in shape, size and echotexture.**

**No evidence of calculus or hydronephrosis seen.**

**URETERS are not dilated.**

**URINARY BLADDER is well distended. No calculus or mass lesion seen.**

**Prostate is enlarged in size (Volume – 35 cc).**

**There is no free fluid or abdominal lymphadenopathy seen.**

**There is no free fluid or abdominal lymphadenopathy seen.**

**There is no free fluid or abdominal lymphadenopathy seen.**

**IMPRESSION: USG reveals,**

- **Borderline hepatomegaly with grade I fatty liver.**
- **Mild prostatomegaly.**



**DR. ANIKET KUSRAM**  
**MBBS, MD, DNB (Radio-diagnosis)**  
 Reg no: 2017094427

**2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT**

Patient Name : Mr. Ravi Dekate  
 Age : 45 years / Male  
 UMR : UMR2223137366  
 Date : 26/08/2023  
 Done by : Dr. Vimmi Goel  
 ECG : NSR, RBBB  
 Blood pressure: 120/80 mm Hg (Right arm, Supine position)  
 BSA : 1.99 m<sup>2</sup>

**Impression: Normal 2D Echocardiography Study**

**Normal chambers dimensions**  
**No RWMA of LV at rest**  
**Good LV systolic function, LVEF 70%**  
**Normal LV diastolic function**  
**E/A is 1.9**  
**E/E' is 7.3 (Normal filling pressure)**  
**Valves are normal**  
**Trivial TR, No pulmonary hypertension**  
**IVC is normal in size and collapsing well with respiration**  
**No clots or pericardial effusion**

**Comments:**

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views). LV size normal. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 70%. Normal LV diastolic function. E Velocity is 77 cm/s, A Velocity is 41 cm/s. E/A is 1.9. Valves are normal. Trivial TR. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen.  
 E' at medial mitral annulus is 9.4 cm/sec & at lateral mitral annulus is 11.7 cm/sec.  
 E/E' is 7.3 (Average).

**M Mode echocardiography and dimension:**

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	34
Aortic root	20-37	7-28	23
LVIDd	35-55	8-47	44
LVIDs	23-39	6-28	26
IVS (d)	6-11	4-8	10
LVPW (d)	6-11	4-8	10
LVEF %	~ 60%	~60%	70%
Fractional Shortening			40%

*Dr. Vimmi Goel*  
**Dr. Vimmi Goel**  
**MD, Sr. Consultant**  
**Non-invasive Cardiology**

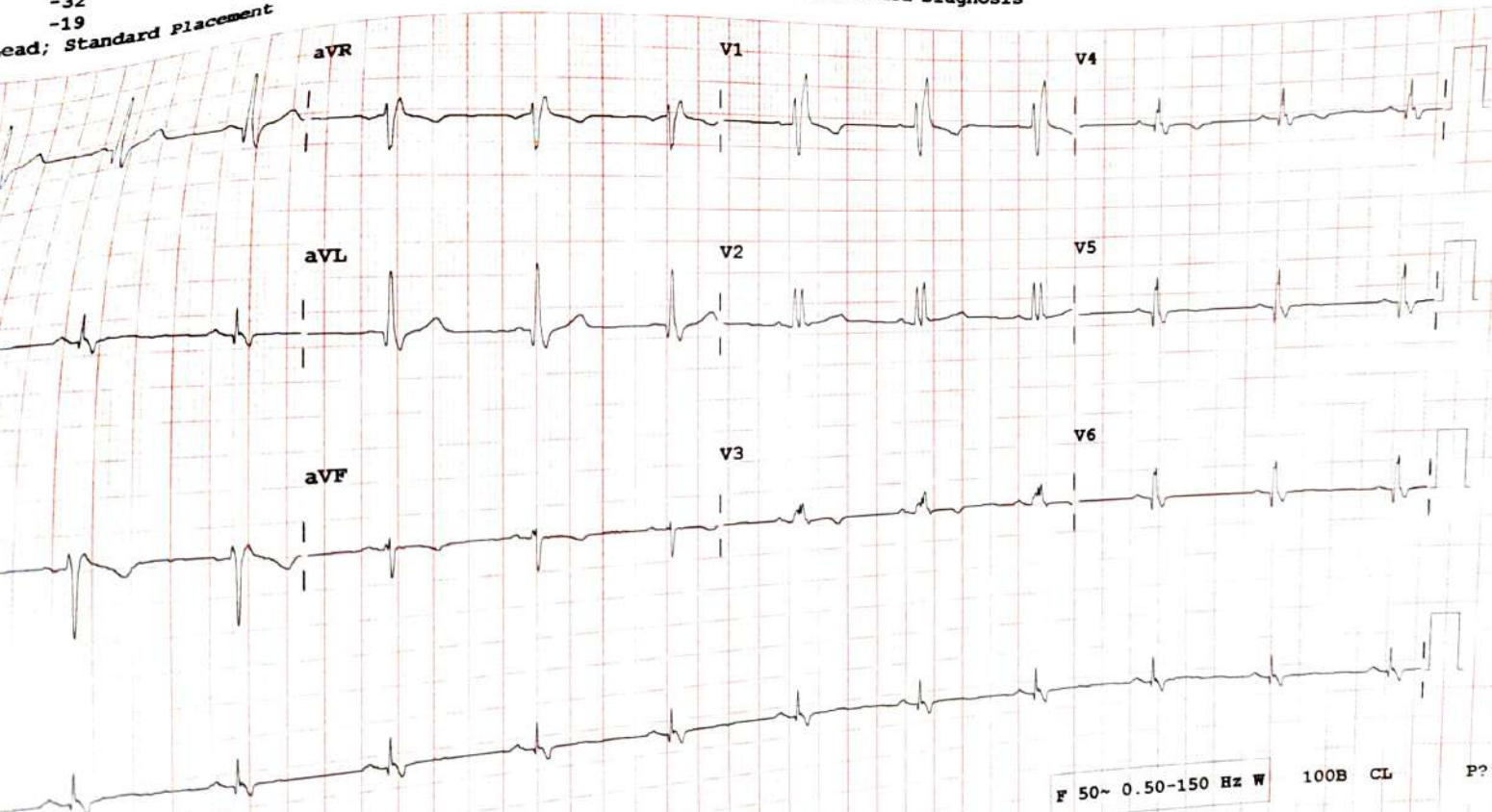
P.T.O

129  
378  
411

- ABNORMAL ECG -

IS--  
31  
-32  
-19  
lead; Standard Placement

Unconfirmed Diagnosis



F 50~ 0.50-150 Hz W 100B CL P?

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

PHILIPS