Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 10/06/23

Name: Mr. Vitthaldas G. Dabholkar Age: 56 yrs Sex: M / F

BP: 150/80 mm/Hg Height (cms): 151 cm Weight(kgs): 75.7 Kg BMI: _____

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	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	Underweight					Healthy						Overweight				Obese					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	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	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	35
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	34
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	33
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	32
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	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	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	17	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	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL

UHID	12521054	Date	10/06/2023		
Name	Mr.Vitthaldas Gajanan Dabholkar	Sex	Male	Age	56
OPD	Opthal 14	Health Check Up			

Drug allergy: → Not known.
Sys illness: → NO.
Habit → NO.

C/o → NO.

H/o - D.M. & HTN.

V-A → RE 6/60 P; LE 6/36 P (B/l)

Refraction → RE + 1.75 DS → 6/6; LE + 1.75 DS → 6/6

Add → + 2.50 → N6; N6

I.O.P. → RE → 12.5; LE → 13.2. (Same at P.U.P.)

[signature]

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Hiranandani HOSPITAL

UHID	12521054		Date	10/06/2023	
Name	Mr. Vitthaldas Gajanan Dabholkar		Sex	Male	Age 56
OPD	Dental 12	7387696540	Health Check Up		

Drug allergy:
Sys illness:

missing $\frac{5 \mid 56}{76 \mid 67}$

Cervical abrasion $\frac{\quad \mid \quad}{54 \mid 45}$

Root piece $\frac{64 \mid 4}{\quad \mid \quad}$

grossly decayed $\frac{7 \mid}{\quad \mid \quad}$

Carious $\frac{\quad \mid 7}{\quad \mid \quad}$

Stains ++ Calculus ++

Treatment

Adv. RCT & Cap $\frac{7 \mid}{54 \mid 45}$

Adv Extraction $\frac{764 \mid 4}{\quad \mid \quad}$

Adv. Partial denture.

Adv. OPG.

Adv. Oral prophylaxis.

Dr Dipika Kaka

MC-2275

LABORATORY REPORT

Fortis | SRL Diagnostics

PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001809** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 11:09:00 RECEIVED : 10/06/2023 11:09:09 REPORTED : 10/06/2023 17:10:18

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

Test Report Status **Final**	Results		Biological Reference Interval	Units
HAEMATOLOGY - CBC				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	13.6		13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	5.01		4.5 - 5.5	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	7.42		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	283		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	**39.2**	Low	40 - 50	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	**78.1**	Low	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.2		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	**34.8**	High	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	12.2		11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	15.6			
MEAN PLATELET VOLUME (MPV)	9.4		6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	55		40 - 80	%
METHOD : FLOWCYTOMETRY				
LYMPHOCYTES	33		20 - 40	%
METHOD : FLOWCYTOMETRY				
MONOCYTES	7		2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS	5		1 - 6	%
METHOD : FLOWCYTOMETRY				

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Fortis | SRL Diagnostics

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BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

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BASOPHILS METHOD : FLOWCYTOMETRY	0		0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	4.08		2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.45		1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.52		0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.37		0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0**	**Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	1.6			
MORPHOLOGY				
RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD MICROCYTOSIS			
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY			
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE			

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

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	12	0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD			

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE 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, Vasculities, 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 (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,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. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis 10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE A	
METHOD : TUBE AGGLUTINATION		
RH TYPE	POSITIVE	
METHOD : TUBE AGGLUTINATION		

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

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BIOCHEMISTRY				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN METHOD : UREASE - UV	7		6 - 20	mg/dL
CREATININE EGFR- EPI				
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	**0.78**	Low	0.90 - 1.30	mg/dL
AGE	56			years
GLOMERULAR FILTRATION RATE (MALE) METHOD : CALCULATED PARAMETER	104.66		Refer Interpretation Below	mL/min/1.73m2
BUN/CREAT RATIO				
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	8.97		5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID METHOD : URICASE UV	6.3		3.5 - 7.2	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.79		0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.17		0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.62		0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.8		6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	4.3		3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.5		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 P5P	29		15 - 37	U/L

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ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	**56**	**High**	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-AMP	111		30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	47		15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	**214**	**High**	100 - 190	U/L
KIDNEY PANEL - 1				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN METHOD : BIURET	7.8		6.4 - 8.2	g/dL
ALBUMIN, SERUM				
ALBUMIN METHOD : BCP DYE BINDING	4.3		3.4 - 5.0	g/dL
GLOBULIN				
GLOBULIN METHOD : CALCULATED PARAMETER	3.5		2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM METHOD : ISE INDIRECT	138		136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	3.93		3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	103		98 - 107	mmol/L
Interpretation(s)				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	**109**	**High**	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL

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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**6.4**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)	**137.0**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI heemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI-GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
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
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,pancreatus,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 Hypophosphatasia,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 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.

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Patient Ref. No. 22000000850568

LABORATORY REPORT

Fortis | SRL Diagnostics

PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001809** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 11:09:00 RECEIVED : 10/06/2023 11:09:09 REPORTED : 10/06/2023 17:10:18

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

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

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
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.
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 sothat 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 Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
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 patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	160		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	**197**	High	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY				

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Patient Ref. No. 22000000850568

LABORATORY REPORT

MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001809** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 11:09:00 RECEIVED : 10/06/2023 11:09:09 REPORTED : 10/06/2023 17:10:18

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

Test Report Status **Final**	Results		Biological Reference Interval	
HDL CHOLESTEROL	**39**	**Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	83		< 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	121		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	**39.4**	**High**	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	4.1		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				
LDL/HDL RATIO	2.1		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				

Interpretation(s)

CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW	
METHOD : PHYSICAL		
APPEARANCE	CLEAR	
METHOD : VISUAL		

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5

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CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

Test Report Status **Final**	Results	Biological Reference Interval	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	0-1	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 IS DONE BY URINARY CENTRIFUGED SEDIMENTS		

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PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001809** AGE : 56 Years SEX : Male ABHA NO :

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CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

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

Interpretation(s)

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	132.8	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	9.83	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.420	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.999	0.0 - 3.1	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 patient.
- It 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-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5

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MC-2275

LABORATORY REPORT

PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001809** AGE : 56 Years SEX : Male ABHA NO :

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CLINICAL INFORMATION :

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

70-79 years 0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)
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- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

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Counsultant Pathologist

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LABORATORY REPORT

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PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001851** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 12:48:00 RECEIVED : 10/06/2023 12:47:50 REPORTED : 10/06/2023 14:04:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	125	70 - 140	mg/dL

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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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Patient Ref. No. 22000000850610

LABORATORY REPORT

MC-2275

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PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001857** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 13:03:00 RECEIVED : 10/06/2023 13:03:38 REPORTED : 10/06/2023 14:51:38

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

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

CLINICAL PATH - STOOL ANALYSIS

STOOL: OVA & PARASITE

PHYSICAL EXAMINATION,STOOL

COLOUR METHOD : VISUAL	BROWN		
CONSISTENCY METHOD : VISUAL	WELL FORMED		
MUCUS METHOD : VISUAL	NOT DETECTED	NOT DETECTED	
VISIBLE BLOOD METHOD : VISUAL	ABSENT	ABSENT	

CHEMICAL EXAMINATION,STOOL

OCCULT BLOOD METHOD : GUAIAC METHOD	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION,STOOL

PUS CELLS METHOD : MICROSCOPIC EXAMINATION	0-1		/hpf
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
CYSTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
OVA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
LARVAE METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
TROPHOZOITES METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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LABORATORY REPORT

MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR.VITTHALDAS GAJANAN DABHOLKAR

PATIENT ID : **FH.12521054** CLIENT PATIENT ID : UID:12521054

ACCESSION NO : **0022WF001857** AGE : 56 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 13:03:00 RECEIVED : 10/06/2023 13:03:38 REPORTED : 10/06/2023 14:51:38

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12521054 REQNO-1533368
CORP-OPD
BILLNO-150123OPCR032615
BILLNO-150123OPCR032615

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

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

LABORATORY REPORT

MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR.SUJAY BISWAS

PATIENT ID : **FH.12520883** CLIENT PATIENT ID : UID:12520883

ACCESSION NO : **0022WF001822** AGE : 43 Years SEX : Male ABHA NO :

DRAWN : 10/06/2023 11:26:00 RECEIVED : 10/06/2023 11:27:18 REPORTED : 10/06/2023 13:19:36

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12520883 REQNO-1533219
CORP-OPD
BILLNO-150123OPCR032586
BILLNO-150123OPCR032586

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

BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	76	70 - 140	mg/dL

METHOD : HEXOKINASE

Comments

NOTE: - POST PRANDIAL PLASMA GLUCOSE VALUES TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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Patient Ref. No. 22000000850581

Male 6/10/2023 11:04:26 AM

Rate	79	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Probable left atrial enlargement.....P >50mS, <-0.10mV V1
PR	162	. RSR' in V1 or V2, right VCD or RVH.....QRS area positive & R' V1/V2
QRSD	93	. Baseline wander in lead(s) V6
QT	366	
QTc	420	

--AXIS--

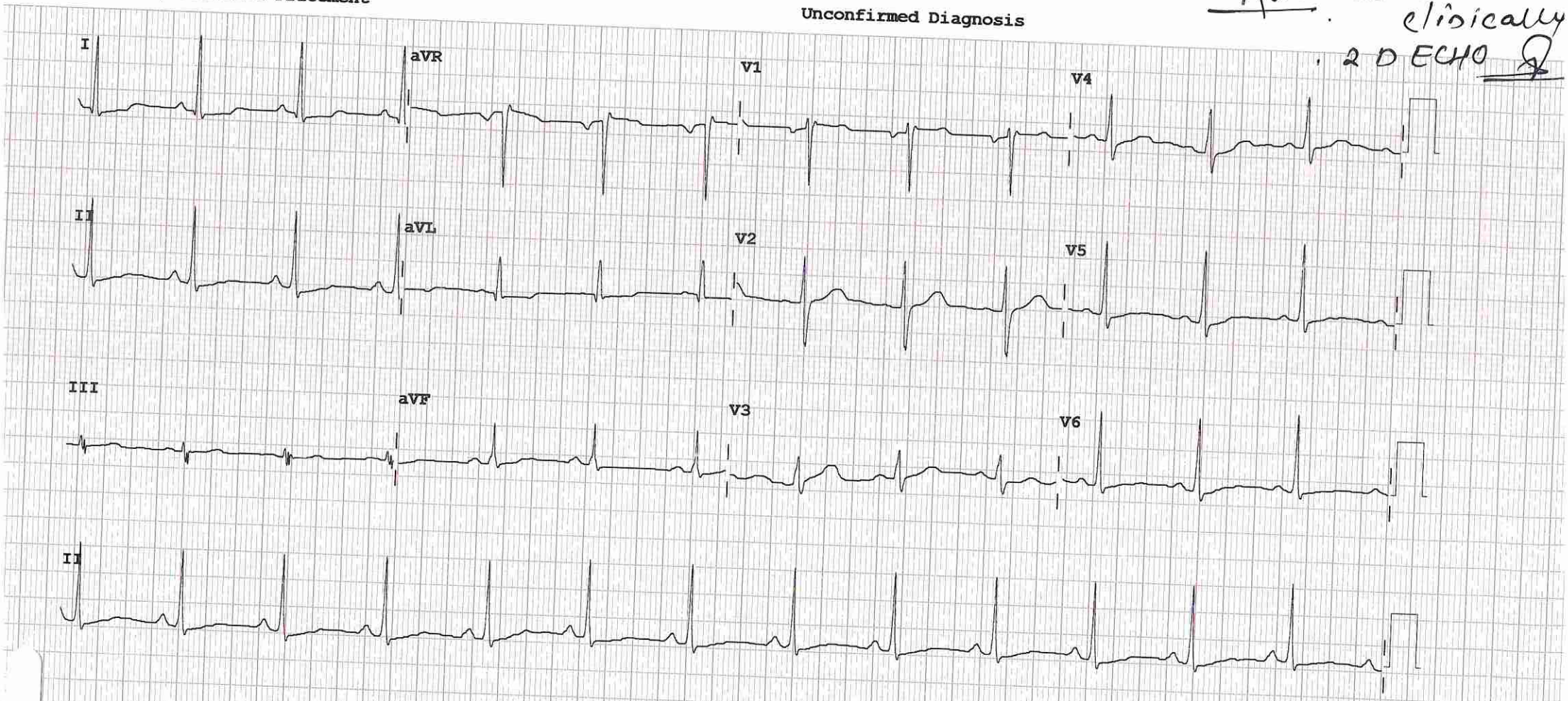
P	41
QRS	31
T	21

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

Sinus rhythm
RBBB
ST ↓, T ↓ in posterior leads
Ado correlate clinically
2D ECHO



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 10/Jun/2023

Name: Mr. Vitthaldas Gajanan Dabholkar
Age | Sex: 56 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12521054 | 32990/23/1501
Order No | Order Date: 1501/PN/OP/2306/68897 | 10-Jun-2023
Admitted On | Reporting Date : 10-Jun-2023 18:03:07
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 55%.
- Grade I left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Mitral annular calcification. Trivial mitral regurgitation.
- Sclerotic aortic valve. Mild aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 25 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 14 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	37	mm
AO Root	27	mm
AO CUSP SEP	18	mm
LVID (s)	25	mm
LVID (d)	48	mm
IVS (d)	11	mm
LVPW (d)	10	mm
RVID (d)	28	mm
RA	30	mm
LVEF	55	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.
A WAVE VELOCITY:0.8 m/sec
E/A RATIO: 0.6

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	12			Mild
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- Grade I LV diastolic dysfunction.
- Mild AR. Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

DR. PRASHANT PAWAR,
DNB(MED), DNB (CARDIOLOGY)

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Hiranandani HOSPITAL
(A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 10/Jun/2023

Name: Mr. Vitthaldas Gajanan Dabholkar
Age | Sex: 56 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12521054 | 32990/23/1501
Order No | Order Date: 1501/PN/OP/2306/68897 | 10-Jun-2023
Admitted On | Reporting Date : 10-Jun-2023 14:41:22
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Unfolding of arch of aorta is seen.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

DR. SIDDHANT LOLGE
MD (Radiologist)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 10/Jun/2023

Name: Mr. Vitthaldas Gajanan Dabholkar	**UHID | Episode No : 12521054 | 32990/23/1501**
Age | Sex: 56 YEAR(S) | Male	**Order No | Order Date: 1501/PN/OP/2306/68897 | 10-Jun-2023**
Order Station : FO-OPD	**Admitted On | Reporting Date : 10-Jun-2023 12:37:56**
Bed Name :	**Order Doctor Name : Dr.SELF .**

US-WHOLE ABDOMEN

LIVER is normal in size and shows moderately raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. *Few tiny cholesterol crystals are noted within.* 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 9.0 x 5.4 cm.Left kidney measures 9.6 x 4.8 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 17.4 cc in volume.

No evidence of ascites.

Impression:

- **Grade II fatty infiltration of liver.**

DR. ADITYA NALAWADE
M.D. (Radiologist)