PATHOLOGY

PATIENT NAME & ADDRESS

MRS. RENU SINGH

B1/ GO3 VICTORIA GREENS , 24pg(S)-24 Parganas (South),West India , 700084

DESUN HOSPITAL
A NABH HOSPITAL
Desun More, E.M. Bypass, Kasba Golpark, Kolkata-700 107, Ph.: 71 222 000, Fax : 2443 9003
Email : desun@desunhospital.com, Website : www.desunhospital.com
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DRAWN : 27-01-2024 09:55 Hrs. | RECEIVED : 27-01-2024 15:41 Hrs. | REPORTED : 27-01-2024 18:27 Hrs.

OPD/IPD DOC NO SD01/OPD/BILL/2023-24/OP40483726 | PATIENT CODE SD01/PAT/1000157905

2331166260

REFERRING DOCTOR

ACCESSION NO DHHI-1/2023-24/0007532 | AGE 53 Yrs 11 Mths 17 Dys | SEX Female

Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - Fasting			
Glucose - Fasting *Specimen : Plasma Flounde* *Methodology : Hexokinase* * CLINICAL CORRELATION REQUESTED.	* **116**	Adult: 74 - 106 Children 60 - 100	mg/dL
Uric Acid			
Uric Acid *Specimen : Serum* *Methodology : Uricase Peroxidase*	6.8	Male : 3.5 - 7.2 Female : 2.6 - 6.0	mg/dL
LFT (Liver Function Test)			
Total Bilirubin *Specimen : Serum* *Methodology : Diazotization*	0.43	Adults: 0.3 - 1.2 Children 0-1 day 1.4 - 8.7 1-2 days 3.4 - 11.5 3-5 days 1.5 - 12.0	mg/dL
Direct Bilirubin *Specimen : Serum* *Methodology : Diazotization*	0.10	Adults and Children: < 0.2	mg/dL
Indirect Bilirubin *Methodology : Calculated Value*	0.33		mg/dL
Total Protein *Specimen : Serum* *Methodology : Biuret*	8.3	Adult : 6.6 - 8.3 Children (1 - 18 y) : 5.7 - 8.0 Newborns (1 - 30 d) : 4.1 - 6.3	g/dL
Albumin *Specimen : Serum* *Methodology : Bromocresol Green (BCG)*	4.5	Adults: 3.5 - 5.2 Newborn (0 - 4 day) : 2.8 - 4.4	g/dL
Globulin *Methodology : Calculated Value*	**3.8**	1.8 - 3.6	g/dL
Aspartate Aminotransferase (SGOT) (AST) *Specimen : Serum* *Methodology : IFCC (UV without P5P)*	24	Male (Adult): <50 Female (Adult): <35 Newborn: 25 - 75 Infant: 15 - 60	U/L
Alanine Aminotransferase (SGPT) (ALT) *Specimen : Serum* *Methodology : IFCC (UV without P5P)*	19	Male(Adult): <50 Female(Adult): <35 Newborn/Infant: 13 - 45	U/L

Dr. Prerana Mondal
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Consultant Pathologist

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REFERRING DOCTOR

ACCESSION NO DHHI-1/2023-24/0007532 **AGE** 53 Yrs 11 Mths 17 Dys **SEX** Female

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
LFT (Liver Function Test)			
Alkaline Phosphatase (ALP) *Specimen : Serum* *Methodology : IFCC (PNPP, AMP buffer)*	80	75 - 316	U/L
Creatinine			
Creatinine *Specimen : Serum* *Methodology : Jaffe Method*	0.85	Male (<50 years) : 0.84 - 1.25 Male (>50 years): 0.81 - 1.44 Female: 0.66 - 1.09 Neonate: 0.5 - 1.2 Infant: 0.4 - 0.7 Child: 0.5 - 1.2	mg/dL

PATIENT SAFETY & QUALITY OF CARE
NABH
ACCREDITED HOSPITAL

290120240954 17

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - PP (Post Prandial)			
Glucose - Post Prandial	92	70.0 - 140.0	mg/dL

Specimen : Plasma Flouride

Methodology : Hexokinase

***PP SUGAR CAN BE LOWER THAN FASTING SUGAR DUE TO THE FOLLOWING REASONS:**

1) IN LATENT DIABETICS, HYPERSECRETION OF INSULIN BY THE ISLET CELLS OF PANCREAS MAY LEAD TO INCREAS UTILISATION OF POST PRANDIAL BLOOD GLUCOSE.

2) OPTIMUM AMOUNT OF GLUCOSE (I.E. 75GM) MAY NOT HAVE BEEN CONSUMED.

3) INSULIN SURGE MAY TAKE PLACE AFTER INGESTION OF DIRECT GLUCOSE.

4) PATIENT MAY BE A KNOWN DIABETIC UNDER TREATMENT.

*** VALUE RECHECKED.**

** Sample Drawn : 27.01.2024 15:32 Hrs. Received : 27.01.2024 13:56 Hrs. Reported : 27.01.2024 17:56 Hr

PATIENT SAFETY & QUALITY OF CARE NABH ACCREDITED HOSPITAL

Dr. Swapan Pathak
MD (Path), WBMC-43069
Sr Consultant

290120240954l7

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total *Specimen : Serum* *Methodology : CHOD-POD*	194	<200 : Desirable 200 - 239 : Borderline High >=240 : High	mg/dL
Cholesterol - HDL *Specimen : Serum* *Methodology : Direct Enzymatic Colorimetric*	36	40.0 - 59.0	mg/dL
Cholesterol - LDL *Methodology : Calculated Value*	94.4	> 160.0 : High Risk 130.0 – 160.0 : Borderline High <= 130.0 : Desirable	mg/dL
Cholesterol - VLDL *Methodology : Calculated Value*	63.6	< 40.0	mg/dL
Triglyceride *Specimen : Serum* *Methodology : GPO POD*	* 318	Normal : <150 Borderline high : 150 - 199 High : 200 - 499 Very high : >=500	mg/dL

* CLINICAL CORRELATION REQUESTED.

PATIENT SAFETY & QUALITY OF CARE
NABH
ACCREDITED HOSPITAL

290120240954l7

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PATHOLOGY

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total/HDL ratio *Methodology : Calculated Value*	**5.39**	3.4 : 1/2 Average Risk 5.0 : Average Risk 9.6 : 2 x Average Risk 23.4 : 3 x Average Risk	ratio
Cholesterol - HDL/LDL ratio *Methodology : Calculated Value*	0.38		

PATIENT SAFETY & QUALITY OF CARE
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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
HbA1c (Glycosylated Haemoglobin)			
Glycosylated Haemoglobin (HBA1C) *Specimen :* *Methodology : NGSP*	**7.4**	4.6 - 6.2	%
BUN (Blood Urea Nitrogen)			
Blood Urea Nitrogen (BUN) *Specimen : Serum* *Methodology : Urease, GLDH*	11	Newborn : 4 - 18 Child : 5 - 18 Adult : 6 - 20	mg/dL
LFT (Liver Function Test)			
A/G Ratio *Specimen : serum* *Methodology : Calculated Value*	1.18	1.1 - 2.2	ratio
GGT (Gamma-glutamyltransferase)			
Gamma-glutamyltransferase (GGT) *Specimen : Serum* *Methodology :*	19.8	12 - 122	U/L

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Haemoglobin (Hb) *Specimen : Whole Blood - EDTA* *Methodology : Colorimetry*	**11.8**	12.0 - 15.0	gm %
RBC Count *Specimen : Whole Blood - EDTA* *Methodology : Electrical Impedance*	4.24	3.8 - 4.8	million/cmm
Packed Cell Volume (Hematocrit) (PCV) *Specimen : Whole Blood - EDTA* *Methodology : Pulse height detection*	**35.0**	36.0 - 46.0	%
Mean Cell Volume (MCV) *Specimen : Whole Blood - EDTA* *Methodology : Calculated Value*	**82.6**	83.0 - 101.0	fL
Mean Cell Haemoglobin (MCH) *Specimen : Whole Blood - EDTA* *Methodology : Calculated Value*	27.8	27 - 32	pg
Mean Cell Haemoglobin Concentration (MCHC) *Specimen : Whole Blood - EDTA* *Methodology : Calculated Value*	33.7	31.5 - 34.5	g/dL
Platelet Count *Specimen : Whole Blood - EDTA* *Methodology : Electrical Impedance*	2.14	1.5 - 4.1	lakh/cmm
Total Count			
WBC Count *Specimen : Whole Blood - EDTA* *Methodology : Electrical Impedance*	5.9	4.0 - 10.0	thou/cmm
Differential Count (Microscopy)			
Neutrophil	67	40 - 80	%
Lymphocyte	30	20 - 40	%
Monocyte	02	2 - 10	%
Eosinophil	01	1 - 6	%
Basophil	00	<1 - 2	%
Peripheral Blood Smear (Microscopy)			

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2901202409541 7

Dr. Palash Kr Mandal
MD (Path), WBMC-51886
Sr Consultant

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
RBC	Normocytic Normochromic		
WBC	Normal morphology. No immature cell seen.		
Erythrocyte Sedimentation Rate (ESR) *Specimen : Whole Blood - EDTA* *Methodology : Westergren*	**26**	<=15	mm / hr

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
ABO Group & RH Type			
ABO Blood Group *Methodology : Tube Agglutination / Slide method*	A		
Rh Typing *Specimen : Whole Blood - EDTA* *Methodology : Tube Agglutination / Slide method*	POSITIVE		

Note : Following factors are responsible for discrepancies in ABO Grouping:
1. Patients may fail to express ABO antigens on red cells due to diseases like Leukaemia & lymphoma.
2. Acquired B antigen can occur due to Infections; gram negative septicaemia, carcinoma colon, Blood Group chimera i.e. an individual with two population of cells which may occur as a result of either Bone marrow transplantation or Transfusion of group 'O' blood to 'A' or 'B' patient.
3. Rouleaux formation: It occurs in patients with abnormal Albumin/globulin concentration or in cord blood samples due to Whartons Jelly contamination.
4. Acquired antibodies i.e.
Anti –A1 in A2 persons
Anti –H in Bombay phenotype
Cold auto – antibodies
Unexpected allo-antibodies.

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Urinalysis			
Physical Examination			
Volume *Methodology : By graduated container*	30		mL
Colour	Pale Straw		
Appearance *Methodology : Visual*	Slightly Hazy		
Specific Gravity *Methodology : pKa change*	1.015		ratio
Chemical Examination			
Reaction *Methodology : Double indicator (Strip)*	Acidic		
Protein *Methodology : Protein-error-of-indicators*	Absent		
Glucose *Methodology : Glucose oxidase (Strip)/ Benedict`s Test*	Absent		
Ketone Bodies *Methodology : Nitroprusside method (Strip)/ Tube*	Absent		
Bile Salt *Methodology : Hay`s Method*	Absent		
Bile Pigment *Methodology : Diazo Method (Strip)*	Absent		
Blood *Methodology : Benzidine method (Strip)/ Microscopy*	Absent		
Microscopic Examination			
Pus Cells	1-2		/hpf
RBC	Not Seen		/hpf
Epithelial Cells	2-3		/hpf

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Dr. Swapan Pathak
MD (Path), WBMC-43069
Sr Consultant

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Casts	Not Seen		
Crystals	Not Seen		

--------- *End of Report* ----------

PATIENT SAFETY & QUALITY OF CARE
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2901202409541 7

Dr. Swapan Pathak
MD (Path), WBMC-43069
Sr Consultant

PATHOLOGY

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9082560901

BED NO : OPD

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2331166260

REFERRING DOCTOR

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AGE 53 Yrs 11 Mths 17 Dys SEX Female

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Thyroid Profile - 1 (T3, T4, TSH)			
Triiodothyronine (T3) *Specimen : Serum* *Methodology : Electrochemiluminescence* *** CLINICAL CORRELATION REQUESTED.**	*** 0.727**	0.80 - 2.00	ng/mL
Thyroxine (T4) *Specimen : Serum* *Methodology : Electrochemiluminescence*	6.39	5.10 - 14.10	µg/dL
Thyroid Stimulating Hormone (TSH) *Specimen : Serum* *Methodology : Electrochemiluminescence* *** CLINICAL CORRELATION REQUESTED.**	*** 10.74**	0.27 - 4.20	µIU/mL

---------- *End of Report* ----------

290120240934 20

Dr. Jayati Gupta
Ph.D (Bio.Chem)
Senior Consultant Biochemist

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CARDIOLOGY

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PROCEDURE DONE ON	: 27.01.2024
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REFERRING DOCTOR	:
ACCESSION NO	: R/DHHI-1/2023-24/0009892
REPORTED	: 27.01.2024
PATIENT CODE	: SD01/PAT/1000157905
AGE	: 53 Yrs 11 Mths 17 Dys
SEX	: F

ELECTROCARDIOGRAM REPORT - NO.392

WITHIN NORMAL LIMIT

Dr. IMRAN AHMED KHAN

Reg No: 64336, MBBS
Dept. of Cardiac Science

Prepared By : Sutapa Checked By : Sumita Bar

IAK

Renu singh

27.01.2024 10:19:43
DESUN HOSPITAL
E M Bypass, Kasba golpark
Kolkata - 700107

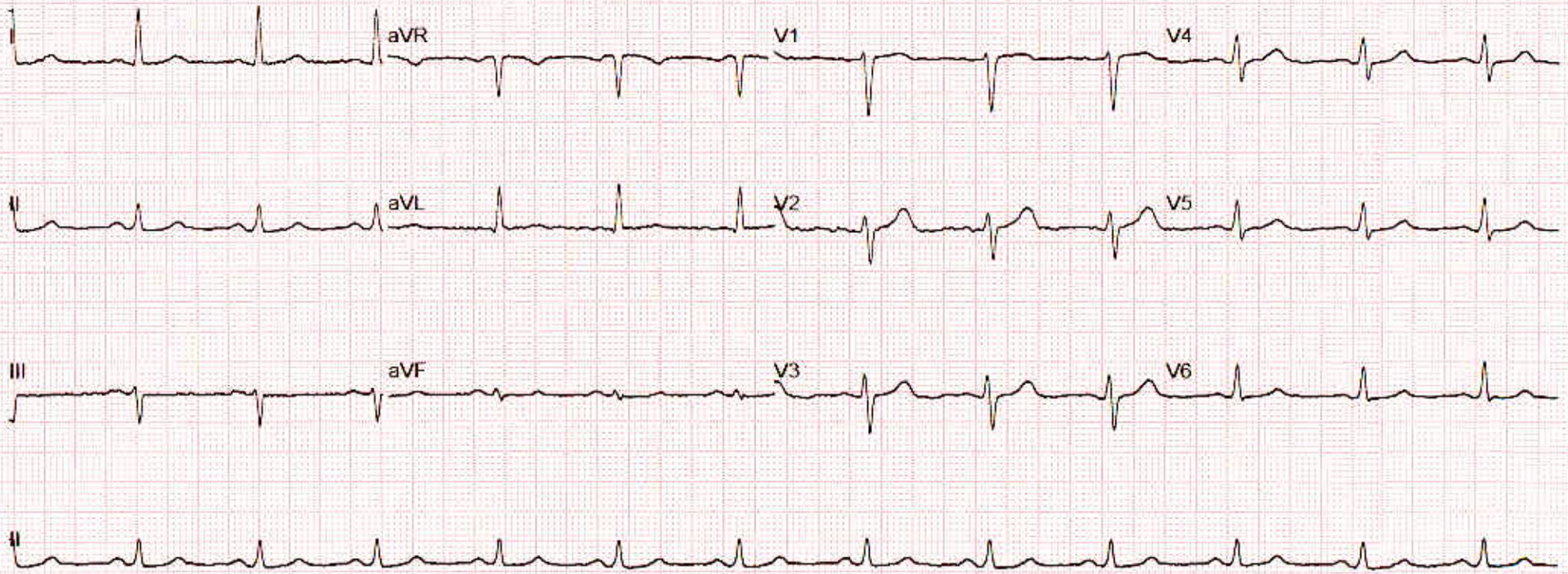
76 bpm
-- / -- mmHg

Female

QRS :	80 ms
QT / QTcBaz :	376 / 423 ms
PR :	156 ms
P :	120 ms
RR / PP :	788 / 789 ms
P / QRS / T :	57 / 3 / 13 degrees

Normal sinus rhythm
Normal ECG

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:



Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz 4x2.5x3_25_R1 1/1

PATIENT NAME & ADDRESS

CARDIOLOGY

MRS. RENU SINGH
B1/ GO3 VICTORIA GREENS , 24pg(S)-24 Parganas (South),West Bengal India , 700084

DESUN HOSPITAL
A NABH HOSPITAL
Desun More, E.M. Bypass, Kasba Golpark, Kolkata-700 107, Ph: 71 222 000, Fax : 2443 9003
E-mail : desun@desunhospital.com, Website : www.desunhospital.com
(A unit of P. N. Memorial Neurocentre & Research Institute Ltd.)

PROCEDURE DONE ON	: 27.01.2024	REPORTED	: 27.01.2024
OPD / IPD DOC NO	: SD01/OPD/BILL/2023-24/OP40483726	PATIENT CODE	: SD01/PAT/1000157905
REFERRING DOCTOR	:	AGE	: 53 Yrs 11 Mths 17 Dys
ACCESSION NO	: R/DHHI-1/2023-24/0009866	SEX	: F

ECHO CARDIOGRAPHY REPORT

ECHO NO : 398

SUMMARY

>> Normal LV cavity size.
>> No Regional wall motion abnormality.
>> Good LV systolic function. LVEF = 60 %.
>> Left ventricular diastolic dysfunction Grade II(E/E'=19).
>> Normal RV systolic function.
>> Trivial MR & TR, TRPG 30 mmHg. Mild PAH.
>> Great arteries normal in size and relation.
>> Interatrial and interventricular septum intact.
>> Systemic and pulmonary venous drainage normal.
>> No PE.
>> IVC collapsing.

FINAL IMPRESSION

>> No Regional wall motion abnormality.
>> Good LV systolic function.
>> Left ventricular diastolic dysfunction Grade II
>> Normal RV systolic function.
>> Mild PAH.

Please Correlate Clinically.

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esai

SKP

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CARDIOLOGY

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M - mode Measurements Valves :-

Aorta - 2.9 cm	LV ed - 4.8 cm
LA - 4.2 cm	LV es - 3.0 cm
ACS - cm	IVS ed - 1.1 cm
RV ed - cm	PW (LV) - 1.1 cm
FS - %	LVEF - 60 %

CHAMBERS:-

Left Ventricle : Normal in size. Walls normal in thickness and motion.

Left Atrium : Normal in size.

Right Atrium : Normal in size.

Right Ventricle : Normal in size.

Dr. SANJIB KUMAR PATRA

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Prepared By : Utpal Checked By : A Esai

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OTHERS :-

GREAT ARTERIES : Normal in size and relation.

PERICARDIUM : Normal

VALVES :-

MITRAL VALVE
Morphology : Normal
Doppler : Mitral Regurgitation : Trivial

TRICUSPID VALVE
Morphology : Normal
Doppler : TRPG : 30 mmHg
Tricuspid Regurgitation : Trivial

AORTIC VALVE
Morphology : Normal
Doppler : Normal

PULMONARY VALVE
Morphology : Normal
Doppler : Normal

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esai

S K P

PATIENT NAME & ADDRESS

RADIOLOGY

MRS. RENU SINGH
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REFERRING DOCTOR	:	AGE	: 53 Yrs 11 Mths 19 Dys
ACCESSION NO	: R/DHHI-1/2023-24/0009938	SEX	: F

(US-10569) USG OF WHOLE ABDOMEN

LIVER
Shows increased echotexture. Intrahepatic biliary ducts and hepatic vein tributaries are not dilated. No obvious focal lesion seen.

GALL BLADDER
Physiologically distended. Wall thickness is normal. No evidence of any intraluminal lesion seen.

C.B.D.
Normal for age. No obvious intraluminal lesion seen in visible parts.

PORTAL VEIN
Normal for age.

PANCREAS
Normal in size, shape and echotexture. No obvious focal lesion or intraparenchymal calcification seen. Main pancreatic duct is not dilated. No peripancreatic fluid collection seen.

SPLEEN
Spleen is normal in size, shape and echotexture. No focal lesion seen. Spleno-portal axis is normal.

KIDNEYS
Both the kidneys are normal in size, shape and axis. Cortical echotexture and cortico-medullary differentiation are normal in both sides. No evidence of any focal lesion seen in either kidneys. No hydronephrosis detected.

URETERS
Pelvi-ureteric junction and vesico-ureteric junctions are normal. No obvious intraluminal lesion seen in visible part.

URINARY BLADDER
Optimally distended, normal in shape and wall thickness. No evidence of any intraluminal lesion seen.

Prepared By : Buddha Checked By : D J

D J

PATIENT NAME & ADDRESS

MRS. RENU SINGH
B1/ GO3 VICTORIA GREENS , 24pg(S)-24 Parganas (South),West Bengal India , 700084

RADIOLOGY

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UTERUS
Anteverted and anteflexed. Endometrial thickness is normal. Myometrial echotexture is homogenous without any focal lesion or abnormal area of focal thickening.

OVARIES
Normal in size, shape and echopattern. No focal cystic or solid lesion seen.
No adnexal or pelvic SOL seen.
Pouch of Douglas - Clear.

RETROPERITONEUM
No obvious sonological evidence of any retroperitoneal mass lesion or lymphadenopathy seen in visible part. Aorta and I.V.C. appear normal.

PERITONEUM
No free fluid seen in the peritoneal cavity. Mesenteric echogenicity appears normal.

LOWER PLEURAL SPACES
No free fluid seen.

R.I.F.
No obvious mass lesion / localised collection seen.

A small defect measuring ≅ 14.5x12.5 mm is seen in midline supra-umbilical rectus sheath with herniation of preperitoneal fat into it.

IMPRESSION:
*** Grade I fatty changes in liver.**
*** Ventral abdominal wall hernia a deviated above in details.**

Dr. DINESH JAIN
WBMC-70597
MD, DNB (Radiology),EDIR,FRCR

Prepared By : Buddha Checked By : D J

D J

PATIENT NAME & ADDRESS

RADIOLOGY

MRS. RENU SINGH
B1/ GO3 VICTORIA GREENS , 24pg(S)-24 Parganas (South),West Bengal India , 700084

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(US-10569) ULTRASONOGRAPHY THIS EXAMINATION OF BOTH BREASTS

Breast architecture appear normal.

No obvious SOL (solid / cystic) is noted in either breast.

No obvious calcification is noted.

Ducts are not dilated.

Skin thickness appear normal.

Retromammary fat planes are maintained.

No obvious lesion is noted in the subareolar area.

No sizable axillary lymph node is demonstrated.

Impression:
Ultrasonography study of the breasts do not reveal any obvious abnormality.

- Clinical correlation is suggested.

Dinesh Jain

Dr. DINESH JAIN
WBMC-70597
MD, DNB (Radiology),EDIR,FRCR

Prepared By : Buddha Checked By : D J

D J

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Patient Name:	**RENU SINGH 53Y OPD**	Study Date/Time:	27-01-2024 10:37 AM
Sex/Age/Modality:	F/53Y/CR	Report Date/Time:	27-01-2024 02:47 PM
Patient ID:	17120	Report:	CHEST
Ref. Physician:	DESUN HOSPITAL & HEART INSTITUTE,KOLKATA	Report ID:	1221930D1305

X-RAY REPORT OF CHEST AP VIEW

FINDINGS:

No evidence of any parenchymal lesion is seen in the lung field.

No focal Space occupying lesion is seen.

Mediastinal shadow is normal and central in position.

Trachea is in midline.

Both domes of diaphragm are smoothly outlined with normal in position.

Both costo-phrenic angles are clear.

Hilum appears normal bilaterally.

C. T. ratio is not assessed.

Bony thorax appears normal.

IMPRESSION:

Normal Study.

Please correlate clinically with other investigations.

Dr. Tarique Ajij
MBBS, MD(Radiology)
Consultant Radiologist
Reg-64888

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DESUN HOSPITAL
A NABH HOSPITAL

Name : Mrs. Renu Singh Date : 27.01.24

U / Doctor : Dr. Anish Chakraborty Age : 53y Sex : F

Doctor's Prescription

℞ ORAL EXAMINATION Reveals.

- No. Caries in any teeth.
- No Mobility in any teeth.
- Rx.

(1) Mouth Rinse - Hexidine (10ml) + lukewarm water (10ml)

dilution

Rinse BD for (10) days.

(2) Toothpaste -
Thermoseal - Repair.
BD for (1) month.

28/1/24

DR. ANISH CHAKRABORTY
(BDS)
DENTISTRY
REGN. NO. 6648 A
DESUN HOSPITAL

P.N. MEMORIAL NEUROCENTRE & RESEARCH INSTITUTE LTD. DESUN HOSPITAL A NABH HOSPITAL KOLKATA

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DESUN HOSPITAL
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Name : Mrs. Renu Singh | Date : 27.01.24

U / Doctor : Dr. Sreemanti Bag | Age : 53Y Sex : F

Doctor's Prescription

C/O tinnitus (B/E)

c̄ B/L diminished hearing (gradual) x 2 yrs.

Known case T2DM
Known HTN
Known Hypothyroidism
} on Rx

no anticoagulant aspirin.

C/O Known allergic rhinitis.

O/E —
B/L TM intact
B/L EAC — visually normal

Nose on AR —
B/L septal ulceration (anterior inf part of nasal septum on both sides)

TFT — B/L Rinne +ve
Weber — Central

Rx

Advise

→ PTA + tympanometry

→ blood for FT3, FT4, TSH, FBS, PPBS

→ Maintain strict glycemic control

→ Avoid nose picking or overblowing of nose.

→ Tab TAXIM-O (200mg) 1 tab BDPC x 5 days

→ NEOSPORIN ophthalmic ointment apply locally on area of septal ulceration TDS x 5 days

→ FURAMIST AZ nasal spray 1 puff twice daily in each nasal cavity x 2 weeks (stop if any bleeding manifestation)

→ SOLSPRE nasal spray 2 puffs TDS in each nasal cavity x 2 weeks

→ Tab MONTICOPE A 1 tab OD AC at HS x 2 weeks

PTO

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→ Cap ADD IOVIT Y 1 cap OD PC
X 2 weeks

→ Review after 2 weeks (reports
or earlier SOS.

19.01.2022

Dr. Sreemanti Bag
MBBS, MS
Reg. No.- 73883 WBMC
Department of ENT
Desun Hospital

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NAME – Mrs. RENU SINGH

AGE – 53 Yrs, F

DATE – 27.01.24

c/o → Blurring in NVA.

Ø under medication.

VA ↓

VA { 6/12
     6/9

RE → +0.75 Dsph
LE → +1.25 Dsph
Add → +1.75 Dsph.

27/01/24

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Dr. Soumyadeep Majumder
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Department of Ophthalmology