

Dr. Goyal's

Path Lab & Imaging Centre

B-51, Ganesh Nagar, Near Metro Pillar No. 109-110, New Sanganeer Road,
Sodala, Jaipur-302019

Tele : 0141-2293346, 4049787, 988704978

Website: www.dr.goyalpathlab.com | E-mail: dr.goyalpiyush@gmail.com

General Physical Examination

Date of Examination: 10/02/2024

Name: PRAVEEN KUMAR VERMA Age: 27 Sex: Male

DOB: 13-07-1986

Referred By: BOB (Medicine)

Photo ID: aadhar ID #: _____

Ht: 165 (cm)

Wt: 67 (Kg)

Chest (Expiration): 97 (cm)

Abdomen Circumference: 92 (cm)

Blood Pressure: 119/80 mm Hg PR: 77 /min

BMI 24.6

Eye Examination: Vision G/G, N/G B/L eyes.

Color vision (Partially color blindness)

Other: not significant

On examination he/she appears physically and mentally fit: Yes / No

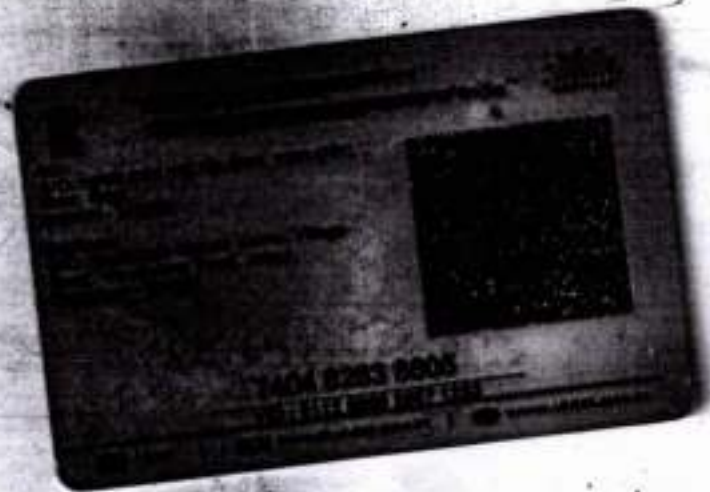
Signature Of Examinee : _____ Name of Examinee: _____

Signature Medical Examiner: _____ Name Medical Examiner: _____

Dr. Piyush Goyal
M.B.B.S. M.R.D.
RMC Reg. No. 17998



Dr. P

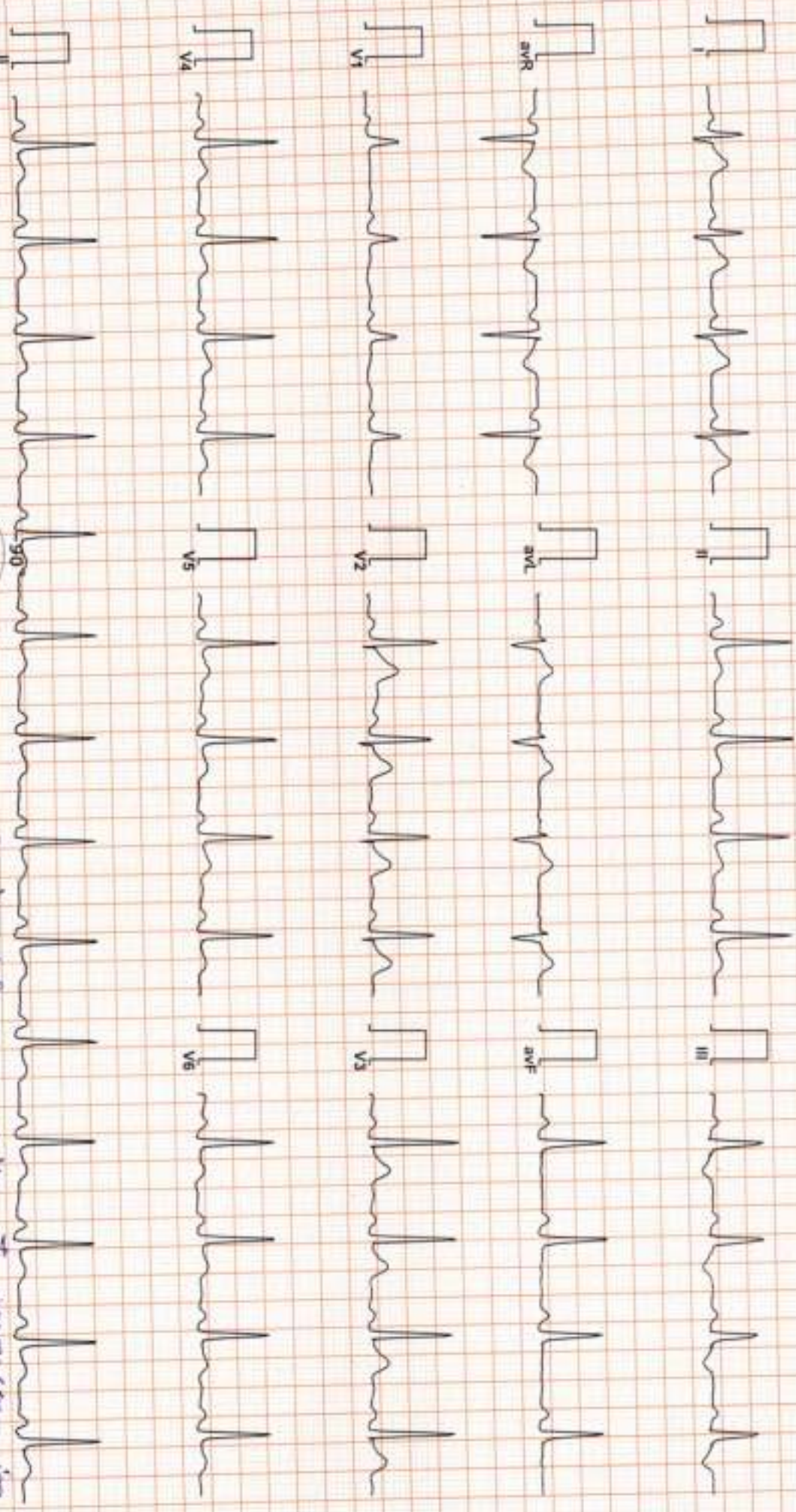


Dr. Piyush Goyal
M.B.B.S. M.R.D.
RMC Reg. No. - 01/998

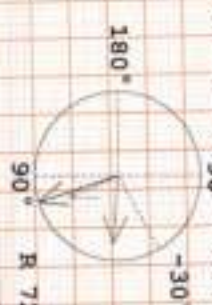
DR. GOYAL PATH LAB

ECG

4134 / MR PRAVEEN KUMAR VERMA / 27 Yrs / M / Non Smoker
Heart Rate : 86 bpm / Tested On : 10-Feb-24 13:12:55 / HF 0.05 Hz - LF 35 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s
/ Reled By: BOB



Vent Rate : 86 bpm
PR Interval : 154 ms
QRS Duration: 74 ms
QT/QTc Int : 322/368 ms
P-QRS-T axis: 66.00° 72.00° 4.00°



sinus rhythm with T inversion in lead III and aVF

Allengers ECG (Pisces)(PISZ1212310312)

Reported By:

Dr. N. K. Kumar
MBBS, DIP. CARD. (LOND)
D.E.M. (RCGP-UK)

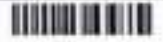
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Tele : 0141-2293346, 4049767, 9887049787
Website: www.drgoyalspathlab.com | E-mail: drgoyalplyush@gmail.com

Date :- 10/02/2024 09:40:51 Patient ID :- 12235696
NAME :- Mr. PRAVEEN KUMAR VERMA Ref. By Dr:- BOB
Sex / Age :- Male 27 Yrs 6 Mon 30 Days Lab/Hosp :-
Company :- MediWheel



Sample Type :- EDTA Sample Collected Time 10/02/2024 09:48:21 Final Authentication : 10/02/2024 14:02:00

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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BOB PACKAGE BELOW 40MALE

GLYCOSYLATED HEMOGLOBIN (HbA1C)
Method:- HPLC

6.4 H %

Non-diabetic: < 5.7
Pre-diabetics: 5.7-6.4
Diabetics: = 6.5 or higher
ADA Target: 7.0
Action suggested: > 6.5

Instrument name: ARKRAY's ADAMS Lite HA 8380V, JAPAN.

Test Interpretation:

HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of HbA to form an unstable schiff base. It is the major fraction, constituting approximately 80% of HbA1c. Formation of glycosylated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHb concentration represents the integrated values for glucose over the period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasma glucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values. The interpretation of GHb depends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb. High GHb have been reported in iron deficiency anemia. GHb has been firmly established as an index of long term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to the mean of HbA1C. Genetic variants (e.g. HbS trait, HbC trait), elevated HbF and chemically modified derivatives of hemoglobin can affect the accuracy of HbA1C measurements. The effects vary depending on the specific Hb variant or derivative and the specific HbA1c method.

Ref by ADA 2020

MEAN PLASMA GLUCOSE
Method:- Calculated Parameter

137 H mg/dL

Non Diabetic < 100 mg/dL
Prediabetic 100- 125 mg/dL
Diabetic 126 mg/dL or Higher

AJAYSINGH
Technologist

Page No: 1 of 12



Dr Abha Gupta
Fellowship Oncopathology
MD pathology
RMC 33520



Date :- 10/02/2024 09:40:51

Patient ID :- 12235696



NAME :- Mr. PRAVEEN KUMAR VERMA

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
HAEMOGARAM			
HAEMOGLOBIN (Hb)	18.5 H	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	7.53	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	60.5	%	40.0 - 80.0
LYMPHOCYTE	33.7	%	20.0 - 40.0
EOSINOPHIL	2.4	%	1.0 - 6.0
MONOCYTE	3.2	%	2.0 - 10.0
BASOPHIL	0.2	%	0.0 - 2.0
NEUT#	4.56	10 ³ /uL	1.50 - 7.00
LYMPH#	2.53	10 ³ /uL	1.00 - 3.70
EO#	0.18	10 ³ /uL	0.00 - 0.40
MONO#	0.24	10 ³ /uL	0.00 - 0.70
BASO#	0.02	10 ³ /uL	0.00 - 0.10
TOTAL RED BLOOD CELL COUNT (RBC)	6.20 H	x10 ⁶ /uL	4.50 - 5.50
HEMATOCRIT (HCT)	56.10 H	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	90.4	fL	83.0 - 101.0
MEAN CORP HB (MCH)	29.8	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	33.0	g/dL	31.5 - 34.5
PLATELET COUNT	240	x10 ³ /uL	150 - 410
RDW-CV	14.6 H	%	11.6 - 14.0
MENTZER INDEX	14.58		

The Mentzer index is used to differentiate iron deficiency anemia from beta thalassemia trait. If a CBC indicates microcytic anemia, these are two of the most likely causes, making it necessary to distinguish between them.

If the quotient of the mean corpuscular volume divided by the red blood cell count is less than 13, thalassemia is more likely. If the result is greater than 13, then iron-deficiency anemia is more likely.

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Technologist

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Sample Type :- EDTA

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
Erythrocyte Sedimentation Rate (ESR)	04	mm/hr.	00 - 13

(ESR) Methodology : Measurement of ESR by cells aggregation.

Instrument Name : Independent form Hematocrit value by Automated Analyzer (Roller-20)

Interpretation : ESR test is a non-specific indicator of inflammatory disease and abnormal protein states.

The test is used to detect, follow course of a certain disease (e.g. tuberculosis, rheumatic fever, myocardial infarction)

Levels are higher in pregnancy due to hyperfibrinogenaemia.

The "3-figure ESR" >100 value nearly always indicates serious disease such as a serious infection, malignant paraproteinaemia (CBC) Methodology: TLC, DLC Fluorescent Flow cytometry, HB SLS method, TRBC, PCV, PLT Hydrodynamically focused Impedance and MCH, MCV, MCHC, MENTZER INDEX are calculated. Instrument Name: Sysmex 6 part fully automatic analyzer XN-L, Japan

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Sample Type :- PLAIN/SERUM Sample Collected Time 10/02/2024 09:46:21 Final Authentication : 10/02/2024 13:36:23

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Method:- Enzymatic Endpoint Method	204.71 H	mg/dl	Desirable <200 Borderline 200-239 High > 240
TRIGLYCERIDES Method:- GPO-PAP	87.04	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
DIRECT HDL CHOLESTEROL Method:- Direct clearance Method	38.24	mg/dl	Low < 40 High > 60
DIRECT LDL CHOLESTEROL Method:- Direct clearance Method	151.96 H	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method:- Calculated	17.41	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	5.35 H		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method:- Calculated	3.97 H		0.00 - 3.50
TOTAL LIPID Method:- CALCULATED	569.18	mg/dl	400.00 - 1000.00
<p>TOTAL CHOLESTEROL InstrumentName:Randox Rx Imola Interpretation: Cholesterol measurements are used in the diagnosis and treatment of lipid lipoprotein metabolism disorders.</p> <p>TRIGLYCERIDES InstrumentName:Randox Rx Imola Interpretation: Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.</p> <p>DIRECT HDL CHOLESTEROL InstrumentName:Randox Rx Imola Interpretation: An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.</p> <p>DIRECT LDL-CHOLESTEROL InstrumentName:Randox Rx Imola Interpretation: Accurate measurement of LDL-Cholesterol is of vital importance in therapies which focus on lipid reduction to prevent atherosclerosis or reduce its progress and to avoid plaque rupture.</p> <p>TOTAL LIPID AND VLDL ARE CALCULATED</p>			

SURENDRAKHANGA

Dr. Rashmi Bakshi
 MBBS, MD (Path)
 RMC No. 17975/008828





Date :- 10/02/2024 09:40:51

Patient ID :- 12235696



NAME :- Mr. PRAVEEN KUMAR VERMA

Ref. By Dr:- BOB

Sex / Age :- Male 27 Yrs 6 Mon 30 Days

Lab/Hosp :-

Company :- MediWheel

Sample Type :- PLAIN/SERUM

Sample Collected Time 10/02/2024 09:48:21

Final Authentication : 10/02/2024 13:36:23

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIVER PROFILE WITH GGT			
SERUM BILIRUBIN (TOTAL) Method:- Colorimetric method	0.60	mg/dl	Up to - 1.0 Cord blood <2 Premature < 6 days <16 Full-term < 6 days= 12 1month - <12 months <2 1-19 years <1.5 Adult - Up to - 1.2 Ref-(ACCP 2020)
SERUM BILIRUBIN (DIRECT) Method:- Colorimetric Method	0.18	mg/dL	Adult - Up to 0.25 Newborn - <0.6 >- 1 month - <0.2
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.42	mg/dl	0.30-0.70
SGOT Method:- IFCC	15.8	U/L	Men- Up to - 37.0 Women - Up to - 31.0
SGPT Method:- IFCC	32.6	U/L	Men- Up to - 40.0 Women - Up to - 31.0
SERUM ALKALINE PHOSPHATASE Method:- AMP Buffer	66.90	IU/L	30.00 - 120.00
SERUM GAMMA GT Method:- IFCC	33.60	U/L	11.00 - 50.00
SERUM TOTAL PROTEIN Method:- Biuret Reagent	7.31	g/dl	6.40 - 8.30
SERUM ALBUMIN Method:- Bromocresol Green	5.00	g/dl	3.80 - 5.00
SERUM GLOBULIN Method:- CALCULATION	2.31	gm/dl	2.20 - 3.50
A/G RATIO	2.16		1.30 - 2.50

Total Bilirubin Methodology: Colorimetric method Instrument Name: Randco Rx Inova Interpretation: An increase in bilirubin concentration in the serum occurs in toxic or infectious diseases of the liver e.g. hepatitis B or obstruction of the bile duct and in these incompatible babies High levels of unconjugated bilirubin indicate that too much haemoglobin is being destroyed or that the liver is not actively treating the haemoglobin it is receiving.

AST Aspartate Aminotransferase Methodology: IFCC Instrument Name: Randco Rx Inova Interpretation: Elevated levels of AST can signal myocardial infarction, hepatic disease, muscular dystrophy and organ damage. Although heart muscle is found to have the most activity of the enzyme, significant activity has also been seen in the brain, liver, gastric mucosa, adipose tissue and kidney of humans.

ALT Alanine Aminotransferase Methodology: IFCC Instrument Name: Randco Rx Inova Interpretation: The enzyme ALT has been found to be in highest concentrations in the liver, with decreasing concentrations found in kidney, heart, skeletal muscle, pancreas, spleen and lung tissue respectively. Elevated levels of the transaminases can indicate myocardial infarction, hepatic disease, muscular dystrophy and organ damage.

Alkaline Phosphatase Methodology: AMP Buffer Instrument Name: Randco Rx Inova Interpretation: Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease.

TOTAL PROTEIN Methodology: Biuret Reagent Instrument Name: Randco Rx Inova Interpretation: Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

ALBUMIN (ALB) Methodology: Bromocresol Green Instrument Name: Randco Rx Inova Interpretation: Albumin measurements are used in the diagnosis and treatment of numerous diseases involving primarily the liver or kidneys. Globulin & A/G ratio is calculated.

Instrument Name Randco Rx Inova Interpretation: Elevations in GGT levels are more rapid and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra- or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)

SURENDRAKHANGA

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Rashmi

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Company :- MediWheel

Patient ID :- 12235696
Ref. By Dr:- BOB
Lab/Hosp :-



Sample Type :- PLAIN/SERUM

Sample Collected Time 10/02/2024 09:48:21

Final Authentication : 10/02/2024 12:24:12

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
TOTAL THYROID PROFILE			
SERUM TOTAL T3 Method:- Chemiluminescence(Competitive immunoassay)	1.330	ng/ml	0.970 - 1.690
SERUM TOTAL T4 Method:- Chemiluminescence(Competitive immunoassay)	8.160	ug/dl	5.530 - 11.000
SERUM TSH ULTRA Method:- Enhanced Chemiluminescence Immunoassay	4.010	µIU/mL	0.350 - 5.500

Interpretation: Triiodothyronine (T3) contributes to the maintenance of the euthyroid state. A decrease in T3 concentration of up to 50% occurs in a variety of clinical situations, including acute and chronic disease. Although T3 results alone cannot be used to diagnose hypothyroidism, T3 concentration may be more sensitive than thyroxine (T4) for hyperthyroidism. Consequently, the total T3 assay can be used in conjunction with other assays to aid in the differential diagnosis of thyroid disease. T3 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, Free T3 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake, or T4 uptake can be used with the total T3 result to calculate the free T3 index and estimate the concentration of free T3.

Interpretation: The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4. Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

Interpretation: TSH stimulates the production of thyroxine (T4) and triiodothyronine (T3) by the thyroid gland. The diagnosis of overt hypothyroidism by the finding of a low total T4 or free T4 concentration is readily confirmed by a raised TSH concentration. Measurement of low or undetectable TSH concentrations may assist the diagnosis of hyperthyroidism, where concentrations of T4 and T3 are elevated and TSH secretion is suppressed. These have the advantage of discriminating between the concentrations of TSH observed in thyrotoxicosis, compared with the low, but detectable, concentrations that occur in subclinical hyperthyroidism. The performance of this assay has not been established for neonatal specimens. Some drugs and some nonthyroidal patient conditions are known to alter TSH concentrations in vivo.

INTERPRETATION

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester	0.10-2.50
2nd Trimester	0.20-3.00
3rd Trimester	0.30-3.00

NARENDRAKUMAR
Technologist

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 Company :- MediWheel



Sample Type :- URINE Sample Collected Time 10/02/2024 09:48:21 Final Authentication : 10/02/2024 11:30:37

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	5.5		5.0 - 7.5
Method:- Reagent Strip(Double indicator blue reaction)			
SPECIFIC GRAVITY	1.025		1.010 - 1.030
Method:- Reagent Strip(bromthymol blue)			
PROTEIN	NIL		NIL
Method:- Reagent Strip (Sulphosalicylic acid test)			
GLUCOSE	NIL		NIL
Method:- Reagent Strip (Glu.Oxidase Peroxidase Benedict)			
BILIRUBIN	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Azo-coupling reaction)			
UROBILINOGEN	NORMAL		NORMAL
Method:- Reagent Strip (Modified cherlich reaction)			
KETONES	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Sodium Nitropruside) Rother's			
NITRITE	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Diazotization reaction)			
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	1-2	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT

VJENDRAMEENA
 Technologist

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Sample Type :- EDTA, URINE, URINE-PP Sample Collected Time 10/02/2024 09:48:21 Final Authentication : 10/02/2024 15:19:38

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
BLOOD GROUP ABO	*O* NEGATIVE		
BLOOD GROUP ABO Methodology : Haemagglutination reaction Kit Name : Monoclonal agglutinating antibodies (Span clone)			
URINE SUGAR (FASTING) Collected Sample Received	Nil		Nil
URINE SUGAR PP Collected Sample Received	Nil		Nil

AJAYSINGH, TRILOK, VIJENDRAMEENA
Technologist

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Sample Collected Time 10/02/2024 09:48:21

Final Authentication : 10/02/2024 13:36:23

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
BLOOD UREA NITROGEN (BUN)	9.6	mg/dl	0.0 - 23.0

*** End of Report ***

SURENDRAKHANGA

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Lab/Hosp :-

Final Authentication : 10/02/2024 13:46:38

BOB PACKAGE BELOW 40MALE

X RAY CHEST PA VIEW:

Both lung fields appears clear.

Bronchovascular markings appear normal.

Trachea is in midline.

Both the hilar shadows are normal.

Both the C.P.angles is clear.

Both the domes of diaphragm are normally placed.

Bony cage and soft tissue shadows are normal.

Heart shadows appear normal.

Impression :- Normal Study

(Please correlate clinically and with relevant further investigations)

Dr. NAVNEET AGARWAL (MD, DNB RADIO-DIAGNOSIS, MNAMS)
EX-SR NEURO-RADIOLOGY AIIMS NEW DELHI
(RMC No. 33613 / 14911)

*** End of Report ***

Page No: 1 of 1

Dr. Piyush Goyal
(D.M.R.D.) ANITASHARMA

Transcript by.

Dr. Piyush Goyal
M.B.B.S., D.M.R.D.
RMC Reg No. 017996

Dr. Ashish Goyal
MBBS, MD (Fetal Medicine)
Fetal Medicine Consultant
FMF ID - 260517 | RMC No 22430

Dr. Abhishek Jain
MBBS, DNB, (Radio-Diagnosis)
RMC No. 21687

Dr. Navneet Agarwal
MD, DNB (Radio Diagnosis)
RMC No. 33613/14911

Dr. Poorvi Malik
MBBS, MD, DNB (Radio Diagnosis)
RMC No. 21505

Dr. Goyal's

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Date :- 10/02/2024 09:40:51	Patient ID :- 12235696
NAME :- Mr. PRAVEEN KUMAR VERMA	Ref. By Doctor:-BOB
Sex / Age :- Male 27 Yrs 6 Mon 30 Days	Lab/Hosp :-
Company :- MediWheel	

Final Authentication : 10/02/2024 14:45:38

BOB PACKAGE BELOW 40MALE
 2D ECHO OPTION TMT (ADULT/CHILD)

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMINATION:

AO	22	mm	LA	27	Mm	IVS-D	8	mm
IVS-S	12	mm	LVID	37	Mm	LVSD	23	mm
LVPW-D	8	mm	LVPW-S	14	Mm	RV		mm
RVWT		mm	EDV		MI	LVVS		ml
LVEF	66 %				RWMA	ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

COLOUR DOPPLER:

MITRAL VALVE			
E VELOCITY	1.0	m/sec	PEAK GRADIENT
A VELOCITY	0.55	m/sec	MEAN GRADIENT
MVA BY PHT		Cm2	MVA BY PLANIMETRY
MITRAL REGURGITATION			ABSENT
AORTIC VALVE			
PEAK VELOCITY	1.13	m/sec	PEAK GRADIENT
AR VMAX		m/sec	MEAN GRADIENT
AORTIC REGURGITATION			ABSENT
TRICUSPID VALVE			
PEAK VELOCITY	0.61	m/sec	PEAK GRADIENT
MEAN VELOCITY		m/sec	MEAN GRADIENT
VMax VELOCITY			
TRICUSPID REGURGITATION			ABSENT
PULMONARY VALVE			
PEAK VELOCITY	0.85	M/sec.	PEAK GRADIENT
MEAN VELOCITY			MEAN GRADIENT
PULMONARY REGURGITATION			ABSENT

Transcript by.

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Impression--

1. Normal LV size & contractility
2. No RWMA, LVEF 66 %.
3. Normal cardiac chamber.
4. Normal valve
5. No clot, no vegetation, no pericardial effusion.


(Cardiologist)

*** End of Report ***



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Sex / Age :- Male 27 Yrs 6 Mon 30 Days
Company :- MediWheel

Patient ID :- 12235696
Ref. By Doctor :- BOB
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BOB PACKAGE BELOW 40MALE

USG WHOLE ABDOMEN

Liver is of normal size. **Echo-texture is bright.** No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is minimally distended. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Urinary bladder is well distended and showing smooth wall with normal thickness. Urinary bladder does not show any calculus or mass lesion.

Prostate is normal in size with normal echo-texture and outline.
No enlarged nodes are visualised. No retro-peritoneal lesion is identified
No significant free fluid is seen in peritoneal cavity.

IMPRESSION:

* Grade I fatty liver.

Needs clinical correlation.

*** End of Report ***