बैंक ऑफ़ बड़ौदा
Bank of Baroda

नाम
Name **Prithvi Singh Shekhawat**

कर्मचारी कूट क्र.
E.C. No. **51423**

जारीकर्ता प्राधिकारी
Issuing Authority

धारक के हस्ताक्षर
Signature of Holder

Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291

P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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General Physical Examination

Date of Examination: 13/05/2023

Name: PRITHVI SINGH SHEKHAWAT Age: 55 DOB: 30/07/1967 Sex: MALE

Referred By: BANK of BARODA

Photo ID: ID CARD ID #: 51423

Ht: 168 (cm) Wt: 95 (Kg)

Chest (Expiration): 112 (cm) Abdomen Circumference: 115 (cm)

Blood Pressure: 125 / 85 mm Hg PR: 78 / min RR: 18 / min Temp: Afebrile

BMI 33

Eye Examination: RE - 6/6, N6 NCB
LE - 6/6, N6 NCB

Other: No

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

Signature Of Examine : ---------- **Name of Examinee:** PRITHVI SINGH SHEKHAWAT

Signature Medical Examiner : ---------- **Name Medical Examiner** U.C. GUPTA

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NAME :- Mr. PRITHVI SINGH SHEKHAWAT	Patient ID :-1223286	Date :- 13/05/2023	09:08:04
Age :- 55 Yrs 9 Mon 14 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP ABOVE 40 MALE			
HAEMOGARAM			
HAEMOGLOBIN (Hb)	**11.3** L	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	**11.30** H	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	58.0	%	40.0 - 80.0
LYMPHOCYTE	35.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	5.29	x10^6/uL	4.50 - 5.50
HEMATOCRIT (HCT)	**37.80** L	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	**71.0** L	fL	83.0 - 101.0
MEAN CORP HB (MCH)	**21.3** L	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	**29.8** L	g/dL	31.5 - 34.5
PLATELET COUNT	291	x10^3/uL	150 - 410
RDW-CV	**16.7** H	%	11.6 - 14.0

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR) Methord:- Westergreen	12	mm in 1st hr	00 - 15

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as

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(CBC): **Methodology**: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Methord - GOD POD	112.0	mg/dl	70.0 - 115.0

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm,
hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin
therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) Methord:- GOD PAP	**157.0** H	mg/dl	70.0 - 140.0

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C)			
Methord:- CAPILLARY with EDTA	6.7	mg%	Non-Diabetic < 6.0 Good Control 6.0-7.0 Weak Control 7.0-8.0 Poor control > 8.0
MEAN PLASMA GLUCOSE	**146** H	mg/dL	68 - 125
Methord:- Calculated Parameter			

INTERPRETATION
AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

CLINICAL NOTES
In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.
Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al.]

1. Erythropoiesis
- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation
- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction
- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others
- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use,chronic renal failure
- Decreased HbA1c: hypertriglyceridemia,reticulocytosis, chronic liver disease, aspirin, vitamin C and E,splenomegaly, rheumatoid arthritis or drugs

Note:
1 Shortened RBC life span –HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs), such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time.
2 Abnormal forms of hemoglobin – The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

Advised:
1 To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
2 Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.
estimated Average Glucose (eAG) : based on value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria

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HAEMATOLOGY

BLOOD GROUP ABO Methord:- Haemagglutination reaction	"B" POSITIVE

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Methord:- CHOD-PAP methodology	140.00	mg/dl	Desirable <200 Borderline 200-239 High> 240
InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Methord:- GPO-PAP	98.70	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
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.			
DIRECT HDL CHOLESTEROL Methord:- Direct clearance Method	35.00	mg/dl	MALE- 30-70 FEMALE - 30-85
Instrument Name:Rx Daytona plus **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.			
LDL CHOLESTEROL Methord:- Calculated Method	88.55	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Methord:- Calculated	19.74	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Methord:- Calculated	4.00		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Methord:- Calculated	2.53		0.00 - 3.50
TOTAL LIPID Methord:- CALCULATED	433.94	mg/dl	400.00 - 1000.00

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended
3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol

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BIOCHEMISTRY

transport, the process by which cholesterol is eliminated fromperipheral tissues.

Comments: **1-** ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all atherogenic lipoproteins (mainly LDL & VLDL). The Non HDL Cholesterolis used as a secondary target of therapy in persons with triglycerides >=200 mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.

2 -For calculation of CHD risk,history of smoking, any medication for hypertension & current B.P. levels are required.

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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Methord:- DMSO/Diazo	0.67	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Methord:- DMSO/Diazo	0.41	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Methord:- Calculated	0.26	mg/dl	0.30-0.70
SGOT Methord:- IFCC	28.8	U/L	0.0 - 40.0
SGPT Methord:- IFCC	21.7	U/L	0.0 - 40.0
SERUM ALKALINE PHOSPHATASE Methord:- DGKC - SCE	120.00	U/L	53.00 - 141.00
SERUM GAMMA GT Methord:- Szasz methodology Instrument Name Randox Rx Imola Interpretation Elevations in GGT levels areseen earlier 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)are observed with infectious hepatitis	15.60	U/L	10.00 - 45.00
SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	7.17	g/dl	6.00 - 8.40
SERUM ALBUMIN Methord:- Bromocresol Green	4.12	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	3.05	gm/dl	2.20 - 3.50
A/G RATIO	1.35		1.30 - 2.50

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.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc.Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA Methord:- Urease/GLDH	18.30	mg/dl	10.00 - 50.00

InstrumentName: HORIBA CA 60 **Interpretation** : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE Methord:- Jaffe's Method	1.25	mg/dl	Males : 0.6-1.50 mg/dl Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID	5.69	mg/dl	2.40 - 7.00

InstrumentName:HORIBA YUMIZEN CA60 Daytona plus **Interpretation**: **Elevated Urate**:High purine diet,Alcohol• Renal insufficiency,Drugs , Polycythaemia vera, Malignancies,Hypothyroidism,Rare enzyme defects ,Downs syndrome,Metabolic syndrome, Pregnancy,Gout.

SODIUM Methord:- ISE	141.2	mmol/L	135.0 - 150.0

Interpretation: Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss,Drugs,Oedematous states,Legionnaire's disease and other chest infections,pseudonatremia, Hyperlipidaemias and paraproteinaemias,endocrine diseases ,SIADH.

POTASSIUM Methord:- ISE	5.03	mmol/L	3.50 - 5.50

Interpretation: A. Elevated potassium (hyperkalaemia)• Artefactual,Physiological elevation,Drugs, Pathological states,Renal failure Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia)Drugs, Liquoric,Diarrhoea and vomiting,Metabolic alkalosis,Corticosteroid excess, Oedematous state,Anorexia nervosa/bulimia

CHLORIDE Methord:- ISE	97.6	mmol/L	94.0 - 110.0

Interpretation: Used for Electrolyte monitoring.

SERUM CALCIUM Methord:- Colorimetric method	8.99	mg/dl	8.10 - 11.50

InstrumentName:Rx Daytona plus **Interpretation**: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN Methord:- Biuret Reagent	7.17	g/dl	6.00 - 8.40

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SERUM ALBUMIN Methord:- Bromocresol Green	4.12	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	3.05	gm/dl	2.20 - 3.50
A/G RATIO	1.35		1.30 - 2.50

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.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.

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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
SPECIFIC GRAVITY	1.015		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/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		

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CLINICAL PATHOLOGY

URINE SUGAR (FASTING) Collected Sample Received	Nil	Nil

RAVIMEENA

Technologist

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

NAME :- Mr. PRITHVI SINGH SHEKHAWAT		Patient ID :-1223286	Date :- 13/05/2023 09:08:04
Age :-	55 Yrs 9 Mon 14 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Male	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 13/05/2023 17:25:18

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
PSA (PROSTATE SPECIFIC ANTIGEN) -TOTAL Methord :- Methodology: CLIA	1.017	ng/mL	0.00-4.00

CLINICAL NOTES:- Prostate-specific antigen (PSA)is a 34-kD glycoprotein produced almost exclusively by the prostate gland.

PSA is normally present in the blood at very low levels. Increased levels of PSA may suggest the presence of prostate cancer.

1.Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not
recommended as they falsely elevate levels

2. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical
findings and other investigations

3. Physiological decrease in PSA level by 18% has been observed in sedentary patients either due to supine position or suspended sexual activity

Clinical Use

• An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more
affected first degree relatives.
• Follow up and management of Prostate cancer patients
• Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

NOTE

PSA levels can be also increased by prostatitis, irritation, benign prostatic hyperplasia (BPH), and recent ejaculation, producing a false positive result. Digital rectal examination (DRE) has been shown in several studies to produce an increase in PSA. However, the effect is clinically insignificant, since DRE causes the most substantial
increases in patients with PSA levels already elevated over 4.0 ng/mL.

Obesity has been reported to reduce serum PSA levels. Delayed early detection may partially explain worse outcomes in obese men with early prostate cancer. Aftertreatment, higher BMI also correlates to higher risk of recurrence.

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IMMUNOASSAY

TOTAL THYROID PROFILE

THYROID-TRIIODOTHYRONINE T3	1.06	ng/mL	0.70 - 2.04

Methord:- ECLIA

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is useful in evaluating differantial diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with " TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & "serum TSH levels8.Normal T4 levels accompanied by " T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or" T3 & "1 10.Normal T3 & T4 along with " TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & " T4 along with " TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with " TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher [illegible] is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly. ***

THYROID- THYROXINE (T4)	9.76	µIU/ml	5.10 - 14.10

Methord:- ECLIA

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TSH	1.680	µIU/mL	0.350 - 5.500

Methord:- ECLIA

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7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
9.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism
13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,rarely they can result from TSH secreting pituitary tumours.

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*** End of Report ***

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NAME:	MR. PRITHVI SINGH SHEKHAWAT	AGE/SEX	55 YRS/M
REF.BY	BANK OF BARODA	DATE	13/05/2023

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

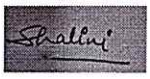
Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

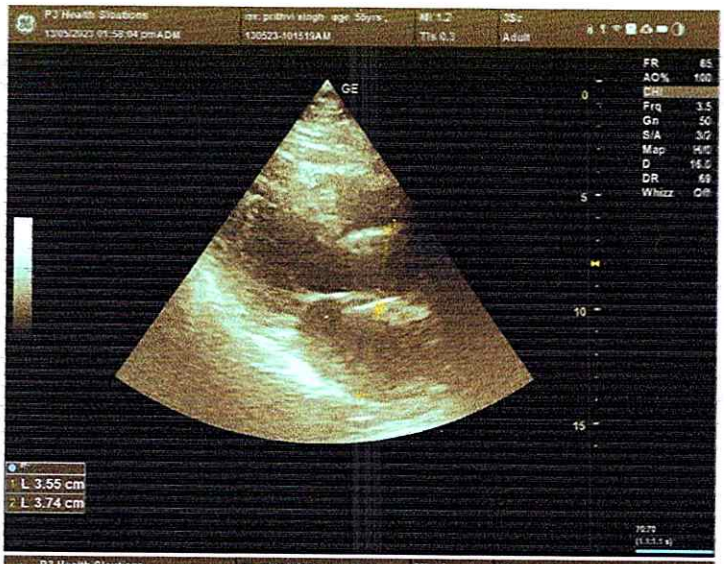
Thoracic soft tissue and skeletal system appear unremarkable.

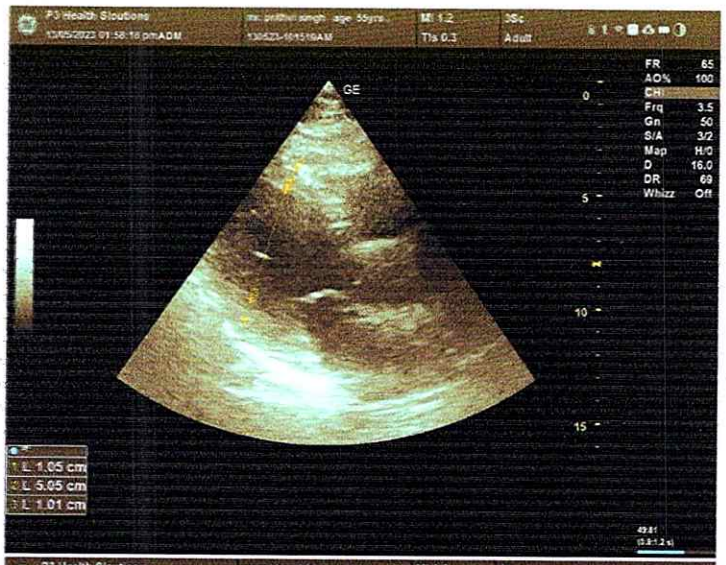
Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected.



DR.SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC No.: 21954


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 1.2
TIs 0.3
Adult
GE
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
S/A 3/2
Map H/0
D 16.0
DR 69
Whizz Off
1 L 3.55 cm
2 L 3.74 cm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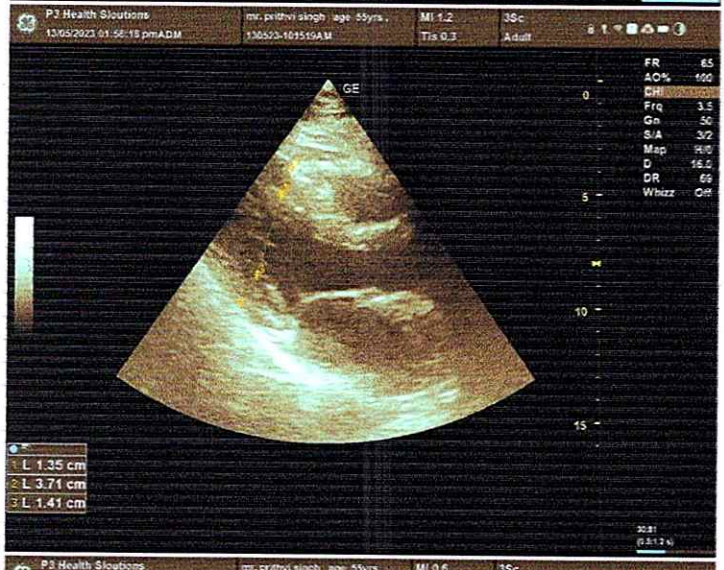
MI 1.2
TIs 0.3
Adult
GE
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
S/A 3/2
Map H/0
D 16.0
DR 69
Whizz Off
1 L 1.05 cm
2 L 5.05 cm
3 L 1.01 cm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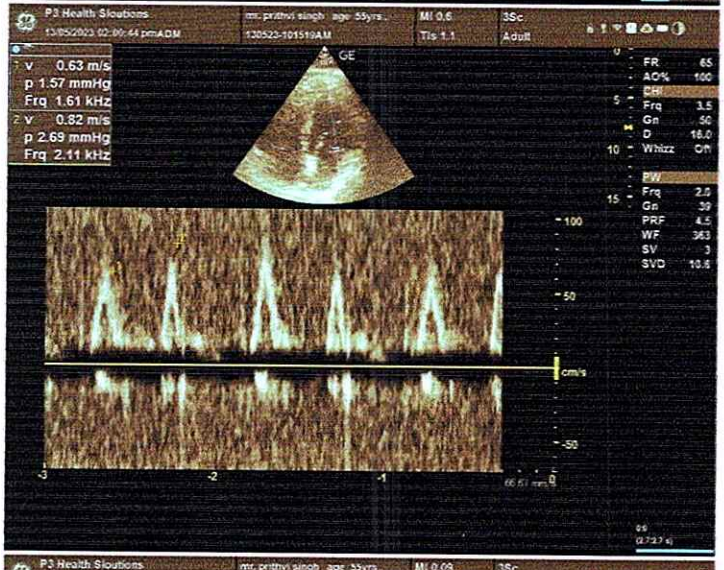
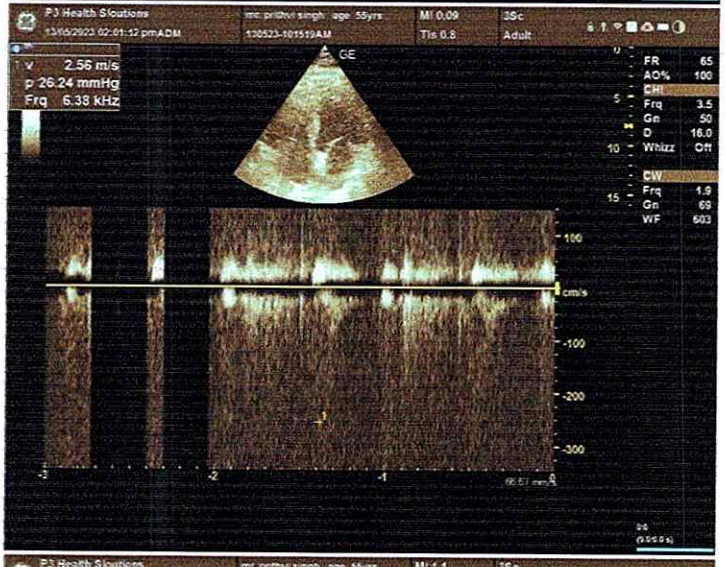
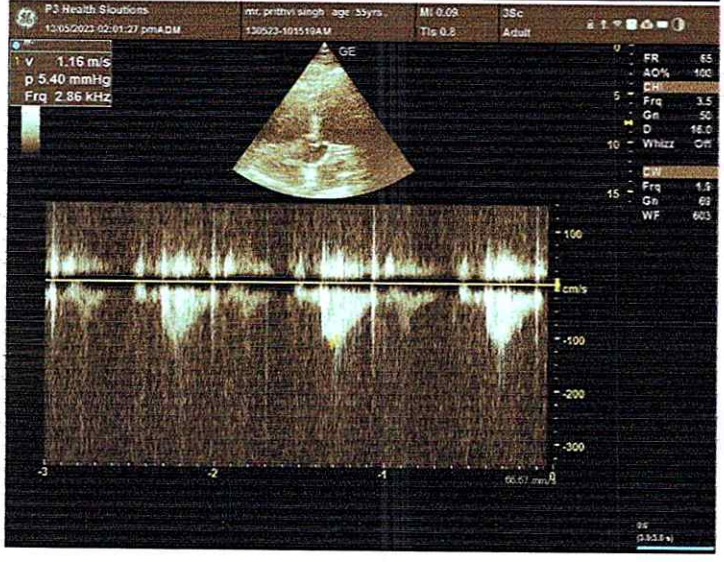
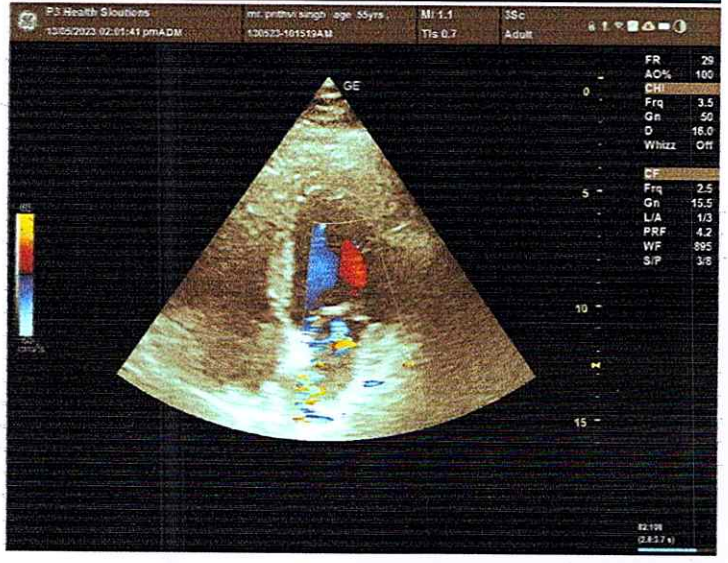
MI 1.2
TIs 0.3
Adult
GE
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
S/A 3/2
Map H/0
D 16.0
DR 69
Whizz Off
1 L 1.35 cm
2 L 3.71 cm
3 L 1.41 cm


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 0.6
TIs 0.5
Adult
GE
v 0.73 m/s
p 2.15 mmHg
Frq 1.90 kHz
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
D 16.0
Whizz Off
PW
Frq 2.0
Gn 39
PRF 4.5
WF 363
SV 3
SVD 6.2
cm/s


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 0.6
TIs 1.1
Adult
GE
1 v 0.63 m/s
p 1.57 mmHg
Frq 1.61 kHz
2 v 0.82 m/s
p 2.69 mmHg
Frq 2.11 kHz
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
D 16.0
Whizz Off
PW
Frq 2.0
Gn 39
PRF 4.5
WF 363
SV 3
SVD 10.6
cm/s


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 0.09
TIs 0.8
Adult
GE
v 2.56 m/s
p 26.24 mmHg
Frq 6.38 kHz
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
D 16.0
Whizz Off
CW
Frq 1.9
Gn 69
WF 603
cm/s


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 0.09
TIs 0.8
Adult
GE
v 1.16 m/s
p 5.40 mmHg
Frq 2.86 kHz
FR 65
AO% 100
CHI
Frq 3.5
Gn 50
D 16.0
Whizz Off
CW
Frq 1.9
Gn 69
WF 603
cm/s


P3 Health Sloutions
mr. prithvi singh age 55yrs.
130523-101519AM
MI 1.1
TIs 0.7
Adult
GE
FR 29
AO% 100
CHI
Frq 3.5
Gn 50
D 16.0
Whizz Off
CF
Frq 2.5
Gn 15.5
L/A 1/3
PRF 4.2
WF 895
S/P 3/8

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Registration Date: 13/05/2023	Ref. by: BANK OF BARODA

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARIDIOGRAPHIC WINDOW MORPHOLOGY:

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

M.MODE EXAMITATION:

AO	3.5	Cm	LA	3.7	cm	IVS-D	1.0	cm
IVS-S	1.3	cm	LVID	5.0	cm	LVSD	3.7	cm
LVPW-D	1.0	cm	LVPW-S	1.4	cm	RV		cm
RVWT		cm	EDV		Ml	LVVS		ml
LVEF	55-60%			RWMA		ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

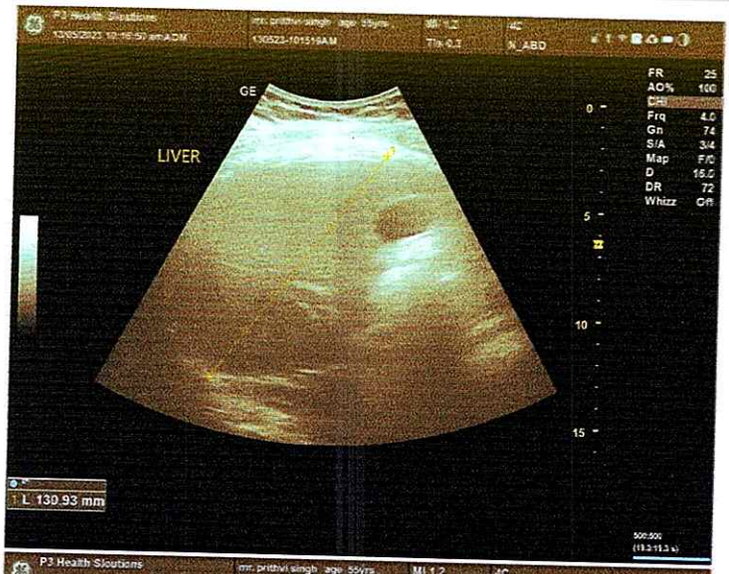
COLOUR DOPPLER:

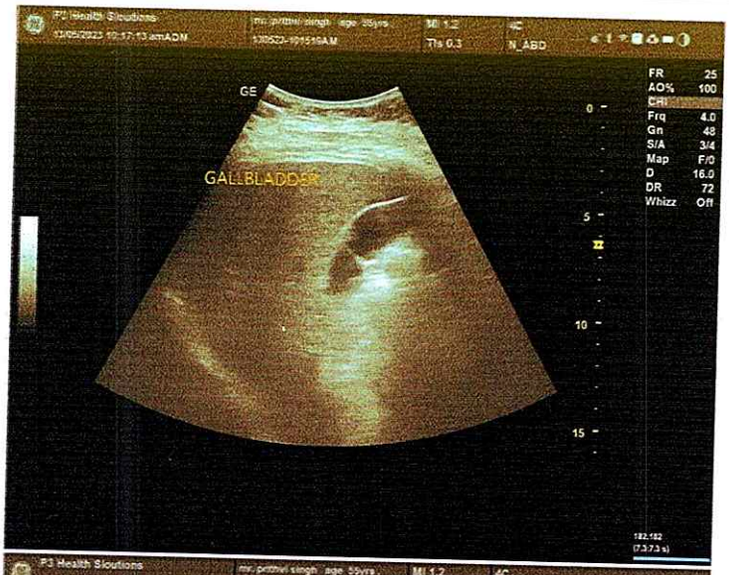
MITRAL VALVE					
E VELOCITY	0.63	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.82	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION			MILD		
AORTIC VALVE					
PEAK VELOCITY	1.16	m/sec	PEAK GRADIENT		mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION			ABSENT		
TRICUSPID VALVE					
PEAK VELOCITY		m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY		m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION			MILD		
PULMONARY VALVE					
PEAK VELOCITY	0.73	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VALOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION			ABSENT		

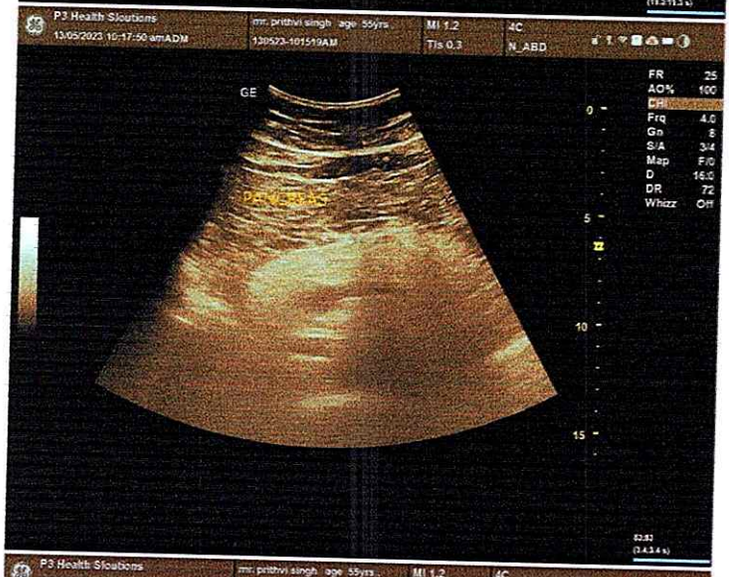
Impression—

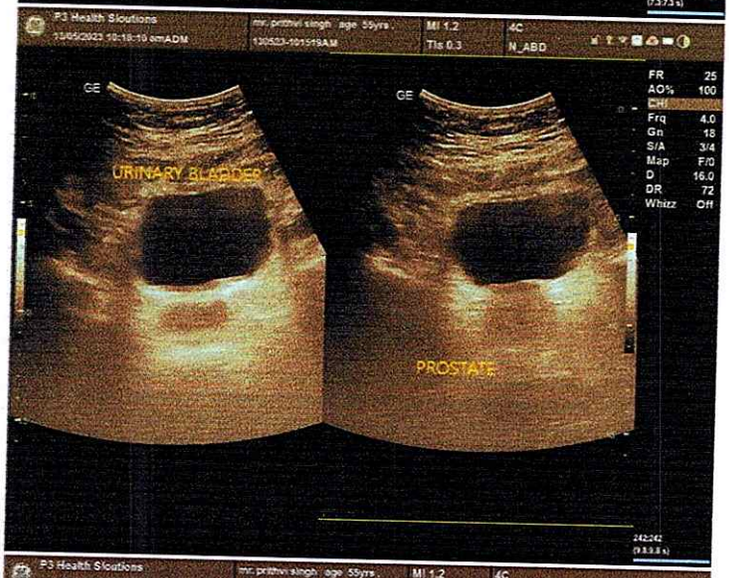
- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- MILD TR/ PAH (RVSP 26 MMHG+ RAP), MILD MR.
- GRADE 1 DIASTOLIC DYSFUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

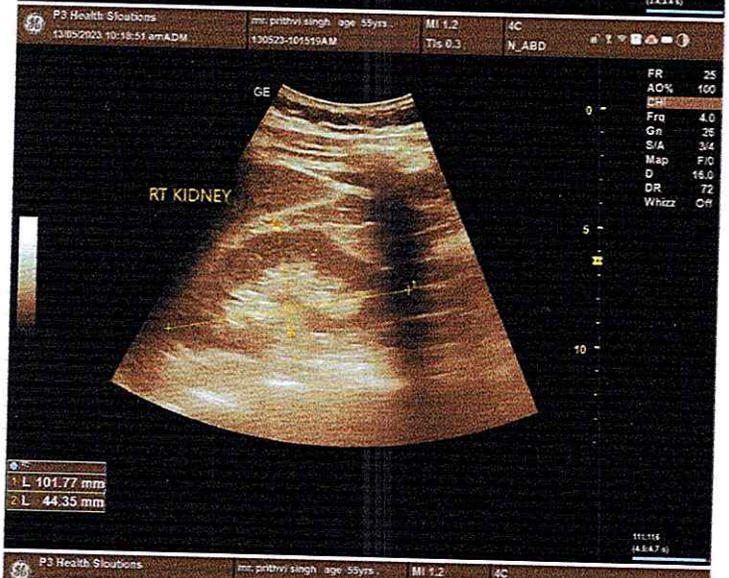
(Cardiologist)

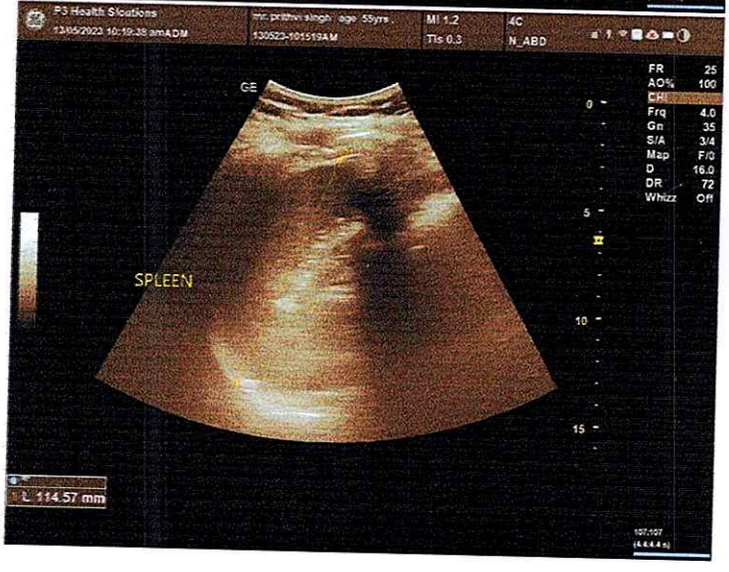

LIVER
L 130.93 mm

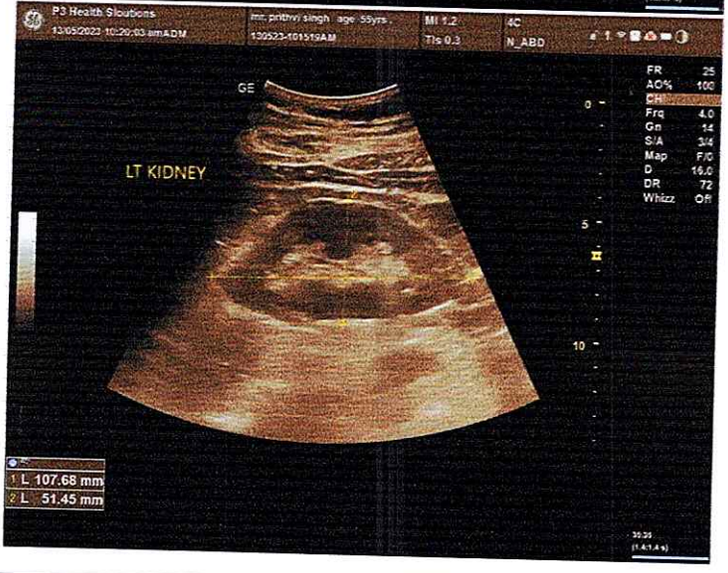

GALLBLADDER


PELVIS


URINARY BLADDER
PROSTATE


RT KIDNEY
L 101.77 mm
L 44.35 mm


SPLEEN
L 114.57 mm


LT KIDNEY
L 107.68 mm
L 51.45 mm

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ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (13.0 cm). **Echotexture is increased obscuring periportal echogenicity.** 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 well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. 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 (11.4 cm). Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.
Right kidney is measuring approx. 10.1 x 4.4 cm.
Left kidney is measuring approx. 10.7 x 5.1 cm.

Urinary bladder does not show any calculus or mass lesion.

Prostate is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
No significant free fluid is seen in pelvis.

IMPRESSION:

- **Grade 2 fatty liver.**
- **Rest no significant abnormality is detected.**

Shalini

DR.SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC no.: 21954

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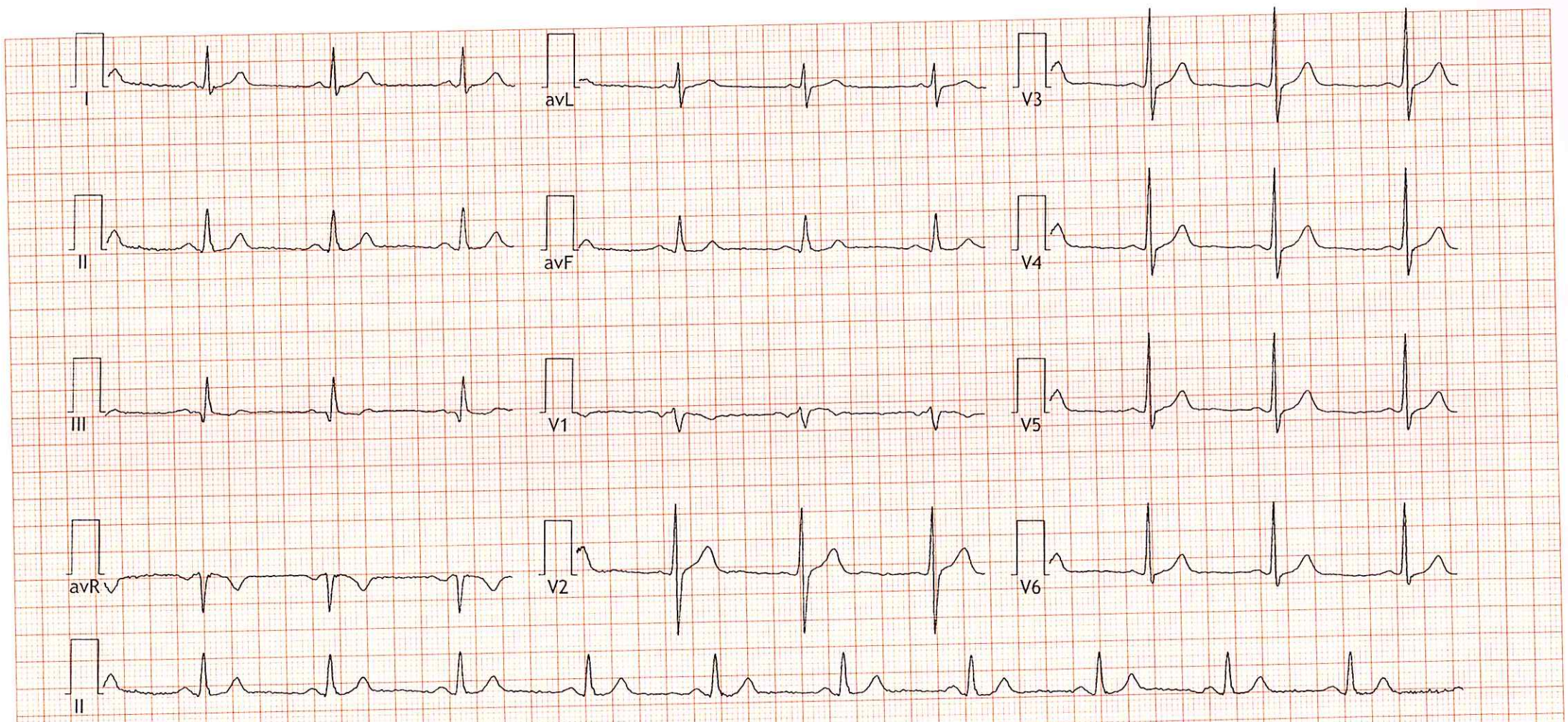
3-14, Vidhyanagar Nagar, Enclave, Phase-2, Jaipur
12229451323639/Mr Prithvi singh Shekhawat 55Yrs/Male Kgs/ Cms BP: ___/___ mmHg
Ref.: BANK OF BARODA Test Date: 13-May-2023(12:43:24) Notch: 50Hz 0.05Hz - 100Hz 10mm/mV 25mm/Sec

HR: 63 bpm

PR Interval: 150 ms
QRS Duration: 92 ms
QT/QTc: 349/360ms
P-QRS-T Axis: 46 - 59 - 26 (Deg)



FINDINGS: Normal Sinus Rhythm
Vent Rate : 63 bpm; **PR Interval :** 150 ms; **QRS Duration:** 92 ms; **QT/QTc Int :** 349/360 ms
P-QRS-T axis: 46• 59• 26• (Deg)
Comments :

Dr. Naresh Kumar Mohanka
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RHQ•