Marengo Asia Hospitals

4110128

NABH
OUR ACCREDITATIONS

DEPARTMENT OF LABORATORY SERVICES

Patient	Mr. PRATEEK JAIN	**Lab No/ManualNo**	4110128/
UHIDNo/IPNO	400216251	**CollectionDate**	23/09/2024 10:19AM
Age/Gender	35 Years/Male	**Receiving Date**	23/09/2024 11:29AM
Bed No/Ward	OPD	**Report Date**	23/09/2024 4:37PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry					
MediWheel Full Body Annual Plus					
***SERUM CREATININE**					Serum
Serum - Creatinine	1.0	mg/dL	0.8 - 1.2	Enzymatic (Creatinine Amidohydrolase)	

Interpretation:-
Serum creatinine and urinary creatinine excretion is a function of lean body mass in normal persons and shows little or no response to dietary changes. The serum creatinine concentration is higher in men than in women. Since urinary creatinine is excreted mainly by glomerular filtration, with only small amounts due to tubular secretion, serum creatinine and a 24-hour urine creatinine excretion can be used to estimate the glomerular filtration rate.Serum creatinine is increased in acute or chronic renal failure, urinary tract obstruction, reduced renal blood flow, shock,dehydration, and rhabdomyolysis. Causes of low serum creatinine concentration include debilitation and decreased muscle mass. common in the elderly, in the bedridden, and in patients with advanced malignancy.

***URIC ACID (SERUM)**					Serum
Serum Uric Acid	7.6	mg/dL	4.0 - 8.6	Uricase	

Interpretation:-
Uric acid is the end product of purine metabolism. Elevationsof uric acid occur in renal failure, prerenal azotemia, gout, lead poisoning,excessive cell destruction (e.g., following chemotherapy), hemolytic anemia,and congestive heart failure and after myocardial infarction. Uric acid is alsoincreased in some endocrine disorders, acidosis, toxemia of pregnancy,hereditary gout, and glycogen storage disease type I. A low uric acidconcentration may be found following treatment by some drugs (e.g., low-doseaspirin), with low dietary intake of purines, in the presence of renal tubulardefects, and in xanthinuria.

***LIPID PROFILE SERUM** Serum

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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L-Low H-High CH - Critical High CL - Critical Low

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Cholesterol		221	mg/dL	Method :Cholesterol oxidase, esterase, peroxidase Adults (>=20 Years) Desirable <200 mg/dL, Borderline200-239 mg/dL High>240 mg/dL	Cholesterol oxidase, esterase,peroxidase
HDL Cholesterol	**L**	**26**	mg/dL	40 - 60	Direct measure, PTA/MgCl2
Triglycerides		154	mg/dL	Method : Enzymatic Normal < 150 mg/dl, Borderline High 150-199 mg/dl, High 200-499 mg/dl, Very High>=500 mg/dl	Enzymatic method
Cholesterol VLDL		30.8	mg/dL	0 - 40	Calculated
Cholesterol / HDL Ratio		8.5			Calculated
LDL	**H**	**164.2**	mg/dL	0 - 100	Calculated
LDL/HDL Ratio		6.32			Calculated

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NCEP Guidelines:

Lipid	Desirable	Borderline High	High	Very High
Total Cholesterol	< 200	200-239	> 240	
LDL Cholesterol	< 100	130-159	160-189	> 190
HDL Cholesterol	> 60	< 40 (Risk factor)		
Triglycerides	< 150	150-199	200-499	> 500

***BLOOD UREA** — Serum

Serum - Urea	20	mg/dL	19 - 43	Urease with indicator dye

Interpretation:-

The major pathway of nitrogen excretion is in the form of urea that is synthesized in the liver, released into the blood, and cleared by the kidneys. A high serum urea nitrogen occurs in glomerulonephritis, shock, urinary tract obstruction, pyelonephritis, and other causes of acute and chronic renal failure. Severe congestive heart failure, hyperalimentation, diabetic ketoacidosis, dehydration, and bleeding from the gastrointestinal tract elevate urea nitrogen. Low urea nitrogen often occurs in normal pregnancy, with decreased protein intake, in acute liver failure, and with intravenous fluid administration.

***FT3 + FT4 + TSH** — Serum

Free T3	3.20	pg/mL	2.77 - 5.27	Chemiluminescence
Free T4	1.41	ng/dL	0.78 - 2.19	Chemiluminescence
Thyroid Stimulating Hormone	2.47	mIU/L	0.46 - 4.68	Chemiluminescence
TSH Interpretation				

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Interpretation :
Elevated free triiodothyronine (FT3) values are associated with thyrotoxicosis or excess thyroid hormone replacement.
Useful for : It provides further confirmation of hyperthyroidism, supplementing the tetraiodothyronine (T4), sensitive thyrotropin (S TSH), and total T3 assays Evaluating clinically euthyroid patients who have an altered distribution of binding proteins Monitoring thyroid hormone replacement therapy Free triiodothyronine(FT3) is not a sensitive test for hypothyroidism.
Elevated values suggest hyperthyroidism or exogenous thyroxine (T4).
Decreased values suggest hypothyroidism.
The test generally is used as a second-line test after thyroid- stimulating hormone (TSH) to help evaluate TSH changes.

The free thyroxine value, combined with the TSH value, gives a more accurate picture of the thyroid status in patients with abnormal thyroid-binding globulin levels such as those who are pregnant or those who are receiving treatment with estrogens, androgens, phenytoin, or salicylates.

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Note
1. TSH levels are subject to circadian variation. Levels may vary during different time intervals .
2. Drugs which can lower TSH without inducting thyroid dysfunction are
* Glucocorticoids in high dose during initial treatment or prolonged exposure of glucocorticoid therapy
* Dopamine or Dobutamine
* Octreotide

NEONATAL BIOLOGICAL REFERENCE RANGE

Test Name	Age	Unit	Biological Ref. Range
FT3:	0- 1 month	pg/ml	(3.0 - 6.0)
	1month - 23 month	pg/ml	(3.28- 5.19)
	24month - 12 years	pg/ml	(3.34 - 4.80)
FT4:	0- 03 days	ng/dL	(2.0 - 5.0)
	03days - 01 month	ng/dL	(0.9- 2.2)
	01month - 18 years	ng/dL	(0.8 - 2.0)
TSH:	0- 03days	mIU/L	(1.0- 20.0)
	03days - 01 month	mIU/L	(0.5- 6.5)
	01month - 18 years	mIU/L	(0.5 - 6.0)

***GLUCOSE (FASTING).** PLASMA(FLUORIDE)

Glucose F	93.00	mg/dL	70.00 - 100.00	Glucose oxidase ,hydrogen Peroxidase

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Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

End Of Report

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Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry						
MediWheel Full Body Annual Plus						
***GLUCOSE (PP)**						PLASMA(FLUORIDE)
Glucose - Post Prandial (PPBS)	**H**	**149**	mg/dL	40 - 140	Glucose oxidase ,hydrogen Peroxidase	

Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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Regd No: MCI 9576

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Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry					
MediWheel Full Body Annual Plus					
***GLYCOCYLATED HEMOGLOBIN (HBA1C)**					EDTA Blood
HbA1C -(Glycosylated Hemoglobin)	5.6	%		HPLC	

Biological Ref. Range:

Hb A1c (%) - Degree of Glucose control
<5.6% - Normal
5.7% to 6.4% - Prediabetes
>=6.5% - Diabetes
<7% - ADA Target
>8% - Action Suggested

End Of Report

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Biochemistry

MediWheel Full Body Annual Plus

***LIVER FUNCTION TEST (LFT) SERUM** — Serum

Test Name		Result	Unit	Bio. Ref. Range	Method
Serum -Total Protein		8.0	g/dL	6.3 - 8.2	Biuret Method
Serum - Albumin		4.0	g/dL	3.5 - 5.0	BCG
Globulin		4	g/dL	2 - 5	Calculated
AG Ratio		1		1 - 2	Calculated
Serum - SGOT / AST (Aspartate Amino Transferase)		41	U/L	17 - 59	Kinetic(leuco dye) with pyridoxal 5 phosphate
Serum - SGPT / ALTV (Alanine Amino Transferase)	**H**	**52**	U/L	10 - 40	Reflectance spectrophotometry/ kinetic with pyridoxal -5-phosphate
Serum- GGT		19	U/L	15 - 73	L-G-glutamyl-p-nitroanilide
Serum - Alkaline Phosphatase		80	U/L	38 - 126	P-nitrophenyl phosphate
Bilirubin Total		0.7	mg/dL	0.2 - 1.3	Diphylline,Diazonium Salt
Bilirubin Direct		0.3	mg/dL		Calculated
				Calculated Neonate Ref. Range. 0 - 30 Days - (0.0 -0.6) mg/dL Adult Ref. Range. >30 Days - (0.0-0.3) mg/dL	
Bilirubin Indirect		0.4	mg/dL	0.0 - 1.1	Dual wavelength

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Interpretation:-
Total bilirubin in serum and plasma is the sum of unconjugated bilirubin (Bu), mono- and di-glucuronide conjugated bilirubin (Bc)?, and delta bilirubin (DELB), a bilirubin fraction covalently bound to albumin. With the exception of anicteric jaundice, total serum bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.
Jaundice has been classified as unconjugated and conjugated hyperbilirubinemia. Increased plasma-unconjugated bilirubin is commonly seen in hemolytic disorders, Gilbert's syndrome, Crigler-Najjar syndrome, neonatal jaundice, and ineffective erythropoiesis and in the presence of drugs competing for glucuronide. Increased plasma-conjugated bilirubin occurs with hepatobiliary disorders, including intrahepatic and extrahepatic biliary tree obstruction, liver cell damage, Dubin-Johnson syndrome, and Rotor syndrome.Neonatal bilirubin, the sum of Bu and Bc, is increased in erythroblastosis fetalis (hemolytic disease of the newborn), which causes jaundice in the first two days of life. Other causes of neonatal jaundice include physiologic jaundice, hematoma/hemorrhage, hypothyroidism, and obstructive jaundice.
Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver. Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, and drug-induced hepatitis.
Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumors, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.
Alkaline phosphatase is present mainly in bone, liver, kidney, intestine, placenta, and lung. Serum alkaline phosphatase may be elevated in increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increase alkaline phosphatase activity; alkaline phosphatase activity may be increased in renal infarction and failure and in the complications of pregnancy. Low alkaline phosphatase activity may occasionally be seen in hypothyroidism.

Serum proteins transport drugs and metabolites and maintain plasma osmotic pressure. Most serum proteins are synthesized in the liver, with the exception of gamma globulins. One of the most important serum proteins produced in the liver is albumin. Total serum protein concentration can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenstrom's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Total protein concentration is occasionally increased in collagen diseases, lupus erythematosus, and other instances of chronic infection or inflammation. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

End Of Report

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Clinical Pathology

MediWheel Full Body Annual Plus

***URINE ROUTINE EXAMINATION** — Urine

Test Name	Result	Unit	Bio. Ref. Range	Method
Physical Examination:				
Volume	20	mL		Physical Examination
Colour	Yellow		Pale Yellow	Physical Examination
Appearence:	Clear			Physical Examination
Chemical Examination:				
pH	5.0		4.6 - 8.0	Indicator Test
Specific Gravity	1.025		1.000 - 1.035	Ion Exchange
Protein	Nil			Protein Error of Indicator/ Sulphosalicylic Acid
Glucose	Nil			Glucose Oxidase - Peroxidase/ Benedict's Method
Ketone	Nil			Nitroprusside Reaction / Rothera's Method
Bilirubin	Absent			Diazonium Method/ Fouchet's Method
Urobilinogen	Normal			Ehrlich's Reaction/ Ehrlich's Reagent
Nitrite:	Negative		Negative	Diazotization Reaction
Blood :	Nil			Peroxidase Reaction
Microscopic Examination:				
Casts	Nil		Nil	Microscopy
Epithelial cells	0-2	/HPF	0 - 1	Microscopy
Pus Cells	0-2	/HPF	0 - 5	Microscopy
RBC	0-2	/HPF	0 - 2	Microscopy
Crystals	Amorphous		Nil	Microscopy

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DMC Regd No: 63478

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Interpretation:-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders.
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever. Protein reported in urine as Negative(<15 mg/dl), 1+(>=30 mg/dl), 2+(>=100 mg/dl) & 3+(>=500 mg/dl).
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications. Glucose reported in urine as Negative (<25 mg/dl), 1+(>=50 mg/dl), 2+(>=100 mg/dl), 3+(>=300 mg/dl), 4+(>=1000 mg/dl).
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or hemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high.Positive nitrite test suggestive of 105 or more organism in 1 ml of urine specimen.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetis insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia.

End Of Report

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Bed No/Ward	OPD	**Report Date**	23/09/2024 1:25PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result		Unit	Bio. Ref. Range	Method	Sample

Haematology

MediWheel Full Body Annual Plus

***ERYTHROCYTE SEDIMENTATION RATE (ESR)** — EDTA Blood

Erythrocyte Sedimentation Rate (ESR)	**H**	**31**	mm/hr	0 - 15	Modified westergren Method

Interpretation:-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post-partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

COMPLETE BLOOD COUNT(CBC) EDTA WHOLE BLOOD — EDTA Blood

Haemoglobin	14.5	g/dL	13.5 - 18.0	Spectrophotometry (Cyanide free method)
Hematocrit/PCV	43.3	%	42.0 - 52.0	Derived from RBC pulse hieght detection
RBC COUNT	4.71	10^6/µL	4.70 - 6.00	Electrical Impedance
MCV	92.0	fl	78.0 - 100.0	Calculated
MCH	30.7	pg	27.0 - 31.0	Calculated
MCHC	33.4	g/dL	31.5 - 34.5	Calculated
RDW-CV	12.6	%	11.5 - 14.0	Calculated
Platelet count	230	10^3/µL	150 - 450	Electrical Impedance
Total Leucocyte Count (TLC)	6.66	10^3/µL	4.00 - 10.50	Double Hydrodynamic Sequential System (DHSS)

Differential Leucocyte Count

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

Dr. Nutan Sood
MD (Pathology)
Senior Consultant,Laboratory Services,
Regd No: HN 012481

L-Low H-High CH - Critical High CL - Critical Low

North East Health Care Pvt Ltd
Registered Address: Pratiksha Hospital, Borbari, VIP Road, Guwahati 781 036, Assam, India
Correspondence Address: Marengo Asia Hospitals, Golf Course Ext. Road, Sushant Lok-2, Sector 56, Gurugram, Haryana - 122011
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MC-6422

Marengo Asia Hospitals

4110128

NABH
OUR ACCREDITATIONS

DEPARTMENT OF LABORATORY SERVICES

Patient	Mr. PRATEEK JAIN	**Lab No/ManualNo**	4110128/
UHIDNo/IPNO	400216251	**CollectionDate**	23/09/2024 10:19AM
Age/Gender	35 Years/Male	**Receiving Date**	23/09/2024 11:29AM
Bed No/Ward	OPD	**Report Date**	23/09/2024 1:25PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Neutrophils	61.4	%	40 - 80	Flow Cytometry
Lymphocytes	32	%	20 - 40	Flow Cytometry
Monocytes	5.3	%	2 - 10	Flow Cytometry
Eosinophils	1.2	%	1 - 6	Flow Cytometry
Basophils	0.1	%	0 - 1	Flow Cytometry
Absolute Leucocyte Count				
Absolute Neutrophil Count	4.09	10^3/µL	1.50 - 6.60	Calculated
Absolute Lymphocyte Count	2.13	10^3/µL	1.50 - 3.50	Calculated
Absolute Monocyte Count	0.35	10^3/µL	0.00 - 1.00	Calculated
Absolute Eosinophil Count	0.08	10^3/µL	0.00 - 0.70	Calculated
Absolute Basophil Count	0.01	10^3/µL	0.00 - 1.00	Calculated

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

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Regd No: HN 012481

Prepared By MAH002618

Printed at 24/09/2024 09:08

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DEPARTMENT OF LABORATORY SERVICES

Patient	Mr. PRATEEK JAIN	**Lab No/ManualNo**	4110128/
UHIDNo/IPNO	400216251	**CollectionDate**	23/09/2024 10:19AM
Age/Gender	35 Years/Male	**Receiving Date**	23/09/2024 11:29AM
Bed No/Ward	OPD	**Report Date**	23/09/2024 2:15PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample

Immuno-Haematology

MediWheel Full Body Annual Plus

***BLOOD GROUPING** — EDTA Blood

ABO GROUP	'B'	Tube Agglutination Method
RH Type	POSITIVE	

Interpretation:-

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.

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

Dr. Nutan Sood
MD (Pathology)
Senior Consultant,Laboratory Services,
Regd No: HN 012481

Prepared By MAH002618 **Printed at 24/09/2024 09:08** **Page: 15 Of 15**

L-Low H-High CH - Critical High CL - Critical Low

ECHOCARDIOGRAPHY REPORT

Name	:	Mr. PRATEEK JAIN		
Age/Sex	:	35 Years / Male	UHID	: ,400216251
Referring Physician	:	SELF		
Indication	:	R/o CAD	Date	: 23/09/2024

M-Mode/2-D Description:

Doppler velocities (cm/sec)

Pulmonary valve		Aortic valve	
Max velocity	95	Max velocity	98
		Mean Velocity	
		Max PG	
		Mean PG	

Mitral valve			Tricuspid valve	
E	80	Max PG =	Max Velocity	51
A	66	Max Velocity =	TAPSE (> 1.5)	~
DT		Mean PG =	E/E' (< 6)	
E/E'		Mean Velocity =		

Regurgitation

MR		TR	
Severity	Trace	Severity	Trace
Max Velocity		PASP	23 mmHg
AR		PR	
Severity	Nil	Severity	Nil

Measurements (mm):

	Observed Values	Normal Values
Aortic root diameter	32 mm	20-36 (22mm/M^2)
Aortic Valve Opening	mm	15-26
Left Atrium size	34 mm	19-40

	End Diastole	End Systole	Normal Values
Left Ventricle size	42 mm	27 mm	(ED= 37-56)
Interventricular Septum	11 mm		(ED= 6-12)
Posterior Wall Thickness	10 mm		(ED= 5-10)
LV Ejection Fraction (%)	55.00%		55%-80%

PRATEEK JAIN,400216251

Final Interpretation:-

Study done at HR of ~ 68 bpm

- **No LV Regional wall motion abnormality, LVEF ~ 55%**
- **Normal RV systolic function.**
- **Normal Cardiac chamber dimensions.**
- **Trace MR, No MS, No AS/AR.**
- **Trace TR with (RVSP~ 23 mmHg), No PS/PR.**
- **Normal mitral inflow pattern.**
- **No intra-cardiac clot/ Vegetation / Pericardial effusion seen.**
- **IVC normal in size with normal respiratory variation (RAP ~ 3 mmHg).**

Dr. Anshul Goyal
MD, Medicine
Attending consultant- Cardiology

Dr. Yogendra Singh Rajput
MBBS, MD, DM FSCAI
Interventional Cardiologist
Associate Clinical Director-Cardiology

Name	Mr. Prateek Jain	Date	23-09-24
Age/Gender	35 yrs/M	UHID	40021625I

Presenting Complaints: K/c of HTN ? Hangardi dm.

Past History: DM| HT | CAD

IOP: Right Eye: mmHg **Left Eye:** mmHg **POG RE:**

LE:

Spectacles	Sphere	Cylinder	Axis	Vision	Near add	Vision
Right Eye				PH+		
Left Eye				PL+		

Clinical Features: Bony spicules (+)

To be evaluated f/u/s.

RDS with AIDS with 15°.

Diagnosis:

Advice: ℓ for dilated retinal eval
+ Fundus foto
+ fundus OCT f/u

Dr Shibal Bhartiya
Clinical Director, Ophthalmology | Program Director, Community Outreach & Wellness
HN-15650
For Appointments: 8882638735 | For Clinical queries: +91 9818700269 | www.drshibalbhartiya.com

Patient ID :	400216251	Paient Name :	Prateek Jain
Age :	035 YRS	Sex :	M
Ref Physician :		Modality/Study :	US
Study Date :	23-Sep-2024	Reported Date :	23-Sep-2024
Study :			

ULTRASOUND WHOLE ABDOMEN

LIVER is **enlarged in size (17.3 cm) and shows diffusely increased echotexture**. No evidence of any focal lesion or IHBR dilation is present. Portal vein and CBD are not dilated.

GALL BLADDER is partially distended and lumen is echofree. Wall thickness is normal. No pericholecystic fluid is seen.

SPLEEN is normal in size (11.9 cm) and echotexture. No focal lesion is seen.

PANCREAS is normal in size and echotexture. Peripancreatic fat planes are clear.

RIGHT KIDNEY: is normal in size (10.3 x 4.1 cm) and position and outline corticomedullary differentiation is maintained. There is no evidence of any focal lesion / calculus / backpressure changes.

LEFT KIDNEY: is normal in size (10.6 x 4.8 cm) and position and outline corticomedullary differentiation is maintained. There is no evidence of any focal lesion / calculus / backpressure changes.

URINARY BLADDER is partially distended and visualized lumen is echofree.

PROSTATE is normal in size and. It has normal echotexture and there is no evidence of focal lesion.

No free fluid is seen in the abdomen

IMPRESSION:

- **Hepatomegaly with grade II fatty liver.**

Please correlate clinically.

Dr. Rushil Jain
Consultant
Dept. of Radiology
MT-A

mr prateek
35 Years Male

23-Sep-24 12:51:07 PM
MARENGO ASIA HOSPITALS
EMERGENCY

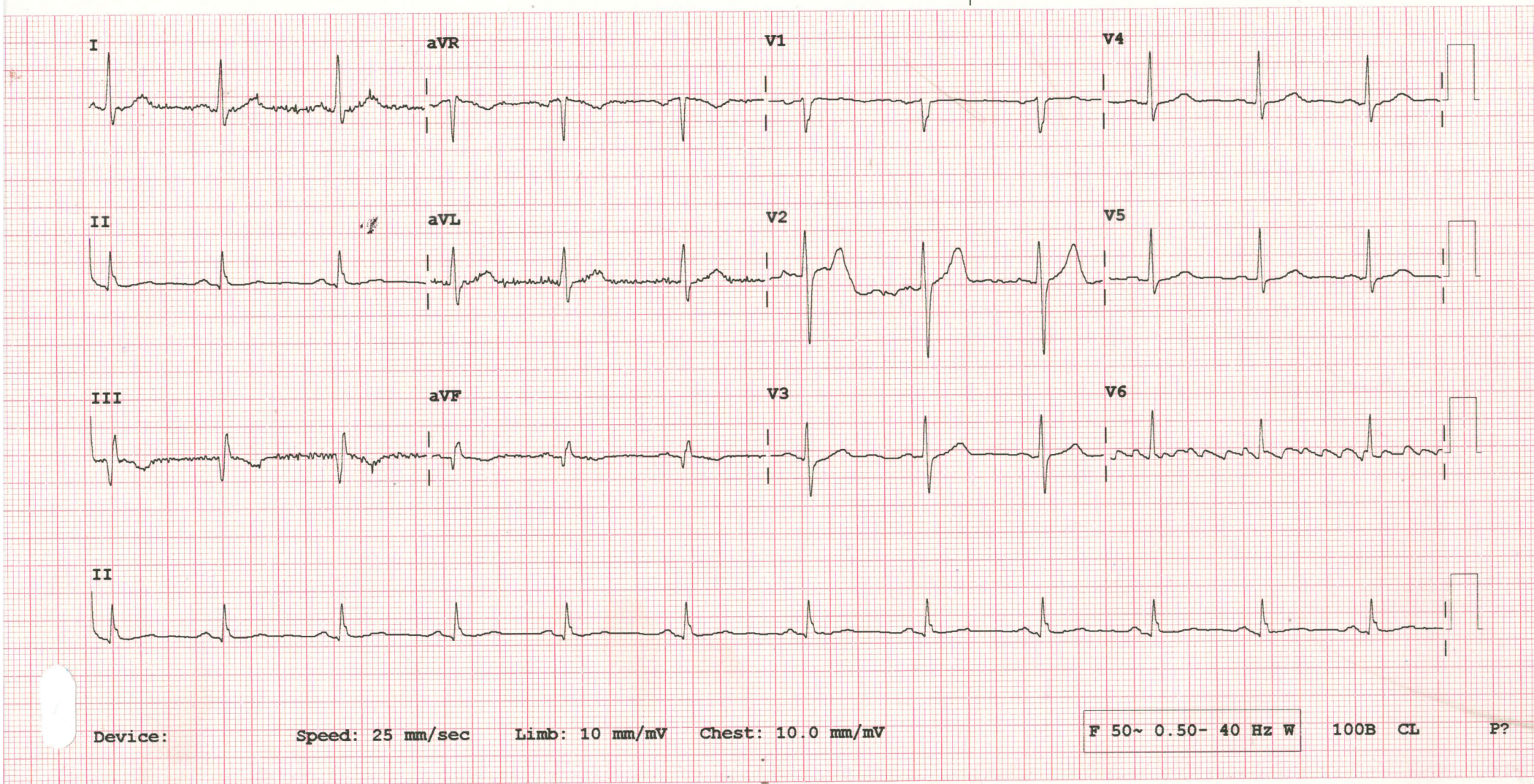
Rate	71	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Inferior infarct, age indeterminate.....Q>35mS, T neg, II III aVF
PR	170	
QRSD	87	
QT	375	
QTc	408	

--AXIS--
P 35
QRS 28
T -9

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50- 40 Hz W 100B CL P?

ARROW CE