Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 04:37PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
SGOT/AST , *GEL SERUM* (Method:Modified IFCC)	21	13-40	U/L
CHLORIDE,BLOOD (Method:ISE INDIRECT)	107	99-109	mEq/L
PHOSPHORUS-INORGANIC,BLOOD (Method:Phosphomolybdate/UV)	2.7	2.4-5.1 mg/dL	mg/dL
ALKALINE PHOSPHATASE (Method:IFCC standardization)	93	46-116	U/L
BILIRUBIN (DIRECT) (Method:Vanadate oxidation)	0.20	<0.2	mg/dL
BILIRUBIN (TOTAL) , *GEL SERUM*			
BILIRUBIN (TOTAL) (Method:Vanadate oxidation)	0.70	0.3-1.2	mg/dL
POTASSIUM,BLOOD (Method:ISE INDIRECT)	4.00	3.5-5.5	mEq/L
UREA,BLOOD (Method:Urease with GLDH)	19.3	19-49	mg/dL
CREATININE, BLOOD (Method:Jaffe, alkaline picrate, kinetic)	0.79	0.7-1.3	mg/dL
GLUCOSE,FASTING (Method:Gluc Oxidase Trinder)	95	Impaired Fasting-100-125 .~Diabetes- >= 126.~Fasting is defined as no caloric intake for at least 8 hours.	mg/dL

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

CALCIUM,BLOOD (Method:Arsenazo III)	9.80	8.7-10.4	mg/dL
URIC ACID,BLOOD (Method:Uricase/Peroxidase)	5.20	3.5-7.2	mg/dL
SGPT/ALT (Method:Modified IFCC)	24	7-40	U/L
SODIUM,BLOOD (Method:ISE INDIRECT)	142	132 - 146	mEq/L

***** End Of Report *****

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

MC-2743

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 04:37PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit

Dr Neepa Chowdhury
MBBS, MD(Biochemistry)
SECTION DIRECTOR AND SENIOR CONSULTANT BIOCHEMIST
Reg no. WBMC 62456

Lab No.	: DUN/05-07-2024/SR9329508	**Lab Add.**	: Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 38 Y 0 M 0 D	**Collection Date**	: 05/Jul/2024 10:19AM
Gender	: M	Report Date	: 05/Jul/2024 08:14PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
THYROID PANEL (T3, T4, TSH) , *GEL SERUM*			
T3-TOTAL (TRI IODOTHYRONINE) (Method:CLIA)	1.02	0.60-1.81 ng/ml	ng/ml
T4-TOTAL (THYROXINE) (Method:CLIA)	9.8	3.2-12.6	µg/dL
TSH (THYROID STIMULATING HORMONE) (Method:CLIA)	1.916	0.55-4.78	µIU/mL

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

References:

1. Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of
individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. Eur J Endocrinol 2001;145:409-13.
2. Bellantone R, Lombardi CP, Bossola M, Ferrante A,Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. Cancer 2001;92:2273-9.

BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]
Trimester specific TSH LEVELS during pregnancy:
FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL
SECOND TRIMESTER: 0.20 -3.50 µ IU/mL
THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

References:

1. *Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan.Thyroid.Mar 2017.315-389.http://doi.org/10.1089/thy.2016.0457*
2. *Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. Indian J Endocr Metab 2018;22:1-4.*

***** End Of Report *****

Dr. SANCHAYAN SINHA
MBBS, MD, DNB (BIOCHEMISTRY)
CONSULTANT BIOCHEMIST
Reg No. WBMC 63214

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 05:19PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
GLYCATED HAEMOGLOBIN (HBA1C) , *EDTA WHOLE BLOOD*			
GLYCATED HEMOGLOBIN (HBA1C)	4.9	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	%
HbA1c (IFCC) (Method:HPLC)	30.0		mmol/mol

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:
Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used :- Bio-Rad-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemic targets
Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
Ø If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.
Ø **For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.**
Ø Some patients may benefit from HbA1c goals that are stringent.
Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B_{12}/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.
Reference: Glycated hemoglobin monitoring BMJ 2006; 333;586-8

References:
1. Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.
2. Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.

PDF Attached

TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .			
TOTAL PROTEIN (Method:BIURET METHOD)	**8.50**	5.7-8.2 g/dL	g/dL
ALBUMIN (Method:BCG Dye Binding)	**5.0**	3.2-4.8 g/dL	g/dL
GLOBULIN (Method:Calculated)	**3.50**	1.8-3.2	g/dl
AG Ratio (Method:Calculated)	1.43	1.0-2.5	
URIC ACID, URINE, SPOT URINE			
URIC ACID, SPOT URINE (Method:URICASE)	57.00	37-92 mg/dL	mg/dL
LIPID PROFILE , *GEL SERUM*			
CHOLESTEROL-TOTAL (Method:Enzymatic)	223	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	mg/dL
TRIGLYCERIDES	133	Normal:: < 150,	mg/dL

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 05:19PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
(Method:GPO-Trinder)		BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	
HDL CHOLESTEROL (Method:Elimination/catalase)	44	< 40 - Low 40-59- Optimum 60 - High	mg/dl
LDL CHOLESTEROL DIRECT (Method:Elimination / Catalase)	**147**	OPTIMAL : <100 mg/dL, Near optimal/ above optimal : 100-129 mg/dL, Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	mg/dL
VLDL (Method:Calculated)	32	< 40 mg/dl	mg/dl
CHOL HDL Ratio (Method:Calculated)	5.1	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	

Reference: *National Cholesterol Education Program. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III).* JAMA. *May 16 2001;285(19):2486-97.*

***** End Of Report *****

DR. ANANNYA GHOSH
MBBS, MD (Biochemistry)
Consultant Biochemist
Reg No. WBMC 73007

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 01:37PM
Gender	**:** M	Report Date	**:** 05/Jul/2024 05:50PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
GLUCOSE,PP (Method:Gluc Oxidase Trinder)	92*	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.	mg/dL

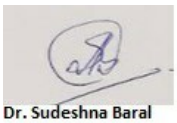
***NOTE: The lower value of Plasma Glucose (PP) compared to that of Plasma Glucose(F), may be interpreted having due to regard to the history of the case with particular reference to Diabetes, if any including the time and dose of antidiabetic drug administered, if any.**

Blood glucose level is maintained by a very complex integrated mechanism involving critical interplay of release of hormones and action of enzymes on key metabolic pathways resulting in a smooth transition normally from a high level of glucose influx following meal / glucose intake to a basal level after 2 – 3 hrs. or so. Excluding alimentary hypoglycemia, renal glycosuria, hereditary fructose intolerance and Galactosemia, the possible causes of post prandial reactive hypoglycemia (PRH) include high insulin sensitivity, exaggerated response of insulin and glucagon like peptide 1, defects in counter-regulation, very lean and /or anxious individuals, after massive weight reduction etc.

The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water.
In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

***** End Of Report *****



Dr. Sudeshna Baral
M.B.B.S MD.
(Biochemistry)
(Consultant Biochemist)
Reg No. WBMC 64124

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 05:32PM

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
BLOOD GROUP ABO+RH [GEL METHOD] , *EDTA WHOLE BLOOD*			
ABO (Method:Gel Card)	A		
RH (Method:Gel Card)	POSITIVE		

TECHNOLOGY USED: GEL METHOD

ADVANTAGES :

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

Historical records check not performed.

CBC WITH PLATELET (THROMBOCYTE) COUNT , *EDTA WHOLE BLOOD*			
HEMOGLOBIN (Method:PHOTOMETRIC)	13.6	13 - 17	g/dL
WBC (Method:DC detection method)	7.8	4 - 10	*10^3/µL
RBC (Method:DC detection method)	4.55	4.5 - 5.5	*10^6/µL
PLATELET (THROMBOCYTE) COUNT (Method:DC detection method/Microscopy)	174	150 - 450*10^3	*10^3/µL
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Flowcytometry/Microscopy)	60	40 - 80 %	%
LYMPHOCYTES (Method:Flowcytometry/Microscopy)	30	20 - 40 %	%
MONOCYTES (Method:Flowcytometry/Microscopy)	08	2 - 10 %	%
EOSINOPHILS (Method:Flowcytometry/Microscopy)	02	1 - 6 %	%
BASOPHILS (Method:Flowcytometry/Microscopy)	00	0-0.9%	%
CBC SUBGROUP			
HEMATOCRIT / PCV (Method:Calculated)	**39.1**	40 - 50 %	%
MCV (Method:Calculated)	86.0	83 - 101 fl	fl
MCH (Method:Calculated)	29.9	27 - 32 pg	pg
MCHC (Method:Calculated)	**34.8**	31.5-34.5 gm/dl	gm/dl
RDW - RED CELL DISTRIBUTION WIDTH (Method:Calculated)	**14.7**	11.6-14%	%
PDW-PLATELET DISTRIBUTION WIDTH (Method:Calculated)	33.3	8.3 - 25 fL	fL
MPV-MEAN PLATELET VOLUME (Method:Calculated)	13.0	7.5 - 11.5 fl	

ESR (ERYTHROCYTE SEDIMENTATION RATE) , *EDTA WHOLE BLOOD*			
1stHour (Method:Westergren)	06	0.00 - 20.00 mm/hr	mm/hr

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 05/Jul/2024 10:19AM
Gender	**:** M	Report Date	**:** 05/Jul/2024 05:32PM

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit

***** End Of Report *****

Kaushik Dey

Dr. KAUSHIK DEY
MD (PATHOLOGY)
CONSULTANT PATHOLOGIST
Reg No. WBMC 66405

Suraksha DIAGNOSTICS

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:**
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:**
Gender	**:** M	Report Date	**:** 05/Jul/2024 12:51PM

DEPARTMENT OF X-RAY

X-RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Bilateral costophrenic angles are unremarkable.

Bilateral hila and vascular markings are unremarkable.

Domes of diaphragm are normal in morphology and contour.

Cardiac size is within normal limits.

Bony thoracic cage appears normal.

IMPRESSION:

No obvious abnormality detected.

No evidence of fracture or dislocation.

Recommended clinical correlation.

***** End Of Report *****

Dr. Manish Kumar Jha
MD Radiodiagnosis

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

Lab No.	: DUN/05-07-2024/SR9329508	**Lab Add.**	: Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 38 Y 0 M 0 D	**Collection Date**	: 06/Jul/2024 07:23AM
Gender	: M	Report Date	: 06/Jul/2024 11:40AM

DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Bio Ref. Interval	Unit
URINE ROUTINE ALL, ALL , *URINE*			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		
APPEARANCE	SLIGHTLY HAZY		
CHEMICAL EXAMINATION			
pH (Method:Dipstick (triple indicator method))	6.0	4.6 - 8.0	
SPECIFIC GRAVITY (Method:Dipstick (ion concentration method))	1.020	1.005 - 1.030	
PROTEIN (Method:Dipstick (protein error of pH indicators)/Manual)	NOT DETECTED	NOT DETECTED	
GLUCOSE (Method:Dipstick(glucose-oxidase-peroxidase method)/Manual)	NOT DETECTED	NOT DETECTED	
KETONES (ACETOACETIC ACID, ACETONE) (Method:Dipstick (Legals test)/Manual)	NOT DETECTED	NOT DETECTED	
BLOOD (Method:Dipstick (pseudoperoxidase reaction))	NOT DETECTED	NOT DETECTED	
BILIRUBIN (Method:Dipstick (azo-diazo reaction)/Manual)	NEGATIVE	NEGATIVE	
UROBILINOGEN (Method:Dipstick (diazonium ion reaction)/Manual)	NEGATIVE	NEGATIVE	
NITRITE (Method:Dipstick (Griess test))	NEGATIVE	NEGATIVE	
LEUCOCYTE ESTERASE (Method:Dipstick (ester hydrolysis reaction))	NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION			
LEUKOCYTES (PUS CELLS) (Method:Microscopy)	0-1	0-5	/hpf
EPITHELIAL CELLS (Method:Microscopy)	1-2	0-5	/hpf
RED BLOOD CELLS (Method:Microscopy)	NOT DETECTED	0-2	/hpf
CAST (Method:Microscopy)	NOT DETECTED	NOT DETECTED	
CRYSTALS (Method:Microscopy)	NOT DETECTED	NOT DETECTED	
BACTERIA (Method:Microscopy)	SCANTY	NOT DETECTED	
YEAST (Method:Microscopy)	NOT DETECTED	NOT DETECTED	

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can occur due to cell lysis.
8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:** Newtown,Kolkata-700156
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:** 06/Jul/2024 07:23AM
Gender	**:** M	Report Date	**:** 06/Jul/2024 11:40AM

DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Bio Ref. Interval	Unit

and/or yeast in the urine.

***** End Of Report *****

Kaushik Dey

Dr. KAUSHIK DEY
MD (PATHOLOGY)
CONSULTANT PATHOLOGIST
Reg No. WBMC 66405

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:**
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:**
Gender	**:** M	Report Date	**:** 05/Jul/2024 04:04PM

DEPARTMENT OF CARDIOLOGY

E.C.G. REPORT

DATA		
HEART RATE	61	Bpm
PR INTERVAL	142	Ms
QRS DURATION	94	Ms
QT INTERVAL	390	Ms
QTC INTERVAL	393	Ms
AXIS		
P WAVE	52	Degree
QRS WAVE	59	Degree
T WAVE	26	Degree

IMPRESSION : **Normal sinus rhythm, within normal limits.**

***** End Of Report *****

Dr. KAUSIK PAL
MD DM (Card)
Reg No-WBMC-56578

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:**
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:**
Gender	**:** M	Report Date	**:** 05/Jul/2024 03:57PM

DEPARTMENT OF ULTRASONOGRAPHY

REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER: It is normal in size (13 cm), normal in shape and parenchymal echopattern. No focal lesion of altered echogenicity is seen. Intrahepatic biliary radicles are not dilated. The portal vein branches and hepatic veins are normal.

GALL BLADDER: Well distended lumen shows no inralumnial calculus or mass. Wall thickness is normal. No pericholecystic collection is noted.

PORTA HEPATIS: The portal vein (0.70 cm) is normal in caliber with clear lumen. The common bile duct is normal in caliber. Visualized lumen is clear till visualised extent. Common bile duct measures approx 0.25 cm in diameter. *Extreme lower end of common bile duct is not visualised due to bowel gas shadow.*

PANCREAS: It is normal in shape, size and echopattern. Main pancreatic duct is not dilated. No focal lesion of altered echogenicity is seen. The peripancreatic region shows no abnormal fluid collection.

SPLEEN: It is normal in shape, size (9.7 cm) and shows homogeneous echopattern. No focal lesion is seen. No abnormal venous dilatation is seen in the splenic hilum.

KIDNEYS: Both Kidneys are normal in shape, size and position. Cortical echogenicity and thickness are normal with normal cortico-medullary differentiation in both kidneys. No calculus, hydronephrosis is noted in either side. The perinephric region shows no abnormal fluid collection.

RIGHT KIDNEY measures 9.8 cm **LEFT KIDNEY** measures 9.4 cm

URETER: Both ureters are not dilated. No calculus is noted in either side.

PERITONEUM & RETROPERITONEUM: The aorta and IVC are normal. Lymph nodes are not enlarged. No free fluid is seen in peritoneum.

URINARY BLADDER: It is adequately distended providing optimum scanning window. The lumen is clear and wall thickness is normal.

PROSTATE: It is normal in shape, size and echopattern. No focal lesion is seen. Capsule is smooth.

Prostate measures : 2.8 x 4.0 x 3.2 cm. Weight 19 gms.

IMPRESSION:

No significant abnormality detected.

Please correlate clinically.

Kindly note

- ***Ultrasound is not the modality of choice to rule out subtle bowel lesion.***
- ***Please Intimate us for any typing mistakes and send the report for correction within 7 days.***
- *The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.*

The report and films are not valid for medico-legal purpose.

Lab No.	**:** DUN/05-07-2024/SR9329508	**Lab Add.**	**:**
Patient Name	: SANTUJIT SARKAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 38 Y 0 M 0 D	**Collection Date**	**:**
Gender	**:** M	Report Date	**:** 05/Jul/2024 03:57PM

DEPARTMENT OF ULTRASONOGRAPHY

Patient Identity not verified

DR. NAMRATA CHATTERJEE
MBBS,CONSULTANT SONOLOGIST
Reg No : 79092

Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

SURAKSHA DIAGNOSTIC,RAJARHAT,KOLKATA **PATIENT REPORT**

BIO-RAD VARIANT-II TURBO CDM5.4. SN-16122 **V2TURBO_A1c_2.0**

Patient Data

Sample ID:	D02135744166
Patient ID:	SR9329508
Name:	SANTUJIT SARKAR
Physician:	
Sex:	M
DOB:	

Comments:

Analysis Data

Analysis Performed:	05/JUL/2024 14:42:01
Injection Number:	3034
Run Number:	42
Rack ID:	0003
Tube Number:	7
Report Generated:	05/JUL/2024 14:50:45
Operator ID:	ANUP

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
Unknown	---	0.1	0.114	3321
A1a	---	0.8	0.163	22688
A1b	---	1.2	0.226	33850
F	---	0.7	0.276	19922
LA1c	---	1.8	0.392	50812
A1c	4.9	---	0.491	126340
P3	---	3.3	0.781	95354
P4	---	1.2	0.858	34322
Ao	---	86.7	1.001	2516422

Total Area: 2,903,030

HbA1c (NGSP) = 4.9 % HbA1c (IFCC) = 30 mmol/mol