Hiranandani
HOSPITAL
(A Fortis Network Hospital)

**Hiranandani Fortis Hospital**
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

# BMI CHART

Date: 23/3/24

Name: Harshit Tiwari Age: 28 yrs Sex: M / F

BP: 130/80 mmHg Height (cms): 177 c.m Weight(kgs): 84 kg BMI: 26.8

| WEIGHT lbs | 100 | 105 | 100 | 115 | 120 | 125 | 130 | 135 | 140 | 145 | 150 | 155 | 160 | 165 | 170 | 175 | 180 | 185 | 190 | 195 | 200 | 205 | 210 | 215 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| kgs | 45.5 | 47.7 | 50.50 | 52.3 | 54.5 | 56.8 | 59.1 | 61.4 | 63.6 | 65.9 | 68.2 | 70.5 | 72.7 | 75.0 | 77.3 | 79.5 | 81.8 | 84.1 | 86.4 | 88.6 | 90.9 | 93.2 | 95.5 | 97.7 |
| HEIGHT in/cm | Underweight | | | | | Healthy | | | | | | Overweight | | | | Obese | | | | | | Extremely Obese | | |
| 5'0" - 152.4 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 |
| 5'1" - 154.9 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 | 39 | 40 |
| 5'2" - 157.4 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 33 | 34 | 35 | 36 | 37 | 38 | 39 |
| 5'3" - 160.0 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
| 5'4" - 162.5 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 31 | 32 | 33 | 34 | 35 | 36 | 37 |
| 5'5" - 165.1 | 16 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 30 | 30 | 31 | 32 | 33 | 34 | 35 | 35 |
| 5'6" - 167.6 | 16 | 17 | 17 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 34 | 34 |
| 5'7" - 170.1 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 33 |
| 5'8" - 172.7 | 15 | 16 | 16 | 17 | 18 | 19 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 32 | 32 |
| 5'9" - 176.2 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 31 |
| 5'10" - 177.8 | 14 | 15 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 30 |
| 5'11" - 180.3 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 |
| 6'0" - 182.8 | 13 | 14 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 | 29 |
| 6'1" - 185.4 | 13 | 13 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 |
| 6'2" - 187.9 | 12 | 13 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 |
| 6'3" - 190.5 | 12 | 13 | 13 | 14 | 15 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 26 |
| 6'4" - 193.0 | 12 | 12 | 13 | 14 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 23 | 24 | 25 | 25 | 26 |

**Doctors Notes:**

Signature

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
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| | | | | | |
|---|---|---|---|---|---|
| **UHID** | **13049612** | **Date** | **23/03/2024** | | |
| **Name** | **Mr Harshit Tiwari** | **Sex** | **M** | **Age** | **28** |
| **OPD** | **Opthal 14** | **Health Check Up** | | | |

Drug allergy: → Not known
Sys illness: → NO
Habit → NO.

Chr. NO

H/o NO

Unaided → Rt 6/36P
→ Lt 6/24P (Ophth)

Ref → Rt -1.25/-0.50 x 90° 6/6.
→ Lt -1.50 Sph 6/6

NV → Rt N6.
→ Lt N6

FBP → Rt → 13.2
→ Lt → 14.5.

Known case of P.U.P

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| **Name** | **Mr Harshit Tiwari** | **Sex** | **M** | **Age** | **28** |
| **OPD** | **Dental** | **Health Check Up** | | | |

Drug allergy:
Sys illness:

O/E - Stain + +

Calculus + +

- Impacted $\frac{\bar{c}}{8|8}$

Treatment

A/d - (1) Scaling Grade II

(2) Extraction $\frac{\bar{c}}{8|8}$

(3) OPG (xray)

Dr. Trupti

Diagnostics Report

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MC-5837

agilus diagnostics

| | | |
|---|---|---|
| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
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**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|

## HAEMATOLOGY - CBC

**CBC-5, EDTA WHOLE BLOOD**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| HEMOGLOBIN (HB)<br>METHOD : SLS METHOD | 14.6 | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT<br>METHOD : HYDRODYNAMIC FOCUSING | 5.06 | 4.5 - 5.5 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT<br>METHOD : FLUORESCENCE FLOW CYTOMETRY | **3.12 Low** | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT<br>METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION | 235 | 150 - 410 | thou/µL |

**RBC AND PLATELET INDICES**

| | | | |
|---|---|---|---|
| HEMATOCRIT (PCV)<br>METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD | 43.9 | 40.0 - 50.0 | % |
| MEAN CORPUSCULAR VOLUME (MCV)<br>METHOD : CALCULATED PARAMETER | 86.8 | 83.0 - 101.0 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH)<br>METHOD : CALCULATED PARAMETER | 28.9 | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)<br>METHOD : CALCULATED PARAMETER | 33.3 | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW)<br>METHOD : CALCULATED PARAMETER | 12.1 | 11.6 - 14.0 | % |
| MENTZER INDEX<br>METHOD : CALCULATED PARAMETER | 17.2 | | |
| MEAN PLATELET VOLUME (MPV)<br>METHOD : CALCULATED PARAMETER | 10.4 | 6.8 - 10.9 | fL |

**WBC DIFFERENTIAL COUNT**

**Dr. Akshay Dhotre, MD**
**(Reg,no. MMC 2019/09/6377)**
**Consultant Pathologist**



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| NEUTROPHILS<br>METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING | 65 | 40.0 - 80.0 | % |
| LYMPHOCYTES<br>METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING | 26 | 20.0 - 40.0 | % |
| MONOCYTES<br>METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING | 7 | 2.0 - 10.0 | % |
| EOSINOPHILS<br>METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING | 2 | 1 - 6 | % |
| BASOPHILS<br>METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING | 0 | 0 - 2 | % |
| ABSOLUTE NEUTROPHIL COUNT<br>METHOD : CALCULATED PARAMETER | 2.03 | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT<br>METHOD : CALCULATED PARAMETER | **0.81 Low** | 1.0 - 3.0 | thou/µL |
| ABSOLUTE MONOCYTE COUNT<br>METHOD : CALCULATED PARAMETER | 0.22 | 0.2 - 1.0 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT<br>METHOD : CALCULATED PARAMETER | 0.06 | 0.02 - 0.50 | thou/µL |
| ABSOLUTE BASOPHIL COUNT<br>METHOD : CALCULATED PARAMETER | **0 Low** | 0.02 - 0.10 | thou/µL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR)<br>METHOD : CALCULATED | 2.5 | | |

**MORPHOLOGY**

| | |
|---|---|
| RBC<br>METHOD : MICROSCOPIC EXAMINATION | PREDOMINANTLY NORMOCYTIC NORMOCHROMIC |
| WBC<br>METHOD : MICROSCOPIC EXAMINATION | LEUCOPENIA |
| PLATELETS<br>METHOD : MICROSCOPIC EXAMINATION | ADEQUATE |



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**Interpretation(s)**
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.



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## HAEMATOLOGY

### ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

| | | | |
|---|---|---|---|
| E.S.R<br>METHOD : WESTERGREN METHOD | 03 | 0 - 14 | mm at 1 hr |

### GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

| | | | |
|---|---|---|---|
| HBA1C | 4.8 | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>Therapeutic goals: < 7.0<br>Action suggested : > 8.0<br>(ADA Guideline 2021) | % |
| METHOD : HB VARIANT (HPLC) | | | |
| ESTIMATED AVERAGE GLUCOSE(EAG)<br>METHOD : CALCULATED PARAMETER | 91.1 | < 116.0 | mg/dL |

**Interpretation(s)**
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION :-**
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

**TEST INTERPRETATION**
**Increase** in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
**Decreased** in: Polycythermia vera, Sickle cell anemia

**LIMITATIONS**
**False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
**False Decreased** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)



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REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis 10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

**HbA1c Estimation can get affected due to :**
1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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## IMMUNOHAEMATOLOGY

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| ABO GROUP<br>METHOD : TUBE AGGLUTINATION | TYPE B | | |
| RH TYPE<br>METHOD : TUBE AGGLUTINATION | POSITIVE | | |

**Interpretation(s)**
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-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.



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| **BIOCHEMISTRY** | | | |
| **LIVER FUNCTION PROFILE, SERUM** | | | |
| BILIRUBIN, TOTAL<br>METHOD : JENDRASSIK AND GROFF | **1.73 High** | 0.2 - 1.0 | mg/dL |
| BILIRUBIN, DIRECT<br>METHOD : JENDRASSIK AND GROFF | **0.36 High** | 0.0 - 0.2 | mg/dL |
| BILIRUBIN, INDIRECT<br>METHOD : CALCULATED PARAMETER | **1.37 High** | 0.1 - 1.0 | mg/dL |
| TOTAL PROTEIN<br>METHOD : BIURET | 7.5 | 6.4 - 8.2 | g/dL |
| ALBUMIN<br>METHOD : BCP DYE BINDING | 4.9 | 3.4 - 5.0 | g/dL |
| GLOBULIN<br>METHOD : CALCULATED PARAMETER | 2.6 | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO<br>METHOD : CALCULATED PARAMETER | 1.9 | 1.0 - 2.1 | RATIO |
| ASPARTATE AMINOTRANSFERASE(AST/SGOT)<br>METHOD : UV WITH P5P | 33 | 15 - 37 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT)<br>METHOD : UV WITH P5P | **58 High** | < 45.0 | U/L |
| ALKALINE PHOSPHATASE<br>METHOD : PNPP-ANP | **124 High** | 30 - 120 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT)<br>METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE | 60 | 15 - 85 | U/L |
| LACTATE DEHYDROGENASE<br>METHOD : LACTATE -PYRUVATE | 155 | 85 - 227 | U/L |
| **GLUCOSE FASTING,FLUORIDE PLASMA** | | | |
| FBS (FASTING BLOOD SUGAR)<br>METHOD : HEXOKINASE | 97 | Normal : < 100<br>Pre-diabetes: 100-125<br>Diabetes: >/=126 | mg/dL |



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Email : -

Patient Ref. No. 22000000910866

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|---|---|---|
| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
| **CODE/NAME & ADDRESS :** C000045507<br>FORTIS VASHI-CHC -SPLZD<br>FORTIS HOSPITAL # VASHI,<br>MUMBAI 440001 | ACCESSION NO : **0022XC004959**<br>PATIENT ID : FH.13049612<br>CLIENT PATIENT ID: UID:13049612<br>ABHA NO : | AGE/SEX : 28 Years Male<br>DRAWN : 23/03/2024 10:34:00<br>RECEIVED : 23/03/2024 10:34:38<br>REPORTED : 23/03/2024 14:48:19 |

**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

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|---|---|---|---|
| **KIDNEY PANEL - 1** | | | |
| **BLOOD UREA NITROGEN (BUN), SERUM** | | | |
| BLOOD UREA NITROGEN<br>METHOD : UREASE - UV | 6 | 6 - 20 | mg/dL |
| **CREATININE EGFR- EPI** | | | |
| CREATININE<br>METHOD : ALKALINE PICRATE KINETIC JAFFES | 0.90 | 0.90 - 1.30 | mg/dL |
| AGE | 28 | | years |
| GLOMERULAR FILTRATION RATE (MALE)<br>METHOD : CALCULATED PARAMETER | 119.31 | Refer Interpretation Below | mL/min/1.73m2 |
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO<br>METHOD : CALCULATED PARAMETER | 6.67 | 5.00 - 15.00 | |
| **URIC ACID, SERUM** | | | |
| URIC ACID<br>METHOD : URICASE UV | **8.0 High** | 3.5 - 7.2 | mg/dL |
| **TOTAL PROTEIN, SERUM** | | | |
| TOTAL PROTEIN<br>METHOD : BIURET | 7.5 | 6.4 - 8.2 | g/dL |



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| **ALBUMIN, SERUM** | | | |
| ALBUMIN<br>METHOD : BCP DYE BINDING | 4.9 | 3.4 - 5.0 | g/dL |
| **GLOBULIN** | | | |
| GLOBULIN<br>METHOD : CALCULATED PARAMETER | 2.6 | 2.0 - 4.1 | g/dL |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM, SERUM<br>METHOD : ISE INDIRECT | 139 | 136 - 145 | mmol/L |
| POTASSIUM, SERUM<br>METHOD : ISE INDIRECT | 4.38 | 3.50 - 5.10 | mmol/L |
| CHLORIDE, SERUM<br>METHOD : ISE INDIRECT | 102 | 98 - 107 | mmol/L |

**Interpretation(s)**

**Interpretation(s)**
LIVER FUNCTION PROFILE, SERUM-
**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.



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**AST** is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

**ALP** is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

**GGT** is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

**Total Protein** also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.

**Albumin** is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
**Increased in**:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
**Decreased in** :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
**Causes of decreased** level include Liver disease, SIADH.
CREATININE EGFR- EPI-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.
- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.
- The GFR is a calculation based on serum creatinine test.
- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.
- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.
- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- This equation takes into account several factors that impact creatinine production, including age, gender, and race.
- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high(>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation-https://testguide.labmed.uw.edu/guideline/egfr
Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325
Harrison''s Principle of Internal Medicine, 21st ed. pg 62 and 334
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
**Higher-than-normal levels may be due to:** Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.



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**Lower-than-normal levels may be due to:** Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.



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## BIOCHEMISTRY - LIPID

**LIPID PROFILE, SERUM**

| | | | |
|---|---|---|---|
| CHOLESTEROL, TOTAL | 174 | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |
| METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE<br>TRIGLYCERIDES | 76 | < 150 Normal<br>150 - 199 Borderline High<br>200 - 499 High<br>>/=500 Very High | mg/dL |
| METHOD : ENZYMATIC ASSAY<br>HDL CHOLESTEROL | 49 | < 40 Low<br>>/=60 High | mg/dL |
| METHOD : DIRECT MEASURE - PEG<br>LDL CHOLESTEROL, DIRECT | 105 | < 100 Optimal<br>100 - 129 Near or above optimal<br>130 - 159 Borderline High<br>160 - 189 High<br>>/= 190 Very High | mg/dL |
| METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT<br>NON HDL CHOLESTEROL | 125 | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |
| METHOD : CALCULATED PARAMETER<br>VERY LOW DENSITY LIPOPROTEIN | 15.2 | </= 30.0 | mg/dL |
| METHOD : CALCULATED PARAMETER<br>CHOL/HDL RATIO | 3.6 | 3.3 - 4.4 Low Risk<br>4.5 - 7.0 Average Risk<br>7.1 - 11.0 Moderate Risk<br>> 11.0 High Risk | |
| METHOD : CALCULATED PARAMETER | | | |



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|---|---|---|---|
| LDL/HDL RATIO | 2.1 | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |

METHOD : CALCULATED PARAMETER

**Interpretation(s)**



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## CLINICAL PATH - URINALYSIS

**KIDNEY PANEL - 1**

**PHYSICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| COLOR | PALE YELLOW | |
| METHOD : PHYSICAL | | |
| APPEARANCE | CLEAR | |
| METHOD : VISUAL | | |

**CHEMICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| PH | 7.0 | 4.7 - 7.5 |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD | | |
| SPECIFIC GRAVITY | 1.010 | 1.003 - 1.035 |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION) | | |
| PROTEIN | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE | | |
| GLUCOSE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD | | |
| KETONES | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE | | |
| BLOOD | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN | | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT | | |
| UROBILINOGEN | NORMAL | NORMAL |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION) | | |
| NITRITE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE | | |
| LEUKOCYTE ESTERASE | NOT DETECTED | NOT DETECTED |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY | | |

Rekha. N



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| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
| **CODE/NAME & ADDRESS :** C000045507<br>FORTIS VASHI-CHC -SPLZD<br>FORTIS HOSPITAL # VASHI,<br>MUMBAI 440001 | ACCESSION NO : **0022XC004959**<br>PATIENT ID : FH.13049612<br>CLIENT PATIENT ID: UID:13049612<br>ABHA NO : | AGE/SEX :28 Years Male<br>DRAWN :23/03/2024 10:34:00<br>RECEIVED : 23/03/2024 10:34:38<br>REPORTED :23/03/2024 14:48:19 |

**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **MICROSCOPIC EXAMINATION, URINE** | | | |
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| PUS CELL (WBC'S) | 2-3 | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| EPITHELIAL CELLS | 0-1 | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| CASTS | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| CRYSTALS | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| BACTERIA | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| YEAST | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| REMARKS | URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT | | |

**Interpretation(s)**



**Dr. Akshay Dhotre, MD**
**(Reg,no. MMC 2019/09/6377)**
**Consultant Pathologist**

**Dr. Rekha Nair, MD**
**(Reg No. MMC 2001/06/2354)**
**Microbiologist**

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Maharashtra, India
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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000910866

Fortis

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| | | |
|---|---|---|
| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
| **CODE/NAME & ADDRESS** : C000045507<br>FORTIS VASHI-CHC -SPLZD<br>FORTIS HOSPITAL # VASHI,<br>MUMBAI 440001 | ACCESSION NO : **0022XC004959**<br>PATIENT ID : FH.13049612<br>CLIENT PATIENT ID: UID:13049612<br>ABHA NO : | AGE/SEX :28 Years Male<br>DRAWN :23/03/2024 10:34:00<br>RECEIVED : 23/03/2024 10:34:38<br>REPORTED :23/03/2024 14:48:19 |

**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|

**SPECIALISED CHEMISTRY - HORMONE**

**THYROID PANEL, SERUM**

| | | | |
|---|---|---|---|
| T3 | 99.4 | 80.0 - 200.0 | ng/dL |
| METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE | | | |
| T4 | 5.38 | 5.10 - 14.10 | µg/dL |
| METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE | | | |
| TSH (ULTRASENSITIVE) | 1.450 | 0.270 - 4.200 | µIU/mL |
| METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY | | | |

**Interpretation(s)**



**Dr. Akshay Dhotre, MD**
**(Reg,no. MMC 2019/09/6377)**
**Consultant Pathologist**

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Patient Ref. No. 22000000910866

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| | | |
|---|---|---|
| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
| **CODE/NAME & ADDRESS** : C000045507<br>FORTIS VASHI-CHC -SPLZD<br>FORTIS HOSPITAL # VASHI,<br>MUMBAI 440001 | ACCESSION NO : **0022XC004959**<br>PATIENT ID : FH.13049612<br>CLIENT PATIENT ID: UID:13049612<br>ABHA NO : | AGE/SEX : 28 Years Male<br>DRAWN : 23/03/2024 10:34:00<br>RECEIVED : 23/03/2024 10:34:38<br>REPORTED : 23/03/2024 14:48:19 |

**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|

**SPECIALISED CHEMISTRY - TUMOR MARKER**

| | | | |
|---|---|---|---|
| **PROSTATE SPECIFIC ANTIGEN, SERUM** | | | |
| PROSTATE SPECIFIC ANTIGEN | 0.482 | 0.0 - 1.4 | ng/mL |

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

**Interpretation(s)**
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References-
1. Burtis CA, Ashwood ER, Bruns DE. Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

****End Of Report****

**Please visit www.agilusdiagnostics.com for related Test Information for this accession**



**Dr. Akshay Dhotre, MD**
**(Reg,no. MMC 2019/09/6377)**
**Consultant Pathologist**

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Email : -

Patient Ref. No. 22000000910866

Diagnostics Report

Fortis

MC-5837

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| | | |
|---|---|---|
| **PATIENT NAME : MR.HARSHIT TIWARI** | **REF. DOCTOR :** | |
| **CODE/NAME & ADDRESS :** C000045507<br>FORTIS VASHI-CHC -SPLZD<br>FORTIS HOSPITAL # VASHI,<br>MUMBAI 440001 | ACCESSION NO : **0022XC005029**<br>PATIENT ID : FH.13049612<br>CLIENT PATIENT ID: UID:13049612<br>ABHA NO : | AGE/SEX :28 Years Male<br>DRAWN :23/03/2024 13:05:00<br>RECEIVED : 23/03/2024 13:05:22<br>REPORTED :23/03/2024 14:53:17 |

**CLINICAL INFORMATION :**

UID:13049612 REQNO-1681904
CORP-OPD
BILLNO-150124OPCR016906
BILLNO-150124OPCR016906

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **BIOCHEMISTRY** | | | |
| **GLUCOSE, POST-PRANDIAL, PLASMA** | | | |
| PPBS(POST PRANDIAL BLOOD SUGAR)<br>METHOD : HEXOKINASE | 102 | 70 - 140 | mg/dL |

**Interpretation(s)**
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****
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**Dr. Akshay Dhotre, MD**
**(Reg,no. MMC 2019/09/6377)**
**Consultant Pathologist**

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Email : -

Patient Ref. No. 22000000910936

| | | |
|---|---|---|
| Rate | 83 | . Sinus rhythm.....normal P axis, V-rate 50- 99 |
| | | . Probable left atrial enlargement.....P >50mS, <-0.10mV V1 |
| PR | 133 | . Borderline T wave abnormalities.....T/QRS ratio < 1/20 or flat T |
| QRSD | 82 | |
| QT | 334 | |
| QTc | 393 | |

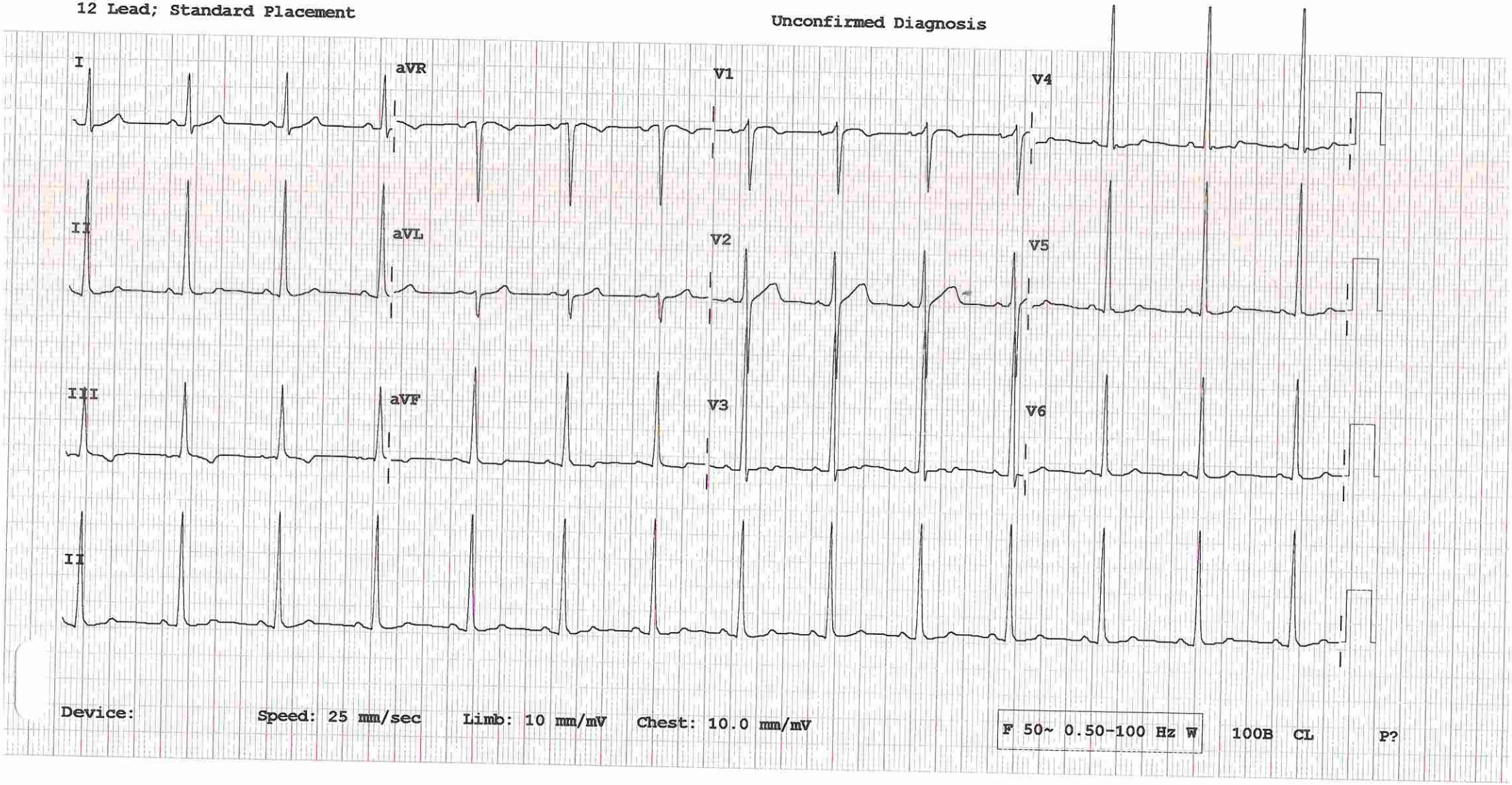
--AXIS--

| | |
|---|---|
| P | 48 |
| QRS | 69 |
| T | 2 |

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis




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

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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

## DEPARTMENT OF NIC

Date: 23/Mar/2024

**Name: Mr. Harshit Tiwari**
**Age | Sex: 28 YEAR(S) | Male**
**Order Station : FO-OPD**
**Bed Name :**

**UHID | Episode No : 13049612 | 17123/24/1501**
**Order No | Order Date: 1501/PN/OP/2403/35911 | 23-Mar-2024**
**Admitted On | Reporting Date : 23-Mar-2024 12:41:23**
**Order Doctor Name : Dr.SELF .**

## ECHOCARDIOGRAPHY TRANSTHORACIC

### FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 30 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 14 mm with normal inspiratory collapse .

### M-MODE MEASUREMENTS:

| | | |
|---|---|---|
| LA | 34 | mm |
| AO Root | 21 | mm |
| AO CUSP SEP | 16 | mm |
| LVID (s) | 30 | mm |
| LVID (d) | 47 | mm |
| IVS (d) | 11 | mm |
| LVPW (d) | 11 | mm |
| RVID (d) | 31 | mm |
| RA | 32 | mm |
| LVEF | 60 | % |

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## DEPARTMENT OF NIC

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**Age | Sex: 28 YEAR(S) | Male**
**Order Station : FO-OPD**
**Bed Name :**

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**Order No | Order Date: 1501/PN/OP/2403/35911 | 23-Mar-2024**
**Admitted On | Reporting Date : 23-Mar-2024 12:41:23**
**Order Doctor Name : Dr.SELF .**

## DOPPLER STUDY:

**E WAVE VELOCITY: 0.9 m/sec.**
**A WAVE VELOCITY:0.8 m/sec**
**E/A RATIO: 1.1**

| | PEAK (mmHg) | MEAN (mmHg) | V max (m/sec) | GRADE OF REGURGITATION |
|---|---|---|---|---|
| MITRAL VALVE | N | | | Trivial |
| AORTIC VALVE | 05 | | | Nil |
| TRICUSPID VALVE | 30 | | | Trivial |
| PULMONARY VALVE | 2.0 | | | Nil |

**Final Impression :**

- No RWMA.
- Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

**DR. PRASHANT PAWAR**
**DNB(MED), DNB (CARD)**

**DR.AMIT SINGH,**
**MD(MED),DM(CARD)**

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

| | | | | | |
|---|---|---|---|---|---|
| Patient Name | : | Harshit Tiwari | Patient ID | : | 13049612 |
| Sex / Age | : | M / 28Y 1M 27D | Accession No. | : | PHC.7773330 |
| Modality | : | US | Scan DateTime | : | 23-03-2024 11:49:42 |
| IPID No | : | 17123/24/1501 | ReportDatetime | : | 23-03-2024 11:55:03 |

## USG – WHOLE ABDOMEN

**LIVER** is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

**GALL BLADDER** is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
**CBD** appears normal in caliber.

**SPLEEN** is normal in size and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 10.8 x 4.8 cm.
Left kidney measures 10.7 x 6.0 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

**PROSTATE** is normal in size & echogenicity. It measures ~ 18.6 cc in volume.

No evidence of ascites.

**Impression:**

- **No significant abnormality is detected.**

**DR. CHETAN KHADKE**
**M.D. (Radiologist)**

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Hiranandani HOSPITAL (A Fortis Network Hospital)

## DEPARTMENT OF RADIOLOGY

Date: 23/Mar/2024

**Name: Mr. Harshit Tiwari**
**Age | Sex: 28 YEAR(S) | Male**
**Order Station : FO-OPD**
**Bed Name :**

**UHID | Episode No : 13049612 | 17123/24/1501**
**Order No | Order Date: 1501/PN/OP/2403/35911 | 23-Mar-2024**
**Admitted On | Reporting Date : 23-Mar-2024 12:54:45**
**Order Doctor Name : Dr.SELF .**

### X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. YOGINI SHAH**
**DMRD., DNB. (Radiologist)**