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7589971164

Dr. Animesh Choudhary
MD (Internal Medicine), FCC, FAGE, PGDC, PGCDM, PGDD
Ex Physician - AIIMS, New Delhi, Fortis Escorts Raipur
Reg. No. CGMC 3583/2011

• मधुमेह • वातरोग • गठियारोग • हृदयरोग • थायराइड • श्वसन रोग • दमा • मोटापा

H- 177cm Mr. Chandra kishore sahu
23/03/24
Wt- 84 kg
BP- 140/100 |130/80 Age- 40y
P- 92 /mt

CBC- 13.9/4.87/6.34/111/20
LFT = 16/22/79
Lipid = 125.0/69.0/24.0/63.20
RBS = F- 97.0/PP- 173.0
Creatinine- 1.04
U. Acid = 4.65

No H/O DM/ /HTN
Family H/O Diabetes Mell
Really small large ASD
ACHD
Dilated RA & RV

℞

- tab Medcm aft BF ×30 d
- tab Valera s4 before BF ×30 d.
- tab Myospas BD ×1 d
- cap Esosal - D रात में ×10 d

A/
HbA1C

- RBS - 98 mg/dl

APOLLO CLINIC ★ RAIPUR ★

Dr. Animesh Choudhary
MD Medicine
Reg. No. CGMC 3583/2011
Apollo Clinic, Raipur

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Mr. Chandra Kishor Sahu

Calculus deposits I 31/12

Advice: Oral prophylaxis

Smile & Shine dental clinic Chhatpara Raipur

7828251782

Dr. Bushra

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CASE Dr Pranab Ray MS ENT

Name :- Chandra Kishor Sahu. 40y Im

No active complaints

On Exam Rt Lt

Ear Clear Clear

TM

B/L TM intact

Nose B/L clear

Throat Oppn Clear

ENT Examination is WNL

Pranab
2/3/24

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NAME OF PATIENT; MR. CHANDRA KISHOR SAHU **AGE: 40YRS/MALE**

REFERRED BY: BOB **DATE: 23/03/2024**

CHEST X – RAY PA VIEW

FINDINGS:

- Both the domes of diaphragm and CP angles are normal.
- Both the hila and mediastinum are normal.
- Both the lung fields are clear. No e/o focal parenchymal lesion.
- Cardio-thoracic ratio is normal.
- Soft tissues and bony cage are unremarkable.

IMPRESSION:

- **NO SIGNIFICANT ABNORMALITY SEEN.**

Advised: Clinical correlation and further evaluation if clinically indicated.

APOLLO CLINIC RAIPUR

Dr. Zeeshan Ateeb Dani,
MBBS MD
Consultant Radiologist
Reg. No. CGMC-2324/2009

DR. ZEESHAN ATEEB DANI
(MD)
CONSULTANT RADIOLOGIST

This report is for perusal of the doctor only not the definitive diagnosis; findings have to be clinically correlated. This report is not for medico-legal purposes.

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PATIENT NAME:- MR. CHANDRA KISHORE SAHU
REF BY :- BOB
AGE/SEX:- 40 YRS/M
DATE:-23.03.2024

USG ABDOMEN

Liver: Liver is normal in size ,smooth in outline with normal echotexture. IHBR's are not dilated. CBD is not dilated. Portal vein and hepatic veins are normal.

Gall bladder: CONTRECTED (PATIENT IS NOT NIL ORALIY)

Pancreas & Paraaortic Region: Normal.

Spleen: Is normal in size and echotexture.

Kidneys	RIGHT	LEFT
SIZE	9.10X4.61cm	10.23X5.06cm
CORTICAL ECHOGENICITY	Normal	Normal
CORTICOMEDULLARY DIFFERENTIATION	Maintained	Maintained
PCS	Not dilated	Not dilated
Any other remarks	Nil	Nil

Urinary bladder.- Distended & normal..

Prostate: is normal in size. shape & echotexture.

No free fluid in abdomen.

Visualized bowel loops are normal.

No significant intra-abdominal lymphadernopathy seen.

IMPRESSION:

- **USG abomen within normal limit.**

Advised clinical correlation/further evaluation if clinically indicated.

APOLLO CLINIC RAIPUR

DR. ANIL WASTI
SONOLOGIST REG.NO. CGMC-1471

This report is for perusal of the doctor only not the definitive diagnosis; findings have to be clinically correlated. Ultrasound has its limitations in obese patients and in retroperitoneal organs. All congenital abnormalities cannot be detected on ultrasound. This report is not for medico-legal purposes.

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ECHOCARDIOGRAPHY REPORT

NAME : MR. CHANDRA KISHOR SAHU	Age/Sex: 40Yrs/male	ECG : Sinus Rhythm
OPD/ IPD : OPD	STUDY DATE: 23/03/2024	REGN. NO. : FRAI.0000020604
Ref.By Dr : BOB	SPO2-99%	

M-MODE MEASUREMENTS:-

	Patient Value (cm)	Normal Value (cm)		Patient Value (cm)	Normal Value (cm)
AorticRoot Diameter	3.2	2.0 – 3.7	IVS Thickness	ED = 1.0 ES = 1.4	0.6 – 1.1
AorticValve Opening	2.0	1.5 – 2.6	PW Thickness	ED = 0.9 ES = 1.3	0.6 – 1.1
LA Dimension	3.8	1.9 – 4.0	RA Dimension	4.2	2.6
LVID(D)	4.4	3.7 – 5.5	RV Dimension	5.2	2.6
LVID(s)	2.5	2.2 – 4.0	TAPSE	2.2	1.6 – 2.6
LV EJECTION FRACTION		> 60%	(NORMAL VALUE: 55 – 60%)		

2D ECHO, COLOR FLOW & DOPPLER ASSESSMENT

Left Ventricle	: LV Size & contractility is Normal, NO RWMA, Calculated EF IS > 60%
Left Atrium	: LA Size Is Normal
Right Ventricle	: DILATED
Right Atrium	: DILATED
IAS	: LARGE OS ASD (27mm) WITH L-->R SHUNT
IVS	: Intact
Pericardium	: Normal, there is no Pericardial Effusion.
Mitral Valve	: E>A , Normal
Tricuspid Valve	: MILD TR (PASP- 30mmHg)
Aortic Valve	: Normal
Pulmonary Valve	: Pulmonary valve appears normal in morphology.
Systemic venous	: IVC normal in size with normal Inspiratory collapse.

FINAL IMPRESSION : ACHD
LARGE SIZE OS-ASD (27mm) WITH L-->R SHUNT
DILATED RA & RV
MILD TR (PASP- 30mmHg)
NORMAL BIVENTRICULLAR SYSTOLIC FUNCTION
NO I/C CLOT VEGITATION OR PERICARDIAL EFFUSION.

APOLLO CLINIC RAIPUR

DR.DEEPAN DAS
MBBS, DIP. CARDIOLOGY
CONSULTANT DEPT OF NIC

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ID: 618
MR CHANDRA KISHOR SAHU
Male 40Years

23-03-2024 10:12:10 AM

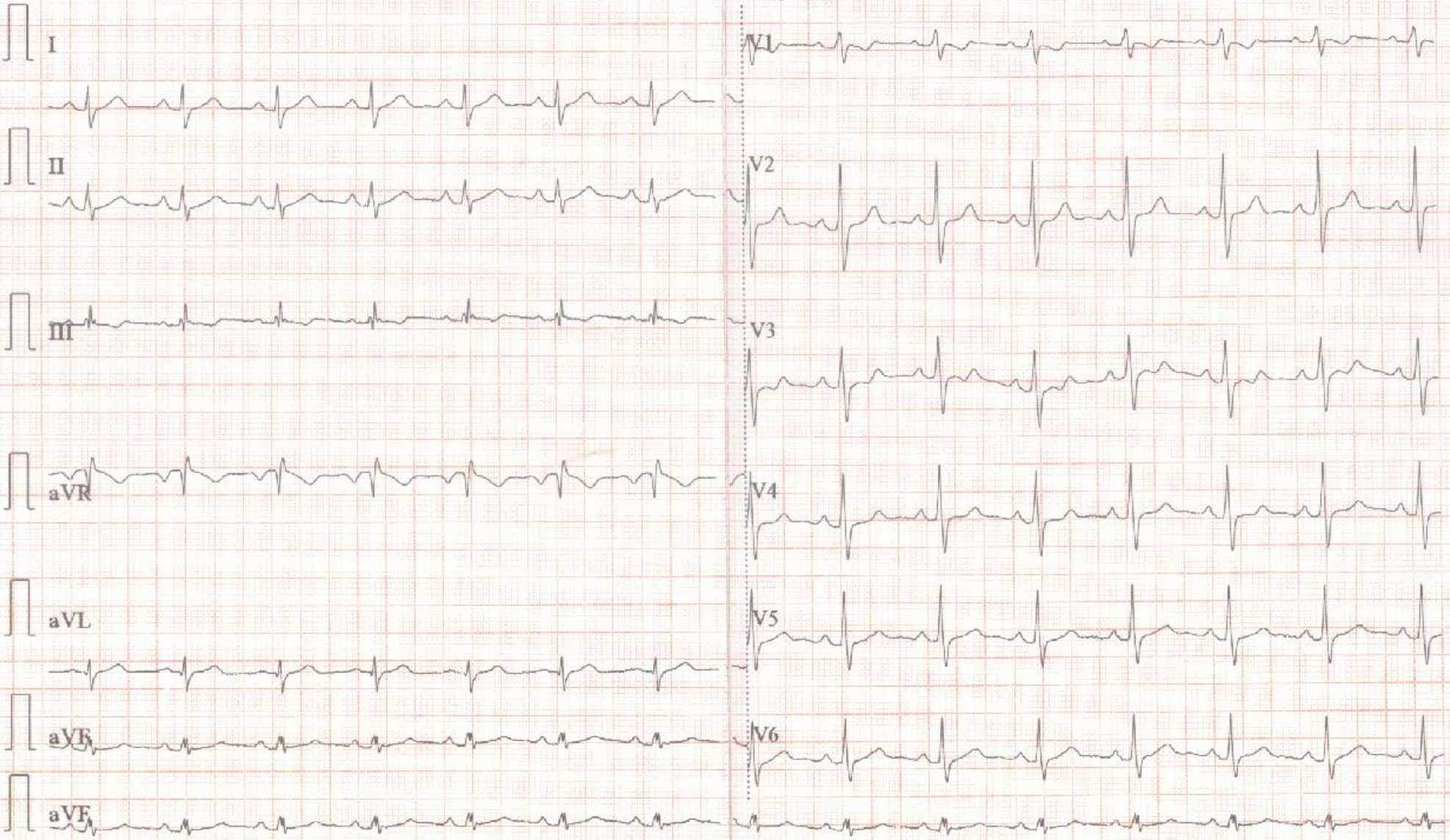
HR	: 87	bpm	
P	: 104	ms	
PR	: 150	ms	
QRS	: 100	ms	
QT/QTc	: 350/421	ms	
P/QRS/T	: 48/86/36	°	
RV5/SV1	: 0.973/0.271	mV	

Diagnosis Information:
Sinus rhythm
Normal ECG

APOLLO CLINIC RAIPUR

Dr. Animesh Choudhary
MD Medicine
Reg. No. CGMC 3583/2011
Apollo Clinic, Raipur

Report Confirmed by:



0.05~45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r ♥87 CAR[redacted] 9108 D V1.43 Glasgow V28.6.0 APOLLO CLINIC RAIPUR

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EXAMINATION OF EYES :-(BY OPHTALMOLOGIST)

Patient Name Mr. Chandra Kishor Sahu Date 23/03/24

Sex/Age M/40 year MR No ..... Employee Id .....

EXTERNAL EXAMINATION			
SQUINT			NIL
NYSTAGMUS			
COLOUR VISION			NORMAL
FUNDUS:(RE):-	NORM	(LE):-	NORM
INDIVIDUAL COLOUR IDENTIFICATION			Good
DISTANT VISION:(RE):-	6/6	(LE):-	6/6
NEAR VISION:(RE):-	N6	(LE):-	N6
NIGHT BLINDNESS			NAD

	SPH	CYL	AXIS	ADD
RIGHT				
LEFT				

REMARKS :-

APOLLO RAIPUR CLINIC

Dr. Vikas Mishra
MBBS,MS(Ophthalmologist)
Reg. No. CGMC 621/2006

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Patient Name	: MR CHANDRA KISHOR SAHU	**Age/Gender**	: 40 Y Male
UHID/ MR No	: 9897	**OP Visit No**	: OPD-UNIT-II-2
Visit Date	: 23/03/2024	**Reported On**	: 23/03/2024 06:29PM
Sample Collected On	: 23/03/2024 05:02PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
HEMOGRAM			
Haemoglobin(HB) Method: CELL COUNTER	13.9	gm/dl	12 - 17
Erythrocyte (RBC) Count Method: CELL COUNTER	4.37	mill/cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	41.70	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	95.4	fL	76.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	31.8	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	12.5	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	6.34	cells/cumm	3.50 - 10.00
Neutrophils Method: CELL COUNTER	65	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	24	%	15.0 - 45.0
Eosinophils Method: CELL COUNTER	03	%	1-6%
Monocytes	08	%	4.0 - 12.0
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report

Results are to be corelated clinically

Lab Technician / Technologist

path

DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

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Sponsor Name	:		

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count Method: CELL COUNTER	111	lacs/cu.mm	150-400
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	10	mm /HR	0 - 10

Blood Group (ABO Typing)

Blood Group (ABO Typing)	O
RhD factor (Rh Typing)	POSITIVE

End of Report
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Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	0.6	mg/dl	0.1- 1.2
Bilirubin - Direct Method: Spectrophotometric	0.2	mg/dl	0.05-0.3
Bilirubin (Indirect) Mathod: Calculated	0.40	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	16	U/L	0 - 40
SGPT (ALT) Method: Spectrophotometric	22	U/L	0 - 41
ALKALINE PHOSPHATASE	79	U/L	25-147
Total Proteins Method: Spectrophotometric	6.6	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.0	mg/dl	3.4 - 5.0
Globulin Mathod: Calculated	2.6	g/dl	1.8 - 3.6
A/G Ratio Mathod: Calculated	1.53	%	1.1 - 2.2

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Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	125.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	89.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotomatric			
HDL Cholesterol	44.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotomatric			
LDL Cholesterol	63.20	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=190
Method: Spectrophotomatric			
VLDL Cholesterol	17.80	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	2.84		3.5-5
Methode: Spectrophotometric			

End of Report

Results are to be corelated clinically

Lab Technician / Technologist

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Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
GLUCOSE - (POST PRANDIAL)			
Glucose -Post prandial Method: REAGENT GRADE WATER	173.0	mg/dl	70-140
GLUCOSE (FASTING)			
Glucose- Fasting SUGAR REAGENT GRADE WATER	97.0	mg/dl	70 - 120
KFT - RENAL PROFILE - SERUM			
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	12	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	1.04	mg/dl	0.6-1.4
Uric Acid Method: Spectrophotomatric	4.65	mg/dL	2.6 - 7.2

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Results are to be corelated clinically

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Sample Collected On	: 23/03/2024 05:02PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

CLINICAL PATHOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
URINE ROUTINE EXAMINATION			
Physical Examination			
Volum of urine	30ML		
Appearance	Clear		Clear
Colour	Pale Yellow		Colourless
Specific Gravity	1.010		1.001 - 1.030
Reaction (pH)	5.0		
Chemical Examination			
Protein(Albumin) Urine	Absent		Absent
Glucose(Sugar) Urine	Absent		Absent
Blood	Absent		Absent
Leukocytes	Absent		Absent
Ketone Urine	Absent		Absent
Bilirubin Urine	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite (Urine)	Absent		Absent
Microscopic Examination			
RBC (Urine)	NIL	/hpf	0 - 2
Pus cells	Occasional	/hpf	0 - 5
Epithelial Cell	Occasional	/hpf	0 - 5
Crystals	Not Seen	/hpf	Not Seen
Bacteria	Not Seen	/hpf	Not Seen
Budding yeast	Not Seen	/hpf	

End of Report

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Patient Name	: Mr.CHANDRA KISHOR SAHU	Collected	: 24/Mar/2024 12:17PM
Age/Gender	: 40 Y 0 M 0 D /M	Received	: 24/Mar/2024 01:38PM
UHID/MR No	: DSUS.0000006978	Reported	: 24/Mar/2024 02:55PM
Visit ID	: DSUSOPV8121	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C (GLYCATED HEMOGLOBIN) , *WHOLE BLOOD EDTA*				
HBA1C, GLYCATED HEMOGLOBIN	5.0	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	97	mg/dL		Calculated

Comment:

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

REFERENCE GROUP	HBA1C %
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

1. HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
2. Trends in HbA1C values is a better indicator of Glycemic control than a single test.
3. Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
4. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
5. In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
   A: HbF >25%
   B: Homozygous Hemoglobinopathy.
   (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)

DR.MAIKAL KUJUR
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Consultant Pathologist

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Patient Name	: Mr.CHANDRA KISHOR SAHU	Collected	: 24/Mar/2024 12:17PM
Age/Gender	: 40 Y 0 M 0 D /M	Received	: 24/Mar/2024 12:52PM
UHID/MR No	: DSUS.0000006978	Reported	: 24/Mar/2024 03:35PM
Visit ID	: DSUSOPV8121	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , *SERUM*				
TRI-IODOTHYRONINE (T3, TOTAL)	1.48	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	10.9	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	**0.020**	µIU/mL	0.35-5.5	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

*** End Of Report ***

DR.MAYKAL KUJUR
M.B.B.S,M.D(Pathology)
Consultant Pathologist

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