NAME	**MR Avinash GUPTA**	**STUDY DATE**	**23/03/2024 3:28PM**
AGE / SEX	**35 y / M**	**HOSPITAL NO.**	**MH005734110**
ACCESSION NO.	**NM12920483**	**MODALITY**	**US**
REPORTED ON	**27/03/2024 2:28PM**	**REFERRED BY**	**Health Check MHD**

2D Echocardiography Report

	End diastole	**End systole**
IVS thickness (cm)	**0.8**	**1.0**
Left Ventricular Dimension (cm)	**4.4**	**2.4**
Left Ventricular Posterior Wall thickness (cm)	**0.9**	**1.1**

Aortic Root Diameter (cm)	**2.5**
Left Atrial Dimension (cm)	**2.8**
Left Ventricular Ejection Fraction (%)	**60%**

LEFT VENTRICLE	:	Normal in size. No RWMA. LVEF=60%
RIGHT VENTRICLE	:	Normal in size. Normal RV function.
LEFT ATRIUM	:	Normal in size
RIGHT ATRIUM	:	Normal in size
MITRAL VALVE	:	Trace MR
AORTIC VALVE	:	Normal
TRICUSPID VALVE	:	Mild TR (PASP~ 28mmHg)
PULMONARY VALVE	:	Normal
MAIN PULMONARY ARTERY & ITS BRANCHES	:	Appears normal.
INTERATRIAL SEPTUM	:	Intact.
INTERVENTRICULAR SEPTUM	:	Intact.
PERICARDIUM	:	No pericardial effusion or thickening

NAME	**MR Avinash GUPTA**	**STUDY DATE**	**23/03/2024 3:28PM**
AGE / SEX	**35 y / M**	**HOSPITAL NO.**	**MH005734110**
ACCESSION NO.	**NM12920483**	**MODALITY**	**US**
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DOPPLER STUDY

VALVE	Peak Velocity (cm/sec)	Maximum P.G. (mmHg)	Mean P. G. (mmHg)	Regurgitation	Stenosis
MITRAL	E= 89 A=75	-	-	Trace	Nil
AORTIC	141	-	-	Nil	Nil
TRICUSPID	-	N	N	Mild	Nil
PULMONARY	84	N	N	Nil	Nil

SUMMARY & INTERPRETATION:

- No LV regional wall motion abnormality with LVEF = 60 %
- Normal sized RA/RV/LV/LA with no chamber hypertrophy. Normal RV function.
- Trace MR
- Mild TR (PASP~ 28mmHg)
- Normal mitral inflow pattern.
- IVC normal in size, >50% collapse with inspiration, suggestive of normal RA pressure.
- No clot/vegetation/pericardial effusion.

Please correlate clinically.

Dr. Samanjoy Mukherjee MBBS, MD, General Medicine, DM(Cardiology) DMC No.12194
Consultant (Cardiology)

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

Name	:	MR AVINASH GUPTA	**Age**	:	35 Yr(s) Sex :Male
Registration No	:	MH005734110	**Lab No**	:	31240301306
Patient Episode	:	H03000061610	**Collection Date :**		23 Mar 2024 11:52
Referred By	:	HEALTH CHECK MHD	**Reporting Date :**		23 Mar 2024 16:58
Receiving Date	:	23 Mar 2024 15:35			

Department of Transfusion Medicine (Blood Bank)

BLOOD GROUPING, RH TYPING & ANTIBODY SCREEN (TYPE & SCREEN)
Specimen-Blood

Blood Group & Rh Typing (Agglutinaton by gel/tube technique)

Blood Group & Rh typing	AB Rh(D) Positive

Antibody Screening (Microtyping in gel cards using reagent red cells)

Final Antibody Screen Result	Negative

Technical Note:
ABO grouping and Rh typing is done by cell and serum grouping by microplate / gel technique.
Antibody screening is done using a 3 cell panel of reagent red cells coated with Rh, Kell,Duffy,Kidd, Lewis, P,MNS,Lutheran and Xg antigens using gel technique.

----------END OF REPORT----------

Dr Himanshu Lamba

Name	:	MR AVINASH GUPTA	**Age**	:	35 Yr(s) Sex :Male
Registration No	:	MH005734110	**Lab No**	:	32240312839
Patient Episode	:	H03000061610	**Collection Date :**		23 Mar 2024 11:51
Referred By	:	HEALTH CHECK MHD	**Reporting Date :**		23 Mar 2024 17:50
Receiving Date	:	23 Mar 2024 12:45			

BIOCHEMISTRY

Specimen: EDTA Whole blood

HbA1c (Glycosylated Hemoglobin)	4.9	%	As per American Diabetes Association(ADA) 2010 [4.0-6.5] HbA1c in % Non diabetic adults : < 5.7 % Prediabetes (At Risk) : 5.7 % - 6.4 % Diabetic Range : > 6.5 %
Estimated Average Glucose (eAG)	94	mg/dl	

Use :

1.Monitoring compliance and long-term blood glucose level control in patients with diabetes.
2.Index of diabetic control (direct relationship between poor control and development of complications).
3. Predicting development and progression of diabetic microvascular complications.

Limitations :

1. A1C values may be falsely elevated or decreased in those with chronic kidney disease.
2.False elevations may be due in part to analytical interference from carbamylated hemoglobin formed in the presence of elevated concentrations of urea, with some assays.
3. False decreases in measured A1C may occur with hemodialysis and altered red cell turnover, especially in the setting of erythropoietin treatment

References : Rao.L.V.,Michael snyder.L.(2021).Wallach's Interpretation of Diagnostic Tests. 11th Edition. Wolterkluwer. NaderRifai,Andrea Rita Horvath,Carl T.wittwer. (2018)Teitz Text book of Clinical Chemistry and Molecular Diagnostics.First edition,Elsevier,South Asia.

Name	:	MR AVINASH GUPTA	**Age**	:	35 Yr(s) Sex :Male
Registration No	:	MH005734110	**Lab No**	:	32240312839
Patient Episode	:	H03000061610	**Collection Date :**		23 Mar 2024 11:51
Referred By	:	HEALTH CHECK MHD	**Reporting Date :**		23 Mar 2024 18:20
Receiving Date	:	23 Mar 2024 12:39			

BIOCHEMISTRY

Lipid Profile (Serum)

TOTAL CHOLESTEROL (CHOD/POD)	**266 #**	**mg/dl**	**[<200]** Moderate risk:200-239 High risk:>240
TRIGLYCERIDES (GPO/POD)	**332 #**	**mg/dl**	**[<150]** Borderline high:151-199 High: 200 - 499 Very high:>500
HDL - CHOLESTEROL (Direct) Methodology: Homogenous Enzymatic	40	mg/dl	[30-60]
VLDL - Cholesterol (Calculated)	**66 #**	**mg/dl**	**[10-40]**
(CALCULATED)LDL- CHOLESTEROL	**160 #**	**mg/dl**	**[<100]** Near/Above optimal-100-129 Borderline High:130-159 High Risk:160-189
T.Chol/HDL.Chol ratio	6.7		<4.0 Optimal 4.0-5.0 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	4.0		<3 Optimal 3-4 Borderline >6 High Risk

Note:
Reference ranges based on ATP III Classifications.
Recommended to do fasting Lipid Profile after a minimum of 8 hours of overnight fasting.

Technical Notes:
Lipid profile is a panel of blood tests that serves as initial broad medical screening tool for abnormalities in lipids, the results of these tests can identify certain genetic

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Name	:	MR AVINASH GUPTA	**Age**	:	35 Yr(s) Sex :Male
Registration No	:	MH005734110	**Lab No**	:	32240312839
Patient Episode	:	H03000061610	**Collection Date :**		23 Mar 2024 11:51
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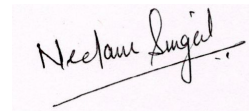
BIOCHEMISTRY

diseases and determine approximate risks for cardiovascular disease, certain forms of pancreatitis and other diseases.

----------END OF REPORT----------



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

Name	: MR AVINASH GUPTA	**Age**	: 35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No**	: 32240312839
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:51
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 18:20
Receiving Date	: 23 Mar 2024 12:39		

BIOCHEMISTRY

THYROID PROFILE, Serum — **Specimen Type : Serum**

T3 - Triiodothyronine (ECLIA)	1.100	ng/ml	[0.800-2.040]
T4 - Thyroxine (ECLIA)	8.350	µg/dl	[4.600-10.500]
Thyroid Stimulating Hormone (ECLIA)	3.250	µIU/mL	[0.340-4.250]

Note : TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m.and at a minimum between 6-10 pm.Factors such as change of seasons hormonal fluctuations,Ca or Fe supplements,high fibre diet,stress and illness affect TSH results.
* References ranges recommended by the American Thyroid Association
1) Thyroid. 2011 Oct;21(10):1081-125.PMID .21787128
2) http://www.thyroid-info.com/articles/tsh-fluctuating.html

Test Name	Result	Unit	Biological Ref. Interval
LIVER FUNCTION TEST (Serum)			
BILIRUBIN-TOTAL (Diazonium Ion)	0.82	mg/dl	[0.10-1.20]
BILIRUBIN - DIRECT (Diazotization)	0.27	mg/dl	[0.00-0.30]
BILIRUBIN - INDIRECT (Calculated)	0.55	mg/dl	[0.20-1.00]
SGOT/ AST (UV without P5P)	24.5	U/L	[10.0-50.0]
SGPT/ ALT (UV without P5P)	37.0	U/L	[0.0-41.0]
ALP (p-NPP,kinetic)*	120	U/L	[45-135]
TOTAL PROTEIN (Biuret)	7.6	g/dl	[6.0-8.2]
SERUM ALBUMIN (BCG-dye)	4.8	g/dl	[3.5-5.2]
SERUM GLOBULIN (Calculated)	2.8	g/dl	[1.8-3.4]
ALB/GLOB (A/G) Ratio(Calculated)	1.71		[1.10-1.80]

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Name	: MR AVINASH GUPTA	**Age**	: 35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No**	: 32240312839
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:51
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 18:20
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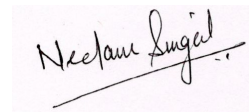
BIOCHEMISTRY

Technical Notes:
Liver function test aids in diagnosis of various pre hepatic, hepatic and post hepatic causes of dysfunction like hemolytic anemia's, viral and alcoholic hepatitis and cholestasis of obstructive causes.

Test Name	Result	Unit	Biological Ref. Interval
KIDNEY PROFILE (Serum)			
BUN (Urease/GLDH)	10.00	mg/dl	[6.00-20.00]
SERUM CREATININE (Jaffe's method)	0.87	mg/dl	[0.80-1.60]
SERUM URIC ACID (Uricase)	**7.4 #**	**mg/dl**	**[3.5-7.2]**
SERUM CALCIUM (NM-BAPTA)	9.92	mg/dl	[8.00-10.50]
SERUM PHOSPHORUS (Molybdate, UV)	3.2	mg/dl	[2.5-4.5]
SERUM SODIUM (ISE)	143.0	mmol/l	[134.0-145.0]
SERUM POTASSIUM (ISE)	4.83	mmol/l	[3.50-5.20]
SERUM CHLORIDE (ISE Indirect)	**105.7 #**	**mmol/L**	**[95.0-105.0]**
eGFR	111.8	ml/min/1.73sq.m	[>60.0]

Technical Note
eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis / Icterus / Lipemia.

----------END OF REPORT----------



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

Name	: MR AVINASH GUPTA	**Age**	: 35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No**	: 32240312840
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 16:46
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	24 Mar 2024 15:20
Receiving Date	: 23 Mar 2024 17:15		

BIOCHEMISTRY

Specimen Type : Plasma

PLASMA GLUCOSE – PP

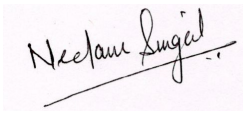
Plasma GLUCOSE – PP (Hexokinase)	117	mg/dl	[70–140]

Note : Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying, brisk glucose absorption , post exercise

Specimen Type : Serum/Plasma

Plasma GLUCOSE-Fasting (Hexokinase)	94	mg/dl	[74–106]

----------END OF REPORT----------



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

Name	: MR AVINASH GUPTA	**Age**	: 35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No**	: 33240308014
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:52
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 13:47
Receiving Date	: 23 Mar 2024 12:46		

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (Automated) Specimen-Whole Blood

ESR	3.0	mm/1sthour	[0.0-10.0]

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 postpartum.

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.

Test Name	Result	Unit	Biological Ref. Interval
COMPLETE BLOOD COUNT (EDTA Blood)			
WBC Count (Flow cytometry)	6770	/cu.mm	[4000-10000]
RBC Count (Impedence)	5.11	million/cu.mm	[4.50-5.50]
Haemoglobin (SLS Method)	15.3	g/dL	[13.0-17.0]
Haematocrit (PCV)	45.4	%	[40.0-50.0]
(RBC Pulse Height Detector Method)			
MCV (Calculated)	88.8	fL	[83.0-101.0]
MCH (Calculated)	29.9	pg	[25.0-32.0]
MCHC (Calculated)	33.7	g/dL	[31.5-34.5]
Platelet Count (Impedence)	238000	/cu.mm	[150000-410000]
RDW-CV (Calculated)	**14.1 #**	**%**	**[11.6-14.0]**
DIFFERENTIAL COUNT			
Neutrophils (Flowcytometry)	47.7	%	[40.0-80.0]
Lymphocytes (Flowcytometry)	**46.2 #**	**%**	**[20.0-40.0]**

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Name	: MR AVINASH GUPTA	**Age** :	35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No** :	33240308014
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:52
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 13:09
Receiving Date	: 23 Mar 2024 12:46		

HAEMATOLOGY

Monocytes (Flowcytometry)	4.3	%		[2.0-10.0]
Eosinophils (Flowcytometry)	1.5	%		[1.0-6.0]
Basophils (Flowcytometry)	**0.3 #**	**%**		**[1.0-2.0]**
IG	0.10	%		
Neutrophil Absolute(Flouroscence flow cytometry)	3.2	/cu mm		[2.0-7.0]x10³
Lymphocyte Absolute(Flouroscence flow cytometry)	**3.1 #**	**/cu mm**		**[1.0-3.0]x10³**
Monocyte Absolute(Flouroscence flow cytometry)	0.3	/cu mm		[0.2-1.2]x10³
Eosinophil Absolute(Flouroscence flow cytometry)	0.1	/cu mm		[0.0-0.5]x10³
Basophil Absolute(Flouroscence flow cytometry)	0.0	/cu mm		[0.0-0.1]x10³

Complete Blood Count is used to evaluate wide range of health disorders, including anemia, infection, and leukemia. Abnormal increase or decrease in cell counts as revealed may indicate that an underlying medical condition that calls for further evaluation.

----------END OF REPORT----------

Dr. Shalakha Agrawal
Associate Consultant,M.B.B.S,M.D. Pathology
--2020

Name	: MR AVINASH GUPTA	**Age**	: 35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No**	: 38240303016
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:52
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 23:39
Receiving Date	: 23 Mar 2024 19:01		

CLINICAL PATHOLOGY

Test Name	Result	Biological Ref. Interval
ROUTINE URINE ANALYSIS		
MACROSCOPIC DESCRIPTION		
Colour (Visual)	PALE YELLOW	(Pale Yellow - Yellow)
Appearance (Visual)	CLEAR	
CHEMICAL EXAMINATION		
Reaction[pH] (Reflectancephotometry(Indicator Method))	6.0	(5.0-9.0)
Specific Gravity (Reflectancephotometry(Indicator Method))	1.015	(1.003-1.035)
Bilirubin	Negative	NEGATIVE
Protein/Albumin (Reflectance photometry(Indicator Method)/Manual SSA)	Negative	(NEGATIVE-TRACE)
Glucose (Reflectance photometry (GOD-POD/Benedict Method))	NOT DETECTED	(NEGATIVE)
Ketone Bodies (Reflectance photometry(Legal's Test)/Manual Rotheras)	NOT DETECTED	(NEGATIVE)
Urobilinogen Reflactance photometry/Diazonium salt reaction	NORMAL	(NORMAL)
Nitrite Reflactance photometry/Griess test	NEGATIVE	NEGATIVE
Leukocytes Reflactance photometry/Action of Esterase	NIL	NEGATIVE
BLOOD (Reflectance photometry(peroxidase))	NIL	NEGATIVE
MICROSCOPIC EXAMINATION (Manual)	**Method: Light microscopy on centrifuged urine**	
WBC/Pus Cells	0-1 /hpf	(4-6)
Red Blood Cells	NIL	(1-2)
Epithelial Cells	1-2 /hpf	(2-4)
Casts	NIL	(NIL)
Crystals	NIL	(NIL)
Bacteria	NIL	
Yeast cells	NIL	

Interpretation:

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Name	: MR AVINASH GUPTA	**Age** :	35 Yr(s) Sex :Male
Registration No	: MH005734110	**Lab No** :	38240303016
Patient Episode	: H03000061610	**Collection Date :**	23 Mar 2024 11:52
Referred By	: HEALTH CHECK MHD	**Reporting Date :**	23 Mar 2024 23:39
Receiving Date	: 23 Mar 2024 19:01		

CLINICAL PATHOLOGY

URINALYSIS-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, urina tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine.
Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
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 haemoglobin, 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. Nitrite concentration duri infection increases with length of time the urine specimen is retained in bladder prior to collection.
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 decrease Specific gravity is seen in excessive fluid intake, renal failure and diabetes 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 case of hemolytic anemia.

----------END OF REPORT----------

Dr. Shalakha Agrawal
Associate Consultant,M.B.B.S,M.D. Pathology
--2020

NAME	**MR Avinash GUPTA**	**STUDY DATE**	**23/03/2024 3:00PM**
AGE / SEX	**35 y / M**	**HOSPITAL NO.**	**MH005734110**
ACCESSION NO.	**R7110460**	**MODALITY**	**US**
REPORTED ON	**23/03/2024 3:08PM**	**REFERRED BY**	**Health Check MHD**

USG WHOLE ABDOMEN

Results:

Liver is normal in size (11.7 cm) and echopattern. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre.

Gall bladder appears echofree with normal wall thickness.
Common bile duct is normal in calibre.

Pancreas is normal in size and echopattern.

Spleen is normal in size (10.8 cm) and echopattern.

RK = 93 x 46 mm
LK = 93 x 47 mm
Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. No focal lesion or calculus seen on either side. Bilateral pelvicalyceal systems are not dilated.

Urinary bladder is normal in wall thickness with clear contents. No significant intra or extraluminal mass is seen.

Prostate is normal in size, shape and echopattern. It measures 7.9 cc in volume.

No significant free fluid is detected.

IMPRESSION: Normal study.

Kindly correlate clinically

Dr. Roly Srivastava MBBS, DNB DMC No.45626
CONSULTANT RADIOLOGIST

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

NAME	**MR Avinash GUPTA**	**STUDY DATE**	**23/03/2024 1:09PM**
AGE / SEX	**35 y / M**	**HOSPITAL NO.**	**MH005734110**
ACCESSION NO.	**R7110461**	**MODALITY**	**CR**
REPORTED ON	**26/03/2024 3:19PM**	**REFERRED BY**	**Health Check MHD**

X-RAY CHEST - PA VIEW

Results:

Visualized lung fields appear clear.

Both hilar shadows appear normal.

Cardiothoracic ratio is within normal limits.

Both hemidiaphragmatic outlines appear normal.

Both costophrenic angles are clear.

Kindly correlate clinically.

Aarushi

Dr. Aarushi MBBS, MD, DNB DMC N0.03291
CONSULTANT RADIOLOGIST

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