



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: 8/3/25

Name: Suman Hamra Age: 30 yrs Sex:  M /  F

BP: 130/90 mmHg Height (cms): 176 cm Weight(kgs): 82 kg BMI: \_\_\_\_\_

WEIGHT lbs	100	105	110	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	50.0	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	37	38	39	40		
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40		
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38		
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38		
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37		
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37		
5'9" - 175.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
5'11" - 180.3	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35		
6'1" - 185.4	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35		
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34		
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34		
6'4" - 193.0	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34		

Doctors Notes:

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Signature



UHID	13019316	Date	08/03/2024		
Name	Mr Suman Hamra	Sex	M	Age	38
OPD	Ophthal	Health Check-Up			

Clus. No.

Hcs No.

Drug allergy: -> Not known.

Sys illness: -> No.

Habit -> No.

UplK → RG. 6/12P.  
 ↘ LG. 6/12P

NR → RG NG  
 ↘ LG NG

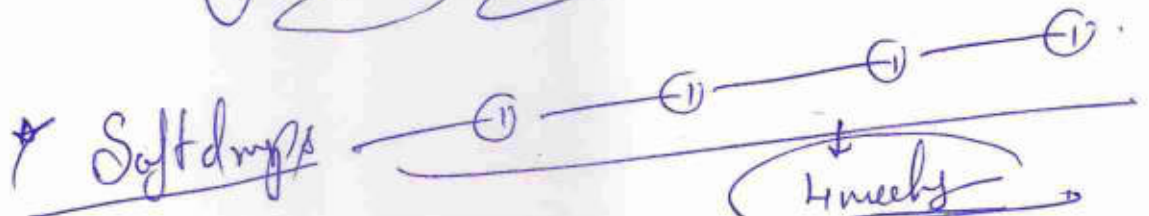
Refu → RG, Plus / -1.25 x 90° 6/6.  
 ↘ LG Plus / -1.25 x 90° 6/6

NR → RG NG  
 ↘ LG NG

P.O.P → RG → 14.8  
 ↘ LG 15.1

Apr  
 Shu as P.O.P.

All up





(Rahija-Fortis, Melin)

UHID	13019316	Date	08/03/2024
Name	Mr Suman Hamra (9903046878)	Sex	M
OPD	Dental	Age	38
Health Check-Up			

Drug allergy:  
 Sys illness:

M/H → NRH

O/E → R.P 7/7

- stains ++, calculus ++
- subgingival calculus present
- suppuration 2/1/1

dx → Adv. Scaling.

✓ → Adv. CBCT (Maxilla) → F  
 (for implant placement)

7/7

(CBCT Full mouth -)  
 ↳ to pay Rs 4500

Parsha

Dr. Varshellam  
 MDS (Perio)  
 A-39457  
 (9833462595)

PATIENT NAME : MR. SUMAN HANRA

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

ACCESSION NO : 0022XC001499  
 PATIENT ID : FH.13019316  
 CLIENT PATIENT ID: UID:13019316  
 ABHA NO :

AGE/SEX : 38 Years Male  
 DRAWN : 08/03/2024 10:36:00  
 RECEIVED : 08/03/2024 10:37:21  
 REPORTED : 08/03/2024 14:10:25

## CLINICAL INFORMATION :

UID:13019316 REQNO-1673374  
 CORP-OPD  
 BILLNO-150124OPCR013545  
 BILLNO-150124OPCR013545

Test Report Status	Final	Results	Biological Reference Interval	Units
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## HAEMATOTOLOGY - CBC

## CBC-5, EDTA WHOLE BLOOD

## BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	14.7	13.0 - 17.0	g/dL
METHOD : SLS METHOD			
RED BLOOD CELL (RBC) COUNT	7.42 High	4.5 - 5.5	mil/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	7.57	4.0 - 10.0	thou/ $\mu$ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	167	150 - 410	thou/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	46.1	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	62.1 Low	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	19.8 Low	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	31.9	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	19.4 High	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	8.4		
METHOD : CALCULATED PARAMETER			

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	49	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			



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



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**Test Report Status Final**

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LYMPHOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	37	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	9	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	4	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	1	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	3.71	2.0 - 7.0	thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.80	1.0 - 3.0	thou/ $\mu$ L
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.68	0.2 - 1.0	thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.30	0.02 - 0.50	thou/ $\mu$ L
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	0.08	0.02 - 0.10	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	1.3		

**MORPHOLOGY**

**RBC**

METHOD : MICROSCOPIC EXAMINATION

**WBC**

METHOD : MICROSCOPIC EXAMINATION

**PLATELETS**

METHOD : MICROSCOPIC EXAMINATION

**REMARKS**

MILD MICROCYTOSIS, MILD ANISOPOIKILOCYTOSIS

NORMAL MORPHOLOGY

ADEQUATE

ADVISED-SERUM IRON STUDIES AND HB ELECTROPHORESIS

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



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**Units**
**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**

<b>E.S.R</b>	<b>02</b>	<b>0 - 14</b>	<b>mm at 1 hr</b>
METHOD : WESTERNGREN METHOD			

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

<b>HBA1C</b>	<b>9.2 High</b>	<b>Non-diabetic: &lt; 5.7</b>	<b>%</b>
		<b>Pre-diabetics: 5.7 - 6.4</b>	
		<b>Diabetics: &gt; or = 6.5</b>	
		<b>Therapeutic goals: &lt; 7.0</b>	
		<b>Action suggested : &gt; 8.0</b>	
		<b>(ADA Guideline 2021)</b>	

METHOD : HB VARIANT (HPLC)

<b>ESTIMATED AVERAGE GLUCOSE(EAG)</b>	<b>217.3 High</b>	<b>&lt; 116.0</b>	<b>mg/dL</b>
METHOD : CALCULATED PARAMETER			

**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, Vasculitides, 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 (Paraproteinemas, 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.

**LIMITATIONS**

**False elevated ESR :** Increased fibrinogen, Drugs (Vitamin A, Dextran etc), Hypercholesterolemia

**False Decreased :** Poikilocytosis, (Sickle Cells, 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. AACCPress, 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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 :**

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin.
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
- 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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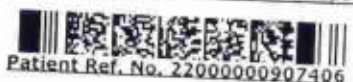
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**IMMUNOHAEMATOLOGY**

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

**ABO GROUP**

METHOD : TUBE AGGLUTINATION

TYPE O

**RH TYPE**

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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Test Report Status **Final**

Results

Biological Reference Interval Units

**BIOCHEMISTRY**

**LIVER FUNCTION PROFILE, SERUM**

Test Name	Result	Biological Reference Interval	Units
<b>BILIRUBIN, TOTAL</b> METHOD : JENDRASSIK AND GROFF	0.60	0.2 - 1.0	mg/dL
<b>BILIRUBIN, DIRECT</b> METHOD : JENDRASSIK AND GROFF	0.12	0.0 - 0.2	mg/dL
<b>BILIRUBIN, INDIRECT</b> METHOD : CALCULATED PARAMETER	0.48	0.1 - 1.0	mg/dL
<b>TOTAL PROTEIN</b> METHOD : BIURET	7.7	6.4 - 8.2	g/dL
<b>ALBUMIN</b> METHOD : BCP DYE BINDING	4.0	3.4 - 5.0	g/dL
<b>GLOBULIN</b> METHOD : CALCULATED PARAMETER	3.7	2.0 - 4.1	g/dL
<b>ALBUMIN/GLOBULIN RATIO</b> METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
<b>ASPARTATE AMINOTRANSFERASE(AST/SGOT)</b> METHOD : UV WITH PSP	124 High	15 - 37	U/L
<b>ALANINE AMINOTRANSFERASE (ALT/SGPT)</b> METHOD : UV WITH PSP	201 High	< 45.0	U/L
<b>ALKALINE PHOSPHATASE</b> METHOD : PNPP-ANP	138 High	30 - 120	U/L
<b>GAMMA GLUTAMYL TRANSFERASE (GGT)</b> METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE	44	15 - 85	U/L
<b>LACTATE DEHYDROGENASE</b> METHOD : LACTATE -PYRUVATE	174	85 - 227	U/L

**GLUCOSE FASTING, FLUORIDE PLASMA**

<b>FBS (FASTING BLOOD SUGAR)</b> METHOD : HEXOKINASE	210 High	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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Dr. Akshay Dhotre, MD  
(Reg.no. MMC 2019/09/6377)  
Consultant Pathologist



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Maharashtra, India  
Tel : 022-39199222, 022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



Patient Ref. No. 22000000907406

**PATIENT NAME : MR. SUMAN HANRA**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000045507**

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : **0022XC001499**

PATIENT ID : FH.13019316

CLIENT PATIENT ID: UID:13019316

ABHA NO :

AGE/SEX : 38 Years Male  
DRAWN : 08/03/2024 10:36:00  
RECEIVED : 08/03/2024 10:37:21  
REPORTED : 08/03/2024 14:10:25

**CLINICAL INFORMATION :**

UID:13019316 REQNO-1673374  
CORP-OPD  
BILLNO-150124OPCR013545  
BILLNO-150124OPCR013545

Test Report Status	Final	Results	Biological Reference Interval	Units
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**KIDNEY PANEL - 1**

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN

METHOD : UREASE - UV

6

6 - 20

mg/dL

**CREATININE EGFR- EPI**

CREATININE

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

0.62 Low

0.90 - 1.30

mg/dL

GLOMERULAR FILTRATION RATE (MALE)

38

years

METHOD : CALCULATED PARAMETER

125.47

Refer Interpretation Below mL/min/1.73m<sup>2</sup>

**BUN/CREAT RATIO**

BUN/CREAT RATIO

METHOD : CALCULATED PARAMETER

9.68

5.00 - 15.00

**URIC ACID, SERUM**

URIC ACID

METHOD : URICASE UV

3.0 Low

3.5 - 7.2

mg/dL

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN

METHOD : BIURET

7.7

6.4 - 8.2

g/dL

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**ALBUMIN, SERUM**

**ALBUMIN**

METHOD : BCP DYE BINDING

4.0

3.4 - 5.0

g/dL

**GLOBULIN**

**GLOBULIN**

METHOD : CALCULATED PARAMETER

3.7

2.0 - 4.1

g/dL

**ELECTROLYTES (NA/K/CL), SERUM**

**SODIUM, SERUM**

METHOD : ISE INDIRECT

135 Low

136 - 145

mmol/L

**POTASSIUM, SERUM**

METHOD : ISE INDIRECT

4.67

3.50 - 5.10

mmol/L

**CHLORIDE, SERUM**

METHOD : ISE INDIRECT

100

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** result 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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**Units**

**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 so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 - 15%), Chronic pancreatitis (30%), Drugs: corticosteroids, phenytoin, estrogen, thiazides, 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 Glycosuria, 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 1.73m<sup>2</sup>). 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.

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



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Email : -

Patient Ref. No. 2200000907406

**PATIENT NAME : MR. SUMAN HANRA**

**CODE/NAME & ADDRESS : C000045507**

FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

**REF. DOCTOR : SELF**

**ACCESSION NO : 0022XC001499**

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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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 Consultant Pathologist



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**Test Report Status Final**

**Results**

**Biological Reference Interval Units**

**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

**CHOLESTEROL, TOTAL**

94

< 200 Desirable  
200 - 239 Borderline High  
>= 240 High  
mg/dL

METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

**TRIGLYCERIDES**

747 High

< 150 Normal  
150 - 199 Borderline High  
200 - 499 High  
>=500 Very High  
mg/dL

METHOD : ENZYMATIC ASSAY

**HDL CHOLESTEROL**

28 Low

< 40 Low  
>=60 High  
mg/dL

METHOD : DIRECT MEASURE - PEG

**LDL CHOLESTEROL, DIRECT**

32

< 100 Optimal  
100 - 129 Near or above optimal  
130 - 159 Borderline High  
160 - 189 High  
>= 190 Very High  
mg/dL

METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT

**NON HDL CHOLESTEROL**

66

Desirable: Less than 130  
Above Desirable: 130 - 159  
Borderline High: 160 - 189  
High: 190 - 219  
Very high: > or = 220  
mg/dL

METHOD : CALCULATED PARAMETER

**VERY LOW DENSITY LIPOPROTEIN**

NOT CALCULATED

<= 30.0  
mg/dL

METHOD : CALCULATED PARAMETER

**CHOL/HDL RATIO**

3.4

3.3 - 4.4 Low Risk  
4.5 - 7.0 Average Risk  
7.1 - 11.0 Moderate Risk  
> 11.0 High Risk

METHOD : CALCULATED PARAMETER

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LDL/HDL RATIO		1.1	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				

**Comments**

NOTE: - SERUM SPECIMEN RECEIVED IS LIPEMIC, VLDL IS CALCULATED VALUE. IF TRIGLYCERIDES VALUE IS > 400 mg/dl, HENCE THE FORMULA IS NOT VALID. HENCE VLDL IS REPORTED AS NOT CALCULATED.

**Interpretation(s)**

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**CLINICAL PATH - URINALYSIS**

**KIDNEY PANEL - 1**

**PHYSICAL EXAMINATION, URINE**

COLOR METHOD : PHYSICAL	PALE YELLOW
APPEARANCE METHOD : VISUAL	CLEAR

**CHEMICAL EXAMINATION, URINE**

PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	>=1.030	1.003 - 1.035
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	<b>DETECTED (+)</b>	NOT DETECTED
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)	NORMAL	NORMAL
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED

**Dr. Akshay Dhotre, MD**  
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 Consultant Pathologist

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



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**MICROSCOPIC EXAMINATION, URINE**

**RED BLOOD CELLS**

METHOD : MICROSCOPIC EXAMINATION

NOT DETECTED

NOT DETECTED

/HPF

**PUS CELL (WBC'S)**

METHOD : MICROSCOPIC EXAMINATION

1-2

0-5

/HPF

**EPITHELIAL CELLS**

METHOD : MICROSCOPIC EXAMINATION

0-1

0-5

/HPF

**CASTS**

METHOD : MICROSCOPIC EXAMINATION

NOT DETECTED

**CRYSTALS**

METHOD : MICROSCOPIC EXAMINATION

NOT DETECTED

**BACTERIA**

METHOD : MICROSCOPIC EXAMINATION

NOT DETECTED

NOT DETECTED

**YEAST**

METHOD : MICROSCOPIC EXAMINATION

NOT DETECTED

NOT DETECTED

**REMARKS**

URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT

**Interpretation(s)**

**Dr. Akshay Dhotre, MD**  
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Consultant Pathologist

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



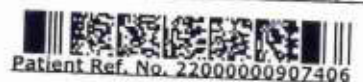
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Navi Mumbai, 400703  
Maharashtra, India  
Tel : 022-39199222,022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



PATIENT NAME : MR. SUMAN HANRA

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : 0022XC001499

PATIENT ID : FH.13019316

CLIENT PATIENT ID: UID:13019316

ABHA NO :

AGE/SEX : 38 Years Male

DRAWN : 08/03/2024 10:36:00

RECEIVED : 08/03/2024 10:37:21

REPORTED : 08/03/2024 14:10:25

## CLINICAL INFORMATION :

UID:13019316 REQNO-1673374

CORP-OPD

BILLNO-150124OPCR013545

BILLNO-150124OPCR013545

Test Report Status	Final	Results	Biological Reference Interval	Units
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## SPECIALISED CHEMISTRY - HORMONE

## THYROID PANEL, SERUM

T3	148.8	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	8.91	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.780	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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## PERFORMED AT :

Agilus Diagnostics Ltd.  
Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,  
Navi Mumbai, 400703  
Maharashtra, India  
Tel : 022-39199222, 022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



Patient Ref. No. 22000000907406

PATIENT NAME : MR. SUMAN HANRA

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : 0022XC001499

PATIENT ID : FH.13019316

CLIENT PATIENT ID: UID:13019316

ABHA NO :

AGE/SEX : 38 Years Male

DRAWN : 08/03/2024 10:36:00

RECEIVED : 08/03/2024 10:37:21

REPORTED : 08/03/2024 14:10:25

## CLINICAL INFORMATION :

UID:13019316 REQNO-1673374

CORP-OPD

BILLNO-150124OPCR013545

BILLNO-150124OPCR013545

Test Report Status	Final	Results	Biological Reference Interval	Units
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## SPECIALISED CHEMISTRY - TUMOR MARKER

## PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.386	0.0 - 1.4	ng/mL
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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 is 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, Teltz. 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](http://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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Tel : 022-39199222,022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



Patient Ref. No. 2200000907406

PATIENT NAME : MR.SUMAN HANRA

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

ACCESSION NO : 0022XC001546  
 PATIENT ID : FH.13019316  
 CLIENT PATIENT ID: UID:13019316  
 ABHA NO :

AGE/SEX : 38 Years Male  
 DRAWN : 08/03/2024 13:13:00  
 RECEIVED : 08/03/2024 13:13:34  
 REPORTED : 08/03/2024 14:16:51

## CLINICAL INFORMATION :

UID:13019316 REQNO-1673374  
 CORP-OPD  
 BILLNO-150124OPCR013545  
 BILLNO-150124OPCR013545

Test Report Status	Final	Results	Biological Reference Interval	Units
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## BIOCHEMISTRY

## GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	351 High	70 - 140	mg/dL
METHOD : HEXOKINASE			

## 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 Glycosuria, 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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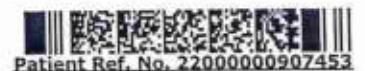
View Details



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## PERFORMED AT :

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 Tel : 022-39199222,022-49723322,  
 CIN - U74899PB1995PLC045956  
 Email : -



Patient Ref. No. 22000000907453

38 Years

Male

HC.

Rate 105 . Sinus tachycardia.....rate> 99  
 PR 145 . LAF, consider biatrial enlargement.....P>80ms <-.15mV V1&>.25mV limb lds  
 QRSD 74 . Borderline ST elevation, anterior leads.....ST >0.15mV in V1-V4  
 QT 320 . Baseline wander in lead(s) V4  
 QTc 423

*Normal ECG*

--AXIS--

P 71

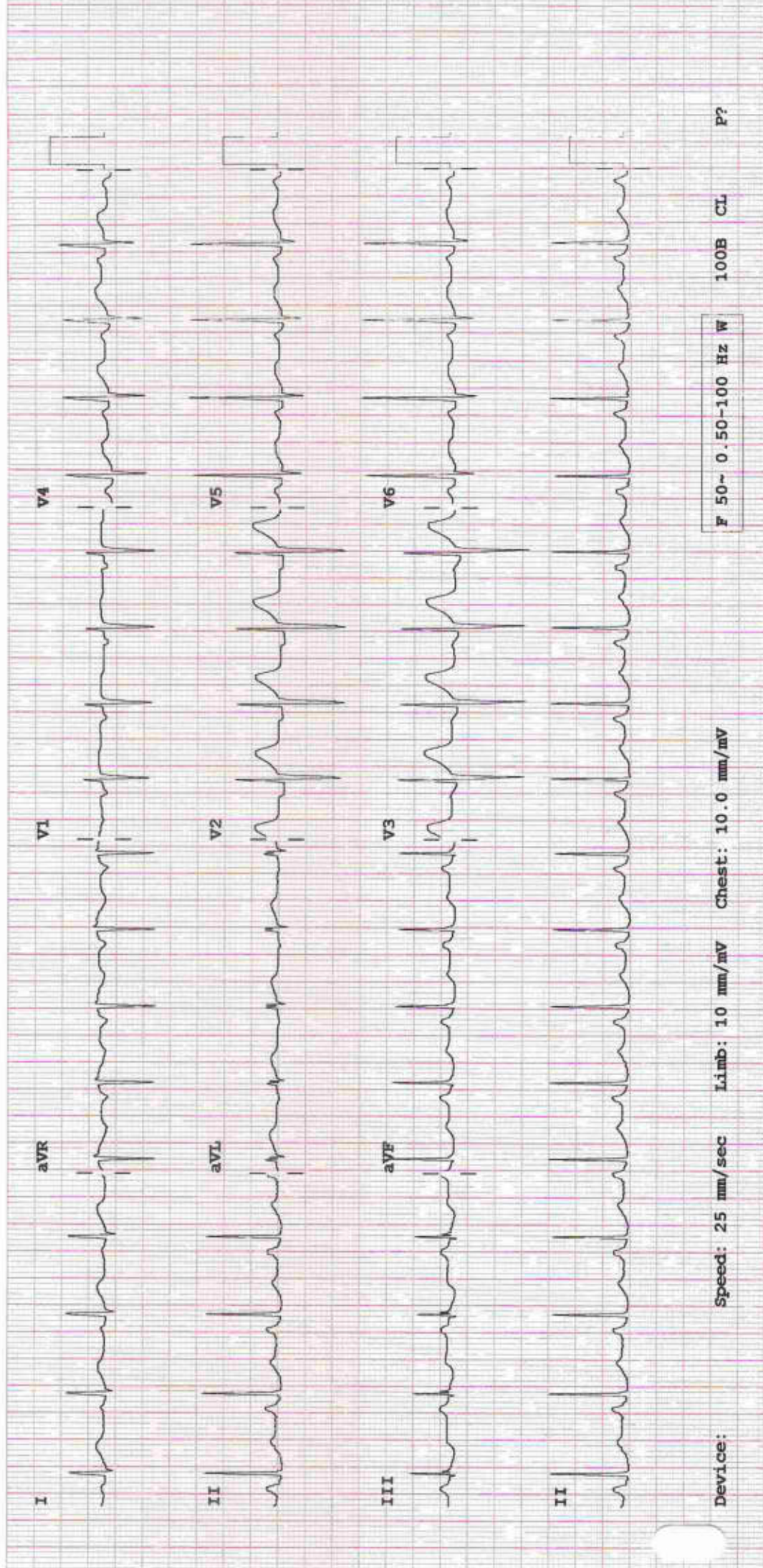
QRS 50

T 7

12 Lead; Standard Placement

-- ABNORMAL 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?

**Hiranandani Healthcare Pvt. Ltd.**

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

Board Line: 022 - 39199222 | Fax: 022 - 39133220

Emergency: 022 - 39199100 | Ambulance: 1255

For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D

**DEPARTMENT OF NIC**

Date: 08/Mar/2024

Name: Mr. Suman Hanra

UHID | Episode No : 13019316 | 13862/24/1501

Age | Sex: 38 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2403/28784 | 08-Mar-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 08-Mar-2024 17:21:12

Bed Name :

Order Doctor Name : Dr.SELF .

**ECHOCARDIOGRAPHY TRANSTHORACIC****FINDINGS:**

- Mild concentric left ventricle hypertrophy.
- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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 right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse .

**M-MODE MEASUREMENTS:**

LA	31	mm
AO Root	22	mm
AO CUSP SEP	17	mm
LVID (s)	26	mm
LVID (d)	40	mm
IVS (d)	14	mm
LVPW (d)	14	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

Hiranandani Healthcare Pvt. Ltd.

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani  
HOSPITAL

(A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 08/Mar/2024

Name: Mr. Suman Hanra

Age | Sex: 38 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13019316 | 13862/24/1501

Order No | Order Date: 1501/PN/OP/2403/28784 | 08-Mar-2024

Admitted On | Reporting Date : 08-Mar-2024 17:21:12

Order Doctor Name : Dr.SELF.

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.4 m/sec.

A WAVE VELOCITY: 0.7 m/sec

E/A RATIO: 0.6

	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 :**

- Mild LVH.
- No RWMA.
- Grade I LV diastolic dysfunction.
- 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)





Patient Name	: Suman Hamra	Patient ID	: 13019316
Sex / Age	: M / 38Y 10M 25D	Accession No.	: PHC.7640005
Modality	: US	Scan DateTime	: 08-03-2024 11:51:38
IPID No	: 13862/24/1501	ReportDatetime	: 08-03-2024 11:59:45

### USG – WHOLE ABDOMEN

**LIVER** is normal in size (14.5 cm) and shows moderately increased echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

**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 (10.3 cm) and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 10.9 x 5.7 cm.

Left kidney measures 10.5 x 6.3 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 mass/calculi.

**PROSTATE** is normal in size & echogenicity. It measures ~ 20 cc in volume.

No evidence of ascites.

### IMPRESSION:

- Grade II fatty infiltration of liver.

  
DR. CHETAN KHADKE  
MD (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 08/Mar/2024

Name: Mr. Suman Hanra

Age | Sex: 38 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13019316 | 13862/24/1501

Order No | Order Date: 1501/PN/OP/2403/28784 | 08-Mar-2024

Admitted On | Reporting Date : 08-Mar-2024 15:09:24

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)**