

Patient Name : Mr.RAMASWAMY NARAYANAN  
Age/Gender : 59 Y 1 M 13 D/M  
UHID/MR No : STAR.0000064215  
Visit ID : STAROPV71602  
Ref Doctor : Dr.SELF  
Emp/Auth/TPA ID : 862546254

Collected : 17/Jul/2024 10:09AM  
Received : 17/Jul/2024 10:38AM  
Reported : 17/Jul/2024 01:23PM  
Status : Final Report  
Sponsor Name : ARCOFEMI HEALTHCARE LIMITED

**DEPARTMENT OF HAEMATOLOGY**

**PERIPHERAL SMEAR , WHOLE BLOOD EDTA**

Methodology : Microscopic

RBC : Normocytic normochromic

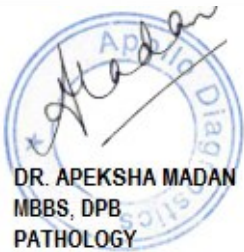
WBC : Normal in number, morphology and distribution. No abnormal cells seen

Platelets : Adequate in Number

Parasites : No Haemoparasites seen

**IMPRESSION : Normocytic normochromic blood picture**

Note/Comment : Please Correlate clinically



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**DEPARTMENT OF HAEMATOLOGY**


**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>HEMOGRAM , WHOLE BLOOD EDTA</b>				
<b>HAEMOGLOBIN</b>	13.6	g/dL	13-17	CYANIDE FREE COLOUROMETER
PCV	41.20	%	40-50	PULSE HEIGHT AVERAGE
RBC COUNT	4.75	Million/cu.mm	4.5-5.5	Electrical Impedance
MCV	86.7	fL	83-101	Calculated
MCH	28.7	pg	27-32	Calculated
MCHC	33.1	g/dL	31.5-34.5	Calculated
R.D.W	12.7	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6,830	cells/cu.mm	4000-10000	Electrical Impedance
<b>DIFFERENTIAL LEUCOCYTIC COUNT (DLC)</b>				
NEUTROPHILS	54	%	40-80	Electrical Impedance
LYMPHOCYTES	32	%	20-40	Electrical Impedance
EOSINOPHILS	06	%	1-6	Electrical Impedance
MONOCYTES	08	%	2-10	Electrical Impedance
BASOPHILS	00	%	<1-2	Electrical Impedance
<b>ABSOLUTE LEUCOCYTE COUNT</b>				
NEUTROPHILS	3688.2	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	2185.6	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	409.8	Cells/cu.mm	20-500	Calculated
MONOCYTES	546.4	Cells/cu.mm	200-1000	Calculated
Neutrophil lymphocyte ratio (NLR)	1.69		0.78- 3.53	Calculated
<b>PLATELET COUNT</b>	269000	cells/cu.mm	150000-410000	IMPEDENCE/MICROSCOPY
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR)</b>	10	mm at the end of 1 hour	0-15	Modified Westergren
<b>PERIPHERAL SMEAR</b>				

Methodology : Microscopic

RBC : Normocytic normochromic

Page 2 of 20

**DR. APEKSHA MADAN**  
MBBS, DPB  
PATHOLOGY

SIN No:BED240187018

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(Formerly known as a Nova Speciality Hospitals Private Limited)

CIN- U85100TG2009PTC099414

Regd Off:1-10-62/62 ,5th Floor, Ashoka RaghupathiChambers,  
Begumpet, Hyderabad, Telangana - 500016

**Address:**

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**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**


WBC : Normal in number, morphology and distribution. No abnormal cells seen

Platelets : Adequate in Number

Parasites : No Haemoparasites seen

**IMPRESSION : Normocytic normochromic blood picture**

Note/Comment : Please Correlate clinically

  
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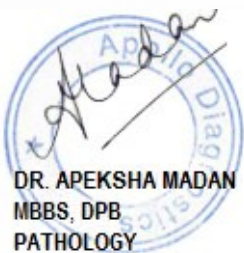


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**DEPARTMENT OF HAEMATOLOGY**

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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>BLOOD GROUP ABO AND RH FACTOR , WHOLE BLOOD EDTA</b>				
BLOOD GROUP TYPE	A			Forward & Reverse Grouping with Slide/Tube Aggluti
Rh TYPE	POSITIVE			Forward & Reverse Grouping with Slide/Tube Agglutination

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Collected : 17/Jul/2024 11:59AM  
Received : 17/Jul/2024 12:55PM  
Reported : 17/Jul/2024 01:46PM  
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**DEPARTMENT OF BIOCHEMISTRY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, FASTING , NAF PLASMA	132	mg/dL	70-100	GOD - POD

**Comment:**

As per American Diabetes Guidelines, 2023

Fasting Glucose Values in mg/dL	Interpretation
70-100 mg/dL	Normal
100-125 mg/dL	Prediabetes
≥126 mg/dL	Diabetes
<70 mg/dL	Hypoglycemia

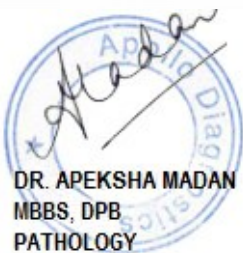
**Note:**

- 1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL and/or a random / 2 hr post glucose value of > or = 200 mg/dL on at least 2 occasions.
2. Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis & is considered critical.

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, POST PRANDIAL (PP), 2 HOURS , SODIUM FLUORIDE PLASMA (2 HR)	101	mg/dL	70-140	GOD - POD

**Comment:**

It is recommended that FBS and PPBS should be interpreted with respect to their Biological reference ranges and not with each other.  
Conditions which may lead to lower postprandial glucose levels as compared to fasting glucose levels may be due to reactive hypoglycemia, dietary meal content, duration or timing of sampling after food digestion and absorption, medications such as insulin preparations, sulfonylureas, amylin analogues, or conditions such as overproduction of insulin.



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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>HBA1C (GLYCATED HEMOGLOBIN) , WHOLE BLOOD EDTA</b>				
HBA1C, GLYCATED HEMOGLOBIN	<b>7.1</b>	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	157	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.

- HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
- Trends in HbA1C values is a better indicator of Glycemic control than a single test.
- 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.
- 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.
- 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. Sandip Kumar Banerjee**  
M.B.B.S., M.D (PATHOLOGY), D.P.B  
Consultant Pathologist

SIN No: EDT240077776



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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIPID PROFILE , SERUM</b>				
TOTAL CHOLESTEROL	180	mg/dL	<200	CHE/CHO/POD
TRIGLYCERIDES	130	mg/dL	<150	
HDL CHOLESTEROL	56	mg/dL	>40	CHE/CHO/POD
NON-HDL CHOLESTEROL	124	mg/dL	<130	Calculated
LDL CHOLESTEROL	98	mg/dL	<100	Calculated
VLDL CHOLESTEROL	26	mg/dL	<30	Calculated
CHOL / HDL RATIO	3.21		0-4.97	Calculated
ATHEROGENIC INDEX (AIP)	0.01		<0.11	Calculated


**Comment:**

Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	< 200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100 Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220

Measurements in the same patient can show physiological and analytical variations.

NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.



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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIVER FUNCTION TEST (LFT) , SERUM</b>				
BILIRUBIN, TOTAL	0.40	mg/dL	0.1-1.2	Azobilirubin
BILIRUBIN CONJUGATED (DIRECT)	0.10	mg/dL	0.1-0.4	DIAZO DYE
BILIRUBIN (INDIRECT)	0.30	mg/dL	0.0-1.1	Dual Wavelength
ALANINE AMINOTRANSFERASE (ALT/SGPT)	25	U/L	4-44	JSCC
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	28.0	U/L	8-38	JSCC
ALKALINE PHOSPHATASE	84.00	U/L	32-111	IFCC
PROTEIN, TOTAL	6.90	g/dL	6.7-8.3	BIURET
ALBUMIN	4.50	g/dL	3.8-5.0	BROMOCRESOL GREEN
GLOBULIN	2.40	g/dL	2.0-3.5	Calculated
A/G RATIO	1.87		0.9-2.0	Calculated

**Comment:**

LFT results reflect different aspects of the health of the liver, i.e., hepatocyte integrity (AST & ALT), synthesis and secretion of bile (Bilirubin, ALP), cholestasis (ALP, GGT), protein synthesis (Albumin)

Common patterns seen:

1. Hepatocellular Injury:

- AST – Elevated levels can be seen. However, it is not specific to liver and can be raised in cardiac and skeletal injuries.
- ALT – Elevated levels indicate hepatocellular damage. It is considered to be most specific lab test for hepatocellular injury.

Values also correlate well with increasing BMI.

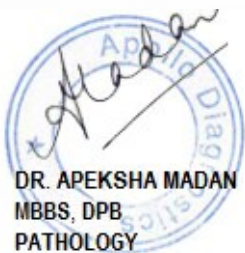
- Disproportionate increase in AST, ALT compared with ALP.
- Bilirubin may be elevated.
- AST: ALT (ratio) – In case of hepatocellular injury AST: ALT > 1

In Alcoholic Liver Disease AST: ALT usually >2

This ratio is also seen to be increased in NAFLD, Wilsons’s diseases, Cirrhosis, but the increase is usually not >2

2. Cholestatic Pattern:

- ALP – Disproportionate increase in ALP compared with AST, ALT.
- Bilirubin may be elevated.



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- ALP elevation also seen in pregnancy, impacted by age and sex.
  - To establish the hepatic origin correlation with GGT helps. If GGT elevated indicates hepatic cause of increased ALP.
  - 3. Synthetic function impairment:
    - Albumin- Liver disease reduces albumin levels.
- Correlation with PT (Prothrombin Time) helps.

  
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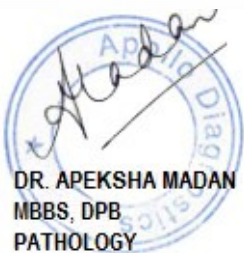
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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>RENAL PROFILE/KIDNEY FUNCTION TEST (RFT/KFT) , SERUM</b>				
CREATININE	0.79	mg/dL	0.6-1.1	ENZYMATIC METHOD
UREA	28.90	mg/dL	17-48	Urease
BLOOD UREA NITROGEN	13.5	mg/dL	8.0 - 23.0	Calculated
URIC ACID	<b>7.60</b>	mg/dL	4.0-7.0	URICASE
CALCIUM	9.40	mg/dL	8.4-10.2	CPC
PHOSPHORUS, INORGANIC	2.90	mg/dL	2.6-4.4	PNP-XOD
SODIUM	139	mmol/L	135-145	Direct ISE
POTASSIUM	4.8	mmol/L	3.5-5.1	Direct ISE
CHLORIDE	98	mmol/L	98-107	Direct ISE
PROTEIN, TOTAL	6.90	g/dL	6.7-8.3	BIURET
ALBUMIN	4.50	g/dL	3.8-5.0	BROMOCRESOL GREEN
GLOBULIN	2.40	g/dL	2.0-3.5	Calculated
A/G RATIO	1.88		0.9-2.0	Calculated



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Test Name	Result	Unit	Bio. Ref. Range	Method
ALKALINE PHOSPHATASE , SERUM	84.00	U/L	32-111	IFCC

Test Name	Result	Unit	Bio. Ref. Range	Method
CALCIUM , SERUM	9.40	mg/dL	8.4-10.2	CPC

**Comments:-**

Serum calcium measurements are done to monitor and diagnose disorders of skeletal system, parathyroid gland, kidney, muscular disorders, and abnormal vitamin D and protein levels.

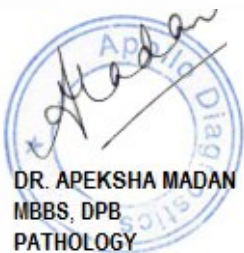
Test Name	Result	Unit	Bio. Ref. Range	Method
C-REACTIVE PROTEIN CRP (QUANTITATIVE) , SERUM	5	mg/L	< 5	IMMUNOTURBIMETRY

**Comment:**

C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation. Measuring changes in the concentration of CRP provides useful diagnostic information about the level of acuity and severity of a disease. Unlike ESR, CRP levels are not influenced by hematologic conditions such as anemia, polycythemia etc.

Increased levels are consistent with an acute inflammatory process. After onset of an acute phase response, the serum CRP concentration rises rapidly (within 6-12 hours and peaks at 24-48 hours) and extensively. Concentrations above 100 mg/L are associated with severe stimuli such as major trauma and severe infection (sepsis).

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>ELECTROLYTES - SERUM , SERUM</b>				
SODIUM	139	mmol/L	135-145	Direct ISE
POTASSIUM	4.8	mmol/L	3.5-5.1	Direct ISE
CHLORIDE	98	mmol/L	98-107	Direct ISE



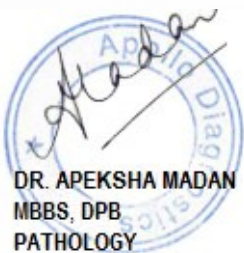
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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>GAMMA GLUTAMYL TRANSPEPTIDASE (GGT), SERUM</b>	25.00	U/L	16-73	Glycylglycine Kinetic method

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>PHOSPHORUS, INORGANIC, SERUM</b>	2.90	mg/dL	2.6-4.4	PNP-XOD



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**Regd Off:**1-10-62/62 ,5th Floor, Ashoka RaghupathiChambers, Begumpet, Hyderabad, Telangana - 500016

**Address:**

156, Famous Cine Labs, Behind Everest Building, Tardeo (Mumbai Central), Mumbai, Maharashtra  
Ph: 022 4332 4500

Patient Name : Mr.RAMASWAMY NARAYANAN	Collected : 17/Jul/2024 10:09AM
Age/Gender : 59 Y 1 M 13 D/M	Received : 17/Jul/2024 10:37AM
UHID/MR No : STAR.0000064215	Reported : 17/Jul/2024 01:24PM
Visit ID : STAROPV71602	Status : Final Report
Ref Doctor : Dr.SELF	Sponsor Name : ARCOFEMI HEALTHCARE LIMITED
Emp/Auth/TPA ID : 862546254	

**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>THYROID PROFILE TOTAL (T3, T4, TSH) , SERUM</b>				
TRI-IODOTHYRONINE (T3, TOTAL)	0.85	ng/mL	0.67-1.81	ELFA
THYROXINE (T4, TOTAL)	6.6	µg/dL	4.66-9.32	ELFA
THYROID STIMULATING HORMONE (TSH)	<b>5.450</b>	µIU/mL	0.25-5.0	ELFA


**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

Page 13 of 20



**DR. APEKSHA MADAN**  
MBBS, DPB  
PATHOLOGY



SIN No: SPL24118742

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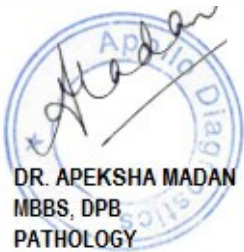
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N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

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**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN D (25 - OH VITAMIN D) , SERUM	9	ng/mL		ELFA

**Comment:**

**BIOLOGICAL REFERENCE RANGES**

VITAMIN D STATUS	VITAMIN D 25 HYDROXY (ng/mL)
DEFICIENCY	<10
INSUFFICIENCY	10 – 30
SUFFICIENCY	30 – 100
TOXICITY	>100

The biological function of Vitamin D is to maintain normal levels of calcium and phosphorus absorption. 25-Hydroxy vitamin D is the storage form of vitamin D. Vitamin D assists in maintaining bone health by facilitating calcium absorption. Vitamin D deficiency can also cause osteomalacia, which frequently affects elderly patients.

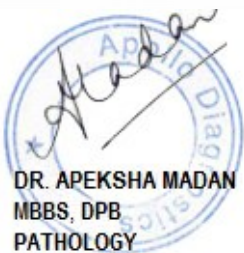
Vitamin D Total levels are composed of two components namely 25-Hydroxy Vitamin D2 and 25-Hydroxy Vitamin D3 both of which are converted into active forms. Vitamin D2 level corresponds with the exogenous dietary intake of Vitamin D rich foods as well as supplements. Vitamin D3 level corresponds with endogenous production as well as exogenous diet and supplements. Vitamin D from sunshine on the skin or from dietary intake is converted predominantly by the liver into 25-hydroxy vitamin D, which has a long half-life and is stored in the adipose tissue. The metabolically active form of vitamin D, 1,25-di-hydroxy vitamin D, which has a short life, is then synthesized in the kidney as needed from circulating 25-hydroxy vitamin D. The reference interval of greater than 30 ng/mL is a target value established by the Endocrine Society.

**Decreased Levels:**

- Inadequate exposure to sunlight.
- Dietary deficiency.
- Vitamin D malabsorption.
- Severe Hepatocellular disease.
- Drugs like Anticonvulsants.
- Nephrotic syndrome.

**Increased levels:**

- Vitamin D intoxication.

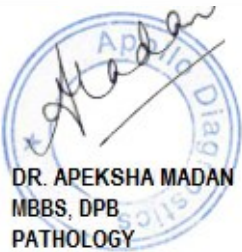


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**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**





Patient Name : Mr.RAMASWAMY NARAYANAN	Collected : 17/Jul/2024 10:09AM
Age/Gender : 59 Y 1 M 13 D/M	Received : 17/Jul/2024 03:22PM
UHID/MR No : STAR.0000064215	Reported : 17/Jul/2024 04:26PM
Visit ID : STAROPV71602	Status : Final Report
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Emp/Auth/TPA ID : 862546254	

**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12 , SERUM	120	pg/mL	120-914	CLIA

**Comment:**

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency.

Patients taking vitamin B12 supplementation may have misleading results. A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 . The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.



Dr.Sandip Kumar Banerjee  
M.B.B.S.,M.D(PATHOLOGY),D.P.B  
Consultant Pathologist

SIN No:IM07891637




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**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>TOTAL PROSTATIC SPECIFIC ANTIGEN (tPSA) , SERUM</b>	0.420	ng/mL	0-4	ELFA

  
**DR. APEKSHA MADAN**  
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Age/Gender : 59 Y 1 M 13 D/M	Received : 17/Jul/2024 01:06PM
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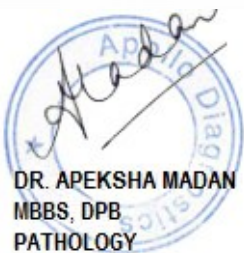
**DEPARTMENT OF CLINICAL PATHOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>COMPLETE URINE EXAMINATION (CUE) , URINE</b>				
<b>PHYSICAL EXAMINATION</b>				
COLOUR	PALE YELLOW		PALE YELLOW	Visual
TRANSPARENCY	CLEAR		CLEAR	Physical measurement
pH	6.0		5-7.5	DOUBLE INDICATOR
SP. GRAVITY	1.025		1.002-1.030	Dipstick
<b>BIOCHEMICAL EXAMINATION</b>				
URINE PROTEIN	NEGATIVE		NEGATIVE	PROTEIN ERROR OF INDICATOR
GLUCOSE	NEGATIVE		NEGATIVE	GLUCOSE OXIDASE
URINE BILIRUBIN	NEGATIVE		NEGATIVE	AZO COUPLING REACTION
URINE KETONES (RANDOM)	NEGATIVE		NEGATIVE	SODIUM NITRO PRUSSIDE
UROBILINOGEN	NEGATIVE		NORMAL	MODIFIED EHRlich REACTION
NITRITE	NEGATIVE		NEGATIVE	Griess reaction
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	Diazonium salt
<b>CENTRIFUGED SEDIMENT WET MOUNT AND MICROSCOPY</b>				
PUS CELLS	2-3	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/hpf	<10	MICROSCOPY
RBC	ABSENT	/hpf	0-2	MICROSCOPY
CASTS	NIL		0-2 Hyaline Cast	MICROSCOPY
CRYSTALS	ABSENT		ABSENT	MICROSCOPY

**Comment:**

All urine samples are checked for adequacy and suitability before examination. Microscopy findings are reported as an average of 10 high power fields.



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**DEPARTMENT OF CLINICAL PATHOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY PLUS PLATIMUM ADVANCE HC MALE - 2D ECHO - PAN INDIA - FY2324**

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

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**DR. APEKSHA MADAN**  
MBBS, DPB  
PATHOLOGY



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**Patient Name** : Mr. RAMASWAMY NARAYANAN

**Age/Gender** : 59 Y/M

**UHID/MR No.** : STAR.0000064215

**OP Visit No** : STAROPV71602

**Sample Collected on** :

**Reported on** : 17-07-2024 12:54

**LRN#** : RAD2380963

**Specimen** :

**Ref Doctor** : SELF

**Emp/Auth/TPA ID** : 862546254

## DEPARTMENT OF RADIOLOGY

### ULTRASOUND - WHOLE ABDOMEN

**LIVER :** The liver is normal in size but shows mild diffuse increased echotexture suggestive of fatty infiltration (Grade I). No focal mass lesion is seen. The intrahepatic biliary tree & venous radicles appear normal. The portal vein and CBD appear normal.

**GALL BLADDER :** The gall bladder is well distended and reveals normal wall thickness. There is no evidence of calculus seen in it.

**PANCREAS :** The pancreas is normal in size and echotexture. No focal mass lesion is seen.

**SPLEEN :** The spleen is normal in size and echotexture. No focal parenchymal mass lesion is seen. The splenic vein is normal.

**KIDNEYS :** The **RIGHT KIDNEY** measures 11.2 x 4.1 cms and the **LEFT KIDNEY** measures 11.1 x 5.5 cms in size. Both kidneys are normal in size, shape and echotexture. There is no evidence of hydronephrosis or calculi seen on either side.

The para-aortic & iliac fossa regions appears normal. There is no free fluid or any lymphadenopathy seen in the abdomen.

**PROSTATE :** The prostate measures 3.0 x 3.0 x 2.6 cms and weighs 12.5 gms. It is normal in size, shape and echotexture. No prostatic calcification is seen.

**URINARY BLADDER :** The urinary bladder is well distended and is normal in shape and contour.

No intrinsic lesion or calculus is seen in it. The bladder wall is normal in thickness.

**IMPRESSION:** The Ultrasound examination reveals mild fatty infiltration of the Liver. No other significant abnormality is detected.



**Dr. VINOD SHETTY**  
Radiology

<b>Patient Name</b>	: Mr. RAMASWAMY NARAYANAN	<b>Age/Gender</b>	: 59 Y/M
<b>UHID/MR No.</b>	: STAR.0000064215	<b>OP Visit No</b>	: STAROPV71602
<b>Sample Collected on</b>	:	<b>Reported on</b>	: 17-07-2024 12:30
<b>LRN#</b>	: RAD2380963	<b>Specimen</b>	:
<b>Ref Doctor</b>	: SELF		
<b>Emp/Auth/TPA ID</b>	: 862546254		

**DEPARTMENT OF RADIOLOGY**

**X-RAY CHEST PA**

Both lung fields and hila are normal .

No obvious active pleuro-parenchymal lesion seen .

Both costophrenic and cardiophrenic angles are clear .

Both diaphragms are normal in position and contour .

Thoracic wall and soft tissues appear normal.

**CONCLUSION :**

No obvious abnormality seen



**Dr. VINOD SHETTY**  
Radiology