

Patient Name :- Kanhaiya Pandey
Part of Examine :- Whole abdomen
Ref by Doctor :- Dr. (Mrs) B.K.Ranjan BAMS

Age :- 49 Years
Sex :- Male
Date :- 13/08/2025

Liver : 152mm, Enlarged in shape & size with increased echogenicity and fatty infiltration changes grade 1st No focal mass or diffuse lesion seen.
IHD not dilated.

G.Bladder : Normal in shape, size with multiple echogenic foci one of the largest size 7.5mm are seen in neck of the gall bladder with posterior acoustic shadowing

C.B.D. : Normal, (Not dilated).

Pancreas : Normal in shape & size. Pancreatic duct is not dilated.

Spleen : Normal in shape & size 104mm Splenic vein is not dilated.

Rt.Kidney : 108mm x 41mm Normal in shape size. cortical thickness is normal.
Parenchymal is normal. Corticomedullary demarked is normal.

Lt.Kidney : 101mm x 39mm Normal in shape size. cortical thickness is normal.
Parenchymal is normal. Corticomedullary demarked is normal.

Ureter : Both not dilated.

U. Bladder : Normal in shape & size. Wall thickness is normal.
No mass or lesion is seen in lumen .

Prostate : 17.32 mm Normal is shape, size & position.No abnormal mass & calcification seen.

R.I.F. : No lump or mass collection are seen in right iliac fossa region.

Other : Excess bowel gaseous shadows are seen in all over abdomen

Impression : * Hepatomegaly with fatty liver (grade 1st)
* Cholelithiasis

Adv-Please correlate clinically finding

Checked by :

Dr. M.R. RANJAN

S.NO.01

PATIENT NAME:- KANHAIYA PANDEY

AGE/SEX:- 49 YRS/MALE.

REFD BY DR.:- B.K.RANJAN (BAMS,DHMS)

DATE:-13-08-2025

*****EXAMINATION OF HAEMATOLOGY*****
INVESTIGATION
PATIENT VALUE
NORMAL RANGE

HEMOGLOBIN
(CALORIMETRIC/AUTOMATED)

11.1

(M: 12-16Gm/dl, F-10-14 Gm/dl)

TOTAL LEUCOCYTE COUNT
(ELECTRICAL IMPEDANCE)

5,900

(4000-11000 CU/MM)

*****DIFFERENTIAL COUNT*****

NEUTROPHIL
LYMPHOCYTES
EOSINOPHIL
MONOCYTE
BASOPHIL

56
34
10
00
00

(55-70%)
(20-40%)
(00-06%)
(00-05%)
(00-03%)

*****EXAMINATION OF BIOCHEMISTRY*****
INVESTIGATION
PATIENT VALUE
NORMAL RANGE

BLOOD SUGAR FASTING
METHOD:- GOD POD

70.65

(70-110mg/dl)

*****EXAMINATION OF SEROLOGY*****
TEST
RESULT

HIV 1ST TEST
HIV 2ND TEST

:
: Negative.
: Negative.

HBsAg

: Negative.

V.D.R.L. Test

: Negative.

****Wish You a Good health****

Checked by :

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****EXAMINATION OF HAEMATOLOGY****

INVESTIGATION	PATIENT VALUE	NORMAL RANGE
BT	1min 36sec	(1min – 4 min)
CT METHOD:- FINGER PRICK METHOD	3 min 43 sec	(2min – 7 min)

GROUP ABO : "B"

RH FACTOR : POSITIVE (+VE)

 ****Wish You a Good health****

 Checked by :
Dr. M.R. RANJAN