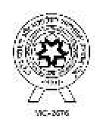
Mrs. AMITA CHAOUDARY 11480892

PID NO: P33723515006611
Age: 50 Year(s) Sex: Female

Reference: DR.ANURAG TANDON

Client Address:
METRO HOSPITAL HEART INST
NOIDA,CGHS
SEC 12 - H0064 NOIDA (U P) NOI
Zone: NOIDASample Processed At:
Metropolis Healthcare Ltd E-21, B1
Mohan Co-op Ind Estate New Delhi-110044

VID: 230111502318028
Registered On:
06/12/2023 01:09 PM
Collected On:
06/12/2023 9:40AM
Reported On:
07/12/2023 05:47 PM



HBV-Hepatitis B Viral Load (Quantitative)

Target Selected : Highly conserved Core region of the HBVgenome across A-H genotypes is selected for amplification & detection.

Equipment : Rotor Gene Q

Specimen Type : Serum/ EDTA Plasma

Result :

HBV - Hepatitis B Viral load (Quantitative)	276 IU/mL
Log Value	2.44
HBV - Hepatitis B Viral load	2266 copies/ml

Result Interpretation:

Result (IU/ml)	Log Value	Comments
Below 31.6 IU/ml	Below 1.50	Sample provided does not contain HBV DNA or HBV DNA detected but below the lower limit of linear range of the assay. These results should be interpreted with caution
>31.6 - 20000000	1.50 – 7.30	HBV DNA Detected within the linear range of the assay
Above 20000000	Above 7.30	HBV DNA Detected above the linear range of the assay

Note:

- This assay is a quantitative assay used for monitoring patients on therapy and not qualitative assay used for screening. Hence a Target Not Detected result should not be considered as HBV status Negative for the patient.
- Quantitative viral load results are best reflected when reported using log transformed units. Logarithmic expression best reflects the process of viral replication and is less subject to over interpretation of non-clinically significant (minor) changes.

Test Details:

Limit of Detection: 31.6 IU/ml
Measuring Range: 31.6 – 20000000 IU/ml
Conversion Factor: 1 IU/ml- 8.21 copies/ml

Clinical utility:

- Determine need to treat chronic HBV infection

Dr. Shaheen.Bhat
M.D (Microbiology)
(DMC Reg. No. - 20785)

- Indicator of chronic hepatitis
- Monitor virological response to therapy
- Demonstrate viral replication in patients with mutant HBV
- Predict likelihood of response to therapy
- Indicate emergence of resistant variants during antiviral therapy

Clinical Background:

- HBV is the most common cause of chronic liver disease worldwide. HBV is a DNA virus that is transmitted primarily through blood exposure and sexual contact, and from mothers to their children.

- The clinical manifestations range from sub clinical hepatitis to symptomatic hepatitis and, in rare instances, fulminant hepatitis. Long-term complications of hepatitis B include cirrhosis and hepatocellular carcinoma.

- Perinatal or childhood infection is associated with few or no symptoms but has a high risk of becoming chronic.

- HBV DNA detection and HBV DNA level measurement are essential for the diagnosis, decision to treat and subsequent monitoring of patients.

- Follow-up using sensitive real-time PCR quantification assays is strongly recommended because of their sensitivity, specificity, accuracy and broad dynamic range.

Limitation of Assay:

PCR is a highly sensitive technique; common reasons for paradoxical results are contamination during specimen collection, selection of inappropriate specimen and inherent PCR inhibitors in the sample. Confirmed HBV cases may have viral load below this detection range. Hence the results Below 31.6 IU/ml do not indicate that the patient is negative for HBV. It is not advisable to compare viral loads between two different techniques.

Reference:

- EASL Clinical practice guidelines: Management of chronic hepatitis B. J Hepatol 2012; 57:167-185.

- Lok ASF, McMahan BJ, Chronic hepatitis B: Update 2009.HEPATOLOGY 2009, 50:No.3.

- WHO Hepatitis B Fact sheet N 204 July 2012.

-- End of Report --

Tests marked with NABL symbol are accredited by NABL vide Certificate no MC-2676; Validity till 04-04-2024

Dr. Shaheen.Bhat
M.D (Microbiology)
(DMC Reg. No. - 20785)

Name	: Mrs. AMITA CHAUDHARY		Collected	: 31/8/2018 10:25:00AM
			Received	: 31/8/2018 10:39:09AM
Lab No.	: 141666619	Age: 45 Years Gender: Female	Reported	: 5/9/2018 6:37:36PM
A/c Status	: P	Ref By : Dr.ATUL SHARMA	Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval

IMMUNOHISTOCHEMISTRY, MICROSATELLITE INSTABILITY PANEL @

IHC MARKER(S)	RESULT
MLHI (MutL Homolog 1)	Intact nuclear expression
MSH2 (MutS Homolog 2)	Intact nuclear expression
MSH6 (MutS Homolog 6)	Loss of nuclear expression
PMS2 (Post meiotic segregation)	Intact nuclear expression

SLIDE NO : B/ 388960/18

SPECIMEN : Colonic tumour tissue (Block) for IHC markers.

CLINICAL HISTORY : Right hemicolectomy - HPE - Moderately differentiated (G2) Adenocarcinoma

GROSS : Received 1 formalin fixed paraffin embedded block labelled as 31738A1

IMPRESSION : **Features consistent with Moderately differentiated (G2) Adenocarcinoma.**

INTERPRETATION : Loss of nuclear expression of MSH6 only: high probability of Lynch syndrome (sequencing and/or large deletion/duplication testing of germline MSH6 may be indicated)

Clinical Use

This panel studies mismatch repair proteins in Colorectal cancer.

COMMENTS

Mismatch repair genes are commonly associated with Hereditary Nonpolyposis Colorectal Cancer (HNPCC) . Their normal function is to provide instructions for making proteins that play an essential role in DNA repair. These proteins fix mistakes that are made when DNA is copied (DNA replication) in preparation for cell division. Strand misalignment during DNA replication can result in alterations in Microsatellite Repeats also called Microsatellite instability.

Microsatellite instability has also been reported in Turcot / Lynch Syndrome which is the association between familial polyposis of the colon and brain tumors like Medulloblastoma & Malignant glioma. MSH2 may also be associated with Leukemias, lymphomas, Endometrial carcinomas & Neurofibromas.

Mutations in the MSH6 gene also have an increased risk of developing cancers of the ovary, stomach, small intestine, liver, gallbladder duct, upper urinary tract, brain, and skin. PMS2 is in addition a cause of

supratentorial Primitive neuroectodermal tumors.

NOTE :

1. Type of specimen Fixation & processing - Formalin fixed paraffin embedded tissue.
2. Detection system used is Polymer HRP
3. The impression is based on the material submitted and is not a complete surgical pathology report.
4. False negative IHC results due to inadequate fixation of the material sent for evaluation cannot be excluded.

FIXATION REQUIREMENTS :

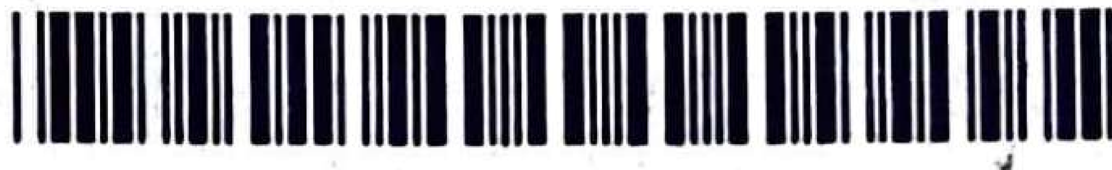
- The volume of formalin fixative should be atleast 10 times the volume of the specimen.
- Decalcification solutions with strong acids should not be used.
- Specimens should be immersed in fixative within 1 hour of the biopsy/resection procedure (time of removal & time of immersion to be mentioned).
- In all resection (large) specimens, the tumour must be bisected prior to immersion in fixative

DR. DEEPTI
MD (PATH)
SR. CONSULTANT PATHOLOGIST

------------------------------End of report ------------------------------

IMPORTANT INSTRUCTIONS

*Test results released pertain to the specimen submitted.*All test results are dependent on the quality of the sample received by the *Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the Referring Physic repeats are accepted on request of Referring Physician within 7 days post reporting.*Report delivery may be delayed due to circumstances. Inconvenience is regretted.*Certain tests may require further testing at additional cost for derivation of exact value. Ki request within 72 hours post reporting.*Test results may show interlaboratory variations.*The Courts/Forum at Delhi shall hav jurisdiction in all disputes/claims concerning the test(s) & or results of test(s).*Test results are not valid for medico legal purpose customer care Tel No. +91-11-39885050 for all queries related to test results.



Certificate No. H-2018-0549
email : info@neohospital.com w-site : www.neohospital.com

MRI SCREENING OF WHOLE SPINE

ID: 130290

AMITA CHOUDHARY 15.05.2019

DR. RAJIV MOTIANI 45YRS/F

STUDY PROTOCOLS:

FAST SPIN ECHO T2W HIGH RESOLUTION SAGGITAL IMAGES OF WHOLE SPINE WERE OBTAINED ON A DEDICATED PHASED ARRAY SURFACE SPINE COIL USING 1.5 TESLA HIGH GRADIENT SYSTEM.

FINDINGS:

Straightening of cervical and lumbar spinal curvatures are seen. Dorsal kyphosis is maintained.

Early degenerative changes are seen in the form of few anterior marginal osteophytes at multiple levels.

Lumbarization of S1 vertebral body is seen.

Rest of the vertebral bodies are normal in height and signal intensity.

Intervertebral discs show variable disc dessication at multiple cervical levels and lower lumbar levels.

Posterior disc bulges with disc osteophytic complexes are seen at C4-C5, C5-C6 and C6-C7 levels indenting on anterior thecal sac. (Anterior posterior spinal canal diameter at C4-C5 is 7.4mm and C5-C6 is 7.2mm and C6-C7 is 7.1mm).

Focal ligamentum flavum hypertrophy are seen at D9-D10, D10-D11, D11-D12 and D12-L1 levels causing indenting on posterior thecal sac. (Anterior posterior spinal canal diameter at D9-D10 is 10.4mm, D10-D11 is 9.2mm, D11-D12 is 9.0mm and D12-L1 is 12.2mm).

Diffuse circumferential annular disc bulge is seen at L5-S1 level indenting on anterior thecal sac, causing narrowing of bilateral neural foramina leading to indentation on bilateral exiting nerve roots. (Anterior posterior spinal canal diameter measures 9.7mm).

Small annular tear is seen at L5-S1 level.

Posterior spinal elements are normal.

Pre and paravertebral soft tissues are normal.

Bony canal is capacious at all levels with no obvious canal stenosis.

P.T.O..........

UHID:	2436629	Date:	26/05/2018	Bill No.:	DIAG/N/18/26406	Slip No.:	10407156
Name:	AMITA CHAUDHARY			Sex:	Female	Age:	44-0
Company:							
Address:	GH-1 , NRI CITY , DR. NOIDA , U P			Tel No:	9318446463		
Sample No:	C			Referred By:	Dr.ASHISH SAINI		

MRI SELLA WITH CONTRAST

Multiplanar high resolution MR scanning of the brain and sella turcica was done on a 1.5 Tesla Multiva MR scanner to obtain the following sequences: T1SE, T2 TSE & T2 FLAIR sections in the axial plane. Thin section high-resolution SE T1W, TSE T2 & T1 dynamic post contrast sections though sella turcica in sagittal and coronal planes.

The study reveals a small ill-defined nodular area of signal alteration measuring approx. 2 x 2 mm appearing iso-intense on T1W images and showing relatively less enhancement than surrounding pituitary parenchyma on dynamic post contrast images, within left side of anteriorly pituitary gland causing mild focal bulge in superior contour likely microadenoma.

Rest of the pituitary gland is normal in size, shape, contour, signal intensity and post contrast dynamic enhancement. Posterior pituitary appears as a normal T1 hyperintense speck. Infundibulum is central and appears normal in thickness. Optic chiasma appears unremarkable. The para/suprasellar regions appear unremarkable.

Multiple punctate T2W / FLAIR hyperintense foci are seen scattered in bilateral frontoparietal white matter likely nonspecific chronic ischemic foci.

Rest of the bilateral cerebral hemispheres appears normal in signal intensity and morphology.

Corpus callosum, basal ganglia, thalami and internal capsules appear unremarkable.

Cerebellum and brainstem appear normal.

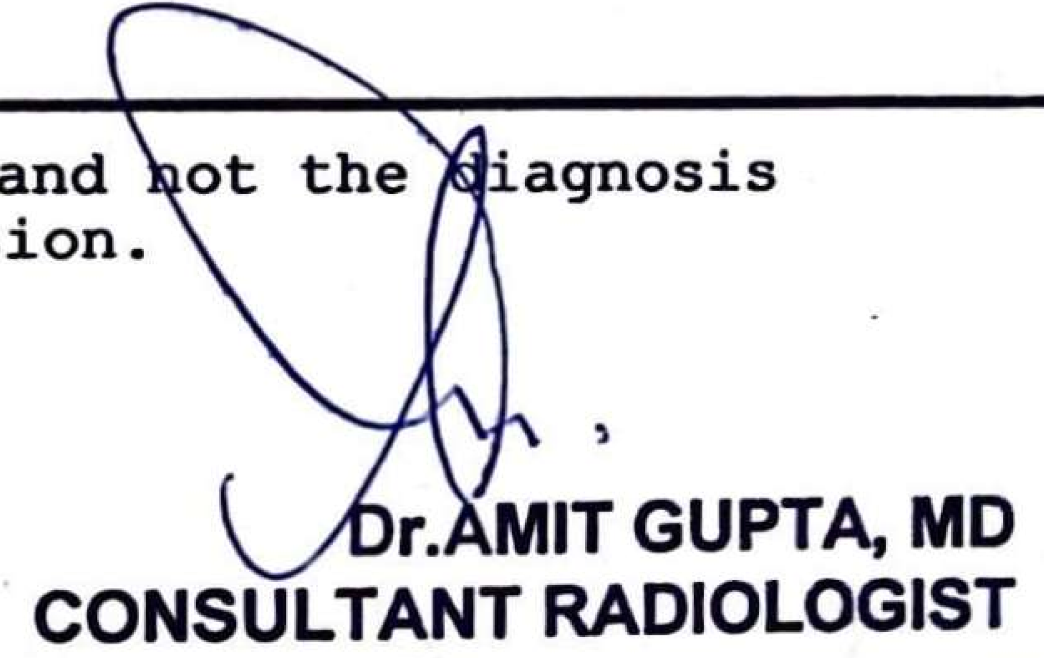
Lateral, third and fourth ventricles are normal in size, shape and position.

Basal cisterns, fissures and sulci appear normal.

Intracranial vascular structures in view are unremarkable.

Advice: Clinical and hormonal correlation.

Note:
1. This is only for professional opinion based on imaging finding and not the diagnosis
2. It should be correlated clinically, to arrive at proper conclusion.
3. NOT VALID FOR MEDICO LEGAL PURPOSES



Dr.AMIT GUPTA, MD
CONSULTANT RADIOLOGIST

Dr. Anurag Tandon
M.D., D.M. (GASTROENTEROLOGY)
SENIOR CONSULTANT
LIVER AND DIGESTIVE DISEASES
Reg. No. : MCI - 6939
DMC - 10338

we treat.... HE CURES
HOSPITALS & HEART INSTITUTE
(a unit of Metro Institutes of Medical Sciences Pvt. Ltd.)
CIN No : U00000DL1990PTC039293
(NABH & ISO 9001: 2008 Certified)

Hospital No. : 60660

Date : 31/x/20

Mrs Amita

T Entehep 0.5mg OD - 4M.

- HBeAg, HBV DNA Quantitative, LFT, Alpha Feto Protein
- Colonoscopy after Coloprep bowel prep. (Mon).
- ~~Collect~~ Anti ds-DNA

[signature]

13.11.20 ~~Continue~~ T. Entehep. - Stop

HBV DNA (Quantitative) after 3 months
LFT
HBsAg

T Allegra 120mg OD
Caladryl lotion LA

[signature]

For Appointments and enquiries please contact: Mr. Sanjeev : +91 98185 47822 / Mr. Joshi : +91 93122 25057 / Mr. Shyam : +91
Queries related to Endoscopy please contact Mr. Ashok Rawat : +91 99718 56075 / Mr. Kalu Ram : +91 90136 03521

UHID:	2436629	Date: 18/05/2018	Bill No.:	DIAG/N/18/22657	Slip No.:	10403407
Name:	AMITA CHAUDHARY		Sex:	Female	Age:	44-0
Company:						
Address:	GH-1 , NRI CITY , DR. NOIDA , U P		Tel No:	9318446463		
Sample No:	$ 155		Referred By:	Dr.NANDITA GUSAIN BARTHWAL		

MAMMOGRAPHY (BOTH BREAST)

Technique: Bilateral film screening mammography performed in mediolateral oblique & craniocaudal projections.

Bilateral nipples and subareolar complexes are normal.

Bilateral subcutaneous fat planes are normal.

Bilateral breast parenchyma appear normal.

No evidence of micro-calcifications on both sides.

Bilateral axilla are normal. No focal lesion is seen.

Impression: BIRADS Category 1.

0. Needs additional Imaging.
1. Negative - There is nothing to comment on.
2. Benign findings.
3. Probably benign finding (< 2 % malignant) - follow up.
4. Suspicious abnormality (2-95 %) - biopsy.
5. Highly suggestive of malignancy (< 95 % malignant). Appropriate action should be taken.
6. Known biopsy -proven malignancy.

Advice: Clinical correlation & further evaluation if need be.

Note: Not all breast abnormalities show up on mammography. False negative rate of mammography is approximately 10%. The management of a palpable abnormality must be based on clinical grounds.

Note:
1. This is only for professional opinion based on imaging finding and not the diagnosis
2. It should be correlated clinically, to arrive at proper conclusion.
3. NOT VALID FOR MEDICO LEGAL PURPOSES

Dr.HEMA CHAUDHARY
CONSULTANT RADIOLOGIST

NEO HOSPITAL

Certificate No. H-2018-0549

D-170A, Sector 50, Noida 201301
Tel. : 0120 - 4880000, Fax : 0120 - 4880099
Mobile : 9971055822, 9971055922
email : info@neohospital.com w-site : www.neohospital.com

MRI BRAIN

ID: 130290
AMITA CHOUDHARY
DR. RAJIV MOTIANI

15.05.2019
45YRS/F

STUDY PROTOCOL:
MR imaging of the brain was performed using FLAIR, T1 and T2 weighted axial sections, and correlated with T2W sagittal and coronal images.

FINDINGS:

Mild periventricular and multiple punctate and discrete subcortical and juxta cortical T2/FLAIR white matter hyperintensities are seen in bilateral fronto-parietal region.

Rest of the cerebral parenchyma is normal in signal intensity with maintained grey and white matter differentiation.

Both cerebellar hemispheres are normal in morphology and signal intensity. Cerebellopontine angle regions are normal.

Brainstem is normal in morphology and signal intensity.

Ventricles are normal in shape, size and outline. Septum is in midline.

Basal cisterns and sylvian fissures are normal.

Cortical sulci are normal.

Sellar and parasellar regions are normal. Corpus callosum displays normal MRI signal.

No area of abnormal restricted diffusion seen in the brain.

The flowvoids of the bilateral major cerebral arteries are maintained.

IMPRESSION:-

- **Non-specific leukoaraiotic changes.**

Please correlate clinically.

DR. ANMOL NIGAM MD RADIODIAGNOSIS CONSULTANT RADIOLOGIST	DR. RITESH SINGH DNB RADIODIAGNOSIS CONSULTANT RADIOLOGIST	DR. VIVEK RATHORE MD RADIODIAGNOSIS CONSULTANT RADIOLOGIST

This is a professional opinion based on imaging findings and not the diagnosis. It should be correlated clinically and with other relevant investigations to arrive at a proper conclusion. Not valid for medico-legal purpose.

AMITA CHAUDARY 11336111

PID NO: P542200177560
Age: 49.0 Year(s) Sex: Female

Reference: Dr.R M O

Client Address:
METRO HOSPITAL HEART INST
NOIDA,CGHS
SEC 12 - H0064 NOIDA (U P) NOI
Zone: NOIDA**Sample Processed At:**
Metropolis Healthcare Ltd E-21, B1
Mohan Co-op Ind Estate New Delhi-
110044

VID: 220054000152714
Registered On:
15/09/2022 06:53 PM
Collected On:
15/09/2022 2:55PM
Reported On:
17/09/2022 10:02 AM

HBV-Hepatitis B Viral Load (Quantitative)

Test Principle : Real Time PCR (Taqman Probe)

Target Selected : Highly conserved Core region of the HBVgenome across A-H genotypes is selected for amplification & detection.

Equipment : Rotor Gene Q

Specimen Type : Serum/ EDTA Plasma

Result :

HBV - Hepatitis B Viral load (Quantitative)	**152 IU/mL**
Log Value	**2.18**
HBV - Hepatitis B Viral load	**1248 copies/ml**

Result Interpretation:

Result (IU/ml)	Log Value	Comments
Below 31.6 IU/ml	Below 1.50	Sample provided does not contain HBV DNA or HBV DNA detected but below the lower limit of linear range of the assay. These results should be interpreted with caution
>31.6 - 20000000	1.50 – 7.30	HBV DNA Detected within the linear range of the assay
Above 20000000	Above 7.30	HBV DNA Detected above the linear range of the assay

Note:

- This assay is a quantitative assay used for monitoring patients on therapy and not qualitative assay used for screening. Hence a Target Not Detected result should not be considered as HBV status Negative for the patient.
- Quantitative viral load results are best reflected when reported using log transformed units. Logarithmic expression best reflects the process of viral replication and is less subject to over interpretation of non-clinically significant (minor) changes.

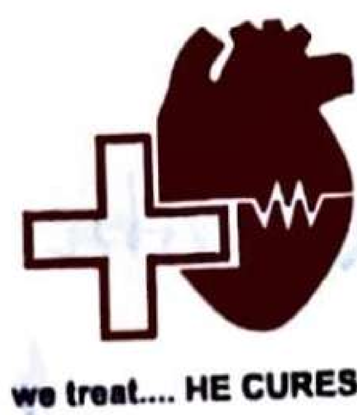
Test Details:

Limit of Detection: 31.6 IU/ml
Measuring Range: 31.6 – 20000000 IU/ml
Conversion Factor: 1 IU/ml- 8.21 copies/ml

Clinical utility:

Dr. Shaheen.Bhat
M.D (Microbiology)

Dr. Anurag Tandon
M.D., D.M. (GASTROENTEROLOGY)
SENIOR CONSULTANT
LIVER AND DIGESTIVE DISEASES
Reg. No. : MCI - 6939
DMC - 10338



METRO
HOSPITALS & HEART INSTITUTE

(a unit of Metro Institutes of Medical Sciences Pvt. Ltd.)
CIN No : U00000DL1990PTC039293
(NABH & ISO 9001: 2008 Certified)

Date : 30/6/18

Hospital No. : 60660

Mrs Amita Chaudhary

Plan
- HBeAg LFT, Hb.
- HBV DNA (Quantitative)
- UGI Endoscopy, Colonoscopy after Coloprep preparation 7 am 8 am
- Old records.
- USG W/A

A Tandon

Rx
T. Nexpro 40mg OD — 0 · bef BF
Syp Gaviscon 2tsp BOD = = after 1/2 hr
T Zevrel 1tab after D only.

A Tandon.

Continue T Tenvir 300mg OD.

Hospital No. : 60660

Date : 19/2/21

Mrs Amira

- Diet as advised
- T. Zenvel (?) 1 tab only one tonight

HBV DNA (Quantitative)
AFP (Alpha Feto Protein) } after 6 months
LFT
USG W/A

Ntandon (signature)

30/8/21

Plan:
LFT
HBV DNA Quantitative
after 1y

Ntandon (signature)

Date : 6/10/22.........

Prabsur

Mrs Amita.

LFT.
HBV DNA Quantitative. | after 6 months.

Alandan

7 June 23 -

No medication.

LFT.
HBV DNA Quantitative | after 6 mth.

USG W/A -

Alandan

... please contact: Mr. Sanjeev : +91 98185 47822 / Mr. Joshi : +91 93122 25057 / Mr. Shyam : +91 ... / Mr. Kalu Ram : +91 90136 0352...

METRO
HOSPITALS & HEART INSTITUTE
we treat....HE CURES
(a unit of Metro Institutes of Medical Sciences Pvt. Ltd.)
CIN No : U00000DL1990PTC039293
(NABH, NABL & ISO 9001: 2008 Certified)

DISCHARGE SUMMARY

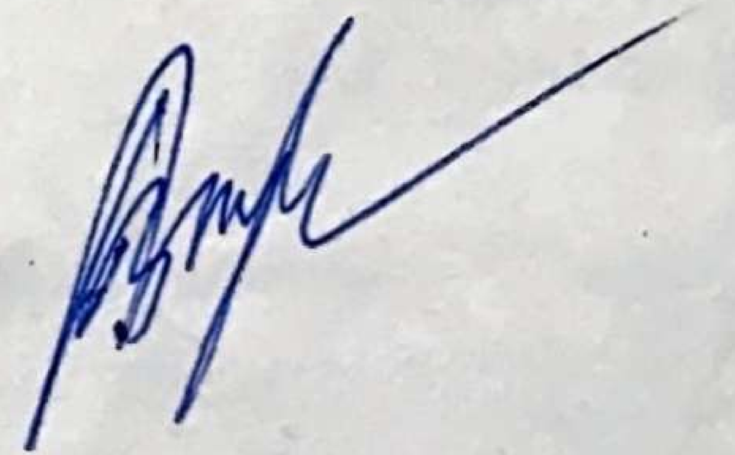
DOA = 18/3/2018   DOD = 20/3/2018

45 years old female, named Mrs. Anita chaudhary ~~c K/c/o~~ c̄ K/c/o HTN presented c̄ complaints of DOE-II-III, intermittent chest pain since 2-3 weeks. TMT was done outside which was POSITIVE for RMI. Lab investigations revealed Hb - 5.5, for that 2 unit PRBC was done. Hb came to 8.8. Blood investigations revealed HBsAg - POSITIVE. Physician, hematology, gastroenterology consultation was done, treatment optimised. Now, she is being discharged c̄ advice of colonoscopy & follow up in OPD. CECT whole abdomen done, report enclosed.

Rx

1) Cap. PAN-D PO - BBF
2) T. UDILIV (300) PO BD (9am - 9pm)
3) T. IROBISH (1 tab) PO (9am)
4) T. FOLATE (5) PO (9 am)
5) Cap. NERVZ - B (1 tab) PO (9pm)
~~6) Ca~~
6) Tab. LIMCEE (500) PO BD (9am, 9pm)
7) Syp. DIGENE GEL (2tsf) every 6 hourly.
8) CALCIMAX FATE (500) with milk at night (9pm).
9) Syp. SPARACID (2tsf) BD (7am, 7pm).

Discharge summary to be collect tomorrow @ 2pm to 4pm.



Cardiology Wing
..., Sector-12, Noida - 201301
Tel. : +91 120 2533 491, 2444 466, 4366 666
Fax : +91 120 2533 487

Multispeciality Wing
L-94, Sector 11, Noida-201301
Tel. : +91 120 2522 959, 2442 666
Fax : +91 120 2442 555

AMITA CHAUDHARY

PID NO: P542300333987
Age: 50.0 Year(s) Sex: Female

Reference:

Client Address:
METRO HOSPITAL HEART INST
NOIDA,CGHS
SEC 12 - H0064 NOIDA (U P) NOI
Zone: NOIDASample Processed At:
Metropolis Healthcare Ltd E-21, B1
Mohan Co-op Ind Estate New Delhi-
110044

Registered On:
24/04/2023 03:45 PM
Collected On:
24/04/2023 3:45PM
Reported On:
25/04/2023 06:05 PM

HBV-Hepatitis B Viral Load (Quantitative)

Test Principle : Real Time PCR (Taqman Probe)

Target Selected : Highly conserved Core region of the HBVgenome across A-H genotypes is selected for amplification & detection.

Equipment : Rotor Gene Q

Specimen Type : Serum/ EDTA Plasma

Result :

HBV - Hepatitis B Viral load (Quantitative)	**374 IU/mL**
Log Value	**2.57**
HBV - Hepatitis B Viral load	**3071 copies/ml**

Result Interpretation:

Result (IU/ml)	Log Value	Comments
Below 31.6 IU/ml	Below 1.50	Sample provided does not contain HBV DNA or HBV DNA detected but below the lower limit of linear range of the assay. These results should be interpreted with caution
>31.6 - 20000000	1.50 – 7.30	HBV DNA Detected within the linear range of the assay
Above 20000000	Above 7.30	HBV DNA Detected above the linear range of the assay

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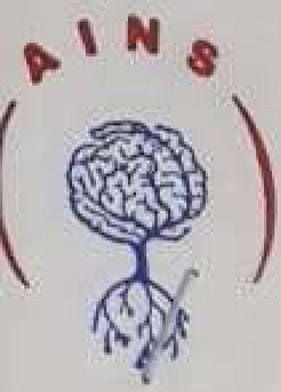
Measuring Range: 31.6 – 20000000 IU/ml
Conversion Factor: 1 IU/ml- 8.21 copies/ml

Clinical utility:

Dr. Shaheen.Bhat
M.D (Microbiology)
(DMC Reg. No. - 20785)



APEX INSTITUTE OF NEURO & SPINE

Dr. Vikas Bhardwaj

MBBS, MS, Mch Neurosurgery
(King George Medical University Lucknow)
Fellow AO Spine (Switzerland)
Sr.Consultant and head, Institute of Neurosciences, Sharda Medical City, Greater Noida

Brain & Spine Specialist

9711303776

Former Neurosurgeon
G.T.B. Hospital, Delhi
AIIMS Hospital, New Delhi
Max Hospital, Noida & Greater Noida
Yatharth Hospital, Greater Noida
Jaypee Hospital, Sector-128, Noida

Membership
Neurological Society of India (NSI)
Neurosurgical Society of India (NSS)
Neurotrauma Society of India (NTSI)
U.P. Neurological Association
Ghaziabad Noida Neurological Association
Delhi Neurological Association

POORANKALA (P18166)

By: Dr. Vikas Bhardwaj

Date: 3 Dec. 2023

P3 sector MRI Brain

Clinical Notes

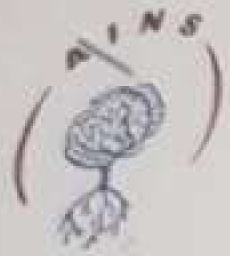
Diagnosis • SUDDEN PYCHOSIS

Prescription(Rx)

	Drug Name	Strength	Frequency	Instructions
1.	Tablet OLAX MD 5 14 tablets		1 (Morning) - 0 (Afternoon) - 1 (Night)	7 day(s)
2.	Tablet Parkin Plus 7 tablets		0 (Morning) - 0 (Afternoon) - 1 (Night)	7 day(s)
3.	Tablet SPERNIA 14 tablets		1 (Morning) - 0 (Afternoon) - 1 (Night)	7 day(s)
4.	Tablet BQUIT 14 tablets	0.5 mg	1 (Morning) - 0 (Afternoon) - 1 (Night)	7 day(s)
5.	~~Tablet Serinace~~ 7 tablets	~~0.50 mg~~	~~0 (Morning) - 0 (Afternoon) - 1 (Night)~~	~~7 day(s)~~

5. Syndopa Plus 0-0
6. Letrol Plus ——0
Syp ~~Lido~~ 10/00 6+8 HS

Timing Morning :10 am to 12:00 am (Monday to Sunday) | **Evening** : 5 pm to 7 pm (Monday to Friday)
This prescription fee is valid max. for 5 days



APEX INSTITUTE OF NEURO & SPINE

Dr. Vikas Bhardwaj

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Membership
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Neurosurgical Society of India (NSS)
Neurotrauma Society of India (NTSI)
U.P. Neurological Association
Ghaziabad Noida Neurological Association
Delhi Neurological Association

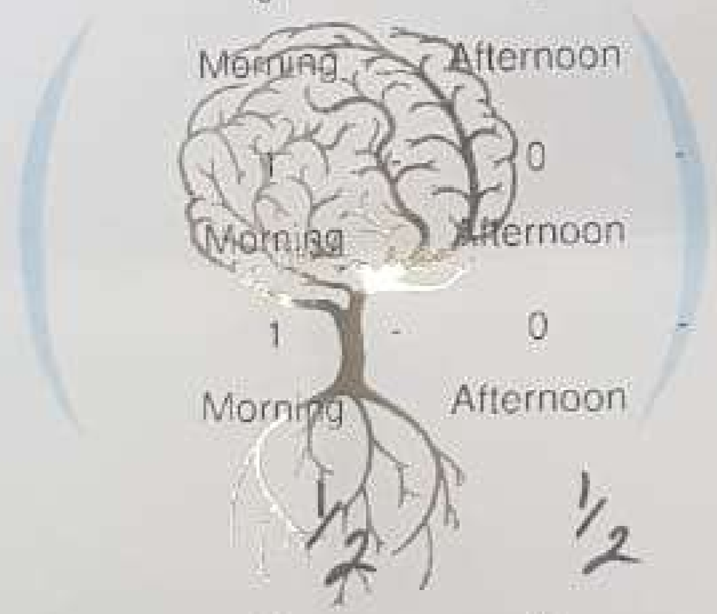
POORANKALA (P18166)

By Dr. Vikas Bhardwaj

Date: 10 Dec, 2023

Prescription(Rx)

Drug Name	Strength	Frequency			Instructions
Table: OLAX MD 5 60 tablets		1 Morning	0 Afternoon	1 Night	30 day(s) After Food
Table: Parkin Plus 30 tablets		0 Morning	0 Afternoon	1 Night	30 day(s) After Food
Table: SPERNIA 60 tablets		1 Morning	0 Afternoon	1 Night	30 day(s) After Food
Table: BQUIT 60 tablets	0.5 mg	1 Morning	0 Afternoon	1 Night	30 day(s) After Food
Table: Syndopa Plus	25 mg	1/2	1/2	1/2	30 day(s) After Food
Table: PETRIL PLUS 0 tablets		0 Morning	0 Afternoon	1 Night	30 day(s) After Food



Timing Morning :10 am to 12:00 am (Monday to Sunday) I Evening : 5 pm to 7 pm (Monday to Friday)
This prescription fee is valid max. for 5 days

APEX INSTITUTE OF NEURO & SPINE
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METRO
HOSPITALS & HEART INSTITUTE
(a unit of Metro Institutes of Medical Sciences Pvt. Ltd.)
CIN No : U00000DL1990PTC039293
(NABH, NABL & ISO 9001: 2008 Certified)

DEPARTMENT OF MEDICAL IMAGING

NAME	Mr. Vineet Choudhary	AGE/SEX	44 Y/ M	OPD/IPD	OPD
Ref.by	Dr. Sonia Lal	DATE	22.08.18	MR NO	2794
EXAMINATION PERFORMED – MRI CERVICAL SPINE PLAIN					

Findings:

Reversal of normal cervical lordosis is noted.

Vertebral bodies are normal in height, alignment & marrow signal intensity with intact cortical margins. End plates are maintained.

There is loss of normal T2 hyperintensity within intervertebral discs s/o degenerative disc disease.

C3-4: Posterior disc bulge with uncovertebral joint hypertrophy seen effacing thecal sac indenting cervical cord and exiting nerve roots bilaterally (spinal canal AP dimension – 6.9 mm).

C4-5: Posterior disc bulge with uncovertebral joint hypertrophy seen effacing thecal sac indenting cervical cord (spinal canal AP dimension – 8.2 mm).

C5-6: Left paracentral disc protrusion and uncovertebral joint hypertrophy (left > right) seen indenting cervical cord and compressing exiting nerve root on left side (spinal canal AP dimension – 6.5 mm).

C6-7: Left paracentral disc extrusion and uncovertebral joint hypertrophy (left > right) seen effacing thecal sac compressing cervical cord and exiting nerve root on left side (spinal canal AP dimension – 5.8 mm).

PLL is intact. Cord-CSF interface is normal.

Remaining cervical cord & cervicomedullary junction is normal in dimension & signal intensity. No intramedullary lesion seen.

Atlanoto-axial joint is normal with preserved atlanto-dental interval. No evidence of basilar invagination seen.

Posterior elements are normal. No focal osseous lesion seen. Facet joints are normal.

Paraspinous muscles show normal in parenchymal signal intensity with preserved intermuscular fat plane. Pre & paravertebral soft tissues are unremarkable.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

❖ *This is a professional opinion based on imaging finding and not the diagnosis.* ❖ *Not valid for medico-legal purposes.*
❖ *In case of any discrepancy due to machine error or typing error, please get it re...*

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