Jan Sanjeevni Trust

Hands to Serve - Heart to Love

Reg. No. 1061 PAN No. AADTJ0816E

Jan Sanjeevni Trust Registration No: 1061/2017
Jan Sanjeevni Trust PAN No: AADTJ0816E
Jan Sanjeevni Trust Website: www.jstngo.org
Jan Sanjeevni Trust E-mail : we@jstngo.org

PATIENT NAME	Rudranil Sinha
GURDIAN	Somnath Sinha
D.O.B/ SEX	2 Years, Male
DISEASE NAME	Hepatoblastoma (liver cancer)
TREATMENT HOSPITAL	AIG Hospital (Hyderabad)
UHID NO	AIGG.21269198
DEPARTMENT NAME	Pediatric Oncology
TREATMENT COST	₹5,60,000/-
GURDIAN's OCCUPATION	Unemployed
ADDRESS	Ichhar, PO: Ichhar, DIST: Puruliya, West Bengal - 723145

Surgery Estimation

Patient's UHID/ IPNO	: AIGG.21269198	**Patient's Name/Age/Sex**	: Mast. RUDRANIL SINHA/2 Year(s) 4 Month(s)/Male/9002766646
Estimation Amount	: 560000		: Jalleda Asaswini Priyanka
Estimation Date/Time	: 27/08/2026 10:58:37	**Estimation Given by**	: PRIYANKA
Requested Bed Type	: Sharing	**Billing Counselling done by**	: POOJA SINHA
Surgeon/Physician Name	: Dr. BALACHANDRAN PALAT	**Billing Counselling done To**	: Mother
Expected day of stay	: 8	**Relationship**	:
Minimum Deposit	: 480000	**Emergency No**	:
Company	:	**Expected Date of Admission**	
		Estimate Type	: Initial Pre-Admission Estimate
		Estimate No.	: ESTG17591
Diagnosis/Medical Problem	: RT HEPATECTOMY		

Estimation Break-Up-

Item Name	Amount
Room Rent Sharing (5X5500)	27500
Investigation Charges	50000
Drug Charges	100000
Consumable Charges	100000
Admission Charges	1500
ICU Charge (3.00X9,000.00)	27000
RT HEPATECTOMY	220000
OTHERS	30000
Total Amount	**560000**

Remarks : OT-5HRS, BLOOD, VIRALS+VE,EXTRA ICU/ROOM STAY/OPEN SURGERY/CUSA-25K REQUIRED CHARGES EXTRA.

Note: Hospital Admission Terms & Conditions

• Estimates & Billing

The admission cost estimate is approximate. Final billing reflects actual treatment and services received. Enhanced treatment and extended stay costs will be communicated timely. It is the responsibility of patient attendants to check the bill everyday at Tower A, 5th Floor.

• Advance Payment

Full estimated cost is payable at admission. A minimum positive balance of ?50,000 must be maintained during the stay.

• Payment Responsibility & Regulations

The patient/legal guardian is responsible for full bill settlement. If a nominee/guardian will pay, a signed undertaking is required. PAN card of the patient or attendant is mandatory at admission.

• Payments & Refunds

Payments accepted via cash, card, DD, UPI, or bank transfer. Cheques are not accepted. Refunds up to ? 20,000 will be issued in cash; higher amounts via NEFT within 4–7 working days.

• Admission & Attender Policy

One attender must stay with the patient throughout, except in general wards (no attenders allowed). Admission without an attender is not permitted. If the patient is moved to ICU/HDU/PICU/OT, the attender must vacate the room. No separate

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accommodation will be provided.

• Belongings

The hospital is not liable for loss/theft of personal belongings. Patients/attenders must safeguard valuables.

Insurance-Specific Terms

• Role of Hospital

a. The hospital acts solely as a facilitator and is not responsible for insurer decisions. If cashless is denied, hospital cash tariff applies, which differs from insurance rates.

b. The hospital is not liable for insurance denial due to non-disclosure of pre-existing conditions, cosmetic treatments, substance-related ailments, self-harm, or war-related injuries.

• Policy Eligibility

Patients must confirm room eligibility with their insurer. Upgrades may lead to proportionate deductions, and the cost difference must be borne by the patient.

• Copay & Exclusions

Policies may include co-payments or sub-limits for specific conditions, payable by the patient. Non-medical expenses are not covered and must also be paid by the patient. Refer to your policy for details.

Self-Declaration

I agree to all hospital terms on billing, discharge, refunds, insurance, and clinical documentation. I take full responsibility for settling my bill before discharge. I understand the estimate is approximate and final billing will reflect actual services. I consent to clinical photography/videotaping for documentation. I agree to maintain a positive balance, vacate my room if moved to ICU/HDU/OT, and confirm that I was counselled about all investigations, treatments, and consumables in the language Hindi known to me.

Signature: Somnath Sinha

Relation: Father

Name:

Date: 27/8/26.

Estimate Given By : Jalleda Asaswini Priyanka

Print DateTime : 27/08/2026 10:58:39

Print By : Jalleda Asaswini Priyanka

AIG HOSPITALS

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Patient Name: Most Rudramil Sinha

UHID No: 2126998

Age&Sex: 24/(P)

Date & Time: 04.08.26

FROM - W.B.

Chief Complaints: *AFP > 1000000

Blood group - NA

c/o - Abd distention from 1 week
intermittent fever - 20 days

History of presenting complaints:

No H/o - previous Sx

Past Medical / Surgical History:

Deper MRCP 31.7.26.
1) Liver - Enlarged
2) 4 lesions: largest is 9.1 x 9.8 x 11.6 cm involving Seg VII, VIII, I, VI.
3) PV - MPD appears stretched with maintained flow void. => ? Hepatoblastoma

Family History/Personal History (including social and psychological factors):

Medication History:

S.No	Medication	Dosage	Route	Frequency
	On 31.07.2026.	APTT - 143/27		
	PT/INR - 11.5/0.94	D/Bil - 4.5	AFP	> 100.000.
	APTT - 28.8	Hb - 7.1, TLC - 11830		
	CRP - 67.00	Plt - 367		
	Bil - T/D - 0.8/0.2			

General & Systemic examination: CVS:

RS:

G.I:

CNS:

OTHERS:

LOCAL EXAMINATION:

USG :- Liver - mildly enlarged.
Lobulated heterogenous mass of liver 109 x 100mm. - Rt lobe.
No IHBRD

mass felt

Large SOL (R) lobe
c RPV & RHV encasement

Provisional Diagnosis:

Consultant Review Notes:

CBN &
Amp

Abd

PET CT Triphasic Scan Abdomen

Final Diagnosis:

& Levels c Reports

Dr. Arif Mohammed Khan
MD(Medicine), DM(Oncology), TMH Mumbai
Senior Consultant Medical & Hemato Oncologist
Bone Marrow Transplant Physician
Reg No: DMC/28455

AIG HOSPITALS

CONSULTATION NOTE

MC-3380

UHID	AIGG.21269198	**Visit Date**	04/08/2026 11:35 AM
Patient Name	Mast. RUDRANIL SINHA	**Age / Gender**	2 Years / Male
Doctor Name	Dr. ARIF KHAN	**Visit ID**	1100.OP.2692754
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR , RAGHUNATHPUR - II, WEST BENGAL, 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	T	N	M	Accuracy
C22.2	MALIGNANT NEOPLASM: HEPATOBLASTOMA					Provisional

Present Complaints:

AFP> 1000000
MRCP:At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma. PRETEXT II (C, F)

Visit Summary:

4.8.26 :

PET CECT (triphasic)

liver transplant opinion

Patient Medical History:

ABDOMINAL DISTENSION FROM 1 WEEK
Fever : 15 days on and off
H/o recurrent fevers every month
No jaundice / vomiting / loose stools / weight loss/ pruritis
Weight < 3rd centile
Height < 3rd centile

Investigations:

PET CT WHOLE BODY WITH CONTRAST - triphasic

UHID	AIGG.21269198	**Patient Name**	Mast. RUDRANIL SINHA
Doctor Name	Dr. ARIF KHAN	**Age / Gender**	2 Years / Male
Visit Date	04/08/2026 11:35 AM		

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT)

Medications:

S. No	Name	Frequency	Route	Dura-tion	Start Date	Instructions
1	CROCIN DS 240MG/5ML 60ML SYP (PARACETAMOL(240MG/5ML))	When Necessary Dose: 1	Oral	1 day	04/08/26	3.5ML / SOS for fever , can be give times a day

Referrals:

Doctor	Speciality	Instructions
Dr. SUMANA KOLAR RAMACHANDRA	Liver Transplant & Heptobiliary Suregry	-

DR ARIF KHAN MOHAM

MBBS | Senior Cons
MEDICAL ONCO

AIG HOSPITALS

Dr. Dharani Nagoji
MBBS, MD
Fellowship in Paediatric Gastroenterology
Hepatology & Nutrition
Consultant Medical Gastroenterology
Reg No : TSMC/FMR/00583

MC-3380

CONSULTATION NOTE

UHID	AIGG.21269198	**Visit Date**	31/07/2026 04:48 PM
Patient Name	Mast. RUDRANIL SINHA	**Age / Gender**	2 Years / Male
Doctor Name	Dr. Dharani Nagoji	**Visit ID**	1100.OP.2682987
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR , RAGHUNATHPUR - II, WEST BENGAL, 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	Accuracy
K76.9	LIVER DISEASE, UNSPECIFIED		Provisional

Present Complaints:

ABDOMINAL DISTENSION FROM 1 WEEK
Fever : 15 days on and off
H/o recurrent fevers every month
No jaundice / vomiting / loose stools / weight loss/ pruritis
Weight < 3rd centile
Height < 3rd centile

Systemic Examination:

P/A: Soft , non tender

Investigations:

CBP (COMPLETE BLOOD PICTURE)
LFT (LIVER FUNCTION TEST)
PT WITH INR AND APTT
AFP
MRCP ↓ Anesthesia
CRP

AIG HOSPITALS

Name: Mast. Rudranil Sinha	Episode: OP	Order Date: 31/07/2026 20:04
AIGG.21269198	Bill No: AGOCS260822976	Collec. Date: 31/07/2026 20:07
Sex: 2 Year(s) / Male	Sample No: AGO1944930D	Ack. Date: 31/07/2026 22:11
No: 8002766646	Ref. Doctor: Dr. Dharani Nageji	Report Date: 31/07/2026 23:02
AIG Hospitals, Gachibowli		

LFT (LIVER FUNCTION TEST) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
TOTAL BILIRUBIN (Method: DPD)	0.8	0.3 - 1.2	mg/dL
DIRECT BILIRUBIN (Method: DPD)	0.2	0-0.2	mg/dL
INDIRECT BILIRUBIN (Method: Calculated)	0.6	-	mg/dL
S.G.P.T (ALT) (Method: Enzymatic without P5P (Ref IFCC))	27 ▲ (H)	10 - 25	U/L
S.G.O.T (AST) (Method: Enzymatic without P5P (Ref IFCC))	143 ▲ (H)	21 - 44	U/L
ALP (Method: AMP optimised to IFCC)	290	134 - 315	U/L
TOTAL PROTEINS (Method: Biuret)	7.8 ▲ (H)	5.6 - 7.5	g/dl
ALBUMIN(SERUM) (Method: BCG)	4.5	3.8 - 5.4	g/dl
GLOBULIN (Method: Calculated)	3.3	2.3 - 3.5	g/dl
A/G RATIO (Method: Caluclated)	1.4	0.9 - 2	

Interpretation: Liver function tests are blood tests used to help diagnose and monitor liver disease or damage. Liver function tests can be used to: Screen for liver infections, such as hepatitis Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working Measure the severity of a disease, particularly scarring of the liver (cirrhosis) Monitor possible side effects of medications.

Report Saved By - V Sekhar (31-07-2026 23:02)

Dr.G. DEEPIKA
Director & HOD – Biochemistry MBBS.
MD

End of Report

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AIG Hospitals (a unit of Asian Institute of Gastroenterology) CIN: U99999TG1994PTC018352

AIG HOSPITALS

Name	: Mast RUDRANIL SINHA	Accession No	: 1O.7182192.33993
UHID	: AIGG.21269198	Bill Date	: 31-Jul-2026 20:04
Gender/Age	: M/2 Y	Reporting Date	: 03/08/2026 1:58PM
Ref. Phys.	: Doctor Dharani Nagoji	Modality	: MR
Procedure Name	: MRCP		

Gallbladder is partially distended. No e/o intraluminal sludge / calculi. Wall thickness is normal. Cystic duct is not well delineated.

PANCREAS:
-Pancreas appears displaced by the mass effect of enlarged liver. Otherwise, normal in bulk and signal intensity. No peripancreatic fluid collection.
-Pancreatic duct: Not dilated.
-Pancreatic divisum could not be commented upon.

Spleen measures 4.9 cm with normal signal intensity.

Both kidneys appear unremarkable.

IMPRESSION:

At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma. PRETEXT II (C, F).

Suggested contrast study for better vascular evaluation.

This examination and reported findings have been reviewed and confirmed.

Approved by:

Dr. Aishvarya Shri Rajasimman
MBBS,MD
Junior Consultant

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

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Telangana - 500032
Tel: 040 4244 4222 | info@aighospitals.com
aighospitals.com

LABORATORY INVESTIGATION REPORT

Patient Name	: Mast. RUDRANIL SINHA	**Age/Sex**	: 2 Year(s) 3 Month(s) / Male
UHID	: AIGG.21269198	**Order Date**	: 31/07/2026 20:04
Episode	: OP	**Bill No.**	: AGOCS260822976
Ref. Doctor	: Dharani Nagoji	**Mobile No**	: 9002766646
		Facility	: AIG Hospitals, Gachibowli
Sample No	: AGO1944930E	**Collec.Date**	: 31/07/26 20:07
Ack. Date	: 31/07/2026 22:11	**Report Date**	: 01/08/26 20:24

Hormones

TEST	RESULT	UNIT	BIOLOGICAL REF INTERVAL
AFP			
Sample Type- Serum			
ALPHA FETOPROTEIN.	**> 1000000 ▲ (H)**	ng/mL	0-87
Method - ECLIA			

Interpretations: AFP produced by the feotus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Dr. Katamareddy Prathyusha (01/08/2026 10:27 AM)

End of Report

Dr.G. DEEPIKA

Director & HOD – Biochemistry
MBBS, MD
RegNo: 54289

AIG HOSPITALS

Patient Name: Mast. Rudranil Sinha	Episode: OP	Order Date: 31/07/2026 20:04
UHID : AIGG.21269198	Bill No: AGOCS260822976	Collec. Date: 31/07/2026 20:07
Age / Sex: 2 Year(s) / Male	Sample No: AGO1944930A	Ack. Date: 31/07/2026 23:14
Mobile No: 9002766648	Ref. Doctor: Dr. Dharani Nagoji	Report Date: 31/07/2026 23:43
Facility: AIG Hospitals, Gachibowli		

PT WITH INR AND APTT *Sample Type - Citrated Plasma* — **Coagulation**

Test (Method)	Result	Normal Range	Unit
PROTHROMBIN TIME *(Method: Photometric Clotting Assay)*	11.3	10.8 - 13.2	Seconds
MEAN NORMAL PROTHROMBIN TIME *(Method: Photometric clotting assay)*	12.0	-	Seconds
INR	0.94	Normal <1.3 Therapeutic Range 2.0 - 3.5 Critical Alert >4.0	
APTT TEST *(Method: Photometric Clotting Assay)*	28.8	26.8-41.5	Seconds

Interpretation: Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), tissue factor and proteins of the common pathway (Factors X, V, II & Fibrinogen).Prolonged PTAdministration of oral anticoagulant drugs Liver disease, particularly obstructive jaundice Vitamin K deficiency Disseminated intravascular coagulation Inherited deficiency of factors in extrinsic pathway (VII) and common pathway (V, X, prothrombin and fibrinogen)International Normalized Ratio \endash Is used for defining the therapeutic ranges for anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity. Recommended Therapeutic range for Oral Anticoagulant therapy INR 2.0-3.5: Treatment of Venous thrombosis & Pulmonary embolism, Prophylaxis of Venous thrombosis (High risk surgery), Prevention of systemic embolism in tissue heart valves, AMI, Valvular heart disease & Atrial fibrillation, Bileaflet mechanical valve in aortic position

Note : 1. Results should be clinically correlated

2. Test done on citrated plasma.CommentsPartial Thromboplastin Time / Activated Partial Thromboplastin Time (PTT / APTT) measures the activity of intrinsic and common pathway of coagulation, which consists of Factor XII, Prekallikrein, High molecular weight kininogen, Factors VIII, IX & XI. It also measures proteins of the common pathway namely factors II, V, X & Fibrinogen.Abnormal Partial Thromboplastin Time Associated with bleeding: Defects of factors VIII, IX & XINot associated with bleeding: Defects of factor XII, Prekallikrein, High molecular weight kininogen & Lupus anticoagulantsIsolated prolonged APTT Undiagnosed haemophilia, Congential coagulation disorders Moderately prolonged APTT Patients taking oral anticoagulant drugs, Presence of vitamin K deficiency Prolonged PTT/APTT Disseminated intravascular coagulation, Liver disease, Massive transfusion with plasma depleted red blood cells, Administration or contamination with heparin or other anticoagulants, A circulating anticoagulant including lupus anticoagulant, Deficiency of a coagulation factor other than factor VII

Note : 1. Results should be clinically correlated

2. Test done on citrated plasma.

Report Saved By - Rajesh Kumar (31-07-2026 23:43)

End of Report

Dr.MD Shareef Ahmed
MBBS, MD Pathology

Dr.ANURADHA SEKARAN
MD, DNB, MNAMS, DipRCPath (UK)
Director of Pathology & Molecular Pathology

View Report

Print Date / Print By : 01-08-2026 09:30 / Tapaswini Priyadashini

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AIG HOSPITALS

nt Name: Mast. Rudranil Sinha	Episode: OP	Order Date: 31/07/2026 20:04
): AIGG.21269198	Bill No: AGOCS260822976	Collec. Date: 31/07/2026 20:07
/ Sex: 2 Year(s) / Male	Sample No: AGO1944930C	Ack. Date: 01/08/2026 01:18
ile No: 9002766648	Ref. Doctor: Dr. Dharani Nagoji	Report Date: 01/08/2026 06:18
ility: AIG Hospitals, Gachibowli		

CRP *Sample Type - Serum*

Serology

Test (Method)	Result	Normal Range	Unit
CRP - C Reactive Protein *(Method: Sandwich Immunoassay)*	67.00 ▲ (H)	Negative <10 mg/L Positive >= 10 mg/L	mg/L

Interpretation:
C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation. Markedly increased levels are observed, for example, after trauma or a heart attack, with active or uncontrolled autoimmune disorders, and with serious bacterial infections like sepsis.

The test measures the amount of CRP in the blood and can be valuable in detecting inflammation due to acute conditions or in monitoring disease activity in chronic conditions.

CRP is detected in pregnant women after the 1st trimester of pregnancy and persists until delivery. Increased levels are also seen in women who are on Oral Contraceptives.

The CRP test is not diagnostic, but it provides information as to whether inflammation is present

Report Saved By - P Siva Nagaraju (01-08-2026 06:18)

Dr.YV. SADHANA
Sr.Consultant, Microbiologist
MD,FRCPath(UK)

End of Report

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AIG Hospitals (a unit of Asian Institute of Gastroenterology) CIN: U99999TG1994PTC018352

AIG HOSPITALS

Name	: Mast RUDRANIL SINHA	**Accession No**	: 10.7182192.33993
UHID	: AIGG.21269198	**Bill Date**	: 31-Jul-2026 20:04
Gender/Age	: M/2 y	**Reporting Date**	: 03/08/2026 1:58PM
Ref. Phys.	: Doctor Dharani Nagoji	**Modality**	: MR
Procedure Name	: MRCP		

DEPARTMENT OF RADIO-DIAGNOSIS
MRCP (NON-CONTRAST)

HNIQUE: Thick slab MR Cholangio-Pancreatography. B-TFE Axials, T1, T2-FS Axials, T2 and T2 FAT Coronals, 3D HR MRCP.

NICAL DETAILS: Abdominal distention for one week. Fever on and off.

SERVATIONS:

er is enlarged measuring 15 cm.

ır well-defined lesions are seen involving the right lobe of liver as described.

i/multifocal: Four discrete lesions are seen.
:ation: Segments VII, VIII, V, VI (PRETEXT II).
e: Largest measuring 9.1 x 9.8 x 11.6 cm (AP X TR X CC).
Hypointense with few T1 hyperintense areas showing diffusion restriction, suspicious for morrhage / necrosis.
Heterogeneously hyperintense.
VI: Few areas of focal restriction (in T1 hyperintense areas).
rtal Vein: MPD appears stretched with maintained flow void. Right portal vein is encased with enuated caliber. Left portal vein normal.
patic Veins: Middle and left hepatic veins are normal. Right hepatic vein is faintly visualized – cased with attenuated caliber.
C: Displaced. Patent with maintained flow void.
udate: Involved.
atures of rupture: Absent.
BRD: Absent.
odes: No significant adenopathy as per size criteria.
trahepatic disease: Absent to the visualized extent.
scites: Absent.

ommon bile duct at porta measures 3 mm. No evidence of intrahepatic biliary dilatation is seen.

IPV at porta measures 5 mm.

AIG HOSPITALS

Patient Name: Mast. Rudranil Sinha	Episode: OP	Order Date: 31/07/2026 20:04
UHID : AIGG.21269198	Bill No: AGOCS260822976	Collec. Date: 31/07/2026 20:07
Age / Sex: 2 Year(s) / Male	Sample No: AGO1944930B	Ack. Date: 31/07/2026 22:22
Mobile No: 9002766646	Ref. Doctor: Dr. Dharani Nagoji	Report Date: 01/08/2026 11:14
Facility: AIG Hospitals, Gachibowli		

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

Haematology

Test (Method)	Result	Normal Range	Unit
HEMOGLOBIN *(Method: Colorimetric / Spectrophotometry Non-Cyanide Method)*	7.1 ▼ (L)	11.0 - 14.0	g/dl
RBC *(Method: Electrical Impedance / Impedance)*	4.11	4.0 - 5.2	cells/cumm
PCV *(Method: Calculated)*	23.6 ▼ (L)	34.0 - 40.0	%
MCV *(Method: Derived From RBC Histogram / Numeric Integration)*	57.4 ▼ (L)	75.0 - 87.0	fl
MCH *(Method: Calculated)*	17.3 ▼ (L)	24.0 - 30.0	pg
MCHC *(Method: Calculated)*	30.1 ▼ (L)	31.0 - 37.0	g/dl
RDW *(Method: Derived From RBC Histogram /Calculated)*	19.5 ▲ (H)	-	%
TOTAL WBC *(Method: Flowcytometry SF CUBE / Flowcytometry DHSS and Impedance)*	11830	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS *(Method: SF Cube Method / Flowcytometry DHSS / Microscopy)*	67.7 ▲ (H)	30 - 53	%
LYMPHOCYTES *(Method: SF Cube Method / Flowcytometry DHSS / Microscopy)*	24.3 ▼ (L)	27 - 57	%
EOSINOPHILS *(Method: SF Cube Method / Flowcytometry DHSS / Microscopy)*	0.8 ▼ (L)	2.0 - 7.0	%
MONOCYTES *(Method: SF Cube Method / Flowcytometry DHSS / Microscopy)*	6.9 ▲ (H)	4.0 - 7.0	%
BASOPHILS *(Method: SF Cube Method / Impedance/Microscopy)*	0.3	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT. *(Method: Calculated / Flowcytometry DHSS)*	8009 ▲ (H)	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT *(Method: Calculated / Flowcytometry DHSS)*	2875 ▼ (L)	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT *(Method: Calculated / Flowcytometry DHSS)*	95 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT *(Method: Calculated / Flowcytometry DHSS)*	816	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT *(Method: Calculated / Impedance)*	35	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO *(Method: Calculated)*	2.8	-	
PLATELET COUNT *(Method: Electrical Impedance / Impedance)*	367	200 - 490	10^3/mm^3
MPV *(Method: Derived From Platelet Histogram / Electrical Impedance)*	11.1 ▲ (H)	7.4-10.4	fl
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. *(Method: Microscopy/Leishman stain)*	Anisocytosis microcytic hypochromic		
WBC MORPHOLOGY. *(Method: Microscopy/Leishman stain)*	Neutrophilic leucocytosis left shift		
PLATELETS.. *(Method: Microscopy/Leishman stain)*	Adequate		
ABNORMAL CELLS. *(Method: Microscopy/Leishman stain)*	Nil		
HEMOPARASITES.. *(Method: Microscopy/Leishman stain)*	Nil		

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete bloo counts.CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Suligitha Madhubabu (01-08-2026 10:08)

End of Report

AIG HOSPITALS

MC-3380

Dr. Dharani Nagoji
MBBS, MD
Fellowship in Paediatric Gastroenterology Hepatology & Nutrition
Consultant Medical Gastroenterology
Reg No : TSMC/FMR/00583

CONSULTATION NOTE

UHID	AIGG.21269198	Visit Date	04/08/2026 08:26 AM
Patient Name	Mast. RUDRANIL SINHA	Age / Gender	2 Years / Male
Doctor Name	Dr. Dharani Nagoji	Visit ID	1100.OP.2691083
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR , RAGHUNATHPUR - II, WEST BENGAL. 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	Accuracy
C22.2	MALIGNANT NEOPLASM HEPATOBLASTOMA		Provisional

Present Complaints:

AFP> 1000000

MRCP:At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma. PRETEXT II (C, F)

Patient Medical History:

ABDOMINAL DISTENSION FROM 1 WEEK

Fever : 15 days on and off

H/o recurrent fevers every month

No jaundice / vomiting / loose stools / weight loss/ pruritis

Weight < 3rd centile

Height < 3rd centile

Medications:

S. No	Name	Frequency	Route	Dura-tion	Start Date	Instructions
1	CROCIN DS 240MG/5ML 60ML SYP (PARACETAMOL(240MG/5ML))	When Necessary Dose: 1	Oral	1 day	04/08/26	3.5ML / SOS for fever , can be given 4 times a day

Referrals:

Doctor	Speciality	Instructions

Mast RUDRANIL SINHA 28M

AIG HOSPITALS

PRE-ANAESTHETIC ASSESSMENT

(Patient Label) UHID 2126918

PAC Done by Dr. Hemalatha
Date / Time: 1/08/26
12:30PM

Problems / Comorbidities:
Blood Group:
Hiv / Hbsag / Anti Hcv:
Allergies: No allergies.

Diagnosis:
Surgery/Procedure: MRCP
Ht / Wt / BMI: → 10 kg → 74 Mc → 8.3%
Surgeon: Dr(s).
Date of Surgery:
Site: Left / Right

MEDICAL HISTORY: Abd. distension since last

CVS : Essential HTN/ IHD/ MI/ Valvular Heart disease/ PTCA/ Peripheral Vascular disease
Angina: Y/N syncope: Y/N palpitations: Y/ N

RS : Bronchial Asthma/ Exposure to TB/ COPD/ILD/Pulmonary Hypertension
Duration- Recent attack- Treatment-

CNS : Epilepsy/ CVA/ Migraine/ spondylosis/ koch's spine
Duration- Recent attack-

Musculo-Skeletal : Large Joints/ Rheumatoid Arthritis

Renal : UTI/ Renovasular disease/ Nephropathy / Hemodialysis/CRRT
Duration- Recent attack- Treatment-

GIT : ulcerative colitis/ abdominal koch's/GERD/Hiatus hernia / Obesity
Duration- Treatment-

Hepato-Biliary / Pancreas
hepatitis/CLD/Acute pancreatitis/Chronic pancreatitis/Cholangitis-

ENT / Eye : Sinusitis/ Snoring/ Glucoma/ Deafness/ Others

Endocrine : Thyroid disorder/ DM/ Cushing's/ PCOD/ steroids / others-specify -
Duration- Disease course-
Autonomic symptoms-
Treatment-

Hematology : h/o blood and blood product transfusion/G6PD deficiency/ sickle cell anemia/Polycythemia/ others -specify -

Malignancy and myeloproliferative disorders & others:

Personal History:
Ethanol/ smoking/CAM/steroids/substance abuse/tobacco chewing/ contraceptive pills / LMP

Paediatric History: Recurrent fever ∴ 7-8 months.
Birth History :
Developmental Milestones : → ND
Immunization : vaccinated till date

List of all previous surgeries / Perioperative or anaesthesia problems / Past hospitalization / ICU admissions:

CURRENT MEDICATIONS

GENERAL EXAMINATION

Temp: 98.4 F
PR: 154/m.
RR:
SpO2: 99
Heart: S1S2 (N)
Lungs: BAE (N)
CNS: NAD. Mental:

Hydration: Fair / Dehydrated
Peripheral Pulses:
NYHA: I II III IV V
Bedside Resp Function: N / F / P
BHT
SMI: PEFR:
Hand grip Dynamometry:
Left: Right:

Pallor: +
Icterus: —
Petechiae : —
Cyanosis: —
Anasarca: —
Spine Gr: I II III IV V VI

AIRWAY ASSESSMENT:
Mouth Opening: cannot be assessed
Dentition: (N)
Extension: (N)
Mento-Thyroid distance:
Nostril patency: (N) Crico-Thyroid memb:
Mallampati @ PAC : I II III IV
Diff. Intubation: **Less likely / Could be / YES**

INVESTIGATIONS 31/07/26

Hb / Hct: 7.1	Amylase / Lipase 7.8/45	CXR:	ECHO
TLC: 18150	TP / Albumin:		
Plt: 367	PT / INR: 11.3/0.94	ECG / TMT / DSE:	MRI / CT: Mild hepatomegaly Liver mass in (R) lobe of liver.
RBS/HBA1C:	APTT: 28.8	CATH:	
Urea / Creatinine:	Fibrinogen:		
Bilirubin: 0.8	TSH	e- GFR:	
AST / ALT: 243/27	FT3 / FT4 :	24 Hrs Proteins:	CULTURES
GGT:	pH / PFR:	PCR:	
Se. Ammonia:	PaCO2 / SBE:	24 Hrs UO:	
	Na+ / K+ :		

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atient Label)

Symbols: PR - • SBP - V DBP - Λ Temp - ⊙ CVP - ■

biotic
NMBA
V
lgesics
o %
2
D2
PaCO2
S
eak / Plat
EP

spontaneous breathing

100 100 100 100 100 100 100

220 200 180 160 140 120 100 80 60 40 20 BP

Temp
Fluids ① 100 ml NS
UO
Time

INTAKE				OUTPUT			Balance
Cryst	Colloids	PRBCs	Plt	Urine	Blood Loss	Ascitis	
FFPs	Cryo Ppt	Auto trans	Salvaged Bld	RTA	Others		

Reversal: Neostigmine - + Atro - Glyco - or Suggamadex

RECOVERY:

☐ Uneventful - Alert, Sustained head lift, Sedated ☐ Elective Ventilation
☐ Laryngospasm ☐ Re-intubation ☐ Unplanned Ventilation
☐ Unplanned SCCU admission

Shifted to: Recovery HDU / SCCU

Vitals Before Shifting: Temp PR BP SpO_2 RR VAS

100%

Special Instructions:

Deep Breathing & Calf Exercises – Mandatory For all
Stringent Epidural protocol – If pts are on Epidurals
PPPC Protocol – For all Major & Bariatric Surgeries
Early Ambulation Protocol for ALL – If no C/I
Maintain VAS < 3/10 – All Surgical Patients
Rest – Follow Surgeons & Anaesthesiologists Instructions

Name and Signature of the Anaesthesiologist:

Date & Time Dr Rooki 3/8/26

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INTRA - OPERATIVE ANAESTHESIA RECORD

Date: 3/2/26 Name of Anaesthesiologist / Tech: Dr Roohi / Rechna Consent: Regular / Mod risk / High Risk

Immediate Pre-operative Anaesthesia Assessment (To be done when the patient is on the OT table)

PAC chart reviewed ☑ Yes ☐ No Pre-op instruction followed ☑ Yes ☐ No NBM Status ☐ Yes ☐

Premedication in pre-OP holding area: Ø

ASA grading I ☐ Airway exam MPG II / III

I.V. Access (Size & Location): 22G (R) hand CVP / AL (Site) from ICU: ☐ Anaesthesia plan MAC + sedation

Surgery Name : MRCP. Site _____ Rt _____ Lt _____ Bilatral _____ TT / ETT from ICU - Size / Cuff Pr:

Immediate Preop Vitals: Temp: PR: RR: BP: SPO_2: GCS: Pupils: Rt - Lt -

Equipment Check Before Sign-In: ☐ Anaesthesia work Station & Drugs ☑ Monitor & Defib ☑ Routine & Diff Airway Trolley ☐ Em

Anes start time: **Patient into OT:** **Surg start time:** **Surg end time:** **Patient out of OT:** Anes end

Surgical Details

Surgery Proposed: MRCP.

Surgery Done (Reason, if change of tech):

Anaesthesia Details

Proposed Technique: MAC + Sed

Change of Technique - Reason:

GA Details: INDUCTION: Parenteral / Inhalational ; **B & MASK VENTILATION:** Easy / Difficult ; **INTUBATION:** Oral / Nasal – Easy / Difficult, **CL GRADE:** I II III

SPECIAL INTUBATING AIDS: Video-Laryngoscope / FOB / Stilette / Bougie **PLANNED / RESCUE**

ETT: Regular / Reinforced / DLT – Lt / Rt / RAE / Double cuffed / Laser **SIZE:**

PLMA / ILMA / I-Gel: Size **Difficulty in Insertion:** Yes / No **Planned Insertion / Rescue**

NOTES:

Ventilatory Settings:
Mode: VC / PC / PRVC / SIMV – PS, vT:
P.Peak / P.Plt: **PEEP:**
RR / MV
Low Flows - L/min/ **Metabolic Flow**
Gases: O2 / Air

EPIDURAL / SPINAL / CSEA / LUMBAR DRAIN / PNB **USG:** Yes / No

Aseptic technique **Needle Size / make:** **DSES:** LOR A / S / T

Position: **Space / Site:** **Fixed at:**

Notes & Unanticipated events, if any: N/A

Time	Drug – Conc / Adjuvant	Vol	D
	N/A.		

Medications & Dosages administered & Time:

Inj GLYCO 0.05mg iv Inj KETAMINE 10mg + 2.5mg iv

Inj MIDAZ 0.2mg iv

ABG - Time

MONITORING:

Temp – NP / R / O SPO_2 NI – CO POCT – TEG / ROTEM **LABS:**

ECG II/V/12 L CVP Flo Trac / SVV Foleys catheter

NIBP – ABP BIS / Entropy Others

EtCO2 PA NMJ Others

- o Body warmer
- o Fluid Warmer
- o Ryles Tube
- o Cell salvage
- o Rapid infusor

LINES	Size	Site		Site	Size		Site	Size	USG Guid
IV Line 1	22G	(R) hand	Art line 1			CL - 1			Notes /
IV Line 2			Art line 2			CL - 2			
IV Line 3						PA			

Patient position:

Supine Prone Rt Lat Lt Lat Kidney Lithotomy Sitting O -

Tourniquet Time / Vascular occlusion:
Site: Duration:

Pressure points padding: EYES / Superficial Nerves / Soft tissues / Extreme extension

Remarks:

SPECIAL NOTES (CPB / TRANSPLANT) CRITICAL INCIDENTS

CONSENT FOR ANAESTHESIA

PROCEDURE NAME : MRCP.

(Patient La

I M/O Ravkanil sinha acknowledge, that my doctors, (surgeon & anaesthesiologist) have explain detail about my operation, diagnostic or treatment procedure. My doctor has explained the cost, risks of the proced me of alternative and benefits treatments and the risks of not having procedure and told me about the expected ou what could happen if my condition remains untreated in a **language that I understand.** (Hindi). It has been explained to me that all forms of anaesthesia involve some risks and no guarantees or promises ca concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anae occur and include the remote possibility of infection, bleeding, drug reactions, blood clots loss of sensation, l function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of a and that additional or specific risks have been identified below as they may apply to a specific type of anaesthesia. I that the type(s) of anaesthesia service checked below will be used for my procedure and that the anaesthetic tech used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or ence, as well as my own desire and alternate techniques . It has been explained to me that sometimes an anaesthesia which involves the use of local anaesthetics, with or without sedation, may not succeed completely and therefo technique may have to be used including general anaesthesia.

Please tick the type of Anaesthesia Planned

☐ General Anaesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe, or othe to secure airway.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other route. Exam
	Risks	Possibility of mouth or throat pain, hoarseness, injury to mouth or teeth, awaren under anaesthesia, injury to blood vessels, aspiration, pneumonia, vomiting.
☐ Spinal or Epidural Analgesia / Anaesthesia ☐ With Sedation ☐ Without Sedation	Expected Result	Temporary decrease or loss or feeling and/or movement to lower part of the bod (unilateral/ bilateral)
	Technique	Drug injected through a needle/ catheter placed either directly into the spinal ca immediately outside the spinal canal (epidural space).
	Risks	Possibility of headache, backache, buzzing in the ears, convulsions infection, per weakness, numbness, residual pain, injury to blood vessels, arrhythmias.
☐ Major/Minor Nerve Block ☐ With Sedation ☐ Without Sedation	Expected Result	Temporary loss of feeling and/ or movement of a specific limb or area
	Technique	Drug injected near nerves providing loss of sensation to the area of the operatio
	Risks	Infection, swelling, persistent numbness, fits, residual pain, injury to blood vessel lung injury / collapse, allergic reaction.
☐ Intravenous Regional Anaesthesia ☐ With Sedation ☐ Without Sedation	Expected Result	Temporary loss of feeling and/or movement of a limb
	Technique	Drug injected into vein of arm or leg while using a tourniquet
	Risks	Infection, fits, weakness, persistent numbness, residual pain, injury to blood vess allergic reaction, anaphylaxis, arrhythmias
☐ Monitored Anaesthesia Care (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes p a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
☐ Monitored Anaesthesia Care (without sedation)	Expected Result	Measurement of vital signs, availability of anaesthesia provider for further interve
	Technique	None
	Risks	Increased awareness, anxiety and/ or discomfort
☐ Invasive Monitoring Internal jugular vein/Subclavian vein/Arterial	Risks	Infections, chestdrain placement, ischemia of extremities

I hereby consent to the anaesthesia service checked above and authorize that it be administered by anaesthet Dr. Roohi or his/her associates : Team

I also consent to an alternative type of anesthesia, if necessary as deemed appropriate by them.

I have also been expected about the post operative pain management and others techniques for pain control.

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(Patient Label)

Fitness for surgery: Can be posted / Needs further evaluation & Review / Combined counseling - Anaesthesia-Surgery team with Patient- Family

ASA Grade: I II III IV V VI E **MELD Score:**	**P-POSUM / Others:** **APACHE II / SOFA:** **PONV:**	**DVT Risk:** Mild / Moderate / High **Discussion of Risk - Benefits:** ☐ Dental damage ☐ Arterial / CVC ☐ Transfusion

ANAESTHESIA PLAN – Pro-con / Alternate methods discussed: Yes / No

GA - ETT / LMA / DLT / Tracheostomy / TIVA / Mask

CNB: SAB / CSEA / CSA / EA PNBs: LA / MAC

Combined Techniques:

Post op Analgesia plan: CIVI / PC-IVA / PCEA - PIEB / CEI / Nerve Blocks

BLOOD REQUIREMENTS: PABD / ANH MABL

Component	Reserve
PRBCs – Leucodepleted / Washed / Regular	
FFP	
Platelets	
Cryo	
Factor VIIa / VIII / Prothrombin Cpmplex Conc. / Fibrinogen Conc.	

NUTRITIONAL STATUS: Normal / GLIM criteria

Pre-op Investigations / Cross consults / Adv.:

Pt. provisionally fit for procedure.

Anaesthetist Sign:

Date & Time: 11/9/26

Post Review Fitness for Surgery: Can be Posted / Needs Further Stabilization / evaluation / Defer Surgery / Combined Counseling

Preoperative instructions:

NPO from: Adult: 6 Hrs for Solids & milk, 4 Hrs – clear liquids Carbohydrate drink

Pre-medication: Tab. Pantaprazole 40mg + Metaclopramide 10mg:
12 & 2 hrs before surgery

DVT Prophylaxis: TED / SCD / LMWH – Time:

Medications to be continued: Thyroid / Epilepsy / BP / Cardiac / Steroids

PPPC Protocol: Spirometry / Nebulization / Physiotherapy consult

Medications to be stopped: ADA / Insulin / Antiplatelets / ACIEs / ARBs / Others:

SSI prophylaxis within 2 hrs before Surgery:

REVIEW PAC – Date: Tim

Anaesthetists Sign

Date & Time

Name	: Mast RUDRANIL SINHA	Accession No	: 1O.7348504.34042
UHID	: AIGG.21269198	Bill Date	: 20-Aug-2026 18:26
Gender/Age	: M/2 y	Reporting Date	: 21/08/2026 9:25AM
Ref. Phys.	: Arif khan	Modality	:US
Procedure Name	: USG ABDOMEN PELVIS		

ULTRASOUND OF ABDOMEN & PELVIS

LIVER: Measures 16 cm, enlarged in size and shows normal echotexture with smooth contour. Intrahepatic biliary and vascular radicles are normal. Large heterogeneous hyperechoic lesion with few areas of necrosis within measuring ~11.5 x 10.5 cm noted in right lobe of liver.
PORTAL VEIN: Appears encased by the lesion.
CBD: Not visualized.

GALLBLADDER: Well distended. No evidence of wall thickening / calculi.

SPLEEN: Measures 6.8 cm, normal in size with normal echotexture.

PANCREAS: Visualized pancreas appears normal in size and echotexture. No ductal dilatation. No calcifications / calculi. No peripancreatic fluid collection.

KIDNEYS: Normal in size, shape with smooth contours. Parenchymal echotexture normal. Corticomedullary differentiation well maintained. No calculi / hydronephrosis.
Right kidney measures 73 x 27 mm. Left kidney measures 73 x 31 mm.

URINARY BLADDER: Well distended. No evidence of wall thickening / calculus.

PROSTATE: Normal for age.

Mild free fluid in abdomen.

IMPRESSION: In a k/c/o Hepatoblastoma, present scan shows:

- Hepatomegaly with large heterogeneous hyperechoic lesion with few areas of necrosis within in right lobe.
- Mild ascites.

For clinical correlation.
sai

This examination and reported findings have been reviewed and confirmed.

Approved by:

Dr. Uday Krishna

Senior Consultant

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

Name	: Mast RUDRANIL SINHA	Accession No	: 1O.7209527.33462
UHID	: AIGG.21269198	Bill Date	: 04-Aug-2026 14:45
Gender/Age	: M/2 y	Reporting Date	: 06/08/2026 4:27PM
Ref. Phys.	: Arif khan	Modality	:PT
Procedure Name	: PET CT WHOLE BODY WITH CONTRAST		

NUCLEAR MEDICINE DEPARTMENT

Whole Body PET-CT Scan

Clinical Diagnosis: History of liver lesions. PET-CT for evaluation.

Technique: Whole body PET images were acquired from vertex to mid-thigh using a dedicated PET-CT scanner after intravenous administration of ~ 3.2 mCi of 18F-FDG. Reported fasting blood sugar level at the time of administration was within acceptable limits. Data was reconstructed with CT based attenuation correction in to axial, sagittal and coronal PET sections and interpreted after fusion with triphasic contrast enhanced CT images. FDG uptake is semi quantitatively assessed as SUV max.

Findings:

BRAIN:

- Brain parenchyma appears normal in attenuation.
- No supra / infratentorial focal / diffuse lesion is noted.
- Physiological FDG uptake is noted in the entire brain parenchyma.

NECK:

- Symmetrically increased FDG uptake (SUV max: 3.7) noted in bilateral palatine tonsils - ? Inflammatory.
- FaintlyFDGavidbilateralcervicallevelIIIlymphnodesnoted,largestmeasuring~0.5x 1.1 cm - ? Inflammatory.
- The upper aero-digestive tract and PNS appears normal.
- Thyroid appears normal with physiological FDG uptake.
- No other significant metabolically active cervical lymphadenopathy is noted.

CHEST:

- Mild right pleural effusion noted with passive collapse of underlying lung parenchyma.
- Fibrotic changes noted in upper lobe right lung.

- Rest of the bilateral lung parenchyma appears normal in attenuation.
- Heart and the great vessels appear normal.

- No significant metabolically active mediastinal / axillary lymphadenopathy is noted.
- No pericardial effusion seen.

ABDOMEN AND PELVIS:

– FDGavidlargeheterogeneouslyenhancinglesionnotedinvolvingsegmentV,VI,VII,VIII & caudate lobe of liver, showing necrotic areas within, measuring ~ 12.2 x 10.8 x 13.9 cm (SUV max: 6.9). It is causing splaying RPV, RHV & MHV with significant attenuation of RHV and MHV. It is closely abutting and indenting the right hemidiaphragm.

– AlsonotedmultipleFDGavidhypoenhancinglesionsinsegmentVIII/IVaofliver,largest measuring ~ 1.5 x 1.3 cm (SUV max: 7.1).

– RestoftheliversshowsphysiologicalFDGuptake.

– Minimalperihepaticfreefluidnoted.

– MildbilobarIHBRDnoted.

– FaintlyFDGavidenhancingmesentericlymphnodesnoted,largestmeasuring~0.9x0.6 cm - ? Nonspecific.

– Spleen, pancreas, bilateral kidneys and adrenals appear normal in attenuation with physiological FDG uptake.

- Rest of the visceral structures appear normal in attenuation with physiological FDG uptake.
- No other significant metabolically active abdominopelvic lymphadenopathy noted.

BONES:

- Diffuse FDG avidity noted in marrow of axial and appendicular skeleton – Reactive.

– Restofthevisualizedbonesappearnormalinattenuationandalignment.

Normal physiological ^{18}F-FDG tracer uptake is seen in rest of the visualized organs.

Name	: Mast RUDRANIL SINHA	Accession No	: 1O.7209527.33462
UHID	: AIGG.21269198	Bill Date	: 04-Aug-2026 14:45
Gender/Age	: M/2 y	Reporting Date	: 06/08/2026 4:27PM
Ref. Phys.	: Arif khan	Modality	:PT
Procedure Name	: PET CT WHOLE BODY WITH CONTRAST		

IMPRESSION:

In a given clinical scenario, the present PET-CT scan findings reveal:

- FDG avid large heterogeneously enhancing lesion involving segment V, VI, VII, VIII & caudate lobe of liver, showing necrotic areas within, causing splaying RPV, RHV & MHV with significant attenuation of RHV and MHV as described - ? Hepatoblastoma. Suggested AFP & HPE correlation.
- FDG avid multiple hypoenhancing lesions in segment VIII/ IVa of liver as described - ? Satellite lesions.
- No other significant metabolically active lesion noted in the rest of the scanned segment of body.

Kindly correlate.

This examination and reported findings have been reviewed and confirmed.

Approved by:

Dr. DAVID JAYA PRAKASH
MBBS, MD (SGPGI, Lucknow)
Junior Consultant

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

Name	: Mast RUDRANIL SINHA	Accession No	: 1O.7384911.34041
UHID	: AIGG.21269198	Bill Date	: 25-Aug-2026 12:45
Gender/Age	: M/2 y	Reporting Date	: 25/08/2026 1:43PM
Ref. Phys.	: LIVER TRANSPLANT TEAM	Modality	:US
Procedure Name	: USG ABDOMEN		

ULTRASOUND ABDOMEN

CLINICAL DETAILS: Follow up case of hepatoblastoma in liver.

LIVER: Enlarged in size (11 mm) and shows normal echotexture with smooth contour. Intrahepatic biliary and vascular radicles are normal. Few heterogeneous lesions with few cystic areas within noted in right lobe of liver largest measuring 12x10.6 cm.
PORTALVEIN: Normal.

GALLBLADDER: Not visualized.

SPLEEN: Measures 72 mm, enlarged in size with normal echopattern.

PANCREAS: Poor window.

KIDNEYS: Normal in size, shape with smooth contours. Parenchymal echotexture normal. Corticomedullary differentiation well maintained. No calculi / calyectases.

URINARY BLADDER: Well distended. No evidence of wall thickening / calculus.
PROSTATE: Normal for age.

No free fluid in abdomen.

IMPRESSION: Follow up case of hepatoblastoma in liver.

- Hepatomegaly with few heterogeneous lesions and few cystic areas within in right lobe of liver – Consistent with hepatoblastoma. No rupture / free fluid adjacent to the liver or in the pelvis in present scan.
- Splenomegaly.

Adv: Clinical correlation and further evaluation.

This examination and reported findings have been reviewed and confirmed.

Approved by:

Dr. ROHAN REDDY P

Consultant Radiologist

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

AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **24/08/2026 08:47**
UHID : **AIGG.21269198**	Bill No: **AGOCS260921086**	Collec. Date: **24/08/2026 08:50**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1996163A**	Ack. Date: **24/08/2026 10:06**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **24/08/2026 13:59**
Facility: **AIG Hospitals, Gachibowli**		

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

Haematology

Test *(Method)*	Result	Normal Range	Unit
HEMOGLOBIN (Method:Colorimetric/Spectrophotometry Non-Cyanide Method)	6.7 ▼ (L)	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	2.44 ▼ (L)	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	19.7 ▼ (L)	34.0 - 40.0	%
MCV (Method:DerivedFromRBCHistogram / Numeric Integration)	80.8	75.0 - 87.0	fl
MCH (Method: Calculated)	27.6	24.0 - 30.0	pg
MCHC (Method: Calculated)	34.2	31.0 - 37.0	g/dl
RDW (Method:DerivedFromRBCHistogram /Calculated)	28.2 ▲ (H)	-	%
TOTAL WBC (Method:FlowcytometrySFCUBE / Flowcytometry DHSS and Impedance)	7430	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	33.2	30 - 53	%
LYMPHOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	47.6 ▼ (L)	27 - 57	%
EOSINOPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	0.6 ▼ (L)	2.0 - 7.0	%
MONOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	17.8 ▲ (H)	4.0 - 7.0	%
BASOPHILS (Method:SFCubeMethod / Impedance/Microscopy)	0.8	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT. (Method: Calculated / Flowcytometry DHSS)	2467	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	3537	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	45 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	1323 ▲ (H)	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	59	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	0.7	-	
PLATELET COUNT (Method:ElectricalImpedance / Impedance)	70 ▼ (L)	200 - 490	10^3/mm^3
MPV (Method:DerivedFromPlateletHistogram / Electrical Impedance)	13.5 ▲ (H)	7.4-10.4	fl
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisopoikilocytosis, normocytic hypochromic, microcytes, macrocytes, ovalocytes, tear drop cells, 14-15n RBC/100 WBC		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Within normal limits, reactive lymphocytes		
PLATELETS.. (Method:Microscopy/Leishman stain)	Thrombocytopenia giant platelets		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		
NOTES(CBP)	Platelets count manually checked.	-	

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts.CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Rajender Reddy Gudi (24-08-2026 13:17)

End of Report

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **24/08/2026 08:47**
UHID : **AIGG.21269198**	Bill No: **AGOCS260921086**	Collec. Date: **24/08/2026 08:50**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1996163A**	Ack. Date: **24/08/2026 10:06**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **24/08/2026 13:59**
Facility: **AIG Hospitals, Gachibowli**		

Dr.SAFIA SULTANA MUSTAFA
Pathologist, DCP

Dr.ANURADHA SEKARAN
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Director of Pathology & Molecular Pathology

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **31/07/2026 20:04**
UHID : **AIGG.21269198**	Bill No: **AGOCS260822976**	Collec. Date: **31/07/2026 20:07**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1944930E**	Ack. Date: **31/07/2026 22:11**
Mobile No: **9002766646**	Ref. Doctor: **Dr. Dharani Nagoji**	Report Date: **01/08/2026 20:24**
Facility: **AIG Hospitals, Gachibowli**		

AFP Sample Type - Serum

Hormones

Test *(Method)*	Result	Normal Range	Unit
ALPHA FETOPROTEIN. (Method: ECLIA)	> 1000000 ▲ (H)	0-87	ng/mL

Interpretations: AFP produced by the feotus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Dr. Katamareddy Prathyusha (01-08-2026 10:27)

Dr.G. DEEPIKA
Director & HOD – Biochemistry MBBS, MD

End of Report

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **31/07/2026 20:04**
UHID : **AIGG.21269198**	Bill No: **AGOCS260822976**	Collec. Date: **31/07/2026 20:07**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1944930D**	Ack. Date: **31/07/2026 22:11**
Mobile No: **9002766646**	Ref. Doctor: **Dr. Dharani Nagoji**	Report Date: **31/07/2026 23:02**
Facility: **AIG Hospitals, Gachibowli**		

LFT (LIVER FUNCTION TEST) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test *(Method)*	Result	Normal Range	Unit
TOTAL BILIRUBIN (Method: DPD)	0.8	0.3 - 1.2	mg/dL
DIRECT BILIRUBIN (Method: DPD)	0.2	0-0.2	mg/dL
INDIRECT BILIRUBIN (Method: Calculated)	0.6	-	mg/dL
S.G.P.T (ALT) (Method: Enzymatic without P5P (Ref IFCC))	**27 ▲ (H)**	10 - 25	U/L
S.G.O.T (AST) (Method: Enzymatic without P5P (Ref IFCC))	**143 ▲ (H)**	21 - 44	U/L
ALP (Method: AMP optimised to IFCC)	290	134 - 315	U/L
TOTAL PROTEINS (Method: Biuret)	**7.8 ▲ (H)**	5.6 - 7.5	g/dl
ALBUMIN(SERUM) (Method: BCG)	4.5	3.8 - 5.4	g/dl
GLOBULIN (Method: Calculated)	3.3	2.3 - 3.5	g/dl
A/G RATIO (Method: Caluclated)	1.4	0.9 - 2	

Interpretation: Liver function tests are blood tests used to help diagnose and monitor liver disease or damage. Liver function tests can be used to: Screen for liver infections, such as hepatitis Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working Measure the severity of a disease, particularly scarring of the liver (cirrhosis) Monitor possible side effects of medications.

Report Saved By - V Sekhar (31-07-2026 23:02)

Dr.G. DEEPIKA
Director & HOD – Biochemistry MBBS, MD

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **31/07/2026 20:04**
UHID : **AIGG.21269198**	Bill No: **AGOCS260822976**	Collec. Date: **31/07/2026 20:07**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1944930C**	Ack. Date: **01/08/2026 01:18**
Mobile No: **9002766646**	Ref. Doctor: **Dr. Dharani Nagoji**	Report Date: **01/08/2026 06:18**
Facility: **AIG Hospitals, Gachibowli**		

CRP Sample Type - Serum

Serology

Test *(Method)*	Result	Normal Range	Unit
CRP - C Reactive Protein (Method: Sandwich Immunoassay)	**67.00** ▲ **(H)**	Negative <10 mg/L Positive >= 10 mg/L	mg/L

Interpretation:
C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation. Markedly increased levels are observed, for example, after trauma or a heart attack, with active or uncontrolled autoimmune disorders, and with serious bacterial infections like sepsis.

The test measures the amount of CRP in the blood and can be valuable in detecting inflammation due to acute conditions or in monitoring disease activity in chronic conditions.

CRP is detected in pregnant women after the 1st trimester of pregnancy and persists until delivery. Increased levels are also seen in women who are on Oral Contraceptives.

The CRP test is not diagnostic, but it provides information as to whether inflammation is present

Report Saved By - P Siva Nagaraju (01-08-2026 06:18)

Y. Sadhana

Dr.YV. SADHANA
Sr.Consultant, Microbiologist
MD,FRCPath(UK)

*****End of Report*****

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **31/07/2026 20:04**
UHID : **AIGG.21269198**	Bill No: **AGOCS260822976**	Collec. Date: **31/07/2026 20:07**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1944930A**	Ack. Date: **31/07/2026 23:14**
Mobile No: **9002766646**	Ref. Doctor: **Dr. Dharani Nagoji**	Report Date: **31/07/2026 23:43**
Facility: **AIG Hospitals, Gachibowli**		

PT WITH INR AND APTT

Sample Type - Citrated Plasma

Coagulation

Test *(Method)*	Result	Normal Range	Unit
PROTHROMBIN TIME (Method: Photometric Clotting Assay)	11.3	10.8 - 13.2	Seconds
MEAN NORMAL PROTHROMBINTIME (Method: Photometric clotting assay)	12.0	-	Seconds
INR	0.94	Normal <1.3 Therapeutic Range 2.0 - 3.5 Critical Alert >4.0	
APTT TEST (Method: Photometric Clotting Assay)	28.8	26.8-41.5	Seconds

Interpretation: Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), tissue factor and proteins of the common pathway (Factors X, V, II & Fibrinogen).Prolonged PTAdministration of oral anticoagulant drugs Liver disease, particularly obstructive jaundice Vitamin K deficiency Disseminated intravascular coagulation Inherited deficiency of factors in extrinsic pathway (VII) and common pathway (V, X, prothrombin and fibrinogen)International Normalized Ratio \endash Is used for defining the therapeutic ranges for anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity. Recommended Therapeutic range for Oral Anticoagulant therapy INR 2.0-3.5: Treatment of Venous thrombosis & Pulmonary embolism, Prophylaxis of Venous thrombosis (High risk surgery), Prevention of systemic embolism in tissue heart valves, AMI, Valvular heart disease & Atrial fibrillation, Bileaflet mechanical valve in aortic position

Note : 1. Results should be clinically correlated

2. Test done on citrated plasma.CommentsPartial Thromboplastin Time / Activated Partial Thromboplastin Time (PTT / APTT) measures the activity of intrinsic and common pathway of coagulation, which consists of Factor XII, Prekallikrein, High molecular weight kininogen, Factors VIII, IX & XI. It also measures proteins of the common pathway namely factors II, V, X & Fibrinogen.Abnormal Partial Thromboplastin

Time Associated with bleeding: Defects of factors VIII, IX & XINot associated with bleeding: Defects of factor XII, Prekallikrein, High molecular weight kininogen & Lupus anticoagulantsIsolated prolonged APTT Undiagnosed haemophilia, Congential coagulation disorders Moderately prolonged APTT Patients taking oral anticoagulant drugs, Presence of vitamin K deficiency Prolonged PTT/APTT Disseminated intravascular coagulation, Liver disease, Massive transfusion with plasma depleted red blood cells, Administration or contamination with heparin or other anticoagulants, A circulating anticoagulant including lupus anticoagulant, Deficiency of a coagulation factor other than factor VII

Note : 1. Results should be clinically correlated

2. Test done on citrated plasma.

Report Saved By - Rajesh Kumar (31-07-2026 23:43)

*****End of Report*****

Dr.MD Shareef Ahmed
MBBS, MD Pathology

Dr.ANURADHA SEKARAN
MD,DNB, MNAMS,DipRCPath(UK)
Director of Pathology & Molecular Pathology

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Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **04/08/2026 14:45**
UHID : **AIGG.21269198**	Bill No: **AGOCS260837549**	Collec. Date: **04/08/2026 14:48**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1952437A**	Ack. Date: **04/08/2026 16:21**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **04/08/2026 17:29**
Facility: **AIG Hospitals, Gachibowli**		

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT)

Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test *(Method)*	Result	Normal Range	Unit
BLOOD UREA (Method: UREASE KINETIC)	22	11 - 39	mg/dL
SERUM CREATININE (Method: Kinetic Jaffe's - IDMS Traceable)	0.48	0.260 - 0.770	mg/dL
SODIUM (Method: ISE INDIRECT)	141	138 - 145	mEq/L
POTASSIUM (Method: ISE INDIRECT)	**5.5** ▲ **(H)**	3.400 - 4.700	mEq/L
CHLORIDE (Method: ISE INDIRECT)	104	98 - 107	mEq/L

Interpretations: Aids in diagnosis and management of conditions affecting kidney function. Useful for general health screening, screening patients at risk of developing kidney disease, management of patients with known kidney disease.

Report Saved By - Connectree (04-08-2026 17:25)

*****End of Report*****

Dr.Mahavadi Srihita
MBBS,MD(Biochem), Consultant Biochemistry

Dr.G. DEEPIKA
Director & HOD – Biochemistry MBBS, MD

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **IP**	Order Date: **07/08/2026 13:15**
UHID : **AIGG.21269198**	IP / Bed: **5036056 / SW408**	Collec. Date: **07/08/2026 13:15**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGI1959722A**	Ack. Date: **07/08/2026 14:55**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **07/08/2026 16:06**
Facility: **AIG Hospitals, Gachibowli**		

BLOOD GROUPING AND RH TYPING

Sample Type - EDTA Whole Blood

Blood Bank

Test *(Method)*	Result	Normal Range	Unit
ABO GROUP	O	-	
RH TYPING	POSITIVE	-	
INTERPRETATION (Method: (Method: Forward And Reverse grouping done by column agglutination Technique (CAT)))	O POSITIVE	-	

Report Saved By - Merati Ravi (07-08-2026 16:06)

Dr.PRAGATI NAIK

MD Transfusion Medicine, Director & HOD Department of Transfusion Medicine

*****End of Report*****

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **20/08/2026 18:26**
UHID : **AIGG.21269198**	Bill No: **AGOCS260911267**	Collec. Date: **20/08/2026 18:32**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1989696B**	Ack. Date: **20/08/2026 20:20**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **20/08/2026 23:35**
Facility: **AIG Hospitals, Gachibowli**		

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT)

Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test *(Method)*	Result	Normal Range	Unit
BLOOD UREA , Serum (Method: UREASE KINETIC)	38	11 - 39	mg/dL
SERUM CREATININE,Serum (Method: Kinetic Jaffe's - IDMS Traceable)	0.47	0.26 - 0.77	mg/dL
SODIUM , Serum (Method: ISE INDIRECT)	132 ▼ (L)	138 - 145	mEq/L
POTASSIUM , Serum (Method: ISE INDIRECT)	4.0	3.4 - 4.7	mEq/L
CHLORIDE , Serum (Method: ISE INDIRECT)	98	98 - 107	mEq/L

Interpretations: Aids in diagnosis and management of conditions affecting kidney function. Useful for general health screening, screening patients at risk of developing kidney disease, management of patients with known kidney disease.

Report Saved By - Tharala Naresh (20-08-2026 23:35)

Dr.G. DEEPIKA

Director & HOD – Biochemistry MBBS, MD

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Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **24/08/2026 08:47**
UHID : **AIGG.21269198**	Bill No: **AGOCS260921086**	Collec. Date: **24/08/2026 08:50**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1996163B**	Ack. Date: **24/08/2026 09:58**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **24/08/2026 15:54**
Facility: **AIG Hospitals, Gachibowli**		

AFP Sample Type - Serum **Hormones**

Test *(Method)*	Result	Normal Range	Unit
ALPHA FETOPROTEIN. (Method: ECLIA)	**932000** ▲ **(H)**	0-87	ng/mL

Interpretations: AFP produced by the feotus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Jupalle Balanjaneyulu (24-08-2026 15:53)

Dr.G. DEEPIKA
Director & HOD – Biochemistry MBBS, MD

End of Report

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AIG HOSPITALS

MC-7137

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **24/08/2026 08:47**
UHID : **AIGG.21269198**	Bill No: **AGOCS260921086**	Collec. Date: **24/08/2026 08:50**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1996163A**	Ack. Date: **24/08/2026 10:06**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **24/08/2026 13:59**
Facility: **AIG Hospitals, Gachibowli**		

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

Haematology

Test *(Method)*	Result	Normal Range	Unit
HEMOGLOBIN (Method:Colorimetric/Spectrophotometry Non-Cyanide Method)	6.7 ▼ (L)	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	2.44 ▼ (L)	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	19.7 ▼ (L)	34.0 - 40.0	%
MCV (Method:DerivedFromRBCHistogram / Numeric Integration)	80.8	75.0 - 87.0	fl
MCH (Method: Calculated)	27.6	24.0 - 30.0	pg
MCHC (Method: Calculated)	34.2	31.0 - 37.0	g/dl
RDW (Method:DerivedFromRBCHistogram /Calculated)	28.2 ▲ (H)	-	%
TOTAL WBC (Method:FlowcytometrySFCUBE / Flowcytometry DHSS and Impedance)	7430	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	33.2	30 - 53	%
LYMPHOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	47.6 ▼ (L)	27 - 57	%
EOSINOPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	0.6 ▼ (L)	2.0 - 7.0	%
MONOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	17.8 ▲ (H)	4.0 - 7.0	%
BASOPHILS (Method:SFCubeMethod / Impedance/Microscopy)	0.8	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT. (Method: Calculated / Flowcytometry DHSS)	2467	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	3537	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	45 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	1323 ▲ (H)	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	59	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	0.7	-	
PLATELET COUNT (Method:ElectricalImpedance / Impedance)	70 ▼ (L)	200 - 490	10^3/mm^3
MPV (Method:DerivedFromPlateletHistogram / Electrical Impedance)	13.5 ▲ (H)	7.4-10.4	fl
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisopoikilocytosis, normocytic hypochromic, microcytes, macrocytes, ovalocytes, tear drop cells, 14-15n RBC/100 WBC		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Within normal limits, reactive lymphocytes		
PLATELETS.. (Method:Microscopy/Leishman stain)	Thrombocytopenia giant platelets		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		
NOTES(CBP)	Platelets count manually checked.	-	

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts.CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Rajender Reddy Gudi (24-08-2026 13:17)

End of Report

Patient Name: **Mast. Rudranil Sinha**	Episode: **OP**	Order Date: **24/08/2026 08:47**
UHID : **AIGG.21269198**	Bill No: **AGOCS260921086**	Collec. Date: **24/08/2026 08:50**
Age / Sex: **2 Year(s) / Male**	Sample No: **AGO1996163A**	Ack. Date: **24/08/2026 10:06**
Mobile No: **9002766646**	Ref. Doctor: **Dr. ARIF KHAN**	Report Date: **24/08/2026 13:59**
Facility: **AIG Hospitals, Gachibowli**		

Dr.SAFIA SULTANA MUSTAFA
Pathologist, DCP

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