

Name	VELANKANNI	ID	MED111242436
Age & Gender	41Year(s)/FEMALE	Visit Date	8/13/2022 12:00:00 AM
Ref Doctor Name	MediWheel		

2 D ECHOCARDIOGRAPHIC STUDY

M mode measurement:

AORTA	:	2.0cms
LEFT ATRIUM	:	3.0cms
AVS	:	----
LEFT VENTRICLE (DIASTOLE)	:	4.6cms
(SYSTOLE)	:	3.2cms
VENTRICULAR SEPTUM (DIASTOLE)	:	0.8cms
(SYSTOLE)	:	1.2cms
POSTERIOR WALL (DIASTOLE)	:	0.8cms
(SYSTOLE)	:	1.2cms
EDV	:	98ml
ESV	:	40ml
FRACTIONAL SHORTENING	:	32%
EJECTION FRACTION	:	60%
EPSS	:	---
RVID	:	1.6cms

DOPPLER MEASUREMENTS:

MITRAL VALVE	:	E' 0.95 m/s	A' 0.66 m/s	NO MR
AORTIC VALVE	:	1.09 m/s		NO AR
TRICUSPID VALVE	:	E' 2.00 m/s	A' - m/s	NO TR
PULMONARY VALVE	:	0.90 m/s		NO PR

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2D ECHOCARDIOGRAPHY FINDINGS:

Left ventricle : Normal size, Normal systolic function.
No regional wall motion abnormalities.

Left Atrium : Normal.

Right Ventricle : Normal.

Right Atrium : Normal.

Mitral valve : Normal, No mitral valve prolapsed.

Aortic valve : Normal, Trileaflet.

Tricuspid valve : Normal.

Pulmonary valve : Normal.

IAS : Intact.

IVS : Intact.

Pericardium : No pericardial effusion.

IMPRESSION:

- **NORMAL SIZED CARDIAC CHAMBERS.**
- **NORMAL LV SYSTOLIC FUNCTION. EF: 60%.**
- **NO REGIONAL WALL MOTION ABNORMALITIES.**
- **NORMAL VALVES.**
- **NO CLOTS / PERICARDIAL EFFUSION / VEGETATION.**

DR. K.S. SUBRAMANI. MBBS, MD, DM (CARDIOLOGY) FESC
SENIOR CONSULTANT INTERVENTIONAL CARDIOLOGIST
Kss/vp

Note:

*** Report to be interpreted by qualified medical professional.**

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*** To be correlated with other clinical findings.**

*** Parameters may be subjected to inter and intra observer variations.**

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X-ray mammogram (mediolateral oblique and craniocaudal views) followed by Sonomammography was performed.

MAMMOGRAPHY OF BOTH BREASTS

Both breasts show symmetrical fibro glandular fatty tissue.

No evidence of focal soft tissue lesion.

No evidence of cluster micro calcification.

Subcutaneous fat deposition is within normal limits.

Left axillary lymph nodes noted.

SONOMAMMOGRAPHY OF BOTH BREASTS

Both breasts show normal echopattern.

No evidence of focal solid / cystic areas in either breast.

No evidence of ductal dilatation.

Few lymphnodes with maintained fatty hilum are noted in both axillae.

IMPRESSION:

➤ **NO SIGNIFICANT ABNORMALITY.**

ASSESSMENT: BI-RADS CATEGORY -1

**DR. MEERA S
CONSULTANT RADIOLOGIST**
MS/vp

BI-RADS CLASSIFICATION

<u>CATEGORY</u>	<u>RESULT</u>
0	Assessment incomplete. Need additional imaging evaluation
1	Negative. Routine mammogram in 1 year recommended.
2	Benign finding. Routine mammogram in 1 year recommended.
3	Probably benign finding. Short interval follow-up suggested.
4	Suspicious. Biopsy should be considered.
5	Highly suggestive of malignancy. Appropriate action should be taken.

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ABDOMINO-PELVIC ULTRASONOGRAPHY

LIVER shows normal in shape, size and has uniform echopattern. No evidence of focal lesion or intrahepatic biliary ductal dilatation. Hepatic and portal vein radicals are normal.

GALL BLADDER shows normal shape and has clear contents. Gall bladder wall is of normal thickness. CBD is of normal calibre.

PANCREAS has normal shape, size and uniform echopattern. No evidence of ductal dilatation or calcification.

SPLEEN shows normal shape, size and echopattern. Spleen measures 9.1cms in long axis and 4.1cms in short axis.

No demonstrable Para -aortic lymphadenopathy.

KIDNEYS move well with respiration and have normal shape, size and echopattern. Cortico- medullary differentiations are well madeout. No evidence of calculus or hydronephrosis.

The kidney measures as follows:

	Bipolar length (cms)	Parenchymal thickness (cms)
Right Kidney	10.5	1.3
Left Kidney	10.6	1.4

URINARY BLADDER shows normal shape and wall thickness. It has clear contents. No evidence of diverticula.

UTERUS is anteverted and slightly bulky. It has uniform myometrial echopattern.

No focal myometrial lesion noted. Endometrial thickness measures mm

Uterus measures as follows: LS: 10.6cms AP: 3.7cms TS: 4.2cms.

OVARIES are normal in size, shape and echotexture. No focal lesion seen.

Right ovary shows a large follicle measuring about 14 x 14mm.

Ovaries measure as follows: **Right ovary:** 3.0 x 1.7cms **Left ovary:** 3.2 x 1.6cms

POD & adnexae are free.

No evidence of ascites/pleural effusion.

IMPRESSION:

➤ **NO SIGNIFICANT ABNORMALITY.**

DR. MEERA S

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CONSULTANT RADIOLOGIST

MS/vp

Name	VELANKANNI	Customer ID	MED111242436
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X - RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Cardiac size is within normal limits.

Bilateral hilar regions appear normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

Impression: Essentially normal study.



DR. APARNA

CONSULTANT RADIOLOGIST

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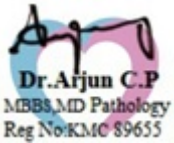
Ref. Dr : MediWheel

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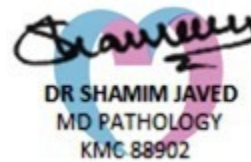
HAEMATOLOGY

Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	11.3	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood)	36.1	%	37 - 47
RBC Count (EDTA Blood)	4.72	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (EDTA Blood)	76.4	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood)	24.0	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood)	31.4	g/dL	32 - 36
RDW-CV (EDTA Blood)	17.7	%	11.5 - 16.0
RDW-SD (EDTA Blood)	47.33	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood)	7100	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood)	55.8	%	40 - 75
Lymphocytes (EDTA Blood)	35.3	%	20 - 45
Eosinophils (EDTA Blood)	1.6	%	01 - 06



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Monocytes (EDTA Blood)	6.6	%	01 - 10
Basophils (Blood)	0.7	%	00 - 02
INTERPRETATION: Tests done on Automated Five Part cell counter. All abnormal results are reviewed and confirmed microscopically.			
Absolute Neutrophil count (EDTA Blood)	3.96	10 ³ / μ l	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood)	2.51	10 ³ / μ l	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood)	0.11	10 ³ / μ l	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood)	0.47	10 ³ / μ l	< 1.0
Absolute Basophil count (EDTA Blood)	0.05	10 ³ / μ l	< 0.2
Platelet Count (EDTA Blood)	245	10 ³ / μ l	150 - 450
MPV (EDTA Blood)	9.2	fL	8.0 - 13.3
PCT (EDTA Blood/Automated Blood cell Counter)	0.23	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Citratd Blood)	26	mm/hr	< 20



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<u>BIOCHEMISTRY</u>			
<u>Liver Function Test</u>			
Bilirubin(Total) (Serum/DCA with ATCS)	0.35	mg/dL	0.1 - 1.2
Bilirubin(Direct) (Serum/Diazotized Sulfanilic Acid)	0.12	mg/dL	0.0 - 0.3
Bilirubin(Indirect) (Serum/Derived)	0.23	mg/dL	0.1 - 1.0
SGOT/AST (Aspartate Aminotransferase) (Serum/Modified IFCC)	13.45	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/Modified IFCC)	12.93	U/L	5 - 41
GGT(Gamma Glutamyl Transpeptidase) (Serum/IFCC / Kinetic)	22.18	U/L	< 38
Alkaline Phosphatase (SAP) (Serum/Modified IFCC)	103.30	U/L	42 - 98
Total Protein (Serum/Biuret)	6.94	gm/dl	6.0 - 8.0
Albumin (Serum/Bromocresol green)	4.15	gm/dl	3.5 - 5.2
Globulin (Serum/Derived)	2.79	gm/dL	2.3 - 3.6
A : G RATIO (Serum/Derived)	1.49		1.1 - 2.2


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<u>Lipid Profile</u>			
Cholesterol Total (Serum/CHOD-PAP with ATCS)	177.63	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/GPO-PAP with ATCS)	96.65	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the usual circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immunoinhibition)	44.81	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/Calculated)	113.5	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	19.3	mg/dL	< 30


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Non HDL Cholesterol (Serum/Calculated)	132.8	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
 2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.

Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	4		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	2.2		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
LDL/HDL Cholesterol Ratio (Serum/Calculated)	2.5		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0


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<u>Investigation</u>	<u>Observed Value</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
<u>Glycosylated Haemoglobin (HbA1c)</u>			
HbA1C (Whole Blood/HPLC)	6.2	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5

INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %

Estimated Average Glucose 131.24 mg/dL
(Whole Blood)


INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glyceemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.

Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.


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IMMUNOASSAY

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/ECLIA)	1.20	ng/ml	0.7 - 2.04
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INTERPRETATION:

Comment :

Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.

T4 (Tyroxine) - Total (Serum/ECLIA)	11.44	µg/dl	4.2 - 12.0
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INTERPRETATION:

Comment :

Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

TSH (Thyroid Stimulating Hormone) (Serum/ECLIA)	4.27	µIU/mL	0.35 - 5.50
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INTERPRETATION:

Reference range for cord blood - upto 20

1 st trimester: 0.1-2.5

2 nd trimester 0.2-3.0

3 rd trimester : 0.3-3.0

(Indian Thyroid Society Guidelines)

Comment :

1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.

2.TSH Levels are subject to circadian variation, reaching peak levels between 2-4am and at a minimum between 6-10PM.The variation can be of the order of 50%,hence time of the day has influence on the measured serum TSH concentrations.

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.


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CLINICAL PATHOLOGY

PHYSICAL EXAMINATION (URINE COMPLETE)


Colour (Urine)	Yellow		Yellow to Amber
Appearance (Urine)	Clear		Clear
Volume(CLU) (Urine)	20		

CHEMICAL EXAMINATION (URINE COMPLETE)

pH (Urine)	6.5		4.5 - 8.0
Specific Gravity (Urine)	1.020		1.002 - 1.035
Ketone (Urine)	Negative		Negative
Urobilinogen (Urine)	Normal		Normal
Blood (Urine)	Negative		Negative
Nitrite (Urine)	Negative		Negative
Bilirubin (Urine)	Negative		Negative
Protein (Urine)	Negative		Negative


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Glucose (Urine/GOD - POD)	Negative		Negative
Leukocytes(CP) (Urine)	Negative		

MICROSCOPIC EXAMINATION
(URINE COMPLETE)


Pus Cells (Urine)	0-2	/hpf	NIL
Epithelial Cells (Urine)	2-4	/hpf	NIL
RBCs (Urine)	NIL	/hpf	NIL
Others (Urine)	NIL		

INTERPRETATION:Note: Done with Automated Urine Analyser & Automated urine sedimentation analyser. All abnormal reports are reviewed and confirmed microscopically.

Casts (Urine)	NIL	/hpf	NIL
Crystals (Urine)	NIL	/hpf	NIL


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PHYSICAL EXAMINATION(STOOL COMPLETE)

Mucus (Stool)	Absent		Absent
Consistency (Stool)	Semi Solid		Semi Solid to Solid
Colour (Stool)	Yellow		Brown
Blood (Stool)	Absent		Absent


MICROSCOPIC EXAMINATION(STOOL COMPLETE)

Ova (Stool)	NIL		NIL
Cysts (Stool)	NIL		NIL
Trophozoites (Stool)	NIL		NIL
RBCs (Stool)	NIL	/hpf	Nil
Pus Cells (Stool)	1-3	/hpf	NIL
Others (Stool)	NIL		

CHEMICAL EXAMINATION(STOOL ROUTINE)


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Reaction (Stool)	Acidic		Alkaline
Reducing Substances (Stool/Benedict's)	Negative		Negative


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IMMUNOHAEMATOLOGY
BLOOD GROUPING AND Rh TYPING
(EDTA Blood/Agglutination)

'B' Positive'


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<u>BIOCHEMISTRY</u>			
BUN / Creatinine Ratio	14.78		6.0 - 22.0
Glucose Fasting (FBS) (Plasma - F/GOD-PAP)	87.40	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose, Fasting (Urine) (Urine - F/GOD - POD)	Negative		Negative
Glucose Postprandial (PPBS) (Plasma - PP/GOD-PAP)	110.29	mg/dL	70 - 140

INTERPRETATION:


Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti-diabetic medication during treatment for Diabetes.

Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
Blood Urea Nitrogen (BUN) (Serum/Urease UV / derived)	10.5	mg/dL	7.0 - 21
Creatinine (Serum/Modified Jaffe)	0.71	mg/dL	0.6 - 1.1

INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin ,cefazolin, ACE inhibitors ,angiotensin II receptor antagonists,N-acetylcyteine , chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/Enzymatic)	5.39	mg/dL	2.6 - 6.0
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Dr RAVIKUMAR R
 MBBS, MD BIOCHEMISTRY
 CONSULTANT BIOCHEMIST
 Reg No : 78771
VERIFIED BY


DR SHAMIM JAVED
 MD PATHOLOGY
 KMC 88902

APPROVED BY

Name : Mrs. VELANKANNI

PID No. : MED111242436

Register On : 13/08/2022 9:45 AM

SID No. : 422060525

Collection On : 13/08/2022 10:54 AM

Age / Sex : 41 Year(s) / Female

Report On : 14/08/2022 4:58 PM

Type : OP

Printed On : 22/08/2022 1:01 PM

Ref. Dr : MediWheel

-- End of Report --

Name : Mrs. VELANKANNI Register On : 13/08/2022 9:45 AM
PID No. : MED111242436 Collection On : 13/08/2022 10:54 AM
SID No. : 422060525 Report On : 14/08/2022 4:58 PM
Age / Sex : 41 Year(s) / Female Printed On : 22/08/2022 1:01 PM
Ref. Dr : MediWheel OP / IP : OP

PAP Smear by LBC(Liquid based Cytology)

Nature of Specimen: Cervical smear

Lab No: GC 1149/22

Specimen type : Liquid based preparation

Specimen adequacy : Satisfactory for evaluation


Endocervical / Transformation zone cells : Absent

General categorization : Within normal limits

DESCRIPTION : Smear show predominantly superficial squamous cells, few intermediate cells in a background of sparse inflammatory cells & few bacilli.

INTERPRETATION : Negative for intraepithelial lesion or malignancy -
Normal pap smear study.


Dr SURAJ JAIN
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