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भारत सरकार Government of India

भारतीय विशिष्ट पहचान प्राधिकरण Unique Identification Authority of India

Enrollment No.:

2003/39022/40753

To SHILPA JAYAN

C/O Parth Madhu Nair,
Madathipadath House,
Kaniyarkode,
Thiruvilwamala,
VTC: Kaniyarkode, PO: Kaniyarkod,
Sub District: Talappilly, District: Thrissur,
State: Kerala, PIN Code: 680594,
Mobile: 7902377527

38916165





आपका आधार क्रमांक / Your Aadhaar No. :

6254 4720 8241

मेरा आधार, मेरी पहचान



भारत सरकार Government of India





SHILPA JAYAN DOB: 13/03/1997 Female

6254 4720 8241

मेरा आधार. मेरी पहचान

402377827







DDRC SRL DIAGNOSTICS

KANNUR KERALA, INDIA Tel: 93334 93334

Email: customercare.ddrc@srl.in

PATIENT NAME: SHILPA JAYAN PATIENT ID: SHILF1911974053

ACCESSION NO: 4053VK001844 AGE: 25 Years SEX: Female

RECEIVED: 19/11/2022 10:06 20/11/2022 20:45 DRAWN: REPORTED:

REFERRING DOCTOR: SELF CLIENT PATIENT ID:

Test Report Status Results **Biological Reference Interval Units**

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

TREADMILL TEST

TREADMILL TEST COMPLETED

OPTHAL

OPTHAL COMPLETED

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION COMPLETED









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SERUM BLOOD UREA NITROGEN

BLOOD UREA NITROGEN 6 Adult(<60 yrs): 6 to 20 mg/dL

BUN/CREAT RATIO

BUN/CREAT RATIO 8.5 5.00 - 15.00

CREATININE, SERUM

CREATININE 0.70 18 - 60 yrs : 0.6 - 1.1 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA RESULT PENDING

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA 80 Diabetes Mellitus: > or = 126. mg/dL

Impaired fasting Glucose/ Prediabetes: 101 - 125. Hypoglycemia: < 55.

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C) 5.0 Normal : 4.0 - 5.6%.%

Non-diabetic level : < 5.7%. Diabetic : > 6.5%

Glycemic control goal

More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%.

Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.

CORONARY RISK PROFILE (LIPID PROFILE), SERUM

CHOLESTEROL 139 Desirable : < 200 mg/dL

Borderline : 200-239 High : >or= 240

TRIGLYCERIDES 63 Normal : < 150 mg/dL

High : 150-199

Hypertriglyceridemia: 200-499

Very High: > 499

HDL CHOLESTEROL 46 General range: 40-60 mg/dL

DIRECT LDL CHOLESTEROL 83 Optimum : < 100
Above Optimum : 100-139

Borderline High : 130-159
High : 160-189
Very High : >or= 190



Scan to View Detai

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mg/dL

Scan to View Report





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NON HDL CHOLESTEROL	93		Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	mg/dL
CHOL/HDL RATIO	3.0	Low	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	1.8		0.5-3 Desirable/Low risk 3.1-6 Borderline/Moderate risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	12.5		= 30</td <td>mg/dL</td>	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.60		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.17		General Range : < 0.2	mg/dL
BILIRUBIN, INDIRECT	0.43		0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.5		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
ALBUMIN	4.2		20-60yrs: 3.5 - 5.2	g/dL
GLOBULIN	3.3		2.0 - 4.0	g/dL
ALBUMIN/GLOBULIN RATIO	1.3		1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	11		Adults: < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	9		Adults: < 34	U/L
ALKALINE PHOSPHATASE	51		Adult(<60yrs): 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	14		Adult(female) : < 40	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.5		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	5.8		Adults: 2.4-5.7	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE A			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	12.6		12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	4.22		3.8 - 4.8	mil/μL
WHITE BLOOD CELL COUNT	9.02		4.0 - 10.0	thou/µL



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Test Report Status	Results			Units
DI ATELET, COUNT	201		150 410	#h = / l
PLATELET COUNT RBC AND PLATELET INDICES	281		150 - 410	thou/µL
	37.6		26 46	%
HEMATOCRIT			36 - 46	
MEAN CORPUSCULAR VOL	89.1		83 - 101	fL
MEAN CORPUSCULAR HGB.	29.8		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.4		31.5 - 34.5	g/dL
MEAN PLATELET VOLUME	9.8		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	65		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	5.86		2.0 - 7.0	thou/µL
LYMPHOCYTES	31		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.80		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.2			
EOSINOPHILS	2		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.18		0.02 - 0.50	thou/µL
MONOCYTES	1	Low	2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.09	Low	0.20 - 1.00	thou/µL
BASOPHILS	1		0 - 2	%
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	5		0 - 20	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING			
SUGAR URINE - POST PRANDIAL	RESULT PENDING			
THYROID PANEL, SERUM				
Т3	132.90		80.00 - 200.00	ng/dL
T4	9.29		5.10 - 14.10	μg/dl
TSH 3RD GENERATION	1.730		Non-Pregnant : 0.4 - 4.2	μIU/mL
			Pregnant Trimester-wise: 1st: 0.1 - 2.5 2nd: 0.2 - 3 3rd: 0.3 - 3	
URINE ANALYSIS				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
PH	6.0		4.7 - 7.5	



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Test Report Status	Results		Units
SPECIFIC GRAVITY	1.010	1.003 - 1.035	
KETONES	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	ABSENT		
CHEMICAL EXAMINATION, URINE			
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
WBC	1-2	0-5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	

Interpretation(s)
SERUM BLOOD UREA NITROGEN-

Causes of Increased levels

Pre renal

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
- Renal Failure
 Post Renal
- Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- · Liver disease
- SIADH.

CREATININE, SERUM-

Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
 Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis

• Muscular dystrophy
GLUCOSE, FASTING, PLASMAADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.









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Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

- 1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R. Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006,
- 2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
- 3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184. CORONARY RISK PROFILE (LIPID PROFILE), SERUM-

Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been

implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL).

NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

TOTAL PROTEIN, SERUM

Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and alobulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc. URIC ACID, SERUM-

Causes of Increased levels

Dietary

- High Protein Intake.
- Prolonged Fasting,Rapid weight loss.

Lesch nyhan syndrome. Type 2 DM.

Metabolic syndrome.

Causes of decreased levels











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- Low Zinc Intake OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- · Limit animal proteins
- High Fibre foods
- Vit C IntakeAntioxidant rich foods

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same.

The test is performed by both forward as well as reverse grouping methods.

BLOOD COUNTS-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology. RBC AND PLATELET INDICES-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

WBC DIFFERENTIAL COUNT - NLRThe optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years

old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504

This ratio element is a calculated parameter and out of NABL scope.

ERYTHRO SEDIMENTATION RATE, BLOOD
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference:

- 1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
- 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"

THYROID PANEL, SERUM-

Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is

hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in TOTAL T4 TSH3G TOTAL T3

(ng/dL) 81 - 190 Pregnancy First Trimester (µg/dL) (µIU/mL) 0.1 - 2.5 0.2 - 3.0 0.3 - 3.0 6.6 - 12.4 100 - 260 100 - 260 2nd Trimester 6.6 - 15.5 3rd Trimester 6.6 - 15.5

Below mentioned are the guidelines for age related reference ranges for T3 and T4. Т3

Ť4 (μg/dL) 1-3 day: 8.2 - 19.9 1 Week: 6.0 - 15.9 (ng/dL) New Born: 75 - 260

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well

documented in the pediatric population including the infant age group. Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.









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Test Report Status Results Units

2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.

3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition MICROSCOPIC EXAMINATION, URINE-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in

bladder prior to collection. pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food

can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia



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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

ECG WITH REPORT

REPORT

COMPLETED

USG ABDOMEN AND PELVIS

REPORT

COMPLETED

CHEST X-RAY WITH REPORT

REPORT

COMPLETED

End Of Report Please visit www.srlworld.com for related Test Information for this accession

JINSHA KRISHNAN **LAB TECHNICIAN**

DR.INDUSARATH S CONSULTANT PATHOLOGIST

NIMISHA K LAB TECHNICIAN **SREENA A**

LAB TECHNICIAN







INDIA'S LEADING DIAGNOSTICS NETWORK

OPTHALMOLOGY REPORT

TO WHOM-SO-EVER IT MAY CONCERN

This is to certify that I have examined Miss. SHILPA JAYAN, 25 years Female on 19.11.2022 and her visual standards are as follows:

OD		OS
UNCORRECTED DISTANCE VISUAL ACUITY	6/6(-1)	6/6(P)
UNCORRECTED NEAR VISUAL ACUITY	N6	N6
BEST CORRECTED VISUAL ACUITY	6/6	6/6
COLOUR VISION	NORMAL	NORMAL

NOTE: HISTORY OF SPECS, PG NOT USING PROPERLY (PG NOT BROUGHT) NO RELEVANT MEDICAL HISTORY

VIMEGA.V OPTOMETRIST DATE: 19.11.2022

Respected Sir/Hadam

This is for your kind information that

one of our client (Hedriheel) - Mrs. SHILPIN JAYAN.

Carnot perform Int. Become she was pregnant.

Miris HA

Leho, TmT, Jechnisian.

19/4/12.





INDIA'S LEADING DIAGNOSTICS NETWORK

Name	Mrs. SHILPA JAYAN	Age/Sex	25/Female
Ref: By:	MEDIWHEEL	Date	19.11.2022

ULTRASOUND SCAN OF ABDOMEN AND PELVIS

(With relevant image copies)

LIVER: Normal in size and echotexture. No e/o focal parenchymal lesions / IHBD. PV, HV & IVC are within normal limits.

GB: Normally distended, shows normal wall thickness. No e/o calculi/polyps/ pericholecystic collections.

CBD: Normal.

PANCREAS: Head and body visualized and are of normal size and echotexture. No e/o focal/diffuse parenchymal lesions/ductal dilatation/calculi. Tail cannot be visualized due to poor window.

SPLEEN: Normal in size and echotexture. Splenic vein shows normal diameter.

KIDNEY'S: Both kidneys are normal in size and echotexture. No e/o calculi/ hydronephrosis/ focal lesions/ perinephric collections.

RIGHT KIDNEY: Measures 105 x 38 mms LEFT KIDNEY: Measures 111 x 43 mms

UB: Moderately distended, shows normal wall thickness. No e/o calculi/growth/diverticulae. Both UV junctions are within normal limits.

UTERUS: Gravid and shows a single intrauterine gestational sac corresponding to 5 weeks (GS: 15.5mm).

Fetal pole not seen

Yolk sac seen.

No subchorionic hemorrhage seen.

RIGHT OVARY: appears normal LEFT OVARY: appears normal.

No.e/o intraperitoneal free fluid/ abdominal lymphadenopathy/ mass lesion.

IMPRESSION

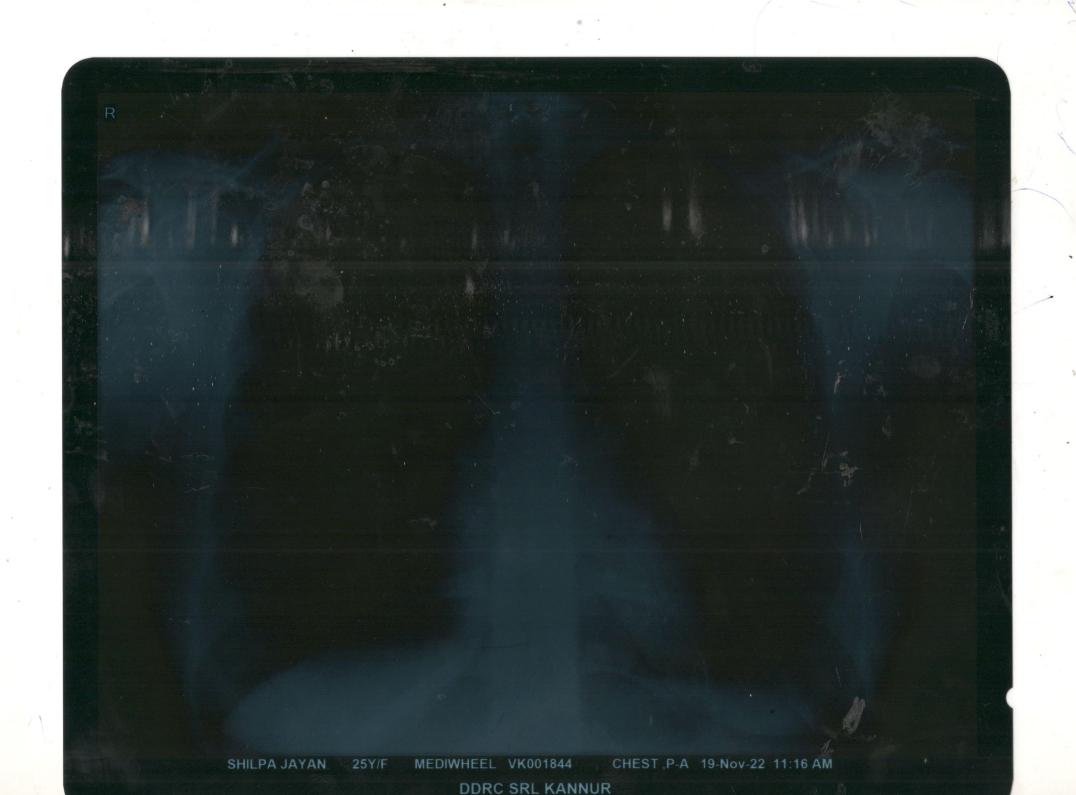
- SINGLE INTRAUTERINE GESTATION CORRESPONDING TO 5 WEEKS IN MATURITY.
- NO SONOLOGICALLY DETECTED ABNORMALITY IN THE ABDOMEN.

Dr. P.NIYAZI NASIR MBBS, DMRD

(Because of technical and technological limitation complete diagnosis cannot be assured on imaging sonography. Clinical correlation, consultation if required repeat imaging required in the event of controversies. This document is not for legal purposes).

Dr. P. NIYAZI NASIR. MBBS, DMRD REG. No. 41419 CONSULTANT RADIOLOGIST DDRC SRL DIAGNOSTIC (P) LTD.

KANNUR





Name	SHILPA JAYAN	Age/Sex	25/Female
Ref: By:	MEDIWEEL	Date	19.11.2022

Thanks for referral

CHEST X-RAY - PA VIEW

Trachea is central. Carina and principal bronchi are normal.

Cardio-thoracic ratio is within normal limits.

Both lungs show normal Broncho-vascular markings. No definite focal opacities noted.

No volume loss in either hemithorax.

No definite mediastinal widening or other abnormalities noted.

CP angles, diaphragm, bony cage and soft tissue shadows - not remarkable.

IMPRESSION:

Normal X-ray chest

DR. P. NIYAZI NASIR, MBBS, DMRD

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