# **CARDIOLOGY**

UHID / IP NO	225923 (8227)	RISNo./Status:	114043/
Patient Name:	Mr. VIKAS N SHETTY	Age/Gender:	40 Y/M
Referred By:	Dr. CMO	Ward/Bed No:	OPD
Bill Date/No:	10/02/2024 8:23AM/ OPCR/24/7369	Scan Date :	
Report Date :	10/02/2024 9:39AM	Company Name:	Final

## **M- MODE MEASUREMENTS**

AO	2.50	cm	RVIDD	1.45	cm
LA	3.51	cm	IVSD	1.14	cm
AO/LA RATIO	0.70	cm	LVIDD	4.58	cm
AV CUP	1.52	cm	LVPWD	1.14	cm
EPSS		cm	IVSS	1.45	cm
DE	1.83	cm	LVIDS	2.78	cm
EF SLOPE	0.7	cm	LVPWS	1.22	cm
sv	57.41		EDV	96.72	ml
СО			ESV	29.34	ml
HR			EF	69.73	%
LVMI			FS	39.90	%
OTHERS			LV MASS	178.32	grams

**DESCRIPTIVE FINDINGS:** Technically Adequate Study. Normal Sinus rhythm during Study.

LEFT VENTRICLE	Normal in size
LEFT ATRIUM	Normal in size
RIGHT VENTRICLE	Normal in size
RIGHT ATRIUM	Normal in size
WALL MOTION ANALYSIS	No RWMA
TRICUSPID VALVE	Normal
MITRAL VALVE	Normal
PULMONIC VALVE	Normal
AORTIC VALVE	Normal
IAS & IVS	Intact
AORTA & PA	Normal In Size
SYSTEMIC & PULMONARY VENIS	Normally Draining
PERICARDIUM	Normal
OTHERS	No Intra Cardiac Thrombus, Tumour or Vegetation

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### **DOPPLER STUDY**

VALVES	VELOCITY	GRADIENT	REGURGITATION	OTHERS
PV	0.71m/s		NO PR	
MV	E: 0.99m/s A: 0.72m/s		NO MR	
AV	1.36m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		MILD TR	
OTHERS				

#### **SUMMARY FINDINGS:**

NORMAL CARDIAC CHAMBERS & VOLUMES

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-69 %)

NO CLOT / PE / VEGETATION / PAH

**Dr. PRANEETHS**CONSULTANT
CARDIOLOGIST

Mr. Naveen Kumar M K

# **CARDIOLOGY**

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NAME **VISIT ID** : Mr. VIKAS N SHETTY : 24030043733

**GENDER** : Male AGE: 40 Years DATE OF REGISTRATION: 10-Feb-2024 12:43

**REFERRED BY** DATE OF COLLECTION : 10-Feb-2024 12:43

**REF CENTER** DATE OF REPORT : 10-Feb-2024 14:03 : VASAVI HOSPITAL & LABORATORY SERVICES

REF NO.

#### LABORATORY TEST REPORT

TEST PARAMETER	RESULT	UNIT	REFERENCE RANGE	SAMPLE TYPE
	CLINICAL BI	OCHEMISTRY	(	
BROSTATE SPECIFIC ANTIGEN (DSA)	0.44	ng/ml	0 - 4 0	Sarum

End Of Report -

**Total** 

Method: ECLIA

Processed By : AUTO

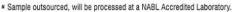
Rajkumar R

MSc Biochemistry **Biochemist** 

Report Status: Final

Outside samples to be correlated with other clinical findings

# All investigation have their limitation which are imposed by the limits of sensitivity and specificity of individual assay procedures as well as the specimen received by the laboratory. Isolated laboratory investigations never confirm the final diagnosis of the disease. They only help in arriving at a diagnosis in conjunction with clinical presentation and other related investigations. Reports to be correlated clinically.



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NAME : Mr. VIKAS N SHETTY VISIT ID : 24030043733

DATE OF REGISTRATION: 10-Feb-2024 12:43 **GENDER** : Male : 40 Years AGE

REFERRED BY DATE OF COLLECTION : 10-Feb-2024 12:43

**REF CENTER** : VASAVI HOSPITAL & LABORATORY SERVICES DATE OF REPORT : 10-Feb-2024 14:03

REF NO.

#### LABORATORY TEST REPORT **TERMS & CONDITIONS OF REPORTING**

It is presumed that the specimen belongs to the patient named or identified in the test request form.

- The report results are for information and interpretation for your referring doctor can be correlated with the patient's clinical history.
- Biological Reference Range/Interval is suggested for your Gender and Age on the basis of available literature. All reference ranges are to be reconsidered by the doctor's advice for your specific care.
- Test requested might not be performed for the following reasons
  - Specimen quality insufficient (inadequate collections/spillage in transit)
  - Specimen quality unacceptable (haemolysed/clotted/ lipemic etc.)
  - Incorrect specimen type.
  - Test cancelled either or request of patient or doctor, or because of incorrect test code, test name of specimen received. Reference may be provided to a new Accession number. Under "COMMENT" if the specimen has been re-accessioned for a different test. It is expected that a fresh specimen will be sent for the purpose of reporting on the same parameter(s), if required.
- This Medical Report is a professional opinion, not a diagnosis. Test results are not valid for medico legal purposes.
- The report will carry the name and age provided at the time of registration. To maintain confidentiality, certain reports may not be e-mailed at the discretion of the management.
- All the notes and interpretation beneath the test result in the report provided are for educational purposes only. It is not intended to be a substitute for doctor's consultation.
- Reports that carries a 'PRELIMINARY' status signifies that results are yet to be reported for one or more of the test, or else as is the case with many microbiology tests, a "FINAL'.' culture, identification or drug susceptibility result might be pending. In such case, the descriptor "RESULTS" column will be replaced by the test results whenever the latter are ready. The report will, when completed, acquire a "FINAL'.' status.
- Results of tests may vary from laboratory to laboratory and in some parameters from time to time for the same patients. Test results and reference range may also vary depending on the technology and methodology used. Laboratory test results may also vary depending on the age, sex, time of the day sample has been taken, diet, medication and !imitation of modern technology.
- In case of any unexpected or alarming test results, please contact us immediately for re-confirmation, further discussion, clarifications and rectifications, if needed only.
- In case of any discrepancy due to typing error, kindly get It rectified immediately. The collection date was not stated in the Test Requisition Form, the same will not be printed on the report.
- The Lab or its employees/representatives does not assume any liability or responsibility for any loss or damage that may be incurred by any person as result of interpreting the meaning of this report.
- In case of any issues or suggestions about your test results, please email us on lab@tridentdiagnostics.com
- Our liability is limited to the amount of investigations booked with us.
- The courts (forums) at Bengaluru shall have exclusive jurisdiction in all disputes/claims concerning the tests and the results of the tests.

Report Status: Final

Outside samples to be correlated with other clinical findings

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UHID	225923	Sample Date	10/02/2024 8:23AM
Age/Gender	40 Yrs/Male	<b>Receiving Date</b>	10/02/2024 9:15AM
Bed No/Ward	OPD	Report Date	10/02/2024 2:01PM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/24/7369	Manual No.	

#### **BIOCHEMISTRY**

Test Name	Result	Unit	Biological Ref. Range	Method
			Sample: Serum	
BLOOD UREA NITROGEN	15.9	mg/dl	Upto 14 years: 5 - 18 mg/dl Male (above 14 years): 8 - 24 mg/dl Female (above 14 years): 6 - 21 mg/dl Pregnant women: 5 - 12 mg/dl	
SERUM CREATININE	0.81	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	95.7	mg/dl	74.00 - 100.00	
<b>GLYCOSYLATED HAEMOGLOBIN</b>	(HbA1c)			
HbA1c (GLYCOSYLATED Hb)	5.3	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	105.41	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	201 H	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	473.8 H	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	44.7	mg/dl	35.00 - 55.00	
LDL CHOLESTROL - CALCULATED	61.54	mg/dl	0 - 130	
TC/HDL	4.50			
LDL/HDL	1.38			
			Sample: Serum	

## **LIVER FUNCTION TEST (LFT)**

**Verified By** Mr. VINAY G M Ravi Shankar K

Kan: Startar

**Bio Chemist** 

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TOTAL BILIRUBIN 0.77 mg/dl Adult - 0.2 - 1.3 mg/dL

#### **Special condition:**

Premature - <2.0 mg/dL
Full term - <2.0 mg/dL
0-1 day - Premature1.0 - 8.0 mg/dL
0-1 day - Full term 2.0 - 6.0 mg/dL
1 - 2 days Premature 6.0 - 12.0 mg/dL
1 - 2 days Full term 6.0 - 10.0 mg/dL
3 - 5 days Premature 10.0 - 14.0 mg/dL
3 - 5 days Full term 4.0 - 8.0 mg/dL

DIRECT BILIRUBIN	0.29	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.48	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	8.7	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	25.7	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	65	IU/L	53.00 - 128.00
TOTAL PROTEIN	7.26	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.31	g/dl	3.50 - 5.20
SERUM GLOBULIN	2.95	g/dl	2.30 - 3.50
A/G RATIO	1.46	%	1.00 - 2.00
POST PRANDIAL BLOOD GLUCOSE	76.4	mg/dl	70.00 - 140.00
URIC ACID	7.3	mg/dl	4.50 - 8.10

**Verified By** Mr. VINAY G M Ravi Shankar K

Kani Startar

**Bio Chemist** 

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Final

Patient Name Mr. VIKAS N SHETTY Lab No 114043

**UHID** 225923 **Sample Date** 10/02/2024 8:23AM

Age/Gender40 Yrs/MaleReceiving DateBed No/WardOPDReport DateReferred ByDr. CMOReport Status

Bill No. OPCR/24/7369 Manual No.

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### **Verified By**

Mr. VINAY G M

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**Patient Name** Mr. VIKAS N SHETTY Lab No 114043 **UHID** 225923 **Sample Date** 10/02/2024 8:23AM

10/02/2024 12:48PM Age/Gender 40 Yrs/Male **Receiving Date** 10/02/2024 1:25PM Bed No/Ward OPD **Report Date** 

Final **Referred By** Dr. CMO **Report Status** 

Bill No. OPCR/24/7369 Manual No.

	CLINIC	CAL PATI	HOLOGY	
Test Name	Result	Unit	Biological Ref. Range	Method
UIRNE GLUCOSE FASTING				·
URINE SUGAR	NIL		NEGATIVE	
			Sample: Urine	
PHYSICAL CHARACTERS				
COLOUR	Pale Yellow			
APPEARANCE	Slightly Turbid			
SPECIFIC GRAVITY	1.010			
PH	6.0			
CHEMICAL CONSTITUENTS				
ALBUMIN	Present (trace)			
SUGAR	Nil			
BILE SALTS	Absent			
BILE PIGMENTS	Absent			
KETONE BODIES	NEGATIVE			
BLOOD	Absent			

**MICROSCOPY** 

**PUS CELLS** 4-5/HPF R.B.C Nil **EPITHELIAL CELLS** 2-3/HPF **CASTS** Absent **CRYSTALS** Absent **BACTERIA** Absent

**URINE GLUCOSE-POST PRANDIAL** 

**URINE SUGAR** NIL **NEGATIVE** 

> **Verified By BADARINATH S** MD (PGI) KMC No 19014 Mr. VINAY G M

HEMATOPATHOLOGIST / PATHOLOGIST

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Age/Gender40 Yrs/MaleReceiving DateBed No/WardOPDReport DateReferred ByDr. CMOReport Status

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**Patient Name** Mr. VIKAS N SHETTY Lab No 114043 **UHID** 225923 **Sample Date** 10/02/2024 8:23AM 40 Yrs/Male 10/02/2024 9:15AM Age/Gender **Receiving Date** 10/02/2024 1:25PM Bed No/Ward OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** OPCR/24/7369 Bill No. Manual No.

### **HAEMATOLOGY**

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD GROUP	" B "			
RH TYPE	POSITIVE			
			Sample: Blood	
HAEMOGLOBIN	14.9	gm/dl	14.00 - 18.00	
TOTAL COUNT	4920	cells/cumm	4500.00 - 11000.00	
DLC				
NEUTROPHILS	47	%	35.00 - 66.00	
LYMPHOCYTES	43	%	24.00 - 44.00	
MONOCYTES	06	%	4.00 - 10.00	
EOSINOPHILS	04	%	1.00 - 6.00	
BASOPHILS	00	%	0.00 - 1.00	
R.B.C COUNT	5.13	mill/cumm	4.50 - 5.90	
PACKED CELL VOLUME (PCV)	42.3	%	40.00 - 50.00	
PLATELET COUNT	1.63	lakh/cumm	1.50 - 4.50	
M.C.V	82.5	fL	80.00 - 100.00	
M.C.H	29.1	pg	26.00 - 34.00	
M.C.H.C	35.3	%	32.00 - 36.00	
ESR (ERYTHROCYTE SEDIMENTATION RATE)	12	mm/hr	0.00 - 12.00	

--End Of Report--

**Verified By** Mr. VINAY G M **BADARINATH S** 

MD (PGI) KMC No 19014 HEMATOPATHOLOGIST / PATHOLOGIST

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## **HORMONES**

Test Name	Result	Unit	Biological Ref. Range	Method		
THYROID PROFILE (T3, T4, TSH	)					
TOTAL TRIIODOTHYRONINE (T3)	1.73	ng/mL	0.59 - 2.15			
TOTAL THYROXINE (T4)	102	ng/mL	52.00 - 127.00			
TSH (THYROID STIMULATING HORMONE)	3.01	uIU/ml	0.30 - 4.50			

--End Of Report--

**Verified By** Mr. VINAY G M Ravi Shankar K

Cari Startar

**Bio Chemist** 

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**UHID** 225923 **Sample Date** 10/02/2024 8:23AM

Age/Gender40 Yrs/MaleReceiving DateBed No/WardOPDReport Date

**Referred By** Dr. CMO **Report Status** Final

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**USG** 

**ABDOMEN & PELVIS (USG)** 

**Verified By** 

Mr. VINAY G M

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Mr. VIKAS N SHETTY 114043 **Patient Name** Lab No **UHID** 225923 **Sample Date** 10/02/2024 8:23AM 10/02/2024 10:56AM Age/Gender 40 Yrs/Male Receiving Date 10/02/2024 11:10AM Bed No/Ward **OPD Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/7369 Manual No.

LIVER: Liver is cm in size, both lobes of liver are normal in size with mild increased echotexture. No evidence of any intrahepatic billiary dilatation noted. CBD and Portal vein normal in size and echotexture. Linear vertical calcification noted in right lobe segment VI measuring approximately for a length of 3.6 cms.

**GALL BLADDER**: Partially distended, gall bladder wall thickness is normal. Contents are clear. No evidence of gall stones / cholecystitis.

**PANCREAS**: Head and body appears normal. Uncinate process and tail could not be assessed due to bowel gas. MPD is normal.

**SPLEEN**: Normal in size measuring 10 cms with normal echotexture.

**KIDNEYS**: Both kidneys are normal in size, shape, contour & position. Cortico medullary differentiation is well maintained. No evidence of any hydronephrosis / hydroureter. Right Kidney measures: 9.8 x 4.9 cms. Parenchymal thickness 1.8 cms.

Left Kidney measures : 9.8 x 4.8 cms. Parenchymal thickness 1.6 cms.

URINARY BLADDER: Well distended with clear contents. Wall thickness is normal.

**PROSTATE**: Normal in size and echotexture, measuring 3.3 x 3.2 x 3.6 cms, vol: 20 cc. No focal lesion seen. Both seminal vesicles appear normal.

No obvious free fluid in the peritoneal cavity.

#### IMPRESSION:

Grade I fatty liver with linear calcified granulomas in right lobe of liver as described.

\*\* Note: All abnormalities cannot be detected by Ultrasound scan due to technical limitation, obesity and other factors. Scan findings to be correlated with old reports or other investigations.

**Verified By** Mr. VINAY G M Dr. NAVEEN SUBBAIAH MBBS, MD -RADIO DIAGNOSIS Visiting Consultant

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**UHID** 225923 **Sample Date** 10/02/2024 8:23AM

Age/Gender40 Yrs/MaleReceiving DateBed No/WardOPDReport Date

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**Patient Name** Mr. VIKAS N SHETTY Lab No 114043 **UHID** 225923 **Sample Date** 10/02/2024 8:23AM 10/02/2024 8:51AM Age/Gender 40 Yrs/Male Receiving Date 10/02/2024 2:20PM **Bed No/Ward** OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/7369 Manual No.

X-RAY

#### **CHEST PA VIEW (X RAY)**

#### FINDINGS:

The lungs on the either side show equal translucency.

Cardiac size and ventricular configuration are normal.

Both hilar region appear normal.

Both C P angles appear clear.

Both domes of diaphragm appear normal.

Bony cage and soft tissue appear normal.

IMPRESSION: ESSENTIALLY NORMAL STUDY.

--End Of Report--

**Verified By** Mr. VINAY G M Dr. NAVEEN SUBBAIAH MBBS, MD -RADIO DIAGNOSIS Visiting Consultant

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