# **CARDIOLOGY**

UHID / IP NO	225279 (5133)	RISNo./Status:	111616/
Patient Name:	Mr. MADHAV BHAT	Age/Gender:	39 Y/M
Referred By:	Dr. CMO	Ward/Bed No:	OPD
Bill Date/No:	27/01/2024 8:18AM/ OPCR/24/7112	Scan Date:	
Report Date :	27/01/2024 9:07AM	Company Name:	Final

## **M- MODE MEASUREMENTS**

AO	3.00	cm	RVIDD	1.45	cm
LA	3.52	cm	IVSD	1.11	cm
AO/LA RATIO	0.78	cm	LVIDD	4.62	cm
AV CUP	1.45	cm	LVPWD	0.95	cm
EPSS		cm	IVSS	1.30	cm
DE	1.83	cm	LVIDS	3.05	cm
EF SLOPE	0.7	cm	LVPWS	1.33	cm
sv	57.41		EDV	98.72	ml
СО			ESV	36.34	ml
HR			EF	63.73	%
LVMI			FS	34.90	%
OTHERS			LV MASS	188.32	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: 1.16m/s A: 0.78m/s		NO MR	_
AV	1.36m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		TRIVIAL TR	
OTHERS				

## **SUMMARY FINDINGS:**

NORMAL CARDIAC CHAMBERS & VOLUMES

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-63 %)

NO CLOT / PE / VEGETATION / PAH

**Dr. PRANEETHS**CONSULTANT
CARDIOLOGIST

Mr. Naveen Kumar M K

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<b>Patient Name</b>	Mr. MADHAV BHAT	Lab No	111616
UHID	225279	Sample Date	27/01/2024 8:18AM
Age/Gender	39 Yrs/Male	Receiving Date	27/01/2024 9:03AM
Bed No/Ward	OPD	Report Date	27/01/2024 3:28PM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/24/7112	Manual No.	

#### **BIOCHEMISTRY**

Test Name	Result	Unit	Biological Ref. Range	Method
		·	Sample: Serum	
BLOOD UREA NITROGEN	8.7	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	1.01	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	91.4	mg/dl	74.00 - 100.00	
GLYCOSYLATED HAEMOGLOBIN	(HbA1c)			
HbA1c (GLYCOSYLATED Hb)	5.4	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	108.28	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	165	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	145.0	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	42.1	mg/dl	35.00 - 55.00	
LDL CHOLESTROL - CALCULATED	93.9	mg/dl	0 - 130	
TC/HDL	3.92			
LDL/HDL	2.23			
			Sample: Serum	

**LIVER FUNCTION TEST (LFT)** 

**Verified By** Shashi Kumar G **BADARINATH S** 

MD (PGI) KMC No 19014 HEMATOPATHOLOGIST / PATHOLOGIST

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<b>Patient Name</b>	Mr. MADHAV BHAT	Lab No	111616
UHID	225279	Sample Date	27/01/2024 8:18AM
Age/Gender	39 Yrs/Male	<b>Receiving Date</b>	27/01/2024 9:03AM
Bed No/Ward	OPD	Report Date	27/01/2024 3:28PM
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TOTAL BILIRUBIN 0.48 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 - Premature-1.0 - 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	0.22	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.26	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	18.3	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	17.5	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	99	IU/L	53.00 - 128.00
TOTAL PROTEIN	7.42	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.25	g/dl	3.50 - 5.20
SERUM GLOBULIN	3.17	g/dl	2.30 - 3.50
A/G RATIO	1.34	%	1.00 - 2.00
URIC ACID	7.1	mg/dl	4.50 - 8.10
		End Of Report	

**Verified By** 

**BADARINATH S** 

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**Patient Name** Mr. MADHAV BHAT Lab No 111616 **UHID** 225279 **Sample Date** 27/01/2024 8:18AM Age/Gender 39 Yrs/Male 27/01/2024 12:31PM **Receiving Date** Bed No/Ward 27/01/2024 3:28PM OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/7112 Manual No.

## **BIOCHEMISTRY**

Test Name	Result	Unit	Biological Ref. Range	Method
POST PRANDIAL BLOOD GLUCOSE	136	mg/dl	70.00 - 140.00	

--End Of Report--

**Verified By** 

Ravi Shankar K

Kari Starcar

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**Bio Chemist** 

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Bill No. OPCR/24/7112 Manual No.

## **CLINICAL PATHOLOGY**

	CLINICAL PATHOLOGY					
Test Name	Result	Unit	Biological Ref. Range	Method		
STOOL ANALYSIS		,	,			
PHYSICAL EXAMINATION						
COLOUR	Brown					
CONSISTANCY	SEMI SOLID					
PH	7.5					
MUCUS	ABSENT					
MICROSCOPIC EXAMINATION						
OVA	ABSENT					
CYST	ABSENT					
TROPHOZOITES	ABSENT					
PUS CELLS	2-3/HPF					
R.B.C	Nil					
BACTERIA	PRESENT 2+					
OTHERS	ABSENT					
MISCELLANEOUS	ABSENT					
<b>UIRNE GLUCOSE FASTING</b>						
URINE SUGAR	NTI		NEGATIVE			

URINE SUGAR NIL NEGATIVE

Sample: Urine

**PHYSICAL CHARACTERS** 

COLOUR Pale Yellow

APPEARANCE Clear Clear

SPECIFIC GRAVITY 1.025 PH 6.0

**CHEMICAL CONSTITUENTS** 

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Shashi Kumar G MD (PGI) KMC No 19014

HEMATÓPATHOLOGIST / PATHOLOGIST

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Manual No.

**Patient Name** Mr. MADHAV BHAT Lab No 111616 **UHID** 225279 **Sample Date** 27/01/2024 8:18AM 27/01/2024 12:31PM Age/Gender 39 Yrs/Male **Receiving Date Bed No/Ward** OPD **Report Date** 27/01/2024 1:24PM Final **Referred By** Dr. CMO **Report Status** 

Referred by Dr. Chio Report Status

ALBUMIN NII
SUGAR NII
BILE SALTS Absent
BILE PIGMENTS Absent
KETONE BODIES NEGATIVE
BLOOD Absent

OPCR/24/7112

**MICROSCOPY** 

**BACTERIA** 

Bill No.

PUS CELLS 2-3/HPF
R.B.C Nil

EPITHELIAL CELLS 0-1 / HPF
CASTS Absent
CRYSTALS Absent

**URINE GLUCOSE-POST PRANDIAL** 

URINE SUGAR NIL NEGATIVE

**Absent** 

--End Of Report--

Verified By

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BADARINATH S

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HEMATOPATHOLOGIST / PATHOLOGIST

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### **HAEMATOLOGY**

HAEMATOLOGY								
Test Name	Result	Unit	Biological Ref. Range	Method				
BLOOD GROUP	"O"							
RH TYPE	POSITIVE							
			Sample: Blood					
HAEMOGLOBIN	13.4 L	gm/dl	14.00 - 18.00					
TOTAL COUNT	6950	cells/cumm	4500.00 - 11000.00					
DLC								
NEUTROPHILS	59	%	35.00 - 66.00					
LYMPHOCYTES	34	%	24.00 - 44.00					
MONOCYTES	04	%	4.00 - 10.00					
EOSINOPHILS	03	%	1.00 - 6.00					
BASOPHILS	00	%	0.00 - 1.00					
R.B.C COUNT	4.67	mill/cumm	4.50 - 5.90					
PACKED CELL VOLUME (PCV)	38.2 L	%	40.00 - 50.00					
PLATELET COUNT	3.31	lakh/cumm	1.50 - 4.50					
M.C.V	81.7	fL	80.00 - 100.00					
M.C.H	28.7	pg	26.00 - 34.00					
M.C.H.C	35.2	%	32.00 - 36.00					
ESR (ERYTHROCYTE SEDIMENTATION RATE)	18 H	mm/hr	0.00 - 12.00					

--End Of Report--

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## **HORMONES**

Test Name	Result	Unit	Biological Ref. Range	Method		
THYROID PROFILE (T3, T4, TSH	1)					
TOTAL TRIIODOTHYRONINE (T3)	1.75	ng/mL	0.59 - 2.15			
TOTAL THYROXINE (T4)	104	ng/mL	52.00 - 127.00			
TSH (THYROID STIMULATING HORMONE)	1.67	uIU/ml	0.30 - 4.50			

--End Of Report--

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Mr. MADHAV BHAT 111616 **Patient Name** Lab No **UHID** 225279 **Sample Date** 27/01/2024 8:18AM 27/01/2024 10:40AM Age/Gender 39 Yrs/Male **Receiving Date** 27/01/2024 10:45AM Bed No/Ward **OPD Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/7112 Manual No.

#### **USG**

#### **ABDOMEN & PELVIS (USG)**

LIVER: Liver is 14 cm in size, both lobes of liver are normal in size with homogeneous echotexture. No evidence of any focal lesion / intrahepatic billiary dilatation noted. CBD and Portal vein normal in size and echotexture.

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

**PANCREAS**: Only head is visualized and appears normal. Rest of the pancreas obscured by bowel gas.

**SPLEEN**: Normal in size measuring 10.4 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: 10.0 x 4.6 cms. Parenchymal thickness 1.8 cms. Left Kidney measures : 10.5 x 5.4 cms. Parenchymal thickness 1.7 cms.

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

PROSTATE: Normal in size and echotexture. Vol: 17 cc. No focal lesion seen. Both seminal vesicles appear normal.

No obvious free fluid in the peritoneal cavity.

#### IMPRESSION: NO SONOLOGICAL ABNORMALITY DETECTED.

\*\* 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.

-- End Of Report--

**Verified By** 

Dr. B SWAROOP

MBBS MD(Radiology)
CONSULTANT RADIOLOGIST

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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** Shashi Kumar G Dr. B SWAROOP

MBBS MD(Radiology)

CONSULTANT RADIOLOGIST

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