Dr. Goyal's
Path Lab & Imaging Centre

B-51, Ganesh Nagar, Opp. Janpath Corner, New Sanganer Road, Jaipur-302019
Tele: 0141-2293346, 4049787, 9887049787
Website: www.drgoyalspathlab.com | E-mail: drgoyalpiyush@gmail.com

MC - 2300

Date :- 08/10/2021 09:26:32
NAME :- Mrs. REKHA SAXENA
Sex / Age :- Female 57 Yrs
Company :- MediWheel

Patient ID :-12212609
Ref. By Dr:- BOB
Lab/Hosp :-

Sample Type :- EDTA
Sample Collected Time08/10/2021 09:29:36
Final Authentication : 08/10/2021 14:15:41

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
HAEMOGARAM			
HAEMOGLOBIN (Hb)	14.5	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	7.73	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	55.7	%	40.0 - 80.0
LYMPHOCYTE	38.5	%	20.0 - 40.0
EOSINOPHIL	2.1	%	1.0 - 6.0
MONOCYTE	3.6	%	2.0 - 10.0
BASOPHIL	0.1	%	0.0 - 2.0
NEUT#	4.31	10^3/uL	1.50 - 7.00
LYMPH#	2.98	10^3/uL	1.00 - 3.70
EO#	0.16	10^3/uL	0.00 - 0.40
MONO#	0.27	10^3/uL	0.00 - 0.70
BASO#	0.01	10^3/uL	0.00 - 0.10
TOTAL RED BLOOD CELL COUNT (RBC)	**5.11** H	x10^6/uL	3.80 - 4.80
HEMATOCRIT (HCT)	43.70	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	85.6	fL	83.0 - 101.0
MEAN CORP HB (MCH)	28.4	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	33.2	g/dL	31.5 - 34.5
PLATELET COUNT	305	x10^3/uL	150 - 410
RDW-CV	13.7	%	11.6 - 14.0
MENTZER INDEX	16.75		

The Mentzer index is used to differentiate iron deficiency anemia from beta thalassemia trait. If a CBC indicates microcytic anemia, these are two of the most likely causes, making it necessary to distinguish between them.
If the quotient of the mean corpuscular volume divided by the red blood cell count is less than 13, thalassemia is more likely. If the result is greater than 13, then iron-deficiency anemia is more likely.

Technologist

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
Erythrocyte Sedimentation Rate (ESR)	09	mm/hr.	00 - 20

(ESR) Methodology : Measurment of ESR by cells aggregation.
Instrument Name : Indepedent form Hematocrit value by Automated Analyzer (Roller-20)
Interpretation : ESR test is a non-specific indicator ofinflammatory disease and abnormal protein states.
The test in used to detect, follow course of a certain disease (e.g-tuberculosis, rheumatic fever, myocardial infarction
Levels are higher in pregnency due to hyperfibrinogenaemia.
The "3-figure ESR " x>100 value nearly always indicates serious disease such as a serious infection, malignant paraproteinaemia or connective tissue disease.

(CBC) : Methodology : FLC DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and **MCH,MCV,MCHC,MENTZER INDEX** are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
BOB PACKAGEFEMALE > 50			
GLYCOSYLATED HEMOGLOBIN (HbA1C) Method:- HPLC	5.8	%	Non-diabetic: < 5.7 Pre-diabetics: 5.7-6.4 Diabetics: = 6.5 or higher ADA Target: 7.0 Action suggested: > 6.5

Instrument name: ARKRAY's ADAMS Lite HA 8380V, JAPAN.

Test Interpretation:
HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of HbA to form an unstable schiff base.It is the major fraction,constituting approximately 80% of HbA1c.Formation of glycated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHb concentration represents the integrated values for glucose overthe period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasmaglucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values. The interpretation of GHbdepends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb.High GHb have been reported in iron deficiency anemia. GHb has been firmly established as an index of long term blood glucose concentrations and as a measureof the risk for the development of complications in patients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to themean of HbA1C.Genetic variants (e.g. HbS trait, HbC trait), elevated HbF and chemically modified derivatives of hemoglobin can affect the accuracy of HbA1cmeasurements. The effects vary depending on the specific Hb vatiant or derivative and the specific HbA1c method.
Ref by ADA 2020

MEAN PLASMA GLUCOSE Method:- Calculated Parameter	114	mg/dL	Non Diabetic < 100 mg/dL Prediabetic 100- 125 mg/dL Diabetic 126 mg/dL or Higher

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Sample Type :- EDTA, PLAIN/SERUM, URINE, SERUM Collected Time 08/10/2021 09:29:36 Final Authentication : 08/10/2021 15:51:15

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
BLOOD GROUP ABO	"O"POSITIVE		
BLOOD GROUP ABO Methodology : Haemagglutination reaction **Kit Name :** Monoclonal agglutinating antibodies (Span clone)			
URINE SUGAR (FASTING) Collected Sample Received	Nil		Nil
URINE SUGAR PP Collected Sample Received	Nil		Nil
BLOOD UREA NITROGEN (BUN)	13.9	mg/dl	0.0 - 23.0

Technologist

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Sample Type :- KOx/Na FLUORIDE-F, KOx/Na FLUORIDE-F, [illegible] SERUM 08/10/2021 12:55:41 Final Authentication : 08/10/2021 14:26:55

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) **Method:- GOD PAP**	107.9	mg/dl	75.0 - 115.0

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: Randox Rx Imola **Interpretation:** Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) **Method:- GOD PAP**	**177.4** H	mg/dl	70.0 - 140.0

Instrument Name: Randox Rx Imola **Interpretation:** Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

SERUM CREATININE **Method:- Colorimetric Method**	0.75	mg/dl	Men - 0.6-1.30 Women - 0.5-1.20
SERUM URIC ACID **Method:- Enzymatic colorimetric**	5.03	mg/dl	Men - 3.4-7.0 Women - 2.4-5.7

Technologist

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Sample Collected Time 08/10/2021 09:29:36
Final Authentication : 08/10/2021 13:06:28

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL **Method:- Enzymatic Endpoint Method**	212.41	mg/dl	Desirable <200 Borderline 200-239 High> 240
TRIGLYCERIDES **Method:- GPO-PAP**	118.06	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
VLDL CHOLESTEROL **Method:- Calculated**	23.61	mg/dl	0.00 - 80.00

Technologist

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
DIRECT HDL CHOLESTEROL **Method:- Direct clearance Method**	39.77	mg/dl	Low < 40 High > 60
DIRECT LDL CHOLESTEROL **Method:- Direct clearance Method**	**152.96** H	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
T.CHOLESTEROL/HDL CHOLESTEROL RATIO **Method:- Calculated**	**5.34** H		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO **Method:- Calculated**	**3.85** H		0.00 - 3.50
TOTAL LIPID **Method:- CALCULATED**	617.67	mg/dl	400.00 - 1000.00

TOTAL CHOLESTEROL **InstrumentName**:Randox Rx-Imola **Interpretation**: Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders

TRIGLYCERIDES **InstrumentName**:Randox Rx Imola **Interpretation** : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

DIRECT HDLCHOLESTERO **InstrumentName**:Randox Rx Imola **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies.Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

DIRECT LDL-CHOLESTEROL **InstrumentName**:Randox Rx Imola **Interpretation:** Accurate measurement of LDL-Cholesterol is of vital importance in therapies which focus on lipid reduction to prevent atherosclerosis or reduce its progress and to avoid plaque rupture.

TOTAL LIPID AND VLDL ARE CALCULATED

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIVER PROFILE WITH GGT			
SERUM BILIRUBIN (TOTAL) **Method:- Colorimetric method**	0.72	mg/dl	Up to - 1.0 Cord blood <2 mg/dL Premature < 6 days <16mg/dL Full-term < 6 days= 12 mg/dL 1month - <12 months <2 mg/dL 1-19 years <1.5 mg/dL Adult - Up to - 1.2 Ref-(ACCP 2020)
SGOT **Method:- IFCC**	26.5	U/L	Men- Up to - 37.0 Women - Up to - 31.0
SGPT **Method:- IFCC**	22.4	U/L	Men- Up to - 40.0 Women - Up to - 31.0
SERUM ALKALINE PHOSPHATASE **Method:- AMP Buffer**	51.70	IU/L	30.00 - 120.00
SERUM TOTAL PROTEIN **Method:- Biuret Reagent**	6.72	g/dl	6.40 - 8.30
SERUM ALBUMIN **Method:- Bromocresol Green**	4.28	g/dl	3.80 - 5.00
SERUM GLOBULIN **Method:- CALCULATION**	2.44	gm/dl	2.20 - 3.50
A/G RATIO	1.75		1.30 - 2.50

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
SERUM BILIRUBIN (DIRECT) **Method:- Colorimetric Method**	0.16	mg/dL	Adult - Up to 0.25 Newborn - <0.6 mg/dL >- 1 month - <0.2 mg/dL
SERUM BILIRUBIN (INDIRECT) **Method:- Calculated**	0.56	mg/dl	0.30-0.70
SERUM GAMMA GT **Method:- IFCC**	15.80	U/L	7.00 - 32.00

Total Bilirubin Methodology Colorimetric method InstrumentName Randox Rx Imola Interpretation An increase in bilirubin concentration in the serum occurs in toxic or infectious diseases of the liver e.g. hepatitis B or obstruction of the bile duct and in rhesus incompatible babies.High levels of unconjugated bilirubin indicate that too much haemoglobin is being destroyed or that the liver is not actively treating the haemoglobin it is receiving.

AST Aspartate Aminotransferase Methodology: IFCC **InstrumentName** Randox Rx Imola **Interpretation**: Elevated levels of AST can signal myocardial infarction, hepatic disease, muscular dystrophy and organ damage. Although heart muscle is found to have the most activity of the enzyme, significant activity has also been seen in the brain, liver, gastric mucosa, adipose tissue and kidneys of humans.

ALT Alanine Aminotransferase Methodology: IFCC**InstrumentName** Randox Rx Imola **Interpretation:** The enzyme ALT has been found to be in highest concentrations in the liver, with decreasing concentrations found in kidney, heart, skeletal muscle, pancreas, spleen and lung tissue respectively. Elevated levels of the transaminases can indicate myocardial infarction, hepatic disease, muscular dystrophy and organ damage.

Alkaline Phosphatase Methodology AMP Buffer InstrumentName Randox Rx Imola Interpretation Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease

TOTAL PROTEIN Methodology:Biuret Reagent **InstrumentName**:Randox Rx Imola **Interpretation** : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

ALBUMIN (ALB) Methodology: Bromocresol Green **InstrumentName**:Randox Rx Imola **Interpretation:** Albumin measurements are used in the diagnosis and treatment of numerous diseases involving primarily the liver or kidneys. Globulin & A/G ratio is calculated.

Instrument Name Randox Rx Imola **Interpretation**: Elevations in GGT levels arecseen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.

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IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
TOTAL THYROID PROFILE			
SERUM TSH **Method:- Enhanced Chemiluminescence Immunoassay**	**5.840** H	µIU/mL	0.465 - 4.680

Technologist

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IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
SERUM TOTAL T3 **Method:- Chemiluminescence(Competitive immunoassay)**	1.130	ng/ml	0.970 - 1.690
SERUM TOTAL T4 **Method:- Chemiluminescence(Competitive immunoassay)**	8.810	ug/dl	5.500 - 11.000

InstrumentName: VITROS ECI **Interpretation:** Triiodothyronine (T3) contributes to the maintenance of the euthyroid state.A decrease in T3 concentration of up to 50% occurs in a variety of clinical situations, including acute and chronic disease. Although T3 results alone cannot be used to diagnose hypothyroidism, T3 concentration may be more sensitive than thyroxine (T4) for hyperthyroidism. Consequently, the total T3 assay can be used in conjunction with other assays to aid in the differential diagnosis of thyroid disease.T3 concentrations may be altered in some conditions, such as pregnancy,that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, Free T3 can provide the best estimate of the metabolically active hormone concentration.Alternatively, T3 uptake, or T4 uptake can be used with the total T3 result to calculate the free T3 index and estimate the concentration of free T3.

InstrumentName: VITROS ECI **Interpretation** :The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy,that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4.Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

InstrumentName: VITROS ECI **Interpretation** :TSH stimulates the production of thyroxine (T4) and triiodothyronine (T3) by the thyroid gland. The diagnosis of overt hypothyroidism by the finding of a low total T4 or free T4 concentration is readily confirmed by a raised TSH concentration. Measurement of low or undetectable TSH concentrations may assist the diagnosis of hyperthyroidism, where concentrations of T4 and T3 are elevated and TSH secretion is suppressed. These have the advantage of discriminating between the concentrations of TSH observed in thyrotoxicosis, compared with the low, but detectable, concentrations that occur in subclinical hyperthyroidism. The performance of this assay has not been established for neonatal specimens. Some drugs and some nonthyroidal patient conditions are known to alter TSH concentrations in vivo.

INTERPRETATION

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester	0.10-2.50
2nd Trimester	0.20-3.00
3rd Trimester	0.30-3.00

Technologist

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CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT

Technologist

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CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	6.0		5.0 - 7.5
SPECIFIC GRAVITY	1.010		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE

Technologist

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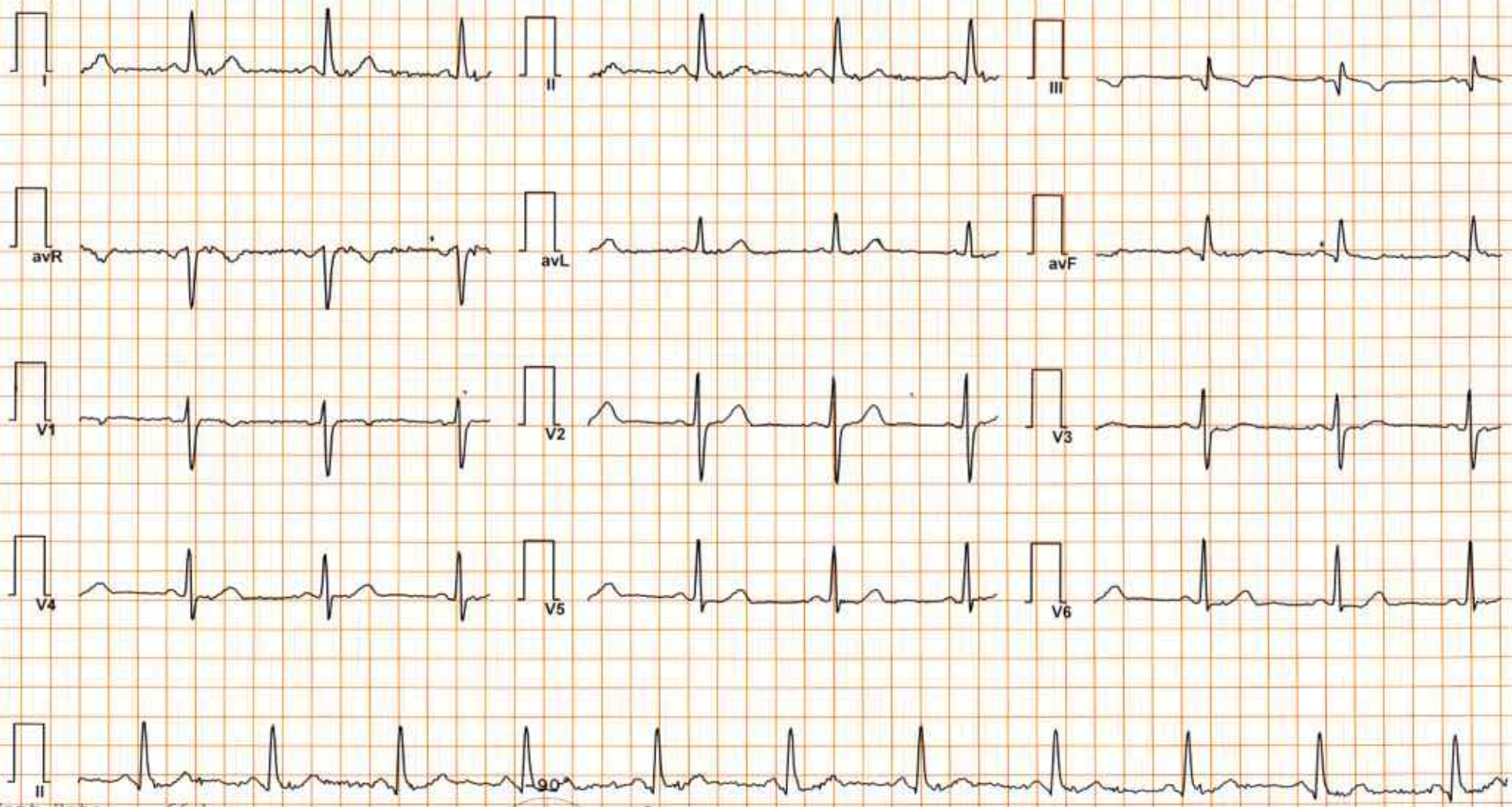
DR.GOYAL PATH LAB & IMAGING CENTER, JAIPUR

473 / MRS REKHA SAXENA / 57 Yrs / F/ Non Smoker

Heart Rate : 66 bpm / Tested On : 08-Oct-21 13:21:51 / HF 0.05 Hz - LF 35 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s / Refd By.: BOB

ECG

AGHPL



Vent Rate : 66 bpm
PR Interval : 136 ms
QRS Duration: 92 ms
QT/QTc Int : 404/415 ms
P-QRS-T axis: 37.00° 33.00° 2.00°

Axis
R 33.00° T 2.00° P 37.00°

Reported By:

Allengers ECG (Pisces)(PIS216200529)

Dr. Goyal's
Path Lab & Imaging Centre

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Website : www.drgoyalspathlab.com | E-mail : drgoyalpiyush@gmail.com

Date :- 08/10/2021 09:26:32	Patient ID :-12212609
NAME :- Mrs. REKHA SAXENA	Ref. By Doctor:-BOB
Sex / Age :- Female 57 Yrs	Lab/Hosp :-
Company :- MediWheel	

Final Authentication : 08/10/2021 15:11:53

BOB PACKAGEFEMALE > 50

ULTRA SOUND SCAN OF ABDOMEN

Liver is mild enlarged in size (15.5 cm). Echo-texture is bright A simple cyst of size 16x11 mm seen in left lobe of liver. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is of normal size. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Urinary Bladder: is well distended and showing smooth wall with normal thickness. Urinary bladder does not show any calculus or mass lesion.

Uterus & ovaries are not seen H/o hysterectomy . No adnexal mass is seen.

No significant free fluid is seen in pouch of douglas.
There is anterior abdominal wall defect 11.8 mm on right paramedian at infta umbilical region herniating omentum & mesentric fat thorough it which is increasing in size on cough reflex.

IMPRESSION:
***Mild hepatomegaly with fatty changes with simple hepatic cyst**
***Inftaumbilical hernia**
Needs clinical correlation & further evaluation

ANITASHARMA

Print Copy

Dr. Piyush Goyal
M.B.B.S., D.M.R.D.
RMC Reg No. 017996

Dr. Poonam Gupta
MBBS/MD (Radio Diagnosis)
RMC No. 32495

Dr. Uma Mathuria
M.B.B.S.- M.D.
RMC Reg No. 22541

Dr. Hitesh Kumar Sharma
M.B.B.S.- D.M.R.D.
RMC Reg No. 27380

Transcript by.

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ULTRASONOGRAPHY report : Breast and axilla

Right breast:

Skin , subcutaneous tissue and retroareolar region is normal

Fibro glandular tissue shows normal architecture and echotexture.

Pre and retro mammary regions are unremarkable .

A cyst of size 5x4 mm seen in the right superior medial quadrant.

Axillary lymph nodes are not significantly enlarged and their hilar shadows are preserved.

Left breast:

Skin , subcutaneous tissue and retroareolar region is normal

Fibro glandular tissue shows normal architecture and echotexture.

Pre and retro mammary regions are unremarkable .

A cyst of size 6x3 mm seen in the left superior lateral quadrant.

Axillary lymph nodes are not significantly enlarged and their hilar shadows are preserved.

IMPRESSION : Bilateral breast simple cyst

*** End of Report ***

ANITASHARMA

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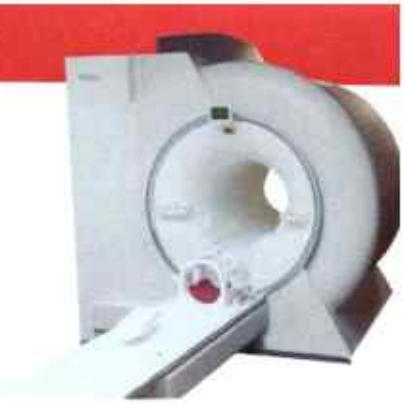

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NAME :- Mrs. REKHA SAXENA
Sex / Age :- Female 57 Yrs
Company :- MediWheel

Patient ID :- 12212609
Ref. By Doctor:-BOB
Lab/Hosp :-

Final Authentication : 08/10/2021 13:16:34

BOB PACKAGEFEMALE > 50

X RAY CHEST PA VIEW:

Expiratory film.

Both lung fields appears clear.

Bronchovascular markings appear normal.

Trachea is in midline.

Both the hilar shadows are normal.

Both the C.P.angles is clear.

Both the domes of diaphragm are normally placed.

Bony cage and soft tissue shadows are normal.

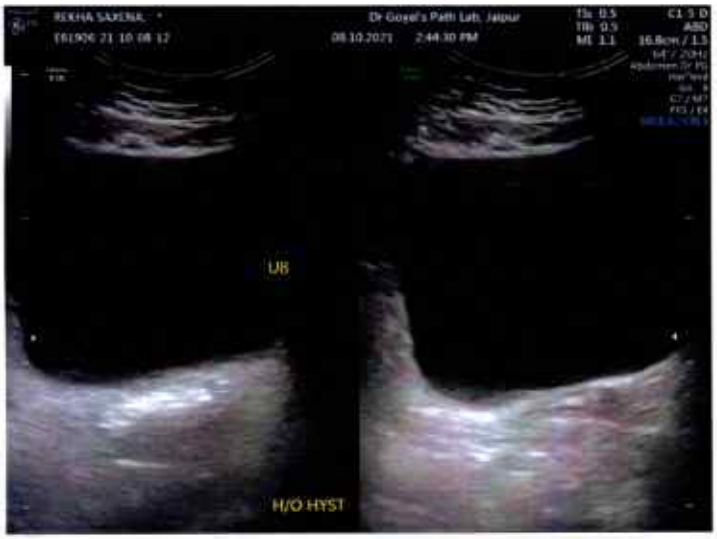
Impression :- Normal Study

(Please correlate clinically and with relevant further investigations)

*** End of Report ***

KANARAM

Dr. Piyush Goyal (D.M.R.D.) | Dr.Poonam Gupta MD (Radiodiagnosis) | Dr. Shankar Tejwani (M.D. Radiodiagnosis) | Dr. Uma Mathuria (M.D. Radiodiagnosis) | Dr. Rathod Heatali Amrutlal (M.D. Radiodiagnosis)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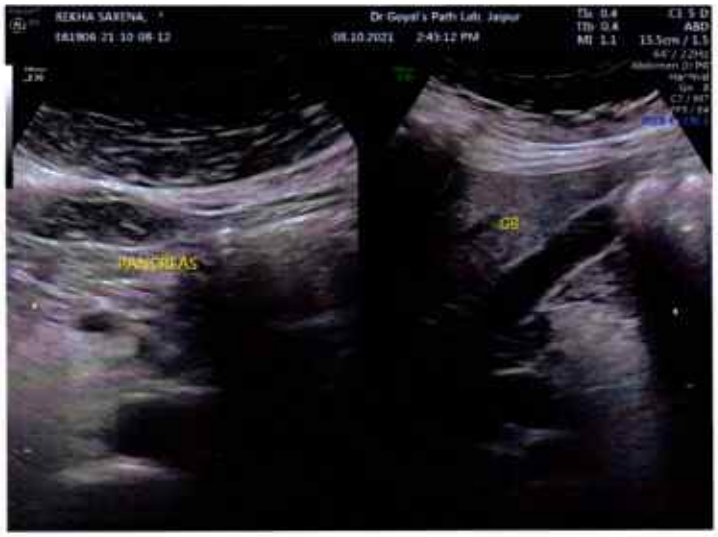
H/O HYST


PANCREAS
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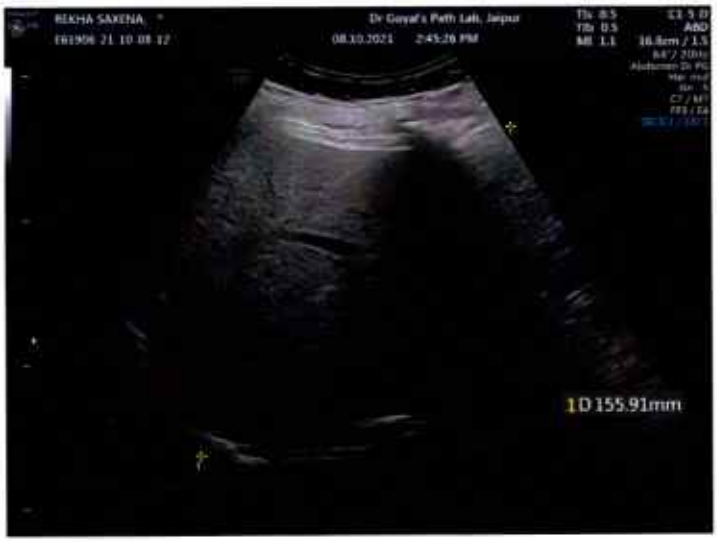
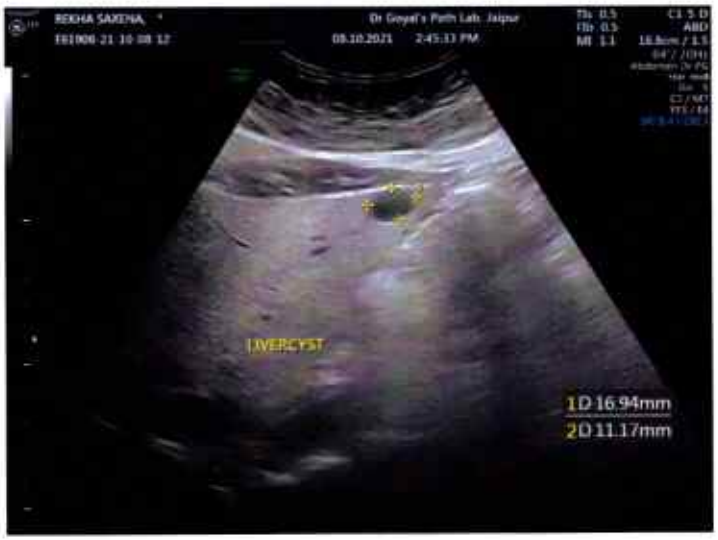
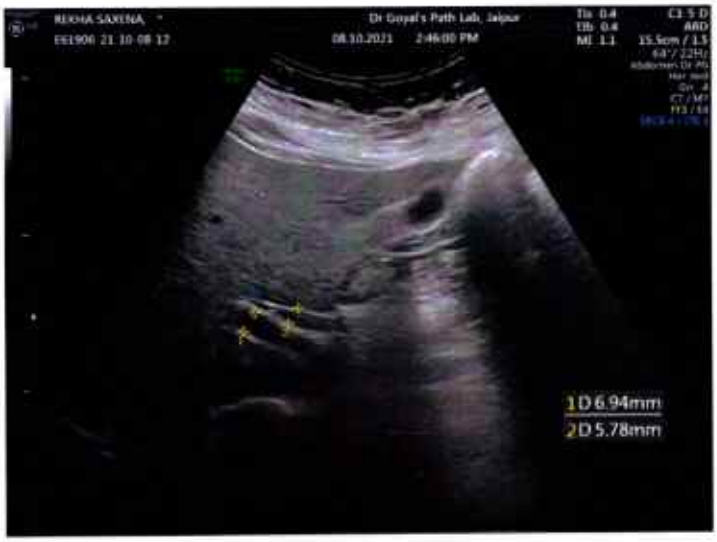
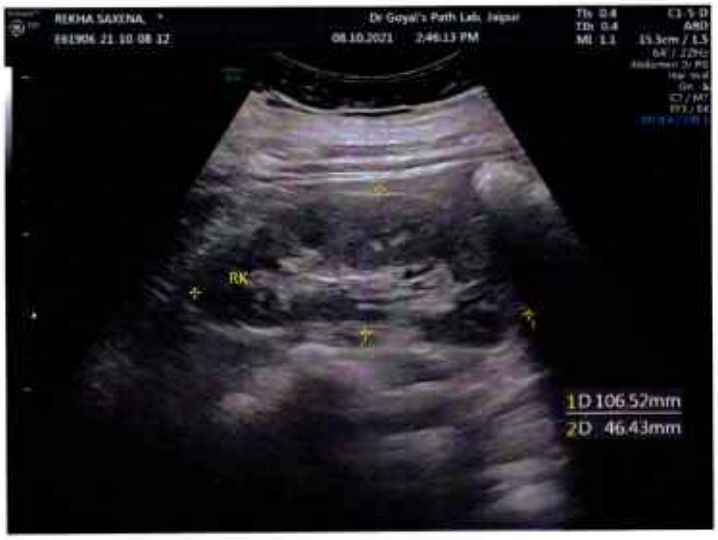
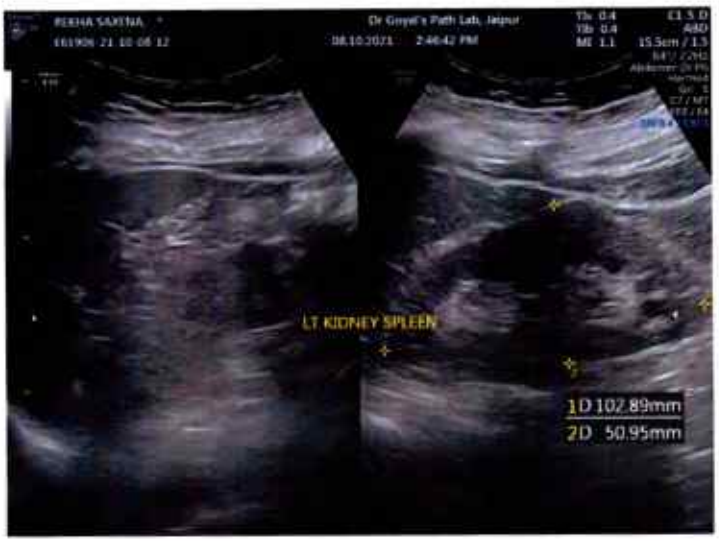
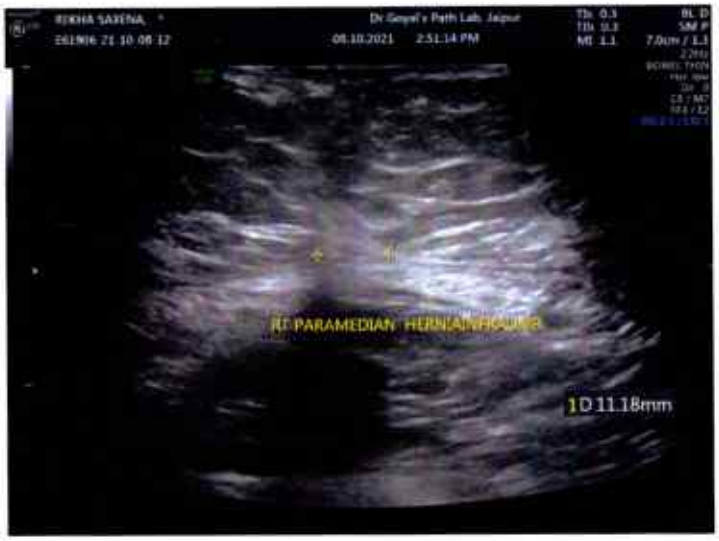

1D 155.91mm

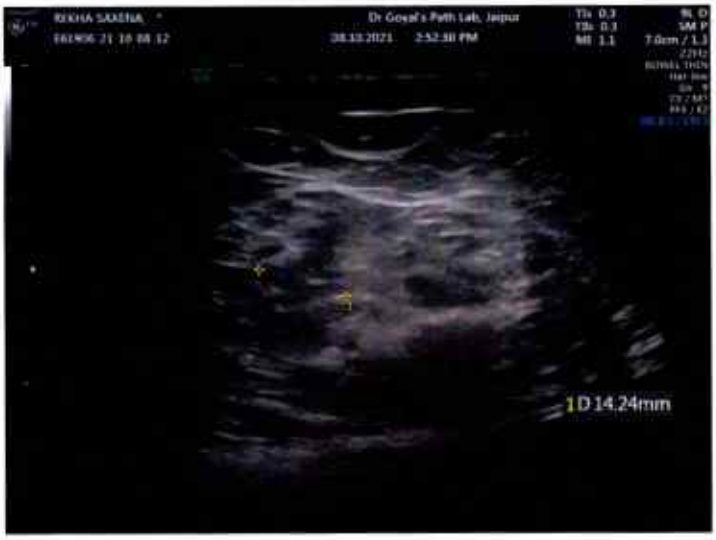

LIVER CYST
1D 16.94mm
2D 11.17mm

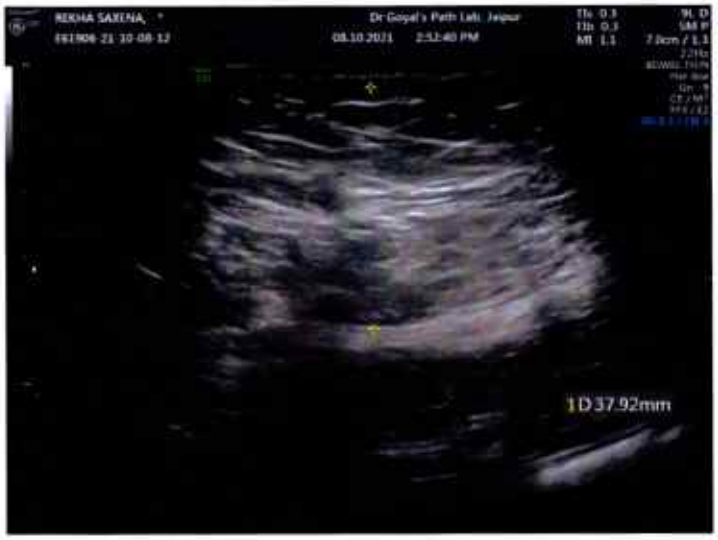

1D 6.94mm
2D 5.78mm

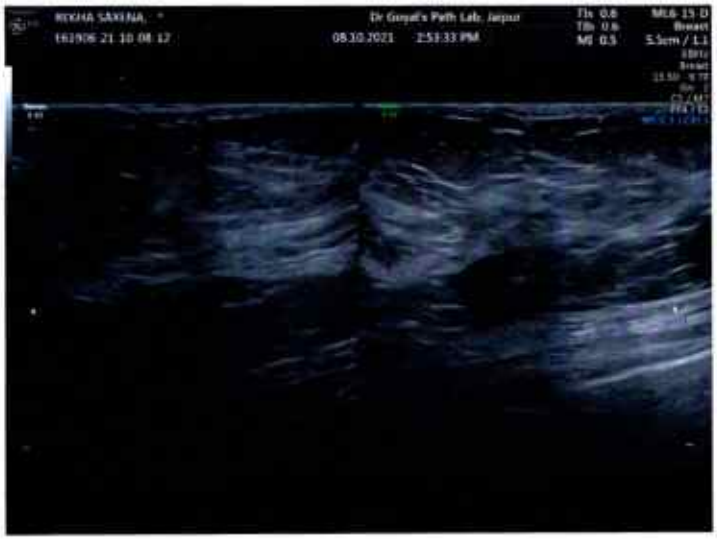

RK
1D 106.52mm
2D 46.43mm

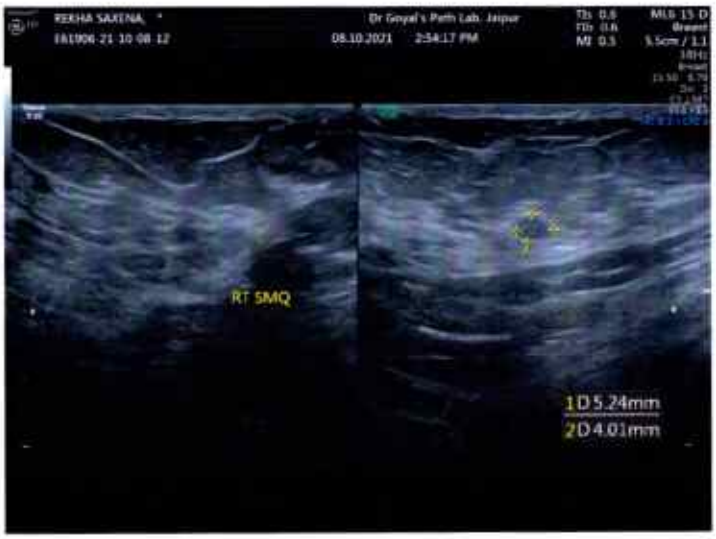

LT KIDNEY SPLEEN
1D 102.89mm
2D 50.95mm

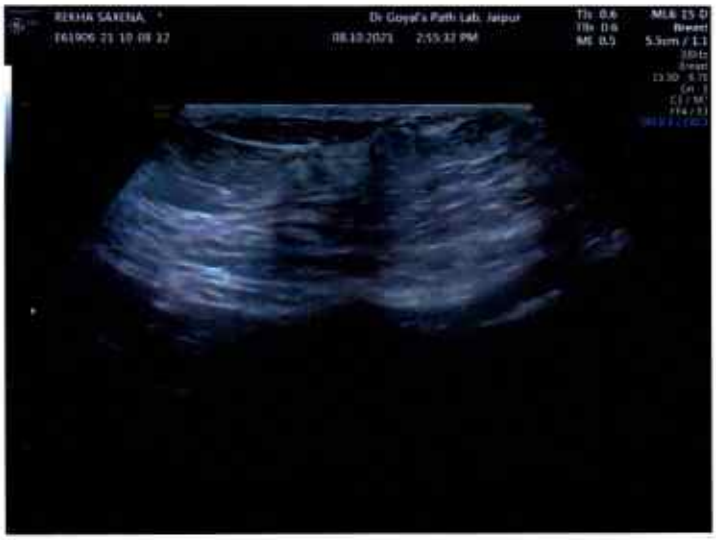

1D 11.18mm

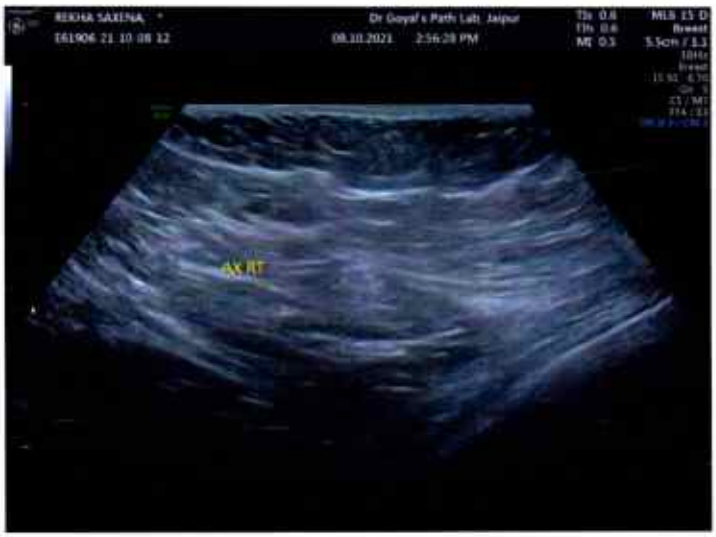

1D 14.24mm

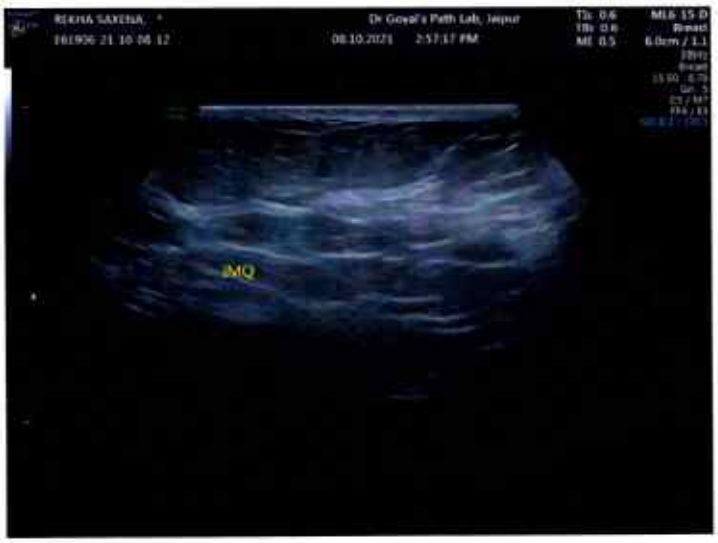

1D 37.92mm




RT SMG
1D 5.24mm
2D 4.01mm




AX RT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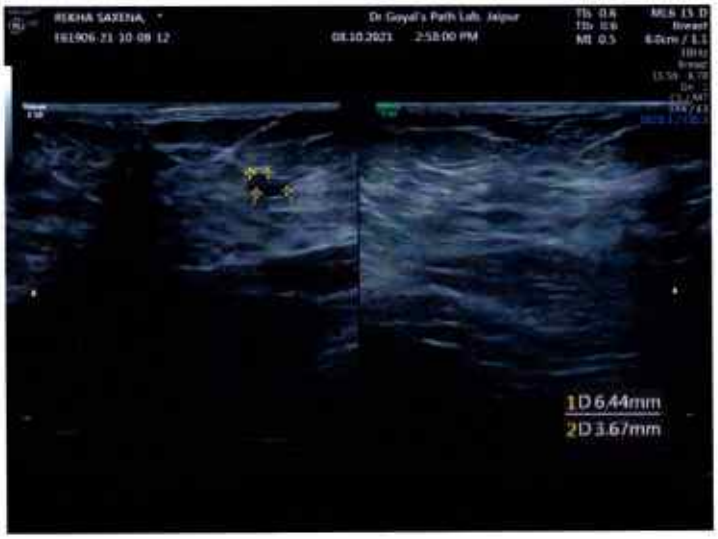
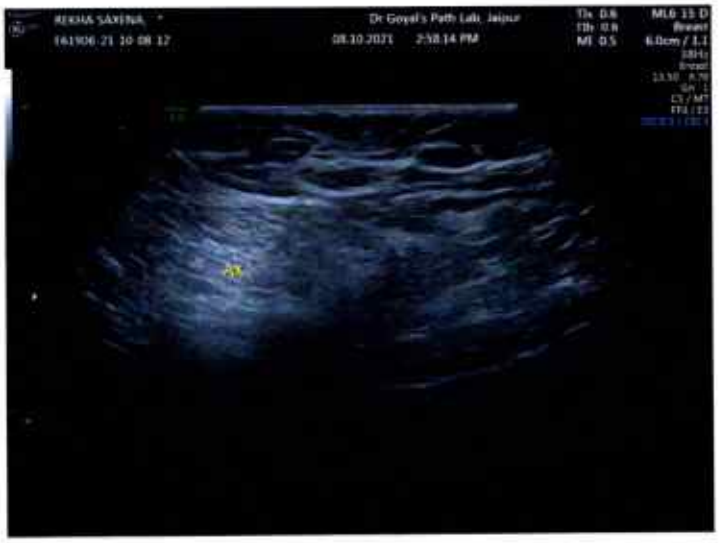

1D 6.44mm
2D 3.67mm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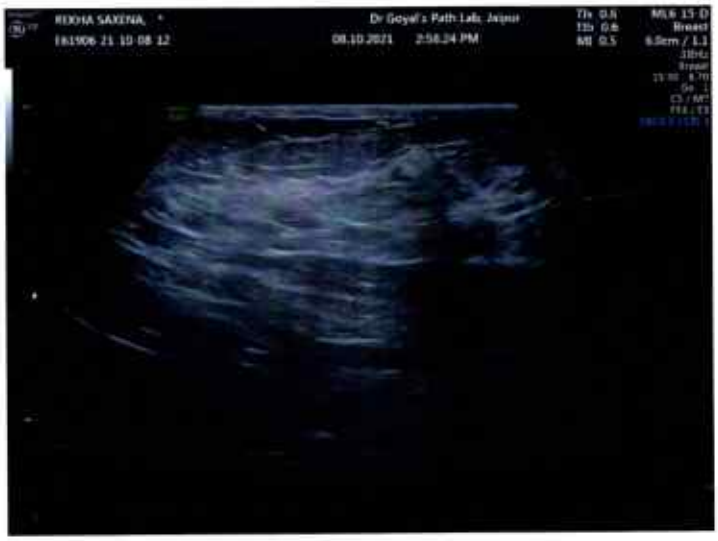

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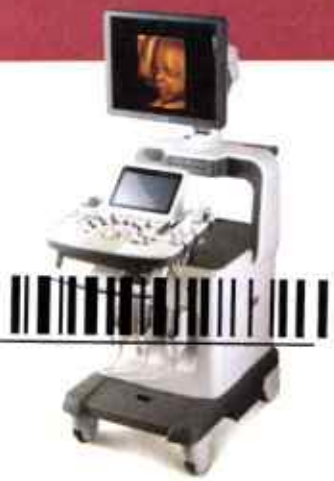

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NAME :- Mrs. REKHA SAXENA Ref. By Dr:- BOB

Sex / Age :- Female 57 Yrs Lab/Hosp :-

Company :- MediWheel

Sample Type :- Sample Collected Time Final Authentication : 08/10/2021 14:42:39

BOB PACKAGEFEMALE > 50

ECHOCARDIOGRAPHY 2D (ADULT/CHILD)

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

_FAIR TRANSTHORACIC ECHOCARIDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMITATION:

AO	35	mm	LA	37	Mm	IVS-D	9	mm
IVS-S	11	mm	LVID	41	Mm	LVSD	28	mm
LVPW-D	9	mm	LVPW-S	12	Mm	RV		mm
RVWT		mm	EDV		Ml	LVVS		ml
LVEF	60%			RWMA		ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

COLOUR DOPPLER:

MITRAL VALVE					
E VELOCITY	0.96	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY		m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION			ABSENT		

AORTIC VALVE					
PEAK VELOCITY	1.0	m/sec	PEAK GRADIENT		mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION			ABSENT		

TRICUSPID VALVE					
PEAK VELOCITY	0.69	m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY		m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION			MILD		

PULMONARY VALVE					
PEAK VELOCITY	0.82	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VALOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION			ABSENT		

PRATHVI1

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Dr. Aman Mamodia M.B.B.S, D.M.R.D., DNB. (Radio Diagnosis) RMC Reg No. 32618
Dr. Ankita Gupta M.D., D.N.B. (Radio-Diagnosis) RMC Reg No. 32838
Dr. Hitesh Kumar Sharma M.B.B.S., D.M.R.D. RMC Reg No. 27380
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Sample Type :-
Sample Collected Time
Final Authentication : 08/10/2021 14:42:39

Impression--

1. **Normal LV size & contractility**
2. **No RWMA, LVEF 60 %.**
3. **Normal cardiac chamber.**
4. **Normal valve,Mild TR-PASP 41mmHg.**
5. **No clot, no vegetation, no pericardial effusion.**

(Cardiologist)

*** End of Report ***

PRATHVI1

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Transcript by

Dr. Goyal's Path Lab

Name **REKHA SAXENA**
Patient Id **REKHA33_33314**

Date **10/08/2021**
Diagnosis Dr.