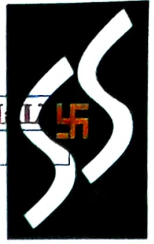


PATIENT NAME : MRS. USHA
REF. By : ANNAMALAIYAR LAB
AGE / SEX : 35 Yrs / FEMALE
DATE : 13.08.2024



BEST OF IMAGING

USG WHOLE ABDOMEN

LIVER : Normal in size with **increased** echotexture. No evidence of intra / extrahepatic biliary tree dilatation noted. Portal and hepatic veins appear normal .

GALL BLADDER : Adequately distended. No evidence of abnormal wall thickening noted

SPLEEN : Appears normal in size, with no focal parenchymal lesions identified.

PANCREAS: Appears normal.

KIDNEYS: Right kidney measures ~ 10.1 x 5.2 cm Left kidney measures ~ 10.2 x 5.0 cm.

	RIGHT KIDNEY	LEFT KIDNEY
Upper calyx	1 Cal - 5 mm	
Middle calyx		1 Cal - 4 mm
Lower calyx	2 Cal - 4 mm Each	

Parenchymal thickness and echopattern appears normal on both sides. Cortico medullary differentiation maintained. Both ureterovesicular junction appear normal.

URINARY BLADDER: Appears normal.

UTERUS : Anteverted and measures 12.8 x 5.0 cm Endometrium-8mm.

Both anterior & posterior myometrium appear thickened.

Mild Free fluid noted in POD .

OVARIES: Right ovary measures 2.5 x 1.7 cm , Left ovary measures 2.4 x 1.6 cm

Both ovaries appear normal in size . Bilateral adnexae appear normal.

PERITONEAL CAVITY : Visualized bowel loops appear normal . No definite lymphadenopathy noted .

IMPRESSION :

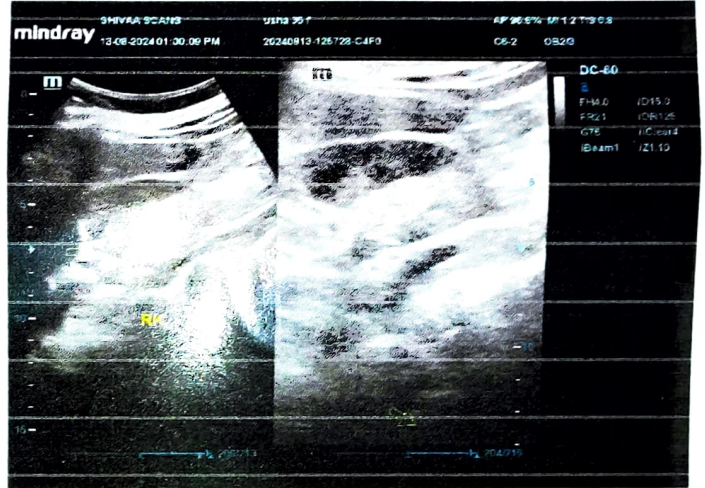
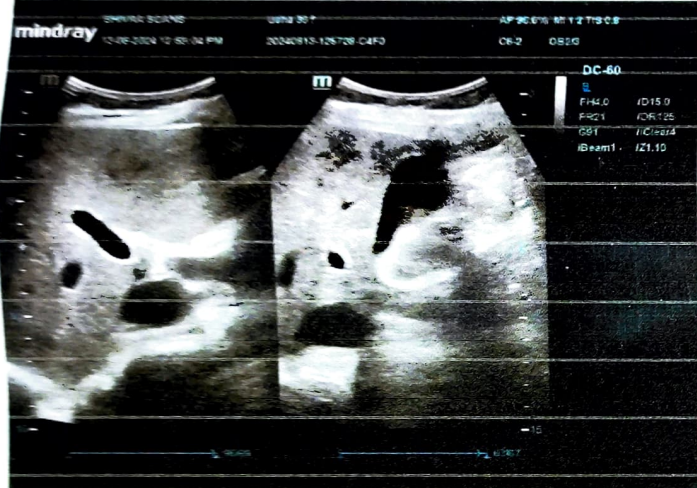
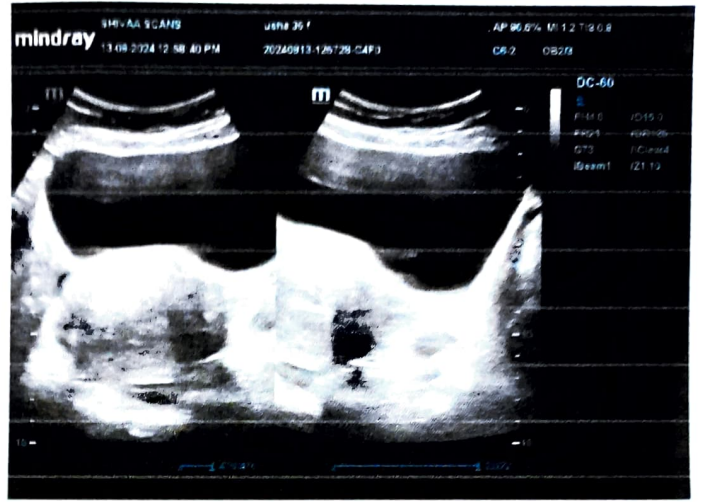
- **Fatty Infiltration Of Liver.**
 - **Bilateral Renal Calculus.**
 - **Mild Free Fluid Noted In Pod .**
 - **Bulky Uterus.**
- Suggested clinical correlation & further evaluation.*



S.V.K

DR.VENKATESWARAN MBBS MD (A2)
MCI REG NO : 37001

NOTE: Impression is professional opinion, not a final diagnosis. This examination has its own limitations. This has to be correlated clinically with other tests. If there is a variance clinically examination may be repeated or reevaluated by other investigation .This report is not for medicolegal purpose



Patient Name:	MRS.USHA	Age/sex	35 Y/F
ID No:	CARDI: SN		
Referred by:	ANNAMALAIYAR LAB	Date:	13.08.2024

CARDIAC REPORT

2D MEASUREMENT:

PARA STERNAL LONG AXIS VIEW:

Left Ventricle : 46 mm
Left Atrium : 30 mm
Aorta : 25 mm

M-MODE MEASUREMENT:

IVS thickness(d) : 11 mm
LVD : 46 mm
LVS : 29 mm
LVPW(d) : 11 mm
Ejection Fraction (EF %) : 67 %

DOPPLER:

AO FLOW : 1.32 m/s.
PV FLOW : 0.97 m/s.

MITRAL VALVE:

E velocity : 0.90 m/s.
A velocity : 0.65 m/s.



INTERPRETATION:

CHAMBERS:

Right atrium, right ventricle, left atrium & left ventricle are normal.

No regional wall motion abnormality.

IAS / IVS Intact; No PDA.

VALVES:

Mitral valve – Trivial MR; No MS

Aortic valve- No AS / AR

Tricuspid valve – Trivial TR; TRPG 26 mmHg

Pulmonary valve appears normal

IMPRESSION:

NO REGIONAL WALL MOTION ABNORMALITY.

NORMAL LV SYSTOLIC FUNCTION (EF- 67 %).

NO LVDD.

GRADE I MVP; TRIVIAL MR

TRIVIAL TR

NORMAL CHAMBER DIMENSIONS

NORMAL RV FUNCTION (TAPSE –21 mm)

NO PULMONARY HYPERTENSION.

NO PERICARDIAL EFFUSION.

NO CLOT.

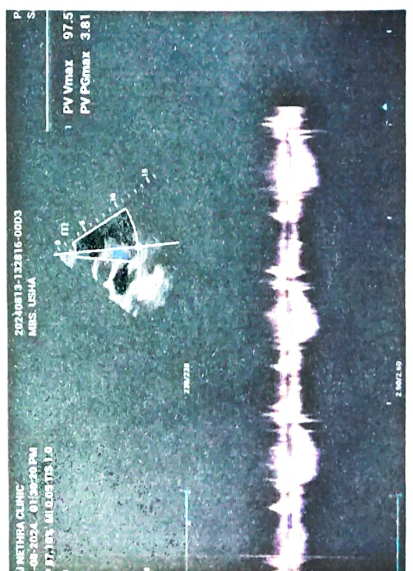
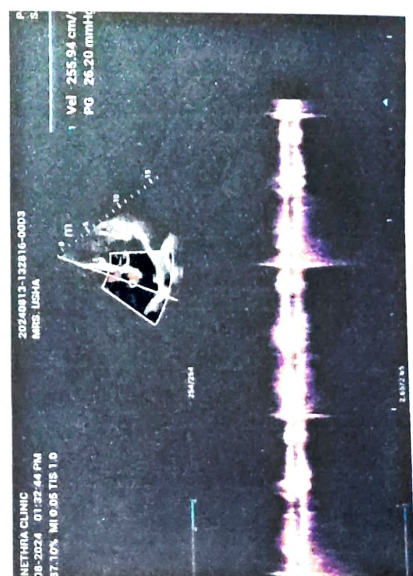
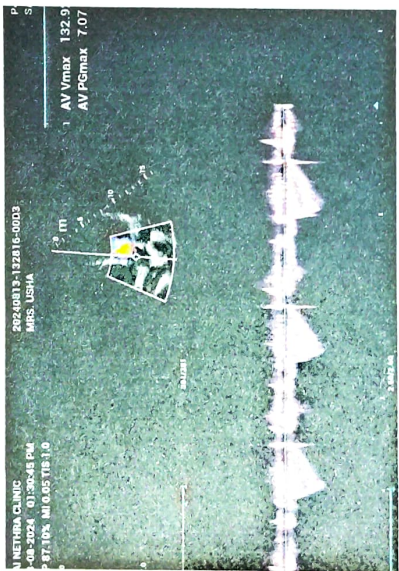
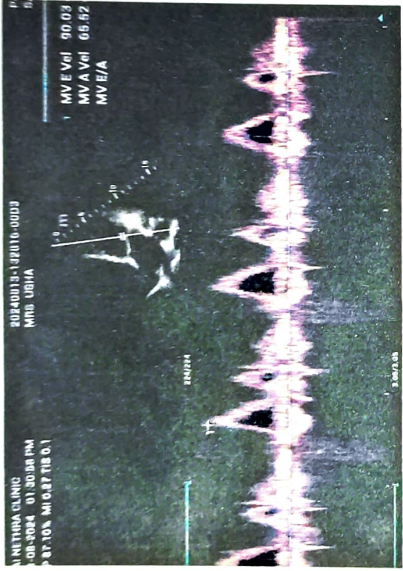
PS: To correlate clinically.

DR.S. RAJESH. M.D., D.M (CARDIOLOGY),

CONSULTANT CARDIOLOGIST.

REG.NO: 92932





ANNAMALAIYAR MEDICAL FOUNDATION

79/105, Big Street, Tiruvannamalai-1

M.S. Srinivasan



1047 MRS.USHA

35 Yrs/F 78 Kg / Ht-162 cms Ref. No.:

Date: 13/08/2024 Time: 11:41 AM

Ref. By:

Tech.:

Hr: 73

P Axis: 60

QRS Int.: 118

QRS Axis: 56

P Int: 102

QT Int.: 382

PR Int: 160

QTc Int.: 421

T Axis: 47

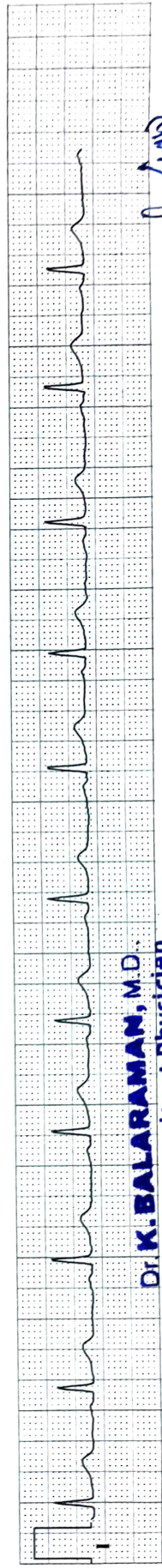
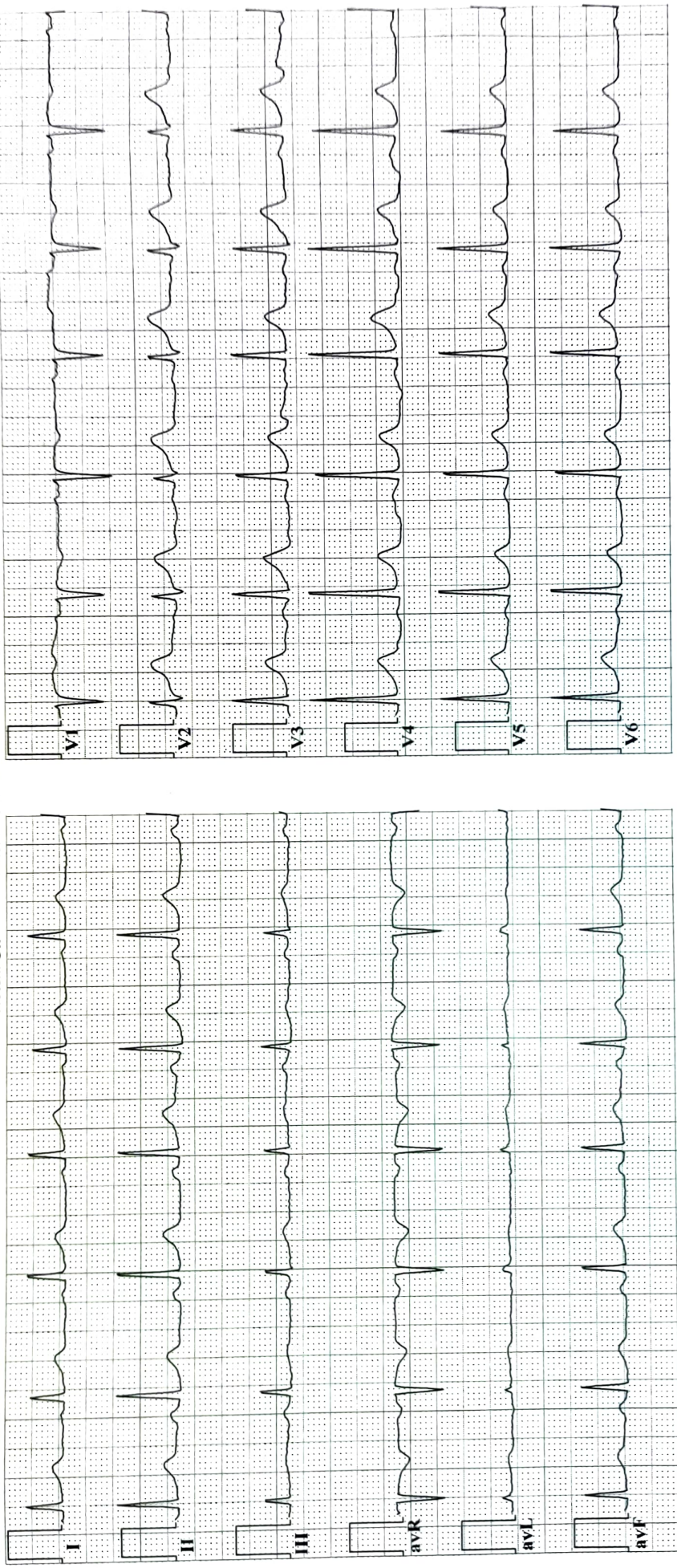
Gain: 10 mm/mV

Sweep: 25 mm/S

BP: -/- mmHg

Filter: 0.1 - 35 Hz

Notch: On



Dr. K. BALARAMAN, M.D.

Comments: Sinus Rhythm **Semior Consultant Physician**

Right bundle branch **Reg. NO: 23334**

May be high lateral Myocardial Infarction

Impression: **Abnormal ECG**

buffer for normal limits

Dr. K. Balaraman
13/8/24

Lab ID No : 2408-00021580

Collection Date : 13-08-24 09:11 am

Pt's Name : Mrs.USHA

Received Date : 13-08-24 09:14 am

Age & Sex : 35 / FEMALE

Report Date : 22-08-24 01:04 pm

Ref. by Dr. : M/ S.MEDI WHEEL

Report Status : Final Report

021580

Sample	Investigation	Result	Units	Normal Range & Methods
HAEMATOLOGY REPORT				
Blood	Grouping	O		
Blood	Rh typing	POSITIVE		

Lab ID No : 2408-00021580

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021580

Sample	Investigation	Result	Units	Normal Range & Methods
BIOCHEMISTRY REPORT				
Blood	Sugar (F)	102	mg/dl	70 - 110
Blood	Sugar (PP)	178	mg/dl	Upto 140
HORMONAL ASSAY				
Serum	THYROID STIMULATING HORMONE (TSH)	2.12	uIU/ml	Adults : 0.270 - 5.350 NewBorn 30days: 0.52 - 16.0 1 - 5 Years : 0.46 - 8.1 6 - 15 Years : 0.37 - 5.8
LIPID PROFILE				
Serum	Total Cholesterol (F)	142	mg/dl	Normal Upto: 200 Borderline : 201 - 239 Elevated if >240 on repeated values
Serum	Triglycerides (F)	103	mg/dl	< 120 Values Variable Depending On Diet, Alcohol, Metabolic state, Exercise etc..
Serum	HDL	42	mg/dl	Normal : > 50
Serum	LDL	79.4	mg/dl	Normal : < 100 Borderline: 100 - 160 High Risk : > 160
Serum	VLDL	20.6	mg/dl	Normal : < 30
	CHO/HDL Ratio	3.4		Normal : < 4.0 Low Risk : 4 - 6 High Risk: >6
	LDL/HDL Ratio	1.9		0.5 - 3.0
Serum	Non HDL Cholesterol	100.0	mg/dl	130 - 160

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021580

Sample	Investigation	Result	Units	Normal Range & Methods
HBA1c Analysis				
Blood	HbA1c	7.9	%	<= 5.7 :Normoglycemia 5.7 - 6.4 :IFG/IGT => 6.5 :Diabetes
Blood	Estimation of Mean blood Glucose	180.03	mgs /dl	068 - 125 Excellent Control 128 - 154 Good Control 157 - 183 Average Control 186 - 240 Action Suggested > 241 Panic Value

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021580

Sample	Investigation	Result	Units	Normal Range & Methods
CLINICAL PATHOLOGY REPORT				
Urine	Sugar (F)	Nil (Blue)		NIL
Urine	Sugar (PP)	Nil (Blue)		NIL
Urine Analysis				
Urine	Colour & Transparency	Pale yellow & Slightly turbid		
Urine	Reaction	Acidic		Acidic
Urine	Specific Gravity	1.012		
URINE BIO-CHEMISTRY ANALYSIS				
Urine	Albumin	Nil		NIL
Urine	Sugar (F)	Nil (Blue)		NIL
Urine	Sugar (PP)	Nil (Blue)		NIL
Urine	Bile Salt	Absent		Absent
Urine	Bile Pigment	Negative		Negative
Deposits (Microscopic Examination)				
Urine	Pus cells	02 - 04 /hpf		
Urine	Epithelial Cells	03 - 05 /hpf		
Urine	RBC	01 - 02 /Hpf		
Urine	Crystals	Nil /Hpf		
Urine	Cast	Nil /Hpf		

End of Report