

Patient Name: SAKSHI	RADIOGRAPH CHEST PA DATE: 20-08-2024
Date of Birth/ Age: 32YRS	
Gender: FEMALE	
Referred By: SELF	

prominent pulmonary vessels noted.

Cardiac silhouette is normal in size.

Bilateral lung fields are grossly unremarkable.

Bilateral costophrenic angles and bilateral domes of the diaphragm are normal.

Bony cage & soft tissues are grossly normal

ADVICE :- CLINICAL CORRELATION



DR. ANANT SHARMA

CONS. RADIOLOGIST

ID: 136 [E] CARPULSE PDBBT

SAKSHI

20/08/2024 11:23:18

AGE: 32 Y M D

FEMALE

HEALIC MULTISPECIALITY CLINIC
INDRAPURAM

Cns K9

RATE: 66 bpm

SINUS RHYTHM

P-R: 906 ms

INDETERMINATE AXIS

QRS: 96 ms

POSSIBLE RIGHT VENTRICULAR HYPERTROPHY

QTc: 400 ms

WIDESPREAD ST-T ABNORMALITY IS PROBABLY DUE TO THE VENTRICULAR HYPERTROPHY

QT: 411 ms

-AXIS-

P: 50°

QRS: 00°

T: 21°

12 SL REPORT FORMAT: 3x4+11 SM

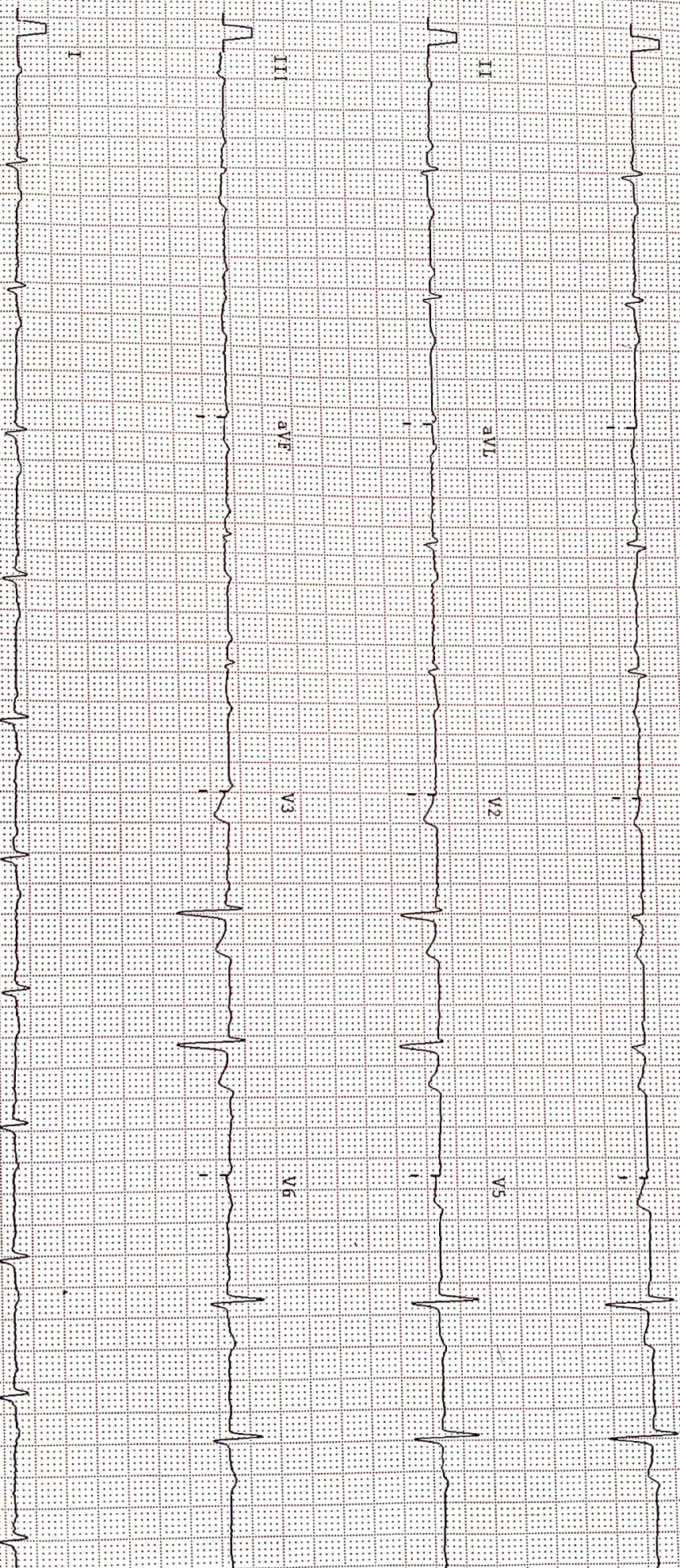
REF: SELF

Dr.

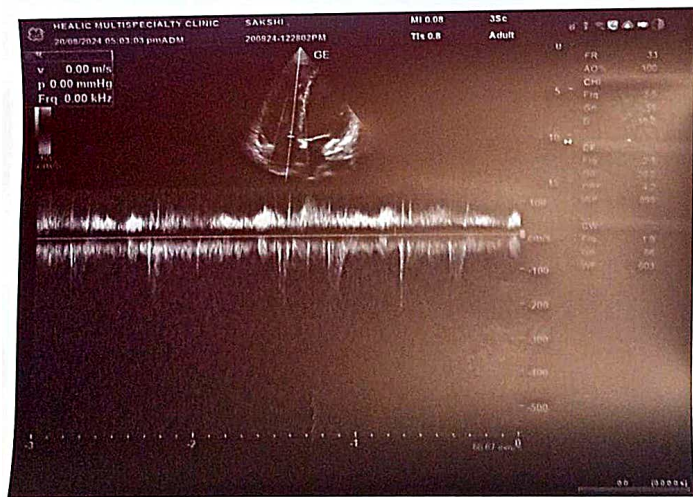
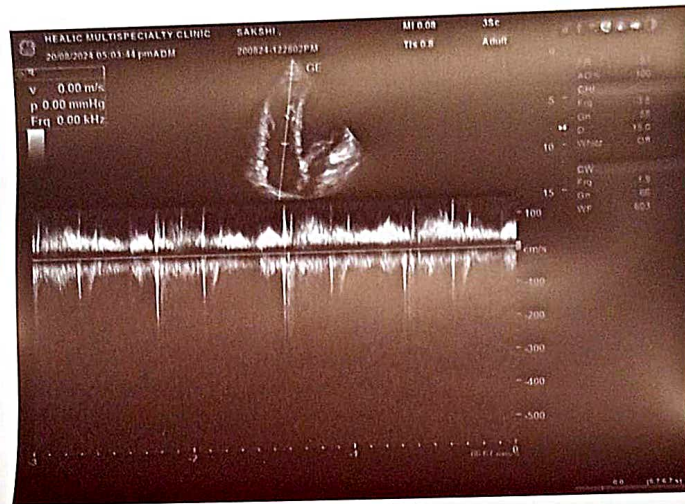
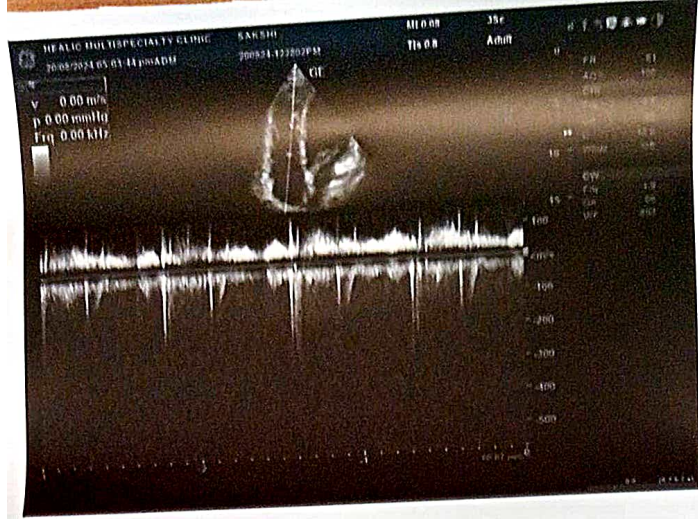
I aVR V1 V4

II aVL V2 V5

III aVF V3 V6



25mm/sec 5mm/mV Notch ON BLC ON 0.05-35 Hz ALLEGENS PISCES 10121 VER 1.11 CLINICALLY CORRELATE THE FINDINGS





Name : Sakshi
Date : 20.08.2024
Referred BY : Dr.
Echogenicity : Parasternal : Good

Age/Sex : 32Yrs/F
Lab No. :
Echo No. :
Apical : Good

ECHOCARDIOGRAPHY REPORT

DIMENSIONS

AO (ed)	27mm (1.5 cm/m ²)	IVS(ed)	10mm (0.6 – 1.2cm)
LA(es)	28mm (1.5cm/m ²)	LVPW(ed)	09mm (0.6 -1.2cm)
RVID (ed)	36mm (0.9cm/m ²)	LV Ejection fraction	60% (0.62- 0.85)
LVID (ed)	41mm (2.6 -3.4 cm/m ²)	% FD	33% (28% -42%)

MORPHOLOGICAL DATA:

Mitral valve: AML	: Normal	Interatrial Septum	: Normal
PML	: Normal	Interventricular Septum	: Normal
Aortic Valve	: Normal	Pulmonary artery	: Dilated
Tricuspid Valve	: Normal	Aorta	: Normal
Pulmonary Valve	: Normal	Right Atrium	: Dilated
Right Ventricle	: Dilated	Left Atrium	: Normal
Left Ventricle	: Normal		



2-D ECHOCARDIOGRAPHY AND COLOR DOPPLER FINDINGS:

Normal mitral valve. Normal aortic valve. Normal LV size. Good LV systolic function. No regional wall motion abnormality. LVEF=60%. Dilated Pulmonary artery. RV and RA are dilated with reduced with RV systolic function. No pericardial effusion. No LA/LV clot.

COLOR FLOW MAPPING:

Mild TR(PG-42MMHG)


DOPPLER STUDIES:

A/E of 0.8 on the mitral Doppler spectral trace.

Normal LV compliance.

IMPRESSION:

Dilated Pulmonary artery. RV and RA are dilated with reduced with RV systolic function. Mild TR(PG-42MMHG)CVP-8,PASP-50MMHG.Normal LV size with Good LV systolic function. No regional wall motion abnormality. LVEF=60%. Normal mitral valve. Normal aortic valve. No pericardial effusion. No LA/LV clot.


DR. BIRENDRA PAWAR
MD (MEDICINE), FIMSA, MIAE
SENIOR CONSULTANT
NON INVASIVE CARDIAC LAB.

THIS IS ONLY A PROFESSIONAL OPINION BASED ON INTERPRETATION OF VARIOUS IMAGES & NOT THE FINAL DIAGNOSIS. THE FINDINGS HAVE TO BE CORRELATED WITH CLINICAL AND OTHER INVESTIGATIONS. IN CASE OF ANY DISCREPANCY, PLEASE CONTACT THE LABORATORY IMMEDIATELY. REPORT/ OPINION ARE NOT VALID FOR MEDICO LEGAL PURPOSES.



Barcode No	: 220311	Registration	: 20/Aug/2024 01:47PM
Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 05:02PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
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COMPLETE BLOOD COUNT+ESR (CBC+ESR)

HAEMOGLOBIN (Hb) Colorimetric SLS	12	gm/dl	12.00-15.00
RED BLOOD CELLS- RBC COUNT Electrical Impedance	4.4	10 ⁶ /uL	4.50-5.50
PACKED CELL VOLUME (PCV) -HEMATOCRIT Calculated	38.4	%	36 - 46
MCV Calculated	88.2	fL	83-101
MCH Calculated	27.5	pg	27-32
MCHC Calculated	31.2	g/dl	32-36
RED CELL DISTRIBUTION WIDTH (RDW-CV) Whole blood EDTA,Flow Cytometry	17.5	%	11.5-14.5
RED CELL DISTRIBUTION WIDTH (RDW - SD) Whole Blood EDTA,Calculated	52	fl	39.0-46.0
PLATELET COUNT Electrical Impedance	395	10 ³ /uL	150-410
PLATELET DISTRIBUTION WIDTH (PDW) Whole Blood EDTA,Calculated	15.9	fL	9.00-17.00
PCT(PLATELETCRIT) Whole blood EDTA,Flow Cytometry	0.34	%	0.108-0.282
MEAN PLATELET VOLUME - MPV Calculated	8.6	fL	7.00-12.00
P-LCR	15.3		
P-LCC Calculated	60.00	%	30.0-90.0
TOTAL LEUKOCYTE COUNT (TLC) Laser - Based Flow Cytometry / Microscopy	6.24	10 ³ /uL	4.0-10.0
DIFFERENTIAL LEUKOCYTE COUNT			
Neutrophils Laser - Based Flow Cytometry / Microscopy	54.6	%	40-80



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HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
Lymphocytes Laser - Based Flow Cytometry / Microscopy	33.9	%	20-40
Eosinophils Laser - Based Flow Cytometry / Microscopy	4.0	%	1-6
Monocytes Laser - Based Flow Cytometry / Microscopy	7.0	%	2-10
Basophils Whole blood EDTA,Flow Cytometry	0.5	%	0.00-1.00
ABSOLUTE NEUTROPHIL COUNT Whole Blood EDTA,Calculated	3.41	10 ³ /μL	2.00-7.00
ABSOLUTE LYMPHOCYTE COUNT Calculated	2.12	10 ³ /μL	1.00-3.00
ABSOLUTE EOSINOPHIL COUNT Calculated	0.25	10 ³ /μL	0.02-0.50
ABSOLUTE MONOCYTE COUNT Calculated	0.44	10 ³ /μL	0.20-1.00
ABSOLUTE BASOPHIL COUNT Calculated	0.03	10 ³ /μL	0.02-0.10
ESR [WESTERGREIN] Sedimentation	10.00	mm/1st	0-15

INTERPRETATION:

A complete blood count (CBC), also known as a full blood count (FBC), is a set of medical laboratory tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells and platelets, the concentration of hemoglobin, and the hematocrit (the volume percentage of red blood cells). The red blood cell indices, which indicate the average size and hemoglobin content of red blood cells, are also reported, and a white blood cell differential, which counts the different types of white blood cells, may be included. The CBC is often carried out as part of a medical assessment and can be used to monitor health or diagnose diseases. The results are interpreted by comparing them to reference ranges, which vary with sex and age. Conditions like anemia and thrombocytopenia are defined by abnormal complete blood count results. The red blood cell indices can provide information about the cause of a person's anemia such as iron deficiency and vitamin B12 deficiency, and the results of the white blood cell differential can help to diagnose viral, bacterial and parasitic infections and blood disorders like leukemia. Not all results falling outside of the reference range require medical intervention.



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Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 05:04PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
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BLOOD GROUP ABO & RH

ABO Gel Columns agglutination	'B'
Rh Typing Gel agglutination	POSITIVE

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.



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Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 06:08PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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LIVER FUNCTION TEST

TOTAL BILIRUBIN	0.86	mg/dL	0.10 - 1.2
Diazo			
CONJUGATED (D. Bilirubin)	0.24	mg/dL	0.0 - 0.30
Diazo			
UNCONJUGATED (I.D. Bilirubin)	0.62	mg/dl	0.0 - 1.0
Calculated			
S.G.P.T	29	U/L	0-35
UV without P5P			
SGOT	24	U/L	0-40
UV without P5P			
ALKALINE PHOSPHATASE	87.20	U/L	42 - 98
AMP			
TOTAL PROTEINS	7.3	g/dL	6.4 - 8.3
Biuret			
ALBUMIN	4.4	g/dL	3.5 - 5.2
Bromocresol Green			
GLOBULIN	2.86	g/dL	2.30-4.50
Calculated			
A/ G RATIO	1.54		1.0-2.3
Calculated			

INTERPRETATION

Bilirubin Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice).
 Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis; drug reactions, alcoholic liver disease conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts.
 Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.
 AST levels increase in viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart attack or strenuous activity.
 ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.
 GGT may be higher with diabetes, heart failure, hyperthyroidism, or pancreatitis. Higher GGT levels also may mean liver damage from heavy, chronic alcohol abuse. GGT levels that are higher than normal may also signal a viral infection
 Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, paget's disease, Rickets, Sarcoidosis etc. Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc.
 Serum total protein, in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation



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Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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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,



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BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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LIPID PROFILE

TOTAL CHOLESTEROL Cholesterol Oxidase,PAP	169.5	mg/dl	<200 Desirable~200 – 239 Borderline >240 High Risk
TRIGLYCERIDES GPO-TRINDER	134.7	mg/dL	Normal : <161~High : 161 - 199~Hyper Triglyceridemic : 200 - 499~Very High : >499
H D L CHOLESTEROL Direct Enzymatic Colorimetric	46	mg/dl	>40 Recommended Range
L D L CHOLESTEROL Calculated	96.56	mg/dl	70-130
VLDL Spectrophotometry/Calculated	26.94	mg/dl	0.00-45.0
T. CHOLESTEROL/ HDL RATIO Calculated	3.68	Ratio	3.40-4.40
LDL/ HDL RATIO Calculated	2.1	Ratio	1.0-3.5

COMMENT :-

(#). A lipid panel measures five different types of lipids from a blood sample, including:

- (1). Total cholesterol: This is your overall cholesterol level — the combination of LDL-C, VLDL-C and HDL-C.
- (2). Low-density lipoprotein (LDL) cholesterol: This is the type of cholesterol that's known as "bad cholesterol." It can collect in your blood vessels and increase your risk of cardiovascular disease.
- (3). Very low-density lipoprotein (VLDL) cholesterol: This is a type of cholesterol that's usually present in very low amounts when the blood sample is a fasting samples since it's mostly comes from food you've recently eaten. An increase in this type of cholesterol in a fasting sample may be a sign of abnormal lipid metabolism.
- (4). High-density lipoprotein (HDL) cholesterol: This is the type of cholesterol that's known as "good cholesterol." It helps decrease the buildup of LDL in your blood vessels.
- (5). Triglycerides: This is a type of fat from the food we eat. Excess amounts of triglycerides in your blood are associated with cardiovascular disease and pancreatic inflammation.



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Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: Serum		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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HBA1C

HBA1c HPLC	5.9	%	
ESTIMATED AVG. GLUCOSE	122.63	mg/dl	

Ref Range for HBA1c

Non-Diabetic :- 4.0 – 5.6

Increased Risk:- 5.7 – 6.4

In Diabetics:

Excellent Control: 6.5 – 7.0

Fair To Good Control: 7.0 – 8.0

Unsatisfactory Control:- 8.0 – 10

Poor Control: >10

COMMENT:

The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months.

This test is used to monitor treatment in someone who has been diagnosed with diabetes.

It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes.

Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year.

The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year.

When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.

Note: If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low.

If someone is iron-deficient, the HbA1c level may be increased.

If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months.



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Sample Type	: Serum		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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PLASMA GLUCOSE - PP

Plasma Glucose PP Glucose Oxidase/Peroxidase	96.3	mg/dL	80-140
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INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders



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Sample Type	: Serum		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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GGT

GGT IFCC	36	U/L	12.0-58.0
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INTERPRETATION:

GGT functions in the body as a transport molecule, helping to move other molecules around the body. It plays a significant role in helping the liver metabolize drugs and other toxins. Increased GGT include overuse of alcohol, chronic viral hepatitis, lack of blood flow to the liver, liver tumor, cirrhosis, or scarred liver, overuse of certain drugs or other toxins, heart failure, diabetes, pancreatitis, fatty liver disease.



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Ref Doctor	: Dr.SELF	Client Code	: UP528
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Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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KIDNEY FUNCTION TEST

SERUM UREA Serum,Urease GLDH	39.50	mg/dL	19.0 - 45.0
SERUM CREATININE Enzymatic	0.82	mg/dL	0.7-1.30
SERUM URIC ACID Serum,Uricase	4.4	mg/dl	2.6 - 6.0
SERUM SODIUM ISE, Direct	139.26	mmol/L	135-150
SERUM POTASSIUM ISE, Direct	4.18	mmol/L	3.5-5.5
SERUM CHLORIDE ISE, Direct	101.4	mmol/L	94-110
Blood Urea Nitrogen (BUN) Calculated	18.46	mg/dl	8.00-23.0
UREA / CREATININE RATIO	48.17		
SERUM TOTAL CALCIUM BAPTA	8.59	mg/dl	8.4-10.6

INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20.

To Differentiate between pre- and postrenal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

- 1.Prenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.
- 2.Catabolic states with increased tissue breakdown.
- 3.GI hemorrhage.
- 4.High protein intake.
- 5.Impaired renal function plus .
- 6.Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high



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Sample Type	: SERUM		

BIOCHEMISTRY

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protein diet, burns,surgery, cachexia, high fever).

- 7.Urine reabsorption (e.g. ureterocolostomy)
- 8.Reduced muscle mass (subnormal creatinine production)
- 9.Certain drugs (e.g. tetracycline, glucocorticoids)

INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

- 1.Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
- 2.Prerenal azotemia superimposed on renal disease.

DECREASED RATIO (<10:1) WITH DECREASED BUN :

- 1.Acute tubular necrosis.
- 2.Low protein diet and starvation.
- 3.Severe liver disease.
- 4.Other causes of decreased urea synthesis.
- 5.Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- 6.Inherited hyperammonemias (urea is virtually absent in blood).
- 7.SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- 8.Pregnancy.

DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

- 1.Phenacimide therapy (accelerates conversion of creatine to creatinine).
- 2.Rhabdomyolysis (releases muscle creatinine).
- 3.Muscular patients who develop renal failure.

INAPPROPRIATE RATIO:

- 1.Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- 2.Cephalosporin therapy (interferes with creatinine measurement).



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Barcode No	: 220300	Registration	: 20/Aug/2024 01:47PM
Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 06:09PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: Urine		

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range
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URINE SUGAR - PP

Result	NILL	Nil
Benedicts test		

INTERPRETATION:

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.



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Barcode No	: 220300	Registration	: 20/Aug/2024 01:47PM
Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 06:17PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: URINE		

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range
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URINE ROUTINE EXAMINATION

PHYSICAL EXAMINATION

QUANTITY visual	30 ML	ml	0-50
COLOUR visual	PALE YELLOW		PALE YELLOW
TRANSPARENCY visual	SLIGHTLY TURBID		Clear
SPECIFIC GRAVITY ION exchange	1.020		1.010 - 1.030

CHEMICAL EXAMINATION

pH Double Indicator	6.5		5-7
PROTEIN Protein - error of Indicators	NEGATIVE	g/dL	
GLUCOSE GOD-POD	NEGATIVE	mg/dl	
UROBILINOGEN Ehrlichs Reaction	NIL		Nil
KETONE BODIES Legals Nitroprasside	NEGATIVE		NEGATIVE
BILIRUBIN Azo-coupling Reaction	NIL		Nil
BLOOD Pseudo-peroxidase	NIL		Nil
NITRITE Diazotization Reaction	NIL		Nil

MICROSCOPIC EXAMINATION

PUS CELLS Microscopy	4-6	cells/HPF	0-5
RBCs Microscopy	NIL	Cells/HPF	Nil



N Kumar
DR. NITIN KUMAR
 MD PATHOLOGIST
 DMC NO:-30700

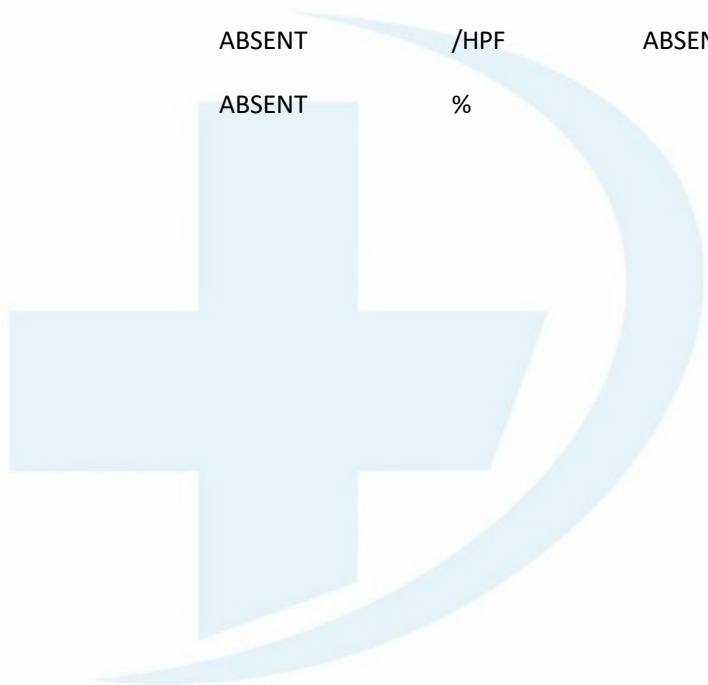
Jehani
JEHAN NIZAMI
 IBBS MD
 Consultant Pathologist



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Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: URINE		

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range
EPITHELIAL CELLS Microscopy	2-4	Cells/HPF	0 - 5
CRYSTALS Microscopy	ABSENT	ABSENT	ABSENT
CASTS Microscopy	ABSENT	/HPF	ABSENT
OTHER	ABSENT	%	



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Barcode No	: 220310	Registration	: 20/Aug/2024 01:47PM
Patient Name	: MRS. SAKSHI	Received	: 20/Aug/2024 04:41PM
Age/Gender	: 32 Y 0 M 0 D /F	Reported	: 20/Aug/2024 06:09PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

HORMONE ASSAYS

Test Description	Observed Value	Unit	Reference Range
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THYROID PROFILE (T3,T4,TSH)

TRIODOXYRONE TOTAL (T3) CLIA	1.21	ng/mL	0.8 - 1.9
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Summary & Interpretation:-

Triiodothyronine (T3) is the hormone principally responsible for the development of the effects of the thyroid hormones on the various target organs. T3 is mainly formed extrathyroidally, particularly in the liver, by deiodination of T4. A reduction in the conversion of T4 to T3 results in a fall in the T3 concentration. It occurs under the influence of medicaments such as propranolol, glucocorticoids or amiodarone and in severe non-thyroidal illness (NTI). The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism, the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

THYROXINE TOTAL (T4) CLIA	9.5	ug/dL	5.0 - 13.0
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Summary & Interpretation:

The hormone thyroxine (T4) is the main product secreted by the thyroid gland. The major part of total thyroxine (T4) in serum is present in protein-bound form. As the concentration of the transport proteins in serum are subject to exogenous and endogenous effects, the status of the binding proteins must also be taken into account in the assessment of the thyroid hormone concentration in serum. The determination of T4 can be utilized for the following indications: the detection of hyperthyroidism, the detection of primary and secondary hypothyroidism and the monitoring of TSH-suppression therapy.

THYROID STIMULATING HORMONE (TSH) CLIA	2.519	μIU/mL	0.35 - 4.75
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Summary & Interpretation

TSH is formed in specific basophil cells of the anterior pituitary and is subject to a circadian secretion sequence. The determination of TSH serves as the initial test in thyroid diagnostics. Accordingly, TSH is a very sensitive and specific parameter for assessing thyroid function and is particularly suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid.

Note:

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm. The variation is of the order of 50%. Hence time of the day has influence on the measured serum TSH concentrations.
2. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.
3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
4. Clinical Use: Primary Hypothyroidism, Hyperthyroidism, Hypothalamic - Pituitary hypothyroidism, Inappropriate TSH secretion, Nonthyroidal illness, Autoimmune thyroid disease, Pregnancy associated thyroid disorders.

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL
1st Trimester	0.05 – 3.70
2nd Trimester	0.31 – 4.35
3rd Trimester	0.41 – 5.18

*** End Of Report ***



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CCCR (Harvard Medical School, USA)

A.D.H.A. Chennai

Ex-RO, Cardiology, AIHF, Delhi

Medical advisor to SICRI, New Delhi
Asthma, Diabetes, Thyroid, Skin, Kidney Stones, Cardiac,
Neurological, Rheumatoid Arthritis of all ages



Services

Pharmacy

Medicines, Personal Care, Nutraceuticals, Devices

Path Lab

Full Body Checkup (83 Parameters)

Ultrasound, X-Ray, ECG

GP Consult, Dental Checkup, Eye Test

Surgeries

Dental Procedure

Skin & Hair Procedure



GPS Map Camera

Top Doctors

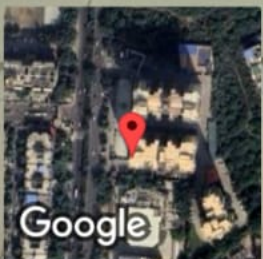
Ghaziabad, Uttar Pradesh, India

Tower-A, Saya Zenith, Indirapuram, Ghaziabad, Uttar Pradesh 201014, India

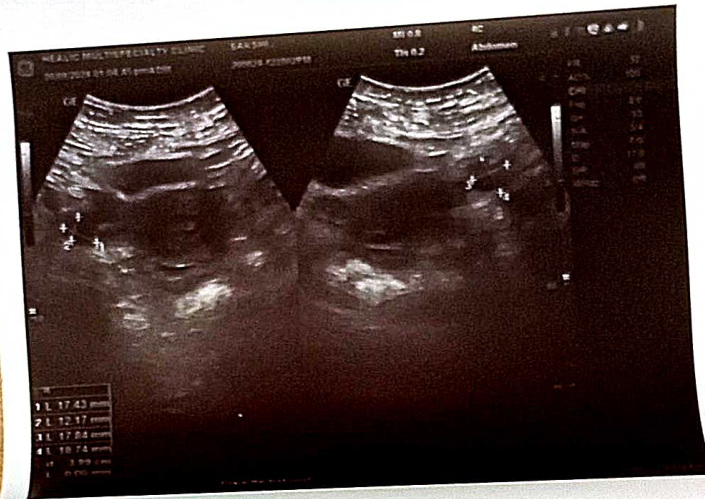
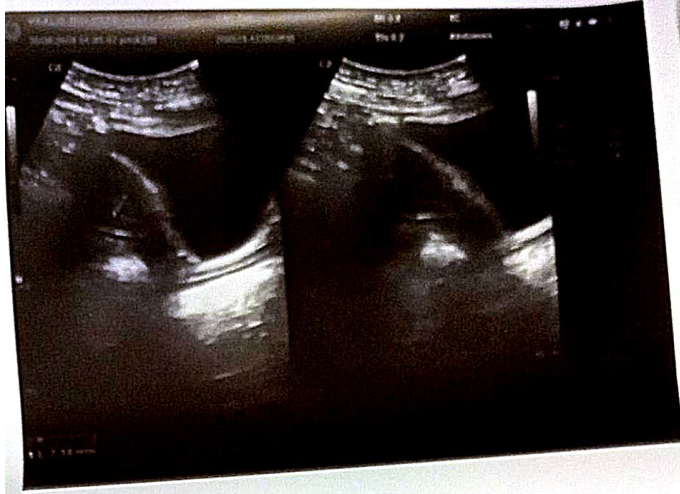
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Long 77.378932°

20/08/24 11:43 AM GMT +05:30



Google





NAME- SAKSHI	ULTRASOUND WHOLE ABDOMEN 20/08/2024
AGE- 32YRS	
GENDER - FEMALE	
REF.BY - SELF	

LIVER: It is normal in size and shows **generalized increase in echopattern**. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre.

GALL BLADDER: It appears echofree with normal wall thickness. Common bile duct is normal in calibre.

PANCREAS: It is normal in size and echopattern.

SPLEEN: It is normal in size (10.1cm) and echopattern.

KIDNEYS: Both kidneys are normal in position, size (RK 9.7x3.4cm and LK 11.8x4.7cm) and outline. Cortico-medullary differentiation of both kidneys is maintained. Central sinus echoes are compact. No focal lesion or calculus seen. Bilateral pelvicalyceal systems are not dilated.

URINARY BLADDER: It is normal in wall thickness with clear contents. No significant intra or extraluminal mass is seen.

UTERUS: It is anteverted .It is normal in size (7.7x4.6x3cm).Myometrial appears uniform. Endometrium is central (7.1mm).

OVARIES: Both ovaries are normal in size and ecopattern.

Right ovary measures:-17x12mm

Left ovary measures:-17x18mm

No free fluid is detected in pouch of Douglas and Morissons pouch.

IMPRESSION: Grade I fatty liver
Advice: Clinical Correlation

Dr. Anant Sharma
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Radiologist
DR. ANANT SHARMA
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