Park Hospital
GROUP SUPER SPECIALITY HOSPITAL

Gynaec

28/11/24
11:30 AM

Sheela Devi, 49 yr/F

Vitals :

Bp - 100/70 mmHg
weight - 70.7 Kg
Height - 5.6 Inch.

Cheif Complaints :

c/o stress incontinence.
Frequent & Irregular cycle.

H/O Present Illness :

m/h : LMP - 7/1/24. mc 4 dy / 15-20 d
↑ -
no Inter menstrual
Ⓐ post cordal bleeding
prev cycle 4 d / 28 d

Past History :

Yn : P2L2A1 adult
Decline.

Drug Allergies : (if any)

Medical : not significant
- lap chole in 2023
- Rt femur sx → >20 y back.

Family : father died of cancer (?)

Investigation :

Treatment :

O/E : Pls GC fair Afeb
P[1] I° ...

P/A soft

P/S stress in contem ent

P/V cystocele ent 1° Ut prolapse
vag discharge mild

Ph - w/t 6-8wk fni mobile
fe predom

Adv

→ USG TVS (ultrasound + bg)
- S. FSH, Urinary PLE
hCG
- Candid cl vaginal pessary - (3) HS
night.
→ pap smear after today
- breast self examina "
→ mammography
- Kegels Exercise

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Eye

29/11/24

694243

Mrs Sheela devi
49/F

Routine

Vitals :

Cheif Complaints :

H/O Present Illness :

UV 6/6 6/6 c glasses

NCT 14 14

Past History :

NV N6 N6 c glasses

Investigation :

Drug Allergies : (if any)

Treatment :

Colour vision - Normal (13)

Fundus - WNL

Gurgaon
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Dental

Shealacleve

Vitals :

Cheif Complaints :

Chronic Periodontitis

O/E. Mobility Grade II 17

H/O Present Illness :

Stain ++, Calculus.

Past History :

Investigation :

Drug Allergies : (if any)

- Surgical Extraction :- 17.

Treatment :

= Scaling & Polishing

Dr. PANKAJ GOYAL
Senior Consultant
Park Hospital, Gurgaon
Reg. No. A12674

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ENT

ENT

Ear
Nose
Throat
NAD.

Vitals :

Cheif Complaints :

Rx 1. FLIXONASE Nasal spray × (1 mo) (2)
2 puff at night

H/O Present Illness :

2. Tab. Bilazest-M × (15) days (1) (1)

Past History :

Investigation :

Drug Allergies : (if any)

Treatment :

✓ Adv
- Sr. total IgE -

29/01/24

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Date - 29/1/24

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Dermatology

Name- Sheela devi
Age- 49y/F

Vitals :

Cheif Complaints :

H/O Present Illness :

Past History :

NIL

Investigation :

Drug Allergies : (if any)

N/K

Treatment :

Adv:-

- FUDIC cream (4/A) → R/v c reports

IgG
HSV I < IgM
IgG
HSV II < IgM

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the health care providers

Park Hospital
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DEPARTMENT OF BIOCHEMISTRY

Patient Name	:	Mrs. SHEELA DEVI			
MR No	:	694243	**Bill Date**	:	29/01/2024
Age/Sex	:	49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024
Type	:	OPD	**Sample ID**	:	241657
TPA/Corporate	:	MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909
			Ref Doctor	:	Dr.RMO

Test	Result		Bio. Ref. Interval	Units	Method
BLOOD SUGAR FASTING					
PLASMA GLUCOSE FASTING	**113**	*H*	60 - 110	mg/dl	GOD TRINDERS

***** END OF THE REPORT *****

Sample no.

Dr. JAY PRAKASH SINGH
MBBS, MD (PATHOLOGY)

Dr.ISHA RASTOGI
MD, MBBS MICROBIOLOGY
CONSULTANT CLINICAL MICROBIOLOGIST

USER NM **AMIT1**

MC - 4830

(This is only professional opinion and not the diagnosis, please correlate clinically)

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Park Hospital
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DEPARTMENT OF PATHOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
STOOL ROUTINE AND MICROSCOPY				
STOOL ROUTINE AND MICROSCOPY				
COLOUR	Greenish	Pale Yellow		Manual Method
CONSISTENCY	Semi Solid	Formed		Manual
OCCULT BLOOD	NIL	NIL		Guaiac test
MUCUS	NIL	NIL		Microscopic
PUS CELL	0-1	0-5	cells/hpf	Microscopic
RBCS	0-1	NIL		
CYSTS	NIL	NIL		Microscopic
OVA	NIL	Nil		Microscopic
FAT QLOBULE	NIL	Nil		Microscopic
PARASITES	NIL	Nil		Microscopic
STOOL - PH	6.5	5.0 - 10.0		PH PAPER
YEAST CELL STOOL	Absent		Present/Absent	Microscopy

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF PATHOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

URINE ROUTINE AND MICROSCOPY

Test	Result	Bio. Ref. Interval	Units	Method
PHYSICAL CHARACTERSTICS				
QUANTITY	20ml	5 - 100	ml	
COLOUR	Pale Yellow	Pale Yellow		Manual Method
TURBIDITY	slightly turbid	clear		
SPECIFIC GRAVITY	1.010	1.000-1.030		urinometer
PH - URINE	6.0	5.0 - 9.0		PH PAPER
CHEMICAL EXAMINATION-1				
UROBILINOGEN	Negative	NIL		Ehrlich
URINE PROTEIN	Absent	NIL	mg/dl	Protein error indicator
BLOOD	NIL	NIL		
URINE BILIRUBIN	NIL	NIL		
GLUCOSE	NIL	NIL	mg/dL	GOD-POD/Benedicts
URINE KETONE	NIL	NIL		SOD.
MICRO.EXAMINATION				
PUS CELL	1-2	0-5	cells/hpf	Microscopic
RED BLOOD CELLS	0-1	0-2	cells/hpf	
EPITHELIAL CELLS	14-16	0-5	cells/hpf	
CASTS	NIL	NIL	/lpf	
CRYSTALS	NIL	NIL	/hpf	
OTHER	NIL			
AMORPHOUS URINE	Absent			MicroScopy

***** END OF THE REPORT *****

Sample no.

Dr. JAY PRAKASH SINGH
MBBS, MD (PATHOLOGY)

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GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF HAEMOTOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
BLOOD GROUPING AND RH FACTOR				
BLOOD GROUP	" O " RH POSITIVE			ABO/Rh (D) SLIDE

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF HAEMOTOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243		**Bill Date**	:	29/01/2024
Age/Sex	: 49 Years 1 Months 27 Days / Female		**Reporting Date**	:	29/01/2024
Type	: OPD		**Sample ID**	:	241657
TPA/Corporate	: MEDIWHEEL PVT LTD		**Bill/Req. No.**	:	25238909
			Ref Doctor	:	Dr.RMO

Test	Result		Bio. Ref. Interval	Units	Method
			CBC		
HAEMOGLOBIN	12.3		12 - 15	gm/dL	COLORIMETRY
TOTAL LEUCOCYTE COUNT	5610		4000-11000	/µL	LASER FLOW
DIFFERENTIAL COUNT					
NEUTROPHILS	**90**	*H*	40.0 - 70.0	%	FLOW CYTOMETRY
LYMPHOCYTES	**06**	*L*	20.0 - 40.0	%	FLOW CYTOMETRY
MONOCYTES	**02**	*L*	3.0 - 8.0	%	FLOW CYTOMETRY
EOSINOPHILS	02		0.5 - 5.0	%	FLOW CYTOMETRY
BASOPHILS	00		0.0 - 2.0	%	FLOW CYTOMETRY
RED BLOOD CELL COUNT	4.7		3.5 - 5.5	millions/µL	ELECTRICAL
PACKED CELL VOLUME	**34.8**	*L*	35.0 - 50.0	%	ELECTRICAL
MEAN CORPUSCULAR VOLUME	**73.3**	*L*	83 - 101	fL	ELECTRICAL
MEAN CORPUSCULAR HAEMOGLOBIN	**25.9**	*L*	27 - 31	Picogrames	CALCULATED
MEAN CORPUSCULAR HB CONC	35.3		33 - 37	g/dl	CALCULATED
PLATELET COUNT	326		150 - 450	thou/µL	ELECTRICAL
RDW	13.6		11.6 - 14.5	%	CALCULATED
SAMPLE TYPE FOR C.B.C	Whole Blood EDTA				

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF HAEMOTOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
ESR (WESTERGREN)				
E.S.R. - I HR.	20	0 - 20	mm/Hr.	Westergren
SPECIMEN TYPE	WHOLE BLOOD-EDTA			

Note : Note
1. C-Reactive Protein (CRP) is the recommended test in acute inflammatory conditions.
2. Test conducted on EDTA whole blood at 37C.
3. ESR readings are auto- corrected with respect to Hematocrit (PCV) values

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF MICROBIOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	31/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
URINE C/S				
NAME OF SPECIMEN	URINE (Uncentrifuged)			
ORGANISM IDENTIFIED	NO ORGANISM GROWN IN CULTURE AFTER 48HRS OF INCUBATION AT 37 C DEGREE.			Aerobic culture

Method :

Note : URINE CULTURE :
Presence of >105 cfu/ml (100000) in midstream urine sample is considered clinically significant. However in symptomatic patients or u rine sample collection from catheter or patients with indwelling catheters, even a smaller count of bacteria may signify infection (100-10000cfu/ml). Kindly correlate clinically.

***** END OF THE REPORT *****

Sample no.

Dr. JAY PRAKASH SINGH
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USER NM **ADITYA**

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Park Hospital
GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF IMMUNOLOGY

Patient Name	: Mrs. SHEELA DEVI				
MR No	: 694243	**Bill Date**	:	29/01/2024	
Age/Sex	: 49 Years 1 Months 27 Days / Female	**Reporting Date**	:	29/01/2024	
Type	: OPD	**Sample ID**	:	241657	
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
THYROID PROFILE				
TRI-IODOTHYRONINE (T3)	1.05	0.60 - 1.81	ng/ml	Chemiluminescence
THYROXINE (T4)	7.8	5.01 - 12.45	µg/dL	Chemiluminescence
THYROID STIMULATING HORMONE	1.76	0.5-5.50 ,	µIU/ml	
SPECIMEN TYPE	SERUM			

Method : chemiluminescent immunoassay

Note : Clinical Significance:
Thyroid function tests (TFTs) is a collective term for blood tests used to check the function of the thyroid.TFTs may be requested if a p atient is thought to suffer from hyperthyroidism (overactive thyroid) or hypothyroidism (underactive thyroid), or to monitor the effectiven ess of either thyroid-
suppression or hormone replacement therapy. It is also requested routinely in conditions linked to thyroid disease, such as atrial fibrill ation and anxiety disorder. A TFT panel typically includes thyroid hormones such as thyroid-
stimulating hormone (TSH, thyrotropin) and thyroxine (T4), and triiodothyronine (T3) depending on local laboratory policy.

Note: Please correlate with clinical condition

***** END OF THE REPORT *****

Sample no.

Dr. JAY PRAKASH SINGH
MBBS, MD (PATHOLOGY)

Dr.ISHA RASTOGI
MD, MBBS MICROBIOLOGY
CONSULTANT CLINICAL MICROBIOLOGIST

USER NM **PAWAN**

MC - 4830

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GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mrs. SHEELA DEVI		**Bill Date**	:	29/01/2024
MR No	: 694243		**Reporting Date**	:	29/01/2024
Age/Sex	: 49 Years 1 Months 27 Days / Female		**Sample ID**	:	241657
Type	: OPD		**Bill/Req. No.**	:	25238909
TPA/Corporate	: MEDIWHEEL PVT LTD		**Ref Doctor**	:	Dr.RMO

LFT (LIVER FUNCTION TEST)

Test	Result		Bio. Ref. Interval	Units	Method
LFT					
TOTAL BILIRUBIN	0.6		0 - 1.2	mg/dL	DIAZO
DIRECT BILIRUBIN	0.2		0 - 0.4	mg/dL	DIAZO
INDIRECT BILIRUBIN	0.4		0.10 - 0.6	mg/dL	CALCULATED
SGOT (AST)	29		0 - 45	U/L	IFCC WITHOUT
SGPT (ALT)	32		0 - 45	U/L	IFCC WITHOUT
ALKALINE PHOSPHATASE	**175**	*H*	30 - 170	IU/L	MODIFIED IFCC
TOTAL PROTEINS	7.6		6.4 - 8.0	g/dL	BIURET
ALBUMIN	4.2		3.3 - 5.5	g/dL	BCG DYE
GLOBULIN	3.4		2.3 - 4.5	g/dL	CALCULATED
A/G RATIO	1.24		1.1 - 2.2		CALCULATED
SAMPLE TYPE:	SERUM				

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF BIOCHEMISTRY

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TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	:	25238909	
		Ref Doctor	:	Dr.RMO	

Test	Result	Bio. Ref. Interval	Units	Method
KFT (RENAL PROFILE)				
KFT				
SERUM UREA	16	10 - 45	mg/dL	UREASE-GLDH
SERUM CREATININE	0.9	0.4 - 1.4	mg/dL	MODIFIED JAFFES
SERUM URIC ACID	4.4	2.5 - 7.0	mg/dL	URICASE
SERUM SODIUM	136	135 - 150	mmol/L	ISE
SERUM POTASSIUM	3.7	3.5 - 5.5	mmol/L	ISE
SERUM CALCIUM	8.6	8.5 - 10.5	mg/dL	ARSENAZO III
SERUM PHOSPHORUS	2.8	2.5 - 4.5	mg/dL	AMMONIUM
SAMPLE TYPE:	SERUM			

***** END OF THE REPORT *****

Sample no.

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DEPARTMENT OF BIOCHEMISTRY

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Type	: OPD	**Sample ID**	: 241657
TPA/Corporate	: MEDIWHEEL PVT LTD	**Bill/Req. No.**	: 25238909
		Ref Doctor	: Dr.RMO

LIPID PROFILE

Test	Result		Bio. Ref. Interval	Units	Method
LIPID PROFILE					
TOTAL CHOLESTEROL	227		0 - 250	mg/dL	CHOD -Trinder
SERUM TRIGLYCERIDES	115		60 - 165	mg/dl	GPO-TRINDER
HDL-CHOLESTEROL	37		30 - 70	mg/dl	DIRECT
VLDL CHOLESTEROL	23		6 - 32	mg/dL	calculated
LDL	**167**	*H*	50 - 135	mg/dl	calculated
LDL CHOLESTEROL/HDL RATIO	**4.51**	*H*	1.0 - 3.0	mg/dL	calculated
TOTAL CHOLESTEROL/HDL RATIO	**6.14**	*H*	2.0 - 5.0	mg/dl	calculated
SAMPLE TYPE:	SERUM				

Note : ATP III Guidelines At-A-Glance Quick Desk Reference

Step 1 - Determine lipoprotein levelsobtain complete lipoprotein profile after 9- to 12-hour fast.

ATP III Classification of LDL, Total, and HDL Cholesterol (mg/dL):-

LDL Cholesterol	Primary Target of Therapy
<100	Optimal
130-159	Borderline high
>190	Very high.

Total Cholesterol

<200	Desirable
200-239	Borderline high
>240	High

HDL Cholesterol

<40	Low
>60	High

***** END OF THE REPORT *****

Sample no.

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Park Hospital
GROUP SUPER SPECIALITY HOSPITAL

NAME	:	MRS. SHEELA DEVI	DATE	:	29 / 1 / 2024
Age Sex	:	49 Years / Female	MR No	:	694243
PERFORMED BY	:	Dr. ELA MADAAN	BILL NO.	:	25238909

TRANS THORACIC ECHO CARDIOGRAPHY REPORT

MITRAL VALVE

Morphology AML: **Normal** / Thickening /Calcification/Flutter/Vegetation/Non significant Prolapse/SAM
PML: **Normal** / Thickening / Calcification/Prolapse/ Paradoxical Motion / Fixed.
Subvalvular deformity: Present / **Absent**

Doppler **Normal** / Abnormal
Mitral Stenosis Present / **Absent**
Mitral Regurgitation; Absent / Normal / Mild /**Trace** / Moderate / Severe

TRICUSPID VALVE

Morphology **Normal** / Atresia / Thickening / Clacification / Prolapse / Vegetation / Doming.
Doppler **Normal** / Abnormal
Tricuspid Stenosis: Present / **Absent.**
Tricuspid Regurgitation: Absent / **Mild** / Trace / Moderate
PASP – 25mm Hg + RAP

PULMONARY VALVE

Morphology **Normal** / Atresia / Thickening / Calcified / Doming / Vegetation.
Doppler **Normal** / Abnormal.
Pulmonary Stenosis: Present / **Absent**
Pulmonary regurgitation: Present / **Absent**

AORTIC VALVE

Morphology **Normal** / Thickened /Mildly/ Calcified / Flutter / Vegetation / Restricted / Opening
No. of Cusps 1 / 2 / **3** / 4

Doppler **Normal** / Abnormal
Aortic Stenosis : Present / **Absent**
Aortic regurgitation : Present / Absent / Mild / **Trace** / Moderate / Severe

Measurements		Normal Values	Measurements		Normal Value
IVSD	: 0.9cm	(0.6-1.1cm)	LA	: 3.6cm	(1.9-4.0cm)
LVID	: 4.5cm	(3.7-5.6cm)	LVOT	: 1.5cm	
LVPW	: 1.0cm	(0.6-1.1cm)	AORTA	: 2.4cm	(2.0-3.7cm)
EF	: 55%	(55% - 80%)	IVSmotion	:	**Normal** / Flat / Paradoxical
Any Other					

CHAMBERS:-

LV **Normal** / Enlarged / **Clear** / Thrombus /
Contraction Normal LV shows concentric LVH, no gradient across LVOT /Inetic / Intra capillary
Regional wall motion abnormality: **Absent**/ Present

LA **Normal** /Enlarged / Clear /Thrombus / Myxoma; **LAA: Clear** / Thrombus

RA **Normal** / **Clear** / Thrombus, Dilated.

RV **Normal** / Mildly Dilated / Enlarged / **Clear** / Thrombus / Hypertrophied

PERICARDIUM **Normal** / Thickening / Calcification / Effusion.

COMMENTS & SUMMARY:-

- **All Cardiac Chambers dimensions are within normal limits.**
- **Global LVEF – 55%**
- **NORMAL LV FUNCTION**
- **NO LVDD**
- **TRACE MR**
- **TRACE AR**
- **MILD TR, PASP – 25mm Hg + RAP**
- **GOOD RV FUNCTION**
- **IAS/IVS. No Flow seen across IAS/IVS.**
- **No Thrombus/Mass in any chamber.**
- **No Pericardial Effusion.**

Please correlate clinically

Dr. ELA MADAAN
MBBS, PGDCC
Fellowship in non Invasive Cardiology

Dr. JOGINDER S. DUHAN
M.D.(Medicine)
D.M (Cardiology)

Dr. SACHIN BANSAL
M.D.(Medicine)
D.M (Cardiology)

Park Ho

GROUP SUPER SPECIAI

Vitals :

Cheif Complaints :

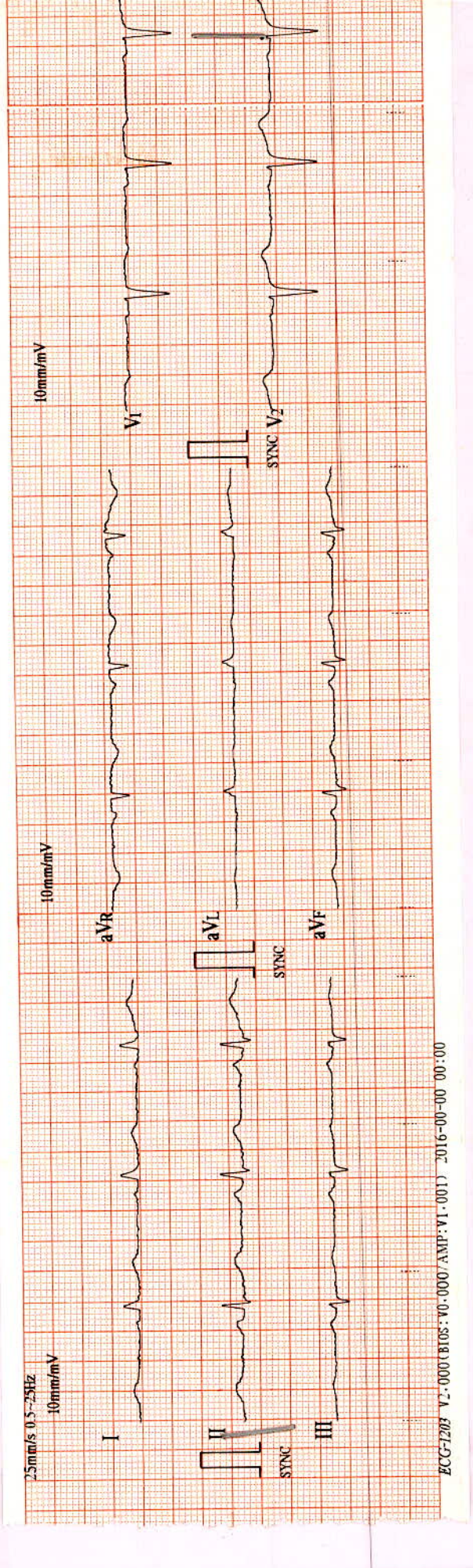
H/O Present Illness :

Past History :

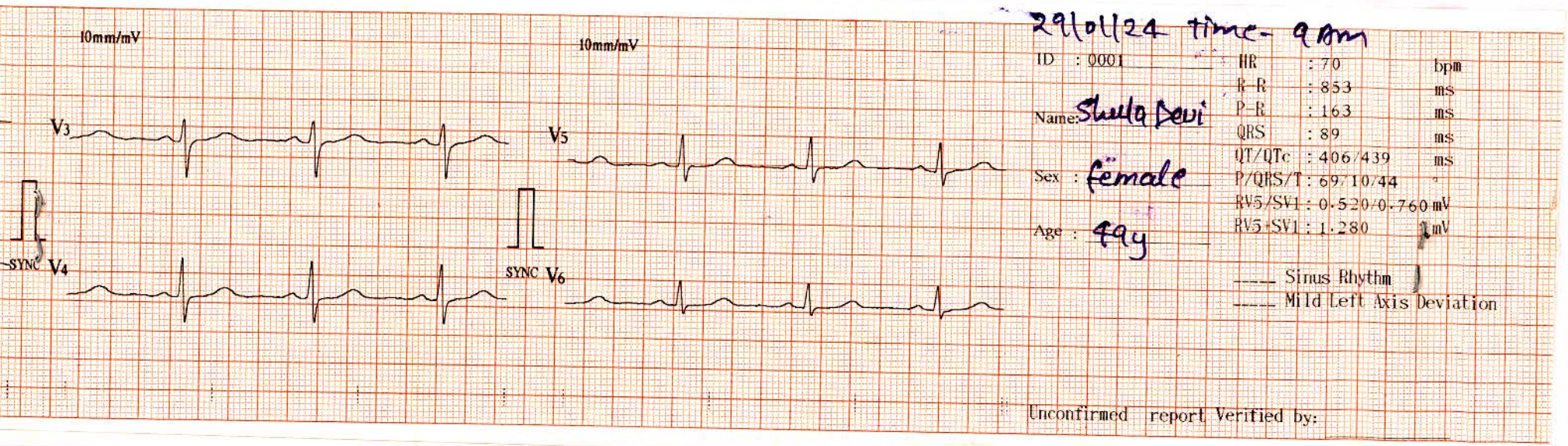
Investigation :

Drug Allergies : (if any)

Treatment :



Gurgaon Q Block South City 11, Sohna Road, Main Sector-47, Gurgaon, Haryana Ph.: 0124-49000000 Fax : 0124-2218733
E-mail : parkmedicenters@gmail.com



29/01/24 time- 9 Am

ID : 0001

Name: Shulla Devi

Sex : female

Age : 49y

HR	: 70	bpm
R-R	: 853	ms
P-R	: 163	ms
QRS	: 89	ms
QT/QTc	: 406/439	ms
P/QRS/T	: 69/10/44	°
RV5/SV1	: 0.520/0.760	mV
RV5+SV1	: 1.280	mV

----- Sinus Rhythm

----- Mild Left Axis Deviation

Unconfirmed report Verified by:

Park Hospital
GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF RADIOLOGY

Patient Name	Mrs. SHEELA DEVI	**Billed Date**	:29/01/2024
Reg No	694243	**Reported Date**	: 29/01/2024
Age/Sex	49 Years 1 Months 27Days / Female	**Req. No.**	: 25238909
Type	OPD	**Consultant Doctor**	: Dr. RMO

X-RAY CHEST AP/PA

Bilateral lungs appears normal.

No focal lung lesion seen.

No evidence of free fluid is seen.

Both hila are normal in size, have equal density and bear normal relationship.

The heart and trachea are central in position and no mediastinal abnormality is visible.

The cardiac size is normal for patient age and view.

The domes of the diaphragms are normal in position,and show smooth outline.

To be correlated clinically

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CONSULTANT RADIOLOGIST
Cert. No. H-2016-0369

Dr,MANJEET SEHRAWAT
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Park Hospital
GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF RADIOLOGY

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USG WHOLE ABDOMEN

LIVER : The liver is mild enlarged in size (15.0cm) and shows bright echotexture. No evidence of any focal lesion. IHBR is not dilated.

GALL BLADDER : The gall bladder is absent.

BILE DUCT : The common bile duct is normal in caliber. No evidence of calculus is noted in common bile duct.

SPLEEN : The spleen is normal in size (9.5cm) and shape.Its echotexture is homogeneous.No evidence of focal lesion is noted.

PANCREAS : The pancreas is normal in size, shape, contours and echotexture.No evidence of solid or cystic mass lesion is noted.MPD is not dilated. No evidence of peripancreatic collection.

KIDNEYS : The bilateral kidneys are normal in size and echotexture. Cortico-medullary differentation is maintained.There is no evidence of obvious calculus or hydronephrosis.

URINARY BLADDER : The urinary bladder is well distended.It shows uniformly thin walls and sharp mucosa.No evidence of calculus is seen. No evidence of mass or diverticulum is noted.

UTERUS: The uterus is anteverted and bulky in size. It measures 10.7 x 7.6 x 7.5 cms.
There is evidence of multiple intramural and subserosal fibroids largest of size 39 x 32 mm in posterior wall.
The endometrial echo is in the midline and measures 5.8 mm.
The ovaries on the either side show normal echotexture.
No adnexal mass is seen. No cyst is seen in ovaries.

the health care providers

No evidence of ascites or interbowel free fluid is seen.

No evidence of obvious retroperitoneal or mesentric lymphadenopathy is seen.

IMPRESSION-

-Mild hepatomegaly with grade I fatty liver.

-Bulky uterus with uterine fibroids.

To be correlated clinically.

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