

Mrs. Deepika Thakker.

Age - 39 yr / F.

Weight - 45 kg

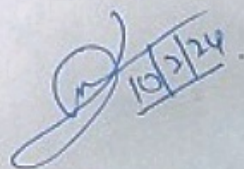
Height - 140 cm

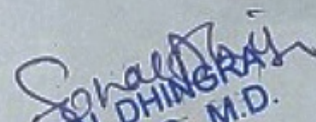
BMI - 23.

BP - 99/52.

Medication - No Medication.

No History.

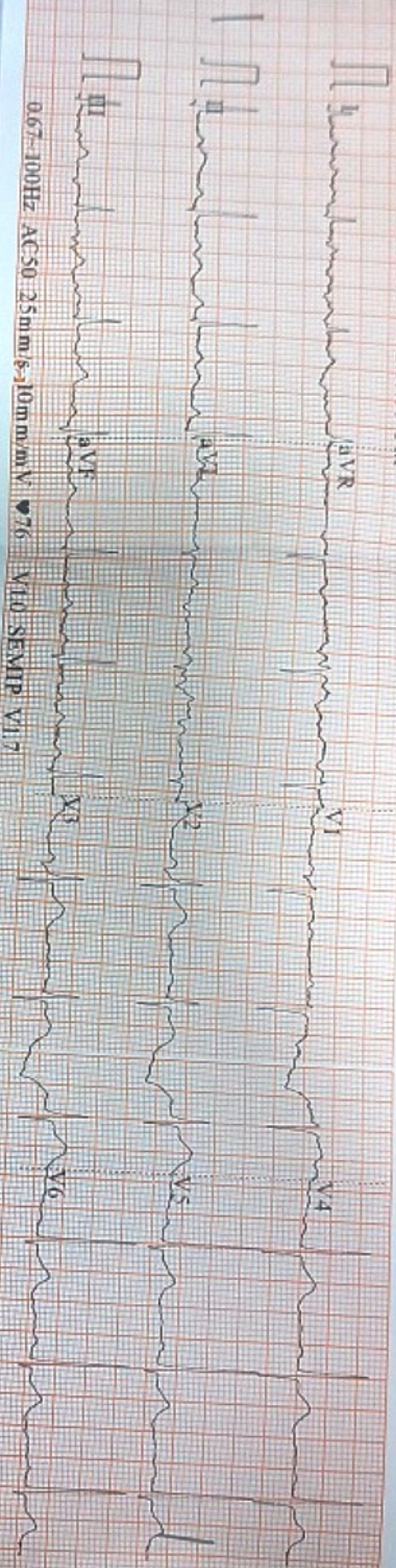
  
19/3/24

  
DR. SONAL DHINGRA  
M.B.B.S., M.D.

ID: 45 10-02-2024 02:16:00 PM

0.67-100Hz AC50 25mm/s-10mm/mV 76 V10 SEMIP V17

ECG CARDIOPRINT



DR. SAMUEL DAINGRA  
M.B.B.S., (M.D.)

ID: 45	Female	19Y ears	mmHg	kg	Diagnosis Information
HR	75	bpm			Sinus Rhythm
P	111	ms			Normal ECG
PR	170	ms			
QRS	73	ms			
QT/QTc	416/467	ms			
P-QRS/T	61/64/203				
RV5/SV1	1.65/2.0	805 mV			Report Confirmed by:

PT. NAME	MRS. DEEPIKA THAKUR	AGE/SEX	39Y/F	FILM
REF. BY	DR. SELF	DATE:	10/02/2024	01

### X-RAY CHEST PA VIEW

- Both CP angles are normal.
- Trachea is normal in position.
- Cardiac size is within normal limits.
- Both hila are normal.
- Heart, aorta & mediastinum are normal
- Bony thoracic cage appears normal.

**NORMAL STUDY**

  
**DR. MOHIT SHARMA**

(MBBS)(DMRD) Chief consultant

Interventional Radiologist

\_\_\_\_\_  
**Dr. Bhavna Sharma**  
M.D. Pathology

\_\_\_\_\_  
**Dr. Swati Tiwari**  
M.D. Microbiology

\_\_\_\_\_  
**Dr. Sonal Dhingra Anand**  
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# Meenakshi Diagnostics

73-C, Garh Road, Near Hotel Harmony Inn, Meerut-250002 (U.P.)  
Ph. : 0121-2766666, 9458802222, 9458803333, 9458804444, 9458806666

Centre equipped with M.R.I. with upgraded software of 3T Platform, 500 Slice VHS C.T. Scan.  
Digital X-Ray, Mammography, O.P.G., 4D / 5D Ultrasound & Colour Doppler, 2-D Echocardiography

Pt. Name	Mrs. Deepika Thakur	Age/Sex	39 Yrs/F	Film
Ref. By	C/o S. D. A. Diagnostics	Date:	10.02.2024	02

Patient identity can't be verified

## USG WHOLE ABDOMEN

**Liver:** is normal in size (14.2 cm) with normal parenchymal echogenicity. No focal/ diffuse mass lesion seen. IHBRs are normal. Margins are regular.

**Gall Bladder:** is well distended. Wall thickness is normal. No calculus / focal mass seen. No pericholecystic collection seen.

**CBD:** is normal in caliber.

**Portal Vein:** is normal in caliber.

**Visualized pancreas:** is normal in size and echotexture. No focal mass seen.

**Spleen:** is normal in size, measuring 10.3 cm and shows normal echopattern.

**Right kidney** measures 9.6x3.4 cm. It is normal in size, position, contour and cortical echotexture. No hydronephrosis is seen. Corticomedullary differentiation is maintained. Renal margins are regular. **Concretion of size 2.1 mm is seen in upper calyx.**

**Left kidney** measures 9.3x3.8 cm. It is normal in size, position, contour and cortical echotexture. No calculus/ hydronephrosis seen. Corticomedullary differentiation is maintained. Renal margins are regular.

**Urinary Bladder:** is well distended with normal wall thickness. No calculus/ focal mass seen.

**Uterus:** is anteverted, normal in size, measuring 7.3x3.1 cm. Myometrial echotexture is normal. No focal mass seen. Endometrial thickness measures 6.5 mm.

**Well defined cystic lesion of size 1.8x1.7 cm with internal echoes and thin septations is seen in right ovary. No internal vascularity is seen within.**

**Left ovary** measures 2.2x1.4 cm (vol. cc) and shows normal size and echopattern.

**Minimal free fluid is seen in pouch of douglas.**

### IMPRESSION: USG findings reveal:

- **Right renal concretion.**
- **Well defined cystic lesion with internal echoes and thin septations in right ovary --- Likely hemorrhagic follicle. Adv- Follow up**
- **Minimal free fluid in pouch of douglas.**

*Adv: Clinical correlation & further work up.*

Dr. Mohd. Saalim  
MD

Dr. Sandeep Sirohi  
DMRD

Dr. Sandeep Singh Soam  
MD

Dr. Renu Diwakar  
MBBS

Dr. Mohd. Saalim  
MD

Dr. Mohd. Qasim  
DMRD  
MB

Note : All congenital anomalies may not be diagnosed in routine USG. The USG findings should always be considered in correlation with clinical and other investigations findings to reach the final diagnosis. Kindly intimate us for any typing mistakes and return the report for correction within 7 days. Not valid for medico-legal purpose.



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## ECHOCARDIOGRAPHY REPORT

### MEASUREMENTS:

DIMENSIONS		NORMAL	NORMAL	
AO (ed)	2.1 cm	(2.1 – 3.7 cm)	IVS (ed)	1.1 cm (0.6 – 1.2 cm)
LA (es)	2.3 cm	(2.1 – 3.7 cm)	LVPW (ed)	1.2 cm (0.6 – 1.2 cm)
RVID (ed)	2.3 cm	(1.1 – 2.3 cm)	EF	70% (62% – 85%)
LVID (ed)	4.9 cm	(3.6 – 5.2 cm)	FS	39% (28% – 42%)

### MORPHOLOGICAL DATA:

Mitral	Normal	LA	Normal
Aortic Valve	Normal	RA	Normal
Pulmonary Valve	Normal	IAS	Intact
Tricuspid Valve	Normal	IVS	Intact
LV	Normal	AO	Normal
RV	Normal	Pericardium	Normal

Contd...2

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::2::

## 2-D ECHOCARDIOGRAPHY FINDINGS:

LV normal in size with normal LV systolic function. No regional wall motion abnormality. RV normal in size with adequate contractions. LA and RA are normal. All cardiac valves structurally normal. Pericardium normal. No intra-cardiac mass. Estimated LV ejection fraction is approximately 70%.

## COLOR FLOW MAPPING:

Normal.

## DOPPLER STUDIES:

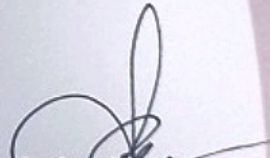
MVIS E > A

Peak systolic velocity across aortic valve = 1.4m/sec.

Peak systolic velocity across pulmonary valve = 1.3m/sec.

## IMPRESSION:

- LV normal in size with adequate LV systolic function
- LVEF = 70%.
- No MS/MR/AS/AR/TR
- No LV clot / mass
- No pericardial effusion.

  
Dr. Sanjeev Khare  
MD (Echocardiologist)

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Age/ Gender : 39Y / Female		Receiving Time : 10-Feb-2024 10:06AM
Referred By : Dr. SELF		Reporting Time : 10-Feb-2024 5:38PM
Sample By :		

Test Name	Results	Units	Biological Ref-Interval
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### HAEMATOLOGY

#### COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	<b>9.40</b>	g/dl	12-16.5
TOTAL LEUCOCYTE COUNT (Electric Impedence)	6300.00	/Cum m	4000-11000
<b>DIFFERENTIAL LEUCOCYTE COUNT</b> (Microscopy)			
Neutrophils	<b>76.00</b>	%	44-68
Lymphocytes	<b>19.00</b>	%	25- 44
Eosinophils	2.00	%	0.0- 4.0
Monocytes	3.00	%	0.0-7.0
Basophils	0.00	%	0.0-1.0
Immature Cells	00	%	
<b>Absolute Count</b>			
Neutrophils Count (calculated)	4788.00	/cumm	2000-7000
Lymphocytes Count (calculated)	1197.00	/cumm	1000-3000
Eosinophils Count (calculated)	126.00	/cumm	40-440
Monocytes Count (calculated)	<b>189.00</b>	/cumm	200-1000
Basophils Count (calculated)	0.00	/cumm	0-30
TOTAL R.B.C. COUNT (Electric Impedence)	4.29	10 <sup>6</sup> /uL	3.50-5.50
Haematocrit Value (P.C.V.) (Calculated)	<b>30.40</b>	%	37.0-54.0
MCV (Calculated)	<b>71.00</b>	fL	76-98
MCH	<b>21.90</b>	pg	27-32



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(Calculated)			
MCHC	31.00	g/dl	31-35
(Calculated)			
RDW-CV	<b>17.20</b>	%	11.5 - 14.5
(Calculated)			
Platelet Count	227	Thousand/cumm	150-450
(Electric Impedence)			
MPV	<b>10.70</b>	fL	11.5-14.5
(Calculated)			
PDW	<b>22.90</b>	fL	9.0-17.0
(Calculated)			
Peripheral Smear	..		

#### BLOOD GROUP

Blood Group : B  
Rh Status : POSITIVE

<b>GLYCATED HAEMOGLOBIN (HbA1c)</b>	5.40	%	4.5-6.0
ESTIMATED AVERAGE GLUCOSE	108.28	mg/dl	

#### EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics : 4.5 % to 6.0 %  
Good Control of diabetes : 6.1 % to 7.0 %  
Fair Control of diabetes : 7.1 % to 8.0 %  
Poor Control od diabetes : 8 % and above

The glycosylated hemoglobin assay has been validated as a reliable indicator of mean blood glucose levels for a period of 8-12 week period prior to HBA1C determination.ADA recommends the testing twice a year in patients with stable blood glucose, and quarterly, if treatment changes, or if blood glucose levels are unstable.



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**BIOCHEMISTRY**

<b>BLOOD GLUCOSE FASTING</b> (GOD/POD method)	105.00	mg/dl	70 - 110
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<b>BLOOD GLUCOSE P.P.</b> (GOD/POD method) After 2.0 hrs of meal	124.00	mg/dl	70-140
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<b>LIVER PROFILE</b>			
<b>SERUM BILIRUBIN</b>			
TOTAL (Diazo)	1.05	mg/dl	0.30-1.20
DIRECT (Diazo)	<b>0.39</b>	mg/dl	0.00-0.20
INDIRECT (Calculated)	0.66	mg/dl	0.20-1.00
S.G.P.T. (IFCC method)	24.00	U/L	0-45
S.G.O.T. (IFCC method)	29.00	U/L	0-45
SERUM ALKALINE PHOSPHATASE (4-nitrophenylphosphate to 2-amino-2-methyl-1propan	91.00	IU/L.	35-145
<b>SERUM PROTEINS</b>			
TOTAL PROTEINS (Biuret)	6.70	Gm/dL.	6.0-8.0
ALBUMIN (Bromocresol green Dye)	4.10	Gm/dL.	3.5-5.2
GLOBULIN (Calculated)	2.60	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	1.58		1.5-2.5

**LIVER FUNCTION TESTS CHECK THE LEVEL OF CERTAIN ENZYMES AND PROTEINS IN BLOOD**

Levels that are higher or lower than normal can indicate liver problems. Some common liver function tests include :

Alanine transaminase (ALT). ALT is an enzyme found in the liver and When the liver is damaged, ALT is released into the bloodstream and levels increase.

Aspartate transaminase (AST). AST is an enzyme that helps metabolize alanine,an amino acid.

AST is normally present in blood at low levels. An increase in AST levels may indicate liver damage or disease or muscle damage.

Alkaline phosphatase (ALP). ALP is an enzyme in the liver, bile ducts and bone.



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<b>RENAL PROFILE</b>			
BLOOD UREA (Urease Glutamate dehydrogenase)	21.0	mg/dl	10-50
SERUM CREATININE (Jaffe`s)	0.80	mg/dL.	0.6-1.2
SERUM URIC ACID (Urease method)	4.1	mg/dL.	3.5-7.5
SERUM SODIUM (Na) (ISE Direct)	140.0	mmol/l	135 - 155
SERUM POTASSIUM (K) (ISE Direct)	4.30	mmol/l	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	9.4	mg/dl	8.5-10.1
<b>SERUM PROTEIN</b>			
TOTAL PROTEINS (Biuret)	6.70	Gm/dL.	6.0-8.0
SERUM ALBUMIN (Bromocresol green Dye)	4.10	Gm/dL.	3.5-5.2
GLOBULIN (Calculated)	2.60	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	1.58	Gm/dL.	1.5-2.5

**INTERPRETATION:**

Urea is the end product of protein metabolism. It reflects on functioning of the kidney in the body. Creatinine is the end product of creatine metabolism. It is a measure of renal function and elevated levels are observed in patients typically with 50% or greater impairment of renal function. Sodium is critical in maintaining water & osmotic equilibrium in extracellular fluids. Disturbances in acid base and water balance are typically reflected in the sodium concentrations. Potassium is an essential element involved in critical cell functions. Potassium levels are influenced by electrolyte intake, excretion and other means of elimination, exercise, hydration and medications. Calcium imbalance may cause a spectrum of disease. High concentrations are seen in Hyperparathyroidism, Malignancy & Sarcoidosis. Low levels may be due to protein deficiency, renal insufficiency and Hypoparathyroidism. Repeat measurement is recommended if the values are outside the reference range.



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<b>LIPID PROFILE</b>			
SERUM CHOLESTEROL (CHOD - PAP)	163.0	mg/dl	125-200
SERUM TRIGLYCERIDE (GPO-PAP)	86.0	mg/dl	50-150
HDL CHOLESTEROL (Direct Method)	43.0	mg/dl	30-80
VLDL CHOLESTEROL (Calculated)	17.2	mg/dl	5-35
LDL CHOLESTEROL (Calculated)	102.8	mg/dL.	70-130
LDL/HDL RATIO (Calculated)	2.4		0.0-4.9
CHOL/HDL CHOLESTROL RATIO (Calculated)	<b>3.8</b>		1.5-3.0

#### INTERPRETATION

TRIGLYCERIDE level > 250mg/dL is associated with an approximately 2-fold greater risk of coronary vascular disease. Elevation of triglycerides can be seen with obesity, medication, fast less than 12 hrs., alcohol intake, diabetes melitus, and pancreatitis.

CHOLESTEROL, its fractions and triglycerides are the important plasma lipids in defining cardiovascular risk factors and in the management of cardiovascular disease. Highest acceptable and optimum values of cholesterol values of cholesterol vary with age. Values above 220 mgm/dl are associated with increased risk of CHD regardless of HDL & LDL values.

HDL-CHOLESTEROL level <35 mg/dL is associated with an increased risk of coronary vascular disease even in the face of desirable levels of cholesterol and LDL - cholesterol.

LDL - CHOLESTEROL & TOTAL CHOLESTEROL levels can be strikingly altered by thyroid, renal and liver disease as well as hereditary factors.

Based on total cholesterol, LDL- cholesterol, and total cholesterol/HDL - cholesterol ratio, patients may be divided into the three risk categories.



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### HORMONE

#### THYRIOD PROFILE

Triiodothyronine (T3) (FIA)	0.89	ng/dl	0.52-1.85
Thyroxine (T4) (FIA)	8.96	ug/dl	4.8-11.6
THYROID STIMULATING HORMONE (TSH) (FIA)	2.15	mIU/L	0.50-5.50

#### Interpretation Note:

Thyroid Stimulating Hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.

Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormones vary according trimester in pregnancy.

#### TSH ref range in Pregnancy      Reference range (microIU/ml)

First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5



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### CLINICAL PATHOLOGY

#### URINE EXAMINATION REPORT

##### PHYSICAL EXAMINATION

VOLUME (visual)	20	ml	
COLOUR (visual)	PALE YELLOW		
APPEARANCE (visual)	CLEAR		
pH	6.50		4.6 - 8.0
SPECIFIC GRAVITY (pKa Change)	1.015		1.010-1.030

##### BIOCHEMICAL EXAMINATION

UROBILINOGEN (Erichs)	NIL		NIL
BILIRUBIN (Azo-coupling reaction)	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
SUGAR (Glucose Oxidase Peroxidase)	NIL		Nil
ALBUMIN (Protein-Error-of-Indicator))	NIL		Nil
PHOSPHATE	NIL		Nil

##### MICROSCOPIC EXAMINATION

(Microscopy)			
RED BLOOD CELLS	NIL	/H.P.F.	0-2
PUS CELLS	1-2	/H.P.F.	0-5
EPITHELIAL CELLS	2-3	/H.P.F.	0-5
CRYSTALS	NIL	/H.P.F.	NIL
CASTS	NIL	/L.P.F.	
OTHER			



*Sonal Dhingra*

**Dr. Bhavna Sharma**  
M.D. Pathology

**Dr. Swati Tiwari**  
M.D. Microbiology

**Dr. Sonal Dhingra Anand**  
M.D. Pathology

- ◆ Test Values may vary with different lab standards, methods, kits used and other physiological & biological factors.
- ◆ The clinico pathological lab tests involve Man-Machine-Computer interface with slight chances of inadvertent discrepancy and should be immediately discussed & alleviated.
- ◆ Report purports for patients care and not for medical legal documents.



Lab Ref. No.	: 234027059	C. NO:	8	Centre Name	: SDA Diagnostics
Name	: Mrs. DEEPIKA THAKUR			Collection Time	: 10-Feb-2024 10:06AM
Age/ Gender	: 39Y / Female			Receiving Time	: 10-Feb-2024 10:06AM
Referred By	: Dr. SELF			Reporting Time	: 10-Feb-2024 5:40PM
Sample By	:				

Test Name	Results	Units	Biological Ref-Interval
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-----{END OF REPORT }-----



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