

Human Care Medical Charitable Trust



Sector-6, Dwarka, New Delhi 110 075

GST: 07AAAAH3917LIZM

PAN NO: AAAAH3917L

NAME	MRS Sunder DEVI	STUDY DATE	06/02/2024 10:29AM
AGE / SEX	52 y / F	HOSPITAL NO.	MH011680042
ACCESSION NO.	R6832658	MODALITY	CR
REPORTED ON	06/02/2024 2:33PM	REFERRED BY	Health Check MHD

X-RAY CHEST - PA VIEW

Results:

Visualized lung fields appear clear.

Both hilar shadows appear normal.

Cardiothoracic ratio is within normal limits.

Both hemidiaphragmatic outlines appear normal.

Both costophrenic angles are clear.

Kindly correlate clinically.

Aarushi

Dr. Aarushi MBBS, MD, DNB DMC NO.03291

CONSULTANT RADIOLOGIST

*******End Of Report*******



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H-2019-0640/09/06/2019-08/06/2022



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NAME	MRS Sunder DEVI	STUDY DATE	06/02/2024 11:12AM
AGE / SEX	52 y / F	HOSPITAL NO.	MH011680042
ACCESSION NO.	NM12097469	MODALITY	US
REPORTED ON	06/02/2024 11:42AM	REFERRED BY	Health Check MHD

2D Echocardiography Report

	End diastole	End systole
IVS thickness (cm)	0.9	1.2
Left Ventricular Dimension (cm)	4.5	2.6
Left Ventricular Posterior Wall thickness (cm)	1.0	1.3

Aortic Root Diameter (cm)	2.8
Left Atrial Dimension (cm)	3.4
Left Ventricular Ejection Fraction (%)	60 %

LEFT VENTRICLE	:	Normal in size. No RWMA. LVEF=60 %
RIGHT VENTRICLE	:	Normal in size. Normal RV function.
LEFT ATRIUM	:	Normal in size
RIGHT ATRIUM	:	Normal in size
MITRAL VALVE	:	Mild MR.
AORTIC VALVE	:	Normal.
TRICUSPID VALVE	:	Mild TR, PASP~ 30 mmHg.
PULMONARY VALVE	:	Normal
MAIN PULMONARY ARTERY & ITS BRANCHES	:	Appears normal.
INTERATRIAL SEPTUM	:	Intact.
INTERVENTRICULAR SEPTUM	:	Intact.
PERICARDIUM	:	No pericardial effusion or thickening



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DOPPLER STUDY

VALVE	Peak Velocity (cm/sec)	Maximum P.G. (mmHg)	Mean P. G. (mmHg)	Regurgitation	Stenosis
MITRAL	E= 67 A=92	-	-	Mild	Nil
AORTIC	110	-	-	Nil	Nil
TRICUSPID	-	N	N	Mild	Nil
PULMONARY	66	N	N	Nil	Nil

SUMMARY & INTERPRETATION:

- No LV regional wall motion abnormality with LVEF = 60 %
- Normal sized RA/RV/LV/LA with no chamber hypertrophy. Normal RV function.
- Mild MR.
- Mild TR, PASP~ 30 mmHg
- Grade- I diastolic dysfunction
- IVC normal in size, >50% collapse with inspiration, suggestive of normal RA pressure.
- No clot/vegetation/pericardial effusion.

Please correlate clinically.

Dr. Sarita Gulati MD, DM DMC No.22600

Senior Interventional Cardiologist

*******End Of Report*******



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Human Care Medical Charitable Trust

Registered Office: Sector-6, Dwarka, New Delhi 110 075

Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 31240200235
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:12
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 12:22
Receiving Date : 06 Feb 2024 11:25

Department of Transfusion Medicine (Blood Bank)

BLOOD GROUPING, RH TYPING & ANTIBODY SCREEN (TYPE & SCREEN)
Specimen-Blood

Blood Group & Rh Typing (Agglutination by gel/tube technique)

Blood Group & Rh typing B Rh(D) Positive

Antibody Screening (Microtyping in gel cards using reagent red cells)

Final Antibody Screen Result Negative

Technical Note:

ABO grouping and Rh typing is done by cell and serum grouping by microplate / gel technique. Antibody screening is done using a 3 cell panel of reagent red cells coated with Rh, Kell, Duffy, Kidd, Lewis, P, MNS, Lutheran and Xg antigens using gel technique.

Page 1 of 11

-----END OF REPORT-----



Dr Himanshu Lamba

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Registered Office: Sector-6, Dwarka, New Delhi 110 075

Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 32240202503
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:11
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 12:14
Receiving Date : 06 Feb 2024 11:13

BIOCHEMISTRY

Specimen: EDTA Whole blood

HbA1c (Glycosylated Hemoglobin) 5.3 % As per American Diabetes Association (ADA) 2010 [4.0-6.5]
HbA1c in %
Non diabetic adults : < 5.7 %
Prediabetes (At Risk) : 5.7 % - 6.4 %
Diabetic Range : > 6.5 %
Methodology High-Performance Liquid Chromatography (HPLC)
Estimated Average Glucose (eAG) 105 mg/dl

Use :

1. Monitoring compliance and long-term blood glucose level control in patients with diabetes.
2. Index of diabetic control (direct relationship between poor control and development of complications).
3. Predicting development and progression of diabetic microvascular complications.

Limitations :

1. A1C values may be falsely elevated or decreased in those with chronic kidney disease.
2. False elevations may be due in part to analytical interference from carbamylated hemoglobin formed in the presence of elevated concentrations of urea, with some assays.
3. False decreases in measured A1C may occur with hemodialysis and altered red cell turnover, especially in the setting of erythropoietin treatment

References : Rao.L.V., Michael Snyder.L. (2021). Wallach's Interpretation of Diagnostic Tests. 11th Edition. Wolterkluwer. Nader Rifai, Andrea Rita Horvath, Carl T. Wittwer.

(2018) Teitz Text book

of Clinical Chemistry and Molecular Diagnostics. First edition, Elsevier, South Asia.

Page 2 of 11

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Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
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Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:11
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 12:14
Receiving Date : 06 Feb 2024 11:00

BIOCHEMISTRY

THYROID PROFILE, Serum

Specimen Type : Serum

T3 - Triiodothyronine (ECLIA)	1.440	ng/ml	[0.400-1.810]
T4 - Thyroxine (ECLIA)	7.220	µg/dl	[4.600-12.000]
Thyroid Stimulating Hormone (ECLIA)	0.578	µIU/mL	[0.340-4.250]
1st Trimester:	0.6 - 3.4	micIU/mL	
2nd Trimester:	0.37 - 3.6	micIU/mL	
3rd Trimester:	0.38 - 4.04	micIU/mL	

Note : TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m.and at a minimum between 6-10 pm.Factors such as change of seasons hormonal fluctuations,Ca or Fe supplements,high fibre diet,stress and illness affect TSH results.

* References ranges recommended by the American Thyroid Association

1) Thyroid. 2011 Oct;21(10):1081-125.PMID .21787128

2) <http://www.thyroid-info.com/articles/tsh-fluctuating.html>

Page 3 of 11

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BIOCHEMISTRY

Lipid Profile (Serum)

TOTAL CHOLESTEROL (CHOD/POD)	228 #	mg/dl	[<200] Moderate risk:200-239 High risk:>240
TRIGLYCERIDES (GPO/POD)	95	mg/dl	[<150] Borderline high:151-199 High: 200 - 499 Very high:>500
HDL - CHOLESTEROL (Direct) Methodology: Homogenous Enzymatic	56	mg/dl	[30-60]
VLDL - Cholesterol (Calculated)	19	mg/dl	[10-40]
(CALCULATED) LDL- CHOLESTEROL	153 #	mg/dl	[<100] Near/Above optimal-100-129 Borderline High:130-159 High Risk:160-189
T.Chol/HDL.Chol ratio	4.1		<4.0 Optimal 4.0-5.0 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	2.7		<3 Optimal 3-4 Borderline >6 High Risk

Note:
Reference ranges based on ATP III Classifications.
Recommended to do fasting Lipid Profile after a minimum of 8 hours of overnight fasting.

Technical Notes:
Lipid profile is a panel of blood tests that serves as initial broad medical screening tool for abnormalities in lipids, the results of these tests can identify certain genetic

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BIOCHEMISTRY

diseases and determine approximate risks for cardiovascular disease, certain forms of pancreatitis and other diseases.

Test Name	Result	Unit	Biological Ref. Interval
LIVER FUNCTION TEST (Serum)			
BILIRUBIN-TOTAL (Diazonium Ion)	0.32	mg/dl	[0.10-1.20]
BILIRUBIN - DIRECT (Diazotization)	0.12	mg/dl	[0.00-0.30]
BILIRUBIN - INDIRECT (Calculated)	0.20	mg/dl	[0.20-1.00]
SGOT/ AST (UV without P5P)	16.9	U/L	[10.0-35.0]
SGPT/ ALT (UV without P5P)	15.9	U/L	[0.0-33.0]
ALP (p-NPP,kinetic)*	65	U/L	[41-108]
TOTAL PROTEIN (Biuret)	7.4	g/dl	[6.0-8.2]
SERUM ALBUMIN (BCG-dye)	4.5	g/dl	[3.5-5.2]
SERUM GLOBULIN (Calculated)	2.9	g/dl	[1.8-3.4]
ALB/GLOB (A/G) Ratio(Calculated)	1.55		[1.10-1.80]

Technical Notes:

Liver function test aids in diagnosis of various pre hepatic, hepatic and post hepatic causes of dysfunction like hemolytic anemia's, viral and alcoholic hepatitis and cholestasis of obstructive causes.

Page 5 of 11

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Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:11
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 12:14
Receiving Date : 06 Feb 2024 11:00

BIOCHEMISTRY

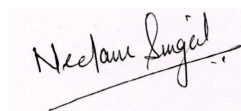
Test Name	Result	Unit	Biological Ref. Interval
KIDNEY PROFILE (Serum)			
BUN (Urease/GLDH)	10.00	mg/dl	[6.00-20.00]
SERUM CREATININE (Jaffe's method)	0.57 #	mg/dl	[0.60-1.40]
SERUM URIC ACID (Uricase)	4.4	mg/dl	[2.6-6.0]
SERUM CALCIUM (NM-BAPTA)	9.31	mg/dl	[8.00-10.50]
SERUM PHOSPHORUS (Molybdate, UV)	3.5	mg/dl	[2.5-4.5]
SERUM SODIUM (ISE)	143.0	mmol/l	[134.0-145.0]
SERUM POTASSIUM (ISE)	3.94	mmol/l	[3.50-5.20]
SERUM CHLORIDE (ISE Indirect)	106.0 #	mmol/L	[95.0-105.0]
eGFR	106.9	ml/min/1.73sq.m	[>60.0]

Technical Note

eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to 1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis / Icterus / Lipemia.

Page 6 of 11

-----END OF REPORT-----



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

Human Care Medical Charitable Trust

Registered Office: Sector-6, Dwarka, New Delhi 110 075

Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 32240202504
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 13:59
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 15:11
Receiving Date : 06 Feb 2024 14:16

BIOCHEMISTRY

Specimen Type : Plasma

PLASMA GLUCOSE - PP

Plasma GLUCOSE - PP (Hexokinase) 141 # mg/dl [70-140]

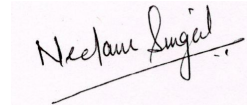
Note : Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying, brisk glucose absorption , post exercise

Specimen Type : Serum/Plasma

Plasma GLUCOSE-Fasting (Hexokinase) 88 mg/dl [74-106]

Page 7 of 11

-----END OF REPORT-----



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

Human Care Medical Charitable Trust

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Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 33240201607
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:12
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 13:11
Receiving Date : 06 Feb 2024 11:14

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (Automated) Specimen-Whole Blood

ESR **35.0 #** **mm/1sthour** **[0.0-20.0]**

Interpretation :

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week postpartum.

ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives).

It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Test Name	Result	Unit	Biological Ref. Interval
COMPLETE BLOOD COUNT (EDTA Blood)			
WBC Count (Flow cytometry)	5320	/cu.mm	[4000-10000]
RBC Count (Impedence)	4.26	million/cu.mm	[3.80-4.80]
Haemoglobin (SLS Method)	11.8 #	g/dL	[12.0-15.0]
Haematocrit (PCV) (RBC Pulse Height Detector Method)	36.6	%	[36.0-46.0]
MCV (Calculated)	85.9	fL	[83.0-101.0]
MCH (Calculated)	27.7	pg	[25.0-32.0]
MCHC (Calculated)	32.2	g/dL	[31.5-34.5]
Platelet Count (Impedence)	262000	/cu.mm	[150000-410000]
RDW-CV (Calculated)	13.0	%	[11.6-14.0]
DIFFERENTIAL COUNT			
Neutrophils (Flowcytometry)	58.6	%	[40.0-80.0]
Lymphocytes (Flowcytometry)	31.8	%	[20.0-40.0]

Page 8 of 11

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Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 33240201607
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:12
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 12:19
Receiving Date : 06 Feb 2024 11:14

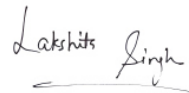
HAEMATOLOGY

Monocytes (Flowcytometry)	7.7	%	[2.0-10.0]
Eosinophils (Flowcytometry)	1.3	%	[1.0-6.0]
Basophils (Flowcytometry)	0.6 #	%	[1.0-2.0]
IG	0.20	%	
Neutrophil Absolute(Flourescence flow cytometry)	3.1	/cu mm	[2.0-7.0]x10 ³
Lymphocyte Absolute(Flourescence flow cytometry)	1.7	/cu mm	[1.0-3.0]x10 ³
Monocyte Absolute(Flourescence flow cytometry)	0.4	/cu mm	[0.2-1.2]x10 ³
Eosinophil Absolute(Flourescence flow cytometry)	0.1	/cu mm	[0.0-0.5]x10 ³
Basophil Absolute(Flourescence flow cytometry)	0.0	/cu mm	[0.0-0.1]x10 ³

Complete Blood Count is used to evaluate wide range of health disorders, including anemia, infection, and leukemia. Abnormal increase or decrease in cell counts as revealed may indicate that an underlying medical condition that calls for further evaluation.

Page 9 of 11

-----END OF REPORT-----



Dr.Lakshita singh

Human Care Medical Charitable Trust

Registered Office: Sector-6, Dwarka, New Delhi 110 075

Department Of Laboratory Medicine

Name : MRS SUNDER DEVI **Age** : 52 Yr(s) Sex :Female
Registration No : MH011680042 **Lab No** : 38240200427
Patient Episode : H03000059640 **Collection Date** : 06 Feb 2024 10:12
Referred By : HEALTH CHECK MHD **Reporting Date** : 06 Feb 2024 14:13
Receiving Date : 06 Feb 2024 10:42

CLINICAL PATHOLOGY

Test Name	Result	Biological Ref. Interval
ROUTINE URINE ANALYSIS		
MACROSCOPIC DESCRIPTION		
Colour (Visual)	PALE YELLOW	(Pale Yellow - Yellow)
Appearance (Visual)	CLEAR	
CHEMICAL EXAMINATION		
Reaction[pH] (Reflectancephotometry(Indicator Method))	5.0	(5.0-9.0)
Specific Gravity (Reflectancephotometry(Indicator Method))	1.015	(1.003-1.035)
Bilirubin	Negative	NEGATIVE
Protein/Albumin (Reflectance photometry(Indicator Method)/Manual SSA)	Negative	(NEGATIVE-TRACE)
Glucose (Reflectance photometry (GOD-POD/Benedict Method))	NOT DETECTED	(NEGATIVE)
Ketone Bodies (Reflectance photometry(Legal's Test)/Manual Rotheras)	NOT DETECTED	(NEGATIVE)
Urobilinogen Reflectance photometry/Diazonium salt reaction	NORMAL	(NORMAL)
Nitrite Reflectance photometry/Griess test	NEGATIVE	NEGATIVE
Leukocytes	TRACE	NEGATIVE
Reflectance photometry/Action of Esterase		
BLOOD (Reflectance photometry(peroxidase))	NIL	NEGATIVE
MICROSCOPIC EXAMINATION (Manual)	Method: Light microscopy on centrifuged urine	
WBC/Pus Cells	4-6 /hpf	(4-6)
Red Blood Cells	NIL	(1-2)
Epithelial Cells	1-2 /hpf	(2-4)
Casts	NIL	(NIL)
Crystals	NIL	(NIL)
Bacteria	NIL	
Yeast cells	NIL	

Interpretation:

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CLINICAL PATHOLOGY

URINALYSIS--Routine urine analysis assists in screening and diagnosis of various metabolic , urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine.

Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine.

Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most Common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased Specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased Specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in case of hemolytic anemia.

Page 11 of 11

-----END OF REPORT-----



Dr. Asha Preethi V.S.
CONSULTANT PATHOLOGY



NAME	MRS Sunder DEVI	STUDY DATE	06/02/2024 1:42PM
AGE / SEX	52 y / F	HOSPITAL NO.	MH011680042
ACCESSION NO.	R6832659	MODALITY	MG
REPORTED ON	06/02/2024 2:29PM	REFERRED BY	Health Check MHD

BILATERAL MAMMOGRAM

Bilateral breast mammogram was performed in craniocaudal and mediolateral oblique projections and the images were reviewed on a mammography compatible digital CR system.

Indication: Screening. No previous mammogram provided.

Findings:

Both breasts show scattered fibro-glandular parenchyma (ACR class B).

An oval shaped soft tissue opacity with an eccentric focus of calcification within is noted in the deep third of the upper outer quadrant.

Presence of any calcification Vascular calcification is seen bilaterally. A speck of benign calcification is noted in the superficial aspect of the upper outer quadrant of left breast in the anterior third.

No skin thickening, nipple retraction or architectural distortion seen in either breast.

Axillary lymph nodes - Nodes with fatty hila are seen in both axillae.

IMPRESSION:

- **Oval shaped soft tissue opacity with an eccentric focus of calcification within in the upper outer quadrant. BIRADS 3.**
- **Speck of benign calcification in the superficial aspect of the upper outer quadrant of left breast. BIRADS 2.**

Kindly correlate clinically

Recommendation- US correlation

Kindly bring these films and the report on your next visit.

Please note: Not all breast abnormalities show up on mammography. The management of a palpable abnormality must be based on clinical grounds. If you detect a lump or any other changes in your breast before your next screening mammogram, consult your doctor immediately.

Dr. Simran Singh DNB, FRCR(UK) DMC N0.36404

CONSULTANT RADIOLOGIST

*******End Of Report*******



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NAME	MRS Sunder DEVI	STUDY DATE	06/02/2024 12:13PM
AGE / SEX	52 y / F	HOSPITAL NO.	MH011680042
ACCESSION NO.	R6832657	MODALITY	US
REPORTED ON	06/02/2024 1:15PM	REFERRED BY	Health Check MHD

USG WHOLE ABDOMEN

Results:

Liver is normal in size and shows grade I fatty changes. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre.

Gall bladder is not seen (h/o surgery).
Common bile duct is normal in calibre.

Pancreas is normal in size and echopattern.

Spleen is normal in size and echopattern.

Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. No focal lesion or calculus seen. Bilateral pelvicalyceal systems are not dilated.

Urinary bladder is normal in wall thickness with clear contents. No significant intra or extraluminal mass is seen.

Uterus is not seen (h/o surgery).

No significant free fluid is detected.

IMPRESSION: Grade I fatty liver.

Kindly correlate clinically

Dr. Prerna Malhotra MBBS, MD, DMC No: 90870

ASSOCIATE CONSULTANT

*******End Of Report*******



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