

भारत सरकार  
GOVERNMENT OF INDIA

उषा वर्मा  
Usha Verma

जन्म वर्ष / Year of Birth: 1971  
महिला / Female

6765

आधार — आम आदमी का अधिकार

Dr. PIYUSH GOYAL  
MBBS, DMRD (Radiologist)  
RMC No.-037041



# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

- B-14, Vidhyadhar Enclave-II, Near Axix Bank
- Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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## General Physical Examination

Date of Examination: 23/08/2024

Name: Usha Verma Age: 52 yrs DOB: 1971 Sex: Female

Referred By: Bank of India

Photo ID: Adhar Card ID #: 6765

Ht: 146 (cm)

Wt: 50 (Kg)

Chest (Expiration): 87 (cm)

Abdomen Circumference: 81 (cm)

Blood Pressure: 130/85 mm Hg PR: 79 / min RR: 18 / min Temp: Absent

BMI 23.5

Eye Examination: R/E, 6/6, N/G, NCB  
L/E, 6/6, N/G, NCB

Other: NO

On examination he/she appears physically and mentally fit:  Yes /  No

Signature Of Examinee : \_\_\_\_\_ Name of Examinee: Usha Verma

Signature Medical Examiner : Dr. Piyush Goyal Name Medical Examiner Dr. Piyush Goyal  
MBBS, DMRD (Radiologist)  
RMC No.-037041





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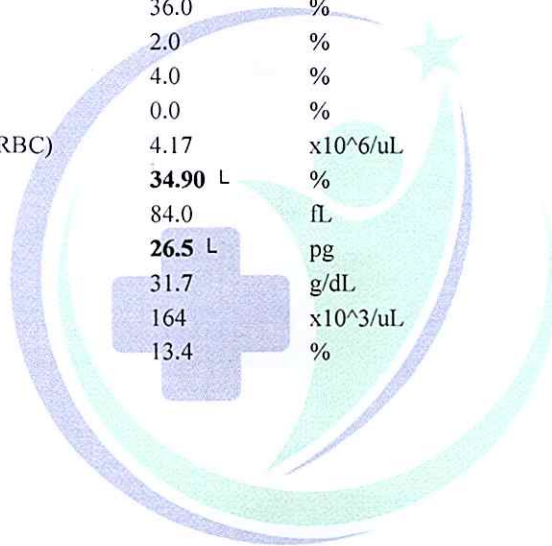
<b>NAME :- Mrs. USHA VERMA</b>	Patient ID :12234956	Date :- 23/03/2024	09:24:43
Age :- 53 Yrs 2 Mon 24 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 24/03/2024 11:28:31

## HAEMOGARAM

## HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP ABOVE 40FEMALE			
<b>HAEMOGLOBIN (Hb)</b>	<b>11.0</b> L	g/dL	12.0 - 15.0
<b>TOTAL LEUCOCYTE COUNT</b>	4.60	/cumm	4.00 - 10.00
<b>DIFFERENTIAL LEUCOCYTE COUNT</b>			
NEUTROPHIL	58.0	%	40.0 - 80.0
LYMPHOCYTE	36.0	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.17	x10 <sup>6</sup> /uL	3.80 - 4.80
HEMATOCRIT (HCT)	<b>34.90</b> L	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	84.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	<b>26.5</b> L	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	31.7	g/dL	31.5 - 34.5
<b>PLATELET COUNT</b>	164	x10 <sup>3</sup> /uL	150 - 410
RDW-CV	13.4	%	11.6 - 14.0



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## HAEMATOLOGY

### Erythrocyte Sedimentation Rate (ESR)

Method:- Westergreen

16

mm in 1st hr

00 - 20

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein. ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



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(CBC): Methodology: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: Sysmex 6 part fully automatic analyzer XN-L,Japan





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## BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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FASTING BLOOD SUGAR (Plasma)  
Method:- GOD POD

94.2

mg/dl

70.0 - 115.0

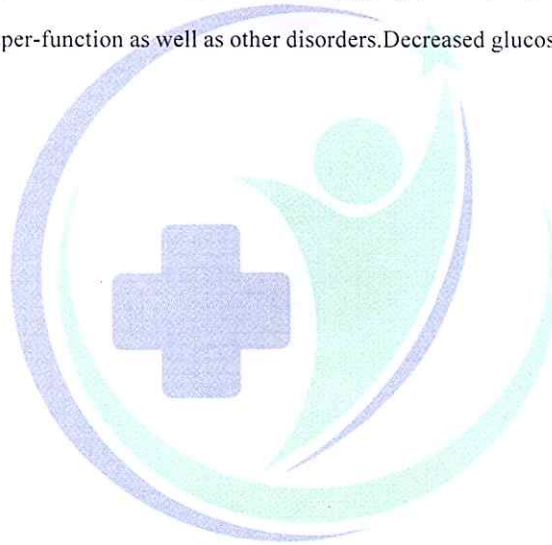
Impaired glucose tolerance (IGT)

111 - 125 mg/dL

Diabetes Mellitus (DM)

> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .



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## HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>GLYCOSYLATED HEMOGLOBIN (HbA1C)</b> Method:- CAPILLARY with EDTA	5.5	%	Non-diabetic: < 5.7 Pre-diabetics: 5.7-6.4 Diabetics: = 6.5 or higher ADA Target: 7.0 Action suggested: > 6.5
MEAN PLASMA GLUCOSE Method:- Calculated Parameter	108	mg/dL	68 - 125

### INTERPRETATION

AS PER AMERICAN DIABETES ASSOCIATION (ADA)

Reference Group HbA1c in %  
Non diabetic adults >=18 years < 5.7  
At risk (Prediabetes) 5.7 - 6.4  
Diagnosing Diabetes >= 6.5

### CLINICAL NOTES

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.

Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al]

#### 1. Erythropoiesis

- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

#### 2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

#### 3. Glycation

- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

#### 4. Erythrocyte destruction

- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

#### 5. Others

- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use, chronic renal failure
- Decreased HbA1c: hypertriglyceridemia, reticulocytosis, chronic liver disease, aspirin, vitamin C and E, splenomegaly, rheumatoid arthritis or drugs

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## HAEMATOLOGY

BLOOD GROUP ABO

Method:- Haemagglutination reaction

"B" POSITIVE



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## BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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### LIPID PROFILE

**TOTAL CHOLESTEROL** 200.00 mg/dl  
 Desirable <200  
 Borderline 200-239  
 High > 240  
 Method:- CHOD-PAP methodology

**InstrumentName:**MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

**TRIGLYCERIDES** 146.00 mg/dl  
 Normal <150  
 Borderline high 150-199  
 High 200-499  
 Very high >500  
 Method:- GPO-PAP

**InstrumentName:**Randox Rx Imola **Interpretation :** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

**DIRECT HDL CHOLESTEROL** 43.20 mg/dl  
 Method:- Direct clearance Method  
 MALE- 30-70  
 FEMALE - 30-85

**Instrument Name:**Rx Daytona plus **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

**LDL CHOLESTEROL** 132.47 mg/dl  
 Optimal <100  
 Near Optimal/above optimal 100-129  
 Borderline High 130-159  
 High 160-189  
 Very High > 190  
 Method:- Calculated Method

**VLDL CHOLESTEROL** 29.20 mg/dl  
 Method:- Calculated  
 0.00 - 80.00

**T.CHOLESTEROL/HDL CHOLESTEROL RATIO** 4.63  
 Method:- Calculated  
 0.00 - 4.90

**L.DL / HDL CHOLESTEROL RATIO** 3.07  
 Method:- Calculated  
 0.00 - 3.50

**TOTAL LIPID** 617.44 mg/dl  
 Method:- CALCULATED  
 400.00 - 1000.00

- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol
- As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is

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## BIOCHEMISTRY

recommended

3 Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.



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## BIOCHEMISTRY

### LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	0.59	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.16	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.43	mg/dl	0.30-0.70
SGOT Method:- IFCC	18.7	U/L	0.0 - 40.0
SGPT Method:- IFCC	26.3	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	86.50	U/L	64.00 - 306.00
<b>InstrumentName:</b> MISPA PLUS <b>Interpretation:</b> Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease.			
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.	32.20	H U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	6.45	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.21	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.24	gm/dl	2.20 - 3.50
A/G RATIO	1.88		1.30 - 2.50

**Interpretation :** Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

**Note :-** These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc. Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as

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## BIOCHEMISTRY

### RFT / KFT WITH ELECTROLYTES

SERUM UREA 26.50 mg/dl 10.00 - 50.00  
 Method:- Urease/GLDH

**InstrumentName:** HORIBA CA 60 **Interpretation :** Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 1.09 mg/dl Males : 0.6-1.50 mg/dl  
 Method:- Jaffe's Method Females : 0.6 -1.40 mg/dl

**Interpretation :**  
 Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 5.21 mg/dl 2.40 - 7.00

**InstrumentName:** HORIBA YUMIZEN CA60 Daytona plus **Interpretation: Elevated Urate:** High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Down's syndrome, Metabolic syndrome, Pregnancy, Gout.

SODIUM 136.3 mmol/L 135.0 - 150.0  
 Method:- ISE

POTASSIUM 4.47 mmol/L 3.50 - 5.50  
 Method:- ISE

CHLORIDE 98.2 mmol/L 94.0 - 110.0  
 Method:- ISE

SERUM CALCIUM 9.32 mg/dL 8.80 - 10.20  
 Method:- Arsenazo III Method

**InstrumentName:** MISPA PLUS **Interpretation:** Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia. Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN 6.45 g/dl 6.00 - 8.40  
 Method:- Direct Biuret Reagent

SERUM ALBUMIN 4.21 g/dl 3.50 - 5.50  
 Method:- Bromocresol Green

SERUM GLOBULIN 2.24 gm/dl 2.20 - 3.50  
 Method:- CALCULATION

A/G RATIO 1.88 1.30 - 2.50

**Interpretation :** Measurements obtained by this method are used in the diagnosis and treatment of a variety of dis... liver, kidney and

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## BIOCHEMISTRY

bone marrow as well as other metabolic or nutritional disorders.

### INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR. In urine, it can be used as a quality assurance tool to assess the accuracy of a 24-hour collection. Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the blood increases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare, they almost always reflect low muscle mass.

Apart from renal failure Blood Urea can increase in dehydration and GI bleed.



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## CLINICAL PATHOLOGY

URINE SUGAR (FASTING)  
Collected Sample Received

Nil

Nil



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## TOTAL THYROID PROFILE

### IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
<b>THYROID-TRIIODOTHYRONINE T3</b> Method:- ECLIA	1.00	ng/mL	0.70 - 2.04
<b>THYROID - THYROXINE (T4)</b> Method:- ECLIA	6.28	ug/dl	5.10 - 14.10
<b>TSH</b> Method:- Chemiluminescence	2.768	μIU/mL	

4th Generation Assay, Reference ranges vary between laboratories

#### PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

1st Trimester : 0.10-2.50 uIU/mL

2nd Trimester : 0.20-3.00 uIU/mL

3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

**NOTE**-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result.

#### INTERPRETATION

1. Primary hyperthyroidism is accompanied by ↑ serum T3 & T4 values along with ↓ TSH level.
2. Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑ serum TSH levels
3. Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
4. Normal or ↓ T3 & ↑ T4 levels indicate T4 Thyrotoxicosis ( problem is conversion of T4 to T3)
5. Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

**COMMENTS:** Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.

**Disclaimer**-TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly

**Reference ranges are from Teitz fundamental of clinical chemistry 8th ed (2018)**

Test performed by Instrument : Beckman coulter Dxi 800

**Note** : The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

\*\*\* End of Report \*\*\*

**DR. TANU RUNGTA**  
MD (Pathology)  
RMC No. 17226

**Technologist**  
MGR  
Page No: 15 of 15



# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

- 📍 B-14, Vidhyadhar Enclave-II, Near Axis Bank  
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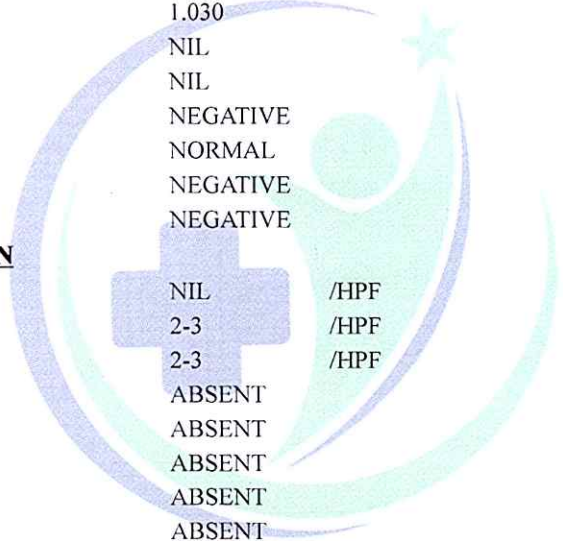


<b>NAME :- Mrs. USHA VERMA</b>	Patient ID :-12234956	Date :- 23/03/2024	09:24:43
Age :- 53 Yrs 2 Mon 24 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 24/03/2024 11:28:31

## CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>Urine Routine</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION(PH)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.030		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<b><u>MICROSCOPY EXAMINATION</u></b>			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT



**Technologist**  
MGR  
Page No: 12 of 15

**DR.TANU RUNGTA**  
MD (Pathology)  
RMC No. 17226

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MRS. USHA VERMA	Age : 53 Y/F
Registration Date: 23/03/2024	Ref. by: BANK OF BARODA

## CHEST-X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

*Degenerative changes are seen in visualized bones and spine.*

**IMPRESSION: No significant abnormality is detected.**

**DR. SHALINI GOEL**  
M.B.B.S, D.N.B (Radiodiagnosis)  
RMC no.: 21954



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5



MRS. USHA VERMA	53 Y/F
Registration Date: 23/03/2024	Ref. by: BANK OF BARODA

## Ultrasonography report: Breast and Axilla

### Right breast:-

Skin, subcutaneous tissue and retroareolar region is normal.

Fibro glandular tissue shows normal architecture and echotexture.

Pre and retro mammary regions are unremarkable.

No obvious cyst, mass or architectural distortion visualized.

Axillary lymph nodes are not significantly enlarged and their hilar shadows are preserved.

### Left breast: -

Skin, subcutaneous tissue and retroareolar region is normal.

Fibro glandular tissue shows normal architecture and echotexture.

Pre and retro mammary regions are unremarkable.

No obvious cyst, mass or architectural distortion visualized.

Axillary lymph nodes are not significantly enlarged and their hilar shadows are preserved.

**IMPRESSION: No significant abnormality is detected.**

**DR.SHALINI GOEL**

**M.B.B.S, D.N.B (Radiodiagnosis)**

**RMC no.: 21954**





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MRS. USHA VERMA	Age : 53 Y/F
Registration Date: 23/03/2024	Ref. by: BANK OF BARODA

## ULTRASOUND OF WHOLE ABDOMEN

**Liver** is of normal size (12.3 cm) with normal echotexture. No focal space occupying lesion is seen within liver parenchyma. Intrahepatic biliary channels are not dilated. Portal vein diameter is normal.

**Gall bladder** is partially distended. Common bile duct is not dilated.

**Pancreas** is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**Spleen** is of normal size and shape (9.6 cm). Echotexture is normal. No focal lesion is seen.

**Right kidney** is normally sited and is of normal size (measuring approx. 10.1 x 3.8 cm) and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

**Left kidney** is small/atrophic (measuring approx. 6.7 x 3.1 cm) with mildly prominent pelvicalyceal system. Few (1-2) concretions (<3 mm) are noted in upper and lower pole calices. Cortical echogenicity is mildly increased with partial loss of cortico-medullary differentiation.

**Urinary bladder** does not show any calculus or mass lesion.

**Uterus** is postoperative.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.  
No significant free fluid is seen in pouch of Douglas.

### IMPRESSION:

- Small/atrophic left kidney with grade 2 CKD changes – likely sequelae to previous obstructive uropathy.
- Rest no significant abnormality is detected

DR. SHALINI GOEL  
M.B.B.S, D.N.B (Radiodiagnosis)  
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MRS. USHA VERMA	53 Y/F
Registration Date:23/03/2024	Ref. by: BANK OF BARODA

**2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:**  
FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

**M.MODE EXAMINATION:**

AO	3.3	Cm	LA	3.0	cm	IVS-D	0.9	cm
IVS-S	1.3	cm	LVID	3.5	cm	LVSD	2.8	cm
LVPW-D	0.9	cm	LVPW-S	1.3	cm	RV		cm
RVWT		cm	EDV		ml	LVVS		ml
LVEF	55-60%		RWMA			ABSENT		

**CHAMBERS:**

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

**COLOUR DOPPLER:**

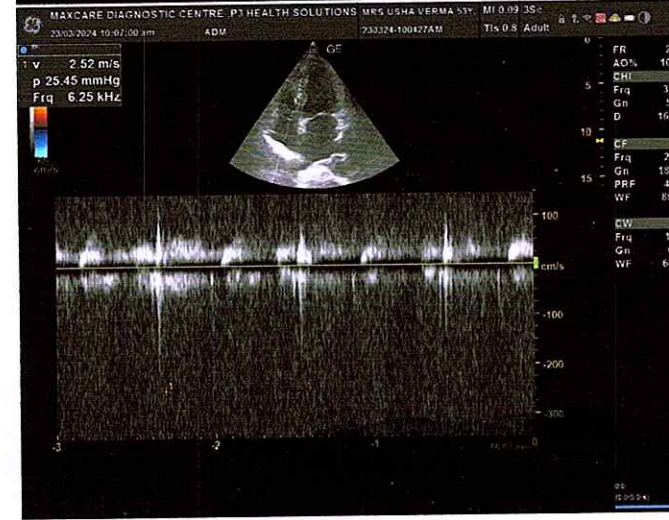
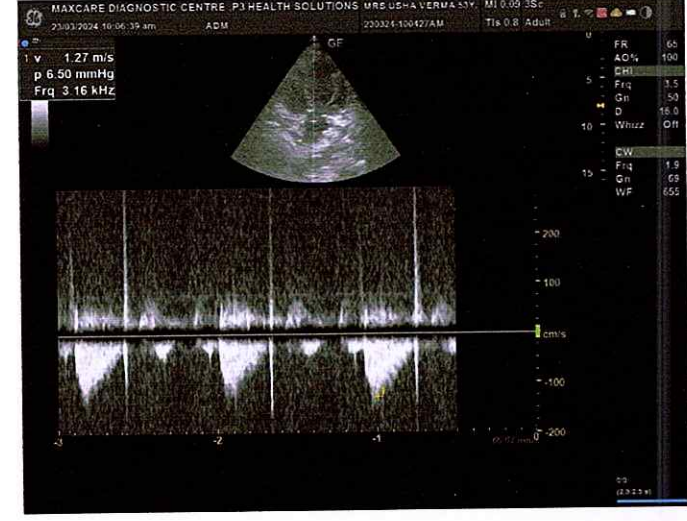
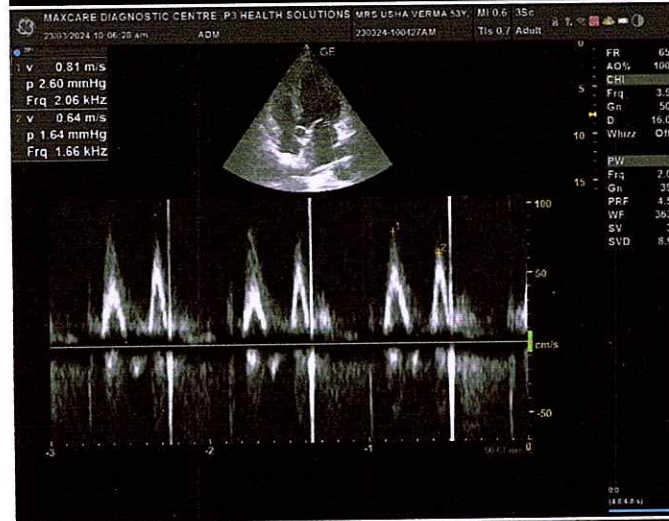
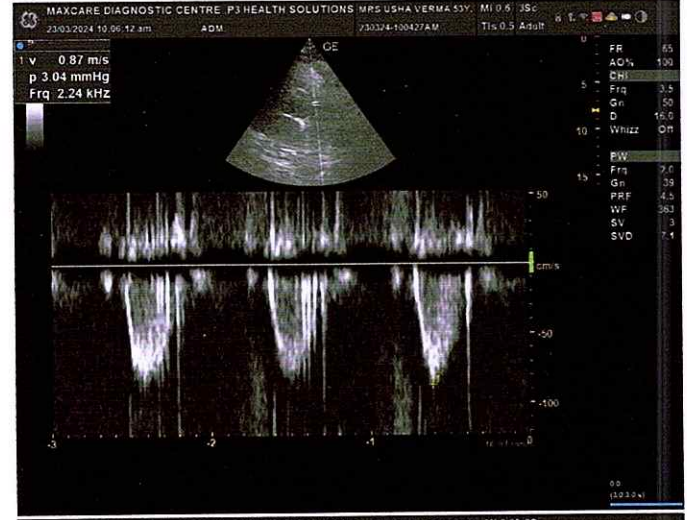
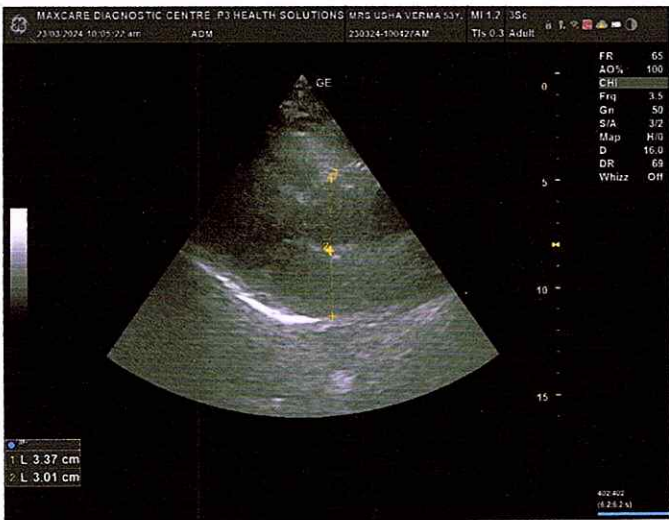
<b>MITRAL VALVE</b>					
E VELOCITY	0.81	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.64	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION			ABSENT		
<b>AORTIC VALVE</b>					
PEAK VELOCITY	1.27	m/sec	PEAK GRADIENT		mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION			ABSENT		
<b>TRICUSPID VALVE</b>					
PEAK VELOCITY		m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY		m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION			MILD		
<b>PULMONARY VALVE</b>					
PEAK VELOCITY	0.87	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VELOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION			ABSENT		

**Impression—**

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- MILD TR/ PAH (RVSP 25 MMHG+ RAP).
- NORMAL DIASTOLIC FUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

(Cardiologist)

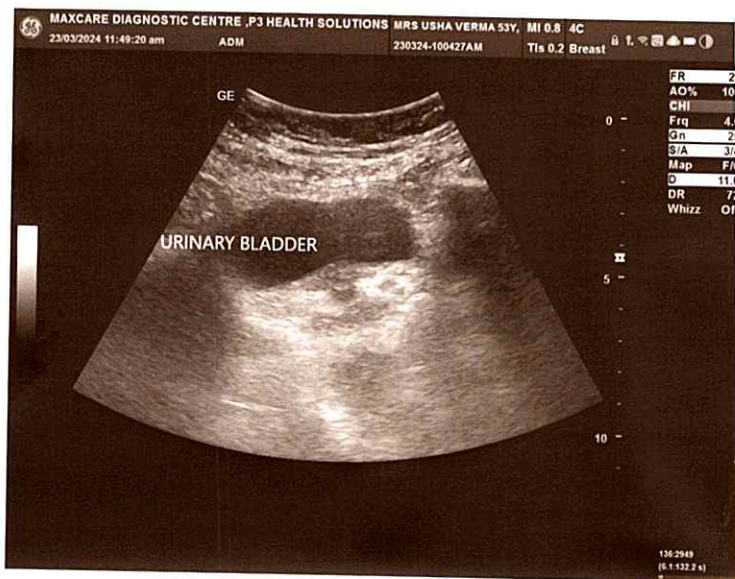




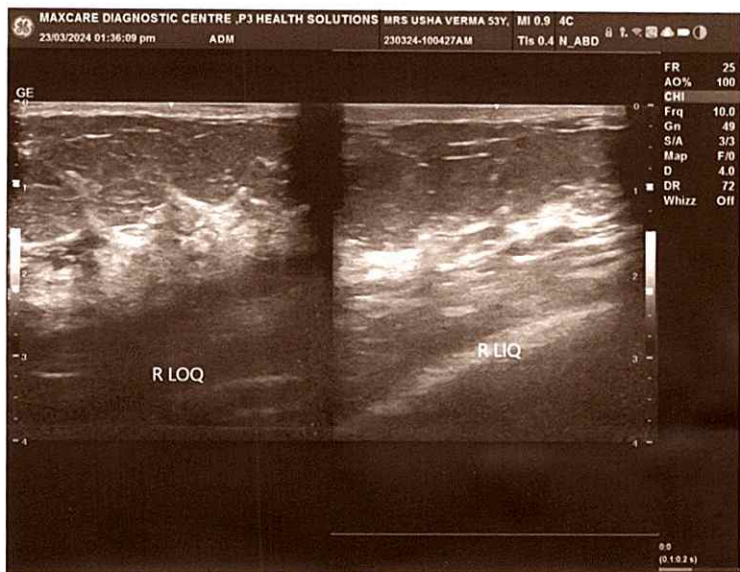
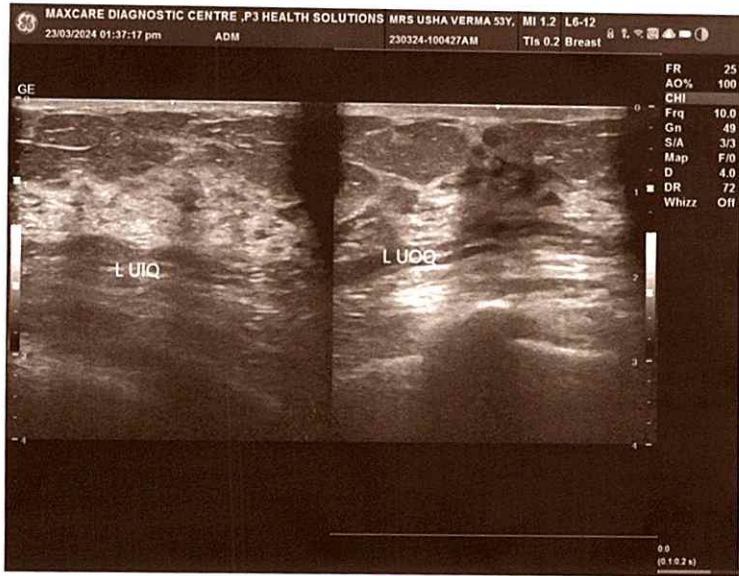
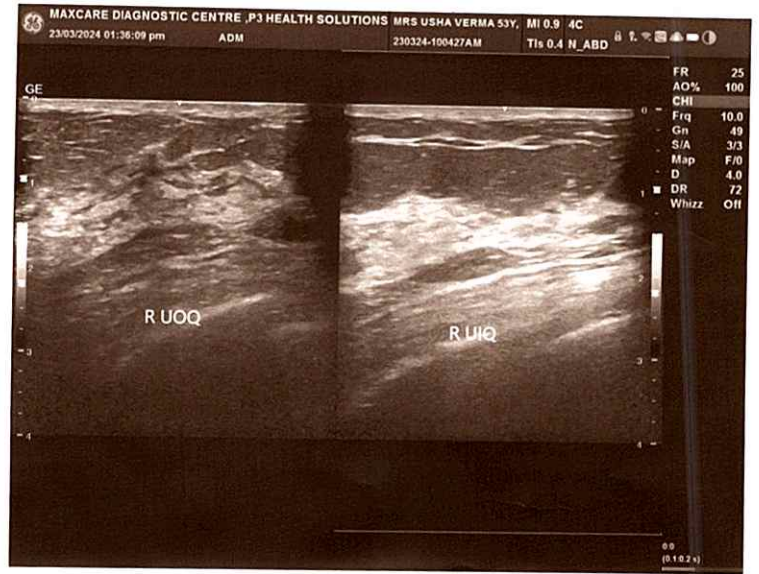
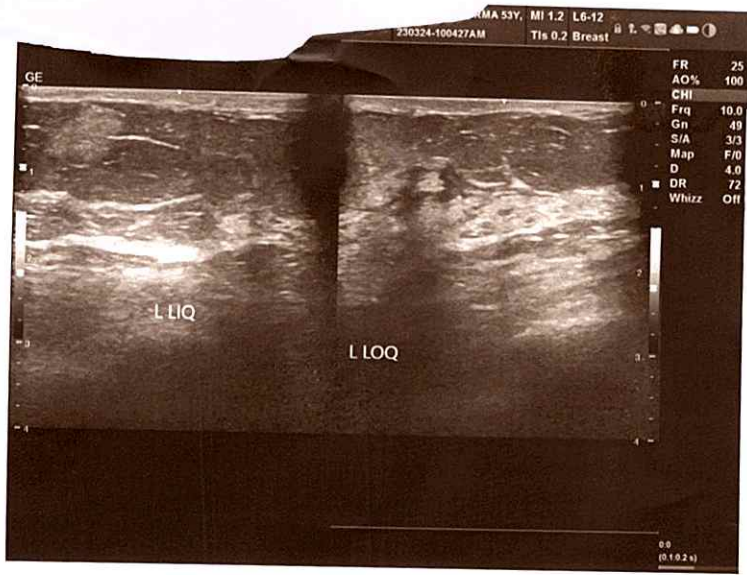








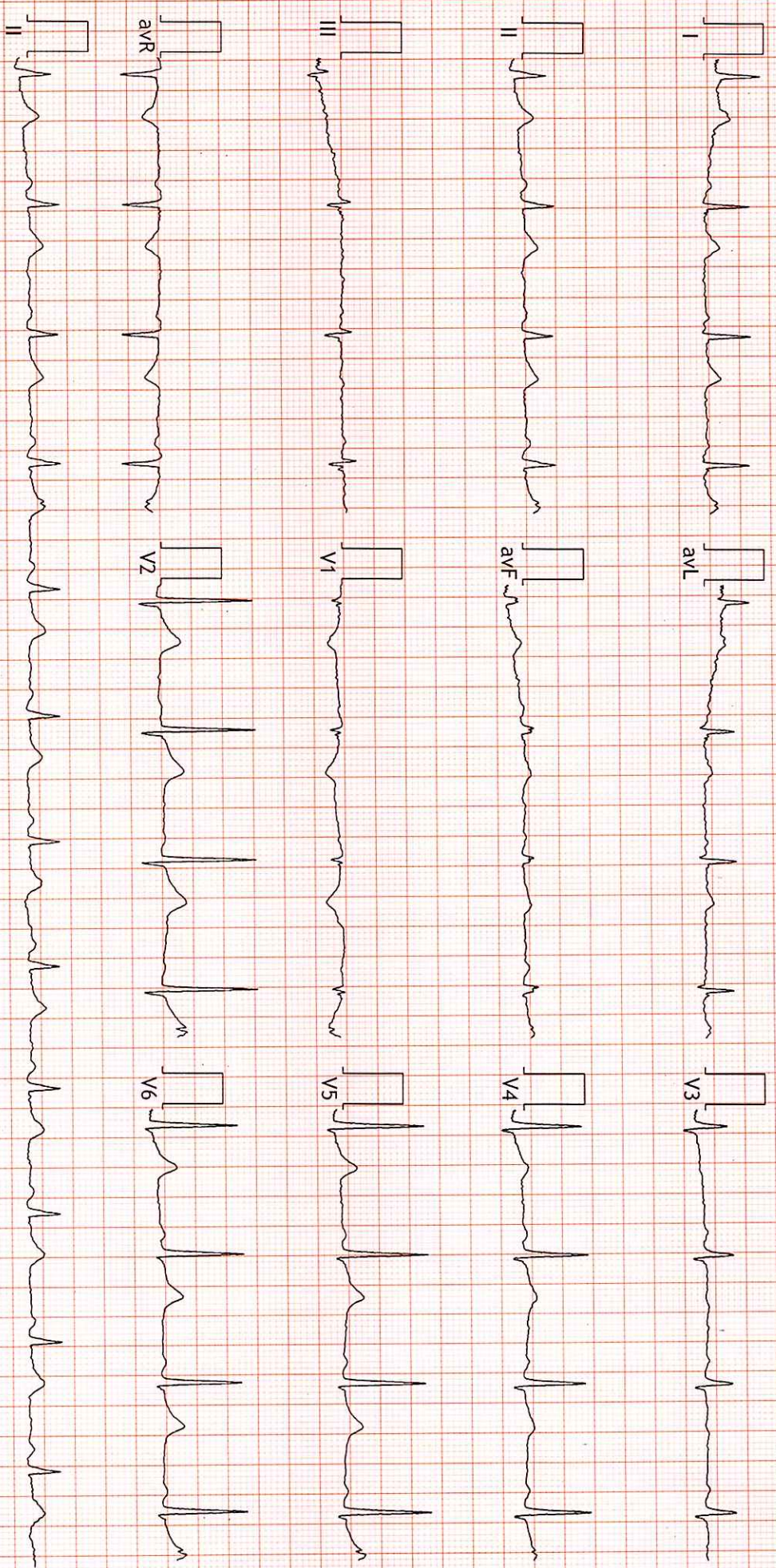






148/31 Cms BP: / / mmHg HR: 71 bpm

PR Interval: 146 ms  
QRS Duration: 100 ms  
QT/QTc: 394/430ms  
P-QRS-T Axis: 55 - 26 - 35 (Deg)



FINDINGS: Normal Sinus Rhythm

Vent Rate : 71 bpm; PR Interval : 146 ms; QRS Duration: 100 ms; QT/QTc Int : 394/430 ms

P-QRS-T axis: 55 • 26 • 35 • (Deg)

Comments :

TUPLE

Dr. Naresh Kumar Mohanka

RMC No.: 35703

MBBS, DIP. CARDIO (ESCORTS)

D.E.M. (RCGP-UK)