Charak dhar DIAGNOSTICS Pvt. Ltd.

292/05, Tulsidas Marg, Basement Chowk, Lucknow-226 003
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CMO Reg. No. RMEE 2445133
NABL Reg. No. MC-2491
Certificate No. MIS-2023-0218

Patient Name	: Ms.REKHA DIXIT	Visit No	: CHA250033743
Age/Gender	: 50 Y/F	Registration ON	: 25/Feb/2025 09:57AM
Lab No	**: 10131039**	Sample Collected ON	: 25/Feb/2025 10:01AM
Referred By	: Dr.AKANKSHA GUPTA	Sample Received ON	: 25/Feb/2025 10:11AM
Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 25/Feb/2025 02:27PM
Doctor Advice	: OCCULT BLOOD,CRP (Quantitative),ESR,DOPPLER BOTH LIMB ARTERIAL&VENOUS,HCV ELISA,HBSAg,HIV,2D ECHO,ECG,USG WHOLE ABDOMEN		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
ESR				
Erythrocyte Sedimentation Rate ESR	**36.00**		0 - 15	Westergreen

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

CRP-QUANTITATIVE			
CRP-QUANTITATIVE TEST	4.4	MG/L	0.1 - 6

Method: Immunoturbidimetric

(Method: Immunoturbidimetric on photometry system)

SUMMARY : C - reactive protien (CRP) is the best known among the acute phase protiens, a group of protien whose concentration increases in blood as a response to inflammatory disorders.CRP is normally present in low concentration in blood of healthy individuals (< 1mg/L). It is elevated up to 500 mg/L in acute inflammatory processes associated with bacterial infections, post operative conditions tissue damage already after 6 hours reaching a peak at 48 hours.. The measurment of CRP represents a useful aboratory test for detection of acute infection as well as for monitoring inflammtory proceses also in acute rheumatic & gastrointestinal disease. In recent studies it has been shows that in apparrently healthy subjects there is a direct orrelation between CRP concentrations & the risk of developing oronary heart disease (CHD).

hsCRP cut off for risk assessment as per CDC/AHA

Level	Risk
<1.0	Low
1.0-3.0	Average
>3.0	High

All reports to be clinically corelated

[Checked By]

Print.Date/Time: 25-02-2025 15:30:10
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DR. NISHANT SHARMA PATHOLOGIST
DR. SHADAB PATHOLOGIST
DR. ADITI D AGARWAL PATHOLOGIST

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Test Name	Result	Unit	Bio. Ref. Range	Method
HEPATITIS B SURFACE ANTIGEN (HBsAg)				
Sample Type : SERUM				
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE		<1 - Non Reactive >1 - Reactive	CMIA

Note: This is only a Screening test. Confirmation of the result (Non Reactive/Reactive)should be done by performing a PCR based test.

COMMENTS:

-HBsAg is the first serological marker after infection with Hepatitis B Virus appearing one to ten weeks after exposure and two to eight weeks before the onset of clinical symptoms. HBsAg persists during the acute phase and clears late in the convalescence phase. Failure to clear HBsAg within six months indicates a chronic HBsAg carrier state. HBsAg assays are used to identify the persons infected with HBV and to prevent transmission of the virus by blood and blood products as well as to monitor the status of infected individuals in combination with other hepatitis B serological markers.
-Borderline cases must be confirmed with confirmatory neutralizing assay.

LIMITATIONS:

-Results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infections.
-Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA) which may produce anomalous values when tested with assay kits that employs mouse monoclonal antibodies.
-Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or animal serum products can be prone to this interference and anomalous results may be observed.
-Cross reactivity for specimens from individual with medical conditions (Pregnancy, HIV etc) has been observed.
-HBsAg mutations may result in a false negative result in some HBsAg assays.
-If HBsAg results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.

HIV			
HIV-SEROLOGY	NON REACTIVE	<1.0 : NON REACTIVE >1.0 : REACTIVE	

Done by: Vitros ECI (Sandwich Assay)
Note:-Elisa test is a screening method for HIV.It is known to give false Positive & Negative result.
Hence confirmation:"Western Blot" method is advised.

[Checked By]

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Test Name	Result	Unit	Bio. Ref. Range	Method
HCV ELISA				
Anti-Hepatitis C Virus Antibodies.	NON REACTIVE		< 1.0 : NON REACTIVE > 1.0 : REACTIVE	Sandwich Assay
OCCULT BLOOD				
Stool for Occult Blood	PRESENT		Absent	

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

[Checked By]

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DR. NISHANT SHARMA PATHOLOGIST
DR. SHADAB PATHOLOGIST
DR. ADITI D AGARWAL PATHOLOGIST

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PR.

ECG -REPORT

RATE : 86 bpm

* RHYTHM : Normal

* P wave : Normal

* PR interval : Normal

* QRS Axis : Normal

Duration : Normal

Configuration : Normal

* ST-T Changes : None

* QT interval :

* QTc interval : Sec.

* Other :

OPINION: **ECG WITH IN NORMAL LIMITS**

(FINDING TO BE CORRELATED CLINICALLY)

[DR. PANKAJ RASTOGI, MD, DM]

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PR.

2D- ECHO & COLOR DOPPLER REPORT

1. **MITRAL VALVE STUDY** : **MVOA** - Normal (perimetry) cm2 (PHT)

Anterior Mitral Leaflet:

(a) Motion: Normal **(b) Thickness** : Normal **(c) DE :1.7** cm.

(d) EF 113 mm/sec **(e) EPSS : 06** mm **(f) Vegetation : -**

(g) Calcium : -

Posterior mitral leaflet : Normal

(a). Motion : Normal **(b) Calcium: -** **(c) Vegetation : -**

Valve Score : Mobility /4 Thickness /4 SVA /4
Calcium /4 Total /16

2. **AORTIC VALVE STUDY**

(a) Aortic root 2.5cms **(b) Aortic Opening :1.4**cms **(c) Closure: Central**
(d) Calcium : - **(e) Eccentricity Index : 1** **(f) Vegetation : -**

(g) Valve Structure : Tricuspid,

3. **PULMONARY VALVE STUDY** Normal

(a) EF Slope : - **(b) A Wave : +** **(c) MSN : -**

(D) Thickness : **(e) Others :**

4. **TRICUSPID VALVE :** Normal

5. **SEPTAL AORTIC CONTINUITY** **6. AORTIC MITRAL CONTINUITY**

Left Atrium : 3.1 cms **Clot : -** **Others :**
Right Atrium : Normal **Clot : -** **Others : -**

Contd…...

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VENTRICLES

RIGHT VENTRICLE : Normal

RVD (D)

RVOT

LEFT VENTRICLE :

LVIVS (D) 0.9 cm (s)1.2cm **Motion :** normal

LVPW (D) 0.8cm (s) 1.5 cm **Motion :** Normal

LVID (D) 4.3 cm (s) 2.7 cm **Ejection Fraction :67%**

Fractional Shortening : 37 %

TOMOGRAPHIC VIEWS

Parasternal Long axis view :

NORMAL LV RV DIMENSION
GOOD LV CONTRACTILITY.

Short axis view

Aortic valve level : AOV - NORMAL

PV - NORMAL

TV - NORMAL

MV - NORMAL

Mitral valve level :

Papillary Muscle Level : NO RWMA

Apical 4 chamber View : No LV CLOT

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PERICARDIUM

Normal

DOPPLER STUDIES

	Velocity (m/sec)	Flow pattern (/4)	Regurgitation	Gradient (mm Hg)	Valve area (cm 2)
MITRAL	**e = 1.1 a = 0.7**	**Normal**	**-**	**-**	**-**
AORTIC	**1.2**	**Normal**	**-**	**-**	**–**
TRICUSPID	**0.4**	**Normal**	**2**	**-**	**-**
PULMONARY	**0.8**	**Normal**	**-**	**-**	**-**

OTHER HAEMODYNAMIC DATA

TR peak vel = 3.0m/sec ; RV-RA PSG =36mmHg ; Expected PASP = 46 mmHg

COLOUR DOPPLER

GR II/IV TR

CONCLUSIONS :

- **NORMAL LV RV DIMENSION**
- **GOOD LV SYSTOLIC FUNCTION**
- **LVEF = 67 %**
- **NO RWMA**
- **MODERATE TR**
- **MILD PAH**
- **NO CLOT / VEGETATION**
- **NO PERICARDIAL EFFUSSION**

DR. PANKAJ RASTOGI, MD,DM

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PR.

ULTRASOUND STUDY OF WHOLE ABDOMEN

- **Liver** is **borderline enlarged in size (~155mm) and shows inhomogenous echotexture of liver parenchyma.** No intrahepatic biliary radicle dilatation is seen. No space occupying lesion is seen. Hepatic veins and IVC are seen normally.
- **Gall bladder** is ***not visualized (post operative).***
- **CBD** is normal at porta. No obstructive lesion is seen.
- **Portal vein** Portal vein is normal measures 11mm at porta.
- **Pancreas** *Head & body appear normal. Rest of the pancreas is obscured by bowel gases*.
- **Spleen** is **moderately enlarged in size (~187mm)** and shows homogenous echotexture of parenchyma. No SOL is seen.
- No ascites is seen.
- **Both kidneys** are normal in size and position. No hydronephrosis is seen. No calculus or mass lesion is seen. Cortico-medullary differentiation is well maintained. Parenchymal thickness is normal. No scarring is seen. Right kidney measures 104 x 42 mm in size. Left kidney measures 107 x 37 mm in size.
- **Urinary bladder** is normal in contour with anechoic lumen. No calculus or mass lesion is seen. UB walls are not thickened.
- **Uterus** is normal in size, measures 86 x 47 x 27mm and shows homogenous myometrial echotexture. Endometrial thickness measures 3.2 mm. No endometrial collection is seen. No mass lesion is seen.
- **Cervix** is normal.
- **Both ovaries** are *not visualized - ? atrophic (post menopausal).*
- No adnexal mass lesion is seen.
- **A defect measuring approx 20.2mm is seen in anterior abdominal wall at umbilicus with herniation of omental fat through it. Contents are reducible on transducer pressure – umbilical hernia.**

OPINION:

- **BORDERLINE HEPATOMEGALY WITH INHOMOGENOUS HEPATIC ECHOTEXTURE.**
- **MODERATE SPLENOMEGALY.**
- **UMBILICAL HERNIA**

Clinical correlation is necessary.

[DR. JAYENDRA KR. ARYA, MD]

Transcribed by Gausiya

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PR.

COLOUR DOPPLER STUDY OF BILATERAL LOWER LIMB VEINS AND ARTERIES

VENOUS:

- Bilateral common femoral, superficial femoral, popliteal and visualized parts of bilateral tibial veins reveal clear lumen and normal colour flow with normal phasicity, compressibility and augmentation response.
- *Bilateral anterior and posterior tibial veins could not be very well evaluated in complete extent.*
- *There is transient reversal of color flow across bilateral sapheno-femoral junctions on valsalva maneuver (duration approx 0.63 sec and 1.27 on right & left sides respectively)*
- *Bilateral sapheno popliteal junctions could not be very well evaluated.*
- **Mild subcutaneous edema is seen in bilateral lower limbs, predominantly in distal leg and foot regions.**
- *Rest of the superficial venous system could not be assessed due to limited patient maneuverability.*

ARTERIAL:

- **Diffuse atherosclerotic changes are seen involving visualized parts of bilateral lower limb arteries causing mild luminal narrowing with maintained color flow and triphasic spectral waveform.**

Colour Doppler study shows following indices-

	FLOW VELOCITY RIGHT	WAVE PATTERN	FLOW VELOCITY LEFT	WAVE PATTERN
Common femoral artery	112 cm/sec	Triphasic	114 cm/sec	Triphasic
Superficial femoral artery	106 cm/sec	Triphasic	110 cm/sec	Triphasic
Popliteal artery	86 cm/sec	Triphasic	85 cm/sec	Triphasic
Anterior tibial artery	69 cm/sec	Triphasic	67cm/sec	Triphasic
Posterior tibial artery	70 cm/sec	Triphasic	67cm/sec	Triphasic
Dorsal paedis artery	52 cm/sec	Triphasic	52cm/sec	Triphasic

IMPRESSION:

- **NO EVIDENCE OF DEEP VEIN THROMBOSIS IN VISUALIZED VEINS.**
- **FEATURES SUGGESTIVE OF EARLY BILATERAL SAPHENO-FEMORAL JUNCTION INCOMPETENCE.**
- **DIFFUSE GENERALIZED ATHEROSCLEROTIC CHANGES IN BILATERAL LOWER LIMB ARTERIES CAUSING MILD LUMINAL NARROWING WITHOUT OBVIOUS SIGINIFICANT HEMODYNAMIC CHANGES.**
- **MILD SUBCUTANEOUS EDEMA IN BILATERAL LOWER LIMBS, PREDOMINANTLY IN DISTAL LEG AND FOOT REGIONS.**

Clinical correlation is necessary.

[DR. JAYENDRA K. ARYA, MD]

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