

Patient Name: RUPALI PAGARE	Date: 15/11/2024
Patient Id: 7636	Age/Sex: 32 Years / FEMALE
Ref Phy: DR. SARDA	Address :

ULTRASONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: The liver is normal in size It measures 13.4 cm, shape, position, echogenicity and echotexture. Normal respiratory movements are seen. No focal solid or cystic mass lesion is noted.

BILIARY SYSTEM: Gall bladder shows normal physiological distention. No mural mass or calculus is noted. There is no evidence of pericholecystic fluid. CBD and intra hepatic biliary radicles show normal caliber.

PANCREAS: The pancreas is normal in size, shape, echogenicity and echo texture. No solid or cystic mass lesion is noted. Pancreatic duct is not dilated.

SPLEEN: The spleen is normal in size It measures 9.3 cm, shape, position, echogenicity and echotexture. No focal mass lesion is noted.

KIDNEYS: Right kidney measures 9.5 x 3.3 cm. Left kidney measures 10.5 x 3.5 cm. Both kidneys are normal in size, shape, position, echogenicity and echotexture. Normal corticomedullary differentiation is noted. No focal solid or cystic mass lesion or any calculus is seen. Pelvicalyceal systems on both sides are normal.

URINARY BLADDER: The urinary bladder shows physiological distention. It shows normal wall thickness. No calculus or mass lesion is seen.

UTERUS: The uterus is anteverted. It measures 59.5 x 43.1 x 35.9 mm. It is normal in size, shape, position, echogenicity and echotexture. There is no focal mass lesion in uterus. Endometrium measures 12.8 mm.

ADNEXA: Right ovary measures 2.9 x 1.2 x 2.4 cm. Volume is 4.5 cc Left ovary measures 2.1 x 1.2 x 2.1 cm. Volume is 2.7 cc. Both ovaries are normal in size, shape, echogenicity and echotexture. There is no focal solid or cystic mass lesion in it. No appreciable other adnexal space occupying lesion is noted.

OTHERS: There is no free or loculated fluid collection in abdomen or pelvis. No significant lymphadenopathy is noted.

IMPRESSION:

- **No significant sonographic abnormality noted.**


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Fellowship in MSK Imaging
Reg. No. 2019/05/3879

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Fellow in MSK imaging



ANUSHREE SONOGRAPHY & X-RAY CENTRE

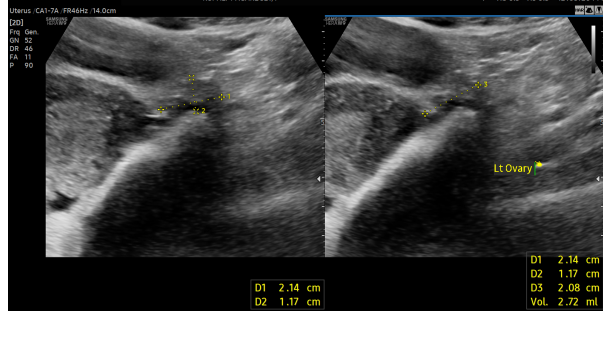
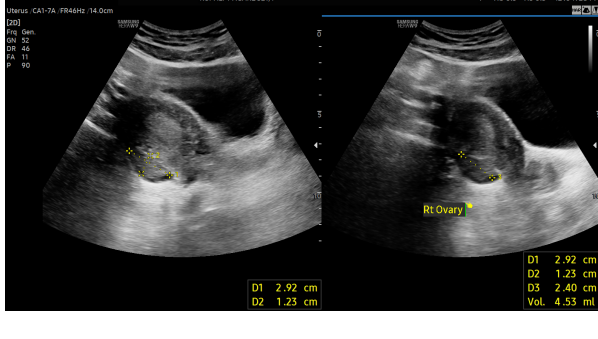
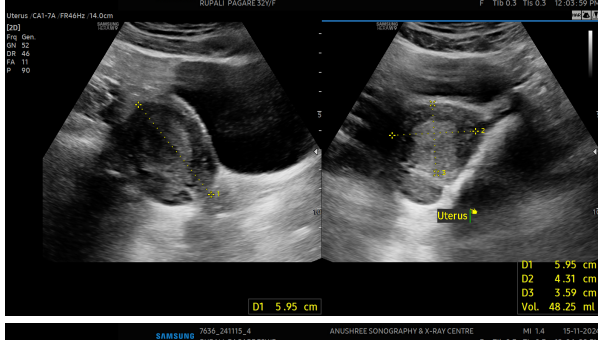
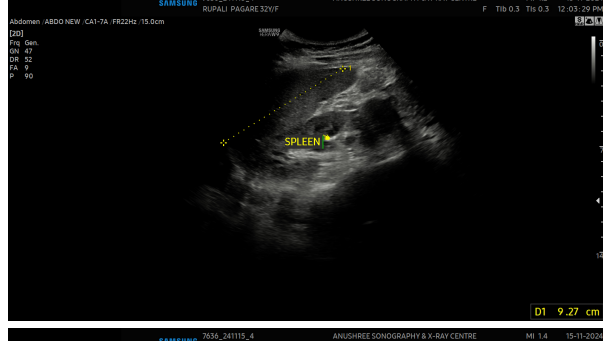
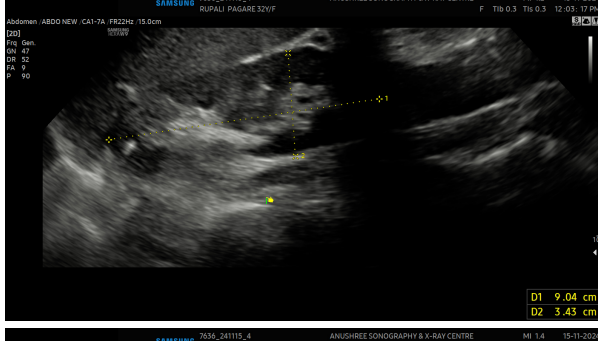
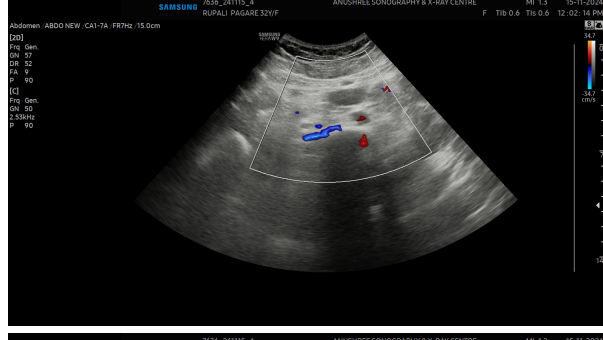
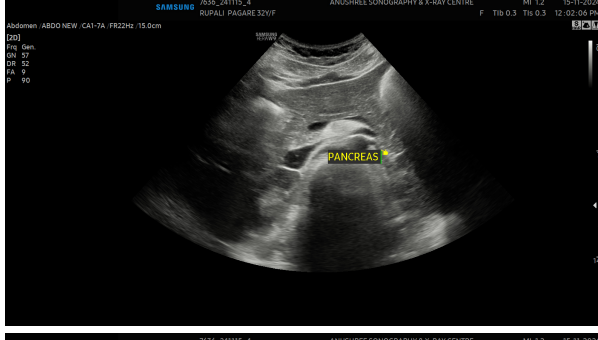
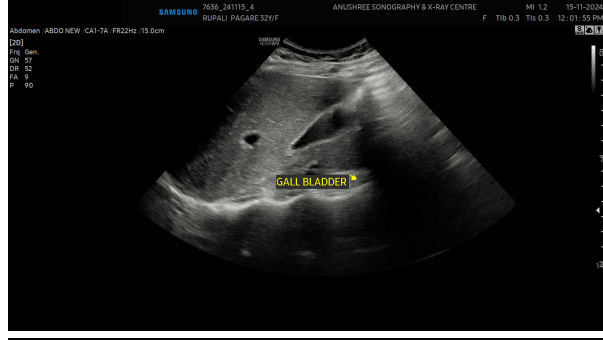
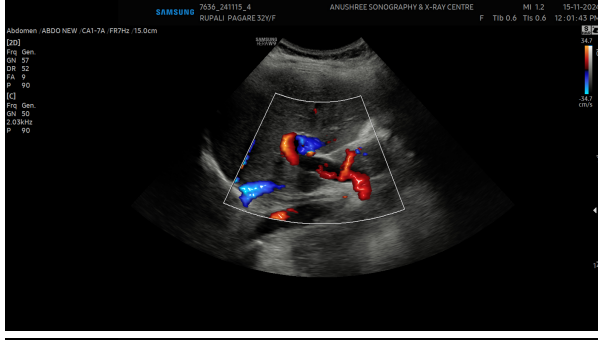
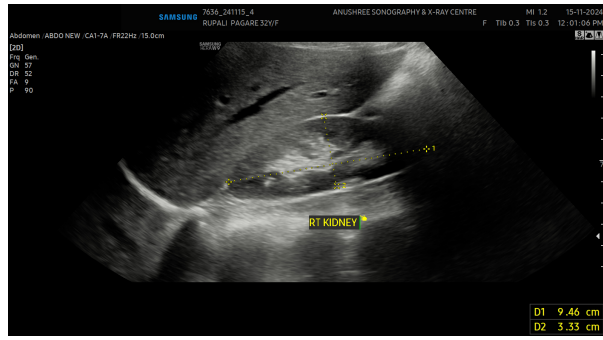
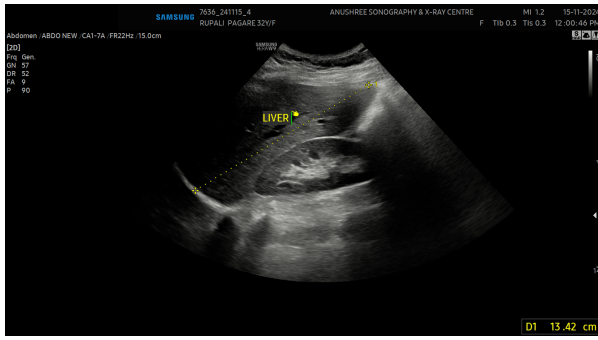
Name: RUPALI PAGARE

Age: 32 Y

Sex: Female

RefDr: Sarda

Date: 15-Nov-2024



Patient Name: RUPALI PAGARE	Date: 15/11/2024
Patient Id: 7642	Age/Sex: 32 Years / FEMALE
Ref Phy: DR. SARDA	Address :

RADIOGRAPH OF CHEST PA VIEW

Findings:

Both the lung fields are clear.
The broncho vascular markings are appears normal.
The hilar shadows are appears normal.
Both Cardiophrenic and Costophrenic angles are clear.
The Cardiac silhoutte is within normal limits.
Aortic shadow is normal.
Both domes of diaphragms are normal.
The visualised bony thorax is normal.

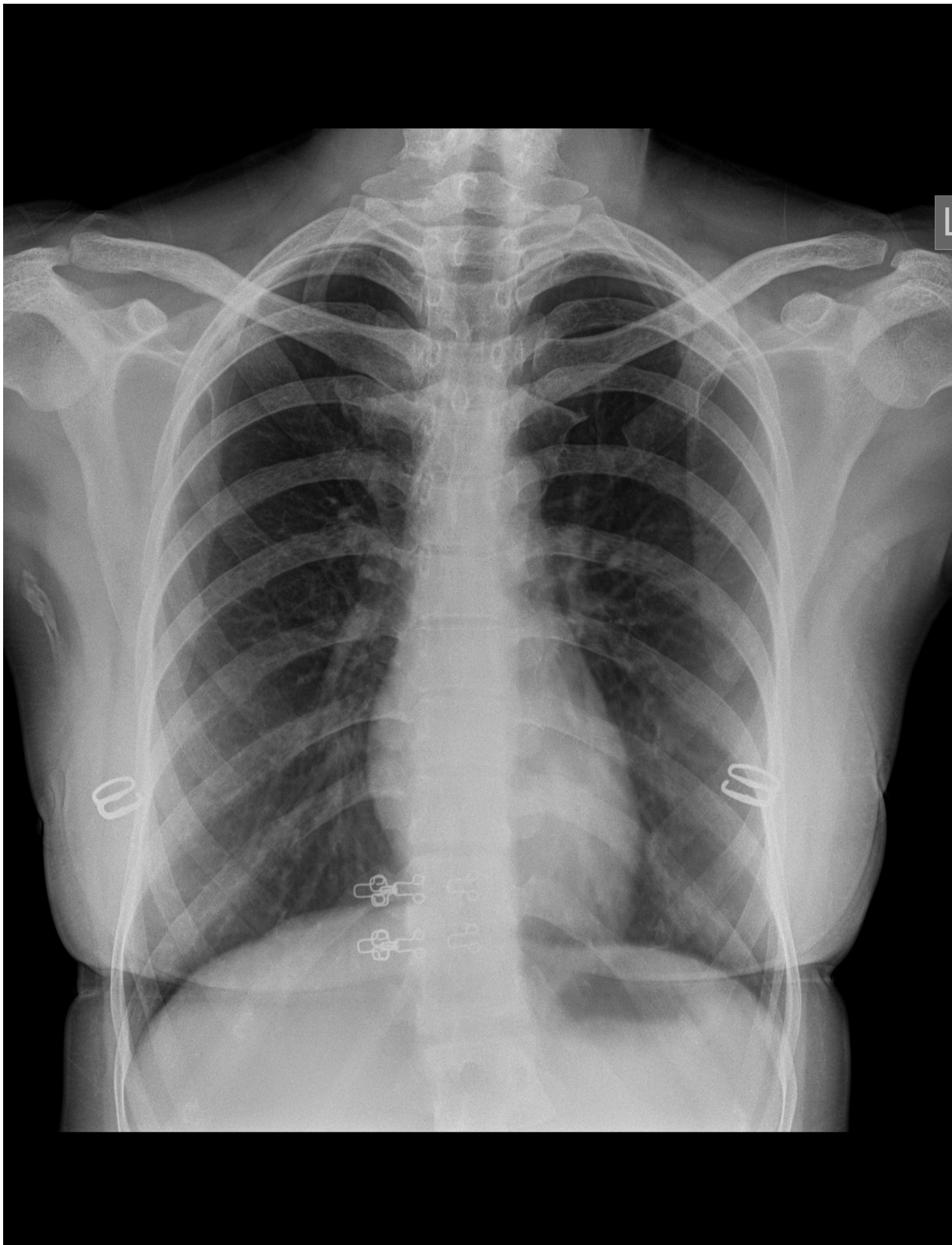
Impression:

No significant abnormality noted in X-ray chest.


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SARDA

CENTRE FOR DIABETES & SELF CARE

PATIENT NAME : MRS. RUPALI PAGARE

AGE :32YR. SEX: FEMALE

REF BY : MEDIWHEEL


DATE :15/11/2024

PAP SMEAR

Source : Cervical Smear

General Characterization : Smear shows plenty of superficial squamous epithelial cells, sparse inflammatory cells. No e/o any abnormal cells No e/o dysplasia in present smear study.

Interpretation : Mild inflammatory smear.


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DR. SAMPAT SARDA
M.D.(PATHOLOGY)
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Phone No. 2333851, 2334858

SARDA

CENTRE FOR DIABETES & SELF CARE

15-11-24,

Mrs. Rupali Pagare has undergone dental check up
in my clinic.
Her dental hygiene is good.

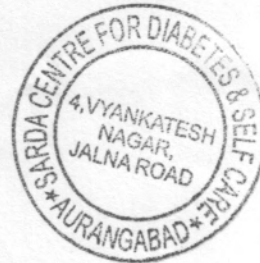
Sonali

DR SONALI LOHIYA

BDS (Dental Surgeon)

Reg No. A 0130

Tirupati, Nutrition & Dental Clinic
Jalna Road, Aurangabad



SARDA

CENTRE FOR DIABETES & SELF CARE

Date:- 15/11/24

Name Mrs Rupali Pagare

Age/Sex 32 yrs / female

Address Bawe of Baroda.

OPHTHALMIC EXAMINATION REPORT

	<u>Right Eye</u>	<u>Left eye</u>
Vision Distant	$\frac{6}{6} \bar{c} -1.75$ $\frac{-0.5}{100}$	$\frac{6}{6} \bar{c} -1.75$ $\frac{-0.5}{100}$
Vision Near	N6	N6
Anterior segment	<u>NAD</u>	<u>NAD</u>
Pupils	<u>NSRTL</u>	<u>NSRTL</u>
Lens	<u>clear</u>	<u>clear</u>
Tension	<u>Normal</u>	<u>Normal</u>
Fundus:-	Clear Disk WM CLOV3	Disk WM CLOV3 RET
Colour Vision	Normal	Normal.

Impression: BE myopic Astigmatism.

Rest within normal limits



[Signature]

DR. AJAY LOHTIA
M.B.B.S., D.O. (BOM) D.N.B.F.C.P.S
REG. NO. 08433
TRUPATI NETRALAYA & DENTAL CLINIC
AURANGABAD

SARDA

CENTRE FOR DIABETES & SELF CARE

Name . Mrs. Reepali Waman Pagare

age 32yr / F

wt 58.7kg

B.P. 120/70mm

PA - soft

PIS - up + vaginit (M)

Pv. UT. Ar. NS. mobile

PAP smear taken

sent for HPR

Answer

Dr. Mrs. A.S. Navandar
MBBS
Reg. No. 38439
Aurangabad.





Mrs. Rupal Pagari
3rd flr 15th Dec

Dr. A. S. ARDA
M.D. (Gen) No. 23570
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4, Vyankateshnagar, Jalna Road, Aurangabad
Phone No. 2330051, 2334858

SARDA

CENTRE FOR DIABETES & SELF CARE

4, Vyankatesh Nagar, Jaina Road, Aurangabad. Ph. : (0240) 2333851, 2334866.

Name: Mrs. Rupali Rayane Age: 32y/f
B&B

CLINICAL SUMMARY:

Weight: _____ Height (Cms): _____ Blood Pressure: _____

ECG FINDINGS:

Rate: 115/min ORS. Complex: Ⓡ

S: Tachycardia ST Segment: Ⓡ

Rhythm: NSR T. Wave: Ⓡ

Mechanism: _____ QT Interval: Ⓡ

Axis: Ⓡ PR Interval: Ⓡ

P. Wave: Ⓡ Recommendation: wn

Date: 15/1/24

Dr. A. S. SARDA
M.D. (Gen. No. 73570)

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Phone No. 2333851, 2334866

ASIAN HOSPITAL
MOTIWALA SQUARE
AURANGABAD

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Pagare, Rupali
Patient ID: 03382
Height: 162 cm
Weight: 58 kg

DOB: 05.06.1992
Age: 32yrs
Gender: Female
Race: Asian

Study Date: 15.11.2024
Test Type: --
Protocol: BRUCE

Referring Physician: --
Attending Physician: Dr. Deorao Thenge
Technician: --

Medications:

--

Medical History:

--

Reason for Exercise Test:

--

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:38	0.00	0.00	125	120/80	
	STANDING	00:04	0.00	0.00	122		
	HYPERV.	00:42	0.50	0.00	131		
EXERCISE	STAGE 1	03:00	1.70	10.00	166	130/80	
	STAGE 2	03:00	2.50	12.00	179	140/80	
	STAGE 3	01:07	3.40	14.00	193		
RECOVERY		04:04	0.00	0.00	120	150/80	

The patient exercised according to the BRUCE for 7:06 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 130 bpm rose to a maximal heart rate of 193 bpm. This value represents 102 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 150/80 mmHg. The exercise test was stopped due to Dyspnea.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions

Exercise of bruce protocol for 07.06min.
Target heart rate achieved
No Angina/Arrhythmias.No Significant Increase in ST-T Changes as Compare to Baseline.
Test is Negative for Induced ischemia

Physician

Technician



Deorao Thenge
Deorao Thenge

Pagare, Rupali
Patient ID 03382
15.11.2024
4:35:19pm

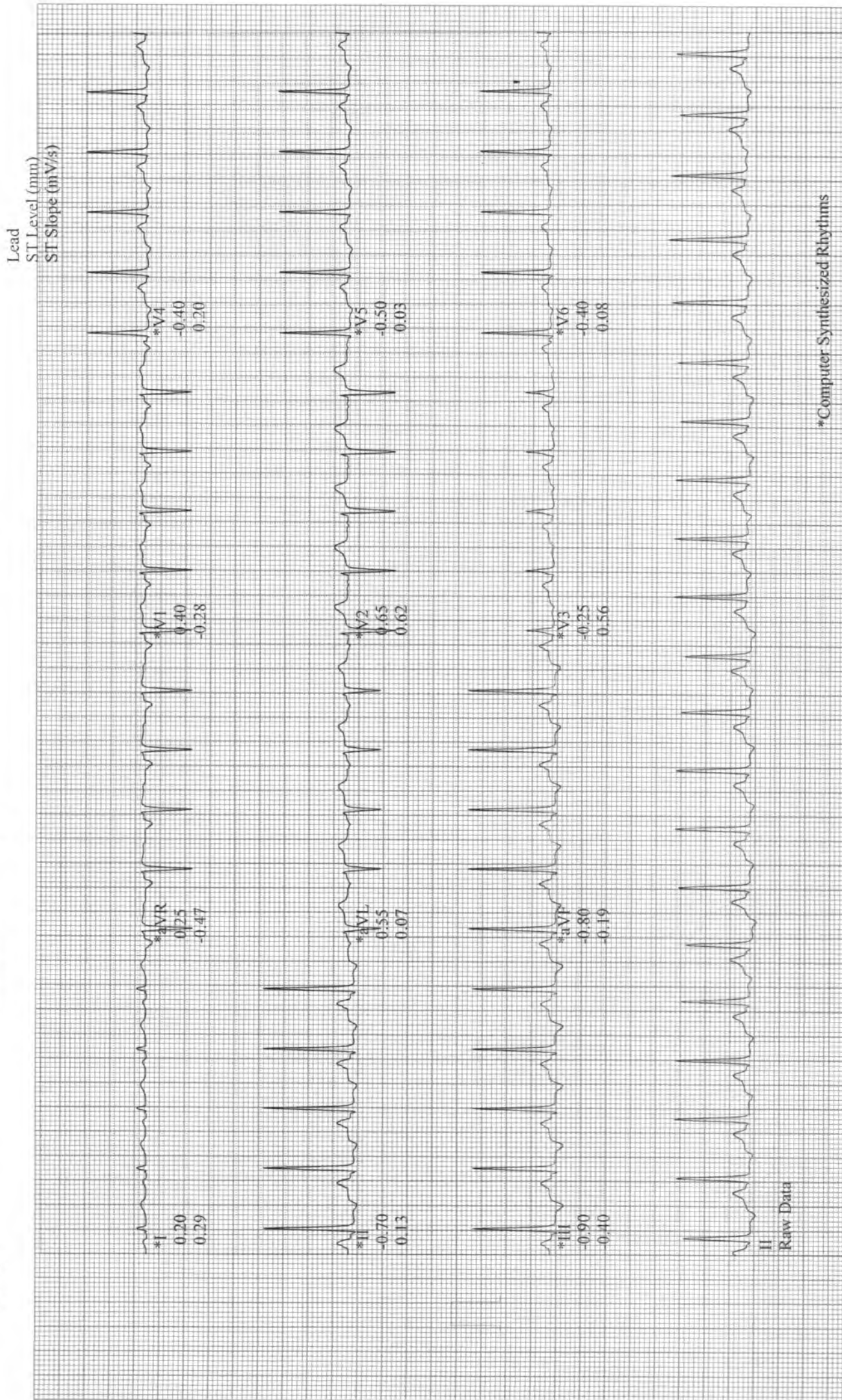
125 bpm
120/80 mmHg

Linked Medians

PRETEST
SUPINE
00:15

BRUCE
0.0 mph
0.0 %

ASIAN HOSPITAL



Pagare, Rupali
Patient ID 03382
15.11.2024
4:35:41pm

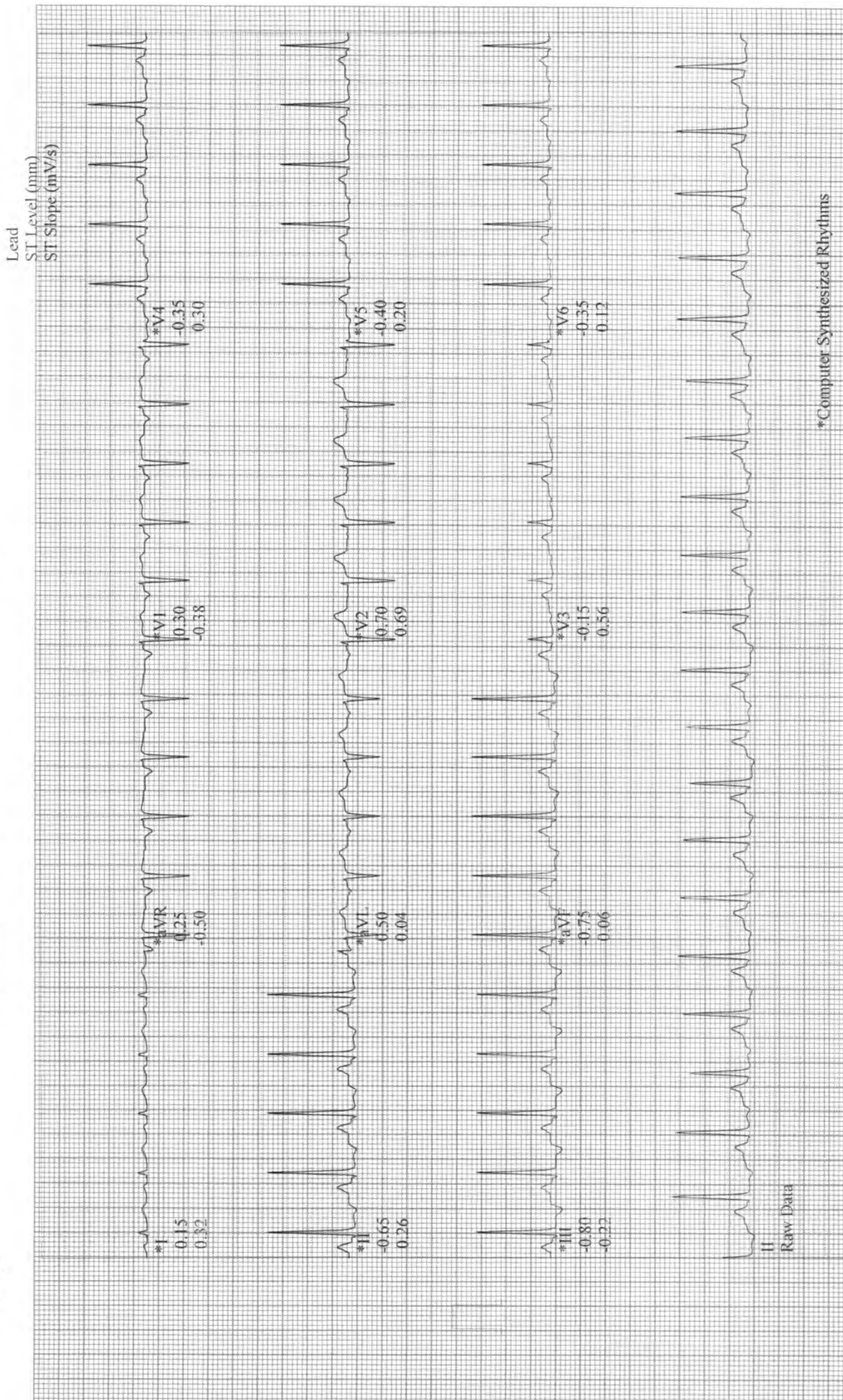
Linked Medians

PRETEST
SUPINE
00:37

125 bpm
120/80 mmHg

BRUCE
0.0 mph
0.0 %

ASIAN HOSPITAL



Pagare, Rupali
Patient ID 03382
15.11.2024
4:35:44pm

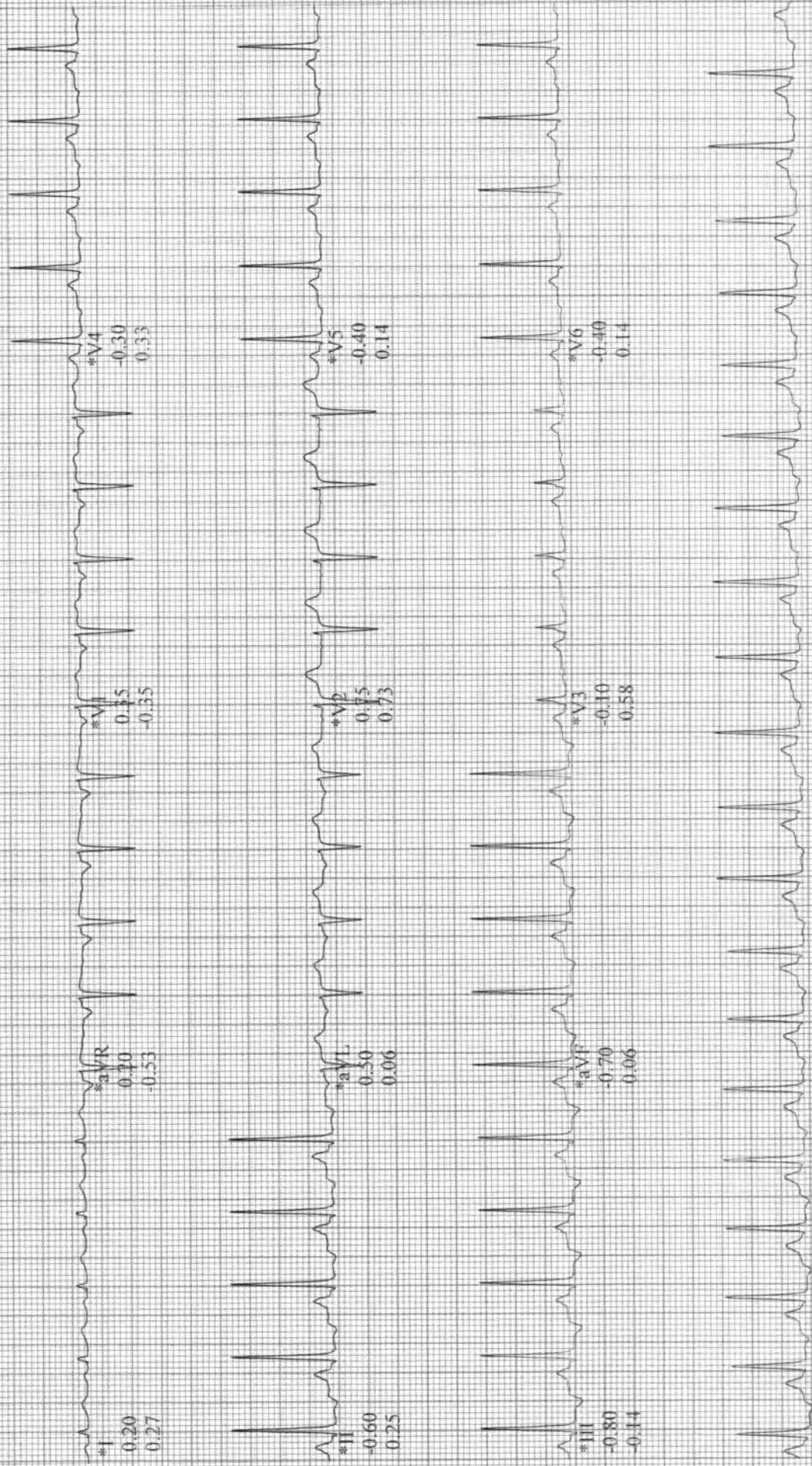
BRUCE
0.0 mph
0.0 %

Linked Medians

PRETEST
HYPERV.
00:41

122 bpm
120/80 mmHg

Lead
ST Level (mm)
ST Slope (mV/s)



Raw Data

*Computer Synthesized Rhythms

Pagare, Rupali
Patient ID 03382
15.11.2024
4:39:19pm

12-Lead Report

EXERCISE
STAGE 1
02:50
BRUCE
1.7 mph
10.0 %

Measured at 60ms Post J (10mm/mV)
Auto Points

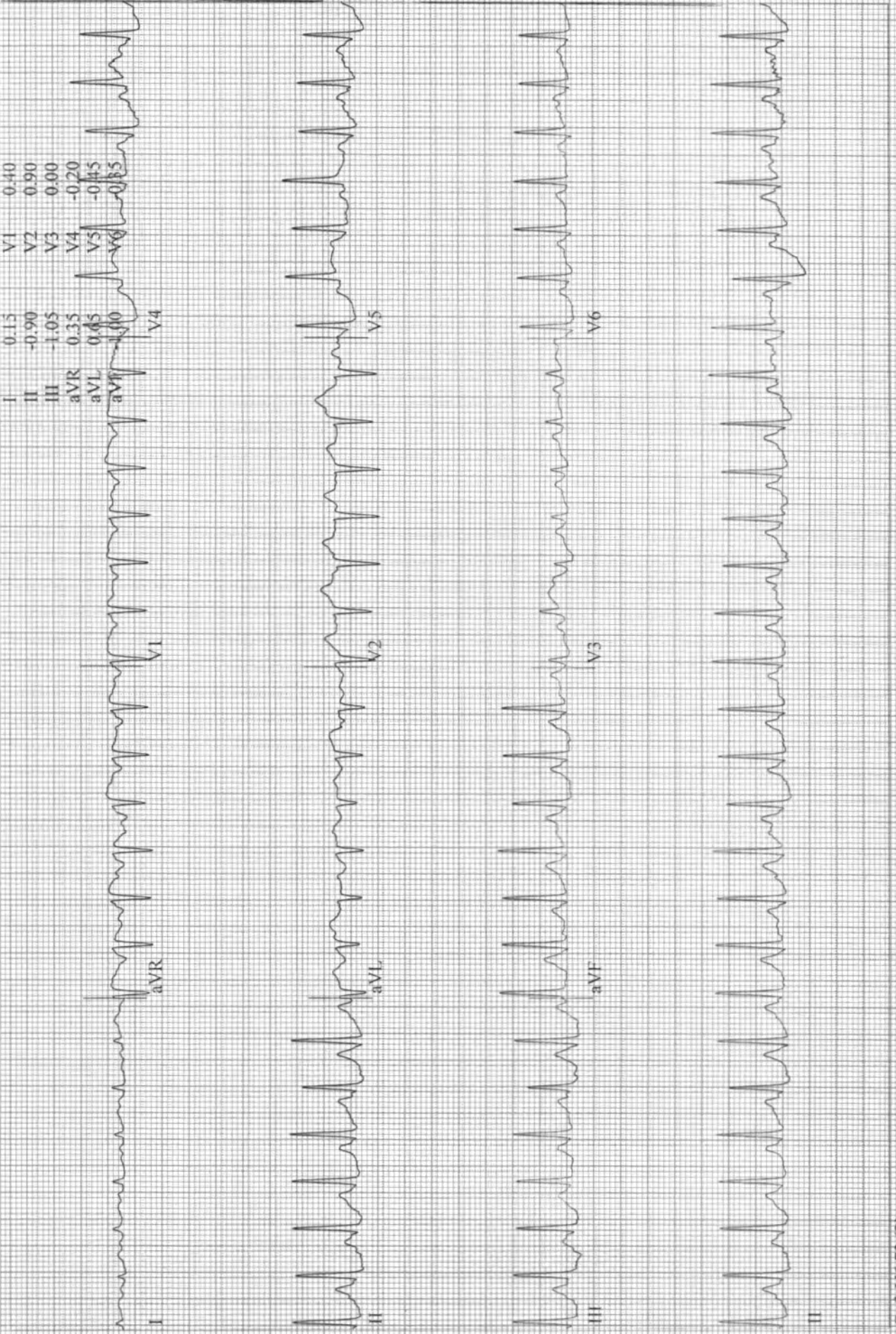
ASIAN HOSPITAL

Physician

Technician

Lead ST(mm)

Lead	ST(mm)
I	0.15
II	-0.90
III	-1.05
aVR	0.35
aVL	0.45
aVF	1.00
V1	0.40
V2	0.90
V3	0.00
V4	-0.20
V5	-0.45
V6	0.55



Pagare, Rupali
Patient ID 03382
15.11.2024
4:42:19pm

12-Lead Report

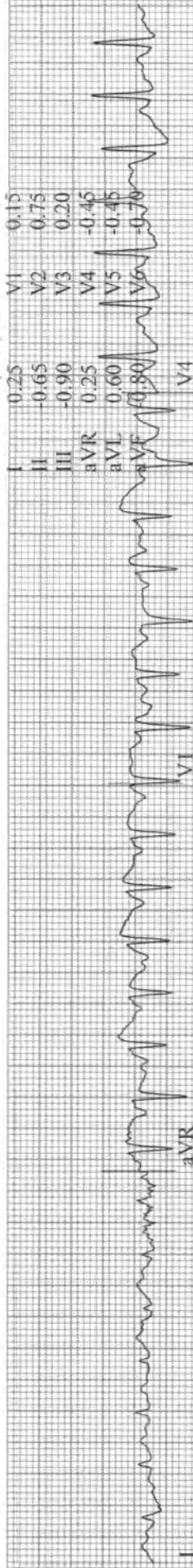
EXERCISE
STAGE 2
05:50

179 bpm
140/80 mmHg

ASIAN HOSPITAL

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead ST(mm) Lead ST(mm)

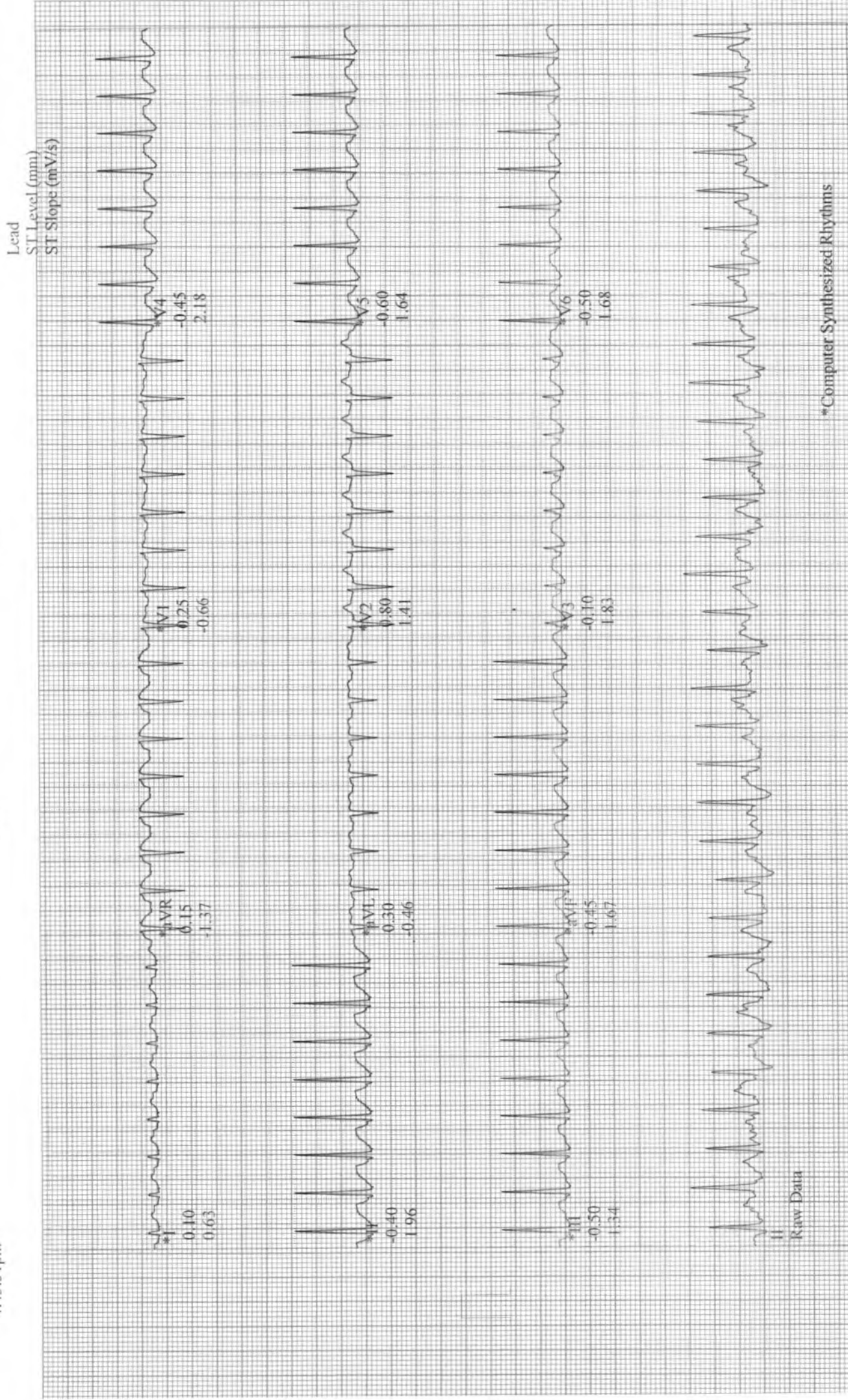


Linked Medians (PEAK EXERCISE)

EXERCISE BRUCE
STAGE 3 3.4 mph
07:07 14.0 %

193 bpm

Pagare, Rupali
Patient ID 03382
15.11.2024
4:43:31pm



*Computer Synthesized Rhythms

Pagare, Rupali
Patient ID 03382
15.11.2024
4:44:25pm

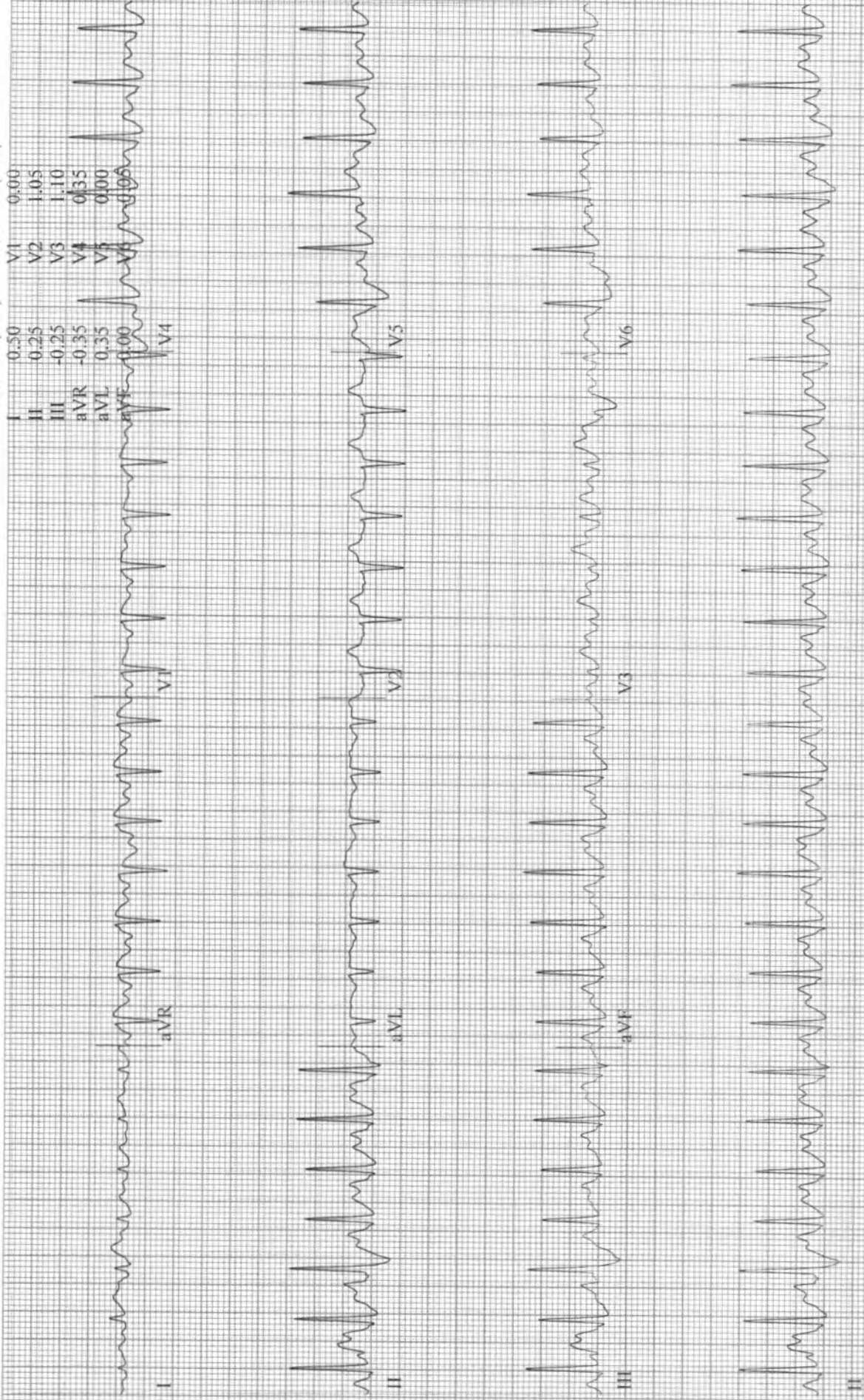
12-Lead Report

RECOVERY
#1
00:50
169 bpm

ASIAN HOSPITAL

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead ST(mm) Lead ST(mm)



Pagare, Rupali
Patient ID 03382
15.11.2024
4:45:25pm

12-Lead Report

RECOVERY

#1
01:50

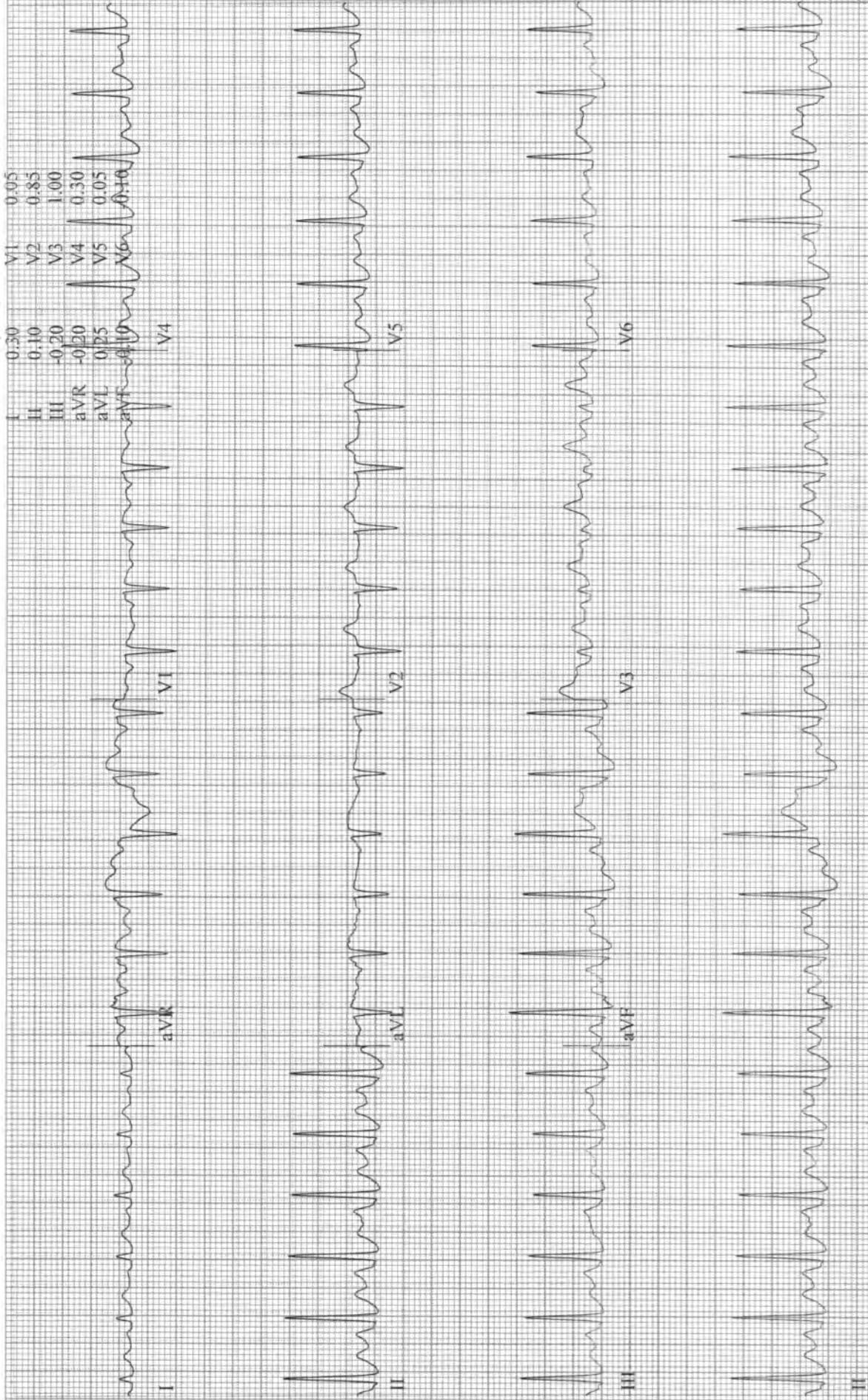
139 bpm

BRUCE
0.0 mph
0.0 %

ASIAN HOSPITAL

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead ST(mm) Lead ST(mm)



Pagare, Rupali
Patient ID 03382
15.11.2024
4:46:25pm

12-Lead Report

RECOVERY
#1
02:50
125 bpm
150/80 mmHg

ASIAN HOSPITAL

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead ST(mm) Lead ST(mm)

I 0.20 V1 0.15

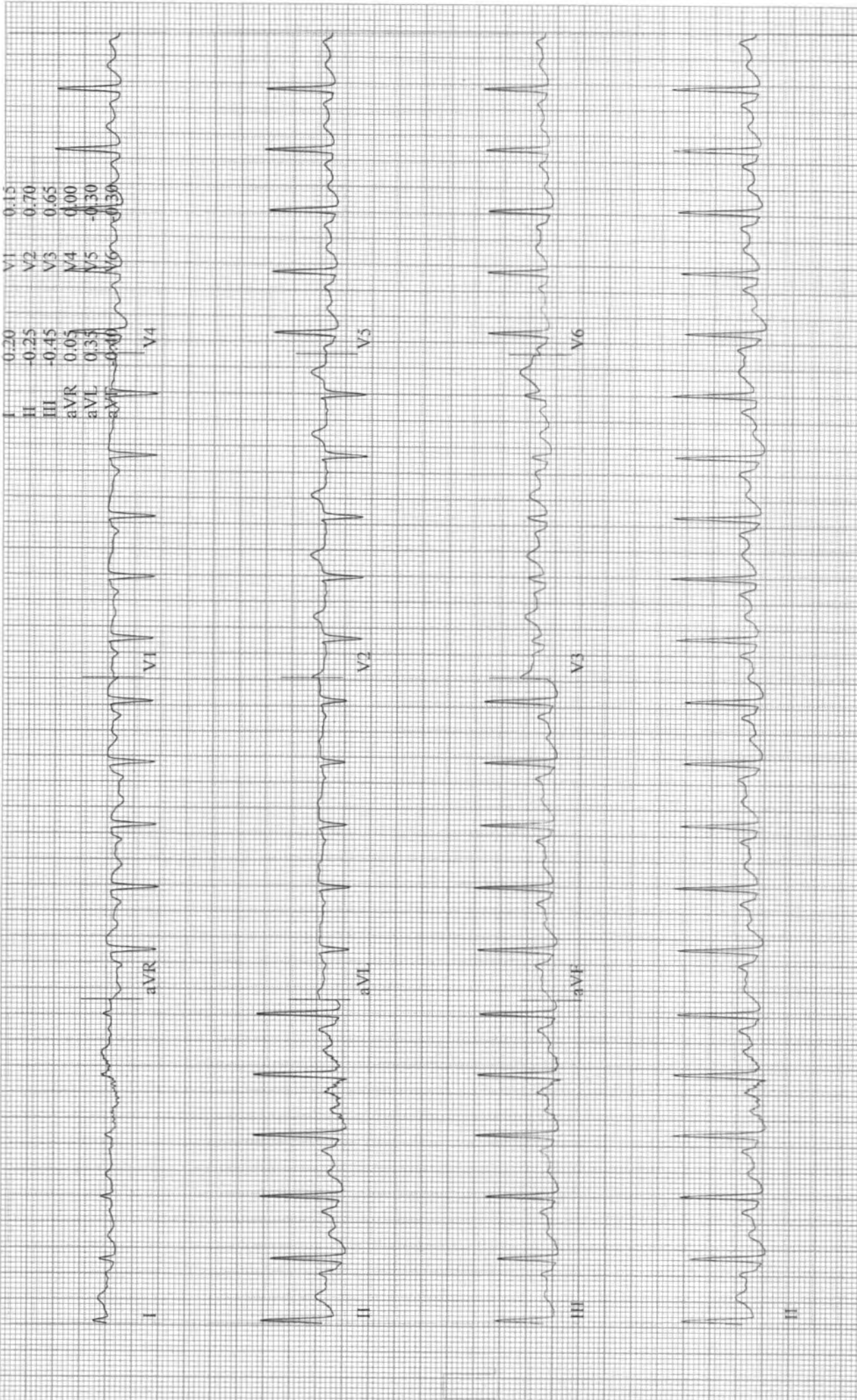
II -0.25 V2 0.70

III -0.45 V3 0.65

aVR 0.05 V4 0.00

aVL 0.35 V5 -0.30

aVF 0.00 V6 0.30



Pagare, Rupali
Patient ID 03382
15.11.2024
4:47:25pm

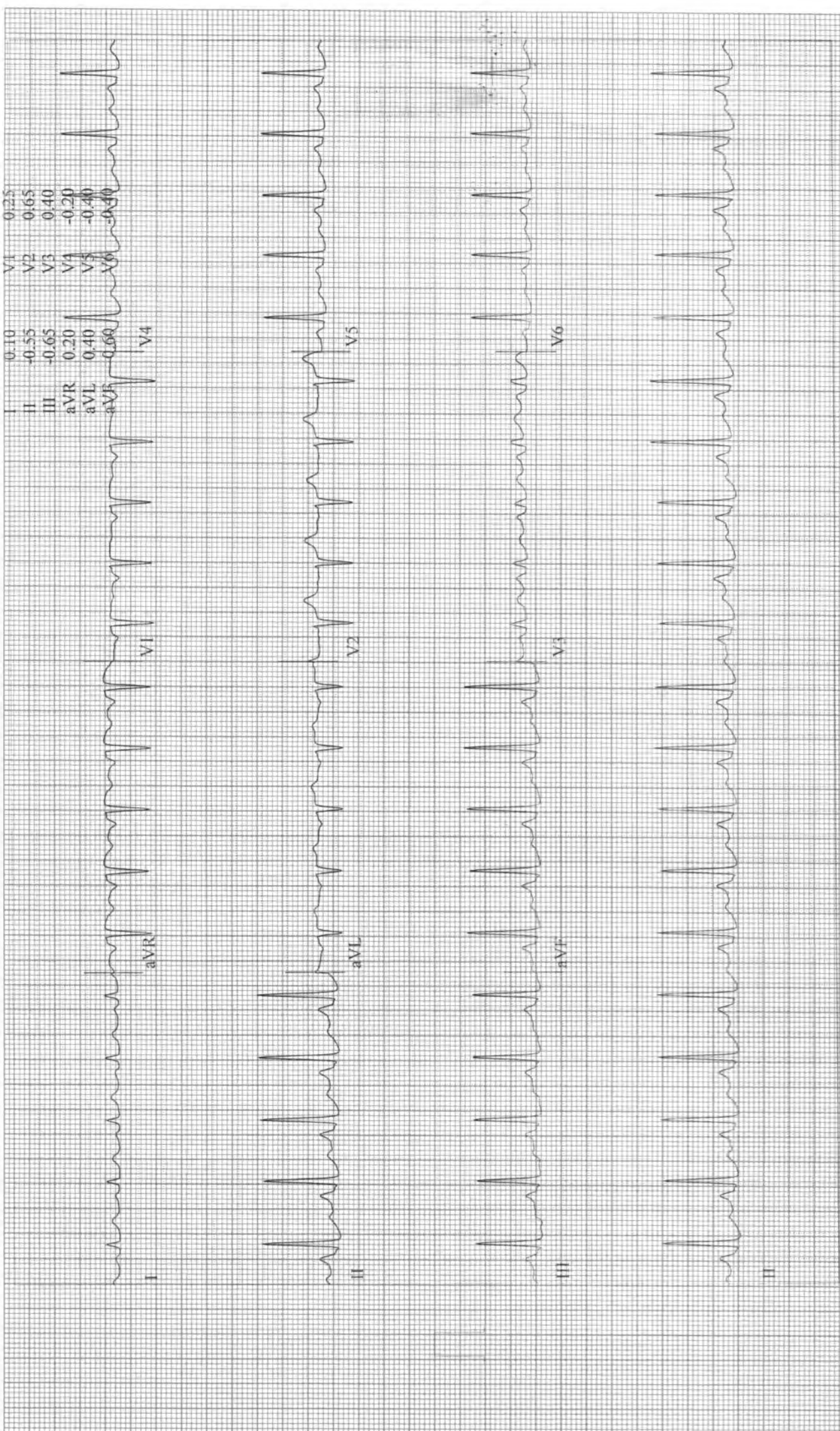
BRUCE
0.0 mph
0.0 %

RECOVERY
#1
03:50

121 bpm

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead ST(mm) Lead ST(mm)



Pagare, Rupali
 Patient ID 03382
 15.11.2024
 4:35:02pm
 Female 162 cm 58 kg
 32yrs Asian
 Meds:

Test Reason:
 Medical History:

Ref. MD: Ordering MD:
 Technician: Test Type:
 Comment:

BRUCE: Total Exercise Time 07:06
 Max HR: 193 bpm 102% of max predicted 188 bpm HR at rest: 130
 Max BP: 150/80 mmHg BP at rest: 120/80 Max RPP: 25060 mmHg*bpm
 Maximum Workload: 10.10 METS
 Max STT: -1.55 mm, 0.00 mV/s in III: EXERCISE STAGE 2 04:00
 ST/HR index: 0.36 μ V/bpm

Reasons for Termination: Dyspnea

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall impression: Normal stress test.

Conclusion: Exercise of bruce protocol for 07.06min.

Target heart rate achieved

No Angina/Arrhythmias No Significant Increase in ST-T Changes as Compare to Baseline.

Test is Negative for Induced ischemia

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (mmHg*bpm)	VE (l/min)	ST Level (mV)	Comment
PRETEST	SUPINE	00:38	0.00	0.00	1.0	125	120/80	15000	0	-0.85	
	STANDING	00:04	0.00	0.00	1.0	122			0	-0.80	
	HYPERV.	00:42	0.50	0.00	1.2	131			0	-0.85	
EXERCISE	STAGE 1	03:00	1.70	10.00	4.6	166	130/80	21580	0	-1.05	
	STAGE 2	03:00	2.50	12.00	7.0	179	140/80	25060	0	-1.05	
	STAGE 3	01:07	3.40	14.00	10.1	193			0	-0.70	
RECOVERY		04:04	0.00	0.00	1.0	120	150/80	18000	0	-0.65	

GE CardioSoft V6.73 (2)

Unconfirmed

Attending MD: Dr. Deorao Thengse

Patient Name : MRS RUPALI PAGARE



SPL24/10098



Age/Gender : 32 Yrs/Female

Report Date

: 15/11/2024

Ref. Dr. : MEDIWHEEL

HAEMATOLOGY REPORT

Test Description	Result	Unit	Biological Reference Range
BLOOD GROUP AND RH FACTOR			
Blood Group	'O'		
Rh Factor	POSITIVE(+VE)		

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Phone No. 2333851, 2334858

Patient Name : MRS RUPALI PAGARE

Age/Gender : 32 Yrs/Female

Ref. Dr. : MEDIWHEEL



SPL24/10098

Report Date

: 15/11/2024



HBA1C/GLYCOCYLATED

HbA1c Glycosilated Haemoglobin 5.2 %

Method: HPLC, NGSP certified

Estimated Average Glucose : 103 mg/dL

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
Therapeutic goals for glycemc control	Age > 19 years Goal of therapy: < 7.0 Action suggested: > 8.0 Age < 19 years Goal of therapy: <7.5

ADA criteria for correlation

HbA1c(%)	Mean Plasma Glucose (mg/dL)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Note:1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled .
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Comments:HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemc control as compared to blood and urinary glucose determinations.

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Patient Name : MRS RUPALI PAGARE

Age/Gender : 32 Yrs/Female

Ref. Dr. : MEDIWHEEL



SPL24/10098

Report Date

: 15/11/2024



BIOCHEMISTRY REPORT

Test Description	Result	Unit	Biological Reference Range
LIPID PROFILE			
Cholesterol-Total <i>Method: CHOD/PAP</i>	147	mg/dL	< 200 : Desirable 200-239 : Borderline risk > 240 : High risk
Triglycerides level <i>Method: Lipase / Glycerol Kinase)</i>	93	mg/dL	< 150 : Normal 150-199 : Borderline-High 200-499 : High > 500 : Very High
HDL Cholesterol <i>Method: CHOD/PAP</i>	36	mg/dL	< 40 : Low 40 - 60 : Optimal > 60 : Desirable
LDL Cholesterol <i>Method: Homogeneous enzymatic end point assay</i>	92.40	mg/dL	< 100 : Normal 100 - 129 : Desirable 130 - 159 : Borderline-High 160 - 189 : High > 190 : Very High
VLDL Cholesterol <i>Method: Calculation</i>	18.60	mg/dL	7 - 40
CHOL/HDL RATIO <i>Method: Calculation</i>	4.08	Ratio	3.5 - 5.0
LDL/HDL RATIO <i>Method: Calculation</i>	2.57	Ratio	0 - 3.5

Interpretation

Lipid profile can measure the amount of Total cholesterol's and triglycerides in blood:

Test	Comment
Total cholesterol:	measures all the cholesterol in all the lipoprotein particles
High-density lipoprotein cholesterol (HDL-C):	measures the cholesterol in HDL particles; often called "good cholesterol" because HDL-C takes up excess cholesterol and carries it to the liver for removal.
Low-density lipoprotein cholesterol (LDL-C):	measures the cholesterol in LDL particles; often called "bad cholesterol" because it deposits excess cholesterol in walls of blood vessels, which can contribute to atherosclerosis
Triglycerides:	measures all the triglycerides in all the lipoprotein particles; most is in the very low-density lipoproteins (VLDL).

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Age/Gender : 32 Yrs/Female

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Report Date

: 15/11/2024



BIOCHEMISTRY REPORT

Test Description	Result	Unit	Biological Reference Range
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BLOOD SUGAR FASTING & PP (BSF & PP)

BLOOD SUGAR FASTING 82 mg/dl

Method: Hexokinase

Fasting Urine Sugar Absent

BLOOD SUGAR POST PRANDIAL 126 mg/dl

Method: Hexokinase

Postprandial Urine Sugar Absent

ADA 2019 Guidelines for diagnosis of Diabetes Mellitus

Fasting Plasma Glucose > 126 mg/dl

Postprandial Blood Glucose > 200 mg/dl

Random Blood Glucose > 200 mg/dl

HbA1c Level > 6.5%

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Phone No. 2333851, 2334858

Patient Name : MRS RUPALI PAGARE

Age/Gender : 32 Yrs/Female

Ref. Dr. : MEDIWHEEL



SPL24/10098

Report Date

: 15/11/2024



BIOCHEMISTRY REPORT

Test Description	Result	Unit	Biological Reference Range
Serum Creatinine <i>Method: Modified Jaffe's</i>	0.7	mg/dL	0.60 - 1.40
LIVER FUNCTION TEST (LFT)			
TOTAL BILIRUBIN <i>Method: Serum, Jendrassik Grof</i>	0.75	mg/dl	0.3 - 1.2
DIRECT BILIRUBIN <i>Method: Serum, Diazotization</i>	0.22	mg/dL	0.0 - 0.3
INDIRECT BILIRUBIN <i>Method: Serum, Calculated</i>	0.53	mg/dl	0.3 - 1.0
SGPT (ALT) <i>Method: Serum, UV with P5P, IFCC 37 degree</i>	26	U/L	15 - 40
SGOT (AST) <i>Method: Serum, UV with P5P, IFCC 37 degree</i>	22	U/L	15 - 40
ALKALINE PHOSPHATASE <i>Method: DGKC</i>	82	U/L	33 - 98
TOTAL PROTEIN <i>Method: Serum, Biuret, reagent blank end point</i>	6.6	g/dl	6.0 - 8.0
SERUM ALBUMIN <i>Method: Serum, Bromocresol green</i>	3.7	g/dl	3.5 - 5.2
SERUM GLOBULIN <i>Method: Serum, Calculated</i>	2.90	g/dl	1.8 - 3.6
A/G RATIO <i>Method: Serum, Calculated</i>	1.28		1.2 - 2.2
Gamma Glutamyl Transferase-Serum <i>Method: Kinetic</i>	19	IU/L	12 - 43

NOTE :
In known cases of Chronic Liver disease due to Viral Hepatitis B & C, Alcoholic liver disease or Non alcoholic fatty liver disease, Enhanced liver fibrosis (ELF) test may be used to evaluate liver fibrosis.

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BUN 11 mg/dl 7 - 21

Method : Calculated

Clinical Significance:

Urea Nitrogen (BUN) - Urea is the principle waste product of protein catabolism. BUN is most commonly measured in the diagnosis and treatment of certain renal and metabolic diseases. Increased BUN concentration may result from increased production of urea due to

(1) diet or excessive destruction of cellular proteins as occurs in massive infection and fevers,

(2) reduced renal perfusion resulting from dehydration or heart failure,

(3) nearly all types of kidney disease, and

(4) mechanical obstruction to urine excretion such as is caused by stones, tumors, infection, or stricture. Decreased urea levels are less frequent and occur primarily in advanced liver disease and in overhydration.

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IMMUNOASSAY REPORT

Test Description	Result	Unit	Biological Reference Range
Thyroid Function Test (TFT)			
T3	134	ng/dl	80-253 : 1 Yr-10 Yr, 76-199 : 11 Yr-15 Yr, 69-201 :16 Yr-18 Yr, 87-173 : > 18 years,
T4	9.96	ng/dl	5.9-21.5 :10-31 Days, 5.9-21.5 :0-1 Month, 6.4-13.9 :2-12 Months, 6.09-12.23 :>1 Yr
TSH(Serum)	3.69	ng/dl	0.52-16.0 :1 Day - 30 Days 0.55-7.10 :1 Mon-5 Years 0.37-6.00 :6 Yrs-18 Years 0.38-5.33 :18 Yrs-88 Years 0.50-8.90 :88 Years

Method : ECLIA

Clinical features of thyroid disease		
Hypothyroidism	Hyperthyroidism	Grave's disease
Lethargy	Tachycardia	Exophthalmos/proptosis
Weight gain	Palpitations (atrial fibrillation)	Chemosis
Cold intolerance	Hyperactivity	Diffuse symmetrical goitre
Constipation	Weight loss with increased appetite	Pretibial myxoedema (rare)
Hair loss	Heat intolerance	Other autoimmune conditions
Dry skin	Sweating	
Depression	Diarrhoea	
Bradycardia	Fine tremor	
Memory impairment	Hyper-reflexia	
Menorrhagia	Goitre	
	Palmar erythema	
	Onycholysis	
	Muscle weakness and wasting	
	Oligomenorrhoea/amenorrhoea	

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URINE EXAMINATION REPORT

Test Description	Result	Unit	Biological Reference Range
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URINE ROUTINE

Physical Examination

Colour	Pale Yellow		Pale Yellow
Apperance	Clear		Clear
Reaction	Acidic		
Deposit	Absent		

Chemical Examination

Specific Gravity	1.005		
Albumin	Absent		
Sugar	NIL		Absent
Acetone	Absent		
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent

Microscopic Examination

RBC's	NIL	/hpf	Nil
Pus cells	1-2/hpf	/hpf	2-3/hpf
Epithelial Cells	NIL	/hpf	1-2/hpf
Crystals	Absent		Absent
Casts	Not Seen		Not Seen
Amorphous Deposit	Absent		Absent

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Test Description	Result	Unit	Biological Reference Range
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COMPLETE BLOOD COUNT

Total WBC Count	6400	cell/cu.mm	4000 - 11000
Haemoglobin	12.3	g%	11 - 16
Platelet Count	289000	/cumm	150000 - 450000
RBC Count	4.18	/Mill/ul	3.50 - 5.50

RBC INDICES

Mean Corp Volume MCV	85.2	fL	80 - 97
Mean Corp Hb MCH	29.4	pg	26 - 32
Mean Corp Hb Conc MCHC	34.6	gm/dL	31.0 - 36.0
Hematocrit HCT	35.6	%	36.0 - 48.0
RDW-CV	12.1	%	11.6 - 14.0
RDW-SD	33.6	fL	37.0 - 54.0

DIFFERENTIAL LEUCOCYTE COUNT

Neutrophils	60	%	40 - 75
Lymphocytes	32	%	20 - 45
Monocytes	04	%	02 - 10
Eosinophils	04	%	01 - 06
Basophils	00	%	00 - 01

NOTE:

- As per the recommendation of International council for Standardization in Hematology, the differential leukocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.
- Test conducted on EDTA whole blood.

ESR	09	mm/hr	Male: 0-8 mm at 1 Hr. Female: 0-20 mm at 1 Hr.
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INTERPRETATION :

- It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
- It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
- It is also increased in pregnancy, multiple myeloma, menstruation, and hypothyroidism.

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