MEDICAL SUMMARY

Apollo Clinic VASHI

NAME:	Mr Shantaram Bansode	UHID:	5484
AGE:	58 years	DATE OF HEALTHCHECK:	13/3/23
GENDER:	Male		

HEIGHT:	175 cm	MARITAL STATUS:	M
WEIGHT:	78.2 kg	NO OF CHILDREN:	2

BMI - 25.5

C/O:

K/C/O:

PRESENT MEDICATION: — No

P/M/H: — No

P/S/H: — No

H/A: SMOKING:
ALCOHOL:
TOBACCO/PAN: — NAD

FAMILY HISTORY FATHER:
MOTHER: — NAD

O/E:

BP: 120/70 PULSE: — 60/min

TEMPERATURE: N SCARS:

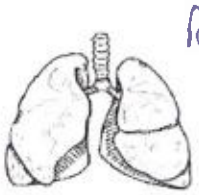
LYMPHADENOPATHY:

PALLOR/ICTERUS/CYNOSIS/CLUBBING: — NAD

OEDEMA: —

S/E:

RS: AE BE



P/A:

— NAD

CVS: S1 S2 +

Extremities & Spine: — NAD

ENT:

Skin: NAD — Blackish discoloration in hands

CNS: Conscious oriented

Vision:

	Without Glass		With Glass	
	Right Eye	Left eye	Right Eye	Left eye
FAR :				
NEAR :				
COLOUR VISION:				
ADVISE :				

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Tel.: (022) - 2788 1322 / 23 / 24 8291490000 • Email: apolloclinicvashi@gmail.com

Name: Mr. Shantaram Bansode	Age: 58 Y	Date of Health check-up: 13/3/23

Findings and Recommendation:

Findings :-

TSH ↑.

PSA - ↑.

Recommendation:-

- Urologist opinion

- T. Thyrox 25 mcg
  1—0—0 × ~~15 20~~ 1½ month

Signature:

Consultant –

DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC- 2005/02/0920

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OPHTHALMIC EVALUATION

UHID No.: 5484 Date : 13/3/23.

Name : Mr Shankar Bansode Age : 58 Gender : Male/Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye N6 Left Eye N6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance		-050	80°				-050	130°		
Near	+2.75					+2.75				

Presbyopia

Colour Vision : Normal (BC)

Anterior Segment Examination : _____

Pupils : NO (BC)

Fundus : early cataract.

Intraocular Pressure : 12 mm Hg (BC)

Diagnosis : _____

Advice : Use glasses

Re-Check on 6 mths (This Prescription needs verification every year)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No.: 3262 / 09/ 02

Dr. _____
(Consultant Ophthalmologist)

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DENTAL CHECKUP

Name: Mr Shantaram Bansode	**MR NO:**
Age/Gender : 58/M	**Date:** 13/3/23

Medical history: ☐ Diabetes ☐ Hypertension ☐ _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus& Stains				
Mobility				
Caries (Cavities)				
a)Class 1 (Occlusal)				
b)Class 2 (Proximal)				
c)Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth			6	
Existing Denture				

TREATMENT ADVICED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: ☑ Scaling & polishing
Orthodontic Advice for Braces: ☐ Yes / ☐ No
Prosthetic Advice to Replace Missing Teeth: ☐ Denture ☐ Bridge ☐ Implant
Oral Habits: ☐ Tobacco ☐ Cigarette ☐ Others since ____ years
☐ Advice to quit any form of tobacco as it can cause cancer.
Other Findings: generalised attrition

DR. SNEHA NITIN GADHIYA
BDS (BACHELOR OF DENTAL SURGERY)
REG NO: 39708

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Apollo Clinic VASHI

Name	: Mr. Shantaram M Bansode	Gender	: Male	Age	: 58 Years
UHID	: FVAH 5484.	Bill No	:	Lab No	: V-1545-23
Ref. by	: SELF	Sample Col.Dt	: 13/03/2023 09:00		
Barcode No	: 8558	Reported On	: 13/03/2023 16:46		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)			
Haemoglobin(Colorimetric method)	15.8	g/dl	13 - 18
RBC Count (Impedance)	5.02	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	46.6	%	35 - 55
MCV:(Calculated)	92.8	fl	78 - 98
MCH:(Calculated)	31.4	pg	26 - 34
MCHC:(Calculated)	33.8	gm/dl	30 - 36
RDW-CV:	13.7	%	11.5 - 16.5
Total Leucocyte count(Impedance)	6430	/cumm.	4000 - 10500
Neutrophils:	62	%	40 - 75
Lymphocytes:	28	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	06	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.45	Lakhs/c.mm	1.5 - 4.5
MPV	7.8	fl	6.0 - 11.0
ESR(Westergren Method)	05	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic,Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Alsaba Shaikh
Entered By

Ms Kaveri Gaonkar
Verified By

Dr Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST	RESULTS
Blood Grouping (ABO & Rh)-WB(EDTA) Serum	
ABO Group:	**:B:**
Rh Type:	**Positive**
Method :	Tube Agglutination (forward and reverse)

Shweta Unavane
Entered By

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	5.4	%	Normal	<5.7 %
			Pre Diabetic	5.7 - 6.5 %
			Diabetic	>6.5 %
			Target for Diabetes on therapy	< 7.0 %
			Re-evalution of therapy	> 8.0 %
Mean Blood Glucose :	108.28	mg/dL		

Corelation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method — High Performance Liquid Chromatography (HPLC).

INTERPRETATION

* The HbA1c levels corelate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
* This Methodology is better then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
* It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
* Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

Alsaba Shaikh
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose :	104	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : >= 126 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Post Prandial Plasma Glucose :	131	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : >= 200 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)

Method : Hexokinase

Vasanti Gondal
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	152	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	79	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	15.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	**24.4**	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	111.8	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	**6.2**		3.5 - 5
Ratio of LDL/HDL	**4.6**		2.5 - 3.5

Ms Kaveri Gaonkar
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.02	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.01	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.01	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.33		0.9 - 2
S.Total Bilirubin (DPD):	0.48	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.17	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.31	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	17	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	14	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	118	U/L	40 - 129
S.GGT(IFCC Kinetic):	26	U/L	11 - 50

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	22.9	mg/dl	10.0 - 45.0
BUN (Calculated)	10.68	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	1.16	mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	9.21		9:1 - 23:1
S.Uric Acid(Uricase Method)	6.9	mg/dl	3.4 - 7.0

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.75	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	79.18	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	**6.22**	□IU/ml	Euthyroid :0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyrodism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
PROSTATE SPECIFIC ANTIGEN		
Prostate Specific Antigen (ECLIA):	**4.39** ng/mL	0.03 - 3.5 ng/ml

INTERPERETATION

Serum PSA is a useful diagnostic tool for diagnosis of prostatic cancer. PSA levels should always be assessed in conjunction with the patient's medical history,clinical examination, prostatic acid phosphatase and radiological findings
Elevated levels are indicative of pathologic conditions of prostatits ,Benign hyperplasia or Prostatic adenocarcinoma
Rate of the fall of PSA levels to non dectectable levels can occur following radiotherapy,hormonal therapy or radical surgical removal of the prostate & provides information of the success of treatment.
Inflammation or trauma of prostate can lead to elevated PSA levels of varying magnitude and duration.

Ms Kaveri Gaonkar
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URINE REPORT

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
PHYSICAL EXAMINATION		
QUANTITY	20 mL	
COLOUR	Pale Yellow	
APPEARANCE	Clear	Clear
SEDIMENT	Absent	Absent
CHEMICAL EXAMINATION(Strip Method)		
REACTION(PH)	5.0	4.6 - 8.0
SPECIFIC GRAVITY	1.015	1.005 - 1.030
URINE ALBUMIN	Absent	Absent
URINE SUGAR(Qualitative)	Absent	Absent
KETONES	Absent	Absent
BILE SALTS	Absent	Absent
BILE PIGMENTS	Absent	Absent
UROBILINOGEN	Normal(<1 mg/dl)	Normal
OCCULT BLOOD	Absent	Absent
Nitrites	Absent	Absent
MICROSCOPIC EXAMINATION		
PUS CELLS	1 - 2/hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	2 - 3 /hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent

Anushka Chavan
Entered By

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Shantaram, Bansode
5484

Male
58 Years

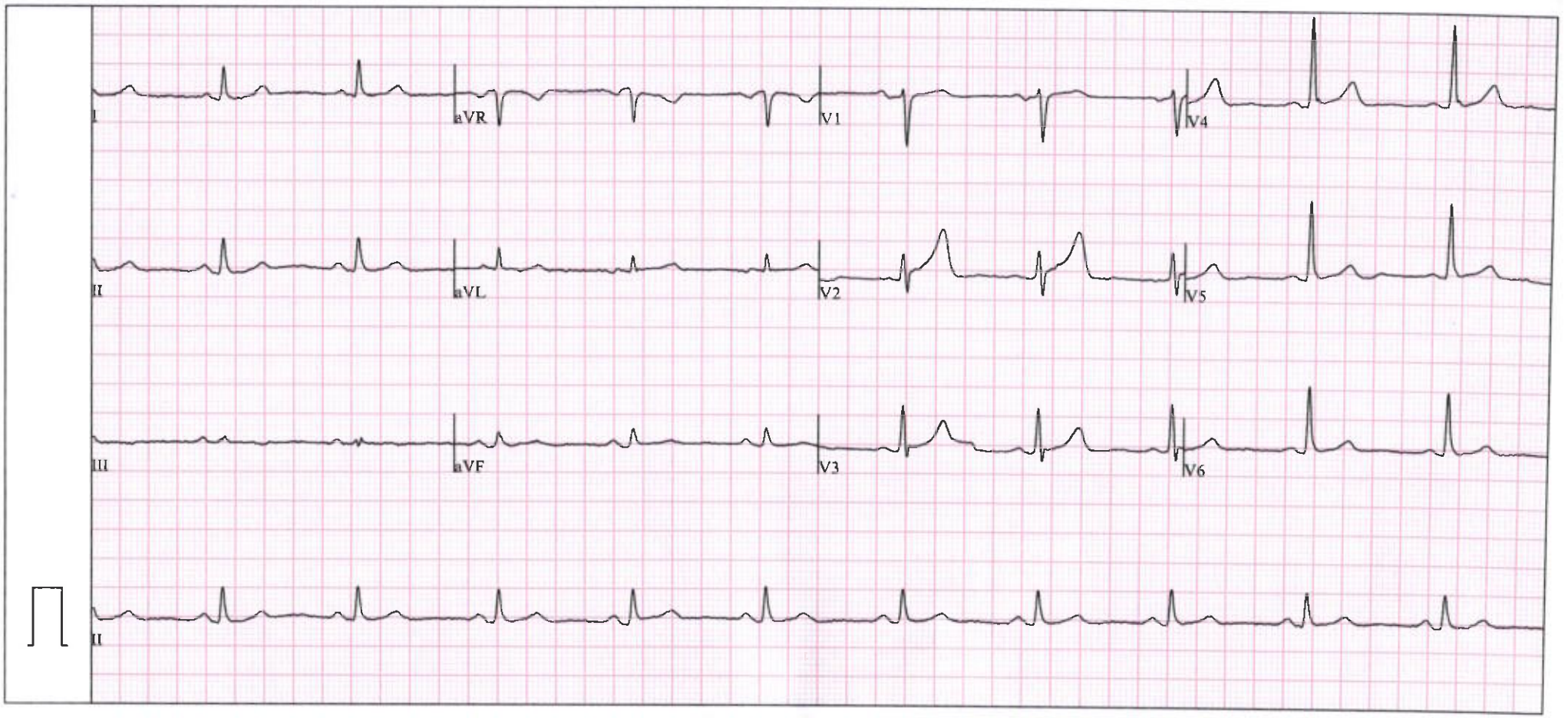
13.03.2023 9:12:42
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

64 bpm
-- / -- mmHg

NORMAL ECG

QRS :	74 ms	Normal sinus rhythm
QT / QTcBaz :	392 / 404 ms	Normal ECG
PR :	130 ms	
P :	92 ms	
RR / PP :	932 / 937 ms	
P / QRS / T :	48 / 25 / 26 degrees	

Dr. ANIRBAN DASGUPTA
M.B.,B.S., D.N.B. Medicine
Diploma Cardiology
MMC -2005/02/0920



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x2.5x3_25_R1 1/1

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PATIENT'S NAME	SHANTARAM M BANSODE	AGE :- 58Y/M
UHID	5484	DATE :- 13-03-23

2D Echo and Colour doppler report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

Grade I diastolic dysfunction.

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Measurements

Aorta annulus	21 mm
Left Atrium	34 mm
LVID(Systole)	20 mm
LVID(Diastole)	36 mm
IVS(Diastole)	10 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- Grade I diastolic dysfunction
- No PAH

Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

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PATIENT'S NAME	SHANTARAM M BANSODE	AGE :- 58y/M
UHID NO	5484	13 Mar 2023

X-RAY CHEST PA VEIW

OBSERVATION:

Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

- **No significant abnormality seen.**

DR.CHHAYA S. SANGANI
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Apollo

Apollo Clinic
VASHI

PATIENT'S NAME	SHANTARAM M BANSODE	AGE :- 58Y/M
UHID NO	5484	13 Mar 2023

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows bright echotexture .No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size, and echotexture. No focal lesion seen. SV is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.
RIGHT KIDNEY measures 10.0 x 4.7 cm. **LEFT KIDNEY** measures 10.7 x 4.7 cm.

Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape & echotexture.
It measures (Vol: 23gms)

Visualised bowel loops appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

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