

12/8/2013

Mrs. Deepa Gawale
42/P.

K/O Thyroidism
on Rx.
T. Thyroxine 25000

P - 85/mm.
B.P. 130/80

Family H/O. Mother suffers
from DM

ECG - DM

P, L, - FTND.

Irregular menses
cycle

W/O ACHD

W/O UP for
Heart VSD

Adv

Height - 146cm
Weight - 49kg
BMI - 23.19/m² (N)

- Blood investⁿ
- DM
- CXR.

Pt fit & conscious
recurrent chills



HELPLINE

022 - 2588 3531

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606

www.siddhivinayakhospitals.org



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

DEEPA GAWALI

AGE

42

DATE -

05.08.2023

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/12	N/12
DISTANT	6/6	6/6
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



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Name - Mrs. Deepa Gawall	Age 42 Y/F
Ref by Dr.-Siddhivinayak Hospital	Date - 12/08/2023

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





ECHOCARDIOGRAM

NAME	MRS. DEEPA GAWALI
AGE/SEX	42 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE (CARDIOLOGIST)
DATE OF EXAMINATION	12/08/2023

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal LEFT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Perimembranous VSD (5 mm on LV side and 3.1 mm on RV side) with adequate aortic rim
CORONARIES: Proximal coronaries normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration
CORONARY SINUS: Normal	
PULMONARY VEINS: Normal	
	PERICARDIUM: Normal

MEASUREMENTS:

PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	19 mm	Left atrium	31 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	45.4 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	27.7 mm	RVEF	%
Ascending aorta	mm	IVSd	8.0 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.0 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	69 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	15 mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

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AGE/SEX	42 YRS/F
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DOCTOR	DR. ANANT MUNDE (CARDIOLOGIST)
DATE OF EXAMINATION	12/08/2023

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.19	0.91
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)		3.5		
REGURGITATION		+++ TRJV= 3.0 m/s PASP=36.0 mmHg		
E/A	1.24			
E/E'	9.5			

Left to right shunt across VSD

FINAL IMPRESSION: ACHD (PERIMEMBRANOUS VSD OF SIZE 5 MM WITH LEFT TO RIGHT SHUNT)

MODERATE TRICUSPID REGURGITATION

- No RWMA
- Normal LV systolic function (LVEF: 69 %)
- Good RV systolic function
- Normal diastolic function
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Work up for and treat VSD

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde

MBBS, DNB, DM (Cardiology)

Reg. No. 2005021228



Name - Mrs. Deepa Gawali	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 12/08/2023

USG - BOTH BREAST

Real time sonography of both breast was performed with high frequency probe.

Both breast show normal, medium level, homogeneous echotexture. No evidence of any solid or cystic focal mass lesion.

No evidence of calcification noted.

The pectorallis major muscles appear normal.

No evidence of axillary lymphadenopathy seen.

IMPRESSION:

- No significant abnormality is noted.

Thanks for the referral.....


DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

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Name - Mrs. Deepa Gawali	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 12/08/2023

USG ABDOMEN & PELVIS

Clinical details:- Routine

The Liver is normal in size and shows raised echogenicity. There is no obvious abnormal focal lesion seen. There is no IHBR dilatation seen in both the lobes of the liver.

The CBD and the Portal vein appear normal.

The Gall bladder is well distended & appears normal. No calculi or filling defects are seen. No evidence of Pericholecystic collection. The wall thickness is normal.

Right Kidney measures 9.2 x 3.7 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

Left Kidney measures 9.8 x 3.4 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

The Pancreas is normal in size & shows homogenous echopattern. It shows no focal lesion.

The Spleen is normal in size (9.8 cm) with homogenous echotexture.

The urinary bladder is adequately distended and appears normal. There is no evidence of any obvious calculi or any mass lesion seen. Both Uretero-vesical junctions appear clear. No abnormal intraluminal lesion noted.

The Uterus is anteverted & measures approximately 6.4 x 5.0 x 5.1 cms with normal homogenous echotexture. The uterine outline is smooth and normal. Endometrial thickness is normal. A fibroid measuring 2.7 x 2.6 cm along anterior wall.

Both ovaries are normal in size and echotexture.

Bilateral adnexae appear normal. No focal lesion noted.

No free fluid or obvious lymphadenopathy is seen in abdomen and pelvis.

IMPRESSION:

- Fatty liver.
- Uterine fibroid

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

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Male Years
Req. No. :

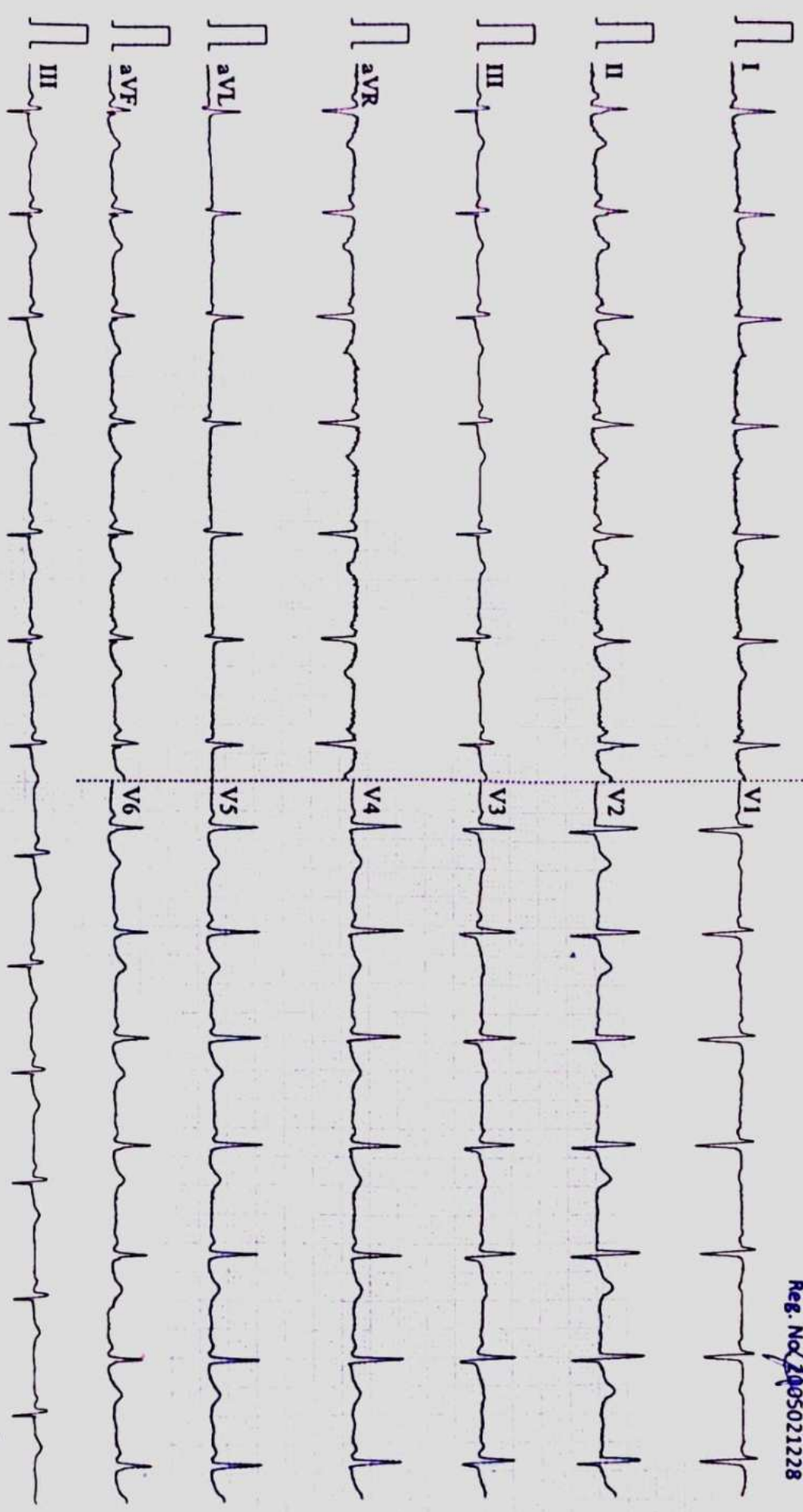
HR : 79 bpm
P : 99 ms
PR : 115 ms
QRS : 82 ms
QT/QTcBz : 364/419 ms
P/QRS/T : 76/21/60
RV5/SV1 : 0.861/0.725 mV

Diagnosis Information:
Sinus Rhythm
Short PR Interval

NSR
No Specific ST-T changes
ADU: No active intervention
required right now.

Report Confirmed by:

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228





MC-4661

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Age/Sex : 24 Years /Female Reported On : 13-Aug-2023 12:19 PM
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : INTERIM

**COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	11.0	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	33.0	%	36 - 46
RBC COUNT	5.01	x10 ⁶ /uL	4.5 - 5.5
MCV	66	fl	80 - 96
MCH	22.0	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	15.6	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	6840	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	67	%	40 - 80
LYMPHOCYTES	26	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	05	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	261000	/cumm	150000 - 450000
MPV	12.2	fl	6.5 - 11.5
PDW	16.3	%	9.0 - 17.0
PCT	0.320	%	0.200 - 0.500
RBC MORPHOLOGY	Mild hypochromia, Mild microcytosis		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

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

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

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HEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	45	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	118.1	ng/dl	84.63 - 201.8
T4	8.55	µg/dl	5.13 - 14.06
TSH	2.87	µIU/ml	0.270 - 4.20
T3 (Triido Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

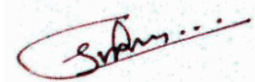
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

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RA FACTOR QUANTITATIVE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
RA FACTOR QUANTITATIVE	3.1	Text	Upto 20
METHOD	Serum, Turbidimetric Immunoassay.		

INTERPRETATION -

Elevated RF is found in collagen vascular diseases such as SLE, rheumatoid arthritis, scleroderma, Sjögren's Syndrome, and in other conditions such as leprosy, tuberculosis, syphilis, malignancy, thyroid disease and in a significant percentage of otherwise normal elderly patients.

Result relates to sample tested, Kindly correlate with clinical findings.

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MC-4661

Dr. Smita Ranveer's
Radiance
CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD		
* ABO GROUP	'B'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
----- END OF REPORT -----			

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***BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	19.3	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	9.02	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.63	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	2.90	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	136.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.18	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	100.0	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.01	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.5	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.48	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.9	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.58	g/dl	1.9 - 3.5
A/G RATIO (Calculated)	1.51		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

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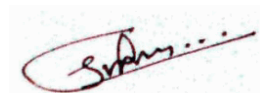
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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Mild hypochromia, Mild microcytosis
WBC	Total leucocyte count is normal on smear.
	Neutrophils:65 %
	Lymphocytes:26 %
	Monocytes:05 %
	Eosinophils:04 %
	Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.
Result relates to sample tested, Kindly correlate with clinical findings.	
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**LIVER FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.47	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.22	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.25	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	15.4	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	12.4	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	95.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.48	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.90	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.58	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.51		0 - 2

METHOD - EM200 Fully Automatic

Result relates to sample tested, Kindly correlate with clinical findings.

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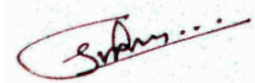
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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.5	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	111.2	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	81.4	mg/dL	70 - 110
BLOOD GLUCOSE PP	99.5	mg/dL	70 - 140
Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).			
1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.			
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn			

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**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT 13.5 U/L 5 - 55

Result relates to sample tested, Kindly correlate with clinical findings.

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