

MICRO MED CHARTS CE BU1493/1164

68020

11-010 2011-05-08 00:16



Dept. of Pathology
(For Report Purpose Only)



PRN : 110385
Patient Name : Mrs. PATIL SMITA .SANJAY
Age/Sex : 31Yr(s)/Female
Company Name : BANK OF BARODA
Referred By : Dr.HOSPITAL PATIENT

Lab No : 6582
Req.No : 6582

Collection Date & Time : 27/08/2022 09:40 AM
Reporting Date & Time : 27/08/2022 03:25 PM
Print Date & Time : 27/08/2022 03:31 PM

PARAMETER NAME	RESULT VALUE	UNIT	NORMAL VALUES
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HAEMATOLOGY

HAEMOGRAM

HAEMOGLOBIN (Hb)	: 12.9	GM/DL	Male : 13.5 - 18.0 Female : 11.5 - 16.5
PCV	: 39.3	%	Male : 40 - 54 Female : 37 - 47
RBC COUNT	: 4.47	Million/cu mm	Male : 4.5 - 6.5 Female : 3.9 - 5.6
M.C.V	: 87.9	cu micron	76 - 96
M.C.H.	: 28.9	pg	27 - 32
M.C.H.C	: 32.8	picograms	32 - 36
RDW-CV	: 12.7	%	11 - 16
WBC TOTAL COUNT	: 8260	/cumm	ADULT : 4000 - 11000 CHILD 1-7 DAYS : 8000 - 18000 CHILD 8-14 DAYS : 7800 - 16000 CHILD 1MONTH-<1YR : 4000 - 10000
PLATELET COUNT	: 359000	cumm	150000 - 450000

WBC DIFFERENTIAL COUNT

NEUTROPHILS	: 58	%	ADULT : 40 - 70 CHILD : 20 - 40
ABSOLUTE NEUTROPHILS	: 4790.80	µL	2000 - 7000
LYMPHOCYTES	: 36	%	ADULT : 20 - 40 CHILD : 40 - 70
ABSOLUTE LYMPHOCYTES	: 2973.60	µL	1000 - 3000
EOSINOPHILS	: 01	%	01 - 04
ABSOLUTE EOSINOPHILS	: 82.60	µL	20 - 500
MONOCYTES	: 05	%	02 - 08
ABSOLUTE MONOCYTES	: 413	µL	200 - 1000
BASOPHILS	: 00	%	00 - 01
ABSOLUTE BASOPHILS	: 0	µL	0 - 100

Technician

Report Type By :- PRITAM WAGHMARE

Dr. POONAM KADAM
MD (Microbiology), Dip.Pathology &
Bacteriology (MMC-2012/03/0668)
Pathologist



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RBC MORPHOLOGY	: Normocytic Normochromic		
WBC MORPHOLOGY	: Within Normal Limits		
PLATELETS	: Adequate		
PARASITES	: Not Detected		

Method : Processed on 5 Part Fully Automated Blood Cell Counter - sysmex XS-800i.

ESR

ESR MM (AT The End of 1 Hr.) By : 14
Westergren Method

mm/hr

Male : 0 - 15
Female : 0 - 20

END OF REPORT

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For Free Home Collection Call : 9545200011



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HAEMATOLOGY

BLOOD GROUP

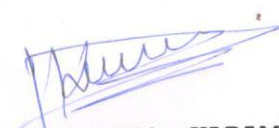
BLOOD GROUP : "O"
RH FACTOR : POSITIVE

NOTE : This is for your information.No transfusion / therapeutic intervention is done without confirmation of blood group by concerned authorities.In case of infants less than 6 months,suggested to repeat Blood Group after 6 months of age for confirmation. Kindly confirm the Negative Blood Group by reverse blood grouping (Tube method).

END OF REPORT


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BIOCHEMISTRY

HbA1C- GLYCOSYLATED -HB

HBA1C	: 5.15	%	Good Control : : 5.5 - 6.7 Fair Control : : 6.8 - 7.6 Poor Control : : >7.6
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Instrument: COBAS C 111

The HbA1C determination is based on turbidimetric inhibition immunoassay (TNIA) for hemolysed whole blood on Cobas c111 system.

NOTE :

- The HbA1C test shows your average blood sugar for last 3 months.
- The HbA1C test does not replace your day-to-day monitoring of blood glucose.
Use this test result along with your daily test results to measure your overall diabetes control.

How does HbA1C works ?

The HbA1C test measures the amount of **sugar that attaches to protein** in your red blood cells. RBCs live for about 3 months, so this test shows your average blood sugar levels during that time. Greater the level of sugar & longer it is high, the more sugar that will attach to RBCs.

Why is this test so important ?

Research studies demonstrated that the **closer to normal your HbA1C level was, the less likely your risk of developing the long- term complications of diabetes.** Such problems include eye disease and kidney problems.

Who should have the HbA1c test done ?

Everyone with diabetes can benefit from taking this test. Knowing your HbA1C level helps you and your doctor decide if you need to change your diabetes management plan.

How often should you have a HbA1C test ?

You should have this test done when you are first diagnosed with diabetes. Then at least twice a year if your treatment goals are being met & blood glucose control is stable. More frequent HbA1C testing (4 times / year) is recommended if your blood glucose management goals.

END OF REPORT

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BIOCHEMISTRY

BSL-F & PP

Blood Sugar Level Fasting	: 99	MG/DL	60 - 110
Blood Sugar Level PP	: 97	MG/DL	70 - 140

RFT (RENAL FUNCTION TEST)

BIOCHEMICAL EXAMINATION

UREA (serum)	: 10	MG/DL	0 - 45
UREA NITROGEN (serum)	: 4.67	MG/DL	7 - 21
CREATININE (serum)	: 0.5	MG/DL	0.5 - 1.5
URIC ACID (serum)	: 4.6	MG/DL	Male : 3.4 - 7.0 Female : 2.4 - 5.7

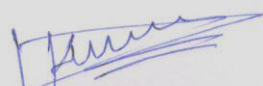
SERUM ELECTROLYTES

SERUM SODIUM	: 138	mEq/L	136 - 149
SERUM POTASSIUM	: 4.5	mEq/L	3.8 - 5.2
SERUM CHLORIDE	: 104	mEq/L	98 - 107

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BIOCHEMISTRY			
LFT (Liver function Test)			
BILIRUBIN TOTAL (serum)	: 1.5	MG/DL	INFANTS : 1.2 - 12.0 ADULT : : 0.1 - 1.2
BILIRUBIN DIRECT (serum)	: 0.8	MG/DL	ADULT & INFANTS : 0.0 - 0.4
BILIRUBIN INDIRECT (serum)	: 0.70	MG/DL	0.0 - 1.0
S.G.O.T (serum)	: 24	IU/L	5 - 40
S.G.P.T (serum)	: 19	IU/L	5 - 40
ALKALINE PHOSPHATASE (serum)	: 98	IU/L	CHILD BELOW 6 YRS : 60 - 321 CHILD : : 67 - 382 ADULT : : 36 - 113
PROTEINS TOTAL (serum)	: 7.0	GM/DL	6.4 - 8.3
ALBUMIN (serum)	: 3.7	GM/DL	3.5 - 5.7
GLOBULIN (serum)	: 3.30	GM/DL	1.8 - 3.6
A/G RATIO	: 1.12		1:2 - 2:1

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BIOCHEMISTRY

LIPID PROFILE

PARAMETER NAME	RESULT VALUE	UNIT	NORMAL VALUES
CHOLESTEROL (serum)	: 150	MG/DL	Male : 120 - 240 Female : 110 - 230
TRIGLYCERIDE (serum)	: 55	MG/DL	0 - 150
HDL (serum)	: 47	MG/DL	Male: : 42 - 79.5 Female: : 42 - 79.5
LDL (serum)	: 89	MG/DL	0 - 130
VLDL (serum)	: 11	MG/DL	5 - 51
CHOLESTROL/HDL RATIO	: 3.19		Male : 1.0 - 5.0 Female: : 1.0 - 4.5
LDL/HDL RATIO	: 1.89		Male : <= 3.6 Female : <=3.2

NCEP Guidelines

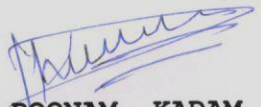
	Desirable	Borderline	Undesirable
Total Cholesterol (mg/dl)	Below 200	200-240	Above 240
HDL Cholesterol (mg/dl)	Above 60	40-59	Below 40
Triglycerides (mg/dl)	Below 150	150-499	Above 500
LDL Cholesterol (mg/dl)	Below 130	130-160	Above 160

Suggested to repeat lipid profile with low fat diet for 2-3 days prior to day of test and abstinence from alcoholic beverages if applicable.
 Cholesterol & Triglycerides reprocessed , & confirmed.

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ENDOCRINOLOGY

TFT (THYROID FUNCTION TEST)

T3-Total (Tri iodothyronine)	: 1.24	ng/mL	0.970 - 1.69
T4 - Total (Thyroxin)	: 9.49	µg/dL	5.53 - 11.0
Thyroid Stimulating Hormones (Ultra TSH)	: 1.06	µIU/mL	0.465 - 4.68

NOTE:-

Three common ways in which there may be inadequate amounts of the thyroid hormone for normal metabolism. Primary hypothyroidism, in which there is a raised TSH & a low T3. This is due to failure of the thyroid gland, possibly due to autoantibody disease, possibly due to toxic stress or possibly due to iodine deficiency. The second, the most common cause of thyroid failure, occurs at the pituitary level. In this condition there is inadequate thyroid stimulating hormone (TSH) produced from the pituitary and so one tends to see low or normal TSH, low T4s and variable T3s. This condition is most common in many patients with chronic fatigue syndrome, where there is a general suppression of the hypothalamic-pituitary-adrenal axis. The third type of under-functioning is due to poor conversion of there are normal or possibly slightly raised levels of TSH, normal levels of T4 but low levels of thyroid problem routinely TSH, a Free T4 and a Free T3 are also advisable. Any patients who are taking T3 as part of their thyroid supplement need to have their T3 levels monitored as well as T4. T3 is much more quickly metabolized than T4 and blood tests should be done between 4-6 hours after their morning dose.

The Guideline for pregnancy reference ranges for total T3, T4, Ultra TSH Level in pregnancy

	Total T3	Total T4	Ultra TSH
First Trimester	0.86 - 1.87	6.60 - 12.4	0.30 - 4.50
2 nd Trimester	1.0 - 2.60	6.60 - 15.5	0.50 - 4.60
3 rd Trimester	1.0 - 2.60	6.60 - 15.5	0.80 - 5.20

The guidelines for age related reference ranges for T3,T4,& Ultra TSH

	Total T3	Total T4	Ultra TSH
Cord Blood	0.30 - 0.70	1-3 day 8.2-19.9	Birth- 4 day: 1.0-38.9
New Born	0.75 - 2.60	1 Week 6.0-15.9	2-20 Week : 1.7-9.1
1-5 Years	1.0-2.60	1-12 Months 6.8 - 14.9	20 Week- 20 years 0.7 - 6.4
5-10 Years	0.90 - 2.40	1-3 Years 6.8-13.5	
10-15 Years	0.80 - 2.10	3-10 Years 5.5-12.8	

END OF REPORT

Technician

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MD (Microbiology), Dip.Pathology &
Bacteriology (MMC-2012/03/0668)
Pathologist

For Free Home Collection Call : 9545200011



Dept. of Pathology
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Print Date & Time : 27/08/2022 08:08 PM

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CYTOLOGY

PAP SMEAR


CODE NO. : C-57/22
CLINICAL DETAILS :
SPECIMEN : 02 Slides Received

MICROSCOPIC DESCRIPTION (Based on the Bethesda System)

BACKGROUND : Inflammatory and haemorrhagic
CELL TYPE : Superficial & Intermediate
ENDOCERVICAL CELLS : Present +
ENDOMETRIAL CELLS : Absent
METAPLASTIC CELLS : Present+
NEUTROPHILS : ++
LYMPHOCYTES : Absent
ORGANISMS : Normal Flora+
ATYPICAL CELLS : Few cells with mild atypia are noted.
CERVICO-VAGINAL CYTOLOGY INTERPRETATION : Suggestive of Atypical Squamous Cells of Unknown Significance (ASCUS)
NOTE : Correlate with clinical details. Advice - follow up /biopsy

Technician

Report Type By :- MONIKA MANE


Dr. POONAM KADAM
MD (Microbiology), Dip.Pathology &
Bacteriology (MMC-2012/03/0668)
Pathologist



Dept. of Pathology

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CLINICAL PATHOLOGY

URINE ROUTINE

PHYSICAL EXAMINATION

QUANTITY : 30 ML
COLOUR : PALE YELLOW
APPEARANCE : SLIGHTLY HAZY
REACTION : ACIDIC
SPECIFIC GRAVITY : 1.010

CHEMICAL EXAMINATION

PROTEIN : ABSENT
SUGAR : ABSENT
KETONES : ABSENT
BILE SALTS : ABSENT
BILE PIGMENTS : ABSENT
UROBILINOGEN : NORMAL

MICROSCOPIC EXAMINATION

PUS CELLS : 0-1 /hpf
RBC CELLS : ABSENT / hpf
EPITHELIAL CELLS : 3-4 /hpf
CASTS : ABSENT /hpf
CRYSTALS : ABSENT
OTHER FINDINGS : ABSENT
BACTERIA : ABSENT

END OF REPORT

Technician

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Pathologist

For Free Home Collection Call : 9545200011

PATIL, SMITA
 Patient ID 29811
 27.08.2022
 12:13:21

Female
 31yrs
 Meds:

Tabular Summary

BRUCE: Total Exercise Time 07:05
 Max HR: 187 bpm 98% of max predicted 189 bpm HR at rest: 85
 Max BP: 150/90 mmHg BP at rest: 110/70 Max RPP: 23920 mmHg*bpm
 Maximum Workload: 10.10 METS

Max. ST: -0.19 mV, 0.00 mV/s in V6; EXERCISE STAGE 3 06:29

Arrhythmia: A:198

ST/HR index: 1.29 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: GOOD EFFORT TOLERANCE

ACHIEVED 98% THR ON RX.

NORMAL BP RESPONSE

NO SIGNIFICANT ST-T CHANGES NOTED FOR THE GIVEN WORKLOAD

STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

DR. RAJDATT DEORE

MD, DM-CARDIOLOGIST

MMC 2005/03/1520

Test Reason: Screening for CAD
 Medical History: NO HISTORY.

Ref. MD: Ordering MD:

Technician: RUPALI Test Type: Treadmill Stress Test

Comment:

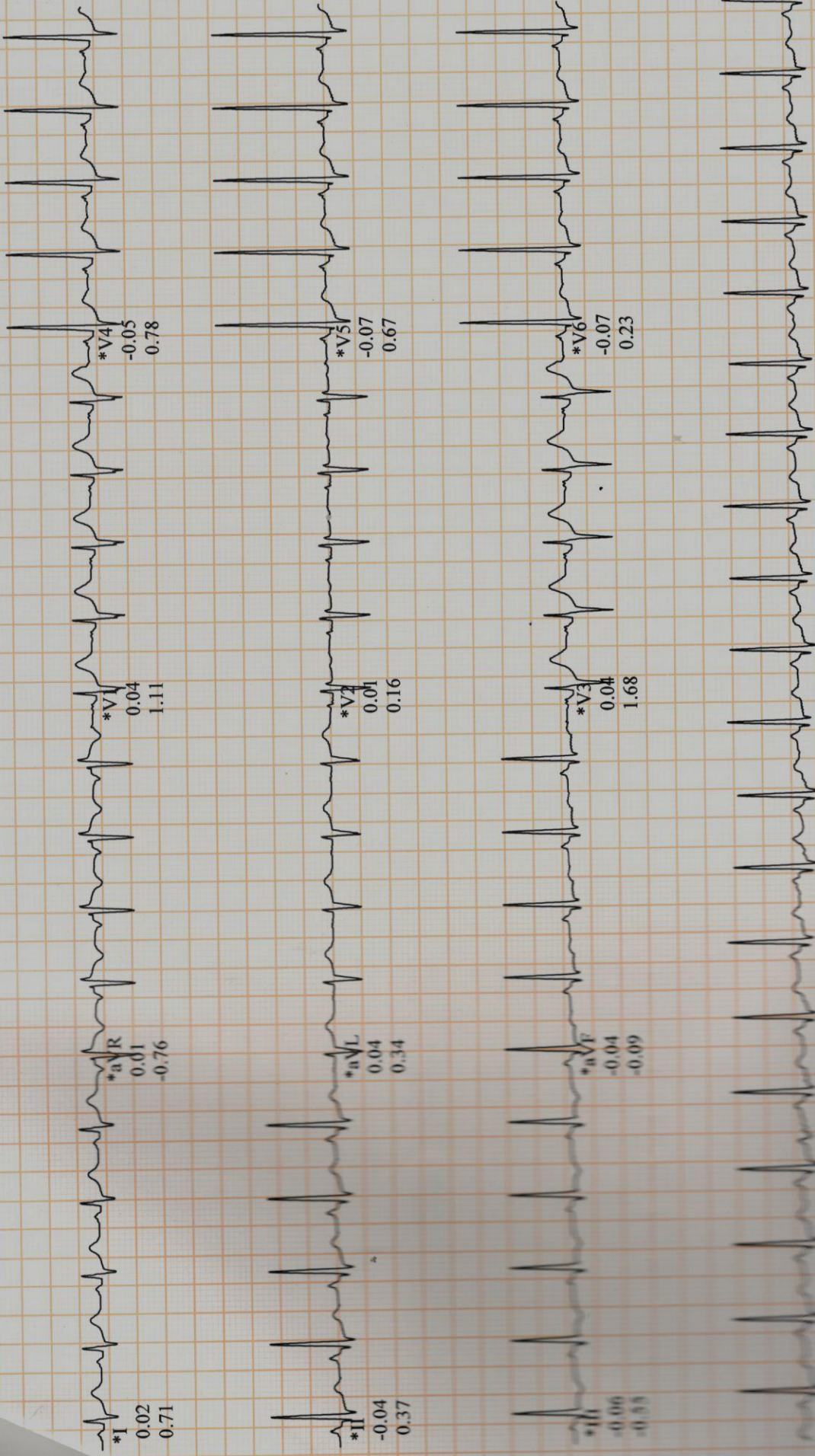
Phase Name	Stage Name	* Time in Stage	Speed (mph)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (mmHg*bpm)	VE (/min)	ST Level (V6 mV)	Comment
PRETEST	SUPINE	00:14	0.00	0.00	1.0	85	110/70	9350	0	-0.03	
	STANDING	00:56	0.00	0.00	1.0	83			0	-0.03	
	HYPERV.	01:06	0.50	0.00	1.3	98	110/70	10780	0	-0.03	
EXERCISE	STAGE 1	03:00	1.70	10.00	4.6	151	110/70	16610	0	-0.11	
	STAGE 2	03:00	2.50	12.00	7.0	181	130/85	23530	0	-0.15	
	STAGE 3	01:05	3.40	14.00	10.1	187	130/85	24310	0	-0.13	
RECOVERY		02:59	0.00	0.00	1.0	118	150/90	17700	0	-0.07	

BRUCE
0.0 mph
0.0 %

RECOVERY
#1
02:50

118 bpm
150/90 mmHg

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



Raw Data

*Computer Synthesized Rhythms



2D ECHO / COLOUR DOPPLER

NAME : MRS. SMITA PATIL
RF BY : DR. HOSPITAL PATIENT

31yrs/F

OPD
27-Aug-22

M - Mode values

Doppler Values

AORTIC ROOT (mm)	21	PULMONARY VEL (m/sec)	
LEFT ATRIUM (mm)	26	PG (mmHg)	
RV (mm)		AORTIC VEL (m/sec)	1.1
LVID - D (mm)	39	PG (mmHg)	5
LVID - S (mm)	24	MITRAL E VEL (m/sec)	0.8
IVS - D (mm)	10	A VEL (m/ sec)	0.5
LVPW -D (mm)	10	TRICUSPID VEL. (m/sec)	
EJECTION FRACTION (%)	60%	PG (mmHg)	

REPORT

Normal LV size & wall thickness.
No regional wall motion abnormality
Normal LV systolic function, LVEF 60%
Normal sized cardiac chambers.

Pliable mitral valve., no Mitral regurgitation.
Normal mitral diastolic flows.

Trileaflet aortic valve. No aortic stenosis / regurgitation.

Normal Tricuspid & pulmonary valve
Trivial tricuspid regurgitation ,
PA pressure = 20 mmHg - normal

Intact IAS & IVS
No PDA, coarctation of aorta.
No clots , vegetations , pericardial effusion noted.

IMPRESSION :

Normal echo study.
No regional wall motion abnormality.
Normal LV systolic & diastolic function , LVEF 60%
Normal PA pressure.


DR. RAJDATT DEORE.
MD, DM-CARDIOLOGIST
MMC 2005/03/1520

(NORMAL 2D-ECHO & COLOR DOPPLER DOESN'T RULE OUT ISCHAEMIC HEART DISEASE)



Dept. of Radiology
(For Report Purpose Only)



REQ. DATE : 27-AUG-2022 REP. DATE : 27-AUG-2022
NAME : MRS. PATIL SMITA .SANJAY
PATIENT CODE : 110385 AGE/SEX : 31 YR(S) / FEMALE
REFERRAL BY : HOSPITAL PATIENT

USG ABDOMEN AND PELVIS

OBSERVATION :

Liver : Is normal in size(13.2 cm), shape & echotexture. No focal lesion / IHBR dilatation.

CBD / PV : Normal.

G.B. : Moderately distended, normal.

Spleen : Is normal in size (7.9 cm), shape & echotexture. No focal lesion.

Pancreas : Normal in size, shape & echotexture.

Both kidneys are normal in size, shape & echotexture, CMD maintained. No calculus/ hydronephrosis / hydroureter on either side.

Right kidney measures : 9.7 x 3.3 cm.

Left kidney measures : 9.3 x 4.0 cm.

Urinary bladder : Moderately distended, normal.

Uterus : Anteverted, normal in size (6.1 x 5.6 x 4.1 cms), shape, echotexture. No fibroid. Endometrium show normal appearance. ET = 9.9 mm.

Both ovaries : show normal features. Adnexa clear.

Right ovary : 3.6 x 2.9 cm

Left ovary :

2.5 x 1.9 cms sized simple cyst is noted in right ovary.

No obvious demonstrable small bowel / RIF pathology.

Normal Aorta, IVC, adrenals and other retroperitoneal structures.

No ascites / lymphadenopathy / pleural effusion.

IMPRESSION :

Simple cyst in right ovary.

- Kindly co-relate clinically.

Dr. PIYUSH YEOLE
(MBBS, DMRE)
CONSULTANT RADIOLOGIST



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BILATERAL SONOMAMMOGRAPHY

OBSERVATION:

RT. BREAST.

Fibro-glandular tissues appear normal.
Skin and subcutaneous tissue appear normal.
Nipple shows normal features.
No significant axillary adenopathy.

LT. BREAST.

Fibro-glandular tissue appear normal.
Skin and subcutaneous tissue appear normal.
Nipple appear normal.
No e/o axillary lymphadenopathy.

IMPRESSION :

No sonologically demonstrable focal breast lesion.

- Kindly correlate clinically.

Dr. PIYUSH YEOLE
(MBBS, DMRE)
CONSULTANT RADIOLOGIST