

ms. shubhangi sarant
47/F

Height - 162 cm

Weight - 55 Kg

BMI - 21 kg/m²

menstrual cycle. ~~is~~ regular.

No any major illness

P₂L₂ - FTD.

- No any medicinal H/O
& Allergy.

father suffering from DM.

S-p-120/80

ECG - WNL
RBCs - WNL

↑ TG. / ↑ TSH level.

consult a physician for
dyslipidemia & Hypothyroidism

pt fit & can resume her
normal duties

Adv

Blood
- "invest"

- CPR



HELPLINE

022 - 2588 3531

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

www.siddhivinayakhospitals.org





Name - Mrs. Smbhanga Sawant	Age - 40 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 16/08/2023

USG -BOTH BREAST

Real time sonography of both breasts 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**

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.





Name - Mrs. Shubhangi Sawant	Age - 47 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 16/08/2023

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. Gall bladder calculus measuring 14-15 mm noted. No evidence of Pericholecystic collection. The wall thickness is normal.

Right Kidney measures 10.7x 4.3 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 10.4 x 5.0 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 (7.8 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 11.5 x 4.8 x 6.0 cms with normal homogenous echotexture. A fibroid measuring 3.9 x 4.7 cm seen along left lateral wall. The uterine outline is smooth and normal. Endometrial thickness is normal..

Both ovaries are normal in size and echotexture.

The right ovary measures 2.9 x 2.4 cms.

The left ovary measures 3.3 x 3.1 cms.


Bilateral adnexae appear normal. No focal lesion noted.

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

IMPRESSION:

- Fatty liver
- Cholelithiasis
- Bulky uterus with fibroid

Adv.: Clinical and lab correlation.


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MBBS; DMRE
CONSULTANT RADIOLOGIST

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Name - Mrs. Shubhangi Sawant	Age 47 Y/F
Ref by Dr.-Siddhivinayak Hospital	Date - 16/08/2023

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

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ECHOCARDIOGRAM

NAME	MRS. SHUBHANGI SAWANT
AGE/SEX	47 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE, DNB, DM (CARDIOLOGY)
DATE OF EXAMINATION	16/08/2023

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: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration
PULMONARY VEINS: Normal	PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	19 mm	Left atrium	30 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	42.2 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	25.3 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	71 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14.1 mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. SHUBHANGI SAWANT
AGE/SEX	47 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE (CARDIOLOGIST)
DATE OF EXAMINATION	16/08/2023

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.38	0.95
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A	1.61			
E/E'	7.59			

FINAL IMPRESSION: NORMAL STUDY

- No RWMA
- Normal LV systolic function (LVEF: 71 %)
- 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: Nil

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

INTERVENTIONAL CARDIOLOGIST

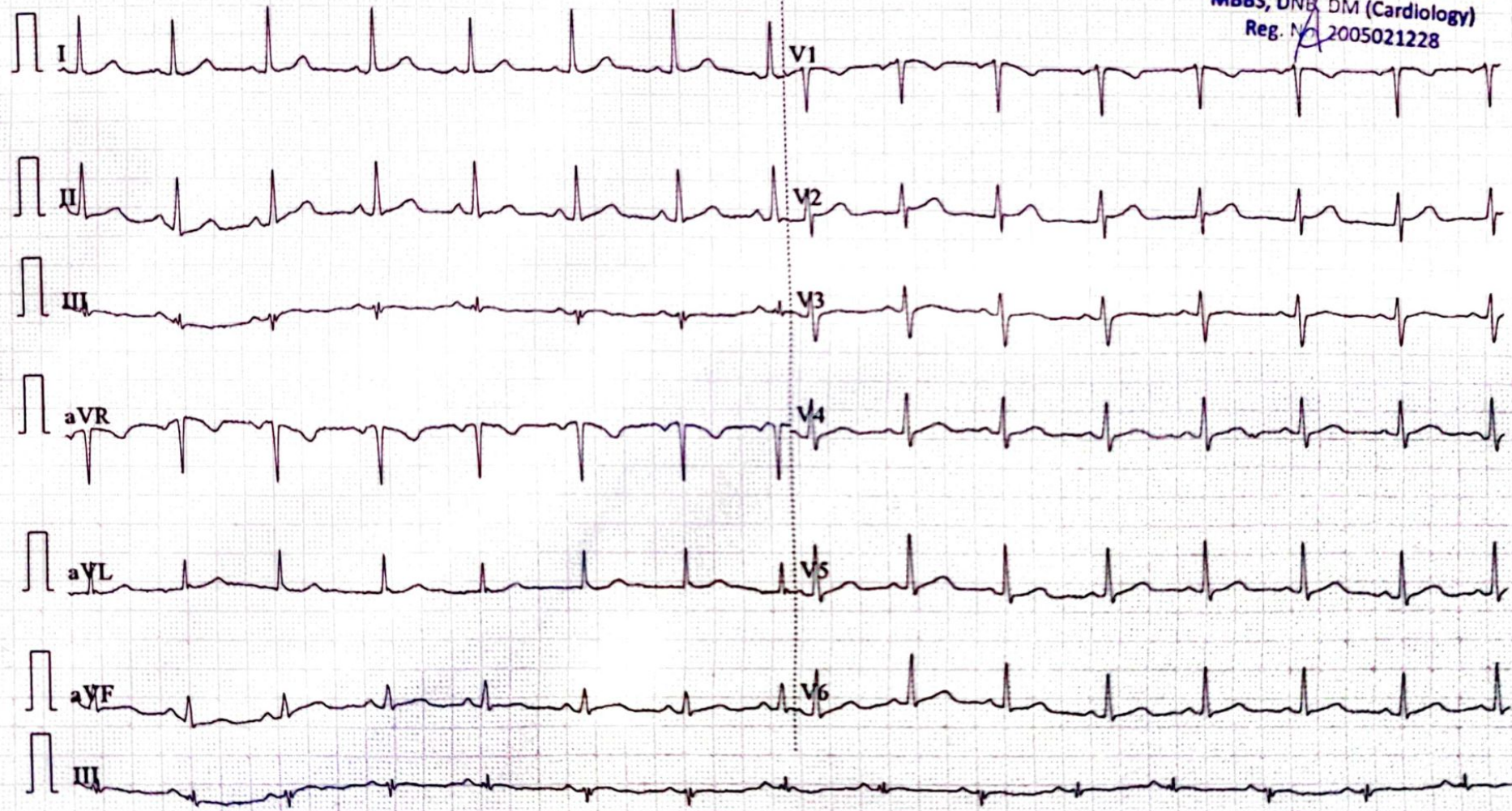
Shubhangi Sawant
47 Years
Req. No. : 47

HR : 88 bpm
P : 90 ms
PR : 133 ms
QRS : 89 ms
QT/QTcBz : 350/425 ms
P/QRS/T : 62/27/26 °
RV5/SV1 : 0.863/0.770 mV

Diagnosis Information: NSR
Sinus Rhythm
Low Voltage (Chest Leads) NO Significant ST-T change
Adv: - No specific intervention required right now.

Report Confirmed by:

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



0.25~35Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital



MC-4661

Name : Mrs. SHUBHANGI SAWANT Collected On : 16-Aug-2023 10:50 AM
Lab ID. : 163568 Received On : 16-Aug-2023 11:00 AM
Age/Sex : 47 Years /Female Reported On : 16-Aug-2023 11:44 PM
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : INTERIM

***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	187.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	42.0	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	323.5	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	65	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	80	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	1.90		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.45		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

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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**COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	13.0	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	39.0	%	36 - 46
RBC COUNT	4.06	x10 ⁶ /uL	4.5 - 5.5
MCV	96	fl	80 - 96
MCH	32.0	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.6	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	7540	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	54	%	40 - 80
LYMPHOCYTES	32	%	20 - 40
EOSINOPHILS	06	%	0 - 6
MONOCYTES	08	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	326000	/cumm	150000 - 450000
MPV	10.7	fl	6.5 - 11.5
PDW	16.1	%	9.0 - 17.0
PCT	0.350	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
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 -----

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HEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	36	mm/1hr.	0 - 20

METHOD - WESTERGREIN

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

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**URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale Yellow		
APPEARANCE	Clear		
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Absent		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent		
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	0-2	/ HPF	0 - 5

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		
	Result relates to sample tested, Kindly correlate with clinical findings.		
	----- END OF REPORT -----		

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	104.5	ng/dl	84.63 - 201.8
T4	8.23	µg/dl	5.13 - 14.06
TSH	6.13	µIU/ml	0.270 - 4.20
T3 (Triiodo 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			

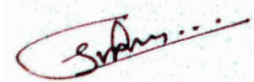
INTERPRETATION :

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.

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

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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	'A'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
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***BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	13.6	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	6.36	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.61	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	5.00	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	139.2	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	3.50	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	101.3	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.09	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	10.2	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.53	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.44	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.09	g/dl	1.9 - 3.5
A/G RATIO (Calculated)	2.12		0 - 2

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

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

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear. Neutrophils:55 % Lymphocytes:33 % Monocytes:07 % Eosinophils:05 % Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.

Result relates to sample tested, Kindly correlate with clinical findings.
----- END OF REPORT -----

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**LIVER FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.58	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.2	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.38	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	9.7	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	12.8	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	43.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.53	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.44	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.09	g/dl	1.90 - 3.50
A/G RATIO Calculated	2.12		0 - 2

METHOD - EM200 Fully Automatic

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	23.0	U/L	5 - 55

BLOOD GLUCOSE FASTING & PP

BLOOD GLUCOSE FASTING	90.9	mg/dL	70 - 110
BLOOD GLUCOSE PP	92.7	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

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

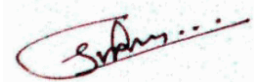
- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms +Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

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

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.3	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	105.4	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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Consultant Histocytopathologist



Name	: Mrs. SHUBHANGI SAWANT	Collected On	: 16-Aug-2023 10:50 AM
Lab ID.	: 163568	Received On	: 16-Aug-2023 11:00 AM
Age/Sex	: 47 Years /Female	Reported On	: 16-Aug-2023 11:44 PM
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: INTERIM



BIOCHEMISTRY

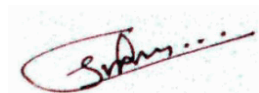
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. 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.

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

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

Checked By
Prasad_A



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

