UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. ISSAC SOPHA ELIZA	Order No	: 1000068651
UHID	: UHJA23016532	Registered On	: 26/01/2024 09:24:56 AM
Age/Sex	: 56/Years Female	Collected On	: 26/01/2024 09:33:47 AM
Ward / Bed No	:	Reported On	: 26/01/2024 01:39:18 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020599
Station	: At Hospital	Mobile No	: 6366112895
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	326	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	600	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	13.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	349.36	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.89	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.34	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.52	ı IU/mL	0.38-5.33
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	261	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	273	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	62.0	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	144.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	54.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.21		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.33		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	199	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.1	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.70	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.59	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.19	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.20	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.30		2:1
SERUM SGOT (Method:IFCC without P5P)	33	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	48	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	176	U/L	46-122
GGT (Method:IFCC)	145	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	38.7	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	18	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.67	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	26.86		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.38	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4490	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	56.89	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	31.90	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.45	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.25	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.51	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.91	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.6	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	14.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.52	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.00	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.8	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	40	mm/hour	1-30

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	B	
Rh Factor (Method:Agglutination Gel Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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Test Name	Result	Unit	Bio. Ref. Interval

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		5.0-8.0
SPECIFIC GRAVITY	1.025		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (1.5%)		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Positive		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Uric acid crystals present		
OTHERS	Bacteria present		
URINE SUGAR, FASTING (Method:GOD-POD)	Present (1.5%)		

Verified By
PREETHI R

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

Patient name :	Mrs. ISSAC SOPHA ELIZA	Date :	26/01/24
Age :	56 years GENDER: FEMALE	Patient ID :	16532
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.1 (2.5-3.7)	LVIDD : 4.1 (3.5-5.5)	MV EV : 77.6	AV : 107	MR : NORMAL
LA : 2.9 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 156		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 98.0		PR : NORMAL
RV : 2.4 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 0.8 (0.6-1.1)	Diastolic Function : GRADE 1 LVDD		
	LVPWS : 0.9 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis	: NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: SCLEROTIC CHANGES, NON-STENOTIC, JET GRDT-10mmHg
Tricuspid Valve	: NORMAL, TRIVIAL TR, JET GRDT-10mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

SCLEROTIC AORTIC VALVE
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE 1 LV DIASTOLIC DYSFUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

Patient name	Mrs. Issac Sophia Eliza	Patient ID	UHJA23016532
Age	56 years	Sex	Female
Referring doctor	Health check	Date	26/01/24

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is smaller in size with coarse echopattern.Mild surface nodularity is noted.
No intra or extra hepatic biliary duct dilatation.
No focal lesions. **Portal vein** is normal in size(10mm), course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.
pancreas- visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size(11cms), shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size(10cms, PT-1.3cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size(10.9cms, PT- 1.5cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Retroperitoneum – Visualized part of the aorta appeared normal. No obvious enlarged para-aortic nodes.
Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus and Ovaries not visualized.
Both adnexa: Normal. No mass is seen.
There is no ascites or pleural effusion.
Appendix could not be localized, obscured by bowel gas. No mass / collection in RIF /LIF.

IMPRESSION:

- **Chronic liver disease**
- **No portal vein thrombosis/focal hepatic lesion.**

Dr. GIRIDHAR V S
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Issac Sophia Eliza	**Date**	25/01/24
Age	56 years	**Hospital ID**	UHJA23016532
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Aortic knuckle calcification is noted.

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

Dr. Giridhar V S
Consultant Radiologist