

**Medipoint Hospitals Pvt. Ltd.**

Regd. Head Office : 241/1, New D P Road, Aundh, Pune - 411007.  
Regd No : LCBP-0506-01397 | Tel : 020-67643200  
info@vitalifemedipoint.in | www.sanjivanivitalife.in  
CIN : U85101PN2000PTC015213



**Sanjivani VitaLife**  
A Medipoint Venture

**Patient's Name** : Dharmendra Dhanjani  
**Age** : 33 yrs /M

**Date:** 26.03.2022

**ULTRASOUND ABDOMEN AND PELVIS**

**Liver:** It is normal in size and echotexture No focal lesion is seen in the liver. No intra hepatic biliary tract dilatation seen. Common bile duct and portal vein appears normal.

**Gall bladder:** Is distended. No evidence of calculus/ sludge noted. Wall thickness is normal.

**Pancreas:** - Normal in size and echotexture. No focal lesion seen.

**Spleen:** -Normal in size and echotexture. No focal lesion seen.

**Both Kidneys:** - are normal in size, shape, position and shows corticomedullary differentiation.

Right kidney measures: 9.7 x 5.4 cms.

Left kidney measures: 10.1 x 5.4 cms.

No evidence of calculus or hydroureteronephrosis on both kidneys.

**Urinary bladder:** - It is distended & appears normal.

**Prostate:** - It is normal in size(vol-22cc) and echotexture. No focal lesion seen.

No evidence of abdominal/ pelvic lymphadenopathy.

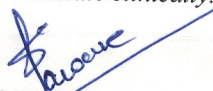
No e/o free fluid in abdomen and pelvis.

Visualized bowel loops appear normal.

**IMPRESSION:** USG abdomen & pelvis reveals,

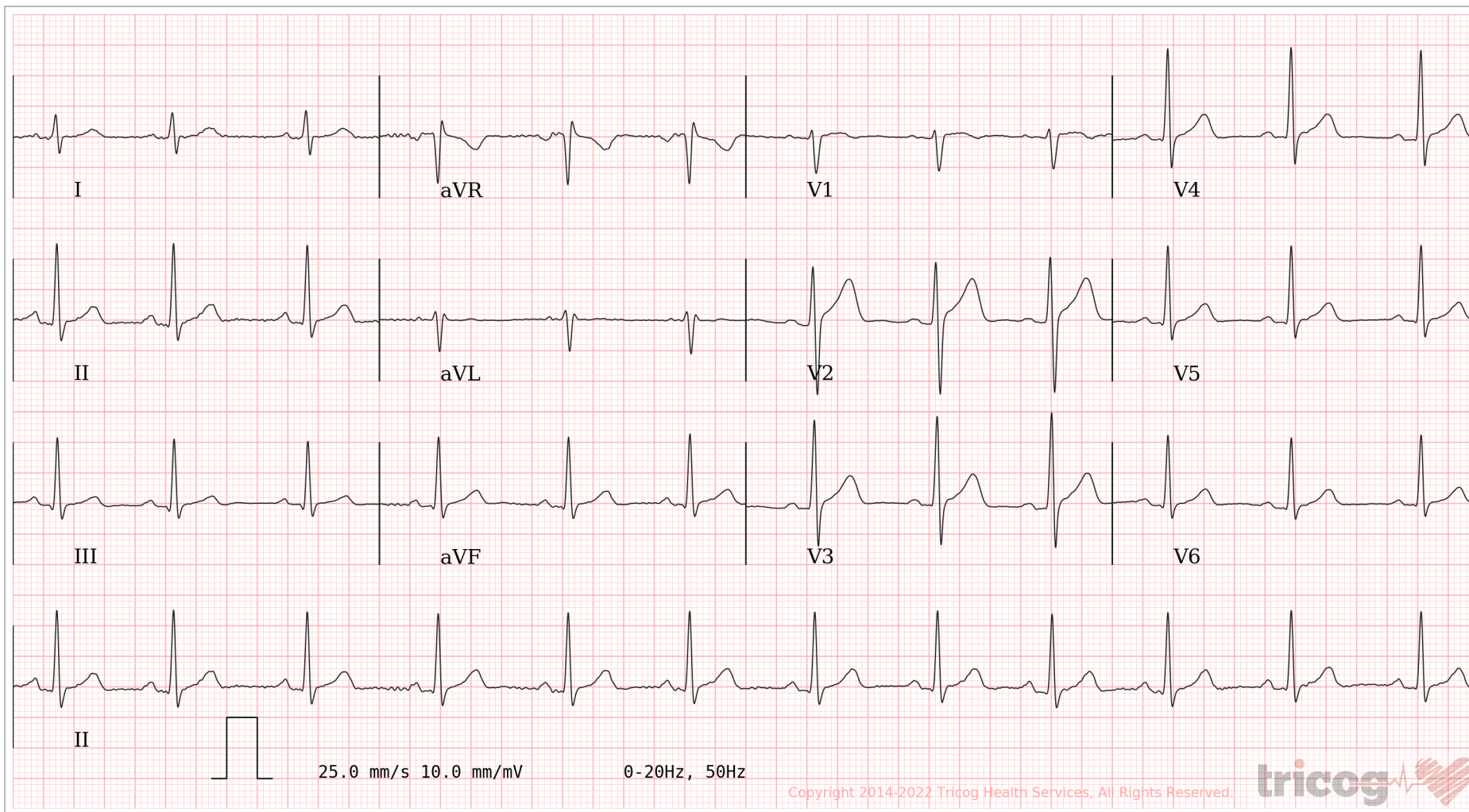
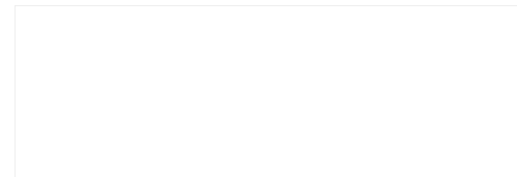
- No significant abnormality noted.

*Kindly correlate clinically.*

  
**Dr. Suraj Sonwane**  
M.B.B.S MD (Radiologist)  
Reg. No. 2014/05/2126

Age / Gender: - /Male  
 Patient ID: 2422120  
 Patient Name: Dharmendra Dhanjani

Date and Time: 26th Mar 22 10:38 AM



AR: NA    VR: 74bpm    QRSD: 104ms    QT: 372ms    QTc: 412ms    PRI: 152ms    P-R-T: 53° NA 58°

ECG Within Normal Limits: Sinus Rhythm, Normal Axis. Please mention age of the patient. Please correlate clinically.

AUTHORIZED BY



Dr. Charit  
MD, DM: Cardiology

63382

REPORTED BY



Dr Sadath Uzma

72392

**Patient Name : Mr. DHARMENDRA DHANJANI**  
**Age / Gender : 34 Y / Male**  
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**SID No. : 56006402**

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**Partial Test Report**

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**HAEMATOLOGY**

**COMPLETE BLOOD COUNT WITH PLATELETS**

**EDTA WHOLE BLOOD**

**HAEMOGLOBIN, RED CELL COUNT & INDICES**

HAEMOGLOBIN (Spectrophotometry)	14.2	gm%	12 - 15.5
PCV (Electrical Impedance)	40.4	%	37 - 47
MCV (Calculated)	83.2	fL	76 - 96
MCH (Calculated)	29.3	pg	27 - 32
MCHC (Calculated)	<b>35.2</b>	g/dl	31.5 - 34.5
RDW-CV (Calculated)	<b>16</b>	%	12 - 14
RDW-SD (Calculated)	<b>35</b>	fL	36 - 46
TOTAL RBC COUNT (Electrical Impedance)	4.86	Million/cmm	3.8 - 5.4
TOTAL WBC COUNT (Electrical Impedance)	5340	/cumm	4000 - 11000

**DIFFERENTIAL WBC COUNT**

NEUTROPHILS (Flow cell)	44.6	%	40-70
LYMPHOCYTES (Flow cell)	39.4	%	20-40
EOSINOPHILS (Flow cell)	<b>7.7</b>	%	1-6
MONOCYTES (Flow cell)	7.8	%	2-10
BASOPHILS (Flow cell)	0.5	%	0-2

**ABSOLUTE WBC COUNT**

ABSOLUTE NEUTROPHIL COUNT (Calculated)	2380	/cumm	2000-7000
ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2100	/cumm	1000-3000

Contd ...

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**HAEMATOLOGY**

**ABSOLUTE WBC COUNT**

ABSOLUTE EOSINOPHIL COUNT (Calculated)	410	/cumm	200-500
ABSOLUTE MONOCYTE COUNT (Calculated)	410	/cumm	200-1000
ABSOLUTE BASOPHIL COUNT (Calculated)	30	/cumm	0-220
PLATELET COUNT (Electrical Impedance)	281000	/cumm	150000 - 450000
MPV (Calculated)	7.0	fL	6-11
PDW (Calculated)	<b>9.9</b>	%	11-18
PCT (Calculated)	0.196	%	0.15-0.50

**PERIPHERAL BLOOD SMEAR**

COMMENTS  
(Microscopic)

Normocytic Normochromic RBCs

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**Dr.Rahul Jain**

**MD,PATHOLOGY**

**Consultant Pathologist**

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**HAEMATOLOGY**

**EDTA Blood**      **ABO BLOOD GROUP\***

BLOOD GROUP (Immuno Gel Column)	A
Rh TYPE (Immuno Gel Column)	POSITIVE

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**BIOCHEMISTRY**

**COMPREHENSIVE LIVER PROFILE  
SERUM**

BILIRUBIN TOTAL (Diazotization)	0.35	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.12	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	0.23	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	<b>55</b>	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	33	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	74	U/L	35-104
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	27	U/L	<40
TOTAL PROTEIN (Colorimetric)	7.80	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.80	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	3.00	gm/dl	2.0-3.5
A/G RATIO (Calculation)	1.6		1-2

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**BIOCHEMISTRY**

**COMPREHENSIVE RENAL PROFILE  
SERUM**

CREATININE (Jaffe Method)	1.0	mg/dl	0.5 - 1.1
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	<b>18.4</b>	mg/dl	7-17
BUN/CREATININE RATIO (Calculation)	18.4		10 - 20
URIC ACID (Uricase Enzyme)	4.8	mg/dl	2.5 - 6.2
CALCIUM (Bapta Method)	9.6	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	4.2	mg/dl	2.5-4.5

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**BIOCHEMISTRY**

**LIPID PROFILE**


SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	<b>232</b>	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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**Notes :** Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	<b>168</b>	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	45	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	<b>154</b>	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	34	mg/dl	15-40
SERUM	CHOL / HDL RATIO	<b>5.2</b>		3-5
SERUM	LDL /HDL RATIO (Calculation)	3.0		0 - 3.5

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**BIOCHEMISTRY**

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	86	mg/dl	70 - 110
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**Notes :** An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	<b>68</b>	mg/dl	70 - 140
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**EDTA WHOLE BLOOD GLYCOSYLATED HAEMOGLOBIN (HbA1C)**

HbA1C (High Performance Liquid Chromatography)	<b>6.1</b>	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	128	mg/dl	

**Notes :** HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations. HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, [https://www.who.int/diabetes/publications/report-hba1c\\_2011.pdf](https://www.who.int/diabetes/publications/report-hba1c_2011.pdf)) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1c assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

Contd ...

\*Tests not included in NABL accredited scope



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Healthspring Corporate Office, 5th Floor, East Wing Forbes Building, Charanjit Rai Marg, Fort, Mumbai- 400001

\*Members only

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**BIOCHEMISTRY**

EDTA	ESR(ERYTHROCYTE	13	mm / 1 hr	0-20
WHOLE	SEDIMENTATION RATE)			
BLOOD	(Photometric Capillary)			

**Notes :** The given result is measured at the end of first hour.

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**BIOCHEMISTRY**

Urine	URINE GLUCOSE POST PRANDIAL (Urodip)	ABSENT		
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**IMMUNOLOGY**

**THYROID PROFILE - TOTAL SERUM**

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.04	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	7.02	ug/dl	5.5 - 11
THYROID STIMULATING HORMONE (TSH) (ECLIA)	1.910	uIU/ml	0.27 - 4.20

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**IMMUNOLOGY**

**Notes :** TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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**CLINICAL PATHOLOGY**

**Urine URINE ANALYSIS**

**PHYSICAL EXAMINATION**

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		
APPEARANCE (Visual Examination)	CLEAR		

**CHEMICAL EXAMINATION**

SP.GRAVITY (Indicator System)	1.020		1.005 - 1.030
REACTION(pH) (Double indicator)	ACIDIC		
PROTEIN (Protein-error-of-Indicators)	ABSENT		
GLUCOSE (GOD-POD)	ABSENT		Absent
KETONES (Legal's Test)	ABSENT		Absent
OCCULT BLOOD (Peroxidase activity)	ABSENT		Absent
BILIRUBIN (Fouchets Test)	ABSENT		Absent
UROBILINOGEN (Ehrlich Reaction)	NORMAL		
NITRITE (Griess Test)	ABSENT		

**MICROSCOPIC EXAMINATION**

ERYTHROCYTES (Microscopy)	ABSENT	/hpf	0-2
PUS CELLS (Microscopy)	2-3	/hpf	0-5
EPITHELIAL CELLS (Microscopy)	2-4	/hpf	0-5
CASTS (Microscopy)	ABSENT		
CRYSTALS (Microscopy)	ABSENT		
ANY OTHER FINDINGS	NIL		

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**Sample Collected at : Aundh**

**Sample Collected on : 26 Mar 2022 11:07**

**Sample Received on : 26 Mar 2022 18:32**

**Barcode :** 



**Dr.Rahul Jain**

**MD,PATHOLOGY**

**Consultant Pathologist**

\*Tests not included in NABL accredited scope

PATIENT'S NAME - Pharamendra Shanjani  
 AGE/GENDER - 34 yrs / m  
 DOCTOR'S NAME - Dr Jitendra Karkar  
 DATE - 26.3.2022

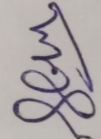
VISION SCREENING

	RE	RE	LE	LE
	Glasses	UNAIDED	Glasses	UNAIDED
DISTANT	-	6/5P	-	6/6
NEAR	-	Ng	-	Ng
COLOUR	Normal			
Recommendations				

VITALS

Pulse - 80/min	B.P. - 136/88 mm Hg	SpO2 97%
Height 168 cm	Weight - 72 kg	BMI - 25.5
Waist - 87	Hip - 92 cm	Waist/Hip Ratio - 0.95
Chest -	Inspiration - 94 cm	Expiration - 83

CENTRE NAME - H.S. Aundh

SIGN & STAMP - 



# HEALTHSPRING

## TREADMILL STRESS TEST REPORT

DATE:28/3/2021

NAME:	DHARMENDRA DHANJANI	AGE:(years)	34	SEX:	M
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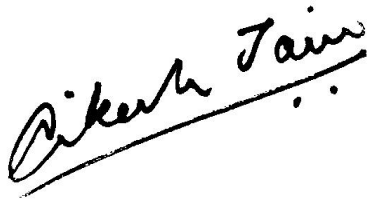
PROTOCOL USED	BRUCE PROTOCOL		
ANGINA SCALE (0 – None, 1 – Non-Limiting, 2 – Limiting)	0	MAXIMUM ST DEPRESSION (mm)	0
WORKLOAD: MAXIMUM METS ACHIEVED (METS)	13.50	DOUBLE PRODUCT	26732 mmHg/Min
DUKES SCORE (High Risk Score $\leq$ -11, Low Risk Score $\geq$ 5)	10		

**CONCLUSION:**

NORMAL INOTROPIC AND CHRONOTROPIC RESPONSE.  
 BASELINE ECG SHOWS NO ST-T CHANGES  
 NO SYMPTOMS, ARRHYTHMIAS OR ST-T CHANGES NOTED DURING EXERCISE  
 GOOD EFFORT TOLERANCE AND FUNCTIONAL CAPACITY.  
 STRESS TEST IS **NEGATIVE** FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD

**IMPRESSION:**

**STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD**



**DR. NIKESH JAIN**

DNB (MEDICINE), DNB (CARDIOLOGY)  
 MOBILE NO : +91-9819925026



**DR.NAVEED SHEIKH**

MBBS,PG Dip Clinical Cardiology

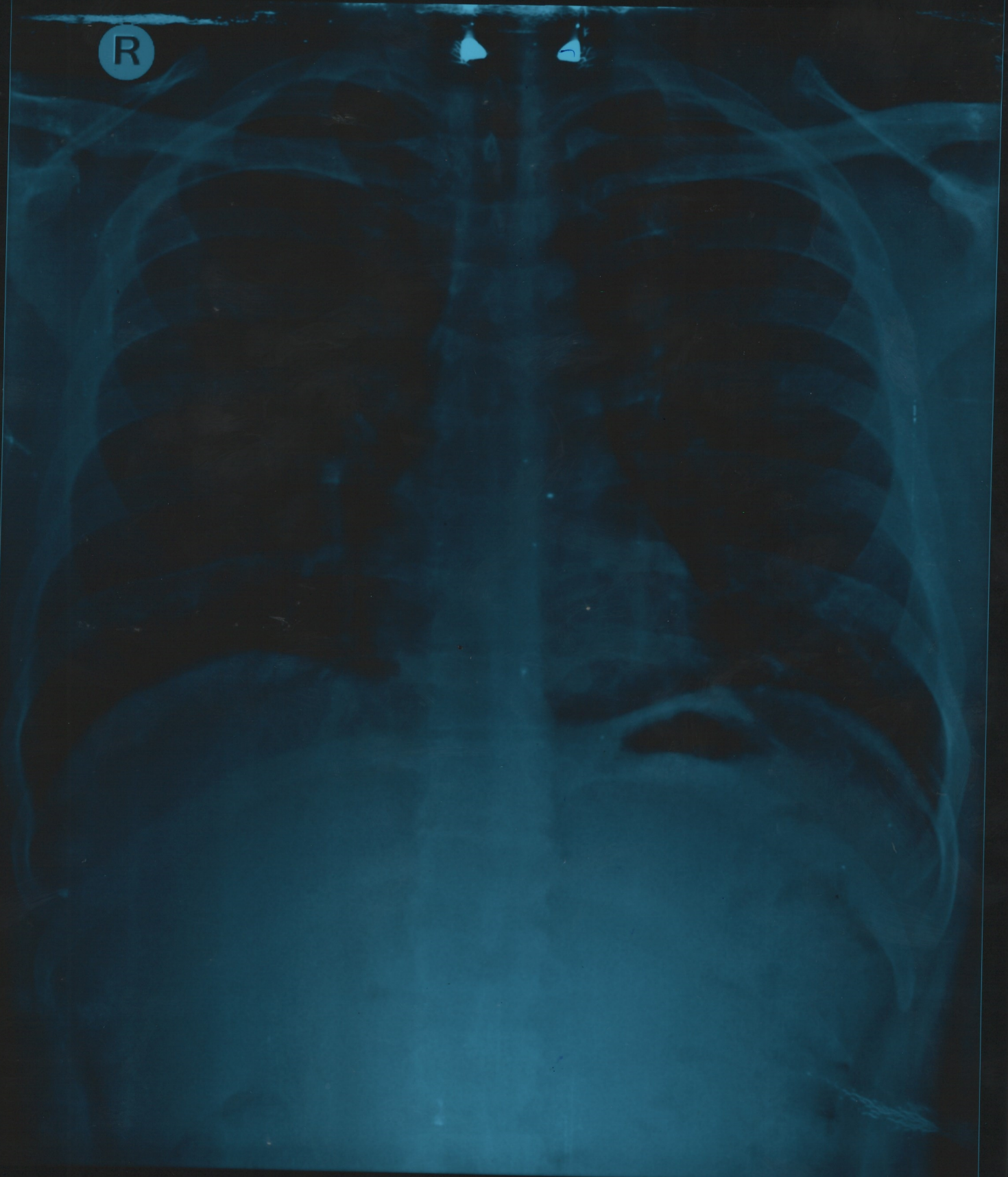
**NOTE-**

A NEGATIVE STRESS TEST DOES NOT CONCLUSIVELY RULE OUT CORONARY ARTERY DISEASE. A POSITIVE STRESS TEST IS NOT CONCLUSIVE EVIDENCE OF CORONARY ARTERY DISEASE. THERE IS A POSSIBILITY OF THE TEST BEING FALSE POSITIVE OR FALSE NEGATIVE DUE OTHER ASSOCIATED MEDICAL CONDITIONS. THESE REPORTS ARE FOR DOCTORS & PHYSICIANS AND NOT FOR MEDICO-LEGAL PURPOSES. KINDLY CO-RELATE THE REPORT WITH CLINICAL CONDITIONS.

THIS TMT/ ECG IS REPORTED ONLINE WITHOUT INTERACTING WITH PATIENTS AND THE RESULT SHOULD BE CLINICALLY CO-RELATED AND INDEPENDENTLY REVIEWED BY THE PATIENT'S CONSULTANT DOCTOR. THE PATIENT WAS NOT SEEN BY DOCTORS PERSONALLY AND THE ABOVE REPORT HAS BEEN REVIEWED BY THE DOCTOR BASED ON THE TMT/ECG RESULT AS PROVIDED TO THE DOCTOR.

DIANJANI DHARMENDRA/M/CXR PA OPD NO 30834/26-Mar-2022/9386

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MEDIPOINT HOSPITAL PVT. LTD. AUNDH PUNE

## Medipoint Hospitals Pvt. Ltd.

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info@vitalifemedipoint.in | www.sanjivanivitalife.in  
CIN : U85101PN2000PTC015213



**Sanjivani VitaLife**  
A Medipoint Venture

Patient's Name : Dharmendra Dhanjani  
Age : 33 yrs /M

Date: 26.03.2022

### CHEST X-RAY (PA VIEW)

Trachea and main bronchi appear normal.

Both lung fields appear normal.

Both costophrenic angles appears clear.

Cardiac size is normal.

Both domes of diaphragm appear normal.

Thoracic bony rib cage & soft tissues appear normal.

*Kindly correlate clinically.*

Dr. Suraj Sonwane  
Consulting Radiologist