23/02/2024

Priyanka Kumari
27yrs / female.

No fresh complaints.
No comorbidities.
PIH- H/O RTA in 2017.
(R) # radius, ulna, operated plating done in 2017
(R) radius, ulna plating implant removal in 2022.

Height - 158
Weight - 79
BMI - 31.6 kg/m²
(obese class I)

LMP - 26/01/24, regular
O/H - No any

BP - 110/70 mmHg
P - 72/min
SPO₂ - 98%

Pt is fit and can resume her normal duties

Adv
Skin ref.
Dental ref.

consult with physician for blood charges
TG, VLDL, TSH, ESR values raised

ID: 945 Priyanka Kumari 23-02-2024 08:44:15 AM

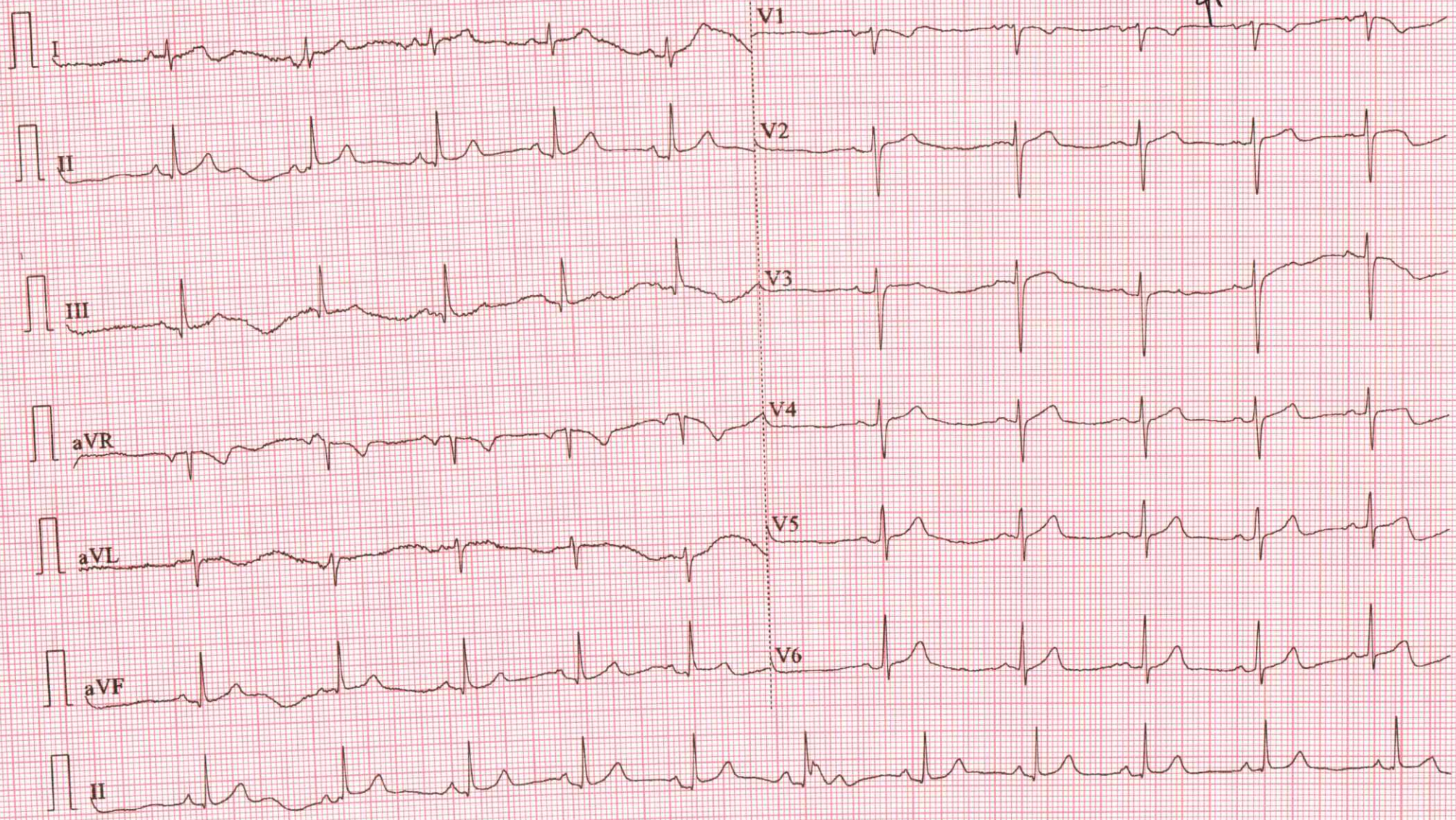
Female Years 27yIF

Req. No. : BP:-110/70 SpO2-98 PR-73

HR	: 69	bpm
P	: 85	ms
PR	: 153	ms
QRS	: 83	ms
QT/QTcBz	: 368/396	ms
P/QRS/T	: 51/82/53	°
RV5/SV1	: 0.611/0.456	mV

Diagnosis Information: NSR
Sinus Arrhythmia
No significant ST-T changes
AAV - No active intervention required right now

Report Confirmed by:



0.15-45Hz AC 50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

Name – Mrs . Priyanka Kumar	**Age - 27 Y/F**
Ref by Dr.- Siddhivinayak Hospital	**Date – 23/02/2024**

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. AMOL BENDRE
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.

Siddhivinayak Hospital
Imaging Department
Sonography | Colour Doppler | 3D / 4D USG
HELPLINE
022 - 2588 3531

Name – Mrs. Priyanka Kumari	**Age – 27 Y/F**
Ref by Dr.- Siddhivinayak Hospital	**Date – 23/02/2024**

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size 14.0 CM. It appears normal in morphology with normal echogenicity. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally with no stones within.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (9.6 cm) and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 8.0 x 4.2 cm.

The left kidney measures 9.7 x 4.9 cm.

Urinary bladder: normally distended. Wall thickness – normal.

Uterus : normal in size and morphology. Size: 7.0 x 3.7 x 4. cm.

Endometrium: 7.3 mm, it appears normal in morphology.

Bilateral ovaries are normal.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- **No obvious significant abnormality detected.**

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MBBS; DMRE
CONSULTANT RADIOLOGIST

OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE PRIYANKA KUMARI

AGE 27 **DATE -** 23.02.2024

Spects : With Glasses

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

SIDDHIVINAYAK HOSPITALS

ECHOCARDIOGRAM

NAME	MRS. PRIYANKA KUMARI
AGE/SEX	27 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	23/02/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	**CHAMBERS:** LEFT ATRIUM: Normal • Left atrial appendage: Normal LEFT VENTRICLE: Normal • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal • RWMA: No • Contraction: Normal
GREAT VESSELS: • AORTA: Normal • PULMONARY ARTERY: Normal	**SEPTAE:** • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal	**VENACAVAE:** • SVC: Normal • IVC: Normal and collapsing >20% with respiration
CORONARY SINUS: Normal	
PULMONARY VEINS: Normal	**PERICARDIUM:** Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	34 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	41.4 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.1 mm	RVEF	%
Ascending aorta	mm	IVSd	8.4 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.4 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	71 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14.0 mm

COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. PRIYANKA KUMARI
AGE/SEX	27 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	23/02/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.07	0.87
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	1.6			
E/E'	7.5			

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

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

Name	: **Mrs. PRIYANKA KUMAR (A)**	**Collected On**	: **23/2/2024 9:06 am**
Lab ID.	: **184627**	**Received On**	: **23/2/2024 9:16 am**
Age/Sex	: **27 Years / Female**	**Reported On**	: **23/2/2024 4:51 pm**
Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS**	**Report Status**	: **FINAL**

184627

PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/62/24		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	Adequate		
CELL TYPE	Superficial, intermediate,squamous metaplastic cells		
BACKGROUND	Clear		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Few neutrophils		
FINAL IMPRESION	Negative for intraepithelial lesion or malignancy.		
NOTE	Cervical cytology is a screening test and has associated false negative and false positive results. Regular sampling and follow up is recommended.		

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

Checked By
Dr_smita.ranveer

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M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

24 HOURS 7
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MC-6135

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184627

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	178.0	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)	43.4	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	**421.3**	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)	**84**	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	50	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)	1.15		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.10		<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
pooja_jadhav

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184627

COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	13.5	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	40.5	%	36 - 46
RBC COUNT	**4.25**	x10^6/uL	4.5 - 5.5
MCV	95	fl	80 - 96
MCH	31.8	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.5	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	8890	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	67	%	40 - 80
LYMPHOCYTES	22	%	20 - 40
EOSINOPHILS	04	%	0 - 6
MONOCYTES	07	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	160000	/ cumm	150000 - 450000
MPV	**13.8**	fl	6.5 - 11.5
PDW	17	%	9.0 - 17.0
PCT	0.220	%	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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pooja_jadhav

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184627

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
CHEMICAL EXAMINATION			
REACTION	Acidic		Acidic
(methyl red and Bromothymol blue indicator)			
SP. GRAVITY	1.010		1.005 - 1.022
(Bromothymol blue indicator)			
PROTEIN	Absent		Absent
(Protein error of PH indicator)			
BLOOD	Absent		Absent
(Peroxidase Method)			
SUGAR	Absent		Absent
(GOD/POD)			
KETONES	Absent		Absent
(Acetoacetic acid)			
BILE SALT & PIGMENT	Absent		Absent
(Diazonium Salt)			
UROBILINOGEN	Normal		Normal
(Red azodye)			
LEUKOCYTES	Absent		Absent
(pyrrole amino acid ester diazonium salt)			
NITRITE	Absent		Negative
(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)			
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	4-6	/ HPF	0 - 5
CASTS	Absent		

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184627

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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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184627

IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPACE		Space	-
SPECIMEN	Serum		
T3	121.6	ng/dl	84.63 - 201.8
T4	8.89	µg/dl	5.13 - 14.06
TSH	**7.20**	µIU/ml	0.270 - 4.20

T3 (Triido Thyronine) hormone)

AGE	RANGE
1-30 days	100-740
1-11 months	105-245
1-5 yrs	105-269
6-10 yrs	94-241
11-15 yrs	82-213
15-20 yrs	80-210

T4 (Thyroxine)

AGE	RANGES
1-14 Days	11.8-22.6
1-2 weeks	9.9-16.6
1-4 months	7.2-14.4
4 -12 months	7.8-16.5
1-5 yrs	7.3-15.0
5-10 yrs	6.4-13.3
11-15 yrs	5.6-11.7

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 wks -5 months	1.7-9.1
6 months-20 yrs	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	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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184627

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* 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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184627

*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	16.1	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	7.52	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.64	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	6.00	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	141.2	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.27	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	106.7	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	4.19	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.30	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.31	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.31	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.00	g/dl	1.9 - 3.5
A/G RATIO calculated	1.44		0 - 2

NOTE BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.

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

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

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

Name	: **Mrs. PRIYANKA KUMARI (A)**	**Collected On**	: **23/2/2024 9:06 am**
Lab ID.	: **184627**	**Received On**	: **23/2/2024 9:16 am**
Age/Sex	: **27 Years / Female**	**Reported On**	: **23/2/2024 4:51 pm**
Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS**	**Report Status**	: **FINAL**

184627

PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/62/24		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	Adequate		
CELL TYPE	Superficial, intermediate,squamous metaplastic cells		
BACKGROUND	Clear		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Few neutrophils		
FINAL IMPRESION	Negative for intraepithelial lesion or malignancy.		
NOTE	Cervical cytology is a screening test and has associated false negative and false positive results. Regular sampling and follow up is recommended.		

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

Checked By
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24 HOURS 7
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* 1 8 4 6 2 7 *

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear.
	Neutrophils:67 %
	Lymphocytes:23 %
	Monocytes:06 %
	Eosinophils:04 %
	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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MC-6135

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CLINICAL DIAGNOSTIC CENTRE

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184627

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.80	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.27	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.53	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	19.8	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	16.3	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	98.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.31	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.31	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.00	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.44		0 - 2

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

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

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184627

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	**22**	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GLYCOCELATED HEMOGLOBIN (HBA1C)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.2	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	102.5	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.

BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	98.4	mg/dL	70 - 110
BLOOD GLUCOSE PP	105.2	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 speciman. 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

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	20.6	U/L	5 - 55

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

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