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GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

9112

Hiranandani HOSPITAL
A Fortis Network Hospital

UHID	**5669185**	**Date**	**29/10/2022**		
Name	**Mrs.Swati Vishwanand Mahadik**	**Sex**	**Female**	**Sex**	**38**
OPD	**Dental 12**	**Health Check-up**			

Drug allergy:
Sys illness:

1) Missy — 5

2) Decayed — 8 7 6 | 2 8
7

Adv
1) OPG - Full mouth

B7 I

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Hiranandani HOSPITAL
(A Fortis Network Hospital)

UHID	**5669185**	**Date**	**29/10/2022**		
Name	**Mrs.Swati Vishwanand Mahadik**	**Sex**	**Female**	**Sex**	**38**
OPD	**Pap Smear**	**Health Check-up**			

Drug allergy:
Sys illness:

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Hiranandani HOSPITAL
Fortis Network Hospital

UHID	**5669185**	**Date**	**29/10/2022**		
Name	**Mrs.Swati Vishwanand Mahadik**	**Sex**	**Female**	**Sex**	**38**
OPD	**Opthal 14**	**Health Check-up**			

Drug allergy: → Not known
Sys illness: → No.

C/o: Redness (sometimes). (LE.)

H/o D.M (since 5 yrs).

Unaided Vn → RE 6/6 → LE 6/6.

Ref → RE Plano 6/6 → LE Plano 6/6

NVn → N6 → N6.

I.O.P. → RE → 14.8 → LE → 13.2

[illegible]

DFG - Tears ← 1 — 1 — 1. 6 weeks

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

DRAWN : 29/10/2022 09:37:00 RECEIVED : 29/10/2022 09:39:11 REPORTED : 29/10/2022 12:50:02

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

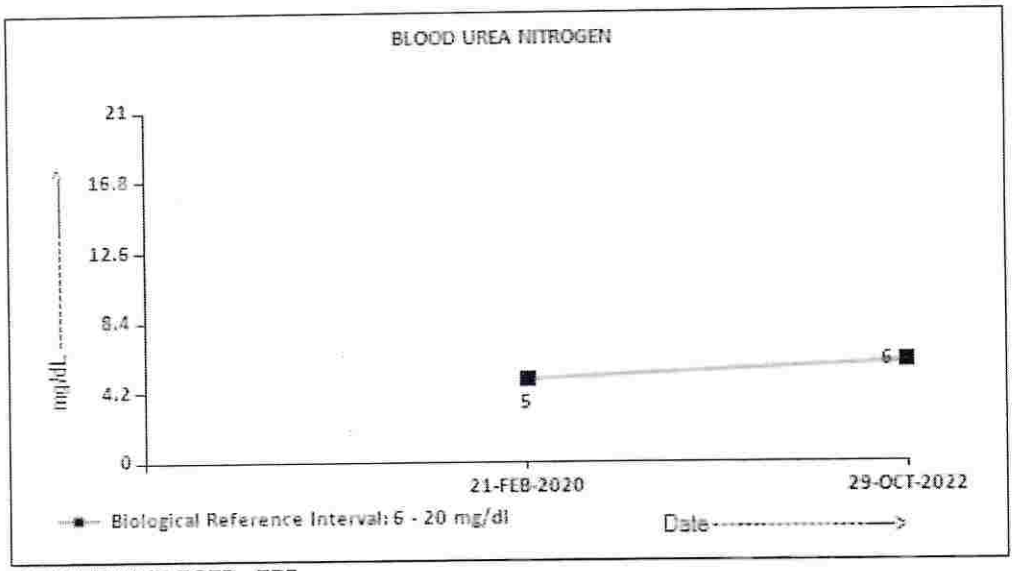
Test Report Status **Final**	Results	Biological Reference Interval	Units

KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	6	6 - 20	mg/dL

METHOD : UREASE - UV



CREATININE EGFR- EPI

CREATININE	**0.46**	**Low**	0.60 - 1.10	mg/dL
AGE	38			years
GLOMERULAR FILTRATION RATE (FEMALE)	125.54		Refer Interpretation Below	mL/min/1.73

METHOD : ALKALINE PICRATE KINETIC JAFFES

METHOD : CALCULATED PARAMETER

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

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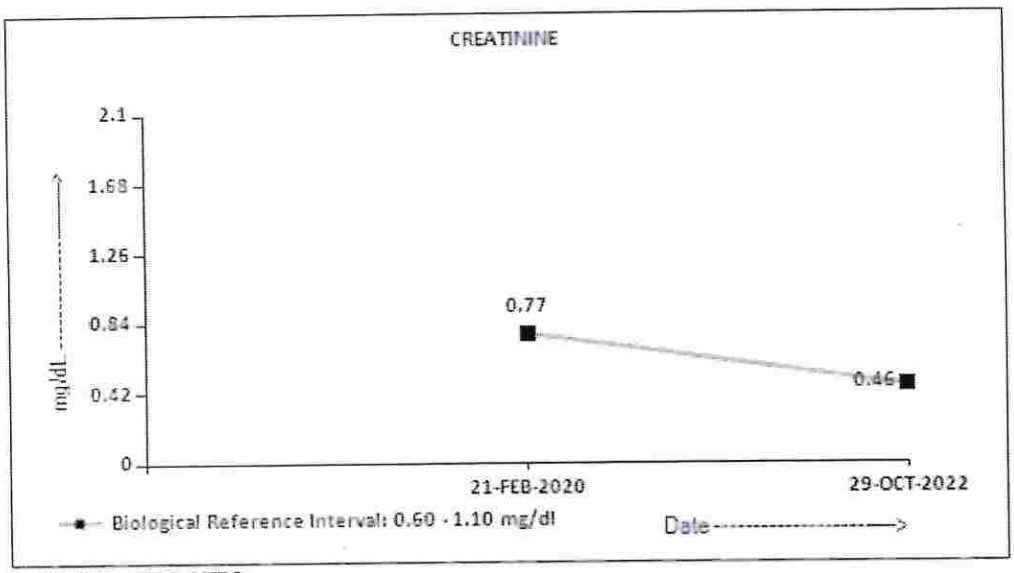
Test Report Status **Final**	Results	Biological Reference Interval	Units



BUN/CREAT RATIO				
BUN/CREAT RATIO	13.04		5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	**2.5**	**Low**	2.6 - 6.0	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.6		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN	3.9		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				
GLOBULIN	3.7		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	136		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM	4.34		3.50 - 5.10	mmol/L

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Patient Ref. No. 2200000080

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval	Units
METHOD : ISE INDIRECT			
CHLORIDE	101	98 - 107	mmol/L
METHOD : ISE INDIRECT			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
METHOD : PHYSICAL			
APPEARANCE	**SLIGHTLY HAZY**		
METHOD : VISUAL			
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
PUS CELL (WBC'S)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	**5-7**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

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CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT	

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI-
GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equat especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
URIC ACID, SERUM-
Causes of Increased levels
Dietary
• High Protein Intake.
• Prolonged Fasting,
• Rapid weight loss.
Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin ar globulin

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CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
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Test Report Status **Final**	Results	Biological Reference Interval

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion an prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of fo can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

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UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval		
HAEMATOLOGY				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	16		0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	**11.0**	**Low**	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	**4.83**	**High**	3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	7.85		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	350		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	**33.3**	**Low**	36 - 46	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	**68.9**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**22.7**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.9		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	**21.2**	**High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	14.3			
MEAN PLATELET VOLUME (MPV)	7.6		6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	64		40 - 80	%
METHOD : FLOW CYTOMETRY				
LYMPHOCYTES	29		20 - 40	%
METHOD : FLOW CYTOMETRY				

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Patient Ref. No. 22000000

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

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CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval	
MONOCYTES	6	2 - 10	%
METHOD : FLOW CYTOMETRY			
EOSINOPHILS	1	1 - 6	%
METHOD : FLOW CYTOMETRY			
BASOPHILS	0	0 - 2	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	5.02	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	2.28	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.47	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.08	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT	**0**	**Low** 0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.2		
METHOD : CALCULATED PARAMETER			
MORPHOLOGY			
RBC	MILD HYPOCHROMASIA, MICROCYTOSIS (+), ANISOCYTOSIS (+)		
METHOD : MICROSCOPIC EXAMINATION			
WBC	NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS	ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION			

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

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PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR054028
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Test Report Status **Final**	Results	Biological Reference Interval

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference f
the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
RBC AND PLATELET INDICES-
Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NL 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106
This ratio element is a calculated parameter and out of NABL scope.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE AB		
METHOD : TUBE AGGLUTINATION			
RH TYPE	POSITIVE		
METHOD : TUBE AGGLUTINATION			

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found i plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIO CHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.44	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.12	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.32	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.6	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.9	3.4 - 5.0	g/dL

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Patient Ref. No. 22000000

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

DRAWN : 29/10/2022 09:37:00 RECEIVED : 29/10/2022 09:39:11 REPORTED : 29/10/2022 12:50:02

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results		Biological Reference Interval	
METHOD : BCP DYE BINDING GLOBULIN	3.7		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER ALBUMIN/GLOBULIN RATIO	1.1		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**9**	**Low**	15 - 37	U/L
METHOD : UV WITH P5P ALANINE AMINOTRANSFERASE (ALT/SGPT)	13		< 34.0	U/L
METHOD : UV WITH P5P ALKALINE PHOSPHATASE	57		30 - 120	U/L
METHOD : PNPP-ANP GAMMA GLUTAMYL TRANSFERASE (GGT)	25		5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE LACTATE DEHYDROGENASE	175		100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
CORONARY RISK PROFILE(LIPID PROFILE), SERUM CHOLESTEROL, TOTAL	192		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE TRIGLYCERIDES	**212**	**High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY HDL CHOLESTEROL	**33**	**Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG LDL CHOLESTEROL, DIRECT	130		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT NON HDL CHOLESTEROL	**159**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

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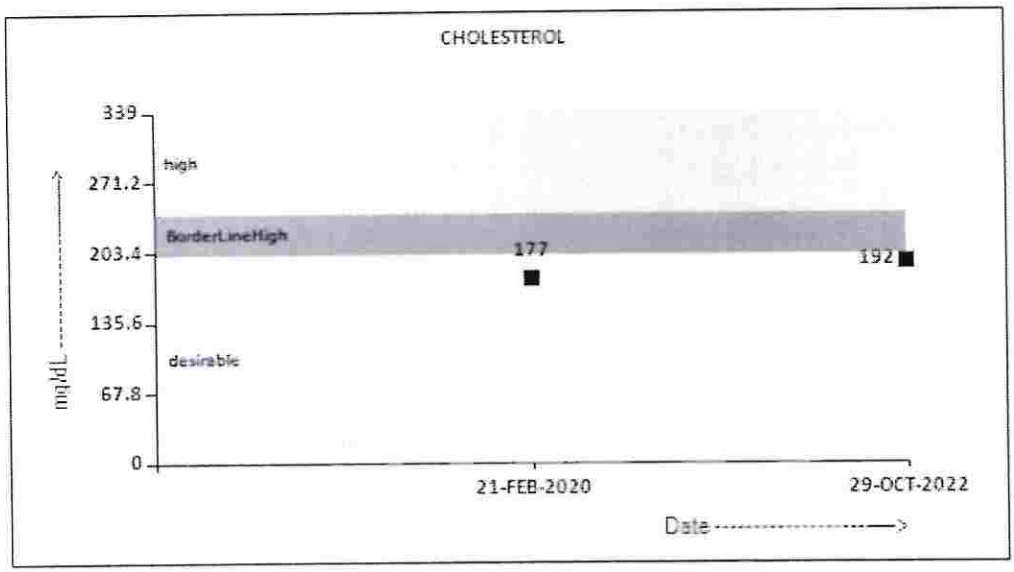
Test Report Status **Final**	Results	Biological Reference Interval	
METHOD : CALCULATED PARAMETER CHOL/HDL RATIO	**5.8**	**High**	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk
METHOD : CALCULATED PARAMETER LDL/HDL RATIO	**3.9**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
METHOD : CALCULATED PARAMETER VERY LOW DENSITY LIPOPROTEIN	**42.4**	**High**	</= 30.0 mg/dL

METHOD : CALCULATED PARAMETER



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Patient Ref. No. 220000008

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

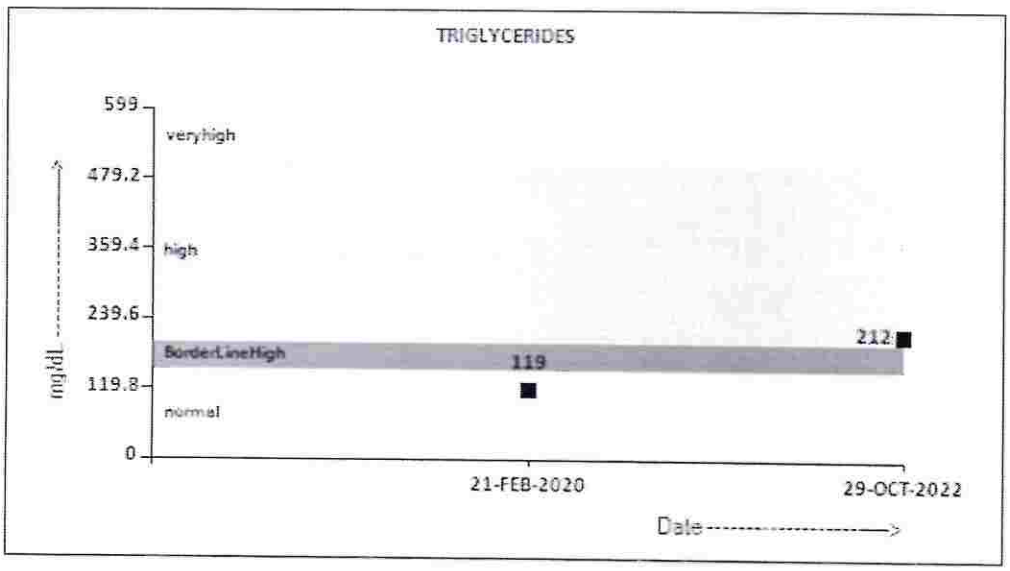
DRAWN : 29/10/2022 09:37:00 RECEIVED : 29/10/2022 09:39:11 REPORTED : 29/10/2022 12:50:02

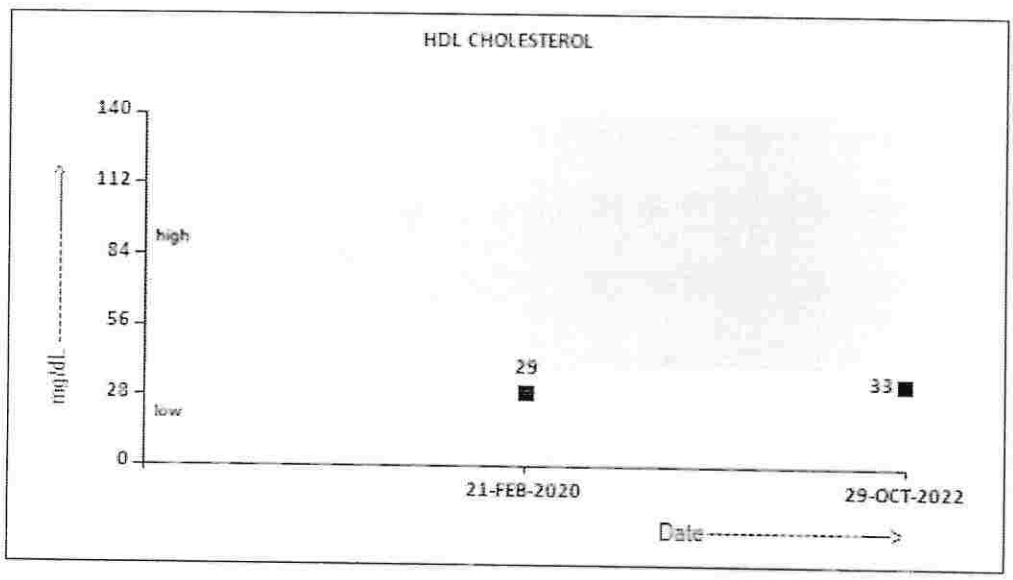
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval





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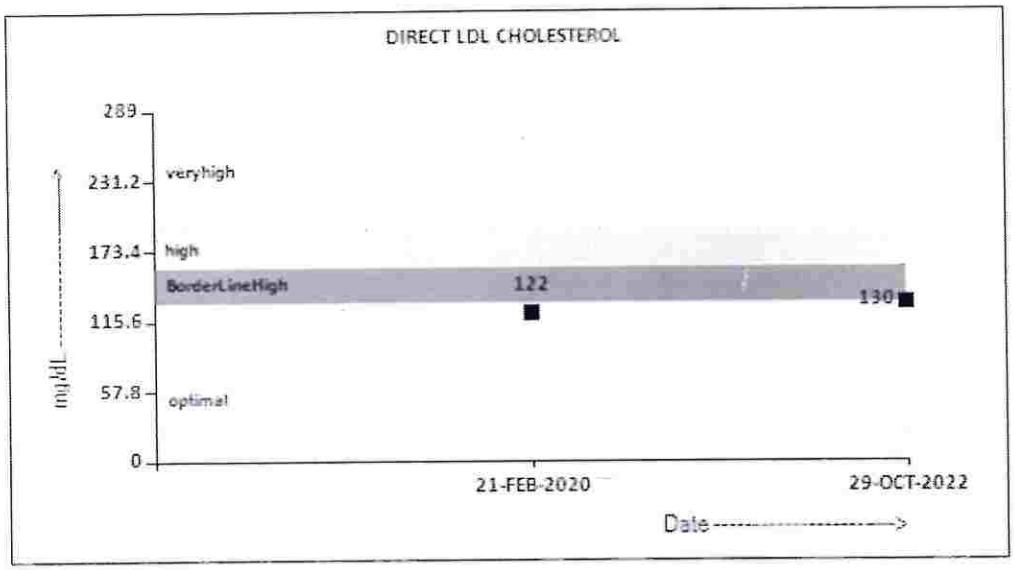

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	**170**	**High**	74 - 99	mg/dL

METHOD : HEXOKINASE

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

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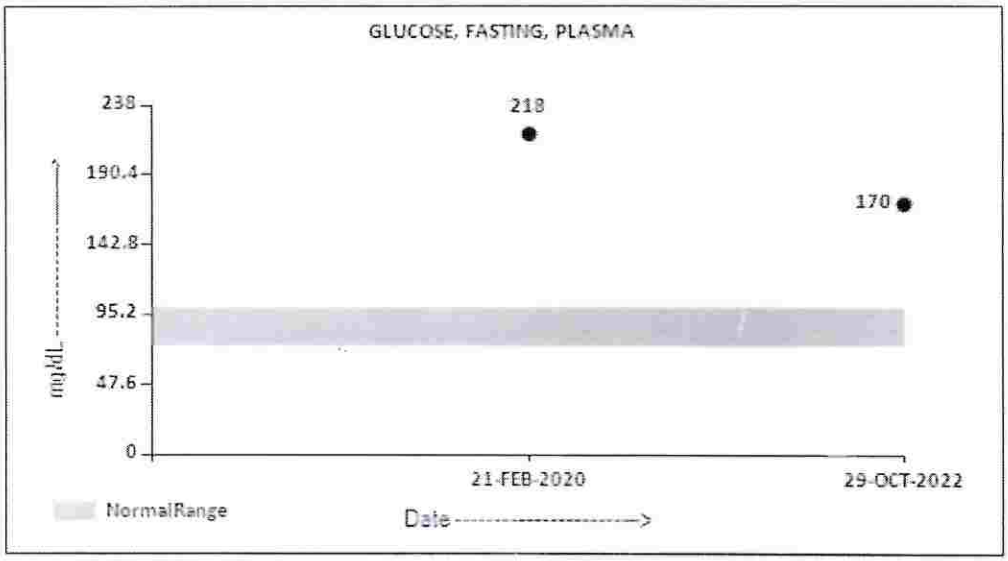

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	**7.4**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)	**165.7**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

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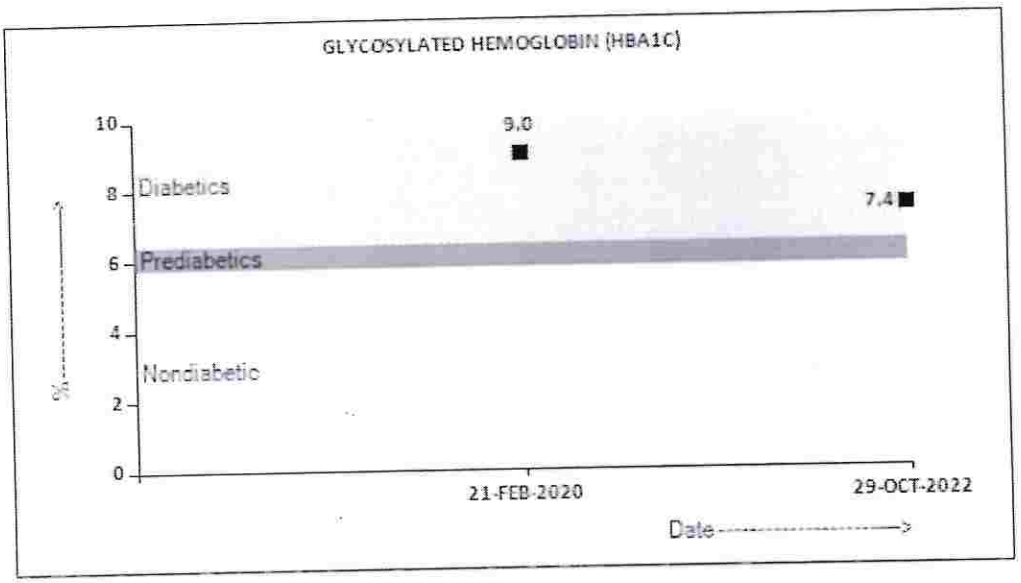

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-

LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may giv yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin whe there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bili may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme th attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measure clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemol anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blo is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstru Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancre is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the sour normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary sys and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,al known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than- levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.H serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood al levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vasc permeability or decreased lymphatic clearance,malnutrition and wasting etc

CORONARY RISK PROFILE(LIPID PROFILE), SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High

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Patient Ref. No. 22000000

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

CLINICAL INFORMATION :

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Test Report Status **Final**	Results	Biological Reference Interval

cholesterol levels usually don''''''''''''''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor f heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''''''''''''''t need into triglycerides, which are stored in fat cells. I triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or ha diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, othe diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determinatio provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumptio and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also b implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both pri and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used i patients for whom fasting is difficult.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycae index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & o addiction are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

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CLINICAL INFORMATION :

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BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval

c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

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LABORATORY REPORT

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PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005822** AGE : 38 Years SEX : Female ABHA NO :

DRAWN : 29/10/2022 09:37:00 RECEIVED : 29/10/2022 09:39:11 REPORTED : 29/10/2022 13:59:41

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. DUMMY

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BILLNO-150122OPCR054028
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Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	93.8	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	6.36	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH 3RD GENERATION	1.600	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)
THYROID PANEL, SERUM-Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metaboli body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley''''s Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

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Dr. Swapnil Sirmukaddam
786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

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LABORATORY REPORT

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SRL Diagnostics

PATIENT NAME : MRS. SWATI VISHWANAD MAHADIK

PATIENT ID : **FH.5669185** CLIENT PATIENT ID : UID:5669185

ACCESSION NO : **0022VJ005893** AGE : 38 Years SEX : Female ABHA NO :

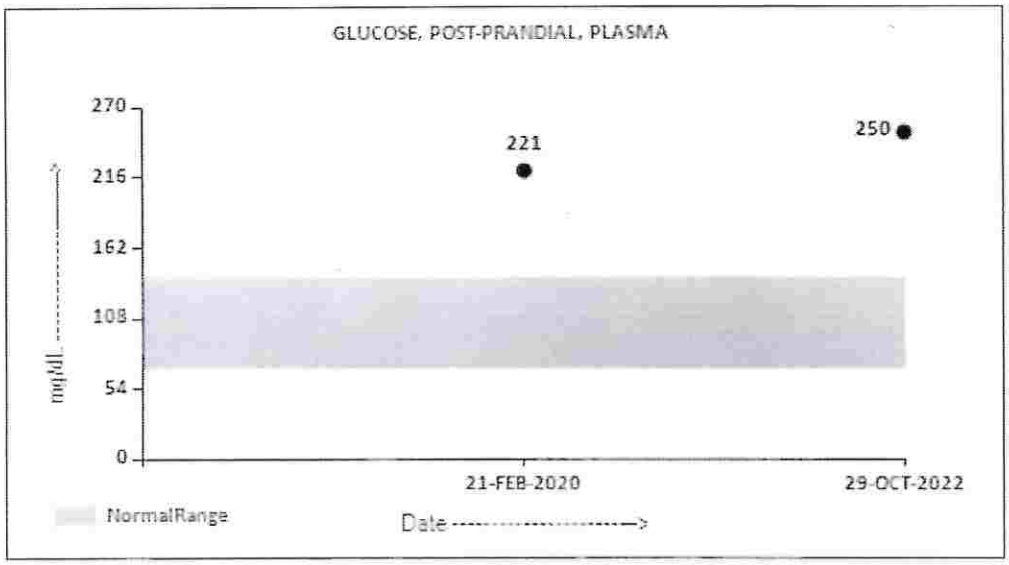
DRAWN : 29/10/2022 11:58:00 RECEIVED : 29/10/2022 11:59:01 REPORTED : 29/10/2022 12:54:09

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:5669185 REQNO-1313238
CORP-OPD
BILLNO-150122OPCR054028
BILLNO-150122OPCR054028

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIO CHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**250**	**High** 70 - 139	mg/dL
METHOD : HEXOKINASE			



Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

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MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

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Patient Ref. No. 2200000080

LABORATORY REPORT

Cert. No. MC-2275

Fortis

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Test Report Status **Final**	Results	Biological Reference Interval	Units

Dr.Akta Dubey
Counsultant Pathologist

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Patient Ref. No. 2200000080498

3669185 mrs.swati 10/29/2022 11:28:36 AM
38 Years Female

HC

Rate	66	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline repolarization abnormality.....ST dep & abnormal T
PR	127	. Baseline wander in lead(s) V1,V2
QRSD	88	
QT	408	
QTc	428	

--AXIS--

P	46
QRS	77
T	33

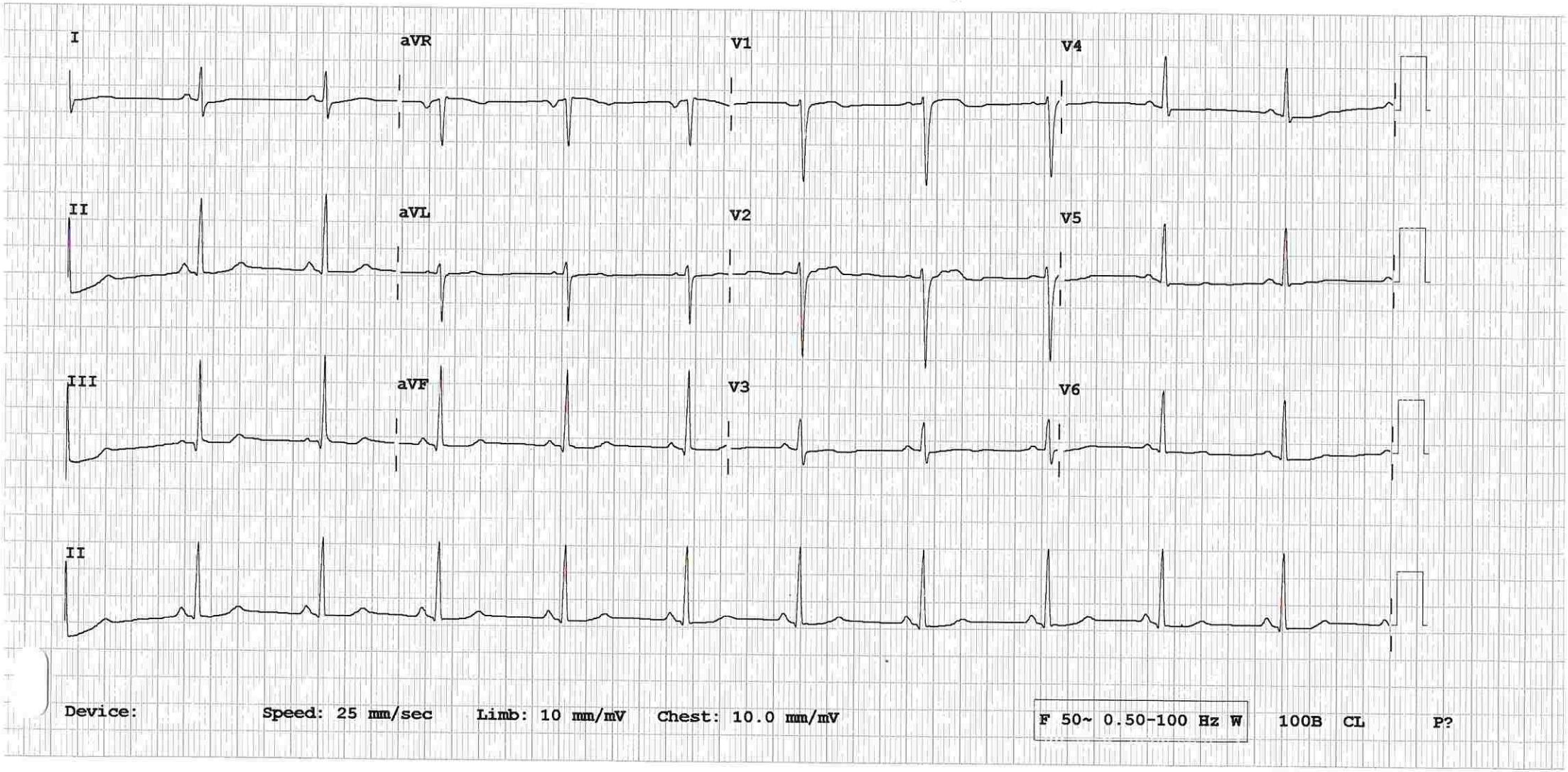
Sinus rhythm
Normal

Dr Prashant Sawant

- BORDERLINE ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

Date: 29/Oct/2022

DEPARTMENT OF NIC

Name: Mrs. Swati Vishwanath Mahadik
Age | Sex: 38 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5669185 | 53519/22/1501
Order No | Order Date: 1501/PN/OP/2210/113653 | 29-Oct-2022
Admitted On | Reporting Date : 29-Oct-2022 12:57:44
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	35	mm
AO Root	29	mm
AO CUSP SEP	18	mm
LVID (s)	31	mm
LVID (d)	43	mm
IVS (d)	10	mm
LVPW (d)	09	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.4 m/sec
E/A RATIO:1.5

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- Trivial MR .
- Normal LV and RV systolic function.

DR. PRASHANT PAWAR,
DNB(MED), DNB (CARDIOLOGY)

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DEPARTMENT OF RADIOLOGY

Date: 29/Oct/2022

Name: Mrs. Swati Vishwanath Mahadik
Age | Sex: 38 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

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Admitted On | Reporting Date : 29-Oct-2022 11:59:46
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)

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Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal.
No evidence of calculi/hydronephrosis.
Right kidney measures 10.6 x 4.5 cm.
Left kidney measures 11.4 x 4.7 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness.
No evidence of intravesical calculi.

UTERUS is normal in size, measuring 7.7 x 3.4 x 4.9 cm.
Endometrium measures 11.3 mm in thickness.

Both ovaries are normal.
Right ovary measures 3.1 x 3.0 x 1.4 cm, volume 7.2 cc.
Left ovary measures 3.2 x 2.0 x 1.7 cm, volume 6.0 cc.

No evidence of ascites.

IMPRESSION:

- **No significant abnormality is detected.**

DR. CHETAN KHADKE
M.D. (Radiologist)

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Order Doctor Name : Dr.SELF .

MAMMOGRAM - BOTH BREAST

Findings:

Bilateral film screen mammography was performed in cranio-caudal and medio-lateral oblique views.

Both breasts show scattered areas of fibroglandular density.

No evidence of any dominant mass, clusters of microcalcifications, nipple retraction, skin thickening or abnormal vascularity is seen in either breast.

No evidence of axillary lymphadenopathy.

IMPRESSION:

- No significant abnormality detected. (BI-RADS category I).
- No obvious mass lesion in the breasts.

Normal-interval follow-up is recommended.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)