

26/2/24

Aditee Joshi.

60 yrs / Female

No fresh complaints.

PH - (NHL Ca) in July, 2011, 2014,
not on any Rx. 2018.

SH - Biopsy done (2011)

not on any Reg Rx

Underwent Chemotherapy &
radiotherapy.

Height - 152cm

Weight - 56kg

BMI - 21.6 kg/m²

Normal

OH - G₂P₂A₀L₂D₀

G₁ - female, 23 yrs, FTND, healthy

G₂ - Male, 18 yrs, FTND, healthy.

TL not done

Menopause - at the age of 47 yrs

BP - 120/70 mmHg

R - 80/min

SpO₂ - 98%

Pt is fit and can resume
her normal duties





Name - Mrs. Aditi Joshi	Age - 60 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 26/02/2024

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size (12.8 cm). It appears normal in morphology with **raised 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 (9.8 cm) and morphology

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

The right kidney measures 10.0 x 4.3 cm.

The left kidney measures 9.8 x 4.2 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus: Post menopausal status.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Fatty liver (Grade I)

DR. AMOL BENDRE

MBBS; DMRE

CONSULTANT RADIOLOGIST





Name - Mrs . Aditi Joshi	Age - 60 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date- 26/02/2024

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.



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

ADITEE JOSHI

AGE

60

DATE -

26.02.2024

Specks : With Glasses

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



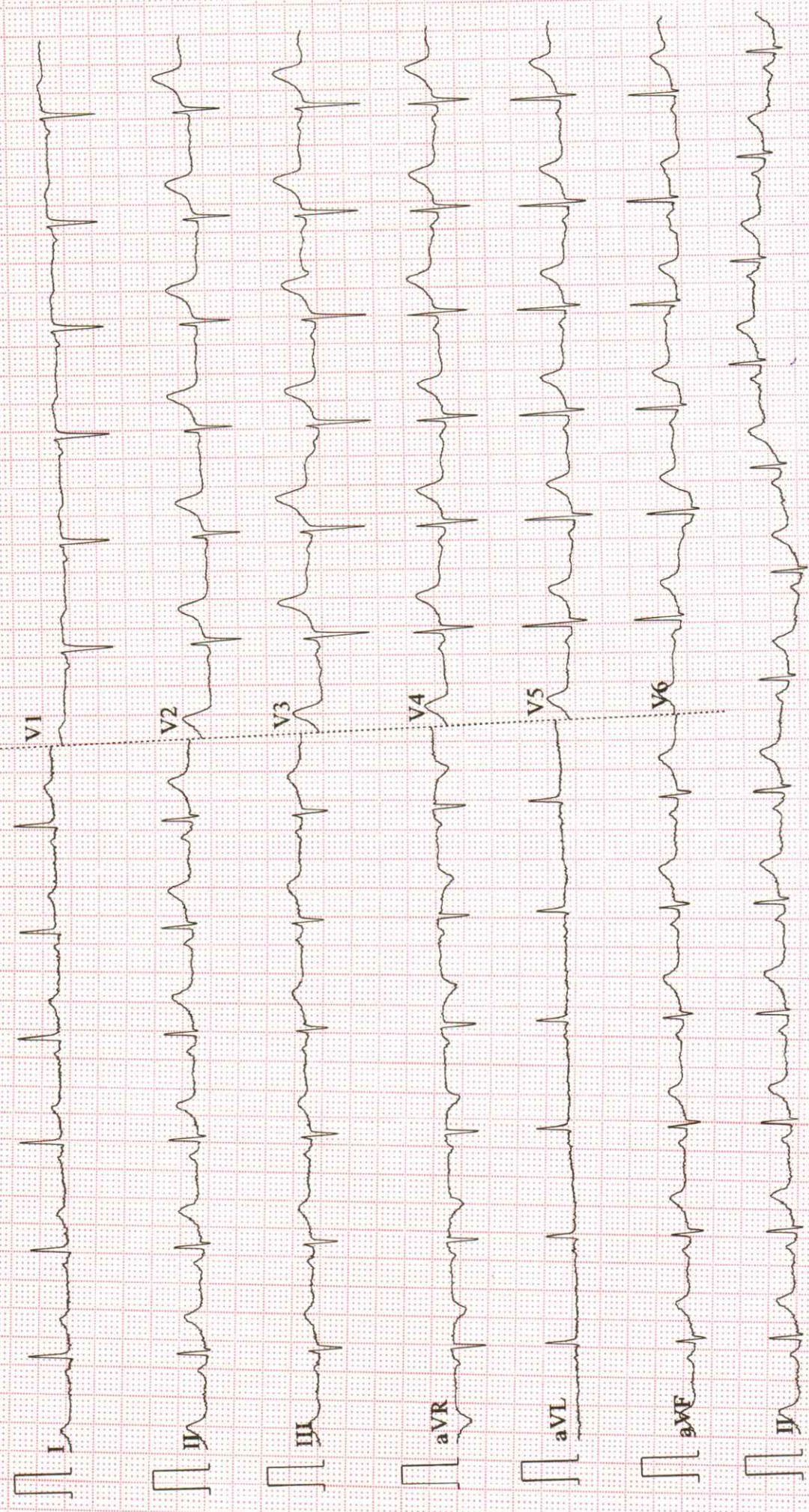
ID: 979 Aditi Joshi 26-02-2024 09:43:12 AM

Female Years 60
Req. No. :
BP - 120/70
SpO2 - 98%
RR - 80/m

Diagnosis Information:
Sinus Rhythm
Normal ECG

MMNL
(R)

Report Confirmed by:





ECHOCARDIOGRAM

NAME	MRS. ADITI JOSHI
AGE/SEX	60 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	26/02/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal <ul style="list-style-type: none"> • Left atrial appendage: Normal LEFT VENTRICLE: Mild concentric LV hypertrophy. <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration 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	32 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	39.4 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.9 mm	RVEF	%
Ascending aorta	mm	IVSd	10.5 mm	TAPSE	mm
Arch of aorta	mm	LYPWd	101 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	67 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14.0 mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. ADITI JOSHI
AGE/SEX	60 YRS/F
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DATE OF EXAMINATION	26/02/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.53	0.95
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A	E<A			
E/E'				

FINAL IMPRESSION: MILD HYPERTENSIVE HEART DISEASE

- No RWMA
- Normal LV systolic function (LVEF 67 %)
- Mild concentric LV hypertrophy.
- Good RV systolic function
- Grade I diastolic dysfunction
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Control HTN

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST



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***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	206.0	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)	45.2	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	112.4	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)	22	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	138	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)	3.05		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.56		<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
Priyanka_Deshmukh

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





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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	11.3	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	33.9	%	36 - 46
RBC COUNT	4.42	x10 ⁶ /uL	4.5 - 5.5
MCV	77	fl	80 - 96
MCH	25.6	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	15.0	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	5010	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	76	%	40 - 80
LYMPHOCYTES	18	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	03	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	230000	/cumm	150000 - 450000
MPV	8.8	fl	6.5 - 11.5
PDW	15.9	%	9.0 - 17.0
PCT	0.200	%	0.200 - 0.500
RBC MORPHOLOGY	Hypochromia(mild)		
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.

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URINE ROUTINE EXAMINATION

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

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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.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	108.0	ng/dl	84.63 - 201.8
T4	9.12	µg/dl	5.13 - 14.06
TSH	2.14	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

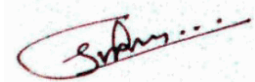
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

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

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'A'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	23.9	mg/dL	21 - 43
BLOOD UREA NITROGEN (Calculated)	11.17	mg/dL	8 - 21
S. CREATININE (Enzymatic)	0.68	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	5.3	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	140.0	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.08	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	102.0	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.39	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.3	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.43	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.8	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.63	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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* 1 8 4 9 1 1 *

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic Normochromic.
WBC	Total Leukocytes count is normal on smear. NEUTROPHILS:78% LYMPHOCYTES:18% EOSINOPHILS:03% MONOCYTES :03% BASOPHILS :00%
PLATELET	Adequate on smear.
HEMOPARASITE	No parasites seen.

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

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.34	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.16	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.18	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	11.3	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	8.4	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	65.0	U/L	56 - 141
S. PROTIEN (Method-Biuret)	6.43	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.8	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.63	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.44		0 - 2

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

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* 1 8 4 9 1 1 *

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	35	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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* 1 8 4 9 1 1 *

BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	17.3	U/L	5 - 55

BLOOD GLUCOSE FASTING & PP

BLOOD GLUCOSE FASTING	94.9	mg/dL	70 - 110
BLOOD GLUCOSE PP	125.8	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

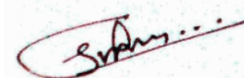
- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms +Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

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

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	6.0	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	125.5	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
-----------	---------	------	-----------------

HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

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

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