ECHOCARDIOGRAPHY REPORT

Name	:	Mrs. JYOTI KUMARI		
Age/Sex	:	34 Years / Female	UHID	: 400214619
Referring Physician	:	SELF		
Indication	:	R/o CAD	Date	: 05/09/2024

M-Mode/2-D Description:

Doppler velocities (cm/sec)

Pulmonary valve		Aortic valve	
Max velocity	70	Max velocity	140
		Mean Velocity	
		Max PG	
		Mean PG	

Mitral valve			Tricuspid valve	
E	74	Max PG =	Max Velocity	51
A	51	Max Velocity =	TAPSE (> 1.5)	
DT		Mean PG =	E/E' (< 6)	
E/E'		Mean Velocity =		

Regurgitation

MR		TR	
Severity	Mild	Severity	Trace
Max Velocity		PASP	25 mmHg
AR		PR	
Severity	Nil	Severity	Nil

Measurements (mm):

	Observed Values	Normal Values
Aortic root diameter	29 mm	20-36 (22mm/M^2)
Aortic Valve Opening	mm	15-26
Left Atrium size	30 mm	19-40

	End Diastole	End Systole	Normal Values
Left Ventricle size	44 mm	25 mm	(ED= 37-56)
Interventricular Septum	09 mm		(ED= 6-12)
Posterior Wall Thickness	09 mm		(ED= 5-10)
LV Ejection Fraction (%)	55.00%		55%-80%

NABH H-2019-0615

JYOTI KUMARI,400214619

Final Interpretation:-

Study done at HR of ~ 66 bpm

- No LV Regional wall motion abnormality, LVEF ~ 55%
- Normal RV systolic function.
- Normal Cardiac chamber dimensions.
- Mild MR, No MS, No AS/AR.
- Trace TR with (RVSP~ 25 mmHg), No PS/PR.
- Normal mitral inflow pattern.
- No intra-cardiac clot/ Vegetation / Pericardial effusion seen.
- IVC normal in size with normal respiratory variation (RAP ~ 3 mmHg).

Dr. Anshul Goyal
MD, Medicine
Attending consultant- Cardiology

Dr. Yogendra Singh Rajput
MBBS, MD, DM FSCAI
Interventional Cardiologist
Associate Clinical Director-Cardiology

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Marengo Asia Hospitals

North East Health Care Private Limited
Golf Course Ext Rd, Sushant Lok II, Sector 56 Gurugram
Haryana
91-124-4131091
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Visit Date	:	05/09/2024 12:44PM	**UHID**	:	400214619
Visit/IP No.	:	85259	**Doctor Name**	:	Dr.Pallavi Vasal
Patient Name	:	Mrs. JYOTI KUMARI	**Visit Type**	:	
DOB	:	20/10/1989	**Mobile**	:	9899399498
Gender/Age	:	34 Years/Female	**Department**	:	Obstetrics And Gynaecology
Sponsor	:	Cash Paying	**Address**	:	A-321 CHHATARPUR ENCLAVE -1 , NEW DELHI, New Delhi, INDIA
State	:	New Delhi	**City**	:	NEW DELHI

Vital Sign

Vital Date	HT	WT	P	BPS	BPD	BP	BMI	BSA	SPO2
05/09/2024 12:44PM	161 cm	63.7 kg	77	100	60	100/60	24.57	1.67	99 %

Chief Complaint

FOR WELLNESS

LMP- 11/08/2024;PaMC- 3-4/30 DAYS, REGULAR; P1A1- 1 SPONT MIS/D AND E/ 2020;1FTCS/M/2.5 YRS/AHI
PAST HISTORY-NIL;DRUG ALELRGY-NIL;FAMILY HISTORY- NIL;SOCIAL HISTORY- NIL

GC- FAIR;AFEB;PALL-NIL;P/A-SOFT;P/S- OS PIN POINT,CX VAG HEALTHY

ADV

REVIEW SOS/AFTER REPORTS

Marengo Asia Hospitals

5/9/24

Jyoti Kumari

Dental Dept.

O/E Buccal ~~7|7~~ 8

Occlusal 8|8

Caries

Calculus +.

Advised Restoration with

7	7 8

Dr Nidhi

marengoasiahospitals.com

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Name	Mrs. Jyoti Kumari	Date	05-09-24
Age/Gender	34 years / F	UHID	400214619

Presenting Complaints: Itching x 2M

Past History: DM | HT | CAD
(-) (-) (-)

IOP: Right Eye: 10 **mmHg** **Left Eye:** 12 **mmHg** **POG RE:**

LE:

UCVA < 6/6 N6, 6/6 N6

Spectacles	Sphere	Cylinder	Axis	Vision	Near add	Vision
Right Eye						
Left Eye						

Color Vsn < WNL, WNL

Clinical Features:

——— Trace

Diagnosis: Allergic conjunctivitis, Dry eye (+)

Advice:

E/D Auripat 12 mg ° °

E/D Refresh Liquigel ° ° ° 8 mg

] one drop each eye x 4 wks

Rx x 4 wks / 90s

Dr Shibal Bhartiya
Clinical Director, Ophthalmology | Program Director, Community Outreach & Wellness
HN-15650
For Appointments: 8882638735 | For Clinical queries: +91 9818700269 | www.drshibalbhartiya.com

NABH H-2019-0615

Patient ID :	400214619	Paient Name :	JYOTI KUMARI
Age :	34 Years	Sex :	F
Ref Physician :	DR. SELF	Modality/Study :	US
Study Date :	05-Sep-2024	Reported Date :	05-Sep-2024
Study :			

ULTRASOUND WHOLE ABDOMEN

LIVER is normal in size (14.3 cm) **and mildly raised echotexture.** No evidence of any focal lesion or IHBR dilation is present. Portal vein and CBD are not dilated.

GALL BLADDER is well distended and lumen is echofree. Wall thickness is normal. No pericholecystic fluid is seen.

SPLEEN is normal in size (7.6 cm) and echotexture. No focal lesion is seen.

PANCREAS is normal in size and echotexture. Peripancreatic fat planes are clear.

RIGHT KIDNEY: is normal in size (11.5 x 3.7 cm) and position and outline corticomedullary differentiation is maintained. There is no evidence of any focal lesion / calculus / backpressure changes.

LEFT KIDNEY: is normal in size (10.9 x 4.8 cm) and position and outline corticomedullary differentiation is maintained. There is no evidence of any focal lesion / calculus / backpressure changes.

URINARY BLADDER is well distended and lumen is echofree. Wall thickness is normal. No evidence of any focal lesion.

Uterus: Anteverted in position and normal in size, measuring ~ 8.5 x 5.7 x 3.9 cm. Myometrial echotexture is normal. There is no focal lesion. Endometrial thickness is 7.6 mm.

Ovaries: Both ovaries are normal in size and echotexture.
Right ovary measures ~ 3.0 x 2.0 x 1.7 cm (vol. 5.79 cc).
Left ovary measures ~ 2.3 x 2.0 x 1.7 cm (vol. 4.46 cc).

No evidence of any adnexal lesion.
Free fluid is seen in pouch of Douglas.

IMPRESSION:

- **Grade I fatty liver.**
- **Mild free fluid in POD.**

Please correlate clinically.

Dr. Rushil Jain
Consultant Radiologist
Dept. of Radiology
MT-SJ

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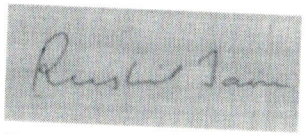
Age :	34 Years	Sex :	F
Ref Physician :		Modality/Study :	CR
Study Date :	05-Sep-2024	Reported Date :	05-Sep-2024
Study :	Chest		

Investigation: Radiograph of Chest (PA View)

Result:

Lung parenchyma is normal.
Bilateral hilar shadow appear normal.
Cardiomediastinal contour is maintained.
Cardiophrenic & costophrenic angles are normal.
Domes of diaphragm are normal.

Please correlate clinically.



Dr. Rushil Jain
Consultant
Dept. of Radiology
MT-SJ

34 Years

Mrs. Jyoti Kumari
Female

05-Sep-24 11:20:47 AM
MARENGO ASIA HOSPITALS

EMERGENCY

Rate 67 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF

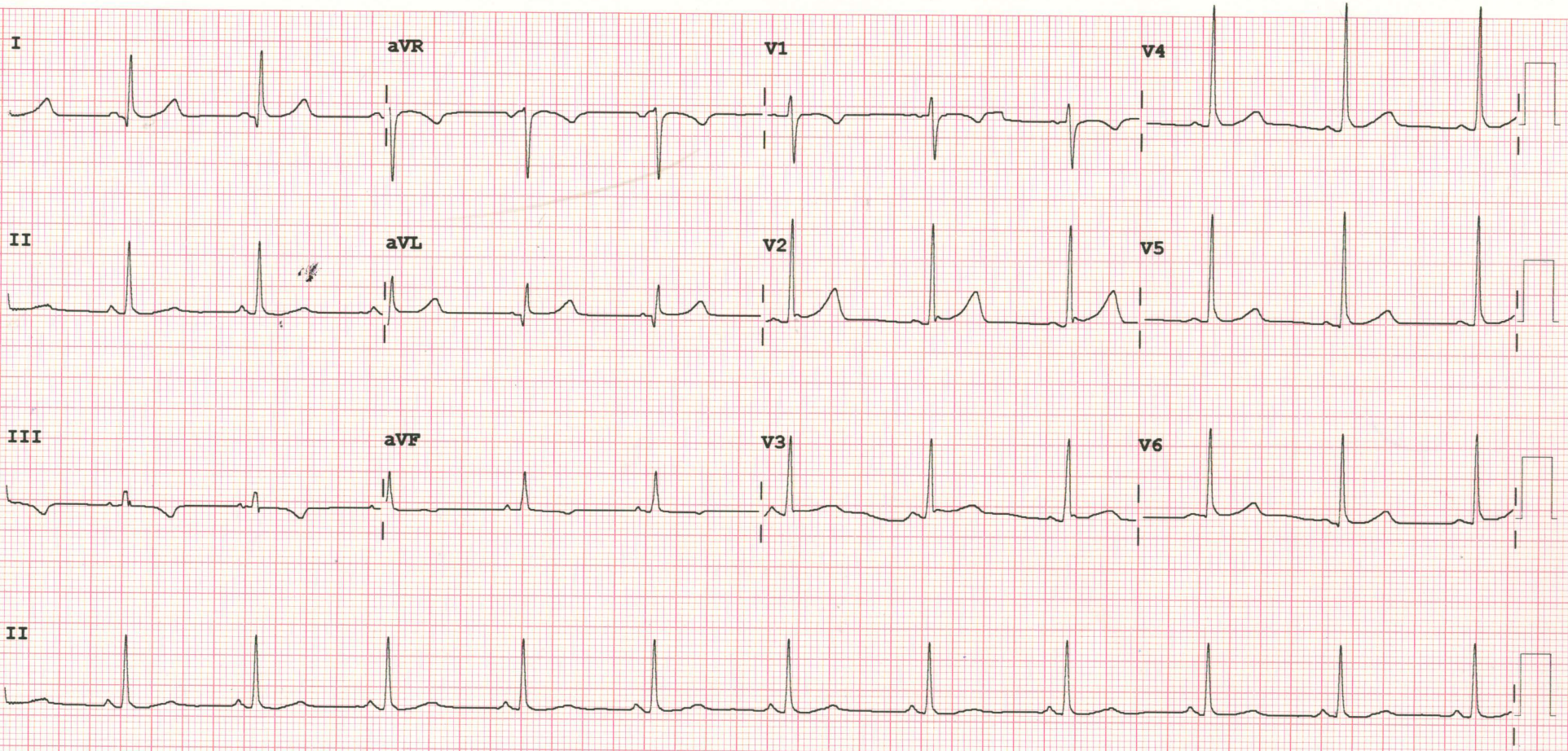
PR 130
QRSD 91
QT 403
QTc 426

--AXIS--
P 38
QRS 40
T -10

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50- 40 Hz W 100B CL P?

ARROW CE

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DEPARTMENT OF LABORATORY SERVICES

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Age/Gender	34 Years/Female	**Receiving Date**	05/09/2024 11:10AM
Bed No/Ward	OPD	**Report Date**	05/09/2024 3:31PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry						
MediWheel Full Body Annual Plus Check Advanced - Female						
***TOTAL PROTEIN**						Serum
Serum -Total Protein		7.5	g/dL	6.3 - 8.2	Biuret Method	

Interpretation:-
Serum proteins transport drugs and metabolites and maintain plasma osmotic pressure. Most serum proteins are synthesized in the liver, with the exception of gamma globulins. One of the most important serum proteins produced in the liver is albumin. Total serum protein concentration can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenstrom's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Total protein concentration is occasionally increased in collagen diseases, lupus erythematosus, and other instances of chronic infection or inflammation. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
***SERUM CREATININE**						Serum
Serum - Creatinine	**L**	**0.4**	mg/dL	0.8 - 1.2	Enzymatic (Creatinine Amidohydrolase)	

Interpretation:-
Serum creatinine and urinary creatinine excretion is a function of lean body mass in normal persons and shows little or no response to dietary changes. The serum creatinine concentration is higher in men than in women. Since urinary creatinine is excreted mainly by glomerular filtration, with only small amounts due to tubular secretion, serum creatinine and a 24-hour urine creatinine excretion can be used to estimate the glomerular filtration rate.Serum creatinine is increased in acute or chronic renal failure, urinary tract obstruction, reduced renal blood flow, shock,dehydration, and rhabdomyolysis. Causes of low serum creatinine concentration include debilitation and decreased muscle mass. common in the elderly, in the bedridden, and in patients with advanced malignancy.

Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
***URIC ACID (SERUM)**						Serum

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Prepared By MAH001891

Printed at 06/09/2024 10:05

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Serum Uric Acid	3.5	mg/dL	3.0 - 5.9	Uricase

Interpretation:-
Uric acid is the end product of purine metabolism. Elevationsof uric acid occur in renal failure, prerenal azotemia, gout, lead poisoning,excessive cell destruction (e.g., following chemotherapy), hemolytic anemia,and congestive heart failure and after myocardial infarction. Uric acid is alsoincreased in some endocrine disorders, acidosis, toxemia of pregnancy,hereditary gout, and glycogen storage disease type I. A low uric acidconcentration may be found following treatment by some drugs (e.g., low-doseaspirin), with low dietary intake of purines, in the presence of renal tubulardefects, and in xanthinuria.

***GLUCOSE (PP)** PLASMA(FLUORIDE)

Glucose - Post Prandial (PPBS)	140	mg/dL	40 - 140	Glucose oxidase ,hydrogen Peroxidase

Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

***LIPID PROFILE SERUM** Serum

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Cholesterol		210	mg/dL	Method :Cholesterol oxidase, esterase, peroxidase Adults (>=20 Years) Desirable <200 mg/dL, Borderline200-239 mg/dL High>240 mg/dL	Cholesterol oxidase, esterase,peroxidase
HDL Cholesterol		49	mg/dL	40 - 60	Direct measure, PTA/MgCl2
Triglycerides		147	mg/dL	Method : Enzymatic Normal < 150 mg/dl, Borderline High 150-199 mg/dl, High 200-499 mg/dl, Very High>=500 mg/dl	Enzymatic method
Cholesterol VLDL		29.4	mg/dL	0 - 40	Calculated
Cholesterol / HDL Ratio		4.29			Calculated
LDL	**H**	**131.6**	mg/dL	0 - 100	Calculated
LDL/HDL Ratio		2.69			Calculated

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NCEP Guidelines:

Lipid	Desirable	Borderline High	High	Very High
Total Cholesterol	< 200	200-239	> 240	
LDL Cholesterol	< 100	130-159	160-189	> 190
HDL Cholesterol	> 60	< 40 (Risk factor)		
Triglycerides	< 150	150-199	200-499	> 500

***BLOOD UREA** — Serum

Serum - Urea	25	mg/dL	15 - 36	Urease with indicator dye

Interpretation:-

The major pathway of nitrogen excretion is in the form of urea that is synthesized in the liver, released into the blood, and cleared by the kidneys. A high serum urea nitrogen occurs in glomerulonephritis, shock, urinary tract obstruction, pyelonephritis, and other causes of acute and chronic renal failure. Severe congestive heart failure, hyperalimentation, diabetic ketoacidosis, dehydration, and bleeding from the gastrointestinal tract elevate urea nitrogen. Low urea nitrogen often occurs in normal pregnancy, with decreased protein intake, in acute liver failure, and with intravenous fluid administration.

***GLUCOSE (FASTING).** — PLASMA(FLUORIDE)

Glucose F	88.00	mg/dL	70.00 - 100.00	Glucose oxidase ,hydrogen Peroxidase

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Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

End Of Report

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Biochemistry

MediWheel Full Body Annual Plus Check Advanced - Female

***LIVER FUNCTION TEST (LFT) SERUM** — Serum

Test Name	Result	Unit	Bio. Ref. Range	Method
Serum -Total Protein	7.5	g/dL	6.3 - 8.2	Biuret Method
Serum - Albumin	4.1	g/dL	3.5 - 5.0	BCG
Globulin	3.4	g/dL	2 - 5	Calculated
AG Ratio	1.21		1 - 2	Calculated
Serum - SGOT / AST (Aspartate Amino Transferase)	27	U/L	14 - 36	Kinetic(leuco dye) with pyridoxal 5 phosphate
Serum - SGPT / ALTV (Alanine Amino Transferase)	35	U/L	5 - 35	Reflectance spectrophotometry/ kinetic with pyridoxal -5-phosphate
Serum- GGT	43	U/L	12 - 43	L-G-glutamyl-p-nitroanilide
Serum - Alkaline Phosphatase	68	U/L	38 - 126	P-nitrophenyl phosphate
Bilirubin Total	0.6	mg/dL	0.2 - 1.3	Diphylline,Diazonium Salt
Bilirubin Direct	0.1	mg/dL	Calculated Neonate Ref. Range. 0 - 30 Days - (0.0 -0.6) mg/dL Adult Ref. Range. >30 Days - (0.0-0.3) mg/dL	Calculated
Bilirubin Indirect	0.5	mg/dL	0.0 - 1.1	Dual wavelength

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Interpretation:-
Total bilirubin in serum and plasma is the sum of unconjugated bilirubin (Bu), mono- and di-glucuronide conjugated bilirubin (Bc)?, and delta bilirubin (DELB), a bilirubin fraction covalently bound to albumin. With the exception of anicteric jaundice, total serum bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.
Jaundice has been classified as unconjugated and conjugated hyperbilirubinemia. Increased plasma-unconjugated bilirubin is commonly seen in hemolytic disorders, Gilbert's syndrome, Crigler-Najjar syndrome, neonatal jaundice, and ineffective erythropoiesis and in the presence of drugs competing for glucuronide. Increased plasma-conjugated bilirubin occurs with hepatobiliary disorders, including intrahepatic and extrahepatic biliary tree obstruction, liver cell damage, Dubin-Johnson syndrome, and Rotor syndrome.Neonatal bilirubin, the sum of Bu and Bc, is increased in erythroblastosis fetalis (hemolytic disease of the newborn), which causes jaundice in the first two days of life. Other causes of neonatal jaundice include physiologic jaundice, hematoma/hemorrhage, hypothyroidism, and obstructive jaundice.
Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver. Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, and drug-induced hepatitis.
Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumors, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.
Alkaline phosphatase is present mainly in bone, liver, kidney, intestine, placenta, and lung. Serum alkaline phosphatase may be elevated in increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increase alkaline phosphatase activity; alkaline phosphatase activity may be increased in renal infarction and failure and in the complications of pregnancy. Low alkaline phosphatase activity may occasionally be seen in hypothyroidism.

Serum proteins transport drugs and metabolites and maintain plasma osmotic pressure. Most serum proteins are synthesized in the liver, with the exception of gamma globulins. One of the most important serum proteins produced in the liver is albumin. Total serum protein concentration can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenstrom's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Total protein concentration is occasionally increased in collagen diseases, lupus erythematosus, and other instances of chronic infection or inflammation. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

End Of Report

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Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry					
MediWheel Full Body Annual Plus Check Advanced - Female					
***GLYCOCYLATED HEMOGLOBIN (HBA1C)**					EDTA Blood
HbA1C -(Glycosylated Hemoglobin)	5.0	%		HPLC	

Biological Ref. Range:

Hb A1c (%) - Degree of Glucose control
<5.6% - Normal
5.7% to 6.4% - Prediabetes
>=6.5% - Diabetes
<7% - ADA Target
>8% - Action Suggested

End Of Report

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Marengo Asia Hospitals

4103377

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DEPARTMENT OF LABORATORY SERVICES

Patient	Mrs. JYOTI KUMARI	**Lab No/ManualNo**	4103377/
UHIDNo/IPNO	400214619	**CollectionDate**	05/09/2024 10:38AM
Age/Gender	34 Years/Female	**Receiving Date**	05/09/2024 11:10AM
Bed No/Ward	OPD	**Report Date**	05/09/2024 1:16PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample

Clinical Pathology

MediWheel Full Body Annual Plus Check Advanced - Female

***URINE ROUTINE EXAMINATION** — Urine

Physical Examination:				
Volume	25	mL		Physical Examination
Colour	Pale Yellow		Pale Yellow	Physical Examination
Appearence:	Clear			Physical Examination
Chemical Examination:				
pH	5.5		4.6 - 8.0	Indicator Test
Specific Gravity	1.010		1.000 - 1.035	Ion Exchange
Protein	Nil			Protein Error of Indicator/ Sulphosalicylic Acid
Glucose	Nil			Glucose Oxidase - Peroxidase/ Benedict's Method
Ketone	Nil			Nitroprusside Reaction / Rothera's Method
Bilirubin	Absent			Diazonium Method/ Fouchet's Method
Urobilinogen	Normal			Ehrlich's Reaction/ Ehrlich's Reagent
Nitrite:	Negative		Negative	Diazotization Reaction
Blood :	Nil			Peroxidase Reaction
Microscopic Examination:				
Casts	Nil		Nil	Microscopy
Epithelial cells	10-12	/HPF	0 - 1	Microscopy
Pus Cells	4-6	/HPF	0 - 5	Microscopy
RBC	00	/HPF	0 - 2	Microscopy
Crystals	Nil		Nil	Microscopy

Dr. Kriti Ganguly
MD,Microbiology,Consultant(Lab Services)
DMC Regd No: 63478

L-Low H-High CH - Critical High CL - Critical Low

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Interpretation:-

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. Protein reported in urine as Negative(<15 mg/dl), 1+(>=30 mg/dl), 2+(>=100 mg/dl) & 3+(>=500 mg/dl).
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications. Glucose reported in urine as Negative (<25 mg/dl), 1+(>=50 mg/dl), 2+(>=100 mg/dl), 3+(>=300 mg/dl), 4+(>=1000 mg/dl).
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 hemoglobin, 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.Positive nitrite test suggestive of 105 or more organism in 1 ml of urine specimen.
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 food 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 diabetis 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.

End Of Report

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Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
Haematology						
MediWheel Full Body Annual Plus Check Advanced - Female						
***ERYTHROCYTE SEDIMENTATION RATE (ESR)**						EDTA Blood
Erythrocyte Sedimentation Rate (ESR)		17	mm/hr	0 - 20	Modified westergren Method	

Interpretation:-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post-partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

COMPLETE BLOOD COUNT(CBC) EDTA WHOLE BLOOD						EDTA Blood
Haemoglobin	**L**	**12.2**	g/dL	12.5 - 16.0	Spectrophotometry (Cyanide free method)	
Hematocrit/PCV		39.1	%	37.0 - 47.0	Derived from RBC pulse hieght detection	
RBC COUNT	**L**	**4.19**	10^6/µL	4.20 - 5.40	Electrical Impedance	
MCV		93.4	fl	78.0 - 100.0	Calculated	
MCH		29.2	pg	27.0 - 31.0	Calculated	
MCHC	**L**	**31.2**	g/dL	31.5 - 34.5	Calculated	
RDW-CV	**H**	**14.2**	%	11.5 - 14.0	Calculated	
Platelet count		314	10^3/µL	150 - 450	Electrical Impedance	
Total Leucocyte Count (TLC)		7.68	10^3/µL	4.00 - 10.50	Double Hydrodynamic Sequential System (DHSS)	

Differential Leucocyte Count

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Neutrophils	61.8	%	40 - 80	Flow Cytometry
Lymphocytes	27.2	%	20 - 40	Flow Cytometry
Monocytes	8.6	%	2 - 10	Flow Cytometry
Eosinophils	2.4	%	1 - 6	Flow Cytometry
Basophils	0	%	0 - 1	Flow Cytometry
Absolute Leucocyte Count				
Absolute Neutrophil Count	4.75	10^3/µL	1.50 - 6.60	Calculated
Absolute Lymphocyte Count	2.08	10^3/µL	1.50 - 3.50	Calculated
Absolute Monocyte Count	0.66	10^3/µL	0.00 - 1.00	Calculated
Absolute Eosinophil Count	0.19	10^3/µL	0.00 - 0.70	Calculated
Absolute Basophil Count	0.00	10^3/µL	0.00 - 1.00	Calculated

End Of Report

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CytoPathology

MediWheel Full Body Annual Plus Check Advanced - Female

***PAP SMEAR** Cervical smear for PAP

PAP smear routine

C/695/24

Cervical Scrape Papanicoalou Stain Report

(based on The 2014 Bethesda System For Reporting Cervical Cytology)

SPECIMEN TYPE Conventional smear (Pap smear)

SPECIMEN ADEQUACY
Satisfactory for evaluation with presence of endocervical/transformation zone

INTERPRETATION/RESULT

Inflammation - *ABSENT*

TYPE - acute -*ABSENT*

chronic- *ABSENT*

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ORGANISMS:
* Trichomonas vaginalis- *ABSENT*
* Fungal organisms morphologically consistent with Candida spp- *ABSENT*
* Shift in flora suggestive of bacterial vaginosis *ABSENT*
* Bacteria morphologically consistent with Actinomyces spp. *ABSENT*
* Cellular changes consistent with Herpes simplex virus *ABSENT*

- OTHER NON NEOPLASTIC FINDINGS * Reactive cellular changes associated with
  - inflammation (includes typical repair) *ABSENT*
  - radiation- *ABSENT*
  - intrauterine contraceptive device (IUD)- *ABSENT*
* Glandular cells status post hysterectomy- *ABSENT*
* Atrophy- *ABSENT*

EPITHELIAL CELL ABNORMALITIES

- SQUAMOUS CELL
* Atypical squamous cells *ABSENT*
  - of undetermined significance (ASC-US) *ABSENT*
  - cannot exclude HSIL (ASC-H)- *ABSENT*
* Low grade squamous intraepithelial lesion (LSIL (consistent with HPV/mild dysplasia/CIN 1)*ABSENT*

* High grade squamous intraepithelial lesion (HSIL) (encompassing: moderate and severe dysplasia, CIS, CIN 2 and CIN 3) *ABSENT*
  - with features suspicious for invasion- *ABSENT*

* Squamous cell carcinoma *ABSENT*

- GLANDULAR CELL
* Atypical
  - endocervical cells (not otherwise specified (NOS) *ABSENT*

endocervical cells with squamous metaplasia - *ABSENT*

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Bed No/Ward	OPD	**Report Date**	05/09/2024 3:35PM
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		Sample Quality	

- endometrial cells (NOS or specify in comments), *ABSENT*
- glandular cells (NOS or specify in comments) *ABSENT*

* Atypical
  - endocervical cells, favor neoplastic *ABSENT*
  - glandular cells, favor neoplastic *ABSENT*
* Endocervical adenocarcinoma in situ *ABSENT*
* Adenocarcinoma: *ABSENT*
  - endocervical *ABSENT*
  - endometrial *ABSENT*
  - extrauterine *ABSENT*
  - not otherwise specified (NOS) *ABSENT*

OTHER FINDINGS

- Endometrial cells (in a woman >= 40 years of age) *ABSENT*

FINAL CATEGORIZATION.

Negative for Intraepithelial Lesion or Malignancy.

Ancillary Testing- Not Needed

DISCLAIMER:

Gynaecological cytology is a screening test that aids in the detection of cervical cancer precursors. Both false positive negative results can occur. The test should be used at regular intervals as per guidelines and positive results should be confirmed before definitive therapy.

End Of Report

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Dr. Renu Madan
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Senior Consultant & HOD,Laboratory Services,
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		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample

Immuno-Haematology

MediWheel Full Body Annual Plus Check Advanced - Female

***BLOOD GROUPING** — EDTA Blood

ABO GROUP	'A'	Tube Agglutination Method
RH Type	POSITIVE	

Interpretation:-

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 in 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.

End Of Report

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Patient	Mrs. JYOTI KUMARI	**Lab No/ManualNo**	4103382/
UHIDNo/IPNO	400214619	**CollectionDate**	05/09/2024 11:06AM
Age/Gender	34 Years/Female	**Receiving Date**	05/09/2024 11:21AM
Bed No/Ward	OPD	**Report Date**	05/09/2024 11:55AM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
		Biochemistry			
***FT3 + FT4 + TSH**					Serum
Free T3	3.52	pg/mL	2.77 - 5.27	Chemiluminescence	
Free T4	0.86	ng/dL	0.78 - 2.19	Chemiluminescence	
Thyroid Stimulating Hormone	1.27	mIU/L	0.46 - 4.68	Chemiluminescence	
TSH Interpretation					

Interpretation :
Elevated free triiodothyronine (FT3) values are associated with thyrotoxicosis or excess thyroid hormone replacement.
Useful for : It provides further confirmation of hyperthyroidism, supplementing the tetraiodothyronine (T4), sensitive thyrotropin (S TSH), and total T3 assays Evaluating clinically euthyroid patients who have an altered distribution of binding proteins Monitoring thyroid hormone replacement therapy Free triiodothyronine(FT3) is not a sensitive test for hypothyroidism.
Elevated values suggest hyperthyroidism or exogenous thyroxine (T4).
Decreased values suggest hypothyroidism.
The test generally is used as a second-line test after thyroid- stimulating hormone (TSH) to help evaluate TSH changes.

The free thyroxine value, combined with the TSH value, gives a more accurate picture of the thyroid status in patients with abnormal thyroid-binding globulin levels such as those who are pregnant or those who are receiving treatment with estrogens, androgens, phenytoin, or salicylates.

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Note
1. TSH levels are subject to circadian variation. Levels may vary during different time intervals .
2. Drugs which can lower TSH without inducting thyroid dysfunction are
* Glucocorticoids in high dose during initial treatment or prolonged exposure of glucocorticoid therapy
* Dopamine or Dobutamine
* Octreotide

NEONATAL BIOLOGICAL REFERENCE RANGE

Test Name	Age	Unit	Biological Ref. Range
FT3:	0- 1 month	pg/ml	(3.0 - 6.0)
	1month - 23 month	pg/ml	(3.28- 5.19)
	24month - 12 years	pg/ml	(3.34 - 4.80)
FT4:	0- 03 days	ng/dL	(2.0 - 5.0)
	03days - 01 month	ng/dL	(0.9- 2.2)
	01month - 18 years	ng/dL	(0.8 - 2.0)
TSH:	0- 03days	mIU/L	(1.0- 20.0)
	03days - 01 month	mIU/L	(0.5- 6.5)
	01month - 18 years	mIU/L	(0.5 - 6.0)

End Of Report

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UHIDNo/IPNO	400214619	**CollectionDate**	05/09/2024 1:08PM
Age/Gender	34 Years/Female	**Receiving Date**	05/09/2024 1:09PM
Bed No/Ward	OPD	**Report Date**	05/09/2024 3:45PM
Referred By	Dr. Pallavi Vasal	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
		Biochemistry			
***B12 VITAMIN**					Serum
Vit-B12	237	pg/mL	200 - 835	Chemiluminescence	

Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function. In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption. The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted. Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases). Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia. Pernicious anemia is a macrocytic anemia caused by vitamin B12 deficiency that is due to a lack of IF secretion by gastric mucosa. Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.

Interpretation :

A serum vitamin B12 level less than 180 pg/ml may cause megaloblastic anemia and peripheral neuropathies , Vitamin B12 levels less than 150 pg/ml is considered evidence of vitamin B12 deficiency.

End Of Report

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Interpretation :

A serum vitamin B12 level less than 180 pg/ml may cause megaloblastic anemia and peripheral neuropathies , Vitamin B12 levels less than 150 pg/ml is considered evidence of vitamin B12 deficiency.

End Of Report

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