Sandhya Hile
36 yrs/ female

24/02/2024

No ~~fresh~~ complaints
No comorbidities
No P/H.
No S/H
LMP - 26/01/24, irregular
O/H - G_1 P_1 A_0 L_1 D_0
Male, 7 yrs, LSCS, healthy

Ht - 148 ~~mm~~ cm
Wt - 61 kg
BMI - 27.8 kg/m2
(overweight)

F/H - mother - } healthy
father - }

BP - 110/70 mmHg
P - 103/min
SpO_2 - 99%.

Pt is fit and can resume her normal duties

Siddhivinayak Hospital
Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

HELPLINE
022 - 2588 3531

Name – Mrs. Sandhya Hile	**Age – 36 Y/F**
Ref by Dr.- Siddhivinayak Hospital	**Date – 24/02/2024**

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size. 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 (9.4 cm) and morphology

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

The right kidney measures 8.6 x 4.4 cm.

The left kidney measures 11.2 x 5.2 cm.

Urinary bladder: normally distended. Wall thickness – normal.

Uterus: is normal in size.

Endometrium: 9.8 mm, it appears normal in morphology.

Both ovaries are normal in size.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- **Fatty Liver (Grade I).**

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

ECHOCARDIOGRAM

NAME	MRS. SANDHYA HILE
AGE/SEX	36 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	24/02/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES:

MITRAL VALVE:
- AML: Normal
- PML: Normal
- Sub-valvular deformity: Absent

AORTIC VALVE: Normal
- No. of cusps: 3

PULMONARY VALVE: Normal

TRICUSPID VALVE: Normal

CHAMBERS:

LEFT ATRIUM: Normal
- Left atrial appendage: Normal

LEFT VENTRICLE: Normal
- RWMA: No
- Contraction: Normal

RIGHT ATRIUM: Normal

RIGHT VENTRICLE: Normal
- RWMA: No
- Contraction: Normal

GREAT VESSELS:
- AORTA: Normal
- PULMONARY ARTERY: Normal

SEPTAE:
- IAS: Intact
- IVS: Intact

CORONARIES: Proximal coronaries normal

CORONARY SINUS: Normal

VENACAVAE:
- SVC: Normal
- IVC: Normal and collapsing >20% with respiration

PULMONARY VEINS: Normal

PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	33 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	38.9 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.6 mm	RVEF	%
Ascending aorta	mm	IVSd	8.4 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.4 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	70 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	13.0 mm

ID: 963 Sandhya Hile.

Female Years 36.

Req. No. : BP: 110/70
SpO2: 98%
PR: 103/m

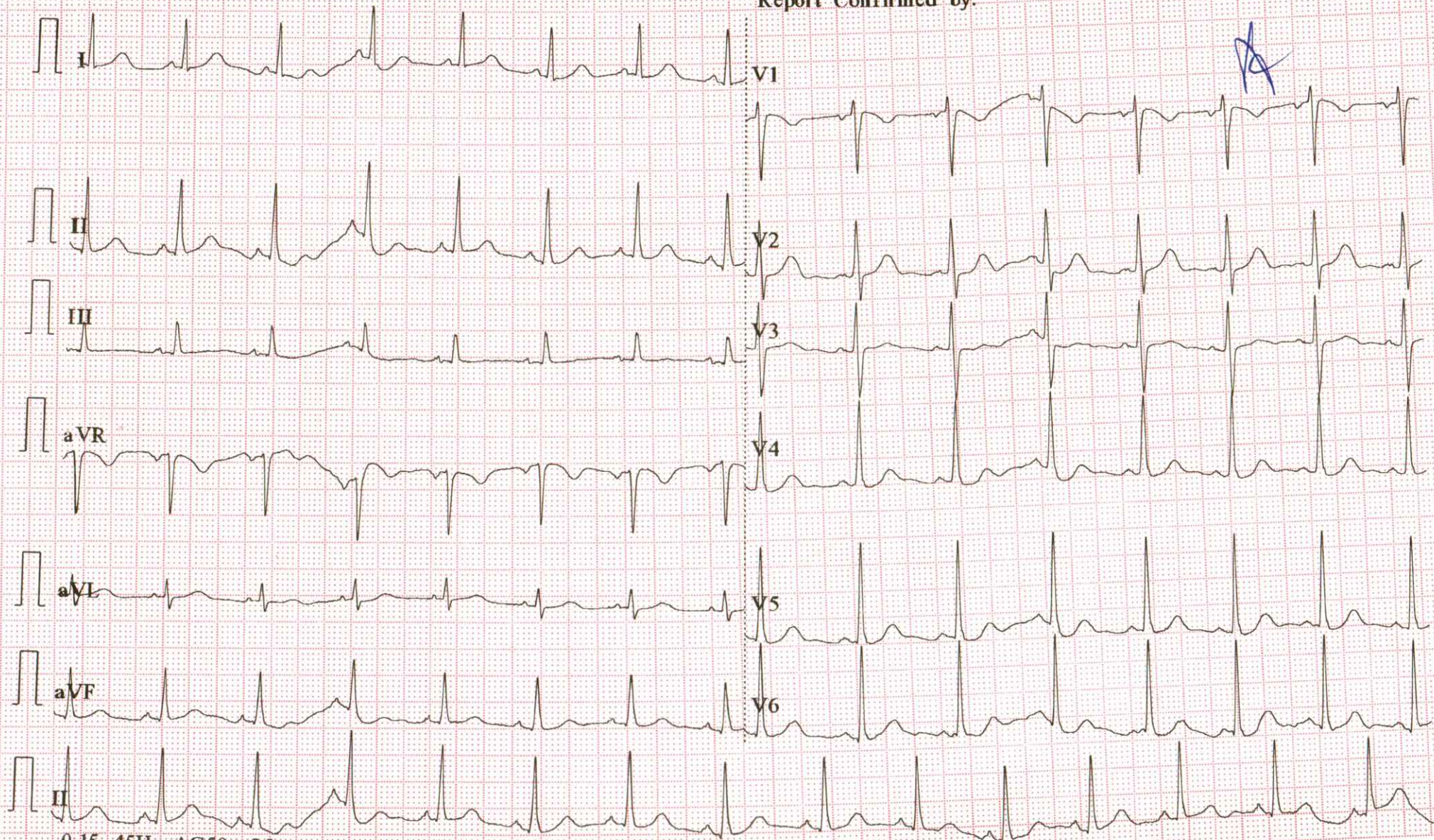
24-02-2024 10:01:26 AM

HR	: 89	bpm	
P	: 89	ms	
PR	: 127	ms	
QRS	: 85	ms	
QT/QTcBz	: 359/437	ms	
P/QRS/T	: 39/51/42	°	
RV5/SV1	: 1.788/1.141	mV	

Diagnosis Information:
Sinus Rhythm
Larged PtfV1

WNL

Report Confirmed by:



0.15-45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE SANDHYA HILE

AGE 36 **DATE -** 24.02.2024

Spects : Without Glasses

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

SIDDHIVINAYAK HOSPITALS

Siddhivinayak Hospital
Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

HELPLINE
022 - 2588 3531

Name – Mrs . Sandhya Hile	**Age - 36 Y/F**
Ref by Dr.- Siddhivinayak hospital	**Date – 24/02/2024**

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.

MC-6135

Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE

COMPLETE PATHOLOGICAL SOLUTION

Name	: Mrs. SANDHYA HILE (A)	**Collected On**	: 24/2/2024 9:56 am
Lab ID.	: 184732	**Received On**	: 24/2/2024 10:06 am
Age/Sex	: 36 Years / Female	**Reported On**	: 24/2/2024 5:50 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	**Report Status**	: FINAL

184732

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	189.0	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)	46.2	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	124.5	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)	25	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	118	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)	2.55		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.09		<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

24 HOURS 7
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184732

COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	14.0	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	42.2	%	36 - 46
RBC COUNT	4.91	x10^6/uL	4.5 - 5.5
MCV	86	fl	80 - 96
MCH	28.5	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.8	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	7650	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	65	%	40 - 80
LYMPHOCYTES	26	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	229000	/ cumm	150000 - 450000
MPV	10.3	fl	6.5 - 11.5
PDW	16.4	%	9.0 - 17.0
PCT	0.240	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

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

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

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184732

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	10ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION	Acidic		Acidic
(methyl red and Bromothymol blue indicator)			
SP. GRAVITY	1.005		1.005 - 1.022
(Bromothymol blue indicator)			
PROTEIN	Absent		Absent
(Protein error of PH indicator)			
BLOOD	Absent		Absent
(Peroxidase Method)			
SUGAR	Absent		Absent
(GOD/POD)			
KETONES	Absent		Absent
(Acetoacetic acid)			
BILE SALT & PIGMENT	Absent		Absent
(Diazonium Salt)			
UROBILINOGEN	Normal		Normal
(Red azodye)			
LEUKOCYTES	Absent		Absent
(pyrrole amino acid ester diazonium salt)			
NITRITE	Absent		Negative
(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)			
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	0-2	/ HPF	0 - 5
EPITHELIAL	0-2	/ HPF	0 - 5
CASTS	Absent		

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184732

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		

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

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

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184732

IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPACE		Space	-
SPECIMEN	Serum		
T3	201.4	ng/dl	84.63 - 201.8
T4	12.85	µg/dl	5.13 - 14.06
TSH	2.46	µIU/ml	0.270 - 4.20

T3 (Triido Thyronine) hormone)

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

T4 (Thyroxine)

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

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 wks -5 months	1.7-9.1
6 months-20 yrs	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

INTERPRETATION :

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

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

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

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
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MC-6135

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Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS**	**Report Status**	: **FINAL**

184732

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'B'		
RH FACTOR	POSITIVE		

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

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

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

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184732

*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	14.2	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	6.64	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.61	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.4	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	140.0	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.0	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	102.0	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.4	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.9	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.42	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.11	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.31	g/dl	1.9 - 3.5
A/G RATIO calculated	1.78		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 ----------

Checked By
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184732

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic, Normochromic
WBC	Total Leukocytes count is normal on smear.
	NEUTROPHILS :65%
	LYMPHOCYTES :26%
	EOSINOPHILS :03%
	MONOCYTES :06%
	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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184732

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.3	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.1	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.20	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	12.5	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	22.9	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	67.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.42	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.11	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.31	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.78		0 - 2

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

24 HOURS 7
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Dr. Smita Ranveer`s
Radiance
CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

Name	: **Mrs. SANDHYA HILE (A)**	**Collected On**	: **24/2/2024 9:56 am**
Lab ID.	: **184732**	**Received On**	: **24/2/2024 10:06 am**
Age/Sex	: **36 Years / Female**	**Reported On**	: **24/2/2024 5:50 pm**
Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS**	**Report Status**	: **FINAL**

184732

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	08	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GLYCOCELATED HEMOGLOBIN (HBA1C)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.8	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	119.8	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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

BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	99.5	mg/dL	70 - 110
BLOOD GLUCOSE PP	**150.3**	mg/dL	70 - 140

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

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

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MC-6135

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE

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

POSTPRANDIAL/POST GLUCOSE (75 grams)
- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : >=200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS
- Fasting plasma glucose >=126 mg/dl
- Classical symptoms +Random plasma glucose >=200 mg/dl
- Plasma glucose >=200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin > 6.5%

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

GAMMA GT	21.8	U/L	5 - 55

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

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