Apollo
TOUCHING LIVES

Certificate No: M[illegible]5587

Apollo Clinic
Expertise. Closer to you.

Patient Name	: Mrs.RANJANA CHAKRAVARTY	Collected	: 10/Apr/2024 02:28PM
Age/Gender	: 38 Y 4 M 21 D/F	Received	: 10/Apr/2024 06:40PM
UHID/MR No	: CWAN.0000135350	Reported	: 10/Apr/2024 07:09PM
Visit ID	: CWANOPV229988	Status	: Final Report
Ref Doctor	: Dr.SELF	Sponsor Name	: ARCOFEMI HEALTHCARE LIMITED
Emp/Auth/TPA ID	: 72124		

DEPARTMENT OF HAEMATOLOGY

PERIPHERAL SMEAR , *WHOLE BLOOD EDTA*

RBC's are Normocytic Normochromic
WBC's are normal in number and morphology
Platelets are Adequate
No hemoparasite seen.

Sneha Shah
Dr Sneha Shah
MBBS, MD (Pathology)
Consultant Pathologist

SIN No:BED240098463
This test has been performed at Apollo Health and Lifestyle ltd- Sadashiv Peth Pune, Diagnostics Lab

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DEPARTMENT OF HAEMATOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
HEMOGRAM , *WHOLE BLOOD EDTA*				
HAEMOGLOBIN	12.7	g/dL	12-15	Spectrophotometer
PCV	38.00	%	36-46	Electronic pulse & Calculation
RBC COUNT	4.45	Million/cu.mm	3.8-4.8	Electrical Impedence
MCV	85.3	fL	83-101	Calculated
MCH	28.6	pg	27-32	Calculated
MCHC	33.6	g/dL	31.5-34.5	Calculated
R.D.W	12.4	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6,660	cells/cu.mm	4000-10000	Electrical Impedance
DIFFERENTIAL LEUCOCYTIC COUNT (DLC)				
NEUTROPHILS	56.6	%	40-80	Electrical Impedance
LYMPHOCYTES	32.9	%	20-40	Electrical Impedance
EOSINOPHILS	2.5	%	1-6	Electrical Impedance
MONOCYTES	7.1	%	2-10	Electrical Impedance
BASOPHILS	0.9	%	<1-2	Electrical Impedance
ABSOLUTE LEUCOCYTE COUNT				
NEUTROPHILS	3769.56	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	2191.14	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	166.5	Cells/cu.mm	20-500	Calculated
MONOCYTES	472.86	Cells/cu.mm	200-1000	Calculated
BASOPHILS	59.94	Cells/cu.mm	0-100	Calculated
Neutrophil lymphocyte ratio (NLR)	1.72		0.78- 3.53	Calculated
PLATELET COUNT	244000	cells/cu.mm	150000-410000	Electrical impedence
ERYTHROCYTE SEDIMENTATION RATE (ESR)	6	mm at the end of 1 hour	0-20	Modified Westergren
PERIPHERAL SMEAR				

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DEPARTMENT OF HAEMATOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

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DEPARTMENT OF HAEMATOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO AND RH FACTOR , *WHOLE BLOOD EDTA*				
BLOOD GROUP TYPE	B			Forward & Reverse Grouping with Slide/Tube Aggluti
Rh TYPE	POSITIVE			Forward & Reverse Grouping with Slide/Tube Agglutination

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, FASTING , *NAF PLASMA*	**105**	mg/dL	70-100	GOD - POD

Comment:

As per American Diabetes Guidelines, 2023

Fasting Glucose Values in mg/dL	Interpretation
70-100 mg/dL	Normal
100-125 mg/dL	Prediabetes
≥126 mg/dL	Diabetes
<70 mg/dL	Hypoglycemia

Note:

1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL and/or a random / 2 hr post glucose value of > or = 200 mg/dL on at least 2 occasions.

2. Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis & is considered critical.

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, POST PRANDIAL (PP), 2 HOURS , *SODIUM FLUORIDE PLASMA (2 HR)*	126	mg/dL	70-140	GOD - POD

Comment:

It is recommended that FBS and PPBS should be interpreted with respect to their Biological reference ranges and not with each other.

Conditions which may lead to lower postprandial glucose levels as compared to fasting glucose levels may be due to reactive hypoglycemia, dietary meal content, duration or timing of sampling after food digestion and absorption, medications such as insulin preparations, sulfonylureas, amylin analogues, or conditions such as overproduction of insulin.

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C (GLYCATED HEMOGLOBIN) , *WHOLE BLOOD EDTA*				
HBA1C, GLYCATED HEMOGLOBIN	**5.9**	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	123	mg/dL		Calculated

Dr Sneha Shah
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Consultant Pathologist

SIN No:EDT240045375

This test has been performed at Apollo Health and Lifestyle ltd- Sadashiv Peth Pune, Diagnostics Lab

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Comment:

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

REFERENCE GROUP	HBA1C %
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

1. HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
2. Trends in HbA1C values is a better indicator of Glycemic control than a single test.
3. Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
4. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
5. In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
   A: HbF >25%
   B: Homozygous Hemoglobinopathy.
   (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)

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Consultant Pathologist

SIN No:EDT240045375

This test has been performed at Apollo Health and Lifestyle ltd- Sadashiv Peth Pune, Diagnostics Lab

Patient Name	: Mrs.RANJANA CHAKRAVARTY	Collected	: 10/Apr/2024 02:29PM
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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE , *SERUM*				
TOTAL CHOLESTEROL	**224**	mg/dL	<200	CHE/CHO/POD
TRIGLYCERIDES	124	mg/dL	<150	Enzymatic
HDL CHOLESTEROL	60	mg/dL	>40	CHE/CHO/POD
NON-HDL CHOLESTEROL	**164**	mg/dL	<130	Calculated
LDL CHOLESTEROL	**139.2**	mg/dL	<100	Calculated
VLDL CHOLESTEROL	24.8	mg/dL	<30	Calculated
CHOL / HDL RATIO	3.73		0-4.97	Calculated
ATHEROGENIC INDEX (AIP)	< 0.01		<0.11	Calculated

Comment:

Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	< 200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100; Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220
ATHEROGENIC INDEX(AIP)	<0.11	0.12 – 0.20	>0.21	

Note:

1) Measurements in the same patient on different days can show physiological and analytical variations.
2) NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.
3) Primary prevention algorithm now includes absolute risk estimation and lower LDL Cholesterol target levels to determine eligibility of drug therapy.

Sneha Shah

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SIN No:SE04692158

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

4) Low HDL levels are associated with coronary heart disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
5) As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
6) VLDL, LDL Cholesterol Non-HDL Cholesterol, CHOL/HDL RATIO, LDL/HDL RATIO are calculated parameters when Triglycerides are below 400 mg/dl. When
Triglycerides are more than 400 mg/dl LDL cholesterol is a direct measurement.
7) Triglycerides and HDL-cholesterol in Atherogenic index (AIP) reflect the balance between the atherogenic and protective lipoproteins. Clinical studies have shown that AIP (log (TG/HDL) & values used are in mmol/L) predicts cardiovascular risk and a useful measure of response to treatment (pharmacological intervention).

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST (LFT) , *SERUM*				
BILIRUBIN, TOTAL	0.48	mg/dL	0.20-1.20	Colorimetric
BILIRUBIN CONJUGATED (DIRECT)	0.08	mg/dL	0.0-0.3	Calculated
BILIRUBIN (INDIRECT)	0.40	mg/dL	0.0-1.1	Dual Wavelength
ALANINE AMINOTRANSFERASE (ALT/SGPT)	27.2	U/L	9-52	UV with P-5-P
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	26.9	U/L	14-36	UV with P-5-P
ALKALINE PHOSPHATASE	82.23	U/L	38-126	p-nitrophenyl phosphate
PROTEIN, TOTAL	7.56	g/dL	6.3-8.2	Biuret
ALBUMIN	4.25	g/dL	3.5 - 5	Bromocresol Green
GLOBULIN	3.31	g/dL	2.0-3.5	Calculated
A/G RATIO	1.28		0.9-2.0	Calculated

Comment:

LFT results reflect different aspects of the health of the liver, i.e., hepatocyte integrity (AST & ALT), synthesis and secretion of bile (Bilirubin, ALP), cholestasis (ALP, GGT), protein synthesis (Albumin)

Common patterns seen:

1. **Hepatocellular Injury:**

• AST – Elevated levels can be seen. However, it is not specific to liver and can be raised in cardiac and skeletal injuries.

• ALT – Elevated levels indicate hepatocellular damage. It is considered to be most specific lab test for hepatocellular injury. Values also correlate well with increasing BMI .• Disproportionate increase in AST, ALT compared with ALP. • Bilirubin may be elevated.

• AST: ALT (ratio) – In case of hepatocellular injury AST: ALT > 1In Alcoholic Liver Disease AST: ALT usually >2. This ratio is also seen to be increased in NAFLD, Wilsons's diseases, Cirrhosis, but the increase is usually not >2.

2. **Cholestatic Pattern:**

• ALP – Disproportionate increase in ALP compared with AST, ALT.

• Bilirubin may be elevated.• ALP elevation also seen in pregnancy, impacted by age and sex.

• To establish the hepatic origin correlation with GGT helps. If GGT elevated indicates hepatic cause of increased ALP.

3. **Synthetic function impairment:** • Albumin- Liver disease reduces albumin levels.• Correlation with PT (Prothrombin Time) helps.

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
GAMMA GLUTAMYL TRANSPEPTIDASE (GGT) , *SERUM*	37.69	U/L	12-43	Glyclyclycine Nitoranalide

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DEPARTMENT OF IMMUNOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , *SERUM*				
TRI-IODOTHYRONINE (T3, TOTAL)	0.95	ng/mL	0.7-2.04	CLIA
THYROXINE (T4, TOTAL)	12.3	µg/dL	5.48-14.28	CLIA
THYROID STIMULATING HORMONE (TSH)	**0.032**	µlU/mL	0.34-5.60	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.

2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.

3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.

4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

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SIN No:SPL24066583

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DEPARTMENT OF CLINICAL PATHOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH ANNUAL PLUS CHECK - FEMALE - 2D ECHO - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE URINE EXAMINATION (CUE) , *URINE*				
PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW		PALE YELLOW	Visual
TRANSPARENCY	CLEAR		CLEAR	Visual
pH	6.0		5-7.5	Bromothymol Blue
SP. GRAVITY	1.025		1.002-1.030	Dipstick
BIOCHEMICAL EXAMINATION				
URINE PROTEIN	NEGATIVE		NEGATIVE	PROTEIN ERROR OF INDICATOR
GLUCOSE	NEGATIVE		NEGATIVE	GOD-POD
URINE BILIRUBIN	NEGATIVE		NEGATIVE	AZO COUPLING
URINE KETONES (RANDOM)	NEGATIVE		NEGATIVE	NITROPRUSSIDE
UROBILINOGEN	NORMAL		NORMAL	EHRLICH
NITRITE	NEGATIVE		NEGATIVE	Dipstick
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	PYRROLE HYDROLYSIS
CENTRIFUGED SEDIMENT WET MOUNT AND MICROSCOPY				
PUS CELLS	2 - 3	/hpf	0-5	Microscopy
EPITHELIAL CELLS	1 - 2	/hpf	<10	MICROSCOPY
RBC	NIL	/hpf	0-2	MICROSCOPY
CASTS	NIL		0-2 Hyaline Cast	MICROSCOPY
CRYSTALS	ABSENT		ABSENT	MICROSCOPY

***** End Of Report *****

Result/s to Follow:
GLUCOSE (FASTING) - URINE, LBC PAP TEST (PAPSURE), RENAL PROFILE/KIDNEY FUNCTION TEST (RFT/KFT), GLUCOSE (POST PRANDIAL) - URINE

Dr Sneha Shah
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Consultant Pathologist

SIN No:UR2328390
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Patient Name	: Mrs. RANJANA CHAKRAVARTY	**Age/Gender**	: 38 Y/F
UHID/MR No.	: CWAN.0000135350	**OP Visit No**	: CWANOPV229988
Sample Collected on	:	**Reported on**	: 13-04-2024 12:26
LRN#	: RAD2297585	**Specimen**	:
Ref Doctor	: SELF		
Emp/Auth/TPA ID	: 72124		

DEPARTMENT OF RADIOLOGY

ULTRASOUND - WHOLE ABDOMEN

Liver appears normal in size and shows mild fatty change. No focal lesion is seen. PV and CBD normal.No dilatation of the intrahepatic biliary radicals.

Gall bladder is distended. No evidence of calculus. Wall thickness appears normal.
No evidence of periGB collection. No evidence of focal lesion.

Spleen appears normal. No focal lesion seen. Splenic vein appears normal.

Pancreas appears normal in echopattern. No focal mass lesion/calcification.
No evidence of peripancreatic free fluid or collection. Pancreatic duct appears normal.

Both the kidneys appear normal in size, shape and echopattern. Cortical thickness and
CM differentiation are maintained. No calculus / hydronephrosis seen on either side.

Urinary Bladder is distended and appears normal. No evidence of any
wall thickening or abnormality. No evidence of any intrinsic or extrinsic bladder abnormality.

Uterus is anteverted, measures 10.0 x 3.6 x 4.4 cms normal in size. It shows normal shape & echo pattern.
Endometrial echo-complex appears normal and measures 9 mm. No focal lesion seen.

Both ovaries are enlarged and show cysts.
Right ovary measures 5.0 x 3.8 cm. Left ovary measures 7.0 x 3.9 cm.

Right ovary shows a 3.4 x 3.0 cm well defined cystic lesion with low level internal echoes s/o complex cyst likely endometrioma. A follicle measuring 18 mm is also seen in the right ovary.

Left ovary shows a 5.2 x 4.1 cm well defined cystic lesion with low level internal echoes s/o complex cyst likely endometrioma. A follicle measuring 23 mm is also seen in the left ovary.

No abnormal vascularity seen on either sides.

No free fluid is detected in abdomen.

No retroperitoneal lymphadenopathy seen.

No obvious bowel mass detected.

IMPRESSION:

Bilateral ovarian endometrioma/chocolate cysts.
Grade I fatty liver.
No other significant abnormality detected.
Suggest – clinical & lab correlation.

(The sonography findings should always be considered in correlation with the clinical and other investigation finding where applicable.) It is only a professional opinion, Not valid for medico legal purpose.

Dr. SHAAZ AHMED KHAN
MBBS,DMRE
Radiology

Patient Name	: Mrs. RANJANA CHAKRAVARTY	**Age/Gender**	: 38 Y/F
UHID/MR No.	: CWAN.0000135350	**OP Visit No**	: CWANOPV229988
Sample Collected on	:	**Reported on**	: 13-04-2024 12:23
LRN#	: RAD2297585	**Specimen**	:
Ref Doctor	: SELF		
Emp/Auth/TPA ID	: 72124		

DEPARTMENT OF RADIOLOGY

X-RAY CHEST PA

Both lung fields and hila are normal .

No obvious active pleuro-parenchymal lesion seen .

Both costophrenic and cardiophrenic angles are clear .

Both diaphragms are normal in position and contour .

Thoracic wall and soft tissues appear normal.

CONCLUSION :

No obvious abnormality seen.

Dr. SHAAZ AHMED KHAN
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Radiology