

Mohd. Ashfaq Khan
57 yrs / Male

07/03/2024

No fresh complaints

~~NO CONC~~

KIDU - DM :: 3-4 yrs
on Reg Rx

HTN :: 3-4 yrs
on Reg Rx

No PIH.

NO SH.

Ht - 174 cm

wt - 78 kg

BMI - 25.8 kg/m²

(overweight)

FM - Mother - healthy
father - DM, HTN (expired)



BP - 150/90 mmHg

P - 78/min

SPO₂ - 98%

pt is fit and can resume
his normal duties

Consult with physician for blood changes
low TSH, TG is raised



HELPLINE

022 - 2588 3531

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606

www.siddhivinayakhospitals.org



ID: 1043

07-03-2024 10:09:16 AM

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Diagnosis Information:

Mobdashfaq Khan

male

Years 57

HR

: 86 bpm

P

: 100 ms

PR

: 175 ms

QRS

: 98 ms

Req. No. :

BP: 150/90

QT/QTcBz : 351/420 ms

P/QRST : 38/34/39 °

RVS/SVI : 1.801/0.479 mV

SpO2: 99%

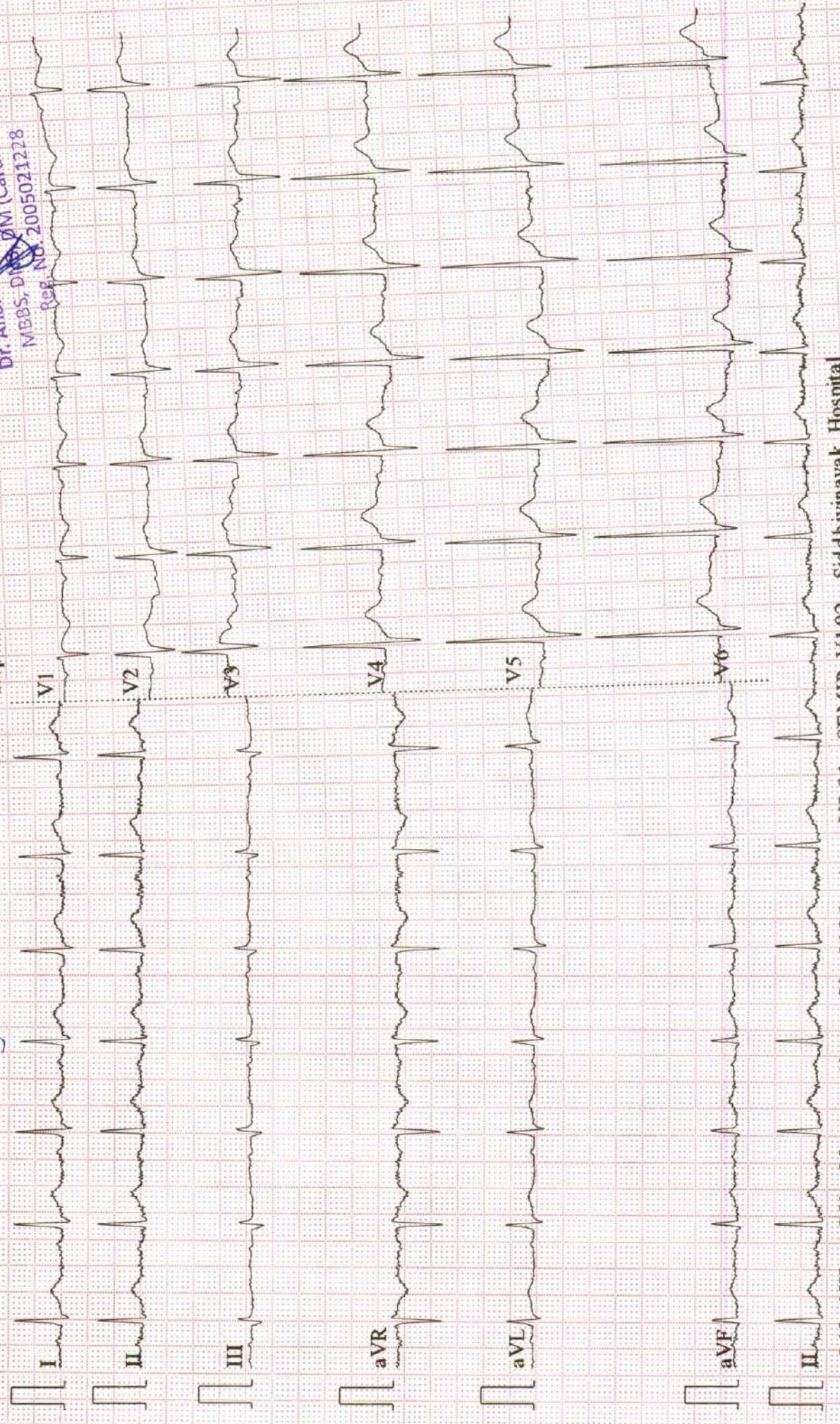
PR: 581m

HT: 176

WT: 78kg

Report Confirmed by:

Dr. Anant Kamkishanrao Munde
MBBS, DNB (Cardiology)
Reg. No. 2005021228



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

OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

MOHD.ASHFAQ KHAN

AGE

57

DATE -

07.03.2024

Specs : With Glasses

	RT Eye	Lt Eye
NEAR	N/8	N/6
DISTANT	6/9	6/9
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



Name - Mrs. AFSARI KHAN	Age - 56 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07 /03/2024

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.





Name - Mrs. Afsari Mohmmad	Age - 56 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07/03/2024

USG -BOTH BREASTS

Real time sonography of both breast was performed with high frequency probe.

Both breast show normal, medium level, homogeneous echotexture. No evidence of any solid or cystic focal mass lesion.

No evidence of calcification noted.

The pectorallis major muscles appear normal.

No evidence of axillary lymphadenopathy seen.

IMPRESSION:

- No significant abnormality is noted.

Thanks for the referral.....

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST





Name - Mrs. Afsari Mohmmad	Age - 56 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07/03/2024

USG ABDOMEN & PELVIS

FINDINGS:

The liver dimension is normal in size (15.6 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 and morphology

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

The right kidney measures 8.3 x 3.9 cm.

The left kidney measures 10.4 x 4.7 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus: post menopausal status.

No free fluid is seen.

IMPRESSION:

- Fatty liver (Grade I)

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST





ECHOCARDIOGRAM

NAME	MRS. AFSARI KHAN
AGE/SEX	56 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	07/03/2024

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: Normal <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	30 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	39.8 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.1 mm	RVEF	%
Ascending aorta	mm	IVSd	7.9 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	7.9 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	70 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm





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



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	207.0	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)	42.2	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	179.4	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)	36	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	129	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)	3.06		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.91		<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
SHAISTA Q

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	12.8	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	38.4	%	36 - 46
RBC COUNT	4.18	x10 ⁶ /uL	4.5 - 5.5
MCV	92	fl	80 - 96
MCH	30.6	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.7	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	4760	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	54	%	40 - 80
LYMPHOCYTES	33	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	10	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	205000	/cumm	150000 - 450000
MPV	11.7	fl	6.5 - 11.5
PDW	16	%	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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Priyanka_Deshmukh

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	10ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		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	1-3	/ 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.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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TFT (THYROID FUNCTION TEST)

SPECIMEN	Serum		
T3	87.97	ng/dl	84.63 - 201.8
T4	6.09	µg/dl	5.13 - 14.06
TSH	0.172	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER COBAS e411.

INTERPRETATION T3 (Triiodo Thyronine) T4 (Thyroxine)

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 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

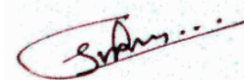
TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	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.

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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	'O'		
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)	21.8	mg/dL	21 - 43
BLOOD UREA NITROGEN (Calculated)	10.19	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.69	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	3.7	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	138.2	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	3.88	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	100.2	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.51	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.9	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.49	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.89	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.60	g/dl	1.9 - 3.5
A/G RATIO calculated	1.50		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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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic ,Normochromic
WBC	Total leukocytes count is normal on smear.
	NEUTROPHILS:54%
	LYMPHOCYTES:33%
	EOSINOPHILS:03%
	MONOCYTES:10%
	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)	0.83	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.4	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.43	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	17.0	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	11.8	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	90.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.49	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.89	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.60	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.50		0 - 2

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

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	11	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
GAMMA GT	19.4	U/L	5 - 55
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	108.5	mg/dL	70 - 110
BLOOD GLUCOSE PP	106.1	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

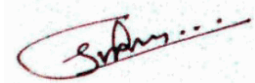
- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms +Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

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

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	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		

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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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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