

Name: Mrs - Pournima Kotangale Date: 07/02/24

Age: 32/yr Sex: M/F Weight: 61 kg Height: 154.2 inc BMI: 25.7

BP: 112/70 mmHg Pulse: 79/min bpm RBS: \_\_\_\_\_ mg/dl

SpO2 - 99

CMP - 03/02/24

32/f

- Non HT
- Non DM
- FH - Father HT  
Grandma DM

Tip

Cu  
L  
P/A / N

Inw.

- Hb - 11.0
- HbA1C - 5.8
- S. TSH - 4.95


Adv.

- Diet as advised
- Daily exercise
- R/A 3 mths  $\bar{c}$

S. TSH, HbA1C  
Repeat

Cap D Rise (60u)

1 Cap weekly x 8 wks

  
**Dr. VIMMI GOEL**  
MBBS, MD  
Sr. Consultant-Non Invasive Cardiology  
Reg. No.: 2014/01/0113



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mrs. Pournima Kotangale	<b>Age / Gender</b> : 32 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324075169/KH125041	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:05 am	<b>Report Date</b> : 07-Feb-24 11:34 am

**HAEMOGRAM**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	<b>11.0</b>	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		<b>34.8</b>	36.0 - 46.0 %	Calculated
RBC Count		<b>5.04</b>	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		<b>69</b>	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		<b>21.8</b>	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		31.6	31.5 - 35.0 g/l	Calculated
RDW		<b>18.0</b>		Calculated
Platelet count		<b>452</b>	11.5 - 14.0 %	Calculated
WBC Count		10400	150 - 450 10 <sup>3</sup> /cumm	Impedance
<b><u>DIFFERENTIAL COUNT</u></b>				
Neutrophils		<b>44.7</b>	4000 - 11000 cells/cumm	Impedance
Lymphocytes		<b>47.1</b>	50 - 70 %	Flow Cytometry/Light microscopy
Eosinophils		1.4	20 - 40 %	Flow Cytometry/Light microscopy
Monocytes		6.8	1 - 6 %	Flow Cytometry/Light microscopy
Basophils		0.0	2 - 10 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		4648.8	0 - 1 %	Flow Cytometry/Light microscopy
			2000 - 7000 /cumm	Calculated



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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		<b>4898.4</b>	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		145.6	20 - 500 /cumm	Calculated
Absolute Monocyte Count		707.2	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated

**PERIPHERAL SMEAR**

Microcytosis	Microcytosis ++(11%-20%)
Hypochromasia	Hypochromia ++(11%-20%)
Anisocytosis	Anisocytosis +(Few)
Target Cells	few
WBC	As Above
Platelets	Mildly Increased
<b>ESR</b>	<b>36</b> 0 - 20 mm/hr

Automated  
Westergren's Method

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

Suggested Clinical Correlation \* If necessary, Please discuss

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Test results related only to the item tested.

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**Dr. VAIDEHEE NAIK, MBBS,MD  
CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. Pournima Kotangale	<b>Age / Gender</b> : 32 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324075169/KH125041	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:03 am	<b>Report Date</b> : 07-Feb-24 11:07 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	88	< 100 mg/dl	GOD/POD,Colorimetric
Post Prandial Plasma Glucose		75	< 140 mg/dl	GOD/POD, Colorimetric
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>				
HbA1c		<b>5.8</b>	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

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

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**Dr. VAIDEHEE NAIK, MBBS,MD**

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Phone: +91 0712 6789100  
CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. Pournima Kotangale	<b>Age /Gender</b> : 32 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324075169/KH125041	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:05 am	<b>Report Date</b> : 07-Feb-24 11:56 am

**LIPID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	169 < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		137 < 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		39 > 50 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		104.50 < 100 mg/dl	Enzymatic
VLDL Cholesterol		27 < 30 mg/dl	Calculated
Tot Chol/HDL Ratio		4 3 - 5	Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129
Multiple major risk factors conferring 10 yrs CHD risk >20%		<100
Two or more additional major risk factors, 10 yrs CHD risk <20%	>130	10 yrs risk 10-20 % >130 <130
No additional major risk or one additional major risk factor	>160	10 yrs risk <10% >160 <160

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. Pournima Kotangale	<b>Age /Gender</b> : 32 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324075169/KH125041	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:05 am	<b>Report Date</b> : 07-Feb-24 11:56 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>RFT</b>				
Blood Urea	Serum	25	15.0 - 36.0 mg/dl	Urease with indicator dye
Creatinine		0.9	0.52 - 1.04 mg/dl	Enzymatic ( creatinine amidohydrolase)
GFR		87.1	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		145	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.46	3.5 - 5.1 mmol/L	Direct ion selective electrode
<b>THYROID PROFILE</b>				
T3		1.02	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		0.99	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		<b>4.95</b>	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

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

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. Pournima Kotangale  
**Age / Gender** : 32 Y(s)/Female  
**Bill No/ UMR No** : BIL2324075169/KH125041  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 07-Feb-24 10:05 am  
**Report Date** : 07-Feb-24 11:56 am

**LIVER FUNCTION TEST(LFT)**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.30	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.29	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		<b>0.01</b>	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric pNPP/AMP buffer
Alkaline Phosphatase		57	38 - 126 U/L	Kinetic with pyridoxal 5 phosphate
SGPT/ALT		15	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		21	13 - 35 U/L	Biuret (Alkaline cupric sulphate)
Serum Total Protein		7.87	6.3 - 8.2 gm/dl	Bromocresol green Dye Binding
Albumin Serum		3.91	3.5 - 5.0 gm/dl	Calculated
Globulin		3.97	2.0 - 4.0 gm/dl	
A/G Ratio		1.0		

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF PATHOLOGY**

**Patient Name** : Mrs. Pournima Kotangale  
**Bill No/ UMR No** : BIL2324075169/KH125041  
**Received Dt** : 07-Feb-24 11:34 am

**Age / Gender** : 32 Y(s)/Female  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Report Date** : 07-Feb-24 01:02 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<b>URINE MICROSCOPY</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	
<b><u>CHEMICAL EXAMINATION</u></b>			
Reaction (pH)	Urine	6.5	4.6 - 8.0
Specific gravity		1.005	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		Negative	Negative
Nitrate		Negative	Negative
Urobilinogen		Negative	Negative
<b><u>MICROSCOPIC EXAMINATION</u></b>			
Epithelial Cells	Urine	0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	Absent
Crystals		Absent	Absent
<b><u>USF(URINE SUGAR FASTING)</u></b>			
Urine Glucose	Urine	Negative	STRIP

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDHEE NAIK, MBBS, MD**

**SPANY CONSULTANT PATHOLOGIST**





Y

**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF IMMUNO HAEMATOLOGY**

<b>Patient Name</b> : Mrs. Pournima Kotangale	<b>Age / Gender</b> : 32 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324075169/KH125041	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:05 am	<b>Report Date</b> : 07-Feb-24 12:08 pm

**BLOOD GROUPING AND RH**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	" B "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	
		*** End Of Report ***	

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**

**DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE**

NAME	Pournima Kotangale	STUDY DATE	07-02-2024 10:50:52
AGE/ SEX	1Y2M8D / F	HOSPITAL NO.	KHI25041
ACCESSION NO.	BIL2324075169-10	MODALITY	DX
REPORTED ON	07-02-2024 11:18	REFERRED BY	Dr. Vimmi Goel

**X-RAY CHEST PA VIEW**

Both the lung fields are clear.

Heart and Aorta are normal.

hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

**IMPRESSION:**

No pleuro-parenchymal abnormality seen.



**DR. R.R. KHANDELWAL**

**SENIOR CONSULTANT**

**MD, RADIODIAGNOSIS [MMC-55870]**

N.B : This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations. Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

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Phone: +91 0712 6789100  
CIN: U74999MH2018PTC303510

PATIENT NAME:	POURNIMA KOTANGALE	AGE /SEX:	32 YRS/F
UMR NO:	KH125041	BILL NO:	2324075169
REF BY	DR. VIMMI GOEL	DATE:	07/02/2024

**USG WHOLE ABDOMEN**

LIVER is normal in size, shape and echotexture.

No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.

PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No sludge or calculus seen.

Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in shape, size and echotexture. No focal lesion seen.

Both KIDNEYS are normal in shape, size and echotexture.

No evidence of calculus or hydronephrosis seen.

URETERS are not dilated.

BLADDER is partially distended. No calculus or mass lesion seen.

Uterus is anteverted and normal.

No focal myometrial lesion seen.

Endometrial echo-complex appear normal. ET – 6.7 mm.

No adnexal mass lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

**IMPRESSION:**

**No significant abnormality seen.**

**Suggest clinical correlation / further evaluation.**

  
**DR. ANIKET KUSRAM**

**MBBS, MD, DNB**

**CONSULTANT RADIOLOGIST**

**2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT**

Patient Name : Mrs. Pournima Kotangale  
 Age : 32 years / Female  
 UMR : KH125041  
 Date : 07/02/2024  
 Done by : Dr. Vimmi Goel  
 ECG : NSR, WNL  
 Blood pressure: 112/70 mm Hg (Right arm, Supine position)  
 BSA : 1.62 m<sup>2</sup>

**Impression:**

**Normal chambers dimensions**  
**No RWMA of LV at rest**  
**Good LV systolic function, LVEF 67%**  
**Normal LV diastolic function**  
**E/A is 2.2**  
**E/E' is 9.4 (Borderline filling pressure)**  
**Valves are normal**  
**No pulmonary hypertension**  
**IVC is normal in size and collapsing well with respiration**  
**No clots or pericardial effusion**

**Comments:**

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views). LV size normal. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 67%. Normal LV diastolic function. E Velocity is 125 cm/s, A Velocity is 55 cm/s. E/A is 2.2. Valves are normal. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen. E' at medial mitral annulus is 11.4 cm/sec & at lateral mitral annulus is 16.1 cm/sec. E/E' is 9.4 (Borderline filling pressure).

M Mode echocardiography and dimension:

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	34
Aortic root	20-37	7-28	22
LVIDd	35-55	8-47	46
LVIDs	23-39	6-28	29
IVS (d)	6-11	4-8	09
LVPW (d)	6-11	4-8	09
LVEF %	~ 60%	~60%	67%
Fractional Shortening			37%



**Dr. Vimmi Goel**  
**MD, Sr. Consultant**  
**Non-invasive Cardiology**

P.T.O

32 Years

MRS POURNIMA KOTANGALE  
Female

07-Feb-24 12:31:31 PM  
KIMS-KINGSWAY HOSPITALS

PBC DEPT.

Rate 71 . Sinus rhythm.....normal P axis, V-rate 50- 99

FR 160  
QRSD 90  
QT 372  
QTc 405

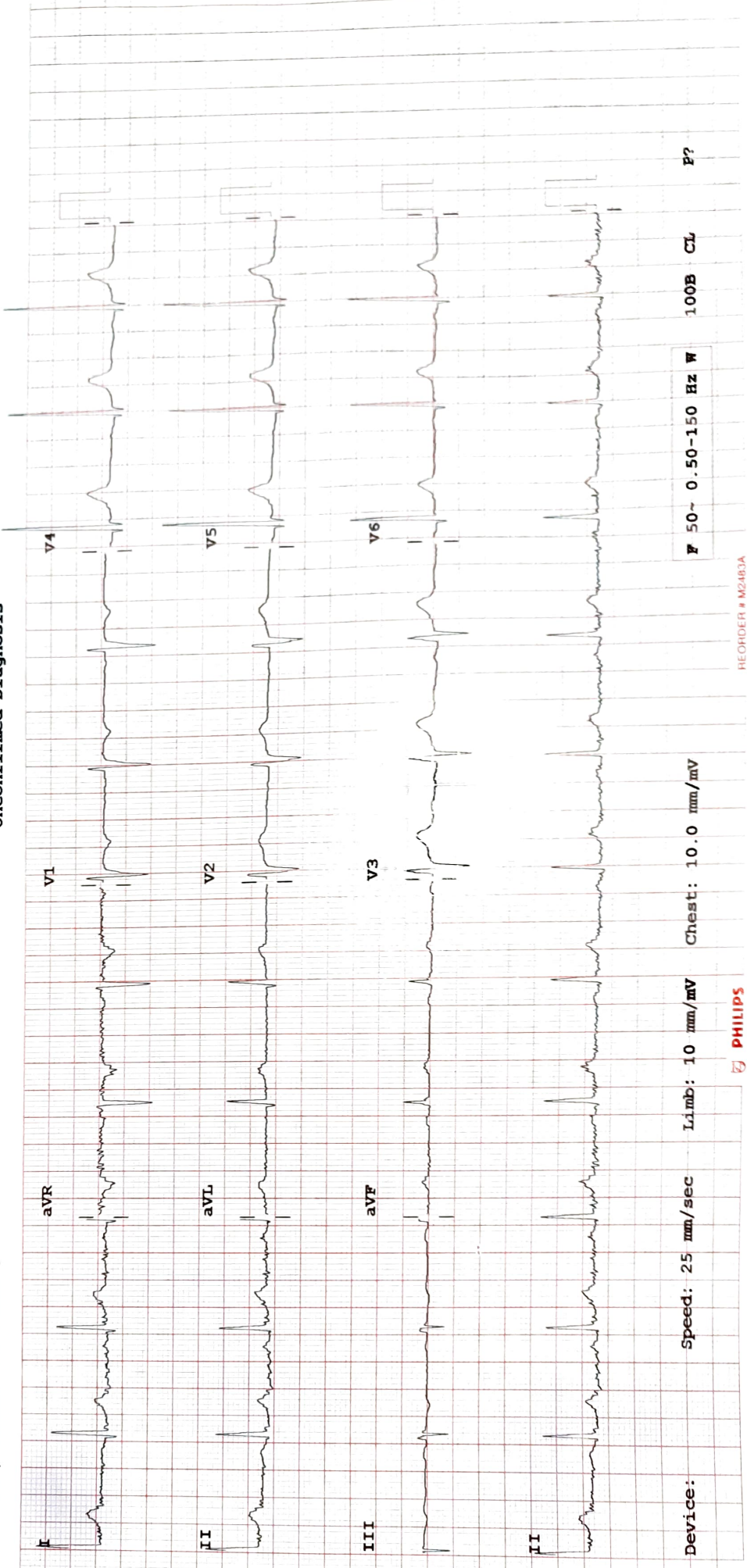
--AXIS--

P 58  
QRS 31  
T 22

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50- 0.50-150 Hz W

100B CL

P?

PHILIPS

REFORDER # M24B3A