

Shiraji Jondhale  
43 yrs / male

24/02/2024

No fresh complaints  
No comorbidities

SH- Umbilical hernia plasty  
in 2019.

F/H- Mother - DM.

father - ~~expired~~ expired,  
due to renal failure

Height - 163 cm  
Weight - 76 kg  
BMI - 28.6 kg/m<sup>2</sup>  
(overweight)

BP - 110/70 mmHg  
P - 67/min  
SpO<sub>2</sub> - 98%

PT is fit and <sup>can</sup> resume  
his normal duties

consult with physician for raised blood sugar



**HELPLINE**

022 - 2588 3531

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

[www.siddhivinayakhospitals.org](http://www.siddhivinayakhospitals.org)



ID: 960

24-02-2024 09:30:39 AM

Shivaji Jondhale  
Male  
Years 48  
Req. No. : BP-110170  
PR-67m  
SpO2-98%

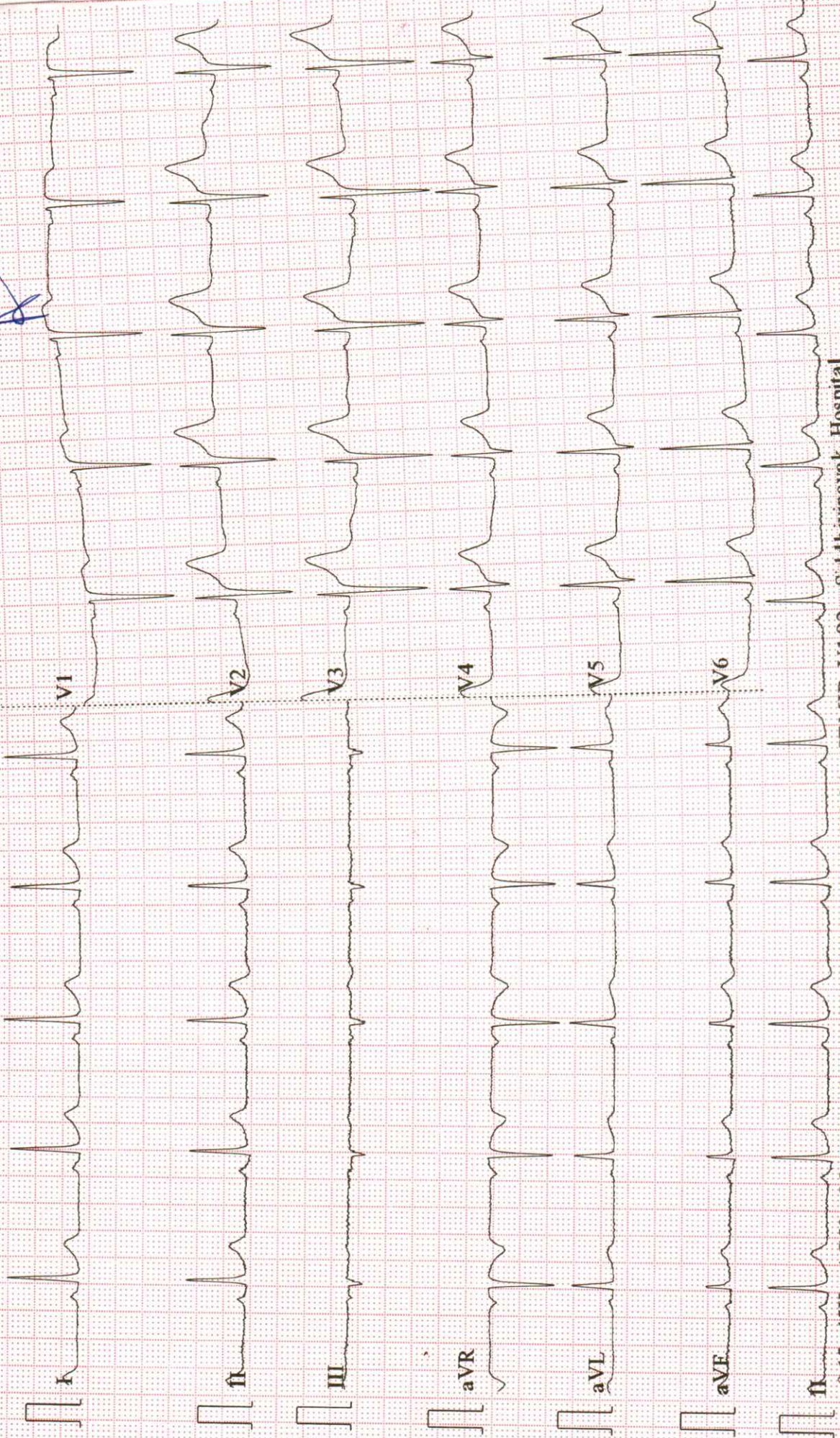
Diagnosis Information:

Sinus Rhythm  
Slight ST Elevation(V2,V3)

WNL

Report Confirmed by: A

HR : 61 bpm  
P : 98 ms  
PR : 145 ms  
QRS : 93 ms  
QT/QTcBz : 390/395 ms  
P/QRST : 24/20/40 °  
RV5/SV1 : 1.131/1.471 mV





Name - Mr. Shivaji Jondle	Age - 43 Y/M
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. Wall thickness is normal.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size ( 9.8 cm ) and morphology.

Both **kidneys** demonstrate normal morphology.

Both kidneys show normal cortical echogenicity.

The right kidney measures 9.9 x 5.5 cm.

The left kidney measures 10.0 x 5.5 cm.

**Urinary bladder:** -normally distended. Wall thickness - normal.

**Prostate** is normal in size and morphology Size: 17.0 gms.

No **free fluid** is seen.

#### IMPRESSION:-

- **Fatty liver ( Grade I )**

**DR. AMOL BENDRE**  
**MBBS; DMRE**  
**CONSULTANT RADIOLOGIST**





Name - Mr. Shivaji Jondle	Age - 43 Y/M
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.



## OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE SHIVAJI JONDHALE

AGE 43

DATE - 24.02.2024

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/10	N/12
DISTANT	6/6	6/6
Color Blind Test	NORMAL	

SIDDHIVINAYAK HOSPITALS



### ECHOCARDIOGRAM

NAME	MR. SHIVAJI JONDLE
AGE/SEX	43 YRS/M
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	24/02/2024

### 2D/M-MODE ECHOCARDIOGRAPHY

<p><b>VALVES:</b></p> <p><b>MITRAL VALVE:</b></p> <ul style="list-style-type: none"> <li>• AML: Normal</li> <li>• PML: Normal</li> <li>• Sub-valvular deformity: Absent</li> </ul> <p><b>AORTIC VALVE:</b> Normal</p> <ul style="list-style-type: none"> <li>• No. of cusps: 3</li> </ul> <p><b>PULMONARY VALVE:</b> Normal</p> <p><b>TRICUSPID VALVE:</b> Normal</p>	<p><b>CHAMBERS:</b></p> <p><b>LEFT ATRIUM:</b> Normal</p> <ul style="list-style-type: none"> <li>• Left atrial appendage: Normal</li> </ul> <p><b>LEFT VENTRICLE:</b> Mild concentric LV hypertrophy.</p> <ul style="list-style-type: none"> <li>• RWMA: No</li> <li>• Contraction: Normal</li> </ul> <p><b>RIGHT ATRIUM:</b> Normal</p> <p><b>RIGHT VENTRICLE:</b> Normal</p> <ul style="list-style-type: none"> <li>• RWMA: No</li> <li>• Contraction: Normal</li> </ul>
<p><b>GREAT VESSELS:</b></p> <ul style="list-style-type: none"> <li>• AORTA: Normal</li> <li>• PULMONARY ARTERY: Normal</li> </ul>	<p><b>SEPTAE:</b></p> <ul style="list-style-type: none"> <li>• IAS: Intact</li> <li>• IVS: Intact</li> </ul>
<p><b>CORONARIES:</b> Proximal coronaries normal</p>	<p><b>VENACAVAE:</b></p> <ul style="list-style-type: none"> <li>• SVC: Normal</li> <li>• IVC: Normal and collapsing &gt;20% with respiration</li> </ul>
<p><b>CORONARY SINUS:</b> Normal</p>	
<p><b>PULMONARY VEINS:</b> Normal</p>	<p><b>PERICARDIUM:</b> Normal</p>

### MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	21 mm	Left atrium	38 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	45.2 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	29.0 mm	RYEF	%
Ascending aorta	mm	IVSd	12.3 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	12.3 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	65 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14.0 mm





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**\*LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)</b>	185.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
<b>S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)</b>	41.9	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
<b>S. TRIGLYCERIDE (ENZYMATIC, END POINT)</b>	84.5	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
<b>VLDL CHOLESTEROL (CALCULATED VALUE)</b>	17	mg/dL	UPTO 40
<b>S.LDL CHOLESTEROL (CALCULATED VALUE)</b>	126	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.
<b>LDL CHOL/HDL RATIO (CALCULATED VALUE)</b>	3.01		UPTO 3.5
<b>CHOL/HDL CHOL RATIO (CALCULATED VALUE)</b>	4.42		<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

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M.B.B.S.M.D. Pathology(Mum)  
Consultant Histocytopathologist





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**COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>HEMOGLOBIN</b>	14.5	gm/dl	13 - 18
HEMATOCRIT (PCV)	43.5	%	42 - 52
RBC COUNT	5.55	x10 <sup>6</sup> /uL	4.70 - 6.50
MCV	<b>78</b>	fl	80 - 96
MCH	<b>26.1</b>	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.8	%	11.5 - 14.5
<b>TOTAL LEUCOCYTE COUNT</b>	5840	/cumm	4000 - 11000
<b><u>DIFFERENTIAL COUNT</u></b>			
NEUTROPHILS	50	%	40 - 80
LYMPHOCYTES	<b>41</b>	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
<b>PLATELET COUNT</b>	248000	/cumm	150000 - 450000
MPV	8.9	fl	6.5 - 11.5
PDW	15.9	%	9.0 - 17.0
PCT	0.220	%	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.**

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**URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>URINE ROUTINE EXAMINATION</u></b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.005		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
<b><u>MICROSCOPIC EXAMINATION</u></b>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	1--2	/ HPF	0 - 5
EPITHELIAL	0-2	/ 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		

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

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

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**IMMUNO ASSAY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>TFT (THYROID FUNCTION TEST )</u></b>			
SPACE		Space	-
SPECIMEN	Serum		
T3	138.8	ng/dl	84.63 - 201.8
T4	8.06	µg/dl	5.13 - 14.06
TSH	<b>6.03</b>	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
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 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

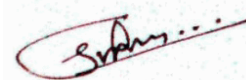
**INTERPRETATION :**

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.**

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**HAEMATOLOGY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>BLOOD GROUP</u></b>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
<b>Result relates to sample tested, Kindly correlate with clinical findings.</b>			
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**\*RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>BLOOD UREA</b> (Urease UV GLDH Kinetic)	26.2	mg/dL	19 - 45
<b>BLOOD UREA NITROGEN</b> (Calculated)	12.24	mg/dL	5 - 20
<b>S. CREATININE</b> (Enzymatic)	0.78	mg/dL	0.6 - 1.4
<b>S. URIC ACID</b> (Uricase)	5.5	mg/dL	3.5 - 7.2
<b>S. SODIUM</b> (ISE Direct Method)	142.2	mEq/L	137 - 145
<b>S. POTASSIUM</b> (ISE Direct Method)	4.01	mEq/L	3.5 - 5.1
<b>S. CHLORIDE</b> (ISE Direct Method)	104.2	mEq/L	98 - 110
<b>S. PHOSPHORUS</b> (Ammonium Molybdate)	2.84	mg/dL	2.5 - 4.5
<b>S. CALCIUM</b> (Arsenazo III)	9.2	mg/dL	8.6 - 10.2
<b>PROTEIN</b> (Biuret)	7.01	g/dl	6.4 - 8.3
<b>S. ALBUMIN</b> (BGC)	4.24	g/dl	3.2 - 4.6
<b>S.GLOBULIN</b> (Calculated)	2.77	g/dl	1.9 - 3.5
<b>A/G RATIO</b> calculated	1.53		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 :50%
	LYMPHOCYTES :41%
	EOSINOPHILS :03%
	MONOCYTES :06%
	BASOPHILS :00%
PLATELET	Adequate on smear.
HEMOPARASITE	No parasites seen.

Result relates to sample tested, Kindly correlate with clinical findings.  
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**LIVER FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TOTAL BILLIRUBIN</b> (Method-Diazo)	0.63	mg/dL	0.1 - 1.2
<b>DIRECT BILLIRUBIN</b> (Method-Diazo)	0.25	mg/dL	0.0 - 0.4
<b>INDIRECT BILLIRUBIN</b> Calculated	0.38	mg/dL	0 - 0.8
<b>SGOT(AST)</b> (UV without PSP)	21.3	U/L	0 - 37
<b>SGPT(ALT)</b> UV Kinetic Without PLP (P-L-P)	27.9	U/L	UP to 40
<b>ALKALINE PHOSPHATASE</b> (Method-ALP-AMP)	53.1	U/L	53 - 128
<b>S. PROTIEN</b> (Method-Biuret)	7.01	g/dl	6.4 - 8.3
<b>S. ALBUMIN</b> (Method-BCG)	4.24	g/dl	3.5 - 5.2
<b>S. GLOBULIN</b> Calculated	2.77	g/dl	1.90 - 3.50
<b>A/G RATIO</b> Calculated	1.53		0 - 2

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

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**HAEMATOLOGY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>ESR</b>			
<b>ESR</b>	20	mm/1hr.	0 - 20

METHOD - WESTERGREIN

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**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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**BLOOD GLUCOSE FASTING & PP**

BLOOD GLUCOSE FASTING	<b>125.2</b>	mg/dL	70 - 110
URINE GLUCOSE FASTING			
BLOOD GLUCOSE PP	134.9	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 :  $\geq 126$  mg/dl

**POSTPRANDIAL/POST GLUCOSE (75 grams)**

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus :  $\geq 200$  mg/dl

**CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS**

- Fasting plasma glucose  $\geq 126$  mg/dl
- Classical symptoms + Random plasma glucose  $\geq 200$  mg/dl
- Plasma glucose  $\geq 200$  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	23.9	U/L	13 - 109
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**GLYCOCELATED HEMOGLOBIN (HBA1C)**

HBA1C (GLYCOSALATED HAEMOGLOBIN)	<b>6.9</b>	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G. )	<b>151.3</b>	mg/dL	NON - DIABETIC : $\leq 5.6$ PRE - DIABETIC : 5.7 - 6.4 DIABETIC : $> 6.5$

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**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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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.

**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**



Name : Mr. SHIVAJI JONDLE (A) Collected On : 24/2/2024 9:04 am  
Lab ID. : 184714 Received On : 24/2/2024 9:14 am  
Age/Sex : 43 Years / Male Reported On : 24/2/2024 4:51 pm  
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



\* 1 8 4 7 1 4 \*

**REPORT ON IMMUNOLOGY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
PSA (PROSTATE SPECIFIC ANTIGEN)(TOTAL) (CLIA)	0.281	ng/ml	0 - 4

**INTERPRETATION:**

Increased levels are noted in prostate cancer, benign prostatic hypertrophy, prostatitis

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

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

Checked By  
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