

DIAGNOSTICS REPORT

Patient Name	: Mrs. SHIVANI BHATTACHARYA	Order Date	: 08/11/2024 08:30
Age/Sex	: 31 Year(s)/Female	Report Date	: 08/11/2024 12:40
UHID	: SHHM.109748		
Ref. Doctor	: self	Facility	: SEVENHILLS HOSPITAL,
Address	: ., ANDHERI EAST,Mumbai, Maharashtra, 400099	Mobile	: 8076048348

2D ECHOCARDIOGRAPHY WITH COLOUR DOPPLER STUDY

Normal LV and RV systolic function.

Estimated LVEF = 60%

No LV regional wall motion abnormality at rest .

All valves are structurally and functionally normal.

Normal sized cardiac chambers.

No LV Diastolic dysfunction .

No pulmonary arterial hypertension.

No regurgitation across any other valves.

Normal forward flow velocities across all the cardiac valves.

Aorta and pulmonary artery dimensions: normal.

IAS / IVS: Intact.

No evidence of clot, vegetation, calcification, pericardial effusion.

COLOUR DOPPLER: NO MR/AR.



Dr.Ganesh Vilas Manudhane
M.ch,MCH/DM

RegNo: 2011/06/1763

LABORATORY INVESTIGATION REPORT

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Blood Bank

Test Name	Result		
Sample No : O0371407A	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 11:22	Report Date : 08/11/24 13:25

BLOOD GROUPING/ CROSS-MATCHING BY SEMI AUTOMATION.

BLOOD GROUP (ABO)	' B '
Rh Type <i>Method - Column Agglutination</i>	POSITIVE

REMARK: THE REPORTED RESULTS PERTAIN TO THE SAMPLE RECEIVED AT THE BLOOD CENTRE.

Interpretation:

Blood typing is used to determine an individual's blood group, to establish whether a person is blood group A, B, AB, or O and whether he or she is Rh positive or Rh negative. Blood typing has the following significance,

- Ensure compatibility between the blood type of a person who requires a transfusion of blood or blood components and the ABO and Rh type of the unit of blood that will be transfused.
- Determine compatibility between a pregnant woman and her developing baby (fetus). Rh typing is especially important during pregnancy because a mother and her fetus could be incompatible.
- Determine the blood group of potential blood donors at a collection facility.
- Determine the blood group of potential donors and recipients of organs, tissues, or bone marrow, as part of a workup for a transplant procedure.
- Cross-matching test is done to assess compatibility of donor red cells to the patient.

End of Report



Dr. Ritesh Kharche
MD Pathology, PGD-HM

Consultant Pathologist and Director of
Laboratory Services
RegNo: 2006/03/1680



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HAEMATOTOLOGY

Test Name	Result	Unit	Biological Reference Interval
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Sample No : O0371407A	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 09:13	Report Date : 08/11/24 11:25
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COMPLETE BLOOD COUNT (CBC) - EDTA WHOLE BLOOD

Test Name	Result	Unit	Biological Reference Interval
Total WBC Count	6.16	x10 ³ /ul	4 - 10
Neutrophils	62.1	%	40 - 80
Lymphocytes	30.4	%	20 - 40
Eosinophils	2.0	%	1 - 6
Monocytes	5.5	%	2 - 10
Basophils	0.0 ▼ (L)	%	1 - 2
Absolute Neutrophil Count	3.82	x10 ³ /ul	2 - 7
Absolute Lymphocyte Count	1.88	x10 ³ /ul	0.8 - 4
Absolute Eosinophil Count	0.12	x10 ³ /ul	0.02 - 0.5
Absolute Monocyte Count	0.34	x10 ³ /ul	0.12 - 1.2
Absolute Basophil Count	0.00	x10 ³ /ul	0 - 0.1
RBCs	3.84 ▼ (L)	x10 ⁶ /ul	4.5 - 5.5
Hemoglobin	11.9 ▼ (L)	gm/dl	12 - 15
Hematocrit	34.7 ▼ (L)	%	35 - 45
MCV	90.4	fl	83 - 101
MCH	31.0	pg	27 - 32
MCHC	34.2	gm/dl	31.5 - 34.5



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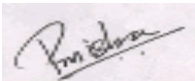
RED CELL DISTRIBUTION WIDTH-CV (RDW-CV)	12.2	%	11 - 16
RED CELL DISTRIBUTION WIDTH-SD (RDW-SD)	41.1	fl	35 - 56
Platelet	226	x10 ³ /ul	150 - 410
Mean Platelet Volume (MPV)	13.8 ▲ (H)	fl	6.78 - 13.46
PLATELET DISTRIBUTION WIDTH (PDW)	16.0	%	9 - 17
PLATELETCRIT (PCT)	0.311 ▲ (H)	%	0.11 - 0.28
Comment	PS Findings: RBCs: Normocytic Normochromic WBCs: Normal Morphology Platelets: Adequate		

Method:-
HB Colorimetric Method.
RBC/PLT Electrical Impedance Method.
WBC data Flow Cytometry by Laser Method.
MCV,MCH,MCHC,RDW and rest parameters - Calculated.
All Abnormal Haemograms are reviewed confirmed microscopically.

NOTE: Wallach's Interpretation of Diagnostic Tests. 11th Ed, Editors: Rao LV. 2021

NOTE :-
The International Council for Standardization in Haematology (ICSH) recommends reporting of absolute counts of various WBC subsets for clinical decision making. This test has been performed on a fully automated 5 part differential cell counter which counts over 10,000 WBCs to derive differential counts. A complete blood count is a blood panel that gives information about the cells in a patient's blood, such as the cell count for each cell type and the concentrations of Hemoglobin and platelets. The cells that circulate in the bloodstream are generally divided into three types: white blood cells (leukocytes), red blood cells (erythrocytes), and platelets (thrombocytes). Abnormally high or low counts may be physiological or may indicate disease conditions, and hence need to be interpreted clinically.

End of Report



Dr.Pooja Vinod Mishra
MD Pathology

Jr Consultant Pathologist, MMC Reg No.
2017052191



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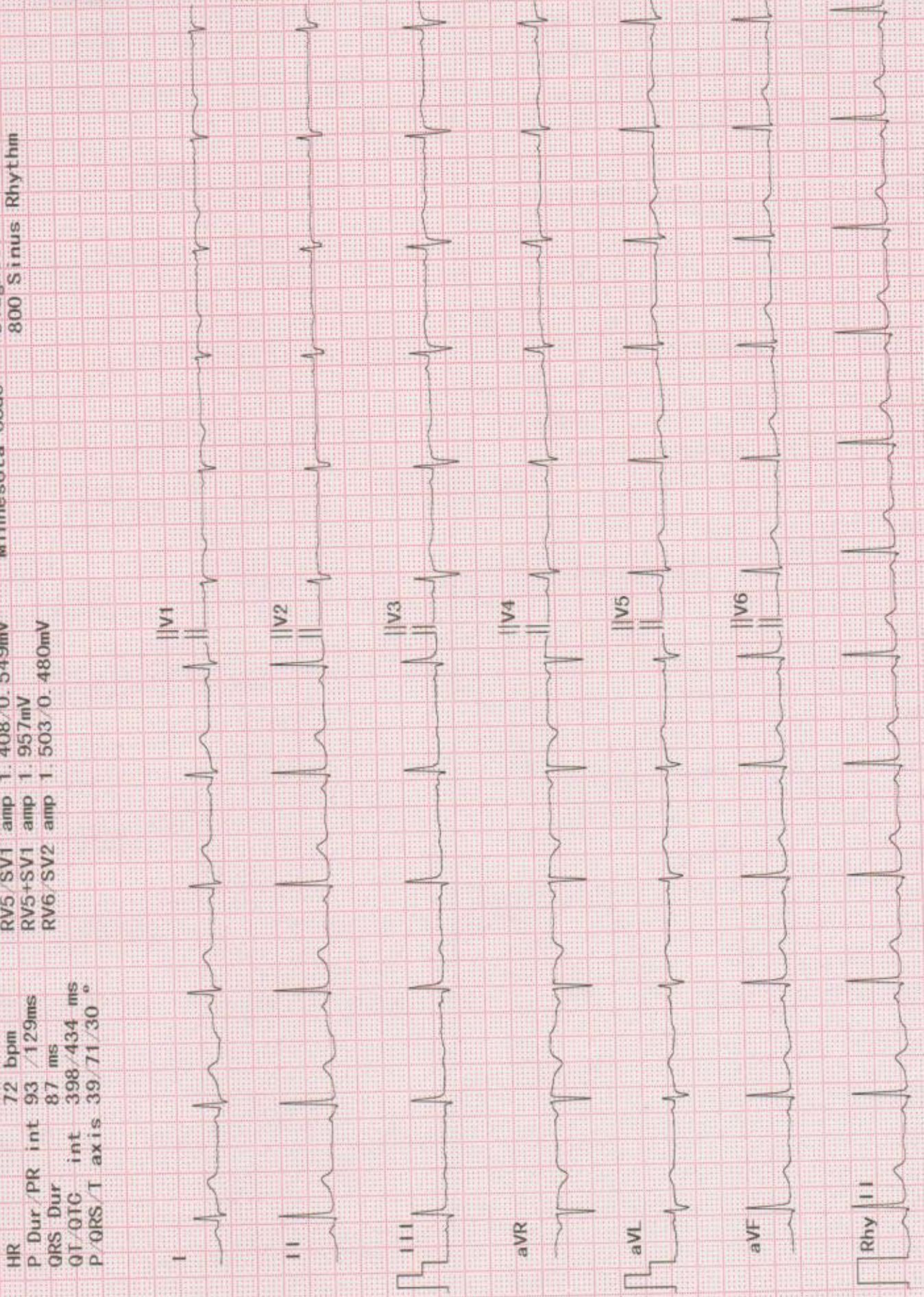
DOB : 21/11/1992

Facility : SEVENHILLS HOSPITAL,
MUMBAI

RegNo: 2017/05/2191



ID : 2411080000 DataTime: 2024-11-08 09:23 Hospital:
 Name : ms.shivani Age : 31 Height : cm
 Sex : Female BP : mmHg Weight : kg
 Divisions: Bed No. : Hospital No. :
 HR : 72 bpm RV5/SV1 amp 1.408/0.549mV Diagnosis Info
 P Dur/PR int 93 /129ms RV5+SV1 amp 1.957mV 800 Sinus Rhythm
 QRS Dur 87 ms RV6/SV2 amp 1.503/0.480mV
 QT/QTc int 398/434 ms
 P/QRS/T axis 39/71/30 °



Diagnosis for reference, ask your doctor to confirm
 AUTO PRINT 6X2+1R 72bpm 10/5mm/mV 0.50Hz-45Hz AC 50Hz 25 mm/sec
 VIII 24 Confirmed By:

SEVENHILLS HEALTHCARE

MAROL ANDHERI

MUMBAI

SHIVANI BHATTACHARYA

TREADMILL TEST REPORT

ID : 65
 DATE : 08-11-2024
 AGE/SEX : 31 / F
 HT/WT : 159 / 67
 REF. BY : SELF

PROTOCOL : Bruce
 HISTORY : NIL
 INDICATION : NIL
 MEDICATION : NIL

PHASE	TOTAL TIME	STAGE TIME	SPEED Km/Hr	GRADE %	H.R. bpm	B.P. mmHg	RPF x100	ST LEVEL (MM)			METS
								II	V1	V5	
WARMING UP	0:5				75	100 / 60	75	0.6	-0.1		0.5
Level 1	2:55	2:55	2.7	10	75	100 / 60	75	0.5	-0.3		0.4
Level 2	5:55	2:55	4	12	73	100 / 60	73	0.5	-0.2		0.5
EXERCISE	7:55	1:55	5.4	14	107	100 / 60	107	-0.1	0.1		0.1
COOLING DOWN	11:5	2:55			118	110 / 60	129	-0.7	-0.1		-0.5
RECOVERY					168	120 / 60	201	-1.7	2.3		-1.5
					92	110 / 60	101	-0.7	0.2		-0.5

RESULTS

EXERCISE DURATION : 7:55
 MAX HEART RATE : 168 bpm 88 % of target heart rate 189 bpm
 MAX BLOOD PRESSURE : 120 / 60 mm Hg
 REASON OF TERMINATION : THR ACHIEVED
 MAX WORK LOAD : 8.95 METS

BP RESPONSE :
 ARRHYTHMIA :
 H.R. RESPONSE :

IMPRESSIONS

GOOD EFFORT TOLERANCE.
 NORMAL CHRONOTROPIC AND
 IONOTROPIC RESPONSES.
 NO ANGINA / ARRHYTHMIA.
 NO ST - T CHANGES.
 STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHAEMIA.

Physician : NAZIA

DR. GANESH MANUDHANE.

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HAEMATOTOLOGY

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Sample No : O0371407A	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 09:13	Report Date : 08/11/24 12:36

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ESR	62 ▲ (H)	mm/hr	0 - 20
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Method: Westergren Method

INTERPRETATION :-

ESR is a non-specific phenomenon, its measurement is clinically useful in disorders associated with an increased production of acute-phase proteins. It provides an index of progress of the disease in rheumatoid arthritis or tuberculosis, and it is of considerable value in diagnosis of temporal arteritis and polymyalgia rheumatica. It is often used if multiple myeloma is suspected, but when the myeloma is non-secretory or light chain, a normal ESR does not exclude this diagnosis.

An elevated ESR may occur as an early feature in myocardial infarction. Although a normal ESR cannot be taken to exclude the presence of organic disease, the vast majority of acute or chronic infections and most neoplastic and degenerative diseases are associated with changes in the plasma proteins that increased ESR values.

The ESR is influenced by age, stage of the menstrual cycle and medications taken (corticosteroids, contraceptive pills). It is especially low (0-1 mm) in polycythaemia, hypofibrinogenaemia and congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis, or sickle cells. In cases of performance enhancing drug intake by athletes the ESR values are generally lower than the usual value for the individual and as a result of the increase in haemoglobin (i.e. the effect of secondary polycythaemia).

End of Report



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Biochemistry

Test Name	Result	Unit	Biological Reference Interval
Sample No : O0371407A	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 09:13	Report Date : 08/11/24 12:38

<u>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</u>			
HbA1c <i>Method - Immunoturbidimetry</i>	5.19	%	4 to 6% Non-diabetic 6.0--7.0% Excellent control 7.0--8.0% Fair to good control 8.0--10% Unsatisfactory control ABOVE 10% Poor control
Estimated Average Glucose (eAG) <i>Method - Calculated</i>	102.25	mg/dl	90 - 126

NOTES :-

1. HbA1c is used for monitoring diabetic control. It reflects the mean plasma glucose over three months
2. HbA1c may be falsely low in diabetics with hemolytic disease. In these individuals a plasma fructosamine level may be used which evaluates diabetes over 15 days.
3. Inappropriately low HbA1c values may be reported due to hemolysis, recent blood transfusion, acute blood loss, hypertriglyceridemia, chronic liver disease. Drugs like dapson, ribavirin, antiretroviral drugs, trimethoprim, may also cause interference with estimation of HbA1c, causing falsely low values.
4. HbA1c may be increased in patients with polycythemia or post-splenectomy.
5. Inappropriately higher values of HbA1c may be caused due to iron deficiency, vitamin B12 deficiency, alcohol intake, uremia, hyperbilirubinemia and large doses of aspirin.
6. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
7. Any sample with >15% HbA1c should be suspected of having a hemoglobin variant, especially in a non-diabetic patient. Similarly, below 4% should prompt additional studies to determine the possible presence of variant hemoglobin.
8. HbA1c target in pregnancy is to attain level <6 % .
9. HbA1c target in paediatric age group is to attain level < 7.5 %.

Method : turbidimetric inhibition immunoassay (TINIA) for hemolyzed whole blood

Reference : American Diabetes Associations. Standards of Medical Care in Diabetes 2015

Sample No : O0371407B	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 09:13	Report Date : 08/11/24 10:53
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GLUCOSE-PLASMA-FASTING

Glucose,Fasting	88.16	mg/dl	70 - 100
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American Diabetes Association Reference Range :

Normal : < 100 mg/dl

Impaired fasting glucose(Prediabetes) : 100 - 126 mg/dl

Diabetes : >= 126 mg/dl

References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation :-

Conditions that can result in an elevated blood glucose level include: Acromegaly, Acute stress (response to trauma, heart attack,and stroke for instance), Chronic kidney disease, Cushing syndrome, Excessive consumption of food, Hyperthyroidism,Pancreatitis.

A low level of glucose may indicate hypoglycemia, a condition characterized by a drop in blood glucose to a level where first it causes nervous system symptoms (sweating, palpitations, hunger, trembling, and anxiety), then begins to affect the brain (causing confusion, hallucinations, blurred vision, and sometimes even coma and death). A low blood glucose level (hypoglycemia) may be

seen with:Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin (insulinomas),Starvation.

Lipid Profile

Total Cholesterol	188.99	mg/dl	CHILD Desirable - Less than : 170 CHILD Borderline High : 170-199 CHILD High - More than : 200 ADULT Desirable - Less than : 200 ADULT Borderline High : 200-239 ADULT High - More than : 240
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Triglycerides <i>Method - glycerol Phosphate Oxidase/Peroxide</i>	81.94	mg/dl	NORMAL : <150 Borderline High : 150-199 High : 200-499 Very High : > 500
HDL Cholesterol <i>Method - Enzymatic immuno inhibition</i>	51.15	mg/dl	Desirable - Above 60 Borderline Risk : 40-59 Undesirable - Below :40
LDL Cholesterol <i>Method - Calculated</i>	121.45	mg/dl	Desirable - Below : 130 Borderline Risk : 130-159 Undesirable - Above : 160
VLDL Cholesterol <i>Method - Calculated</i>	16.39	mg/dl	5 - 51
Total Cholesterol / HDL Cholesterol Ratio - Calculated <i>Method - Calculated</i>	3.69	RATIO	0 - 4.5
LDL / HDL Cholesterol Ratio - Calculated <i>Method - Calculated</i>	2.37	RATIO	0 - 3.2

Note:

1) Biological Reference Intervals are as per ATP III, NCEP Guidelines and National Lipid Association (NLA) 2014 Recommendations

2) Tests done on Fully Automated Biosystem BA-400 Biochemistry Analyser.

3) The LDL-Cholesterol is calculated by the Friedewald equation which provides a reliable LDL-Cholesterol value estimate when triglyceride levels are below 400 mg/dL. A direct measurement is advised if the triglyceride levels are >400mg/dL.

Interpretation

1. Triglycerides: When triglycerides are very high greater than 1000 mg/dL, there is a risk of developing pancreatitis in children and adults. Triglycerides change dramatically in response to meals, increasing as much as 5 to 10 times higher than fasting levels just a few hours after eating. Even fasting levels vary considerably day to day. Therefore, modest changes in fasting triglycerides measured on different days are not considered to be abnormal.

2. HDL-Cholesterol: HDL- C is considered to be beneficial, the so-called "good" cholesterol, because it removes



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excess cholesterol from tissues and carries it to the liver for disposal. If HDL-C is less than 40 mg/dL for men and less than 50 mg/dL for women, there is an increased risk of heart disease that is independent of other risk factors, including the LDL-C level. The NCEP guidelines suggest that an HDL cholesterol value greater than 60 mg/dL is protective and should be treated as a negative risk factor.

3. LDL-Cholesterol: Desired goals for LDL-C levels change based on individual risk factors. For young adults, less than 120 mg/dL is acceptable. Values between 120-159 mg/dL are considered Borderline high. Values greater than 160 mg/dL are considered high. Low levels of LDL cholesterol may be seen in people with an inherited lipoprotein deficiency and in people with hyperthyroidism, infection, inflammation, or cirrhosis.

<u>Uric Acid (Serum)</u>			
<i>Method - Uricase</i>			
Uric Acid	3.84	mg/dl	2.6 - 6
<i>Method - Uricase</i>			

References:

- 1) Pack Insert of Bio system
- 2) TIETZ Textbook of Clinical chemistry and Molecular Diagnostics Edited by: Carl A. burtis, Edward R. Ashwood, David e. Bruns

Interpretation:-

Uric acid is produced by the breakdown of purines. Purines are nitrogen-containing compounds found in the cells of the body, including our DNA. Increased concentrations of uric acid can cause crystals to form in the joints, which can lead to the joint inflammation and pain characteristic of gout. Low values can be associated with some kinds of liver or kidney diseases, Fanconi syndrome, exposure to toxic compounds, and rarely as the result of an inherited metabolic defect (Wilson disease).

<u>Liver Function Test (LFT)</u>			
SGOT (Aspartate Transaminase) - SERUM	13.41	IU/L	0 - 31
<i>Method - IFCC</i>			
SGPT (Alanine Transaminase) - SERUM	11.57	IU/L	0 - 34
<i>Method - IFCC</i>			
Total Bilirubin - SERUM	1.05	mg/dl	0 - 2
<i>Method - Diazo</i>			
Direct Bilirubin - - SERUM	0.48 ▲ (H)	mg/dl	0 - 0.4
<i>Method - Diazotization</i>			
Indirect Bilirubin - Calculated	0.57	mg/dl	0.1 - 0.8
<i>Method - Calculated</i>			



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Alkaline Phosphatase - SERUM <i>Method - IFCC AMP Buffer</i>	120.58 ▲ (H)	IU/L	33 - 98
Total Protein - SERUM <i>Method - Biuret</i>	7.94 ▲ (H)	gm/dl	6 - 7.8
Albumin - SERUM <i>Method - Bromo Cresol Green(BCG)</i>	4.22	gm/dl	3.5 - 5.2
Globulin - Calculated <i>Method - Calculated</i>	3.72	gm/dl	2 - 4
A:G Ratio <i>Method - Calculated</i>	1.13	:1	1 - 3

References:

- 1) Pack Insert of Bio system
- 2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interperatation :-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice). conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.

AST levels increase in viral hepatitis, blockage of the bile duct ,cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart attck or strenuous activity. ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury , to determine liver health. Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, paget's disease, Rickets, Sarcoidosis etc.

Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc.

Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum.. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease.

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic - Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

Renal Function Test (RFT)



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Urea - SERUM <i>Method - Urease</i>	15.01	mg/dl	15 - 39
BUN - SERUM <i>Method - Urease-GLDH</i>	6.71	mg/dl	4 - 18
Creatinine - SERUM <i>Method - Jaffes Kinetic</i>	0.66	mg/dl	0.5 - 1.1

References:

- 1) Pack Insert of Bio system
- 2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation:-

The blood urea nitrogen or BUN test is primarily used, along with the creatinine test, to evaluate kidney function in a wide range of circumstances, to help diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status.

<u>GLUCOSE-PLASMA POST PRANDIAL</u>			
Glucose, Post Prandial	98.2	mg/dl	70 - 140

American Diabetes Association Reference Range :

Post-Prandial Blood Glucose:

- Non- Diabetic: Up to 140mg/dL
- Pre-Diabetic: 140-199 mg/dL
- Diabetic :>200 mg/dL

References:

- 1) Pack Insert of Bio system
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seen with: Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin



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Facility : SEVENHILLS HOSPITAL,
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(insulinomas), Starvation.

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Consultant Pathologist and Director of
Laboratory Services


RegNo: 2006/03/1680



Dr. Nipa Dhorda
MD

Pathologist

RegNo: 91821



Dr. Pooja Vinod Mishra
MD Pathology

Jr Consultant Pathologist, MMC Reg No.
2017052191

RegNo: 2017/05/2191



GLUCOSE PLASMA POST PRANDIAL (PPBS)- Report has been amended at Nov 8 2024 4:10PM by Dr Pooja Vinod Mishra.



LABORATORY INVESTIGATION REPORT

Patient Name	: Mrs. SHIVANI BHATTACHARYA	Age/Sex	: 31 Year(s) / Female
UHID	: SHHM.109748	Order Date	: 08/11/2024 08:30
Episode	: OP	Mobile No	: 8076048348
Ref. Doctor	: self	DOB	: 21/11/1992
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

HISTOPATHOLOGY AND CYTOLOGY

Test Name	Result
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Sample No :	O0371473B	Collection Date :	08/11/24 12:56	Ack Date :	08/11/2024 12:57	Report Date :	08/11/24 16:45
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ROUTINE CERVICOVAGINAL PAP SMEAR

REPORT

C-GY-412/24

CLINICAL DETAILS :

LMP: 03/11/2024
PS: Cervix/vagina appears healthy
Curdy white discharge present

MATERIAL RECEIVED :

2 wet- fixed conventional cervico-vaginal smears received.

MICROSCOPIC EXAMINATION :

The smears are satisfactory for evaluation.
Endocervical / transformation zone component is present.
Benign superficial, intermediate & parabasal squamous cells noted.
Dysplastic cells are not seen.

IMPRESSION :

Negative for intraepithelial lesion or malignancy.

NOTE :-

The 2014 Bethesda system for reporting cervical cytology was followed.

Comments :

Cervicovaginal cytology is a screening test primarily for squamous cancer and precursors and has associated false-negative and false-positive results. Regular sampling and follow-up of unexplained clinical signs and symptoms are recommended to minimize false negative results.

End of Report



Dr.Nipa Dhorda

MD

Pathologist

RegNo: 91821

LABORATORY INVESTIGATION REPORT

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Age/Sex : 31 Year(s) / Female

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MUMBAI



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	DOB : 21/11/1992
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IMMUNOLOGY

Test Name	Result	Unit	Biological Reference Interval
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Sample No : O0371407C Collection Date : 08/11/24 08:41 Ack Date : 08/11/2024 09:13 Report Date : 08/11/24 12:34

T3 - SERUM <i>Method - CLIA</i>	93.28	ng/dl	70.00 - 204.00
<u>TFT- Thyroid Function Tests</u>			
T4 - SERUM <i>Method - CLIA</i>	7.47	ug/dL	4.60 - 10.50
TSH - SERUM <i>Method - CLIA</i>	5.06 ▲ (H)	uIU/ml	0.40 - 4.50

Reference Ranges (T3) Pregnancy:

First Trimester 81 - 190

Second Trimester & Third Trimester 100 - 260

Reference Ranges (TSH) Pregnancy:

1st Trimester : 0.1 – 2.5

2nd Trimester : 0.2 – 3.0

3rd Trimester : 0.3 – 3.0

Reference:

1. Clinical Chemistry and Molecular Diagnostics, Tietz Fundamentals, 7th Edition & Endocrinology Guidelines

Interpretation :-

It is recommended that the following potential sources of variation should be considered while interpreting thyroid hormone results:

1. Thyroid hormones undergo rhythmic variation within the body this is called circadian variation in TSH secretion: Peak levels are seen between 2-4 am. Minimum levels seen between 6-10 am. This variation may be as much as 50% thus, influence of sampling time needs to be considered for clinical interpretation.
2. Circulating forms of T3 and T4 are mostly reversibly bound with Thyroxine binding globulins (TBG), and to a lesser extent with albumin and Thyroid binding PreAlbumin. Thus the conditions in which TBG and protein levels alter such as chronic liver disorders, pregnancy, excess of estrogens, androgens, anabolic steroids and glucocorticoids may cause misleading total T3, total T4 and TSH interpretations.
3. Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment.
4. T4 may be normal the presence of hyperthyroidism under the following conditions : T3 thyrotoxicosis, Hypoproteinemia related reduced binding, during intake of certain drugs (eg Phenytoin, Salicylates etc)
5. Neonates and infants have higher levels of T4 due to increased concentration of TBG
6. TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism,



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pregnancy, phenytoin therapy etc.

7. TSH values of <0.03 uIU/mL must be clinically correlated to evaluate the presence of a rare TSH variant in certain individuals which is undetectable by conventional methods.

8. Presence of Autoimmune disorders may lead to spurious results of thyroid hormones

9. Various drugs can lead to interference in test results.

10. It is recommended that evaluation of unbound fractions, that is free T3 (fT3) and free T4 (fT4) for clinic-pathologic correlation, as these are the metabolically active forms.

End of Report



Dr. Ritesh Kharche
MD Pathology, PGD-HM

Consultant Pathologist and Director of
Laboratory Services
RegNo: 2006/03/1680



LABORATORY INVESTIGATION REPORT

Patient Name : Mrs. SHIVANI BHATTACHARYA UHID : SHHM.109748 Episode : OP Ref. Doctor : self	Age/Sex : 31 Year(s) / Female Order Date : 08/11/2024 08:30 Mobile No : 8076048348 DOB : 21/11/1992 Facility : SEVENHILLS HOSPITAL, MUMBAI
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Urinalysis

Test Name	Result	Unit	Biological Reference Interval
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Sample No : O0371407D	Collection Date : 08/11/24 08:41	Ack Date : 08/11/2024 09:12	Report Date : 08/11/24 14:56
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<u>Physical Examination</u>			
QUANTITY	50	ml	
Colour	Pale Yellow		
Appearance	Slightly Hazy		
DEPOSIT	Absent		Absent
pH	Acidic		
Specific Gravity	1.010		
<u>Chemical Examination</u>			
Protein	Absent		Absent
Glucose	Absent		
ketones	Absent		
Blood	NEGATIVE		Negative
Bilirubin	Negative		
Urobilinogen	NORMAL		Normal
NITRITE	Absent		Absent
LEUKOCYTES	POSITIVE (+)		
<u>Microscopic Examination</u>			
Pus cells	10-15	/HPF	
Epithelial Cells	20-25	/HPF	

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UHID : SHHM.109748

Order Date : 08/11/2024 08:30

Episode : OP

Ref. Doctor : self

Mobile No : 8076048348

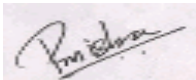
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RBC	Absent	/HPF	Absent
Cast	GRANULAR CAST PRESENT	/LPF	
Crystal	Absent	/HPF	
Amorphous Materials	Absent		
Yeast	Absent		
Bacteria	POSITIVE (++)		
<u>URINE SUGAR AND KETONE (FASTING)</u>			
Glucose	Absent		
ketones	Absent		

<u>URINE SUGAR AND KETONE (PP)</u>			
Glucose	Absent		
ketones	Absent		

End of Report



Dr.Pooja Vinod Mishra

MD Pathology

Jr Consultant Pathologist, MMC Reg No.
2017052191

RegNo: 2017/05/2191



DIAGNOSTICS REPORT

Patient Name	: Mrs. SHIVANI BHATTACHARYA	Order Date	: 08/11/2024 08:30
Age/Sex	: 31 Year(s)/Female	Report Date	: 08/11/2024 15:39
UHID	: SHHM.109748		
Ref. Doctor	: self	Facility	: SEVENHILLS HOSPITAL,
Address	: ., ANDHERI EAST, Mumbai, Maharashtra, 400099	Mobile	: 8076048348

USG ABDOMEN PELVIS

Liver is normal in size (13.7 cm) and echotexture. No focal liver parenchymal lesion is seen. Intrahepatic portal and biliary radicles are normal.

Gall-bladder is partially distended. No evidence of intraluminal calculus is seen. Wall thickness appears normal. No e/o peri-cholecystic fluid noted.

Portal vein and CBD are normal in course and calibre.

Visualised part of pancreas appears normal in size and echotexture. No evidence of duct dilatation or parenchymal calcification seen.

Spleen is normal in size (9.1 cm) and echotexture. No focal lesion is seen in the spleen.

Both the kidneys are normal in size, shape and echotexture. Cortico-medullary differentiation is maintained. No evidence of calculus or hydronephrosis on either side.

Right kidney measures 10.3 x 4.1 cm.

Left kidney measures 11.8 x 5.2 cm.

Urinary bladder is well distended and appears normal. No evidence of intra-luminal calculus or mass lesion.

Uterus is normal in size, shape and echotexture. It measures 7.6 x 5.5 x 3.0cm.

Endometrial thickness measures 6.2 mm.

Few nabothian cyst notes in the cervix.

Both ovaries are normal in size and echotexture.

The right ovary measures: 3.8 x 1.5 cm.

The left ovary measures: 3.2 x 1.7 cm.

Both adnexae are clear.

There is no free fluid in abdomen and pelvis.

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UHID	: SHHM.109748		
Ref. Doctor	: self	Facility	: SEVENHILLS HOSPITAL,
Address	: ., ANDHERI EAST, Mumbai,		MUMBAI
	Maharashtra, 400099	Mobile	: 8076048348

IMPRESSION

·No significant abnormality is detected.



Dr. Priya Vinod Phayde
MBBS, DMRE

RegNo: 2020/11/6493

DIAGNOSTICS REPORT

Patient Name	: Mrs. SHIVANI BHATTACHARYA	Order Date	: 08/11/2024 08:30
Age/Sex	: 31 Year(s)/Female	Report Date	: 11/11/2024 09:13
UHID	: SHHM.109748		
Ref. Doctor	: self	Facility	: SEVENHILLS HOSPITAL,
Address	: ., ANDHERI EAST,Mumbai, Maharashtra, 400099	Mobile	: 8076048348

X-RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

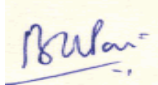
The pleural spaces are clear.

Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

IMPRESSION: No pleuroparenchymal lesion is seen.



Dr. Bhujang Pai
MBBS, MD

Consultant

RegNo: 49380