

PATIENT NAME & ADDRESS

MRS. SUSHMITA ROY

SUGAM SUDHIR, GH BLOCK- 4 , 24pg(S)-24 Parganas (South)
West Bengal, India , 700103

PATHOLOGY


DESUN
HOSPITAL
A NABH HOSPITAL

 Desun More, E.M. Bypass, Kasta Gopark, Kolkata-700 107, Ph.: 71 222 000, Fax : 2443 9003
 Email : desun@desunhospital.com, Website : www.desunhospital.com
 (A Unit of P. N. Memorial Neurocentre & Research Institute Ltd.)
DRAWN : 27-01-2024
10:12 Hrs.RECEIVED : 27-01-2024
14:11 Hrs.REPORTED : 27-01-2024
18:27 Hrs.

OPD/IPD DOC NO SD01/OPD/BILL/2023-24/OP40483746

PATIENT CODE SD01/PAT/1000157916



2331166270

REFERRING DOCTOR

ACCESSION NO DHHI-1/2023-24/0007533

AGE 41 Yrs 4 Mths 10 Dys SEX Female

Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - Fasting			
Glucose - Fasting Specimen : Plasma Flouride Methodology : Hexokinase	91	Adult: 74 - 106 Children 60 - 100	mg/dL
Uric Acid			
Uric Acid Specimen : Serum Methodology : Uricase Peroxidase	4.9	Male : 3.5 - 7.2 Female : 2.6 - 6.0	mg/dL
Creatinine			
Creatinine Specimen : Serum Methodology : Jaffe Method	0.56	Male (<50 years) : 0.84 - 1.25 Male (>50 years) : 0.81 - 1.44 Female : 0.66 - 1.09 Neonate : 0.5 - 1.2 Infant : 0.4 - 0.7 Child : 0.5 - 1.2	mg/dL
LFT (Liver Function Test)			
Total Bilirubin Specimen : Serum Methodology : Diazotization	0.60	Adults : 0.3 - 1.2 Children 0-1 day 1.4 - 8.7 1-2 days 3.4 - 11.5 3-5 days 1.5 - 12.0	mg/dL
Direct Bilirubin Specimen : Serum Methodology : Diazotization	0.13	Adults and Children : < 0.2	mg/dL
Indirect Bilirubin Methodology : Calculated Value	0.47		mg/dL
Total Protein Specimen : Serum Methodology : Biuret	7.8	Adult : 6.6 - 8.3 Children (1 - 18 y) : 5.7 - 8.0 Newborns (1 - 30 d) 4.1 - 6.3	g/dL
Albumin Specimen : Serum Methodology : Bromocresol Green (BCG)	4.1	Adults : 3.5 - 5.2 Newborn (0 - 4 day) : 2.8 - 4.4	g/dL
Globulin Methodology : Calculated Value	3.7	1.8 - 3.6	g/dL



29012024095316

 Dr. Prerana Mondal
 MD (Path), WBMC-70606
 Consultant Pathologist

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
LFT (Liver Function Test)			
Aspartate Aminotransferase (SGOT) (AST)	30	Male (Adult): <50 Female (Adult): <35 Newborn: 25 - 75 Infant: 15 - 60	U/L
Specimen : Serum Methodology : IFCC (UV without P5P)			
Alanine Aminotransferase (SGPT) (ALT)	22	Male(Adult): <50 Female(Adult): <35 Newborn/Infant: 13 - 45	U/L
Specimen : Serum Methodology : IFCC (UV without P5P)			
Alkaline Phosphatase (ALP)	146	75 - 316	U/L
Specimen : Serum Methodology : IFCC (PNPP, AMP buffer)			



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Glucose - PP (Post Prandial)			
Glucose - Post Prandial	98	70.0 - 140.0	mg/dL
Specimen : Plasma Fluoride			
Methodology : Hexokinase			
** Sample Drawn : 27.01.2024 14:05 Hrs.	Received : 27.01.2024 14:39 Hrs.	Reported : 27.01.2024 17:57 Hr	



Dr. Swapan Pathak
MD (Path), WBMC-43069
Sr Consultant

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total Specimen : Serum Methodology : CHOD-POD	138	<200 : Desirable 200 - 239 : Borderline High >=240 : High	mg/dL
Cholesterol - HDL Specimen : Serum Methodology : Direct Enzymatic Colorimetric	35	40.0 - 59.0	mg/dL
Cholesterol - LDL Methodology : Calculated Value	85	> 160.0 : High Risk 130.0 - 160.0 : Borderline High <= 130.0 : Desirable	mg/dL
Cholesterol - VLDL Methodology : Calculated Value	18	< 40.0	mg/dL
Triglyceride Specimen : Serum Methodology : GPO POD	90	Normal : <150 Borderline high : 150 - 199 High : 200 - 499 Very high : >=500	mg/dL



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Lipid Profile			
Cholesterol - Total/HDL ratio Methodology : Calculated Value	3.94	3.4 : 1/2 Average Risk 5.0 : Average Risk 9.6 : 2 x Average Risk 23.4 : 3 x Average Risk	ratio
Cholesterol - HDL/LDL ratio Methodology : Calculated Value	0.41		



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
HbA1c (Glycosylated Haemoglobin)			
Glycosylated Haemoglobin (HBA1C)	5.9	4.6 - 6.2	%
Specimen : Methodology : NGSP			
BUN (Blood Urea Nitrogen)			
Blood Urea Nitrogen (BUN)	10	Newborn : 4 - 18 Child : 5 - 18 Adult : 6 - 20	mg/dL
Specimen : Serum Methodology : Urease, GLDH			
LFT (Liver Function Test)			
A/G Ratio	1.11	1.1 - 2.2	ratio
Specimen : serum Methodology : Calculated Value			
GGT (Gamma-glutamyltransferase)			
Gamma-glutamyltransferase (GGT)	68.7	12 - 122	U/L
Specimen : Serum Methodology :			



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Haemoglobin (Hb) Specimen : Whole Blood - EDTA Methodology : Colorimetry * CLINICAL CORRELATION REQUESTED. * VALUE RECHECKED.	* 7.9	12.0 - 15.0	gm %
RBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	4.66	3.8 - 4.8	million/cmm
Packed Cell Volume (Hematocrit) (PCV) Specimen : Whole Blood - EDTA Methodology : Pulse height detection	26.7	36.0 - 46.0	%
Mean Cell Volume (MCV) Specimen : Whole Blood - EDTA Methodology : Calculated Value	57.4	83.0 - 101.0	fL
Mean Cell Haemoglobin (MCH) Specimen : Whole Blood - EDTA Methodology : Calculated Value	16.9	27 - 32	pg
Mean Cell Haemoglobin Concentration (MCHC) Specimen : Whole Blood - EDTA Methodology : Calculated Value	29.6	31.5 - 34.5	g/dL
Platelet Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	2.42	1.5 - 4.1	lakh/cmm
Total Count			
WBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	6.5	4.0 - 10.0	thou/cmm
Differential Count (Microscopy)			
Neutrophil	65	40 - 80	%
Lymphocyte	32	20 - 40	%
Monocyte	02	2 - 10	%
Eosinophil	01	1 - 6	%



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 Sr Consultant

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Basophil	00	<1 - 2	%
<i>Peripheral Blood Smear (Microscopy)</i>			
RBC	Moderately microcytic hypochromic with anisocytosis.		
WBC	Normal morphology. No immature cell seen.		
Erythrocyte Sedimentation Rate (ESR)	45	<=15	mm / hr
<i>Specimen : Whole Blood - EDTA</i>			
<i>Methodology : Westergren</i>			



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
ABO Group & RH Type ABO Blood Group Methodology : Tube Agglutination / Slide method Rh Typing Specimen : Whole Blood - EDTA Methodology : Tube Agglutination / Slide method	O POSITIVE		
'H' ANTIGEN PRESENT.	<p>Note : Following factors are responsible for discrepancies in ABO Grouping:</p> <ol style="list-style-type: none"> 1. Patients may fail to express ABO antigens on red cells due to diseases like Leukaemia & lymphoma. 2. Acquired B antigen can occur due to Infections; gram negative septicaemia, carcinoma colon, Blood Group chimera i.e. an individual with two population of cells which may occur as a result of either Bone marrow transplantation or Transfusion of group 'O' blood to 'A' or 'B' patient. 3. Rouleaux formation: It occurs in patients with abnormal Albumin/globulin concentration or in cord blood samples due to Whartons Jelly contamination. 4. Acquired antibodies i.e. Anti -A1 in A2 persons Anti -H in Bombay phenotype Cold auto - antibodies Unexpected allo-antibodies. 		



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Urinalysis			
Physical Examination			
Volume <i>Methodology : By graduated container</i>	35		mL
Colour	Pale Straw		
Appearance <i>Methodology : Visual</i>	Slightly Hazy		
Specific Gravity <i>Methodology : pKa change</i>	1.015		ratio
Chemical Examination			
Reaction <i>Methodology : Double indicator (Strip)</i>	Alkaline		
Protein <i>Methodology : Protein-error-of-indicators</i>	Absent		
Glucose <i>Methodology : Glucose oxidase (Strip)/ Benedict's Test</i>	Absent		
Ketone Bodies <i>Methodology : Nitroprusside method (Strip)/ Tube</i>	Absent		
Bile Salt <i>Methodology : Hay's Method</i>	Absent		
Bile Pigment <i>Methodology : Diazo Method (Strip)</i>	Absent		
Blood <i>Methodology : Benzidine method (Strip)/ Microscopy</i>	Absent		
Microscopic Examination			
Pus Cells	2-4		/hpf
RBC	Not Seen		/hpf
Epithelial Cells	10-12		/hpf



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Casts	Not Seen		
Crystals	Not Seen		
----- End of Report -----			



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ACCESSION NO DHHI-3/2023-24/0014867

AGE 41 Yrs 4 Mths 10 Dys SEX Female



DESUN

REFERENCE LAB

AN ISO 9001:2000 ORGANISATION

A Unit of Desun Healthcare & Research Institute Ltd.

S-16, Phase-III, K. I. Estate, E. M. Bypass, Kolkata-700 107, India

Phone No. : 033 40016355, 033 46006439

Email : care@desunpathology.com

Website : www.desunpathology.com



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Thyroid Profile - 1 (T3, T4, TSH)			
Triiodothyronine (T3) Specimen : Serum Methodology : Electrochemiluminescence	1.47	0.80 - 2.00	ng/mL
Thyroxine (T4) Specimen : Serum Methodology : Electrochemiluminescence	10.55	5.10 - 14.10	µg/dL
Thyroid Stimulating Hormone (TSH) Specimen : Serum Methodology : Electrochemiluminescence	* 5.67	Non-Pregnant : 0.27 - 4.20 Pregnant 1st Trimester : 0.10 - 2.5 2nd Trimester : 0.20 - 3.0 3rd Trimester : 0.30 - 3.0	µIU/mL
* CLINICAL CORRELATION REQUESTED.			
----- End of Report -----			

Dr. Jayati Gupta
Ph.D (Bio.Chem)
Senior Consultant Biochemist

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CARDIOLOGY

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SEX : F

ELECTROCARDIOGRAM REPORT - NO.393



Dr. IMRAN AHMED KHAN

Reg No: 64336, MBBS
Dept. of Cardiac Science

Prepared By : Sutapa Checked By : Sumita Bar

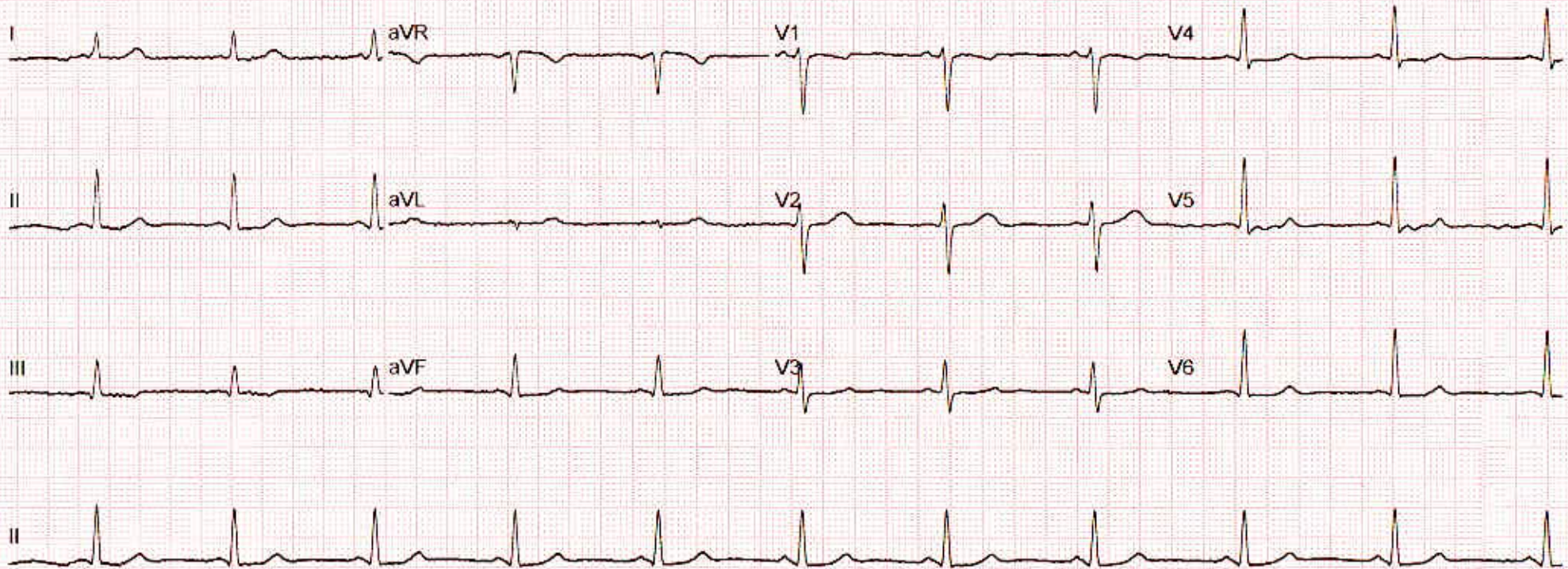
I A K

Female

QRS : 80 ms
QT / QTcBaz : 400 / 412 ms
PR : 106 ms
P : 96 ms
RR / PP : 932 / 937 ms
P / QRS / T : 54 / 55 / 26 degrees

Sinus rhythm with short PR
Nonspecific ST and T wave abnormality
Abnormal ECG

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:



PATIENT NAME & ADDRESS

CARDIOLOGY

MRS. SUSHMITA ROY
SUGAM SUDHIR, GH BLOCK- 4 . 24pg(S)-24 Parganas (South)
West Bengal, India , 700103

DESUN
HOSPITAL
A NABH HOSPITAL

Desun More, E.M. Bypass, Kasta Golpark, Kolkata-700 107, Ph: 71 222 000, Fax : 2443 9003.
E-mail : desun@desunhospital.com, Website : www.desunhospital.com
(A unit of P. N. Memorial Neurocentre & Research Institute Ltd.)

PROCEDURE DONE ON	: 27.01.2024	REPORTED	: 27.01.2024
OPD / IPD DOC NO	: SD01/OPD/BILL/2023-24/OP40483746	PATIENT CODE	: SD01/PAT/1000157916
REFERRING DOCTOR	:	AGE	: 41 Yrs 4 Mths 10 Dys
ACCESSION NO	: R/DHHI-1/2023-24/0009862	SEX	: F

ECHO CARDIOGRAPHY REPORT**ECHO NO : 400****SUMMARY**

- >> Normal LV cavity size.
- >> No Regional wall motion abnormality.
- >> Good LV systolic function. LVEF = 65 %.
- >> Great arteries normal in size and relation.
- >> Interatrial and interventricular septum intact.
- >> Systemic and pulmonary venous drainage normal.
- >> No PE.

FINAL IMPRESSION

- >> No Regional wall motion abnormality.
- >> Good LV systolic function.

Please Correlate Clinically.


Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esai

SKP

PATIENT NAME & ADDRESS

CARDIOLOGY

MRS. SUSHMITA ROY
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M - mode Measurements Valves :-

Aorta - 2.6 cm LV ed - 4.1 cm
LA - 3.0 cm LV es - 2.4 cm
ACS - cm IVS ed - 1.0 cm
RV ed - cm PW (LV) - 1.0 cm
FS - % LVEF - 65 %

CHAMBERS:-

Left Ventricle : Normal in size. Walls normal in thickness and motion.

Left Atrium : Normal in size.

Right Atrium : Normal in size.

Right Ventricle : Normal in size.

OTHERS :-

Sanjib Kumar Patra

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esai

S K P

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GREAT ARTERIES : Normal in size and relation.

PERICARDIUM : Normal

VALVES :-

MITRAL VALVE

Morphology : Normal
Doppler : Normal

TRICUSPID VALVE

Morphology : Normal
Doppler : Normal

AORTIC VALVE

Morphology : Normal
Doppler : Normal

PULMONARY VALVE

Morphology : Normal
Doppler : Normal

Sanjib Kumar Patra

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esal

SKP

PATIENT NAME & ADDRESS

RADIOLOGY

MRS. SUSHMITA ROYSUGAM SUDHIR, GH BLOCK- 4 , 24pg(S)-24 Parganas (South)
West Bengal, India , 700103


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PROCEDURE DONE ON : 27.01.2024
OPD / IPD DOC NO : SD01/OPD/BILL/2023-24/OP40483746
REFERRING DOCTOR :
ACCESSION NO : R/DHHI-1/2023-24/0009939

REPORTED : 29.01.2024
PATIENT CODE : SD01/PAT/1000157916
AGE : 41 Yrs 4 Mths 12 Dys
SEX : F

(US-10570) USG OF WHOLE ABDOMEN

LIVER

Shows normal homogeneous echotexture. Intrahepatic biliary ducts and hepatic vein tributaries are not dilated. Echogenic lesion seen in segment VII measuring 1.3x1.0 cm suggestive of hemangioma.

GALL BLADDER

Physiologically distended. Wall thickness is normal. No evidence of any intraluminal lesion seen.

C.B.D.

Normal for age. No obvious intraluminal lesion seen in visible parts.

PORTAL VEIN

Normal for age.

PANCREAS

Normal in size, shape and echotexture. No obvious focal lesion or intraparenchymal calcification seen. Main pancreatic duct is not dilated. No peripancreatic fluid collection seen.

SPLEEN

Spleen is normal in size, shape and echotexture. No focal lesion seen. Spleno-portal axis is normal.

KIDNEYS

Both the kidneys are normal in size, shape and axis. Cortical echotexture and cortico-medullary differentiation are normal in both sides. No evidence of any focal lesion seen in either kidneys. No hydronephrosis detected.

URETERS

Pelvi-ureteric junction and vesico-ureteric junctions are normal. No obvious intraluminal lesion seen in visible part.

URINARY BLADDER

Optimally distended, normal in shape and wall thickness. No evidence of any intraluminal lesion seen.

PATIENT NAME & ADDRESS

RADIOLOGY

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AGE : 41 Yrs 4 Mths 12 Dys
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UTERUS

Anteverted and anteflexed. Endometrial thickness is normal. Hypoechoic lesion measuring $\cong 3.6 \times 4.0$ cm seen in the posterior wall possibility fibroid.

OVARIES

Normal in size, shape and echopattern. Hemorrhagic cyst seen in left ovary measuring 3.3×2.9 cm
Pouch of Douglas - Clear.

RETROPERITONEUM

No obvious sonological evidence of any retroperitoneal mass lesion or lymphadenopathy seen in visible part. Aorta and I.V.C. appear normal.

PERITONEUM

No free fluid seen in the peritoneal cavity. Mesenteric echogenicity appears normal.

LOWER PLEURAL SPACES


No free fluid seen.

R.I.F.

No obvious mass lesion / localised collection seen.

IMPRESSION:

- * Hemangioma in segment VII of liver.
- * Hypoechoic mass in posterior wall of uterus suggestive of likely fibroid.
- Suggested TVS correlation



Dr. DINESH JAIN
WBMC-70597
MD, DNB (Radiology), EDIR, FRCR

Prepared By : Buddha Checked By : D J

D J

PATIENT NAME & ADDRESS

RADIOLOGY

MRS. SUSHMITA ROY
SUGAM SUDHIR, GH BLOCK- 4 , 24pg(S)-24 Parganas (South)
West Bengal,India , 700103

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ACCESSION NO	: R/DHHI-1/2023-24/0009939	SEX	: F

(US-10570) ULTRASONOGRAPHY THIS EXAMINATION OF BOTH BREASTS

Breast architecture appear normal.

No obvious SOL (solid / cystic) is noted in either breast.

No obvious calcification is noted.

Ducts are not dilated.

Skin thickness appear normal.

Retromammary fat planes are maintained.

No obvious lesion is noted in the subareolar area.

No sizable axillary lymph node is demonstrated.

Impression:

Ultrasonography study of the breasts do not reveal any obvious abnormality.

- Clinical correlation is suggested.

Dinesh Jain

Dr. DINESH JAIN
WBMC-70597
MD, DNB (Radiology), EDIR, FRCR

Prepared By : Buddha Checked By : DJ

DJ

Patient Name :	SUSHMITA ROY 41Y OPD	Patient ID :	17121
Modality :	CR	Sex :	F
Age :	41Y	Study :	CXR PA
Reff. Dr. :		Study Date :	27-01-2024

PA view of the chest

The view is rotated.

Lung parenchyma does not show any definite pathology.

Both costophrenic angles are clear.

Cardiac size is normal.

Impression:

No significant abnormality is seen in the view obtained. Clinical correlation is necessary.



Dr. Ajay Aggarwal
M.B.B.S, M.D. (RADIO-DIAGNOSIS)
Reg. No: 6800
Date 28-01-2024 Time 07-33-46



Disclaimer: - It is an online interpretation of medical imaging based on clinical data. All modern machines/ procedures have their own limitation. If there is any clinical discrepancy, this investigation may be repeated or reassessed by other tests. Patient's identification in online reporting is not established, so in no way can this report be utilized for any medico legal purpose.

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Name : Mrs. Sushmita Roy

Date : 27.01.24

U / Doctor : Dr. Anish Chakraborty

Age : 41y Sex : F

Doctor's Prescription

Rx

$\frac{0/3}{}$,
Grossly decayed $\frac{618}{707}$

Adv extraction of $\frac{618}{707}$.

Adv ROPAR $\frac{61}{}$, $\frac{18}{}$, $\frac{7}{}$, $\frac{7}{}$.
and OPG.

Anish Chakraborty
27/1/24

DR. ANISH CHAKRABORTY
(BDS)
DENTISTRY
REGN. NO. 6648 A
DESUN HOSPITAL





Name : Mrs. Sushmita Roy
U / Doctor : Dr. Sreemanti Bag

Date : 27.01.24
Age : 41y Sex : F

Doctor's Prescription

prominent eye swelling
over dorsum of nose
involves both
↓
on medication prescribed by ophthalmic physician
↓
was diagnosed as acute rhino-sinusitis complicated with subacute co-among dacryocystitis
Now on Flarep nasal spray

Rx

NOH/Obstrua

Also eye tearing & itching on Right eye
off! -
B/L TM defect
mild anterior uveitis
B/L EAC - clear
Tend. - No post. abscess
H.T. - 110/70 mmHg
Wt. - 55 kg
B/L hearing normal



- Advice
- Xray PNS (ON view)
 - PTA + hyperbaric
 - Cont. Flarep nasal spray (or advised by physician)
 - SOLSPARE nasal spray 2 puffs 7AS in each nasal cavity X 4 weeks
 - Tab ALLEGRA 100mg 1 Tab BID X 2 weeks
 - NASOCLEAR nasal spray apply locally B/L nasal cavity X 2 weeks.
 - Tab BROCLEARY 1 Tab BID X 5 days
 - Mirex 2 reports

Dr. Sreemanti Bag
MBBS, MS
Reg. No. - 73883 WBMC
Department of ENT
Desun Hospital

27.01.

DNS(U)
Mx JH (R)



NAME - Mrs. SUSHMITA ROY

AGE - 41 Yrs , F

DATE - 27.01.24

C/O - ~~distressing~~ Bleeding in RSE sometimes.

VA { C/C
S/G.
NVA { NG
NG

Rx - Teceplus. (3 drops/day x 1 month)
4 times/day



Dr. Soumyadeep Majumder

MBBS MS
Reg. No. 60358 WBMC
Department of Ophthalmology

DESUN HOSPITAL

(A unit of P N Memorial Neurocentre & Research Institute Ltd.)
CIN - U85110WB2000PLC091118

Regd. Add. : - 8/1A/1 Keyatala Road, Kolkata - 700 029

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Phone No. : 033 40016355, 033 48006439
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BED NO : OPD

DRAWN : 27-01-2024
14:40 Hrs.

RECEIVED : 27-01-2024
16:39 Hrs.

REPORTED : 29-01-2024
19:16 Hrs.

PATIENT CODE 157916

OPD/IPD DOC NO OP40483746



2331167840

REFERRING DOCTOR

ACCESSION NO DHHI-3/2023-24/0014899

AGE 41 Yrs 4 Mths 10 Dys SEX Female

Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
PAP Stain for Malignant Cell [Cervical PAP]			
Cytology No.	C-87/2024		
Specimen	Cervical cytology (PAP stain).		
Microscopic Examination	Smears are satisfactory with endocervical cells. There is superficial, intermediate squamous cells, few basal & parabasal cells. There is moderate mixed inflammation & reactive changes are also noted. There is no anisonucleosis, LSIL, HSIL, dysplasia or malignancy seen.		
Diagnosis	CERVICAL PAP SMEAR SHOW INFLAMMATION & IS NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY. (BETHESDA 2014)		
NOTE :	Enclosed: Two slides.(C-87/2024)		
	----- End of Report -----		

30012024102214

Dr. Keya Mukhopadhyay
DCP, DNB(Path)
Consultant Pathologist

Dr. Prof. Tanushri Mukherjee
MBBS, MD, DNB, MNAMS, DipFRCI
Senior Consultant Pathologist

Any investigation has limited significance in terms of sensitivity and specificity of the assay procedure and the quality of the sample received in the laboratory.
Any laboratory test results is not the final diagnosis. It has to be interpreted with clinical correlation and other related investigations.