

BMI CHART

Hiranandani Fortis Hospital  
Mini Seeshore Road,  
Sector 10 - A, Vashi,  
Navi Mumbai - 400 703.  
Tel.: +91-22-3919 9222  
Fax: +91-22-3919 9220/21  
Email: vashi@vashihospital.com

Name: Rajini Kumar Age: 44 yrs Sex: M/F  
 BP: 110/70 mmHg Height (cms): 165 cm Weight(kgs): 87 kg  
 SPO<sub>2</sub>: 95 pulse: 85  
 Date: 26/1/20

WEIGHT lbs 100 105 100 115 120 125 130 135 140 145 150 155 160 165 170 175 180 185 190 195 200 205 210 215  
 kgs 45.5 47.7 50.50 52.3 54.5 56.8 59.1 61.4 63.6 65.9 68.2 70.5 72.7 75.0 77.3 79.5 81.8 84.1 86.4 88.6 90.9 93.2 95.5 97.7

<input type="checkbox"/>	Underweight	<input type="checkbox"/>	Healthy	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	Obese	<input type="checkbox"/>	Extremely Obese					
HEIGHT in/cm	150	155	160	165	170	175	180	185	190	195	200	205	210	215
HEIGHT in/cm	145	150	155	160	165	170	175	180	185	190	195	200	205	210
HEIGHT in/cm	140	145	150	155	160	165	170	175	180	185	190	195	200	205
HEIGHT in/cm	135	140	145	150	155	160	165	170	175	180	185	190	195	200
HEIGHT in/cm	130	135	140	145	150	155	160	165	170	175	180	185	190	195
HEIGHT in/cm	125	130	135	140	145	150	155	160	165	170	175	180	185	190
HEIGHT in/cm	120	125	130	135	140	145	150	155	160	165	170	175	180	185
HEIGHT in/cm	115	120	125	130	135	140	145	150	155	160	165	170	175	180
HEIGHT in/cm	110	115	120	125	130	135	140	145	150	155	160	165	170	175
HEIGHT in/cm	105	110	115	120	125	130	135	140	145	150	155	160	165	170
HEIGHT in/cm	100	105	110	115	120	125	130	135	140	145	150	155	160	165
HEIGHT in/cm	95	100	105	110	115	120	125	130	135	140	145	150	155	160
HEIGHT in/cm	90	95	100	105	110	115	120	125	130	135	140	145	150	155
HEIGHT in/cm	85	90	95	100	105	110	115	120	125	130	135	140	145	150
HEIGHT in/cm	80	85	90	95	100	105	110	115	120	125	130	135	140	145
HEIGHT in/cm	75	80	85	90	95	100	105	110	115	120	125	130	135	140
HEIGHT in/cm	70	75	80	85	90	95	100	105	110	115	120	125	130	135
HEIGHT in/cm	65	70	75	80	85	90	95	100	105	110	115	120	125	130
HEIGHT in/cm	60	65	70	75	80	85	90	95	100	105	110	115	120	125
HEIGHT in/cm	55	60	65	70	75	80	85	90	95	100	105	110	115	120
HEIGHT in/cm	50	55	60	65	70	75	80	85	90	95	100	105	110	115
HEIGHT in/cm	45	50	55	60	65	70	75	80	85	90	95	100	105	110
HEIGHT in/cm	40	45	50	55	60	65	70	75	80	85	90	95	100	105
HEIGHT in/cm	35	40	45	50	55	60	65	70	75	80	85	90	95	100
HEIGHT in/cm	30	35	40	45	50	55	60	65	70	75	80	85	90	95
HEIGHT in/cm	25	30	35	40	45	50	55	60	65	70	75	80	85	90
HEIGHT in/cm	20	25	30	35	40	45	50	55	60	65	70	75	80	85
HEIGHT in/cm	15	20	25	30	35	40	45	50	55	60	65	70	75	80
HEIGHT in/cm	10	15	20	25	30	35	40	45	50	55	60	65	70	75
HEIGHT in/cm	5	10	15	20	25	30	35	40	45	50	55	60	65	70
HEIGHT in/cm	0	5	10	15	20	25	30	35	40	45	50	55	60	65

Doctors Notes:

Signature



UHID	13112556	Date	26/04/2024		
Name	Mrs Ragini Kumari	Sex	F	Age	44
OPD	Opthal	Health Check Up			

Chz NVA (Bluy)

Drug allergy: → No  
 Sys illness: → No  
 Habit: → No

Hb → No

Unif → re 6/6p  
 → G 6/9p (Bluy)

Ref → RG +0.50 / -0.75 X 90° 6/6.  
 → G +0.50 / -1.00 X 90° 6/6.

Add → +1.50 → WC  
 → WC.

JOP → R → 15.5  
 → G → 15.7



UHID	13112556	Date	26/04/2024	
Name	Mrs Ragini Kumari	Sex	F	Age 44
OPD	PAP	Health Check Up		

S13 Dr. Shefali / Dr. Sonamm. → No  
 Drug allergy: → No.  
 Sys illness: → No.  
 44/F P14 o prev LSCS.

H/o Clo Heavy menstrual bleeding ∴ 4 yrs  
 H/o Mirena insertion done June 2023  
 Clo Spotting pv ∴ Since then for month.

H/o T. Norelon took 1 month ago → no  
 Spotting pv for 21 days → later again spotting pv

No Comorbidities.

Pap Smear done 1 yr ago → (n)

Mother }  
 father } ATN

PS → CA/UP → (H)  
 IUD thread seen  
 Brownish discharge ⊕

Adv  
 - USG AHP  
 - Pap Smear taken

Pv → ut & wle size  
 Rv  
 b/a fornice free

- fw e reports  
 - So PSH, Prolactin

Hiranandani Healthcare Pvt. Ltd.  
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703  
Board Line: 022 - 39199222 | Fax: 022 - 39199220  
Emergency: 022 - 39199100 | Ambulance: 1255  
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300  
www.fortishealthcare.com |  
CIN : U85100MH2005PTC154823  
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani  
HOSPITAL  
(A Fortis Network Hospital)

UHID	13112556	Date	26/04/2024		
Name	Mrs Ragini Kumari	Sex	F	Age	44
OPD	Dental	Health Check Up			

O/E - Stains +  
Calculus +

Drug allergy:  
Sys illness:

Treatment

A/d - Scaling Grade I

Dr. Trupti

**PATIENT NAME : MRS.RAGINI KUMARI**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**  
FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL - VASHI,  
MUMBAI 440001

**ACCESSION NO : 0022XD004712**  
**PATIENT ID : FH.13112556**  
**CLIENT PATIENT ID: UID:13112556**  
**ABHA NO :**

**AGE/SEX : 44 Years Female**  
**DRAWN : 26/04/2024 10:06:00**  
**RECEIVED : 26/04/2024 10:07:00**  
**REPORTED : 26/04/2024 14:17:31**

**CLINICAL INFORMATION :**

UID:13112556 REQNO-1696121  
CORP-OPD  
BILLNO-150124OPCR022835  
BILLNO-150124OPCR022835

Test Report Status	Final	Results	Biological Reference Interval	Units
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**HAEMATOLOGY - CBC**

**CBC-5, EDTA WHOLE BLOOD**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB) METHOD : SLS METHOD	<b>11.4 Low</b>	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	3.93	3.8 - 4.8	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	7.75	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	<b>124 Low</b>	150 - 410	thou/ $\mu$ L

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	36.5	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	92.9	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	29.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	<b>31.2 Low</b>	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	<b>14.6 High</b>	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	23.6		

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	71	40.0 - 80.0	%
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**Dr. Akshay Dhotre, MD**  
(Reg.no. MMC 2019/09/6377)  
Consultant Pathologist

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Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,  
Navi Mumbai, 400703  
Maharashtra, India  
Tel : 022-39199222, 022-49723322, Fax :  
CIN - U74899PB1995PLC045956  
Email : -



ULR No.22000000917253-0022

PATIENT NAME : MRS.RAGINI KUMARI

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LYMPHOCYTES		21	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		6	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		2	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		5.50	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.63	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.47	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.16	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		3.4		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

WBC

METHOD : MICROSCOPIC EXAMINATION

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

MILD HYPOCHROMASIA, MILD ANISOCYTOSIS

NORMAL MORPHOLOGY

SLIGHTLY REDUCED ON SMEAR, FEW MACROPLATELETS SEEN  
 PLATELETS SEEN ON SMEAR ~ 1,20,000 TO 1,30,000 / microliter

Dr. Akshay Dhotre, MD  
 (Reg.no. MMC 2019/09/6377)  
 Consultant Pathologist



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## Interpretation(s)

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504  
This ratio element is a calculated parameter and out of NABL scope.



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## HAEMATOLOGY

## ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	29 High	0 - 20	mm at 1 hr
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METHOD : WESTERGREEN METHOD

## GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.7	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	88.2	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

## Interpretation(s)

## ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

## TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue Injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemia, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

## LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Polikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)



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## REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition. GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
  - Diagnosing diabetes.
  - Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
  - eAG gives an evaluation of blood glucose levels for the last couple of months.
  - eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

## HbA1c Estimation can get affected due to :

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in

- Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
- Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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## IMMUNOHAEMATOLOGY

## ABO GROUP &amp; RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE O

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

## Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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## BIOCHEMISTRY

## LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.69	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.21 High	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.48	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	8.2	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	4.3 High	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	0.9 Low	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	22	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	40 High	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	71	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	23	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	158	81 - 234	U/L

## GLUCOSE FASTING, FLUORIDE PLASMA



Dr. Akshay Dhotre, MD  
(Reg.no. MMC 2019/09/6377)  
Consultant Pathologist

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Email : -



ULR No. 2200000917253-0022

**PATIENT NAME : MRS.RAGINI KUMARI**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL - VASHI,  
 MUMBAI 440001

**ACCESSION NO: 0022XD004712**  
**PATIENT ID. : FH.13112556**  
**CLIENT PATIENT ID: UID:13112556**  
**ABHA NO :**

**AGE/SEX :44 Years Female**  
**DRAWN :26/04/2024 10:06:00**  
**RECEIVED :26/04/2024 10:07:00**  
**REPORTED :26/04/2024 14:17:31**

**CLINICAL INFORMATION :**

UID:13112556 REQNO-1696121  
 CORP-OPD  
 BILLNO-150124OPCR022835  
 BILLNO-150124OPCR022835

Test Report Status	Final	Results	Biological Reference Interval	Units
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<b>FBS (FASTING BLOOD SUGAR)</b>	88	(Normal <100, Impaired fasting glucose:100 to 125, Diabetes mellitus: >=126 (on more than 1 occasion) (ADA guidelines 2024))		
----------------------------------	----	--	--	--

METHOD : HEXOKINASE

**KIDNEY PANEL - 1**

**BLOOD UREA NITROGEN (BUN), SERUM**

<b>BLOOD UREA NITROGEN</b>	7	6 - 20		mg/dL
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METHOD : UREASE - UV

**CREATININE EGFR- EPI**

<b>CREATININE</b>	0.67	0.60 - 1.10		mg/dL
<b>AGE</b>	44			years
<b>GLOMERULAR FILTRATION RATE (FEMALE)</b>	110.46	Refer Interpretation Below		mL/min/1.73m <sup>2</sup>

METHOD : CALCULATED PARAMETER

**BUN/CREAT RATIO**

<b>BUN/CREAT RATIO</b>	10.45	5.00 - 15.00		
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METHOD : CALCULATED PARAMETER

**URIC ACID, SERUM**

<b>URIC ACID</b>	2.6	2.6 - 6.0		mg/dL
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METHOD : URICASE UV

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**TOTAL PROTEIN, SERUM**

**TOTAL PROTEIN** 8.2 6.4 - 8.2 g/dL  
 METHOD : BIURET

**ALBUMIN, SERUM**

**ALBUMIN** 3.9 3.4 - 5.0 g/dL  
 METHOD : BCP DYE BINDING

**GLOBULIN**

**GLOBULIN** 4.3 High 2.0 - 4.1 g/dL  
 METHOD : CALCULATED PARAMETER

**ELECTROLYTES (NA/K/CL), SERUM**

**SODIUM, SERUM** 141 136 - 145 mmol/L  
 METHOD : ISE INDIRECT  
**POTASSIUM, SERUM** 3.84 3.50 - 5.10 mmol/L  
 METHOD : ISE INDIRECT  
**CHLORIDE, SERUM** 106 98 - 107 mmol/L  
 METHOD : ISE INDIRECT

**Interpretation(s)**

**Dr. Akshay Dhotre, MD**  
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**Interpretation(s)**

**LIVER FUNCTION PROFILE, SERUM-**

**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result 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 elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease 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, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

**AST** is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic 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 attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

**ALP** is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons disease.

**GGT** is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. 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-inducing drugs etc.

**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, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

**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

**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in:** Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs-insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

**BLOOD UREA NITROGEN (BUN), SERUM-** Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

**Causes of decreased level include** Liver disease, SIADH.

**CREATININE EGFR- EPI--** Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

**Dr. Akshay Dhotre, MD**  
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ULR No.22000000917253-0022

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<b>CODE/NAME &amp; ADDRESS : C000045507</b>		<b>ACCESSION NO : 0022XD004712</b>	<b>AGE/SEX : 44 Years Female</b>
FORTIS VASHI-CHC -SPLZD		<b>PATIENT ID : FH.13112556</b>	<b>DRAWN : 26/04/2024 10:06:00</b>
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**References:**

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).  
 Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.uw.edu/guideline/egfr>  
 Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. *Kidney Med* 2022, 4:100471. 35756325  
 Harrison's Principle of Internal Medicine, 21st ed. pg 62 and 334  
 URIC ACID, SERUM-Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis  
 TOTAL PROTEIN, SERUM-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,Waldenstroms disease.  
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.  
 ALBUMIN, SERUM-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.

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**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	193	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	88	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	42	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	130	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	151 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	17.6	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.6 High	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO

3.1 High

0.5 - 3.0 Desirable/Low Risk  
3.1 - 6.0 Borderline/Moderate Risk  
>6.0 High Risk

METHOD : CALCULATED PARAMETER

Interpretation(s)

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**CLINICAL PATH - URINALYSIS**

**KIDNEY PANEL - 1**

**PHYSICAL EXAMINATION, URINE**

<b>COLOR</b>	<b>PALE YELLOW</b>
METHOD : PHYSICAL	
<b>APPEARANCE</b>	<b>SLIGHTLY HAZY</b>
METHOD : VISUAL	

**CHEMICAL EXAMINATION, URINE**

<b>PH</b>	<b>6.5</b>	<b>4.7 - 7.5</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
<b>SPECIFIC GRAVITY</b>	<b>1.015</b>	<b>1.003 - 1.035</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
<b>PROTEIN</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
<b>GLUCOSE</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD		
<b>KETONES</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
<b>BLOOD</b>	<b>DETECTED (++) IN URINE</b>	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
<b>BILIRUBIN</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
<b>UROBILINOGEN</b>	<b>NORMAL</b>	<b>NORMAL</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		
<b>NITRITE</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
<b>LEUKOCYTE ESTERASE</b>	<b>NOT DETECTED</b>	<b>NOT DETECTED</b>
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

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**Dr. Rekha Nair, MD**  
 (Reg No. MMC 2001/06/2354)  
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**MICROSCOPIC EXAMINATION, URINE**

RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	8 - 10	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	2-3	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	8-10	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

**Interpretation(s)**

**Dr. Akshay Dhotre, MD**  
 (Reg.no. MMC 2019/09/6377)  
 Consultant Pathologist

**Dr. Rekha Nair, MD**  
 (Reg No. MMC 2001/06/2354)  
 Microbiologist



View Details



View Report

**PERFORMED AT :**

**Agilus Diagnostics Ltd**  
 Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,  
 Navi Mumbai, 400703  
 Maharashtra, India  
 Tel : 022-39199222,022-49723322, Fax :  
 CIN - U74899PB1995PLC045956  
 Email : -



ULR No.22000000917253-0022

**PATIENT NAME : MRS.RAGINI KUMARI**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL - VASHI,  
 MUMBAI 440001

**ACCESSION NO : 0022XD004712**  
**PATIENT ID. : FH.13112556**  
**CLIENT PATIENT ID: UID:13112556**  
**ABHA NO :**

**AGE/SEX : 44 Years Female**  
**DRAWN : 26/04/2024 10:06:00**  
**RECEIVED : 26/04/2024 10:07:00**  
**REPORTED : 26/04/2024 14:17:31**

**CLINICAL INFORMATION :**

UID:13112556 REQNO-1696121  
 CORP-OPD  
 BILLNO-150124OPCR022835  
 BILLNO-150124OPCR022835

Test Report Status	Final	Results	Biological Reference Interval	Units
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**SPECIALISED CHEMISTRY - HORMONE**

**THYROID PANEL, SERUM**

**T3** 143.5 Non-Pregnant Women ng/dL  
 80.0 - 200.0  
 Pregnant Women  
 1st Trimester: 105.0 - 230.0  
 2nd Trimester: 129.0 - 262.0  
 3rd Trimester: 135.0 - 262.0

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

**T4** 10.20 Non-Pregnant Women µg/dL  
 5.10 - 14.10  
 Pregnant Women  
 1st Trimester: 7.33 - 14.80  
 2nd Trimester: 7.93 - 16.10  
 3rd Trimester: 6.95 - 15.70

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

**TSH (ULTRASENSITIVE)** 2.380 Non Pregnant Women µIU/mL  
 0.27 - 4.20  
 Pregnant Women (As per American Thyroid Association)  
 1st Trimester 0.100 - 2.500  
 2nd Trimester 0.200 - 3.000  
 3rd Trimester 0.300 - 3.000

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

**Interpretation(s)**

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

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

**Dr. Akshay Dhotre, MD**  
 (Reg.no. MMC 2019/09/6377)  
 Consultant Pathologist



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**PERFORMED AT :**

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 CIN - U74899PB1995PLC045956  
 Email : -



ULR No.22000000917253-0022



PATIENT NAME : MRS.RAGINI KUMARI

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507  
FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL - VASHI,  
MUMBAI 440001

ACCESSION NO : 0022XD004747  
PATIENT ID : FH.13112556  
CLIENT PATIENT ID: UID:13112556  
ABHA NO :

AGE/SEX :44 Years Female  
DRAWN :26/04/2024 12:34:00  
RECEIVED :26/04/2024 12:34:44  
REPORTED :26/04/2024 14:37:09

CLINICAL INFORMATION :

UID:13112556 REQNO-1696121  
CORP-OPD  
BILLNO-150124OPCR022835  
BILLNO-150124OPCR022835

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	93	70 - 140	mg/dL
METHOD : HEXOKINASE			

Interpretation(s)  
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Allimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

**\*\*End Of Report\*\***  
Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

Dr. Akshay Dhotre, MD  
(Reg.no. MMC 2019/09/6377)  
Consultant Pathologist



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PERFORMED AT :  
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Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,  
Navi Mumbai, 400703  
Maharashtra, India  
Tel : 022-39199222,022-49723322, Fax :  
CIN - U74899PB1995PLC045956  
Email : -



ULR No.22000000917288-0022

PATIENT NAME : MRS.RAGINI KUMARI

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000018055

ACCESSION NO : 0022XD004751

AGE/SEX : 44 Years Female

HIRANANDANI HOSPITAL - VASHI -  
SECTOR 10, A, VASHI, SECTOR 10, MINI SEA  
SHORE ROAD, SECTOR 10, A, VASHI,  
NAVI MUMBAI 400703  
022 39199222

PATIENT ID : FH.13112556

DRAWN : 26/04/2024 12:46:00

CLIENT PATIENT ID: UID:13112556

RECEIVED : 26/04/2024 12:53:36

ABHA NO :

REPORTED : 26/04/2024 17:38:18

## CLINICAL INFORMATION :

UID:13112556 REQNO-7048197  
OPD-OPD  
BILLNO-150124OPCS022930  
BILLNO-150124OPCS022930

Test Report Status	Final	Results	Biological Reference Interval	Units
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## SPECIALISED CHEMISTRY - HORMONE

PROLACTIN, SERUM

PROLACTIN	13.03	Women(Non-Pregnant) 4.79 ng/mL 23.3
-----------	-------	--

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

## Interpretation(s)

FOLLICLE STIMULATING HORMONE (FSH), SERUM.

FOLLICLE STIMULATING HORMONE(FSH)	14.11	Follicular phase: 3.5 - 12.5 mIU/mL Ovulation phase: 4.7- 21.5 Luteal phase: 1.7 - 7.7 Postmenopause: 25.8 - 134.8
-----------------------------------	-------	---

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

## Interpretation(s)

FOLLICLE STIMULATING HORMONE (FSH),SERUM-Test description:-FSH is a glycoprotein produced by anterior pituitary gland. FSH stimulates follicular growth, prepares ovarian follicles for the action of LH & enhances LH induced release of estrogens. In males FSH stimulates seminiferous tubules & testicular growth & is involved in the early stage of spermatogenesis.

## HIGH LEVELS are seen in:

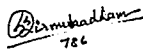
- 1.Primary hypogonadism including primary testicular failure.
- 2.Gonadotrophin secreting pituitary tumors.
- 3.Menopause.

## LOW LEVELS are seen in :

- 1.Hypothalamic gonadotrophin releasing hormone deficiency.
- 2.Pituitary FSH deficiency.
- 3.Ectopic steroid hormone production.

Thus FSH is used in the diagnosis of gonadal function disorders.and in gynecology to check for cause of irregular periods.

\*\*End Of Report\*\*

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

  
786
Dr. Swapnil Sirmukaddam  
Consultant Pathologist

Dr. Rashmi Shrivastava  
Consultant Pathologist

Page 1 Of 1



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## PERFORMED AT :

Agilus Diagnostics Ltd  
Bhoomi Tower, 1st Floor, Hall No.1, Plot No.28 Sector 4, Kharghar  
Navi Mumbai, 410210  
Maharashtra, India  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956

ULR No.22000000917292-0040

<b>PATIENT NAME : MRS.RAGINI KUMARI</b>		<b>REF. DOCTOR :</b>	
<b>CODE/NAME &amp; ADDRESS : C000045507</b>	<b>ACCESSION NO : 0022XD004768</b>	<b>AGE/SEX : 44 Years Female</b>	
FORTIS VASHI-CHC -SPLZD	<b>PATIENT ID : FH.13112556</b>	<b>DRAWN : 26/04/2024 14:33:00</b>	
FORTIS HOSPITAL - VASHI,	<b>CLIENT PATIENT ID: UID:13112556</b>	<b>RECEIVED : 26/04/2024 14:33:43</b>	
MUMBAI 440001	<b>ABHA NO :</b>	<b>REPORTED : 29/04/2024 10:33:28</b>	

**CLINICAL INFORMATION :**

UID:13112556 REQNO-1696121  
 CORP-OPD  
 BILLNO-150124OPCR022835  
 BILLNO-150124OPCR022835

<b>Test Report Status</b> <b>Final</b>	<b>Units</b>
--	--------------

**CYTOLOGY**

**PAPANICOLAOU SMEAR**

**PAPANICOLAOU SMEAR**

TEST METHOD  
 SPECIMEN TYPE  
 REPORTING SYSTEM  
 SPECIMEN ADEQUACY  
 METHOD : MICROSCOPIC EXAMINATION  
 MICROSCOPY

CONVENTIONAL GYNEC CYTOLOGY  
 TWO UNSTAINED CERVICAL SMEARS RECEIVED  
 2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY  
 SATISFACTORY

SMEARS STUDIED SHOW SUPERFICIAL SQUAMOUS CELLS,  
 INTERMEDIATE SQUAMOUS CELLS IN THE BACKGROUND OF MODERATE  
 POLYMORPHS AND RBCS.  
 ENDOCERVICAL CELLS ARE NOT SEEN.  
 NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

INTERPRETATION / RESULT

**Comments**

PLEASE NOTE PAPANICOLAOU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL  
 CANCER WITH INHERENT FALSE NEGATIVE RESULTS, HENCE SHOULD BE INTERPRETED  
 WITH CAUTION.

NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

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

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

**Dr. Akshay Dhotre, MD**  
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 Consultant Pathologist



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 CIN - U74899PB1995PLC045956  
 Email : -



ULR No.22000000917309-0022

13112556

ragini kumari

Female

44 Years

4/26/2024 10:45:10 AM

HC

Rate 87

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

PR 143

Borderline T abnormalities, diffuse leads.....T flat/neg

QRSD 76

QT 333

QTc 401

--AXIS--

P 49

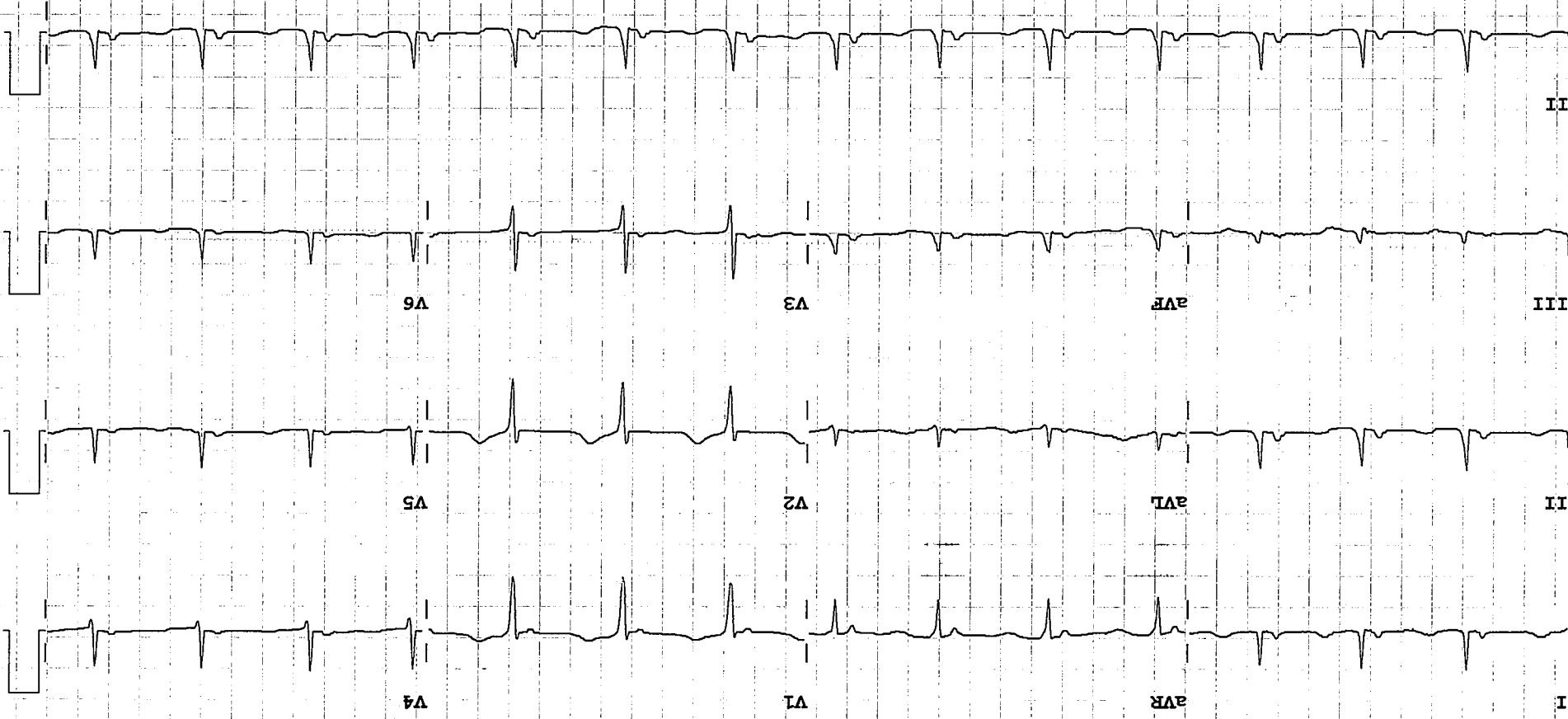
QRS 44

T -5

12 lead; Standard Placement

Unconfirmed Diagnosis

- BORDERLINE ECG -



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV  
 F 50~0.50-100 Hz W 100B CL P3

Normal





DEPARTMENT OF NIC

Date: 26/Apr/2024

Name: Mrs. Ragini Kumari

Age | Sex: 44 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13112556 | 23335/24/1501

Order No | Order Date: 1501/PN/OP/2404/48463 | 26-Apr-2024

Admitted On | Reporting Date : 26-Apr-2024 12:01:11

Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- Normal chambers dimensions.
- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- Trivial aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.  
PASP = 30mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 16 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	27	mm
AO Root	17	mm
AO CUSP SEP	11	mm
LVID (s)	26	mm
LVID (d)	44	mm
IVS (d)	11	mm
LVPW (d)	11	mm
RVID (d)	24	mm
RA	26	mm
LVEF	60	%



DEPARTMENT OF NIC

Date: 26/Apr/2024

Name: Mrs. Ragini Kumari  
Age | Sex: 44 YEAR(S) | Female  
Order Station : FO-OPD  
Bed Name :

UHD | Episode No : 13112556 | 23335/24/1501  
Order No | Order Date: 1501/PN/OP/2404/48463 | 26-Apr-2024  
Admitted On | Reporting Date : 26-Apr-2024 12:01:11  
Order Doctor Name : Dr.SELF .

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.9 m/sec.


A WAVE VELOCITY: 0.6 m/sec

E/A RATIO: 1.3

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	05			Trivial
TRICUSPID VALVE	30			Trivial
PULMONARY VALVE	2.0			Nil

**Final Impression :**

- Normal chambers dimensions.
- No RWMA.
- Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

  
DR. PRASHANT PAWAR  
DNB(MED), DNB (CARD)

DR. AMIT SINGH,  
MD(MED), DM(CARD)

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

Board Line: 022 - 39199222 | Fax: 022 - 39133220

Emergency: 022 - 39199100 | Ambulance: 1255

For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani  
HOSPITAL  
(A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 26/Apr/2024

Name: Mrs. Ragini Kumari

UHD | Episode No : 13112556 | 23335/24/1501

Age | Sex: 44 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2404/48463 | 26-Apr-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 26-Apr-2024 13:02:24

Bed Name :

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. YOGINI SHAH**  
**DMRD., DNB. (Radiologist)**



Patient Name	:	Ragini Kumari	Patient ID	:	13112556
Sex / Age	:	F / 44Y 4M 12D	Accession No.	:	PHC.7991063
Modality	:	US	Scan DateTime	:	26-04-2024 12:04:34
IPID No	:	23335/24/1501	ReportDatetime	:	26-04-2024 12:32:51

**USG – WHOLE ABDOMEN**

**LIVER** is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

**GALL BLADDER** is contracted.

**CBD** appears normal in caliber.

**SPLEEN** is mildly enlarged in size (12.5 cm) and normal in echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 10.9 x 4.6 cm.

Left kidney measures 11.7 x 5.5 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

**UTERUS** is mildly bulky, measuring 9.5 x 5.8 x 5.1 cm.

Endometrium measures 5.8 mm in thickness. IUCD is seen in situ.

Both ovaries are normal.

Right ovary measures 2.0 x 1.1 cm.

Left ovary measures 1.1 x 0.8 cm.

No evidence of ascites.

**Impression:**

- Mild splenomegaly.

**DR. SIDDHESH PURUSHOTTAM**

**MD, DNB (Radiologist)**



DEPARTMENT OF RADIOLOGY

Date: 26/Apr/2024

Name: Mrs. Ragini Kumari

Age | Sex: 44 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13112556 | 23335/24/1501

Order No | Order Date: 1501/PN/OP/2404/48463 | 26-Apr-2024

Admitted On | Reporting Date : 26-Apr-2024 12:17:39

Order Doctor Name : Dr.SELF .

US- BOTH BREAST

**Findings:**

Few simple cysts are seen in left breast, largest measuring 5.3 x 4.8 mm at 12 O' clock position.

Rest of the breast parenchyma appears normal.

No dilated ducts are noted.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

**Impression:**

- Simple cysts in left breast as described.

*Y. Shah*

DR. YOGINI SHAH

DMRD., DNB. (Radiologist)