

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

Patient Name	Mrs. RATNA JHA	Lab No	4030805
UHID	40012944	Collection Date	13/04/2024 9:30AM
Age/Gender	48 Yrs/Female	Receiving Date	13/04/2024 9:40AM
IP/OP Location	O-OPD	Report Date	13/04/2024 2:45PM
Referred By	Dr. EHS CONSULTANT	Report Status	Final
Mobile No.	7597312245		

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Sample: FI. Plasma
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BLOOD GLUCOSE (FASTING)

BLOOD GLUCOSE (FASTING)	122 H	mg/dl	71 - 109
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Method: Hexokinase assay.

Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

BLOOD GLUCOSE (PP)

BLOOD GLUCOSE (PP)	122	mg/dl	Non – Diabetic: - < 140 mg/dl Pre – Diabetic: - 140-199 mg/dl Diabetic: - >=200 mg/dl
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Sample: PLASMA

Method: Hexokinase assay.

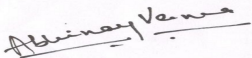
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

THYROID T3 T4 TSH

T3	1.410	ng/mL	0.970 - 1.690
T4	10.00	ug/dl	5.53 - 11.00
TSH	2.35	μIU/mL	0.40 - 4.05

Sample: Serum

RESULT ENTERED BY : NEETU SHARMA



Dr. ABHINAY VERMA

MBBS|MD|INCHARGE PATHOLOGY

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BIOCHEMISTRY

T3:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

T4:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T4 assay employs a competitive test principle with an antibody specifically directed against T4.

TSH - THYROID STIMULATING HORMONE :- ElectroChemiLuminescenceImmunoAssay - ECLIA

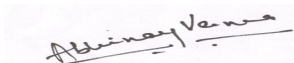
Interpretation:-The determination of TSH serves as the initial test in thyroid diagnostics. Even very slight changes in the concentrations of the free thyroid hormones bring about much greater opposite changes in the TSH levels.

LFT (LIVER FUNCTION TEST)

Sample: Serum

BILIRUBIN TOTAL	0.55	mg/dl	0.00 - 1.20
BILIRUBIN INDIRECT	0.33	mg/dl	0.20 - 1.00
BILIRUBIN DIRECT	0.22	mg/dl	0.00 - 0.30
SGOT	55.0 H	U/L	0.0 - 32.0
SGPT	54.3 H	U/L	0.0 - 33.0
TOTAL PROTEIN	8.1	g/dl	6.6 - 8.7
ALBUMIN	4.9	g/dl	3.5 - 5.2
GLOBULIN	3.2		1.8 - 3.6
ALKALINE PHOSPHATASE	104	U/L	35 - 104
A/G RATIO	1.5	Ratio	1.5 - 2.5
GGTP	32.0	U/L	0.0 - 40.0

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BIOCHEMISTRY

BILIRUBIN TOTAL :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structure.

BILIRUBIN DIRECT :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.

SGOT - AST :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT(AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.

SGPT - ALT :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT(ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.

TOTAL PROTEINS :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.

ALBUMIN :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.

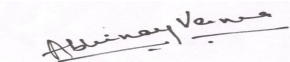
ALKALINE PHOSPHATASE :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method:

Enzymatic colorimetric assay. Interpretation:- γ -glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

LIPID PROFILE

TOTAL CHOLESTEROL	186		<200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High
HDL CHOLESTEROL	42.7		High Risk :-<40 mg/dl (Male), <40 mg/dl (Female) Low Risk :->=60 mg/dl (Male), >=60 mg/dl (Female)
LDL CHOLESTEROL	129.9		Optimal :- <100 mg/dl Near or Above Optimal :- 100-129 mg/dl Borderline :- 130-159 mg/dl High :- 160-189 mg/dl Very High :- >190 mg/dl
CHOLESTERO VLDL	24	mg/dl	10 - 50
TRIGLYCERIDES	121		Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl
CHOLESTEROL/HDL RATIO	4	%	

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BIOCHEMISTRY

CHOLESTEROL TOTAL :- Method: CHOD-PAP enzymatic colorimetric assay. **Interpretation**:-The determination of the individual total cholesterol (TC) level is used for screening purposes while for a better risk assessment it is necessary to measure additionally lipid & lipoprotein metabolic disorders. **HDL CHOLESTEROL** :- Method:-Homogenous enzymatic colorimetric method. **Interpretation**:-HDL-cholesterol has a protective against coronary heart disease, while reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase the cardiovascular disease. **LDL CHOLESTEROL** :- Method: Homogenous enzymatic colorimetric assay. **Interpretation**:-LDL play a key role in causing and influencing the progression of atherosclerosis and in particular coronary sclerosis. The LDL are derived form VLDL rich in TG by the action of various lipolytic enzymes and are synthesized in the liver. **CHOLESTEROL VLDL** :- Method: VLDL Calculative

TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay. **Interpretation**:-High triglyceride levels also occur in various diseases of liver, kidneys and pancreas. DM, nephrosis, liver obstruction. **CHOLESTEROL/HDL RATIO** :- Method: Cholesterol/HDL Ratio Calculative

Sample: Serum

UREA	21.30	mg/dl	16.60 - 48.50
BUN	10	mg/dl	6 - 20
CREATININE	0.75	mg/dl	0.50 - 0.90
SODIUM	136	mmol/L	136 - 145
POTASSIUM	4.42	mmol/L	3.50 - 5.50
CHLORIDE	99.4	mmol/L	98 - 107
URIC ACID	6.4 H	mg/dl	2.4 - 5.7
CALCIUM	9.57	mg/dl	8.60 - 10.00

CREATININE - SERUM :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidneydisease.

URIC ACID :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uricacid are renal diseases with decreased excretion of waste products, starvation,drug abuse and increased alcohol consume.

SODIUM:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea,diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake andkidney reabsorption.

POTASSIUM :- Method: ISE electrode. Intrapretation:-Low level: Intake excessive loss formbodydue to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renalfailure.

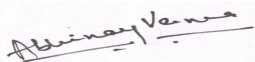
CHLORIDE - SERUM :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake,prolonged vomiting and reduced renal reabsorption as well as forms of acidosisand alkalosis. Increase: dehydration, kidney failure, some form ofacidosis, high dietary or parenteral chloride intake, and salicylate poisoning.

UREA:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogenconcentration are seen in inadequate renal perfusion, shock, diminished bloodvolume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerularnephritis and UTI.

CALCIUM TOTAL :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usuallyassociated with hypercalcemia. Increased serum calcium levels may also beobserved in multiple myeloma and other neoplastic diseases. Hypocalcemia may beobserved in hypoparathyroidism, nephrosis, and pancreatitis.

Sample: WHOLE BLOOD EDTA

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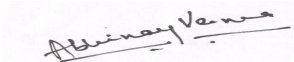
BIOCHEMISTRY

HbA1C	5.2	%			
				< 5.7%	Nondiabetic
				5.7-6.4%	Pre-diabetic
				> 6.4%	Indicate Diabetes

Known Diabetic Patients	
< 7 %	Excellent Control
7 - 8 %	Good Control
> 8 %	Poor Control

Method : - Turbidimetric inhibition immunoassay (TINIA), **Interpretation:-**Monitoring long term glyceimic control, testing every 3 to 4 months is generally sufficient. The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

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BLOOD BANK INVESTIGATION

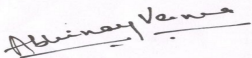
Test Name	Result	Unit	Biological Ref. Range
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BLOOD GROUPING	"B" Rh Positive		
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Note :

1. Both forward and reverse grouping performed.
2. Test conducted on EDTA whole blood.

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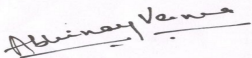
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CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Sample: Urine
<u>URINE SUGAR (POST PRANDIAL)</u>				
URINE SUGAR (POST PRANDIAL)	NEGATIVE		NEGATIVE	Sample: Urine
<u>URINE SUGAR (RANDOM)</u>				
URINE SUGAR (RANDOM)	NEGATIVE		NEGATIVE	Sample: Urine
PHYSICAL EXAMINATION				
VOLUME	20	ml		Sample: Urine
COLOUR	PALE YELLOW		P YELLOW	
APPEARANCE	CLEAR		CLEAR	
CHEMICAL EXAMINATION				
PH	6.0		5.5 - 7.0	
SPECIFIC GRAVITY	1.000		1.016-1.022	
PROTEIN	NEGATIVE		NEGATIVE	
SUGAR	NEGATIVE		NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
BLOOD	NEGATIVE			
KETONES	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
UROBILINOGEN	NEGATIVE		NEGATIVE	
LEUCOCYTE	NEGATIVE		NEGATIVE	
MICROSCOPIC EXAMINATION				
WBCS/HPF	1-2	/hpf	0 - 3	
RBCS/HPF	0-0	/hpf	0 - 2	
EPITHELIAL CELLS/HPF	1-2	/hpf	0 - 1	
CASTS	NIL		NIL	
CRYSTALS	NIL		NIL	

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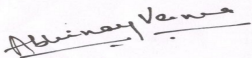
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CLINICAL PATHOLOGY

BACTERIA NIL NIL
OHTERS NIL NIL

Methodology:-Glucose: GOD-POD, Bilirubin: Diazo-Azo-coupling reaction with a diazonium, Ketone: Nitro Pruside reaction, Specific Gravity: Proton release from ions, Blood: Psuedo-Peroxidase activity oh Haem moiety, pH: Methye Red-Bromothymol Blue (Double indicator system), Protein: H+ Release by buffer, microscopic & chemical method.. interpretation: Diagnosis of Kidney function, UTI, Presence of Protein, Glucoses, Blood. Vocubulary syntax: Kit insert

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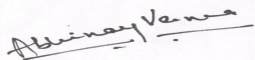
HEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range
<u>CBC (COMPLETE BLOOD COUNT)</u>			
Sample: WHOLE BLOOD EDTA			
HAEMOGLOBIN	11.8 L	g/dl	12.0 - 15.0
PACKED CELL VOLUME(PCV)	40.1	%	36.0 - 46.0
MCV	88.3	fl	82 - 92
MCH	26.0 L	pg	27 - 32
MCHC	29.4 L	g/dl	32 - 36
RBC COUNT	4.54	millions/cu.mm	3.80 - 4.80
TLC (TOTAL WBC COUNT)	5.79	10 ³ / uL	4 - 10
<u>DIFFERENTIAL LEUCOCYTE COUNT</u>			
NEUTROPHILS	67.5	%	40 - 80
LYMPHOCYTE	23.8	%	20 - 40
EOSINOPHILS	1.9	%	1 - 6
BASOPHIL	0.9 L	%	1 - 2
MONOCYTES	5.9	%	2 - 10
PLATELET COUNT	2.22	lakh/cumm	1.500 - 4.500

HAEMOGLOBIN :- Method:-SLS Hemoglobin Methodology by Cell Counter. Interpretation:-Low-Anemia, High-Polycythemia.
MCV :- Method:- Calculation by sysmex.
MCH :- Method:- Calculation by sysmex.
MCHC :- Method:- Calculation by sysmex.
RBC COUNT :- Method:-Hydrodynamic focusing. Interpretation:-Low-Anemia, High-Polycythemia.
TLC (TOTAL WBC COUNT) :- Method:-Optical Detector block based on Flowcytometry. Interpretation:-High-Leucocytosis, Low-Leucopenia.
NEUTROPHILS :- Method: Optical detector block based on Flowcytometry
LYMPHOCYTES :- Method: Optical detector block based on Flowcytometry
EOSINOPHILS :- Method: Optical detector block based on Flowcytometry
MONOCYTES :- Method: Optical detector block based on Flowcytometry
BASOPHIL :- Method: Optical detector block based on Flowcytometry
PLATELET COUNT :- Method:-Hydrodynamic focusing method. Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

ESR (ERYTHROCYTE SEDIMENTATION RATE) **70 H** mm/1st hr 0 - 15

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Method:-Modified Westergrens.

Interpretation:-Increased in infections, sepsis, and malignancy.

****End Of Report****

RESULT ENTERED BY : NEETU SHARMA

DEPARTMENT OF RADIO DIAGNOSIS

UHD / IP NO	40012944 (11519)	RISNo./Status :	4030805/
Patient Name :	Mrs. RATNA JHA	Age/Gender :	48 Y/F
Referred By :	Dr. EHS CONSULTANT	Ward/Bed No :	OPD
Bill Date/No :	13/04/2024 9:06AM/ OPSCR24-25/1232	Scan Date :	
Report Date :	13/04/2024 10:07AM	Company Name:	Mediwheel - Arcofemi Health Care Ltd.

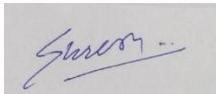
ULTRASOUND STUDY OF WHOLE ABDOMEN

- Liver:** Normal in size & echotexture. No obvious significant focal parenchymal mass lesion noted. Intrahepatic biliary radicals are not dilated. Portal vein is normal.
- Gall Bladder:** Lumen is clear. Wall thickness is normal. CBD is normal.
- Pancreas:** Normal in size & echotexture.
- Spleen:** Normal in size & echotexture. No focal lesion seen.
- Right Kidney:** Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.
- Left Kidney:** Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.
- Urinary Bladder:** Normal in size, shape & volume. No obvious calculus or mass lesion is seen. Wall thickness is normal.
- Uterus:** Not seen. History of hysterectomy.
No adnexal mass is noted.
- Others:** No significant free fluid is seen in pelvic peritoneal cavity.

IMPRESSION: USG findings are suggestive of

- **No significant sonographic abnormality noted.**

Correlate clinically & with other related investigations.



DR. SURESH KUMAR SAINI
RADIOLOGIST
MBBS, MD.
Reg. No. 22597, 36208.

DEPARTMENT OF RADIO DIAGNOSIS

UHID / IP NO	40012944 (11519)	RISNo./Status :	4030805/ Provisional
Patient Name :	Mrs. RATNA JHA	Age/Gender :	48 Y/F
Referred By :	Dr. EHS CONSULTANT	Ward/Bed No :	OPD
Bill Date/No :	13/04/2024 9:06AM/ OPSCR24-25/1232	Scan Date :	
Report Date :	13/04/2024 1:56PM	Company Name:	Mediwheel - Arcofemi Health Care Ltd.

ULTRASOUND BOTH BREASTS

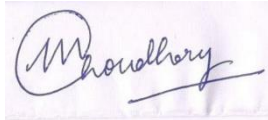
Both the breasts were examined by high frequency linear transducer.

Evidence of approx. 7x3mm sized well-defined heterogeneously hypoechoic lesion with post acoustic enhancement is seen at 1-2 O' clock position adjacent to left nipple areolar complex in left breast – likely BIRADS III lesion. Adv. Follow-up scan after 6 months.

Right breast shows predominant fibroglandular component No evidence of any focal lesion was seen on right side in the breast parenchyma in any of the quadrants.

Few subcentimetric bilateral axillary lymphnodes are seen with maintained fatty hilum.

Correlate clinically & with other related investigations.



DR. MRINAL CHOUDHARY

MBBS, MD Radiodiagnosis

Reg. No. 48304, 27464

DEPARTMENT OF CARDIOLOGY

UHID / IP NO	40012944 (11519)	RISNo./Status :	4030805/
Patient Name :	Mrs. RATNA JHA	Age/Gender :	48 Y/F
Referred By :	Dr. EHS CONSULTANT	Ward/Bed No :	OPD
Bill Date/No :	13/04/2024 9:06AM/ OPSCR24-25/1232	Scan Date :	
Report Date :	13/04/2024 12:15PM	Company Name:	Final

REFERRAL REASON: HEALTH CHCEKUP

2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

M MODE DIMENSIONS: -

		Normal		Normal
IVSD	10.9	6-12mm	LVIDS	30.8
LVIDD	46.2	32-57mm	LVPWS	16.3
LVPWD	9.9	6-12mm	AO	28.6
IVSS	16.3	mm	LA	36.7
LVEF	60-62	>55%	RA	-

DOPPLER MEASUREMENTS & CALCULATIONS:

STRUCTURE	MORPHOLOGY	VELOCITY (m/s)				GRADIENT (mmHg)	REGURGITATION
		E	0.72	e'	-		
MITRAL VALVE	NORMAL	A	0.76	E/e'	-	-	NIL
		E	0.61		-		
TRICUSPID VALVE	NORMAL	A	0.50			-	NIL
		E	1.15				
AORTIC VALVE	NORMAL	1.15				-	NIL
PULMONARY VALVE	NORMAL	0.81				-	NIL

COMMENTS & CONCLUSION: -

- ALL CARDIAC CHAMBERS ARE NORMAL
- NO RWMA, LVEF 60-62%
- NORMAL LV SYSTOLIC FUNCTION
- GRADE I LV DIASTOLIC DYSFUNCTION
- ALL CARDIAC VALVES ARE NORMAL
- NO EVIDENCE OF CLOT/VEGETATION, SMALL THIN LINED PERICARDIAL EFFUSION SEEN INFERIORLY
- INTACT IVS/IAS

IMPRESSION: - GRADE I LV DIASTOLIC DYSFUNCTION, NORMAL BI VENTRICULAR SYSTOLIC FUNCTION, SMALL THIN LINED PERICARDIAL EFFUSION SEEN INFERIORLY

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