

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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<b>Patient Name</b>	Mrs. SUSHILA MEENA	<b>Lab No</b>	4024972
<b>UHID</b>	40010809	<b>Sample Date</b>	24/02/2024 3:17PM
<b>Age/Gender</b>	34 Yrs/Female	<b>Report Date</b>	24/02/2024 3:29PM
<b>Prescribed By</b>	Dr. EHS CONSULTANT	<b>Bed No / Ward</b>	OPD
<b>Referred By</b>	Dr. EHS CONSULTANT	<b>Report Status</b>	Final
<b>Company</b>	Mediwheel - Arcofemi Health Care Ltd.		

**CYTOLOGY**

**CYTOLOGY\***

**Type of Specimen**

No. of smears examined

Adequacy

Endocervical cells

Inflammation

Organisms

Epithelial cell abnormality

Others

**Impression**

**Note: Test marked as \* are not accredited by NABL**

Bethesda2014

**Pap smear (Conventional)**

Two

Satisfactory for evaluation.

Adequate

Seen.

Mild acute inflammation

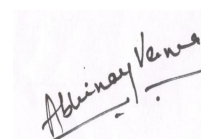
Not seen

Not seen

-

Negative for intraepithelial lesion / malignancy.

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



**Dr. ABHINAV VERMA**  
**MBBS|MD|INCHARGE PATHOLOGY**

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<b>Referred By</b>	Dr. EHS CONSULTANT	<b>Report Status</b>	Final
<b>Mobile No.</b>	9950955558		

### BIOCHEMISTRY

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

BLOOD GLUCOSE (FASTING)	79.0	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 )	92	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.

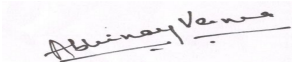
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

**THYROID T3 T4 TSH**

T3	1.470	ng/mL	0.970 - 1.690
T4	7.10	ug/dl	5.53 - 11.00
TSH	2.44	μIU/mL	0.40 - 4.05

Sample: Serum

RESULT ENTERED BY : Mr. JITENDRA MARWAL



Dr. ABHINAY VERMA

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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	0.38	mg/dl	0.00 - 1.20
BILIRUBIN INDIRECT	0.25	mg/dl	0.20 - 1.00
BILIRUBIN DIRECT	0.13	mg/dl	0.00 - 0.30
SGOT	21.0	U/L	0.0 - 32.0
SGPT	18.4	U/L	0.0 - 33.0
TOTAL PROTEIN	7.5	g/dl	6.6 - 8.7
ALBUMIN	4.2	g/dl	3.5 - 5.2
GLOBULIN	3.3		1.8 - 3.6
ALKALINE PHOSPHATASE	96.0	U/L	35 - 104
A/G RATIO	<b>1.3 L</b>	Ratio	1.5 - 2.5
GGTP	10.0	U/L	0.0 - 40.0

RESULT ENTERED BY : Mr. JITENDRA MARWAL

*Abhinay Verma*

Dr. ABHINAY VERMA

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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.

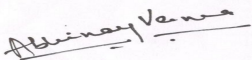
**ALKALINE PHOSPHATASE** :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction.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

Enzymatic colorimetric assay. Interpretation:- $\gamma$ -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	173		<200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High
HDL CHOLESTEROL	49.2		High Risk :- <40 mg/dl (Male), <40 mg/dl (Female) Low Risk :- >=60 mg/dl (Male), >=60 mg/dl (Female)
LDL CHOLESTEROL	113.3		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	13	mg/dl	10 - 50
TRIGLYCERIDES	65		Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl
CHOLESTEROL/HDL RATIO	4	%	

RESULT ENTERED BY : Mr. JITENDRA MARWAL



Dr. ABHINAY VERMA

MBBS|MD|INCHARGE PATHOLOGY

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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 enzymetic 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

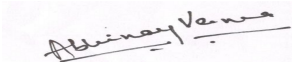
TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay.  
 Interpretation:-High triglycerde levels also occur in various diseases of liver, kidneys and pancreas. DM, nephrosis, liver obstruction.

CHOLESTEROL/HDL RATIO :- Method: Cholesterol/HDL Ratio Calculative

Sample: Serum

UREA	22.8	mg/dl	16.60 - 48.50
BUN	11	mg/dl	6 - 20
CREATININE	0.51	mg/dl	0.50 - 0.90
SODIUM	<b>135 L</b>	mmol/L	136 - 145
POTASSIUM	3.97	mmol/L	3.50 - 5.50
CHLORIDE	102	mmol/L	98 - 107
URIC ACID	2.6	mg/dl	2.4 - 5.7
CALCIUM	8.6	mg/dl	8.60 - 10.00

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**CREATININE - SERUM** :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidney disease.

**URIC ACID** :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uric acid 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 and kidney reabsorption.

**POTASSIUM** :- Method: ISE electrode. Interpretation:-Low level: Intake excessive loss from body due to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renal failure.

**CHLORIDE - SERUM** :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake, prolonged vomiting and reduced renal reabsorption as well as forms of acidosis and alkalosis.

Increase: dehydration, kidney failure, some form of acidosis, high dietary or parenteral chloride intake, and salicylate poisoning.

**UREA**:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogen concentration are seen in inadequate renal perfusion, shock, diminished blood volume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerular nephritis and UTI.

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

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### BLOOD BANK INVESTIGATION

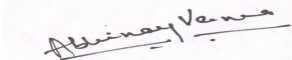
Test Name	Result	Unit	Biological Ref. Range
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BLOOD GROUPING	"A" Rh Positive		
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Note :

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

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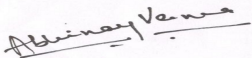
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### CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Sample: Urine
<b><u>URINE SUGAR (POST PRANDIAL)</u></b>				
URINE SUGAR (POST PRANDIAL)	NEGATIVE		NEGATIVE	Sample: Urine
<b><u>URINE SUGAR (RANDOM)</u></b>				
URINE SUGAR (RANDOM)	NEGATIVE		NEGATIVE	Sample: Urine
<b>PHYSICAL EXAMINATION</b>				
VOLUME	35	ml		Sample: Urine
COLOUR	PALE YELLOW		P YELLOW	
APPEARANCE	CLEAR		CLEAR	
<b>CHEMICAL EXAMINATION</b>				
PH	6.0		5.5 - 7.0	
SPECIFIC GRAVITY	1.010		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	
<b>MICROSCOPIC EXAMINATION</b>				
WBCS/HPF	0-1	/hpf	0 - 3	
RBCS/HPF	0-0	/hpf	0 - 2	
EPITHELIAL CELLS/HPF	1-3	/hpf	0 - 1	
CASTS	NIL		NIL	
CRYSTALS	NIL		NIL	

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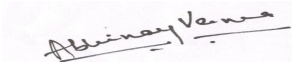
### CLINICAL PATHOLOGY

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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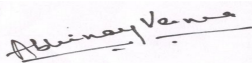
### HEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range
<b><u>CBC (COMPLETE BLOOD COUNT)</u></b>			
Sample: WHOLE BLOOD EDTA			
HAEMOGLOBIN	9.5 L	g/dl	12.0 - 15.0
PACKED CELL VOLUME(PCV)	32.3 L	%	36.0 - 46.0
MCV	78.8 L	fl	82 - 92
MCH	23.2 L	pg	27 - 32
MCHC	29.4 L	g/dl	32 - 36
RBC COUNT	4.10	millions/cu.mm	3.80 - 4.80
TLC (TOTAL WBC COUNT)	6.62	10 <sup>3</sup> / uL	4 - 10
<b><u>DIFFERENTIAL LEUCOCYTE COUNT</u></b>			
NEUTROPHILS	58.3	%	40 - 80
LYMPHOCYTE	34.1	%	20 - 40
EOSINOPHILS	1.7	%	1 - 6
MONOCYTES	5.3	%	2 - 10
BASOPHIL	0.6 L	%	1 - 2
PLATELET COUNT	2.66	lakh/cumm	1.500 - 4.500

**HAEMOGLOBIN** :- Method:-SLS HemoglobinMethodology by Cell Counter.Interpretation:-Low-Anemia, High-Polycythemia.  
**MCV** :- Method:- Calculation bysystemex.  
**MCH** :- Method:- Calculation bysystemex.  
**MCHC** :- Method:- Calculation bysystemex.  
**RBC COUNT** :- Method:-Hydrodynamicfocusing.Interpretation:-Low-Anemia,High-Polycythemia.  
**TLC (TOTAL WBC COUNT)** :- Method:-Optical Detectorblock based on Flowcytometry.Interpretation:-High-Leucocytosis, Low-Leucopenia.  
**NEUTROPHILS** :- Method: Optical detectorblock based on Flowcytometry  
**LYMPHOCYTS** :- Method: Optical detectorblock based on Flowcytometry  
**EOSINOPHILS** :- Method: Optical detectorblock based on Flowcytometry  
**MONOCYTES** :- Method: Optical detectorblock based on Flowcytometry  
**BASOPHIL** :- Method: Optical detectorblock based on Flowcytometry  
**PLATELET COUNT** :- Method:-Hydrodynamicfocusing 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)      **40 H**      mm/1st hr      0 - 15

RESULT ENTERED BY : Mr. JITENDRA MARWAL



Dr. ABHINAV VERMA

MBBS|MD|INCHARGE PATHOLOGY

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Method:-Modified Westergrens.

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

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### X Ray

Test Name	Result	Unit	Biological Ref. Range
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#### X-RAY CHEST P. A. VIEW

Both lung fields are clear.

Both CP angles are clear.

Both hemi-diaphragms are normal in shape and outlines.

Cardiac shadow is within normal limits.

Visualized bony thorax is unremarkable.

**Correlate clinically & with other related investigations.**

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

RESULT ENTERED BY : Mr. JITENDRA MARWAL



Dr. RENU JADIYA  
MBBS, DNB  
RADIOLOGIST

## DEPARTMENT OF RADIO DIAGNOSIS

<b>UHID / IP NO</b>	40010809 (5205)	<b>RISNo./Status :</b>	4024972/
<b>Patient Name :</b>	Mrs. SUSHILA MEENA	<b>Age/Gender :</b>	34 Y/F
<b>Referred By :</b>	Dr. EHS CONSULTANT	<b>Ward/Bed No :</b>	OPD
<b>Bill Date/No :</b>	24/02/2024 9:37AM/ OPSCR23-24/13884	<b>Scan Date :</b>	
<b>Report Date :</b>	24/02/2024 11:49AM	<b>Company Name:</b>	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:** Normal in size, shape & anteverted in position. Endometrial thickness is normal. Endometrial cavity is empty. No mass lesion is seen. Cervix is normal.
- Both ovaries:** Bilateral ovaries are normal in size, shape & volume.
- 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. APOORVA JETWANI**

**Incharge & Senior Consultant Radiology**

**MBBS, DMRD, DNB**

**Reg. No. 26466, 16307**

## DEPARTMENT OF CARDIOLOGY

<b>UHID / IP NO</b>	40010809 (5205)	<b>RISNo./Status :</b>	4024972/
<b>Patient Name :</b>	Mrs. SUSHILA MEENA	<b>Age/Gender :</b>	34 Y/F
<b>Referred By :</b>	Dr. EHS CONSULTANT	<b>Ward/Bed No :</b>	OPD
<b>Bill Date/No :</b>	24/02/2024 9:37AM/ OPSCR23-24/13884	<b>Scan Date :</b>	
<b>Report Date :</b>	24/02/2024 11:57AM	<b>Company Name:</b>	Final

**REFERRAL REASON: HEALTH CHECKUP**

### 2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

**M MODE DIMENSIONS: -**

		Normal		Normal
<b>IVSD</b>	<b>10.1</b>	<b>6-12mm</b>	<b>LVIDS</b>	<b>26.0</b>
<b>LVIDD</b>	<b>39.0</b>	<b>32-57mm</b>	<b>LVPWS</b>	<b>15.4</b>
<b>LVPWD</b>	<b>10.1</b>	<b>6-12mm</b>	<b>AO</b>	<b>30.8</b>
<b>IVSS</b>	<b>15.4</b>	<b>mm</b>	<b>LA</b>	<b>30.3</b>
<b>LVEF</b>	<b>60-62</b>	<b>&gt;55%</b>	<b>RA</b>	<b>-</b>

### DOPPLER MEASUREMENTS & CALCULATIONS:

STRUCTURE	MORPHOLOGY	VELOCITY (m/s)				GRADIENT (mmHg)	REGURGITATION
		E	1.09	e'	-		
MITRAL VALVE	NORMAL	A	0.67	E/e'	-	-	NIL
		E	0.66		RVSP 33mmHg		
TRICUSPID VALVE	NORMAL	A	0.59			MILD TR	
		E	1.07				
AORTIC VALVE	NORMAL	1.07				-	NIL
PULMONARY VALVE	NORMAL	0.64				-	NIL

**COMMENTS & CONCLUSION: -**

- ALL CARDIAC CHAMBERS ARE NORMAL
- NO RWMA, LVEF 60-62%
- NORMAL LV SYSTOLIC FUNCTION
- NORMAL LV DIASTOLIC FUNCTION
- MILD TR/PAH, OTHER CARDIAC VALVES ARE NORMAL
- NO EVIDENCE OF CLOT/VEGETATION/PE
- INTACT IVS/IAS

**IMPRESSION: - MILD TR/PAH, NORMAL BI VENTRICULAR FUNCTIONS**

**DR SUPRIY JAIN**  
**MBBS, M.D., D.M. (CARDIOLOGY)**  
**INCHARGE & SR. CONSULTANT**  
**INTERVENTIONAL CARDIOLOGY**

**DR ROOPAM SHARMA**  
**MBBS, PGDCC, FIAE**  
**CONSULTANT & INCHARGE**  
**EMERGENCY, PREVENTIVE CARDIOLOGY**  
**AND WELLNESS CENTRE**

## ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

<b>Patient Name</b>	Mrs. SUSHILA MEENA	<b>Lab No</b>	634764
<b>UHID</b>	341092	<b>Collection Date</b>	24/02/2024 12:19PM
<b>Age/Gender</b>	34 Yrs/Female	<b>Receiving Date</b>	24/02/2024 12:24PM
<b>IP/OP Location</b>	O-OPD	<b>Report Date</b>	24/02/2024 1:20PM
<b>Referred By</b>	Dr. EHCC Consultant	<b>Report Status</b>	Final
<b>Mobile No.</b>	9773349797		



MC-2561

### BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range
HBA1C	5.3	%	< 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

Sample: WHOLE BLOOD EDTA

Method : - Tetradecyltrimethylammonium bromide

Interpretation:-Monitoring long term glycemic 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.

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

RESULT ENTERED BY : Mr. Ravi

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