10/02/2024

Sangita Shinde
48yrs/ female

No fresh complaints.
K/C/O - HTN. :10-12 yrs.
Hypothyroidism. :7-8 yrs.
On Reg Rx.
S/H- Appendisectomy done 20 yrs ago.

Height-150cm
Weight-54kg
BMI-24kg/m2

M/H- Menopausal at 35yrs of age.
O/H- $G_2P_2A_0L_2D_0$.
1st - female - 25 yrs, healthy
2nd - female - 24 yrs, healthy

BP- 140/90 mmHg
P- 72/min
SpO_2 - 98%.

consult with physician for blood change

Pt is fit and can resume her normal duties

559
150

OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE SANGEETA SHINDE

AGE 48 DATE - 10.02.2024

Spects : With Glasses

	RT Eye	Lt Eye
NEAR	N/12	N/10
DISTANT	6/9	6/6
Color Blind Test	NORMAL	

SIDDHIVINAYAK HOSPITALS

Siddhivinayak Hospital

Imaging Department

Sonography | Colour Doppler | 3D / 4D USG

HELPLINE
022 - 2588 3531

Name – Mrs . Sangita Shinde	Age - 48 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 10/02/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- **No significant abnormality seen.**

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.

S-1, Vedant Complex,
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Siddhivinayak Hospital
Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

HELPLINE
022 - 2588 3531

Name - Mrs. Sangeeta Shinde	Age - 48 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date -10/02/2024

USG -BOTH BREASTS

Real time sonography of both breasts was performed with high frequency probe.

Both breast show normal, medium level, homogeneous echotexture. No evidence of any solid or cystic focal mass lesion.

No evidence of calcification noted.

The pectorallis major muscles appear normal.

No evidence of axillary lymphadenopathy seen.

IMPRESSION:

- **No significant abnormality is noted.**

Thanks for the referral...............

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

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HELPLINE
022 - 2588 3531

Name - Mrs. Sangeeta Shinde	Age - 48 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 10/02/2024

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size 15.1 cm . It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally with no stones within.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (9.4 cm) and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 9.0 x 4.1 cm.

The left kidney measures 9.9 x 4.5 cm.

Urinary bladder: normally distended. Wall thickness – normal.

Uterus : Post menopausal status.

No free fluid is seen.

IMPRESSION:

- **Fatty liver (Grade I)**

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

ID: 887
Sangita shinde
Female Years 48
Req. No. :
BP:- 140/90.

10-02-2024 10:19:23 AM

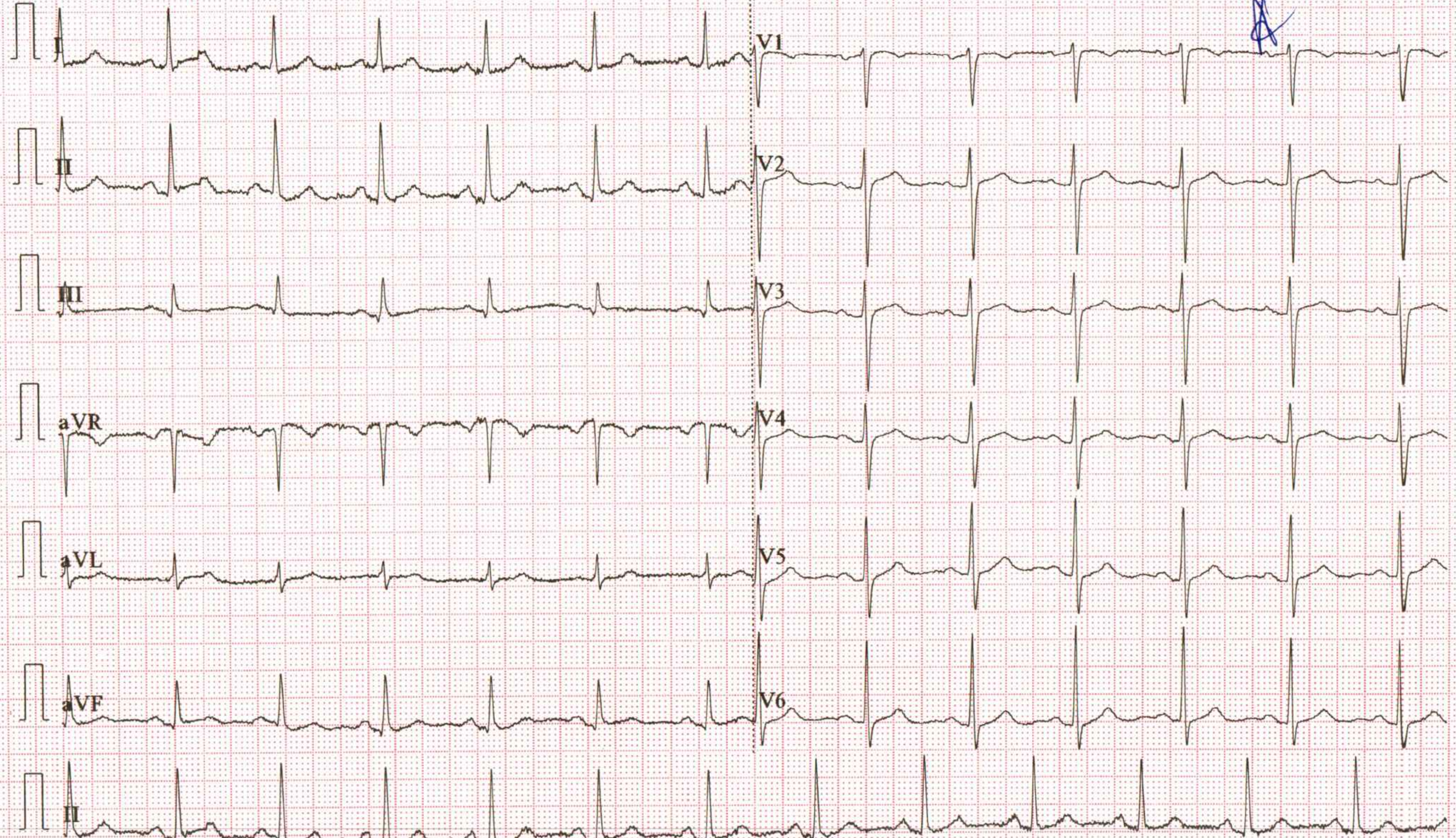
HR	: 77	bpm
P	: 119	ms
PR	: 175	ms
QRS	: 86	ms
QT/QTcBz	: 373/423	ms
P/QRS/T	: 50/52/41	°
RV5/SV1	: 1.264/0.902	mV

Diagnosis Information:
Sinus Rhythm
Normal ECG

No Significant ST-T changes
Adv- No active intervention required right Now.

Report Confirmed by:

Dr. Anant Ram[illegible]rao Munde
MBBS, DNB, [illegible]ardiology)
Reg. No.: [illegible]1228



0.15~45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

ECHOCARDIOGRAM

NAME	MRS. SANGEETA SHINDE
AGE/SEX	48 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	/02/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES:

MITRAL VALVE:

- **AML:** Normal
- **PML:** Normal
- **Sub-valvular deformity:** Absent

AORTIC VALVE: Normal

- **No. of cusps:** 3

PULMONARY VALVE: Normal

TRICUSPID VALVE: Normal

CHAMBERS:

LEFT ATRIUM: Normal

- **Left atrial appendage:** Normal

LEFT VENTRICLE: Normal

- **RWMA:** No
- **Contraction:** Normal

RIGHT ATRIUM: Normal

RIGHT VENTRICLE: Normal

- **RWMA:** No
- **Contraction:** Normal

GREAT VESSELS:

- **AORTA:** Normal
- **PULMONARY ARTERY:** Normal

SEPTAE:

- **IAS:** Intact
- **IVS:** Intact

CORONARIES: Proximal coronaries normal

CORONARY SINUS: Normal

VENACAVAE:

- **SVC:** Normal
- **IVC:** Normal and collapsing >20% with respiration

PULMONARY VEINS: Normal

PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	33 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	44.8 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	26.6 mm	RVEF	%
Ascending aorta	mm	IVSd	7.4 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	7.4 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	71 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm

COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. SANGEETA SHINDE
AGE/SEX	48 YRSF
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	/02/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.3	0.9
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm^2)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A	E<A			
E/E'				

FINAL IMPRESSION: NORMAL STUDY

- No RWMA
- Normal LV systolic function (LVEF 71 %)
- Good RV systolic function
- Grade I diastolic dysfunction
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Nil

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228

CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

Name	: Mrs. SANGEETA SHINDE (A)	Collected On	: 10/2/2024 10:31 am
Lab ID.	: 183307	Received On	: 10/2/2024 10:41 am
Age/Sex	: 48 Years / Female	Reported On	: 12/2/2024 7:02 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL

*LIPID PROFILE

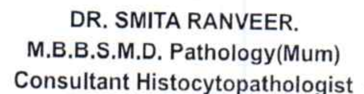
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDA SE)	**225.0**	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	42.4	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	88	mg/dL	Desirable level : <161 mg/dl. High :>= 161 - 199 mg/dl. Borderline High :200 - 499 mg/dl. Very high :>499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	18	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	**165**	mg/dL	Optimal:<100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high :>= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	3.89		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	5.31		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT -----------------

Checked By
SHAISTA Q



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Dr. Smita Ranveer's

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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	14.8	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	44.4	%	36 - 46
RBC COUNT	5.41	x10^6/uL	4.5 - 5.5
MCV	82	fl	80 - 96
MCH	27.4	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.6	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	9800	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	56	%	40 - 80
LYMPHOCYTES	33	%	20 - 40
EOSINOPHILS	**07**	%	0 - 6
MONOCYTES	04	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	332000	/ cumm	150000 - 450000
MPV	9.4	fl	6.5 - 11.5
PDW	15.8	%	9.0 - 17.0
PCT	0.310	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT ---------------

Checked By
SHAISTA Q

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CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

MC-6135

Name	: Mrs. SANGEETA SHINDE (A)	Collected On	: 10/2/2024 10:31 am
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* 1 8 3 3 0 7 *

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
CHEMICAL EXAMINATION			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent		Absent
PUS CELLS	1-2	/ HPF	0 - 5

Checked By
Priyanka_Deshmukh

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
EPITHELIAL	2-4	/ HPF	0 - 5
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		

Result relates to sample tested, Kindly correlate with clinical findings.

---------------- END OF REPORT ------------------

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183307

IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPACE		Space	-
SPECIMEN	Serum		
T3	103.5	ng/dl	84.63 - 201.8
T4	9.48	µg/dl	5.13 - 14.06
TSH	**5.58**	µIU/ml	0.270 - 4.20

T3 (Triido Thyronine) hormone)		T4 (Thyroxine)		TSH(Thyroid stimulating	
AGE	RANGE	AGE	RANGES	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6	0-14 Days	1.0-39
1-11 months	105-245	1-2 weeks	9.9-16.6	2 wks -5 months	1.7-9.1
1-5 yrs	105-269	1-4 months	7.2-14.4	6 months-20 yrs	0.7-6.4
6-10 yrs	94-241	4 -12 months	7.8-16.5	Pregnancy	
11-15 yrs	82-213	1-5 yrs	7.3-15.0	1st Trimester	
0.1-2.5					
15-20 yrs	80-210	5-10 yrs	6.4-13.3	2nd Trimester	
0.20-3.0					
		11-15 yrs	5.6-11.7	3rd Trimester	
0.30-3.0					

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT -----------------

Checked By
Priyanka_Deshmukh

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

Result relates to sample tested, Kindly correlate with clinical findings.

---------------- END OF REPORT ------------------

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*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	31.7	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	14.81	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.69	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	**7.00**	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	142.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.22	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	103.4	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.53	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	10.2	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.8	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.30	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.50	g/dl	1.9 - 3.5
A/G RATIO calculated	1.23		0 - 2
NOTE	BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.		

Checked By
SHAISTA Q

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Dr. Smita Ranveer`s

Radiance

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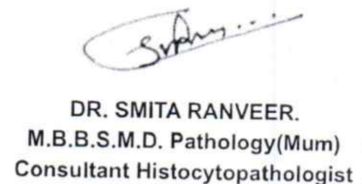
PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/46/24		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	equate		
CELL TYPE	Superficial, intermediate,squamous metaplastic and few endocervical cells		
BACKGROUND	Cytolytic		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Many neutrophils		
INTERPRETATION/RESULT	Reactive atypia (associated with inflammation?). Repeat pap smear is advised after antibioptic treatment		
NOTE	Cervical cytology is a screening test and has associated false negative and false positive results. Regular sampling and follow up is recommended.		

--------------- END OF REPORT -----------------

Checked By
Dr_smita.ranveer



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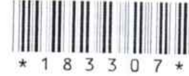
Name	: Mrs. SANGEETA SHINDE (A)	Collected On	: 10/2/2024 10:31 am
Lab ID.	: 183307	Received On	: 10/2/2024 10:41 am
Age/Sex	: 48 Years / Female	Reported On	: 12/2/2024 7:02 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



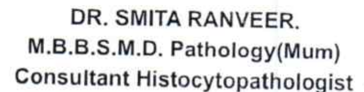
Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear. Neutrophils:55 % Lymphocytes:35 % Monocytes:04 % Eosinophils:06 % Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT ---------------

Checked By
SHAISTA Q



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COMPLETE PATHOLOGICAL SOLUTION

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* 1 8 3 3 0 7 *

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.88	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.37	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.51	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	22.5	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	14.5	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	75.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.8	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.30	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.50	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.23		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT ---------------

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	**32**	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

--------------- END OF REPORT -----------------

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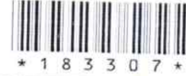

BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	14.9	U/L	5 - 55
BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	95.7	mg/dL	70 - 110
BLOOD GLUCOSE PP	98.8	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION
- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : >=126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)
- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : >=200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS
- Fasting plasma glucose >=126 mg/dl
- Classical symptoms +Random plasma glucose >=200 mg/dl
- Plasma glucose >=200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin > 6.5%

***Any positive criteria should be tested on subsequent day with same or other criteria.

GLYCOCELATED HEMOGLOBIN (HBA1C)

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.4	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	108.3	mg/dL	65.1 - 136.3

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
METHOD	Particle Enhanced Immunoturbidimetry		

HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

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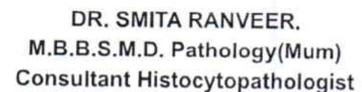

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