UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. K S SANDHYA	Order No	: 1000099031
UHID	: UHJA24006567	Registered On	: 14/10/2024 10:04:06 AM
Age/Sex	: 48/Years Female	Collected On	: 14/10/2024 10:17:01 AM
Ward / Bed No	:	Reported On	: 14/10/2024 12:58:37 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009026
Station	: At Hospital	Mobile No	: 9964209003
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	113	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	147	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.92	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.85	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.45	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	233	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	285	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.0	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	129.00	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	57.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.96		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.74		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	186.00	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.1	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.28	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.05	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.23	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.22	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.98	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.42		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	12	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	79	U/L	46-122
GGT (Method:IFCC)	14	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	18.0	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.56	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	14.2		12¯20 : 1

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	8.34	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	28.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7410	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	62.62	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.54	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.30	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.14	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.40	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.45	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	63.1	fL	78-100
MCH (Method: Calculated)	18.7	pg	27-31
MCHC (Method: Calculated)	29.7	g/dL	31-37
RDW - CV (Method: Calculated)	20.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.60	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.95	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	45.4	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4640	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method:Calculated Automated)	390	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1970	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	380	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	30	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	22	mm/hour	1-20

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	O	
Rh Factor (Method:Agglutination Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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Test Name	Result	Unit	Bio. Ref. Interval

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION

VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.005		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative

MICROSCOPIC EXAMINATION

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
Rashmita

---End of Report---

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

14-Oct-2024 AM11:19:33

ID:24006567
Name:mrs sandhya
ex:F Birth date:
cm kg / mmHg
edication:
ymptoms:
istory:

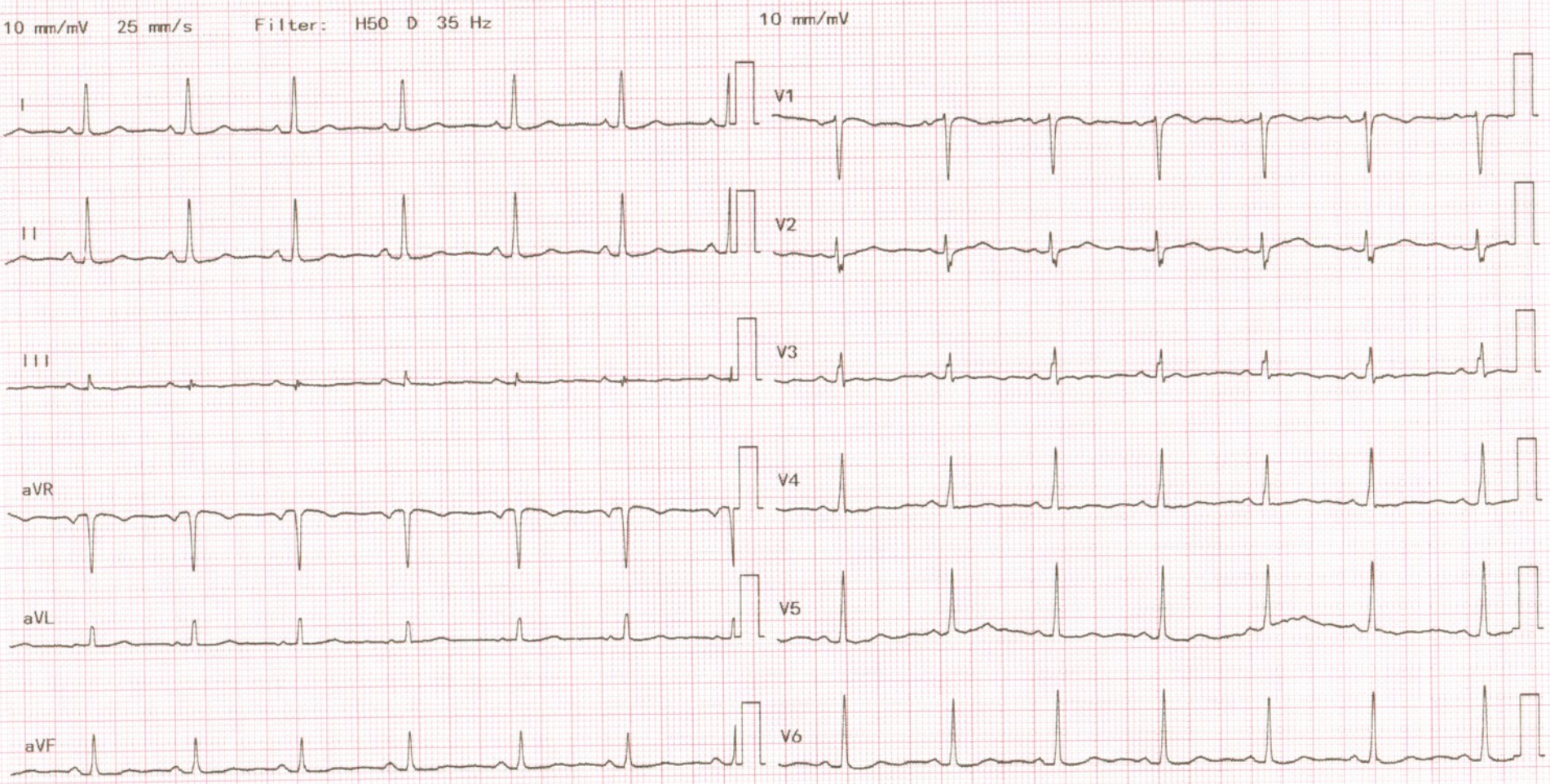
48 years

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, II, aVF, V3, V4, V5, V6)]
8305 Short QTc interval [QTc int. < 360 ms]
9150 ** abnormal ECG **

ent. rate	86	bpm
R int	140	ms
RS dur	64	ms
T/QTc(E) int	304/ 347	ms
/QRS/T axis	48/ 40/ 30	°
V5/SV1 amp	1.21/ 1.00	mV
V5+SV1 amp	2.22	mV

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

NABH No.1

Out Patient Record

Patient Name	**: Mrs.K S SANDHYA**	**UHID**	**: UHJA24006567**
Age / Sex	: 48 Years / Female	OP NO/Reg Dt	: 14-10-2024 10:04 AM
Spouse / Father Name	: SHIVAKUMAR G N	Department	:
Address	: 1362, 9TH MAIN, VIJAYANAGAR, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

HT - 148 cm
wt - 57.2 kg
SpO_2 - 98 %
PR - 100 b/m
BP - 125/79 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

Dr. Yogalakshmi

NABH No.1

Mrs. K.S. Sandhya
48yrs /F

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

14.10.24.

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90304

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United Hospital

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mrs. K S SANDHYA	DATE :	14/10/24
AGE :	48 YEARS GENDER : FEMALE	PATIENT ID :	24006567
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO : 2.0 (2.5-3.7)	LVIDD : 3.9 (3.5-5.5)	MV EV: 0.9	AV: 0.8	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 1.3		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 1.0		PR : NORMAL
RV : 1.4 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE : 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis	: NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF RADIODIAGNOSIS

Name	K S Sandhya	**Date**	14/10/24
Age	48 years	**Hospital ID**	UHJA24006567
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.1 cms) and shows mild increased echopattern.*** No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (9.7 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.7 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and ***bulky in size, measures 9.9 x 6.4 x 7.3 cms. There are few mural and submucosal fibroids, largest measures 3.9 x 3.5 x 2.9 cms in the posterior wall and 3.1 x 2.6 x 2.3 cms in the anterior wall.*** Endometrium measures 4.9 mm. ***Endometrial cavity is deformed by indentation from the fibroids.***
Right ovary is normal in size and echopattern, measures 4.9 cc.
Left ovary could not be visualized - likely obscured by bowel gas.
Both adnexa: Normal. No mass is seen.

There is no ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Bulky uterus with few fibroids.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

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DEPARTMENT OF RADIODIAGNOSIS

Name	K S Sandhya	**Date**	14/10/24
Age	48 years	**Hospital ID**	UHJA24006567
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

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DEPARTMENT OF RADIODIAGNOSIS

Name	K S Sandhya	**Date**	14/10/24
Age	48 years	**Hospital ID**	UHJA24006567
Sex	Female	**Ref.**	Health check

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

There are few dilated ducts in bilateral retroareolar region, measures upto 3.3 mm in right and 4.5 mm in left breast respectively. Anechoic contents are seen within the ducts with no obvious wall thickening.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Few dilated ducts in bilateral retroareolar region - likely duct ectasia.**
- **No other significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist