Siddhivinayak Hospital

Hosp. Reg. No.: TMC - Zone C - 386

INDUSTRIAL HEALTH SERVICES

13/01/2024

Vimal Nagare
57 yrs / female

No fresh complaints
backache ⊕.
b/L LL pain ⊕.
~~No~~
K/C/O - HTN, BA
NO PIH.
NO SIH.
~~A~~ Menopausal since 9-10 yrs.
O/H - $G_6 P_4 A_2 L_4 D_0$
TL done in 2000.

BP - 140/90 mmHg
P - 80/min
SPO_2 - 98%.

Adv
X-ray CS < AP / L
X-ray LS < AP / L.

Pt is fit and can resume her normal duties.

⊛ Consult with physician for blood changes.

OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE **VIMAL NAGARE**

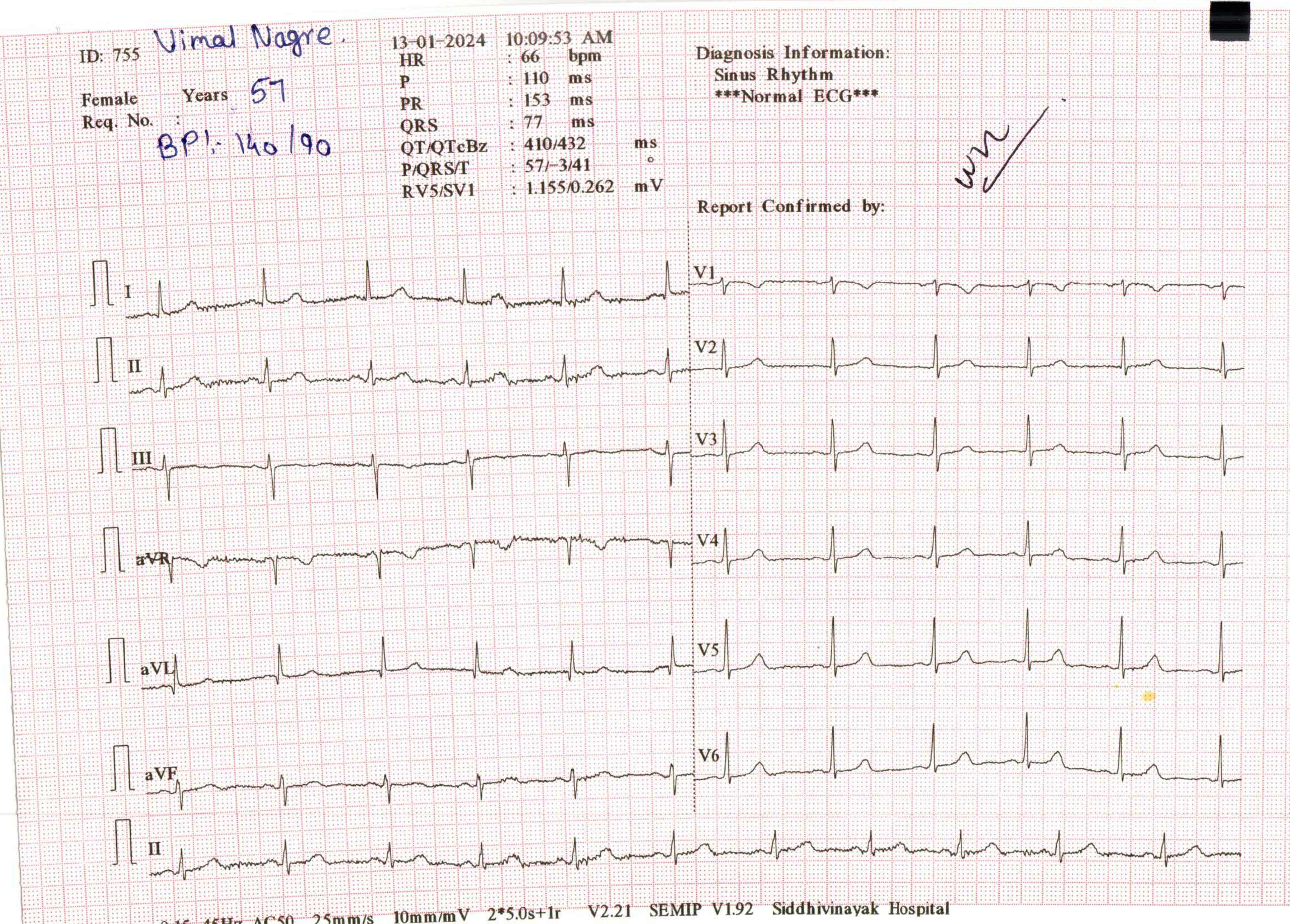
AGE **57** **DATE -** **13.01.2024**

Spects : Without Glasses

	RT Eye	Lt Eye
NEAR	N/18	N/12
DISTANT	6/9	6/6
Color Blind Test	NORMAL	

Siddhivinayak Hospital * Vartak Nagar, Thane (W.) * Reg.No.TMC/ZONE-C/386

SIDDHIVINAYAK HOSPITALS



ID: 755 Vimal Nagre.
Female Years 57
Req. No. :
BP:- 140/90
13-01-2024 10:09:53 AM
HR : 66 bpm
P : 110 ms
PR : 153 ms
QRS : 77 ms
QT/QTcBz : 410/432 ms
P/QRS/T : 57/-3/41 °
RV5/SV1 : 1.155/0.262 mV
Diagnosis Information:
Sinus Rhythm
Normal ECG
Report Confirmed by:
I
II
III
aVR
aVL
aVF
II
V1
V2
V3
V4
V5
V6
10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

Siddhivinayak Hospital

Imaging Department

Sonography | Colour Doppler | 3D / 4D USG

Name – Mrs. Vimal Nagre	Age – 57 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 13/01/2024

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size (15.4 cm). It appears normal in morphology with normal echogenicity. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is minimally distended.

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

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (10.3 cm) and morphology

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

The right kidney measures 8.2 x 4.1cm.

The left kidney measures 9.6 x 4.5 cm.

Urinary bladder: normally distended. Wall thickness – normal.

Uterus : Post menopausal status.

No free fluid is seen.

IMPRESSION:

- **No obvious significant abnormality detected.**

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

A

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606
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Siddhivinayak Hospital

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Sonography | Colour Doppler | 3D / 4D USG

Name – Mrs. Vimal Nagre	Age – 57 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date –13/01/2024

USG –BOTH BREASTS

Real time sonography of both breast 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

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.

Siddhivinayak Hospital

Imaging Department

Sonography | Colour Doppler | 3D / 4D USG

022 - 2588 3531

Name – Mrs. Vimal Nagre	Age - 57 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date – 13/01/2024

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. MOHAMMAD SOHAIB
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.

Siddhivinayak Hospital

Imaging Department

Sonography | Colour Doppler | 3D / 4D USG

022 - 2588 3531

ECHOCARDIOGRAM

NAME	MRS. VIMAL NAGRE
AGE/SEX	57 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	13/01/2024

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: Mild concentric LV hypertrophy

- **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

VENACAVAE:

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

CORONARY SINUS: Normal

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	41.8 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.9 mm	RVEF	%
Ascending aorta	mm	IVSd	10.5 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	10.5 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	71 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14 mm

COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MR. VIMAL NAGRE
AGE/SEX	57 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	13/01/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.9	1.03
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	1.3			
E/E'	9.5			

FINAL IMPRESSION: MILD HYPERTENSIVE HEART DISEASE

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

ADVICE: Control HTN

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

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

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Age/Sex	: 57 Years / Female	Reported On	: 13/1/2024 5:18 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /	Report Status	: FINAL

* 1 8 0 4 3 7 *

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	**236.0**	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)	**35.9**	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	86.9	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)	17	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	**183**	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)	**5.10**		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	6.57		<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
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	**10.4**	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	**31.9**	%	36 - 46
RBC COUNT	**3.51**	x10^6/uL	4.5 - 5.5
MCV	91	fl	80 - 96
MCH	29.6	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.4	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	4550	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	51	%	40 - 80
LYMPHOCYTES	40	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	07	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	251000	/ cumm	150000 - 450000
MPV	10.6	fl	6.5 - 11.5
PDW	15.8	%	9.0 - 17.0
PCT	0.270	%	0.200 - 0.500

RBC MORPHOLOGY	Normocytic Normochromic, Reduced red blood cells count
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
Priyanka_Deshmukh

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24 HOURS 7
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Dr. Smita Ranveer's
Radiance
CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

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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)	1.015		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Present (Trace)		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)	Present (+)		Negative
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	3-5 /HPF		Absent
PUS CELLS	2-4	/ HPF	0 - 5
EPITHELIAL	1-2	/ HPF	0 - 5
CASTS	Absent		

Checked By
SHAISTA Q

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MC-6135

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* 1 8 0 4 3 7 *

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Present (++)		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 ------------------

Checked By
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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPACE		Space	-
SPECIMEN	Serum		
T3	92.34	ng/dl	84.63 - 201.8
T4	8.27	µg/dl	5.13 - 14.06
TSH	3.48	µIU/ml	0.270 - 4.20

T3 (Triido Thyronine) T4 (Thyroxine) TSH(Thyroid stimulating hormone)

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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* 1 8 0 4 3 7 *

HAEMATOLOGY

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

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

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

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*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA	29.7	mg/dL	21 - 43
(Urease UV GLDH Kinetic)			
BLOOD UREA NITROGEN	13.88	mg/dL	5 - 20
(Calculated)			
S. CREATININE	0.63	mg/dL	0.6 - 1.4
(Enzymatic)			
S. URIC ACID	6.0	mg/dL	2.6 - 6.0
(Uricase)			
S. SODIUM	138.7	mEq/L	137 - 145
(ISE Direct Method)			
S. POTASSIUM	4.31	mEq/L	3.5 - 5.1
(ISE Direct Method)			
S. CHLORIDE	100.2	mEq/L	98 - 110
(ISE Direct Method)			
S. PHOSPHORUS	3.01	mg/dL	2.5 - 4.5
(Ammonium Molybdate)			
S. CALCIUM	9.1	mg/dL	8.6 - 10.2
(Arsenazo III)			
PROTEIN	6.85	g/dl	6.4 - 8.3
(Biuret)			
S. ALBUMIN	3.75	g/dl	3.2 - 4.6
(BGC)			
S.GLOBULIN	3.10	g/dl	1.9 - 3.5
(Calculated)			
A/G RATIO	1.21		0 - 2
calculated			
NOTE	BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.		

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

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

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic, Normochromic
WBC	Total leukocytes count normal on smear. Neutrophils - 51% Lymphocytes - 40% Monocytes - 07% Eosinophils - 02%
PLATELET	Adequate on smear
HEMOPARASITE	No parasites seen

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

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

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
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Name	: Mrs. VIMAL NAGRE (A)	Collected On	: 13/1/2024 9:25 am
Lab ID.	: 180437	Received On	: 13/1/2024 9:35 am
Age/Sex	: 57 Years / Female	Reported On	: 13/1/2024 5:18 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /	Report Status	: FINAL

* 1 8 0 4 3 7 *

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN	0.52	mg/dL	0.0 - 2.0
(Method-Diazo)			
DIRECT BILLIRUBIN	0.19	mg/dL	0.0 - 0.4
(Method-Diazo)			
INDIRECT BILLIRUBIN	0.33	mg/dL	0 - 0.8
Calculated			
SGOT(AST)	13.3	U/L	0 - 37
(UV without PSP)			
SGPT(ALT)	12.3	U/L	UP to 40
UV Kinetic Without PLP (P-L-P)			
ALKALINE PHOSPHATASE	**35.0**	U/L	42 - 98
(Method-ALP-AMP)			
S. PROTIEN	6.85	g/dl	6.4 - 8.3
(Method-Biuret)			
S. ALBUMIN	3.75	g/dl	3.5 - 5.2
(Method-BCG)			
S. GLOBULIN	3.10	g/dl	1.90 - 3.50
Calculated			
A/G RATIO	1.21		0 - 2
Calculated			

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	**62**	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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

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24 HOURS 7
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Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS /**	**Report Status**	: **FINAL**

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	18.5	U/L	5 - 55
BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	91.6	mg/dL	70 - 110
BLOOD GLUCOSE PP	106.4	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)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.9	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	122.6	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE

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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