

09/03/2024

Saraswati Nand
42 yrs / female

No fresh complaints.

No co morbidities

No PIH.

No SM.

LMP - 18/2/24, regular

O/H - G₂ P₂ A₀ L₂ D₀.

G₁ - female, 14 yrs., FTND, healthy

G₂ - female, 11 yrs., FTND, healthy.

Ht - wt

Ht - 161 cm

wt - 87 kg

BMI - 33.6 kg/m²

(obese class 1)

F/H - mother - DM

father - DM

BP - 130/100 mmHg

P - ~~100~~ 90/min

SPO₂ - 98%

Pt is fit and can resume her

normal duties

Low HB↓



HELPLINE

022 - 2588 3531

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

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ID: 1066 09-03-2024 08:48:57 AM

Female Years 62

Req. No. BP: 130/100

SPo2: 99

PR: 144

WT: 87 HT: 161

HR: 80 bpm

P: 93 ms

PR: 148 ms

QRS: 73 ms

QT/QTcBz: 352/408 ms

PQRST: -9/44/44 °

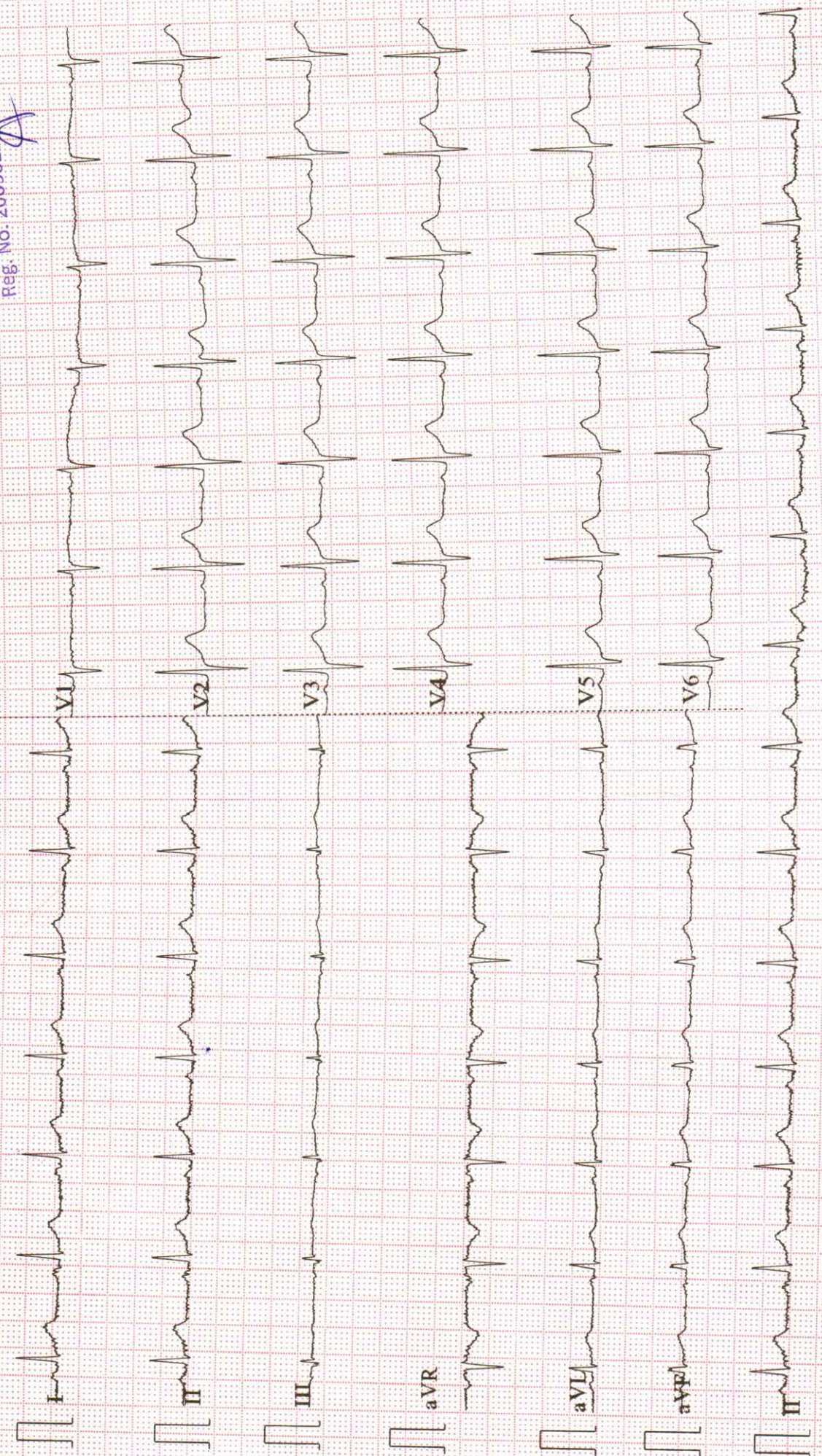
RV5/SV1: 1.072/0.506 mV

Diagnosis Information:
Sinus Rhythm
Normal ECG

CWNL

DR. R. P. ...
MBBS, DNB, DIM (Cardiology)
Reg. No. 2005021788

Report Confirmed by:





Name - Mrs. Saraswati Nand	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 09/03/2024

USG ABDOMEN & PELVIS

FINDINGS:

The liver dimension is enlarged in size (17.3 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 and morphology

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

The right kidney measures 9.7 x 4.2 cm.

The left kidney measures 10.0 x 4.2 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus : normal in size

Endometrium: 10.3 mm, it appears normal in morphology.

Both ovaries are normal in size.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Hepatomegaly with fatty liver (Grade I).

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST





Name - Mrs. Saraswati Nand	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 09/03/2024

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





Name - Mrs. SARASWATI NAND	Age - 32 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 09 /03/2024

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.

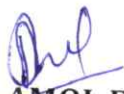
Both domes of diaphragm appear normal.

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.





ECHOCARDIOGRAM

NAME	MRS. SARASWATI NAND
AGE/SEX	42 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	09 /03/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal <ul style="list-style-type: none"> • Left atrial appendage: Normal LEFT VENTRICLE: Mild concentric LV hypertrophy <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	22 mm	Left atrium	36 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	47.4 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	32.9 mm	RVEF	%
Ascending aorta	mm	IVSd	11.7 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	11.7 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	70 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. SARASWATI NAND
AGE/SEX	42 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	09 /03/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.72	1.15
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: MILD HYPERTENSIVE HEART DISEASE

- No RWMA
- Normal LV systolic function (LVEF 70 %)
- 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



Name : Mrs. SARASWATI NAND (A) Collected On : 9/3/2024 9:43 am
Lab ID. : 186169 Received On : 9/3/2024 9:53 am
Age/Sex : 42 Years / Female Reported On : 9/3/2024 9:08 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	175.0	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)	43.4	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	96.9	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)	19	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	112	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)	2.58		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.03		<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)	31.2	%	36 - 46
RBC COUNT	4.03	x10 ⁶ /uL	4.5 - 5.5
MCV	77	fl	80 - 96
MCH	25.8	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	16.2	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	8280	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	62	%	40 - 80
LYMPHOCYTES	30	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	05	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	167000	/cumm	150000 - 450000
MPV	15.7	fl	6.5 - 11.5
PDW	16.6	%	9.0 - 17.0
PCT	0.260	%	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.

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SHAISTA Q

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
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
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	0-2	/ HPF	0 - 5
CASTS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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TFT (THYROID FUNCTION TEST)

SPECIMEN	Serum		
T3	130.9	ng/dl	84.63 - 201.8
T4	7.29	µg/dl	5.13 - 14.06
TSH	3.18	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER COBAS e411.

INTERPRETATION T3 (Triiodo Thyronine) T4 (Thyroxine)

AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

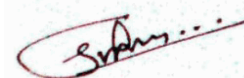
TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
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.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'B'		
RH FACTOR	NEGATIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	22.7	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	10.61	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.65	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.7	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	140.1	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.21	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	103.1	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.82	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.4	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.77	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.94	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.83	g/dl	1.9 - 3.5
A/G RATIO calculated	1.39		0 - 2

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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Priyanka_Deshmukh

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic, Normochromic
WBC	Total leukocytes count is normal on smear.
	NEUTROPHILS: 62%
	LYMPHOCYTES: 30%
	EOSINOPHILS: 03%
	MONOCYTES: 05%
	BASOPHILS: 00%
PLATELET	Adequate on smear.
HEMOPARASITE	No parasites seen.

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

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

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.93	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.4	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.53	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	22.3	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	23.8	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	88.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.77	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.94	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.83	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.39		0 - 2

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

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	25	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	17.0	U/L	5 - 55

BLOOD GLUCOSE FASTING & PP

BLOOD GLUCOSE FASTING	104.7	mg/dL	70 - 110
BLOOD GLUCOSE PP	113.0	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 specimen. 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

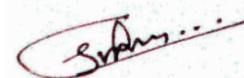
- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms +Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

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

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.8	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	119.8	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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Name : Mrs. SARASWATI NAND (A) Collected On : 9/3/2024 9:43 am
Lab ID. : 186169 Received On : 9/3/2024 9:53 am
Age/Sex : 42 Years / Female Reported On : 9/3/2024 9:08 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 6 1 6 9 *

BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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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.

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

Checked By
SHAISTA Q

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

