ECG report

ID : 2
Name : VIKASKUMAR PARMAR
Gender : M
Age : 38 Years
Dept :
Bed No :

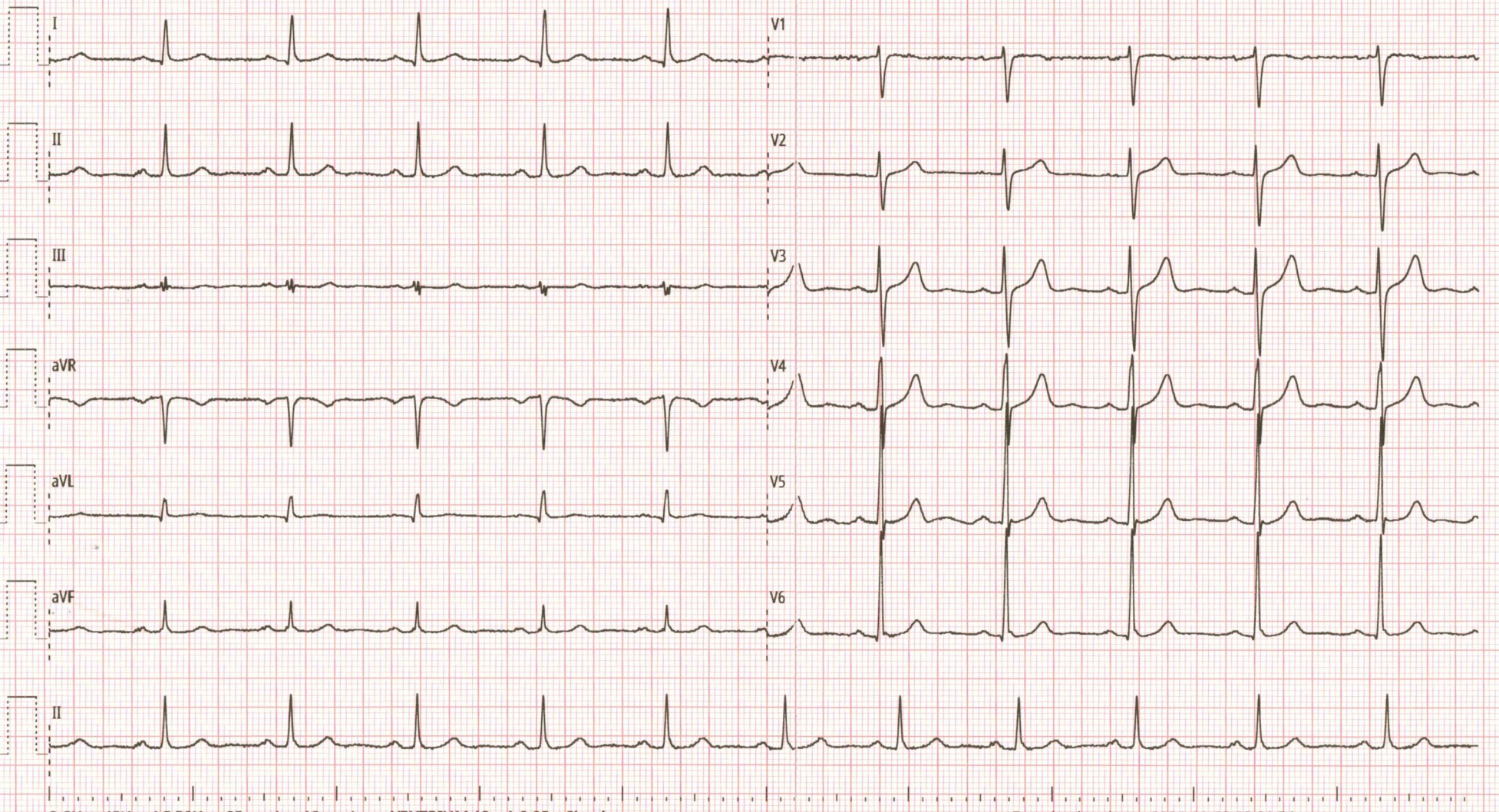
HR : 70 bpm
PR : 176 ms
QRS : 82 ms
QT/QTc : 380/398 ms
P/QRS/T : 39/31/39 °
RV5/SV1 : 1.936/0.763 mv
RV5+SV1 : 2.699 mv

<<Interpretations >>
Sinus rhythm
Normal ECG

Confirm and sign :

DHS Multispeciality Hospital Ahmedabad

DR. ARCHIT PARIKH
G-[illegible]352
M.D.(General Medicine)
DHS MULTISPECIALITY HOSPITAL



PATIENT NAME	**MR.VIKASHKUMAR PARMAR**
AGE / SEX	**38 YRS/MALE**
REF. DOCTOR	**DR. DHS DOCTOR TEAM**
DATE	**09/11/2024**

2D ECHO CARDIOGRAPHY REPORT

Observation:

1. **Normal LV size with normal LV systolic function. LVEF: 65%.**
2. **No RWMA at rest.**
3. **Reduced LV compliance.**
4. **Normal sized LA, RA and RV. Normal RV function.**
5. **All valves are normal in structure.**
6. **IAS and IVS are intact.**
7. **Mild PAH. RVSP = 36 mmHg.**
8. **No clot/ vegetation / pericardial effusion.**
9. **Doppler: Mild MR, Mild TR, No AR, No PR.**
10. **IVC is normal in size and well collapse on inspiration.**

Conclusion:

Normal LV systolic function.
No RWMA.
Mild PAH.

Measurements :

LVIDD	**44.0 mm**	**AO**	**22.0mm**
LVIDS	**23.0 mm**	**LA**	**28.0mm**
LVEF	**65%**		
IVSD/LVPWD	**09.0mm/10.0mm**		

DOPPLER STUDY:

Valves	velocity	Max gradient	Mean gradient	Area	Regurgitation
Aortic	1.3	5.2			No AR
Mitral	E:0.3 A: 0.1				Mild MR
Pulmonary	0.4	3.3			No PR
Tricuspid	0.5	1.1			Mild TR

Dr.ARCHIT PARIKH

DR. ARCHIT PARIKH
G - 30352
M. D.(General Medicine)
DHS MULTISPECIALTY HOSPITAL

VIKASKUMAR PARMAR
38 Y/M
HEALTH CHECK UP
09/11/2024

U.S.G. OF ABDOMEN AND PELVIS

s

Liver: appears **mild enlarged** in size (17 cm) & shows **grade 2 fatty changes**. No focal lesion is seen. No dilated IHBR is seen. Portal vein appears normal in course and caliber.

Gall bladder: is moderately distended & **shows approx.10 mm sized calculus.** No sludge or mass is seen. Gall bladder wall thickness appears normal. CBD appears normal – 3.5 mm.

Pancreas: appears normal in size & echopattern. No focal lesion is seen.

Spleen: appears normal in size and shows normal echotexture. No focal lesion is seen.

Both Kidneys appear normal in size, position and echopattern.
C-M differentiation is well preserved on either side.
No calculus or hydronephrosis on either side.
Cortical thickness appears normal on both sides.
No focal lesion is seen on either side.

Urinary bladder is moderately distended & appears normal. No calculus, internal echoes or mass is seen. Urinary bladder wall thickness appears normal.

Prostate appears normal in size and shows parenchymal calcification.

Para-aortic region appears normal.
No abdominal lymphadenopathy is seen.
Bowel loops appear normal in caliber & show normal peristalsis.
No abnormal dilatation of bowel loops or wall thickening is seen.
No fluid collection or lump formation is seen in RIF.
No ascites is seen.

IMPRESSION:
Mild hepatomegaly with grade 2 fatty changes
Gall bladder calculus as described

Clinical correlation suggested. Thanks for reference.

DR. BHADRESH CHUDASAMA
MD RADIOLOGY

TEST REPORT

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Age/Sex :	38 Years / Male			**Report Date :**	09-Nov-2024
Ref. By :	MEDIWHEEL				

Parameter	Result	Unit	Reference Interval
COMPLETE BLOOD COUNT (CBC)			
Hemoglobin (SLS method)	14.4	g/dL	13.0 - 17.0
Hematrocrit (Electrical Impedance)	42.7	%	40 - 54
RBC Count (Electrical Impedance)	4.82	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	5700	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	199000	/cmm	150000 - 410000
MCV (Calculated)	88.5	fL	83 - 101
MCH (Calculated)	29.8	Pg	27 - 32
MCHC (Calculated)	33.7	%	31.5 - 34.5
RDW (Calculated)	12.8	%	11.5 - 14.5
DIFFERENTIAL WBC COUNT			
Neutrophils (%)	43	%	38 - 70
Lymphocytes (%)	43	%	20 - 45
Monocytes (%)	08	%	2 - 8
Eosinophils (%)	**06**	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	2430	/cmm	1800 - 7700
Lymphocytes (Absolute)	2450	/cmm	1000 - 3900
Monocytes (Absolute)	440	/cmm	200 - 800
Eosinophils (Absolute)	360	/cmm	20 - 500
Basophils (Absolute)	20	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	0.99	/cmm	0.7 - 4.0
PERIPHERAL SMEAR EXAMINATION			
RBC Morphology	RBCs are Normochromic Normocytic.		
WBC Morphology	Total WBC and differential count is within normal.		
Platelets	Platelets are adequate with normal morphology.		
Parasites	Malarial parasite is not detected.		
ERYTHROCYTE SEDIMENTATION RATE			
ESR (After 1 hour)	12	mm/hr	0 - 14

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Parameter	Result	Unit	Reference Interval
FBS			
Fasting Blood Sugar (FBS)	93.6	mg/dL	70 - 110
Glucose Oxidase-Peroxidase			
PPBS			
Post Prandial Blood Sugar (PPBS)	137.1	mg/dL	110 - 140
Glucose Oxidase-Peroxidase			

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Parameter	Result	Unit	Biological Reference Interval

HEMOGLOBIN A1 C ESTIMATION

Specimen: Blood EDTA

Hb A1C *HPLC, NGSP Certified*	5.8	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
Mean Blood Glucose *Calculated*	119.76	mg/dL	

Criteria for the diagnosis of diabetes:

1. HbA1c >/= 6.5 *Or
2. Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
3. Two hour plasma glucose >/= 200mg/dL during an oral glucose tolerence test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >/= 200 mg/dL.

*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:

- HbA1C, also known as glycated heamoglobin, is the most important test for the assessment of long term blood glucose control(also called glycemic control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glycemic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glyemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD) is considered most important.

(Ref. National Glycohaemoglobin Standardization Program - NGSP).

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Parameter	Result	Unit	Reference Interval
LIVER FUNCTION TEST			
SGPT *Optimized UV-IFCC*	18.2	U/L	1 - 45
SGOT *Optimized UV-IFCC*	13.2	U/L	1 - 35
Total Bilirubin *DCA method*	0.48	mg/dL	0 - 2.0
Direct Bilirubin *DCA method*	0.24	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN *Calculated*	0.24	mg/dL	0.0 - 1.6
Alkaline Phosphatase *PNP-AMP Buffer, Multiple-point rate*	57	U/L	53 - 128
Total Protein	6.46	g/dL	6.4 - 8.2
Albumin *By Bromocresol Green*	3.70	g/dL	3.5 - 5.2
Globulin *Calculated*	2.76	g/dL	2.3 - 3.5
A/G Ratio *Calculated*	1.34		0.8 - 2.0
GGT	52	U/L	1 - 55

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Parameter	Result	Unit	Reference Interval
RENAL FUNCTION TEST			
Creatinine *Enzymatic ,IDMS Traceable*	0.92	mg/dL	0.7 - 1.3
Urea *Urease-GLDH, enzmatic UV*	28.3	mg/dL	19.0 - 45.0
BUN *Calculated*	13.22	mg/dL	7 - 18
Uric Acid *Enzymatic using TBHBA*	4.5	mg/dL	3.5 - 7.2
Sodium *Direct ISE*	139.6	mmol/L	137 - 145
Potassium *Direct ISE*	4.85	mmol/L	3.6 - 5.1
Chloride *Direct ISE*	95.3	mmol/L	94 - 110
Ionized Calcium *Direct ISE*	4.79	mg/dL	4.4 - 5.4

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Parameter	Result	Unit	Biological Reference Interval
LIPID PROFILE			
Cholesterol *CHOD-PAP method*	222	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride *Enzymatic with GPO method*	364.5	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL *Calculated*	**72.90**	mg/dL	15 - 35
LDL CHOLESTEROL	99.50	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol *Magnetic Cholesterol Oxidase*	49.6	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio *Calculated*	4.48		0 - 5.0
LDL / HDL RATIO *Calculated*	2.01		0 - 3.5
Total Lipids *Calculated*	**1133.00**		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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Parameter	Result	Unit	Biological Reference Interval
THYROID FUNCTION TEST			
T3 (Triiodothyronine) *CMIA*	0.90	ng/mL	0.6 - 1.81
T4 (Thyroxine) *CMIA*	8.04	µg/dL	4.5 - 12.5
TSH *ELFA-Enzyme Linked Fluorescent Assay*	**7.346**	µIU/ml	0.35 - 4.94

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-relasing hormone (TRH),directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4.Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary(hypothalamus) hypothyroidism.In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiaryhypothyroidism, TSH levels are low.

TSH levels During Pregnancy :
First Trimester :0.1 to 2.5 µIU/mL
Second Trimester : 0.2 to 3.0 µIU/mL
Third trimester : 0.3 to 3.0 µIU/mL

Referance : Carl A.Burtis,Edward R.Ashwood,David E.Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Eddition.
Philadelphia: WB Sounders,2012:2170

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Parameter	Result	Reference Interval
URINE ROUTINE EXAMINATION		
PHYSICAL EXAMINATION		
Quantity	10 cc	
Colour	Pale Yellow	
Clarity	Clear	
CHEMICAL EXAMINATION (BY REFLECTANCE PHOTOMETRIC METHOD)		
pH	7.0	4.6 - 8.0
Sp. Gravity	1.015	1.002 - 1.03
Protein	Nil	
Glucose	Nil	
Ketone Bodies	Nil	
Urobilinogen	Nil	
Bilirubin	Nil	
Nitrite	Nil	
Leucocytes	Nil	
Blood	Nil	
MICROSCOPIC EXAMINATION (MANUAL BY MICROSCOPY)		
Leucocytes (Pus Cells)	1 - 5/hpf	
Erythrocytes (Red Cells)	Nil	
Epithelial Cells	1-2/hpf	
Amorphous Material	Nil	
Casts	Nil	
Crystals	Nil	
Bacteria	Nil	
Yeast	Nil	
T. Vaginalis	Nil	
Spermatozoa	Nil	

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Parameter	Result	Unit	Reference Interval
BLOOD GROUP & RH			
SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION			
ABO	'O'		
Rh (D)	Positive		

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Parameter	Result	Unit	Biological Reference Interval
VITAMIN B12	**<148**	pg/mL	211 - 911

Vitamin B12 is essential in DNA synthesis, hematopoiesis, and CNS integrity.

Interpretation:
Increased In
-Chronic granulocytic leukemia
-COPD and Chronic renal failure
-Leukocytosis
-Liver cell damage (hepatitis, cirrhosis)
-Obesity and Severe CHF
-Polycythemia vera
-Protein malnutrition

Decreased In
-Abnormalities of cobalamin transport or metabolism
-Bacterial overgrowth
-Crohn disease
-Dietary deficiency (e.g. in vegetarians)
-Diphyllobothrium (fish tapeworm) infestation
-Gastric or small intestine surgery
-Hypochlorhydria
-Inflammatory bowel diseas
-Intestinal malabsorption and Intrinsic factor deficiency

Limitations:
-Drugs such as chloral hydrate increase vitamin B12 levels. On the other hand ,alcohol, aminosalicylic acid, anticonvulsants, ascorbic acid,cholestyramine, cimetidine, colchicines, metformin, neomycin, oral contraceptives, ranitidine, and triamterene decrease vitamin B12 levels.
-The evaluation of macrocytic anemia requires measurements of both vitamin B12 and folate levels; ideally they should be measured simultaneously.
Specimen collection soon after blood transfusion can falsely increase vitamin B12 levels.
-Patients taking vitamin B12 supplementation may have misleading results.
-A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B`12 concentrations are normal.

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Parameter	Result	Unit	Biological Reference Interval
25 OH VITAMIN D TOTAL *CHEMILUMINESCENCE*	13.20	ng/mL	Deficiency : <10 Insufficiency : 10 - 30 Sufficiency : 30 - 100 Toxicity : >100

Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol(vitamin D3) which is synthesized in skin from 7 dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25 (OH)vitamin D in liver.

Interpretation:
Increased In
-Vitamin D intoxication
-Excessive exposure to sunlight

Decreased In

-Malabsorption
-Steatorrhea
-Dietary osteomalacia, anticonvulsant osteomalacia
-Biliary and portal cirrhosis
-Thyrotoxicosis
-Pancreatic insufficiency
-Celiac disease
-Rickets
-Alzheimer disease

Limitations:

More recently, it has become clear that receptors for vitamin D are present in a wide variety of cells and that this hormone has biologic effects extending beyond the control of mineral metabolism. Vitamin D deficiency is not clear. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels. In turn, those levels are lower than levels needed tooptimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL. A recent studystates that increasing mean baseline levels from 29 to 38 ng/mL was associated with a 50% lower risk for colon cancer and levels of 52 ng/mL with a 50% reduction in the incidence of breast cancer. It is recommended to have clinical correlation with serum 25(OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.

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