

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

| | | | |
|-----------------------|--------------------------|------------------------|--------------------|
| Patient Name | Mr. GANESH NARAYAN MEENA | Lab No | 4059431 |
| UHID | 40022527 | Collection Date | 26/10/2024 10:51AM |
| Age/Gender | 32 Yrs/Male | Receiving Date | 26/10/2024 10:53AM |
| IP/OP Location | O-OPD | Report Date | 26/10/2024 6:23PM |
| Referred By | Dr. EHS CONSULTANT | Report Status | Final |
| Mobile No. | 9950555133 | | |

BIOCHEMISTRY

| Test Name | Result | Unit | Biological Ref. Range | Sample: FI. Plasma |
|-----------|--------|------|-----------------------|--------------------|
|-----------|--------|------|-----------------------|--------------------|

BLOOD GLUCOSE (FASTING)

| | | | |
|-------------------------|------|-------|----------|
| BLOOD GLUCOSE (FASTING) | 94.4 | mg/dl | 71 - 109 |
|-------------------------|------|-------|----------|

Method: Hexokinase assay.

Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

BLOOD GLUCOSE (PP)

| | | | |
|---------------------|-------|-------|---|
| BLOOD GLUCOSE (PP) | 107.1 | mg/dl | Non – Diabetic: - < 140 mg/dl Pre – Diabetic: - 140-199 mg/dl Diabetic: - >=200 mg/dl |
|---------------------|-------|-------|---|

Sample: PLASMA

Method: Hexokinase assay.

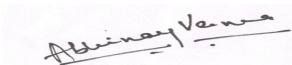
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

THYROID T3 T4 TSH

| | | | |
|-----|-------|--------|---------------|
| T3 | 1.380 | ng/mL | 0.970 - 1.690 |
| T4 | 8.68 | ug/dl | 5.53 - 11.00 |
| TSH | 1.65 | μIU/mL | 0.27 - 4.20 |

Sample: Serum

RESULT ENTERED BY : SUNIL EHS



Dr. ABHINAY VERMA

MBBS|MD|INCHARGE PATHOLOGY

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BIOCHEMISTRY

T3:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

T4:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T4 assay employs a competitive test principle with an antibody specifically directed against T4.

TSH - THYROID STIMULATING HORMONE :- ElectroChemiLuminescenceImmunoAssay - ECLIA

Interpretation:-The determination of TSH serves as the initial test in thyroid diagnostics. Even very slight changes in the concentrations of the free thyroid hormones bring about much greater opposite changes in the TSH levels.

LFT (LIVER FUNCTION TEST)

Sample: Serum

| | | | |
|----------------------|------|-------|-------------|
| BILIRUBIN TOTAL | 0.71 | mg/dl | 0.00 - 1.20 |
| BILIRUBIN INDIRECT | 0.50 | mg/dl | 0.20 - 1.00 |
| BILIRUBIN DIRECT | 0.21 | mg/dl | 0.00 - 0.30 |
| SGOT | 26.4 | U/L | 0.0 - 40.0 |
| SGPT | 29.9 | U/L | 0.0 - 41.0 |
| TOTAL PROTEIN | 8.5 | g/dl | 6.6 - 8.7 |
| ALBUMIN | 5.1 | g/dl | 3.5 - 5.2 |
| GLOBULIN | 3.4 | | 1.8 - 3.6 |
| ALKALINE PHOSPHATASE | 79 | U/L | 40 - 129 |
| A/G RATIO | 1.5 | Ratio | 1.5 - 2.5 |
| GGTP | 22.0 | U/L | 10.0 - 60.0 |

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Abhinay Verma

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BIOCHEMISTRY

BILIRUBIN TOTAL :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structure.

BILIRUBIN DIRECT :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.

SGOT - AST :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT(AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.

SGPT - ALT :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT(ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.

TOTAL PROTEINS :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.

ALBUMIN :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.

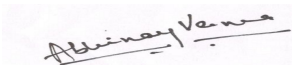
ALKALINE PHOSPHATASE :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method:

Enzymatic colorimetric assay. Interpretation:- γ -glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

LIPID PROFILE

| | | | |
|-----------------------|-------|-------|--|
| TOTAL CHOLESTEROL | 213.6 | | <200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High |
| HDL CHOLESTEROL | 36.5 | | High Risk :-<40 mg/dl (Male), <40 mg/dl (Female) Low Risk :->=60 mg/dl (Male), >=60 mg/dl (Female) |
| LDL CHOLESTEROL | 159.6 | | Optimal :- <100 mg/dl Near or Above Optimal :- 100-129 mg/dl Borderline :- 130-159 mg/dl High :- 160-189 mg/dl Very High :- >190 mg/dl |
| CHOLESTERO VLDL | 35 | mg/dl | 10 - 50 |
| TRIGLYCERIDES | 176.3 | | Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl |
| CHOLESTEROL/HDL RATIO | 6 | % | |

RESULT ENTERED BY : SUNIL EHS



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BIOCHEMISTRY

CHOLESTEROL TOTAL :- Method: CHOD-PAP enzymatic colorimetric assay. **Interpretation**:-The determination of the individual total cholesterol (TC) level is used for screening purposes while for a better risk assessment it is necessary to measure additionally lipid & lipoprotein metabolic disorders. **HDL CHOLESTEROL** :- Method:-Homogenous enzymatic colorimetric method. **Interpretation**:-HDL-cholesterol has a protective against coronary heart disease, while reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase the cardiovascular disease. **LDL CHOLESTEROL** :- Method: Homogenous enzymatic colorimetric assay. **Interpretation**:-LDL play a key role in causing and influencing the progression of atherosclerosis and in particular coronary sclerosis. The LDL are derived form VLDL rich in TG by the action of various lipolytic enzymes and are synthesized in the liver. **CHOLESTEROL VLDL** :- Method: VLDL Calculative

TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay. **Interpretation**:-High triglycerde levels also occur in various diseases of liver, kidneys and pancreas. DM, nephrosis, liver obstruction. **CHOLESTEROL/HDL RATIO** :- Method: Cholesterol/HDL Ratio Calculative

Sample: Serum

| | | | |
|------------|---------------|--------|---------------|
| UREA | 21.20 | mg/dl | 16.60 - 48.50 |
| BUN | 10 | mg/dl | 6 - 20 |
| CREATININE | 0.62 L | mg/dl | 0.70 - 1.20 |
| SODIUM | 141 | mmol/L | 136 - 145 |
| POTASSIUM | 3.88 | mmol/L | 3.50 - 5.50 |
| CHLORIDE | 101.2 | mmol/L | 98 - 107 |
| URIC ACID | 5.0 | mg/dl | 3.4 - 7.0 |
| CALCIUM | 9.90 | mg/dl | 8.60 - 10.00 |

CREATININE - SERUM :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidneydisease.

URIC ACID :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uricacid are renal diseases with decreased excretion of waste products, starvation,drug abuse and increased alcohol consume.

SODIUM:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea,diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake andkidney reabsorption.

POTASSIUM :- Method: ISE electrode. Intrapretation:-Low level: Intake excessive loss formbodydue to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renalfailure.

CHLORIDE - SERUM :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake,prolonged vomiting and reduced renal reabsorption as well as forms of acidosisand alkalosis. Increase: dehydration, kidney failure, some form ofacidosis, high dietary or parenteral chloride intake, and salicylate poisoning.

UREA:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogenconcentration are seen in inadequate renal perfusion, shock, diminished bloodvolume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerularnephritis and UTI.

CALCIUM TOTAL :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usuallyassociated with hypercalcemia. Increased serum calcium levels may also beobserved in multiple myeloma and other neoplastic diseases. Hypocalcemia may beobserved in hypoparathyroidism, nephrosis, and pancreatitis.

Sample: WHOLE BLOOD EDTA

RESULT ENTERED BY : SUNIL EHS

Abhinav Verma

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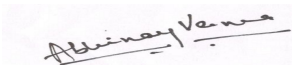
BIOCHEMISTRY

| | | | | |
|-------|-----|---|--|-----------------------------|
| HbA1C | 5.2 | % | | < 5.7% Nondiabetic |
| | | | | 5.7-6.4% Pre-diabetic |
| | | | | > 6.4% Indicate Diabetes |

| | |
|-------------------------|-------------------|
| Known Diabetic Patients | |
| < 7 % | Excellent Control |
| 7 - 8 % | Good Control |
| > 8 % | Poor Control |

Method : - Turbidimetric inhibition immunoassay (TINIA), **Interpretation:-**Monitoring long term glyceimic control, testing every 3 to 4 months is generally sufficient. The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

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BLOOD BANK INVESTIGATION

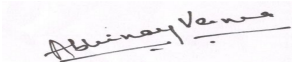
| Test Name | Result | Unit | Biological Ref. Range |
|-----------|--------|------|-----------------------|
|-----------|--------|------|-----------------------|

| | | | |
|----------------|-----------------|--|--|
| BLOOD GROUPING | "B" Rh Positive | | |
|----------------|-----------------|--|--|

Note :

1. Both forward and reverse grouping performed.
2. Test conducted on EDTA whole blood.

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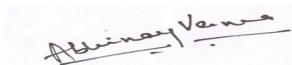
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CLINICAL PATHOLOGY

| Test Name | Result | Unit | Biological Ref. Range | Sample: Urine |
|---|-------------|------|-----------------------|---------------|
| <u>URINE SUGAR (POST PRANDIAL)</u> | | | | |
| URINE SUGAR (POST PRANDIAL) | NEGATIVE | | NEGATIVE | Sample: Urine |
| <u>URINE SUGAR (RANDOM)</u> | | | | |
| URINE SUGAR (RANDOM) | NEGATIVE | | NEGATIVE | Sample: Urine |
| PHYSICAL EXAMINATION | | | | |
| VOLUME | 20 | ml | | Sample: Urine |
| COLOUR | PALE YELLOW | | P YELLOW | |
| APPEARANCE | CLEAR | | CLEAR | |
| CHEMICAL EXAMINATION | | | | |
| PH | 6.5 | | 5.5 - 7.0 | |
| SPECIFIC GRAVITY | 1.010 | | 1.016-1.022 | |
| PROTEIN | NEGATIVE | | NEGATIVE | |
| SUGAR | NEGATIVE | | NEGATIVE | |
| BILIRUBIN | NEGATIVE | | NEGATIVE | |
| BLOOD | NEGATIVE | | | |
| KETONES | NEGATIVE | | NEGATIVE | |
| NITRITE | NEGATIVE | | NEGATIVE | |
| UROBILINOGEN | NEGATIVE | | NEGATIVE | |
| LEUCOCYTE | NEGATIVE | | NEGATIVE | |
| MICROSCOPIC EXAMINATION | | | | |
| WBCS/HPF | 1-2 | /hpf | 0 - 3 | |
| RBCS/HPF | 0-0 | /hpf | 0 - 2 | |
| EPITHELIAL CELLS/HPF | 1-2 | /hpf | 0 - 1 | |
| CASTS | NIL | | NIL | |
| CRYSTALS | NIL | | NIL | |

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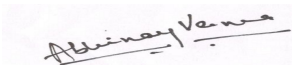
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CLINICAL PATHOLOGY

BACTERIA NIL NIL
OHTERS NIL NIL

Methodology:-Glucose: GOD-POD, Bilirubin: Diazo-Azo-coupling reaction with a diazonium, Ketone: Nitro Pruside reaction, Specific Gravity: Proton release from ions, Blood: Psuedo-Peroxidase activity oh Haem moiety, pH: Methye Red-Bromothymol Blue (Double indicator system), Protein: H+ Release by buffer, microscopic & chemical method.. interpretation: Diagnosis of Kidney function, UTI, Presence of Protein, Glucoses, Blood. Vocubulary syntax: Kit insert

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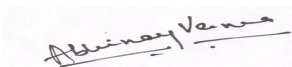
HEMATOLOGY

| Test Name | Result | Unit | Biological Ref. Range |
|-------------------------------------|----------------|----------------------|-----------------------|
| Sample: WHOLE BLOOD EDTA | | | |
| HAEMOGLOBIN | 15.2 | g/dl | 13.0 - 17.0 |
| PACKED CELL VOLUME(PCV) | 43.2 | % | 40.0 - 50.0 |
| MCV | 100.9 H | fl | 82 - 92 |
| MCH | 35.5 H | pg | 27 - 32 |
| MCHC | 35.2 | g/dl | 32 - 36 |
| RBC COUNT | 4.28 L | millions/cu.mm | 4.50 - 5.50 |
| TLC (TOTAL WBC COUNT) | 6.88 | 10 ³ / uL | 4 - 10 |
| DIFFERENTIAL LEUCOCYTE COUNT | | | |
| NEUTROPHILS | 63.2 | % | 40 - 80 |
| LYMPHOCYTE | 31.4 | % | 20 - 40 |
| EOSINOPHILS | 1.3 | % | 1 - 6 |
| BASOPHIL | 0.3 L | % | 1 - 2 |
| MONOCYTES | 3.8 | % | 2 - 10 |
| PLATELET COUNT | 2.03 | lakh/cumm | 1.500 - 4.500 |

HAEMOGLOBIN :- Method:-SLS Hemoglobin Methodology by Cell Counter. Interpretation:-Low-Anemia, High-Polycythemia.
MCV :- Method:- Calculation by sysmex.
MCH :- Method:- Calculation by sysmex.
MCHC :- Method:- Calculation by sysmex.
RBC COUNT :- Method:-Hydrodynamic focusing. Interpretation:-Low-Anemia, High-Polycythemia.
TLC (TOTAL WBC COUNT) :- Method:-Optical Detector block based on Flowcytometry. Interpretation:-High-Leucocytosis, Low-Leucopenia.
NEUTROPHILS :- Method: Optical detector block based on Flowcytometry
LYMPHOCYTES :- Method: Optical detector block based on Flowcytometry
EOSINOPHILS :- Method: Optical detector block based on Flowcytometry
MONOCYTES :- Method: Optical detector block based on Flowcytometry
BASOPHIL :- Method: Optical detector block based on Flowcytometry
PLATELET COUNT :- Method:-Hydrodynamic focusing method. Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

ESR (ERYTHROCYTE SEDIMENTATION RATE) **30 H** mm/1st hr 0 - 15

RESULT ENTERED BY : SUNIL EHS



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Method:-Modified Westergrens.

Interpretation:-Increased in infections, sepsis, and malignancy.

****End Of Report****

RESULT ENTERED BY : SUNIL EHS

DEPARTMENT OF RADIO DIAGNOSIS

| | | | |
|-----------------------|--------------------------------------|------------------------|---------------------------------------|
| UHID / IP NO | 40022527 (43040) | RISNo./Status : | 4059431/ |
| Patient Name : | Mr. GANESH NARAYAN MEENA | Age/Gender : | 32 Y/M |
| Referred By : | Dr. EHS CONSULTANT | Ward/Bed No : | OPD |
| Bill Date/No : | 26/10/2024 10:30AM/ OPSCR24-25/25208 | Scan Date : | |
| Report Date : | 26/10/2024 11:03AM | Company Name: | Mediwheel - Arcofemi Health Care Ltd. |

ULTRASOUND STUDY OF WHOLE ABDOMEN

Liver: Normal in size & echotexture. No obvious significant focal parenchymal mass lesion noted. Intrahepatic biliary radicals are not dilated. Portal vein is normal.

Gall Bladder: Lumen is clear. Wall thickness is normal. CBD is normal.

Pancreas: Normal in size & echotexture.

Spleen: Normal in size & echotexture. No focal lesion seen.

Right Kidney: Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.

Left Kidney: Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.

Urinary Bladder: Normal in size, shape & volume. No obvious calculus or mass lesion is seen. Wall thickness is normal.

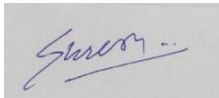
Prostate: Is normal in size and echotexture.

Others: No significant free fluid is seen in pelvic peritoneal cavity.

IMPRESSION: USG findings are suggestive of

- **No obvious significant sonographic abnormality noted.**

Correlate clinically & with other related investigations.



DR. SURESH KUMAR SAINI
RADIOLOGIST
MBBS, MD.
Reg. No. 22597, 36208.

DEPARTMENT OF CARDIOLOGY

| | | | |
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| UHID / IP NO | 40022527 (43040) | RISNo./Status : | 4059431/ |
| Patient Name : | Mr. GANESH NARAYAN MEENA | Age/Gender : | 32 Y/M |
| Referred By : | Dr. EHS CONSULTANT | Ward/Bed No : | OPD |
| Bill Date/No : | 26/10/2024 10:30AM/ OPSCR24-25/25208 | Scan Date : | |
| Report Date : | 26/10/2024 11:39AM | Company Name: | Final |

REFERRAL REASON: HEALTH CHECKUP

2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

M MODE DIMENSIONS: -

| | | Normal | | Normal |
|--------------|--------------|----------------|--------------|-------------|
| IVSD | 9.1 | 6-12mm | LVIDS | 23.2 |
| LVIDD | 40.4 | 32-57mm | LVPWS | 15.6 |
| LVPWD | 9.1 | 6-12mm | AO | 28.0 |
| IVSS | 15.1 | mm | LA | 27.5 |
| LVEF | 60-62 | >55% | RA | - |

DOPPLER MEASUREMENTS & CALCULATIONS:

| STRUCTURE | MORPHOLOGY | VELOCITY (m/s) | | | | GRADIENT (mmHg) | REGURGITATION |
|-----------------|------------|----------------|------|-------------|---|-----------------|---------------|
| | | E | 0.75 | e' | - | | |
| MITRAL VALVE | NORMAL | A | 0.60 | E/e' | - | - | NIL |
| | | E | 0.69 | RVSP 30mmHg | | | |
| TRICUSPID VALVE | NORMAL | A | 0.52 | | | - | NIL |
| | | E | 1.07 | | | | |
| AORTIC VALVE | NORMAL | 1.07 | | | | - | NIL |
| PULMONARY VALVE | NORMAL | 0.80 | | | | - | NIL |

COMMENTS & CONCLUSION: -

- ALL CARDIAC CHAMBERS ARE NORMAL
- NO RWMA, LVEF 60-62%
- NORMAL LV SYSTOLIC FUNCTION
- NORMAL LV DIASTOLIC FUNCTION
- MILD TR/PAH, OTHER CARDIAC VALVES ARE NORMAL
- NO EVIDENCE OF CLOT/VEGETATION/PE
- INTACT IVS/IAS

IMPRESSION: - MILD TR/PAH, NORMAL BI VENTRICULAR FUNCTIONS

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