DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:28 AM Reported On : 10/12/2022 11:15 AM

Barcode : 012212100750 Specimen : Serum Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
SERUM CREATININE			
Serum Creatinine (Two Point Rate - Creatinine Aminohydrolase)	0.82	mg/dL	0.6-1.0
eGFR (Calculated)	83.7	mL/min/1.73m^2	Indicative of renal impairment < 60 Note:eGFR is inaccurate for Hemodyamically unstable patients eGFR is not applicable for less than 18 years of age.

Interpretation Notes

- **CLINICAL INFORMATION AND CLINICAL INTERPRETATION**:
  Diagnosing and monitoring treatment of acute and chronic kidney diseases
  Adjusting dosage of renally excreted medications
  Monitoring kidney transplant recipients
  Estimating glomerular filtration rate for people with chronic kidney disease (CKD) and those with risk factors for CKD (diabetes, hypertension, cardiovascular disease, and family history of kidney disease). Several factors may influence serum creatinine independent of changes in GFR. For instance, creatinine generation is dependent upon muscle mass. Thus, young, muscular male patients may have significantly higher serum creatinine levels than older adult female patients, despite having similar GFRs. Also, because some renal clearance of creatinine is due to tubular secretion, drugs that inhibit this secretory component (eg, cimetidine and trimethoprim) may cause small increases in serum creatinine without an actual decrease in GFR.
  POTENTIAL SOURCE OF VARIATION:
  Hemolyzed specimens from patients with hemoglobin F values of 600 mg/dL and higher interfere with the test.
  2-Phenyl-1,3-indandion (phenindione) at therapeutic concentrations interferes with the assay. In patients receiving catecholamines (dopamine, dobutamine, epinephrine, and norepinephrine) falsely low results might be observed.

Blood Urea Nitrogen (BUN) (Endpoint /Colorimetric – Urease)	13	mg/dL	7.0-17.0

Interpretation Notes

- **CLINICAL INFORMATION AND INTERPRETATION:**
  For evaluation if Renal function tests. Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis), and post renal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).
  Serum / plasma concentration is increased in:

Glomerulonephritis, Shock, Urinary tract obstruction, Pyelonephritis, Acute and chronic renal failure, severe congestive heart failure, Hyperalimentation, Diabetic ketoacidosis, Dehydration
Serum / plasma concentration is decreased in:
Pregnancy, decreased protein intake, acute liver, intravenous fluid administration.
POTENTIAL SOURCE OF VARIATION:
Ammonium ions may cause an increase in measured BUN/UREA value equivalent to the specimen's nitrogen content.

Serum Uric Acid (Colorimetric - Uricase,Peroxidase)	6.16	mg/dL	2.5-6.2

LIPID PROFILE (CHOL,TRIG,HDL,LDL,VLDL)

Cholesterol Total (Colorimetric - Cholesterol Oxidase)	186	mg/dL	Desirable: < 200 Borderline High: 200-239 High: > 240
Triglycerides (Colorimetric - Lip/Glycerol Kinase)	64	mg/dL	Normal: < 150 Borderline: 150-199 High: 200-499 Very High: > 500
HDL Cholesterol (HDLC) (Colorimetric: Non HDL Precipitation Phosphotungstic Acid Method)	46	mg/dL	40.0-60.0
Non-HDL Cholesterol (Calculated)	**140.0 H**	mg/dL	Desirable: < 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190-219 Very High: => 220
LDL Cholesterol (Colorimetric)	**109 L**	mg/dL	Optimal: < 100 Near to above optimal: 100-129 Borderline High: 130-159 High: 160-189 Very High: > 190
VLDL Cholesterol (Calculated)	12.8	mg/dL	0.0-40.0
Cholesterol /HDL Ratio (Calculated)	4.1	-	0.0-5.0

Interpretation Notes

- **Clinical Information and Interpretation:**
  Diagnosing dyslipoproteinemia, Quantitation of cholesterol and triglycerides in very-low-density lipoprotein, low-density lipoprotein (LDL), high-density lipoproteins (HDL), and chylomicrons, Identification of LpX, classifying hyperlipoproteinemias (lipoprotein phenotyping), Evaluating patients with abnormal lipid values (cholesterol, triglyceride, HDL, LDL) for specific phenotypes, Quantifying lipoprotein a cholesterol.
  These elevations can be indicative of a genetic deficiency in lipid metabolism or transport, nephrotic syndrome, endocrine dysfunction, or even cholestasis.Proper characterization of a patient's dyslipidemic phenotype aids clinical decisions and guides appropriate therapy.
  Total Cholesterol in serum is increased in:
  Obesity**,** Smoking**,** Alcohol**,** Diet high cholesterol and fats**,** Renal failure**,** Hypothyroidism
  Total Cholesterol in serum is decreased in:
  Malnutrition**,** Liver disease**,** Myeloproliferative disease

Cholesterol measurements are used to evaluate the risk of developing coronary artery occlusion, atherosclerosis, myocardial infarction, and cerebrovascular disease. Coronary atherosclerosis correlates with a high cholesterol level.

1. Triglycerides concentration are increased in
2. Hyperlipoproteinemia, Von Gierke disease, Diabetes, Hypothyroidism, Liver disease, alcoholism
3. Triglycerides concentration are Decreased in

Abetalipoproteinemia, Malnutrition, Hyperparathyroidism, Hyperthyroidism, Malabsorption.

dHDL concentration are increased in

Hyperalphalipoproteinemia ,Regular physical activity or exercise ,Weight loss ,Chronic liver disease

dHDL concentration are Decreased in

Uncontrolled diabetes **,** Hepatocellular disease **,**Chronic renal failure, nephrosis, uremia
Cholestasis ,Abetalipoproteinemia.

Chol/HDL ratio is helpful in for predicting the risk of heart disease. According to the American Heart Association (AHA), the ratio should be aimed to be kept below 5 for men and below 4.4 for women, with the ideal cholesterol ratio being 3.5.

Low Density Lipoprotein (LDL) cholesterol is used to evaluate the risk of developing coronary heart disease (CHD). The risk of CHD increases with higher LDL cholesterol concentrations. Lowering the LDL cholesterol level in the blood is a primary target of various cholesterol-lowering therapeutic agents.

dLDL concentration are increased in

Familial hypercholesterolemia, Nephrotic syndrome, Hepatic disease, Hepatic obstruction chronic renal failure, Hyperlipidemia type II and III, Diabetes mellitus

dLDL concentration are Decreased in

Abetalipoproteinemia, Hyperthyroidism, Tangier disease, Hypolipoproteinemia
Chronic anemia.

POTENTIAL SOURCE OF VARIATION:

Cholesterol results can be falsely decreased in patients with elevated levels of N-acetyl-p-benzoquinone imine (NAPQI), a metabolite of acetaminophen, N-acetylcysteine (NAC), and metamizole. Potassium Oxalate/Sodium Fluoride can decrease cholesterol results an average of 12%.

Small amounts of free glycerol may be found in blood samples from healthy individuals due to natural lipolysis. The concentration of free glycerol may be increased by stress, disease states or administration of intravenous infusates. Free glycerol or other polyols may cause a positive interference.

Certain drugs and clinical conditions are known to alter HDL cholesterol concentration in vivo.

LDL Cholesterol values may be high because of a diet high in saturated fats, pregnancy or use of steroids

LDL Cholesterol may be decreased because of acute stress, recent illness, and estrogen supplements

THYROID PROFILE (T3, T4, TSH)

Tri Iodo Thyronine (T3) (Enhanced Chemiluminesence)	1.13	ng/mL	0.97-1.69
Thyroxine (T4) (Enhanced Chemiluminesence)	8.71	µg/dl	5.53-11.0
TSH (Thyroid Stimulating Hormone) (Enhanced Chemiluminesence)	**4.428 H**	µIU/mL	> 18 Year(s) : 0.4 -4.5 Pregnancy: 1st Trimester: 0.129-3.120 2nd Trimester: 0.274-2.652 3rd Trimester: 0.312-2.947

Interpretation Notes

- **CLINICAL INFORMATION AND INTERPRETATION:**

TSH is measured quantitatively to aid in the differential diagnosis of Thyroid disease.
TSH concentration is increased in: Primary Hypothyroidism, Hashimoto Thyroiditis, Iodide deficiency goiter, Myxedema
TSH concentration is decreased in
Toxic multinodular goitre, Thyroid Adenoma, Thyroiditis, Secondary pituitary or hypothalamic hypothyroidism
TSH measurement help in differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low or normal. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively.
POTENTIAL SOURCES OF VARIATION:
Certain drugs and clinical conditions are known to alter TSH concentrations *in vivo*.
TSH levels are subject to circadian variation, reaching peak levels between 2 – 4 a.m. and at a minimum between 6 – 10 pm. The variation is of the order 50%, hence time of the day has influence on the measured serum TSH concentrations.
Transient increase in TSH levels or abnormal TSH levels can be seen in various non-thyroidal diseases. Simultaneous measurement of TSH with free T4 is useful in evaluating the differential diagnosis.
The possibility of interference of human heterophile antibodies in the patient specimen may interfere with the measurement of TSH, that interfere with immunoassays. This may falsely elevate or falsely decrease the results.
Interference due to extremely high titers of antibodies to analyte-specific antibodies, streptavidin, or ruthenium can occur.
Pregnancy also affects TSH levels. They are often a little low during the first three months. But sometimes, thyroid disease develops during pregnancy.
TT3
CLINICAL INFORMATION AND INTERPRETATION:
A fall in T3 concentrations of up to 50% is known to occur in a variety of clinical situations, including acute and chronic disease.
In hyperthyroidism, both T4 and T3 levels are usually elevated, but in a small subset of hyperthyroid patients, only T3 is elevated (T3 toxicosis).
In hypothyroidism T4 and T3 levels are decreased. T3 levels are frequently low in sick or hospitalized euthyroid patients.
Increased levels: Pregnancy, Grave's disease, T3 thyrotoxicosis, TSH dependent hyperthyroidism, Increased TBG
Decreased levels: Non thyroidal illness, hypothyroidism, Nutritional deficiency, systemic illness, Decreased TBG
Abnormal levels (high or low) of thyroid hormone-binding proteins (primarily albumin and thyroid-binding globulin) may cause abnormal T3 concentrations in euthyroid patients.
POTENTIAL SOURCES OF VARIATION:
Therapy with amiodarone can lead to depressed T3 values.
Phenytoin, phenylbutazone, and salicylates cause release of T3 from the binding proteins, thus leading to a reduction in the total T3 hormone level at normal free T3 levels.
Autoantibodies to thyroid hormones can interfere with the assay.
Binding protein anomalies may cause values that deviate from the expected results. Pathological concentrations of binding proteins can lead to results outside the reference range, although the patient may be in a euthyroid state. Free T3 or free T4 testing is indicated in these cases
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedures, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.
T3 has a 15-fold higher affinity for thyroid receptor compared to T4.
TT4
CLINICAL INFORMATION AND INTERPRETATION:
TT4 concentration is increased in:
Hyperthyroidism, Pregnancy, Euthyroid sick syndrome, Increase in Thyroxine-binding globulin (TBG), Familial dysalbuminemic hyperthyroxinemia, much higher in first 2 months of life than in normal adults
TT4 concentration is decreased in
Hypothyroidism, Hypoproteinemia, Euthyroid sick syndrome, Decrease in TBG
POTENTIAL SOURCES OF VARIATION:

In pregnancy, incomplete release of thyroxine (T4) from its binding proteins might result in falsely low total T4 levels. Therefore, total T4 should not be used as the only marker for thyroid function evaluation.
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.
Autoantibodies to thyroid hormones can interfere with testing.
In rare cases, interference due to extremely high titers of antibodies to analyte-specific antibodies, ruthenium or streptavidin can occur.
* For 12 hours before specimen collection for any thyroid function test, the patient should not take multivitamins or dietary supplements containing biotin (vitamin B7), which is commonly found in hair, skin, and nail supplements and multivitamins.

LIVER FUNCTION TEST(LFT)

Bilirubin Total (Colorimetric -Diazo Method)	1.10	mg/dL	0.2-1.3
Conjugated Bilirubin (Direct) (Dual Wavelength - Reflectance Spectrophotometry)	0.20	mg/dL	0.0-0.4
Unconjugated Bilirubin (Indirect) (Calculated)	0.9	mg/dL	0.0-1.1
Total Protein (Colorimetric - Biuret Method)	7.80	gm/dL	6.3-8.2
Serum Albumin (Colorimetric - Bromo-Cresol Green)	4.50	gm/dL	3.5-5.0
Serum Globulin (Calculated)	3.3	gm/dL	2.0-3.5
Albumin To Globulin (A/G)Ratio (Calculated)	1.36	-	1.0-2.1
SGOT (AST) (Multipoint-Rate With P-5-P (pyridoxal-5-phosphate))	27	U/L	14.0-36.0
SGPT (ALT) (Multipoint-Rate With P-5-P (pyridoxal-5-phosphate))	23	U/L	<35.0
Alkaline Phosphatase (ALP) (Multipoint-Rate - P-nitro Phenyl Phosphate, AMP Buffer)	66	U/L	38.0-126.0
Gamma Glutamyl Transferase (GGT) (Multipoint Rate - L-glutamyl-p-nitroanilide (Szasz Method))	**11 L**	U/L	12.0-43.0

Interpretation Notes

- Indirect Bilirubin result is a calculated parameter (Indirect Bilirubin = Total Bilirubin - Direct Bilirubin).
  Indirect bilirubin result includes the delta bilirubin fraction also. Delta Bilirubin is the bilirubin which is covalently bound to albumin. Delta Bilirubin is not expected to be present in healthy adults or neonates.
  CLINICAL INFORMATION AND CLINICAL INTERPRETATION:
  Initial screening for hepatobiliary inflammation. Panel includes albumin; ALP; AST; ALT; bilirubin, direct; protein, total; and bilirubin, total. The hepatic function panel may be used to help diagnose liver disease if a person has signs and symptoms that indicate possible

liver dysfunction. Indications for liver function testing include investigating and monitoring patients with suspected liver disease, at risk patient groups, or monitoring malignancy; and before initiating and monitoring hepatotoxic medications
Hepatic function panel results are not diagnostic of a specific condition. Results of liver panels are usually evaluated together. Several sets of results from tests performed over a few days or weeks are often assessed together to determine if a pattern is present.

POTENTIAL SOURCE OF VARIATION:

Pyridoxal phosphate is a cofactor in the reaction and must be present for optimal enzyme activity.
In Vitro exposure to light may alter bilirubin chemical and spectral properties because of the formation of photobilirubin.
Bc results flagged with a Potential Interferent (PI) code should be repeated with the VITROSTBIL slide, which is not sensitive to the same spectral Interferents.
Bu result flagged with a Potential Interferent (PI) code should be diluted with a normal patient sample or VITROS7% BSA and return on the BuBc Slide.
Certain drugs and Clinical conditions are known to alter Bu and Bc concentration in vivo.
Falsely elevated proteins (pseudohyperproteinemia) can be caused by hemoconcentration due to dehydration or sample desiccation.
Upright posture for several hours after rising increases Total Protein and several other analytes.
An average positive bias of 6% with an individual sample bias up to 10% may be observed with heparin plasma results compared to serum results.
CMPF (3-carboxy-4-methyl-5-propyl-2-furanpropanoic acid) present in sera of patients with renal failure has been reported to give falsely low albumin values.
Certain drugs and clinical conditions are known to alter alkaline phosphatase activity.
ALKP day-to-day variation is 5 -10 %. Recent food ingestion can increase as much as 30 U/L.
ALKP is 25% higher with increased body mass index, 10% higher with smoking, and 20% lower with the use of oral contraceptives.
GGT in Certain drugs and clinical conditions are known to alter gamma glutamyltransferase activity *in vivo*.
GGT shows 25 -50 % activity increase with higher body mass index.
GGT Values are 25% lower during early pregnancy.

--End of Report-

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:28 AM Reported On : 10/12/2022 10:23 AM

Barcode : 012212100749 Specimen : Whole Blood Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
HBA1C			
HbA1c (HPLC NGSP Certified)	5.3	%	Normal: 4.0-5.6 Prediabetes: 5.7-6.4 Diabetes: => 6.5 ADA standards 2020
Estimated Average Glucose (Calculated)	105.41	-	-

Interpretation:

1. HbA1C above 6.5% can be used to diagnose diabetes provided the patient has symptoms. If the patient does not have symptoms with HbA1C>6.5%, repeat measurement on further sample. If the repeat test result is <6.5%, consider as diabetes high risk and repeat measurement after 6 months.

2. HbA1C measurement is not appropriate in diagnosing diabetes in children, suspicion of type 1 diabetes, symptoms of diabetes for less than 2 months, pregnancy, hemoglobinopathies, medications that may result sudden increase in glucose, anemia, renal failure, HIV infection, malignancies, severe chronic hepatic, and renal disease.

3. Any sample with >15% should be suspected of having a haemoglobin variant.

Interpretation Notes

- **CLINICAL INFORMATION AND CLINICAL INTERPRETATION**:
  Diabetes mellitus is a chronic disorder associated with disturbances in carbohydrate, fat, and protein metabolism characterized by hyperglycemia. HbA1c level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks, depending on the individual) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations.
  Diagnosing diabetes: American Diabetes Association (ADA)
  -Hemoglobin A1c (HbA1c): > or =6.5%
  Therapeutic goals for glycemic control (ADA)
  -Adults:
  - Goal of therapy: < 7.0% HbA1c
  - Action suggested: > 8.0% HbA1c

  -Pediatric patients:
  - Toddlers and preschoolers: < 8.5% (but >7.5%)
  - School age (6-12 years): < 8%
  - Adolescents and young adults (13-19 years): < 7.5%

  The ADA recommendations for clinical practice suggest maintaining a HbA1c value closer to normal yields improved microvascular outcomes for diabetics. Target goals of less than 7% may be beneficial in patients such as those with short duration of diabetes, long life expectancy, and no significant cardiovascular disease.
  POTENTIAL SOURCE OF VARIATION:
  The presence of hemoglobin variants can interfere with the measurement of hemoglobin A1c (HbA1c). The advantage of using ion exchange chromatography methods is most variants that would affect HbA1c results can be detected from analysis of the chromatogram so inaccurate results are less likely to be reported.

HbA1c results less than 4.0% are reported with the comment:

--End of Report-

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

MC-2688

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- Kindly correlate clinically.

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:23 AM Reported On : 10/12/2022 10:00 AM

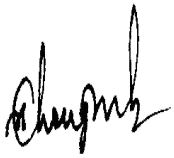
Barcode : 032212100110 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

CLINICAL PATHOLOGY

Test	Result	Unit
Urine For Sugar (Post Prandial) (Enzyme Method (GOD POD))	Not Present	-

--End of Report-



Dr. Sudarshan Chougule
MBBS, MD, Pathology
Consultant & Head - Hematology & Flow Cytometry

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MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:23 AM Reported On : 10/12/2022 10:31 AM

Barcode : 032212100110 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

CLINICAL PATHOLOGY

Test	Result	Unit	Biological Reference Interval
URINE ROUTINE & MICROSCOPY			
PHYSICAL EXAMINATION			
Colour	STRAW	-	-
Appearance	Clear	-	-
CHEMICAL EXAMINATION			
pH(Reaction) (pH Indicator Method)	7.5	-	4.5-7.5
Sp. Gravity (Refractive Index)	1.024	-	1.002 - 1.030
Protein (Automated Protein Error Or Ph Indicator)	Not Present	-	Not Present
Urine Glucose (Enzyme Method (GOD POD))	Not Present	-	Not Present
Ketone Bodies (Nitroprusside Method)	**Present +**	-	Not Present
Bile Salts (Azo Coupling Method)	Not Present	-	Not Present
Bile Pigment (Bilirubin) (Azo Coupling Method)	Not Present	-	Not Present
Urobilinogen (Azo Coupling Method)	Normal	-	Normal
Urine Leucocyte Esterase (Measurement Of Leukocyte Esterase Activity)	Not Present	-	Not Present
Blood Urine (Peroxidase Reaction)	Not Present	-	Not Present
Nitrite (Gries Method)	Not Present	-	Not Present
MICROSCOPIC EXAMINATION			
Pus Cells	0.3	/hpf	0-5

RBC	2.3	/hpf	0-4
Epithelial Cells	1.9	/hpf	0-6
Crystals	0.0	/hpf	0-2
Casts	0.00	/hpf	0-1
Bacteria	3.3	/hpf	0-200
Yeast Cells	0.1	/hpf	0-1
Mucus	Not Present	-	Not Present

--End of Report-

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Consultant & Head - Hematology & Flow Cytometry

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:27 AM Reported On : 10/12/2022 10:23 AM

Barcode : 022212100442 Specimen : Whole Blood - ESR Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

HEMATOLOGY

Test	Result	Unit	Biological Reference Interval
Erythrocyte Sedimentation Rate (ESR) (Westergren Method)	1	mm/1hr	0.0-12.0

Interpretation Notes

- ESR high - Infections, chronic disorders,, plasma cell dyscrasias.
  DISCLAIMER:**All the laboratory findings should mandatorily interpreted in correlation with clinical findings by a medical expert**

--End of Report-

Dr. Shalini K S
DCP, DNB, Pathology
Consultant

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 12:26 PM Received On : 10/12/2022 12:46 PM Reported On : 10/12/2022 01:22 PM

Barcode : 012212101406 Specimen : Plasma Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
Post Prandial Blood Sugar (PPBS) (Colorimetric - Glucose Oxidase Peroxidase)	98	mg/dL	70 to 139 : Normal 140 to 199 : Pre-diabetes =>200 : Diabetes ADA standards 2020

--End of Report-

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Incharge, Consultant Biochemistry

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(Post Prandial Blood Sugar (PPBS) -> autoAuthorised)

MC-2688

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Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:37 AM Reported On : 10/12/2022 10:24 AM

Barcode : 1B2212100014 Specimen : Whole Blood Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

NARAYANA HRUDAYALAYA BLOOD CENTRE

Test	Result	Unit
BLOOD GROUP & RH TYPING		
Blood Group (Column Agglutination Technology)	AB	-
RH Typing (Column Agglutination Technology)	Negative	-

--End of Report-

Dr. Prathip Kumar B R
MBBS,MD, Immunohaematology & Blood Transfusion
Consultant

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Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:28 AM Reported On : 10/12/2022 09:43 AM

Barcode : 022212100443 Specimen : Whole Blood Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

HEMATOLOGY

Test	Result	Unit	Biological Reference Interval
COMPLETE BLOOD COUNT (CBC)			
Haemoglobin (Hb%) (Photometric Measurement)	13.1	g/dL	12.0-15.0
Red Blood Cell Count (Electrical Impedance)	**5.16 H**	million/µl	3.8-4.8
PCV (Packed Cell Volume) / Hematocrit (Calculated)	41.2	%	36.0-46.0
MCV (Mean Corpuscular Volume) (Derived)	**79.8 L**	fL	83.0-101.0
MCH (Mean Corpuscular Haemoglobin) (Calculated)	**25.4 L**	pg	27.0-32.0
MCHC (Mean Corpuscular Haemoglobin Concentration) (Calculated)	31.9	%	31.5-34.5
Red Cell Distribution Width (RDW) (Derived)	**14.3 H**	%	11.6-14.0
Platelet Count (Electrical Impedance Plus Microscopy)	204	10^3/µL	150.0-450.0
Total Leucocyte Count(WBC) (Electrical Impedance)	7.0	10^3/µL	4.0-10.0
DIFFERENTIAL COUNT (DC)			
Neutrophils (VCS Technology Plus Microscopy)	**83.5 H**	%	40.0-75.0
Lymphocytes (VCS Technology Plus Microscopy)	**9.3 L**	%	20.0-40.0
Monocytes (VCS Technology Plus Microscopy)	5.0	%	2.0-10.0
Eosinophils (VCS Technology Plus Microscopy)	1.9	%	1.0-6.0
Basophils (VCS Technology Plus Microscopy)	0.3	%	0.0-2.0

Absolute Neutrophil Count (Calculated)	5.9	$x10^3$cells/µl	2.0-7.0
Absolute Lympocyte Count (Calculated)	**0.7 L**	$x10^3$cells/µl	1.0-3.0
Absolute Monocyte Count (Calculated)	0.4	$x10^3$cells/µl	0.2-1.0
Absolute Eosinophil Count (Calculated)	0.2	$x10^3$cells/µl	0.02-0.5
Absolute Basophil Count (Calculated)	0.1	-	-

As per the recommendation of International Council for Standardization in Hematology, the differential counts are additionally being reported as absolute numbers.

Interpretation Notes

- Haemoglobin , RBC Count and PCV: If below reference range, indicates Anemia. Further evaluation is suggested .
  RBC Indices aid in typing of anemia.
  WBC Count: If below reference range, susceptibility to infection.
  If above reference range- Infection*
  If very high in lakhs-Leukemia
  Neutrophils -If above reference range-acute infection, mostly bacterial
  Lymphocytes -If above reference range-chronic infection/ viral infection
  Monocytes -If above reference range- TB,Typhoid,UTI
  Eosinophils -If above reference range -Allergy,cough,Common cold,Asthma & worms
  Basophils - If above reference range, Leukemia, allergy
  Platelets: If below reference range- bleeding disorder, Dengue, drug- induced, malignancies
  * In bacterial infection with fever total WBC count increases.
  Eg Tonsillitis,Sinusitis,Bronchitis,Pneumonia,Appendicitis,UTI -12000-25000 cells/cumm.
  In typhoid and viral fever WBC may be normal.
  DISCLAIMER:**All the laboratory findings should mandatorily interpreted in correlation with clinical findings by a medical expert.**

--End of Report-

Dr. Deepak M B
MD, PDF, Hematopathology
Consultant

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Ms Priya Dharshini MRN : 10200000266939 Gender/Age : FEMALE , 27y (17/03/1995)

Collected On : 10/12/2022 09:02 AM Received On : 10/12/2022 09:28 AM Reported On : 10/12/2022 10:09 AM

Barcode : 012212100748 Specimen : Plasma Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 9043976158

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
Fasting Blood Sugar (FBS) (Colorimetric - Glucose Oxidase Peroxidase)	86	mg/dL	70 to 99 : Normal 100 to 125 : Pre-diabetes =>126 : Diabetes ADA standards 2020

--End of Report-

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

(Fasting Blood Sugar (FBS) -> autoAuthorised)

MC-2688

OP CASESHEET

Mazumdar Shaw Medical Center
Unit of Narayana Health

Patient MRN	: 10200000266939	Date	: 10/12/2022 02:00 PM
Patient Name	: Ms Priya Dharshini	Department	: CARDIOLOGY - ADULT
Sex/Age	: Female , 27y 8m	Consultant	: Dr. Ashutosh Vashistha
Address	: H No- 49, Amutham Colony , Dharmapuri, Dharmapuri, Tamil Nadu, India, 636701	Ref. Hospital	: -
		Ref. Doctor	: -
t Number	: OP-001	Sponsor Name	: ARCOFEMI HEALTHCARE LIMITED
sultation Type	: OP, New Visit		
bile Number	: 9043976158		

SpO_2 – 100%

ALS

(mmHg)	: 114/83 mmHg	Heart Rate(bpm)	: 107	Temp (*F)	:
ight (cm)	: 171 cm	Weight (kg)	: 71kg	BMI	:
spiratory Rate(brpm)	:	Fall Score	:	Pain Score	:

IEF COMPLAINTS AND HPI

NERAL EXAMINATION

ergies	: Known/Unknown
dy Habitus:	: Cachectic/ Thin Built/ Average Built/ Obese/ Normal
tinent Family History	: Negative/ Unknown
chological Assessment:	: Normal/Any Psychological Problem

USG → XRay –

TEMIC EXAMINATION

Non HDL – 143

TSH 4.4

TRITIONAL ASSESSMENT

ESTIGATIONS

TMENT SUGGESTED

IEW ON

Generated By : Navitha N(320679)

Generated On : 10/12/2022 09:00 AM

One free consultation with the same doctor within next 6 days

Mazumdar Shaw Medical Center
(A Unit of Narayana Hrudayalaya Limited) CIN: L85110KA2000PLC027497
Registered Office: 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore 560099
Hospital Address: NH Health City, 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore 560099
Tel +91 80 712 22222 | Email: info.msmc@narayanahealth.org | www.narayanahealth.org

Appointments
1800-309-0309 (Toll Free)
Emergencies
97384 97384

CONSULTATION SUMMARY

Mazumdar Shaw Medical Center
Unit of Narayana Health

Patient MRN	:10200000266939	**Consultation Date:**	10/12/2022 11:25 AM
Patient Name	:Ms Priya Dharshini	**Consultant**	:Dr. Rohit Raghunath Ranade (GYNAECOLOGY - ONCOLOGY)
Gender/Age/Dob	:Female , 27 Years , 17/03/95		
Patient Phone No	:9043976158	**Consultation Type**	:OP , NEW VISIT
Patient Address	:H No- 49, Amutham Colony , Dharmapuri,Dharmapuri,Tamil Nadu,India,-636701		

NOTES

- P1L1 Lscs
  LMP: 2/12/22

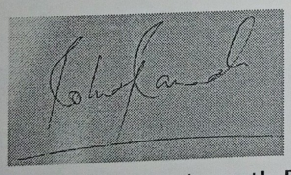
  doing well
  No complaints

  O/e
  B/L breast : soft
  P/A: soft, NT
  P/s/v/r : cervix healthy - pap smear taken
  uterus normal size, FF, NT

ADVICE

- Follow up with reports

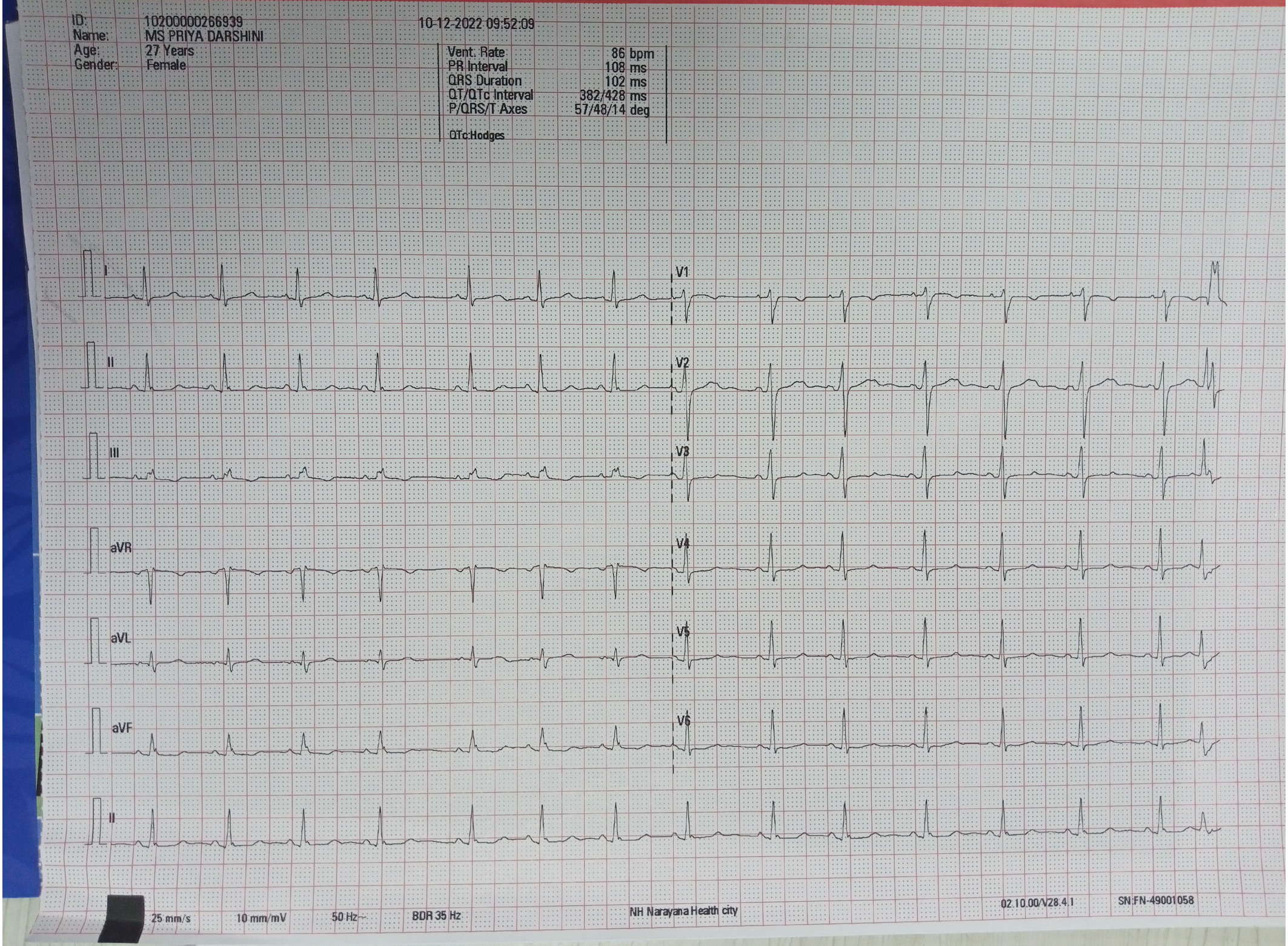
CONSULTANT DETAILS



Dr. Rohit Raghunath Ranade , CONSULTANT , GYNAECOLOGY - ONCOLOGY

One free consultation with the same doctor within next 6 days.

Printed By: Dr. Rohit Raghunath Ranade | Printed On: 10.12.2022 11:32


ID: 10200000266939
Name: MS PRIYA DARSHINI
Age: 27 Years
Gender: Female
10-12-2022 09:52:09
Vent. Rate 86 bpm
PR Interval 108 ms
QRS Duration 102 ms
QT/QTc Interval 382/428 ms
P/QRS/T Axes 57/48/14 deg
QTc:Hodges
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
25 mm/s
10 mm/mV
50 Hz
BDR 35 Hz
NH Narayana Health city
02.10.00/V28.4.1
SN:FN-49001058

NH Narayana
Institute of Cardiac Sciences
Unit of Narayana Health

Patient Name	**: Ms. Priya Dharshini**	**MRN**	**: 10200000266939**
Age	**: 27 Years**	**Sex**	**: Female**
Referring Doctor	**: EHC**	**Date**	**: 10.12.2022**

ULTRASOUND ABDOMEN AND PELVIS

CLINICAL DETAILS: Health check-up.

FINDINGS:

Liver is normal in size and shows diffuse increase in parenchymal echogenicity, suggestive of mild fatty infiltration. No intra or extra hepatic biliary duct dilatation. No focal lesions.

Portal vein is normal in course and caliber. Hepatic veins and their confluence draining into the IVC appear normal. **CBD** is not dilated.

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

Pancreas to the extent visualized, appears normal in size, contour and echogenicity.

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

Right Kidney is normal in size, position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size, position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum – Obscured by bowel gas.

Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.

Uterus is anteverted and normal in size, measuring 6.6 x 5.3 x 3.7 cm. Myometrial and endometrial echoes are normal. **Endometrium** measures 5.9 mm. Endometrial cavity is empty.

Both ovaries demonstrate multiple small peripherally arranged follicles with raised central cortical echogenicity, *suggestive of polycystic ovarian pattern.*

Right ovary: measures 4.2 x 3.2 x 1.9 cm (volume – 14.5 cc). **Left ovary**: measures 4.7 x 3.5 x 1.9 cm (volume – 16.6 cc).

Both adnexa: No mass is seen.

There is no ascites.

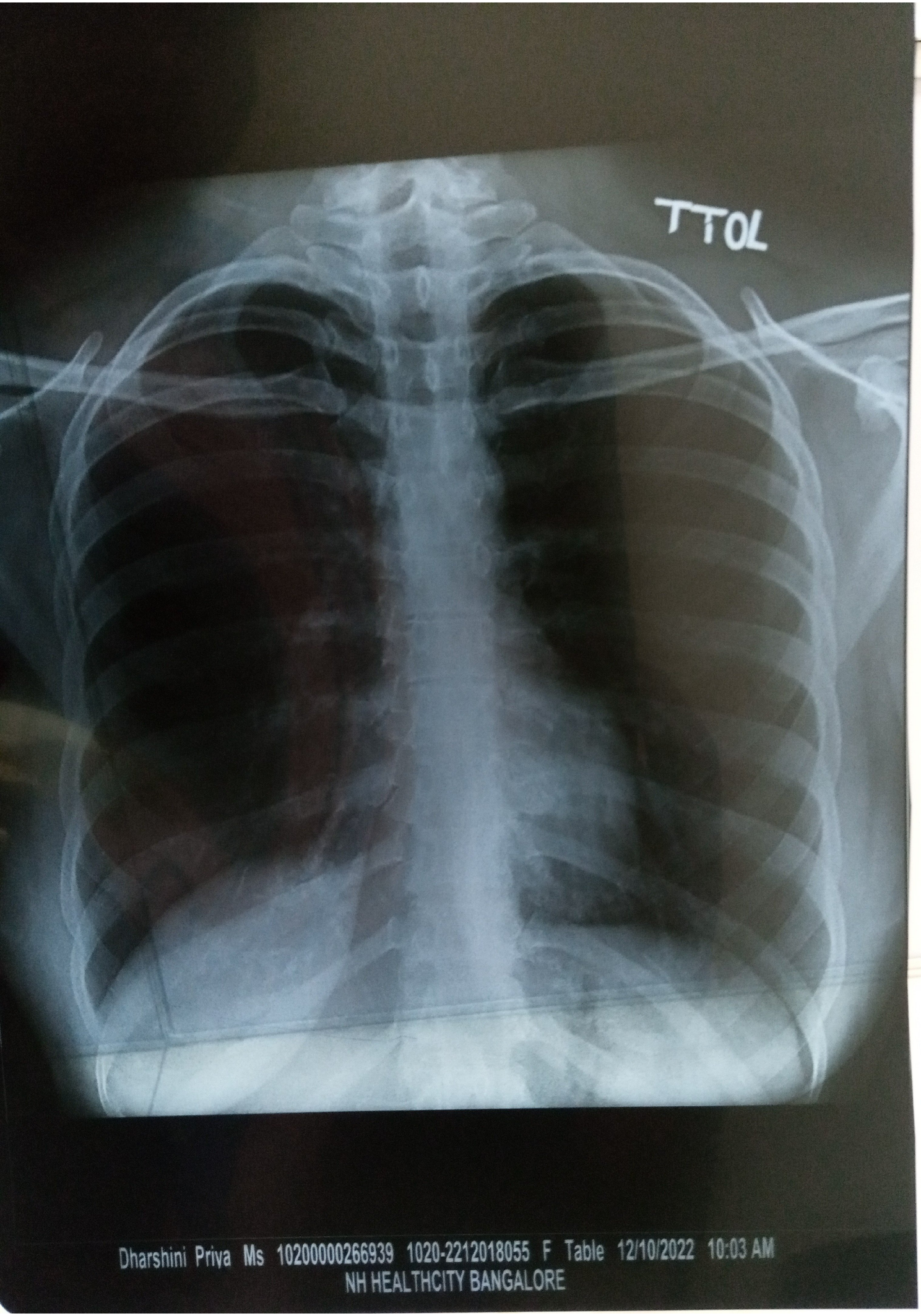
There is a large anterior abdominal wall defect, ~ measuring 5.6 cm with omentum and bowel as herniating content. Cough impulse is present.

IMPRESSION:

- **Mild fatty infiltration of liver.**
- **Large umbilical hernia.**
- **Bilateral polycystic ovarian pattern.**
  Recommended clinical / lab correlation.

Dr. Prateek Agarwal
Resident

Typed by Shobha. G


TTOL
Dharshini Priya Ms 10200000266939 1020-2212018055 F Table 12/10/2022 10:03 AM
NH HEALTHCITY BANGALORE

NN1,NN2,NN4

CERTIFICATE

NARAYANA NETHRALAYA
your faith shall heal you
Super Speciality Eye Hospital & Post Graduate Institute of Ophthalmology

CELEBRATING 40 YEARS IN EYE CARE

Mr. /Mrs. /Ms. Priyadarshini aged 27/F year

MR# 1034803 was seen on 10/12/22

	Right Eye	Left Eye
Vision (BCVA)	cg 6/6 , N6	cg 6/6 , N6
Color Vision	WNL	WNL
Anterior Segment	=	=
Pupils	3mm RRR	3mm RRR
Fundus	Disc, Macula & Retina Normal	Disc, Macula & Retina Normal
IOP	19 mm/Hg	19mm/Hg
ADVICE: - Yearly Eye Check Up		

Doctor Signature

Dr. GAGAN DUDEJA
Consultant, Ophthalmologist
Reg. No. 85404 (KMC)
NARAYANA NETHRALAYA

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