

68820
3(BF05:V1-010) 2011-03-20 01:37

SARDA, KRISHNAKANT
 Patient ID 33008
 09.07.2022
 12:27:37

Tabular Summary

Male
 36yrs
 Meds:

BRUCE: Total Exercise Time 07:09
 Max HR: 150 bpm 81% of max predicted 184 bpm HR at rest: 97
 Max BP: 140/90 mmHg BP at rest: 110/75 Max RPP: 18720 mmHg*bpm
 Maximum Workload: 6.60 METS

Test Reason: Screening for CAD
 Medical History: NO HISTORY.

Ref. MD: Ordering MD:

Technician: RUPALI Test Type: Treadmill Stress Test
 Comment:

Max. ST: -0.05 mV, 0.00 mV/s in III; EXERCISE STAGE 3 06:29
 Arrhythmia: A:48
 ST/HR index: 0.28 μ V/bpm

Reasons for Termination: Fatigue

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall impression: Normal stress test.

Conclusion: GOOD EFFORT TOLERANCE

ACHIEVED 81 % THR ON RX.

NORMAL BP RESPONSE

NO SIGNIFICANT ST-T CHANGES NOTED FOR THE GIVEN WORKLOAD

STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

DR. RAJDAAT DEORE
 MD,DM-CARDIOLOGIST
 MMC 2005/03/1520

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (mmHg*bpm)	VE (/min)	ST Level (III mV)	Comment
PRETEST	SUPINE	00:25	0.00	0.00	1.0	93	110/75	10230	0	-0.04	
	STANDING	00:21	0.00	0.00	1.0	85			0	-0.06	
	HYPERV.	01:30	0.00	0.00	1.0	96	110/75	10560	0	-0.04	
EXERCISE	STAGE 1	03:00	1.70	10.00	3.2	120	120/88	14400	0	-0.03	
	STAGE 2	03:00	2.50	12.00	4.7	139	130/90	18070	0	-0.01	
	STAGE 3	01:10	3.40	14.00	6.6	148	130/90	19240	0	-0.05	
RECOVERY		02:53	0.00	0.00	1.0	94	140/90	13160	0	-0.02	

Lead
ST Level (mV)
ST Slope (mV/s)



II Raw Data

*Computer Synthesized Rhythms



Dept. of Pathology

(For Report Purpose Only)



PRN : 081720
Patient Name : Mr. SARDA KRISHNAKANT
Age/Sex : 36Yr(s)/Male
Company Name : BANK OF BARODA
Referred By : Dr.HOSPITAL PATIENT

Lab No : 4105
Req.No : 4105

Collection Date & Time : 09/07/2022 10:29 AM
Reporting Date & Time : 09/07/2022 02:05 PM
Print Date & Time : 09/07/2022 02:10 PM

PARAMETER NAME	RESULT VALUE	UNIT	NORMAL VALUES
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BIOCHEMISTRY

BSL-F & PP

Blood Sugar Level Fasting	: 94	MG/DL	60 - 110
Blood Sugar Level PP	: 97	MG/DL	70 - 140

CALCIUM

CALCIUM (serum)	: 9.40	MG/DL	8.4 - 10.4
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RFT (RENAL FUNCTION TEST)

BIOCHEMICAL EXAMINATION

UREA (serum)	: 28	MG/DL	0 - 45
UREA NITROGEN (serum)	: 13.08	MG/DL	7 - 21
CREATININE (serum)	: 0.9	MG/DL	0.5 - 1.5
URIC ACID (serum)	: 6.7	MG/DL	Male : 3.4 - 7.0 Female : 2.4 - 5.7


SERUM ELECTROLYTES

SERUM SODIUM	: 139	mEq/L	136 - 149
SERUM POTASSIUM	: 4.5	mEq/L	3.8 - 5.2
SERUM CHLORIDE	: 101	mEq/L	98 - 107

END OF REPORT

Technician

Report Type By :- PRITAM WAGHMARE


Dr. POONAM KADAM
MD (Microbiology), Dip.Pathology &
Bacteriology (MMC-2012/03/0668)
Pathologist

For Free Home Collection Call : 9545200011



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BLOOD GROUP

HAEMATOLOGY

BLOOD GROUP : "B"
RH FACTOR : POSITIVE

NOTE : This is for your information.No transfusion / therapeutic intervention is done without confirmation of blood group by concerned authorities.In case of infants less than 6 months,suggested to repeat Blood Group after 6 months of age for confirmation. Kindly confirm the Negative Blood Group by reverse blood grouping (Tube method).

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HAEMATOLOGY

HAEMOGRAM

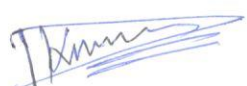
HAEMOGLOBIN (Hb)	: 15.0	GM/DL	Male : 13.5 - 18.0 Female : 11.5 - 16.5
PCV	: 47.1	%	Male : 40 - 54 Female : 37 - 47
RBC COUNT	: 5.34	Million/cu mm	Male : 4.5 - 6.5 Female : 3.9 - 5.6
M.C.V	: 88.2	cu micron	76 - 96
M.C.H.	: 28.1	pg	27 - 32
M.C.H.C	: 31.8	picograms	32 - 36
RDW-CV	: 11.9	%	11 - 16
WBC TOTAL COUNT	: 5560	/cumm	ADULT : 4000 - 11000 CHILD 1-7 DAYS : 8000 - 18000 CHILD 8-14 DAYS : 7800 - 16000 CHILD 1MONTH-<1YR : 4000 - 10000
PLATELET COUNT	: 263000	cumm	150000 - 450000

WBC DIFFERENTIAL COUNT

NEUTROPHILS	: 52	%	ADULT : 40 - 70 CHILD : 20 - 40
ABSOLUTE NEUTROPHILS	: 2891.20	µL	2000 - 7000
LYMPHOCYTES	: 37	%	ADULT : 20 - 40 CHILD : 40 - 70
ABSOLUTE LYMPHOCYTES	: 2057.20	µL	1000 - 3000
EOSINOPHILS	: 03	%	01 - 04
ABSOLUTE EOSINOPHILS	: 166.80	µL	20 - 500
MONOCYTES	: 08	%	02 - 08
ABSOLUTE MONOCYTES	: 444.80	µL	200 - 1000
BASOPHILS	: 00	%	00 - 01
ABSOLUTE BASOPHILS	: 0	µL	0 - 100

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RBC MORPHOLOGY	: Normocytic Normochromic		
WBC MORPHOLOGY	: Within Normal Limits		
PLATELETS	: Adequate		
PARASITES	: Not Detected		

Method : Processed on 5 Part Fully Automated Blood Cell Counter - sysmex XS-800i.

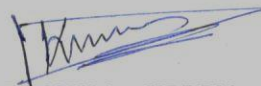
ESR

ESR MM (AT The End of 1 Hr.) By : 05 mm/hr
Westergren Method Male : 0 - 15
Female : 0 - 20

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BIOCHEMISTRY

HbA1C- GLYCOSYLATED -HB

HBA1C : 5.53 %
Normal Control : : 4.2 - 6.2
Good Control : : 5.5 - 6.7
Fair Control : : 6.8 - 7.6
Poor Control : : >7.6

Instrument: COBAS C 111

The HbA1C determination is based on turbidimetric inhibition immunoassay (TNIA) for hemolysed whole blood on Cobas c111 system.

NOTE :

1. The HbA1C test shows your average blood sugar for last 3 months.
2. The HbA1C test does not replace your day-to-day monitoring of blood glucose.
Use this test result along with your daily test results to measure your overall diabetes control.

How does HbA1C works ?

The HbA1C test measures the amount of **sugar that attaches to protein** in your red blood cells. RBCs live for about 3 months, so this test shows your average blood sugar levels during that time. Greater the level of sugar & longer it is high, the more sugar that will attach to RBCs.

Why is this test so important ?

Research studies demonstrated that **the closer to normal your HbA1C level was, the less likely your risk of developing the long- term complications of diabetes.** Such problems include eye disease and kidney problems.

Who should have the HbA1c test done ?

Everyone with diabetes can benefit from taking this test. Knowing your HbA1C level helps you and your doctor decide if you need to change your diabetes management plan.

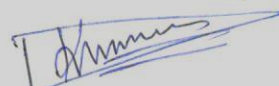
How often should you have a HbA1C test ?

You should have this test done when you are first diagnosed with diabetes. Then at least twice a year if your treatment goals are being met & blood glucose control is stable. More frequent HbA1C testing (4 times / year) is recommended if your blood glucose management goals.

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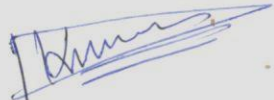
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<u>BIOCHEMISTRY</u>			
<u>LFT (Liver function Test)</u>			
BILIRUBIN TOTAL (serum)	: 0.7	MG/DL	INFANTS : 1.2 - 12.0 ADULT : 0.1 - 1.2
BILIRUBIN.DIRECT (serum)	: 0.3	MG/DL	ADULT & INFANTS : 0.0 - 0.4
BILIRUBIN INDIRECT (serum)	: 0.40	MG/DL	0.0 - 1.0
S.G.O.T (serum)	: 37	IU/L	5 - 40
S.G.P.T (serum)	: 46	IU/L	5 - 40
ALKALINE PHOSPHATASE (serum)	: 99	IU/L	CHILD BELOW 6 YRS : 60 - 321 CHILD : 67 - 382 ADULT : 36 - 113
PROTEINS TOTAL (serum)	: 7.0	GM/DL	6.4 - 8.3
ALBUMIN (serum)	: 4.6	GM/DL	3.5 - 5.7
GLOBULIN (serum)	: 2.40	GM/DL	1.8 - 3.6
A/G RATIO	: 1.92		1:2 - 2:1

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BIOCHEMISTRY

LIPID PROFILE

CHOLESTEROL (serum)	: 197	MG/DL	Male : 120 - 240 Female : 110 - 230
TRIGLYCERIDE (serum)	: 153	MG/DL	0 - 150
HDL (serum)	: 34	MG/DL	Male: : 42 - 79.5 Female: : 42 - 79.5
LDL (serum)	: 146	MG/DL	0 - 130
VLDL (serum)	: 30.60	MG/DL	5 - 51
CHOLESTROL/HDL RATIO	: 5.79		Male : 1.0 - 5.0 Female: : 1.0 - 4.5
LDL/HDL RATIO	: 4.29		Male : <= 3.6 Female : <=3.2

NCEP Guidelines

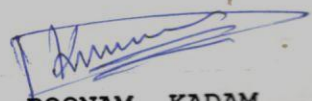
	Desirable	Borderline	Undesirable
Total Cholesterol (mg/dl)	Below 200	200-240	Above 240
HDL Cholesterol (mg/dl)	Above 60	40-59	Below 40
Triglycerides (mg/dl)	Below 150	150-499	Above 500
LDL Cholesterol (mg/dl)	Below 130	130-160	Above 160

Suggested to repeat lipid profile with low fat diet for 2-3 days prior to day of test and abstinence from alcoholic beverages if applicable.
 Cholesterol & Triglycerides reprocessed , & confirmed.

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ENDOCRINOLOGY

TFT (THYROID FUNCTION TEST)

T3-Total (Tri iodothyronine)	: 1.49	ng/mL	0.970 - 1.69
T4 - Total (Thyroxin)	: 9.67	µg/dL	5.53 - 11.0
Thyroid Stimulating Hormones (Ultra TSH)	: 1.42	µIU/mL	0.465 - 4.68

NOTE:-

Three common ways in which there may be inadequate amounts of the thyroid hormone for normal metabolism. Primary hypothyroidism, in which there is a raised TSH & a low T3. This is due to failure of the thyroid gland, possibly due to autoantibody disease, possibly due to toxic stress or possibly due to iodine deficiency. The second, the most common cause of thyroid failure, occurs at the pituitary level. In this condition there is inadequate thyroid stimulating hormone (TSH) produced from the pituitary and so one tends to see low or normal TSH, low T4s and variable T3s. This condition is most common in many patients with chronic fatigue syndrome, where there is a general suppression of the hypothalamic-pituitary-adrenal axis. The third type of under-functioning is due to poor conversion of there are normal or possibly slightly raised levels of TSH, normal levels of T4 but low levels of thyroid problem routinely TSH, a Free T4 and a Free T3 are also advisable. Any patients who are taking T3 as part of their thyroid supplement need to have their T3 levels monitored as well as T4. T3 is much more quickly metabolized than T4 and blood tests should be done between 4-6 hours after their morning dose.

The Guideline for pregnancy reference ranges for total T3, T4, Ultra TSH Level in pregnancy

	Total T3	Total T4	Ultra TSH
First Trimester	0.86 - 1.87	6.60 - 12.4	0.30 - 4.50
2nd Trimester	1.0 - 2.60	6.60 - 15.5	0.50 - 4.60
3rd Trimester	1.0 - 2.60	6.60 - 15.5	0.80 - 5.20

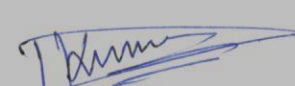
The guidelines for age related reference ranges for T3, T4, & Ultra TSH

	Total T3	Total T4	Ultra TSH
Cord Blood	0.30 - 0.70	1-3 day 8.2-19.9	Birth- 4 day: 1.0-38.9
New Born	0.75 - 2.60	1 Week 6.0-15.9	2-20 Week : 1.7-9.1
1-5 Years	1.0-2.60	1-12 Months 6.8 - 14.9	20 Week- 20 years 0.7 - 6.4
5-10 Years	0.90 - 2.40	1-3 Years 6.8-13.5	
10-15 Years	0.80 - 2.10	3-10 Years 5.5-12.8	

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Lab No : 4105
Req.No : 4106

Company Name : BANK OF BARODA
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Collection Date & Time : 09/07/2022 10:30 AM
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SPECIAL TEST

VITAMIN D

25 - HYDROXY VITAMIN D	: 61.9	ng/mL	Deficient : : <20 Insufficient : : 20 - 30 Sufficient : : >30 - 100 Toxicity : >100
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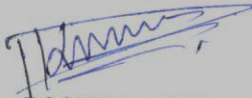
NOTE :-

- 1) Vitamin D is a fat-soluble steroid hormone precursor that is mainly produced in the skin by exposure to sunlight or it is supplied via dietary sources (mainly egg yolk, fish oil and plants).
- 2) Vitamin D is biologically inert and must undergo two successive hydroxylations in the liver and kidney to become the biologically active 1,25 dihydroxyvitamin D.
- 3) The two most important forms of vitamin D are vitamin D3 (cholecalciferol) and vitamin D2 (ergocalciferol).
- 4) In contrast to vitamin D3, vitamin D2 has to be taken up with food. In the human body vitamin D3 D2 are bound to vitamin D-binding protein in plasma and transported to the liver where both are hydroxylated in position 25 forming 25-OH vitamin D. 25 OH vitamin D is the metabolite that should be measured in blood to determine the overall vitamin D status because it is the major storage form of vitamin D in human body.
- 5) This primary circulating form of vitamin D is biologically inactive with levels approximately 1000-fold greater than the circulating 1,25 (OH)₂ vitamin D. The half life of circulating 25-OH vitamin D is 2-3 weeks. More than 95% of 25-OH vitamin D reaches measurable levels only in patients taking vitamin D2 supplements.
- 6) Vitamin D deficiency is a common cause of secondary hyperparathyroidism. Elevation of PTH levels, especially in elderly Vitamin D deficient adults can result in osteomalacia, increased bone turnover, reduced bone mass and risk of bone fractures.
- 7) Low 25-OH vitamin D concentration are also associated with lower bone mineral density. In conjunction with other clinical data, the results may be used as an aid in the assessment of bone metabolism.
- 8) The Roche Cobas Vitamin D3 (25-OH) assay employs a polyclonal antibody directed against vitamin D3.

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CLINICAL PATHOLOGY

URINE ROUTINE

PHYSICAL EXAMINATION

QUANTITY : 25 ML
COLOUR : PALE YELLOW
APPEARANCE : SLIGHTLY HAZY
REACTION : NEUTRAL
SPECIFIC GRAVITY : 1.005

CHEMICAL EXAMINATION

PROTEIN : ABSENT
SUGAR : ABSENT
KETONES : ABSENT
BILE SALTS : ABSENT
BILE PIGMENTS : ABSENT
UROBILINOGEN : NORMAL

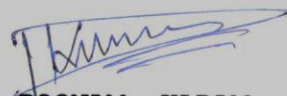
MICROSCOPIC EXAMINATION

PUS CELLS : 0-1 /hpf
RBC CELLS : ABSENT / hpf
EPITHELIAL CELLS : 0-1 /hpf
CASTS : ABSENT /hpf
CRYSTALS : ABSENT
OTHER FINDINGS : ABSENT
BACTERIA : ABSENT

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Lab No : 4105
 Req.No : 4106

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IMMUNOLOGY

VITAMIN B12

VITAMIN B12 LEVEL	: 491	pg/mL	239 - 931
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NOTE :

- 1) Nutritional and macrocytic anemias can be caused by a deficiency of Vitamin B12. This deficiency can result from diets devoid of meat and bacterial products, from alcoholism, or from structural/functional damage to digestive or absorptive processes (forms of pernicious anemia). Malabsorption is the major cause of this deficiency, gastric atrophy or gastrectomy, intestinal damage, loss of intestinal damage, loss of intestinal Vitamin B12 binding protein (intrinsic factor), production of autoantibodies directed against intrinsic factor, or related causes.
- 2) This vitamin is necessary for normal metabolism, DNA synthesis and red blood cell regeneration. Untreated deficiencies will lead to megaloblastic anemia and Vitamin B12 deficiency results in irreversible central nervous system degeneration.
- 3) Vitamin B12 or folate are both of diagnostic importance for the recognition of Vitamin B12 or folate deficiency, especially in the context of the differential diagnosis of megaloblastic anemia. Radioassays were first reported for Vitamin B12 in 1961. All utilize co-cyanocobalamin radiolabeled tracers and intrinsic factor for binding Vitamin B12.
- 4) The various commercial assays differ in their free versus bound separation techniques and choice of specimen pretreatment. The presence of endogenous serum binding proteins for cyanocobalamin (transcobalamin including R- protein) and of immunoglobulins directed against intrinsic factor require that specimen are either boiled at an alkaline pH to release the Vitamin B12 and destroy the binding proteins.
- 5) In the late 1970s, radioassays using serum binding proteins or partially purified intrinsic factor measured levels of Vitamin B12 which exceeded those determined by microbiological methods. This was caused by the presence of the serum binding protein or R-proteins in the assay.
- 6) R-protein specificity is poor compared to that of intrinsic factor measured in addition to Vitamin B12 analogs were being measured in addition to Vitamin B12 itself. Since that time, recommendations have been established for the use of highly purified intrinsic factor throughout the industry.
- 7) Roche Cobase Vitamin B12 employs a competitive test principle using intrinsic factor specific for Vitamin B12. Vitamin B12 in the sample using competes with the added Vitamin B12 labeled with biotin for the binding sites on the ruthenium-labeled intrinsic factor complex**.

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Report Type By :- PRITAM WAGHMARE

Dr. POONAM KADAM
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 Pathologist



Dept. of Radiology
(For Report Purpose Only)



REQ. DATE : 09-JUL-2022 REP. DATE : 09-JUL-2022
NAME : MR. SARDA KRISHNAKANT
PATIENT CODE : 081720 AGE/SEX : 36 YR(S) / MALE
REFERRAL BY : HOSPITAL PATIENT

USG ABDOMEN AND PELVIS

OBSERVATION :

Liver : Is normal in size (13.6 cm), shape & bright in echotexture. No focal lesion / IHBR dilatation.

CBD & PV : Normal in caliber.

G.B. : Moderately distended, Normal.

Spleen : Is normal in size (8.1 cm) , shape & echotexture. No focal lesion.

Pancreas : Normal in size, shape & echotexture.

Both kidneys are normal in size, shape & echotexture, CMD maintained.
No calculus/ hydronephrosis / hydroureter on either side.
Partially exophytic simple cyst is noted in the mid pole region of right kidney measuring 3.7 x 3.0 cms.
Small simple cortical cyst is noted in the upper pole region of left kidney measuring 1.5 x 1.1 cm.
Right kidney measures : 10.1 x 4.8 cm.
Left kidney measures : 9.5 x 4.4 cm.

Urinary bladder : Moderately distended, normal.

Prostate : is normal in size, shape and echotexture. No focal lesion seen.

No demonstrable small bowel / RIF pathology.

No ascites / lymphadenopathy.

IMPRESSION :

Grade I fatty liver.

- Kindly correlate clinically.

Dr. PIYUSH YEOLE
(MBBS, DMRE)
CONSULTANT RADIOLOGIST



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Caring Redefined

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CHEST X-RAY PA VIEW

OBSERVATION :

Prominent bronchovascular markings are noted in both lung fields.

Heart and mediastinum are normal.

Diaphragm and both CP angles are normal.

Visualised bones & extra-thoracic soft tissues appear normal.

IMPRESSION :

Prominent bronchovascular markings in both lung fields ? bronchitis.

-Kindly correlate clinically.

Dr. PIYUSH YEOLE
(MBBS, DMRE)
CONSULTANT RADIOLOGIST



2D ECHO / COLOUR DOPPLER

NAME : MR. KRISHNAKANT SARDA
REF BY : DR. HOSPITAL PATIENT

37yrs/M

OPD
9-Jul-22

M - Mode values

Doppler Values

AORTIC ROOT (mm)	22	PULMONARY VEL (m/sec)	
LEFT ATRIUM (mm)	28	PG (mmHg)	
RV (mm)		AORTIC VEL (m/sec)	1.2
LVID - D (mm)	41	PG (mmHg)	6
LVID - S (mm)	21	MITRAL E VEL (m/sec)	0.9
IVS - D (mm)	10	A VEL (m/sec)	0.6
LVPW -D (mm)	9	TRICUSPID VEL. (m/sec)	
EJECTION FRACTION (%)	60%	PG (mmHg)	

REPORT

Normal LV size & wall thickness.
No regional wall motion abnormality
Normal LV systolic function , LVEF 60%
Normal sized cardiac chambers.

Pliable mitral valve., no Mitral regurgitation.
Normal mitral diastolic flows.

Trileaflet aortic valve. No aortic stenosis / regurgitation.

Normal Tricuspid & pulmonary valve
Trivial tricuspid regurgitation ,
PA pressure = 20 mmHg - normal

Intact IAS & IVS
No PDA, coarctation of aorta.
No clots , vegetations , pericardial effusion noted.

IMPRESSION :

Normal echo study.
No regional wall motion abnormality.
Normal LV systolic & diastolic function , LVEF 60%
Normal PA pressure.


DR. RAJDATT DEORE.
MD, DM-CARDIOLOGIST
MMC 2005/03/1520

(NORMAL 2D-ECHO & COLOR DOPPLER DOESN'T RULE OUT ISCHAEMIC HEART DISEASE)