DIAGNOSTIC REPORT

MC-2559

PATIENT NAME : ANKUR VADHERA **REF. DOCTOR :** SELF

FORTIS MOHALI-CHC -SPLZD
FORTIS HOSPITAL # MOHALI,
MOHALI 160062
7087030817

ACCESSION NO : **0006WB022555**
PATIENT ID : FH.12316109
CLIENT PATIENT ID: UID:12316109
ABHA NO :

AGE/SEX : 32 Years Male
DRAWN : 25/02/2023 08:31:00
RECEIVED : 25/02/2023 14:09:13
REPORTED : 25/02/2023 16:15:56

CLINICAL INFORMATION :

UID:12316109 REQNO-1376961
CORP-OPD
BILLNO-1002123OPCS002731
BILLNO-1002123OPCS002731

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SLS- HEMOGLOBIN DETECTION METHOD	15.1	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	5.04	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLOWCYTOMETRY	7.08	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY	212	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : HYDRODYNAMIC FOCUSING	47.1	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	93.5	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	30.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	32.1	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	12.9	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	18.6		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	**11.7 High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	57	40.0 - 80.0	%
LYMPHOCYTES	33	20.0 - 40.0	%

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Patient Ref. No. 6000002959615

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METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
MONOCYTES	7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
EOSINOPHILS	3	1 - 6	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
BASOPHILS	00	0 - 2	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	4.04	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	2.34	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.50	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.21	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.7		
METHOD : CALCULATED PARAMETER			

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	05	0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD			

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.79	UPTO 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.24	0.00 - 0.30	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.55	0.00 - 0.60	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.3	6.6 - 8.7	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN	4.6	3.97 - 4.94	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.7	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.7	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	24	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	25	0 - 41	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	104	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	14	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE UV	176	135 - 225	U/L
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	89	74 - 106	mg/dL

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BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	13	6 - 20	mg/dL
URIC ACID, SERUM			
URIC ACID METHOD : URICASE, COLORIMETRIC	6.1	3.4 - 7.0	mg/dL
CALCIUM, SERUM			
CALCIUM METHOD : NM-BAPTA	9.5	8.6 - 10.0	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C METHOD : HPLC	5.6	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	114.0	< 116.0	mg/dL
CREATININE EGFR			
CREATININE METHOD : ALKALINE PICRATE-KINETIC	0.70	0.70 - 1.20	mg/dL
AGE	32		years

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GLOMERULAR FILTRATION RATE (MALE)	131	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)	
GLUCOSE POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	85	Non-Diabetes 70 - 140	mg/dL

METHOD : HEXOKINASE

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget'''''''s disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson'''''''s disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom'''''''s disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about

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half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
CALCIUM, SERUM-Commom causes of decreased value of calcium (hypocalcemia) are chronic renal failure, hypomagnesemia and hypoalbuminemia.

Hypercalcemia (increased value of calcium) can be caused by increased intestinal absorbtion (vitamin d intoxication), increased skeletal reasorption (immobilization), or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95% of all cases of hypercalcemia.

Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels. The following regression equation may be helpful.
Corrected total calcium (mg/dl)= total calcium (mg/dl) + 0.8 (4- albumin [g/dl])*
because regression equations vary among group of patients in different physiological and pathological conditions, mathematical corrections are only approximations. The possible mathematical corrections should be replaced by direct determination of free calcium by ISE (available with srl) a common and important source of preanalytical error in the measurement of calcium is prolonged torniquet application during sampling. Thus, this along with fist clenching should be avoided before phlebotomy.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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CREATININE EGFR-GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

This equation takes into account several factors that impact creatinine production, including age, gender, and race. In children, eGFR is calculated using original schwartz equation.

The equation has not been validated in children & will only be reported for patients > 16 years of age. The equation is normalized for an average adult body surface area of 1.73m², weight & height adjustment is not necessary.

The IDMS Traceable MDRD equation has not been validated in children & will only be reported for patients = 18 years of age. The equation is normalized for an average adult body surface area of 1.73m², weight & height adjustment is not necessary. Estimation of GFR in children and adolescence (0- < 18 years) is performed by bedside IDMS- Traceable Schwartz formula
GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

Dr. Ritu Pankaj, MD, PDCC
Senior Consultant,30897

Dr. Meenakshi Malhotra, MD
Senior Consultant,48159

Ms. Hardeep Kaur, M.Sc.
Biochemistry

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FORTIS HOSPITAL, SECTOR 62,PHASE VIII,
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PUNJAB, INDIA
Tel : 0172-469-2222 Extn. 6726, 6727), 0172-469-2221 - CIN - L85110DL1996PLC076704
Email : srl.mohali@fortishealthcare.com

Patient Ref. No. 6000002959615

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : ANKUR VADHERA **REF. DOCTOR :** SELF

FORTIS MOHALI-CHC -SPLZD
FORTIS HOSPITAL # MOHALI,
MOHALI 160062
7087030817

ACCESSION NO : **0006WB022555**
PATIENT ID : FH.12316109
CLIENT PATIENT ID: UID:12316109
ABHA NO :

AGE/SEX : 32 Years Male
DRAWN : 25/02/2023 08:31:00
RECEIVED : 25/02/2023 14:09:13
REPORTED : 25/02/2023 16:15:56

CLINICAL INFORMATION :

UID:12316109 REQNO-1376961
CORP-OPD
BILLNO-1002123OPCS002731
BILLNO-1002123OPCS002731

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	180	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	78	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	48	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	**123 High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	**132 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	15.6	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.8	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

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Test Report Status **Final**	Results	Biological Reference Interval	Units
LDL/HDL RATIO	2.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

Dr. Ritu Pankaj, MD, PDCC
Senior Consultant,30897

Ms. Hardeep Kaur, M.Sc.
Biochemistry

Dr. Meenakshi Malhotra, MD
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MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : ANKUR VADHERA **REF. DOCTOR :** SELF

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	YELLOW		
METHOD : MANUAL EXAMINATION			
APPEARANCE	CLEAR		
METHOD : MANUAL EXAMINATION			

CHEMICAL EXAMINATION, URINE

PH	6.5	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE PHOTOMETRY (EHRLICH'S REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPY			
PUS CELL (WBC'S)	NOT DETECTED	0-5	/HPF
METHOD : REFLECTANCE PHOTOMETRY & MICROSCOPY			

Dr. Irneet Mundi, MD
Associate Consultant,34080

Dr. Meenakshi Malhotra, MD
Senior Consultant,48159

Dr. Ritu Pankaj, MD, PDCC
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DIAGNOSTIC REPORT

MC-2559

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EPITHELIAL CELLS METHOD : MICROSCOPY	NOT DETECTED	0-5	/HPF
CASTS METHOD : MICROSCOPY	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPY	NOT DETECTED		
BACTERIA METHOD : MICROSCOPY	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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Dr. Meenakshi Malhotra, MD
Senior Consultant,48159

Dr. Ritu Pankaj, MD, PDCC
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Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	104.4	80.00 - 200.00	ng/dL
METHOD : SANDWICH (ECLIA)			
T4	5.97	5.10 - 14.10	µg/dL
METHOD : SANDWICH (ECLIA)			
TSH (ULTRASENSITIVE)	2.210	0.270 - 4.200	µIU/mL
METHOD : SANDWICH (ECLIA)			

Interpretation(s)

Meenakshi Malhotra

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Ritu Pankaj

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DIAGNOSTIC REPORT

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Fortis HOSPITAL Mohali

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.950	0.0 - 1.4	ng/mL

METHOD : SANDWICH (ECLIA)

Interpretation(s)
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

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Email : srl.mohali@fortishealthcare.com

Patient Ref. No. 6000002959615

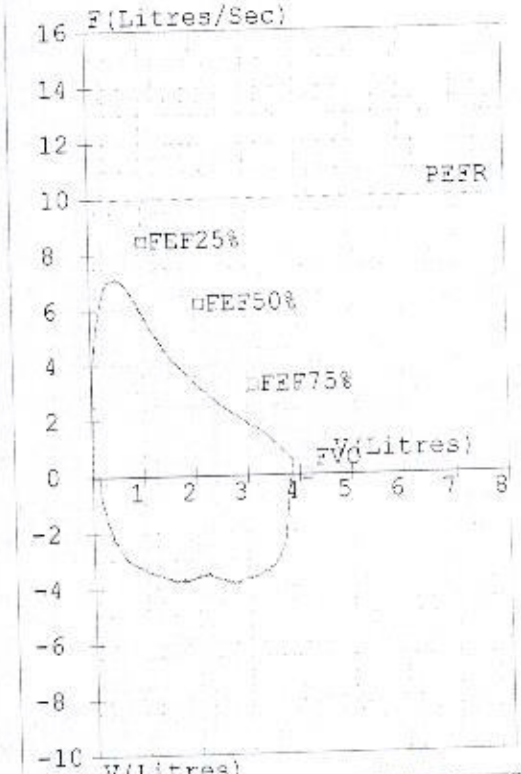
RECORDERS & MEDICARE SYSTEMS

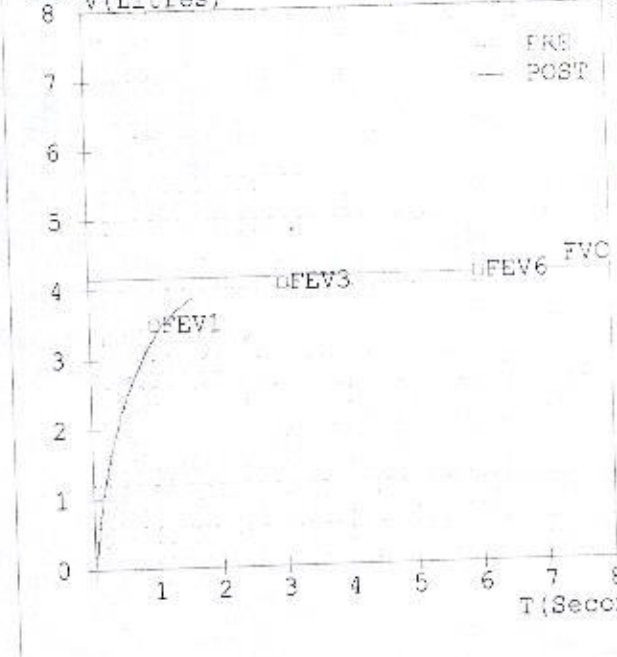
181/5,Phase-I,Industrial Area,Chandigarh-160002

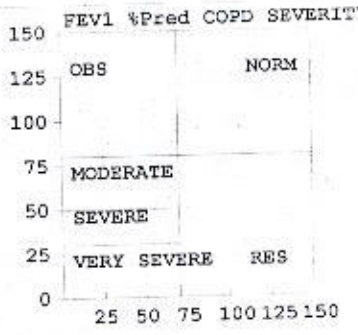
Patient: ANKUR VADHERA
Refd. By:
Pred.Eqns: RECORDERS
Date : 25-Feb-2023 09:06 AM

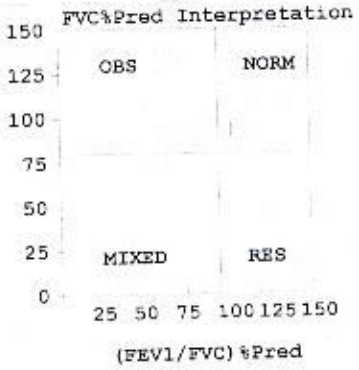
Age : 32 Years
Height : 182 Cms
Weight : 76 Kgs
ID: 12316109

Gender : Male
Smoker : No
Eth. Corr: 100
Temp :









Spirometry(FVC Results)

Parameter		Pred	M.Pre	%Pred	M.Post	%Pred	%Imp
FVC	(L)	04.16	03.86	093	-----	---	
FEV1	(L)	03.48	03.34	096	-----	---	
FEV1/FVC	(%)	83.65	86.53	103	-----	---	
FEF25-75	(L/s)	04.53	03.22	071	-----	---	
PEFR	(L/s)	09.98	07.03	070	-----	---	
FIVC	(L)	-----	03.73	---	-----	---	
FEV.5	(L)	-----	02.34	---	-----	---	
FEV3	(L)	04.04	03.86	096	-----	---	
PIFR	(L/s)	-----	03.86	---	-----	---	
FEF75-85	(L/s)	-----	01.68	---	-----	---	
FEF.2-1.2	(L/s)	08.05	06.27	078	-----	---	
FEF 25%	(L/s)	08.46	05.90	070	-----	---	
FEF 50%	(L/s)	06.17	03.34	054	-----	---	
FEF 75%	(L/s)	03.22	01.98	061	-----	---	
FEV.5/FVC	(%)	-----	60.62	---	-----	---	
FEV3/FVC	(%)	97.12	100.00	103	-----	---	
FET	(Sec)	-----	01.59	---	-----	---	
ExplTime	(Sec)	-----	00.06	---	-----	---	
Lung Age	(Yrs)	032	033	103	-----	---	
FEV6	(L)	04.16	-----	---	-----	---	
FIF25%	(L/s)	-----	03.65	---	-----	---	
FIF50%	(L/s)	-----	03.57	---	-----	---	
FIF75%	(L/s)	-----	03.51	---	-----	---	

Pre Test COPD Severity

Test within normal limits

Pre Medication Report Indicates
Spirometry within normal limits as (FEV1/FVC)%Pred >95 and FVC%Pred >80.

GE Healthcare REF 1016728LSL CE LOT D750

Vadhera, Ankur
ID: 12316109

Male

25.02.2023 12:24:58
Fortis Med Centre
sector 11
Chandgarh

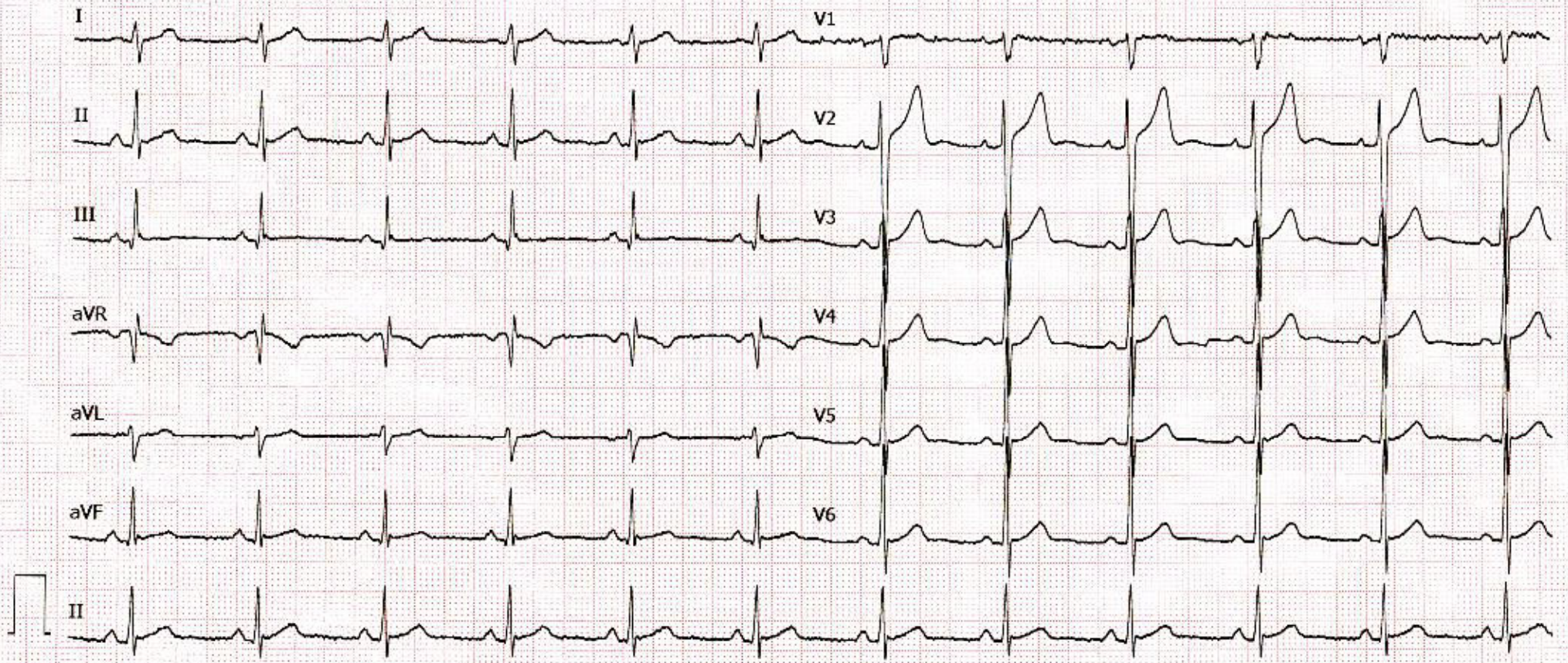
Location:
Order Number:
Visit:
Indication:
Medication 1:
Medication 2:
Medication 3:

Room:

71 bpm
-- / -- mmHg

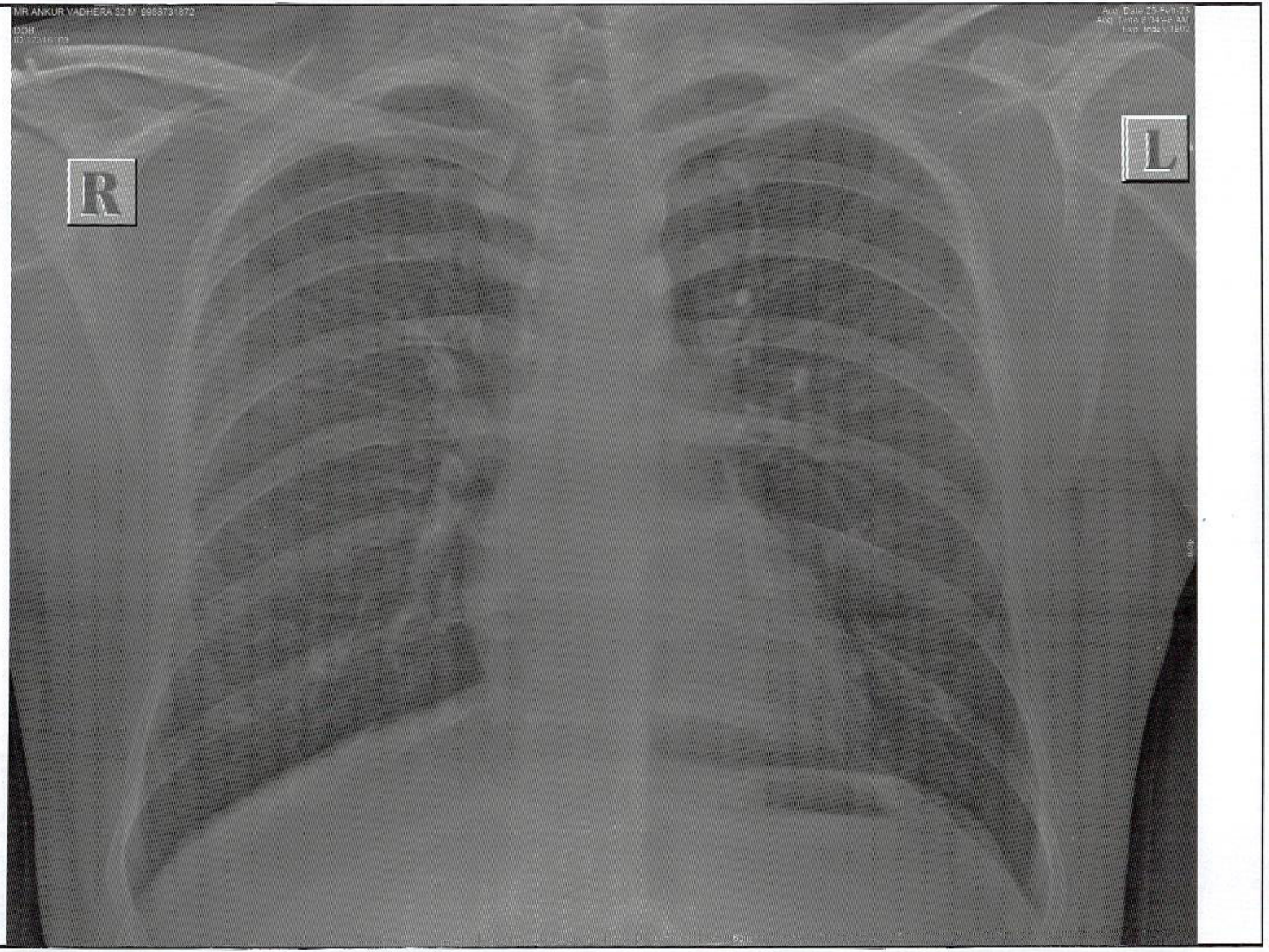
Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS :	80 ms	Normal sinus rhythm
QT / QTcBaz :	366 / 397 ms	Rightward axis
PR :	136 ms	Borderline ECG
P :	94 ms	
RR / PP :	842 / 845 ms	
P / QRS / T :	69 / 90 / 46 degrees	



Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-40 Hz 50 Hz 2x5x6_25_R1 1/1


MR ANKUR VADHERA 32 M 998873 1872
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Fortis MEDCENTRE
CHANDIGARH

Fortis Medcentre
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Chandigarh - 160 011 (India)
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E-mail : contactus.fmc@fortishealthcare.com
Website : www.fortishealthcare.com

DEPARTMENT OF CARDIOLOGY
ECHOCARDIOGRAPHY LABORATORY
Phone 0172-5061222; Ext. 6422

Dated:25 February 2023

Name:	**MR. ANKUR VADHERA**	**Age 32**	**Sex : Male**
FHL No:	**12316109**	**Lab No:**	
Clinical Diagnosis:	**R/O CAD**		
Ref By:	**FMC**		

MEASUREMENTS

Aortic Root Diameter	:	2.5	cm	Left Atrial dimension		2.5	cm
Aortic Valve Opening	:	----	cm	Right Ventricular dimension		1.2	cm
Left Ventricular ED dimension	:	3.7	cm	Left Ventricular ES dimension		2.2	cm
Interventricular Septal thickness	ED:	1.0	cm		ES:	1.1	cm
Left Ventricular PW thickness	ED:	1.0	cm		ES:	1.1	cm

INDICES OF LEFT VENTRICULAR FUNCTION:

LV Ejection Fraction : 64 %

IMAGING:

M mode examination revealed normal movement of both Mitral leaflets during diastole. No SAM or Mitral valve prolapse is seen. Aortic root is normal in size. Dimensions of left atrium and left ventricle are normal

2-D imaging in PLAX. SAX and apical views revealed normal sized left ventricle. Movement of anterior wall, septum, apex, inferior wall, posterior and lateral walls is normal. Mitral valve opening is normal. No evidence of Mitral valve prolapse is seen. Aortic valve has three cusps and its opening is not restricted. Pulmonary valve is normal. Interatrial and interventricular septa are intact. No intracardiac mass or thrombus is seen. No pericardial pathology is observed.

Fortis MEDCENTRE
CHANDIGARH

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DOPPLER: PULSE WAVE; CONTINUOUS WAVE & COLOR FLOW MAPPING

Mitral Valve	:	E= 84 A= 61 cm/sec; E > A; No MR
		E wave Deceleration Time = 183 msec
Aortic Valve	:	106 cm/sec No AR
Tricuspid Valve	:	Mild TR ; RVSP = 14+ RAP mmHg
Pulmonary Valve	:	78 cm/sec

FINAL DIAGNOSIS

- **NO REGIONAL WALL MOTION ABNORMALITY OF LEFT VENTRICLE**
- **NORMAL LEFT VENTRICULAR SYSTOLIC FUNCTION (LVEF 64%)**

Dr. MUKTI SHARMA
MD, DNB, FIAP, FCSI
Sr. Consultant
Fortis MEDCENTRE

Fortis MEDCENTRE
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DEPARTMENT OF FMC-RADIOLOGY LAB

Date: 25/Feb/2023

Name: Mr. Ankur Vadhera
Age | Sex: 32 YEAR(S) | Male
Order Station : FRONTOFFICE-FMC
Bed Name :

UHID | Episode No : 12316109 | 2148/23/10021
Order No | Order Date: 10021/PN/OP/2302/5594 | 25-Feb-2023
Admitted On | Reporting Date : 25-Feb-2023 10:16:54
Order Doctor Name : Dr.SELF .

CHEST X-RAY (PA VIEW)

Both the domes of diaphragm are normal.

Both costophrenic angles are normal.

Both lung fields are clear.

Cardiac size and silhouette are normal.

Both hila and mediastinum are normal.

Bony cage and soft tissues are normal.

IMPRESSION: NORMAL STUDY.

Please correlate clinically and with other relevant investigations.

DR NEHA CHHABRA

CONSULTANT RADIOLOGIST

Fortis MEDCENTRE
CHANDIGARH

Fortis Medcentre
SCO-11, Sector-11-D,
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Website : www.fortishealthcare.com

NAME: MR. ANKUR VADHERA
AGE AND SEX: 32Y/M
UHID NO: 12316109
DATE: 25/02/2023
ROI: WHOLE ABDOMEN

Liver is normal in size, outline and shows mildly increased echogenicity. No focal lesion seen. IHBR's are not dilated. Portal vein and hepatic veins are normal.

Gall bladder is normally distended with anechoic lumen. Wall thickness is normal. No calculus / focal lesion seen. No pericholecystic fluid / collection seen. CBD is normal.

Pancreas is visualized in region of head and proximal body and is normal in size, shape, outline and echotexture. No focal lesion seen. Distal body and tail are obscured by bowel gases.

Spleen is normal in size, outline and echotexture. No focal lesion seen.

Right kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Left kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Retroperitoneum is normal.

The urinary bladder is fully distended and is normal in outline and wall thickness. No calculi or growth seen

Prostate is normal in size, and shows normal outline and echopattern. No focal lesion seen.

No free fluid is seen.

Opinion: Fatty Liver Grade I

Suggested clinical correlation.

Dr. NEHA CHHABRA.
Consultant Radiologist

ANKUR VADHERA 32M **Study Date: 25/02/2023**

Patient ID: 12316109 Accession #: Alt ID:

DOB: Age: Gender: M Ht: Wt: BSA:

Institution: Fortis MEDCENTRE, Chandigarh

Referring Physician:

Physician of Record: Performed By:

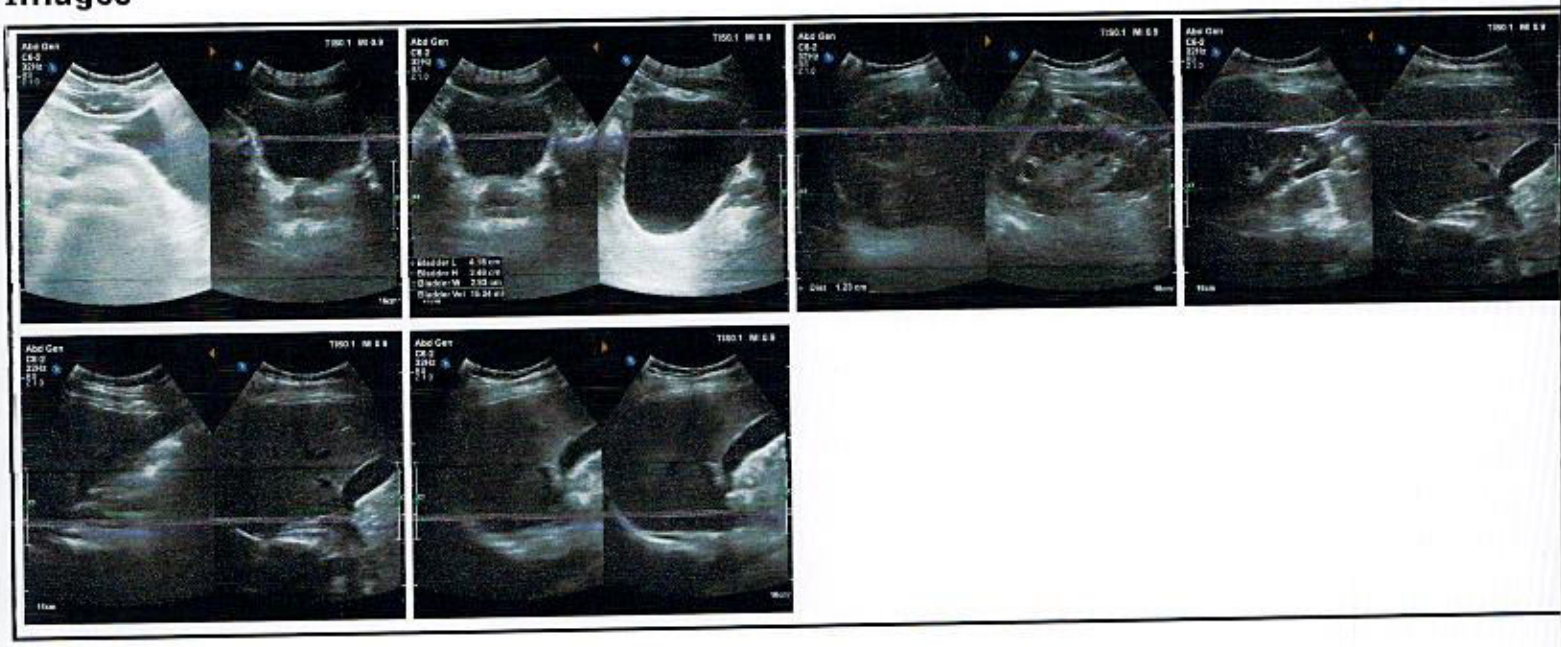
Comments:

Abdominal: Measurements and Calculations

2D Abdominal Organs and Vessels

Bladder Vol	**15.24 ml**	Bladder H	2.46 cm
Bladder L	4.18 cm	Bladder W	2.83 cm

Images



Signature

Signature:

Name(Print): Date:

Fortis MEDCENTRE
CHANDIGARH
(A unit of Fortis Hospital Mohali)
SCO 11, Sector 11-D, Chandigarh - 160011

Name MR ANKUR VADHERA
UHID : 1231610 Date : 25/2/23.
Age : 32 Yrs Gender : male.

Nursing Assessment

Profile	
Height (cm) : 182 cms	Waist Circumference (cm) : 32 inches.
Weight (Kg.) : 76.7 kgs.	Body Mass Index :
Occupation : BOB.	Marital Status ☐ Single ☑ Married

Vital Signs	
Pulse Rate (/min) : 72 b/min	Respiratory Rate (/min) : 20/min SpO2- 98%
Blood Pressure (mmHg) : 110/70 mmHg	Temperature (if febrile) : Afebrile.

Past History	
☐ Hypertension :	☑ Diabetes :
☐ Heart disease :	☒ Dyslipidemia :
☐ Asthma :	☐ Tuberculosis :
☐ Allergies :	
☐ Others :	

For Women	
LMP:	Last Pap smear done in
Menopause ☐ Yes ☐ No	Last Mammography done in
Consent for X-ray & Mammography	

Current Medications

Signature, Name and Emp. ID of the Nurse : _____

Fortis MEDCENTRE
CHANDIGARH
(A unit of Fortis Hospital Mohali)
SCO 11, Sector 11-D, Chandigarh - 160011

Name : Mr. Ankur Vaidya

UHID : 1231610 9 Date : 25/2/23

Age : 32 Year Gender : male

Internal Medicine Consultation

Relevant History:

Diagnosis:

Examination Findings:

Advice / Treatment Plan:

Investigations:

Signature and stamp of the Consultant : _____