Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 8 / 9 / 23

Name: Mrs. Reshma Unawala Age: 50 yrs Sex: M / F

BP: 140/90 mmHg Height (cms): 162 cm Weight(kgs): 84.8 kg BMI:

SpO2 - 97%.
Pulse 100 b/m

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese					Extremely Obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

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For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	12696369	Date	08/09/2023		
Name	Mrs.Reshma Nasir Unawala	Sex	Female	Age	50
OPD	Opthal 14	Health Check-up			

CM - No

Drug allergy: No
Sys illness:

H/o HTN : 10yrs on Rx. Habit → No

H/o

Left +0.75DS / -1.00 DC X 90 - 6/6
+0.75DS / -0.75 DC X 100° - 6/6

Near Add { +2.00 DS
+2.00 DS

IOP { 15-2
14.3 mHg

Advise prescribe Spectacles

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UHID	12696369	Date	08/09/2023		
Name	Mrs.Reshma Nasir Unawala	Sex	Female	Age	50
OPD	Pap	Health Check-up			

Drug allergy:
Sys illness:

S/B Dr Hina

M/H - Post-hysterectomy (open TAH) done.
5yrs back i/v/o - fibroids.

Obs H/- P1L3D1 All FTND..
TL done.

H/o - HTN on medications.
- TAH done 5yrs back

O/E
Vault healthy

Adv
F/v c
other reports

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UHID	12696369	Date	08/09/2023		
Name	Mrs.Reshma Nasir Unawala	Sex	Female	Age	50
OPD	Dental 12 - 7387696540	Health Check-up			

Drug allergy:
Sys illness:

O/E-

stains +
calculus.

dislodged ~~pro~~ crown ē |6 :

caries ē |67

root pieces ē |5

missing ē 6|

Treatment:

1. Adv. Oral prophylaxis.
2. Adv. CBCT (full mouth).
3. Adv. replacement of crown ē |6.

Dr. Bhuwala

Diagnostic Report

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PATIENT NAME : MRS.RESHMA NASIK UNAWALA	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI001807** PATIENT ID : FH.12696406 CLIENT PATIENT ID: UID:12696406 ABHA NO :	AGE/SEX :50 Years Female DRAWN :08/09/2023 09:18:00 RECEIVED : 08/09/2023 09:21:23 REPORTED :08/09/2023 14:39:22

CLINICAL INFORMATION :

UID:12696406 REQNO-1579435
CORP-OPD
BILLNO-150123OPCR051650
BILLNO-150123OPCR051650

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 METHOD	14.1	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	**4.94 High**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	6.08	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	267	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	43.0	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	87.0	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	28.5	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	32.8	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	12.2	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	17.6		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	9.3	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

Dr.Akshay Dhotre
Consultant Pathologist

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NEUTROPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	41	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	**49 High**	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	7	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	3	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	2.49	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.98	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.43	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.18	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0.00 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	0.8		

MORPHOLOGY

RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
WBC METHOD : MICROSCOPIC EXAMINATION	REACTIVE LYMPHOCYTES SEEN
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE

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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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Patient Ref. No. 2200000871074

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	12	0 - 20	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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Diagnostic Report

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE B		
RH TYPE METHOD : TUBE AGGLUTINATION	POSITIVE		

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.30	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF BILIRUBIN, DIRECT	0.09	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF BILIRUBIN, INDIRECT	0.21	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING GLOBULIN	3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER ASPARTATE AMINOTRANSFERASE(AST/SGOT)	**55 High**	15 - 37	U/L
METHOD : UV WITH P5P ALANINE AMINOTRANSFERASE (ALT/SGPT)	**80 High**	< 34.0	U/L
METHOD : UV WITH P5P ALKALINE PHOSPHATASE	77	30 - 120	U/L
METHOD : PNPP-ANP GAMMA GLUTAMYL TRANSFERASE (GGT)	**56 High**	5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE LACTATE DEHYDROGENASE	163	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	**165 High**	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
METHOD : HEXOKINASE			

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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	**7.8 High**	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)	%
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	**177.2 High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	6	6 - 20	mg/dL
METHOD : UREASE - UV			
CREATININE EGFR- EPI			
CREATININE	0.95	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	50		years
GLOMERULAR FILTRATION RATE (FEMALE)	72.99	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			
BUN/CREAT RATIO			
BUN/CREAT RATIO	6.32	5.00 - 15.00	

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METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM URIC ACID METHOD : URICASE UV	4.3	2.6 - 6.0	mg/dL
TOTAL PROTEIN, SERUM TOTAL PROTEIN METHOD : BIURET	7.4	6.4 - 8.2	g/dL
ALBUMIN, SERUM ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN GLOBULIN METHOD : CALCULATED PARAMETER	3.5	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	140	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	**5.20 High**	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	104	98 - 107	mmol/L

Dr.Akshay Dhotre
Consultant Pathologist

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Maharashtra, India
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PATIENT NAME : MRS.RESHMA NASIK UNAWALA	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI001807** PATIENT ID : FH.12696406 CLIENT PATIENT ID: UID:12696406 ABHA NO :	AGE/SEX :50 Years Female DRAWN :08/09/2023 09:18:00 RECEIVED : 08/09/2023 09:21:23 REPORTED :08/09/2023 14:39:22

CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150123OPCR051650
BILLNO-150123OPCR051650

Test Report Status **Final**	Results	Biological Reference Interval	Units

Interpretation(s)

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.
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,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about 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 Glysouria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.

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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 :
1. 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.
2.Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin.
3. 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.
4. 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
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.
CREATININE EGFR- EPI-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.
- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.
- The GFR is a calculation based on serum creatinine test.
- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.
- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.
- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- This equation takes into account several factors that impact creatinine production, including age, gender, and race.
- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high(>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation-https://testguide.labmed.uw.edu/guideline/egfr
Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325
Harrison''s Principle of Internal Medicine, 21st ed. pg 62 and 334
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
TOTAL PROTEIN, SERUM-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,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about 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.

Dr.Akshay Dhotre
Consultant Pathologist

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CLINICAL INFORMATION :

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Test Report Status **Final**	Results	Biological Reference Interval	Units

BIOCHEMISTRY - LIPID

	Results	Biological Reference Interval	Units
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	178	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE TRIGLYCERIDES	135	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY HDL CHOLESTEROL	42	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG LDL CHOLESTEROL, DIRECT	124	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT NON HDL CHOLESTEROL	**136 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER VERY LOW DENSITY LIPOPROTEIN	27.0	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER CHOL/HDL RATIO	4.2	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO	3.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

Dr.Akshay Dhotre
Consultant Pathologist

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**		

CHEMICAL EXAMINATION, URINE

PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	1.025	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NORMAL	NORMAL	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NOT DETECTED	NOT DETECTED	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			

Dr.Akta Dubey
Counsultant Pathologist

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

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MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	**5-7**	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	**8-10**	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

Dr.Akta Dubey
Counsultant Pathologist

Rekha. N
Dr. Rekha Nair, MD
Microbiologist

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	155.1	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	10.30	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	3.600	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

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BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**237 High**	70 - 140	mg/dL
METHOD : HEXOKINASE			

Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-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.Additional test HbA1c

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Dr.Akshay Dhotre
Consultant Pathologist

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1269406
50 Years

RESHMA UNAWALA
Female

9/8/2023 10:51:04 AM

HC

Rate	90	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Probable left atrial enlargement.....P >50mS, <-0.10mV V1
PR	131	. Abnormal R-wave progression, late transition.....QRS area<0 in V5/V6
QRSD	95	. Borderline T wave abnormalities.....T/QRS ratio < 1/20 or flat T
QT	359	
QTc	440	

--AXIS--

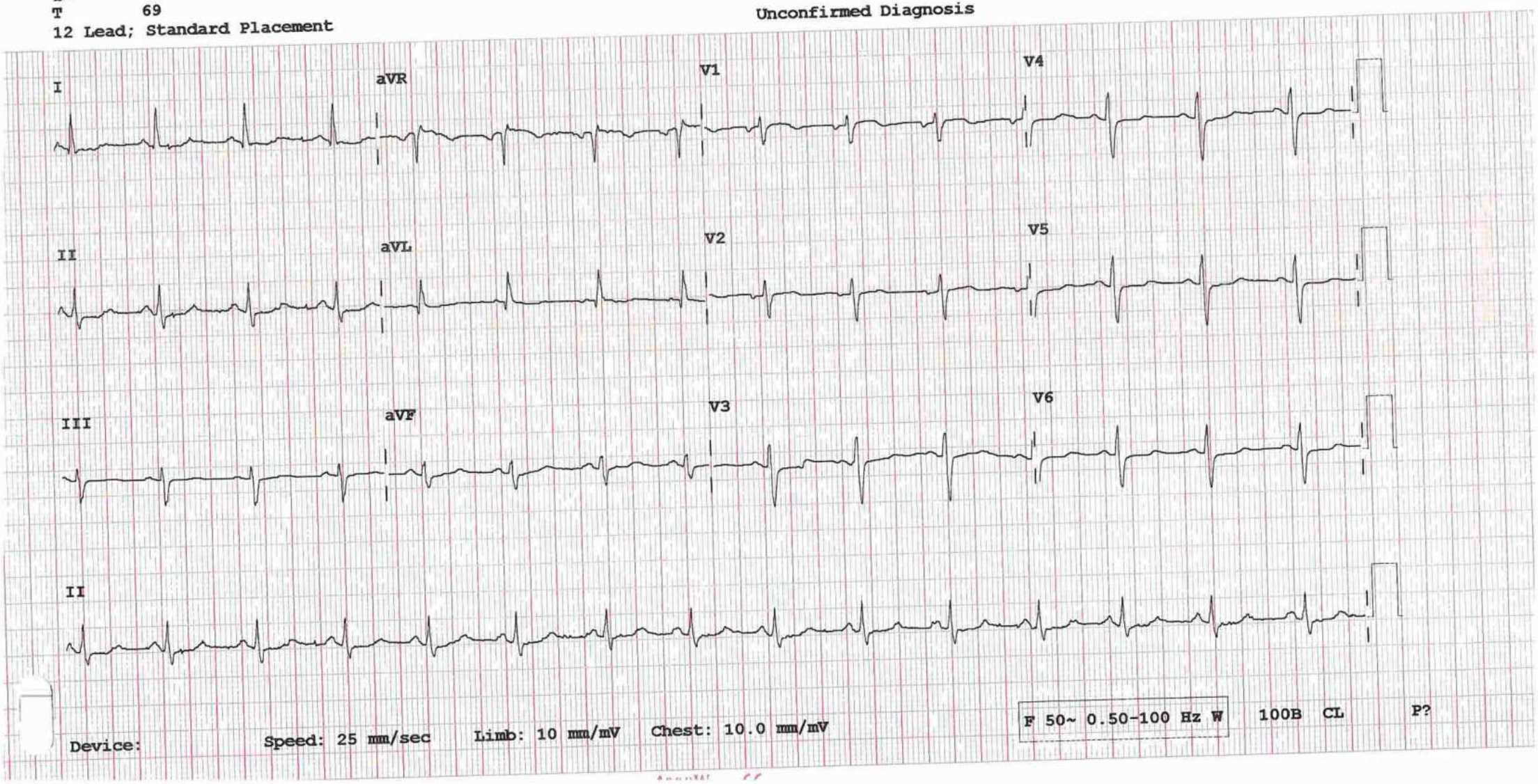
P	55
QRS	-12
T	69

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

— Sinus rhythm



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 09/Sep/2023

DEPARTMENT OF NIC

Name: Mrs. Reshma Nasik Unawala
Age | Sex: 50 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12696406 | 52291/23/1501
Order No | Order Date: 1501/PN/OP/2309/109085 | 08-Sep-2023
Admitted On | Reporting Date : 09-Sep-2023 14:04:27
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	33	mm
AO Root	30	mm
AO CUSP SEP	26	mm
LVID (s)	30	mm
LVID (d)	44	mm
IVS (d)	11	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	28	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.6 m/sec.
A WAVE VELOCITY:0.5 m/sec
E/A RATIO:1.2

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	12			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	03			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

DR. PRASHANT PAWAR
DNB(MED), DNB (CARDIOLOGY)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 08/Sep/2023

DEPARTMENT OF RADIOLOGY

Name: Mrs. Reshma Nasik Unawala
Age | Sex: 50 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

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Order No | Order Date: 1501/PN/OP/2309/109085 | 08-Sep-2023
Admitted On | Reporting Date : 08-Sep-2023 11:01:42
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

Patient Name	:	Reshma Nasik Unawala	Patient ID	:	12696406
Sex / Age	:	F / 50Y 9M 23D	Accession No.	:	PHC.6545655
Modality	:	US	Scan DateTime	:	08-09-2023 10:36:20
IPID No	:	52291/23/1501	ReportDatetime	:	08-09-2023 10:53:52

USG – WHOLE ABDOMEN

LIVER is normal in size and shows grossly raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 11.0 x 6.1 cm.
Left kidney measures 11.3 x 5.3 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is partially distended.

UTERUS is not visualised – post hysterectomy status.

Both adnexae are clear.

No evidence of ascites.

Impression:

- **Grade III fatty infiltration of liver.**

DR. CHETAN KHADKE
M.D. (Radiologist)

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Order Doctor Name : Dr.SELF .

MAMMOGRAM - BOTH BREAST

Findings:

Bilateral film screen mammography was performed in cranio-caudal and medio-lateral oblique views.

Both breasts show scattered areas of fibroglandular density.

Subcentimeter sized oval radio-opacity is seen in the superolateral quadrant of the left breast, most likely benign lesion.

No evidence of any dominant mass, clusters of microcalcifications, nipple retraction, skin thickening or abnormal vascularity is seen in either breast.

No evidence of axillary lymphadenopathy.

IMPRESSION:

- **Subcentimeter sized oval radio-opacity in the superolateral quadrant of the left breast, most likely benign lesion. (BI-RADS category II).**

  Normal-interval follow-up is recommended.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)