ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

Patient Name	Mr. NIKHIL MEENA	**Lab No**	4005624
UHID	40003386	**Collection Date**	28/06/2023 12:10PM
Age/Gender	31 Yrs/Male	**Receiving Date**	28/06/2023 12:16PM
IP/OP Location	O-OPD	**Report Date**	28/06/2023 5:31PM
Referred By	EHS CONSULTANT	**Report Status**	Final
Mobile No.	9549493550		

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range
BLOOD GLUCOSE (FASTING)			Sample: Fl. Plasma
BLOOD GLUCOSE (FASTING)	99.4	mg/dl	74 - 106

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

BLOOD GLUCOSE (PP)			Sample: PLASMA
BLOOD GLUCOSE (PP)	139.1	mg/dl	Non – Diabetic: - < 140 mg/dl Pre – Diabetic: - 140-199 mg/dl Diabetic: - >=200 mg/dl

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

THYROID T3 T4 TSH			Sample: Serum
T3	1.670	ng/mL	0.970 - 1.690
T4	8.61	ug/dl	5.53 - 11.00
TSH	2.97	µIU/mL	0.40 - 4.05

RESULT ENTERED BY : SUNIL EHS

Dr. MUDITA SHARMA

MBBS|MD| PATHOLOGY

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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BIOCHEMISTRY

T3:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

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

T4:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

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

TSH - THYROID STIMULATING HORMONE :- ElectroChemiLuminescenceImmunoAssay - ECLIA

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

LFT (LIVER FUNCTION TEST) Sample: Serum

BILIRUBIN TOTAL	0.47	mg/dl	0.00 - 1.20
BILIRUBIN INDIRECT	0.34	mg/dl	0.20 - 1.00
BILIRUBIN DIRECT	0.13	mg/dl	0.00 - 0.40
SGOT	**40.3 H**	U/L	0.0 - 40.0
SGPT	**86.9 H**	U/L	0.0 - 40.0
TOTAL PROTEIN	8.7	g/dl	6.6 - 8.7
ALBUMIN	4.5	g/dl	3.5 - 5.2
GLOBULIN	**4.2 H**		1.8 - 3.6
ALKALINE PHOSPHATASE	**141.8 H**	U/L	53 - 128
A/G RATIO	**1.1 L**	Ratio	1.5 - 2.5
GGTP	**114.8 H**	U/L	10.0 - 55.0

RESULT ENTERED BY : SUNIL EHS

Dr. MUDITA SHARMA

MBBS|MD| PATHOLOGY

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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BIOCHEMISTRY

BILIRUBIN TOTAL :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structive.
BILIRUBIN DIRECT :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.
SGOT - AST :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT(AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.
SGPT - ALT :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT(ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.
TOTAL PROTEINS :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.
ALBUMIN :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.
ALKALINE PHOSPHATASE :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method: Enzymetic colorimetric assay. Interpretation:-y-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

LIPID PROFILE

TOTAL CHOLESTEROL	172		<200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High
HDL CHOLESTEROL	37.2		High Risk :-<40 mg/dl (Male), <40 mg/dl (Female) Low Risk :->=60 mg/dl (Male), >=60 mg/dl (Female)
LDL CHOLESTEROL	134.6		Optimal :- <100 mg/dl Near or Above Optimal :- 100-129 mg/dl Borderline :- 130-159 mg/dl High :- 160-189 mg/dl Very High :- >190 mg/dl
CHOLESTERO VLDL	23	mg/dl	10 - 50
TRIGLYCERIDES	117.2		Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl
CHOLESTEROL/HDL RATIO	4.6	%	

RESULT ENTERED BY : SUNIL EHS

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MBBS|MD| PATHOLOGY

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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BIOCHEMISTRY

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

RENAL PROFILE TEST Sample: Serum

UREA	35.10	mg/dl	16.60 - 48.50
BUN	16.4	mg/dl	6 - 20
CREATININE	0.72	mg/dl	0.60 - 1.10
SODIUM	141.6	mmol/L	136 - 145
POTASSIUM	4.01	mmol/L	3.50 - 5.50
CHLORIDE	104.1	mmol/L	98 - 107
URIC ACID	4.5	mg/dl	3.5 - 7.2
CALCIUM	9.33	mg/dl	8.60 - 10.30

RESULT ENTERED BY : SUNIL EHS

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MBBS|MD| PATHOLOGY

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CREATININE – SERUM :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidneydisease.
URIC ACID :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uricacid are renal diseases with decreased excretion of waste products, starvation,drug abuse and increased alcohol consume.
SODIUM:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea,diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake andkidney reabsorption.
POTASSIUM :- Method: ISE electrode. Intrpretation:-Low level: Intake excessive loss formbodydue to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renalfailure.
CHLORIDE – SERUM :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake,prolonged vomiting and reduced renal reabsorption as well as forms of acidosisand alkalosis.
Increase: dehydration, kidney failure, some form ofacidosis, high dietary or parenteral chloride intake, and salicylate poisoning.
UREA:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogenconcentration are seen in inadequate renal perfusion, shock, diminished bloodvolume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerularnephritis and UTI.
CALCIUM TOTAL :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usuallyassociated with hypercalcemia. Increased serum calcium levels may also beobserved in multiple myeloma and other neoplastic diseases. Hypocalcemia may
beobserved in hypoparathyroidism, nephrosis, and pancreatitis.

RESULT ENTERED BY : SUNIL EHS

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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BLOOD BANK INVESTIGATION

Test Name	Result	Unit	Biological Ref. Range
BLOOD GROUPING	"O" Rh Positive		

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

RESULT ENTERED BY : SUNIL EHS

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MBBS|MD| PATHOLOGY

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CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	
URINE SUGAR (POST PRANDIAL)				Sample: Urine
URINE SUGAR (POST PRANDIAL)	NEGATIVE		NEGATIVE	
URINE SUGAR (RANDOM)				Sample: Urine
URINE SUGAR (RANDOM)	NEGATIVE		NEGATIVE	
ROUTINE EXAMINATION - URINE				Sample: Urine
PHYSICAL EXAMINATION				
VOLUME	15	ml		
COLOUR	PALE YELLOW		P YELLOW	
APPEARANCE	CLEAR		CLEAR	
CHEMICAL EXAMINATION				
PH	6.0		5.5 - 7.0	
SPECIFIC GRAVITY	1.015		1.016-1.022	
PROTEIN	NEGATIVE		NEGATIVE	
SUGAR	NEGATIVE		NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
BLOOD	NEGATIVE			
KETONES	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
UROBILINOGEN	NEGATIVE		NEGATIVE	
LEUCOCYTE	NEGATIVE		NEGATIVE	
MICROSCOPIC EXAMINATION				
WBCS/HPF	1-2	/hpf	0 - 3	
RBCS/HPF	0-0	/hpf	0 - 2	
EPITHELIAL CELLS/HPF	1-2	/hpf	0 - 1	
CASTS	NIL		NIL	
CRYSTALS	NIL		NIL	

RESULT ENTERED BY : SUNIL EHS

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MBBS|MD| PATHOLOGY

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CLINICAL PATHOLOGY

BACTERIA	NIL	NIL
OHTERS	NIL	NIL

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

RESULT ENTERED BY : SUNIL EHS

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MBBS|MD| PATHOLOGY

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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Mobile No.	9549493550		

HEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range
CBC (COMPLETE BLOOD COUNT)			Sample: WHOLE BLOOD EDTA
HAEMOGLOBIN	13.7	g/dl	13.0 - 17.0
PACKED CELL VOLUME(PCV)	42.9	%	40.0 - 50.0
MCV	**93.1 H**	fl	82 - 92
MCH	29.7	pg	27 - 32
MCHC	**31.9 L**	g/dl	32 - 36
RBC COUNT	4.61	millions/cu.mm	4.50 - 5.50
TLC (TOTAL WBC COUNT)	6.55	10^3/ uL	4 - 10
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHILS	57.2	%	40 - 80
LYMPHOCYTE	31.6	%	20 - 40
EOSINOPHILS	3.7	%	1 - 6
MONOCYTES	6.6	%	2 - 10
BASOPHIL	**0.9 L**	%	1 - 2
PLATELET COUNT	1.93	lakh/cumm	1.500 - 4.500

HAEMOGLOBIN :- Method:-SLS HemoglobinMethodology by Cell Counter.Interpretation:-Low-Anemia, High-Polycythemia.
MCV :- Method:- Calculation bysysmex.
MCH :- Method:- Calculation bysysmex.
MCHC :- Method:- Calculation bysysmex.
RBC COUNT :- Method:-Hydrodynamicfocusing.Interpretation:-Low-Anemia,High-Polycythemia.
TLC (TOTAL WBC COUNT) :- Method:-Optical Detectorblock based on Flowcytometry.Interpretation:-High-Leucocytosis, Low-Leucopenia.
NEUTROPHILS :- Method: Optical detectorblock based on Flowcytometry
LYMPHOCYTS :- Method: Optical detectorblock based on Flowcytometry
EOSINOPHILS :- Method: Optical detectorblock based on Flowcytometry
MONOCYTES :- Method: Optical detectorblock based on Flowcytometry
BASOPHIL :- Method: Optical detectorblock based on Flowcytometry
PLATELET COUNT :- Method:-Hydrodynamicfocusing method.Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

ESR (ERYTHROCYTE SEDIMENTATION RATE)	12	mm/1st hr	0 - 15

RESULT ENTERED BY : SUNIL EHS

Dr. MUDITA SHARMA

MBBS|MD| PATHOLOGY

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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Method:-Modified Westergrens.
Interpretation:-Increased in infections, sepsis, and malignancy.

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ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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Test Name	Result	Unit	Biological Ref. Range

USG REPORT - ABDOMEN AND PELVIS

LIVER:

Is normal in size **143 mm and shows diffuse increased echogenicity**. No obvious focal lesion seen. No intra hepatic biliary radical dilatation seen.

GALLBLADDER:

Partially distended with no obvious wall thickening/pericholecystic fat stranding/fluid. No obvious calculus/polyp/mass seen within.

PANCREAS:

Appears normal in size and shows uniform echo texture. The pancreatic duct is normal. No calcifications are seen.

SPLEEN:

Appears normal in size and it shows uniform echo texture. It measures **83 mm** in long axis.

RIGHT KIDNEY:

Right kidney measures **99 x 48 mm.**

The shape, size and contour of the right kidney appear normal.

Corticomedullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

LEFT KIDNEY:

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USG

Left kidney measures **97 x 52 mm**.

The shape, size and contour of the left kidney appear normal.

Corticomedullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

URINARY BLADDER:

Is normal in contour. No intraluminal echoes are seen. No calculus or diverticulum is seen.

PROSTATE:

Measures **16 cc** in volume. Normal

RIGHT ILIAC FOSSA:

No focal fluid collections seen.

IMPRESSION:

Diffuse grade I fatty liver.

RESULT ENTERED BY : SUNIL EHS

Dr. RENU JADIYA
MBBS, DNB
RADIOLOGIST

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

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X Ray

Test Name	Result	Unit	Biological Ref. Range

X-RAY - CHEST PA VIEW

OBSERVATION:

The trachea is central.

The mediastinal and cardiac silhouette are normal.

Cardiothoracic ratio is normal.

Cardiophrenic and costophrenic angles are normal.

Both hila are normal.

The lung fields are clear.

Bones of the thoracic cage are normal.

End Of Report

RESULT ENTERED BY : SUNIL EHS

APOORVA JETWANI

Select

DEPARTMENT OF CARDIOLOGY

UHID / IP NO	40003386 (5147)	**RISNo./Status :**	4005624/
Patient Name :	Mr. NIKHIL MEENA	**Age/Gender :**	31 Y/M
Referred By :	EHS CONSULTANT	**Ward/Bed No :**	OPD
Bill Date/No :	28/06/2023 11:32AM/ OPSCR23-24/2028	**Scan Date :**	
Report Date :	28/06/2023 1:09PM	**Company Name:**	Final

REFERRAL REASON: - HEALTH CHECKUP

2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

M MODE DIMENSIONS: -

		Normal			Normal
IVSD	**11.8**	**6-12mm**	**LVIDS**	**34.0**	**20-40mm**
LVIDD	**49.9**	**32-57mm**	**LVPWS**	**19.0**	**mm**
LVPWD	**11.8**	**6-12mm**	**AO**	**30.8**	**19-37mm**
IVSS	**19.0**	**mm**	**LA**	**37.2**	**19-40mm**
LVEF	**60-62**	**>55%**	**RA**	**-**	**mm**

DOPPLER MEASUREMENTS & CALCULATIONS:

STRUCTURE	MORPHOLOGY	VELOCITY (m/s)				GRADIENT (mmHg)	REGURGITATION
MITRAL VALVE	**NORMAL**	**E**	**1.06**	**e'**		**-**	**NIL**
		A	**0.52**	**E/e'**			
TRICUSPID VALVE	**NORMAL**	**E**		**0.67**		_	**NIL**
		A		**0.47**			
AORTIC VALVE	**NORMAL**	**1.02**				-	**NIL**
PULMONARY VALVE	**NORMAL**	**0.76**				-	**NIL**

COMMENTS & CONCLUSION: -

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

IMPRESSION: - NORMAL BI VENTRICULAR FUNCTIONS

DR SUPRIY JAIN
MBBS, M.D., D.M. (CARDIOLOGY)
INCHARGE & SR. CONSULTANT
INTERVENTIONAL CARDIOLOGY

DR ROOPAM SHARMA
MBBS, PGDCC, FIAE
CONSULTANT & INCHARGE
EMERGENCY, PREVENTIVE CARDIOLOGY AND WELLNESS CENTRE

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

Patient Name	Mr. NIKHIL MEENA	**Lab No**	483311
UHID	309931	**Collection Date**	28/06/2023 1:27PM
Age/Gender	31 Yrs/Male	**Receiving Date**	28/06/2023 1:29PM
IP/OP Location	O-OPD	**Report Date**	28/06/2023 2:11PM
Referred By	Dr. EHCC Consultant	**Report Status**	Final
Mobile No.	9773349797		

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range
			Sample: WHOLE BLOOD EDTA
HBA1C	5.8	%	< 5.7% Nondiabetic 5.7-6.4% Pre-diabetic > 6.4% Indicate Diabetes Known Diabetic Patients < 7 % Excellent Control 7 - 8 % Good Control > 8 % Poor Control

Method : - High - performance liquid chromatography HPLC
Interpretation:-Monitoring long term glycemic control, testing every 3 to 4 months is generally sufficient.
The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

End Of Report

RESULT ENTERED BY : Mr. MAHENDRA KUMAR

Dr. SURENDRA SINGH
CONSULTANT & HOD
MBBS|MD| PATHOLOGY

Dr. ASHISH SHARMA
CONSULTANT
MBBS|MD|INCHARGE PATHOLOGY