



UHID	2744880	Date	23/12/2022
Name	Mrs. Pratima Rane	Sex	Female Age 57
OPD	Opthal 14	Health Check Up	

Drug allergy: → Not known
 Sys illness: → No

cls. No

Mrs. D.M. (since 7-8 yrs)

Unifed V → a 6/18P
 → b 6/6

Ref → a -1.0/-1.0 → 90° 6/6
 → a Plane 6/6
 Add → +2.25 → W6
 → W6

IOL → A 14.5
 → B 14.8

All good

Aquidube (1) — (1) — (1)
 Gank



UHID	2744880	Date	23/12/2022		
Name	Mrs. Pratima Rane	Sex	Female	Age	57
OPD	Dental 12	Health Check Up			

Drug allergy:
Sys illness:

Chipped off cap \leftarrow & food lodgment.

stains \leftarrow

calculus \leftarrow

Treatment

Adv. new cap \leftarrow

Adv. oral prophylaxis.

Dr. Diksha Kerkar



Cert. No. MC-2275



LABORATORY REPORT
PATIENT NAME : MRS.PRATIMA RANE

PATIENT ID : **FH.2744880**

CLIENT PATIENT ID : UID:2744880

ACCESSION NO : **0022VL005360** AGE : 57 Years SEX : Female ABHA NO :
 DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:51 REPORTED : 24/12/2022 13:53:04

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:2744880 REQNO-1349087
 CORP-OPD
 BILLNO-150122OPCR066019
 BILLNO-150122OPCR066019

Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 11 6 - 20 mg/dL
 METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE 0.75 0.60 - 1.10 mg/dL
 METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE 57 years
 GLOMERULAR FILTRATION RATE (FEMALE) 92.80 Refer Interpretation Below mL/min/1.73
 METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO 14.67 5.00 - 15.00
 METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 4.1 2.6 - 6.0 mg/dL
 METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.3 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.1 3.4 - 5.0 g/dL
 METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN 3.2 2.0 - 4.1 g/dL
 METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 139 136 - 145 mmol/L
 METHOD : ISE INDIRECT

POTASSIUM, SERUM 4.01 3.50 - 5.10 mmol/L
 METHOD : ISE INDIRECT

CHLORIDE, SERUM 103 98 - 107 mmol/L
 METHOD : ISE INDIRECT

Interpretation(s)

PHYSICAL EXAMINATION, URINE

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Patient Ref. No. 220000008



Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRATIMA RANE



PATIENT ID : **FH.2744880**

CLIENT PATIENT ID : UID:2744880

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COLOR

PALE YELLOW

METHOD : PHYSICAL

APPEARANCE

CLEAR

METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH

6.5

4.7 - 7.5

METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY

<=1.005

1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD

KETONES

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN

BILIRUBIN

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT

UROBILINOGEN

NORMAL

NORMAL

METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)

NITRITE

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS

NOT DETECTED

NOT DETECTED

/HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S)

0-1

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS

1-2

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

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Patient Ref. No. 2200000817627



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BACTERIA		NOT DETECTED	NOT DETECTED
METHOD : MICROSCOPIC EXAMINATION			
YEAST		NOT DETECTED	NOT DETECTED
METHOD : MICROSCOPIC EXAMINATION			
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.	

Interpretation(s)

Interpretation(s)

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-

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.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

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-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.

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.

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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	12.9	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.59	3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.71	4.0 - 10.0	thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	253	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	38.3	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	83.5	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.1	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.7	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.3	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	18.2		
MEAN PLATELET VOLUME (MPV)	9.4	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	63	40 - 80	%
METHOD : FLOW CYTOMETRY			
LYMPHOCYTES	27	20 - 40	%
METHOD : FLOW CYTOMETRY			
MONOCYTES	5	2 - 10	%
METHOD : FLOW CYTOMETRY			
EOSINOPHILS	5	1 - 6	%
METHOD : FLOW CYTOMETRY			

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BASOPHILS		00	0 - 2 %
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT		4.86	2.0 - 7.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT		2.08	1.0 - 3.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT		0.39	0.2 - 1.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT		0.39	0.02 - 0.50 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10 thou/ μ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.3	
METHOD : CALCULATED PARAMETER			
MORPHOLOGY			
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC	
METHOD : MICROSCOPIC EXAMINATION			
WBC		NORMAL MORPHOLOGY	
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS		ADEQUATE	
METHOD : MICROSCOPIC EXAMINATION			

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) 10650. This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	10	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

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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, Vasculitides, 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: Polycythemia 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.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE B

METHOD : TUBE AGGLUTINATION

RH TYPE NEGATIVE

METHOD : TUBE AGGLUTINATION

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.

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL 0.94 0.2 - 1.0 mg/dL

METHOD : JENDRASSIK AND GROFF

BILIRUBIN, DIRECT 0.24 High 0.0 - 0.2 mg/dL

METHOD : JENDRASSIK AND GROFF

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BILIRUBIN, INDIRECT		0.70	0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN		7.3	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		4.1	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.2	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.3	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		21	15 - 37 U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		36	High < 34.0 U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE		94	30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		21	5 - 55 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE		211	High 100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)		111	High 74 - 99 mg/dL
METHOD : HEXOKINASE			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C		6.3	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)		134.1	High < 116.0 mg/dL
METHOD : CALCULATED PARAMETER			

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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 are 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. Hum 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

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 so that no glucose is excreted in 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; sulfonyleureas, 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. Fructosylated 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 Glycosuria, Glycaemia 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.
 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 patient's metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 & opi addition 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

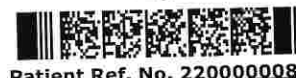
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HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
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NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222, 022-49723322,
022-49723322



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Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRATIMA RANE



PATIENT ID : FH.2744880

CLIENT PATIENT ID : UID:2744880

ACCESSION NO : 0022VL005360

AGE : 57 Years

SEX : Female

ABHA NO :

DRAWN : 24/12/2022 09:12:00

RECEIVED : 24/12/2022 09:13:51

REPORTED : 24/12/2022 13:53:04

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:2744880 REQNO-1349087

CORP-OPD

BILLNO-150122OPCR066019

BILLNO-150122OPCR066019

Test Report Status	Final	Results	Biological Reference Interval
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BIOCHEMISTRY- LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	143		< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, 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	72	High	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	61		< 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	71		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	2.0	Low	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				
LDL/HDL RATIO	0.9		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	15.6		<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				

Interpretation(s)

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and

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LABORATORY REPORT
PATIENT NAME : MRS.PRATIMA RANE

PATIENT ID : **FH.2744880** CLIENT PATIENT ID : UID:2744880
ACCESSION NO : **0022VL005360** AGE : 57 Years SEX : Female ABHA NO :
DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:51 REPORTED : 24/12/2022 13:53:04
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:2744880 REQNO-1349087
CORP-OPD
BILLNO-150122OPCR066019
BILLNO-150122OPCR066019

Test Report Status	Final	Results	Biological Reference Interval
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important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

****End Of Report****

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

Dr. Akta Dubey
Consultant Pathologist

Dr. Rekha Nair, MD
Microbiologist



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Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRATIMA RANE



PATIENT ID : **FH.2744880**

CLIENT PATIENT ID : UID:2744880

ACCESSION NO : **0022VL005462**

AGE : 57 Years

SEX : Female

ABHA NO :

DRAWN : 24/12/2022 12:12:00

RECEIVED : 24/12/2022 12:12:16

REPORTED : 24/12/2022 13:35:41

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:2744880 REQNO-1349087

CORP-OPD

BILLNO-150122OPCR066019

BILLNO-150122OPCR066019

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)

162

High 70 - 139

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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased Insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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

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Cert. No. MC-2984

LABORATORY REPORT
PATIENT NAME : MRS.PRATIMA RANE



PATIENT ID : **FH.2744880** CLIENT PATIENT ID : UID:2744880
ACCESSION NO : **0022VL005360** AGE : 57 Years SEX : Female ABHA NO :
DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:51 REPORTED : 24/12/2022 16:14:34
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

CLINICAL INFORMATION :
UID:2744880 REQNO-1349087
CORP-OPD
BILLNO-150122OPCR066019
BILLNO-150122OPCR066019

Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	129.4	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, COMPETITIVE IMMUNOASSAY

T4	10.39	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, COMPETITIVE IMMUNOASSAY

TSH (ULTRASENSITIVE)	1.760	0.270 - 4.200	µIU/mL
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METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

Interpretation(s)

****End Of Report****

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

Dr. Swapnil Sirmukaddam
786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

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Rate 65 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Borderline prolonged PR interval.....PR >202, V-rate 50- 90
 . Borderline low voltage, extremity leads.....all extremity leads <0.6mV

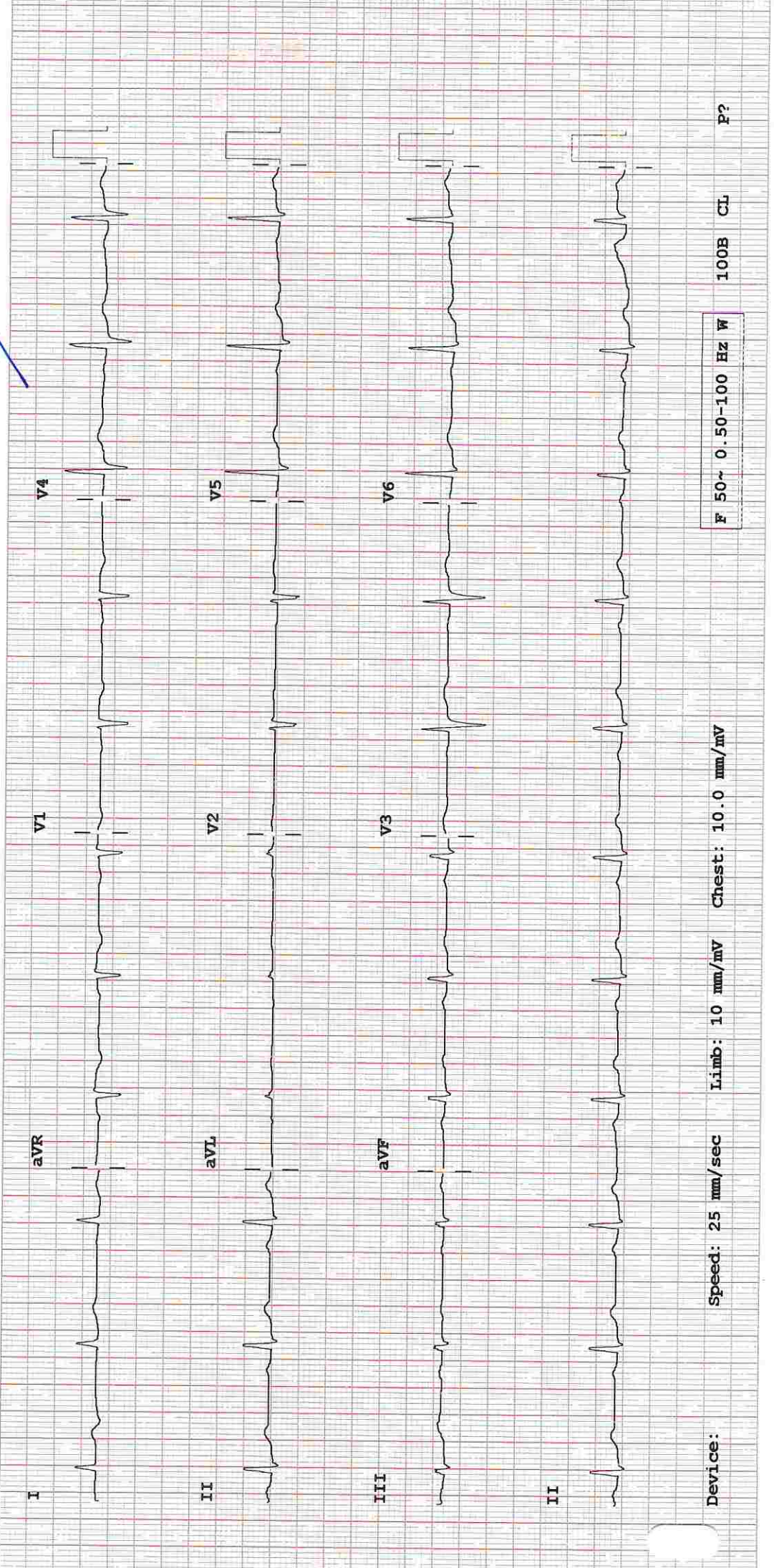
Sinus Rhythm
PR Prolonged

--AXIS--
 P 70
 QRS 40
 T 54

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis



**(For Billing/Reports & Discharge Summary only)****DEPARTMENT OF NIC**

Date: 24/Dec/2022

Name: Mrs. Pratima Rane**UHID | Episode No : 2744880 | 65329/22/1501****Age | Sex: 57 YEAR(S) | Female****Order No | Order Date: 1501/PN/OP/2212/138914 | 24-Dec-2022****Order Station : FO-OPD****Admitted On | Reporting Date : 24-Dec-2022 15:32:22****Bed Name :****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 e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	30	mm
AO Root	25	mm
AO CUSP SEP	15	mm
LVID (s)	25	mm
LVID (d)	43	mm
IVS (d)	07	mm
LVPW (d)	08	mm
RVID (d)	21	mm
RA	30	mm
LVEF	60	%



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mrs. Pratima Rane

UHID | Episode No : 2744880 | 65329/22/1501

Age | Sex: 57 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2212/138914 | 24-Dec-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 24-Dec-2022 15:32:22

Bed Name :

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.8 m/sec.

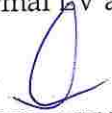
A WAVE VELOCITY:0.7 m/sec

E/A RATIO: 1.62,E/E'=10

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	10			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	3.0			Nil

Final Impression :

- No RWMA.
- No LV diastolic dysfunction.
- Trivial MR..
- Normal LV and RV systolic function.


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



DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mrs. Pratima Rane

Age | Sex: 57 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 2744880 | 65329/22/1501

Order No | Order Date: 1501/PN/OP/2212/138914 | 24-Dec-2022

Admitted On | Reporting Date : 24-Dec-2022 18:40:52

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)



Date: 24/Dec/2022

DEPARTMENT OF RADIOLOGY

Name: Mrs. Pratima Rane
Age | Sex: 57 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 2744880 | 65329/22/1501
Order No | Order Date: 1501/PN/OP/2212/138914 | 24-Dec-2022
Admitted On | Reporting Date : 24-Dec-2022 10:40:43
Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

Very suboptimal scan due to gaseous abdominal distention.

LIVER is normal in size (13.1 cm) and 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 8.7 x 4.1 cm.
Left kidney measures 9.3 x 4.5 cm.

PANCREAS: Head of pancreas appears unremarkable. Rest of the pancreas is obscured.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

UTERUS is not seen – post operative status.

Both ovaries are not seen, however both adnexae appears clear.

No evidence of ascites.

IMPRESSION:

- No significant abnormality is detected. Suggest clinical correlation.

Signature

DR. YOGESH PATHADE
(MD Radio-diagnosis)