836 vikrant parate 18/05/2024 09:54:09
Years Male SEVENHILLS HEALTHCARE

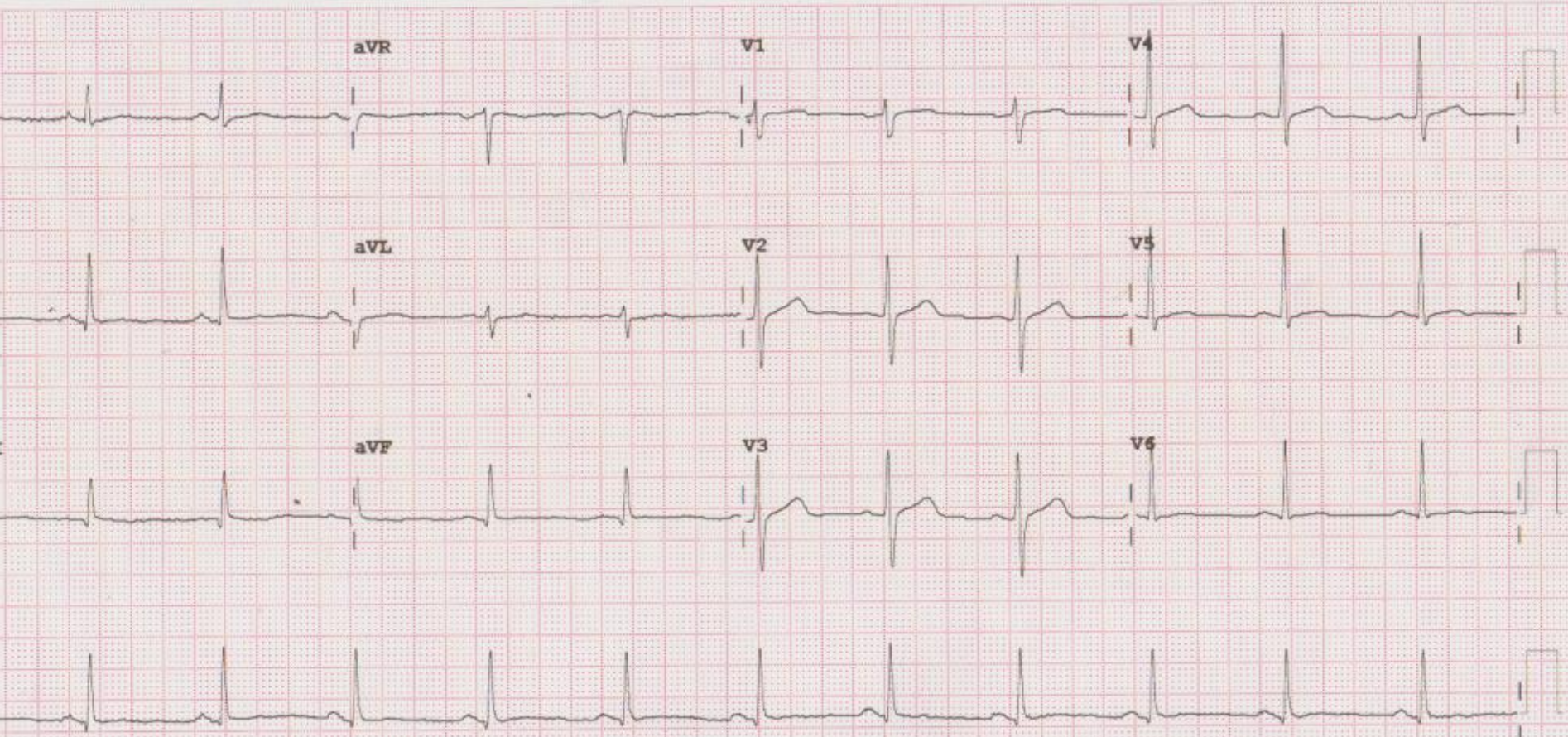
OPD

te 70 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Abnormal R-wave progression, early transition.....QRS area>0 in V2
153 . Borderline T wave abnormalities.....T/QRS ratio < 1/20 or flat T
D 88
390
421

AXIS--
37
68
4

- BORDERLINE ECG -

Lead; Standard Placement



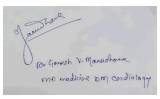
vice: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL? P?

DIAGNOSTICS REPORT

Patient Name	: Mr. VIKRANT PARATE	Order Date	: 18/05/2024 09:37
Age/Sex	: 51 Year(s)/Male	Report Date	: 18/05/2024 12:25
UHID	: SHHM.94836		
Ref. Doctor	: Self	Facility	: SEVENHILLS HOSPITAL, MUMBAI
Address	: AMBOLI, ANDHERI EAST,Mumbai, Maharastra, 400058	Mobile	: 9082877526

2D ECHOCARDIOGRAPHY WITH COLOUR DOPPLER STUDY

Normal LV and RV systolic function.
Estimated LVEF = 60%
No LV regional wall motion abnormality at rest .
AII valves are structurally and functionally normal.
Normal sized cardiac chambers.
No LV Diastolic dysfunction .
No pulmonary arterial hypertension.
No regurgitation across any other valves.
Normal forward flow velocities across all the cardiac valves.
Aorta and pulmonary artery dimensions: normal.
IAS / IVS: Intact.
No evidence of clot, vegetation, calcification, pericardial effusion.
COLOUR DOPPLER: NO MR/AR.



Dr.Ganesh Vilas Manudhane
M.ch,MCH/DM

RegNo: 2011/06/1763

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
Episode	: OP		
Ref. Doctor	: Self	**Mobile No**	: 9082877526
		DOB	: 22/11/1972
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

Biochemistry

Test Name	Result	Unit	Biological Reference Interval
Sample No : O0332566C Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 09:51 Report Date : 18/05/24 11:20			
Alkaline Phosphatase - SERUM *Method - IFCC AMP Buffer*	78.61	IU/L	43 - 115

References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

End of Report

Dr.Ritesh Kharche
MD, PGD-HM
Consultant Pathologist and Director of Laboratory Services
RegNo: 2006/03/1680

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
Episode	: OP		
Ref. Doctor	: Self	**Mobile No**	: 9082877526
		DOB	: 22/11/1972
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

Blood Bank

Test Name	Result

Sample No : O0332566A Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 10:51 Report Date : 18/05/24 15:22

BLOOD GROUPING/ CROSS-MATCHING BY SEMI AUTOMATION			
BLOOD GROUP (ABO)	' B '		
Rh Type *Method - Column Agglutination*	NEGATIVE		
Comment	DU TEST--- NEGATIVE		

REMARK: THE REPORTED RESULTS PERTAIN TO THE SAMPLE RECEIVED AT THE BLOOD CENTRE.

Interpretation:
Blood typing is used to determine an individual's blood group, to establish whether a person is blood group A, B, AB, or O and whether he or she is Rh positive or Rh negative. Blood typing has the following significance,
• Ensure compatibility between the blood type of a person who requires a transfusion of blood or blood components and the ABO and Rh type of the unit of blood that will be transfused.
• Determine compatibility between a pregnant woman and her developing baby (fetus). Rh typing is especially important during pregnancy because a mother and her fetus could be incompatible.
• Determine the blood group of potential blood donors at a collection facility.
• Determine the blood group of potential donors and recipients of organs, tissues, or bone marrow, as part of a workup for a transplant procedure.

End of Report

Dr.Pooja Vinod Mishra
MD Pathology
Jr Consultant Pathologist, MMC Reg No. 2017052191
RegNo: 2017/05/2191

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
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		DOB	: 22/11/1972
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
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		DOB	: 22/11/1972
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HAEMATOLOGY

Sample No : O0332566A Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 09:51 Report Date : 18/05/24 10:35

Test Name	Result	Unit	Biological Reference Interval
COMPLETE BLOOD COUNT (CBC) - EDTA WHOLE BLOOD			
Total WBC Count	6.70	x10^3/ul	4 - 10
Neutrophils	60.3	%	40 - 80
Lymphocytes	28.5	%	20 - 40
Eosinophils	4.1	%	1 - 6
Monocytes	7.0	%	2 - 10
Basophils	**0.1 ▼ (L)**	%	1 - 2
Absolute Neutrophil Count	4.04	x10^3/ul	2 - 7
Absolute Lymphocyte Count	1.91	x10^3/ul	0.8 - 4
Absolute Eosinophil Count	0.28	x10^3/ul	0.02 - 0.5
Absolute Monocyte Count	0.46	x10^3/ul	0.12 - 1.2
Absolute Basophil Count	0.01	x10^3/ul	0 - 0.1
RBCs	5.07	x10^6/ul	4.5 - 5.5
Hemoglobin	14.8	gm/dl	13 - 17
Hematocrit	42.9	%	40 - 50
MCV	84.7	fl	83 - 101
MCH	29.1	pg	27 - 32

MC-5288

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
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MCHC	34.4	gm/dl	31.5 - 34.5
RED CELL DISTRIBUTION WIDTH-CV (RDW-CV)	12.3	%	11 - 16
RED CELL DISTRIBUTION WIDTH-SD (RDW-SD)	39.6	fl	35 - 56
Platelet	186	x10^3/ul	150 - 410
Mean Platelet Volume (MPV)	9.7	fl	6.78 - 13.46
PLATELET DISTRIBUTION WIDTH (PDW)	15.9	%	9 - 17
PLATELETCRIT (PCT)	0.181	%	0.11 - 0.28
Comment	PS Findings: RBCs: Normocytic Normochromic WBCs: Normal Morphology Platelets: Adequate		

Method:-
HB Colorimetric Method.
RBC/PLT Electrical Impedance Method.
WBC data Flow Cytometry by Laser Method.
MCV,MCH,MCHC,RDW and rest parameters - Calculated.
All Abnormal Haemograms are reviewed confirmed microscopically.

NOTE: Wallach's Interpretation of Diagnostic Tests. 11th Ed, Editors: Rao LV. 2021

NOTE :-
The International Council for Standardization in Haematology (ICSH) recommends reporting of absolute counts of various WBC subsets for clinical decision making.This test has been performed on a fully automated 5 part differential cell counter which counts over 10,000 WBCs to derive differential counts. A complete blood count is a blood panel that gives information about the cells in a patient's blood, such as the cell count for each cell type and the concentrations of Hemoglobin and platelets. The cells that circulate in the bloodstream are generally divided into three types: white blood cells (leukocytes), red blood cells (erythrocytes), and platelets (thrombocytes). Abnormally high or low counts may be physiological or may indicate disease conditions, and hence need to be interpreted clinically.

MC-5288

LABORATORY INVESTIGATION REPORT

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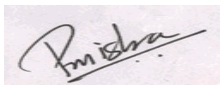
End of Report



Dr.Pooja Vinod Mishra
MD Pathology
Jr Consultant Pathologist, MMC Reg No. 2017052191
RegNo: 2017/05/2191

MC-5288

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
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		DOB	: 22/11/1972
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HAEMATOLOGY

Test Name	Result	Unit	Biological Reference Interval

Sample No : O0332566A Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 10:54 Report Date : 18/05/24 12:11

ERYTHROCYTE SEDIMENTATION RATE (ESR)			
ESR	15	mm/hr	0 - 20

Method: Westergren Method

INTERPRETATION :-
ESR is a non-specific phenomenon, its measurement is clinically useful in disorders associated with an increased production of acute-phase proteins. It provides an index of progress of the disease in rheumatoid arthritis or tuberculosis, and it is of considerable value in diagnosis of temporal arteritis and polymyalgia rheumatica. It is often used if multiple myeloma is suspected, but when the myeloma is non-secretory or light chain, a normal ESR does not exclude this diagnosis.

An elevated ESR may occur as an early feature in myocardial infarction. Although a normal ESR cannot be taken to exclude the presence of organic disease, the vast majority of acute or chronic infections and most neoplastic and degenerative diseases are associated with changes in the plasma proteins that increased ESR values.

The ESR is influenced by age, stage of the menstrual cycle and medications taken (corticosteroids, contraceptive pills). It is especially low (0–1 mm) in polycythaemia, hypofibrinogenaemia and congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis, or sickle cells. In cases of performance enhancing drug intake by athletes the ESR values are generally lower than the usual value for the individual and as a result of the increase in haemoglobin (i.e. the effect of secondary polycythaemia).

End of Report

Dr.Ritesh Kharche
MD, PGD-HM
Consultant Pathologist and Director of Laboratory Services
RegNo: 2006/03/1680

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
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Biochemistry

Sample No : O0332566A Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 10:54 Report Date : 18/05/24 11:20

Test Name	Result	Unit	Biological Reference Interval
GLYCOSLYATED HAEMOGLOBIN (HBA1C)			
HbA1c *Method - Immunoturbidimetry*	**6.91 ▲ (H)**	%	4 to 6% Non-diabetic 6.0--7.0% Excellent control 7.0--8.0% Fair to good control 8.0--10% Unsatisfactory control ABOVE 10% Poor control
Estimated Average Glucose (eAG) *Method - Calculated*	**151.62 ▲ (H)**	mg/dl	90 - 126

NOTES :-

1. HbA1c is used for monitoring diabetic control. It reflects the mean plasma glucose over three months

2. HbA1c may be falsely low in diabetics with hemolytic disease. In these individuals a plasma fructosamine level may be used which evaluates diabetes over 15 days.

3. Inappropriately low HbA1c values may be reported due to hemolysis, recent blood transfusion, acute blood loss, hypertriglyceridemia, chronic liver disease.Drugs like dapsone, ribavirin, antiretroviral drugs, trimethoprim, may also cause interference with estimation of HbA1c, causing falsely low values.

4. HbA1c may be increased in patients with polycythemia or post-splenectomy.

5. Inappropriately higher values of HbA1c may be caused due to iron deficiency, vitamin B12 deficiency, alcohol intake, uremia, hyperbilirubinemia and large doses of aspirin.

6. Trends in HbA1c are a better indicator of diabetic control than a solitary test.

7. Any sample with >15% HbA1c should be suspected of having a hemoglobin variant, especially in a non-diabetic patient. Similarly, below 4% should prompt additional studies to determine the possible presence of variant hemoglobin.

8. HbA1c target in pregnancy is to attain level <6 % .

9. HbA1c target in paediatric age group is to attain level < 7.5 %.

MC-5288

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
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Ref. Doctor	: Self	**Mobile No**	: 9082877526
		DOB	: 22/11/1972
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Method : turbidimetric inhibition immunoassay (TINIA) for hemolyzed whole blood
Reference : American Diabetes Associations. Standards of Medical Care in Diabetes 2015

GLUCOSE-PLASMA-FASTING			
Glucose,Fasting	**128.35 ▲ (H)**	mg/dl	70 - 100

American Diabetes Association Reference Range :

Normal : < 100 mg/dl
Impaired fasting glucose(Prediabetes) : 100 - 126 mg/dl
Diabetes : >= 126 mg/dl

References:
1)Pack Insert of Bio system
2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation :-
Conditions that can result in an elevated blood glucose level include: Acromegaly, Acute stress (response to trauma, heart attack,and stroke for instance), Chronic kidney disease, Cushing syndrome, Excessive consumption of food, Hyperthyroidism,Pancreatitis.
A low level of glucose may indicate hypoglycemia, a condition characterized by a drop in blood glucose to a level where first it causes nervous system symptoms (sweating, palpitations, hunger, trembling, and anxiety), then begins to affect the brain (causing confusion, hallucinations, blurred vision, and sometimes even coma and death). A low blood glucose level (hypoglycemia) may be
seen with:Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin (insulinomas),Starvation.

Lipid Profile			

MC-5288

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
Episode	: OP		
Ref. Doctor	: Self	**Mobile No**	: 9082877526
		DOB	: 22/11/1972
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Total Cholesterol	**210.75 ▲ (H)**	mg/dl	CHILD Desirable - Less than : 170 CHILD Borderline High : 170-199 CHILD High - More than : 200 ADULT Desirable - Less than : 200 ADULT Borderline High : 200-239 ADULT High - More than : 240
Triglycerides *Method - glycerol Phosphate Oxidase/Peroxide*	**156.35 ▲ (H)**	mg/dl	NORMAL : <150 Borderline High : 150-199 High : 200-499 Very High : > 500
HDL Cholesterol *Method - Enzymatic immuno inhibition*	45.31	mg/dl	Desirable - Above 60 Borderline Risk : 40-59 Undesirable - Below :40
LDL Cholesterol *Method - Calculated*	**134.17 ▲ (H)**	mg/dl	Desirable - Below : 130 Borderline Risk : 130-159 Undesirable - Above : 160
VLDL Cholesterol *Method - Calculated*	31.27	mg/dl	5 - 51
Total Cholesterol / HDL Cholesterol Ratio - Calculated *Method - Calculated*	4.65	RATIO	0 - 5

MC-5288

LABORATORY INVESTIGATION REPORT

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LDL / HDL Cholesterol Ratio - Calculated *Method - Calculated*	2.96	RATIO	0 - 3.6

Note:
1) Biological Reference Interval is as per National Cholestrol Education Program (NCEP) Guidlines.
2) tests done on Fully Automated Biosystem BA-400 Biochemistry Analyser.

Interpretation
1.Triglycerides: When triglycerides are very high greater than 1000 mg/dL, there is a risk of developing pancreatitis in children and adults. Triglycerides change dramatically in response to meals, increasing as much as 5 to 10 times higher than fasting levels just a few hours after eating. Even fasting levels vary considerably day to day. Therefore, modest changes in fasting triglycerides measured on different days are not considered to be abnormal.
2. HDL-Cholesterol: HDL- C is considered to be beneficial, the so-called "good" cholesterol, because it removes excess cholesterol from tissues and carries it to the liver for disposal. If HDL-C is less than 40 mg/ dL for men and less than 50 mg/dL for women, there is an increased risk of heart disease that is independent of other risk factors, including the LDL-C level. The NCEP guidelines suggest that an HDL cholesterol value greater than 60 mg/dL is protective and should be treated as a negative
risk factor.
3. LDL-Cholesterol: Desired goals for LDL-C levels change based on individual risk factors. For young adults, less than 120 mg/dL is acceptable. Values between 120-159 mg/dL are considered Borderline high. Values greater than 160 mg/dL are considered high. Low levels of LDL cholesterol may be seen in people with an inherited lipoprotein deficiency and in people with hyperthyroidism, infection, inflammation, or cirrhosis.

Phosphorus *Method - Phosphomolybdate*	4.07	mg/dl	2.5 - 4.5

Interpretation:-
Phosphorus comes into the body through the diet. About 70-80% of the body's phosphates combine with calcium to help form bones and teeth, another 10% are found in muscle, and about 1% is in nerve tissue. Low levels of phosphorus (hypophosphatemia) in the blood may be due to or associated with Hypercalcemia, especially due to hyperparathyroidism ,Overuse of diuretics, Malnutrition, Alcoholism, Severe burns, Diabetic ketoacidosis after treatment),Hypothyroidism,Hypokalemia,Chronic antacid use, Rickets and osteomalacia (due to vitamin D deficiencies). Higher levels of phosphorus
(hyperphosphatemia) in the blood may be due to or associated with Kidney failure, Liver disease, Hypoparathyroidism, Diabetic ketoacidosis (when first seen), increased dietary intake (phosphate supplementation).

Liver Function Test (LFT)			
SGOT (Aspartate Transaminase) - SERUM *Method - IFCC*	26.03	IU/L	0 - 35

MC-5288

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SGPT (Alanine Transaminase) - SERUM *Method - IFCC*	22.81	IU/L	0 - 45
Total Bilirubin - SERUM *Method - Diazo*	0.61	mg/dl	0 - 2
Direct Bilirubin - - SERUM *Method - Diazotization*	0.33	mg/dl	0 - 0.4
Indirect Bilirubin - Calculated *Method - Calculated*	0.28	mg/dl	0.1 - 0.8
Alkaline Phosphatase - SERUM *Method - IFCC AMP Buffer*	78.61	IU/L	43 - 115
Total Protein - SERUM *Method - Biuret*	7.66	gm/dl	6 - 7.8
Albumin - SERUM *Method - Bromo Cresol Green(BCG)*	4.77	gm/dl	3.5 - 5.2
Globulin - Calculated *Method - Calculated*	2.89	gm/dl	2 - 4
A:G Ratio *Method - Calculated*	1.65	:1	1 - 3

References:
1)Pack Insert of Bio system
2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interperatation :-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. 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 also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstonesgetting 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.
AST levels increase in 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 attck or strenuous activity. ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyriodism, Leukemia,Lymphoma, paget`s disease, Rickets, Sarcoidosis etc.

MC-5288

LABORATORY INVESTIGATION REPORT

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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-including 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 - 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.

Renal Function Test (RFT)			
Urea - SERUM *Method - Urease*	26.32	mg/dl	15 - 39
BUN - SERUM *Method - Urease-GLDH*	12.30	mg/dl	4 - 18
Creatinine - SERUM *Method - Jaffes Kinetic*	1.06	mg/dl	0.5 - 1.3

References:
1)Pack Insert of Bio system
2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation:-
The blood urea nitrogen or BUN test is primarily used, along with the creatinine test, to evaluate kidney function in a wide range of circumstances, to help diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status.

GLUCOSE-PLASMA POST PRANDIAL			
Glucose,Post Prandial	**155.94 ▲ (H)**	mg/dl	70 - 140

American Diabetes Association Reference Range :

Post-Prandial Blood Glucose:
Non- Diabetic: Up to 140mg/dL
Pre-Diabetic: 140-199 mg/dL
Diabetic :>200 mg/dL

MC-5288

LABORATORY INVESTIGATION REPORT

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Interpretation :-
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A low level of glucose may indicate hypoglycemia, a condition characterized by a drop in blood glucose to a level where first it causes nervous system symptoms (sweating, palpitations, hunger, trembling, and anxiety), then begins to affect the brain (causing confusion, hallucinations, blurred vision, and sometimes even coma and death). A low blood glucose level (hypoglycemia) may be
seen with:Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin (insulinomas),Starvation.

End of Report

Dr.Ritesh Kharche
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Consultant Pathologist and Director of Laboratory Services
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MC-5288

LABORATORY INVESTIGATION REPORT

Patient Name	: Mr. VIKRANT PARATE	**Age/Sex**	: 51 Year(s) / Male
UHID	: SHHM.94836	**Order Date**	: 18/05/2024 09:37
Episode	: OP		
Ref. Doctor	: Self	**Mobile No**	: 9082877526
		DOB	: 22/11/1972
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

IMMUNOLOGY

Test Name	Result	Unit	Biological Reference Interval

Sample No : O0332566C Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 09:51 Report Date : 18/05/24 12:13

PSA -TOTAL-SERUM *Method - (Serum,ECLIA)*			
PSA- Prostate Specific Antigen - SERUM	0.43	ng/ml	0.00 - 4.00

Biological Reference Interval :-
Conventional for all ages: <=4
60 - 69 yrs: 0 - 4.5
Note : Change in method and Reference range

INTERPRETATION :
Prostate-specific antigen (PSA) is a glycoprotein that is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland. PSA exists in serum mainly in two forms, complexed to alpha-1-anti-chymotrypsin (PSA-ACT complex) and unbound (free PSA). Increases in prostatic glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels. Transient increase in PSA can also be seen following per rectal digital or sonological examinations.

NOTE:
Patients on Biotin supplement may have interference in some immunoassays. With individuals taking high dose Biotin (more than 5 mg per day) supplements, at least 8-hour wait time before blood draw is recommended.
Ref: Arch Pathol Lab Med—Vol 141, November 2017

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Vitamin D3 - SERUM *Method - CLIA*	14.42	ng/ml	DEFICIENCY :- < 10 MODERATE INSUFFICIENCY :- 11 - 20 MILD INSUFFICIENCY :- 21 - 25 SUFFICIENCY :- 26 - 70 TOXICITY :- > 70

VITAMIN D -TOTAL(25 HYDROXY)

Interpretation :-
Vitamin D is a lipid-soluble steroid hormone that is produced in the skin through the action of sunlight or is obtained from dietary sources The role of vitamin D in maintaining homeostasis of calcium and phosphorus is well established.

The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D. Vitamin D status is best determined by measurement of 25 hydroxy
vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs)

The reference ranges discussed in the preceding are related to total 25-OHD; as long as the combined total is 30 ng/mL or more, the patient has sufficient vitamin D. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels (20–30 ng/mL). In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL.

Vitamin B12 - SERUM *Method - CLIA*	274.4	pg/ml	211.00 - 911.00

Vitamin B12 - SERUM

Interpretation :-
Vitamin B12 is a coenzyme that is involved in two very important metabolic functions vital to normal cell growth and DNA synthesis: 1) the synthesis of methionine,
and 2) the conversion of methylmalonyl CoA to succinyl CoA. Deficiency of this vitamin can lead to megaloblastic anemia and ultimately to severe neurological problems. Also causes macrocytic anemia, glossitis, peripheral

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neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency.

Patients taking vitamin B12 supplementation may have misleading results. A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 .The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concerations are normal.

End of Report

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Consultant Pathologist and Director of Laboratory Services
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IMMUNOLOGY

Sample No : O0332566C Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 09:51 Report Date : 18/05/24 12:13

Test Name	Result	Unit	Biological Reference Interval
T3 - SERUM *Method - CLIA*	139.5	ng/dl	47.00 - 200.00
TFT- Thyroid Function Tests			
T4 - SERUM *Method - CLIA*	7.45	ug/dL	4.60 - 10.50
TSH - SERUM *Method - CLIA*	2.73	uIU/ml	0.40 - 4.50

Reference Ranges (T3) Pregnancy:
First Trimester 81 - 190
Second Trimester & Third Trimester 100 - 260

Reference Ranges (TSH) Pregnancy:
1st Trimester : 0.1 – 2.5
2nd Trimester : 0.2 – 3.0
3rd Trimester : 0.3 – 3.0

Reference:
1.Clinical Chemistry and Molecular Diagnostics, Tietz Fundamentals, 7th Edition & Endocronology Guideliens

Interpretation :-
It is recommended that the following potential sources of variation should be considered while interpreting thyroid hormone results:
1. Thyroid hormones undergo rhythmic variation within the body this is called circadian variation in TSH secretion: Peak levels are seen between 2-4 am. Minimum levels seen between 6-10 am. This variation may be as much as 50% thus, influence of sampling time needs to be considered for clinical interpretation.
2. Circulating forms of T3 and T4 are mostly reversibly bound with Thyroxine binding globulins (TBG), and to a lesser extent with albumin and Thyroid binding PreAlbumin. Thus the conditions in which TBG and protein levels alter such as chronic liver disorders, pregnancy, excess of estrogens, androgens, anabolic steroids and glucocorticoids may cause misleading total T3, total T4 and TSH interpretations.
3. Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment.
4. T4 may be normal the presence of hyperthyroidism under the following conditions : T3 thyrotoxicosis,

MC-5288

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Hypoproteinemia related reduced binding, during intake of certain drugs (eg Phenytoin, Salicylates etc)
5. Neonates and infants have higher levels of T4 due to increased concentration of TBG
6. TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism, pregnancy, phenytoin therapy etc.
7. TSH values of <0.03 uIU/mL must be clinically correlated to evaluate the presence of a rare TSH variant in certain individuals which is undetectable by conventional methods.
8. Presence of Autoimmune disorders may lead to spurious results of thyroid hormones
9. Various drugs can lead to interference in test results.
10. It is recommended that evaluation of unbound fractions, that is free T3 (fT3) and free T4 (fT4) for clinic-pathologic correlation, as these are the metabolically active forms.

End of Report

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Urinalysis

Sample No : O0332566D Collection Date : 18/05/24 09:41 Ack Date : 18/05/2024 09:51 Report Date : 18/05/24 13:51

Test Name	Result	Unit	Biological Reference Interval
Physical Examination			
QUANTITY	20	ml	
Colour	Pale Yellow		
Appearance	Clear		
DEPOSIT	Absent		Absent
pH	Acidic		
Specific Gravity	1.020		
Chemical Examination			
Protein	Absent		Absent
Sugar	Absent		Absent
ketones	Absent		Absent
Occult Blood	NEGATIVE		Negative
Bile Salt	Absent		Absent
Bile Pigments	Absent		Absent
Urobilinogen	normal		Normal
NITRATE	Absent		Absent
LEUKOCYTES	Absent		Absent

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Microscopic Examination			
Pus cells	2-3	/HPF	
Epithelial Cells	4-6	/HPF	
RBC	Absent	/HPF	Absent
Cast	Absent	/LPF	Absent
Crystal	Absent	/HPF	Absent
Amorphous Materials	Absent		Absent
Yeast	Absent		Absent
Bacteria	Absent		Absent
URINE SUGAR AND KETONE (FASTING)			
Sugar	Absent		
ketones	Absent		

URINE SUGAR AND KETONE (PP)			
Sugar	POSITIVE (+)		
ketones	Absent		

End of Report

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DIAGNOSTICS REPORT

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Address	: AMBOLI, ANDHERI EAST,Mumbai, Maharastra, 400058	Mobile	: 9082877526

USG ABDOMEN

Liver measures 14.5 cm and shows bright echotexture with obscured periportal fat . No focal liver parenchymal lesion is seen.
Intrahepatic portal and biliary radicles are normal.

Gall-bladder is physiologically distended. No evidence of intraluminal calculus is seen. Wall thickness appears normal. No evidence of peri-cholecystic fluid is seen.

Portal vein and CBD are normal in course and calibre.

Visualised part of pancreas appears normal in size and echotexture . No evidence of duct dilatation or parenchymal calcification seen.

Spleen is normal in size (9.9 cm) and echotexture. No focal lesion is seen in the spleen.

Right kidney measures 9.5 X 5.1 cm.
Left kidney measures 11.0 X 5.2 cm.**There is e/o 6.4 mm hyperechoic focus with posterior acoustic shadowing noted at the interpolar calyx..**

Both the kidneys are normal in size, shape and echotexture. Cortico-medullary differentiation is maintained. No evidence of calculus or hydronephrosis on right side.

There is no free fluid in abdomen and pelvis.

IMPRESSION

- **Grade II fatty liver,.**
- **Nonobstructive left renal calculus.**

Dr.Bhavesh Rajesh Dubey
MBBS,MD

RegNo: 2017/03/0656

DIAGNOSTICS REPORT

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DIAGNOSTICS REPORT

Patient Name	: Mr. VIKRANT PARATE	Order Date	: 18/05/2024 09:37
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X-RAY CHEST PA VIEW

Both lungs are clear.
The frontal cardiac dimensions are normal.
The pleural spaces are clear.
Both hilar shadows are normal in position and density.
No diaphragmatic abnormality is seen.
The soft tissues and bony thorax are normal.

IMPRESSION: No pleuroparenchymal lesion is seen.

Dr.Priya Vinod Phayde
MBBS,DMRE

RegNo: 2020/11/6493