

Patient Name	: Amit Kumar	Episode No.	: 0
UHID	: 12644013	Sample ID	: FHM23-R12186
Age / Gender	: 37 Year/ Male	Sample Drawn	:
Ward	:	Sample Received	: 12/Aug/2023 08:17 PM
Referred By	:	Reported	: 12/Aug/2023 09:50 PM
Diagnosis / Clinical Information	:		

Blood Group Report
Final Report

Sample Type : EDTA
Method : AUTOMATION
Forward Blood Group : B Rh Positive
Reverse Blood Group : B
Final Blood Group : B Rh Positive
Remark :

Tested By : SAGAR

Verified By : SAGAR

Approved By :


Dr. Apra Kalra
Addl Director & Head
Transfusion Medicine

Note : Blood group is identified by ABO antigens (forward grouping) present on red cell membrane And anti-ABO antibodies (reverse grouping) present in the plasma. A grouping discrepancy is when there is a mismatch in forward and reverse Blood grouping. Special methods need to be Performed to solve such discrepancies.

In case of Newborn/cord blood grouping, only forward blood grouping would be done as the anti-ABO antibodies (for reverse grouping) Are not present till 4 to 6 months of age. Thus new born grouping should be considered as provisional report and should be supplemented by re-blood grouping after 4 to 6 months of age/ or by more sensitive tests like molecular blood grouping.

"Blood grouping is done on the received sample. In case of any suspected discrepancy, Blood centre should be contacted , 1724692270"

*****End of Report *****

Reference:

Method section 2: Red cell typing; AABB technical manual 19th Ed
Wong ECC, Punzalan RC. Neonatal and Pediatric
Transfusion practice. Technical Manual,
AABB, 19th Ed; p613-640

Name: Mr Amit Kumar
UHID: 12640013 Date: 12.08.23
Age: 37 years Gender: male

Internal Medicine Consultation

Relevant History:

- No complaints
- No medications

- Non smoker
- No Alcohol
- Father is a diabetic
- Non veg

Examination Findings:

BMI = 26.5 / kg / m²
- wnl

B+ve

Investigations:

ECG - wnl
 USG - (RT) Renal concentrations
 MRI - wnl
 TMT - wnl
 HB - 16.4 (↑ RBC, PCV, PCH, MCH, MCV)
 OT - 20, PT - 137
 FBS - 54, HBA_{1c} - 5.96
 uric acid - 8.4
 RFT - wnl
 chrl - 255, TA - 20, LDL - 180
 HDL - 204
 urine - wnl
 TFT - wnl

- Diagnosis: (RT) Renal concentrations
- Polycythemia
 - Desmopressin
 - Pre-diabetes
 - hyperuricemia
 - psoriasis
 - OVERWEIGHT

Advice / Treatment Plan:

- plenty of oral fluid
- Hematology opinion
- Regular Exercise
- Dietary Advice
- LYSLIN 100
- Review with reports

Am

- PRF
- B-12
- folic acid
- ferritin
- iron study
- PP (sugar)
- 25-OH-D

Manjeet Singh
1818123

Dr. MANJEET SINGH TREHAN
MBBS, MD
Additional Director - Internal Medicine (FMC)
Fortis Hospital, Mohali (Pb.)
Mobile No. 9814104609
Reg. No. PMC 24797

Signature and stamp of the Consultant:

Name: Mr Amit Kumar
 UHID: 12644013 Date: 12-08-23
 Age: 37 Gender: male

Ophthalmology Consultation

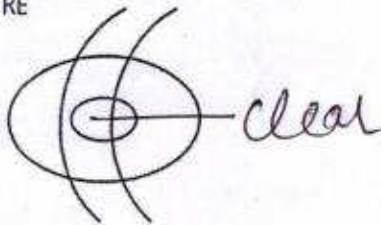
History: NIL

Examination findings:

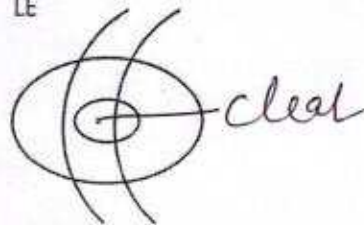
Visual acuity $\left\{ \begin{array}{l} R 6/36 \\ L 6/36 \end{array} \right.$ Visual acuity with glasses $\left\{ \begin{array}{l} R 6/6 \\ L 6/6 \end{array} \right.$ Colour Vision $\left\{ \begin{array}{l} R WNL \\ L WNL \end{array} \right.$

Slit Lamp Examination

RE

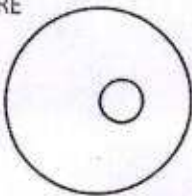


LE

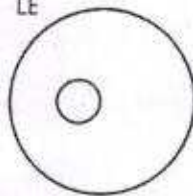


Fundus Examination

RE



LE



Diagnosis: Myopia BE

Treatment

Spectacle prescription:

Right eye

	SPH	CYL	AXIS	VA
Distance				6/6
Near	aided			N/6

Left eye

	SPH	CYL	AXIS	VA
Distance				6/6
Near	aided			N/6

Signature and stamp of the Ophthalmologist: _____

Male

12.08.2023 12:51:36
Forts Med Centre
sector 11
Chandgarh

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

Room:

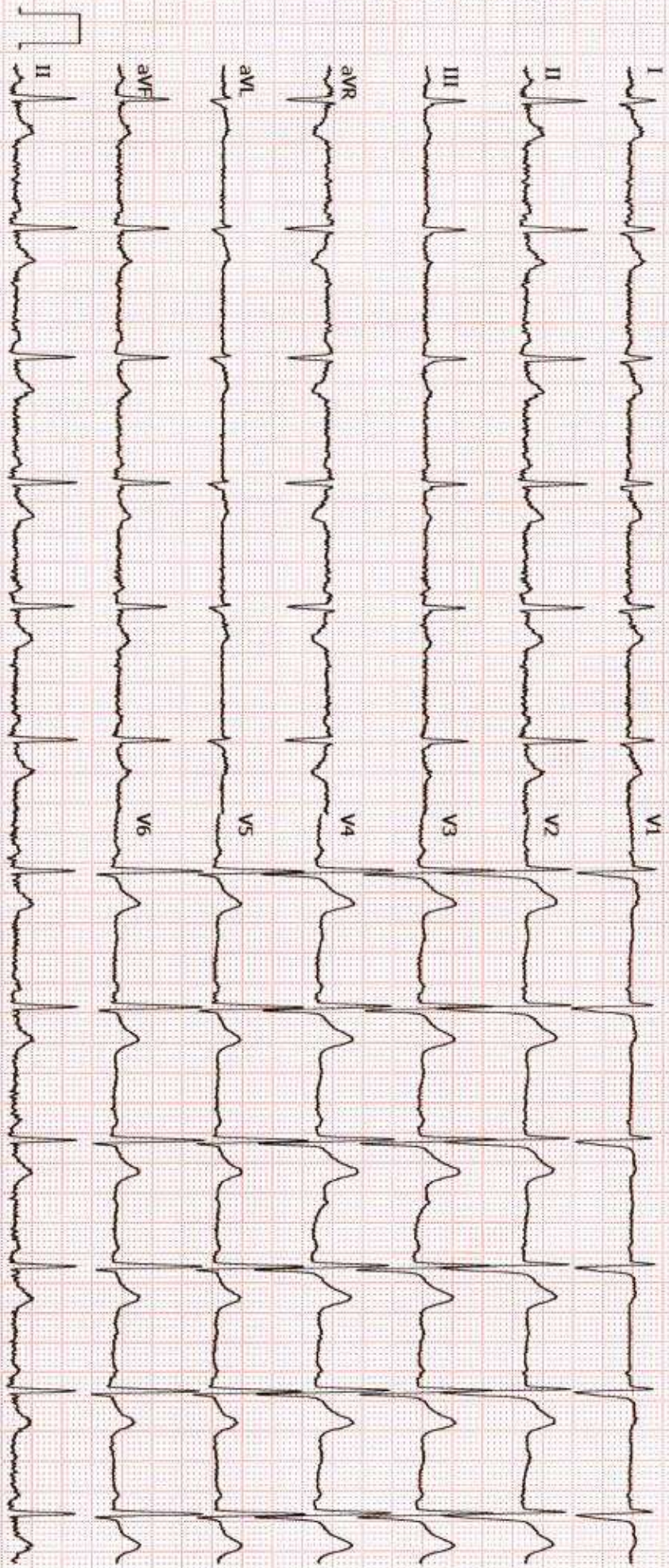
70 bpm

— / — mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 84 ms
QT / QTcBaz : 346 / 373 ms
PR : 134 ms
P : 84 ms
RR / PP : 858 / 857 ms
P / QRS / T : 49 / 74 / 50 degrees

Normal sinus rhythm
Normal ECG



NAME: MR. AMIT KUMAR**AGE AND SEX: 37Y/M****UHID NO: 12644013****DATE: 18/08/2023****ROI: WHOLE ABDOMEN**

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

Gall bladder is not seen – status post op. CBD is normal.

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

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

Right kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis is seen. Few concretions are seen in lower calyx.

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

Retroperitoneum is normal.

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

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

No free fluid is seen.

Opinion: Right Renal Concretions.

Suggested clinical correlation.

Dr. ADITI PANWAR**PMC - 41230****Consultant Radiologist**

AMIT KUMAR 37/M

Study Date: 18/08/2023

Patient ID: 12644013

Accession #:

Alt ID:

DOB:

Age:

Gender:

Ht:

Wt:

BSA:

Institution: Fortis MEDCENTRE, Chandigarh

Referring Physician:

Physician of Record:

Performed By:

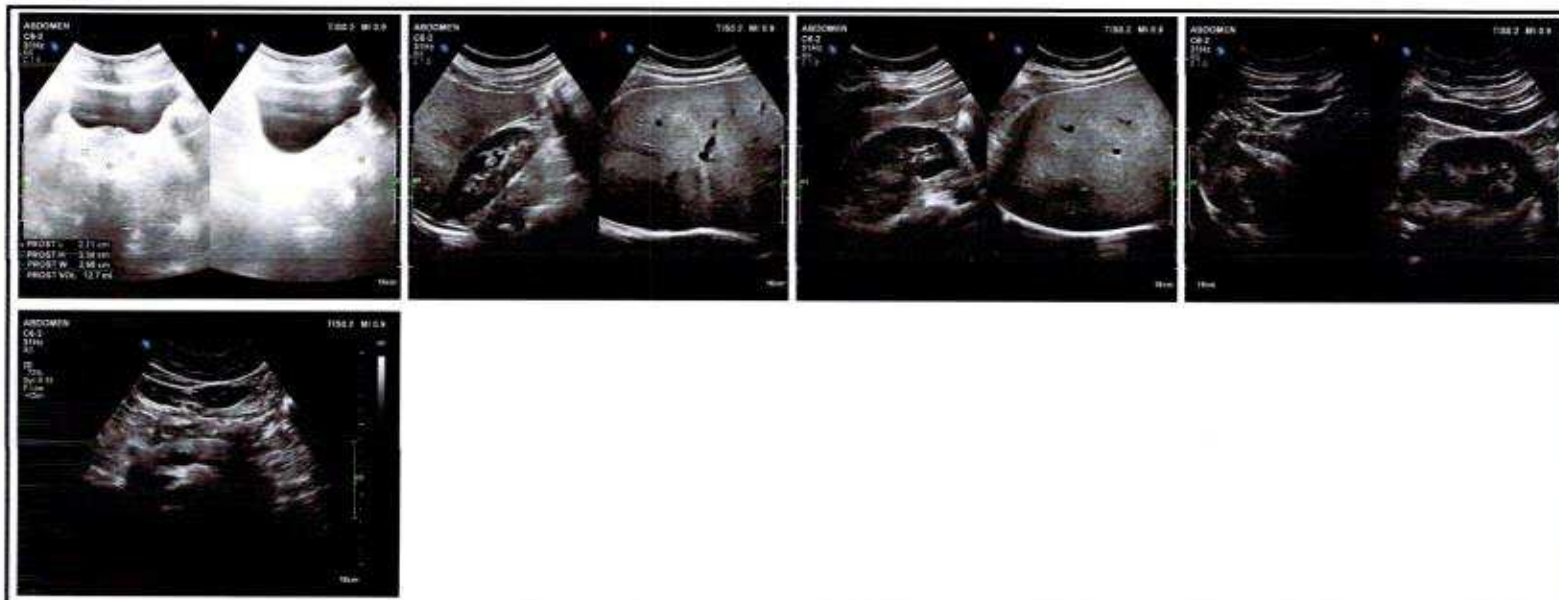
Comments:

Other Measurements

Abdomen General: Bladder Dimensions

PROST L	2.71 cm
PROST H	3.34 cm
PROST W	2.68 cm

Images



Signature

Signature:

Name(Print):

Date:

DEPARTMENT OF FMC-RADIOLOGY LAB

Date: 12/Aug/2023

Name: Mr. Amit Kumar

UHID | Episode No : 12644013 | 9856/23/10021

Age | Sex: 37 YEAR(S) | Male

Order No | Order Date: 10021/PN/OP/2308/25535 | 12-Aug-2023

Order Station : FRONTOFFICE-FMC

Admitted On | Reporting Date : 12-Aug-2023 13:26:34

Bed Name :

Order Doctor Name : Dr.SELF .

CHEST X-RAY (PA VIEW)

Both the domes of diaphragm are normal.

Both costophrenic angles are normal.

Both lung fields are clear.

Cardiac size and silhouette are normal.

Both hila and mediastinum are normal.

Bony cage and soft tissues are normal.

IMPRESSION: NORMAL STUDY.

Please correlate clinically and with other relevant investigations.

Dr. ADITI PANWAR

PMC - 41230

Consultant Radiologist

A unit of FORTIS HOSPITAL MOHALI

Sector 62, Phase - VIII, Mohali - 160062, Punjab (India); Tel: +91 172 469 2222, 469 2250 Fax: +91 172 469 2221

Regd. Office : Fortis Hospital, Sector 62, Phase - VIII, Mohali - 160062

Tel. : 91-11-2682 5000, 2682 5001, Fax : + 91-11-4162 8435, CIN No. : L85110DL1996PLC076704

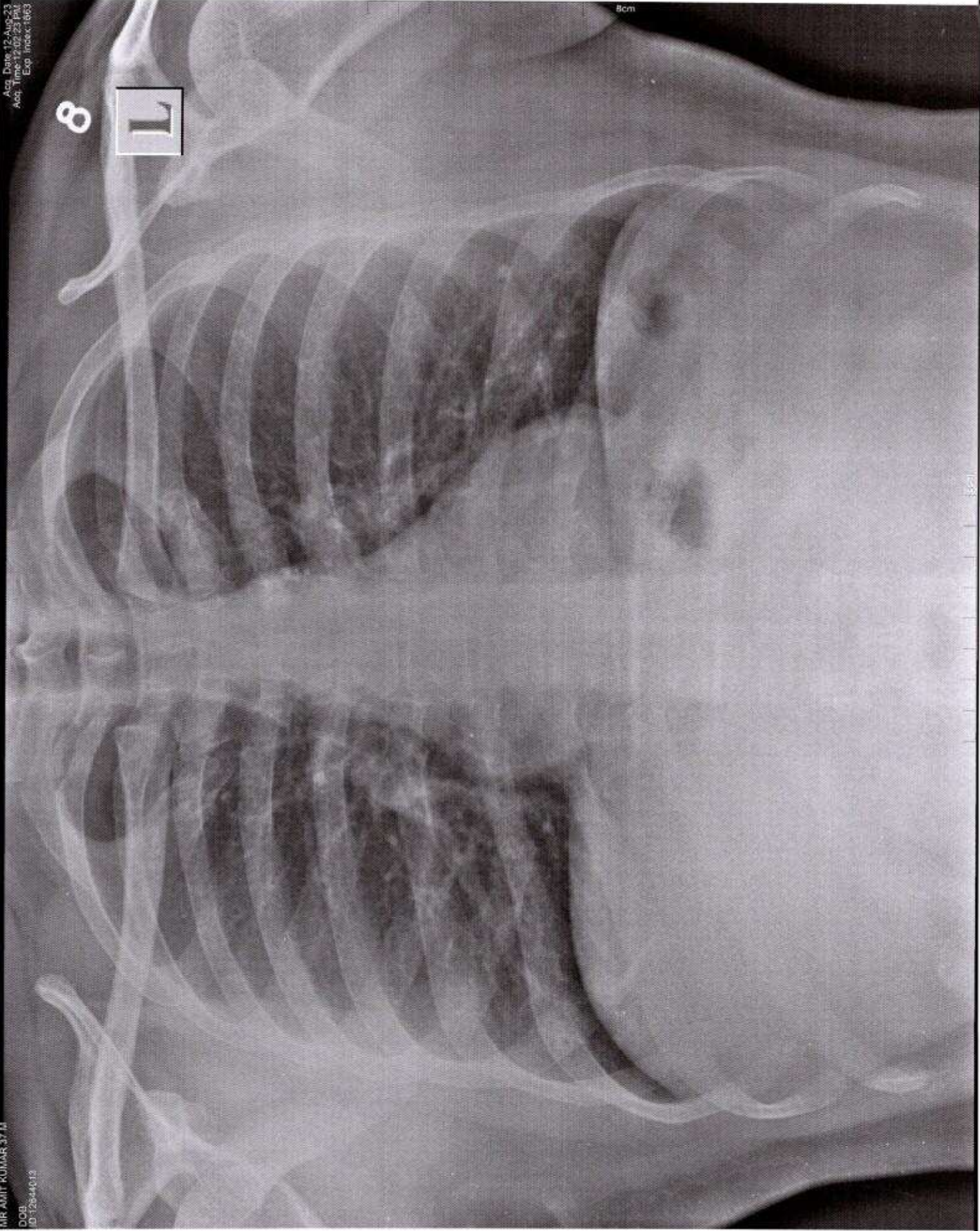
Acq. Date: 12-Aug-23
Acq. Time: 12:02:23 PM
Exp. Index: 1663

8

L

8cm

MR AMIT KUMAR 37 M
DOB: 10-12-84-44013



Fortis Medentre
SCO 11, Sector 11 D
Chandigarh

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: KUMAR, AMIT
Patient ID: 12644013
Height: 165 cm
Weight: 69 kg

DOB: 26.10.1985
Age: 37yrs
Gender: Male
Race: Indian

Study Date: 18.08.2023
Test Type: --
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR MANJEET/DR VIJAY HARJAI

Medications:
--

Medical History:
--

Reason for Exercise Test:
--

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:06	0.00	0.00	86	120/80	
	STANDING	00:13	0.00	0.00	89		
EXERCISE	STAGE 1	03:00	2.70	10.00	127	120/80	
	STAGE 2	03:00	4.00	12.00	136		
	STAGE 3	01:59	5.50	14.00	153	130/80	
RECOVERY		02:23	0.00	9.00	104	140/90	

The patient exercised according to the BRUCE for 7:59 min:s, achieving a work level of Max. METS: 10.20. The resting heart rate of 86 bpm rose to a maximal heart rate of 153 bpm. This value represents 83 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.

Conclusions *negative for inducible ischemia*

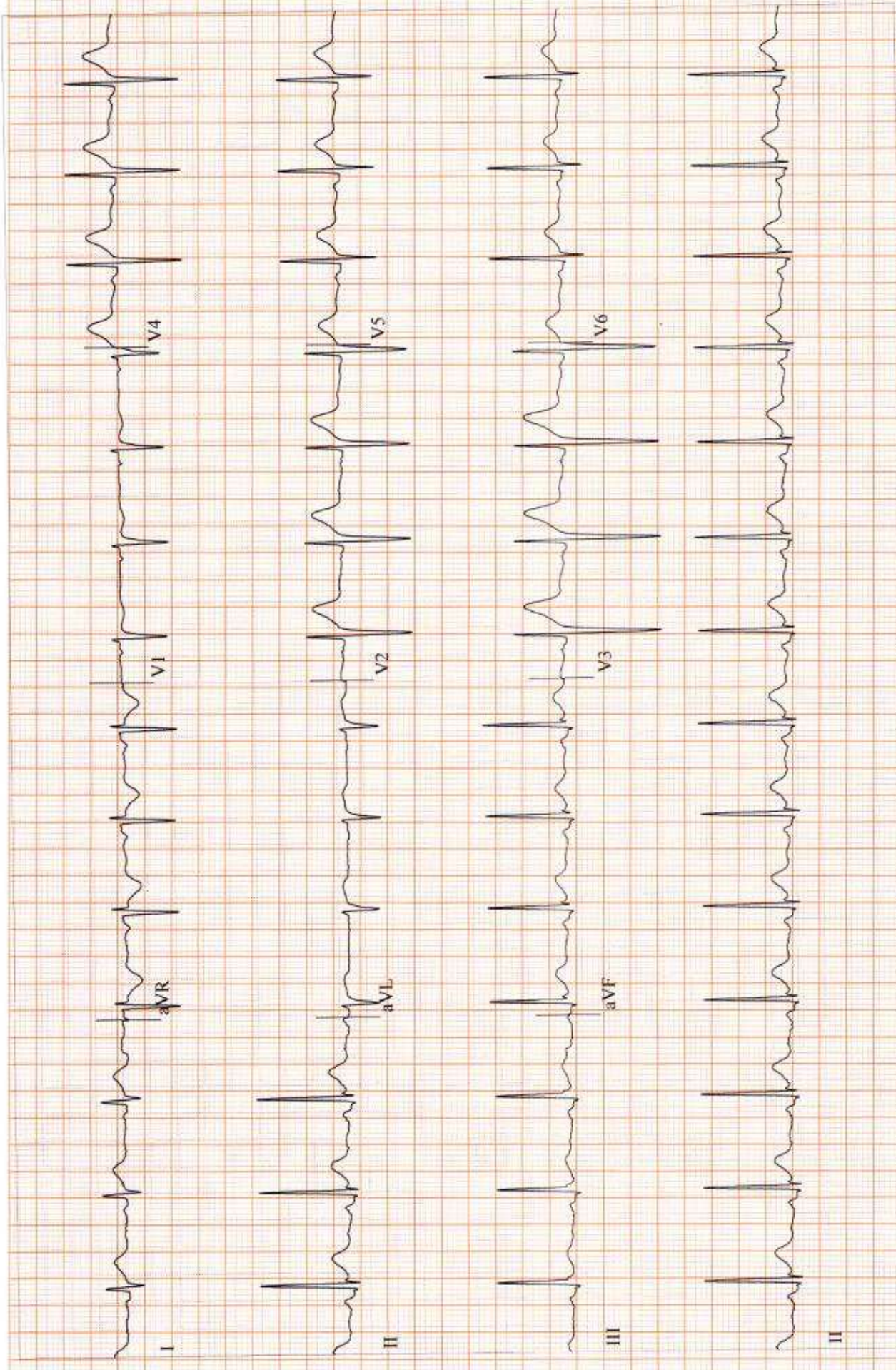
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Physician

[Signature]
~~DR. MANJEET SINGH TREHAN~~
MBBS, MD
Additional Director - Internal Medicine (FMC)
Fortis Hospital, Mohali (Pb.)
Mobile No. 9814104609
Reg. No. PMC 24797

KUMAR, AMIT
Patient ID 12644013
18.08.2023
11:40:17am

85 bpm
120/80 mmHg

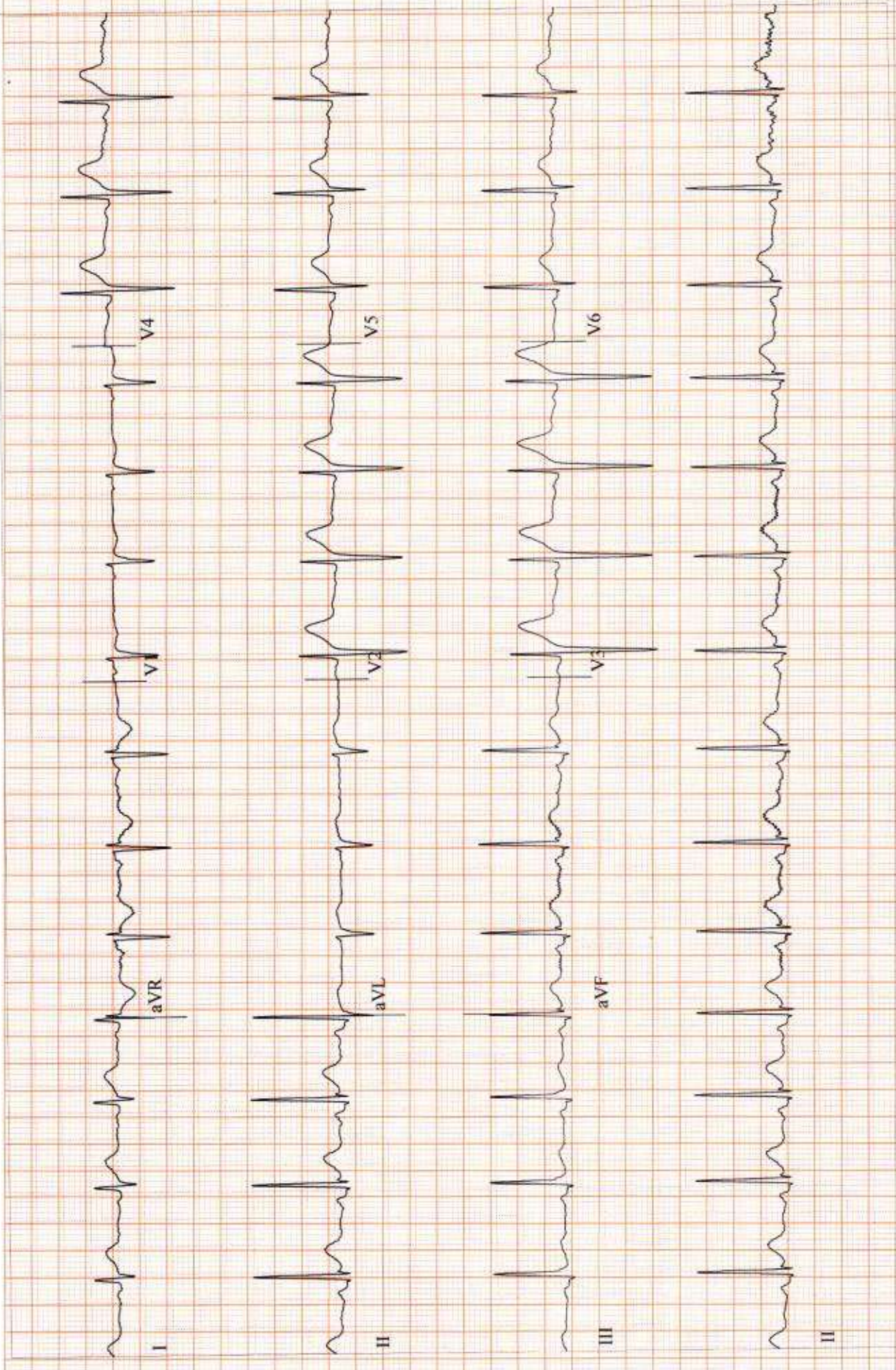


BRUCE
0.0 km/h
0.0 %

PRETEST
STANDING
00:14

90 bpm
120/80 mmHg

KUMAR, AMIT
Patient ID 12644013
18.08.2023
11:40:33am



KUMAR, AMIT
 Patient ID 12644013
 18.08.2023
 11:43:22am

125 bpm
 120/80 mmHg

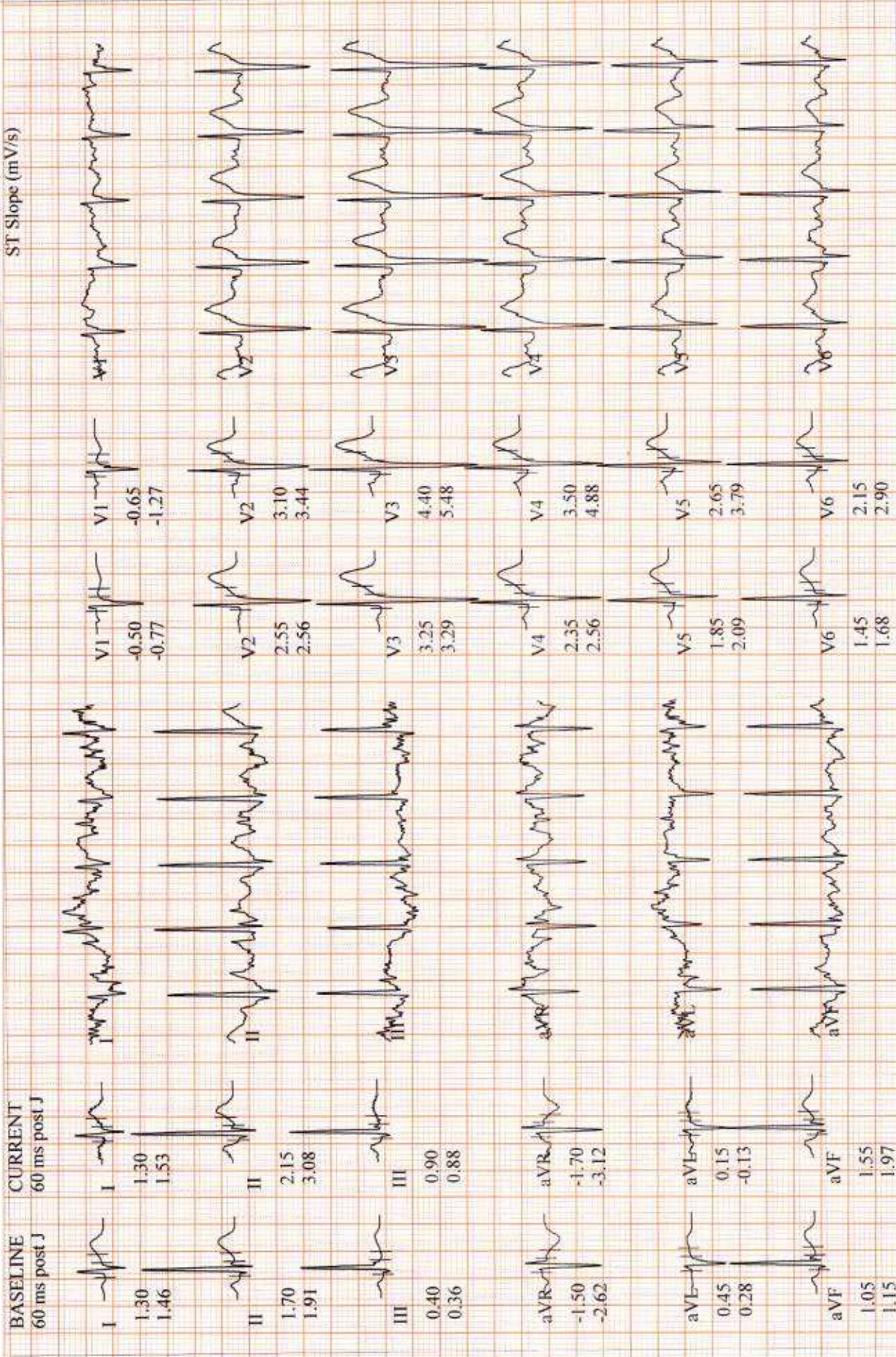
EXERCISE
 STAGE 1
 02:50

BRUCE
 2.7 km/h
 10.0 %

Comparative Medians Report

Fortis Medcentre

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V3,V4)

Start of Test: 11:40:13am

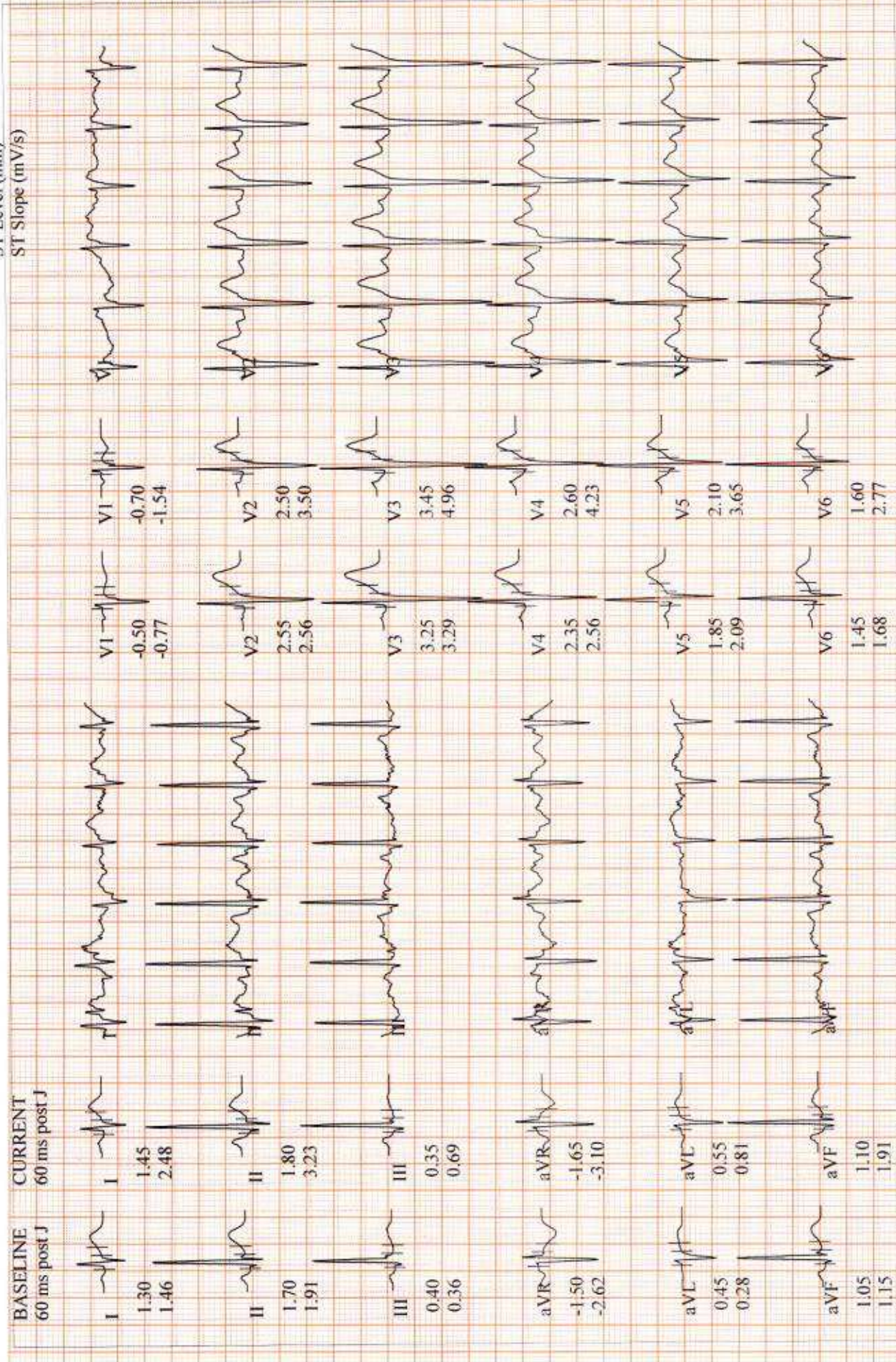
Page 3

KUMAR, AMIT
Patient ID 12644013
18.08.2023
11:46:22am

BRUCE
4.0 km/h
12.0 %
EXERCISE
STAGE 2
05:50

134 bpm

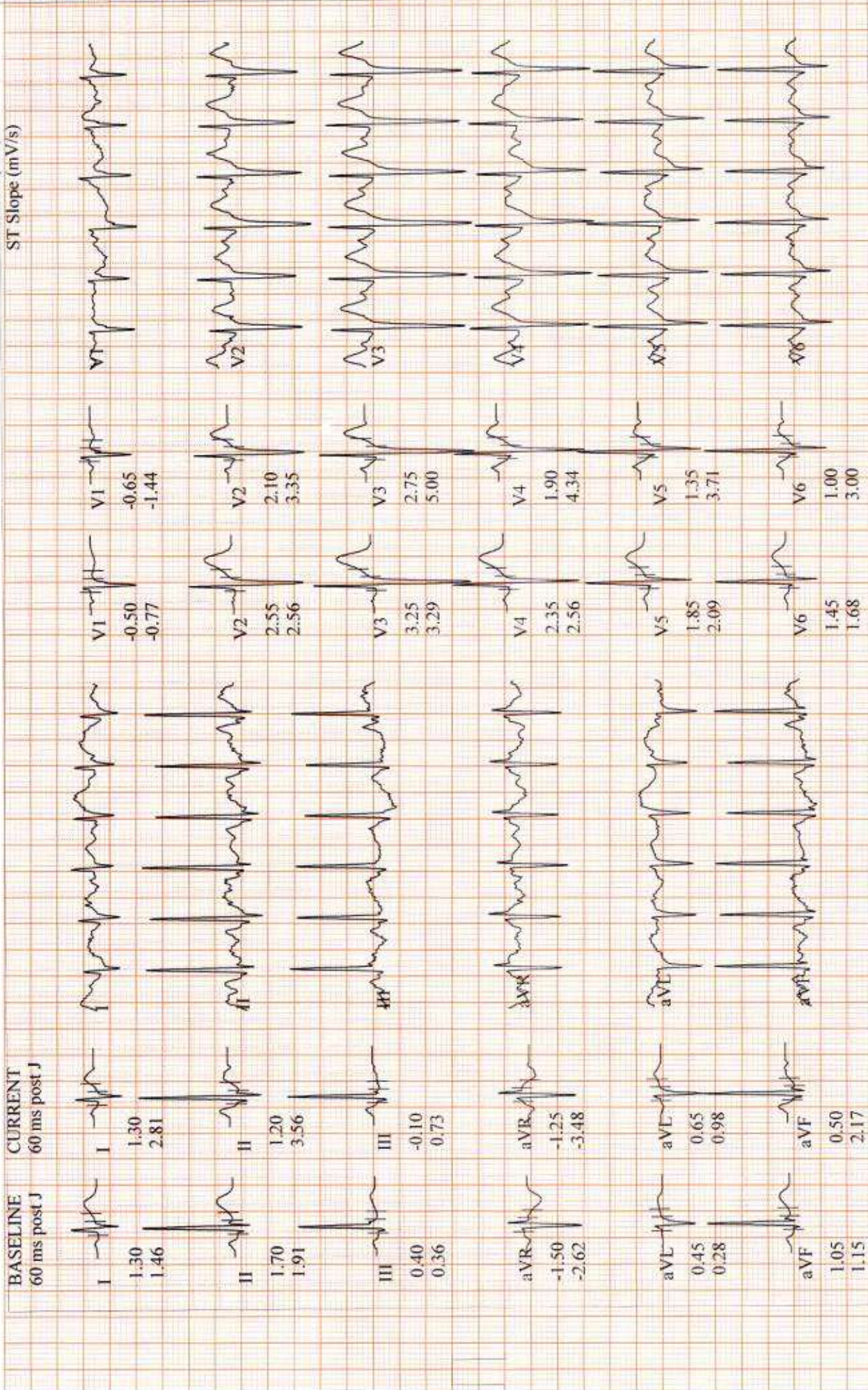
Lead
ST Level (mm)
ST Slope (mV/s)



KUMAR, AMIT
 Patient ID 12644013
 18.08.2023
 11:48:31am

EXERCISE STAGE 3
 07:59
BRUCE
 5.5 km/h
 14.0 %

Lead
 ST Level (mm)
 ST Slope (mV/s)



Start of Test: 11:40:13am

GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V3,V4)

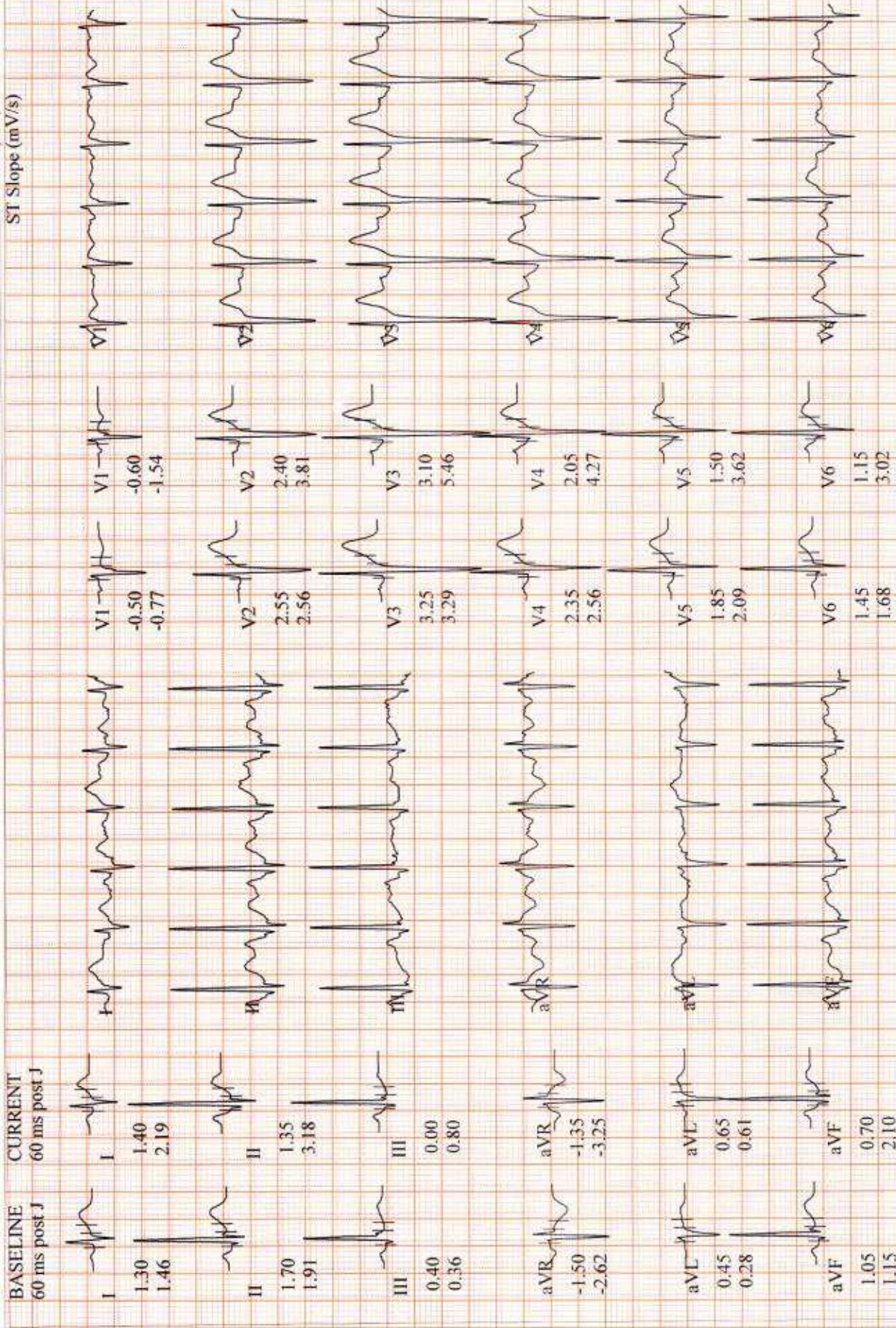
KUMAR, AMIT
 Patient ID 12644013
 18.08.2023
 11:49:21 am

136 bpm

RECOVERY
 #1
 00:50

BRUCE
 2.4 km/h
 9.0 %

Lead
 ST Level (mm)
 ST Slope (mV/s)



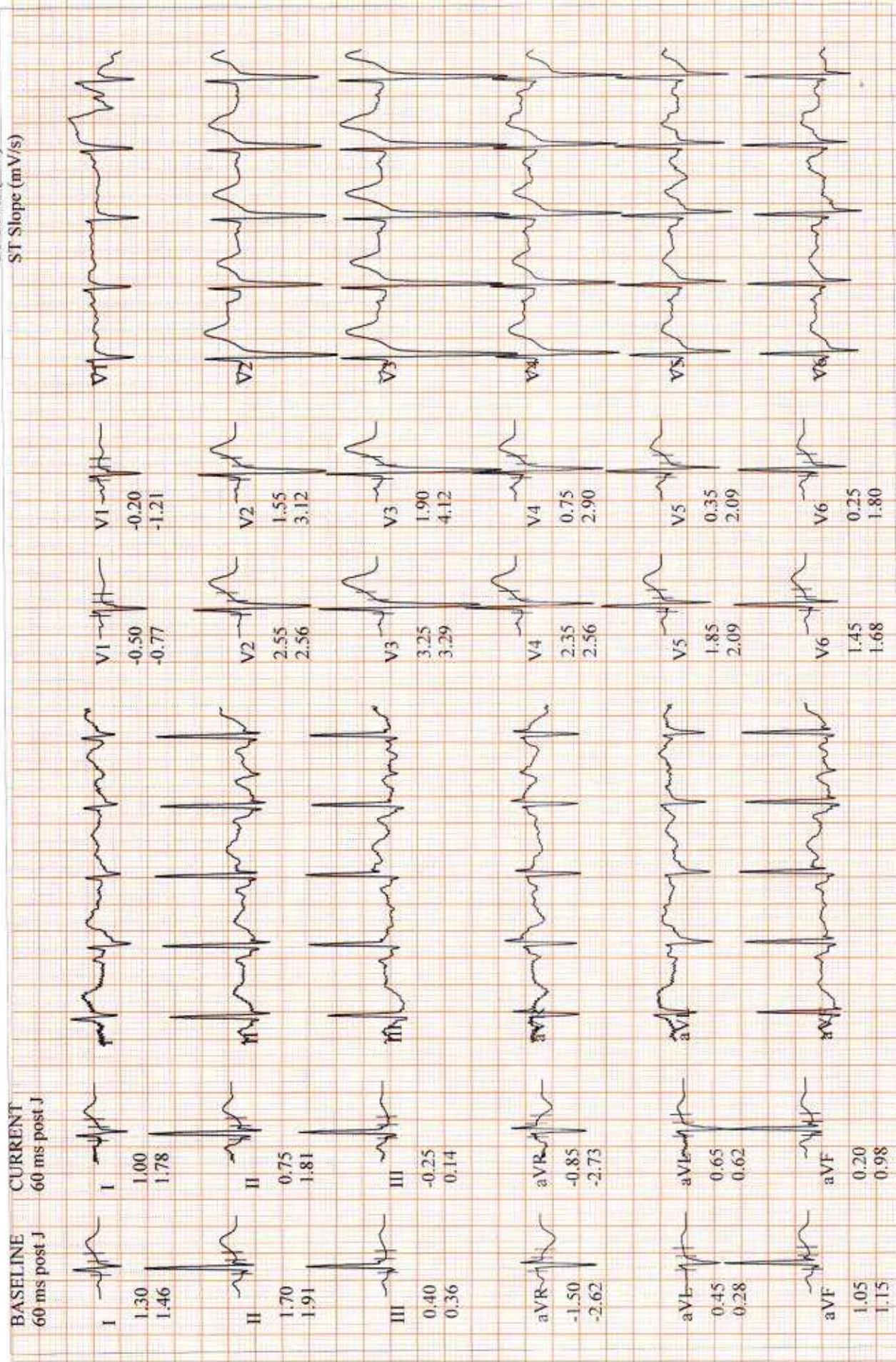
KUMAR, AMIT
Patient ID 12644013
18.08.2023
11:50:21am

RECOVERY
#1
01:50

BRUCE
0.0 km/h
9.0 %

116 bpm

Lead
ST Level (mm)
ST Slope (mV/s)



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V3,V4)

Start of Test: 11:40:13am



MC-2559

PATIENT NAME : AMIT KUMAR

REF. DOCTOR : SELF

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

ACCESSION NO : **0006WH010991**
PATIENT ID : FH.12644013
CLIENT PATIENT ID: UID:12644013
ABHA NO :

AGE/SEX : 37 Years Male
DRAWN : 12/08/2023 11:18:00
RECEIVED : 12/08/2023 20:04:37
REPORTED : 26/08/2023 19:36:27

CLINICAL INFORMATION :

UID:12644013 REQNO-1559078
CORP-OPD
BILLNO-1002123OPCS012492
BILLNO-1002123OPCS012492

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	16.4	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.93 High	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	7.83	4.0 - 10.0	thou/ μ L
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	202	150 - 410	thou/ μ L
METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	54.5 High	40.0 - 50.0	%
METHOD : HYDRODYNAMIC FOCUSING			
MEAN CORPUSCULAR VOLUME (MCV)	91.9	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	30.1 Low	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	15.4 High	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	15.5		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	14.5 High	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

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

Dr. Meenakshi Malhotra, MD
Senior Consultant,48159

Page 1 Of 12



View Details



View Report

PERFORMED AT :

CLINICAL LABORATORY
Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase VIII,
Mohali, 160062
Punjab, India
Tel : 0172-469-2222 Extn. 6726, 6727), 0172-469-2221 - CIN -
L85110DL1996PLC076704
Email : srl.mohali@fortishealthcare.com



Patient Ref. No. 600003108054



MC-2559

PATIENT NAME : AMIT KUMAR

REF. DOCTOR : SELF

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

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Test Report Status	Final	Results	Biological Reference Interval	Units
NEUTROPHILS		58	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
LYMPHOCYTES		34	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
MONOCYTES		6	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
EOSINOPHILS		2	1 - 6	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		4.54	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.66	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.47	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.16	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.7		
METHOD : CALCULATED PARAMETER				

Interpretation(s)

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

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	09	0 - 14	mm at 1 hr
-------	----	--------	------------

METHOD : WESTERGREN METHOD

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-TEST DESCRIPTION :-

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

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, 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.

Dr. Shafira Garg (MD, Pathology)
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Patient Ref. No. 600003108054



MC-2559



PATIENT NAME : AMIT KUMAR

REF. DOCTOR : SELF

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

ACCESSION NO : **0006WH010991**
 PATIENT ID : FH.12644013
 CLIENT PATIENT ID: UID:12644013
 ABHA NO :

AGE/SEX : 37 Years Male
 DRAWN : 12/08/2023 11:18:00
 RECEIVED : 12/08/2023 20:04:37
 REPORTED : 26/08/2023 19:36:27

CLINICAL INFORMATION :

UID:12644013 REQNO-1559078
 CORP-OPD
 BILLNO-1002123OPCS012492
 BILLNO-1002123OPCS012492

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.49	UPTO 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.14	0.00 - 0.30	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.35	0.00 - 0.60	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.7	6.6 - 8.7	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN	5.1 High	3.97 - 4.94	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.6	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	2.0	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	70 High	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	137 High	0 - 41	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	202 High	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	31	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE UV	220	135 - 225	U/L

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	84	74 - 106	mg/dL
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Patient Ref. No. 600003108054



MC-2559

PATIENT NAME : AMIT KUMAR

REF. DOCTOR : SELF

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

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BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN METHOD : UREASE - UV	11	6 - 20	mg/dL
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URIC ACID, SERUM

URIC ACID METHOD : URICASE, COLORIMETRIC	8.4 High	3.4 - 7.0	mg/dL
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C METHOD : HPLC	5.9 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)	%
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ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	122.6 High	< 116.0	mg/dL
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CREATININE EGFR

CREATININE METHOD : ALKALINE PICRATE-KINETIC	1.10	0.70 - 1.20	mg/dL
AGE	37		years

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<p>GLOMERULAR FILTRATION RATE (MALE)</p>	<p>75</p>	<p>GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)</p>		
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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

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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 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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

URIC ACID, SERUM- Causes of Increased levels: Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome **Causes of decreased levels:** Low Zinc intake, OCP, Multiple Sclerosis

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD-Used For:

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

- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
- eAG gives an evaluation of blood glucose levels for the last couple of months.
- eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
- 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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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	255 High	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	200 High	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	46	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	180 High	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	209 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	40.0 High	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	5.5 High	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

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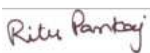
LDL/HDL RATIO

3.9 High

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

METHOD : CALCULATED PARAMETER

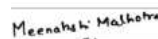
Interpretation(s)



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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

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

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE		
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE PHOTOMETRY (EHRlich'S REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		

MICROSCOPIC EXAMINATION, URINE

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

Interpretation(s)

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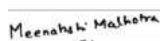
SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

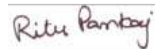
T3 METHOD : SANDWICH (ECLIA)	120.8	80.00 - 200.00	ng/dL
T4 METHOD : SANDWICH (ECLIA)	8.89	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : SANDWICH (ECLIA)	3.350	0.270 - 4.200	µIU/mL

Interpretation(s)

End Of Report

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


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