Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
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Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
A Fortis Network Hospital

UHID	5627069	**Date**	**13/06/2023**		
Name	Mrs. Abilasha Singh	**Sex**	**female**	**Age**	45
OPD	PAP	**Health Check-up**			

Drug allergy: – None
Sys illness:

S/B Dr. Hina.

PILI for pap test.
(Last pap done 2yrs back).

M/H:- LMP – 7yrs back menopause (early menopause).
(mother died at age of 40 yrs).

O/H:- PILI - 16yrs | FTND | a&w.

Med H/:- Klclo- hypothyroidism on Tab Thyronorm 50mcg :- 6-7yrs
HTN :- 3-4 yrs on medications

O/E

Cx / healthy.
Vg

Adv

FU E reports
& Pap
mammography
USG pelvis
for consultation

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Hiranandani HOSPITAL
(A Fortis Network Hospital)

UHID	5627069	**Date**	**13/06/2023**
Name	Mrs. Abilasha Singh	**Sex**	**female** **Age** 45
OPD	Opthal 14	**Health Check-up**	

Drug allergy: -> Not known.
Sys illness: -> No
Habit -> No

Known No.

H/o. HTN (since 3-4y-) Thyroid (+8-9y-).

Unaided → Rt 6/9P
Lt 6/9P

→ Rt -0.50 Dsph 6/6.
Lt -0.50 Dsph 6/6
Add -> +1.50 → Rt N6
Lt N6

IOP → Rt -> 14.2.
Lt -> 15.2

Agnihotri

iranandani Healthcare Pvt. Ltd.
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Hiranandani HOSPITAL
Fortis

UHID	5627069	**Date**	**13/06/2023**
Name	Mrs. Abilasha Singh	**Sex**	**female** **Age** 45
OPD	Dental 12 7387696540	**Health Check-up**	

Drug allergy:
Sys illness:

Caries $\frac{8 \mid 8}{876 \mid 678}$

Stains ++ Calculus ++

Treatment

- Adv. filling $\frac{8 \mid 8}{876 \mid 678}$
- Adv. oral prophylaxis.

Dr Diksha Kekan.

Diagnostic Report

MC-2275

Fortis | agilus diagnostics

Agilus Diagnostics Ltd. (Formerly SRL Ltd.)

PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002362** AGE : 45 Years SEX : Female ABHA NO :

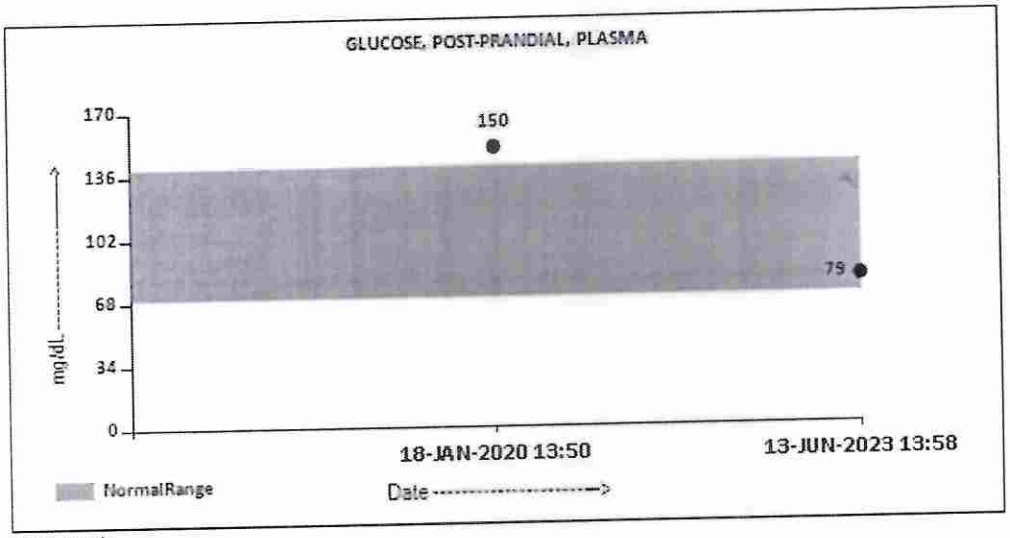
DRAWN : 13/06/2023 12:43:00 RECEIVED : 13/06/2023 12:43:54 REPORTED : 13/06/2023 14:28:56

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

CLINICAL INFORMATION :

UID:5627069 REQNO-1534435
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	79	70 - 140	mg/dL
METHOD : HEXOKINASE			



Comments

NOTE:- POST PRANDIAL PLASMA GLUCOSE VALUES TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

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

Diagnostic Report

MC-2275

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

Dr.Akta Dubey
Counsultant Pathologist

Diagnostic Report

MC-2275

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PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 13/06/2023 09:56:00 RECEIVED : 13/06/2023 09:56:57 REPORTED : 13/06/2023 16:23:49

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

CLINICAL INFORMATION :

UID:5627069 REQNO-1534435
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	12.4	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.37	3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	5.62	4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	197	150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE			
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	36.0	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	**82.3**	**Low** 83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.4	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	**34.6**	**High** 31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	**14.1**	**High** 11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	18.8		
MEAN PLATELET VOLUME (MPV)	**14.4**	**High** 6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	66	40 - 80	%
METHOD : FLOWCYTOMETRY			
LYMPHOCYTES	22	20 - 40	%
METHOD : FLOWCYTOMETRY			
MONOCYTES	08	2 - 10	%
METHOD : FLOWCYTOMETRY			
EOSINOPHILS	04	1 - 6	%
METHOD : FLOWCYTOMETRY			

PATIENT NAME : MRS.ABHILASHA SINGH

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BILLNO-150123OPCR033114
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Test Report Status **Final**	Results	Biological Reference Interval	Units
BASOPHILS	00	0 - 2	%
METHOD : FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	3.71	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.24	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.45	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.22	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT	**0**	**Low** 0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.0		
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 correletion and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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Maharashtra, India
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CIN - U74899PB1995PLC045956
Email : -

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Patient Ref. No. 22000000851087

Diagnostic Report

MC-2275

Fortis

agilus diagnostics
Agilus Diagnostics Ltd. (Formerly SRL Ltd.)

PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

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

CLINICAL INFORMATION :

UID:5627069 REQNO-1534435
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

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

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	**25**	**High** 0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

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

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

TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR(**>100 mm/hour**) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD		
ABO GROUP	TYPE A	
METHOD : TUBE AGGLUTINATION		
RH TYPE	POSITIVE	
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.

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Patient Ref. No. 2200000085108Z

PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

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CLINICAL INFORMATION :

UID:5627069 REQNO-1534435
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

Test Report Status **Final**	Results		Biological Reference Interval	
BIOCHEMISTRY				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.89		0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, DIRECT	0.19		0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, INDIRECT	0.70		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	**8.6**	High	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN	4.3		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN	**4.3**	High	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.0		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	27		15 - 37	U/L
METHOD : UV WITH P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	31		< 34.0	U/L
METHOD : UV WITH P5P				
ALKALINE PHOSPHATASE	98		30 - 120	U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)	35		5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE				
LACTATE DEHYDROGENASE	156		100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	8		6 - 20	mg/dL
METHOD : UREASE - UV				

PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

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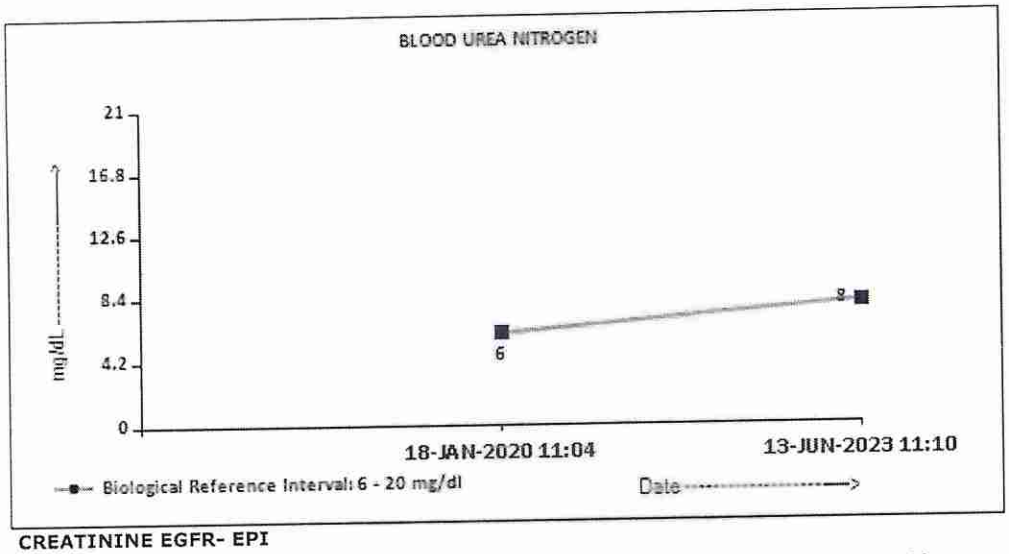
Test Report Status **Final**	Results	Biological Reference Interval	



CREATININE EGFR- EPI

CREATININE	0.84	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	45		years
GLOMERULAR FILTRATION RATE (FEMALE)	87.28	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			

Diagnostic Report

MC-2275

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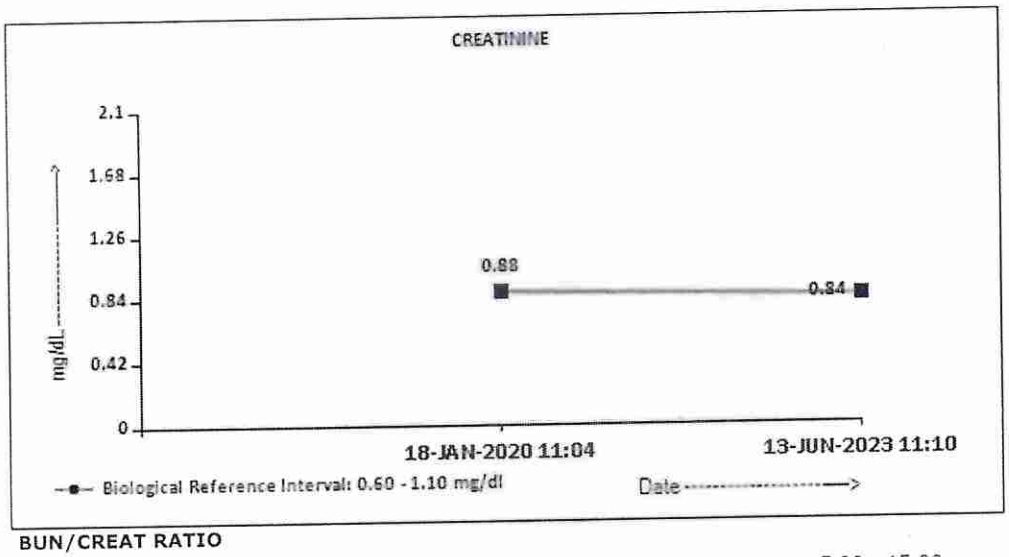

BUN/CREAT RATIO				
BUN/CREAT RATIO	9.52		5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	4.1		2.6 - 6.0	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	**8.6**	**High**	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN	4.3		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				
GLOBULIN	**4.3**	**High**	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	143		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM	4.74		3.50 - 5.10	mmol/L

PATIENT NAME : MRS.ABHILASHA SINGH

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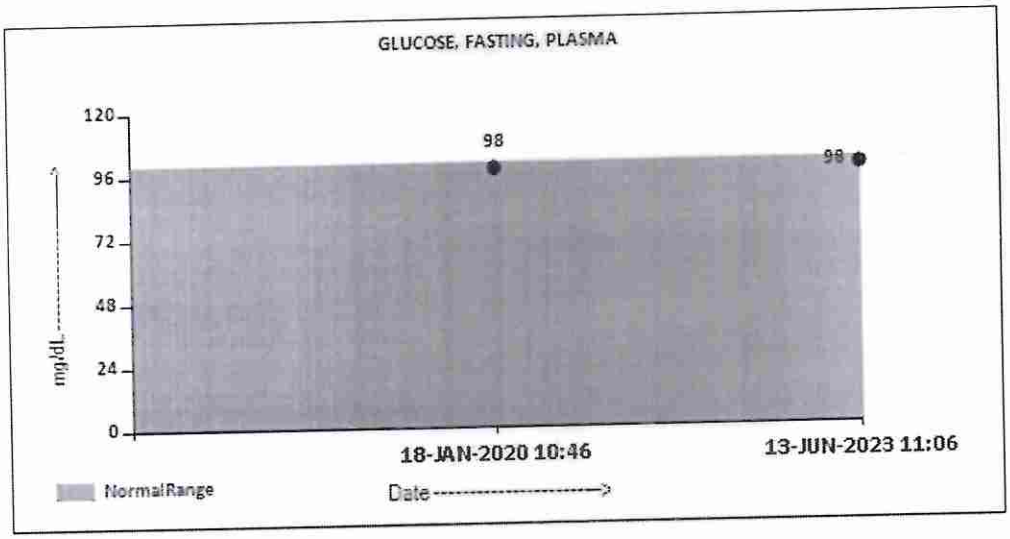
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

Test Report Status **Final**	Results	Biological Reference Interval	
METHOD : ISE INDIRECT CHLORIDE, SERUM	106	98 - 107	mmol/L
METHOD : ISE INDIRECT **Interpretation(s)**			
GLUCOSE FASTING,FLUORIDE PLASMA FBS (FASTING BLOOD SUGAR)	98	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
METHOD : HEXOKINASE			



GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD HBA1C	5.2	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)

PATIENT NAME : MRS.ABHILASHA SINGH

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ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

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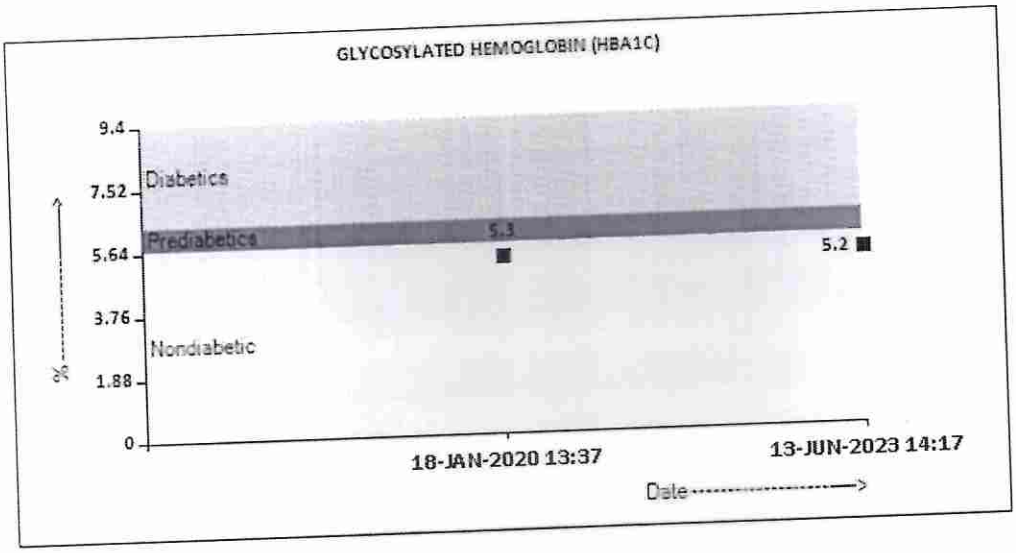
Test Report Status **Final**	Results	Biological Reference Interval	
ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	102.5	< 116.0	mg/dL



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.

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Patient Ref. No. 22000000851087

PATIENT NAME : MRS.ABHILASHA SINGH

PATIENT ID : **FH.5627069** CLIENT PATIENT ID : UID:5627069

ACCESSION NO : **0022WF002328** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 13/06/2023 09:56:00 RECEIVED : 13/06/2023 09:56:57 REPORTED : 13/06/2023 16:23:49

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

CLINICAL INFORMATION :

UID:5627069 REQNO-1534435
CORP-OPD
BILLNO-150123OPCR033114
BILLNO-150123OPCR033114

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

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

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-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.

ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylurea,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.

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 patients metabolic control has remained continuously within the target range.

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

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2. Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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BILLNO-150123OPCR033114
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Test Report Status **Final**	Results	Biological Reference Interval	
BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	158	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	117	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	48	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	92	< 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	110	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	23.4	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.3	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	1.9	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			

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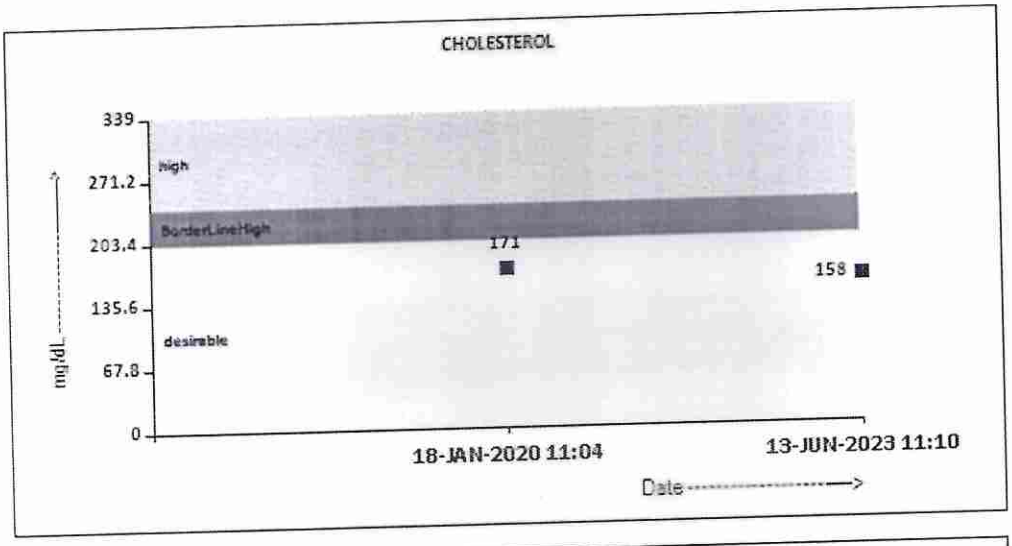

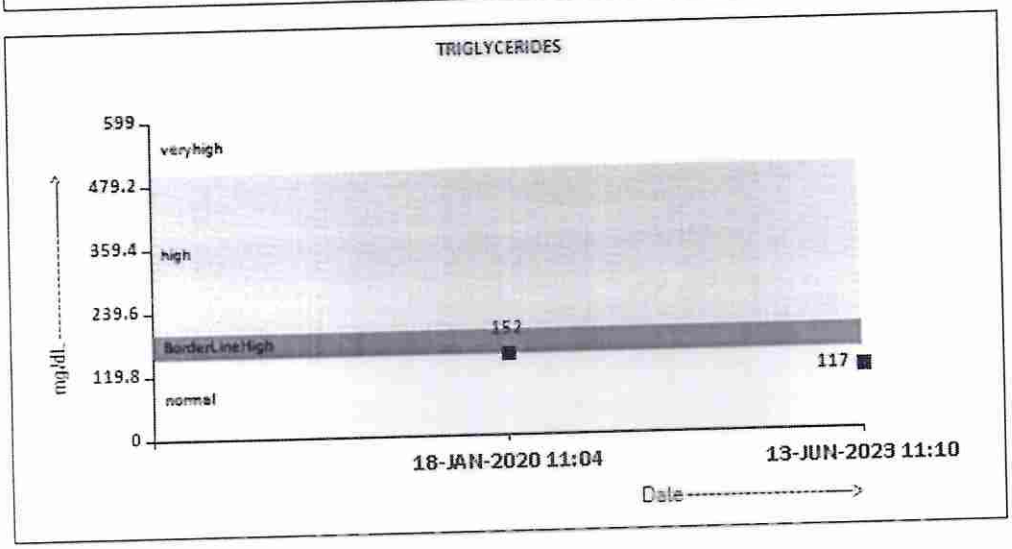

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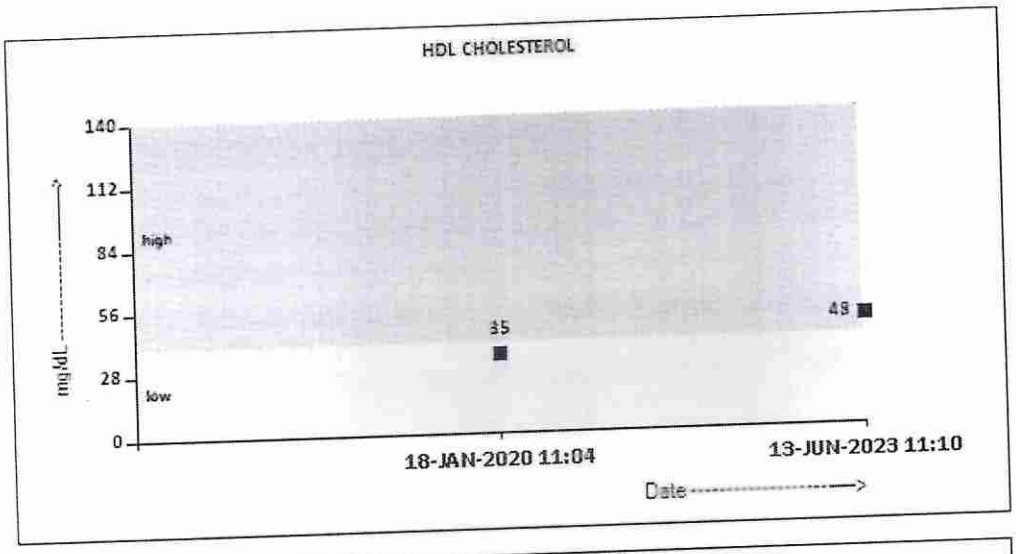

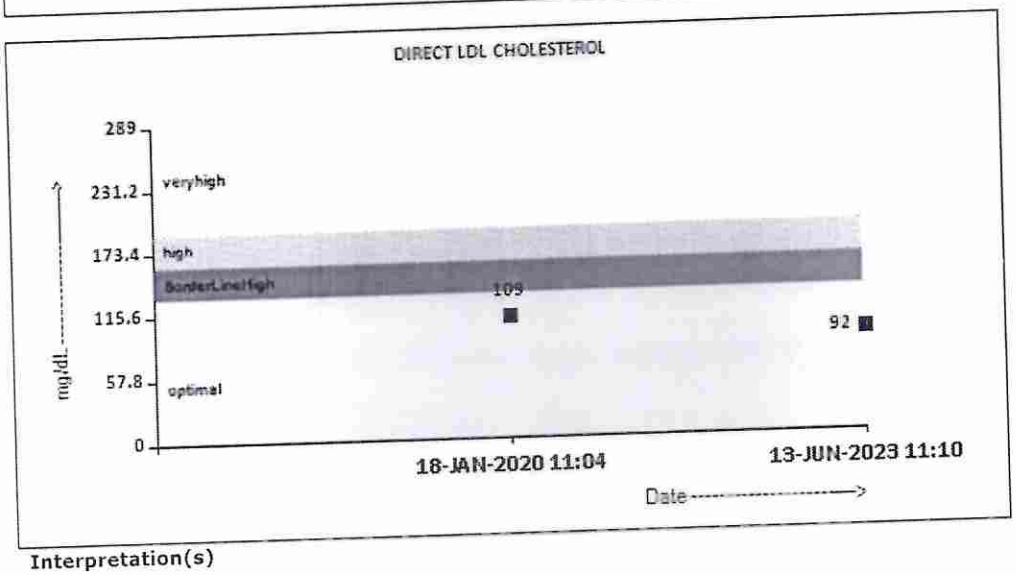

Interpretation(s)

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Test Report Status **Final**	Results	Biological Reference Interval	
CLINICAL PATH - URINALYSIS			
KIDNEY PANEL - 1			
PHYSICAL EXAMINATION, URINE			
COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**		
CHEMICAL EXAMINATION, URINE			
PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	>=1.030	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	**DETECTED (TRACE)**	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	**DETECTED (TRACE)**	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	**DETECTED (FEW)**	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	**8-10**	0-5	/HPF

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Diagnostic Report

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Test Report Status **Final**	Results	Biological Reference Interval	
EPITHELIAL CELLS	**15-20**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	**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)

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	112.1	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	11.45	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	0.697	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

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TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

Dr.Akta Dubey
Counsultant Pathologist

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Diagnostic Report

MC-2275

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Agilus Diagnostics Ltd. (Formerly SRL Ltd)

PATIENT NAME : MRS.ABHILASHA SINGH	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WF002365** PATIENT ID : FH.5627069 CLIENT PATIENT ID: UID:5627069 ABHA NO :	AGE/SEX :45 Years Female DRAWN :13/06/2023 12:52:00 RECEIVED : 13/06/2023 12:52:15 REPORTED :14/06/2023 08:52:28

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Test Report Status Final	**Units**

CYTOLOGY

PAPANICOLAOU SMEAR

PAPANICOLAOU SMEAR	
TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY
SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY
SPECIMEN ADEQUACY	SATISFACTORY
METHOD : MICROSCOPIC EXAMINATION MICROSCOPY	SMEARS STUDIED SHOW PARABASAL CELLS, INTERMEDIATE SQUAMOUS CELLS AND OCCASIONAL POLYMORPHS AND LACTOBACILLI
INTERPRETATION / RESULT	ENDOCERVICAL CELLS ARE NOT SEEN. NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY
ENDOMETRIAL CELLS (IN A WOMAN >/= 45 YRS) METHOD : MICROSCOPIC EXAMINATION	ABSENT

****End Of Report****

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Dr.Akta Dubey
Counsultant Pathologist

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Patient Ref. No. 22000000851124

45 Years Female

HC.

Rate	87	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Probable left atrial enlargement.....P >50mS, <-0.10mV V1
PR	142	. Borderline abnrm T, anterolateral leads.....T flat/neg, I aVL V2-V6
QRSD	92	. Baseline wander in lead(s) V4
QT	345	
QTc	415	

--AXIS--

P	52
QRS	66
T	2

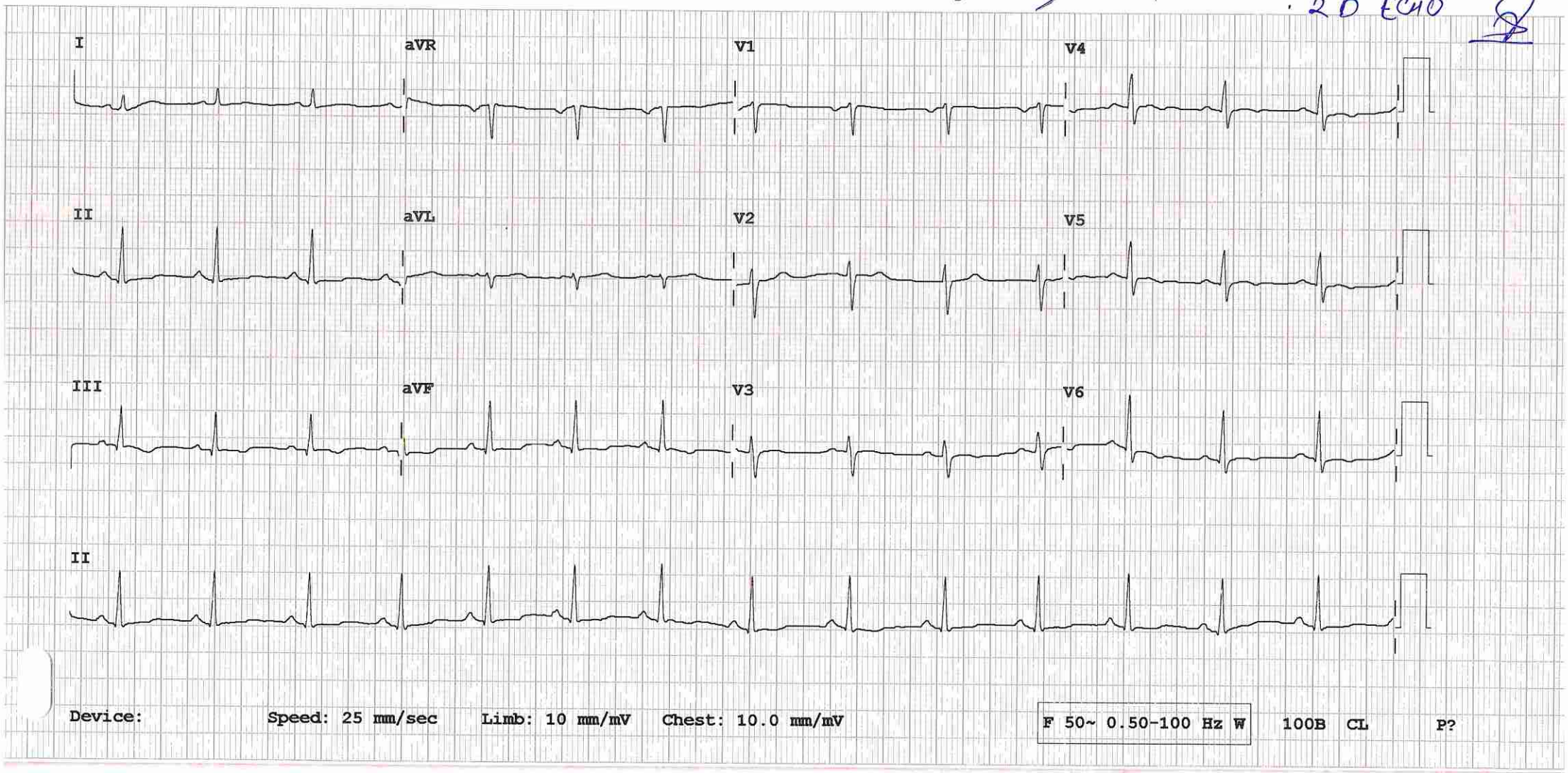
12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

Sinus rhythm
ST ↓ II, III, aVF
T ↓ in inferior, V4, V6

Adv
correlate clinically
2D ECHO



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

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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 13/Jun/2023

DEPARTMENT OF NIC

Name: Mrs. Abhilasha Singh
Age | Sex: 45 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5627069 | 33511/23/1501
Order No | Order Date: 1501/PN/OP/2306/69948 | 13-Jun-2023
Admitted On | Reporting Date : 13-Jun-2023 17:31:27
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

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

M-MODE MEASUREMENTS:

LA	33	mm
AO Root	31	mm
AO CUSP SEP	19	mm
LVID (s)	23	mm
LVID (d)	40	mm
IVS (d)	08	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.5 m/sec
E/A RATIO:1.4

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	07			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 13/Jun/2023

Name: Mrs. Abhilasha Singh
Age | Sex: 45 YEAR(S) | Female
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Admitted On | Reporting Date : 13-Jun-2023 13:54:11
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 are unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)

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DEPARTMENT OF RADIOLOGY

Date: 13/Jun/2023

Name: Mrs. Abhilasha Singh	**UHID | Episode No : 5627069 | 33511/23/1501**
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Order Station : FO-OPD	**Admitted On | Reporting Date : 13-Jun-2023 15:34:58**
Bed Name :	**Order Doctor Name : Dr.SELF .**

USG-WHOLE ABDOMEN

LIVER is normal in size 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 9.2 x 4.0 cm.
Left kidney measures 9.8 x 4.0 cm.

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

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

UTERUS is post-menopausal in status.

Endometrium measures 1.7 mm in thickness.

Both ovaries are not visualized. However, adnexae are clear.

No evidence of ascites.

Impression:

- **No significant abnormality is detected.**

DR. ADITYA NALAWADE
M.D. (Radiologist)

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MAMMOGRAM - BOTH BREAST

Findings:

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

Both breasts show scattered areas of fibroglandular density.

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

Subcentimeter sized bilateral axillary lymph nodes are seen.

IMPRESSION:

- No significant abnormality detected. (BI-RADS category I).
- No obvious mass lesion in the breasts.

Normal-interval follow-up is recommended.

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