

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	12493593	Date	27/05/2023		
Name	Mr. Prashant Kottawar	Sex	Male	Age	35
OPD	Opthal 14	Health Check Up			

Drug allergy:
 Sys illness:

OP opthal

o/e : well
 H/S

Fundus exam - well

Vu 6/6
 6/6

stop - 15.1
 15.4

Rx
 - eyedrop Aqualube
 C30 1-1-1
 - blue block FAKO glasses
 (zero power)
 ↓

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR		REF. DOCTOR :
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WE004388 PATIENT ID : FH.12493593 CLIENT PATIENT ID: UID:12493593 ABHA NO :	AGE/SEX : 35 Years Male DRAWN : 27/05/2023 09:42:00 RECEIVED : 27/05/2023 09:42:25 REPORTED : 27/05/2023 13:01:01

CLINICAL INFORMATION :
 UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
 BILLNO-150123OPCR029843

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)	15.8	13.0 - 17.0	g/dL
<small>METHOD : SPECTROPHOTOMETRY</small>			
RED BLOOD CELL (RBC) COUNT	4.97	4.5 - 5.5	mil/ μ L
<small>METHOD : ELECTRICAL IMPEDANCE</small>			
WHITE BLOOD CELL (WBC) COUNT	4.10	4.0 - 10.0	thou/ μ L
<small>METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY</small>			
PLATELET COUNT	271	150 - 410	thou/ μ L
<small>METHOD : ELECTRICAL IMPEDANCE</small>			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	45.4	40 - 50	%
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR VOLUME (MCV)	91.3	83 - 101	fL
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	31.8	27.0 - 32.0	pg
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	34.8 High	31.5 - 34.5	g/dL
<small>METHOD : CALCULATED PARAMETER</small>			
RED CELL DISTRIBUTION WIDTH (RDW)	15.5 High	11.6 - 14.0	%
<small>METHOD : CALCULATED PARAMETER</small>			
MENTZER INDEX	18.4		
MEAN PLATELET VOLUME (MPV)	8.6	6.8 - 10.9	fL
<small>METHOD : CALCULATED PARAMETER</small>			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40 - 80	%
<small>METHOD : FLOWCYTOMETRY</small>			
LYMPHOCYTES	35	20 - 40	%
<small>METHOD : FLOWCYTOMETRY</small>			
MONOCYTES	8	2 - 10	%
<small>METHOD : FLOWCYTOMETRY</small>			

Akta Dubey

Dr.Akta Dubey
 Counsultant Pathologist



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Patient Ref. No. 22000000847962

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WE004388
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AGE/SEX : 35 Years Male
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EOSINOPHILS		2	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		2.26	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.44	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.33	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.08	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.5		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)

RBC AND PLATELET INDICES-Mentzer Index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta-thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of RDW 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 34 (2015) 106504
 This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	03	0 - 14	mm at 1 hr
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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, Vasculitis, 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 (Paraproteinemia, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy ESR in first trimester is 0-40 mm/hr (52 if anemic) and in second trimester (0-70 mm /hr (85 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 : Polikilocytosis,(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. AACCPress. 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

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 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WE004388
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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE O
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. 22000000847962

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PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR

CODE/NAME & ADDRESS : C000045507

ACCESSION NO : 0022WE004388

AGE/SEX : 35 Years Male

FORTIS VASHI-CHC -SPLZD

PATIENT ID : FH.12493593

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FORTIS HOSPITAL # VASHI,

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MUMBAI 440001

ABHA NO :

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CORP-OPD

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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.61	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.10	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.51	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.0	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	2.9	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.4	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	17	15 - 37	U/L
METHOD : UV WITH PSP			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	31	< 45.0	U/L
METHOD : UV WITH PSP			
ALKALINE PHOSPHATASE	98	30 - 120	U/L
METHOD : PNP/PANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	26	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANTHLIDE			
LACTATE DEHYDROGENASE	177	100 - 190	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	95	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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METHOD : HEXOKINASE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

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Patient Ref. No. 22000000647962

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : **0022WE004388**
 PATIENT ID : FH.12493593
 CLIENT PATIENT ID: UID:12493593
 ABHA NO :

AGE/SEX : 35 Years Male
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HBA1C		5.4	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)		108.3	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		10	6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE		0.95	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE		35		years
GLOMERULAR FILTRATION RATE (MALE)		107.05	Refer Interpretation Below	mL/min/1.73m ²
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO		10.53	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		4.8	3.5 - 7.2	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.0	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN		4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				
GLOBULIN		2.9	2.0 - 4.1	g/dL

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METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	141	136 - 145	mmol/L
POTASSIUM, SERUM	4.68	3.50 - 5.10	mmol/L
CHLORIDE, SERUM	104	98 - 107	mmol/L

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, pericarditis, 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 Hypophosphatemia, 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 (hypalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in 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.

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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 glycaemic 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:**

- 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.
- Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- 2,3-DPG, 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, anemia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates, sulfonamides are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in

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

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 (Hyalinosis, 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 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, Nephrotic, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

Dubey

Dr. Akta Dubey
Consultant Pathologist



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CIN - U71999PB1995PLC045956
Email : -



LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WE004388
 PATIENT ID : FH.12493593
 CLIENT PATIENT ID: UID:12493593
 ABHA NO :

AGE/SEX : 35 Years Male
 DRAWN : 27/05/2023 09:42:00
 RECEIVED : 27/05/2023 09:42:25
 REPORTED : 27/05/2023 13:01:01

CLINICAL INFORMATION :

UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
 BILLNO-150123OPCR029843

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	153	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
<small>METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE</small>			
TRIGLYCERIDES	92	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
<small>METHOD : ENZYMATIC ASSAY</small>			
HDL CHOLESTEROL	38 Low	< 40 Low >=60 High	mg/dL
<small>METHOD : DIRECT MEASURE - PEG</small>			
LDL CHOLESTEROL, DIRECT	103	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
<small>METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT</small>			
NON HDL CHOLESTEROL	115	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
<small>METHOD : CALCULATED PARAMETER</small>			
VERY LOW DENSITY LIPOPROTEIN	18.4	<= 30.0	mg/dL
<small>METHOD : CALCULATED PARAMETER</small>			
CHOL/HDL RATIO	4.0	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
<small>METHOD : CALCULATED PARAMETER</small>			

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 Consultant Pathologist

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 CIN - U74899MH1995PLC045956
 Email : -



Patient Ref. No. 22000000947962

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022WE004388

PATIENT ID : FH.12493593

CLIENT PATIENT ID: UID:12493593

ABHA NO :

AGE/SEX : 35 Years Male

DRAWN : 27/05/2023 09:42:00

RECEIVED : 27/05/2023 09:42:25

REPORTED : 27/05/2023 13:01:01

CLINICAL INFORMATION :

UTD:12493593 REQNO-1527642
CORP-OPD
BILLNO-150123OPCR029843
BILLNO-150123OPCR029843

Test Report Status	Final	Results	Biological Reference Interval	Units
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LDL/HDL RATIO 2.7 0.5 - 3.0 Desirable/Low Risk
3.1 - 6.0 Borderline/Moderate Risk
>6.0 High Risk

METHOD : CALCULATED PARAMETER
Interpretation(s)

Dr. Akta Dubey
Counsultant Pathologist



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Email : -



Patient Ref. No. 22000000847962

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WE004388
PATIENT ID : FH.12493593
CLIENT PATIENT ID: UID:12493593
ABHA NO :

AGE/SEX : 35 Years Male
DRAWN : 27/05/2023 09:42:00
RECEIVED : 27/05/2023 09:42:25
REPORTED : 27/05/2023 13:01:01

CLINICAL INFORMATION :

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Test Report Status	Final	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
METHOD : PHYSICAL

APPEARANCE CLEAR
METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY 1.015 1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION- GOD/POD

KETONES NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN

BILIRUBIN NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT

UROBILINOGEN NORMAL NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)

NITRITE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF
METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 0-1 0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION

Akta

Dr. Akta Dubey
 Consultant Pathologist

Rekha

Dr. Rekha Nair, MD
 Microbiologist



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LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507	ACCESSION NO : 0022WE004388	AGE/SEX : 35 Years Male	
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.12493593	DRAWN : 27/05/2023 09:42:00	
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:12493593	RECEIVED : 27/05/2023 09:42:25	
MUMBAI 440001	ABHA NO :	REPORTED : 27/05/2023 13:01:01	

CLINICAL INFORMATION :

UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
 BILLNO-150123OPCR029843

Test Report Status	Final	Results	Biological Reference Interval	Units
EPITHELIAL CELLS		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

Dubey
 Dr. Akta Dubey
 Consultant Pathologist

Rekha N
 Dr. Rekha Nair, MD
 Microbiologist



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 CIN - U71899PB1995PLC045956
 Email : -



Patient Ref. No. 22000000847962

PATIENT NAME : MR.PRASHANT KOTTAWAR CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001		REF. DOCTOR : AGE/SEX : 35 Years Male DRAWN : 27/05/2023 09:42:00 RECEIVED : 27/05/2023 09:42:25 REPORTED : 27/05/2023 13:01:01
ACCESSION NO : 0022WE004388 PATIENT ID : FH.12493593 CLIENT PATIENT ID: UID:12493593 ABHA NO :		

CLINICAL INFORMATION :
 UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
 BILLNO-150123OPCR029843

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

THYROID PANEL, SERUM

T3	160.6	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	9.49	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.640	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY			

Interpretation(s)

Dr. Akta Dubey
 Counsultant Pathologist



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Patient Ref. No. 2200000847962

PATIENT NAME : MR.PRASHANT KOTTAWAR		REF. DOCTOR :
CODE/NAME & ADDRESS : C000045507	ACCESSION NO : 0022WE004388	AGE/SEX : 35 Years Male
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.12493593	DRAWN : 27/05/2023 09:42:00
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:12493593	RECEIVED : 27/05/2023 09:42:25
MUMBAI 440001	ABHA NO :	REPORTED : 27/05/2023 13:01:01

CLINICAL INFORMATION :

UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
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Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN **0.585** **0.0 - 1.4** **ng/mL**

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostates.
 - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.
 - It is a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serum PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in defining residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-5.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report, which covers all agegroup with 95% prediction interval)
 PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References- Taitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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Dubey

Dr.Akfa Dubey
 Counsultant Pathologist



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Patient Ref. No. 22000000847952

LABORATORY REPORT



PATIENT NAME : MR.PRASHANT KOTTAWAR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507	ACCESSION NO : 0022WE004463	AGE/SEX : 35 Years Male	
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.12493593	DRAWN : 27/05/2023 12:57:00	
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:12493593	RECEIVED : 27/05/2023 12:57:20	
MUMBAI 440001	ABHA NO :	REPORTED : 27/05/2023 14:06:25	

CLINICAL INFORMATION :

UID:12493593 REQNO-1527642
 CORP-OPD
 BILLNO-150123OPCR029843
 BILLNO-150123OPCR029843

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	94	70 - 140	mg/dL
<small>METHOD : HEXOKINASE</small>			

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

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Dr. Akta Dubey
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 Email :-



Patient Ref. No. 2200000046037

35 Years

Male

H/C
Diagnosis pending
— A —

Rate 59 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Borderline right axis deviation.....QRS axis (90, 99)

PR 131
 QRSD 88
 QT 407
 QTC 404

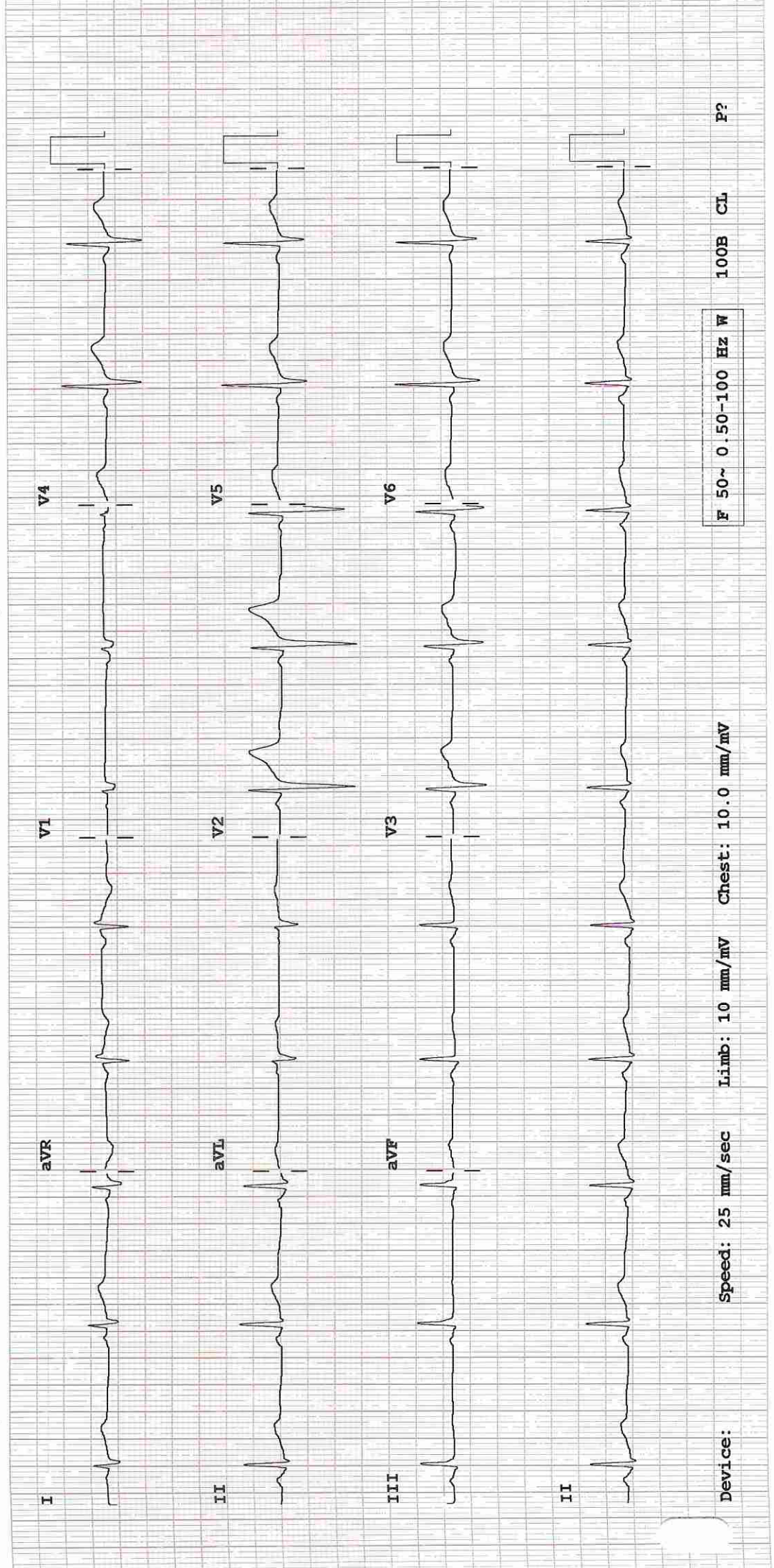
--AXIS--

P 60
 QRS 90
 T 37

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CI P?



DEPARTMENT OF NIC

Date: 27/May/2023

Name: Mr. Prashant Kottawar

UHID | Episode No : 12493593 | 30197/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2305/63089 | 27-May-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 27-May-2023 16:32:27

Bed Name :

Order Doctor Name : Dr.SELF .

TREAD MILL TEST (TMT)

Resting Heart rate	65 bpm
Resting Blood pressure	110/80 mmHg
Medication	Nil
Supine ECG	Normal
Standard protocol	BRUCE
Total Exercise time	09 min 00 seconds
Maximum heart rate	159 bpm
Maximum blood pressure	140/80 mmHg
Workload achieved	10.1 METS
Reason for termination	Target heart rate achieved

Final Impression :

STRESS TEST IS NEGATIVE FOR EXERCISE INDUCED MYOCARDIAL ISCHEMIA AT 10.1 METS AND 85 % OF MAXIMUM PREDICTED HEART RATE.

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



DEPARTMENT OF RADIOLOGY

Date: 27/May/2023

Name: Mr. Prashant Kottawar

UHID | Episode No : 12493593 | 30197/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2305/63089 | 27-May-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 27-May-2023 16:01:40

Bed Name :

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 appear normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

Aditya

DR. ADITYA NALAWADE

M.D. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 27/May/2023

Name: Mr. Prashant Kottawar

UHID | Episode No : 12493593 | 30197/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2305/63089 | 27-May-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 27-May-2023 11:19:43

Bed Name :

Order Doctor Name : Dr.SELF .

US-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 3.7 cm. Left kidney measures 8.7 x 4.4 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.

PROSTATE is normal in size & echogenicity. It measures ~ 9.6cc in volume.

No evidence of ascites.

Impression:

- No significant abnormality is detected.


DR. ADITYA NALAWADE
M.D. (Radiologist)