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DATE- 23/3/24

NAME - Komal

PHONE - 9871528242

AGE/GENDER - female

ADDRESS - W/O Inchhajani, Jaunpur Gurgaon 122414

EMAIL - PKTEKARIA8892@GMAIL.COM

CORPORATE NAME - BOB.

1. **Past medical history & medications:-**

Anxiety

2. **Any existing disease: -**

— NA —

3. **Current medications :-**

— NA —

4. **VITALS** - (To be filled by medical personnel)

- BLOOD PRESSURE - 101...../...56
- PULSE RATE - 79.....
- TEMPERATURE – 97.1F
- SPO2 – 96..
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 155.
- WEIGHT – 50..
- BMI – 20.8.

vision- RE - 6/9

LE - 6/9.

Colour vision- Normal.

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5. **FINDINGS: -**

LAB INVESTIGATION: - Hb - 12.20 gm/dl.
PP BS - 143.50 mg/dl. (N)
Rest investigations - Normal.

CARDIOLOGY INVESTIGATIONS: - 2D Echo - Normal.
ECG - Normal.

USG - Normal., CXR - Normal

RADIOLOGY INVESTIGATIONS: - Sonology Breast - Benign lesion in left upper outer Quadrant c/c Bilc fibroadenosis.
- BIRAD's Rt - II, Left - III.

6. **DOCTOR REMARKS: -**

Gynecologist consultation.

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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Komal on 24/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	✓
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____ recommended	
• Unfit	

Dr. [signature]
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

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PATIENT NAME	MS KOMAL		REPORT DATE	3/23/2024
REF BY	P.H.M.C		AGE/SEX	25 YRS / F

ULTRASOUND – ABDOMEN & PELVIS

Clinical Profile-HEALTH CHECKUP.

Findings

The liver is normal in size, outline and parenchymal echotexture. No focal lesion is seen. The portal vein is normal in calibre and course.

The gall bladder shows normal contents. The intra hepatic biliary radicals and CBD are normal. The pancreas and spleen are normal.

Both the kidneys are normal in size, outline and parenchymal echopattern. No calculus, hydronephrosis or any other abnormality is seen on either side.

No free fluid is seen in the peritoneal cavity. No lymph node enlargement is seen in the para-aortic region.

The urinary bladder is normal in outline.

The uterus is normal in size with smooth outline. The myometrial echoes are homogenous and the endometrial lining is central, 9mm. Both the adnexal regions are clear without any mass or collection.

The Pouch of Douglas does not show any free fluid.

IMPRESSION-
NO OBVIOUS SONOLOGICAL ABNORMALITY IS SEEN IN THIS STUDY

Clinical correlation is necessary.

DR. RAJNISH JUNEJA,
D.N.B (RADIO – DIAGNOSIS)

Disclaimer
The science of radiology is based upon interpretation of shadows of normal and abnormal tissues and hence does not represent histopathology and ultimate diagnosis. Findings should always be interpreted in to the light of clinico-histo-pathological correlation. Not meant for medico legal purposes.

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PATIENT NAME	MS KOMAL		REPORT DATE	3/23/2024
REF BY	P.H.M.C		AGE/SEX	25 YRS / F

SONOLOGICAL EVALUATION OF THE BREASTS

Scanning scheme used : longitudinal, transverse, radial & orthogonal ante-radial scan obtained using high frequency probes.

Both the breasts display decrease parenchymal echogenicity with multiple hypoechoic areas within.

A well defined lobulated hypoechoic lesion, measuring 41x23mm is seen in left upper outer quadrant. *On color/power Doppler evaluation vascularity was noted in it.*

Both the axillae do not reveal any significant lymphadenopathy.

IMPRESSION:

FINDINGS ARE SUGGESTIVE OF A BENIGN LESION IN THE LEFT UPPER OUTER QUADRANT WITH BILATERAL FIBROADENOSIS.

ADVISED FNAC & FOLLOW UPS.

BIRAD'S RIGHT BREAST - II **BIRAD'S LEFT BREAST – III**

BIRAD'S GRADING : -

CATEGORY o	Incomplete. Needs additional imaging evaluation and / or prior films for comparison
CATEGORY 1	Negative (Normal)
CATEGORY 2	Benign
CATEGORY 3	Probably benign (<2% risk of malignancy) Initial short - internal follow-up suggested (6 monthly)
CATEGORY 4	Suspicious Abnormality
4 A	Finding needing intervention (low suspicious of malignancy)
4 B	Close radiological & pathologic correlation (Intermediate suspicious of malignancy)
4 C	Moderate concern for malignancy
CATEGORY 5	Highly suggestive of malignancy > 95%
CATEGORY 6	Known Biopsy - Proven malignancy.

DR. RAJNISH JUNEJA,
D.N.B (RADIO – DIAGNOSIS)

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Patient's Name:-	MS. KOMAL	Date	:- 23/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 25Y/F

Radiograph of Chest (PA View)

Visualized lungs fields appear normal.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

Dr Arushi Gupta

MBBS, DNB (Radio – Diagnosis)

Radiologist

Name	**Komal Emergency**
Patient ID	**afd63d19-9fba-408c-bf11-70822bdfb4a1**

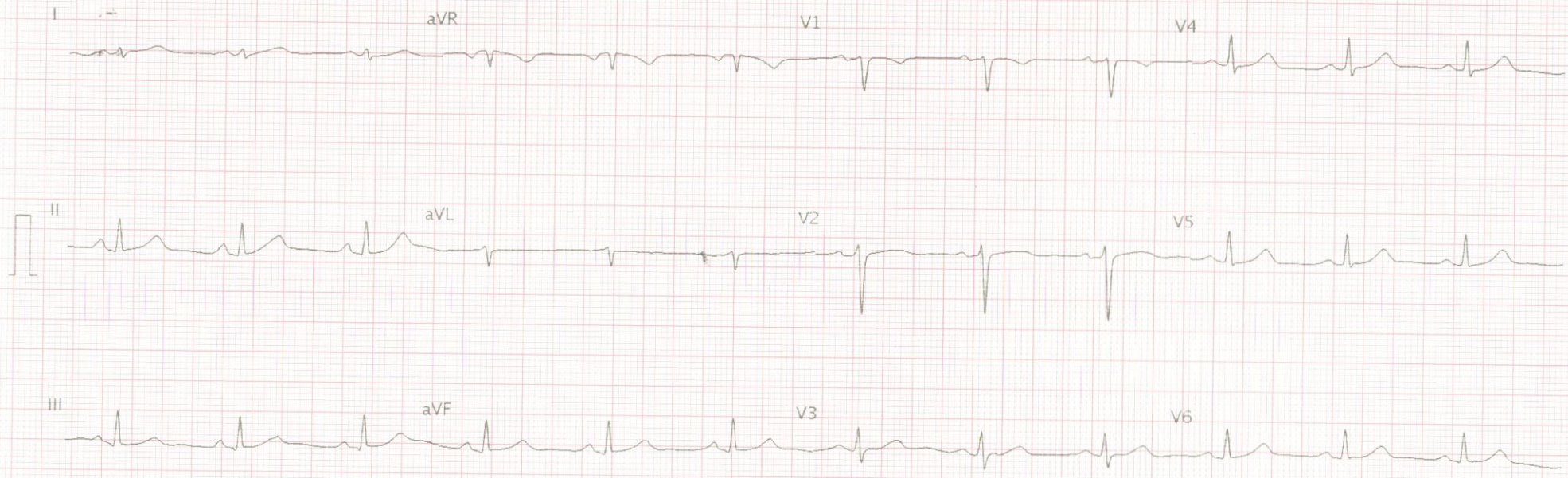
23.03.2024 11:41:17
Standard 12-Lead

Date of birth	29.01.1998	Visit ID	
Gender	Female	Room	
Height		Medication	
Weight		Order ID	
Ethnicity	Undefined	Ord. prov.	
Pacemaker	Unknown	Ord. prot.	

Indication
Remark

HR	**73 bpm**	RR	824 ms	Ventricular premature complex(es)
		P	92 ms	Sinus rhythm
		PR	140 ms	Normal electrical axis
P axis	72 °	QRS	73 ms	Abnormal ECG
QRS axis	86 °	QT	373 ms	
T axis	61 °	QTcB	411 ms	**Unconfirmed report**

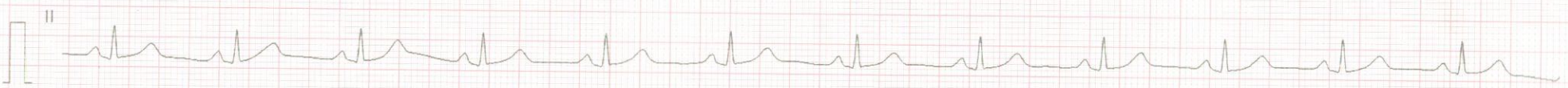
Abnormal



25 mm/s. 10 mm/mV

Sequential

LP 25Hz. AC 60Hz



25 mm/s. 10 mm/mV

LP 25Hz. AC 60Hz

SCHILLER

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ECHOCARDIOGRAPHY REPORT

Patient's Name	MS KOMAL	Date	23-03-2024
Referred by	HEALTH CHECK UP	Age &Sex	25Yrs/F

MITRAL VALVE

Morphology **AML** - **Normal** / Thickening/Calcification/ Flutter/ Vegetation/ Prolapse/ SAM/ Doming
PML - **Normal**/ Thickening/ Calcification/ Mild Prolapse/ Paradoxical motion/ fixed.
Sub valvular deformity Present/ **Absent** Score: .....

Doppler **Normal**/Abnormal **E>A** A>E
Mitral Stenosis Present/**Absent** RR interval.....msec
EDG.....mmHg MDG.....mmHg MVA.....cm^2
Mitral Regurgitation **Absent** /Trivial/Mild/Moderate/Severe

TRICUSPID VALVE

Morphology **Normal**/ Atresia/Thickening/ Calcification/ Prolapse/ Vegetation/ Doming
Doppler **Normal**/ Abnormal
Tricuspid Stenosis Present/ **Absent** RR interval.....
EDG.....mmHg MDG.....mmHg
Tricuspid Regurgitation: **Absent**/ Trivial/ Mild/ Moderate/ Severe Fragmented signals
Velocity.....m/sec

PULMONARY VALVE

Morphology **Normal**/ Atresia/ Thickening/ Doming/ Vegetation
Doppler **Normal**/ Abnormal
Pulmonary Stenosis Present/**Absent** Level Valvular and Sub valvular
PV Max = **1.0 m/sec** PSG.....mmHg Pulmonary annulus.....mm
Pulmonary Regurgitation Present/ **Absent**
Early diastolic gradient.....mmHg. End Diastolic Gradient.....mmHg

AORTIC VALVE

Morphology **Normal**/ Thickening/ Tip Calcification/ Restricted Opening/ Flutter vegetation
No. of cusps 1/2/**3**/4

Doppler **Normal**/ Abnormal
Aortic Stenosis: Present/**Absent**
AV Max = **1.4** m/sec Aortic Annulus.....mm
Aortic Regurgitation **Absent**/ Trivial/ Mild/Moderate/ Severe

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Measurements	Normal Values	Measurements	Normal Values
Aorta- 2.0	(2.0-3.7 cm)	LAes- 2.7	(1.9-4.0 cm)
LVes- 2.2	(2.2-4.0 cm)	LVed- 3.3	(3.7-5.6 cm)
IVSed-0.9	(0.6-1.1 cm)	PW (LV) 0.6	(0.6-1.1 cm)
RV ed	(0.7-2.6 cm)	RV anterior wall	(up to 5 mm)
LVVd (ml)		LVVs (ml)	
EF **60-65 %**	(54%-76%)	IVS motion	**Normal**/ Flat/ Paradoxical

CHAMBERS:

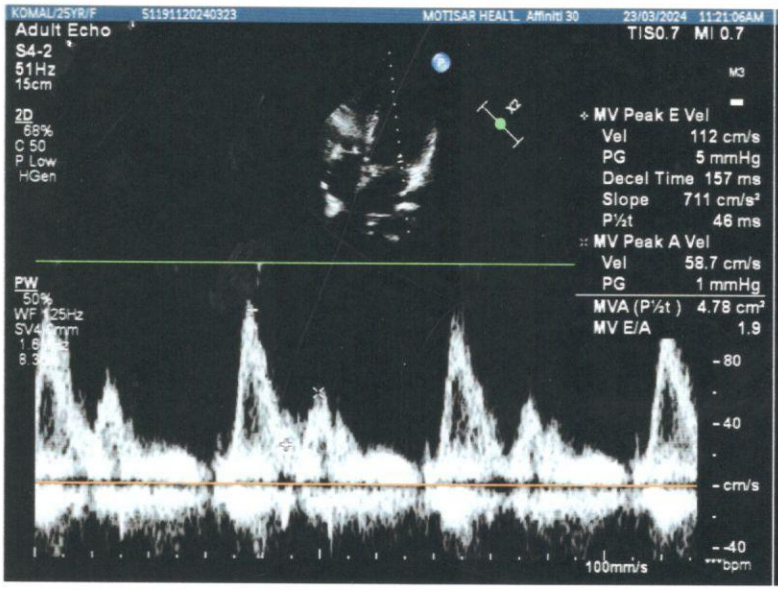
LV	**Normal** / Enlarged/ Clear/ Thrombus/hypertrophy Contraction **Normal** / Reduced
LA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RV	**Normal**/ Enlarged/ **Clear**/ Thrombus
Pericardium	**Normal**/ Thickening/ Calcification/ Effusion

COMMENTS AND SUMMARY

- **ALL FOUR CHAMBERS NORMAL IS SIZE AND SHAPE**
- **ALL FOUR VALVES NORMAL IN MORPHOLOGY**
- **NO MR/AR/TR**
- **NO AORTIC STENOSIS**
- **NORMAL LV DIASTOLIC FUNCTION**
- **NO CLOT/MASS/PE SEEN**
- **NORMAL LV SYSTOLIC FUNCTION, LVEF= 60-65%**

Kindly correlate clinically

DR. ROHIT GOEL
M.D, D.M (Cardiology)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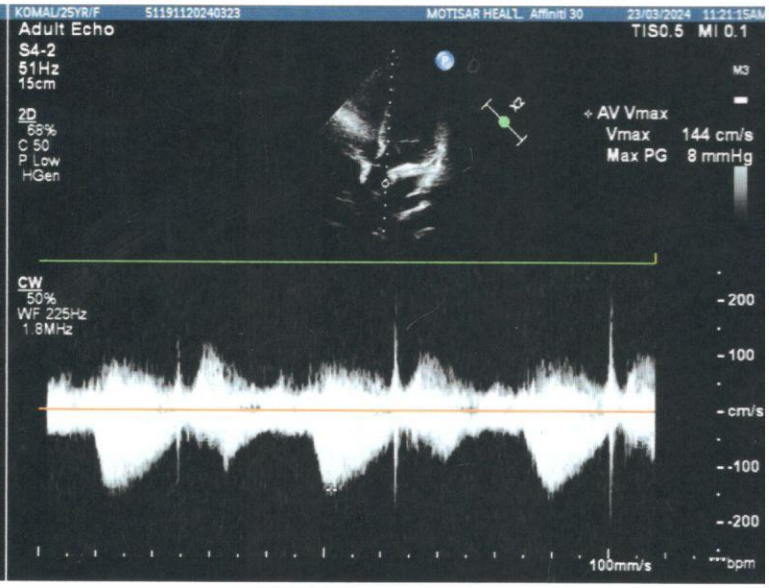
Adult Echo
TIS0.7 MI 0.7
S4-2
51Hz
15cm
2D
68%
C 50
P Low
HGen
MV Peak E Vel
Vel 112 cm/s
PG 5 mmHg
Decel Time 157 ms
Slope 711 cm/s²
P½t 46 ms
MV Peak A Vel
Vel 58.7 cm/s
PG 1 mmHg
MVA (P½t) 4.78 cm²
MV E/A 1.9
PW
50%
WF 125Hz
-80
-40
cm/s
-40
100mm/s
***bpm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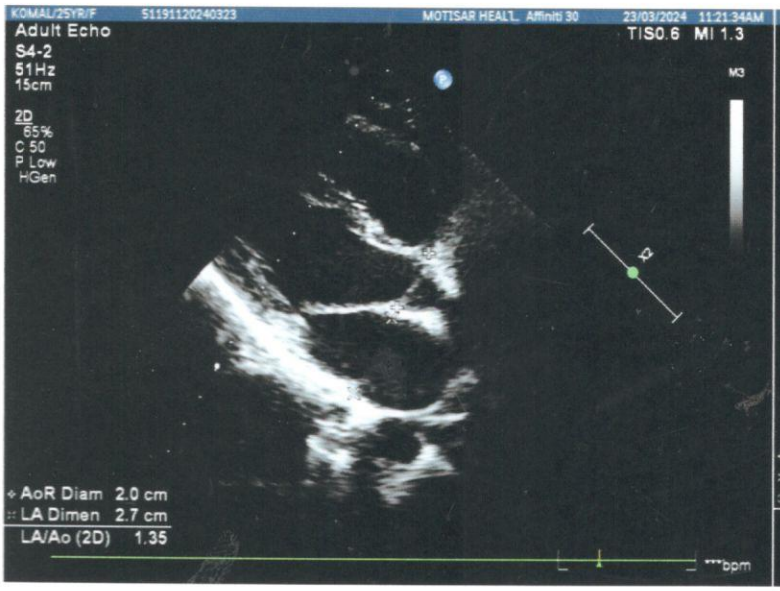
Adult Echo
TIS0.5 MI 0.1
S4-2
51Hz
15cm
2D
68%
C 50
P Low
HGen
AV Vmax
Vmax 144 cm/s
Max PG 8 mmHg
CW
50%
WF 225Hz
1.8MHz
-200
-100
cm/s
-100
-200
100mm/s
***bpm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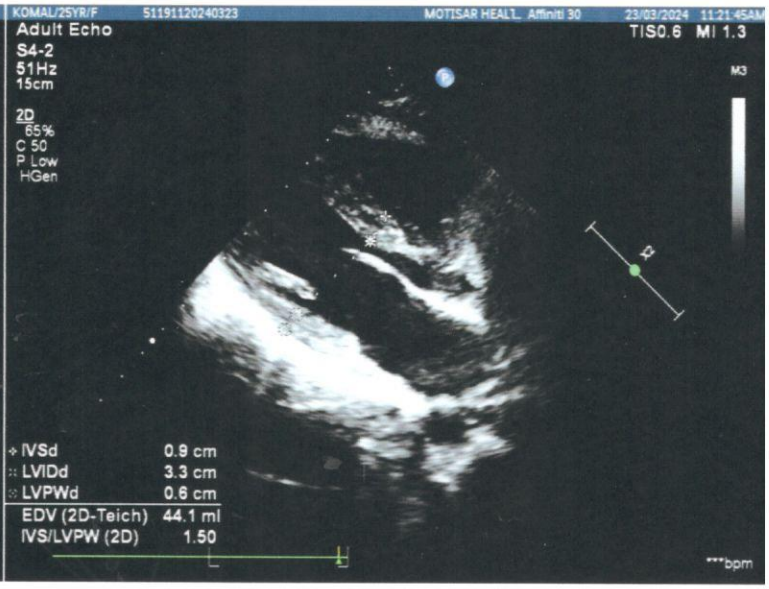
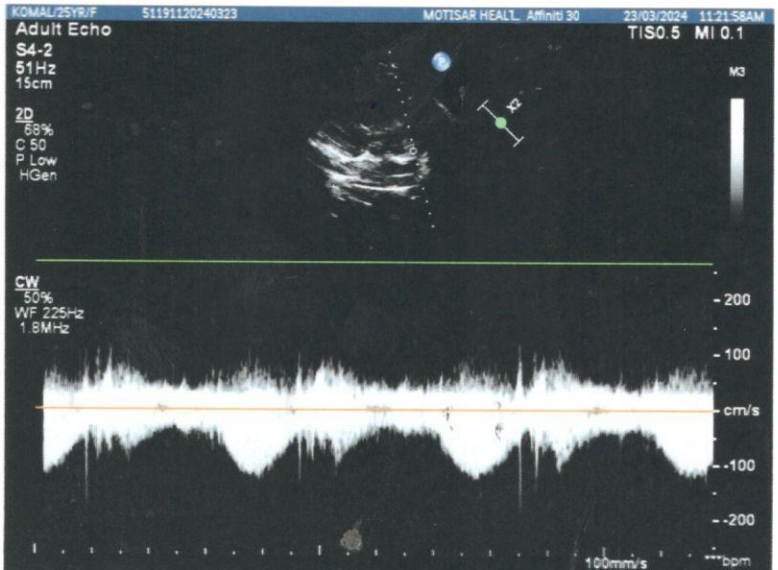
Adult Echo
TIS0.6 MI 1.3
S4-2
51Hz
15cm
2D
65%
C 50
P Low
HGen
AoR Diam 2.0 cm
LA Dimen 2.7 cm
LA/Ao (2D) 1.35
***bpm


KOMAL/25YR/F 51191120240323 MOTISAR HEALTL Affiniti 30 23/03/2024 11:21:45AM
Adult Echo
TIS0.6 MI 1.3
S4-2
51Hz
15cm
2D
65%
C 50
P Low
HGen
IVSd 0.9 cm
LVIDd 3.3 cm
LVPWd 0.6 cm
EDV (2D-Teich) 44.1 ml
IVS/LVPW (2D) 1.50
***bpm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Adult Echo
TIS0.5 MI 0.1
S4-2
51Hz
15cm
2D
68%
C 50
P Low
HGen
CW
50%
WF 225Hz
1.8MHz
-200
-100
cm/s
-100
-200
100mm/s
***bpm

Komal
25/F

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P/S - Cx healthy, curdy D/S ⊕

P/V - UL upright, NS
CAV B/L fornix

Rx
Vag Tab. Canesoft CL 1HS x3

Gangotri
23/3/2024

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

TO BOOK AN APPOINTMENT
08079 838383

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Kemal AGE/SEX: 25/F DATE: 23 March 24

through health checkup

O/E → Stains ++
Calculus +

T/t advice → scaling + polishing

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

Patient NAME	: MRS.KOMAL	Barcode NO	: 20011725
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 23/Mar/2024 04:24PM
LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:36PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	**12.20**	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	**4.2**	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	**37.9**	%	42-52	Calculated
MCV	89.50	fL	78-100	Electrical Impedence
MCH	28.7	pg	27-31	Calculated
MCHC	32.1	gm/dL	32-36	Calculated
RDW-SD	**13.3**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	4760	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	50	%	40-80	VCSn Technology
LYMPHOCYTE	**42**	%	20-40	VCSn Technology
MONOCYTE	06	%	2-10	VCSn Technology
EOSINOPHIL	02	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	**98**	10^3/ul	150 - 450	Electrical Impedence
MPV	**12.5**	fL	7.2 - 11.7	Electrical Impedence
PCT	**0.1**	%	0.2 - 0.5	Calculated
PDW	**17.6**	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	2.38	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	2	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.29	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.1**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.KOMAL	Barcode NO	: 20011725
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 23/Mar/2024 04:24PM
LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:59PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	15	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

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MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.KOMAL	Barcode NO	: 20011725
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 23/Mar/2024 04:24PM
LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:54PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	"O"			Gel Columns agglutination
Rh Typing	**POSITIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

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MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.KOMAL	Barcode NO	: 20011725
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 23/Mar/2024 04:24PM
LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.70	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.20	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.50	mg/dL	0.1 - 1.0	Calculated
SGPT	16.00	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	20.20	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	1.26	Ratio	0.7 - 1.4	
GGT	18	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	80.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.10	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.60	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	2.5	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.84	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

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Patient NAME	: MRS.KOMAL	Barcode NO	: 20011725
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 23/Mar/2024 04:24PM
LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:49PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	182.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	61.70	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	52.60	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	117.06	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	129.4	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	12.34	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	**3.46**	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	2.23	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.45	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method

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LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:31PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.3	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	104.84	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	83.6	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	**143.50**	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	23.69	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	11.07	mg/dL	7 - 18	Urease
SERUM URIC ACID	3.66	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.68	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	10.30	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	138.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.10	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	102.5	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

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LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:36PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.41	ng/mL	0.79 - 1.58	CLIA
T4	9.25	µg/dl	4.9 - 11.00	CLIA
TSH	**5.00**	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 09:21PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	30	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.50		4.5 - 7.0	
SPECIFIC GRAVITY	1.020		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	Absent		Nill	
Urine Protein	Absent		Nil	
Urine Ketones	Absent		Nil	
BLOOD	Absent		Absent	
Leukocyte esterase	Absent		Negative	
Bile pigments	Absent		Absent	
NITRITE	Absent		Negative	
UROBILINOGEN	Absent		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	2-4	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	Absent	/hpf	Absent	
CRYSTALS	Absent		Absent	
CASTS	Absent		Absent	
OTHER	Absent			
URINE SUGAR - PP				
Sample Type : Urine				
Result	Absent		Nil	Benedicts test

INTERPRETATION:

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.

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LabNo	: DPL23763	Sample Collected Date	: 23/Mar/2024 04:24PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 09:21PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 24

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE FOR SUGAR - FASTING				
Sample Type : Urine				
Result	Absent		Nil	Benedicts test

INTERPRETATION:

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.

***** End Of Report *****

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Patient NAME	: Mrs.KOMAL	Barcode NO	: 20011812
Age/Gender	: 25 Y 0 M 0 D /F	Registration Date	: 24/Mar/2024 11:46AM
LabNo	: DPL23865	Sample Collected Date	: 24/Mar/2024 11:46AM
Referred BY	: SELF	Report Generated Date	: 26/Mar/2024 06:36PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CYTOPATHOLOGY

LIQUID BASED CYTOLOGY - PAP SMEAR

CASE NO:	LBC /77/2024
SPECIMEN:	LBC fluid. Received 14.0 ml of fluid with brush. Single smear prepared from the cyto centrifuged sediment and stained with pap's stain.
MICROSCOPIC EXAMINATION:	Satisfactory for Evaluation Transformation zone: Absent Squamous cellularity: Adequate Inflammatory change: Moderate Negative for intraepithelial lesion or malignancy (NILM)
DIAGNOSIS:	**Negative for intraepithelial lesion or malignancy (NILM)**
ADVICE:	Follow up.

The PAP Smear is not a diagnostic procedure and should not be used as the sole means to evaluate cervical cancer. It is a screening procedure to aid in detection of cervical cancer and its precursors.
The foundation of Liquid Based Cytology (LBC) is that it produces uniform, thin layer slides and minimizes obscuring artefacts as, blood and mucus. On balance, LBC provides consistent improvement compared with conventional PAP testing in specimen adequacy and detection of LSIL and HSIL categories.
Cervico - vaginal cytology is screened & reported as per the Bethesda 2014.

References :

1. Johnson J and Patnick J. 2000. Achievable standards, benchmarks for reporting, and criteria for evaluating cervical cytopathology. Revised 2nd Edition. NHSCSP Publications NHS Cancer Screening Programmes.
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3. Gibb RK, Martens MG. The Impact of Liquid Based Cytology in decreasing the incidence of cervical cancer. Rev Obstet Gynecol 2011; 4(Suppl 1):S2-S11
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***** End Of Report *****

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