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Dr. Animesh Choudhary

MD (Internal Medicine), FCC, FAGE, PGDC, PGCDM, PGDDR
Ex Physician - AIIMS, New Delhi, Fortis Escorts Raipur
Reg. No. CGMC 3583/2011

• मधुमेह • वातरोग • गठियारोग • हृदयरोग • थायराइड • श्वसन रोग • दमा • मोटापा

Mrs. Manisha Pandya 27/03/24
Age - 52y/F

BP - 130/80
P - 98/mt
H - 158 c.m
Wt - 69 kg

K/c/o DM II
Hypothyroidism

CBC - 12.3/4.38/7.34/277
FBS - 95 / PP - 153.0
Creat - 0.90
Urea - 10
Lipid - 176/150/56/90
LFT - 15/23/48
HBA1C - 6.0
T3 - 0.68
T4 - 12.1
TSH - 0.220
Vit B12 - 720
Vit D3 - 24.09
ECW - No Abnormality
FA 52

℞

- Tab Thyrox 75 — Before BF
- Tab Rybelsus 7 mg — before BF
- Tab Swiftcal K2 — दोपहर में

- Cap Gabapin 400 — रात में ×30

Dr. Animesh Choudhary
MD Medicine
Reg. No. CGMC 3583/...

CLINIC RAIPUR

ID: 657
MRS MANISHA PANDYA
Female 52Years

27-03-2024 11:22:15 AM

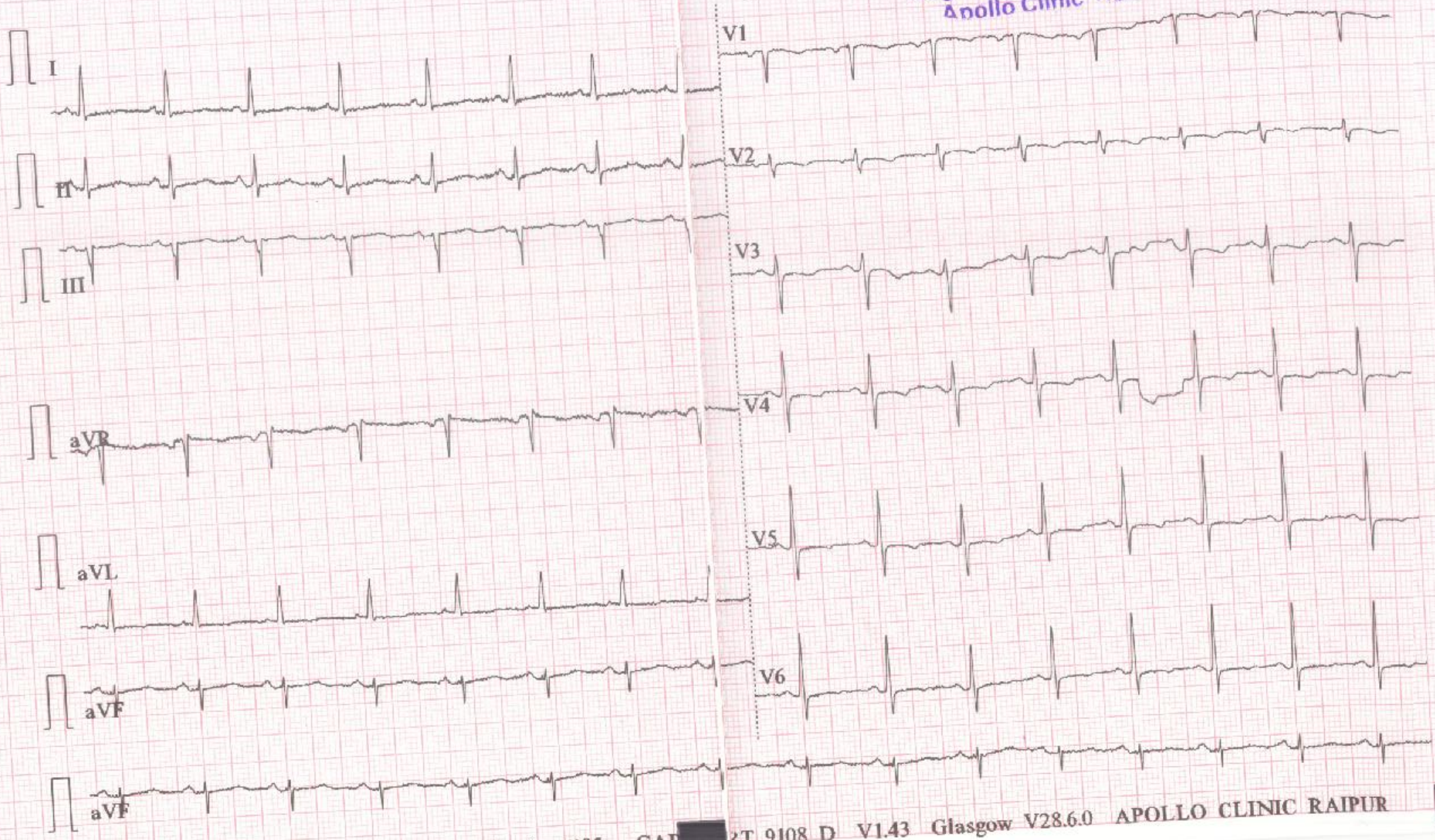
HR	: 95	bpm
P	: 104	ms
PR	: 134	ms
QRS	: 86	ms
QT/QTc	: 370/466	ms
P/QRS/T	: 58/-5/63	°
RV5/SV1	: 1.134/0.585	mV

Diagnosis Information:
Sinus rhythm
Anterolateral T wave abnormality is nonspecific
Borderline ECG

Report Confirmed by:

Dr. Animesh Choudhary
MD Medicine
Reg. No. CGMC 3583/20
Apollo Clinic Rai

APOLLO CLINIC RAIPUR



0.05 45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r ♥95 CAR [redacted]RT 9108 D V1.43 Glasgow V28.6.0 APOLLO CLINIC RAIPUR

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NAME OF PATIENT; MRS. MANISHA PANDEY **AGE: 52YRS/FEMALE**

REFERRED BY: BOB **DATE: 27/03/2024**

CHEST X – RAY PA VIEW

FINDINGS:

- Both the domes of diaphragm and CP angles are normal.
- Both the hila and mediastinum are normal.
- Both the lung fields are clear. No e/o focal parenchymal lesion.
- Cardio-thoracic ratio is normal.
- Soft tissues and bony cage are unremarkable.

IMPRESSION:

- **NO SIGNIFICANT ABNORMALITY SEEN.**

Advised: Clinical correlation and further evaluation if clinically indicated.

Dr. Zeeshan Ateeb Dani
MB[illegible] MD
Consultant
Reg. No. CGMC-[illegible]

APOLLO CLINIC RAIPUR

DR. ZEESHAN ATEEB DANI
(MD)
CONSULTANT RADIOLOGIST

This report is for perusal of the doctor only not the definitive diagnosis; findings have to be clinically correlated. This report is not for medico-legal purposes.

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PATIENT NAME: MRS. MANISHA PANDYA | AGE / SEX: 52 Y/F
REF BY: BOB | DATE: 27/03 /2024

SONOGRAPHY BILATERAL BREASTS

FINDINGS:

- Both breast tissues are symmetrical and appear normal in size and echotexture.
- No evidence of any focal mass lesion or any collection seen.
- Nipple, areola and subareolar region also appear normal.
- Bilateral axilla visualised normal without any evidence of lymphadenopathy.

IMPRESSION:

- **USG BREAST WITHIN NORMAL LIMITS.**

  Advised clinical correlation and further evaluation.

Dr. Zeeshan Ateeb Dani
MBBS, M.D.
Consultant Radiologist
Reg. No. CGMC

APOLLO CLINIC RAIPUR

DR. ZEESHAN ATEEB DANI

(MD)

CONSULTANT RADIOLOGIS

This report is for perusal of the doctor only not the definitive diagnosis; findings have to be clinically correlated. Ultrasound has its limitations in obese patients and in retroperitoneal organs. All congenital abnormalities cannot be detected on ultrasound. Sex of the fetus is not determined here. This report is not for medico-legal purposes.

* Only large obvious hypo/anechoic mass lesion can be diagnosed by USG. Mammography/breast MRI are much more sensitive and specific imaging modalities for evaluation of breast parenchyma & breast lesion. Advised further evaluation with these imaging modalities if clinically indicated/strong suspicion of breast lesion.

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PATIENT NAME: MRS. MANISHA PANDYA | AGE / SEX: 52 YRS/F
REF BY: BOB | DATE: 27.03.2024

USG ABDOMEN

Liver: Liver is normal in size smooth in outline & echotexture. IHBR's are not dilated. CBD is not dilated. Portal vein and hepatic veins are normal.

Gall bladder: - Distended & normal.

Pancreas & Paraaortic Region: Normal.

Spleen: Is normal in size measures cm, and echotexture.

Kidneys	RIGHT	LEFT
SIZE	10.14X4.05Cm	10.16x4.49Cm
CORTICAL ECHOGENICITY	Normal	Normal
CORTICOMEDULLARY DIFFERENTIATION	Maintained	Maintained
PCS	Not Dilated	Not Dilated
Any other remarks	Nil	Nil

Urinary bladder: Distended & normal.

Uterus is normal in size (7.93 x 4.08 x 3.17 cm, Vol. – 53 cc) and echotexture. Endometrial thickness 5.4 mm.
Right Ovary: Normal in size (3.33 x 1.95 cm), shape and echotexture.
Left Ovary: Normal in size (3.92 x 2.30 cm), shape and echotexture.
No evidence of free fluid in abdomen or pelvis.

IMPRESSION:

USG abomen within normal limit.

Advised clinical correlation/further evaluation if clinically indicated.

Dr. Zeeshan Ateeb Dani
MBBS, MD
Consultant
Reg. No.

APOLLO CLINIC RAIPUR

DR. ZEESHAN ATEEB DANI
(MD)
CONSULTANT RADIOLOGIST

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ECHOCARDIOGRAPHY REPORT

NAME : MRS. MANISHA PANDYA	Age/Sex: 52Yrs/female	ECG : Sinus Rhythm
OPD/ IPD : OPD	STUDY DATE: 27/03/2024	REGN. NO. : FRAI.0000020604
Ref.By Dr : BOB		

M-MODE MEASUREMENTS:-

	Patient Value (cm)	Normal Value (cm)		Patient Value (cm)	Normal Value (cm)
AorticRoot Diameter	3.0	2.0 – 3.7	IVS Thickness	ED = 1.1 ES = 1.5	0.6 – 1.1
AorticValve Opening	1.7	1.5 – 2.6	PW Thickness	ED = 1.1 ES = 1.5	0.6 – 1.1
LA Dimension	3.2	1.9 – 4.0	RA Dimension	---	2.6
LVID(D)	4.1	3.7 – 5.5	RV Dimension	---	2.6
LVID(s)	2.6	2.2 – 4.0	TAPSE	----	1.6 – 2.6
LV EJECTION FRACTION		> 60%	(NORMAL VALUE: 55 – 60%)		

2D ECHO, COLOR FLOW & DOPPLER ASSESSMENT

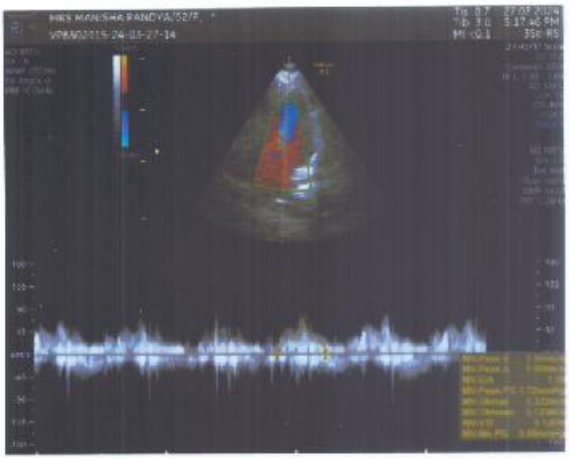
Left Ventricle	: LV Size & contractility is Normal, NO RWMA, Calculated EF IS > 60%
Left Atrium	: LA Size Is Normal
Right Ventricle	: Normal
Right Atrium	: Normal
IAS/IVS	: Intact
Pericardium	: Normal, there is no Pericardial Effusion.
Mitral Valve	: E<A , Normal
Tricuspid Valve	: TRACE TR
Aortic Valve	: Normal
Pulmonary Valve	: Pulmonary valve appears normal in morphology.
Systemic venous	: IVC normal in size with normal Inspiratory collapse.

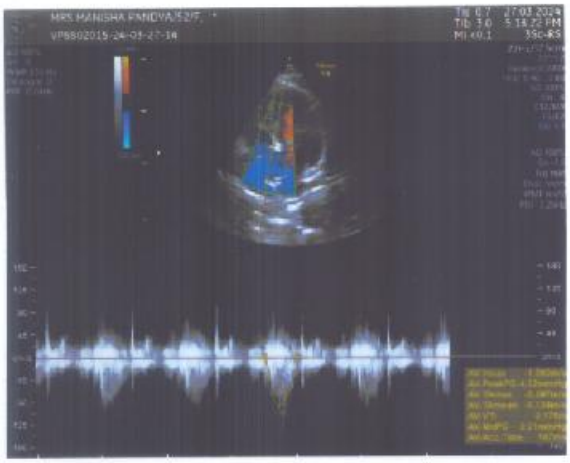
FINAL IMPRESSION : NO RWMA AT REST.
NORMAL LV SYSTOLIC FUNCTION.
TRACE TRICUSPID REGURGITATION
LV DIASTOLIC DYSFUNCTION GRADE I
NO I/C CLOT VEGITATION OR PERICARDIAL EFFUSION.

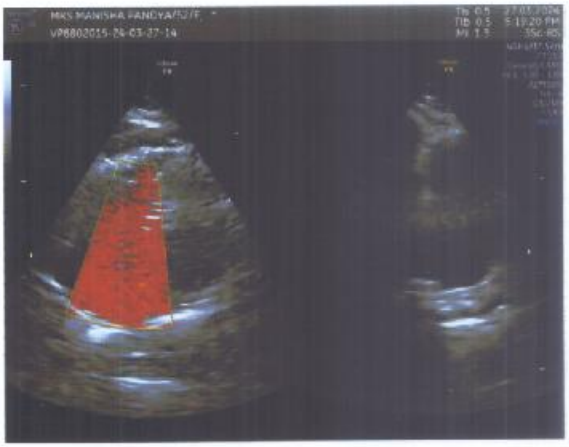
APOLLO CLINIC RAIPUR

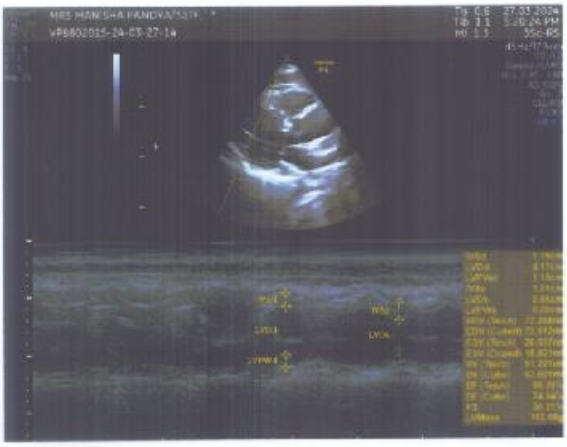
DR.DEEPAN DAS
MBBS, DIP. CARDIOLOGY
CONSULTANT DEPT.OF NIC

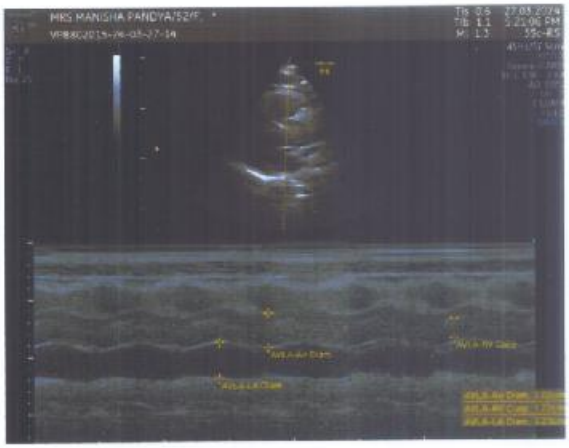
*THIS PAPER IS USED FOR CLINICAL REPORTING PURPOSE ONLY

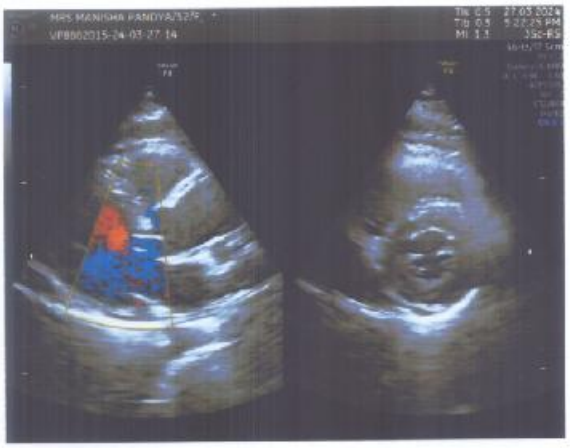


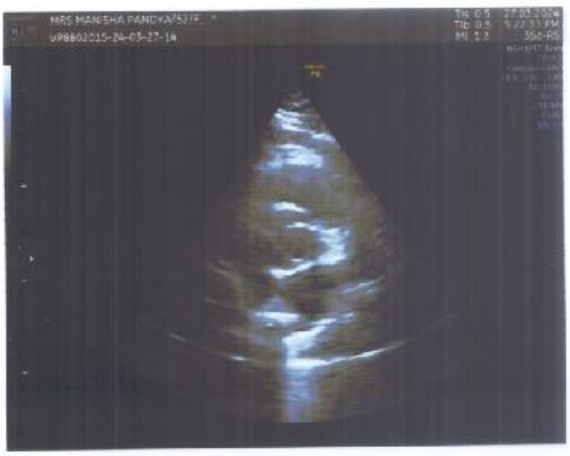


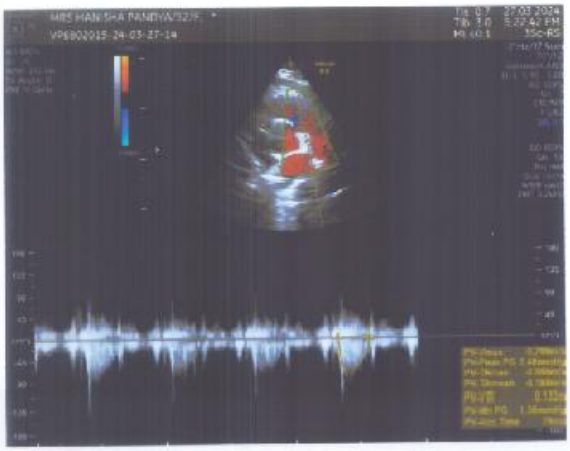












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EXAMINATION OF EYES :-(BY OPHTALMOLOGIST)

Patient Name ..Mrs. Manisha Pandya Date..27/03/24.....

Sex/Age ..F/52 Year MR No ..... Employee Id .....

EXTERNAL EXAMINATION			
SQUINT		NO	
NYSTAGMUS			
COLOUR VISION		NORMAL	
FUNDUS:(RE):-	WNL	(LE):-	WNL
INDIVIDUAL COLOUR IDENTIFICATION		Normal	
DISTANT VISION:(RE):-	6/6	(LE):-	6/12 E 6/6
NEAR VISION:(RE):-	N18 E N6	(LE):-	N18 E N6
NIGHT BLINDNESS		NAD	

	SPH	CYL	AXIS	ADD
RIGHT				+2.25
LEFT	-	-1.0	90	+2.25

REMARKS :-

Dr. Vikas Mishra
MBBS,MS(Ophthalmologist)
Reg. No. CGMC 621/2006

APOLLO RAIPUR

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Patient Name	: MRS MANISHA PANDYA	Age/Gender	: 52 Y Female
UHID/ MR No	: 9938	OP Visit No	: OPD-UNIT-II-2
Visit Date	: 27/03/2024	Reported On	: 27/03/2024 06:43PM
Sample Collected On	: 27/03/2024 02:01PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
HEMOGRAM			
Haemoglobin(HB) Method: CELL COUNTER	12.3	gm/dl	12 - 16
Erythrocyte (RBC) Count Method: CELL COUNTER	4.38	mill/cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	36.90	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	84.2	fL	76.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	28.1	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	18.4	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	7.34	cells/cumm	3.50 - 11.00
Neutrophils Method: CELL COUNTER	69	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	25	%	15.0 - 45.0
Eosinophils Method: CELL COUNTER	02	%	1-6%
Monocytes	04	%	4.0 - 12.0
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report

Results are to be corelated clinically

Lab Technician / Technologist

path

DR DHANANJAY RAMCHANDRA PRASA
M.D. PATHOLOGY

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Sponsor Name	:		

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count Method: CELL COUNTER	277	lacs/cu.mm	150-400
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	14	mm /HR	0 - 20

Blood Group (ABO Typing)

Blood Group (ABO Typing)	O		
RhD factor (Rh Typing)	NEGATIVE		

End of Report
Results are to be corelated clinically

Lab Technician / Technologist
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Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
GLUCOSE - (POST PRANDIAL)			
Glucose -Post prandial Method: REAGENT GRADE WATER	153.0	mg/dl	70-140
GLUCOSE (FASTING)			
Glucose- Fasting SUGAR REAGENT GRADE WATER	95.0	mg/dl	70 - 120
KFT - RENAL PROFILE - SERUM			
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	10	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	0.90	mg/dl	0.6-1.4
Uric Acid Method: Spectrophotomatric	5.2	mg/dL	2.6 - 7.2

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UHID/ MR No	: 9938	OP Visit No	: OPD-UNIT-II-2
Visit Date	: 27/03/2024	Reported On	: 27/03/2024 06:43PM
Sample Collected On	: 27/03/2024 02:01PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	176.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	150.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotomatric HDL Cholesterol	56.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotomatric LDL Cholesterol	90	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very HiOptimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=1
Method: Spectrophotomatric VLDL Cholesterol	30	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	3.14		3.5 - 5
Methode: Spectrophotometric			

End of Report

Results are to be corelated clinically

Lab Technician / Technologist
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Ref. Doctor	: SELF		
Sponsor Name	:		

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	0.8	mg/dl	0.1-1.2
Bilirubin - Direct Method: Spectrophotometric	0.3	mg/dl	0.05-0.3
Bilirubin (Indirect) Mathod: Calculated	0.50	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	15	U/L	0 - 32
SGPT (ALT) Method: Spectrophotometric	23	U/L	0 - 33
ALKALINE PHOSPHATASE	48	U/L	
Total Proteins Method: Spectrophotometric	6.5	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.3	mg/dl	3.4 - 5.0
Globulin Mathod: Calculated	2.7	g/dl	1.8 - 3.6
A/G Ratio Mathod: Calculated	1.59	%	1.1 - 2.2

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Sample Collected On	: 27/03/2024 02:01PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

CLINICAL PATHOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
URINE ROUTINE EXAMINATION			
Physical Examination			
Volum of urine	30ML		
Appearance	Clear		Clear
Colour	Pale Yellow		Colourless
Specific Gravity	1.020		1.001 - 1.030
Reaction (pH)	5.0		
Chemical Examination			
Protein(Albumin) Urine	Absent		Absent
Glucose(Sugar) Urine	Absent		Absent
Blood	Absent		Absent
Leukocytes	Absent		Absent
Ketone Urine	Absent		Absent
Bilirubin Urine	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite (Urine)	Absent		Absent
Microscopic Examination			
RBC (Urine)	0-1	/hpf	0 - 2
Pus cells	2-4	/hpf	0 - 5
Epithelial Cell	Occasional	/hpf	0 - 5
Crystals	Not Seen	/hpf	Not Seen
Bacteria	Not Seen	/hpf	Not Seen
Budding yeast	Not Seen	/hpf	

End of Report

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Patient Name	: Mrs.MANISHA PANDYA	Collected	: 27/Mar/2024 12:53PM
Age/Gender	: 52 Y 0 M 0 D /F	Received	: 27/Mar/2024 01:42PM
UHID/MR No	: DSUS.0000006992	Reported	: 27/Mar/2024 02:49PM
Visit ID	: DSUSOPV8135	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C (GLYCATED HEMOGLOBIN) , *WHOLE BLOOD EDTA*				
HBA1C, GLYCATED HEMOGLOBIN	6.0	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	126	mg/dL		Calculated

Comment:

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

	HBA1C %
REFERENCE GROUP	
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

1. HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
2. Trends in HbA1C values is a better indicator of Glycemic control than a single test.
3. Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
4. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
5. In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
   A: HbF >25%
   B: Homozygous Hemoglobinopathy.
   (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)

*THIS PAPER IS USED FOR CLINICAL REPORTING PURPOSE ONLY

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Consultant Pathologist

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Patient Name	: Mrs.MANISHA PANDYA	Collected	: 27/Mar/2024 12:53PM
Age/Gender	: 52 Y 0 M 0 D /F	Received	: 27/Mar/2024 04:41PM
UHID/MR No	: DSUS.0000006992	Reported	: 27/Mar/2024 05:26PM
Visit ID	: DSUSOPV8135	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , *SERUM*				
TRI-IODOTHYRONINE (T3, TOTAL)	0.68	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	12.1	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	0.220	µIU/mL	0.35-5.5	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

*** End Of Report ***

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Patient Name	: Mrs.MANISHA PANDYA	Collected	: 27/Mar/2024 05:33PM
Age/Gender	: 52 Y 0 M 0 D /F	Received	: 27/Mar/2024 06:07PM
UHID/MR No	: DSUS.0000006994	Reported	: 27/Mar/2024 06:52PM
Visit ID	: DSUSOPV8137	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12 , *SERUM*	720	pg/mL	180–914	CLIA

Comment:

- Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes.
- The most common cause of deficiency is malabsorption either due to atrophy of gastric mucosa or diseases of terminal ileum. Patients taking vitamin B12 supplementation may have misleading results.
- A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 .
- The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.
- Increased levels can be seen in Chronic renal failure, Congestive heart failure, Leukemias, Polycythemia vera, Liver disease etc.

*** End Of Report ***

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Patient Name	: Mrs.MANISHA PANDYA	Collected	: 27/Mar/2024 05:33PM
Age/Gender	: 52 Y.0 M 0 D /F	Received	: 27/Mar/2024 06:07PM
UHID/MR No	: DSUS.0000006994	Reported	: 27/Mar/2024 06:44PM
Visit ID	: DSUSOPV8137	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN D (25 - OH VITAMIN D) , *SERUM*	24.09	ng/mL	30-100	CLIA

Comment:

BIOLOGICAL REFERENCE RANGES

VITAMIN D STATUS	VITAMIN D 25 HYDROXY (ng/mL)
DEFICIENCY	<10
INSUFFICIENCY	10 – 30
SUFFICIENCY	30 – 100
TOXICITY	>100

The biological function of Vitamin D is to maintain normal levels of calcium and phosphorus absorption. 25-Hydroxy vitamin D is the storage form of vitamin D. Vitamin D assists in maintaining bone health by facilitating calcium absorption. Vitamin D deficiency can also cause osteomalacia, which frequently affects elderly patients.

Vitamin D Total levels are composed of two components namely 25-Hydroxy Vitamin D2 and 25-Hydroxy Vitamin D3 both of which are converted into active forms. Vitamin D2 level corresponds with the exogenous dietary intake of Vitamin D rich foods as well as supplements. Vitamin D3 level corresponds with endogenous production as well as exogenous diet and supplements.

Vitamin D from sunshine on the skin or from dietary intake is converted predominantly by the liver into 25-hydroxy vitamin D, which has a long half-life and is stored in the adipose tissue. The metabolically active form of vitamin D, 1,25-di-hydroxy vitamin D, which has a short life, is then synthesized in the kidney as needed from circulating 25-hydroxy vitamin D. The reference interval of greater than 30 ng/mL is a target value established by the Endocrine Society.

Decreased Levels:
Inadequate exposure to sunlight.
Dietary deficiency.
Vitamin D malabsorption.
Severe Hepatocellular disease.
Drugs like Anticonvulsants.
Nephrotic syndrome.

Increased levels:
Vitamin D intoxication.

*** End Of Report ***

Result/s to Follow:
VITAMIN B12

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Diploma in ART and Reproductive Medicine (UKSH, Germany)
Ex. Consultant Gynecology (Shri Balaji Hospitals, Mova, Raipur)
Reg. No. CGMC 4071
Laparoscopic Surgeon & Infertility Specialist

27/03/2024

Mrs. Manisha 52 F

K/c/o Diabetes / Hypothyroidism / Asthma

Rx (pre l8os) TT done

(menopausal for 8 mths)

PAP smear (Done last year) Not willing to get it done

Vit D3 levels - 24 (↓)

Cap. Dolmia D3 60K weekly x 8 wks

Continue with Entical 60K sachets as advised