Name : **Mr. RAMPAL S/o**		**UHID :** 131786	**PID :** 36188
Age/Gender : 51 Year/Male		**Sample Date :** 14-Sep-2024	10:28 AM
Ref. By Dr. : MEDIWHEEL		**Report Date :** 14-Sep-2024	
Address : ADAMPUR		**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range
HEAMATOLOGY			
CBC (Complete Blood Count)			
Haemoglobin (Hb)	14.6	g/dl	12.0 - 17.4 g/dl
Total RBC Count	5.32	m/cumm	4.70 - 6.10
Haematocrit	**50.5**	%	35.0 - 50.0 %
Mean Cell Volume	95.0	fL	80.0 - 100 fL
Mean Cell Haemoglobin	**36.9**	pg	27.0 - 34.0 pg
Mean Cell Haemoglobin Conc	**38.8**	%	32.0 - 36.0
Red Cell Distribution Width (RDW)-CV	12.8	%	11.0 - 16.0 %
Red Cell Distribution Width (RDW)-SD	49.0	fL	35.0 - 56.0 fL
-			
Total Leucocyte Count	5370	cells/cumm	4000 - 11000
Differential Leucocyte Count	.		
Neutrophils	50	%	32 - 72 %
Lymphocytes	45	%	20 - 50 %
Monocytes	03	%	2 - 11 %
Eosinophils	02	%	1 - 3 %
Basophils	0	%	0 - 2 %
Platelet Count	2,87,000	cells/cumm	150,000 - 450,000
Platelet Distribution Width	**14.2**	fL	15.0 - 18.0 fL
Mean Platelet Volume	9.4	fL	7.0 - 13.0 fL

Sample Type : Whole Blood

1.Spurious elevation of platelet count may be seen in patients with extensive burns, extreme microcytosis ,microangiopathic hemolytic anemia, red cell fragmentation ,micro-organisms like bacteria, fungi or yeast, hyperlipidemia, fragments of white blood cell (WBC) cytoplasm in patients with acute leukemia, hairy cell leukemia, lymphomas and in presence of cryoglobulins.
2.Spuriously low platelet counts may be seen in cases of platelet clumping (EDTA induced , platelet cold agglutinins , multiple myeloma) , platelet satellitism and in giant platelet syndromes.
3.Delay in processing due to sample transport may cause a mild time dependent fall in platelet count. It is advisable to repeat the test using a citrate / heparin collection tube to avoid this pitfall.
4. Automated platelet counting is subject to 10-15% variation in the result on the same as well as different analysers due to various preanalytic variables like the sampling site ,skill in sample collection, anticoagulant used ,sample mixing and sample transport etc.

ABO Blood Grouping

Blood Group	A"POSITIVE		

Haemagglutination reaction
A Rh Positive,B Rh Positive,AB Rh Positive,O Rh Positive,A Rh Negative,B Rh Negative,AB Rh Negative,O Rh Negative

Sample Type : Whole Blood

HBA1C

HBA1C	5.3	%	4.27 - 6.00 %

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Address	**:** ADAMPUR	**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range
HBA1C			
turbidimetric immunoassay Average Blood Glucose turbidimetric immunoassay	105.41	mg/dl	90.00 - 120.00 mg/dl
Sample Type : Whole Blood			

Remarks :
GLYCOSYLATED HEMOGLOBIN (HbA1c)
Reference Range : Please correlate with clinical conditions.
Bellow 6.0 % Normal value
6.0 %-7.0 % Good control
7.0 %-8.0 % Fair control
8.0 %-10 % Unsatisfactory control
Above10 % Poor control
Technology : Immunoassay and chemistry technology to measure A1C and total HB (A1C now Bayer)
AVERAGE BLOOD GLUCOSE (ABG) CALCULATED

Reference Range: Please correlate with clinical conditions.
90-120 mg/dl Excellent control
121-150 mg/d Good control
151-180 mg/dl Average control
181-210 mg/dl Action suggested
> 211 mg/dl Panic values
NOTE: Average blood glucose value is calculated from HbA1C value and it indicates average blood sugar level over past three months.
Technology: Derived from Hb A1C Values
Sample Type: Sodium heparin:

ESR			
ESR	10	mmHr	0 - 15 mmHr
Sample Type : Whole Blood			

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Address	**:** ADAMPUR	**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range

CLINICAL COMMENTS:
Erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specifictest that indirectly measures the degree of
inflammation present in the body. Inflammation is part of the body's immune response. It can be acute, developing rapidly after trauma,
injury or infection, for example, or can occur over an extended time (chronic) with conditions such as autoimmune diseases or cancer.
Moderately elevated ESR occurs with inflammation but also with anemia, infection, pregnancy, and with aging. A very high ESR usually has
an obvious cause, such as a severe infection, marked by an increase in globulins, systemic vasculitis, polymyalgia rheumatica or temporal
arteritis. People with multiple myeloma or Waldenstrom's macroglobulinemia (tumors that make large amounts of immunoglobulins) typically
have very high ESRs even if they don't have inflammation.
Factors increasing ESR:
Advanced age
Anemia
Pregnancy
High fibrinogen
Macrocytosis
Kidney problems
Thyroid disease
Some cancers, such as multiple myeloma
Infection
Factors decreasing ESR
Microcytosis
Low fibrinogen
Polycythemia
Marked leukocytosis

CLINICAL-CHEMISTRY

URIC ACID

Uric acid	4.99	mg/dL	3.5 - 7.2
Uricase - POD			
Sample Type : SERUM			

URIC ACID: Increases in case of renal failure, disseminated neoplasms, pregnancy toxaemia, psoriasis, liver disease, sarcoidosis etc. Decrease is reported in Wilson's disease, Fanconi's syndrome,
xanthinuria.

Total Protein

Total Protein	6.9	gm/dl	6.0 - 8.3
BIURET			
Albumin	4.12	g/dl	2.9 - 4.5
BCG			
Globulin	2.78	gm/dl	2.0 - 3.5
Albumin-Globulin Ratio	1.34		1.2 - 2.5

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Age/Gender : 51 Year/Male		**Sample Date :** 14-Sep-2024	10:28 AM
Ref. By Dr. : MEDIWHEEL		**Report Date :** 14-Sep-2024	
Address : ADAMPUR		**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range
Sample Type : SERUM			
UREA. SERUM			
UREA	23.28	mg/dL	14 - 51
KINETIC METHOD WITH UREASE AND GLDH			
Sample Type : SERUM			
UREA: High urea levels suggest poor kidney function, congestive heart failure, shock, stress, recent heart attack or severe burns; bleeding from the gastrointestinal tract; conditions that cause obstruction of urine flow; or dehydration. Low urea levels can be seen in severe liver disease or malnutrition but are not used to diagnose or monitor these conditions. Low urea levels are also seen in normal pregnancy.			
CREATININE SERUM			
CREATININE SERUM	1.2	mg/dL	0.5 - 1.4 mg/dL
Jaffe Kinetic			
Sample Type : SERUM			
CREATININE: Increases in any renal functional impairment (intrinsic renal lesions, decreased perfusion of the kidney, or obstruction of the lower urinary tract), acromegaly and hyperthyroidism. Decreases in pregnancy, muscle wasting.			
LIVER FUNCTION TEST (LFT) (S)			
Total Bilirubin-Serum	0.90	mg/dl	0.20 - 1.00 mg/dl
Bilirubin Direct Serum	0.40	mg/dl	0.10 - 0.50 mg/dl
Bilirubin Indirect-Serum	0.50	mg/dl	0.20 - 0.70 mg/dl
SGOT	18.6	IU/L	10 - 40 IU/L
IFCC with Pyridoxal Phosphate			
SGPT	24.1	IU/L	07 - 56 IU/L
IFCC with Pyridoxal Phosphate			
Alkaline Phosphatase	85.3	U/L	44 - 147 U/L
IFCC PNPP Buffer			
Total Protein	6.9	gm/dl	6.0 - 8.3
BIURET			
Albumin	4.12	g/dl	3.5 - 5.5 g/dl
BCG			
Globulin	2.78	gm/dl	2.0 - 3.5 gm/dl
AG RATIO	1.34		1.2 - 2.5
Sample Type : SERUM			

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Age/Gender :	51 Year/Male	**Sample Date :** 14-Sep-2024	10:28 AM
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Address	**:** ADAMPUR	**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range

CLINICAL COMMENT:
Liver function tests can be suggested in case of hepatitis, liver cirrhosis and monitor possible side effects of medications. A variety of diseases and infections can cause acute or chronic damage to the liver, causing inflammation
(hepatitis), scarring (cirrhosis), bile duct obstructions, liver tumors, and liver dysfunction. Alcohol, drugs, some herbal supplements, and toxins can also inure the liver. A significant amount of liver damage may occur before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarrhea, and unexplained weight loss or gain appear. Early detection of liver injury is essential in order to minimize damage and preserve liver function.
Alanine aminotransferase (ALT) A very high level of ALT is frequently seen with acute hepatitis. Moderate increases may be seen with chronic hepatitis. People with blocked bile ducts, cirrhosis, and liver cancer may have ALT concentrations that are only moderately elevated or close to normal. Aspartate aminotransferase (AST) A very high level of AST is frequently seen with acute hepatitis. AST may be normal to moderately increased with chronic hepatitis. In people with blocked bile ducts, cirrhosis, and liver cancer, AST concentrations may be moderately increased or close to normal. When liver damage is due to alcohol, AST often increases much more than ALT (this is a
pattern seen with few other liver diseases). AST is also increased after heart attacks and with muscle injury.
AST is a less sensitive and less specific marker of liver injury than ALT. AST is more elevated than ALT in alcohol-induced liver injury. AST could elevated more than ALT like: (i)

Lipid Profile

Cholesterol	142.55	mg/dl	<200.0 mg/dl
CHOD - PAP			
Triglycerides	119.0	mg/dl	< 150 mg/dl
GPO - PAP			
HDL Cholesterol	42.3	mg/dl	Adult males >45 mg/dl
Homogeneous Enzymatic Colorimetric test			
LDL Cholesterol	76.45	mg/dl	<100 mg/dl
VLDL Cholesterol	23.8	mg/dl	<30.0 mg/dl
CHO/HDL Ratio	3.37	mg/dl	Low risk 3.3-4.4
Non HDL Cholesterol	100.25	mg/dl	<130 mg/dl
Calculated			

Sample Type : SERUM

Interpretation
Note
1.Measurements in the same patient can show physiological& analytical variations. 3 serial samples 1 wk apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
4. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.

CLINICAL PATHOLOGY

PHYSICAL EXAMINATION

Name	**: Mr. RAMPAL S/o**	**UHID :** 131786	**PID :** 36188
Age/Gender :	51 Year/Male	**Sample Date :** 14-Sep-2024	10:28 AM
Ref. By Dr. :	MEDIWHEEL	**Report Date :** 14-Sep-2024	
Address	: ADAMPUR	**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range
Colour Pale-yellow,Yellowish,Colorless,YELLOW	PALE YELLOW		
Quantity	40	ml	
pH	6.5		
Mucus Absent,Present	ABSENT		
Appearance Slightly turbid,Turbid,Clear	CLEAR		
Chemical Examination (Strip)	.		
Specific Gravity	1.025		
Albumin Absent,Present(+),Present(2+),Present(3+)	NEGATIVE		
Sugar Absent,Present(+),Present(2+),Present(3+)	NEGATIVE		
Bilirubin Absent,Present	NEGATIVE		
Microscopic Examination (Microscopy)	.		
Pus Cells	1-2	/HPF	
Epithelial Cells	0-1	/HPF	
RBC	NIL	/HPF	
Casts	ABSENT		
Crystals	ABSENT		
Bacteria	ABSENT		
Others			
Sample Type : Urine			

Laboratory

Blood Sugar (PP) Blood Sugar PP **Sample Type :** Others	113.4	mg/dl	70.00 - 140.00 mg/dl

GLUCOSE FASTING

Glucose, Fasting **Sample Type :** SERUM	80.3	mg/dl	70 - 110 mg/dl

Name	**: Mr. RAMPAL S/o**		**UHID :** 131786	**S No :**	**PID :** 36188
Age/Gender :	51 Year/Male	**A.S : NP**	**Sample Date :** 14-Sep-2024		10:28 AM
Ref. By Dr. :	MEDIWHEEL		**Report Date :** 14-Sep-2024		07:13 PM
Address	**:** ADAMPUR		**Sample Type :** Inside		*36188*

Test Name	Value	Unit	Reference Range

Criteria for the diagnosis of diabetes (American diabetes association, 2019)

• Fasting Plasma Glucose ≥126 mg/dL. Fasting is defined as no caloric intake for at least 8 h.
OR
• 2-h PG ≥200 mg/dL during OGTT. The test should be performed using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water.*
OR
• HbA1c ≥6.5%.
OR
• Random plasma glucose ≥200 mg/dL in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis .

Criteria defining prediabetes (American diabetes association, 2019)

• FPG 100 mg/dL to 125 mg/dL (Impaired fasting glucose, IFG)
OR
• 2-h PG during 75-g OGTT 140 mg/dL to 199 mg/dL (Impaired glucose tolerance, IGT)
OR
• HbA1c 5.7-6.4%

Note:
All abnormal results must be confirmed with a repeat test on a different day .

ENDOCRINE

Thvroid Hormones (T3 .T4 & TSH)

T3	1.30	ng/ml	0.60 - 1.81 ng/ml
T4	7.75	ng/dl	5.01 - 12.45 ng/dl
TSH Ultrasensitive	1.40	ulU/ml	0.3 - 4.5 ulU/ml

Sample Type : SERUM

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Address	**:** ADAMPUR	**Sample Type :** Inside	*36188*

Test Name	Value	Unit	Reference Range

Remarks :
Note1.TSH levels are subject to circadian variation, reaching peak
levels between 2-4.a.m and at a minium between 6-10 pm. The variation
is of the 50 %, hence time of the day has influence on the measured serum TSH
concentrations.
2. Recommended test for T3 and T4 unbound or free level as it is metabollically active.
3. Physiological rise in Total T3 and T4 level is seen in pregnancy and in patients on
steroid therapy.
Clinical Use-
* Primary Hypothyroidism
* Hperthyroidism
* Hypothalamic- Pituitary hypothyroidism
* Inappropriate-TSH secretion
* Nonthyroidal illness
* Autoimmune thyroid disease
* Pregnency associated thyroid disorders
* Thyroid dysfunction in infancy and early childhood

IMMUNOLOGY

Total PSA	2.13	ng/ml	0.00 - 4.0 ng/ml

Sample Type : SERUM

Summary & Interpretation:
Elevated concentrations of PSA in serum are generally indicative of a patho-logic-condition of the prostate (prostatitis, begin hyperplasia or carcinoma). PSA determinations are employed are the
monitoring of progress and efficiency of therapy in patients with prostate carcinoma or receiving hormonal therapy . An inflammation or trauma of the prostate(e.g. In case of urinary retention or
following rectal examination, cystoscopy, coloscopy, transurethral biopsy, lasertreatment or ergometry)can lead to PSA elevations of varying duration and magnitu

--End of Report--

Lotus Diagnostic
& Imaging Centre
A Unit of Lotus Diagnostic & Imaging Solution Pvt. Ltd.
HB से लेकर MRI तक एक ही छत के नीचे

PATIENT NAME: RAMPAL	AGE/SEX: 51YRS/M
REF. BY: TPA	DATE: SEPTEMBER 14, 2024

X-RAY CHEST PA VIEW

- **Hyperinflatory changes involving bilateral lower lung zones- ? COPD.**
- **Mild blunting of right CP angle.**
- Bilateral domes of diaphragm and left costophrenic angle are normal.
- Cardiac and mediastinal shadow appear normal.
- Bilateral hila appear normal.
- Bony thorax and soft tissue appear normal.

Advised: Clinical correlation and CT Chest for further evaluation

Dr. Rambaksh Sharma
Consultant Radiologist

Dr. Anshul Jain
Consultant Radiologist

Dr. Rajesh Reddu
MBBS, DMRD
Consultant Radiologist

Dr. Amit Verma
Echocardiography Specialist

Dr. Sonam Aneja
Consultant Pathologist

GEETANJALI HOSPITAL

270, Gurudwara Road, Near Post Office, Model Town, Hisar, Haryana
geetanjalihospitalhisar@gmail.com | www.geetanjalihospitalhisar.com
+91-99925-64300, +91-90680 23930

H-2020-0688
Jan 11, 2023 – Jan 10, 2027
Since Jan 11, 2020

Name: Mr. Rampal	AGE: 51 Y/M	UHID. No. 131786
Ref. by: Mediwheel		DATE: 14.09.2024

PCPNDT Reg. No.: HSR-117

USG WHOLE ABDOMEN

(Technique: USG done with 1-5 MHz convex/9 MHz linear probes in spine position)

Liver: is normal in size (12.8cm), outline and shows **fatty changes (Grade-I).** Hepatic vasculature is normal. IHBR are not dilated. No SOL seen.

Gall Bladder: is physiologically distended with anechoic lumen & normal wall thickness. No e/o Ac/chronic cholecystitis seen.

Portal Vein & CBD: normal in course and caliber.

Pancreas: is normal in size, outline and echotexture. PD is not dilated.

Spleen: normal in size, outline and echotexture. No focal solid/cystic lesion seen.

Right Kidney: is normal in size, shape, echotexture & outline. Corticomedullary differentiation is well maintained. No evidence of calculus/hydronephrosis seen.

Left Kidney: is normal in size, shape, echotexture & outline. Corticomedullary differentiation is well maintained. No evidence of calculus/hydronephrosis seen.

Urinary bladder: is normal in distention & wall thickness.

No e/o vesicles calculus/mass seen.

Prostate is normal in size & echotexture. **A cyst is seen measuring approx 6mm**.

No free fluid is seen in abdomen.

Remark: 1. Non obstructing ureteric calculi are usually not visualised on USG.

2. USG is not the modality of choice for bowel pathologies and retroperitoneal evaluation.

IMPRESSION:-

- **Fatty liver (Grade-I)**
- **Prostatic utricle cyst**

Advised: Clinical correlation

Dr. Anshul
MBBS, MD
Reg. No.: HN 21248
Consultant Radiologist

Report Typed By:- Mr. Manish Kumar (Emp. ID – 304) (Time 10:40 AM)

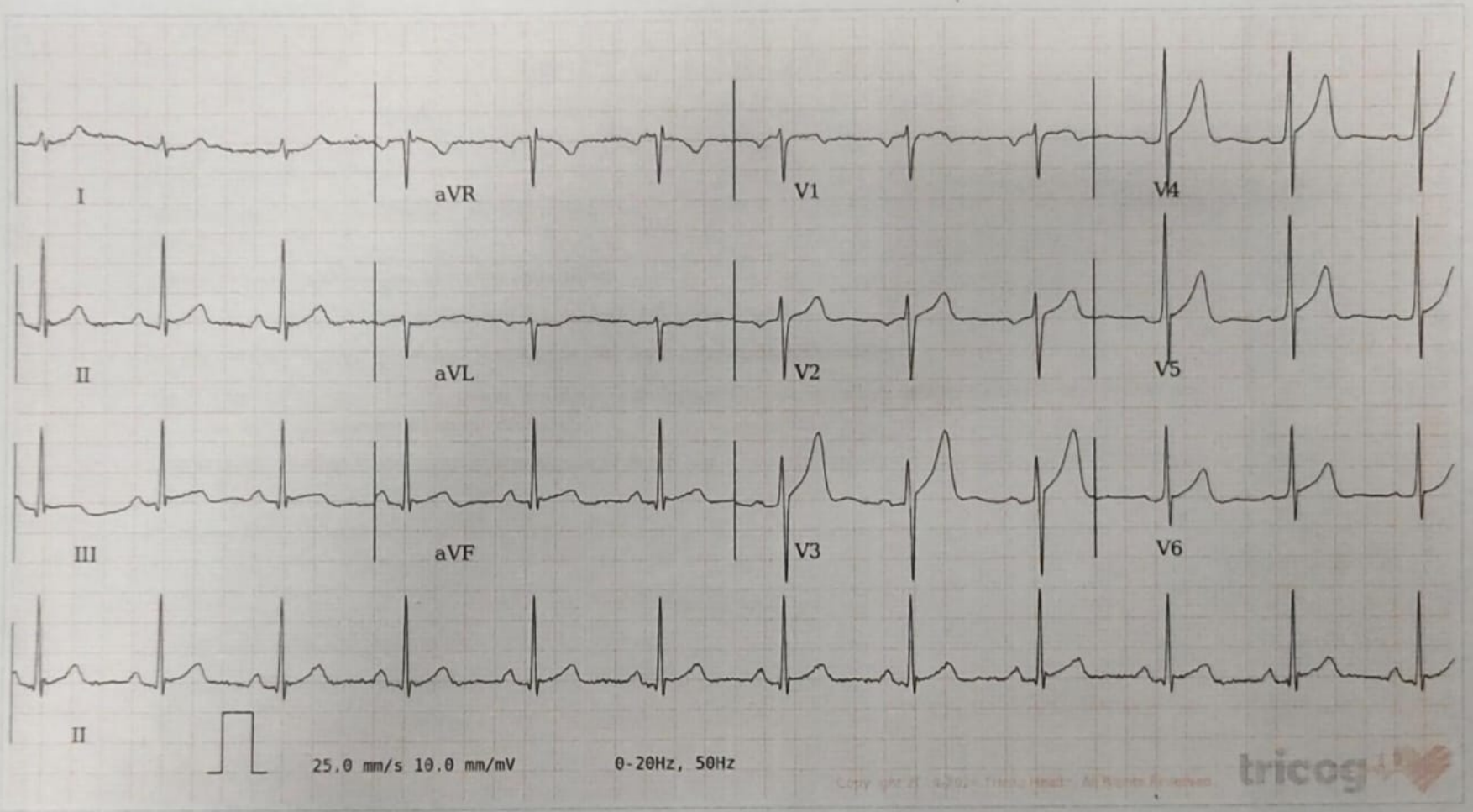
Patient's identity can not be ascertained at present, so this report can not be used for MLC Case.

Disclaimer • Size & position of renal calculi may differ on different occasions. • Ureteric calculi may not be visible in absence of hydronephrosis. • Gall stones may not be visible in contracted state. • All congenital anomalies may not be detectable on routine obstetric scan. • For some foetal anomalies, serial ultrasound examination are required. • For Gynecological disease, transvaginal ultrasound (TVS) shows better results. • Not valid for medico legal purposes. • If the result (s) is/are alarming or unexpected, the patient/consultant is advised to contact Centre immediately for a recheck. • This is only a professional opinion, it may kindly be correlated clinically. • No procedure/surgery is advised on the basis of this report only. • This Report is for the purpose of doctor only.

Lotus Diagnostic & Imaging Centre

Age / Gender: 51/Male
Patient ID: 36188
Patient Name: Rampal

Date and Time: 14th Sep 24 11:18 AM



AR: 71bpm VR: 72bpm QRSD: 84ms QT: 380ms QTcB: 416.27ms PRI: 176ms P-R-T: 74° 87° 43°

Sinus Rhythm.Hyperacute T waves along with J point elevation in leads V3, V4.Suggested further cardiac evaluation based on ECG changes. Please correlate clinically.

Disclaimer: Analysis in this report is based on ECG alone and should only be used as an adjunct to clinical history, symptoms and results of other invasive and non-invasive tests and must be interpreted by a qualified physician.