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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	**12726313**	**Date**	**23/09/2023**		
Name	**Mrs.Rachana Khobragade**	**Sex**	**Female**	**Age**	**40**
OPD	**Pap**	**Health Check Up**			

Drug allergy:
Sys illness:

40 yr Fe, MS 10yr, P2L2, both FTLSCS

C/o - Nil at present.

LMP - 1/9/23

P/MC - 4-5 D / 28-32 D / RMPL

O/H - MS 10yr.
P2L2, both FTLSCS
LCB - 1.5yrs
TL - not done

M/H - NS

S/H - Prev 2 caesarean sect.

Adv

P/A
P/V { NS.

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Hiranandani HOSPITAL
(A Fortis Network Hospital)

UHID	**12726313**	**Date**	**23/09/2023**		
Name	**Mrs.Rachana Khobragade**	**Sex**	**Female**	**Age**	**40**
OPD	**Opthal 14**	**Health Check Up**			

Clear waters (since 1 mth).

H/ear. NO

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

Unaided VA → RE -> 6/36P
LE -> 6/36P

VN → N6
N6

RA → R.E. -> -1.00 / -1.25 X 40° 6/6.
L.E. -> -1.00 / -1.00 X 150° 6/6

Add -> VN → N6
N6

I.O.P → R.E. -> 13.8.
L.E. -> 14.9.

Same as P.H.P

Diagnostic Report

Fortis

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MC-2275

PATIENT NAME : MRS.RACHANA KHOBRAGADE	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI004821** PATIENT ID : FH.12726313 CLIENT PATIENT ID: UID:12726313 ABHA NO :	AGE/SEX :40 Years Female DRAWN :23/09/2023 10:07:00 RECEIVED : 23/09/2023 10:06:40 REPORTED :23/09/2023 11:46:43

CLINICAL INFORMATION :

UID:12726313 REQNO-1585590
CORP-OPD
BILLNO-150123OPCR054543
BILLNO-150123OPCR054543

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

CLINICAL PATH - STOOL ANALYSIS

STOOL: OVA & PARASITE

PHYSICAL EXAMINATION,STOOL

COLOUR METHOD : VISUAL	BROWN		
CONSISTENCY METHOD : VISUAL	WELL FORMED		
MUCUS METHOD : VISUAL	ABSENT	NOT DETECTED	
VISIBLE BLOOD METHOD : VISUAL	ABSENT	ABSENT	

CHEMICAL EXAMINATION,STOOL

OCCULT BLOOD METHOD : GUAIAC ACID METHOD	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION,STOOL

PUS CELLS METHOD : MICROSCOPIC EXAMINATION	0-1		/hpf
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
CYSTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
OVA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
LARVAE METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
TROPHOZOITES METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

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Patient Ref. No. 22000000874088

Diagnostic Report

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MC-2275

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Interpretation(s)

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Dr. Rekha Nair, MD
Microbiologist

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MC-2275

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CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI004856** PATIENT ID : FH.12726313 CLIENT PATIENT ID: UID:12726313 ABHA NO :	AGE/SEX :40 Years Female DRAWN :23/09/2023 12:40:00 RECEIVED : 23/09/2023 12:41:19 REPORTED :23/09/2023 15:37:49

CLINICAL INFORMATION :

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BILLNO-150123OPCR054543

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	87	70 - 140	mg/dL

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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****
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Dr.Akshay Dhotre
Consultant Pathologist

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Patient Ref. No. 22000000874123

Diagnostic Report

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MC-2275

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CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI004815** PATIENT ID : FH.12726313 CLIENT PATIENT ID: UID:12726313 ABHA NO :	AGE/SEX :40 Years Female DRAWN :23/09/2023 09:46:00 RECEIVED : 23/09/2023 09:48:58 REPORTED :23/09/2023 15:12:30

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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	**9.8 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.48	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	8.24	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	**420 High**	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	**32.0 Low**	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	**71.4 Low**	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	**21.9 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	**30.6 Low**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**16.6 High**	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	15.9		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	10.6	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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Consultant Pathologist

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NEUTROPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	62	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	26	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	10	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	2	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	5.11	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.14	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.82	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.16	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	2.4		

MORPHOLOGY

RBC METHOD : MICROSCOPIC EXAMINATION	MILD HYPOCHROMASIA, MILD MICROCYTOSIS, MILD ANISOCYTOSIS
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE

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

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 HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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FORTIS HOSPITAL # VASHI,
MUMBAI 440001

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Test Report Status **Final**

	Results	Biological Reference Interval	Units
HAEMATOLOGY			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R			
METHOD : WESTERGREN METHOD	**50 High**	0 - 20	mm at 1 hr
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	**5.8 High**	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)	**119.8 High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

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

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

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

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

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MUMBAI 440001

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REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG(mg/dl) = 28.7 * HbA1c - 46.7

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

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

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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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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.39	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.08	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.31	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.5	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.5	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	4.0	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	**0.9 Low**	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	17	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	21	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	93	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	20	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	143	81 - 234	U/L
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	83	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL

Dr.Akshay Dhotre
Consultant Pathologist

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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000874082

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MC-2275

PATIENT NAME : MRS.RACHANA KHOBRAGADE **REF. DOCTOR :**

CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WI004815** PATIENT ID : FH.12726313 CLIENT PATIENT ID: UID:12726313 ABHA NO :	AGE/SEX :40 Years Female DRAWN :23/09/2023 09:46:00 RECEIVED : 23/09/2023 09:48:58 REPORTED :23/09/2023 15:12:30

CLINICAL INFORMATION :

UID:12726313 REQNO-1585590
CORP-OPD
BILLNO-150123OPCR054543
BILLNO-150123OPCR054543

Test Report Status **Final**	Results	Biological Reference Interval	Units
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	**5 Low**	6 - 20	mg/dL
CREATININE EGFR- EPI			
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	0.70	0.60 - 1.10	mg/dL
AGE	40		years
GLOMERULAR FILTRATION RATE (FEMALE) METHOD : CALCULATED PARAMETER	112.05	Refer Interpretation Below	mL/min/1.73m2
BUN/CREAT RATIO			
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	7.14	5.00 - 15.00	
URIC ACID, SERUM			
URIC ACID METHOD : URICASE UV	3.1	2.6 - 6.0	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	7.5	6.4 - 8.2	g/dL

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ALBUMIN, SERUM			
ALBUMIN METHOD : BCP DYE BINDING	3.5	3.4 - 5.0	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	4.0	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	138	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.51	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	105	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.

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AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

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

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

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

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

Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.

Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glycosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.
- The GFR is a calculation based on serum creatinine test.
- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.
- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.
- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- This equation takes into account several factors that impact creatinine production, including age, gender, and race.
- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high(>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation-https://testguide.labmed.uw.edu/guideline/egfr
Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325
Harrison''s Principle of Internal Medicine, 21st ed. pg 62 and 334

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.

Dr.Akshay Dhotre
Consultant Pathologist

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Diagnostic Report

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MC-2275

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

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	155	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	39	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	49	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	97	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	106	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	7.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**3.2 Low**	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO	2.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

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Consultant Pathologist

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR METHOD : PHYSICAL	PALE YELLOW	
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**	

CHEMICAL EXAMINATION, URINE

PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	<=1.005	1.003 - 1.035
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	**DETECTED (+)**	NOT DETECTED

Dr.Akshay Dhotre
Consultant Pathologist

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

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MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	3-5	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	**5-7**	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

Interpretation(s)

Dr.Akshay Dhotre
Consultant Pathologist

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM			
T3	104.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	7.98	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	1.170	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

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127263 13
40 Years

rachana khobragade
Female

9/23/2023 11:12:04 AM

HC

Rate	76	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline short PR interval.....PR int <120mS
PR	110	. Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF
QRSD	101	
QT	372	
QTc	419	

--AXIS--

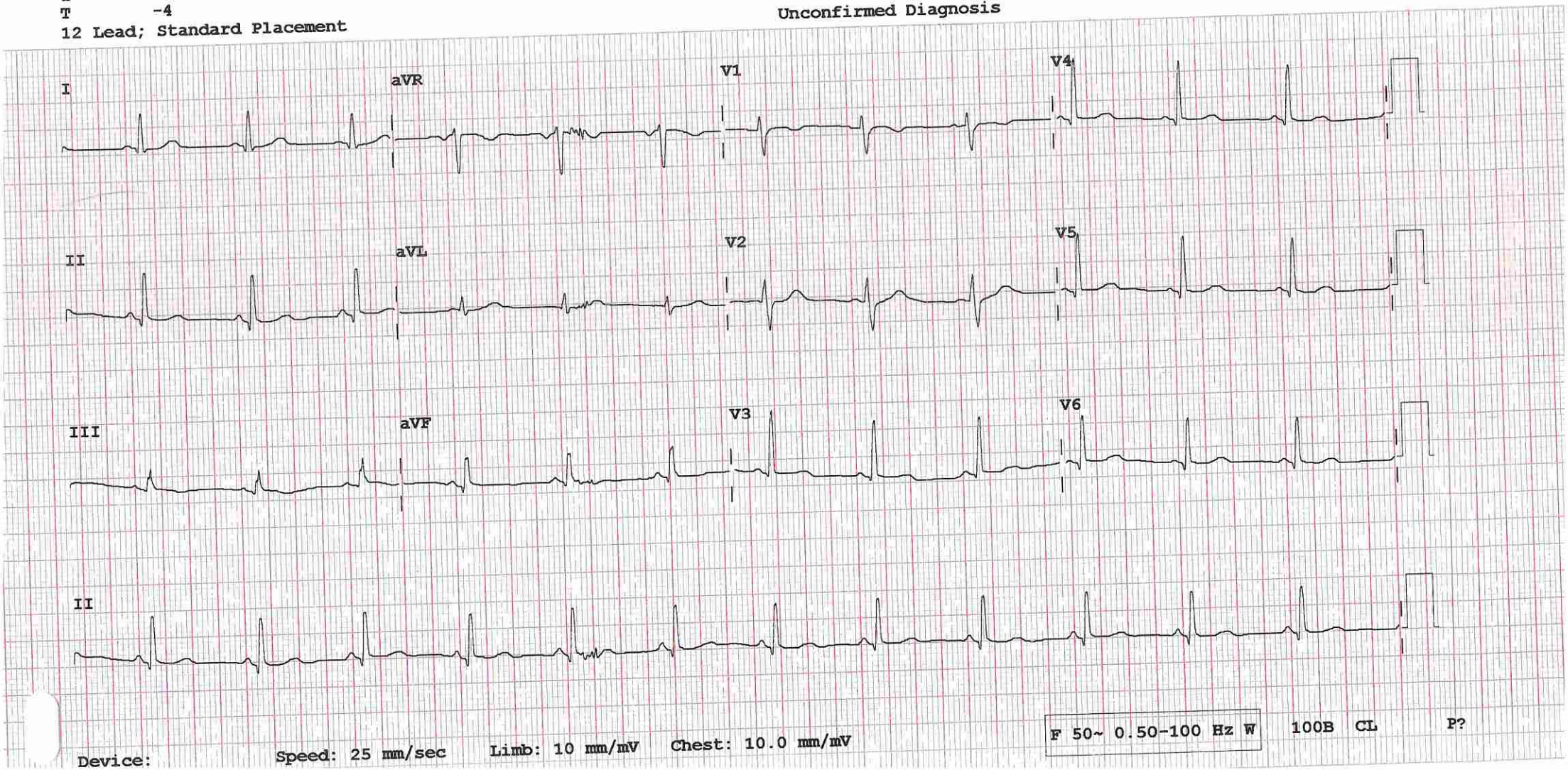
P	54
QRS	54
T	-4

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

Sinus rhythm



Device:

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

F 50~ 0.50-100 Hz W 100B CL P?

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PAN NO : AABCH5894D

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 23/Sep/2023

DEPARTMENT OF RADIOLOGY

Name: Mrs. Rachana Khobragade
Age | Sex: 40 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12726313 | 55218/23/1501
Order No | Order Date: 1501/PN/OP/2309/115130 | 23-Sep-2023
Admitted On | Reporting Date : 23-Sep-2023 12:21:45
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax are unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)

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Patient Name	:	Rachana Khobragade	Patient ID	:	12726313
Sex / Age	:	F / 40Y 3M 14D	Accession No.	:	PHC.6635994
Modality	:	US	Scan DateTime	:	23-09-2023 10:58:59
IPID No	:	55218/23/1501	ReportDatetime	:	23-09-2023 13:47:30

USG – WHOLE ABDOMEN (TAS + TVS)

Suboptimal scan due to gaseous abdominal distension.

LIVER is normal in size and shows mildly raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is minimally distended.
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 9.6 x 4.5 cm.
Left kidney measures 10.3 x 5. cm.

PANCREAS: Head and body of pancreas is visualised and appears normal. Rest of the pancreas is obscured.

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

UTERUS is normal in size, measuring 7.7 x 4.4 x 5.5 cm.
Endometrium measures 10 mm in thickness.

Both ovaries are normal.
Right ovary measures 3.0 x 1.8 cm.
Left ovary measures 3.0 x 1.9 cm.

Minimal free fluid is seen in POD.

Impression:

- **Grade I fatty infiltration of liver.**
  Suggest clinical correlation/ Follow up.

DR. YOGESH PATHADE
M.D. (Radiologist)