UHID	CIMS-13036	Visit Type/No	OP/EPD-18178/EPD-18178
Name	Mr Ashok Kumar	Order No	OR-36349
Age/Gender	52 Y/Male	Order Date/Time	29-05-2024
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Haematology

Service Name	Result	Unit	Reference Range	Method
BLOOD GROUP (ABO)				
BLOOD GROUP (ABO)-	"AB'			
RH TYPING	POSITIVE			
The upper agglutination test for grouping has some limitations.				
CBC (Complete Blood Count), Blood				
Hemoglobin (Hb)	13.0	gm/dl	13-17	Spectrophotometry
TLC (Total Leukocyte Count)	6800	/cumm	4000-11000	Impedance
DIFFERENTIAL LEUCOCYTE COUNT				
Neutrophils	55	%	40-80	
Lymphocytes	38	%	20-45	
Monocytes	06	%	4-10	
Eosinophils	01	%	1-6	
Basophils	00	%	0-1	
RBC Count	**4.22 L**	millions/cumm	4.5-5.5	
PCV / HCt (Hematocrit)	**38.0 L**	%	40-45	Calculated
MCV	90.1	fl	76-96	
MCH	30.8	pg	27-32	
MCHC	34.2	g/dL	30-35	
Platelet Count	1.75	lakh/cumm	1.5-4.5	Impedance
RDW	12.9	%	1-15	
ESR (Erythrocyte Sedimentation Rate), **Blood**	10	mm 1st Hr.	0-10	Wintrobe

Clinical Biochemistry

Service Name	Result	Unit	Reference Range	Method
VITAMIN B12 CYANOCOBALAMIN, **Serum**	335.0	pg/mL	200-1100	CLIA

Near Radha Valley, NH-19, Mathura-281001 CIMS

CIMS
City Institute of Medical Sciences
(Multi Super Speciality 200 Bedded Hospital)

DEPARTMENT OF RADIOLOGY

NAME: ASHOK KUMAR	AGE : 52 YRS.	SEX : M
REF. BY: DR. SELF	UHID: 13036	DATE: 29-05-2024

ULTRASOUND SCAN OF ABDOMEN

FINDINGS:

Liver is normal in size (15.0 cm). **Echotexture is slightly echogenic.** No focal space occupying lesion is seen within liver parenchyma. Intrahepatic biliary channel are not dilated. Portal vein is normal in caliber.

Gall bladder wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal in size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas. (Only head & proximal body is visualized)

Spleen is normal in size (10.2 cm). Echotexture is normal. No focal Lesion is seen.

Right kidney is normally sited and is of normal size (RT ~ 10.7 x 4.8 cm) and shape. Cortico medullary echoes are normal. No focal mass lesion is seen. Collecting system does not show any calculus.

Left kidney is normally sited and is of normal size (LT ~ 11.2 x 4.9 cm) and shape. Cortico medullary echoes are normal. No focal mass lesion is seen. Collecting system does not show any calculus.

Urinary bladder is partial in distension and wall is not thickened. No calculi seen.

Prostate is normal in size and normal in echotexture.

No free fluid seen in peritoneal cavity.

IMPRESSION-

- GRADE I FATTY CHANGES IN LIVER.

PLEASE CORRELATE CLINICALLY & F/E.

DR. ABHAY BAINA
M.B.B.S., D.N.B (RADIO-DIAGNOSIS)
CONSULTANT RADIOLOGIST

Note: Impression is a professional opinion and not a diagnosis. All modern machine/procedures have their limitations if there is variance clinically this examination may be repeated or re-evaluated by other investigations. Kindly intimate us for any typing mistakes and return the report for correction within 7days.
NOT VALID FOR MEDICO-LEGAL PURPOSE.

Near Radha Valley, NH-19, Mathura
+91 - 9258113570, +91 - 9258113571
www.cimsmathura.com

DEPARTMENT OF CARDIOLOGY

Name	: MR.ASHOK KUMAR	Age/Sex	: 52Yrs/ Male
Date	: 29/05/2024	ID No.	: CIMS-13036
Done By	: DR. ARPIT AGARWAL		

ECHOCARDIOGRAPHY

- All Cardiac chamber normal size.
- Normal LV systolic function, LVEF ~ 60%.
- No RWMA
- **Grade I/IV DDF.**
- **Trace MR.**
- **Trivial AR.**
- **Trace TR.**
- RVSP=RAP+14mmHg
- Normal AFV
- Intact IAS/IVS.
- **Minimal pericardial effusion posterior to RA**. No clot/vegetation.
- IVC non-dilated & collapsing > 50% during inspiration.

CLINICAL IMPRESSION:

- Normal LV systolic function, LVEF ~ 60%.
- No RWMA
- **Grade I/IV DDF.**
- **Trace MR.**
- **Trivial AR.**
- **Trace TR.**
- No PHT, PASP = 19mmHg.
- **Minimal pericardial effusion posterior to RA**

Radha Valley, NH-19, Mathura CIMS

Dr. ARPIT AGARWAL
MBBS, MD, DM (CARDIOLOGY)
Consultant Intervention Cardiologist
Ex. Fortis Escort Heart Institute, Delhi

NOTE: Normal Echocardiography report does not rule out CAD.
This report is not valid for Medico-Legal purpose.

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Service Name	Result	Unit	Reference Range	Method
Note	:To differentiate vitamin B12 & folate deficiency, measurement of Methyl malonic acid in urine & serum. Homocysteine level is suggested			

Comments:
Vitamin B12 performs many important functions in the body, but the most significant function is to act as coenzyme for reducing ribonucleotides to deoxyribonucleotides, a step in the formation of genes.Inadequate dietary intake is not the commonest cause for cobalamine deficiency. The most common cause is malabsorption either due to atrophy of gastric mucosa or diseases of terminal ileum. Cobalamine deficiency leads to Megaloblastic anemia and demyelination of large nerve fibres of spinal cord. Normal body stores are sufficient to last for 3-6 years.Sources of Vitamin B12 are liver, shellfish, fish, meat, eggs, milk, cheese &yogurt.

Decreased Levels
* Lack of Intrinsic factor: Total or partial gastrectomy, Atrophic gastritis, Intrinsic factor antibodies
* Malabsorption: Regional ileitis, resected bowel, Tropical Sprue, Celiac disease, pancreatic insufficiency, bacterial overgrowth & achlorhydria
* Loss of ingested vitamin B12: fish tapeworm
* Dietary deficiency: Vegetarians
* Congenital disorders: Orotic aciduria & transcobalamine deficiency
* Increased demand: Pregnancy specially last trimester

Increased Levels
Chronic renal failure, Congestive heart failure, Acute & Chronic Myeloid Leukemia, Polycythemia vera, Carcinomas with liver metastasis, Liver disease, Drug induced cholestasis & Protein malnutrition

Glucose (Fasting), **Plasma**	104.8	mg/dL	60-110	GOD/POD
Glucose (Post Prandial), **Plasma**	134.0	mg/dL	80-150	GOD/POD
KFT (Kidney Profile) -I, Serum				
Urea, Blood	24.0	mg/dL	15-50	Urease-uv
Creatinine, Serum	0.76	mg/dL	0.6-1.2	Enzymatic
Blood Urea Nitrogen (BUN)	11.20	mg%	7.5-22.0	Calculated
BUN-CREATININE RATIO	14.74		10-20	Calculated
Sodium,Serum	136.5	mmol/L	135-150	ISE
Potassium, Serum	4.10	mmol/L	3.5-5.5	ISE
Calcium, Serum	10.96	mg/dL	8.7-11.0	ISE
Chloride, Serum	100.0	mmol/L	94-110	ISE
Uric acid, Serum	4.80	mg/dL	3.4-7.0	Uricase
Magnesium, Serum	1.88	mg/dL	1.6-2.8	XYLIDYL BLUE
Phosphorus, Serum	3.30	mg/dL	2.4-5.0	MOLYBDATE UV
Alkaline phosphatase, Serum	66.8	U/L	53-165	IFCC
Albumin, Serum	4.13	g/dL	3.5-5.4	BCG
LFT (Liver Function Test) Profile, Serum				
Bilirubin Total, Serum	0.59	mg/dL	0.1-1.0	DMSO
Conjugated (Direct), Serum	0.18	mg%	0.0-0.3	DMSO
Unconjugated (Indirect)	0.41	mg%	0.0-0.75	Calculated
SGOT/AST	35.7	U/L	0-40	IFCC
SGPT/ALT	**56.0 H**	U/L	0-48	IFCC
AST/ALT Ratio	0.64		0-1	Calculated
Gamma GT, Serum	24.0	U/L	10-45	IFCC

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Service Name	Result	Unit	Reference Range	Method
Alkaline phosphatase, Serum	66.8	U/L	53-165	IFCC
Total Protein, serum	6.54	gm/dl	6.0-8.4	Biuret
Albumin, Serum	4.13	g/dL	3.5-5.4	BCG
Globulin	2.41	g/dL	2.3-3.6	Calculated
A/G Ratio	1.71		1.0-2.3	Calculated
Lipid Profile, Serum				
Cholestrol, serum	188.3	mg%	Optimal: < 200 mg/dl Boder Line High Risk: 150 -240 mg/dl High Risk: > 250 mg/dl	
Triglycerides, serum	109.0	mg%	Optimal: < 150 mg/dl Border Line High Risk: 150 - 199 mg/dl High Risk: 200 - 499 mg /dl Very High Risk: > 500 mg /dl	
HDL Cholesterol	49.2	mg%	Optimal: 70 mg/dl Border Line High Risk: 80 - 100 mg/dl High Risk: > 120 mg/dl	
LDL Cholesterol	117.30	mg%	Optimal: < 100 mg/dl Border Line High Risk: 100 - 129 mg/dl High Risk: > 160 mg/dl	
VLDL Cholestrol	21.80	mg%	Male : 10 - 40 mg/dl Female : 10 - 40 mg/dl Child : 10 - 40 mg/dl	
LDL / HDL Cholesterol ratio	2.38		0.0-3.5	

Interpretation :

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
2. ATP III recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.
3. .Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL

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Service Name	Result	Unit	Reference Range	Method
HbA1c				
GLYCOSYLATED HAEMOGLOBIN (HbA1c)				
Method- Immunofluorescence Assay				
Glycosylated Hemoglobin (HbA1c)	6.10	%	<6.5 : Non Diabetic 6.5-7 : Good Control 7-8 : Weak Control > 8 : Poor Control	
Estimated average blood glucose (eAG)	128.37	mg/dl	90-120: Excellent Control 121-150: Good Control 151-180: Average Control 181-210: Action Suggested	

Note:

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.

2.Target goals of 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of 7.0 % may not be appropriate.

Comments:
HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

VITAMIN D3, Cholecalciferol, **Serum**	**18.8 L**	ng/mL	30-100	CLIA

Interpretation :

Deficiency	<10 ng/mL
Insufficiency	10-29 ng/mL
Toxicity	>100 ng/mL

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Service Name	Result	Unit	Reference Range	Method

Note

:**Note** 1. Reference ranges represent clinical decision values and are established only for 25-Hydroxy Vitamin D, Total.

2. Conventional Immunoassays may have sample-specific interferences that can lead to variable performance. These interferences include other vitamin D metabolites (e.g. 24,25-dihydroxyvitamin D3, 3-epi 25 hydroxy vitamin D3) and certain lipid.

3. Physiologically inactive epimers of Vitamin D2 & D3 are separated chromatographically with Vitamin D metabolites as they may result in overestimation of Total Active Vitamin D levels. This can create therapeutic errors since patients who are deficient or insufficient may appear sufficient and toxicity may be reported in patients with high normal levels.

COMMENT:

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia.it can also lead to Hypocalcemia and Tetany.Vitamin D status is best determined by measurement of 25 hyroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than Dihydroxy vitamin D (5- 8 hrs).

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

Increased levels -Vitamin D intoxication

Pathology

Service Name	Result	Unit	Reference Range	Method
Thyroid Profile -T3, T4, TSH, Blood				
Triiodothyronine (T3)	1.61	ng/mL	0.69-2.15	CLIA
Thyroxine (T4)	104.0	ng/mL	52-127	CLIA
Thyroid Stimulating Hormone (TSH)	**5.06 H**	uIU/mL	0.3-4.5	CLIA

Interpretation

:**Note:**

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations.
2. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.
3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.

Clinical Use

Primary Hypothyroidism
Hyperthyroidism Hypothalamic – Pituitary hypothyroidism
Inappropriate TSH secretion
Nonthyroidal illness
Autoimmune thyroid disease
Pregnancy associated thyroid disorders
Thyroid dysfunction in infancy and early childhood

URINE ANALYSIS/ URINE ROUTINE EXAMINATION, Urine

Physical Examination				
COLOUR	Pale Yellow			Manual method
TRANSPARENCY	Clear			Manual
SPECIFIC GRAVITY	1.025		1.001-1.035	Strip

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Service Name	Result	Unit	Reference Range	Method
PH URINE	5.0		5-8	Strip
DEPOSIT	Absent			Manual
BIOCHEMICAL EXAMINATION				
ALBUMIN	Trace			Strip
SUGAR	Absent			Strip
BILE SALTS (BS)	Absent			Manual
BILE PIGMENT (BP)	Absent			Manual
MICROSCOPIC EXAMINATION				
PUS CELLS	1-2	/ hpf		Microscopy
EPITHELIAL CELLS	0-1	/ hpf		Microscopy
RBC'S	Absent	/hpf		Microscopy
CASTS	Absent			Microscopy
CRYSTALS	Absent			Macroscopy
BACTERIA	Absent			Macroscopy
FUNGUS	Absent			Microscopy
SPERMATOZOA	Absent			Microscopy
OTHERS	Absent			Microscopy

----------End of the Report----------

Dr Ambrish Kumar
Pathology
MD (Pathology)