

बैंक ऑफ बड़ौदा
Bank of Baroda

नाम : ममता गुप्ता
Name : Ms. Mamta Gupta
कर्मचारी कूट क्र.
E.C.No : 84801
[Handwritten Signature]
जारीकर्ता प्राधिकारी
Issuing Authority



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धारक के हस्ताक्षर
Holder's Signature

[Handwritten Signature]
- ममता गुप्ता

[Handwritten Signature]
Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 281



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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General Physical Examination

Date of Examination: 09/04/2023

Name: MAMTA GUPTA Age: 36 DOB: 22/07/1986 Sex: Male

Referred By: BANK of BARODA

Photo ID: IDCARD ID #: 84801

Ht: 160 (cm) Wt: 72 (Kg)

Chest (Expiration): 96 (cm) Abdomen Circumference: 86 (cm)

Blood Pressure: 104/73 mm Hg PR: 86 / min RR: 18 / min Temp: Afebrile

BMI 33.6

Eye Examination: RIEY GIG, NIG, NCB
LIEY GIG, NIG, NCB

Other: No

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examinee: [Signature] Name of Examinee: MAMTA GUPTA

Signature Medical Examiner: [Signature] Name Medical Examiner: DR. U.C. GUPTA

Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291



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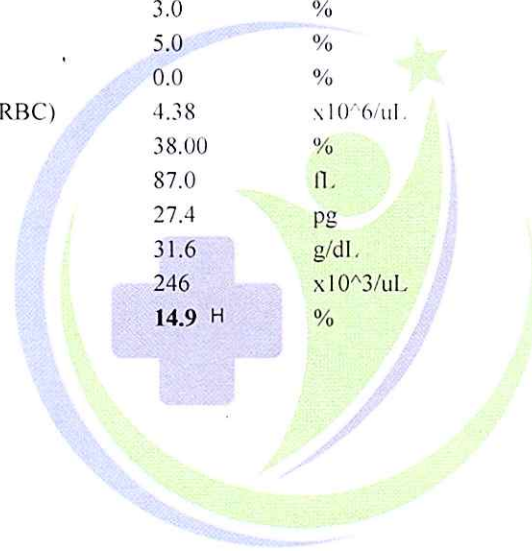


NAME :- Mrs. MAMTA GUPTA	Patient ID :-122369	Date :- 09/04/2023	08:47:56
Age :- 36 Yrs 8 Mon 18 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 10/04/2023 13:16:52

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGARAM			
HAEMOGLOBIN (Hb)	12.0	g/dl.	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	6.60	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	59.0	%	40.0 - 80.0
LYMPHOCYTE	33.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	5.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.38	$\times 10^6/\mu\text{L}$	3.80 - 4.80
HEMATOCRIT (HCT)	38.00	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	87.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	27.4	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	31.6	g/dl.	31.5 - 34.5
PLATELET COUNT	246	$\times 10^3/\mu\text{L}$	150 - 410
RDW-CV	14.9 H	%	11.6 - 14.0



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DR.TANU RUNGTA

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

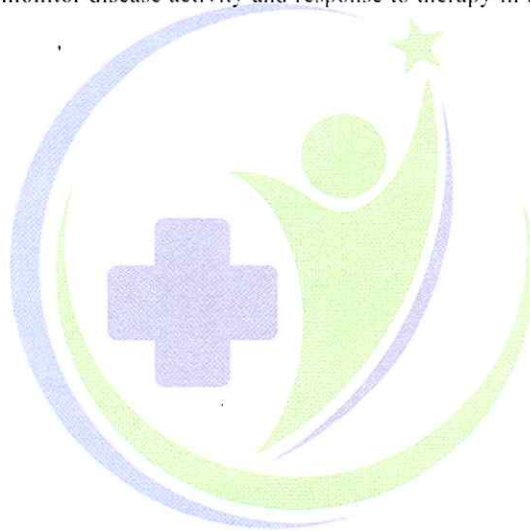
Method:- Westergreen

12

mm in 1st hr

00 - 20

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein. ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



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(CBC): Methodology: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC.PCV,PLT Hydrodynamically focused Impedance and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: Sysmex 6 part fully automatic analyzer XN-L,Japan



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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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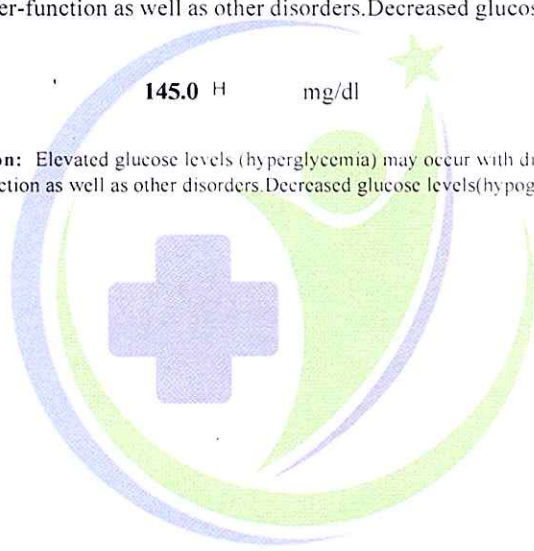
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	115.0	mg/dl	70.0 - 115.0
--	-------	-------	--------------

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) Method:- GOD PAP	145.0 H	mg/dl	70.0 - 140.0
--	----------------	-------	--------------

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .



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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C) Method:- CAPILLARY with EDTA	5.9	mg%	Non-Diabetic < 6.0 Good Control 6.0-7.0 Weak Control 7.0-8.0 Poor control > 8.0
MEAN PLASMA GLUCOSE Method:- Calculated Parameter	123	mg/dl	68 - 125

INTERPRETATION

AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

CLINICAL NOTES

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings. Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al]

1. Erythropoiesis

- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation

- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction

- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others

- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use, chronic renal failure
- Decreased HbA1c: hypertriglyceridemia, reticulocytosis, chronic liver disease, aspirin, vitamin C and E, splenomegaly, rheumatoid arthritis or drugs.

Note:

1. Shortened RBC life span -HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs), such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time.
2. Abnormal forms of hemoglobin - The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

Advised:

1. To follow patient for glyceimic control test like fructosamine or glycated albumin may be performed instead.
2. Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.
estimated Averagee Glucose (eAG) : based on value calculated according to National Givcohemoglobin Standardization Program (NGSP) criteria

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HAEMATOLOGY

BLOOD GROUP ABO
Method:- Haemagglutination reaction

"O" POSITIVE



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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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LIPID PROFILE

TOTAL CHOLESTEROL
Method:- CHOD-PAP methodology

138.00 mg/dl

Desirable <200
Borderline 200-239
High > 240

InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

TRIGLYCERIDES
Method:- GPO-PAP

100.00 mg/dl

Normal <150
Borderline high 150-199
High 200-499
Very high >500

InstrumentName:Ranox Rx Imola **Interpretation :** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

DIRECT HDL CHOLESTEROL
Method:- Selective inhibition Method

59.00 mg/dl

Male 35-80
Female 42-88

Instrument Name:MISPA PLUS **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

LDL CHOLESTEROL
Method:- Calculated Method

62.33 mg/dl

Optimal <100
Near Optimal/above optimal 100-129
Borderline High 130-159
High 160-189
Very High > 190

VLDL CHOLESTEROL
Method:- Calculated

20.00 mg/dl

0.00 - 80.00

T.CHOLESTEROL/HDL CHOLESTEROL RATIO
Method:- Calculated

2.34

0,00 - 4,90

LDL / HDL CHOLESTEROL RATIO
Method:- Calculated

1.06

0,00 - 3,50

TOTAL LIPID
Method:- CALCULATED

430.70 mg/dl

400.00 - 1000.00

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. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.

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BIOCHEMISTRY

Comments: 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all atherogenic lipoproteins (mainly LDL & VLDL). The Non HDL Cholesterol is used as a secondary target of therapy in persons with triglycerides ≥ 200 mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.
2 -For calculation of CHD risk, history of smoking, any medication for hypertension & current B.P. levels are required



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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	0.55	mg/dL	Infants . 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.12	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.43	mg/dL	0.30-0.70
SGOT Method:- IFCC	20.7	U/L	0.0 - 40.0
SGPT Method:- IFCC	18.6	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	52.40	U/L	42.00 - 110.00
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis	20.50	U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	7.86	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.85	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	3.01	gm/dl	2.20 - 3.50
A/G RATIO	1.61		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A, B, C, paracetamol toxicity etc. Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA 28.20 mg/dl 10.00 - 50.00
Method:- Urease/GLDH

InstrumentName: HORIBA CA 60 **Interpretation :** Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 0.84 mg/dl Males : 0.6-1.50 mg/dl
Method:- Jaffe's Method Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 4.20 mg/dl 2.40 - 7.00

InstrumentName: HORIBA YUMIZEN CA60 Daytona plus **Interpretation Elevated Urate:** High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Downs syndrome, Metabolic syndrome, Pregnancy, Gout

SODIUM 143.8 mmol/l 135.0 - 150.0
Method:- ISE

Interpretation: Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss, Drugs, Oedematous states, Legionnaire's disease and other chest infections, pseudonatremia, Hyperlipidaemias and paraproteinaemias, endocrine diseases, SIADH.

POTASSIUM 4.46 mmol/l 3.50 - 5.50
Method:- ISE

Interpretation: A. Elevated potassium (hyperkalaemia) Artefactual, Physiologic elevation, Drugs, Pathological states, Renal failure, Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia) Drugs, Liqueuric, Diarrhoea and vomiting, Metabolic alkalosis, Corticosteroid excess, Oedematous state, Anorexia nervosa bulimia

CHLORIDE 101.0 mmol/l 94.0 - 110.0
Method:- ISE

Interpretation: Used for Electrolyte monitoring.

SERUM CALCIUM 10.00 mg/dl 8.10 - 11.50
Method:- Colorimetric method

InstrumentName: Rx Daytona plus **Interpretation:** Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia. Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN 7.86 g/dl 6.00 - 8.40
Method:- Direct Biuret Reagent

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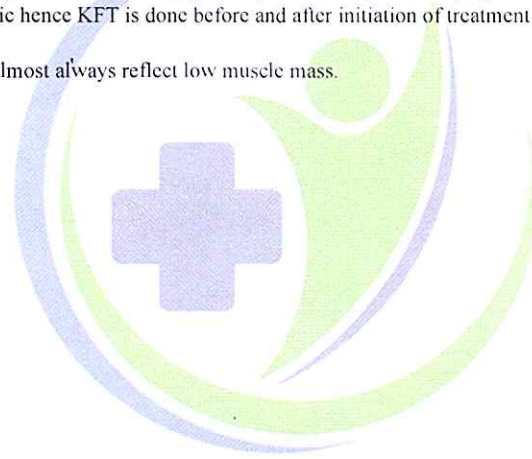
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SERUM GLOBULIN Method:- CALCULATION	3.01	gm/dl	2.20 - 3.50
A/G RATIO	1.61		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR. In urine, it can remove the need for 24-hour collections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection. Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the blood increases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.



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CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION(PH)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.010		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<u>MICROSCOPY EXAMINATION</u>			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT

ADIYTA

Technologist

Page No: 12 of 15

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
01 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. MAMTA GUPTA	Patient ID :-122369	Date :- 09/04/2023	08:47:56
Age :- 36 Yrs 8 Mon 18 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 10/04/2023 13:16:52

TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

THYROID-TRIODOETHYRONINE T3

0.97

ng/mL

0.70 - 2.04

Method:- ECLIA

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓TSH level 2.Low TSH,high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by ↓serum T3 and T4 values & ↑serum TSH levels 8.Normal T4 levels accompanied by ↓T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or ↓T3 & ↓T4 10.Normal T3 & T4 along with ↑TSH indicate mild / Subclinical Hyperthyroidism 11.Normal T3 & ↑T4 along with ↓TSH is seen in Hypothyroidism 12.Normal T3 & T4 levels with ↑TSH indicate Mild / Subclinical Hypo

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly. 5.10 - 14.10

THYROID THYRONINE (T4)

Method:- ECLIA

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓TSH level 2.Low TSH,high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by ↓serum T3 and T4 values & ↑serum TSH levels 8.Normal T4 levels accompanied by ↓T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or ↓T3 & ↓T4 10.Normal T3 & T4 along with ↑TSH indicate mild / Subclinical Hyperthyroidism 11.Normal T3 & ↑T4 along with ↓TSH is seen in Hypothyroidism 12.Normal T3 & T4 levels with ↑TSH indicate Mild / Subclinical Hypo

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REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

TSH

2.533

uIU/mL

0.350 - 5.500

Method:- ECLIA

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓TSH level.

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

Technologist

Page No: 14 of 15



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. MAMTA GUPTA	Patient ID :-122369	Date :- 09/04/2023	08:47:56
Age :- 36 Yrs 8 Mon 18 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 10/04/2023 13:16:52

IMMUNOASSAY

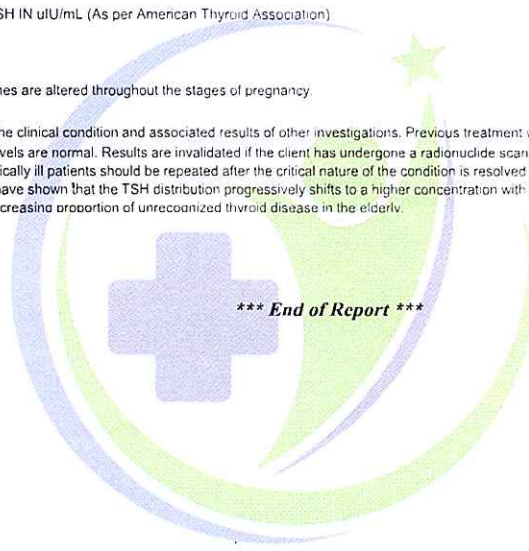
- 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease.
- 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter
- 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis
- 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency
- 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
- 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 9.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
- 11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
- 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
- 13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol.
- 14.Although ↑ TSH levels are nearly always indicative of Primary Hypothyroidism ,rarely they can result from TSH secreting pituitary tumours.

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

- 1st Trimester : 0.10-2.50 uIU/mL
- 2nd Trimester : 0.20-3.00 uIU/mL
- 3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radiouclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.



*** End of Report ***

ADIYTA

Technologist

Page No: 15 of 15

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

- 📍 B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
- 📞 +91 141 4824885 ✉️ maxcarediagnostics1@gmail.com



MRS. MAMTA GUPTA	Age: 36 Y/F
Registration Date: 09/04/2023	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (13.1 cm). Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

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

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape (10.2 cm). Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Right kidney is measuring approx. 10.5 x 4.5 cm.

Left kidney is measuring approx. 11.3 x 5.7 cm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size (measuring approx. 8.4 x 4.6 x 4.3 cm).

Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 6.5 mm.

Both ovaries are visualized and are normal. No adnexal mass lesion is seen.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

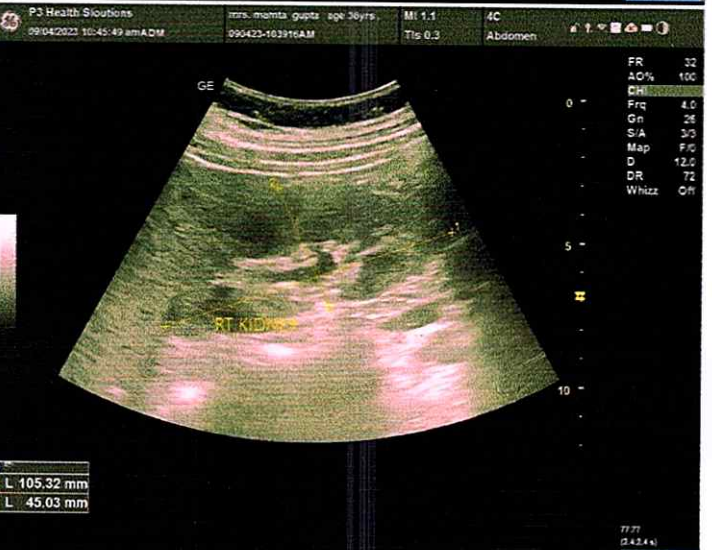
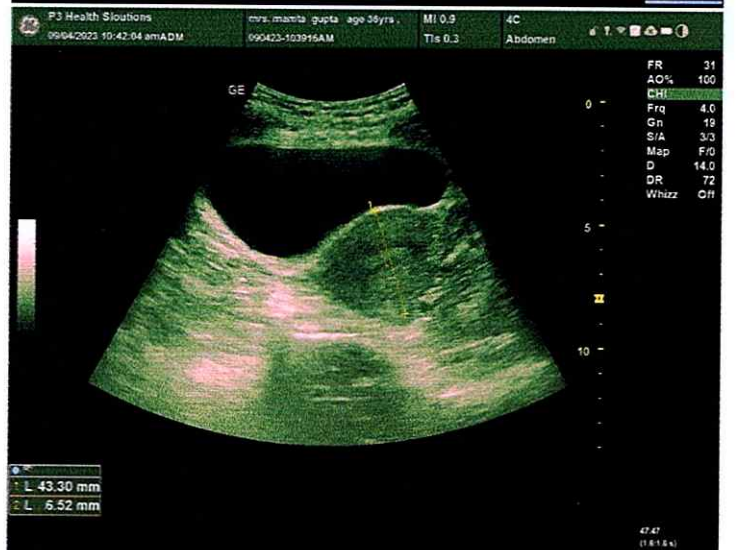
No significant free fluid is seen in pouch of Douglas.

IMPRESSION: No significant abnormality is detected.

DR.SHALINI GOEL

M.B.B.S, D.N.B (Radiodiagnosis)

RMC no.: 21954







NAME:	MRS. MAMTA GUPTA	AGE/SEX	36 YRS/F
REF.BY	BOB	DATE	10/04/2023

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

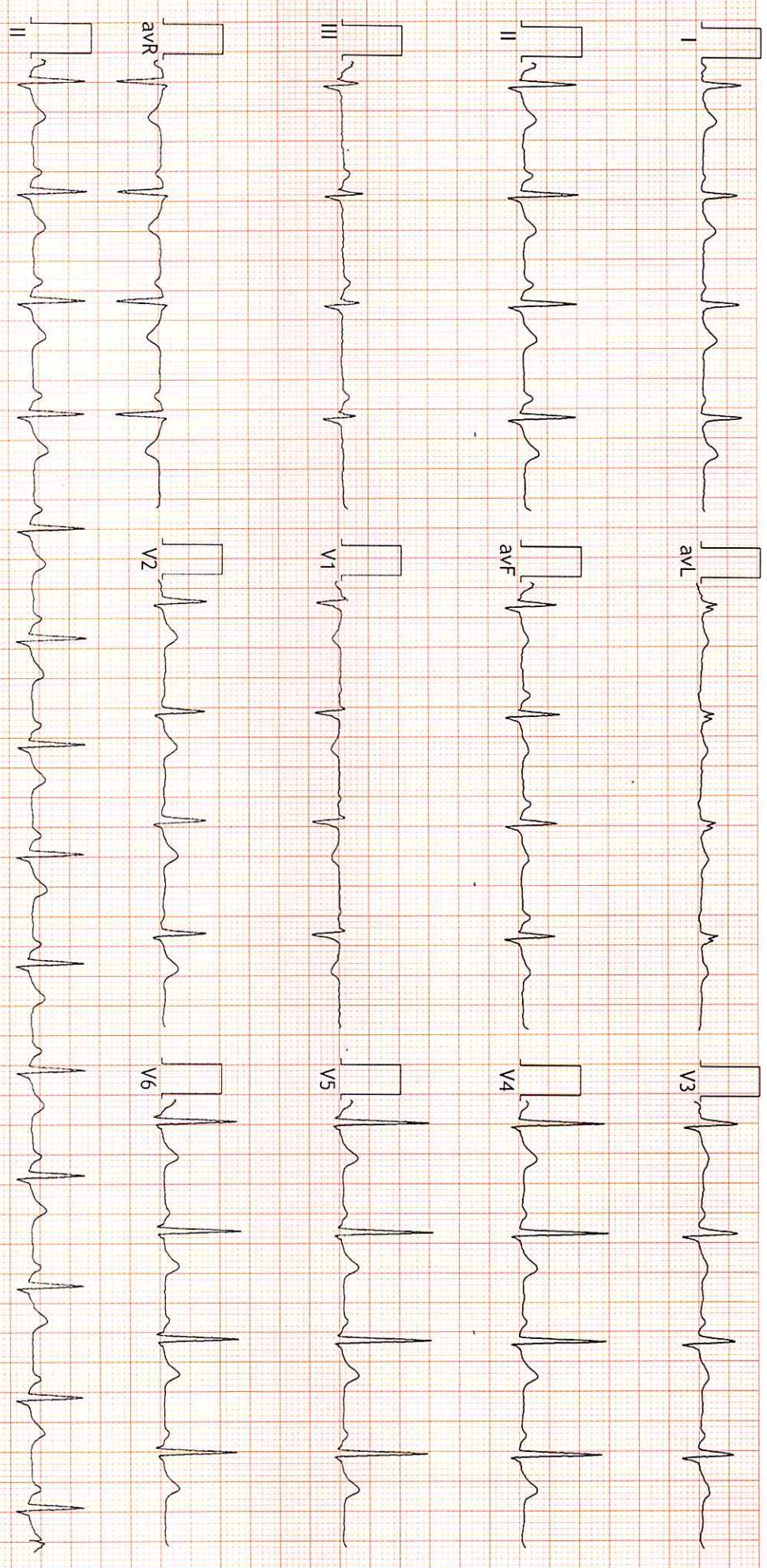
Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected.

DR.SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC No.: 21954



FINDINGS: Normal Sinus Rhythm
Vent Rate : 81 bpm; PR Interval : 124 ms; QRS Duration: 92 ms; QT/QTc Int : 352/410 ms
P-QRS-T axis: 65 • 17 • 24 • (Deg)
Comments :

TUNZ

DR. NAREESH KUMAR MOHANKA
RMC No.: 35703
DR. NAREESH KUMAR MOHANKA
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (PGCP-JK)

'3 HEALTH SOLUTIONS LLP
B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

Summary

1322556/MRS MAMTA GUPTA 36 Yrs/Female 0 Kg/0 Cms
 Date: 09-Apr-2023 11:06:19 AM
 Ref. By : BANK OF BARODA
 Medication :

Protocol : BRUCE
 History :

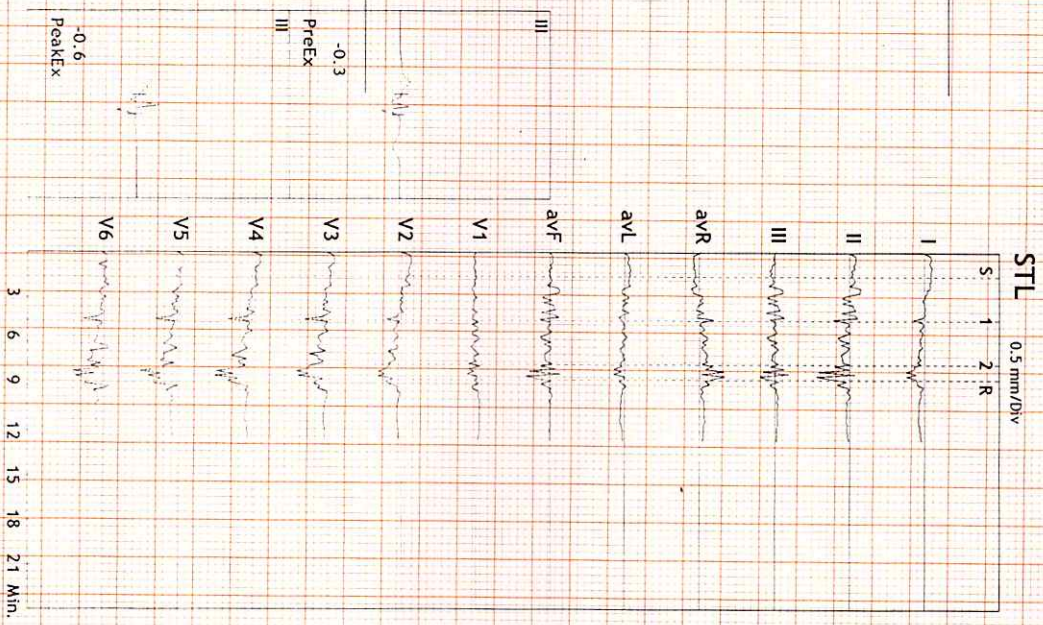
Objective :

Stage	StageTime (Min:Sec)	PhaseTime (Min:Sec)	Speed (mph)	Grade (%)	METS	H.R. (bpm)	B.P. (mmHg)	R.P.P. x100	PVC	Comments
Supine					1.0	90	120/80	108	-	
Standing					1.0	85	120/80	102	-	
HV					1.0	88	120/80	105	-	
ExStart					1.0	101	120/80	121	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	135	130/80	175	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	159	140/80	222	-	
PeakX	1:01	7:02	3.4	14.0	8.2	166	140/80	232	-	
Recovery	1:00		0.0	0.0	1.2	130	140/80	182	-	
Recovery	2:00		0.0	0.0	1.0	109	150/85	163	-	
Recovery	3:00		0.0	0.0	1.0	107	140/80	149	-	
Recovery	4:00		0.0	0.0	1.0	105	130/80	136	-	

Findings :

Exercise Time : 07:01
 Max HR Attained : 166 bpm 90% of Max Predictable HR 184
 Max BP : 150/85(mmHg)
 Max Workload attained : 8.2(Fair Effort Tolerance)

TMT is negative for RM1



Advice/Comments:

Dr. Nagesh K. Khandelwal
 MBBS, DIP. CARDIO (ESCORTS)
 D.E.M. (RCGP-UK)
 RMIC No.: 35703



HR: 89 bpm

METS: 1.0

BP: 120/80

MPHR: 48% of 184

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 00:34

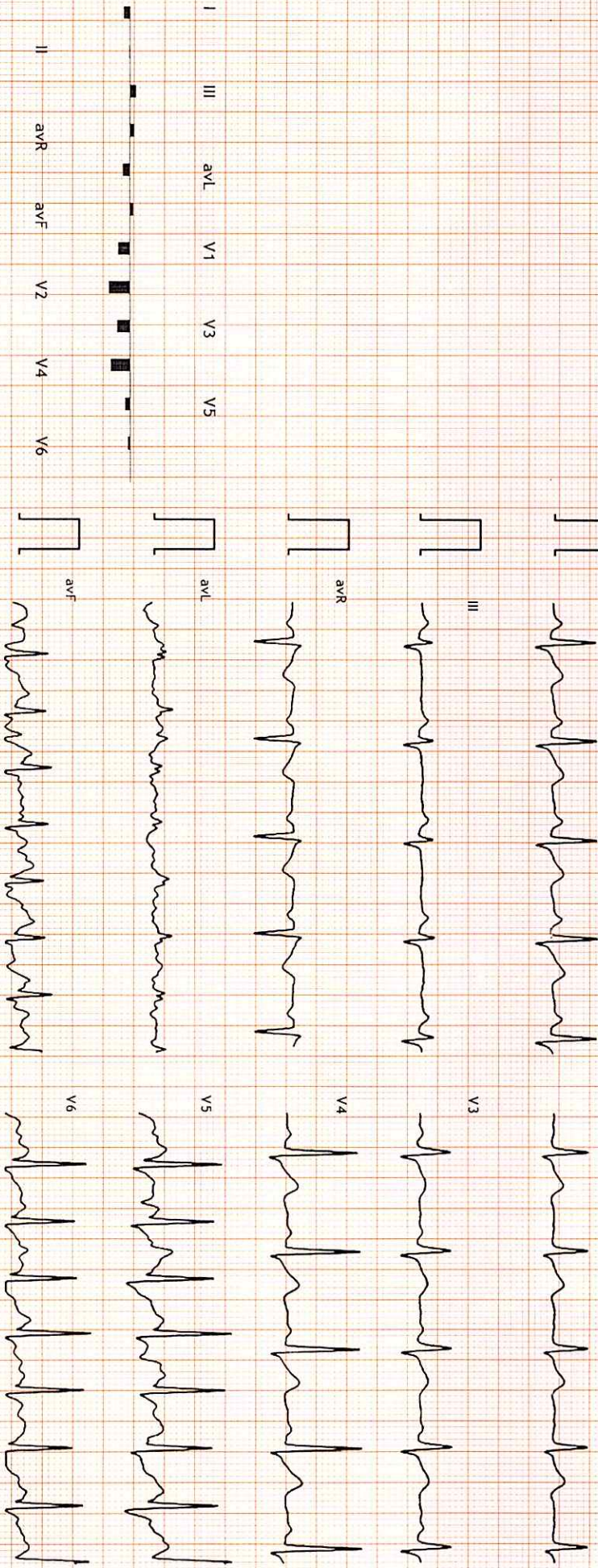
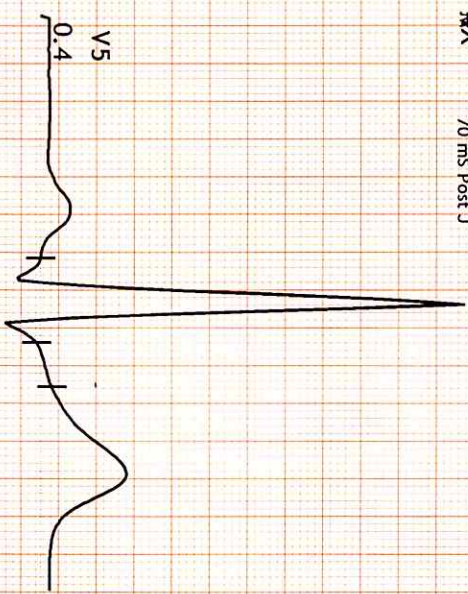
BLC : On

Notch : On

Supine

10.0 mm/mV

25 mm/Sec.



HR: 89 bpm

METS: 1.0

BP: 120/80

MPHR: 48% of 184

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)HZ

Ex Time 01:01

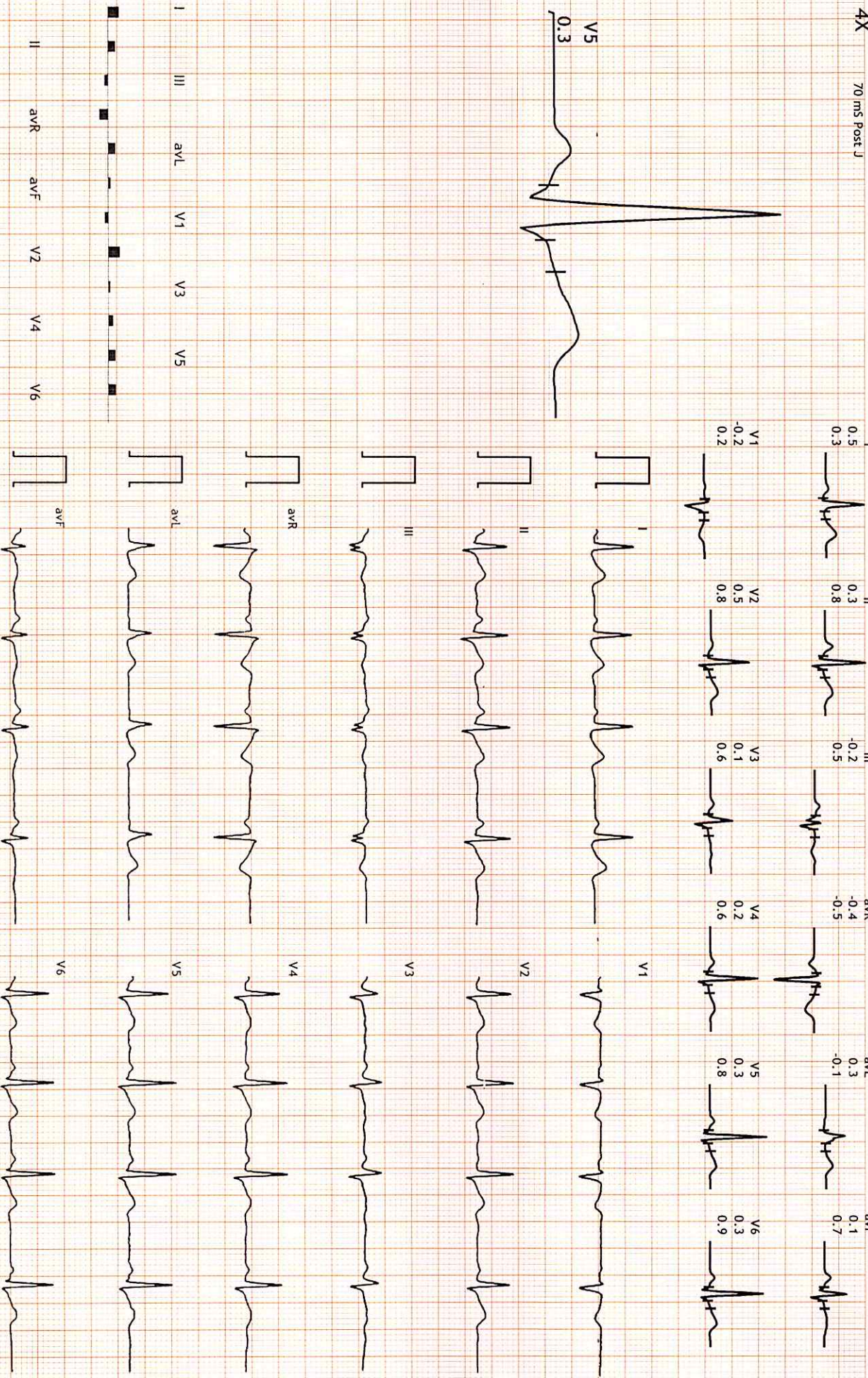
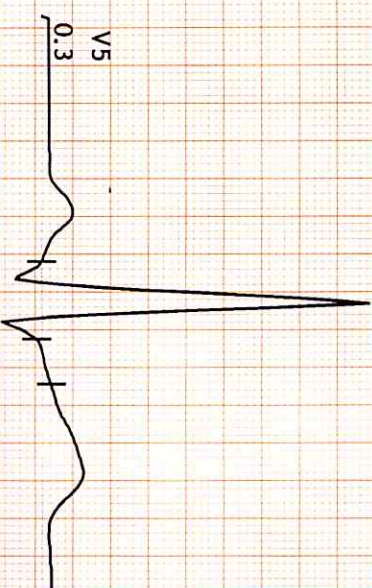
BLC : On

Notch : On

Standing

10.0 mm/mV

25 mm/Sec.



B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

I322556/MRS MAMTA GUPTA

36 Yrs/Female

0 Kg/0 Cms

Date: 09-Apr-2023 11:06:19 AM

4X

70 ms Post J

HR: 88 bpm

METS: 1.0

BP: 120/80

MPHR: 47% of 184

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 01:15

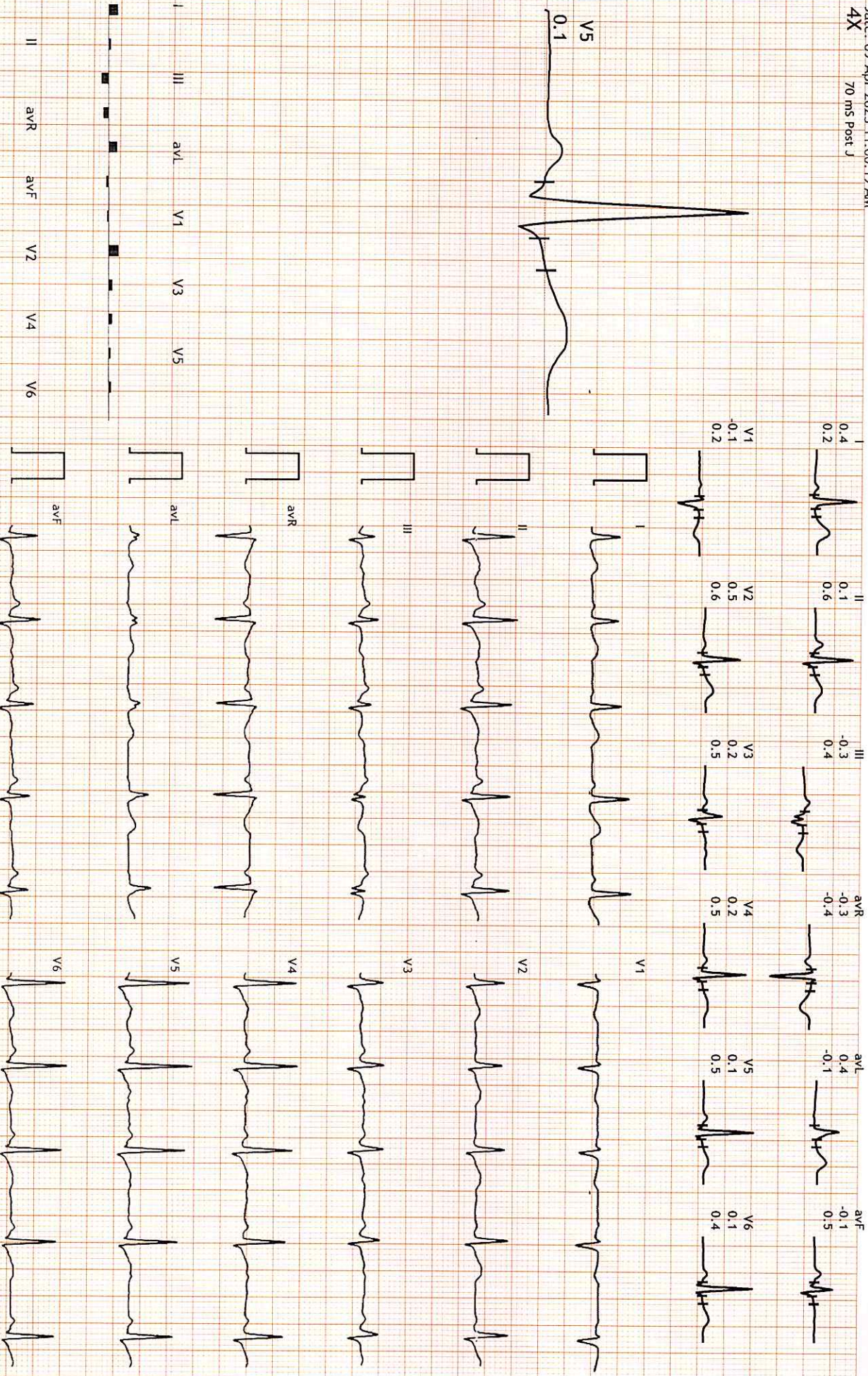
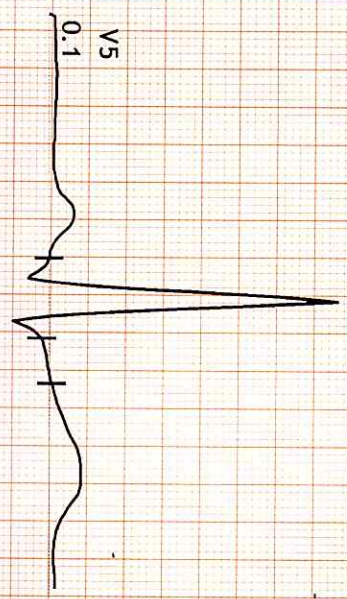
BLC: On

Notch: On

HV

10.0 mm/mv

25 mm/Sec.



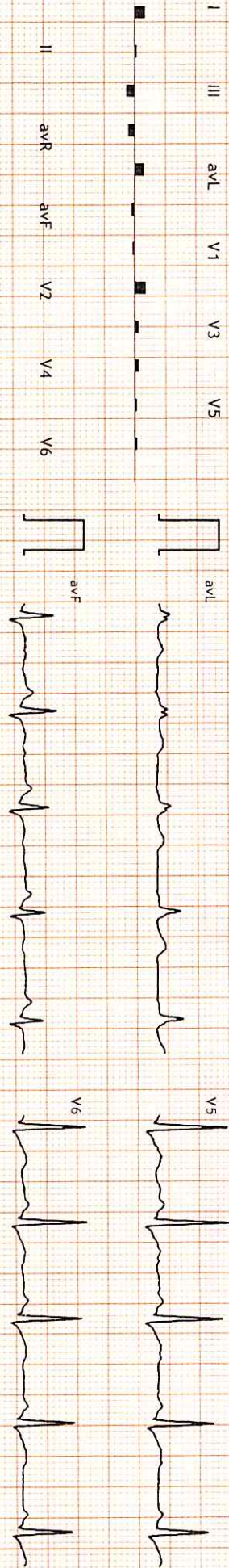
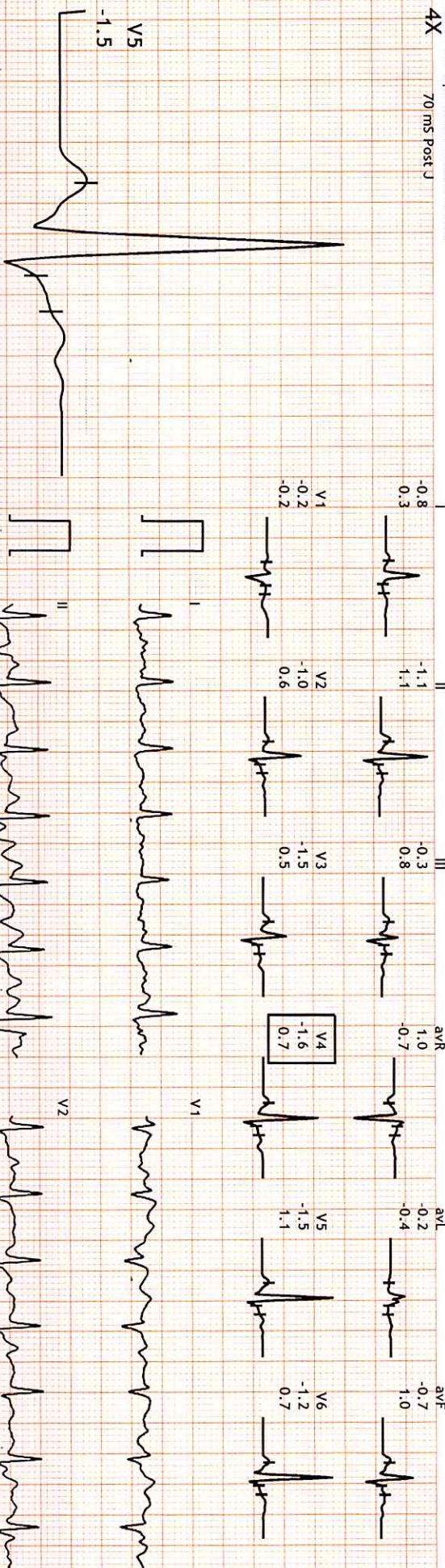
HR: 135 bpm
METS: 4.7
BP: 130/80

MPHR: 73% of 184
Speed: 1.7 mph
Grade: 10.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 02:59
BLC : On
Notch : On

BRUCE: Stage 1(3:00)
10.0 mm/mV
25 mm/Sec.



B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

1322556/MRS MAAMTA GUPTA

36 Yrs/Female

0 Kg/0 Cms

Date: 09-Apr-2023 11:06:19

HR: 166 bpm
METS: 8.2
BP: 140/80

MPHR:90% of 184
Speed: 3.4 mph
Grade: 14.0%

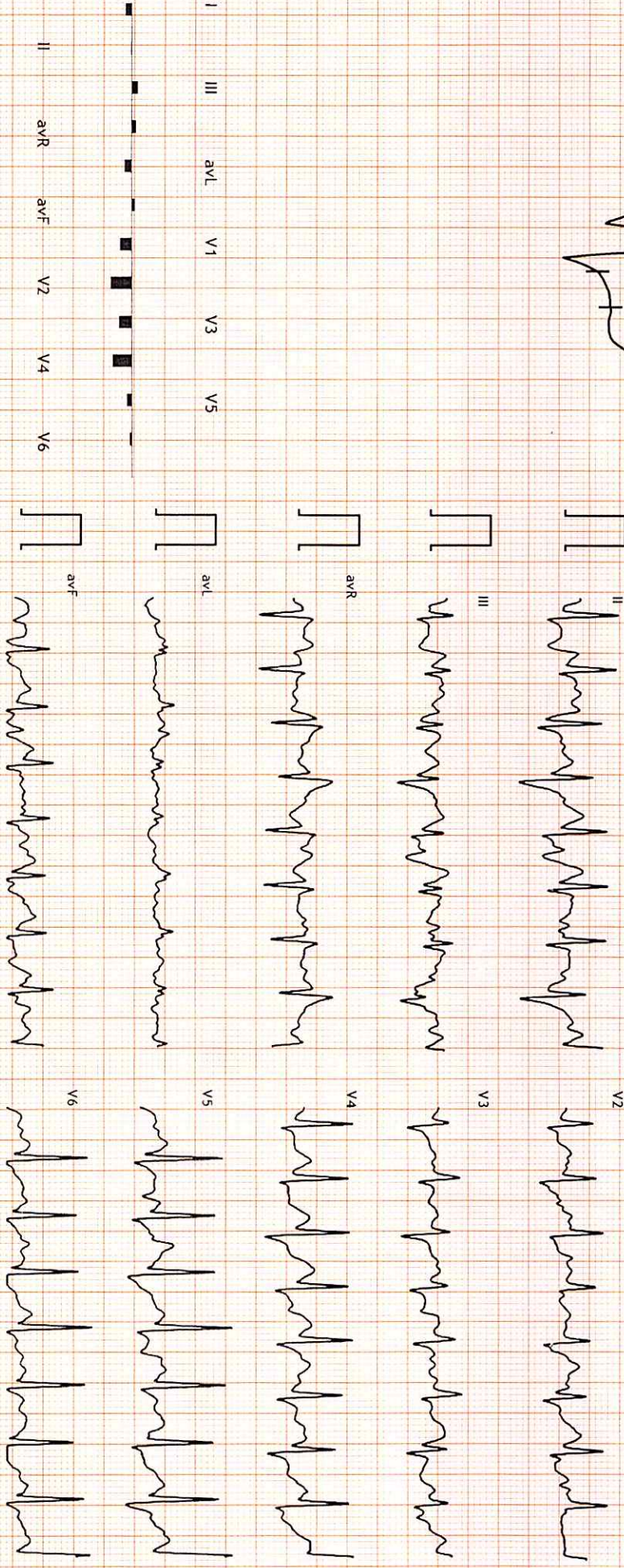
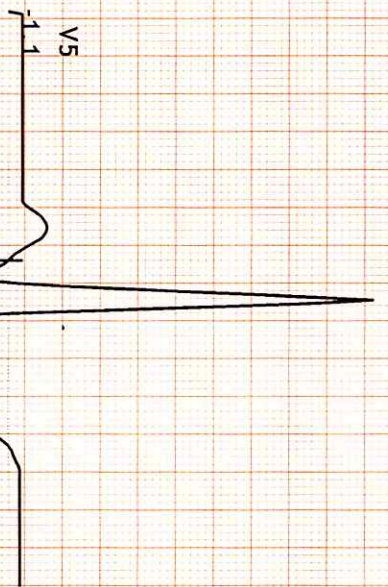
Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 06:59
BLC :On
Notch :On

BRUCE: PeakEx(1:00)
10.0 mm/mv
25 mm/Sec.



M 4X 70 ms Post J



'S HEALTH SOLUTIONS LLP
 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

1322556/MRS MAMTA GUPTA
 36 Yrs/Female
 0 Kg/0 Cms
 Date: 09-Apr-2023 11:06:19 AM
 4X 70 ms Post J

HR: 158 bpm
 METS: 7.1
 BP: 140/80

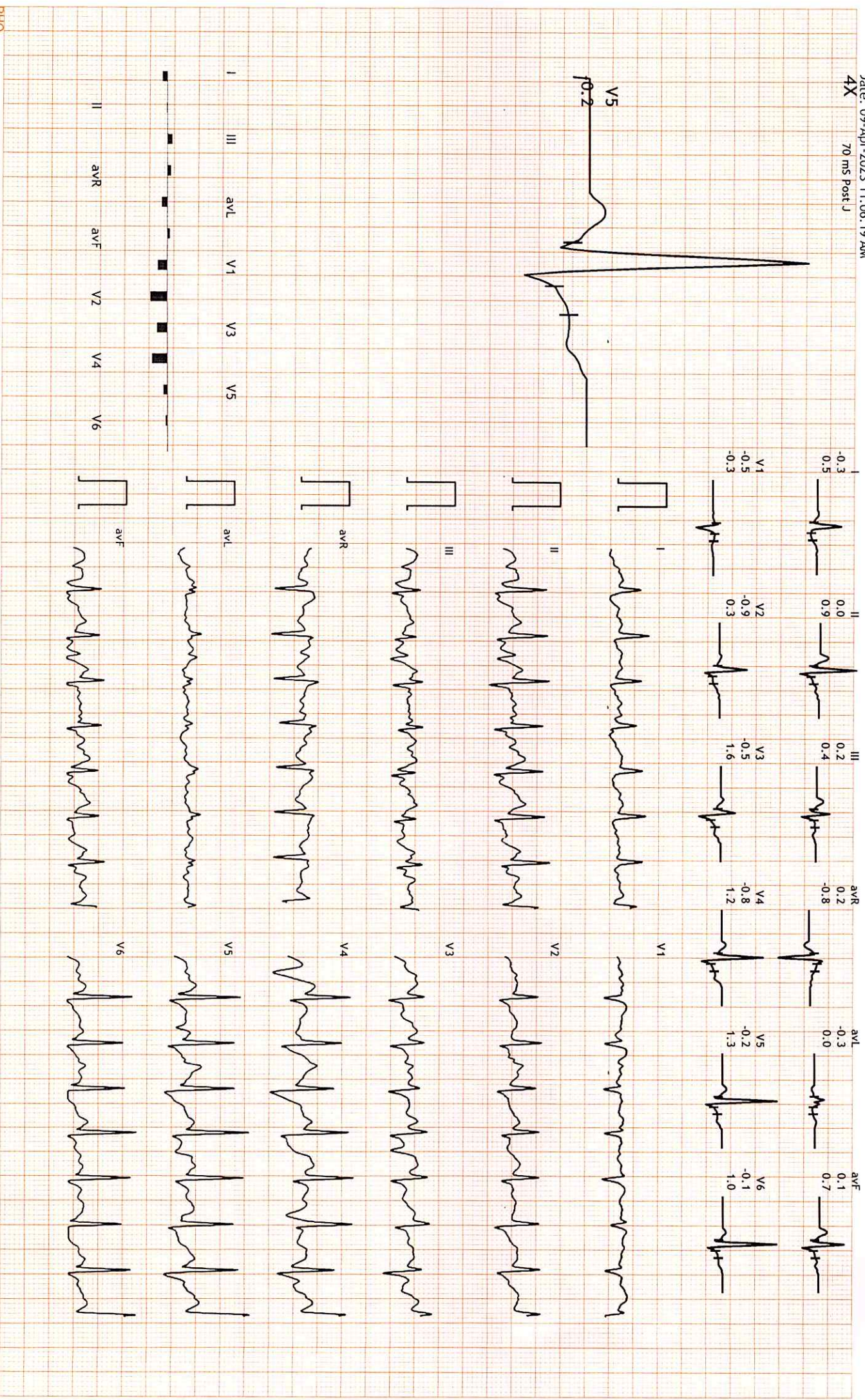
MPHR: 85% of 184
 Speed: 2.5 mph
 Grade: 12.0%

Raw ECG
 BRUCE
 (1.0-35)Hz

Ex Time 05:59
 BLC : On
 Notch : On

BRUCE: Stage 2(3:00)
 10.0 mm/mV
 25 mm/Sec.

12 Lead + Median



B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

1322556/MRS MAAMTA GUPTA

36 Yrs/ Female

0 Kg/0 Cms

Date: 09-Apr-2023 11:06:19 AM

4X 70 ms Post J

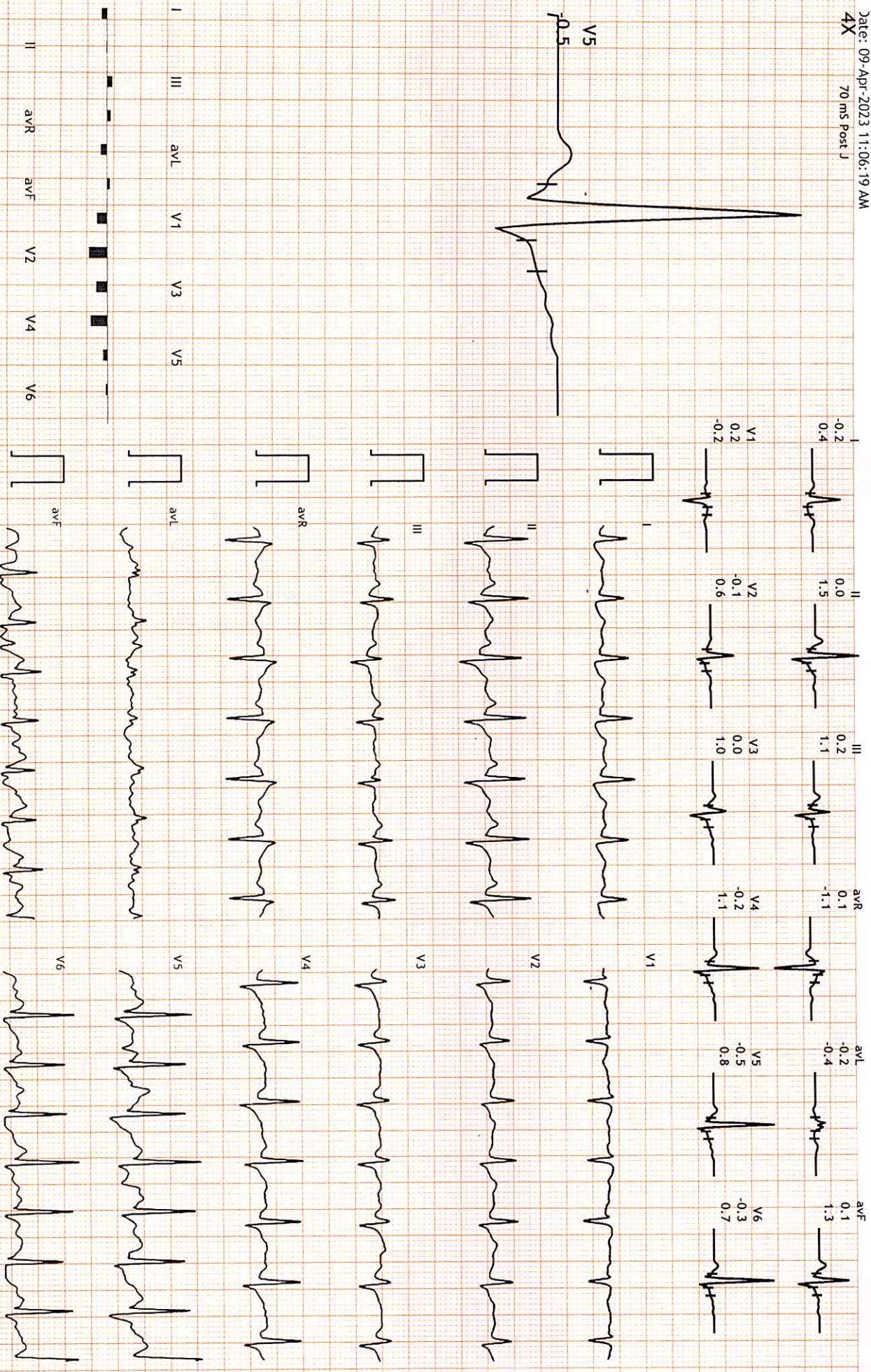
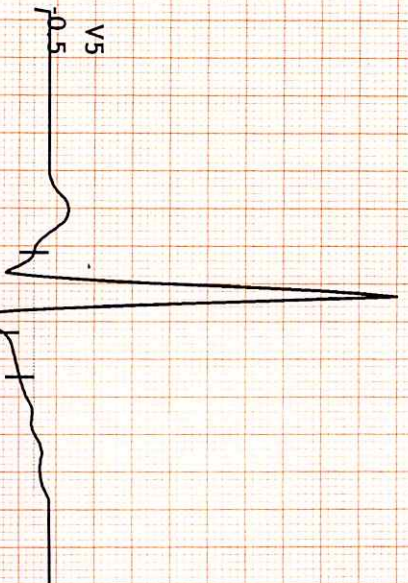
HR: 130 bpm
METs: 1.3
BP: 140/80

MPHR: 70% of 184
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 07:01
BLC :On
Notch :On

Recovery(1:00)
10.0 mm/mV
25 mm/Sec.



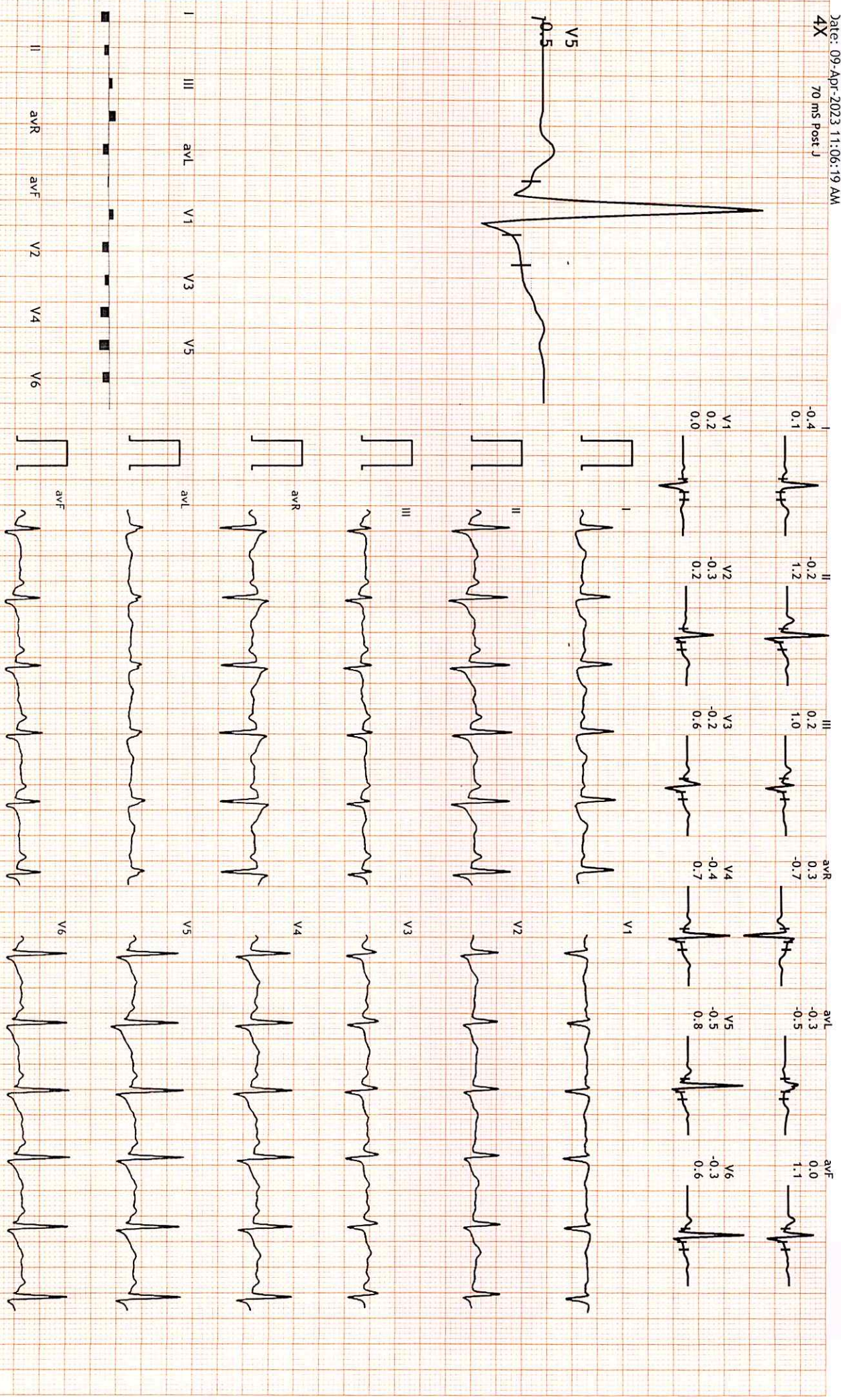
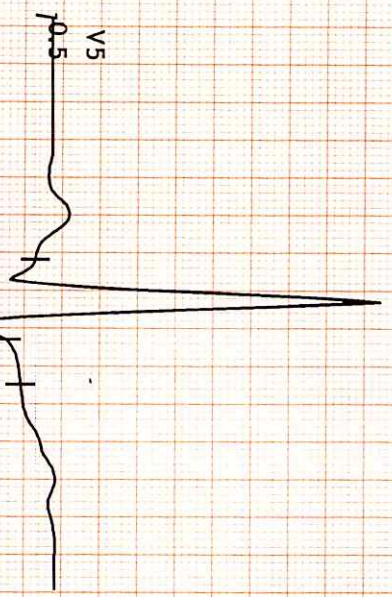
HEALTH SOLUTIONS LLP
 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur
 I322556/MRS MAAMTA GUPTA
 36 Yrs/Female
 5 Kg/0 Cms
 Date: 09-Apr-2023 11:06:19 AM
 4X 70 ms Post J

HR: 109 bpm
 METS: 1.0
 BP: 150/85

MPHR: 59% of 184
 Speed: 0.0 mph
 Grade: 0.0%

Raw ECG
 BRUCE
 (1.0-35)Hz

Ex Time 07:01
 BLC : On
 Notch : On
 Recovery(2:00)
 10.0 mm/mV
 25 mm/Sec.



HR: 108 bpm

METS: 1.0

BP: 140/80

MPHR: 58% of 184

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)HZ

Ex Time 07:01

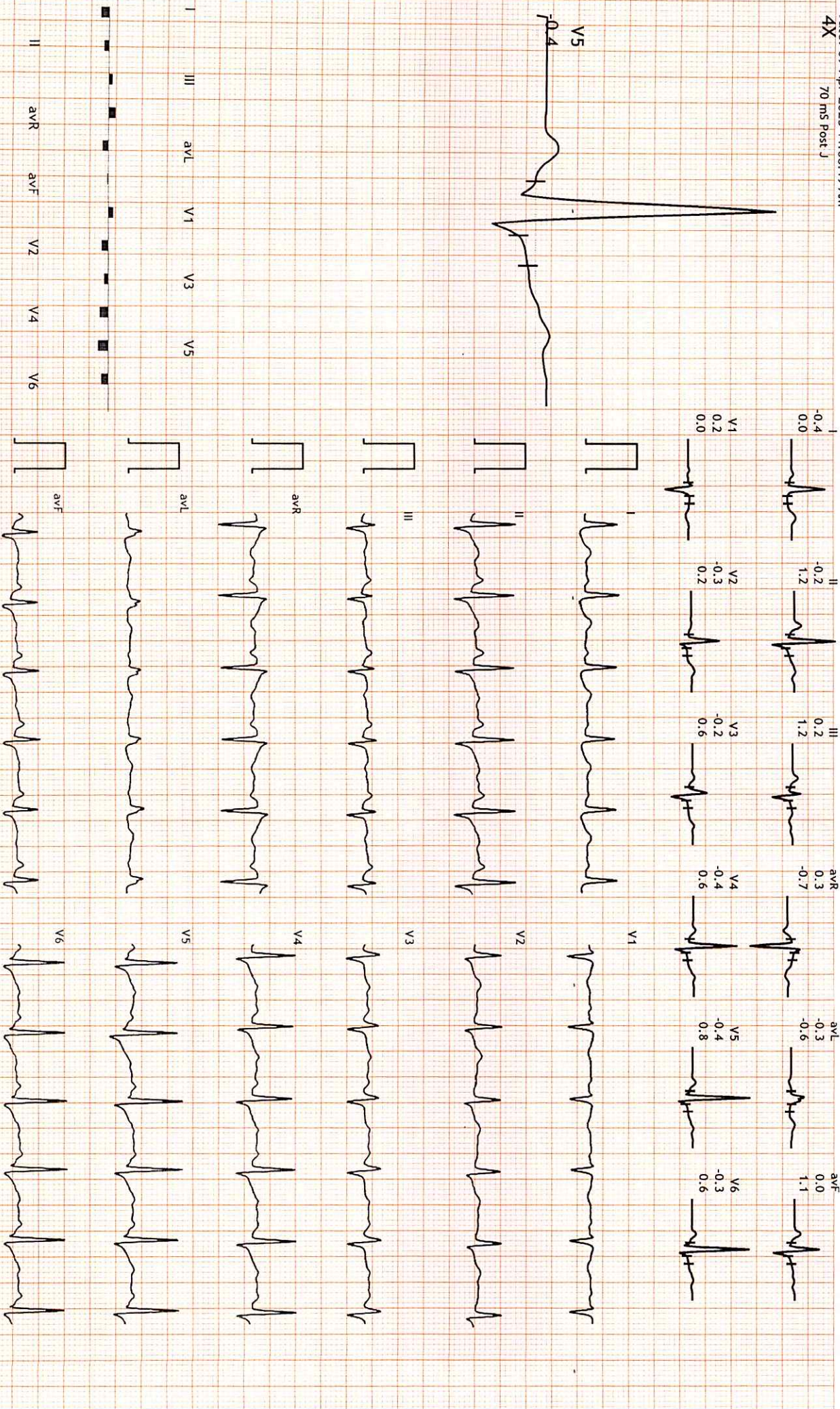
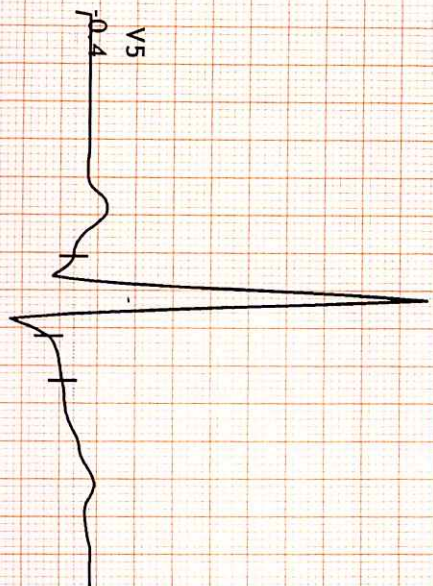
BLC : On

Notch : On

Recovery(3:00)

10.0 mm/mV

25 mm/Sec.



'S HEALTH SOLUTIONS LLP
 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur
 1322556/MRS MAAMTA GUPTA
 36 Yrs/Female
 0 Kg/0 Cms
 Date: 09-Apr-2023 11:06:19 AM
 4X 70 ms Post J

1.2 Lead + Median

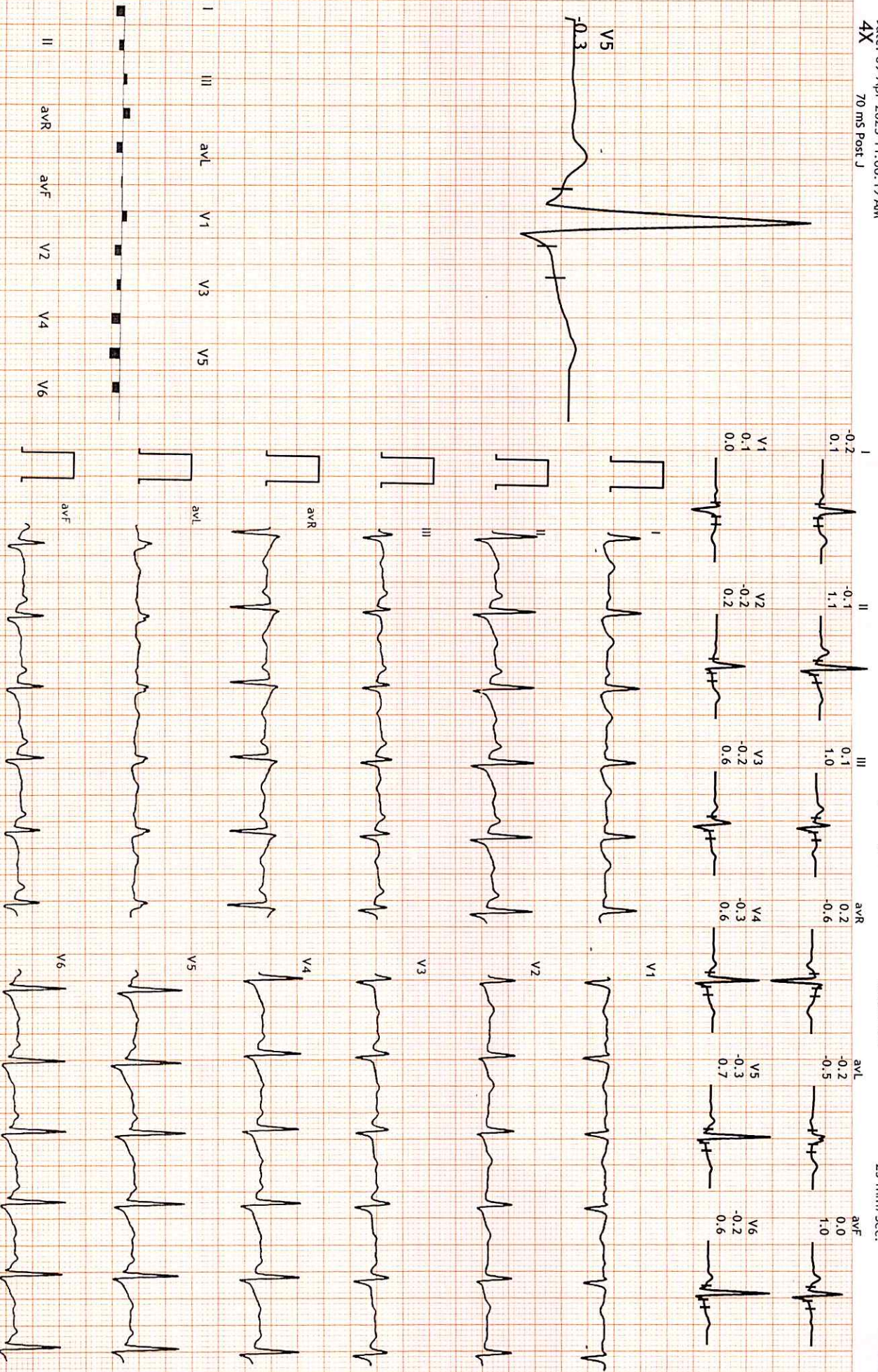
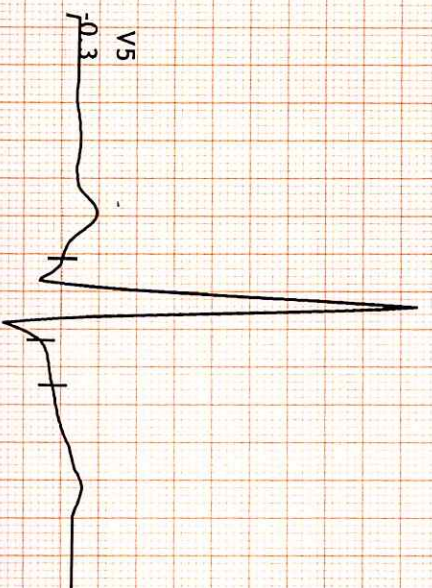
HR: 105 bpm
 METS: 1.0
 BP: 130/80

MPHR: 57% of 184
 Speed: 0.0 mph
 Grade: 0.0%

Raw ECG
 BRUCE
 (1.0-35)Hz

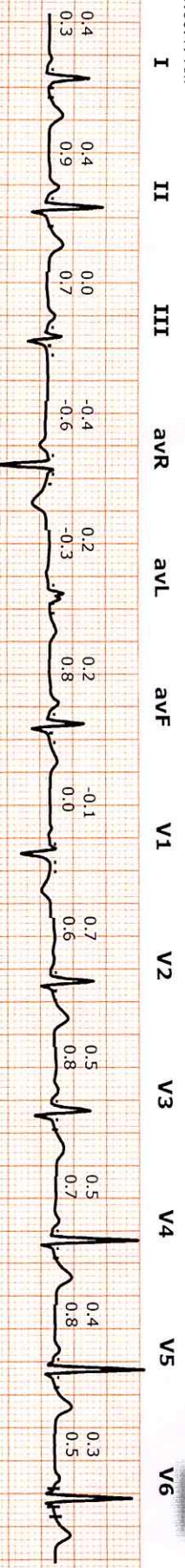
Ex Time 07:01
 BLC : On
 Notch : On

Recovery(4:00)
 10.0 mm/mV
 25 mm/Sec.

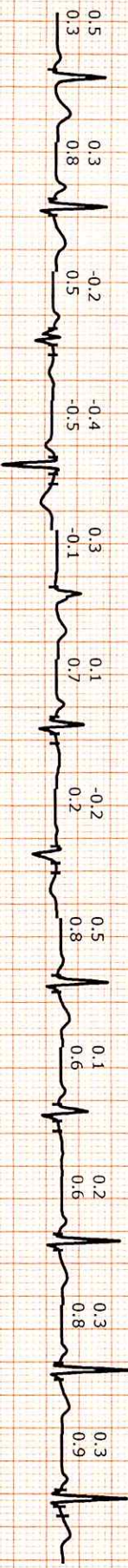




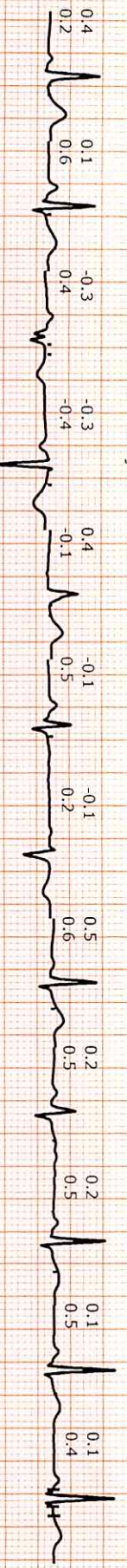
Supine
 (1) 0:00 0.0 mph 0.3
 (2) 0:00 0.0 %
 90 bpm 120/80



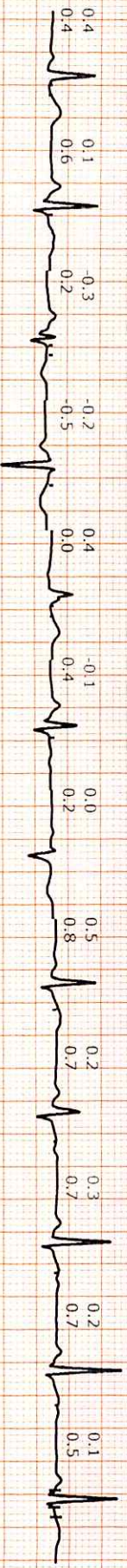
Standing
 (1) 0:00 0.0 mph 0.3
 (2) 0:00 0.0 %
 85 bpm 120/80



HV
 (1) 0:00 0.0 mph 0.2
 (2) 0:00 0.0 %
 88 bpm 120/80



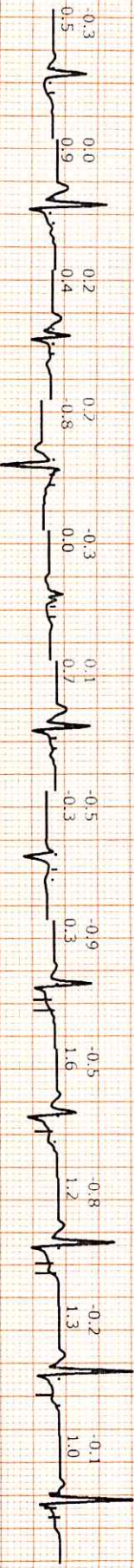
ExStart
 (1) 0:00 0.0 mph 0.4
 (2) 0:00 0.0 %
 101 bpm 120/80



Stage 1
 (1) 3:01 1.7 mph 0.3
 (2) 3:01 10.0 %
 135 bpm 130/80



Stage 2
 (1) 6:01 2.5 mph 0.5
 (2) 3:01 12.0 %
 159 bpm 140/80



Average

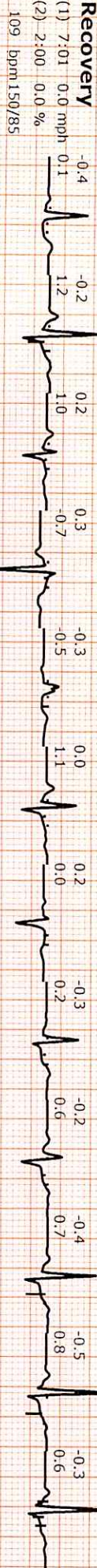
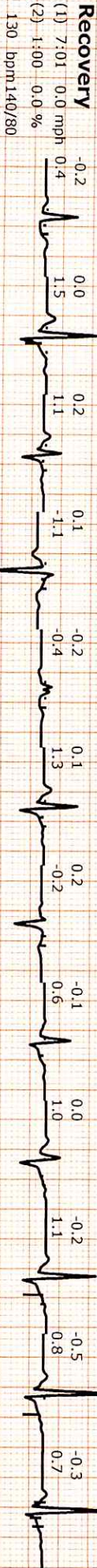
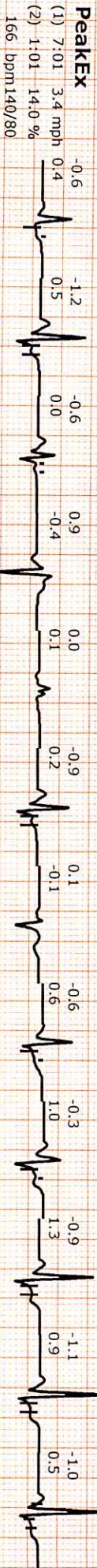
P 3 HEAL IH SOLUTIONS LLP

B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

1322556/MRS MAMTA GUPTA 36 Yrs/Female 0 Kg/0 Cms

ate: 09-Apr-2023 11:06:19 AM

I II III aVR aVL aVF V1 V2 V3 V4 V5 V6



R

122369 MRS.MAMTA GUPTA 36YRS BANK OF BARODA F
09.APR.2023
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

