SPECTRUM
DIAGNOSTICS & HEALTH CARE

CERTIFICATE OF MEDICAL FITNESS

NAME: Amaresh. M

AGE/ GENDER: 59yl male

HEIGHT: 168cm WEIGHT: 67.2 kg

IDENTIFICATION MARK: —

BLOOD PRESSURE: 110/70 mmHg

PULSE: 104 b/m

CVS: } Normal
RS:P }

ANY OTHER DISEASE DIAGNOSED IN THE PAST: Diabetic - Inj. Ryzodeg - 8 units
Tab: Gluconorm - 1mg

ALLERGIES, IF ANY: Nil

LIST OF PRESCRIBED MEDICINES: Nil

ANY OTHER REMARKS: No

I Certify that I have carefully examined Mr/~~Mrs~~. Amaresh. m son/~~daughter~~ of Mr M. Sadhanandaiah. who has signed in my presence. He/ she has no physical disease and is fit for employment.

Dr. BINDURAJ. R
MBBS, MD
Internal Medicine

~~Signature~~ of candidate **Signature of Medical Officer**

Place: Spectrum diagnostics & healthcare

Date: 08/04/24

Disclaimer: The patient has not been checked for COVID. This certificate does not relate to the covid status of the patient examined

SPECTRUM
DIAGNOSTICS & HEALTH CARE

Dr.Ashok S
Bsc.,MBBS., D.O.M.S
Consultant Opthalmologist
KMC No: 31827

DATE: 08.02.24

EYE EXAMINATION

NAME: M. Ambika. M. **AGE:** 59y **GENDER : F / M**

	RIGHT EYE	LEFT EYE
Vision	6/6p	6/6p
Vision With glass	6/6	6/6
Color Vision	Normal	Normal
Anterior segment examination	Normal	Normal
Fundus Examination	Normal	Normal
Any other abnormality	Nill	Nill
Diagnosis/ impression	Normal	Normal

To wear Spectacles

Dr. ASHOK SARODHE
B.Sc., M.B.B.S., D.O.M.S.
Eye Consultant Surgeon

Consultant (Opthalmologist)

SPECTRUM
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NAME	AGE	GENDER
Mr. Anavesh - M.	59 yrs	Male.

DENTAL EXAMINATION REPORT:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

C: CAVITY → None.

M: MISSING → None.

O: OTHERS

ADVISED:

CLEANING / SCALING / ROOTS PLANNING / FLOSSING & POLISHING / OTHERS

REMARKS:

08/04/24.

SIGNATURE OF THE DENTAL SURGEON

SEAL

DATE

Dr. SACHDEV NAGARKAR
B.D.S., F.A.G.E., F.P.F.A. (USA)
Reg. No : 2247/A

ID: 240017
AMARESH
Male 59Years

08-04-2024 09:47:46

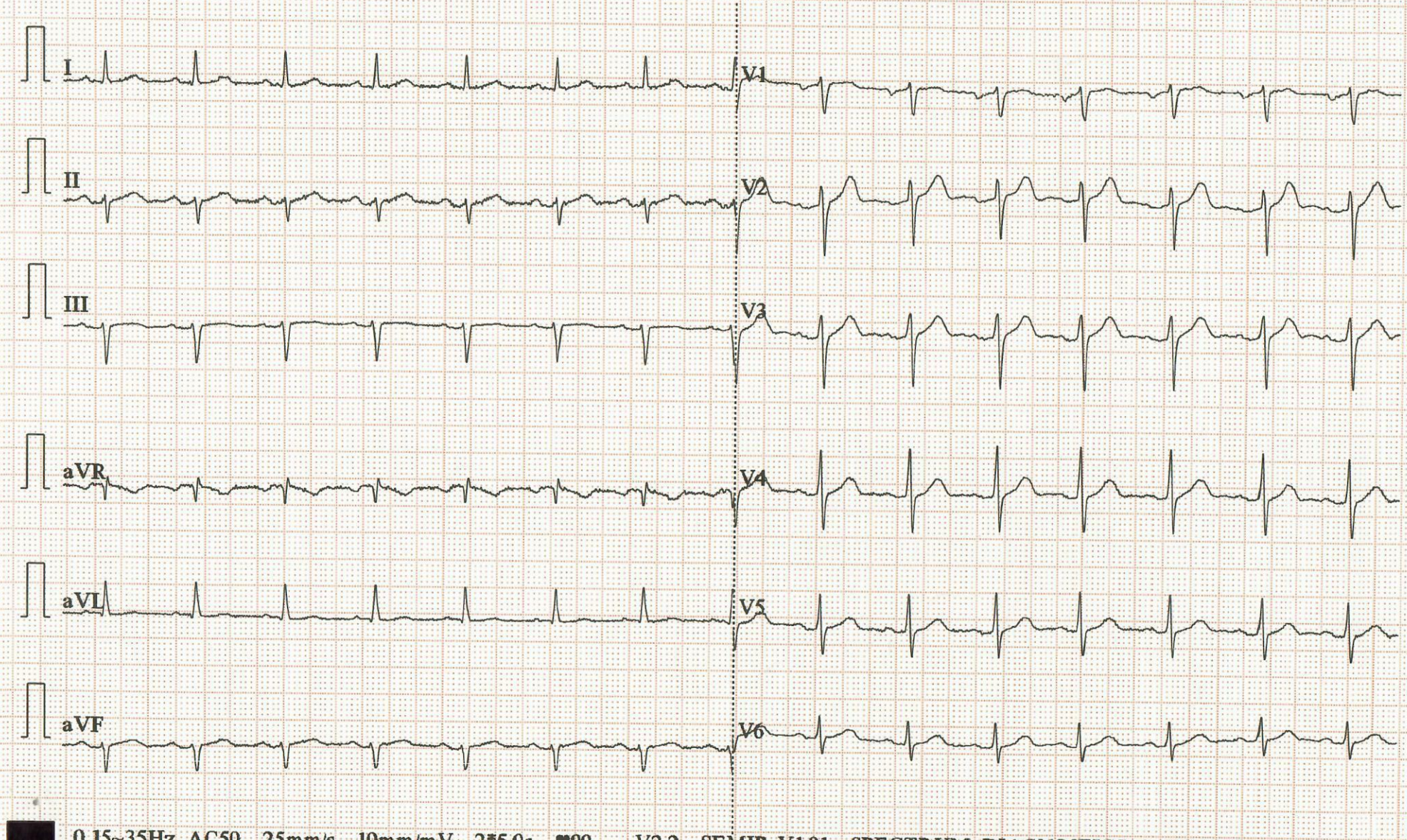
For BPL

HR	: 90	bpm
P	: 109	ms
PR	: 171	ms
QRS	: 84	ms
QT/QTc	: 345/423	ms
P/QRS/T	: 45/-26/51	°
RV5/SV1	: 0.689/0.490	mV

Diagnosis Information:
Sinus Rhythm
Larged PtfV1

SPECTRUM DIAGNOSTICS AND HEALTH CARE BENGALURU

Report Confirmed by:



0.15~35Hz AC50 25mm/s 10mm/mV 2*5.0s ♥90 V2.2 SEMIP V1.81 SPECTRUM DIAGNOSTICS & HEALTH CARE

SPECTRUM
DIAGNOSTICS & HEALTH CARE

NAME : MR. AMARESH M	**DATE : 08/04/2024**
AGE/SEX : 59 YEARS / MALE	**REG NO: 0504240010**
REF BY : APOLO CLINIC	

CHEST PA VIEW

- Visualised lungs are clear .
- Bilateral hila appears normal .
- Cardia is normal in size
- No pleural effusion

IMPRESSION: No significant abnormality .

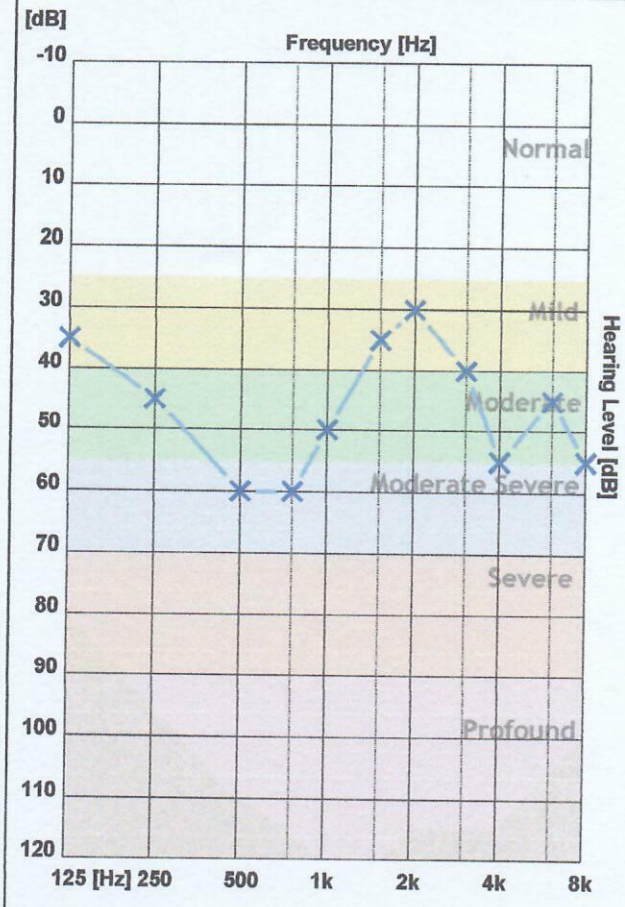
DR PRAVEEN B,DMRD ,DNB
Consultant Radiologist

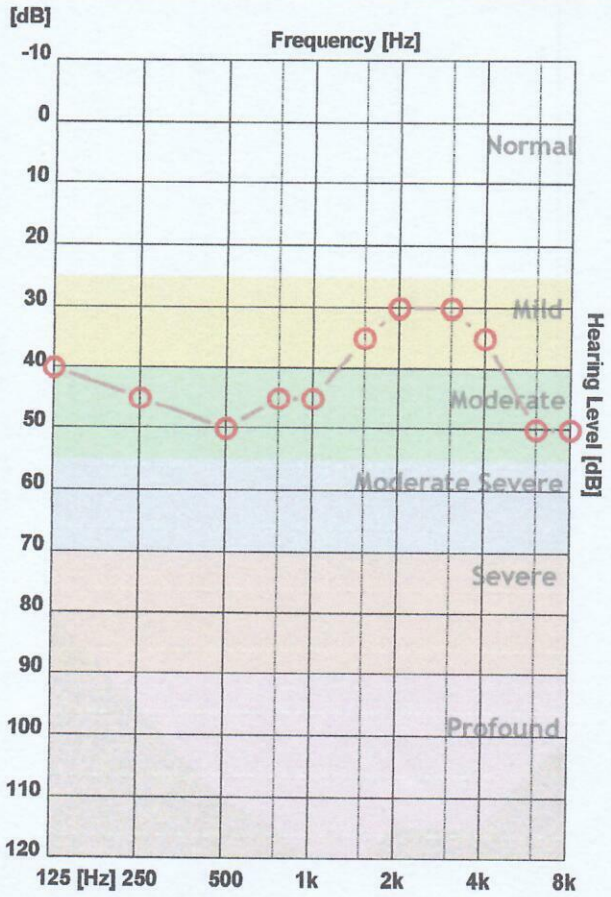
SPECTRUM DIAGNOSTICS

Bangalore

Patient ID : 0310
Name : MR AMERESH M
CR Number : 20240408111049
Registration Date : 08-Apr-2024

Age : 59
Gender : Male
Operator : spectrum diagnostics





	125 Hz	250 Hz	500 Hz	750 Hz	1000 H	1500 H	2000 H	3000 H	4000 H	6000 H	8000 H
X - Air Left	35	45	60	60	50	35	30	40	55	45	55
O - Air Right	40	45	50	45	45	35	30	30	35	50	50
> - Bone Left											
< - Bone Right											

	Average	High	Mid	Low
AIR Left	46.36 dB	48.75 dB	38.33 dB	50.00 dB
AIR Right	41.36 dB	41.25 dB	36.67 dB	45.00 dB

Clinical Notes :

Not Found

SPECTRUM DIAGNOSTICS AND HEALTH CARE BANGALURU

SPECTRUM
DIAGNOSTICS & HEALTH CARE

PATIENT NAME	MR AMARESH M	ID NO	0804240010
AGE	59YEARS	SEX	MALE
REF BY	DR.APOLO CLINIC	DATE	08.04.2024

2D ECHO CARDIOGRAHIC STUDY

M-MODE

AORTA	32mm
LEFT ATRIUM	39mm
RIGHT VENTRICLE	20mm
LEFT VENTRICLE (DIASTOLE)	31mm
LEFT VENTRICLE(SYSTOLE)	27mm
VENTRICULAR SEPTUM (DIASTOLE)	09mm
VENTRICULAR SEPTUM (SYSTOLE)	11mm
POSTERIOR WALL (DIASTOLE)	09mm
POSTERIOR WALL (SYSTOLE)	11mm
FRACTIONAL SHORTENING	30%
EJECTION FRACTION	60%

DOPPLER /COLOUR FLOW

Mitral Valve Velocity : MVE- 0.53m/s MVA – 0.89m/s E/A-0.61

Tissue Doppler : e' (Septal) -10cm/s E/e'(Septal) -5

Velocity/ Gradient across the Pulmonic valve : 0.83m/s 3mmHg

Max. Velocity / Gradient across the Aortic valve : 1.19m/s 4mmHg

Velocity / Gradient across the Tricuspid valve : 1.87 m/s 19mmHg

SPECTRUM
DIAGNOSTICS & HEALTH CARE

PATIENT NAME	MR AMARESH M	ID NO	0804240010
AGE	59YEARS	SEX	MALE
REF BY	DR.APOLO CLINIC	DATE	08.04.2024

2D ECHO CARDIOGRAHIC STUDY

LEFT VENTRICLE	SIZE& THICKNESS	NORMAL
CONTRACTILITY	REGIONAL GLOBAL	NO RWMA

RIGHT VENTRICLE	:	NORMAL
LEFT ATRIUM	:	NORMAL
RIGHT ATRIUM	:	NORMAL
MITRAL VALVE	:	NORMAL
AORTIC VALVE	:	NORMAL
PULMONARY VALVE	:	NORMAL
TRICUSPID VALVE	:	NORMAL
INTER ATRIAL SEPTUM	:	INTACT
INTER VENTRICULAR SEPTUM	:	INTACT
PERICARDIUM	:	NORMAL
OTHERS	:	- NIL

IMPRESSION

- NO REGIONAL WALL MOTION ABNORMALITY PRESENT
- NORMAL VALVES AND DIMENSIONS
- NORMAL LV SYSTOLIC FUNCTION, LVEF- 60%
- GRADE I LVDD
- TRIVIAL MR / TRIVIAL TR
- NORMAL RV FUNCTION
- NO CLOT / VEGETATION / EFFUSION

DURGA V
ECHO TECHNICIAN

The science of radiology is based upon interpretation of shadows of normal and abnormal tissue. This is neither complete nor accurate; hence, findings should always be interpreted in to the light of clinico-pathological correction.

SPECTRUM
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NAME AND LAB NO	MR AMARESH M	REG-40010
AGE & SEX	59YRS	MALE
DATE AND AREA OF INTEREST	08.04.2024	ABDOMEN & PELVIS
REF BY	C/O APOLO CLINIC	

USG ABDOMEN AND PELVIS

LIVER: **Normal in size and shows diffuse increased echogenicity.**
No e/o IHBR dilatation. No evidence of focal lesion.
Portal vein appears normal. CBD appears normal.

GALL BLADDER: Well distended. Wall appears normal.No e/o calculus.

SPLEEN: Normal in size and echotexture. No e/o focal lesion.

PANCREAS: Head and body appears normal . Tail obscured by bowel gas shadows .

RETROPERITONEUM: Suboptimal visualised due to bowel gas

RIGHT KIDNEY: Right kidney measures 10.1 x1.4 cm ,is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid lesions.

LEFT KIDNEY: Left kidney measures 10.0 x1.5 cm ,is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid lesions.

URINARY BLADDER: Well distended. No wall thickening/ calculi.

PROSTATE: Normal in size volume 23 cc(upper limit) and echotexture.

- No evidence of ascites/pleural effusion.

IMPRESSION:

- ***Grade I fatty liver.***
  - ***Suggested clinical / lab correlation.***

DR PRAVEEN B , DMRD , DNB
CONSULTANT RADIOLOGIST

SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-4196

Name	: MR. AMARESH M			**Bill Date**	: 08-Apr-2024 08:22 AM
Age / Gender	: 59 years / Male	**UHID**	: 0804240010	**Sample Col. Date**	: 08-Apr-2024 08:22 AM
Ref. By Dr.	: Dr. APOLO CLINIC	0804240010		**Result Date**	: 08-Apr-2024 12:09 PM
Reg. No.	: 0804240010			**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
Complete Haemogram-Whole Blood EDTA				
Haemoglobin (HB)	15.20	g/dL	Male: 14.0-17.0 Female:12.0-15.0 Newborn:16.50 - 19.50	Spectrophotmeter
Red Blood Cell (RBC)	4.74	million/cumm	3.50 - 5.50	Volumetric Impedance
Packed Cell Volume (PCV)	42.90	%	Male: 42.0-51.0 Female: 36.0-45.0	Electronic Pulse
Mean corpuscular volume (MCV)	90.50	fL	78.0- 94.0	Calculated
Mean corpuscular hemoglobin (MCH)	32.00	pg	27.50-32.20	Calculated
Mean corpuscular hemoglobin concentration (MCHC)	35.30	%	33.00-35.50	Calculated
Red Blood Cell Distribution Width SD (RDW-SD)	40.60	fL	40.0-55.0	Volumetric Impedance
Red Blood Cell Distribution CV (RDW-CV)	**14.80**	%	Male: 11.80-14.50 Female:12.20-16.10	Volumetric Impedance
Mean Platelet Volume (MPV)	10.90	fL	8.0-15.0	Volumetric Impedance
Platelet	2.38	lakh/cumm	1.50-4.50	Volumetric Impedance
Platelet Distribution Width (PDW)	12.80	%	8.30 - 56.60	Volumetric Impedance
White Blood cell Count (WBC)	7670.00	cells/cumm	Male: 4000-11000 Female 4000-11000 Children: 6000-17500 Infants : 9000-30000	Volumetric Impedance
Neutrophils	51.70	%	40.0-75.0	Light scattering/Manual
Lymphocytes	39.50	%	20.0-40.0	Light scattering/Manual
Eosinophils	4.50	%	0.0-8.0	Light scattering/Manual

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Other Branch: #466/A, Ideal Homes Township, 80 Feet Road, Kenchanahalli, Rajarajeshwari Nagar, Bengaluru-560098 +91 6361 253 097 | 080-2991 6944 | 080-49511985

SCAN FOR LOCATION

SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-4196

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Test Name	Result	Unit	Reference Value	Method
Monocytes	4.30	%	0.0-10.0	Light scattering/Manual
Basophils	0.00	%	0.0-1.0	Light scattering/Manual
Absolute Neutrophil Count	3.97	10^3/uL	2.0- 7.0	Calculated
Absolute Lymphocyte Count	**3.03**	10^3/uL	1.0-3.0	Calculated
Absolute Monocyte Count	0.33	10^3/uL	0.20-1.00	Calculated
Absolute Eosinophil Count	340.00	cells/cumm	40-440	Calculated
Absolute Basophil Count	0.00	10^3/uL	0.0-0.10	Calculated
Erythrocyte Sedimentation Rate (ESR)	**16**	mm/hr	Female : 0.0-20.0 Male : 0.0-10.0	Westergren

Peripheral Smear Examination-Whole Blood EDTA

Method: (Microscopy-Manual)

RBC'S : Normocytic Normochromic.
WBC'S : Are normal in total number, morphology and distribution.
Platelets : Adequate in number and normal in morphology.
No abnormal cells or hemoparasites are present.
Impression : Normocytic Normochromic Blood picture.

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Printed On : 12 Apr, 2024 07:18 pm

Dr. Nithun Reddy C,MD,Consultant Pathologist

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Test Name	Result	Unit	Reference Value	Method
Glycosylated Haemoglobin (HbA1c)-Whole Blood EDTA				
Glycosylated Haemoglobin (HbA1c)	9.80	%	Non diabetic adults :<5.7 At risk (Prediabetes) : 5.7 - 6.4 Diagnosing Diabetes :>= 6.5 Diabetes Excellent Control : 6-7 Fair to good Control : 7-8 Unsatisfactory Control :8-10 Poor Control :>10	HPLC
Estimated Average Glucose(eAG)	234.56	mg/dL		Calculated

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.

.

Fasting Blood Sugar (FBS)-Plasma	188	mg/dL	60.0-110.0	Hexo Kinase

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Test Name	Result	Unit	Reference Value	Method

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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Dr. Nithun Reddy C,MD,Consultant Pathologist

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Test Name	Result	Unit	Reference Value	Method
Postprandial Urine glucose-Urine	Positive(+++)		Negative	Dipstick/Benedicts (Manual)

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

Fasting Urine Glucose-Urine	Positive(++)		Negative	Dipstick/Benedicts (Manual)

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Test Name	Result	Unit	Reference Value	Method
LFT-Liver Function Test -Serum				
Bilirubin Total-Serum	0.57	mg/dL	0.2-1.0	Caffeine Benzoate
Bilirubin Direct-Serum	0.12	mg/dL	0.0-0.2	Diazotised Sulphanilic Acid
Bilirubin Indirect-Serum	0.45	mg/dL	Male: 0.0 - 1.10	Direct Measure
Aspartate Aminotransferase (AST/SGOT)-Serum	17.00	U/L	Male: 15.0 - 37.0	UV with Pyridoxal - 5 - Phosphate
Alanine Aminotransferase (ALT/SGPT)-Serum	19.00	U/L	Male: 16.0 - 63.0	UV with Pyridoxal - 5 - Phosphate
Alkaline Phosphatase (ALP)-Serum	71.00	U/L	Male: 45.0 - 117.0	PNPP,AMP-Buffer
Protein, Total-Serum	7.00	g/dL	6.40-8.20	Biuret/Endpoint-With Blank
Albumin-Serum	4.90	g/dL	Male: 3.40 - 5.50	Bromocresol Purple
Globulin-Serum	2.10	g/dL	2.0-3.50	Calculated
Albumin/Globulin Ratio-Serum	2.33	Ratio	0.80-2.0	Calculated

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Test Name	Result	Unit	Reference Value	Method
Lipid Profile-Serum				
Cholesterol Total-Serum	**210.00**	mg/dL	Male: 0.0 - 200	Cholesterol Oxidase/Peroxidase
Triglycerides-Serum	**160.00**	mg/dL	Male: 0.0 - 150	Lipase/Glycerol Dehydrogenase
High-density lipoprotein (HDL) Cholesterol-Serum	49.00	mg/dL	Male: 40.0 - 60.0	Accelerator/Selective Detergent
Non-HDL cholesterol-Serum	**161**	mg/dL	Male: 0.0 - 130	Calculated
Low-density lipoprotein (LDL) Cholesterol-Serum	**139.00**	mg/dL	Male: 0.0 - 100.0	Cholesterol esterase and cholesterol oxidase
Very-low-density lipoprotein (VLDL) cholesterol-Serum	32	mg/dL	Male: 0.0 - 40	Calculated
Cholesterol/HDL Ratio-Serum	4.29	Ratio	Male: 0.0 - 5.0	Calculated

Interpretation:

Parameter	Desirable	Borderline High	High	Very High
Total Cholesterol	<200	200-239	>240	
Triglycerides	<150	150-199	200-499	>500
Non-HDL cholesterol	<130	160-189	190-219	>220
Low-density lipoprotein (LDL) Cholesterol	<100	100-129	160-189	>190

Comments: As per Lipid Association of India (LAI), for routine screening, overnight fasting preferred but not mandatory. Indians are at very high risk of developing Atherosclerotic Cardiovascular (ASCVD). Among the various risk factors for ASCVD such as dyslipidemia, Diabetes Mellitus, sedentary lifestyle, Hypertension, smoking etc., dyslipidemia has the highest population attributable risk for MI both because of direct association with disease pathogenesis and very high prevalence in Indian population. Hence monitoring lipid profile regularly for effective management of dyslipidemia remains one of the most important healthcare targets for prevention of ASCVD. In addition, estimation of ASCVD risk is an essential, initial step in the management of individuals requiring primary prevention of ASCVD. In the context of lipid management, such a risk estimate forms the basis for several key therapeutic decisions, such as the need for and aggressiveness of statin therapy.

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MC-4196

Name	: MR. AMARESH M			**Bill Date**	: 08-Apr-2024 08:22 AM
Age / Gender	: 59 years / Male	**UHID**	: 0804240010	**Sample Col. Date**	: 08-Apr-2024 08:22 AM
Ref. By Dr.	: Dr. APOLO CLINIC	0804240010		**Result Date**	: 08-Apr-2024 12:09 PM
Reg. No.	: 0804240010			**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
KFT (Kidney Function Test) :				
Blood Urea Nitrogen (BUN)-Serum	14.00	mg/dL	7.0-18.0	GLDH,Kinetic Assay
Creatinine-Serum	1.07	mg/dL	Male: 0.70-1.30 Female: 0.55-1.02	Modified kinetic Jaffe
Uric Acid-Serum	5.73	mg/dL	Male: 3.50-7.20 Female: 2.60-6.00	Uricase PAP
Sodium (Na+)-Serum	137.4	mmol/L	135.0-145.0	Ion-Selective Electrodes (ISE)
Potassium (K+)-Serum	4.24	mmol/L	3.5 to 5.5	Ion-Selective Electrodes (ISE)
Chloride(Cl-)-Serum	103.92	mmol/L	96.0-108.0	Ion-Selective Electrodes (ISE)

Comments: Renal Function Test (RFT), also called kidney function tests, are a group of tests performed to evaluate the functions of the kidneys. The kidneys play a vital role in removing waste, toxins, and extra water from the body. They are responsible for maintaining a healthy balance of water, salts, and minerals such as calcium, sodium, potassium, and phosphorus. They are also essential for blood pressure control, maintenance of the body's pH balance, making red blood cell production hormones, and promoting bone health. Hence, keeping your kidneys healthy is essential for maintaining overall health. It helps diagnose inflammation, infection or damage in the kidneys. The test measures Uric Acid, Creatinine, BUN and electrolytes in the blood to determine the health of the kidneys. Risk factors for kidney dysfunction such as hypertension, diabetes, cardiovascular disease, obesity elevated cholesterol or a family history of kidney disease. It may also be when has signs and symptoms of kidney disease, though in early stage often no noticeable symptoms are observed. Kidney panel is useful for general health screening; screening patients at risk of developing kidney disease; management of patients with known kidney disease. Estimated GFR is especially important in CKD patients CKD for monitoring, it helps to identify disease at early stage in those with risk factors for CKD (diabetes, hypertension, cardiovascular disease, and family history of kidney disease). Early recognition and intervention are important in slowing the progression of CKD and preventing its complications.

Calcium,Total- Serum	9.70	mg/dL	8.50-10.10	Spectrophotometry (O-Cresolphthalein complexone)
Gamma-Glutamyl Transferase (GGT)-Serum	21.00	U/L	Male: 15.0-85.0 Female: 5.0-55.0	Other g-Glut-3-carboxy-4 nitro

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Test Name	Result	Unit	Reference Value	Method

Comments: Gamma-glutamyltransferase (GGT) is primarily present in kidney, liver, and pancreatic cells. Small amounts are present in other tissues Even though renal tissue has the highest level of GGT, the enzyme present in the serum appears to originate primarily from the hepatobiliary system, and GGT activity is elevated in any and all forms of liver disease. It is highest in cases of intra- or posthepatic biliary obstruction, reaching levels some 5 to 30 times normal. GGT is more sensitive than alkaline phosphatase (ALP), leucine aminopeptidase, aspartate transaminase, and alanine aminotransferase in detecting obstructive jaundice, cholangitis, and cholecystitis; its rise occurs earlier than with these other enzymes and persists longer. Only modest elevations (2-5 times normal) occur in infectious hepatitis, and in this condition, GGT determinations are less useful diagnostically than are measurements of the transaminases. High elevations of GGT are also observed in patients with either primary or secondary (metastatic) neoplasms. Elevated levels of GGT are noted not only in the sera of patients with alcoholic cirrhosis but also in the majority of sera from persons who are heavy drinkers. Studies have emphasized the value of serum GGT levels in detecting alcohol-induced liver disease. Elevated serum values are also seen in patients receiving drugs such as phenytoin and phenobarbital, and this is thought to reflect induction of new enzyme activity.

Blood Group & Rh Typing-Whole Blood EDTA

Blood Group	B	Slide/Tube agglutination
Rh Type	Positive	Slide/Tube agglutination

Note: Confirm by tube or gel method.

Comments: ABO blood group system, the classification of human blood based on the inherited properties of red blood cells (erythrocytes) as determined by the presence or absence of the antigens A and B, which are carried on the surface of the red cells. Persons may thus have type A, type B, type O, or type AB blood.

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Test Name	Result	Unit	Reference Value	Method
Vitamin D Total (25 Hydroxy Cholecalciferol)	**19.5**	ng/mL	30.0 - 100.0	CLIA

Interpretation: Deficiency :<10, Insufficiency:10-30, Sufficiency:30-100, Toxicity:>100

Note: The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.It shows seasonal variation, with values being 40-50% lower in winter than in summer.Levels vary with age and are increased in pregnancy.A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available.

Comments: 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 hydroxy vitamin D, as it is the major
circulating form and has longer half life (2-3 weeks) than 1,25 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.

Vitamin B12-Serum	545.5	pg/mL	211.0-911.0	CLIA

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.

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Test Name	Result	Unit	Reference Value	Method
Urine Routine Examination-Urine				
Physical Examination				
Colour	Pale Yellow		Pale Yellow	Visual
Appearance	Clear		Clear	Visual
Reaction (pH)	5.50		5.0-7.5	Dipstick
Specific Gravity	1.025		1.000-1.030	Dipstick
Biochemical Examination				
Albumin	Negative		Negative	Dipstick/Precipitation
Glucose	Positive (+++)		Negative	Dipstick/Benedicts
Bilirubin	Negative		Negative	Dipstick/Fouchets
Ketone Bodies	Negative		Negative	Dipstick/Rotheras
Urobilinogen	Normal		Normal	Dipstick/Ehrlichs
Nitrite	Negative		Negative	Dipstick
Microscopic Examination				
Pus Cells	2-3	hpf	0.0-5.0	Microscopy
Epithelial Cells	2-3	hpf	0.0-10.0	Microscopy
RBCs	Absent	hpf	Absent	Microscopy
Casts	Absent		Absent	Microscopy
Crystals	Absent		Absent	Microscopy
Others	Absent		Absent	Microscopy

Comments: The kidneys help infiltration of the blood by eliminating waste out of the body through urine.They also regulate water in the body by conserving electrolytes, proteins, and other compounds. But due to some conditions and abnormalities in kidney function, the urine may encompass some abnormal constituents, which are not normally present.A complete urine examination helps in detecting such abnormal constituents in urine. Several disorders can be detected byidentifying and measuring the levels of such substances. Blood cells, bilirubin, bacteria, pus cells, epithelial cells may be present in urine due to kidney disease or infection. Routine urine examination helps to diagnose kidney diseases, urinary tract infections, diabetes and other metabolic disorders.

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Test Name	Result	Unit	Reference Value	Method
Post prandial Blood Glucose (PPBS)-Plasma	212	mg/dL	70-140	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

Prostate-Specific Antigen(PSA)-Serum	0.58	ng/mL	0.0-4.0	CLIA

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Test Name	Result	Unit	Reference Value	Method

Note: 1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding.
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with
clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, periurethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized /sedentary patients either due to supine position or suspended sexua. activity.
Recommended Testing Intervals: Pre-operatively (Baseline), 2-4 days post-operatively,Prior to discharge from hospital,Monthly followup if levels are high or show a rising trend.

Clinical Use: -An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
-Followup and management of Prostate cancer patients
-Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer.
Increased Levels : Prostate cancer,Benign Prostatic Hyperplasia,Prostatitis,Genitourinary infections.

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Test Name	Result	Unit	Reference Value	Method
Thyroid function tests (TFT)-Serum				
Tri-Iodo Thyronine (T3)-Serum	1.17	ng/mL	Male: 0.60 - 1.81	Chemiluminescence Immunoassay (CLIA)
Thyroxine (T4)-Serum	9.80	µg/dL	Male: 5.50 - 12.10	Chemiluminescence Immunoassay (CLIA)
Thyroid Stimulating Hormone (TSH)-Serum	3.48	µIU/mL	Male: 0.35 - 5.50	Chemiluminescence Immunoassay (CLIA)

Comments: Triiodothyronine (T3) assay is a useful test for hyperthyroidism in patients with low TSH and normal T4 levels. It is also used for the diagnosis of T3 toxicosis. It is not a reliable marker for Hypothyroidism. This test is not recommended for general screening of the population without a clinical suspicion of hyperthyroidism.
Reference range: Cord: (37 Weeks): 0.5-1.41, Children:1-3 Days: 1.0-7.40,1-11 Months: 1.05-2.45,1-5 Years: 1.05-2.69,6-10 Years: 0.94-2.41,11-15 Years: 0.82-2.13,Adolescents (16-20 Years): 0.80-2.10
Reference range: Adults: 20-50 Years: 0.70-2.04, 50-90 Years: 0.40-1.81,
Reference range in Pregnancy: First Trimester : 0.81-1.90,Second Trimester : 1.0-2.60
Increased Levels: Pregnancy, Graves disease, T3 thyrotoxicosis, TSH dependent Hyperthyroidism, increased Thyroid-binding globulin (TBG).
Decreased Levels: Nonthyroidal illness, hypothyroidism , nutritional deficiency, systemic illness, decreased Thyroid-binding globulin (TBG).

Comments: Total T4 levels offer a good index of thyroid function when TBG is normal and non-thyroidal illness is not present. This assay is useful for monitoring treatment with synthetic hormones (synthetic T3 will cause low total T4).It also helps to monitor treatment of Hyperthyroidism with Thiouracil or other anti-thyroid drugs.
Reference Range: Males : 4.6-10.5,Females : 5.5-11.0,> 60 Years: 5.0-10.70,Cord :7.40-13.10,Children:1-3 Days :11.80-22.60,1-2 Weeks : 9.90-16.60,1-4 Months: 7.20-14.40,1-5 Years : 7.30-15.0,5-10 Years: 6.4-13.3
1-15 Years: 5.60-11.70,Newborn Screen:1-5 Days: >7.5,6 Days : >6.5
Increased Levels: Hyperthyroidism, increased TBG, familial dysalbuminemic hyperthyroxinemia,Increased transthyretin, estrogen therapy, pregnancy.
Decreased Levels: Primary hypothyroidism, pituitary TSH deficiency, hypothalamic TRH deficiency, non thyroidal illness, decreased TBG.

Comments:TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies. It is important to confirm any TSH abnormality in a fresh specimen drawn after ~ 3 weeks before assigning a diagnosis, as the cause of an isolated TSH abnormality.
Reference range in Pregnancy: I- trimester:0.1-2.5; II -trimester:0.2-3.0; III- trimester:0.3-3.0
Reference range in Newborns: 0-4 days: 1.0-39.0; 2-20 Weeks:1.7-9.1
Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism and Thyroid hormone resistance.
Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH defi

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