PATIENT NAME: PARVEEN KUMAR	AGE/SEX: 47 YRS/M
REF. BY: TPA	DATE: JUNE 22, 2024

X-RAY CHEST PA VIEW

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

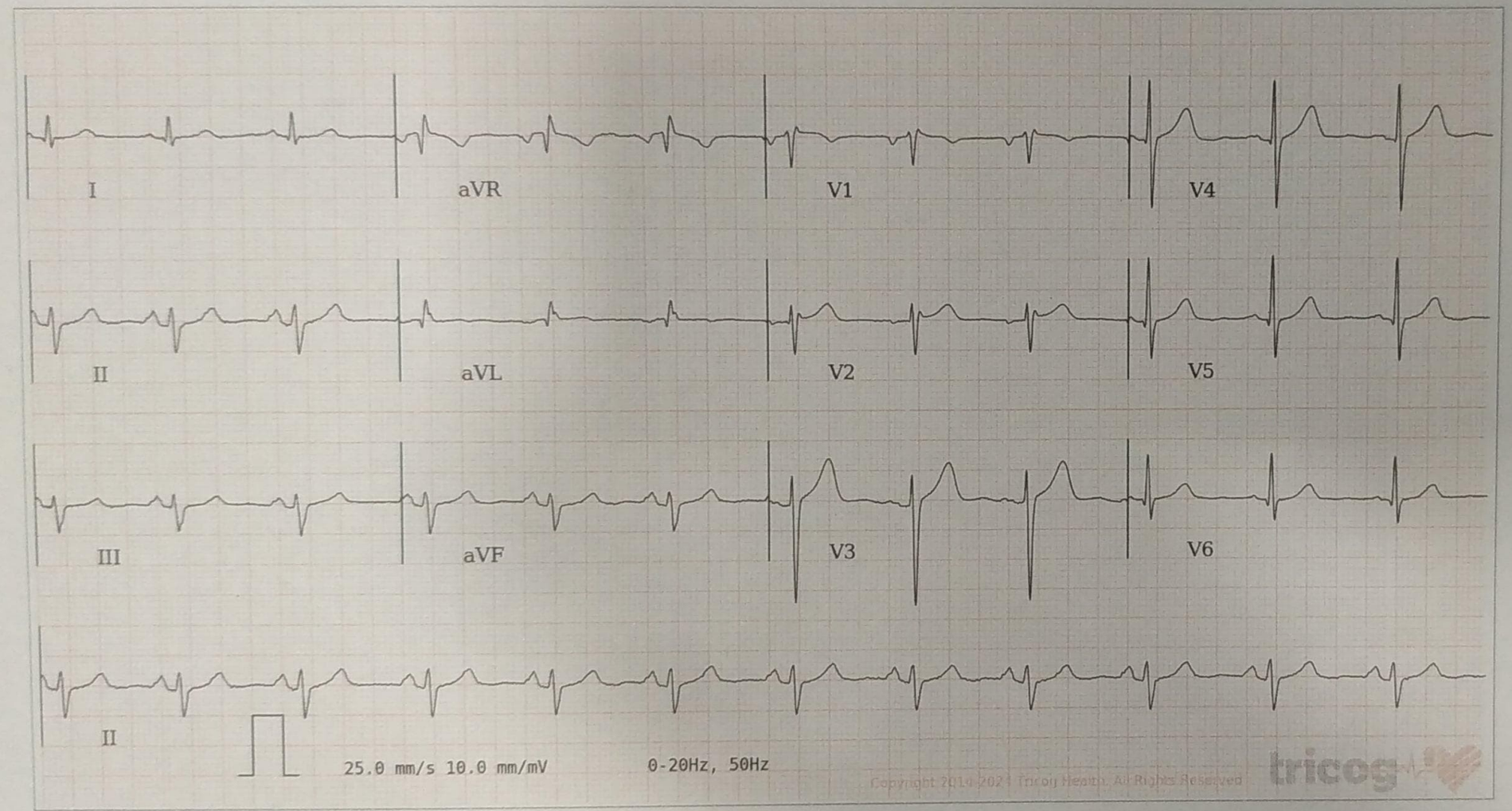
Advised: Clinical correlation and CT Chest

Dr. Rambaksh Sharma, Consultant Radiologist
Dr. Anshul Jain, Consultant Radiologist
Dr. Rajesh Reddu, MDBS, DMRD, Consultant Radiologist
Dr. Amit Verma, Echocardiography Specialist
Dr. Sonam Aneja, Consultant Pathologist

Lotus Diagnostic & Imaging Centre

Age / Sex: 47 / MALE
Patient ID: 2345
Patient Name: Parveen kumar

Date of ECG: **June 25th 2024, 21:25:06**



AR: 75bpm VR: 75bpm QRSD: 92ms QT: 374ms QTcB: 418.14ms PRI: 160ms P-R-T: 72° -54° 65°

Sinus Rhythm, Left Axis Deviation.

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

PATIENT NAME: PARVEEN
REF. BY: TPA

AGE/SEX: 47 YRS/M
DATE: JUNE 22, 2024

USG WHOLE ABDOMEN

Liver: normal in size. Parenchymal echotexture is normal and no focal area of altered echogenicity is seen. IHBR not dilated. CBD is normal in diameter.

GB: is normal, Wall thickness is normal.

Pancreas: head and body shows normal size and parenchymal attenuation.

Spleen: normal in size and normal echotexture.

Right Kidney: is normal in position, size and morphology. No evidence of any calculus detected. Pelvi calyceal system is normal. CMD is maintained.

Left Kidney: is normal in position, size and morphology. No evidence of any calculus detected. Pelvi calyceal system is normal. CMD is maintained.

Urinary Bladder: appears normal.

Prostate: normal in size and echotexture.

No obvious abnormal bowel dilatation or wall thickening is seen in present scan.

No free fluid seen.

IMPRESSION: - No significant abnormality seen sonologically

Clinical correlation and further evaluation is suggested.

Note: 1. Non obstructive calculus may not be visualized on USG.
2. Ureteric calculus may have been recently passed.

Dr. Ram Baksh Sharma
Radiologist

Dr. Rambaksh Sharma
Consultant Radiologist

Dr. Anshul Jain
Consultant Radiologist

Dr. Rajesh Reddu
MBBS, DMRD
Consultant Radiologist

Dr. Amit Verma
Echocardiography Specialist

Dr. Sonam Aneja
Consultant Pathologist

Name	**: Mr. PARVEEN KUMAR S/o**	**UHID :** 118294	**PID :** 31007
Age/Gender :	47 Year/Male	**Sample Date :** 22-Jun-2024	07:15 PM
Ref. By Dr. :	MEDIWHEEL	**Report Date :** 22-Jun-2024	
Address	: HISAR	**Sample Type :** Inside	*31007*

HEAMATOLOGY

CBC (Complete Blood Count)

Test Name	Value	Unit	Reference Range
Haemoglobin (Hb)	16.1	g/dl	12.0 - 17.4 g/dl
Total RBC Count	5.49	m/cumm	4.70 - 6.10
Haematocrit	49.3	%	35.0 - 50.0 %
Mean Cell Volume	89.9	fL	80.0 - 100 fL
Mean Cell Haemoglobin	30.0	pg	27.0 - 34.0 pg
Mean Cell Haemoglobin Conc	33.4	%	32.0 - 36.0
Red Cell Distribution Width (RDW)-CV	13.3	%	11.0 - 16.0 %
Red Cell Distribution Width (RDW)-SD	48.6	fL	35.0 - 56.0 fL
-			
Total Leucocyte Count	8900	cells/cumm	4000 - 11000
Differential Leucocyte Count	.		
Neutrophils	70	%	32 - 72 %
Lymphocytes	25	%	20 - 50 %
Monocytes	03	%	2 - 11 %
Eosinophils	02	%	1 - 3 %
Basophils	0	%	0 - 2 %
Platelet Count	**1,18,000**	cells/cunmm	150,000 - 450,000
Platelet Distribution Width	16.1	fL	15.0 - 18.0 fL
Mean Platelet Volume	11.8	fL	7.0 - 13.0 fL

Sample Type : Whole Blood

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

ABO Blood Grouping

Blood Group	B"POSITIVE		

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

Sample Type : Whole Blood

HBA1C

HBA1C	5.1	%	4.27 - 6.00 %

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Test Name	Value	Unit	Reference Range
HBA1C			
turbidimetric immunoassav Average Blood Glucose turbidimetric immunoassav	99.67	mg/dl	90.00 - 120.00 mg/dl
Sample Type : Whole Blood			

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

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

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

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Test Name	Value	Unit	Reference Range

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

CLINICAL-CHEMISTRY

Glucose, Post Prandial Hexokinase / GOD - POD	121.4	mg/dl	70 - 140 mg/dl
Glucose, Fasting Hexokinase / GOD - POD	94.1	mg/dl	70 - 110 mg/dl

Sample Type : SERUM

KIDNEY FUNCTION TEST (KFT Special)

UREA KINETIC METHOD WITH UREASE AND GLDH	28.8	mg/dL	14 - 45 mg/dL
CREATININE SERUM Jaffe Kinetic	1.0	mg/dL	0.5 - 1.4
Uric acid Uricase - POD	4.2	mg/dL	3.5 - 7.2
BUN SERUM KINETIC METHOD WITH UREASE & GLDH	13.46	mg/dL	07 - 24
SODIUM-SERUM ISE(DIRECT)	138.2	mmol/L	135 - 150

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Test Name	Value	Unit	Reference Range
KIDNEY FUNCTION TEST (KFT Special)			
POTASSIUM SERUM ISE(DIRECT)	3.9	mmol/L	3.5 - 5.0
Chloride Ion Selective Electrode (indirect)	99.5	mmol/L	96 - 106
Urea / Creatinine Ratio	28.8		40:1 - 100:1
BUN / Creatinine Ratio	13.46		10:1 - 20:1
Sample Type : SERUM			

CLINICAL COMMENTS :
UREA: High urea levels suggest poor kidney function, congestive heart failure, shock, stress, recent heart attack or severe burns; bleeding from the gastrointestinal tract; conditions that cause obstruction of urine flow; or dehydration.
Low urea levels can be seen in severe liver disease or malnutrition but are not used to diagnose or monitor these conditions. Low urea levels are also seen in normal pregnancy.
CREATININE: Increases in any renal functional impairment (intrinsic renal lesions, decreased perfusion of the kidney, or obstruction of the lower urinary tract), acromegaly and hyperthyroidism. Decreases in pregnancy, muscle wasting.
URIC ACID: Increases in case of renal failure, disseminated neoplasms, pregnancy toxaemia, psoriasis, liver disease, sarcoidosis etc. Decrease is reported in Wilson's disease, Fanconi's syndrome, xanthinuria.
SODIUM: Increases due to water loss (severe diarrhea profuse sweating, polyuria or vomiting), hypergluco- or mineralo-corticoidism, and inadequate water intake. Decreases due to intake of free water or

LIVER FUNCTION TEST (LFT) (S)			
Total Bilirubin-Serum	0.90	mg/dl	0.20 - 1.00 mg/dl
Bilirubin Direct Serum	0.40	mg/dl	0.10 - 0.50 mg/dl
Bilirubin Indirect-Serum	0.50	mg/dl	0.20 - 0.70 mg/dl
SGOT IFCC with Pyridoxal Phosphate	26.2	IU/L	10 - 40 IU/L
SGPT IFCC with Pyridoxal Phosphate	21.5	IU/L	07 - 56 IU/L
Alkaline Phosphatase IFCC PNPP Buffer	65.3	U/L	44 - 147 U/L
Total Protein BIURET	7.2	gm/dl	6.0 - 8.3
Albumin BCG	3.9	g/dl	3.5 - 5.5 g/dl
Globulin	3.3	gm/dl	2.0 - 3.5 gm/dl
AG RATIO	1.9		1.2 - 2.5
Sample Type : SERUM			

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Test Name	Value	Unit	Reference Range

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

Lipid Profile

Cholesterol CHOD - PAP	159.55	mg/dl	<200.0 mg/dl
Triglycerides GPO - PAP	**180.9**	mg/dl	< 150 mg/dl
HDL Cholesterol Homogeneous Enzymatic Colorimetric test	43.1	mg/dl	Adult males >45 mg/dl
LDL Cholesterol	80.27	mg/dl	<100 mg/dl
VLDL Cholesterol	36.18	mg/dl	<30.0 mg/dl
CHO/HDL Ratio	3.7	mg/dl	Low risk 3.3-4.4
Non HDL Cholesterol Calculated	116.45	mg/dl	<130 mg/dl

Sample Type : SERUM

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

CLINICAL PATHOLOGY

PHYSICAL EXAMINATION

Colour Pale-yellow,Yellowish,Colorless,YELLOW	PALE YELLOW	
Quantity	25	ml

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Test Name	Value	Unit	Reference Range
pH	6.1		
Mucus	ABSENT		
Absent,Present			
Appearance	CLEAR		
Slightly turbid,Turbid,Clear			
Chemical Examination (Strip)	.		
Specific Gravity	1.025		
Albumin	NEGATIVE		
Absent,Present(+),Present(2+),Present(3+)			
Sugar	NEGATIVE		
Absent,Present(+),Present(2+),Present(3+)			
Bilirubin	NEGATIVE		
Absent,Present			
Microscopic Examination (Microscopy)	.		
Pus Cells	1-3	/HPF	
Epithelial Cells	0-1	/HPF	
RBC	NIL	/HPF	
Casts	ABSENT		
Crystals	ABSENT		
Bacteria	ABSENT		
Others			
Sample Type : Urine			

Laboratorv

URINE SUGAR FASTING	NEGATIVE		
Sample Type : Urine			

ENDOCRINE

Thvroid Hormones (T3 .T4 & TSH)

T3	0.98	ng/ml	0.60 - 1.81 ng/ml
T4	10.23	ng/dl	5.01 - 12.45 ng/dl
TSH Ultrasensitive	2.07	ulU/ml	0.3 - 4.5 ulU/ml
Sample Type : SERUM			

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Test Name	Value	Unit	Reference Range

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

--End of Report--