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TEST RE

LABORATORY REPORT

Name	: **Mr DEIVASIGAMANI**	Sex/Age	: **Male / 57 Years**	Case ID	: **40634603490**
Ref. By	:	Dis. At	:	Pt. ID	:
Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:

Reg Date and Time	: 22-Jun-2024 08:55	Sample Type	:	Mobile No.	: 9840074376
Sample Date and Time	: 22-Jun-2024 09:03	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	:	Acc. Remarks	:	Ref Id2	:

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Glyco Hemoglobin (HbA1c)			
HbA1C	**6.60**	%	Non Diabetic : Less than 5.7 % Pre Diabetic : 5.7 - 6.4 Diabetic : => 6.5 %
Lipid Profile			
HDL Cholesterol	**39.0**	mg/dL	< 40 - Low Level 40 - 60 - Average Level > 60 - High Level NCEP Guidelines ATP III.
LDL Cholesterol	**108.4**	mg/dL	0.00 - 100.00
Chol/HDL	**4.28**		0 - 4.1
Liver Function Test			
Proteins (Total)	**6.30**	gm/dL	6.4 - 8.3
25 OH Cholecalciferol (D2+D3)	**25**	ng/mL	Below 20 ng/ml : Deficient 20-30 ng/ml : Insufficient 30 - 100 ng/ml : Sufficient
Plasma Glucose - F	**108.00**	mg/dL	Fasting blood glucose : 70 - 99 mg/dl - Normal 100 - 125 mg/dl - Impaired Fasting : Diabetic : =>126.

Abnormal Result(s) Summary End

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Sample Date and Time	: 22-Jun-2024 09:54	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 12:23	Acc. Remarks	: -	Ref Id2	:

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Phosphorus Inorganic *Phosphomolybdate*		**3.60**	mg/dL	New born - 4.2 to 9.0 Up to 1 Year - 3.8 to 6.2 2 - 5 Years - 3.5 to 6.8 Adult - 2.3 - 4.7	
25 OH Cholecalciferol (D2+D3) *CMIA*	L	**25**	ng/mL	Below 20 ng/ml : Deficient 20-30 ng/ml : Insufficient 30 - 100 ng/ml : Sufficient	

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g, due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

INTERPRETATION

- Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.
- Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.
- Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH- VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.
- Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients.CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

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Dr.Selvi R

Consultant Biochemist

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VITAMIN B - 12

Vitamin B - 12 Level *CMIA*	**332.0**	pg/mL	187 - 883

Introduction :
Vitamin B12, a member of the corrin family, s a cofactor for the formation of myelin, and along with folate, is required for DNA synthesis. Levels above 300 or 400 are rarely associated with B12 deficiency induced hematological or neurological disease.

Clinical Significance :
Causes of Vitamin B12 deficiency can be divided into three classes: Nutritional, malabsorption syndromes and gastrointestinal causes. B12 deficiency can cause Megaloblastic anemia (MA), nerve damage and degeneration of the spinal cord. Lack of B12 even mild deficiencies damages the myelin sheath. The nerve damage caused by a lack of B12 may become permanently debilitating.
The relationship between B12 and MA is not always clear that some patients with MA will have normal B12 levels; conversely, many individuals with B12 deficiency are not afflicted with MA.

Decreased in:
Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraception, parasitic competition, pancreatic deficiency, treated epilepsy and advancing age.

Increased in:
Renal failure, liver disease and myeloproliferative diseases.
Variations due to age Increases: with age.
Temporarily Increased after Drug.
Falsely high in Deteriorated sample.

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Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:
Reg Date and Time	: 22-Jun-2024 08:55	Sample Type	: Whole Blood EDTA,Plasma Fluoride PP,Urine PP	Mobile No.	: 9840074376
Sample Date and Time	: 22-Jun-2024 09:06	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 15:40	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Complete Blood Counts				
RBC Count *Electrical Impedance*	**4.75**	millions/cmm	4.5 - 6.5	
Haemoglobin *SLS*	**13.7**	g/dL	13.5 - 18	
PCV	**41.3**	%	40 - 54	
Mean Corpuscular Volume *Calculated*	**86.9**	fL	76 - 96	
Mean Corpuscular Hemoglobin *Calculated*	**28.8**	pg	27 - 32	
Mean Corpuscular Hb Concentration *Calculated*	**33.2**	g/dL	30 - 35	
Red Cell Distribution Width (RDW) *Calculated*	**12.9**	%	11.5 - 14	
Total Leucocyte Count(TLC) *Fluorescent Flowcytometry*	**6530**	Cells/cmm	4000 - 11000	
Differential Counts				
Neutrophils *Fluorescent Flowcytometry*	**60.3**	%	40 - 75	
Lymphocytes *Fluorescent Flowcytometry*	**31.1**	%	20 - 45	
Monocytes *Fluorescent Flowcytometry*	**4.1**	%	2 - 10	
Eosinophils	**3.7**	%	1 - 6	
Basophils *Fluorescent Flowcytometry*	**0.8**	%	0 - 1	
Absolute Counts				
Absolute Neutrophil Count *Calculated*	**3940**	Cells/cmm	2000-7000	
Absolute Lymphocyte Count *Calculated*	**2030**	Cells/cmm	1000-5000	
Absolute Monocyte Count *Calculated*	**270**	Cells/cmm	200-1000	
Absolute Eosinophil Count *Calculated*	**240**	Cells/cmm	20-500	

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Absolute Basophil Count *Calculated*	**50**	Cell/cmm	20-100
Platelet Count *Electrical Impedance*	**194000**	Cells/cmm	150000 - 400000
Mean Platelet Volume (MPV)	**9.0**	fL	7.2 - 11.7

According to ICSH guideline (international Council for Standardisation in Hematology), the differential counts should be reported in absolute numbers.

BIOCHEMICAL INVESTIGATIONS

Plasma Glucose - PP *HEXOKINASE/G-6-PDH*	**128.00**	mg/dL	Normal : 70-140 mg/dL Impaired Tolerance : 141 - 199 Diabetic : => 200

Clinical Pathology

Urine Glucose (Post Prandial)	**Trace**		Absent

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Sample Date and Time	: 22-Jun-2024 09:05	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 14:43	Acc. Remarks	: -	Ref Id2	:

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR *Photometrical capillary stopped flow kinetic analysis*		**3**	mm/hour	0 - 15	
Blood Group & Rh Type *Manual Method (Forward & Reverse Typing)*		**AB Positive**			

This is a screening method. Advise higher method for confirmation.

BIOCHEMICAL INVESTIGATIONS

Plasma Glucose - F *HEXOKINASE/G-6-PDH*	H	**108.00**	mg/dL	Fasting blood glucose : 70 - 99 mg/dl - Normal 100 - 125 mg/dl - Impaired Fasting : Diabetic : =>126.

Glycated Haemoglobin Estimation

HbA1C *High Performance Liquid Chromatography (HPLC)*	H	**6.60**	%	Non Diabetic : Less than 5.7 % Pre Diabetic : 5.7 - 6.4 Diabetic : => 6.5 %
Estimated Avg Glucose (3 Mths) *Calculated*		**142.72**	mg/dL	Not available

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy,comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

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BIOCHEMICAL INVESTIGATIONS

Prostate Specific Antigen (PSA)

Prostate Specific Antigen	**0.447**	ng/mL	0.0 - 4.0

	0 - 0.5 *(ng/mL)	>0.5 - 2.5 (ng/mL)	>2.5 - 5.0 (ng/mL)	>5.0 - 10 (ng/mL)	>10 (ng/mL)
Healthy Males	87.2	12.8	0.0	0.0	0.0
BPH	51.9	42.9	4.2	0.5	0.5
Stage A Prostate Cancer	38.5	42.3	11.5	3.8	3.8
Stage B Prostate Cancer	23.9	68.7	7.5	0.0	0.0

*% of population

Use

The total PSA test and digital rectal exam (DRE) are used together to help determine the need for a prostate biopsy. The goal of screening is to minimize unnecessary biopsies and to detect clinically significant prostate cancer while it is still confined to the prostate.

Clinical Significance of elevated levels of PSA are associated with prostate cancer, but they may also be seen with prostatitis and benign prostatic hyperplasia (BPH). Mild to moderately increased concentrations of PSA may be seen in those of African American heritage, and levels tend to increase in all men as they age.

Prostate biopsy is required for the diagnosis of cancer.

FREE PSA:TOTAL PSA

Males:

When Total PSA concentration is in the range of 4.0-10.0 ng/mL:

	Probability of cancer		
Free PSA/total PSA ratio	50-59 years	60-69 years	> or =70 years
< or =0.10	49%	58%	65%
0.11-0.18	27%	34%	41%
0.19-0.25	18%	24%	30%
>0.25	9%	12%	16%

Thyroid Function Test

Triiodothyronine (T3) *CMIA*	**81.84**	ng/dL	58 - 159
Thyroxine (T4) *CMIA*	**7.27**	µg/dL	4.87 - 11.72

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BIOCHEMICAL INVESTIGATIONS

Thyroid Function Test

TSH *CMIA*	**1.53**	µIU/mL	0.35 - 4.94

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipent hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a supressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

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BIOCHEMICAL INVESTIGATIONS

Interpretation Note:
Ultra sensitive-thyroid–stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone.Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.
Normal ranges of TSH & thyroid hormons vary according trimesper in pregnancy.

TSH ref range in Pregnacy	Reference range (microIU/ml)
First triemester	0.24 - 2.00
Second triemester	0.43-2.2
Third triemester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

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TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	TEST REMARK
Cholesterol *Enzymatic*		**167.00**	mg/dL	<200 - Desirable 200 - 239 - Borderline High > 240 - High "NCEP Guidelines ATP III".	
Triglyceride *Glycerol Phosphate Oxidase*		**98.00**	mg/dL	< 150 - Normal 150 - 199 - Borderline 200 - 499 - High > 500 - Very High "NCEP Guidelines ATP III".	
HDL Cholesterol *Accelerator Selective Detergent*	**L**	**39.0**	mg/dL	< 40 - Low Level 40 - 60 - Average Level > 60 - High Level NCEP Guidelines ATP III.	
LDL Cholesterol *Calculated*	**H**	**108.4**	mg/dL	0.00 - 100.00	
VLDL *Calculated*		**19.6**	mg/dL	10 - 40	
Non-HDL Cholesterol		**128**	mg/dL	0-130	
LDL/HDL Ratio		**2.78**			
Chol/HDL *Calculated*	**H**	**4.28**		0 - 4.1	

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	TEST REMARK
Kidney Function Test				
Urea *Calculated*	**23.54**	mg/dL	17.97 - 54.99	
Creatinine *Kinetic Alkaline Picrate*	**0.76**	mg/dL	0.5 - 1.4	
Uric Acid *Uricase*	**5.60**	mg/dL	3.5 - 7.2	

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LABORATORY REPORT

Name	: **Mr DEIVASIGAMANI**	Sex/Age	: **Male** / **57 Years**	Case ID	: **40634603490**
Ref. By	:	Dis. At	:	Pt. ID	:
Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:
Reg Date and Time	: 22-Jun-2024 08:55	Sample Type	: Serum	Mobile No.	: 9840074376
Sample Date and Time	: 22-Jun-2024 09:54	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 14:43	Acc. Remarks	: -	Ref Id2	:

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	TEST REMARK
Bilirubin Total *Diazonium Salt*		**0.80**	mg/dL	0.2 - 1.2	
Bilirubin Direct *DIAZO REACTION*		**0.30**	mg/dL	0 - 0.5	
Bilirubin Indirect *Calculated*		**0.50**	mg/dL	0.1 - 1	
S.G.P.T. *NADH (Without P-5-P)*		**16.00**	U/L	0 - 55	
S.G.O.T. *NADH (Without P-5-P)*		**15.00**	U/L	5 - 34	
Alkaline Phosphatase *Para-Nitrophenyl Phosphate*		**47.00**	U/L	40-150	
Gamma Glutamyl Transferase *L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate*		**17.00**	U/L	12 -64	
Proteins (Total) *Biuret*	**L**	**6.30**	gm/dL	6.4 - 8.3	
Albumin *Bromo Cresol Green*		**4.20**	g/dL	3.5-5.2	
Globulin *Calculated*		**2.10**	gm/dL	2 - 4.1	
A/G Ratio *Calculated*		**2.0**		1.0 - 2.1	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr.Selvi R
Consultant Biochemist

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LABORATORY REPORT

Name	: **Mr DEIVASIGAMANI**	Sex/Age	: **Male** / **57 Years**	Case ID	: **40634603490**
Ref. By	:	Dis. At	:	Pt. ID	:
Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:
Reg Date and Time	: 22-Jun-2024 08:55	Sample Type	: Urine	Mobile No.	: 9840074376
Sample Date and Time	: 22-Jun-2024 09:06	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 15:40	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	TEST REMARK
Urine Routine Examination				
Appearance *Manual*	**Clear**		Clear	
Colour	**Pale yellow**		Straw to Yellow	
Reaction (pH) *Ion concentration*	**6.0**		4.6 - 8	
Specific gravity *pKa change*	**1.005**		1.003 - 1.035	
Chemical Examination				
Protein *Tetrabromophenol blue*	**Negative**		Negative	
Glucose *GOD-POD*	**Negative**		Negative	
Bile Pigments *Biochemical*	**Negative**		Negative	
Urobilinogen *Diazotization reaction*	**Not Increased**		Negative	
Ketones *Nitroprusside*	**Negative**		Negative	
Nitrites *N-(1-naphthyl)-ethylenediamine*	**Negative**		Negative	
Blood *Peroxidase*	**Negative**		Negative	
Leucocyte *Microscopy*	**Negative**	/HPF	0 - 5 cells/hpf	
Microscopic Examination				
Red Blood Cells	**Nil**	/HPF	Nil	
Pus Cells *Microscopy*	**3-4**	/HPF	0-5 cells/hpf	
Epithelial Cells *Microscopy*	**2-3**	/HPF	Negative	
Hyaline Casts *Microscopy*	**Nil**	/HPF	Nil	
Pathological Casts *Reflectance Photometry*	**Nil**	/HPF	NIL	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

DR.MONICA KUMBHAT M
MBBS,MD (Pathology) FGIL

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Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:

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Sample Date and Time	: 22-Jun-2024 09:06	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 15:40	Acc. Remarks	:	Ref Id2	:

Crystals

Calcium oxalate Monohydrate	**Nil**	/HPF	Nil
Calcium oxalate Dihydrate	**Nil**	/HPF	Nil
Triple phosphate	**Nil**	/HPF	Nil
Uric Acid	**Nil**	/HPF	Nil
Bacteria	**Nil**	/µL	Nil
Yeast	**Nil**	/µL	Nil
Amorphous Deposits *Phase Contrast Microscopy*	**0.0**	/HPF	0-29.5 p/hpf

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT

Name	: **Mr DEIVASIGAMANI**	Sex/Age	: **Male** / **57 Years**	Case ID	: **40634603490**
Ref. By	:	Dis. At	:	Pt. ID	:
Bill. Loc.	: NDPL - Mediwheel			Pt. Loc	:

Reg Date and Time	: 22-Jun-2024 08:55	Sample Type	: Other,Health Check	Mobile No.	: 9840074376
Sample Date and Time	: 22-Jun-2024 09:03	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 22-Jun-2024 12:58	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Physical Examination				
Height	**172**			
Blood Pressure	**140/80**	mmHg		
Body Weight	**77**			
Body Mass Index	**26.0**			
EYE Test (Near,Far and Color)	**Report Attached**			
DENTAL EXAMINATION	**.**			

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr.Dinesh

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Date: IST: 2024-06-22 09:50:18

Report ID: NELR_01VLL2K26WC0R9Z_V6WC0RBS

Neubeg DIAGNOSTICS
India ● UAE ● South Africa ● USA

imedrix

Personal Details
UHID: 01VLL2K26WC0R9Z
PatientID: 3490
Name: Deivasigamani
Age: 57
Gender: Male
Mobile: 9840074376

Pre-Existing Medical-Conditions

Symptoms

TEST REPORT

Vitals

Measurements
HR: 54 BPM
PR: 185 ms
PD: 123 ms
QRSD: 104 ms
QRS Axis: 28 deg
QT/QTc: 384/384 ms

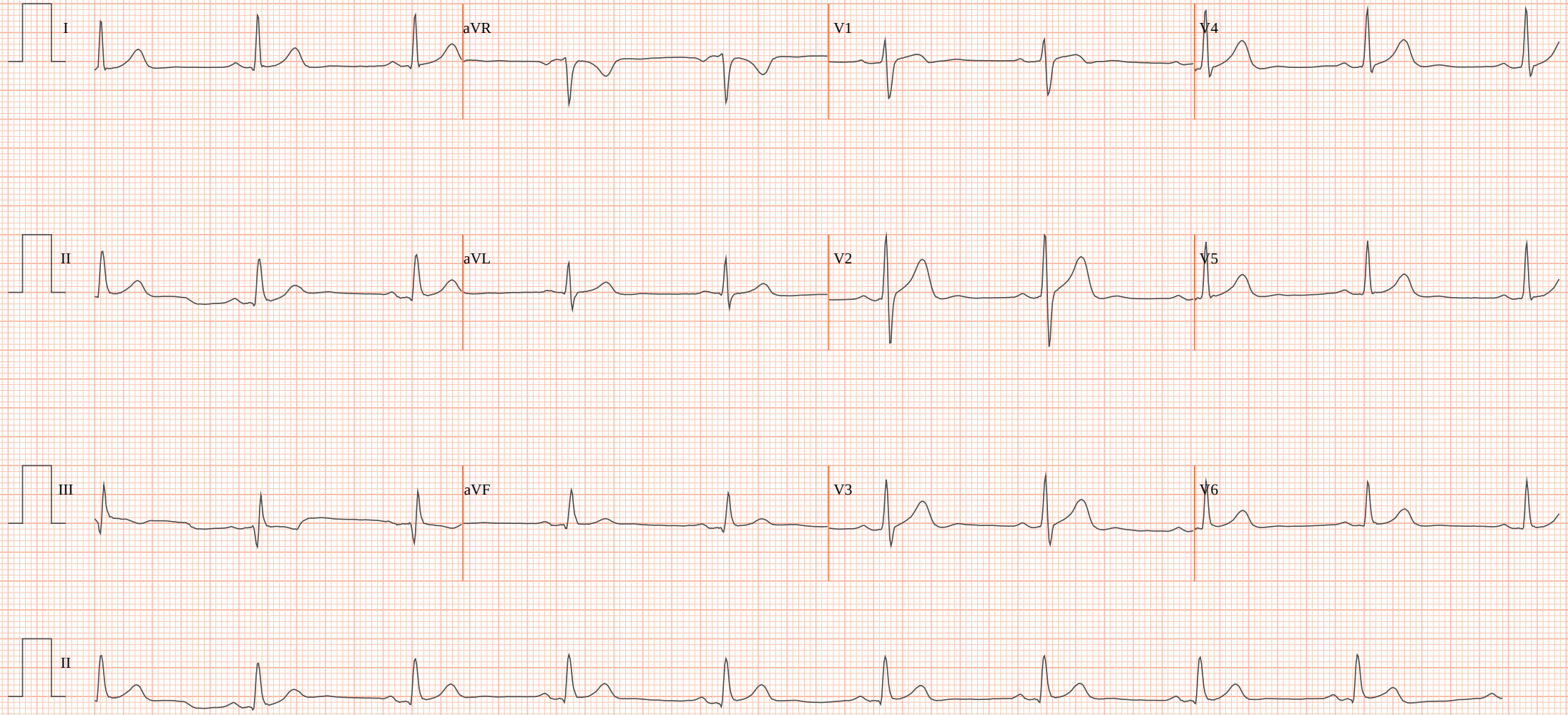
Interpretation

Sinus bradycardia
Normal axis

Authorized by

Dr.Yogesh Kothari
MD,DNB,FESC,FEP
Reg No- KMC 44065

*This trace is generated by **KardioScreen;** Cloud-Connected, Portable, Digital, 6-12 Lead Scalable ECG Platform from **IMEDRIX***



Speed: 25 mm/sec F: 0.05 - 40 Hz Limb: 10 mm/mV Chest: 10 mm/mV

Patient Name	**Mr DEIVASIGAMANI P**	*Patient ID*	**603490**
Age/D.O.B	**57Y**	*Gender*	**M**
Referring Doctor	**NA**	*Date*	**22 Jun 24**

XRAY RADIOGRAPH CHEST - PA

History

.

Observations

Soft tissues of the chest wall are normal.
Cardiothoracic ratio is normal.
Both costophrenic angles appear normal.
Visualized thoracic vertebral is normal.
Sternum appears normal.
Both lung fields are clear.

Impression

The study is within normal limits.

Reported By,

Dr. Farid Khan

MBBS, MD
Consultant Radiologist
MPMC - 23324

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TEST REPORT

LABORATORY REPORT

Name	:Mr DEIVASIGAMANI	Sex/Age	: Male/ 57 Years	Case ID	: 40634603490
Ref By	:	Dis.Loc.	:	Pt ID	:
Bill. Loc.	:NDPL - Mediwheel			Pt. Loc.	:
Registration Date & Time	: 22-Jun-2024 08:55	Sample Type	: Ultrasound	Ph #	: 9840074376
Sample Date & Time	: 22-Jun-2024 09:03	Sample Coll. By	:	Ref Id	:
Report Date & Time	: 22-Jun-2024 13:49	Acc. Remarks	:	Ref Id 2	:

WholeAbdomen :

ULTRASOUND WHOLE ABDOMEN

The liver is normal in size and shows uniform echotexture with no focal abnormality.

The gall bladder is normal sized and smooth walled and contains no calculus.

There is no intra or extra hepatic biliary ductal dilatation.

The pancreas shows a normal configuration and echotexture. The pancreatic duct is normal.

The portal vein and IVC are normal.

The spleen is normal.

There is no free or loculated peritoneal fluid.

No para aortic lymphadenopathy is seen.

No abnormality is seen in the region of the adrenal glands.

The right kidney measures: 9.9 x 4.8 cms.

An irregular clear cortical cyst of 1.6 x 1.3 cm is seen in inter pole region.

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DR. RAMYA
Sonologist

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The left kidney measures: 9.6 x 4.8 cms.

A clear cortical cyst of 3.0 x 3.2 cm is seen in inter pole region.

Both kidneys are normal in size, shape and position. Cortical echoes are normal bilaterally. There is no calculus or calyceal dilatation.

The ureters are not dilated.

The urinary bladder is smooth walled and uniformly transonic. There is no intravesical mass or calculus.

The prostate measures: 2.9 x 3.2 x 3.1 cms, volume: 15.2 cc and is normal sized.

The echotexture is homogeneous.

The seminal vesicles are normal.

Iliac fossae are normal.

No mass or fluid collection is seen in the right iliac fossa. The appendix is not visualized.

IMPRESSION :

- ***BILATERAL RENAL CORTICAL CYSTS***
- ***OTHER ORGANS ARE NORMAL***

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● India ● UAE ● South Africa ● USA

TEST REPORT

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Bill. Loc.	:NDPL - Mediwheel			Pt. Loc.	:
Registration Date & Time	: 22-Jun-2024 08:55	Sample Type	: Ultrasound	Ph #	: 9840074376
Sample Date & Time	: 22-Jun-2024 09:03	Sample Coll. By	:	Ref Id	:
Report Date & Time	: 22-Jun-2024 13:49	Acc. Remarks	:	Ref Id 2	:

---------- End Of Report ----------

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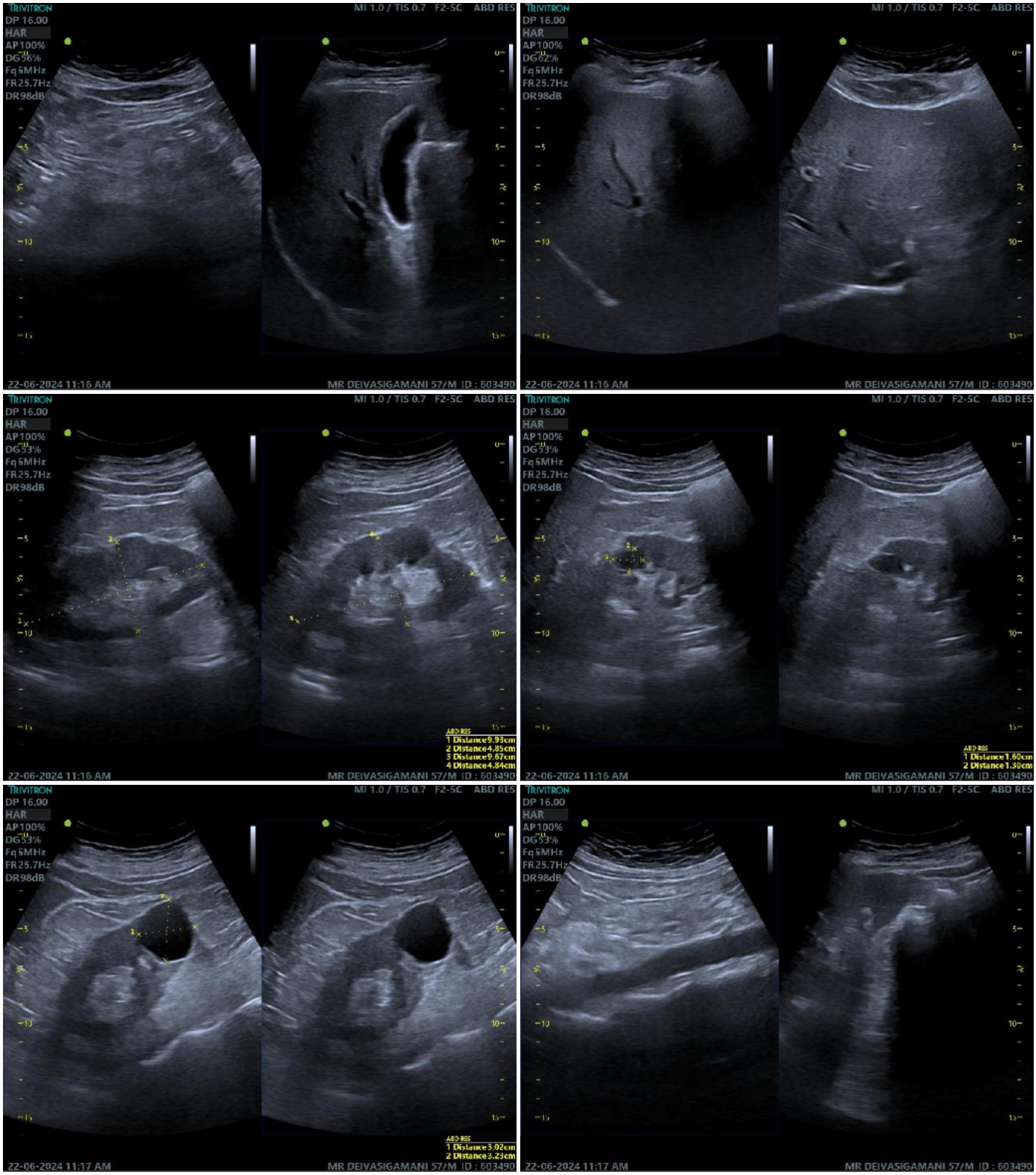
Patient name	MR DEIVASIGAMANI	Age/Sex	
Patient ID	603490	Visit No	1
Referred by		Visit Date	22/06/2024

TEST REPORT



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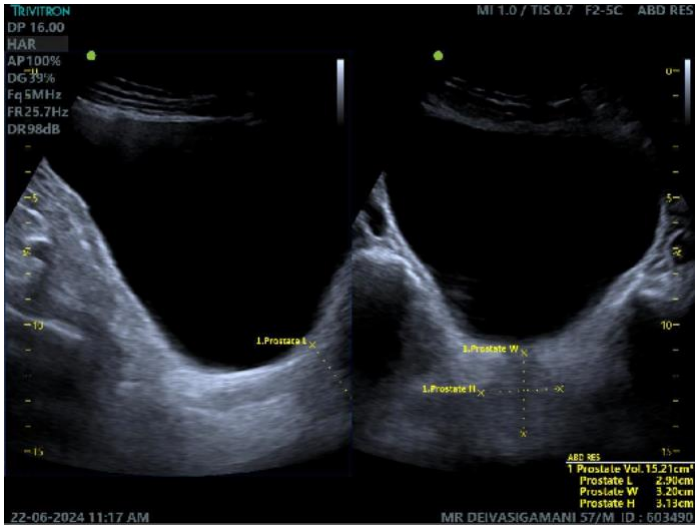
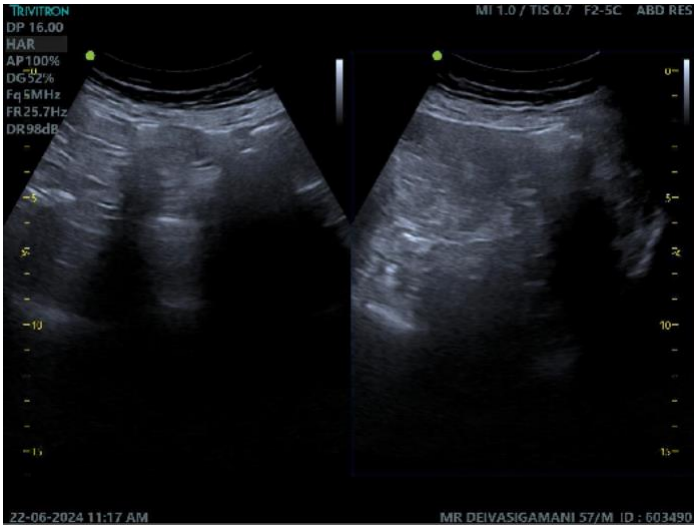
Patient name	MR DEIVASIGAMANI	Age/Sex	
Patient ID	603490	Visit No	1
Referred by		Visit Date	22/06/2024

TEST REPORT





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		LABORATORY REPORT			PID	:	
Name	: Mr DEIVASIGAMANI		Sex/Age :	Male/57 Years	Lab ID	:	40634603490
Ref. By	:				Ref. ID	:	
Corporate	: NDPL - Mediwheel				UID	:	
Reg Dt. Time	: 22-Jun-2024 08:55	Report Released @	:	24-Jun-2024 12:39	Sample Type	:	Health Check
Sample Dt. Time	: 22-Jun-2024 09:03	Report Printed @	:	29-Jun-2024 11:54			

Tread Mill Test :

TMT Negative for Inducible Ischaemia

---------- End Of Report ----------

CHRISTINA KAYALVIZHI
Verified By

Dr.Dinesh

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