



**Hiranandani**  
**HOSPITAL**  
(A Fortis Network Hospital)

**Hiranandani Fortis Hospital**  
Mini Seashore Road,  
Sector 10 - A, Vashi,  
Navi Mumbai - 400 703.  
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Fax : +91-22-3919 9220/21  
Email : vashi@vashihospital.com

**BMI CHART**

Date: 02/11/22

Name: Mr. Dhruv Chaudhary Age: 40 yrs Sex:  M /  F

BP: 120/80 mmHg Height (cms): 168 cm Weight(kgs): 74.1 kg BMI: 26

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese			Extremely Obese					
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38		
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37			
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
5'9" - 176.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
5'11" - 180.3	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33			
6'1" - 185.4	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33			
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			
6'4" - 193.0	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			

**Doctors Notes:**

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Signature



UHID	5044208	Date	02/11/2022		
Name	Mr.Dhananjay Chaudhary	Sex	Male	Sex	40
OPD	Ophthal 14	Health Check-up			

Drug allergy: -> Not known -  
 Sys illness:

Obs. No.

Hcs No.

Unilateral → RA 6/60 (Blw).  
 → CL 6/60

Ref → RA -2.75 D 6/6 NV → W  
 → L -3.50 D 6/6 → U

Add ->

I.O.P. → RA 16.2  
 → CL 16.8

Antseg / wnt

Prf CD -0.4-0.5 NRM  
 CD -0.4-0.5 Healthy

VA

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703

Board Line: 022 - 39199222 | Fax: 022 - 39199220 9112

Emergency: 022 - 39199100 | Ambulance: 1255

For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300

www.fortishealthcare.com |

CIN : U85100MH2005PTC154823

GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani  
HOSPITAL

A Fortis Network Hospital

UHID	5044208	Date	02/11/2022		
Name	Mr.Dhananjay Chaudhary	Sex	Male	Sex	40
OPD	Dental 12	Health Check-up			

Calculus Ht

Sliding Ht

Drug allergy:  
Sys illness:

Treatment

ble - oral prophylaxis.

Dr Dikesh Keekar

**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**

PATIENT ID : **FH.5044208**

CLIENT PATIENT ID : UID:5044208

ACCESSION NO : **0022VK000321**

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 02/11/2022 10:08:00

RECEIVED : 02/11/2022 10:08:11

REPORTED : 02/11/2022 16:45:45

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

**CLINICAL INFORMATION :**

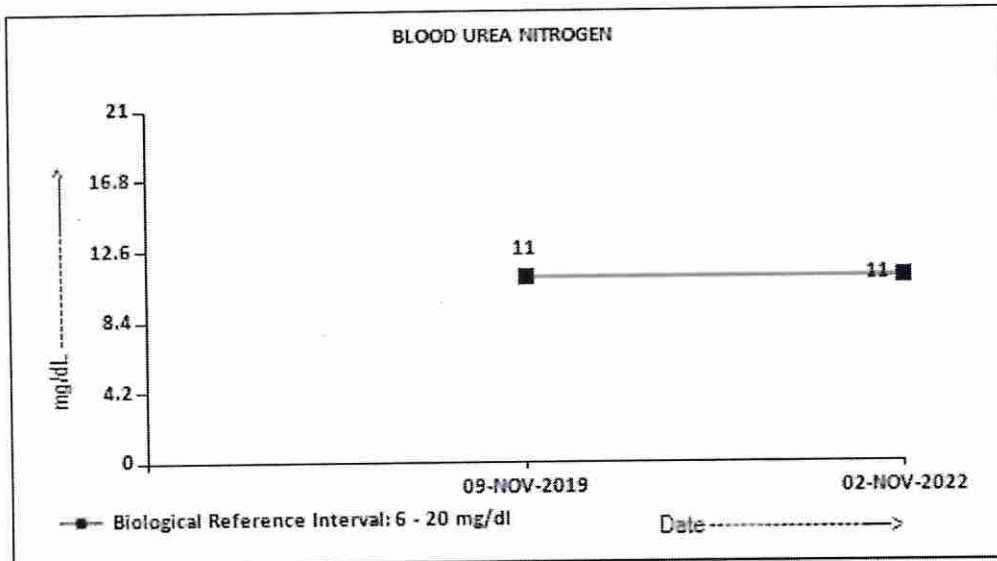
UID:5044208 REQNO-1314759  
CORP-OPD  
BILLNO-1501220PCR054787  
BILLNO-1501220PCR054787

Test Report Status	Final	Results	Biological Reference Interval	Units
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**KIDNEY PANEL - 1**

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN 11 6 - 20 mg/dL  
METHOD : UREASE - UV



**CREATININE EGFR- EPI**

CREATININE 0.80 Low 0.90 - 1.30 mg/dL  
METHOD : ALKALINE PICRATE KINETIC JAFFES  
AGE 40 years  
GLOMERULAR FILTRATION RATE (MALE) 114.74 mL/min/1.73m<sup>2</sup>



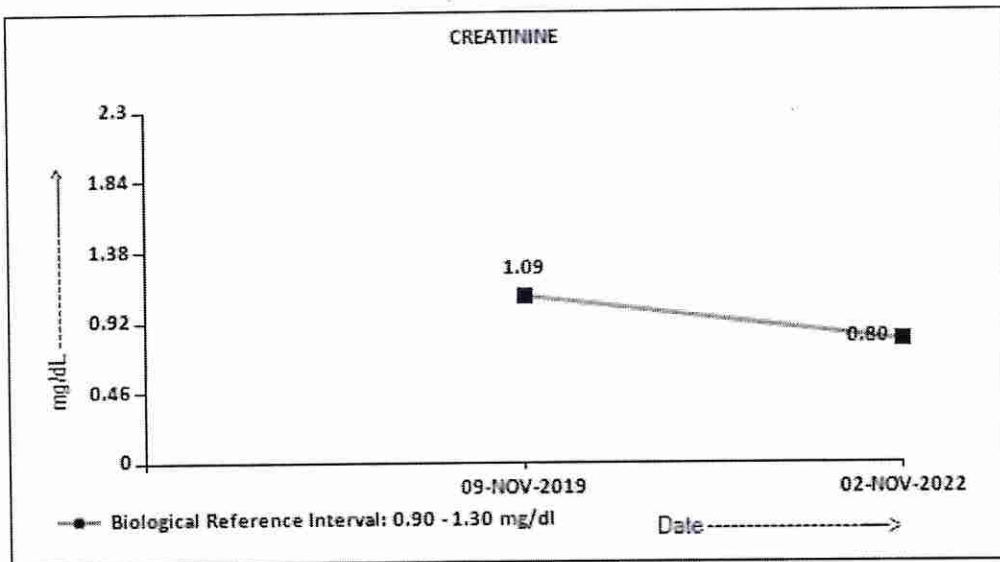
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**BUN/CREAT RATIO**

BUN/CREAT RATIO 13.75 5.00 - 15.00  
 METHOD : CALCULATED PARAMETER

**URIC ACID, SERUM**

URIC ACID 7.1 3.5 - 7.2 mg/dL  
 METHOD : URICASE UV

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN 8.1 6.4 - 8.2 g/dL  
 METHOD : BIURET

**ALBUMIN, SERUM**

ALBUMIN 4.5 3.4 - 5.0 g/dL  
 METHOD : BCP DYE BINDING

**GLOBULIN**

GLOBULIN 3.6 2.0 - 4.1 g/dL  
 METHOD : CALCULATED PARAMETER

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM 139 136 - 145 mmol/L  
 METHOD : ISE INDIRECT

POTASSIUM 4.07 3.50 - 5.10 mmol/L

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METHOD : ISE INDIRECT				
CHLORIDE		104	98 - 107	mmol/L
METHOD : ISE INDIRECT				
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		PALE YELLOW		
METHOD : PHYSICAL				
APPEARANCE		CLEAR		
METHOD : VISUAL				
SPECIFIC GRAVITY		1.020	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)				
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD				
PROTEIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE				
GLUCOSE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD				
KETONES		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE				
BLOOD		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN				
BILIRUBIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT				
UROBILINOGEN		NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)				
NITRITE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE				
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY				
<b>MICROSCOPIC EXAMINATION, URINE</b>				
PUS CELL (WBC'S)		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
ERYTHROCYTES (RBC'S)		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				



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Patient Ref. No. 22000000

**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**

PATIENT ID : **FH.5044208** CLIENT PATIENT ID : UID:5044208  
 ACCESSION NO : **0022VK000321** AGE : 40 Years SEX : Male ABHA NO :  
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 CORP-OPD  
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CASTS		NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS		NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA		NOT DETECTED	NOT DETECTED
METHOD : MICROSCOPIC EXAMINATION			
YEAST		NOT DETECTED	NOT DETECTED
METHOD : MICROSCOPIC EXAMINATION			
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.	

**Interpretation(s)**

**BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)  
 Causes of decreased level include Liver disease, SIADH.

**CREATININE EGFR- EPI-**

**GFR—** Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

**URIC ACID, SERUM-**

Causes of Increased levels

Dietary

- High Protein Intake.
- Prolonged Fasting,
- Rapid weight loss.

Gout

Lesch nyhan syndrome.

Type 2 DM.

Metabolic syndrome.

Causes of decreased levels

- Low Zinc Intake
- OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High Fibre foods
- Vit C Intake
- Antioxidant rich foods

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**TOTAL PROTEIN, SERUM-**

Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease  
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

**ALBUMIN, SERUM-**

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

**ELECTROLYTES (NA/K/CL), SERUM-** Sodium levels are Increased in dehydration, Cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion. Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfunction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting.

**MICROSCOPIC EXAMINATION, URINE-**

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders  
 Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever  
 Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia





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**HAEMATOLOGY**

**CBC-5, EDTA WHOLE BLOOD**

**MORPHOLOGY**

RBC PREDOMINANTLY NORMOCYTIC NORMOCHROMIC  
 METHOD : MICROSCOPIC EXAMINATION  
 WBC NORMAL MORPHOLOGY  
 METHOD : MICROSCOPIC EXAMINATION  
 PLATELETS ADEQUATE  
 METHOD : MICROSCOPIC EXAMINATION

**ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD**

E.S.R 02 0 - 14 mm at 1 h  
 METHOD : WESTERGREN METHOD

**CBC-5, EDTA WHOLE BLOOD**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB) 13.5 13.0 - 17.0 g/dL  
 METHOD : SPECTROPHOTOMETRY  
 RED BLOOD CELL (RBC) COUNT **4.29** Low 4.5 - 5.5 mil/ $\mu$ L  
 METHOD : ELECTRICAL IMPEDANCE  
 WHITE BLOOD CELL (WBC) COUNT 6.22 4.0 - 10.0 thou/ $\mu$ L  
 METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY  
 PLATELET COUNT 175 150 - 410 thou/ $\mu$ L  
 METHOD : ELECTRICAL IMPEDANCE

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV) **39.1** Low 40 - 50 %  
 METHOD : CALCULATED PARAMETER  
 MEAN CORPUSCULAR VOLUME (MCV) 91.3 83 - 101 fL  
 METHOD : CALCULATED PARAMETER  
 MEAN CORPUSCULAR HEMOGLOBIN (MCH) 31.4 27.0 - 32.0 pg  
 METHOD : CALCULATED PARAMETER  
 MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) 34.4 31.5 - 34.5 g/dL  
 METHOD : CALCULATED PARAMETER



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RED CELL DISTRIBUTION WIDTH (RDW)		<b>14.2</b>	High 11.6 - 14.0 %
METHOD : CALCULATED PARAMETER			
MENTZER INDEX		21.3	
MEAN PLATELET VOLUME (MPV)		<b>12.0</b>	High 6.8 - 10.9 fL
METHOD : CALCULATED PARAMETER			
<b>WBC DIFFERENTIAL COUNT</b>			
NEUTROPHILS		58	40 - 80 %
METHOD : FLOW CYTOMETRY			
LYMPHOCYTES		26	20 - 40 %
METHOD : FLOW CYTOMETRY			
MONOCYTES		7	2 - 10 %
METHOD : FLOW CYTOMETRY			
EOSINOPHILS		<b>9</b>	High 1 - 6 %
METHOD : FLOW CYTOMETRY			
BASOPHILS		0	0 - 2 %
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT		3.61	2.0 - 7.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT		1.62	1.0 - 3.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT		0.44	0.2 - 1.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT		<b>0.56</b>	High 0.02 - 0.50 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT		<b>0</b>	Low 0.02 - 0.10 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.2	
METHOD : CALCULATED PARAMETER			

**Interpretation(s)**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-**  
 Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

**TEST INTERPRETATION**

**Increase** in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

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 CIN - U74899PB1995PLC045956  
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Patient Ref. No. 22000000

**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**

PATIENT ID : **FH.5044208** CLIENT PATIENT ID : UID:5044208  
 ACCESSION NO : **0022VK000321** AGE : 40 Years SEX : Male ABHA NO :  
 DRAWN : 02/11/2022 10:08:00 RECEIVED : 02/11/2022 10:08:11 REPORTED : 02/11/2022 16:45:45  
 CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

**CLINICAL INFORMATION :**

UID:5044208 REQNO-1314759  
 CORP-OPD  
 BILLNO-150122OPCR054787  
 BILLNO-150122OPCR054787

Test Report Status	Final	Results	Biological Reference Interval
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Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).  
 In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.  
**Decreased** in: Polycythemia vera, Sickle cell anemia

**LIMITATIONS**

**False elevated ESR :** Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia  
**False Decreased :** Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

**REFERENCE :**

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.  
**RBC AND PLATELET INDICES-**  
 Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia tra (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.  
**WBC DIFFERENTIAL COUNT-**The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and I 3.3, COVID-19 patients tend to show mild disease.  
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 10  
 This ratio element is a calculated parameter and out of NABL scope.

**IMMUNOHAEMATOLOGY**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP TYPE A  
 METHOD : TUBE AGGLUTINATION  
 RH TYPE POSITIVE  
 METHOD : TUBE AGGLUTINATION

**Interpretation(s)**

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-  
 Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

**BIO CHEMISTRY**

**CORONARY RISK PROFILE(LIPID PROFILE).**

SERUM	Result	High	Reference Range	Unit
CHOLESTEROL, TOTAL	208	High	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	217	High	< 150 Normal 150 - 199 Borderline High 200 - 499 High	mg/dL

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METHOD : ENZYMATIC ASSAY			>/=500 Very High
HDL CHOLESTEROL	<b>35</b>	<b>Low</b>	< 40 Low >/=60 High mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	<b>135</b>	<b>High</b>	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	<b>173</b>	<b>High</b>	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220 mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	<b>5.9</b>	<b>High</b>	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	<b>3.9</b>	<b>High</b>	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	<b>43.4</b>	<b>High</b>	</= 30.0 mg/dL
METHOD : CALCULATED PARAMETER			



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PATIENT ID : **FH.5044208**

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ACCESSION NO : **0022VK000321**

AGE : 40 Years

SEX : Male

ABHA NO :

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REFERRING DOCTOR : SELF

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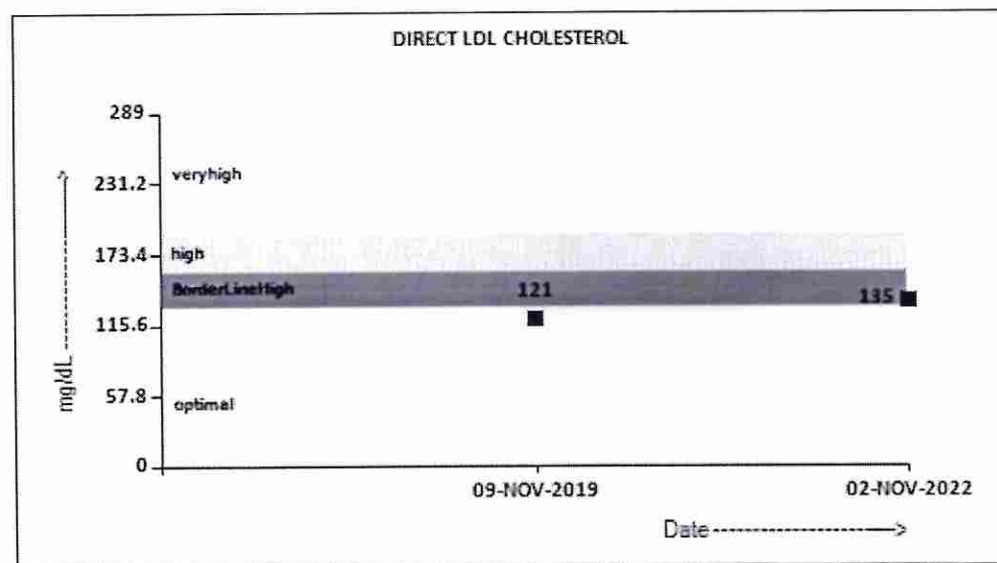
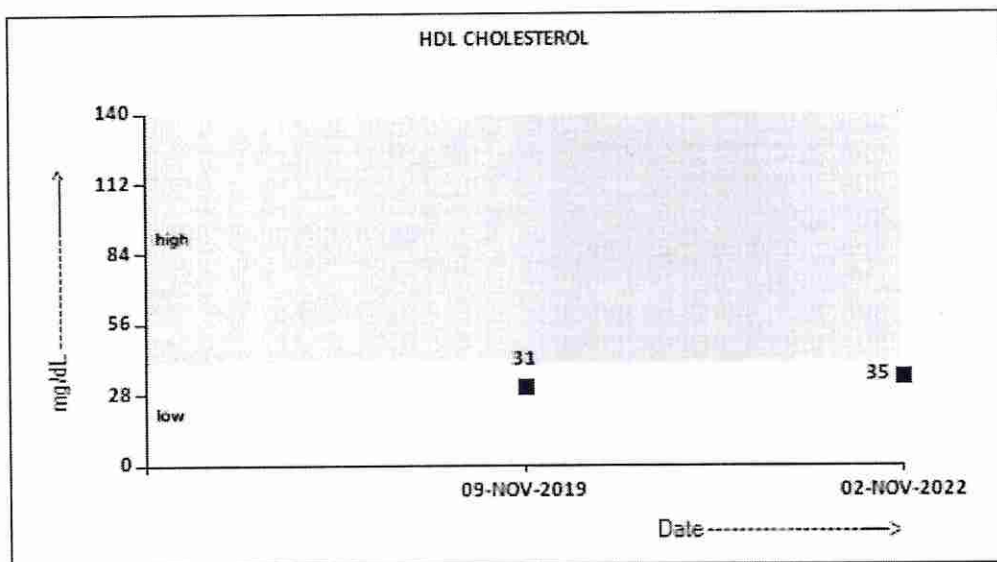
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CORP-OPD

BILLNO-150122OPCR054787

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**LIVER FUNCTION PROFILE, SERUM**

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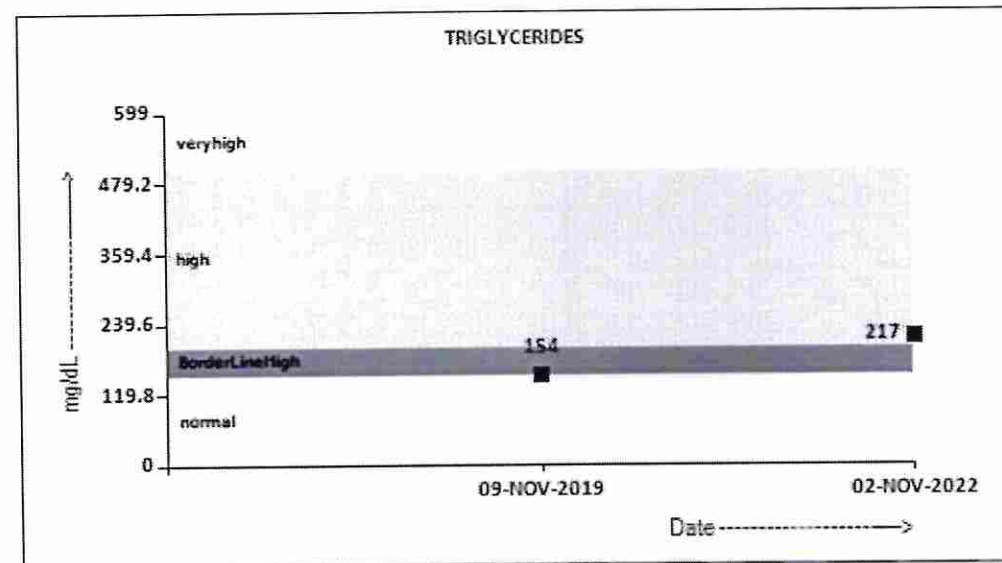
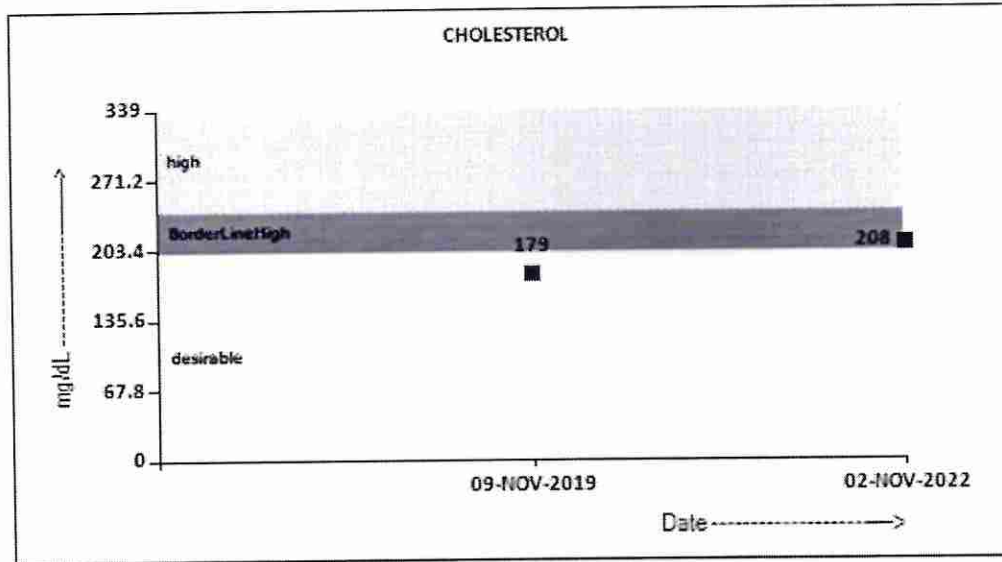
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BILIRUBIN, TOTAL		0.73	0.2 - 1.0 mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT		0.17	0.0 - 0.2 mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT		0.56	0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN		8.1	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		4.5	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.6	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.3	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		30	15 - 37 U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		<b>66</b>	<b>High</b> < 45.0 U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE		80	30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		29	15 - 85 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE		153	100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>			
FBS (FASTING BLOOD SUGAR)		93	74 - 99 mg/dL
METHOD : HEXOKINASE			



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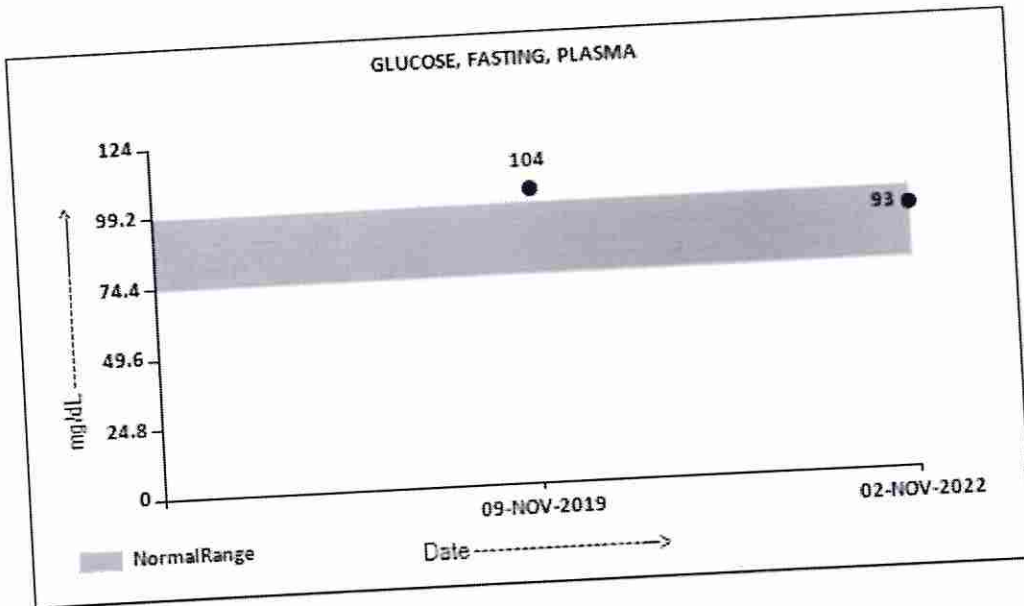
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Test Report Status	Results	Biological Reference Interval
Final		



**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA  
 WHOLE BLOOD**

HBA1C 5.5 Non-diabetic: < 5.7 %  
 Pre-diabetics: 5.7 - 6.4  
 Diabetics: > or = 6.5  
 ADA Target: 7.0  
 Action suggested: > 8.0

METHOD : HB VARIANT (HPLC)  
 ESTIMATED AVERAGE GLUCOSE(EAG) 111.2 < 116.0 mg/dL  
 METHOD : CALCULATED PARAMETER





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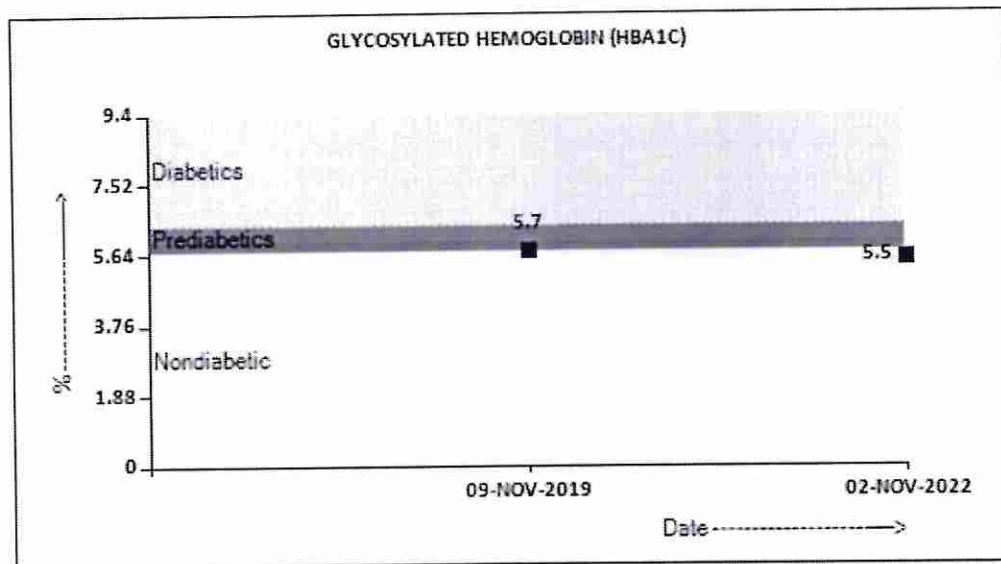
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CORP-OPD

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**Interpretation(s)**

**CORONARY RISK PROFILE(LIPID PROFILE), SERUM-Serum cholesterol** is a blood test that can provide valuable information for the risk of coronary artery disease. This can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

**Serum Triglyceride** are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. Triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, and diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

**High-density lipoprotein (HDL) cholesterol.** This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption, and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

**SERUM LDL** The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.

Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

**Non HDL Cholesterol - Adult treatment panel ATP III** suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

**Recommendations:**

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

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NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

**LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE**

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels are seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in urine.

**Increased in**  
 Diabetes mellitus, Cushing's syndrome (10 – 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in**  
 Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol; sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:**  
 Hypoglycemia is defined as a glucose of < 50 mg/dL in men and < 40 mg/dL in women. While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control. High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.  
**GLYCOSYLATED HEMOGLOBIN (HbA1c), EDTA WHOLE BLOOD-Used For:**

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
  2. Diagnosing diabetes.
  3. Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
  2. eAG gives an evaluation of blood glucose levels for the last couple of months.
  3. eAG is calculated as eAG (mg/dl) = 28.7 \* HbA1c - 46.7

**HbA1c Estimation can get affected due to :**

- I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & op addition are reported to interfere with some assay methods, falsely increasing results.
- IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
  - a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
  - b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

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PATIENT ID : **FH.5044208**

CLIENT PATIENT ID : UID:5044208

ACCESSION NO : **0022VK000321**

AGE : 40 Years SEX : Male

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REFERRING DOCTOR : SELF

**CLINICAL INFORMATION :**

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CORP-OPD

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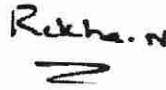
c.HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession



**Dr. Akta Dubey**  
Consultant Pathologist



**Dr. Rekha Nair, MD**  
Microbiologist



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**Patient Ref. No. 220000080575**

**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**

PATIENT ID : **FH.5044208** CLIENT PATIENT ID : UID:5044208  
 ACCESSION NO : **0022VK000407** AGE : 40 Years SEX : Male ABHA NO :  
 DRAWN : 02/11/2022 13:06:00 RECEIVED : 02/11/2022 13:06:55 REPORTED : 02/11/2022 15:15:47  
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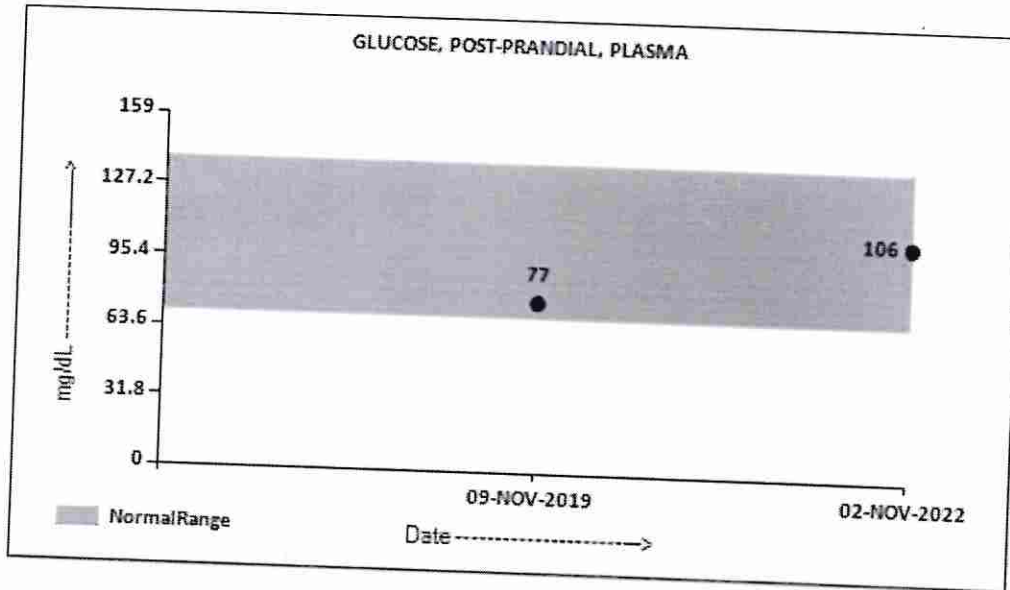
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**BIO CHEMISTRY**

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR) 106 70 - 139 mg/dL  
 METHOD : HEXOKINASE



**Interpretation(s)**

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c

**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

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 CIN - U74899PB1995PLC045956  
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**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**

PATIENT ID : **FH.5044208**

CLIENT PATIENT ID : UID:5044208

ACCESSION NO : **0022VK000407**

AGE : 40 Years SEX : Male

ABHA NO :

DRAWN : 02/11/2022 13:06:00

RECEIVED : 02/11/2022 13:06:55

REPORTED : 02/11/2022 15:15:47

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:5044208 REQNO-1314759

CORP-OPD

BILLNO-1501220PCR054787

BILLNO-1501220PCR054787

Test Report Status	Final	Results	Biological Reference Interval	Unit
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**Dr.Akta Dubey**

**Consultant Pathologist**

**SRL Ltd**

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Page 2 Of 2



**Patient Ref. No. 220000080584**

**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**PATIENT ID : **FH.5044208**

CLIENT PATIENT ID : UID:5044208

ACCESSION NO : **0022VK000321**

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 02/11/2022 10:08:00

RECEIVED : 02/11/2022 10:08:11

REPORTED : 02/11/2022 17:23:14

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

**CLINICAL INFORMATION :**

UID:5044208 REQNO-1314759

CORP-OPD

BILLNO-150122OPCR054787

BILLNO-150122OPCR054787

Test Report Status	Final	Results	Biological Reference Interval	Units
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**SPECIALISED CHEMISTRY - HORMONE****THYROID PANEL, SERUM**

T3	108.2	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	6.97	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH 3RD GENERATION	2.080	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

**Interpretation(s)**

THYROID PANEL, SERUM-Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy	6.6 - 12.4	0.1 - 2.5	81 - 190
1st Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is documented in the pediatric population including the infant age group.

Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

**Reference:**

1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition



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**PATIENT NAME : MR. MR.DHANANJAY CHAUDHARY**PATIENT ID : **FH.5044208**

CLIENT PATIENT ID : UID:5044208

ACCESSION NO : **0022VK000321**

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 02/11/2022 10:08:00

RECEIVED : 02/11/2022 10:08:11

REPORTED : 02/11/2022 17:23:14

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

**CLINICAL INFORMATION :**

UID:5044208 REQNO-1314759

CORP-OPD

BILLNO-150122OPCR054787

BILLNO-150122OPCR054787

Test Report Status	Final	Results	Biological Reference Interval	Units
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**SPECIALISED CHEMISTRY - TUMOR MARKER****PROSTATE SPECIFIC ANTIGEN, SERUM**

PROSTATE SPECIFIC ANTIGEN

0.818

&lt; 2.0

ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

**Interpretation(s)**

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prost  
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue ( because of radical prostatectomy or cystoprostatectomy) and also in the female patient.

- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific referen  
range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(\* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

**\*\*End Of Report\*\*****Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession**


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**Dr. Swapnil Sirmukaddam**  
Consultant Pathologist

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CIN - U74899PB1995PLC045956



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**Patient Ref. No. 220000008**

5044208  
40 Years

DHANANJAY CHAUDHARY  
Male

11/2/2022 12:51:06 PM

HC

Rate 82 . Sinus rhythm.....normal P axis, V-rate 50- 99  
. ST elev, probable normal early repol pattern.....ST elevation, age<55

PR 155  
QRS 87  
QT 357  
QTc 417

Sinus Rhythm  
Normal  
A

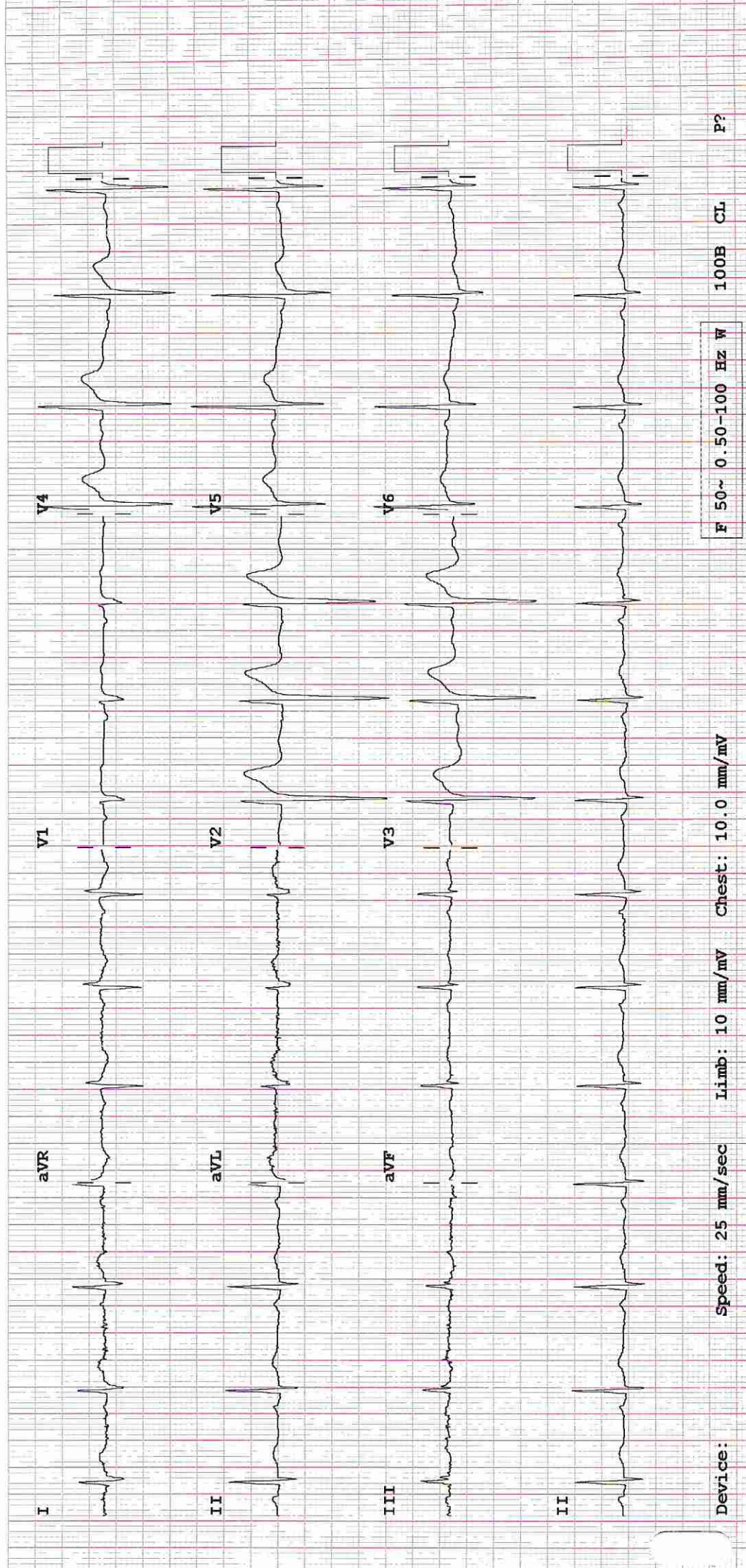
--AXIS--

P 52  
QRS 68  
T 20

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?



**(For Billing/Reports & Discharge Summary only)****DEPARTMENT OF NIC**

Date: 02/Nov/2022

**Name: Mr. Dhananjay Chaudhary****UHID | Episode No : 5044208 | 54273/22/1501****Age | Sex: 40 YEAR(S) | Male****Order No | Order Date: 1501/PN/OP/2211/115282 | 02-Nov-2022****Order Station : FO-OPD****Admitted On | Reporting Date : 02-Nov-2022 17:35:26****Bed Name :****Order Doctor Name : Dr.SELF .****ECHOCARDIOGRAPHY TRANSTHORACIC****FINDINGS:**

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 25 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 15 mm with normal inspiratory collapse .

**M-MODE MEASUREMENTS:**

LA	35	mm
AO Root	29	mm
AO CUSP SEP	18	mm
LVID (s)	31	mm
LVID (d)	43	mm
IVS (d)	10	mm
LVPW (d)	09	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

**(For Billing/Reports & Discharge Summary only)****DEPARTMENT OF NIC**

Date: 02/Nov/2022

Name: Mr. Dhananjay Chaudhary

UHID | Episode No : 5044208 | 54273/22/1501

Age | Sex: 40 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2211/115282 | 02-Nov-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 02-Nov-2022 17:35:26

Bed Name :

Order Doctor Name : Dr.SELF .

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.7 m/sec.

A WAVE VELOCITY: 0.8 m/sec

E/A RATIO: 0.6

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

**Final Impression :**

- No RWMA.
- No LV diastolic dysfunction.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

**DR. PRASHANT PAWAR,**  
**DNB(MED), DNB (CARDIOLOGY)**



DEPARTMENT OF RADIOLOGY

Date: 02/Nov/2022

Name: Mr. Dhananjay Chaudhary

UHID | Episode No : 5044208 | 54273/22/1501

Age | Sex: 40 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2211/115282 | 02-Nov-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 02-Nov-2022 12:18:18

Bed Name :

Order Doctor Name : Dr.SELF.

X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. YOGINI SHAH**  
**DMRD., DNB. (Radiologist)**



DEPARTMENT OF RADIOLOGY

Date: 04/Nov/2022

Name: Mr. Dhananjay Chaudhary

UHID | Episode No : 5044208 | 54273/22/1501

Age | Sex: 40 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2211/115282 | 02-Nov-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 04-Nov-2022 17:41:59

Bed Name :

Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

**LIVER** is normal in size (14.2 cm) and shows raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

**GALL BLADDER** is partially distended.

**SPLEEN** is normal in size (9.5 cm) and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 11.3 x 5.6 cm.

Left kidney measures 10.5 x 5.0 cm.

**PANCREAS:** Head & body of pancreas appear unremarkable. Rest of the pancreas is obscured.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical mass/calculi.

**PROSTATE** is normal in size & echogenicity. It measures ~ 14.8 cc in volume.

No evidence of ascites.

**IMPRESSION:**

- Fatty infiltration of liver.

**DR. YOGESH PATHADE**  
(MD Radio-diagnosis)