LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results		Biological Reference Interval	Uni
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN METHOD : UREASE - UV	11		6 - 20	mg/dL
CREATININE EGFR- EPI				
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	1.18		0.90 - 1.30	mg/dL
AGE	28			years
GLOMERULAR FILTRATION RATE (MALE) METHOD : CALCULATED PARAMETER	86.20		Refer Interpretation Below	mL/min/1
BUN/CREAT RATIO				
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	9.32		5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID METHOD : URICASE UV	**8.8**	**High**	3.5 - 7.2	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN METHOD : BIURET	8.0		6.4 - 8.2	g/dL
ALBUMIN, SERUM				
ALBUMIN METHOD : BCP DYE BINDING	4.5		3.4 - 5.0	g/dL
GLOBULIN				
GLOBULIN METHOD : CALCULATED PARAMETER	3.5		2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM METHOD : ISE INDIRECT	139		136 - 145	mmol/L
POTASSIUM METHOD : ISE INDIRECT	4.13		3.50 - 5.10	mmol/L
CHLORIDE METHOD : ISE INDIRECT	103		98 - 107	mmol/L

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)

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000080

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval	Uni

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 w 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 a 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 Re 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 estima 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 eq 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 Pediat 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
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 a 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,l disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage re failure, hemolysis, trauma, Addison"s disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tul acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidu adrenocortical hyperfuction, 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,

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results		Biological Reference Interval	Unit
HAEMATOLOGY				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	16.6		13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.09		4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	6.04		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	271		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	48.6		40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	95.5		83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	**32.7**	**High**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	34.2		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**14.5**	**High**	11.6 - 14.0	%
MENTZER INDEX	18.8			
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.9		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
NEUTROPHILS METHOD : FLOW CYTOMETRY	52		40 - 80	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY	35		20 - 40	%
MONOCYTES METHOD : FLOW CYTOMETRY	10		2 - 10	%
EOSINOPHILS METHOD : FLOW CYTOMETRY	3		1 - 6	%

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results		Biological Reference Interval	Units
BASOPHILS	0		0 - 2	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT	3.14		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT	2.11		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT	0.60		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.18		0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.5			
METHOD : CALCULATED PARAMETER				
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	03		0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD				

Interpretation(s)
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 trait (<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 NLR < 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) 106504
This ratio element is a calculated parameter and out of NABL scope.
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) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval

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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
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: Polycythermia 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.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B			
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

CHOLESTEROL, TOTAL	**201**	**High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	86		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY				

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results		Biological Reference Interval	
HDL CHOLESTEROL	**39**	**Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	**141**	**High**	< 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	**162**	**High**	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	**5.2**	**High**	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	**3.6**	**High**	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	17.2		</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.68		0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, DIRECT	0.18		0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, INDIRECT	0.50		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	8.0		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN	4.5		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN	3.5		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.3		1.0 - 2.1	RATIO

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 22000000

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results		Biological Reference Interval	
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	28		15 - 37	U/L
METHOD : UV WITH P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**51**	**High**	< 45.0	U/L
METHOD : UV WITH P5P				
ALKALINE PHOSPHATASE	72		30 - 120	U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)	62		15 - 85	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE				
LACTATE DEHYDROGENASE	154		100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**110**	**High**	74 - 99	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	5.2		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)	102.5		< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

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 fact 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 cell 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, ot diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determina 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 blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consum 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

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval

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 b 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 VLD 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 pri 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.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used i 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 gi yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugatec (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin wh 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) bili 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 th 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 measure 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,hemol 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 blo 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 obstru Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels 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 pancre 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 sour 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 sys and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,al 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- 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 Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.H 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 al levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vasc 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 sothat no glucose is excrete 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; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 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 Glyosuria, Glyca 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 patients metabolic control has remained continuously within the target range.

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval

1.eAG (Estimated average glucose) converts percentage HbA1c to md/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 & opi addiction 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.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

CLINICAL PATH

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW	
METHOD : PHYSICAL		
APPEARANCE	CLEAR	
METHOD : VISUAL		
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		

CHEMICAL EXAMINATION, URINE

PH	5.5	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		

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
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			
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)
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 protei 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 retain 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 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

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 13:15:26

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000

LABORATORY REPORT

Cert. No. MC-2984

Fortis

SRL Diagnostics

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 15:12:40

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	101.8		80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
T4	7.68		5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
TSH 3RD GENERATION	**4.440**	**High**	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				

Comments

NOTE: PLEASE CORRELATE VALUES OF THYROID FUNCTION TEST WITH THE CLINICAL & TREATMENT HISTORY OF THE PATIENT.

Interpretation(s)

THYROID PANEL, SERUM-Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabo 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 th 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 Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First 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 i 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. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

SRL Ltd
BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4, KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000(

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006201** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 09:47:00 RECEIVED : 31/10/2022 09:47:33 REPORTED : 31/10/2022 15:12:40

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - TUMOR MARKER			
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN	0.825	< 1.4	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 pros
- 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 refere 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 for related Test Information for this accession

Sirmukaddam 786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006234** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 12:17:00 RECEIVED : 31/10/2022 12:17:36 REPORTED : 31/10/2022 13:10:27

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

CLINICAL INFORMATION :

UID:12091159 REQNO-1313831
CORP-OPD
BILLNO-150122OPCR054258
BILLNO-150122OPCR054258

Test Report Status **Final**	Results	Biological Reference Interval	Unit
BIO CHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	125	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 & Insu treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA:

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr.Akta Dubey
Counsultant Pathologist

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000

LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006292** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 15:49:00 RECEIVED : 31/10/2022 16:05:29 REPORTED : 31/10/2022 16:50:32

CLIENT NAME : **HIRANANDANI HOSPITAL - VASHI -** **REFERRING DOCTOR :** DR. Prashant Dilip Pawar

CLINICAL INFORMATION :

UID:12091159 REQNO-11327751
IPD-TRIAGE
IPID-53923/22/1501
IPID-53923/22/1501

Test Report Status **Final**	Results	Biological Reference Interval	Units
SEROLOGY			
HEPATITIS B SURFACE ANTIGEN, SERUM			
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	NON REACTIVE	
METHOD : IMMUNOCHROMATOGRAPHY			
HCV ABS, SERUM			
HEPATITIS C ABS	NON REACTIVE	NON REACTIVE	
METHOD : IMMUNOCHROMATOGRAPHY			

Interpretation(s)
HEPATITIS B SURFACE ANTIGEN, SERUM-
Hepatitis B is caused by infection with HBV, a enveloped DNA agent that is classified as hepadnavirus.This test detects the presence of viral surface antigen (HbsAg) in serum sample and is indicative of an active HBV infection, either acute or chronic.

Test Utility:
HbsAg is the first serologic marker appearing in the serum 6-16 weeks following hepatitis B viral infection. In typical HBV infection, HBsAg will be detected 2-4 weeks the liver enzyme levels (ALT) become abnormal and 3-5 weeks before patient develops jaundice.In acute cases HbsAg usually disappears 1-2 months after the onset symptoms.Persistence of HbsAg for more than 6 months indicates development of either a chronic carrier state or chronic liver disease.The presence of HbsAg is frequ associated with infectivity. HbsAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.

Limitations:
- For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection. If the anti results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.
- HBsAg detection will only indicate the presence of surface antigens in the serum and should not be used as the sole criteria for diagnosis, staging or monitoring of H infection This test may be negative during ""window period"" i.e. after disappearance of anti-HBs.
- The current assay being a highly sensitive test , may yield a small percentage of false positive reports. Hence all HbsAg positive specimens should be confirmed wit assay based upon Neutralisation of Human anti Hepatitis B Surface antibody.
HCV ABS, SERUM-Hepatitis C Virus (HCV) is a blood borne flavivirus. It is one of the most important causes of post-blood transfusion as well as community acquired non-B hepatitis and chronic liver failure. Although the majority of infected individuals may be asymptomatic, HCV infection may develop into chronic hepatitis, cirrhos and/or increased risk of hepatocellular carcinoma.

Notes & Limitations:
- HCV antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance of the first biochemical marker of illness) and is al always detectable by the late convalescent stage of infection. - A negative result may also be observed due to loss of HCV antigen, years following resolution of infection. Infants born to hepatitis C infected mothers may have delayed seroconversion to anti-HCV. Hence a negative result should be evaluated cautiously with re clinical findings. It is to be noted that absence of HCV antibodies after 14 weeks of exposure is strong evidence against HCV infection.
- Presence of HCV antibodies does not imply an active Hepatitis C infection but is indicative of both past and/or recent infection .It has been reported that as many a of individuals receiving intravenous commercial immunoglobulin test falsely positive for HCV antibody. Also,patients with autoimmune liver disease may show a false HCV antibody result. Hence it is advisable to confirm a positive antibody result with a supplemental test. A positive result when followed by a positive supplemental HCV-RNA-PCR) suggests active hepatitis C infection.

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000

PATIENT NAME : MR. MR.ANIL REDDY DAMMA

PATIENT ID : **FH.12091159** CLIENT PATIENT ID : UID:12091159

ACCESSION NO : **0022VJ006292** AGE : 28 Years SEX : Male ABHA NO :

DRAWN : 31/10/2022 15:49:00 RECEIVED : 31/10/2022 16:05:29 REPORTED : 31/10/2022 16:50:32

CLIENT NAME : **HIRANANDANI HOSPITAL - VASHI -** **REFERRING DOCTOR :** DR. Prashant Dilip Pawar

CLINICAL INFORMATION :

UID:12091159 REQNO-11327751
IPD-TRIAGE
IPID-53923/22/1501
IPID-53923/22/1501

Test Report Status **Final**	Results	Biological Reference Interval	Units

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.
Board Line: 022 - 39199222 | Fax: 022 - 39133220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300
www.fortishealthcare.com | vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

Date: 09/Nov/2022

DEPARTMENT OF NIC

Name: Mr. Anil Reddy Damma
Age | Sex: 28 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12091159 | 53778/22/1501
Order No | Order Date: 1501/PN/OP/2210/114135 | 31-Oct-2022
Admitted On | Reporting Date : 31-Oct-2022 14:35:11
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- **A tiny , homogenous , mass measuring about 10 x 7 mm at LV apex (? clot) .**
- All apical segments of Left ventricle are severely hypokinetic.
  Rest of the left ventricle wall shows normal contractility.
- Mildly depressed left ventricle systolic function. LVEF approximately: 45%.
- No e/o left ventricle diastolic dysfunction. No e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- IAS and IVS are intact.
- Normal right atrium and right ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse

M-MODE MEASUREMENTS:

LA	35	mm
AO Root	29	mm
AO CUSP SEP	16	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	45	%

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.
Board Line: 022 - 39199222 I Fax: 022 - 39133220
Emergency: 022 - 39199100 I Ambulance: 1255
For Appointment: 022 - 39199200 I Health Checkup: 022 - 39199300
www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

Date: 09/Nov/2022

DEPARTMENT OF NIC

Name: Mr. Anil Reddy Damma
Age | Sex: 28 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12091159 | 53778/22/1501
Order No | Order Date: 1501/PN/OP/2210/114135 | 31-Oct-2022
Admitted On | Reporting Date : 31-Oct-2022 14:35:11
Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.8 m/sec
E/A RATIO: 1.1

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

Final Impression :

- IHD with mild LV systolic dysfunction.
- RWMA as above.
- **A tiny , homogenous ,mass at LV apex (? clot) .**
- No e/o LV diastolic dysfunction.

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

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.
Board Line: 022 - 39199222 I Fax: 022 - 39133220
Emergency: 022 - 39199100 I Ambulance: 1255
For Appointment: 022 - 39199200 I Health Checkup: 022 - 39199300
www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 31/Oct/2022

Name: Mr. Anil Reddy Damma	**UHID | Episode No : 12091159 | 53778/22/1501**
Age | Sex: 28 YEAR(S) | Male	**Order No | Order Date: 1501/PN/OP/2210/114135 | 31-Oct-2022**
Order Station : FO-OPD	**Admitted On | Reporting Date : 31-Oct-2022 10:36:48**
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)