भारत सरकार
Government of India

सूरेश कुमार सैनी
Suresh Kumar Saini
जन्म तिथि / DOB : 11/06/1975
पुरुष / Male

9443 0924 8382

मेरा आधार, मेरी पहचान

Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:
S/O ज्वाला प्रसाद सैनी, मालीयो की ढाणी, तहसील-सूरजगढ़, गोपालपुरा, झुंझुनू, लोटिया, राजस्थान, 333029

Address:
S/O Jwala Prasad Saini, maliyo ki dhani, tahasil-surajgarh, Gopalpura, Jhunjhunun, Lotia, Rajasthan, 333029

9443 0924 8382

1947 | help@uidai.gov.in | www.uidai.gov.in

P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

General Physical Examination

Date of Examination: 09/12/22

Name: SURESH KUMAR SAINI Age: 47 DOB: 11/06/1975 Sex: Male

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD ID #: 8388

Ht: 176 (cm) Wt: 75 (Kg)

Chest (Expiration): 96 (cm) Abdomen Circumference: 93 (cm)

Blood Pressure: 130/85 mm Hg PR: 78 / min RR: 18 / min Temp: _____

BMI 23

Eye Examination: RIE] GIG ; NIG , NCB
LIE] GIG , NIG , NCB

Other: N/A

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examine : ---------- **Name of Examinee:** SURESH KUMAR SAINI

Signature Medical Examiner : ---------- **Name Medical Examiner** DR. U.C GUPTA

Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291

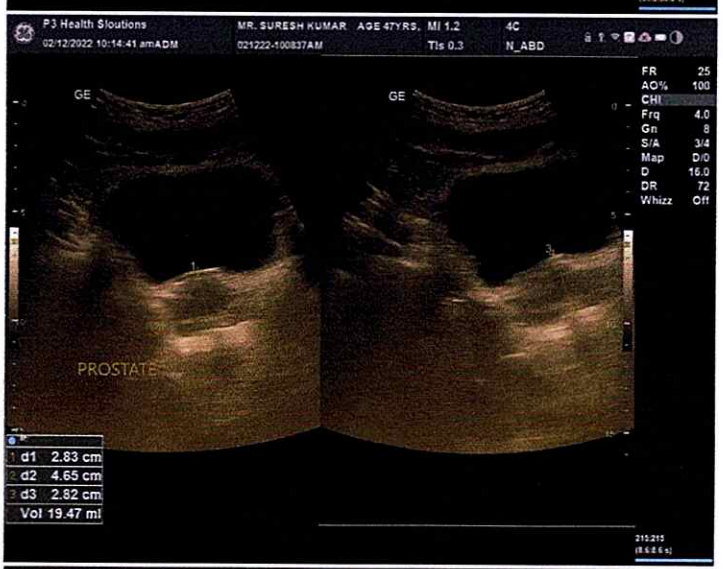

P3 Health Sloutions
02/12/2022 10:11:30 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.1
Tis 0.3
4C
N_ABD
GE
LIVER
FR 23
AO% 100
CHI
Frq 4.0
Gn 42
S/A 3/4
Map F/0
D 18.0
DR 72
Whizz Off
L 138.07 mm


P3 Health Sloutions
02/12/2022 10:12:05 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.2
Tis 0.3
4C
N_ABD
GE
GALLBLADDER
FR 25
AO% 100
CHI
Frq 4.0
Gn 44
S/A 3/4
Map F/0
D 16.0
DR 72
Whizz Off


P3 Health Sloutions
02/12/2022 10:12:36 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.0
Tis 0.3
4C
N_ABD
GE
FR 20
AO% 100
CHI
Frq 4.0
Gn 23
S/A 3/4
Map F/0
D 21.0
DR 72
Whizz Off


P3 Health Sloutions
02/12/2022 10:13:22 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.1
Tis 0.4
4C
N_ABD
GE
RT KIDNEY
FR 29
AO% 100
CHI
Frq 4.0
Gn 21
S/A 3/4
Map F/0
D 14.0
DR 72
Whizz Off
L 106.10 mm
L 52.38 mm


P3 Health Sloutions
02/12/2022 10:14:24 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.2
Tis 0.3
4C
N_ABD
GE
URINARY BLADDER
FR 25
AO% 100
CHI
Frq 4.0
Gn 18
S/A 3/4
Map F/0
D 16.0
DR 72
Whizz Off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02/12/2022 10:14:41 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.2
Tis 0.3
4C
N_ABD
GE
GE
PROSTATE
FR 25
AO% 100
CHI
Frq 4.0
Gn 8
S/A 3/4
Map D/0
D 16.0
DR 72
Whizz Off
d1 2.83 cm
d2 4.65 cm
d3 2.82 cm
Vol 19.47 ml


P3 Health Sloutions
02/12/2022 10:15:18 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.2
Tis 0.3
4C
N_ABD
GE
SPLEEN
FR 25
AO% 100
CHI
Frq 4.0
Gn 37
S/A 3/4
Map F/0
D 16.0
DR 72
Whizz Off
L 125.16 mm


P3 Health Sloutions
02/12/2022 10:15:55 amADM
MR. SURESH KUMAR AGE 47YRS.
021222-100837AM
MI 1.1
Tis 0.4
4C
N_ABD
GE
LT KIDNEY
FR 26
AO% 100
CHI
Frq 4.0
Gn 22
S/A 3/4
Map F/0
D 15.0
DR 72
Whizz Off
L 121.60 mm
L 50.53 mm

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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

MR. SURESH KUMAR SAINI	AGE: 47 Y/Male
Registration Date: 02-11-2022	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (13.8 cm). Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is collapsed. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape (12.5 cm). Echotexture is normal. No focal lesion is seen.

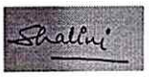
Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.
Right kidney is measuring approx. 10.6 x 5.2 cm.
Left kidney is measuring approx. 12.1 x 5.0 cm.

Urinary bladder does not show any calculus or mass lesion.

Prostate is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
No significant free fluid is seen in pelvis.

IMPRESSION: No significant abnormality is detected.



DR.SHALINI GOEL

M.B.B.S, D.N.B (Radiodiagnosis)

RMC no.: 21954

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B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

NAME:	MR. SURESH KUMAR SAINI	AGE	47 YRS/M
REF.BY	DR. BANK OF BARODA	DATE	02-12-2022

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected.

DR.SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC No.: 21954

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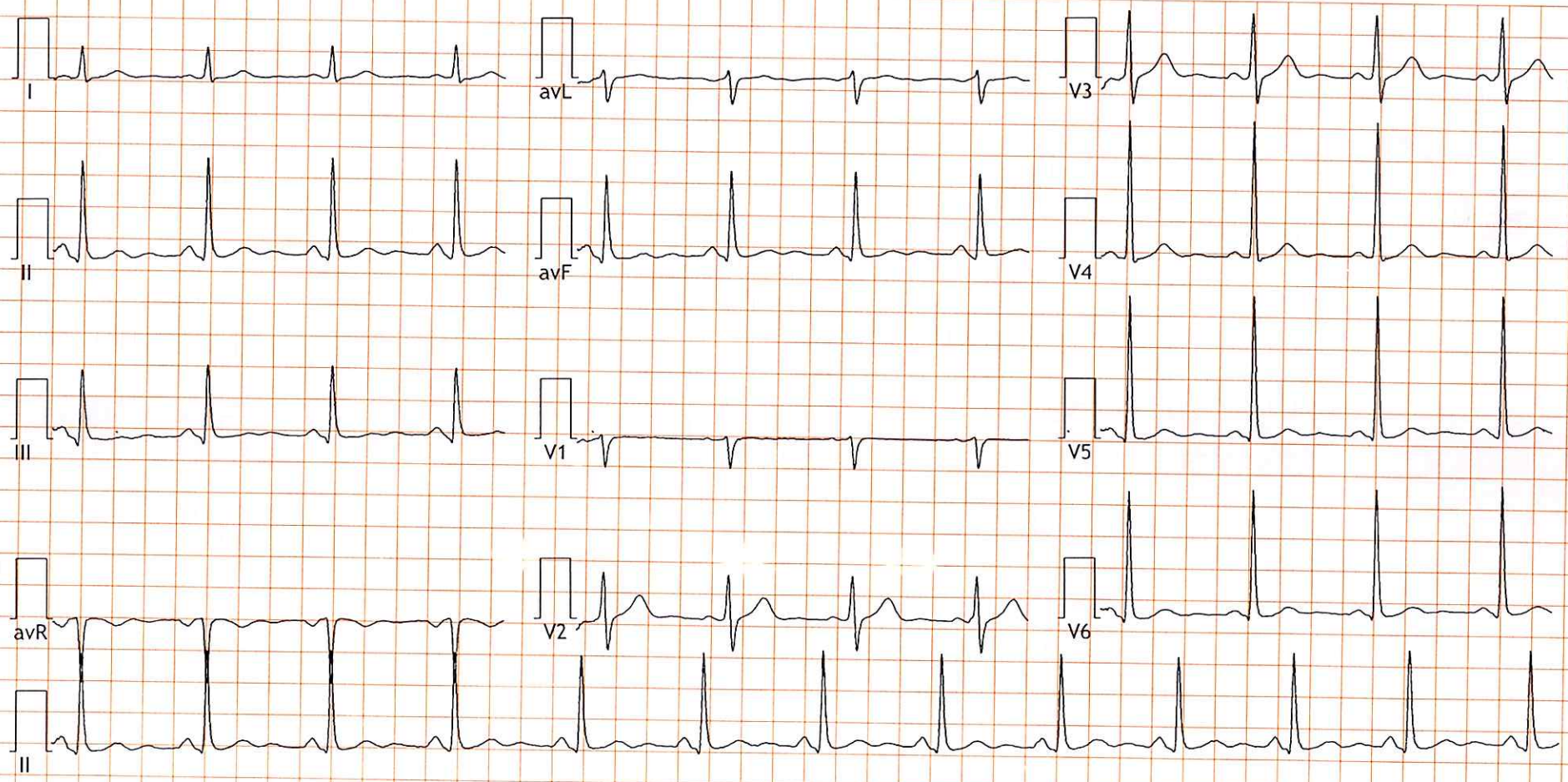
B-14, Vidhyanagar Nagar, Enclave, Phase-2, Jaipur
12229451322600/Mr Suresh Kumar Saini 47Yrs-2Months/Male Kgs/ Cms BP: ___/___ mmHg HR: 74 bpm
Ref.: BANK OF BARODA Test Date: 02-Dec-2022(11:41:06) Notch: 50Hz 0.05Hz - 100Hz 10mm/mV 25mm/Sec

PR Interval: 146 ms
QRS Duration: 90 ms
QT/QTc: 355/396ms
P-QRS-T Axis: 73 - 73 - 46 (Deg)



TWNL

FINDINGS: Normal Sinus Rhythm
Vent Rate : 74 bpm; **PR Interval :** 146 ms; **QRS Duration:** 90 ms; **QT/QTc Int :** 355/396 ms
P-QRS-T axis: 73• 73• 46• (Deg)
Comments :

Dr. Naresh Kumar Mohanka
RMC No.: 35703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)

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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

Summary

1322252/MR SURESH KUMAR SAINI 47 Yrs/Male 0 Kg/0 Cms

Date: 02-Dec-2022 11:44:11 AM

Ref.By : BANK OF BARODA

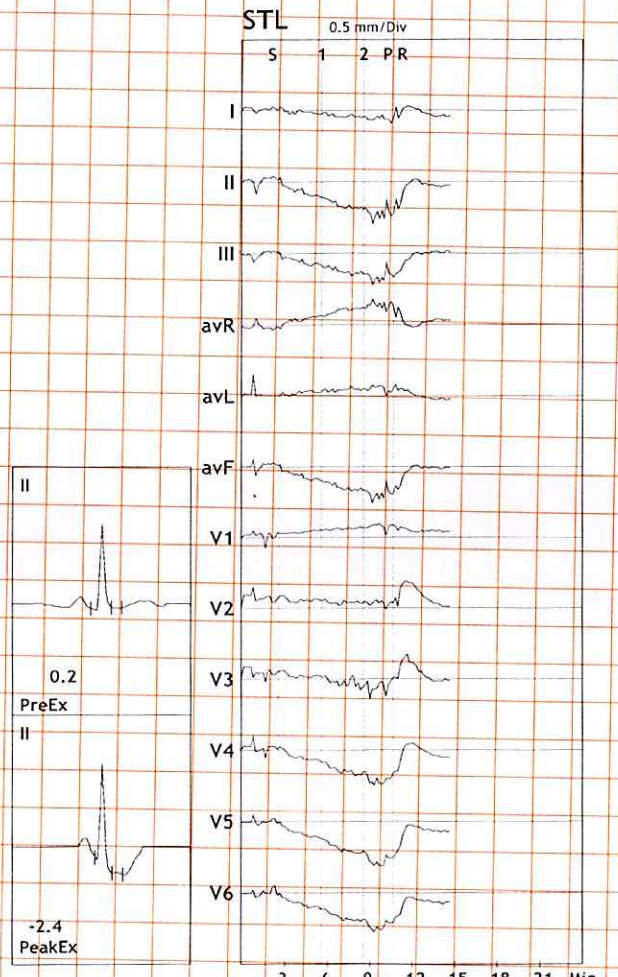
Protocol : BRUCE

Medication :

History :

Objective :

Stage	StageTime (Min:Sec)	PhaseTime (Min:Sec)	Speed (mph)	Grade (%)	METs	H.R. (bpm)	B.P. (mmHg)	R.P.P. x100	PVC	Comments
Supine					1.0	76	120/80	91	-	
Standing					1.0	78	120/80	93	-	
HV					1.0	79	120/80	94	-	
ExStart					1.0	79	120/80	94	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	122	130/80	158	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	143	140/85	200	-	
PeakEx	2:07	8:08	3.4	14.0	9.3	163	150/85	244	-	
Recovery	1:00		0.0	0.0	1.2	132	150/85	198	-	
Recovery	2:00		0.0	0.0	1.0	99	140/85	138	-	
Recovery	3:00		0.0	0.0	1.0	90	130/80	117	-	
Recovery	4:00		0.0	0.0	1.0	87	120/80	104	-	



Findings :

Exercise Time :08:07

Max HR Attained :163 bpm 94% of Max Predictable HR 173

Max BP : 150/85(mmHg)

Max WorkLoad attained :9.3(Good Effort Tolerance)

Base line ecg show WNL
There is St/T changes seen during exercise in inferolateral leads which reverted to base line within 1 Min of recovery

Advice/Comments:

T.M.T. positive for RMI
correlate clinically !

Dr. Naresh Kumar Mohanka
RMC No.: 35703
MBBS, DIP, CARDIO (ESC...S)
D.E.M. (RCC...)

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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms

HR: 77 bpm
METS: 1.0
BP: 120/80

MPHR:44% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 00:33
BLC :On
Notch :On

Supine
10.0 mm/mV
25 mm/Sec.

Date: 02-Dec-2022 11:44:11 AM

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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

HR: 81 bpm
METS: 1.0
BP: 120/80

MPHR:46% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 01:05
BLC :On
Notch :On

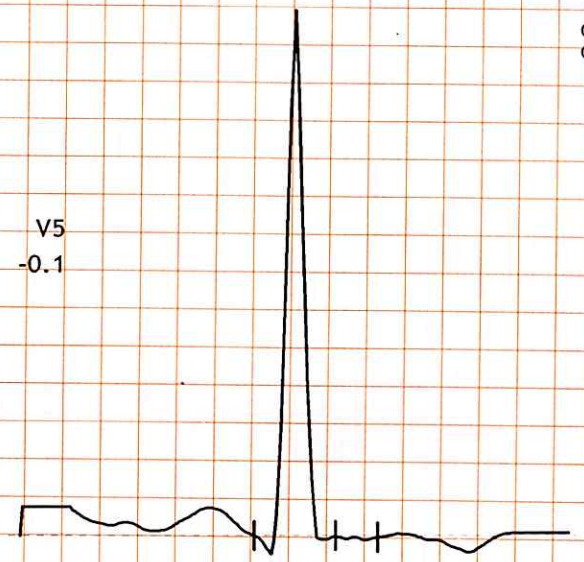
Standing
10.0 mm/mV
25 mm/Sec.

4X 60 mS Post J

I -0.2 0.0 | II -0.8 -0.1 | III -0.4 -0.9 | avR 0.5 0.1 | avL 0.0 0.7 | avF -0.6 -0.6

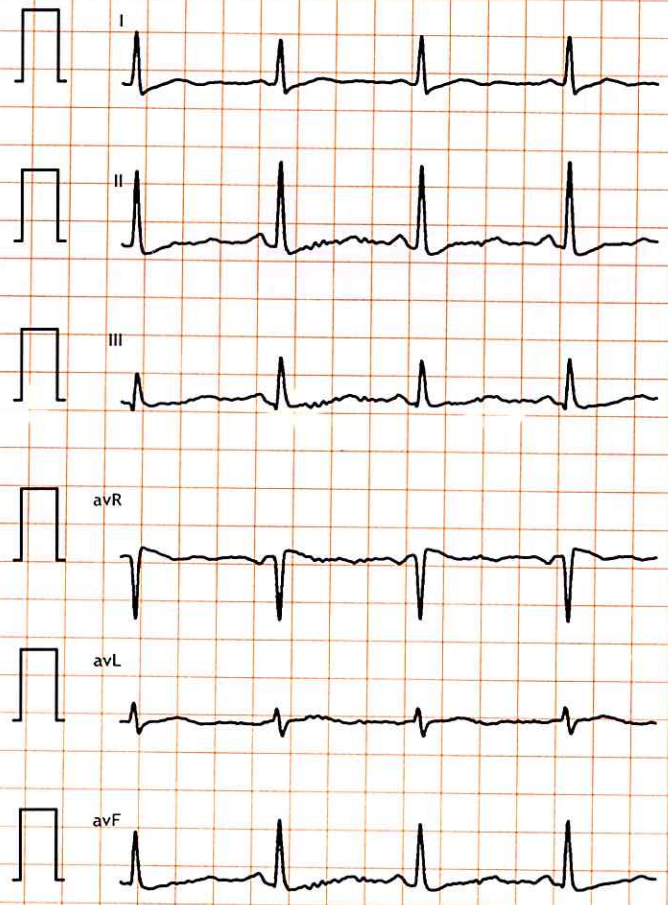
V1 0.2 0.3 | V2 0.5 1.3 | V3 0.5 1.1 | V4 -0.1 0.3 | V5 -0.1 -0.1 | V6 -0.3 0.0

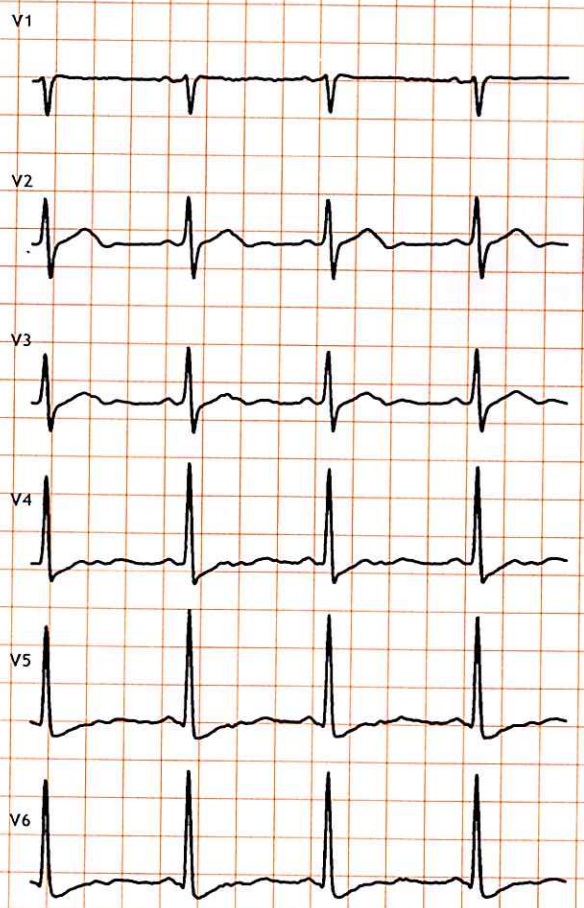
V5
-0.1



I III avL V1 V3 V5

II avR avF V2 V4 V6





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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

HR: 79 bpm
METS: 1.0
BP: 120/80

MPHR:45% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

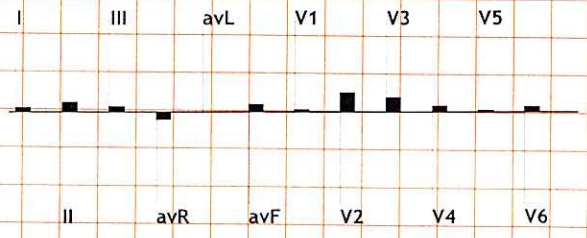
Ex Time 01:35
BLC :On
Notch :On

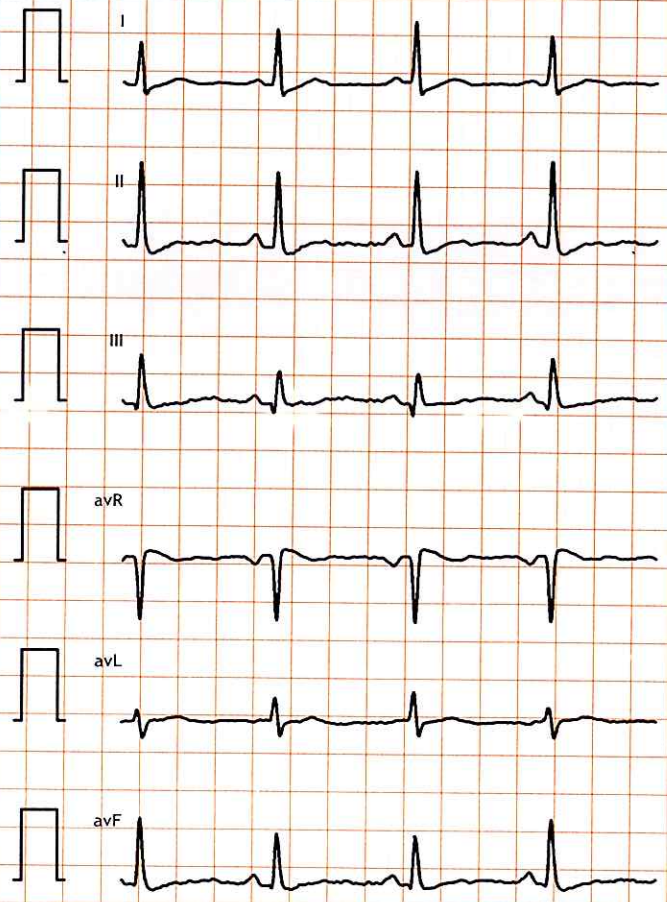
HV
10.0 mm/mV
25 mm/Sec.

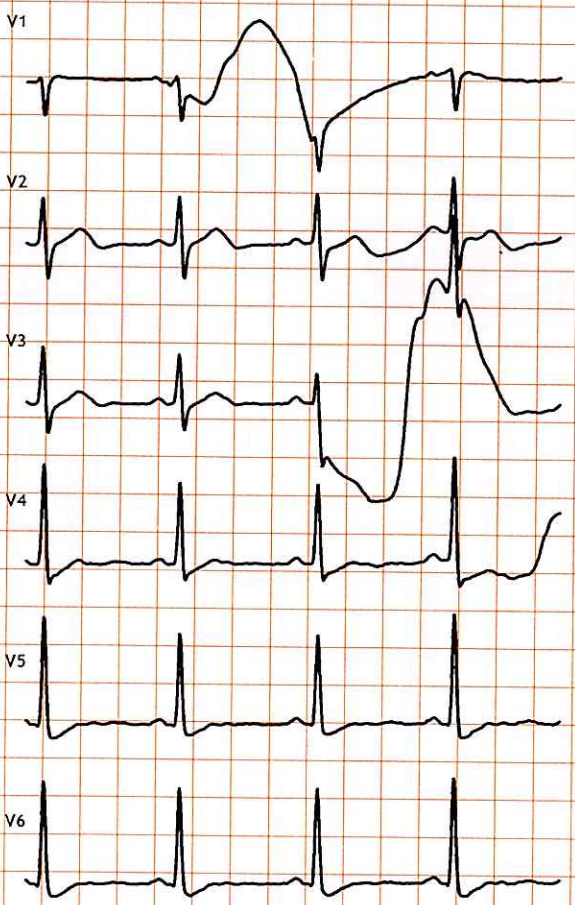
4X 60 mS Post J

I	II	III	avR	avL	avF
0.1 / 0.3	0.3 / 0.2	0.2 / -0.2	-0.3 / -0.3	0.0 / 0.3	0.3 / 0.0

V1	V2	V3	V4	V5	V6
0.1 / 0.2	0.7 / 1.4	0.5 / 1.2	0.2 / 0.6	0.1 / 0.1	0.2 / 0.1







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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

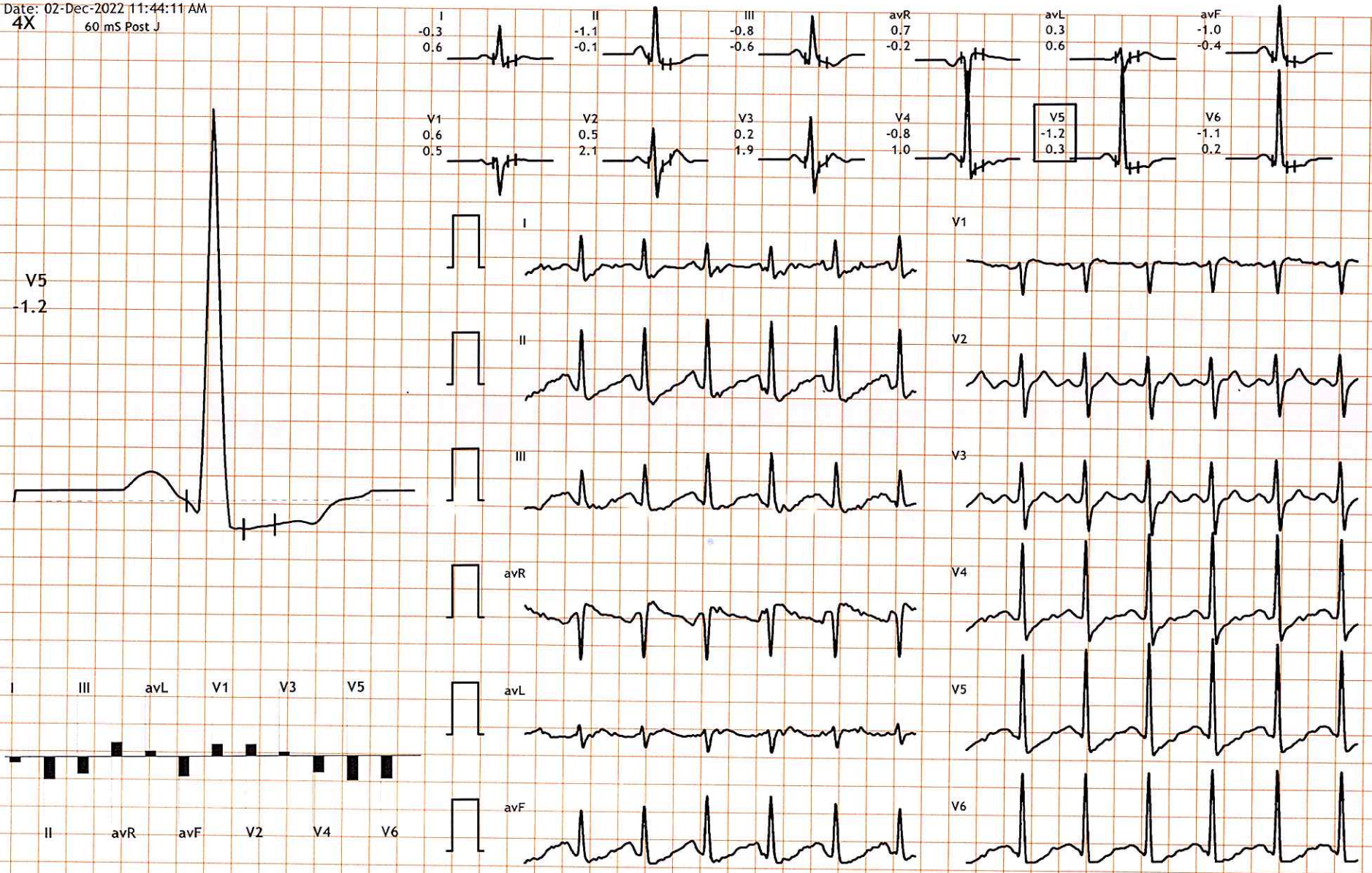
HR: 122 bpm
METS: 4.7
BP: 130/80

MPHR:70% of 173
Speed: 1.7 mph
Grade: 10.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 02:59
BLC :On
Notch :On

BRUCE:Stage 1(3:00)
10.0 mm/mV
25 mm/Sec.



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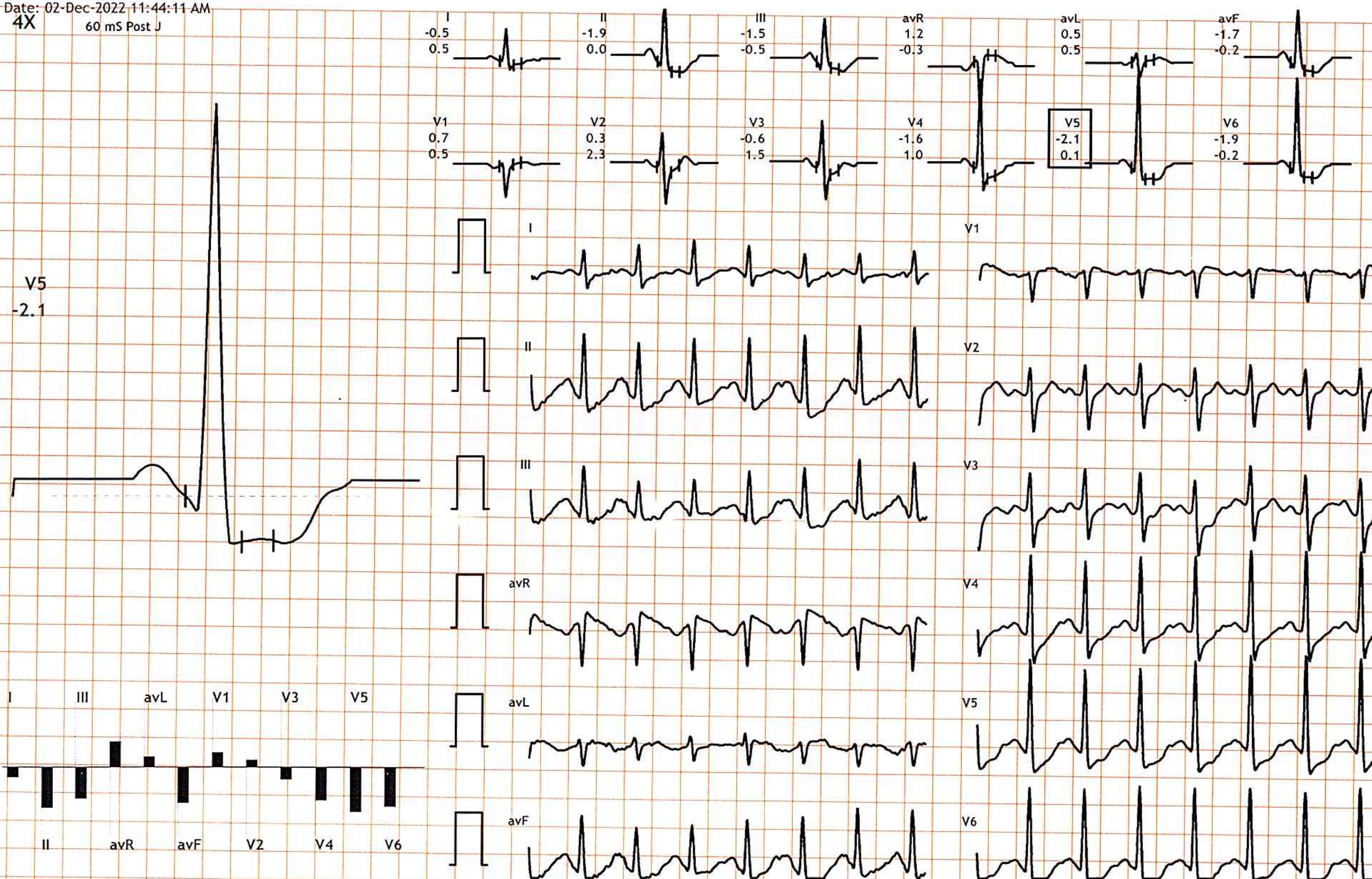
B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

HR: 144 bpm	MPHR:83% of 173	Raw ECG	Ex Time 05:59	BRUCE:Stage 2(3:00)
METS: 7.1	Speed: 2.5 mph	BRUCE	BLC :On	10.0 mm/mV
BP: 140/85	Grade: 12.0%	(1.0-35)Hz	Notch :On	25 mm/Sec.



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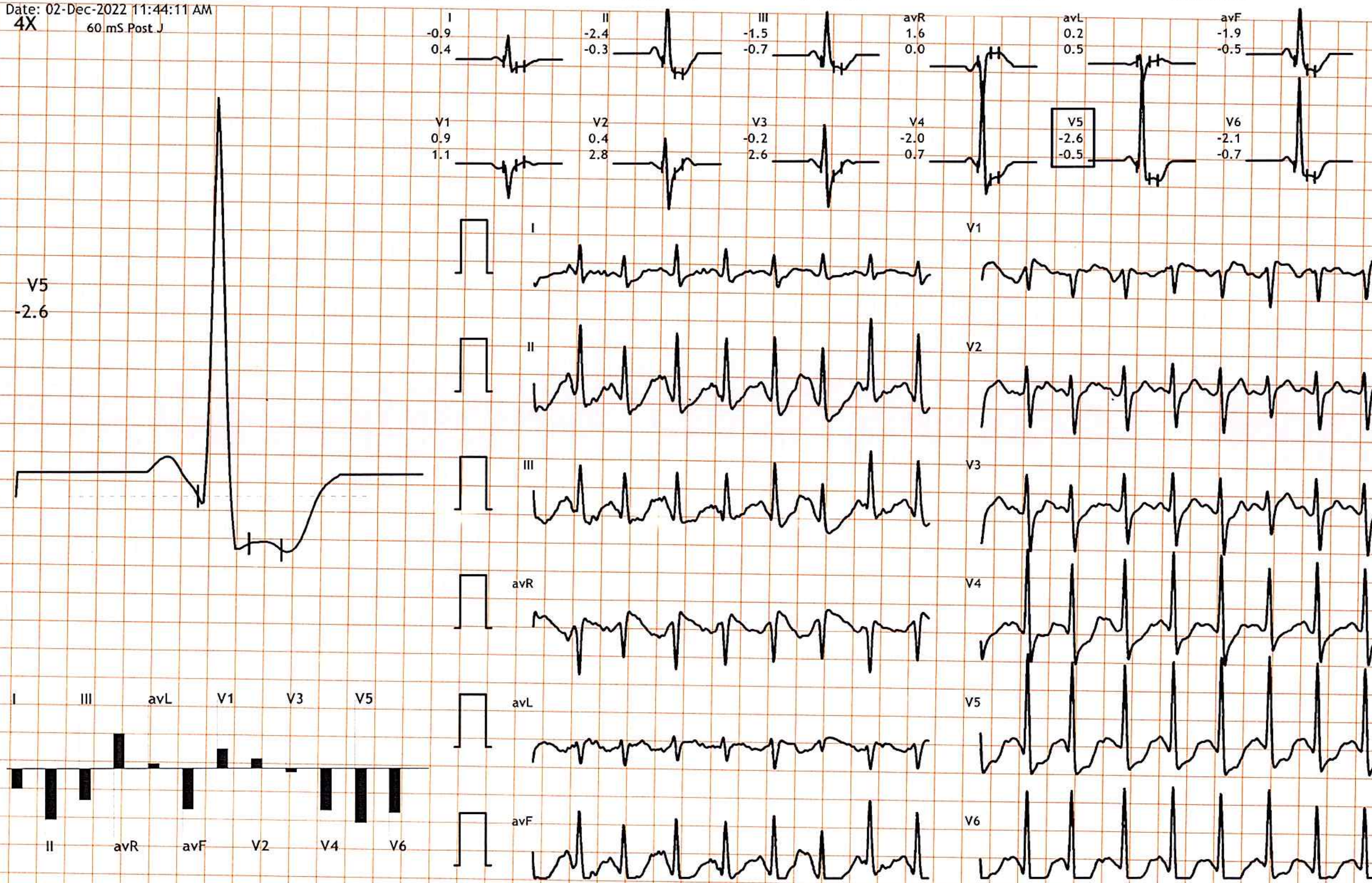
B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI	HR: 164 bpm	MPHR:94% of 173	Raw ECG	Ex Time 08:05	BRUCE:PeakEx(2:05)
47 Yrs/Male	METS: 9.3	Speed: 3.4 mph	BRUCE	BLC :On	10.0 mm/mV
0 Kg/0 Cms	BP: 150/85	Grade: 14.0%	(1.0-35)Hz	Notch :On	25 mm/Sec.

Date: 02-Dec-2022 11:44:11 AM



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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

HR: 130 bpm
METS: 1.3
BP: 150/85

MPHR:75% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

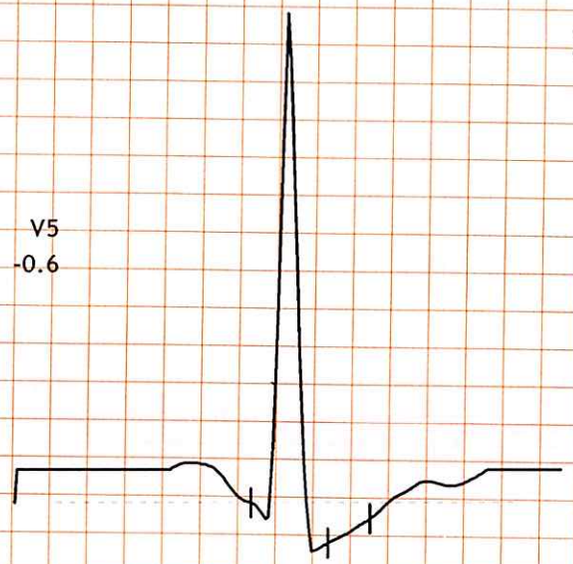
Ex Time 08:07
BLC :On
Notch :On

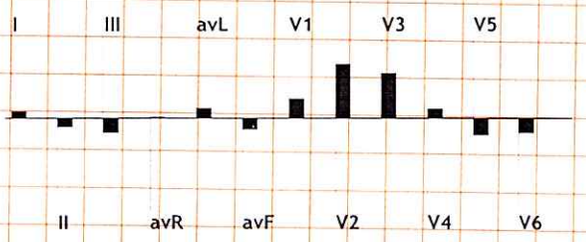
Recovery(1:00)
10.0 mm/mV
25 mm/Sec.

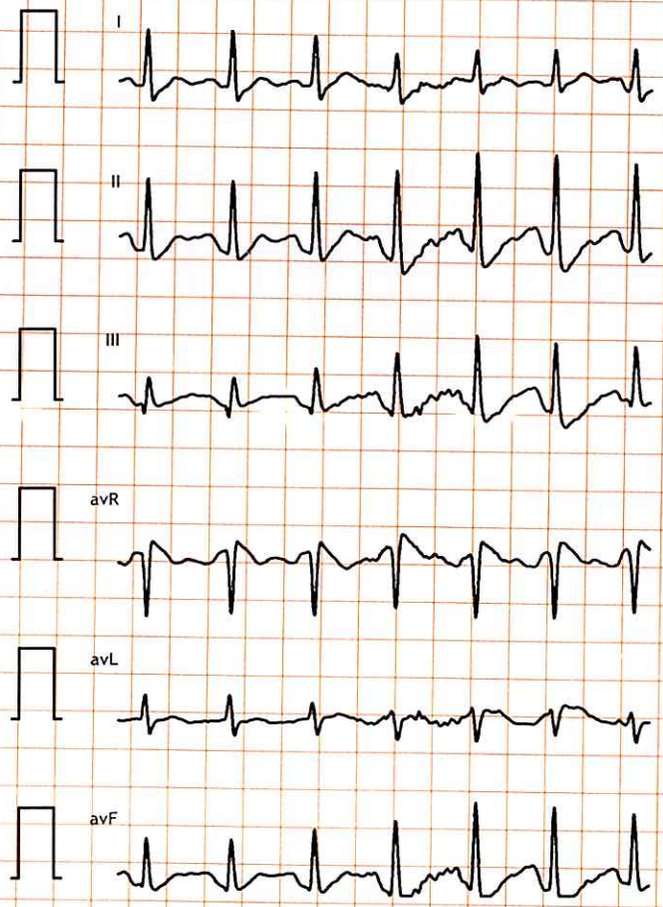
4X 60 mS Post J

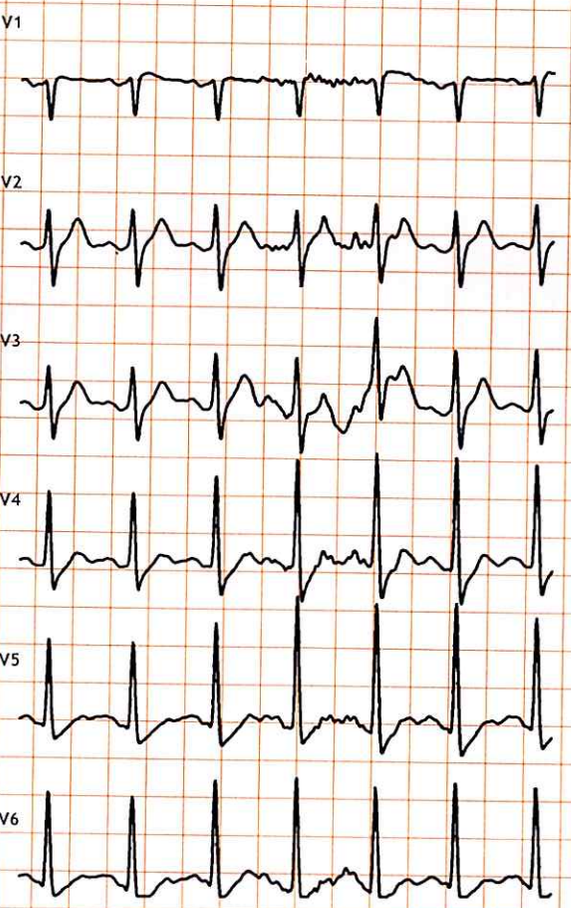
I	II	III	avR	avL	avF
0.2	-0.3	-0.5	0.0	0.3	-0.4
1.2	1.6	0.3	-1.4	0.4	0.9

V1	V2	V3	V4	V5	V6
0.7	1.9	1.6	0.3	-0.6	-0.5
0.3	4.0	3.8	2.8	1.4	1.0









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B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

HR: 99 bpm
METS: 1.0
BP: 140/85

MPHR:57% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 08:07
BLC :On
Notch :On

Recovery(2:00)
10.0 mm/mV
25 mm/Sec.

4X 60 mS Post J

I	II	III	avR	avL	avF
0.1	0.1	0.0	-0.1	0.0	0.0
0.8	1.4	0.5	-1.1	0.2	0.9

V1	V2	V3	V4	V5	V6
0.4	1.2	0.5	0.2	-0.4	-0.5
0.1	2.6	1.2	1.8	0.9	0.5

V5
-0.4

I III avL V1 V3 V5

II avR avF V2 V4 V6

I
II
III
avR
avL
avF

V1
V2
V3
V4
V5
V6

P3 HEALTH SOLUTIONS LLP

B-14,Vidhyadhar Nagar Enclave,Phase -2,Jaipur

12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

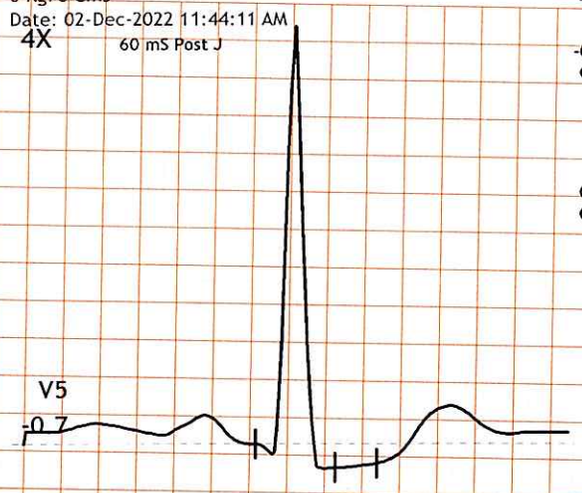
HR: 90 bpm
METS: 1.0
BP: 130/80

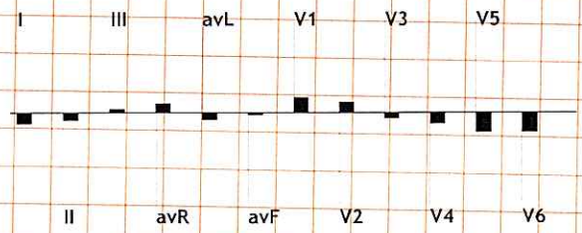
MPHR:52% of 173
Speed: 0.0 mph
Grade: 0.0%

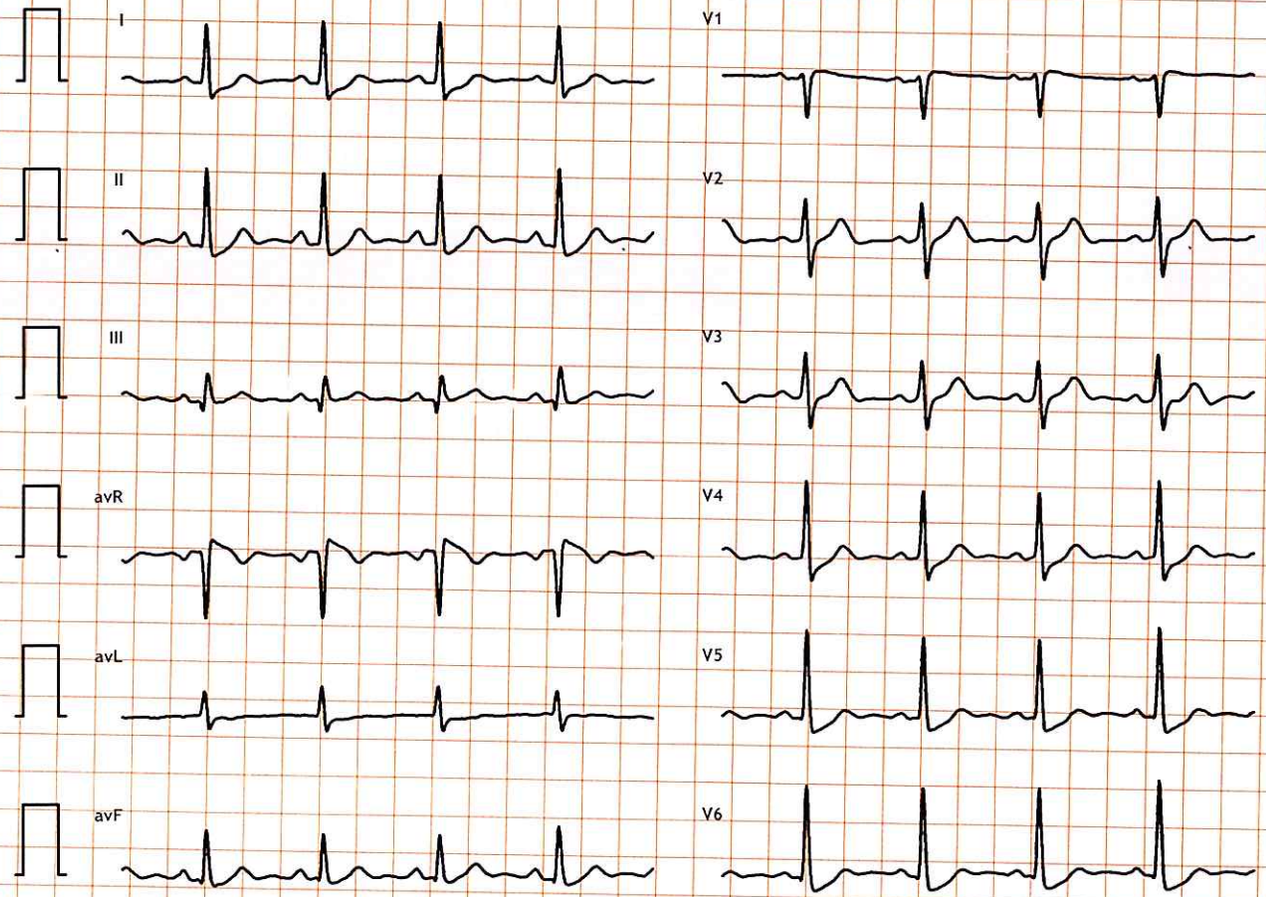
Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 08:07
BLC :On
Notch :On

Recovery(3:00)
10.0 mm/mV
25 mm/Sec.







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12 Lead + Median

1322252/MR SURESH KUMAR SAINI
47 Yrs/Male
0 Kg/0 Cms
Date: 02-Dec-2022 11:44:11 AM

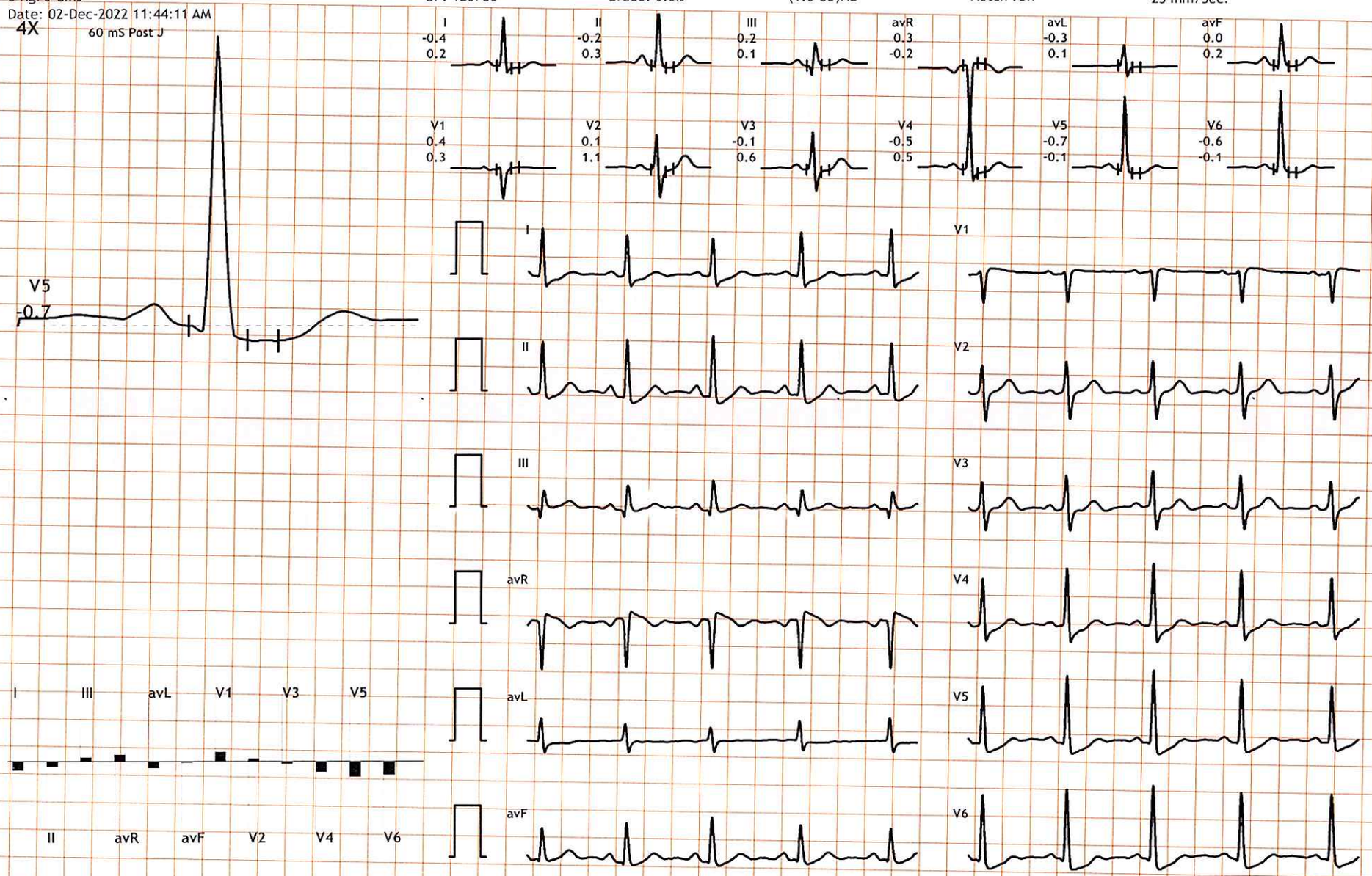
HR: 87 bpm
METS: 1.0
BP: 120/80

MPHR:50% of 173
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 08:07
BLC :On
Notch :On

Recovery(4:00)
10.0 mm/mV
25 mm/Sec.



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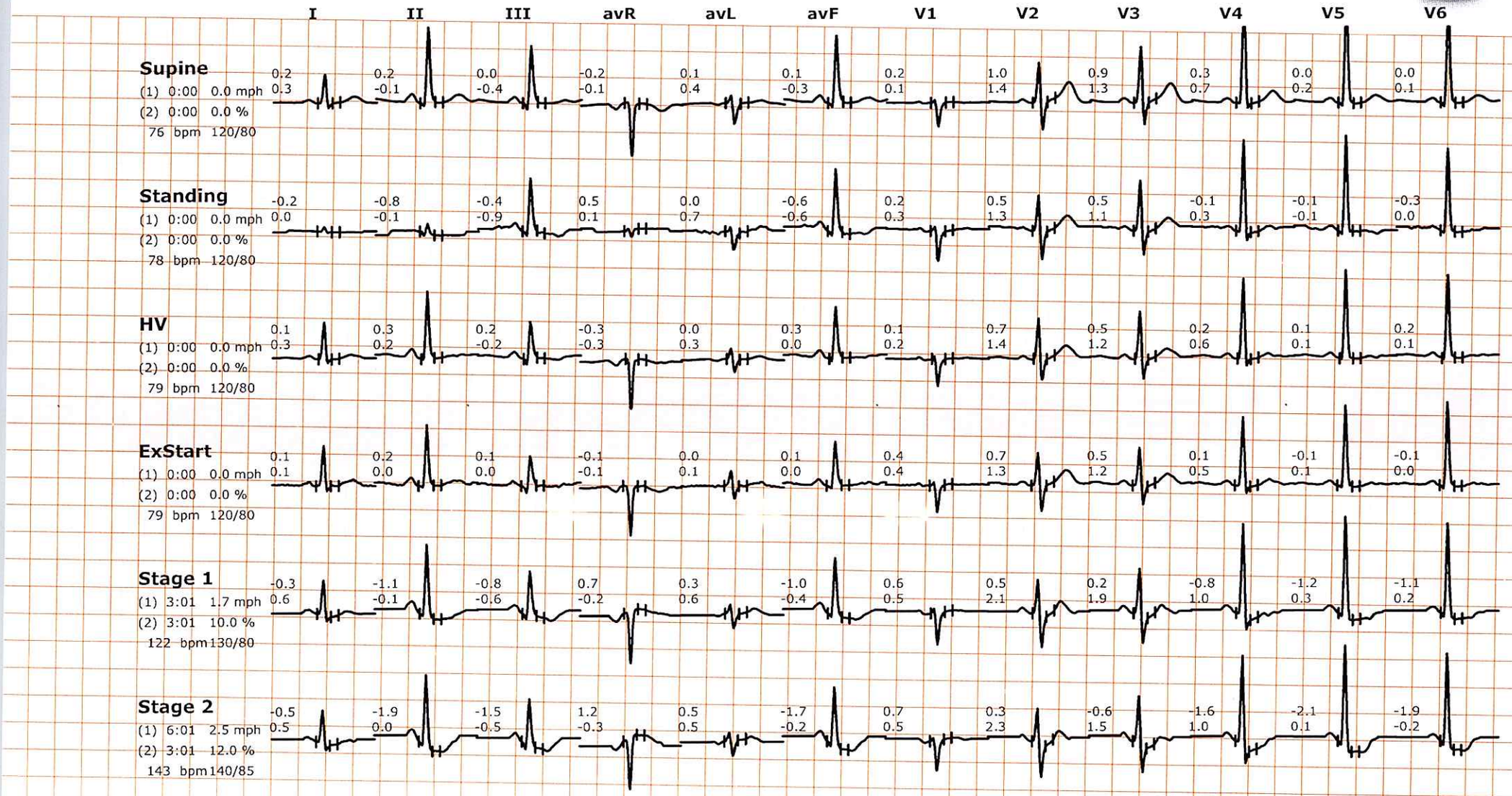
1322252/MR SURESH KUMAR SAINI 47 Yrs/Male 0 Kg/0 Cms

Date: 02-Dec-2022 11:44:11 AM

Average



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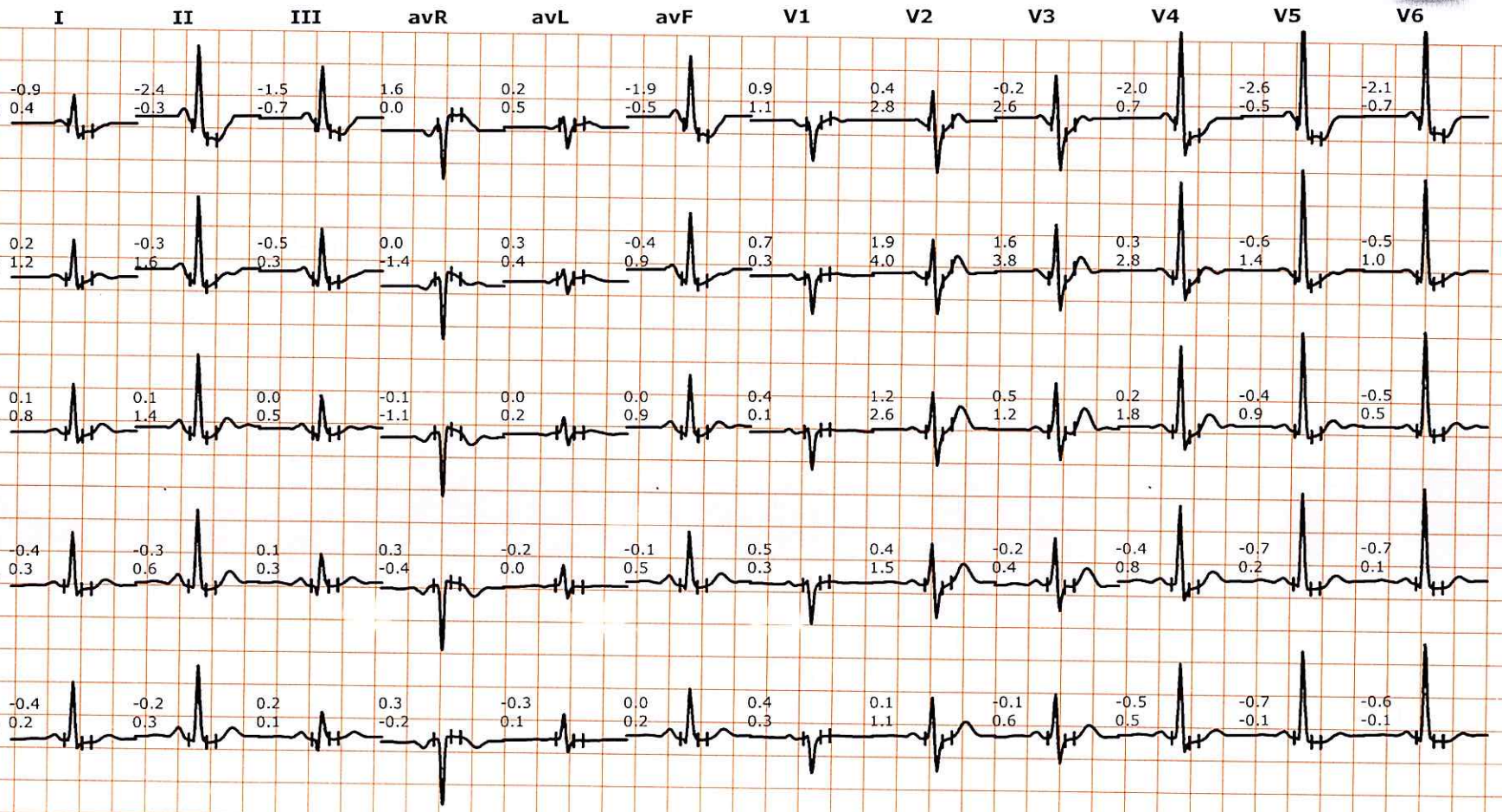
Average



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NAME :- Mr. SURESH KUMAR SAINI
Age :- 47 Yrs 5 Mon 23 Days
Sex :- Male

Patient ID :-12222580 Date :- 02/12/2022 09:12:58
Ref. By Doctor:-BANK OF BARODA
Lab/Hosp :-
Company :- Mr.MEDIWHEEL

Final Authentication : 02/12/2022 14:22:52

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP ABOVE 40 MALE			
HAEMOGARAM			
HAEMOGLOBIN (Hb)	**9.5** L	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	4.00	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	52.0	%	40.0 - 80.0
LYMPHOCYTE	40.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	5.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.69	x10^6/uL	4.50 - 5.50
HEMATOCRIT (HCT)	**31.60** L	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	**67.0** L	fL	83.0 - 101.0
MEAN CORP HB (MCH)	**19.9** L	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	**29.5** L	g/dL	31.5 - 34.5
PLATELET COUNT	**68** L	x10^3/uL	150 - 410
RDW-CV	**14.1** H	%	11.6 - 14.0
MENTZER INDEX	**14.29** H		0.00 - 0.00

A complete blood picture (CBP) is a kind of blood test that is done to assess a person's overall health and diagnose a wide range of health disorders like leukemia, anemia and other infections.

A complete blood count (CBC) is a complete blood test that diagnose many components and features of a persons blood which includes: -

***Red Blood Cells (RBC),** which carry oxygen -

***White Blood Cells (WBC)**, which help in fighting against infections -

***Hemoglobin**, which is the oxygen carrying protein in the red blood cells -

***Hematocrit (HCT)**, the proportion of RBC to the fluid component, or plasma present in blood -

***Platelets,** which aid in blood clotting

(CBC): Methodology: TLC,TRBC,PCV,PLT Impedance method, HB Calorimetric method,. and **MCH,MCV,MCHC,MENTZER INDEX** are calculated. **InstrumentName: MINDRAY BC-3000 Plus 3** part automatic analyzer,

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)	06	mm in 1st hr	00 - 15

Methord:- Westergreen

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as

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Sex :-	Male	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

(CBC): Methodology: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and **MCH,MCV,MCHC,MENTZER INDEX** are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Methord:- GOD POD	81.6	mg/dl	70.0 - 115.0

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm,
hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin
therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) Methord:- GOD PAP	100.0	mg/dl	70.0 - 140.0

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C)			
Methord:- CAPILLARY with EDTA	5.1	mg%	Non-Diabetic < 6.0 Good Control 6.0-7.0 Weak Control 7.0-8.0 Poor control > 8.0
MEAN PLASMA GLUCOSE Methord:- Calculated Parameter	100	mg/dL	68 - 125

INTERPRETATION
AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

CLINICAL NOTES
In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.
Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al]

1. Erythropoiesis
- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation
- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction
- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others
- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use,chronic renal failure
- Decreased HbA1c: hypertriglyceridemia,reticulocytosis, chronic liver disease, aspirin, vitamin C and E,splenomegaly, rheumatoid arthritis or drugs

Note:
1.Shortened RBC life span –HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs), such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time.
2.Abnormal forms of hemoglobin – The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

Advised:
1.To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
2.Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.
estimated Average Glucose (eAG) : based on value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

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HAEMATOLOGY

BLOOD GROUP ABO Methord:- Haemagglutination reaction	"AB" POSITIVE

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Sex :- Male Lab/Hosp :-

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Methord:- CHOD-PAP methodology	140.00	mg/dl	Desirable <200 Borderline 200-239 High> 240
InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Methord:- GPO-TOPS methodology	120.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
InstrumentName:MISPA PLUS **Interpretation** : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.			
DIRECT HDL CHOLESTEROL Methord:- Selective inhibition Method	60.70	mg/dl	Male 35-80 Female 42-88
Instrument Name:MISPA PLUS **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies.Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.			
LDL CHOLESTEROL Methord:- Calculated Method	59.30	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Methord:- Calculated	24.00	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Methord:- Calculated	2.31		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Methord:- Calculated	0.98		0.00 - 3.50
TOTAL LIPID Methord:- CALCULATED	455.24	mg/dl	400.00 - 1000.00

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended
3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated fromperipheral tissues.

Comments: **1-** ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all

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BIOCHEMISTRY

atherogenic lipoproteins (mainly LDL & VLDL). The Non HDL Cholesterolis used as a secondary target of therapy in persons with triglycerides >=200 mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.

2 -For calculation of CHD risk,history of smoking, any medication for hypertension & current B.P. levels are required.

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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Methord:- DMSO/Diazo	0.71	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Methord:- DMSO/Diazo	0.31	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Methord:- Calculated	0.40	mg/dl	0.30-0.70
SGOT Methord:- IFCC	24.4	U/L	Men- Up to - 37.0 Female - Up to - 31.0
SGPT Methord:- IFCC	22.9	U/L	Men- Up to - 40.0 Female- Up to - 31.0
SERUM ALKALINE PHOSPHATASE Methord:- DGKC - SCE	57.50	U/L	53.00 - 141.00
SERUM GAMMA GT Methord:- Szasz methodology Instrument Name Randox Rx Imola	16.80	U/L	10.00 - 45.00

Interpretation: Elevations in GGT levels areseen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)are observed with infectious hepatitis.

SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	5.80	g/dl	5.10 - 8.00
SERUM ALBUMIN Methord:- Bromocresol Green	4.01	g/dl	2.80 - 4.50
SERUM GLOBULIN Methord:- CALCULATION	**1.79** L	gm/dl	2.20 - 3.50
A/G RATIO	2.24		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc.Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA Methord:- Urease/GLDH	15.20	mg/dl	10.00 - 50.00

InstrumentName: HORIBA CA 60 **Interpretation** : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE Methord:- Jaffe's Method	0.88	mg/dl	Males : 0.6-1.50 mg/dl Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID	3.96	mg/dl	2.40 - 7.00

InstrumentName:HORIBA YUMIZEN CA60 Daytona plus **Interpretation**: **Elevated Urate**:High purine diet,Alcohol• Renal insufficiency,Drugs , Polycythaemia vera, Malignancies,Hypothyroidism,Rare enzyme defects ,Downs syndrome,Metabolic syndrome, Pregnancy,Gout.

SODIUM Methord:- ISE	135.0	mmol/L	135.0 - 150.0

Interpretation: Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss,Drugs,Oedematous states,Legionnaire's disease and other chest infections,pseudonatremia, Hyperlipidaemias and paraproteinaemias,endocrine diseases ,SIADH.

POTASSIUM Methord:- ISE	4.10	mmol/L	3.50 - 5.50

Interpretation: A. Elevated potassium (hyperkalaemia)• Artefactual,Physiological,Drugs, Pathological states,Renal failure Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia)Drugs, Liquoric,Diarrhoea and vomiting,Metabolic alkalosis,Corticosteroid excess, Oedematous state,Anorexia nervosa/bulimia

CHLORIDE Methord:- ISE	108.0	mmol/L	94.0 - 110.0

Interpretation: Used for Electrolyte monitoring.

SERUM CALCIUM Methord:- Colorimetric method	10.60	mg/dl	8.10 - 11.50

InstrumentName:Rx Daytona plus **Interpretation**: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	5.80	g/dl	5.10 - 8.00

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SERUM ALBUMIN Methord:- Bromocresol Green	4.01	g/dl	2.80 - 4.50
SERUM GLOBULIN Methord:- CALCULATION	**1.79** L	gm/dl	2.20 - 3.50
A/G RATIO	2.24		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.

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NAME :- Mr. SURESH KUMAR SAINI Patient ID :-12222580 Date :- 02/12/2022 09:12:58
Age :- 47 Yrs 5 Mon 23 Days Ref. By Doctor:-BANK OF BARODA
Sex :- Male Lab/Hosp :-
Company :- Mr.MEDIWHEEL

Final Authentication : 02/12/2022 14:22:52

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.015		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		

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CLINICAL PATHOLOGY

URINE SUGAR (FASTING) **Collected Sample Received**	Nil	Nil

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CLINICAL PATHOLOGY

STOOL ANALYSIS

PHYSICAL EXAMINATION

COLOUR	YELLOW BROWN	
CONSISTENCY	SEMI SOLID	
MUCUS	ABSENT	
BLOOD	ABSENT	

MICROSCOPIC EXAMINATION

RBC's	NIL	/HPF
WBC/HPF	NIL	/HPF
MACROPHAGES	ABSENT	
OVA	ABSENT	
CYSTS	ABSENT	
TROPHOZOITES	ABSENT	
CHARCOT LEYDEN CRYSTALS	ABSENT	
OTHERS	ABSENT	

Collected Sample Received

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IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
PSA (PROSTATE SPECIFIC ANTIGEN) -TOTAL Methord:- Methodology: CLIA	2.297	ng/mL	0.00-4.00

CLINICAL NOTES:- Prostate-specific antigen (PSA)is a 34-kD glycoprotein produced almost exclusively by the prostate gland.

PSA is normally present in the blood at very low levels. Increased levels of PSA may suggest the presence of prostate cancer.

1.Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not
recommended as they falsely elevate levels

2. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical
findings and other investigations

3. Physiological decrease in PSA level by 18% has been observed in sedentary patients either due to supine position or suspended sexual activity

Clinical Use

• An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more
affected first degree relatives.
• Follow up and management of Prostate cancer patients
• Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

NOTE

PSA levels can be also increased by prostatitis, irritation, benign prostatic hyperplasia (BPH), and recent ejaculation, producing a false positive result. Digital rectal examination (DRE) has been shown in several studies to produce an increase in PSA. However, the effect is clinically insignificant, since DRE causes the most substantial
increases in patients with PSA levels already elevated over 4.0 ng/mL.

Obesity has been reported to reduce serum PSA levels. Delayed early detection may partially explain worse outcomes in obese men with early prostate cancer. Aftertreatment, higher BMI also correlates to higher risk of recurrence.

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IMMUNOASSAY

TOTAL THYROID PROFILE

THYROID-TRIIODOTHYRONINE T3	1.02	ng/mL	0.70 - 2.04

Methord:- ECLIA

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is useful in evaluating differantial diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with " TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & 'serum TSH levels8.Normal T4 levels accompanied by ' T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or" T3 & 'T 10.Normal T3 & T4 along with " TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & " T4 along with ' TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with ' TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

THYROID - THYROXINE (T4)	8.05	µIU/ml	5.10 - 14.10

Methord:- ECLIA

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TSH	3.060	µIU/mL	0.350 - 5.500

Methord:- ECLIA

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IMMUNOASSAY

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7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
9.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,rarely they can result from TSH secreting pituitary tumours.

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*** End of Report ***

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