CHANDAN DIAGNOSTIC CENTRE

Add: 49/19-B, Kamla Nehru Road, Katra, Prayagraj
Ph: 9235447965,0532-3559261
CIN: U85110UP2003PLC193493

Patient Name	: Mr.NANAKA KUMAR	Registered On	: 26/Oct/2024 12:10:33
Age/Gender	: 36 Y 1 M 20 D /M	Collected	: 2024-10-26 13:51:49
UHID/MR NO	: ALDP.0000152991	Received	: 2024-10-26 13:51:49
Visit ID	: ALDP0284022425	Reported	: 27/Oct/2024 10:08:42
Ref Doctor	: Dr. MEDIWHEEL-ARCOFEMI HEALTH CARE LTD -	Status	: Final Report

DEPARTMENT OF CARDIOLOGY-ECG

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

ECG / EKG

1. Machnism, Rhythm	Sinus, Regular	
2. Atrial Rate	**74**	/mt
3. Ventricular Rate	**74**	/mt
4. P - Wave	Normal	
5. P R Interval	Normal	
6. Q R S		
Axis :	Normal	
R/S Ratio :	Normal	
Configuration :	Normal	
7. Q T c Interval	Normal	
8. S - T Segment	Normal	
9. T – Wave	Normal	

FINAL IMPRESSION

ECG Within Normal Limits: Sinus Rhythm. Please correlate clinically

Dr. R K VERMA
MBBS, PGDGM

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DEPARTMENT OF HAEMATOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Blood Group (ABO & Rh typing) , *Blood*				
Blood Group	B			ERYTHROCYTE MAGNETIZED TECHNOLOGY/ TUBE AGGLUTINA
Rh (Anti-D)	POSITIVE			ERYTHROCYTE MAGNETIZED TECHNOLOGY/ TUBE AGGLUTINA
Complete Blood Count (CBC) , *Whole Blood*				
Haemoglobin	13.40	g/dl	1 Day- 14.5-22.5 g/dl 1 Wk- 13.5-19.5 g/dl 1 Mo- 10.0-18.0 g/dl 3-6 Mo- 9.5-13.5 g/dl 0.5-2 Yr- 10.5-13.5 g/dl 2-6 Yr- 11.5-15.5 g/dl 6-12 Yr- 11.5-15.5 g/dl 12-18 Yr 13.0-16.0 g/dl Male- 13.5-17.5 g/dl Female- 12.0-15.5 g/dl	COLORIMETRIC METHOD (CYANIDE-FREE REAGENT)
TLC (WBC)	6,500.00	/Cu mm	4000-10000	IMPEDANCE METHOD
DLC				
Polymorphs (Neutrophils)	62.00	%	40-80	FLOW CYTOMETRY
Lymphocytes	28.00	%	20-40	FLOW CYTOMETRY
Monocytes	4.00	%	2-10	FLOW CYTOMETRY
Eosinophils	6.00	%	1-6	FLOW CYTOMETRY
Basophils	0.00	%	<1-2	FLOW CYTOMETRY
ESR				
Observed	6.00	MM/1H	10-19 Yr 8.0 20-29 Yr 10.8 30-39 Yr 10.4 40-49 Yr 13.6 50-59 Yr 14.2 60-69 Yr 16.0 70-79 Yr 16.5 80-91 Yr 15.8	

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DEPARTMENT OF HAEMATOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
			Pregnancy Early gestation - 48 (62 if anaemic) Leter gestation - 70 (95 if anaemic)	
Corrected	-	Mm for 1st hr.	<9	
PCV (HCT)	**39.00**	%	40-54	
Platelet count				
Platelet Count	2.02	LACS/cu mm	1.5-4.0	ELECTRONIC IMPEDANCE/ MICROSCOPIC
PDW (Platelet Distribution width)	16.70	fL	9-17	ELECTRONIC IMPEDANCE
P-LCR (Platelet Large Cell Ratio)	-	%	35-60	ELECTRONIC IMPEDANCE
PCT (Platelet Hematocrit)	0.22	%	0.108-0.282	ELECTRONIC IMPEDANCE
MPV (Mean Platelet Volume)	10.90	fL	6.5-12.0	ELECTRONIC IMPEDANCE
RBC Count				
RBC Count	**3.88**	Mill./cu mm	4.2-5.5	ELECTRONIC IMPEDANCE
Blood Indices (MCV, MCH, MCHC)				
MCV	**100.40**	fl	80-100	CALCULATED PARAMETER
MCH	**34.40**	pg	27-32	CALCULATED PARAMETER
MCHC	34.30	%	30-38	CALCULATED PARAMETER
RDW-CV	15.30	%	11-16	ELECTRONIC IMPEDANCE
RDW-SD	**60.50**	fL	35-60	ELECTRONIC IMPEDANCE
Absolute Neutrophils Count	4,030.00	/cu mm	3000-7000	
Absolute Eosinophils Count (AEC)	390.00	/cu mm	40-440	

AS

Dr.Akanksha Singh (MD Pathology)

CHANDAN DIAGNOSTIC CENTRE

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
GLUCOSE FASTING , *Plasma*				
Glucose Fasting	85.70	mg/dl	< 100 Normal 100-125 Pre-diabetes ≥ 126 Diabetes	GOD POD

Interpretation:

a) Kindly correlate clinically with intake of hypoglycemic agents, drug dosage variations and other drug interactions.
b) A negative test result only shows that the person does not have diabetes at the time of testing. It does not mean that the person will never get diabetics in future, which is why an Annual Health Check up is essential.
c) I.G.T = Impaired Glucose Tolerance.

CLINICAL SIGNIFICANCE:- Glucose is the major source of energy in the body . Lack of insulin or resistance to it section at the cellular level causes diabetes. Therefore, the blood glucose levels are very high. Elevated serum glucose levels are observed in diabetes mellitus and may be associated with pancreatitis, pituitary or thyroid dysfunction and liver disease. Hypoglycaemia occurs most frequently due to over dosage of insulin.

Glucose PP *Sample:Plasma After Meal*	108.20	mg/dl	<140 Normal 140-199 Pre-diabetes >200 Diabetes	GOD POD

Interpretation:
a) Kindly correlate clinically with intake of hypoglycemic agents, drug dosage variations and other drug interactions.
b) A negative test result only shows that the person does not have diabetes at the time of testing. It does not mean that the person will never get diabetics in future, which is why an Annual Health Check up is essential.
c) I.G.T = Impaired Glucose Tolerance.

GLYCOSYLATED HAEMOGLOBIN (HBA1C) , *EDTA BLOOD*

Glycosylated Haemoglobin (HbA1c)	5.30	%NGSP	HPLC (NGSP)
Glycosylated Haemoglobin (HbA1c)	34.80	mmol/mol/IFCC	
Estimated Average Glucose (eAG)	106	mg/dl	

Interpretation:

NOTE:-

- eAG is directly related to A1c.

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method

- An A1c of 7% -the goal for most people with diabetes-is the equivalent of an eAG of 154 mg/dl.
- eAG may help facilitate a better understanding of actual daily control helping you and your health care provider to make necessary changes to your diet and physical activity to improve overall diabetes mnagement.

The following ranges may be used for interpretation of results. However, factors such as duration of diabetes, adherence to therapy and the age of the patient should also be considered in assessing the degree of blood glucose control.

Haemoglobin A1C (%)NGSP	mmol/mol / IFCC Unit	eAG (mg/dl)	Degree of Glucose Control Unit
> 8	>63.9	>183	Action Suggested*
7-8	53.0 -63.9	154-183	Fair Control
< 7	<63.9	<154	Goal**
6-7	42.1 -63.9	126-154	Near-normal glycemia
< 6%	<42.1	<126	Non-diabetic level

*High risk of developing long term complications such as Retinopathy, Nephropathy, Neuropathy, Cardiopathy, etc.
**Some danger of hypoglycemic reaction in Type 1diabetics. Some glucose intolerant individuals and "subclinical" diabetics may demonstrate HbA1C levels in this area.

N.B. : Test carried out on Automated VARIANT II TURBO HPLC Analyser.

Clinical Implications:

*Values are frequently increased in persons with poorly controlled or newly diagnosed diabetes.
*With optimal control, the HbA 1c moves toward normal levels.
*A diabetic patient who recently comes under good control may still show higher concentrations of glycosylated hemoglobin. This level declines gradually over several months as nearly normal glycosylated *Increases in glycosylated hemoglobin occur in the following non-diabetic conditions: a. Iron-deficiency anemia b. Splenectomy
c. Alcohol toxicity d. Lead toxicity
*Decreases in A 1c occur in the following non-diabetic conditions: a. Hemolytic anemia b. chronic blood loss
*Pregnancy d. chronic renal failure. Interfering Factors:
*Presence of Hb F and H causes falsely elevated values. 2. Presence of Hb S, C, E, D, G, and Lepore (autosomal recessive mutation resulting in a hemoglobinopathy) causes falsely decreased values.

BUN (Blood Urea Nitrogen)	8.13	mg/dL	7.0-23.0	CALCULATED

Sample:Serum

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method

Interpretation:
Note: Elevated BUN levels can be seen in the following:

High-protein diet, Dehydration, Aging, Certain medications, Burns, Gastrointestimal (GI) bleeding.

Low BUN levels can be seen in the following:

Low-protein diet, overhydration, Liver disease.

Creatinine *Sample:Serum*	0.99	mg/dl	0.7-1.30	MODIFIED JAFFES

Interpretation:
The significance of single creatinine value must be interpreted in light of the patients muscle mass. A patient with a greater muscle mass will have a higher creatinine concentration. The trend of serum creatinine concentrations over time is more important than absolute creatinine concentration. Serum creatinine concentrations may increase when an ACE inhibitor (ACE) is taken. The assay could be affected mildly and may result in anomalous values if serum samples have heterophilic antibodies, hemolyzed, icteric or lipemic.

Uric Acid *Sample:Serum*	5.44	mg/dl	3.4-7.0	URICASE

Interpretation:
Note:-
Elevated uric acid levels can be seen in the following:

Drugs, Diet (high-protein diet, alcohol), Chronic kidney disease, Hypertension, Obesity.

LFT (WITH GAMMA GT) , *Serum*

SGOT / Aspartate Aminotransferase (AST)	27.30	U/L	<35	IFCC WITHOUT P5P
SGPT / Alanine Aminotransferase (ALT)	24.70	U/L	<40	IFCC WITHOUT P5P
Gamma GT (GGT)	26.60	IU/L	11-50	OPTIMIZED SZAZING
Protein	6.89	gm/dl	6.2-8.0	BIURET
Albumin	4.09	gm/dl	3.4-5.4	B.C.G.
Globulin	2.80	gm/dl	1.8-3.6	CALCULATED
A:G Ratio	1.46		1.1-2.0	CALCULATED

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DEPARTMENT OF BIOCHEMISTRY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
Alkaline Phosphatase (Total)	84.00	U/L	42.0-165.0	PNP/AMP KINETIC
Bilirubin (Total)	1.03	mg/dl	0.3-1.2	JENDRASSIK & GROF
Bilirubin (Direct)	**0.40**	mg/dl	<0.30	JENDRASSIK & GROF
Bilirubin (Indirect)	0.63	mg/dl	<0.8	JENDRASSIK & GROF
LIPID PROFILE (MINI) , *Serum*				
Cholesterol (Total)	152.00	mg/dl	<200 Desirable 200-239 Borderline High >240 High	CHOD-PAP
HDL Cholesterol (Good Cholesterol)	42.10	mg/dl	30-70	DIRECT ENZYMATIC
LDL Cholesterol (Bad Cholesterol)	68	mg/dl	<100 Optimal 100-129 Nr. Optimal/Above Optimal 130-159 Borderline High 160-189 High >190 Very High	CALCULATED
VLDL	**42.36**	mg/dl	10-33	CALCULATED
Triglycerides	**211.80**	mg/dl	<150 Normal 150-199 Borderline High 200-499 High >500 Very High	GPO-PAP

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DEPARTMENT OF CLINICAL PATHOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
URINE EXAMINATION, ROUTINE, *Urine*				
Color	PALE YELLOW			
Specific Gravity	1.020			
Reaction PH	Acidic (5.0)			DIPSTICK
Appearance	CLEAR			
Protein	ABSENT	mg %	<10 Absent 10-40 (+) 40-200 (++) 200-500 (+++) >500 (++++)	DIPSTICK
Sugar	ABSENT	gms%	<0.5 (+) 0.5-1.0 (++) 1-2 (+++) >2 (++++)	DIPSTICK
Ketone	ABSENT	mg/dl	Serum-0.1-3.0 Urine-0.0-14.0	BIOCHEMISTRY
Bile Salts	ABSENT			
Bile Pigments	ABSENT			
Bilirubin	ABSENT			DIPSTICK
Leucocyte Esterase	ABSENT			DIPSTICK
Urobilinogen(1:20 dilution)	ABSENT			
Nitrite	ABSENT			DIPSTICK
Blood	ABSENT			DIPSTICK
Microscopic Examination:				
Epithelial cells	0-2/h.p.f			MICROSCOPIC EXAMINATION
Pus cells	0-2/h.p.f			
RBCs	ABSENT			MICROSCOPIC EXAMINATION
Cast	ABSENT			
Crystals	ABSENT			MICROSCOPIC EXAMINATION
Others	ABSENT			

Urine Microscopy is done on centrifuged urine sediment.

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DEPARTMENT OF CLINICAL PATHOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
SUGAR, FASTING STAGE, *Urine*				
Sugar, Fasting stage	ABSENT	gms%		

Interpretation:

(+) < 0.5
(++) 0.5-1.0
(+++) 1-2
(++++) > 2

Test Name	Result	Unit	Bio. Ref. Interval	Method
SUGAR, PP STAGE, *Urine*				
Sugar, PP Stage	ABSENT			

Interpretation:

(+) < 0.5 gms%
(++) 0.5-1.0 gms%
(+++) 1-2 gms%
(++++) > 2 gms%

Dr.Akanksha Singh (MD Pathology)

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DEPARTMENT OF IMMUNOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method
PSA (Prostate Specific Antigen), Total *Sample:Serum*	1.14	ng/mL	<4.1	CLIA

Interpretation:

1. PSA is detected in the serum of males with normal, benign hypertrophic, and malignant prostate tissue.
2. Measurement of serum PSA levels is not recommended as a screening procedure for the diagnosis of cancer because elevated PSA levels also are observed in patients with benign prostatic hypertrophy. However, studies suggest that the measurement of PSA in conjunction with digital rectal examination (DRE) and ultrasound provide a better method of detecting prostate cancer than DRE alone.
3. PSA levels increase in men with cancer of the prostate, and after radical prostatectomy PSA levels routinely fall to the undetectable range.
4. If prostatic tissue remains after surgery or metastasis has occurred, PSA appears to be useful in detecting residual and early recurrence of tumor.
5. Therefore, serial PSA levels can help determine the success of prostatectomy, and the need for further treatment, such as radiation, endocrine or chemotherapy, and in the monitoring of the effectiveness of therapy.

THYROID PROFILE - TOTAL, *Serum*

T3, Total (tri-iodothyronine)	141.00	ng/dl	84.61–201.7	CLIA
T4, Total (Thyroxine)	9.34	ug/dl	3.2-12.6	CLIA
TSH (Thyroid Stimulating Hormone)	4.250	µIU/mL	0.27 - 5.5	CLIA

Interpretation:

0.3-4.5	µIU/mL	First Trimester	
0.5-4.6	µIU/mL	Second Trimester	
0.8-5.2	µIU/mL	Third Trimester	
0.5-8.9	µIU/mL	Adults	55-87 Years
0.7-27	µIU/mL	Premature	28-36 Week
2.3-13.2	µIU/mL	Cord Blood	> 37Week
0.7-64	µIU/mL	Child(21 wk - 20 Yrs.)	
1-39	µIU/mL	Child	0-4 Days
1.7-9.1	µIU/mL	Child	2-20 Week

1) Patients having low T3 and T4 levels but high TSH levels suffer from primary hypothyroidism, cretinism, juvenile myxedema or

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DEPARTMENT OF IMMUNOLOGY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

Test Name	Result	Unit	Bio. Ref. Interval	Method

autoimmune disorders.

2) Patients having high T3 and T4 levels but low TSH levels suffer from Grave's disease, toxic adenoma or sub-acute thyroiditis.
3) Patients having either low or normal T3 and T4 levels but low TSH values suffer from iodine deficiency or secondary hypothyroidism.
4) Patients having high T3 and T4 levels but normal TSH levels may suffer from toxic multinodular goiter. This condition is mostly a symptomatic and may cause transient hyperthyroidism but no persistent symptoms.
5) Patients with high or normal T3 and T4 levels and low or normal TSH levels suffer either from T3 toxicosis or T4 toxicosis respectively.
6) In patients with non thyroidal illness abnormal test results are not necessarily indicative of thyroidism but may be due to adaptation to the catabolic state and may revert to normal when the patient recovers.
7) There are many drugs for eg. Glucocorticoids, Dopamine, Lithium, Iodides, Oral radiographic dyes, etc. which may affect the thyroid function tests.
8) Generally when total T3 and total T4 results are indecisive then Free T3 and Free T4 tests are recommended for further confirmation along with TSH levels.

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DEPARTMENT OF X-RAY

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

X-RAY DIGITAL CHEST PA

X-RAY REPORT

(300 mA COMPUTERISED UNIT SPOT FILM DEVICE)

CHEST P-A VIEW

- Both lung field did not reveal any significant lesion.
- Costo-phrenic angles are bilaterally clear.
- Trachea is central in position.
- Cardiac size & contours are normal.
- Hilar shadows are normal.
- Soft tissue shadow appears normal.
- Bony cage is normal.

Please correlare clinically.

Dr. Aishwarya Neha (MD Radiodiagnosis

CHANDAN DIAGNOSTIC CENTRE

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DEPARTMENT OF ULTRASOUND

MEDIWHEEL BANK OF BARODA MALE ABOVE 40 YRS

ULTRASOUND WHOLE ABDOMEN (UPPER & LOWER)

LIVER: - Normal in size (13.3 cm), shape and **shows diffusely raised echotexture**. No focal lesion is seen. No intra hepatic biliary radicle dilation is seen.

GALL BLADDER :- Well distended. Normal wall thickness is seen. No evidence of calculus/focal mass lesion/pericholecystic fluid is seen.

CBD :- Normal in calibre at porta.

PORTAL VEIN: - Normal in calibre and colour uptake at porta.

PANCREAS: - Head is visualised, normal in size & echopattern. No evidence of ductal dilatation or calcification is seen. Rest of the pancreas is obscured by bowel gases.

SPLEEN: - Normal in size (11.0 cm), shape and echogenicity. No evidence of mass lesion is seen.

RIGHT KIDNEY: - Normal in size, shape and position. Cortical echogenicity is normal with maintained corticomedullary differentiation. No focal lesion or calculus is seen. Pelvicalyceal system is not dilated.

LEFT KIDNEY: - Normal in size, shape and position. Cortical echogenicity is normal with maintained corticomedullary differentiation. No focal lesion or calculus is seen. Pelvicalyceal system is not dilated.

URINARY BLADDER :- Is minimally distended. Patient unable to hold urine further.

HIGH RESOLUTION :- No evidence of bowel loop dilatation or abnormal wall thickening is seen. No significant retroperitoneal lymphadenopathy is seen. No free fluid is seen in the abdomen/pelvis.

IMPRESSION : Grade I fatty changes.

Please correlate clinically

*** End Of Report ***

Result/s to Follow:
STOOL, ROUTINE EXAMINATION, Tread Mill Test (TMT)

Dr. Aishwarya Neha (MD Radiodiagnosis