SPECTRUM
DIAGNOSTICS & HEALTH CARE

CERTIFICATE OF MEDICAL FITNESS

NAME: Mr. Chandra Sekhar Sethi

AGE/ GENDER: 53/M

HEIGHT: 156 cm WEIGHT: 55.7 kg

IDENTIFICATION MARK: —

BLOOD PRESSURE: 120/90 mm/Hg

PULSE: 64/mit

CVS: & Normal

RS:

ANY OTHER DISEASE DIAGNOSED IN THE PAST: Nill

ALLERGIES, IF ANY: Nill

LIST OF PRESCRIBED MEDICINES: Nill

ANY OTHER REMARKS: NO

I Certify that I have carefully examined Mr/Mrs. Chandra Sekhar Sethi son/daughter of Ms Mankanda who has signed in my presence. He/ she has no physical disease and is fit for employment.

Signature of candidate

Dr. SATISH KINI
MD (MEDICINE)
Consultant Physician

Signature of Medical Officer

Place: Spectrum diagnostics & healthcare

Date: 5/07/23

Disclaimer: The patient has not been checked for COVID. This certificate does not relate to the covid status of the patient examined

Dr. MOHAMMED AZEEZ, M.B.B.S
PHYSICIAN
K.M.C : 115364

SPECTRUM DIAGNOSTICS AND HEALTH CARE BENGALURU

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DIAGNOSTICS & HEALTH CARE

Dr.Ashok S
Bsc.,MBBS., D.O.M.S
Consultant Opthalmologist
KMC No: 31827

DATE: 05.07.23.

EYE EXAMINATIONP

NAME: Mr. Chaythra Sneka Sethi AGE: 33y GENDER : F / M

	RIGHT EYE	LEFT EYE
Vision	6/18 ; N10	6/18 ; N10
Vision With glass	6/6 ; N8	6/6 ; N8
Color Vision	Normal	Normal
Anterior segment examination	Normal	Normal
Fundus Examination	Normal	Normal
Any other abnormality	Nill	Nill
Diagnosis/ impression	Normal	Normal

To continue spectacles.

Dr. ASHOK SARODHE
B.Sc., M.B.B.S., D.O.M.S.
Eye Consultant & Surgeon
KMC 31827

Consultant (Opthalmologist)

ID: 7230018
MR CHANDRA SHKHAR SETHI
Male 53Years

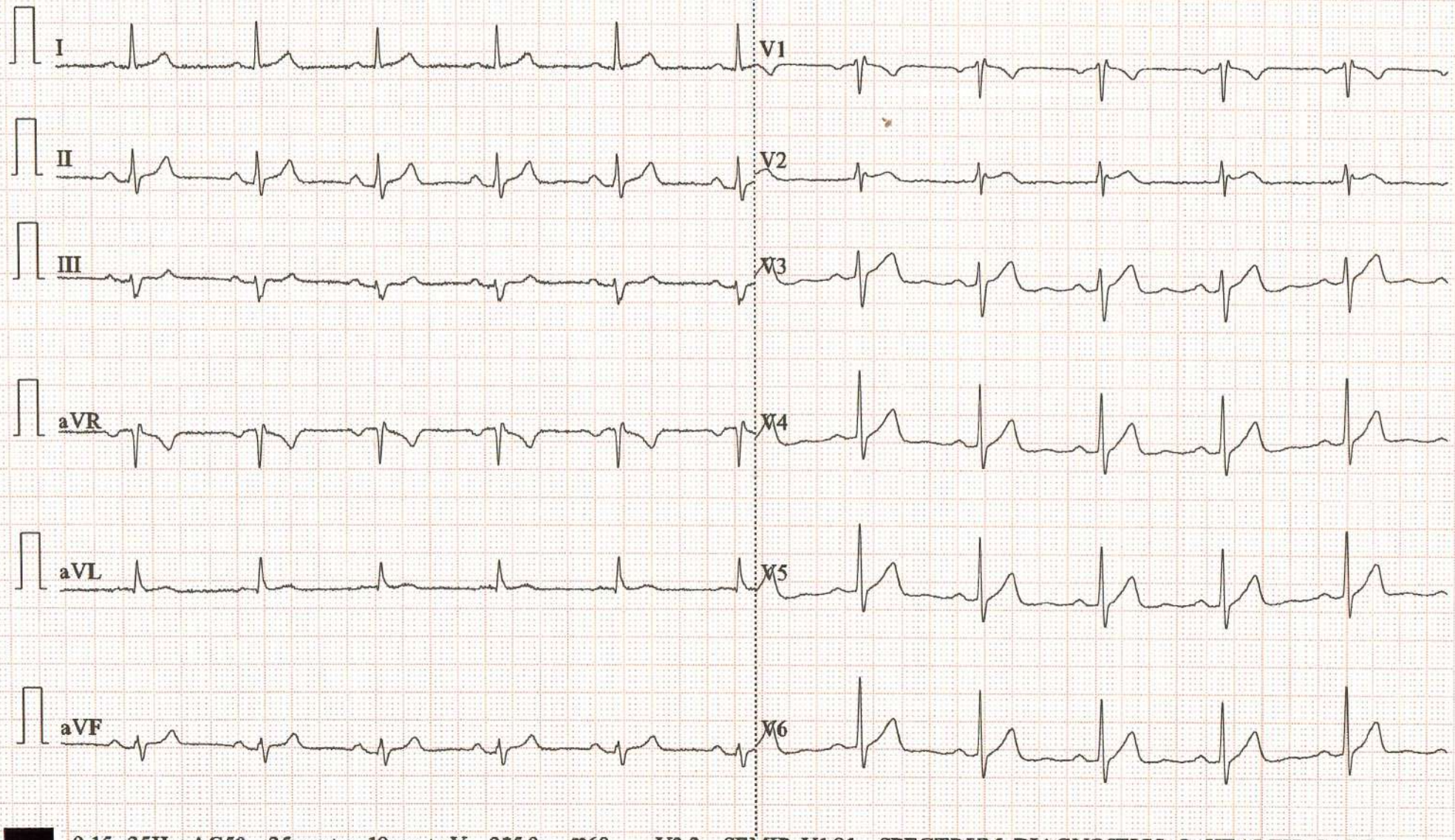
05-07-2023 11:04:03

For BPL

HR	: 68	bpm
P	: 105	ms
PR	: 175	ms
QRS	: 89	ms
QT/QTc	: 347/372	ms
P/QRS/T	: 58/17/54	°
RV5/SV1	: 1.095/0.564	mV

Diagnosis Information:
Sinus Rhythm
Normal ECG

Report Confirmed by:



0.15~35Hz AC50 25mm/s 10mm/mV 2*5.0s ♥68 V2.2 SEMIP V1.81 SPECTRUM DIAGNOSTICS & HEALTH CARE

SPECTRUM
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NAME : MR. CHANDRA SHEKAR SETHI	**DATE :05/07/2023**
AGE/SEX : 53 YEARS/MALE	**REG NO:0018**
REF BY : DR. APOLO CLINIC	

CHEST PA VIEW

Lung fields are clear.

Cardiovascular shadows are within normal limits.

Both CP angles are free.

Domes of diaphragm and bony thoracic cage are normal.

IMPRESSION: NORMAL CHEST RADIOGRAPH.

DR.RAM PRAKASH G MDRD
CONSULTANT RADIOLOGIST

Your suggestion / feedback is a valuable input for improving our services

PRINTED BY : RAVI M P

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PATIENT NAME	MR. CHANDRA SEKHAR SETHI	ID NO	0507230018
AGE	53YEARS	SEX	MALE
REF BY	DR.APOLO CLINIC	DATE	05/07/2023

2D ECHO CARDIOGRAHIC STUDY

M-MODE

AORTA	25mm
LEFT ATRIUM	26mm
RIGHT VENTRICLE	18mm
LEFT VENTRICLE (DIASTOLE)	47mm
LEFT VENTRICLE(SYSTOLE)	32mm
VENTRICULAR SEPTUM (DIASTOLE)	12mm
VENTRICULAR SEPTUM (SYSTOLE)	13mm
POSTERIOR WALL (DIASTOLE)	11mm
POSTERIOR WALL (SYSTOLE)	10mm
FRACTIONAL SHORTENING	30%
EJECTION FRACTION	60%

DOPPLER /COLOUR FLOW

MITRAL VALVE	E-0.76m/sec	A-0.52 m/sec	NO MR
AORTIC VALVE	1.32 m/sec		NO AR
PULMONARY VALVE	0.99 m/sec		NO PR
TRISCUSPID VALVE		30mmHg	MILD TR

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AGE	53YEARS	SEX	MALE
REF BY	DR.APOLO CLINIC	DATE	05/07/2023

2D ECHO CARDIOGRAHIC STUDY

LEFT VENTRICLE	SIZE& THICKNESS	NORMAL
CONTRACTILITY	REGIONAL GLOBAL	NO RWMA

RIGHT VENTRICLE : NORMAL
LEFT ATRIUM : NORMAL
RIGHT ATRIUM : NORMAL
MITRAL VALVE : NORMAL
AORTIC VALVE : NORMAL
PULMONARY VALVE: NORMAL
TRICUSPID VALVE : NORMAL
INTER ATRIAL SEPTUM :INTACT
INTER VENTRICULAR SEPTUM: INTACT
PERICARDIUM : NORMAL
OTHERS : - NIL

IMPRESSION

- NO RWMA OF LV AT REST
- NORMAL CARDIAC VALVES
- NORMAL LV FUNCTION, LVEF-60%
- LVH+
- MILD TR / MILD PAH
- AV SCLEROTIC/ NO AS
- NORMAL CARDIAC CHAMBER DIMENSIONS
- NO CLOT / PERICARDIAL EFFUSION

V. DURGA
ECHO TECHNICIAN

The science of radiology is based upon interpretation of shadows of normal and abnormal tissue. This is neither complete nor accurate; hence, findings should always be interpreted in to the light of clinico-pathological correction. This is a professional opinion

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NAME AND LAB NO	MR. CHANDRA SEKHAR SETHI	REG-30018
AGE & SEX	53YRS	MALE
DATE AND AREA OF INTEREST	05.07.2023	ABDOMEN & PELVIS
REF BY	C/O APOLO CLINIC	

USG ABDOMEN AND PELVIS

LIVER: Measures **12.5** cm. Normal in size an echotexture.
No e/o IHBR dilatation. No evidence of SOL. Portal vein appears normal.
CBD appears normal. . No e/o calculus / SOL

GALL BLADDER: Collapsed .

SPLEEN: Measures 8.0 cm. Normal in size and echotexture. No e/o SOL/ calcification.

PANCREAS: Normal in size and echotexture.
Pancreatic duct appears normal. No e/o calculus / calcifications.

RETROPERITONEUM: Poor window.

RIGHT KIDNEY: Right kidney measures 9.6 x 4.7 cm ,is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid / cystic lesions.

LEFT KIDNEY: Left kidney measures 9.7 x 4.7 cm ,is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid / cystic lesions.

URETERS: Bilateral ureters are not dilated.

URINARY BLADDER: Well distended. No wall thickening/ calculi.
Prevoid 390 cc , Post void nil

PROSTATE: Normal in size (- vol -22 cc) and echotexture.

- No evidence of ascites/pleural effusion.

IMPRESSION:

- **No significant sonological abnormality detected in the abdomen and pelvis.**

Akshatha R Bhat

DR AKSHATHA R BHAT
MDRD DNB FRCR

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MC-4196

Name	: MR. CHANDRA SEKHAR SETHI			**Bill Date**	: 05-Jul-2023 09:00 AM
Age / Gender	: 53 years / Male	**UHID**	: 0507230018	**Sample Col. Date**	: 05-Jul-2023 09:00 AM
Ref. By Dr.	: Dr. APOLO CLINIC			**Result Date**	: 05-Jul-2023 01:23 PM
Reg. No.	: 0507230018	0507230018		**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
Complete Haemogram-Whole Blood EDTA				
Haemoglobin (HB)	**13.2**	g/dL	Male:14.0-17.0	Spectrophotmeter
Red Blood Cell (RBC)	4.53	million/cumm	3.50 - 5.50	Volumetric Impedance
Packed Cell Volume (PCV)	**41.4**	%	Male: 42.0-51.0	Electronic Pulse
Mean corpuscular volume (MCV)	91.4	fL	78.0- 94.0	Calculated
Mean corpuscular hemoglobin (MCH)	29.3	pg	27.50-32.20	Calculated
Mean corpuscular hemoglobin concentration (MCHC)	33.0	%	33.00-35.50	Calculated
Red Blood Cell Distribution Width SD (RDW-SD)	44.3	fL	40.0-55.0	Volumetric Impedance
Red Blood Cell Distribution CV (RDW-CV)	**14.9**	%	Male: 11.80-14.50	Volumetric Impedance
Mean Platelet Volume (MPV)	10.5	fL	8.0-15.0	Volumetric Impedance
Platelet	1.9	lakh/cumm	1.50-4.50	Volumetric Impedance
Platelet Distribution Width (PDW)	21.9	%	8.30 - 56.60	Volumetric Impedance
White Blood cell Count (WBC)	5230.0	cells/cumm	Male: 4000.0-11000.0	Volumetric Impedance
Neutrophils	56.7	%	40.0-75.0	Light scattering/Manual
Lymphocytes	34.0	%	20.0-40.0	Light scattering/Manual
Eosinophils	1.4	%	0.0-6.0	Light scattering/Manual
Monocytes	7.5	%	0.0-8.0	Light scattering/Manual
Basophils	0.4	%	0.0-1.0	Light scattering/Manual
Absolute Neutrophil Count	2.96	10^3/uL	2.0- 7.0	Calculated

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Test Name	Result	Unit	Reference Value	Method
Absolute Lymphocyte Count	1.62	10^3/uL	1.0-3.0	Calculated
Absolute Monocyte Count	0.55	10^3/uL	0.20-1.00	Calculated
Absolute Eosinophil Count	70	cells/cumm	40-440	Calculated
Absolute Basophil Count	0.02	10^3/uL	0.0-0.10	Calculated
Erythrocyte Sedimentation Rate (ESR)	**15**	mm/hr	Male: 0.0-10.0	Westergren

Peripheral Smear Examination-Whole Blood EDTA

Method: (Microscopy-Manual)

RBC'S : Normocytic Normochromic.
WBC'S : Are normal in total number, morphology and distribution.
Platelets : Adequate in number and normal in morphology.
No abnormal cells or hemoparasites are present.
Impression : Normocytic Normochromic Blood picture.

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Reg. No.	: 0507230018		0507230018	**Report Status**	: Final
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Test Name	Result	Unit	Reference Value	Method
Thyroid function tests (TFT)-Serum				
Tri-Iodo Thyronine (T3)-Serum	0.97	ng/mL	0.60-1.81	Chemiluminescence Immunoassay (CLIA)
Thyroxine (T4)-Serum	6.80	µg/dL	5.50-12.10	Chemiluminescence Immunoassay (CLIA)
Thyroid Stimulating Hormone (TSH)-Serum	3.03	µIU/mL	0.35-5.50	Chemiluminescence Immunoassay (CLIA)

Comments: Triiodothyronine (T3) assay is a useful test for hyperthyroidism in patients with low TSH and normal T4 levels. It is also used for the diagnosis of T3 toxicosis. It is not a reliable marker for Hypothyroidism. This test is not recommended for general screening of the population without a clinical suspicion of hyperthyroidism.
Reference range: Cord: (37 Weeks): 0.5-1.41, Children:1-3 Days: 1.0-7.40,1-11 Months: 1.05-2.45,1-5 Years: 1.05-2.69,6-10 Years: 0.94-2.41,11-15 Years: 0.82-2.13,Adolescents (16-20 Years): 0.80-2.10
Reference range: Adults: 20-50 Years: 0.70-2.04, 50-90 Years: 0.40-1.81,
Reference range in Pregnancy: First Trimester : 0.81-1.90,Second Trimester : 1.0-2.60
Increased Levels: Pregnancy, Graves disease, T3 thyrotoxicosis, TSH dependent Hyperthyroidism, increased Thyroid-binding globulin (TBG).
Decreased Levels: Nonthyroidal illness, hypothyroidism , nutritional deficiency, systemic illness, decreased Thyroid-binding globulin (TBG).

Comments: Total T4 levels offer a good index of thyroid function when TBG is normal and non-thyroidal illness is not present. This assay is useful for monitoring treatment with synthetic hormones (synthetic T3 will cause low total T4).It also helps to monitor treatment of Hyperthyroidism with Thiouracil or other anti-thyroid drugs.
Reference Range: Males : 4.6-10.5,Females : 5.5-11.0,> 60 Years: 5.0-10.70,Cord :7.40-13.10,Children:1-3 Days :11.80-22.60,1-2 Weeks : 9.90-16.60,1-4 Months: 7.20-14.40,1-5 Years : 7.30-15.0,5-10 Years: 6.4-13.3
1-15 Years: 5.60-11.70,Newborn Screen:1-5 Days: >7.5,6 Days : >6.5
Increased Levels: Hyperthyroidism, increased TBG, familial dysalbuminemic hyperthyroxinemia,Increased transthyretin, estrogen therapy, pregnancy.
Decreased Levels: Primary hypothyroidism, pituitary TSH deficiency, hypothalamic TRH deficiency, non thyroidal illness, decreased TBG.

Comments:TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies. It is important to confirm any TSH abnormality in a fresh specimen drawn after ~ 3 weeks before assigning a diagnosis, as the cause of an isolated TSH abnormality.
Reference range in Pregnancy: I- trimester:0.1-2.5; II -trimester:0.2-3.0; III- trimester:0.3-3.0
Reference range in Newborns: 0-4 days: 1.0-39.0; 2-20 Weeks:1.7-9.1
Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism and Thyroid hormone resistance.
Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH deficiency.

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Dr. Nithun Reddy C,MD,Consultant Pathologist

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Test Name	Result	Unit	Reference Value	Method
RFT (Urea, Creatinine, BUN, Na+, K+, Cl-, RBS Uric acid,HB)				
RFT (Renal Function Test)-Serum				
Urea-Serum	21.00	mg/dL	Male: 06 - 40	Urease
Creatinine-Serum	0.70	mg/dL	Male: 0.6 - 1.5	Modified kinetic Jaffe
Blood Urea Nitrogen (BUN)-Serum	10.00	mg/dL	Male: 6 - 20	:GLDH,Kinetic Assay
Sodium (Na+)-Serum	139.3	mmol/L	Male: 135 - 145	ISE-Direct
Potassium (K+)-Serum	4.45	mmol/L	Male: 3.5 - 5.5	ISE-Direct
Chloride (Cl-)-Serum	100.00	mmol/L	94.0 - 110.0	ISE-Direct
Uric Acid-Serum	4.80	mg/dL	Male: 3.50 - 7.20	Uricase PAP

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Test Name	Result	Unit	Reference Value	Method
Glycosylated Haemoglobin (HbA1c)-Whole Blood EDTA				
Glycosylated Haemoglobin (HbA1c)	4.80	%	Non diabetic adults :<5.7 At risk (Prediabetes) : 5.7 - 6.4 Diagnosing Diabetes :>= 6.5 Diabetes Excellent Control : 6-7 Fair to good Control : 7-8 Unsatisfactory Control :8-10 Poor Control :>10	HPLC
Estimated Average Glucose(eAG)	91.06	mg/dL		Calculated

Note: 1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.

2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Comments: HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

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SCAN FOR LOCATION

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Test Name	Result	Unit	Reference Value	Method
LFT-Liver Function Test -Serum				
Bilirubin Total-Serum	0.80	mg/dL	0.2-1.0	Caffeine Benzoate
Bilirubin Direct-Serum	0.12	mg/dL	0.0-0.2	Diazotised Sulphanilic Acid
Bilirubin Indirect-Serum	0.68	mg/dL	0.0-1.10	Direct Measure
Aspartate Aminotransferase (AST/SGOT)-Serum	31.00	U/L	15.0-37.0	UV with Pyridoxal - 5 - Phosphate
Alanine Aminotransferase (ALT/SGPT)-Serum	34.00	U/L	16.0-63.0	UV with Pyridoxal - 5 - Phosphate
Alkaline Phosphatase (ALP)-Serum	67.00	U/L	45.0-117.0	PNPP,AMP-Buffer
Protein, Total-Serum	7.12	g/dL	6.40-8.20	Biuret/Endpoint-With Blank
Albumin-Serum	4.10	g/dL	3.40-5.00	Bromocresol Purple
Globulin-Serum	3.02	g/dL	2.0-3.50	Calculated
Albumin/Globulin Ratio-Serum	1.36	Ratio	0.80-1.20	Calculated

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Test Name	Result	Unit	Reference Value	Method
Lipid Profile-Serum				
Cholesterol Total-Serum	181.00	mg/dL	0.0-200	Cholesterol Oxidase/Peroxidase
Triglycerides-Serum	68.00	mg/dL	0.0-150	Lipase/Glycerol Dehydrogenase
High-density lipoprotein (HDL) Cholesterol-Serum	50.00	mg/dL	40.0-60.0	Accelerator/Selective Detergent
Non-HDL cholesterol-Serum	131	mg/dL	0.0-130	Calculated
Low-density lipoprotein (LDL) Cholesterol-Serum	98.00	mg/dL	0.0-100.0	Cholesterol esterase and cholesterol oxidase
Very-low-density lipoprotein (VLDL) cholesterol-Serum	14	mg/dL	0.0-40	Calculated
Cholesterol/HDL Ratio-Serum	3.62	Ratio	0.0-5.0	Calculated

Interpretation:

Parameter	Desirable	Borderline High	High	Very High
Total Cholesterol	<200	200-239	>240	
Triglycerides	<150	150-199	200-499	>500
Non-HDL cholesterol	<130	160-189	190-219	>220
Low-density lipoprotein (LDL) Cholesterol	<100	100-129	160-189	>190

Comments: As per Lipid Association of India (LAI), for routine screening, overnight fasting preferred but not mandatory. Indians are at very high risk of developing Atherosclerotic Cardiovascular (ASCVD). Among the various risk factors for ASCVD such as dyslipidemia, Diabetes Mellitus, sedentary lifestyle, Hypertension, smoking etc., dyslipidemia has the highest population attributable risk for MI both because of direct association with disease pathogenesis and very high prevalence in Indian population. Hence monitoring lipid profile regularly for effective management of dyslipidemia remains one of the most important healthcare targets for prevention of ASCVD. In addition, estimation of ASCVD risk is an essential, initial step in the management of individuals requiring primary prevention of ASCVD. In the context of lipid management, such a risk estimate forms the basis for several key therapeutic decisions, such as the need for and aggressiveness of statin therapy.

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Test Name	Result	Unit	Reference Value	Method
Gamma-Glutamyl Transferase (GGT)-Serum	29.00	U/L	Male: 15.0-85.0	Other g-Glut-3-carboxy-4 nitro

Comments: Gamma-glutamyltransferase (GGT) is primarily present in kidney, liver, and pancreatic cells. Small amounts are present in other tissues. Even though renal tissue has the highest level of GGT, the enzyme present in the serum appears to originate primarily from the hepatobiliary system, and GGT activity is elevated in any and all forms of liver disease. It is highest in cases of intra- or posthepatic biliary obstruction, reaching levels some 5 to 30 times normal. GGT is more sensitive than alkaline phosphatase (ALP), leucine aminopeptidase, aspartate transaminase, and alanine aminotransferase in detecting obstructive jaundice, cholangitis, and cholecystitis; its rise occurs earlier than with these other enzymes and persists longer. Only modest elevations (2-5 times normal) occur in infectious hepatitis, and in this condition, GGT determinations are less useful diagnostically than are measurements of the transaminases. High elevations of GGT are also observed in patients with either primary or secondary (metastatic) neoplasms. Elevated levels of GGT are noted not only in the sera of patients with alcoholic cirrhosis but also in the majority of sera from persons who are heavy drinkers. Studies have emphasized the value of serum GGT levels in detecting alcohol-induced liver disease. Elevated serum values are also seen in patients receiving drugs such as phenytoin and phenobarbital, and this is thought to reflect induction of new enzyme activity.

Fasting Blood Sugar (FBS)-Plasma	84	mg/dL	60.0-110.0	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

Blood Group & Rh Typing-Whole Blood EDTA

Blood Group	O	Slide/Tube agglutination
Rh Type	Positive	Slide/Tube agglutination

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Reg. No.	: 0507230018	0507230018		**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method

Note: Confirm by tube or gel method.

Comments: ABO blood group system, the classification of human blood based on the inherited properties of red blood cells (erythrocytes) as determined by the presence or absence of the antigens A and B, which are carried on the surface of the red cells. Persons may thus have type A, type B, type O, or type AB blood.

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Dr. Nithun Reddy C,MD,Consultant Pathologist

SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-4196

Name	: MR. CHANDRA SEKHAR SETHI			**Bill Date**	: 05-Jul-2023 09:00 AM
Age / Gender	: 53 years / Male	**UHID**	: 0507230018	**Sample Col. Date**	: 05-Jul-2023 09:00 AM
Ref. By Dr.	: Dr. APOLO CLINIC			**Result Date**	: 05-Jul-2023 01:23 PM
Reg. No.	: 0507230018	0507230018		**Report Status**	: Final
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Test Name	Result	Unit	Reference Value	Method
Vitamin D Total (25 Hydroxy Cholecalciferol)	**15.00**	ng/mL	30.0 -100.0	CLIA

Interpretation: Deficiency :<10, Insufficiency:10-30, Sufficiency:30-100, Toxicity:>100

Note: The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.It shows seasonal variation, with values being 40-50% lower in winter than in summer.Levels vary with age and are increased in pregnancy.A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available.

Comments: Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major
circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels:Inadequate exposure to sunlight,Dietary deficiency,Vitamin D malabsorption,Severe Hepatocellular disease,Drugs like Anticonvulsants,Nephrotic syndrome

Increased levels: Vitamin D intoxication.

Vitamin B12-Serum	388.00	pg/mL	(211-911)	CLIA

Comments: Vitamin B12 performs many important functions in the body, but the most significant function is to act as coenzyme for reducing ribonucleotides to deoxyribonucleotides, a step in the formation of genes. Inadequate dietary intake is not the commonest cause for cobalamine deficiency. The most common cause is malabsorption either due to atrophy of gastric mucosa or diseases of terminal ileum. Cobalamine deficiency leads to Megaloblastic anemia and demyelination of large nerve fibres of spinal cord. Normal body stores are sufficient to last for 3-6 years. Sources of Vitamin B12 are liver, shellfish, fish, meat, eggs, milk, cheese & yogurt.

Decreased Levels: Lack of Intrinsic factor: Total or partial gastrectomy, Atrophic gastritis, Intrinsic factor antibodies,Malabsorption: Regional ileitis, resected bowel, Tropical Sprue, Celiac disease, pancreatic insufficiency, bacterial overgrowth & achlorhydria, Loss of ingested vitamin B12: fish tapeworm,Dietary deficiency: Vegetarians,Congenital disorders: Orotic aciduria & transcobalamine deficiency,Increased demand: Pregnancy specially last trimester.

Increased Levels: Chronic renal failure, Congestive heart failure, Acute & Chronic Myeloid Leukemia, Polycythemia vera, Carcinomas with liver metastasis, Liver disease, Drug induced cholestasis & Protein malnutrition.

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Test Name	Result	Unit	Reference Value	Method
Urine Routine Examination-Urine				
Physical Examination				
Colour	Pale Yellow		Pale Yellow	Visual
Appearance	Clear		Clear	Visual
Reaction (pH)	6.5		5.0 - 7.5	Dipstick
Specific Gravity	1.015		1.000 - 1.030	Dipstick
Biochemical Examination				
Albumin	Negative		Negative	Dipstick/Precipitation
Glucose	Negative		Negative	Dipstick/Benedicts
Bilirubin	Negative		Negative	Dipstick/Fouchets
Ketone Bodies	Negative		Negative	Dipstick/Rotheras
Urobilinogen	Normal		Normal	Dipstick/Ehrlichs
Nitrite	Negative		Negative	Dipstick
Microscopic Examination				
Pus Cells	2-3	hpf	0.0 - 5.0	Microscopy
Epithelial Cells	1-2	hpf	0.0 - 10.0	Microscopy
RBCs	Absent	hpf	Absent	Microscopy
Casts	Absent		Absent	Microscopy
Crystals	Absent		Absent	Microscopy
Others	Absent		Absent	Microscopy

Comments: The kidneys help infiltration of the blood by eliminating waste out of the body through urine.They also regulate water in the body by conserving electrolytes, proteins, and other compounds. But due to some conditions and abnormalities in kidney function, the urine may encompass some abnormal constituents, which are not normally present.A complete urine examination helps in detecting such abnormal constituents in urine. Several disorders can be detected byidentifying and measuring the levels of such substances. Blood cells, bilirubin, bacteria, pus cells, epithelial cells may be present in urine due to kidney disease or infection. Routine urine examination helps to diagnose kidney diseases, urinary tract infections, diabetes and other metabolic disorders.

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Test Name	Result	Unit	Reference Value	Method
Postprandial Urine glucose-Urine	Negative		Negative	Dipstick/Benedicts (Manual)

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

Post prandial Blood Glucose (PPBS)-Plasma	92	mg/dL	80.0-150.0	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

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