DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:29 AM Reported On : 10/12/2022 10:35 AM

Barcode : 012212100753 Specimen : Serum Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
SERUM CREATININE			
Serum Creatinine (Two Point Rate - Creatinine Aminohydrolase)	0.77	mg/dL	0.66-1.25
eGFR (Calculated)	120.3	mL/min/1.73m^2	Indicative of renal impairment < 60 Note:eGFR is inaccurate for Hemodyamically unstable patients eGFR is not applicable for less than 18 years of age.

Interpretation Notes

- **CLINICAL INFORMATION AND CLINICAL INTERPRETATION**:
  Diagnosing and monitoring treatment of acute and chronic kidney diseases
  Adjusting dosage of renally excreted medications
  Monitoring kidney transplant recipients
  Estimating glomerular filtration rate for people with chronic kidney disease (CKD) and those with risk factors for CKD (diabetes, hypertension, cardiovascular disease, and family history of kidney disease). Several factors may influence serum creatinine independent of changes in GFR. For instance, creatinine generation is dependent upon muscle mass. Thus, young, muscular male patients may have significantly higher serum creatinine levels than older adult female patients, despite having similar GFRs. Also, because some renal clearance of creatinine is due to tubular secretion, drugs that inhibit this secretory component (eg, cimetidine and trimethoprim) may cause small increases in serum creatinine without an actual decrease in GFR.
  POTENTIAL SOURCE OF VARIATION:
  Hemolyzed specimens from patients with hemoglobin F values of 600 mg/dL and higher interfere with the test.
  2-Phenyl-1,3-indandion (phenindione) at therapeutic concentrations interferes with the assay. In patients receiving catecholamines (dopamine, dobutamine, epinephrine, and norepinephrine) falsely low results might be observed.

Blood Urea Nitrogen (BUN) (Endpoint /Colorimetric – Urease)	12	mg/dL	9.0-20.0

Interpretation Notes

- **CLINICAL INFORMATION AND INTERPRETATION:**
  For evaluation if Renal function tests. Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis), and post renal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).
  Serum / plasma concentration is increased in:

Glomerulonephritis, Shock, Urinary tract obstruction, Pyelonephritis, Acute and chronic renal failure, severe congestive heart failure, Hyperalimentation, Diabetic ketoacidosis, Dehydration
Serum / plasma concentration is decreased in:
Pregnancy, decreased protein intake, acute liver, intravenous fluid administration.
POTENTIAL SOURCE OF VARIATION:
Ammonium ions may cause an increase in measured BUN/UREA value equivalent to the specimen's nitrogen content.

Serum Uric Acid (Colorimetric - Uricase,Peroxidase)	5.93	mg/dL	3.5-8.5

LIPID PROFILE (CHOL,TRIG,HDL,LDL,VLDL)

Cholesterol Total (Colorimetric - Cholesterol Oxidase)	190	mg/dL	Desirable: < 200 Borderline High: 200-239 High: > 240
Triglycerides (Colorimetric - Lip/Glycerol Kinase)	93	mg/dL	Normal: < 150 Borderline: 150-199 High: 200-499 Very High: > 500
HDL Cholesterol (HDLC) (Colorimetric: Non HDL Precipitation Phosphotungstic Acid Method)	**35 L**	mg/dL	40.0-60.0
Non-HDL Cholesterol (Calculated)	**155.0 H**	mg/dL	Desirable: < 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190-219 Very High: => 220
LDL Cholesterol (Colorimetric)	**123 L**	mg/dL	Optimal: < 100 Near to above optimal: 100-129 Borderline High: 130-159 High: 160-189 Very High: > 190
VLDL Cholesterol (Calculated)	18.6	mg/dL	0.0-40.0
Cholesterol /HDL Ratio (Calculated)	**5.5 H**	-	0.0-5.0

Interpretation Notes

- **Clinical Information and Interpretation:**
  Diagnosing dyslipoproteinemia, Quantitation of cholesterol and triglycerides in very-low-density lipoprotein, low-density lipoprotein (LDL), high-density lipoproteins (HDL), and chylomicrons, Identification of LpX, classifying hyperlipoproteinemias (lipoprotein phenotyping), Evaluating patients with abnormal lipid values (cholesterol, triglyceride, HDL, LDL) for specific phenotypes, Quantifying lipoprotein a cholesterol.
  These elevations can be indicative of a genetic deficiency in lipid metabolism or transport, nephrotic syndrome, endocrine dysfunction, or even cholestasis.Proper characterization of a patient's dyslipidemic phenotype aids clinical decisions and guides appropriate therapy.
  Total Cholesterol in serum is increased in:
  Obesity**,** Smoking**,** Alcohol**,** Diet high cholesterol and fats**,** Renal failure**,** Hypothyroidism
  Total Cholesterol in serum is decreased in:
  Malnutrition**,** Liver disease**,** Myeloproliferative disease

Cholesterol measurements are used to evaluate the risk of developing coronary artery occlusion, atherosclerosis, myocardial infarction, and cerebrovascular disease. Coronary atherosclerosis correlates with a high cholesterol level.

1. Triglycerides concentration are increased in
2. Hyperlipoproteinemia, Von Gierke disease, Diabetes, Hypothyroidism, Liver disease, alcoholism
3. Triglycerides concentration are Decreased in

Abetalipoproteinemia, Malnutrition, Hyperparathyroidism, Hyperthyroidism, Malabsorption.

dHDL concentration are increased in

Hyperalphalipoproteinemia ,Regular physical activity or exercise ,Weight loss ,Chronic liver disease

dHDL concentration are Decreased in

Uncontrolled diabetes **,** Hepatocellular disease **,**Chronic renal failure, nephrosis, uremia

Cholestasis ,Abetalipoproteinemia.

Chol/HDL ratio is helpful in for predicting the risk of heart disease. According to the American Heart Association (AHA), the ratio should be aimed to be kept below 5 for men and below 4.4 for women, with the ideal cholesterol ratio being 3.5.

Low Density Lipoprotein (LDL) cholesterol is used to evaluate the risk of developing coronary heart disease (CHD). The risk of CHD increases with higher LDL cholesterol concentrations. Lowering the LDL cholesterol level in the blood is a primary target of various cholesterol-lowering therapeutic agents.

dLDL concentration are increased in

Familial hypercholesterolemia, Nephrotic syndrome, Hepatic disease, Hepatic obstruction chronic renal failure, Hyperlipidemia type II and III, Diabetes mellitus

dLDL concentration are Decreased in

Abetalipoproteinemia, Hyperthyroidism, Tangier disease, Hypolipoproteinemia

Chronic anemia.

POTENTIAL SOURCE OF VARIATION:

Cholesterol results can be falsely decreased in patients with elevated levels of N-acetyl-p-benzoquinone imine (NAPQI), a metabolite of acetaminophen, N-acetylcysteine (NAC), and metamizole. Potassium Oxalate/Sodium Fluoride can decrease cholesterol results an average of 12%.

Small amounts of free glycerol may be found in blood samples from healthy individuals due to natural lipolysis. The concentration of free glycerol may be increased by stress, disease states or administration of intravenous infusates. Free glycerol or other polyols may cause a positive interference.

Certain drugs and clinical conditions are known to alter HDL cholesterol concentration in vivo.

LDL Cholesterol values may be high because of a diet high in saturated fats, pregnancy or use of steroids

LDL Cholesterol may be decreased because of acute stress, recent illness, and estrogen supplements

LIVER FUNCTION TEST(LFT)

Bilirubin Total (Colorimetric -Diazo Method)	0.37	mg/dL	0.2-1.3
Conjugated Bilirubin (Direct) (Dual Wavelength - Reflectance Spectrophotometry)	0.10	mg/dL	0.0-0.4
Unconjugated Bilirubin (Indirect) (Calculated)	0.27	mg/dL	0.0-1.1
Total Protein (Colorimetric - Biuret Method)	**8.30 H**	gm/dL	6.3-8.2
Serum Albumin (Colorimetric - Bromo-Cresol Green)	4.30	gm/dL	3.5-5.0
Serum Globulin (Calculated)	**4.1 H**	gm/dL	2.0-3.5

Albumin To Globulin (A/G)Ratio (Calculated)	1.05	-	1.0-2.1
SGOT (AST) (Multipoint-Rate With P-5-P (pyridoxal-5-phosphate))	32	U/L	17.0-59.0
SGPT (ALT) (Multipoint-Rate With P-5-P (pyridoxal-5-phosphate))	41	U/L	<50.0
Alkaline Phosphatase (ALP) (Multipoint-Rate - P-nitro Phenyl Phosphate, AMP Buffer)	95	U/L	38.0-126.0
Gamma Glutamyl Transferase (GGT) (Multipoint Rate - L-glutamyl-p-nitroanilide (Szasz Method))	29	U/L	15.0-73.0

Interpretation Notes

- Indirect Bilirubin result is a calculated parameter (Indirect Bilirubin = Total Bilirubin - Direct Bilirubin).
  Indirect bilirubin result includes the delta bilirubin fraction also. Delta Bilirubin is the bilirubin which is covalently bound to albumin. Delta Bilirubin is not expected to be present in healthy adults or neonates.
  CLINICAL INFORMATION AND CLINICAL INTERPRETATION:
  Initial screening for hepatobiliary inflammation. Panel includes albumin; ALP; AST; ALT; bilirubin, direct; protein, total; and bilirubin, total. The hepatic function panel may be used to help diagnose liver disease if a person has signs and symptoms that indicate possible liver dysfunction. Indications for liver function testing include investigating and monitoring patients with suspected liver disease, at risk patient groups, or monitoring malignancy; and before initiating and monitoring hepatotoxic medications
  Hepatic function panel results are not diagnostic of a specific condition. Results of liver panels are usually evaluated together. Several sets of results from tests performed over a few days or weeks are often assessed together to determine if a pattern is present.
  POTENTIAL SOURCE OF VARIATION:
  Pyridoxal phosphate is a cofactor in the reaction and must be present for optimal enzyme activity.
  In Vitro exposure to light may alter bilirubin chemical and spectral properties because of the formation of photobilirubin.
  Bc results flagged with a Potential Interferent (PI) code should be repeated with the VITROSTBIL slide, which is not sensitive to the same spectral Interferents.
  Bu result flagged with a Potential Interferent (PI) code should be diluted with a normal patient sample or VITROS7% BSA and return on the BuBc Slide.
  Certain drugs and Clinical conditions are known to alter Bu and Bc concentration in vivo.
  Falsely elevated proteins (pseudohyperproteinemia) can be caused by hemoconcentration due to dehydration or sample desiccation.
  Upright posture for several hours after rising increases Total Protein and several other analytes.
  An average positive bias of 6% with an individual sample bias up to 10% may be observed with heparin plasma results compared to serum results.
  CMPF (3-carboxy-4-methyl-5-propyl-2-furanpropanoic acid) present in sera of patients with renal failure has been reported to give falsely low albumin values.
  Certain drugs and clinical conditions are known to alter alkaline phosphatase activity.
  ALKP day-to-day variation is 5 -10 %. Recent food ingestion can increase as much as 30 U/L.
  ALKP is 25% higher with increased body mass index, 10% higher with smoking, and 20% lower with the use of oral contraceptives.
  GGT in Certain drugs and clinical conditions are known to alter gamma glutamyltransferase activity *in vivo.*
  GGT shows 25 -50 % activity increase with higher body mass index.
  GGT Values are 25% lower during early pregnancy.

THYROID PROFILE (T3, T4, TSH)

Tri Iodo Thyronine (T3) (Enhanced Chemiluminesence)	1.34	ng/mL	0.97-1.69
Thyroxine (T4) (Enhanced Chemiluminesence)	9.92	µg/dl	5.53-11.0
TSH (Thyroid Stimulating Hormone) (Enhanced Chemiluminesence)	1.787	µIU/mL	0.4-4.049

Interpretation Notes

- **CLINICAL INFORMATION AND INTERPRETATION:**
  TSH is measured quantitatively to aid in the differential diagnosis of Thyroid disease.
  TSH concentration is increased in: Primary Hypothyroidism, Hashimoto Thyroiditis, Iodide deficiency goiter, Myxedema
  TSH concentration is decreased in
  Toxic multinodular goitre, Thyroid Adenoma, Thyroiditis, Secondary pituitary or hypothalamic hypothyroidism
  TSH measurement help in differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low or normal. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively.
  POTENTIAL SOURCES OF VARIATION:
  Certain drugs and clinical conditions are known to alter TSH concentrations *in vivo*.
  TSH levels are subject to circadian variation, reaching peak levels between 2 – 4 a.m. and at a minimum between 6 – 10 pm. The variation is of the order 50%, hence time of the day has influence on the measured serum TSH concentrations.
  Transient increase in TSH levels or abnormal TSH levels can be seen in various non-thyroidal diseases. Simultaneous measurement of TSH with free T4 is useful in evaluating the differential diagnosis.
  The possibility of interference of human heterophile antibodies in the patient specimen may interfere with the measurement of TSH, that interfere with immunoassays. This may falsely elevate or falsely decrease the results.
  Interference due to extremely high titers of antibodies to analyte-specific antibodies, streptavidin, or ruthenium can occur.
  Pregnancy also affects TSH levels. They are often a little low during the first three months. But sometimes, thyroid disease develops during pregnancy.
  TT3
  CLINICAL INFORMATION AND INTERPRETATION:
  A fall in T3 concentrations of up to 50% is known to occur in a variety of clinical situations, including acute and chronic disease.
  In hyperthyroidism, both T4 and T3 levels are usually elevated, but in a small subset of hyperthyroid patients, only T3 is elevated (T3 toxicosis).
  In hypothyroidism T4 and T3 levels are decreased. T3 levels are frequently low in sick or hospitalized euthyroid patients.
  Increased levels: Pregnancy, Grave's disease, T3 thyrotoxicosis, TSH dependent hyperthyroidism, Increased TBG
  Decreased levels: Non thyroidal illness, hypothyroidism, Nutritional deficiency, systemic illness, Decreased TBG
  Abnormal levels (high or low) of thyroid hormone-binding proteins (primarily albumin and thyroid-binding globulin) may cause abnormal T3 concentrations in euthyroid patients.
  POTENTIAL SOURCES OF VARIATION:
  Therapy with amiodarone can lead to depressed T3 values.
  Phenytoin, phenylbutazone, and salicylates cause release of T3 from the binding proteins, thus leading to a reduction in the total T3 hormone level at normal free T3 levels.
  Autoantibodies to thyroid hormones can interfere with the assay.
  Binding protein anomalies may cause values that deviate from the expected results. Pathological concentrations of binding proteins can lead to results outside the reference range, although the patient may be in a euthyroid state. Free T3 or free T4 testing is indicated in these cases

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedures, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.
T3 has a 15-fold higher affinity for thyroid receptor compared to T4.

TT4

CLINICAL INFORMATION AND INTERPRETATION:

TT4 concentration is increased in:

Hyperthyroidism, Pregnancy, Euthyroid sick syndrome, Increase in Thyroxine-binding globulin (TBG), Familial dysalbuminemic hyperthyroxinemia, much higher in first 2 months of life than in normal adults

TT4 concentration is decreased in

Hypothyroidism, Hypoproteinemia, Euthyroid sick syndrome, Decrease in TBG

POTENTIAL SOURCES OF VARIATION:

In pregnancy, incomplete release of thyroxine (T4) from its binding proteins might result in falsely low total T4 levels. Therefore, total T4 should not be used as the only marker for thyroid function evaluation.
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.
Autoantibodies to thyroid hormones can interfere with testing.
In rare cases, interference due to extremely high titers of antibodies to analyte-specific antibodies, ruthenium or streptavidin can occur.
* For 12 hours before specimen collection for any thyroid function test, the patient should not take multivitamins or dietary supplements containing biotin (vitamin B7), which is commonly found in hair, skin, and nail supplements and multivitamins.

--End of Report-

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

(Lipid Profile, -> autoAuthorised)

(CR, -> autoAuthorised)

(LFT, -> autoAuthorised)

(, -> autoAuthorised)

(Uric Acid, -> autoAuthorised)

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(Blood Urea Nitrogen (Bun) -> autoAuthorised)

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:29 AM Reported On : 10/12/2022 10:23 AM

Barcode : 012212100752 Specimen : Whole Blood Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
HBA1C			
HbA1c (HPLC NGSP Certified)	5.3	%	Normal: 4.0-5.6 Prediabetes: 5.7-6.4 Diabetes: => 6.5 ADA standards 2020
Estimated Average Glucose (Calculated)	105.41	-	-

Interpretation:

1. HbA1C above 6.5% can be used to diagnose diabetes provided the patient has symptoms. If the patient does not have symptoms with HbA1C>6.5%, repeat measurement on further sample. If the repeat test result is <6.5%, consider as diabetes high risk and repeat measurement after 6 months.

2. HbA1C measurement is not appropriate in diagnosing diabetes in children, suspicion of type 1 diabetes, symptoms of diabetes for less than 2 months, pregnancy, hemoglobinopathies, medications that may result sudden increase in glucose, anemia, renal failure, HIV infection, malignancies, severe chronic hepatic, and renal disease.

3. Any sample with >15% should be suspected of having a haemoglobin variant.

Interpretation Notes

- **CLINICAL INFORMATION AND CLINICAL INTERPRETATION**:
  Diabetes mellitus is a chronic disorder associated with disturbances in carbohydrate, fat, and protein metabolism characterized by hyperglycemia. HbA1c level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks, depending on the individual) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations.
  Diagnosing diabetes: American Diabetes Association (ADA)
  -Hemoglobin A1c (HbA1c): > or =6.5%
  Therapeutic goals for glycemic control (ADA)
  -Adults:
  - Goal of therapy: < 7.0% HbA1c
  - Action suggested: > 8.0% HbA1c
  -Pediatric patients:
  - Toddlers and preschoolers: < 8.5% (but >7.5%)
  - School age (6-12 years): < 8%
  - Adolescents and young adults (13-19 years): < 7.5%
  The ADA recommendations for clinical practice suggest maintaining a HbA1c value closer to normal yields improved microvascular outcomes for diabetics. Target goals of less than 7% may be beneficial in patients such as those with short duration of diabetes, long life expectancy, and no significant cardiovascular disease.
  POTENTIAL SOURCE OF VARIATION:
  The presence of hemoglobin variants can interfere with the measurement of hemoglobin A1c (HbA1c). The advantage of using ion exchange chromatography methods is most variants that would affect HbA1c results can be detected from analysis of the chromatogram so inaccurate results are less likely to be reported.

HbA1c results less than 4.0% are reported with the comment:

--End of Report-

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

MC-2688

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:29 AM Reported On : 10/12/2022 10:03 AM

Barcode : 012212100751 Specimen : Plasma Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
Fasting Blood Sugar (FBS) (Colorimetric - Glucose Oxidase Peroxidase)	94	mg/dL	70 to 99 : Normal 100 to 125 : Pre-diabetes =>126 : Diabetes ADA standards 2020

--End of Report-

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

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(Fasting Blood Sugar (FBS) -> autoAuthorised)

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:29 AM Reported On : 10/12/2022 10:23 AM

Barcode : 022212100445 Specimen : Whole Blood - ESR Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

HEMATOLOGY

Test	Result	Unit	Biological Reference Interval
Erythrocyte Sedimentation Rate (ESR) (Westergren Method)	**20 H**	mm/1hr	0.0-10.0

Interpretation Notes

- ESR high - Infections, chronic disorders,, plasma cell dyscrasias.
  DISCLAIMER:**All the laboratory findings should mandatorily interpreted in correlation with clinical findings by a medical expert**

--End of Report-

Dr. Shalini K S
DCP, DNB, Pathology
Consultant

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:24 AM Reported On : 10/12/2022 10:00 AM

Barcode : 032212100111 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

CLINICAL PATHOLOGY

Test	Result	Unit
Urine For Sugar (Fasting) (Enzyme Method (GOD POD))	Not Present	-

--End of Report-

Dr. Sudarshan Chougule
MBBS, MD, Pathology
Consultant & Head - Hematology & Flow Cytometry

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MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:24 AM Reported On : 10/12/2022 10:31 AM

Barcode : 032212100111 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

CLINICAL PATHOLOGY

Test	Result	Unit	Biological Reference Interval
URINE ROUTINE & MICROSCOPY			
PHYSICAL EXAMINATION			
Colour	Yellow	-	-
Appearance	Clear	-	-
CHEMICAL EXAMINATION			
pH(Reaction) (pH Indicator Method)	6.0	-	4.5-7.5
Sp. Gravity (Refractive Index)	1.011	-	1.002 - 1.030
Protein (Automated Protein Error Or Ph Indicator)	Not Present	-	Not Present
Urine Glucose (Enzyme Method (GOD POD))	Not Present	-	Not Present
Ketone Bodies (Nitroprusside Method)	Not Present	-	Not Present
Bile Salts (Azo Coupling Method)	Not Present	-	Not Present
Bile Pigment (Bilirubin) (Azo Coupling Method)	Not Present	-	Not Present
Urobilinogen (Azo Coupling Method)	Normal	-	Normal
Urine Leucocyte Esterase (Measurement Of Leukocyte Esterase Activity)	Not Present	-	Not Present
Blood Urine (Peroxidase Reaction)	Not Present	-	Not Present
Nitrite (Gries Method)	Not Present	-	Not Present
MICROSCOPIC EXAMINATION			
Pus Cells	0.0	/hpf	0-5

RBC	0.2	/hpf	0-4
Epithelial Cells	0.0	/hpf	0-6
Crystals	0.0	/hpf	0-2
Casts	0.00	/hpf	0-1
Bacteria	1.2	/hpf	0-200
Yeast Cells	0.0	/hpf	0-1
Mucus	Not Present	-	Not Present

--End of Report-

Dr. Sudarshan Chougule
MBBS, MD, Pathology
Consultant & Head - Hematology & Flow Cytometry

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:37 AM Reported On : 10/12/2022 10:44 AM

Barcode : 1B2212100015 Specimen : Whole Blood Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

NARAYANA HRUDAYALAYA BLOOD CENTRE

Test	Result	Unit
BLOOD GROUP & RH TYPING		
Blood Group (Column Agglutination Technology)	O	-
RH Typing (Column Agglutination Technology)	Positive	-

--End of Report-

Dr. Prathip Kumar B R
MBBS,MD, Immunohaematology & Blood Transfusion
Consultant

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 12:32 PM Received On : 10/12/2022 12:46 PM Reported On : 10/12/2022 01:22 PM

Barcode : 012212101422 Specimen : Plasma Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
Post Prandial Blood Sugar (PPBS) (Colorimetric - Glucose Oxidase Peroxidase)	83	mg/dL	70 to 139 : Normal 140 to 199 : Pre-diabetes =>200 : Diabetes ADA standards 2020

--End of Report-

Dr. Anushre Prasad
MBBS,MD, Biochemistry
Consultant Biochemistry

Mrs. Latha B S
MSc, Mphil, Biochemistry
Incharge, Consultant Biochemistry

Note

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(Post Prandial Blood Sugar (PPBS) -> autoAuthorised)

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 12:32 PM Received On : 10/12/2022 12:51 PM Reported On : 10/12/2022 01:29 PM

Barcode : 032212100222 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

CLINICAL PATHOLOGY

Test	Result	Unit
Urine For Sugar (Post Prandial) (Enzyme Method (GOD POD))	Negative	-

--End of Report-

Hema S

Dr. Hema S
MD, DNB, Pathology
Associate Consultant

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MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:24 AM Reported On : 10/12/2022 10:00 AM

Barcode : 032212100111 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

CLINICAL PATHOLOGY

Test	Result	Unit
Urine For Sugar (Fasting) (Enzyme Method (GOD POD))	Not Present	-

--End of Report-

Dr. Sudarshan Chougule
MBBS, MD, Pathology
Consultant & Head - Hematology & Flow Cytometry

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

MC-2688

DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Mr G POOVARASAN MRN : 10080000182269 Gender/Age : MALE , 28y (12/09/1994)

Collected On : 10/12/2022 09:03 AM Received On : 10/12/2022 09:24 AM Reported On : 10/12/2022 10:31 AM

Barcode : 032212100111 Specimen : Urine Consultant : Dr. Ashutosh Vashistha(CARDIOLOGY - ADULT)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8660434575

CLINICAL PATHOLOGY

Test	Result	Unit	Biological Reference Interval
URINE ROUTINE & MICROSCOPY			
PHYSICAL EXAMINATION			
Colour	Yellow	-	-
Appearance	Clear	-	-
CHEMICAL EXAMINATION			
pH(Reaction) (pH Indicator Method)	6.0	-	4.5-7.5
Sp. Gravity (Refractive Index)	1.011	-	1.002 - 1.030
Protein (Automated Protein Error Or Ph Indicator)	Not Present	-	Not Present
Urine Glucose (Enzyme Method (GOD POD))	Not Present	-	Not Present
Ketone Bodies (Nitroprusside Method)	Not Present	-	Not Present
Bile Salts (Azo Coupling Method)	Not Present	-	Not Present
Bile Pigment (Bilirubin) (Azo Coupling Method)	Not Present	-	Not Present
Urobilinogen (Azo Coupling Method)	Normal	-	Normal
Urine Leucocyte Esterase (Measurement Of Leukocyte Esterase Activity)	Not Present	-	Not Present
Blood Urine (Peroxidase Reaction)	Not Present	-	Not Present
Nitrite (Gries Method)	Not Present	-	Not Present
MICROSCOPIC EXAMINATION			
Pus Cells	0.0	/hpf	0-5

RBC	0.2	/hpf	0-4
Epithelial Cells	0.0	/hpf	0-6
Crystals	0.0	/hpf	0-2
Casts	0.00	/hpf	0-1
Bacteria	1.2	/hpf	0-200
Yeast Cells	0.0	/hpf	0-1
Mucus	Not Present	-	Not Present

--End of Report-

Dr. Sudarshan Chougule
MBBS, MD, Pathology
Consultant & Head - Hematology & Flow Cytometry

Note

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

OP CASESHEET

1020 - 3212001194

Mazumdar Shaw Medical Center
Unit of Narayana Health

Patient MRN	: 10080000182269	Date	: 10/12/2022 01:30 PM
Patient Name	: Mr G POOVARASAN	Department	: CARDIOLOGY - ADULT
Sex/Age	: Male , 28y 2m	Consultant	: Dr. Ashutosh Vashistha
Address	: BUDDIGERE, WHITEFIELD, , Bangalore Urban, Karnataka, IN,	Ref. Hospital	: -
Visit Number	: OP-001	Ref. Doctor	: -
Consultation Type	: OP, New Visit	Sponsor Name	: ARCOFEMI HEALTHCARE LIMITED
Mobile Number	: 8660434575		

SpO2 = 99%.

VITALS

BP (mmHg)	: 119/75 mmHg	Heart Rate(bpm)	: 91 b/m	Temp (*F)	:
Height (cm)	: 171 cm	Weight (kg)	: 87 kg	BMI	:
Respiratory Rate(brpm)	:	Fall Score	:	Pain Score	:

CHIEF COMPLAINTS AND HPI

GENERAL EXAMINATION

Allergies	: Known/Unknown
Body Habitus:	: Cachectic/ Thin Built/ Average Built/ Obese/ Normal
Pertinent Family History	: Negative/ Unknown
Psychological Assessment:	: Normal/Any Psychological Problem

Known Allergy
PMH –

Non HDL 155

SYSTEMIC EXAMINATION

NUTRITIONAL ASSESSMENT

INVESTIGATIONS

TREATMENT SUGGESTED

REVIEW ON

Cardiology Consult

Generated By : Navitha N(320679)

Generated On : 10/12/2022 08:56 AM

One free consultation with the same doctor within next 6 days

Tab Cyplon 2 tab 1-0-1 CO x 2M

Mazumdar Shaw Medical Center
(A Unit of Narayana Hrudayalaya Limited) CIN: L85110KA2000PLC027497
Registered Office: 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore 560099
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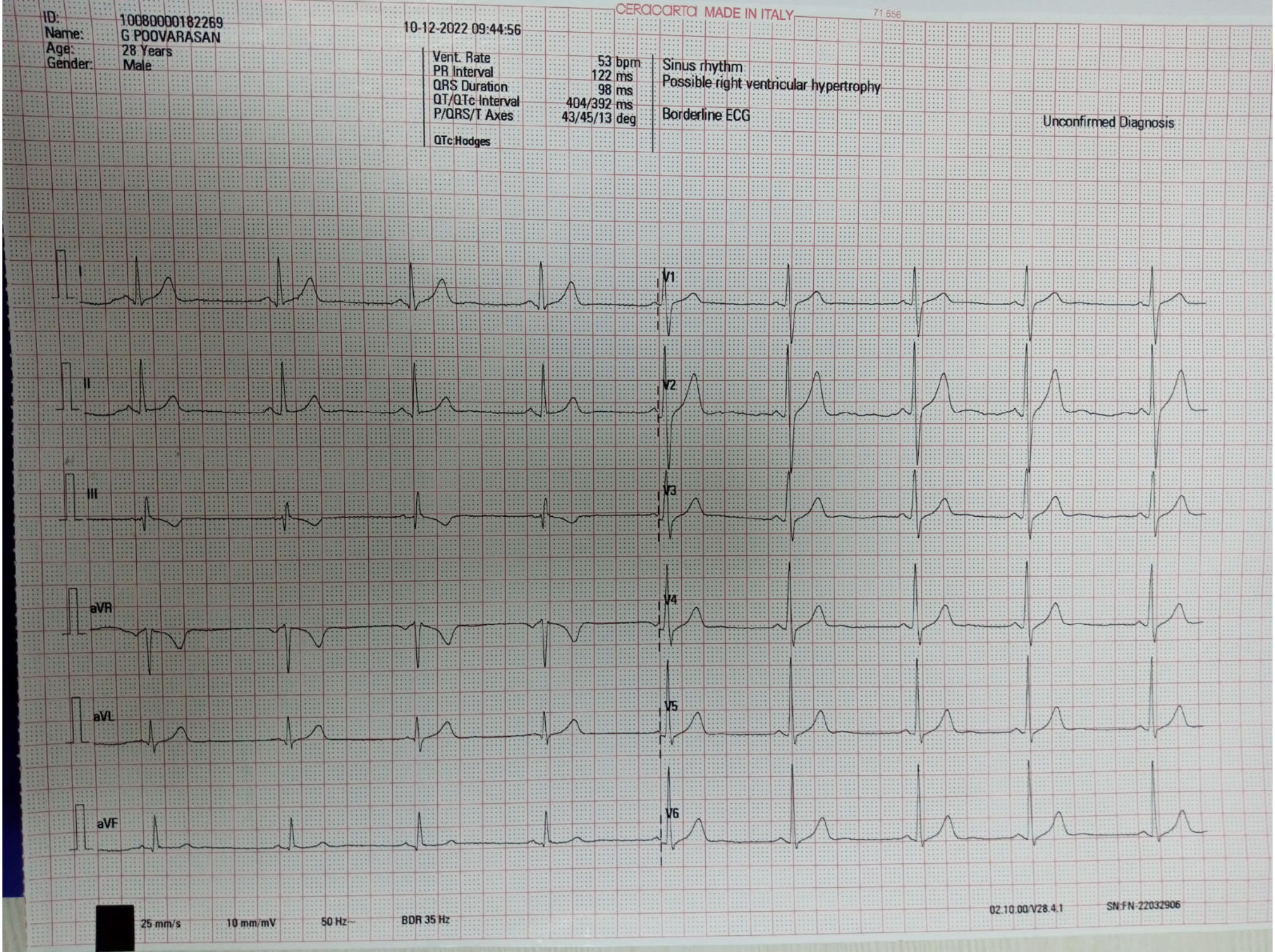
ID: 10080000182269
Name: G POOVARASAN
Age: 28 Years
Gender: Male
10-12-2022 09:44:56
CERACARTA MADE IN ITALY
71 556
Vent. Rate 53 bpm
PR Interval 122 ms
QRS Duration 98 ms
QT/QTc Interval 404/392 ms
P/QRS/T Axes 43/45/13 deg
QTc:Hodges
Sinus rhythm
Possible right ventricular hypertrophy
Borderline ECG
Unconfirmed Diagnosis
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
25 mm/s
10 mm/mV
50 Hz~
BDR 35 Hz
02.10.00/V28.4.1
SN:FN-22032906

NARAYANA INSTITUTE OF CARDIAC SCIENCES
NH HEALTH CITY
BENGALURU

Station : ASP, TMT
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: G POOVARASAN,
Patient ID: 10080000182269
Height: 171 cm
Weight: 87 kg

DOB: 12.09.1994
Age: 28yrs
Gender: Male
Race: Asian

Study Date: 10.12.2022
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: EHC
Attending Physician: DR ASHUTOSH VASHISTA
Technician: NANDINI

Medications:
--

Medical History:
HEALTH CHECK

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	02:55	0.00	0.00	81	120/80	
	STANDING	00:02	0.00	0.00	83		
	WARM-UP	00:10	0.00	0.00	93		
EXERCISE	STAGE 1	02:15	1.70	10.00	127	120/80	
	STAGE 2	01:57	2.50	12.00	151	130/80	
	STAGE 3	01:49	3.40	14.00	176	130/80	
	STAGE 4	00:18	4.20	16.00	181		
RECOVERY		03:01	0.00	0.00	112	140/80	

The patient exercised according to the BRUCE for 6:15 min:s, achieving a work level of Max. METS: 11.00. The resting heart rate of 99 bpm rose to a maximal heart rate of 184 bpm. This value represents 95 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg , rose to a maximum blood pressure of 150/80 mmHg. The exercise test was stopped due to Heart rate achieved.

Conclusions

GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO CHEST PAIN OR ARRHYTHMIAS
NO ST-T CHANGES NOTED

Physician _____ Technician _____

NH Narayana
Institute of Cardiac Sciences
Unit of Narayana Health

Patient Name	**: Mr. G Poovarasan**	**MRN**	**: 10080000182269**
Age	**: 28 Years**	**Sex**	**: Male**
Referring Doctor	**: EHC**	**Date**	**: 10.12.2022**

ULTRASOUND ABDOMEN AND PELVIS

CLINICAL DETAILS: Health check-up.

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions.

Portal vein is normal in course and caliber. Hepatic veins and their confluence draining into the IVC appear normal. **CBD** is not dilated.

Gallbladder is well distended without evidence of calculi or pericholecystic fluid.

Pancreas is obscured by bowel gas.

Spleen is normal in size (12.2 cm), shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size, position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size, position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of hydronephrosis. There is a non-obstructing calculus measuring 3 mm in the lower pole calyx.

Retroperitoneum – Obscured by bowel gas.

Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.

Prostate is normal in size, (volume – 11.3 cc).

There is no ascites.

IMPRESSION:

- **Left non-obstructing renal calculus.**

Dr. K Vishnu Vardhan Reddy
Sr. Registrar

Typed by Shobha. G

NH HEALTHCITY BANGALORE
G POOVARASAN Mr 1008000018226g 1020-221201801 1 M Table 12/10/2022 09:59 AM

NN1,NN2,NN4

NARAYANA NETHRALAYA
your faith shall heal you
Super Speciality Eye Hospital & Post Graduate Institute of Ophthalmology

CELEBRATING 40 YEARS IN EYE CARE

CERTIFICATE

Mr. /Mrs. /Ms. Poorvashan G1 aged 28/M year

MR# 1034806 was seen on 10/12/2022

	Right Eye	Left Eye
Vision (BCVA)	cg 6/6 9N6	cg 6/6 9N6
Color Vision	WNL	WNL
Anterior Segment	=	=
Pupils	3mm RRR	3mm RRR
Fundus	Disc, Macula & Retina Normal	Disc, Macula & Retina Normal
IOP	19mmHg	17mmHg

ADVICE: -

Yearly Eye Check Up

Doctor Signature

Dr. GAGAN DUDEJA
Consultant, Ophthalmologist
Reg. No. 85404 (KMC)
NARAYANA NETHRALAYA

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