Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
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Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 24 / 2 / 24

Name: Mrs. Sunita Kumari Age: 48 yrs Sex: M / F ✓

BP: 130/90 mmHg Height (cms): 156 cm Weight(kgs): 81.1 kg BMI: _____

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese					Extremely Obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	26	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	12154470	Date	24/02/2024		
Name	Mrs. Sunita Kumari	Sex	Female	Age	48
OPD	Ophthal 14	Health Check-up			

Drug allergy: → Not know.
Sys illness: → No
Habit. → No

C/o NV (Blur)

H/o No

Vision → RE 6/6.P, → LE 6/6P

NV → N10. → N10.

Refraction → RE −0.50 Dsph 6/6.
→ LE −0.75 Dsph 6/6.
Add → +1.75 Dsph → N6 → N6.

IOP: → RE 13.7
→ LE 15.7

[signature]

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VR8 7387696540 (Rental).

UHID	**12154470**	**Date**	**24/02/2024**		
Name	**Mrs. Sunita Kumari**	**Sex**	**Female**	**Age**	**48**
OPD	**Dental 12**	**Health Check-up**			

~~9099648476~~

Drug allergy:
Sys illness:

M/H → NRM.

O/E →

Grade II mobility 1/1

I " " 2/2

Missing 6

R. oot Piece 6

Scaling ++ Calculus ++

Adv

- OPG, RVG 3/3. Splinting?
- Scaling & Polishing
- Replacement 6
- Extraction 6

Dr Varsha Valam
(MDS)
A-39457
(Periodontist)

Diagnostics Report

Fortis

MC-5027

agilus diagnostics

PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS :C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005164** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:25:00 RECEIVED : 24/02/2024 09:25:38 REPORTED :24/02/2024 13:30:09

CLINICAL INFORMATION :

UID:12154470 REQNO-1666896
CORP-OPD
BILLNO-150124OPCR010906
BILLNO-150124OPCR010906

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.44	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.12	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.32	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.0	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.5	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.5	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.0	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	20	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	31	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-AMP	85	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANELIDE	**73 High**	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	143	81 - 234	U/L

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin

Dr. Akshay Dhotre, MD
(Reg,no. MMC 2019/09/6377)
Consultant Pathologist

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Patient Ref. No. 220000009047761

PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005164** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:25:00 RECEIVED : 24/02/2024 09:25:38 REPORTED :24/02/2024 13:30:09

CLINICAL INFORMATION :

UID:12154470 REQNO-1666696
CORP-OPD
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Test Report Status **Final**	Results	Biological Reference Interval	Units

may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells. and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.

Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc

****End Of Report****

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Patient Ref. No. 22000000904761

Diagnostics Report

Fortis

MC-5037

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS :C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

CLINICAL INFORMATION :

UID:12154470 REQNO-1666896
CORP-OPD
BILLNO-150124OPCR010906
BILLNO-150124OPCR010906

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SLS METHOD	**11.7 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.11	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	5.90	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	169	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	38.5	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	93.7	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	28.5	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	**30.4 Low**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.8	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	22.8		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	**12.9 High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			

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Patient Ref. No. 2200000904763

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022X8005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

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Test Report Status **Final**	Results	Biological Reference Interval	Units
NEUTROPHILS	72	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	22	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	5	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	1	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
BASOPHILS	0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	4.25	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.30	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.30	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.06	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT	**0.00 Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.3		
METHOD : CALCULATED			

MORPHOLOGY

RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
METHOD : MICROSCOPIC EXAMINATION	
WBC	NORMAL MORPHOLOGY
METHOD : MICROSCOPIC EXAMINATION	
PLATELETS	ADEQUATE
METHOD : MICROSCOPIC EXAMINATION	

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022X8005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

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Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cause of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age < 49.5 years old and NLR > 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

Dr. Akshay Dhotre, MD
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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R METHOD : WESTERGREN METHOD	**28 High**	0 - 20	mm at 1 hr

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	**6.0 High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC) ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	**122.6 High**	< 116.0	mg/dL

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Patient Ref. No. 2200000004763

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

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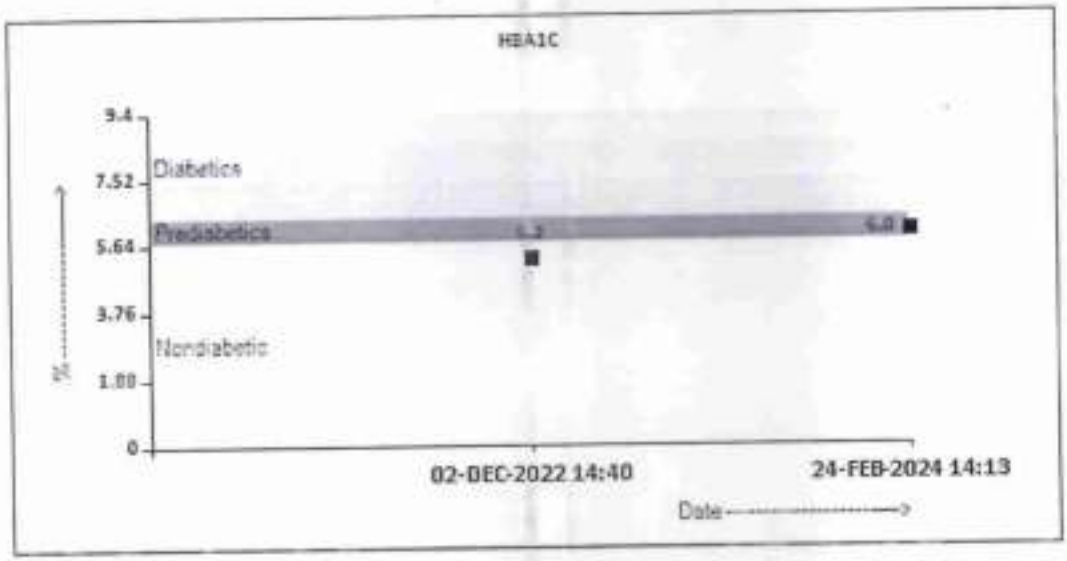

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy ESR in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(55 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for

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Email : -

Patient Ref. No. 22000000904763

Diagnostics Report

Fortis

MC-5837

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022X8005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

CLINICAL INFORMATION :

UID:12154470 REQNO-1666896
CORP-OPD
BILLNO-150124OPCR010906
BILLNO-150124OPCR010906

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

the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood lost,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate patrform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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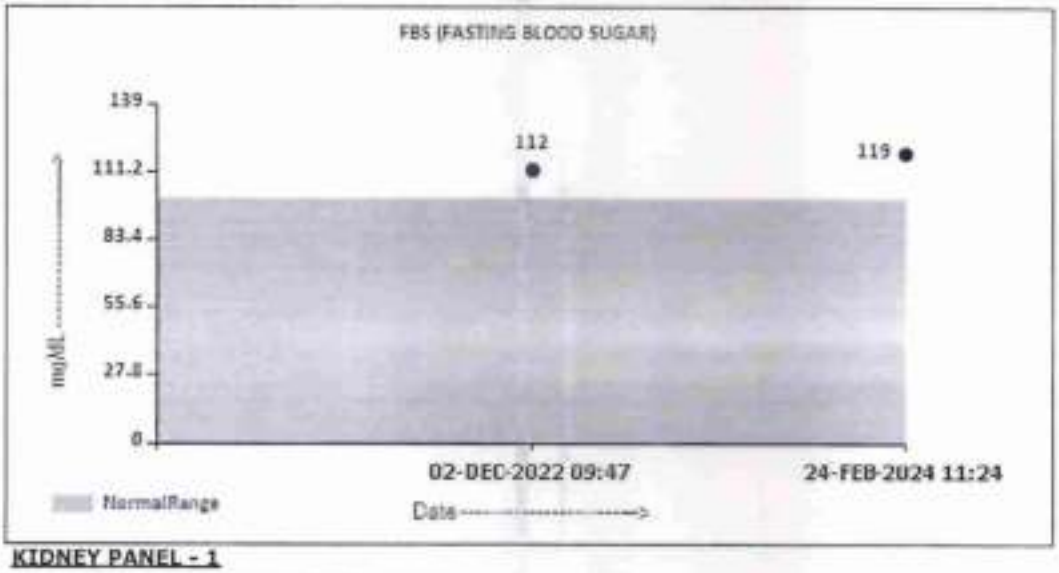
BIOCHEMISTRY

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	**119 High**	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL

METHOD : HEXOKINASE



KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	8	6 - 20	mg/dL

METHOD : UREASE - UV

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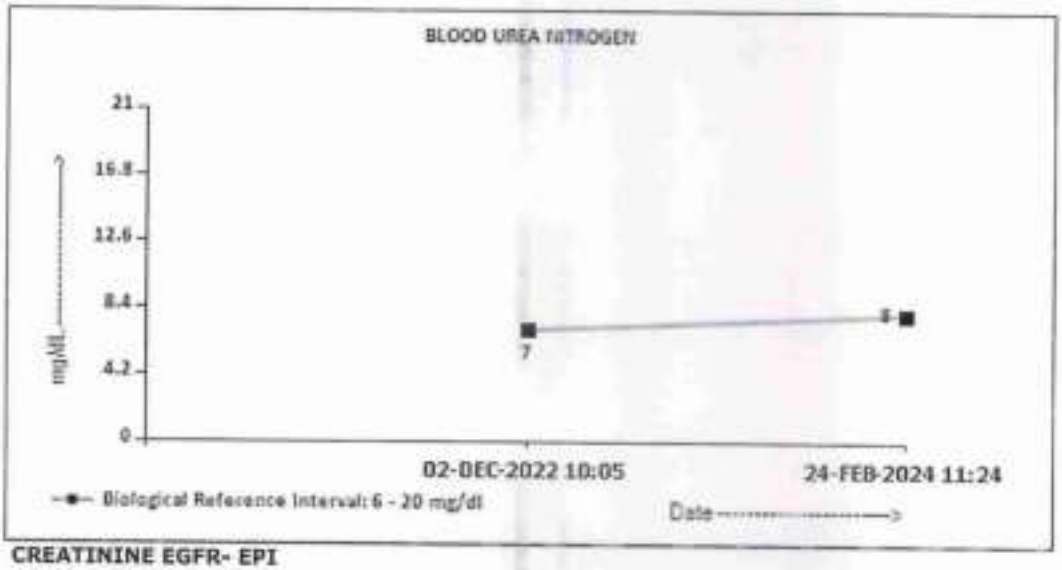

CREATININE EGFR- EPI

CREATININE	0.83	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	48		years
GLOMERULAR FILTRATION RATE (FEMALE)	86.90	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			

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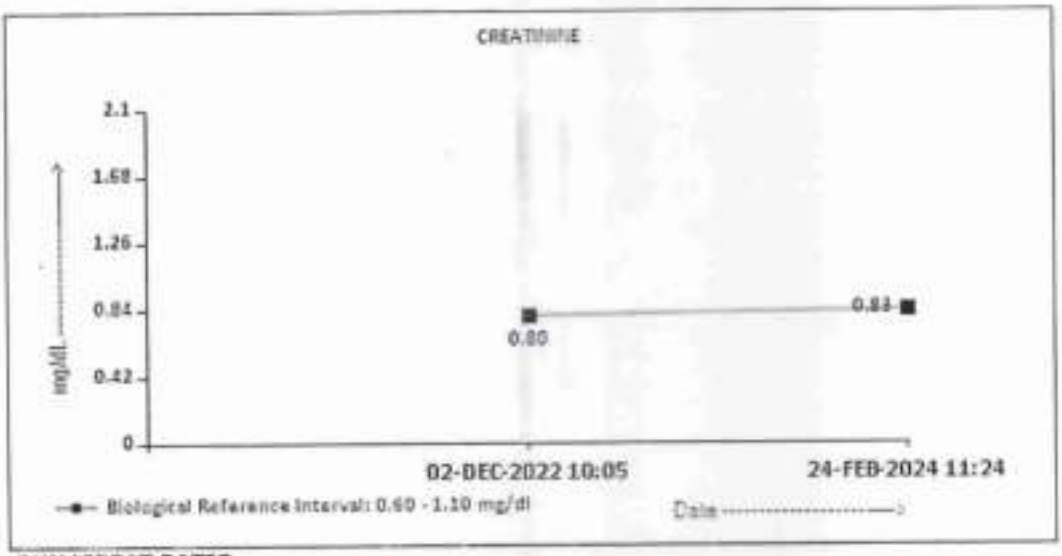

BUN/CREAT RATIO

BUN/CREAT RATIO	9.64	5.00 - 15.00	

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID	4.8	2.6 - 6.0	mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL

METHOD : BIURET

ALBUMIN, SERUM

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ALBUMIN METHOD : BCP DYE BINDING	3.5	3.4 - 5.0	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	3.9	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	139	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.25	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	102	98 - 107	mmol/L

Interpretation(s)

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 - 15%), chronic pancreatitis (30%), Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency disorders(e g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylurea,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values) there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glycosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycaemia,Increased insulin response & sensitivity etc.
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI— Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the kidney function.
- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.
- The GFR is a calculation based on serum creatinine test.
- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.
- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

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- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- This equation takes into account several factors that impact creatinine production, including age, gender, and race.
- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high(>60 ml/min per 1.73m2)... This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation-https://labguide.labmed.uw.edu/guidelines/egfr
Ghoman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756125
Harrison"s Principle of Internal Medicine, 21st ed. pg 62 and 334
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels-**Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

	Results	Biological Reference Interval	Units
CHOLESTEROL, TOTAL	**221 High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	**232 High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	**39 Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	**148 High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	**182 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	**46.4 High**	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**5.7 High**	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO	**3.8 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

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FORTIS HOSPITAL # VASHI,
MUMBAI 440001

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PATIENT ID : FH.12154470
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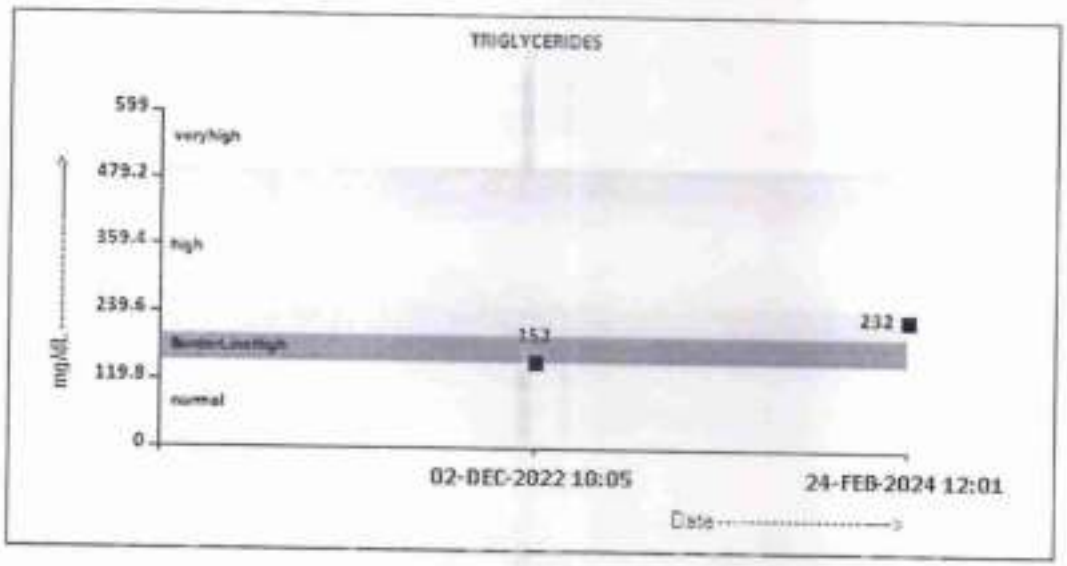

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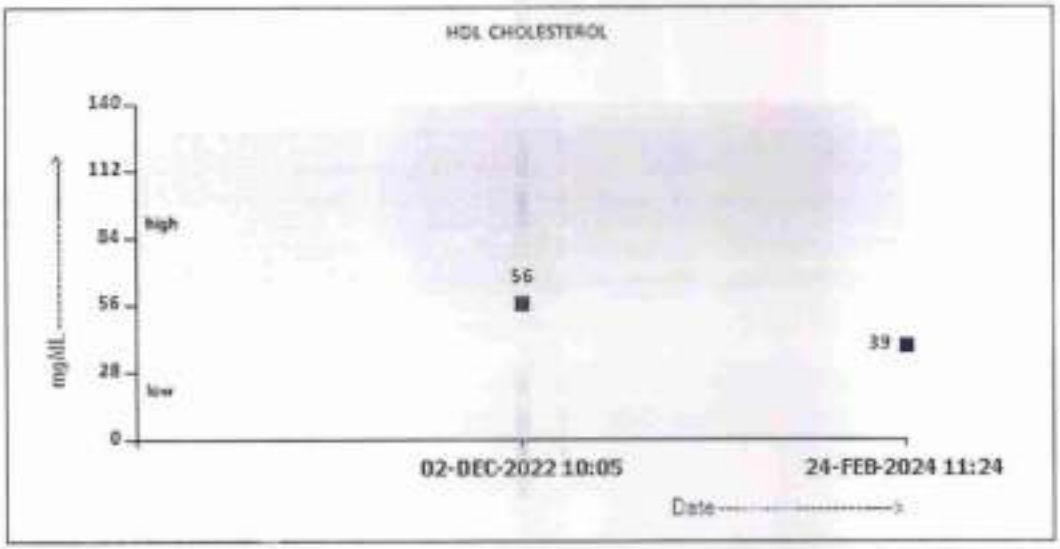

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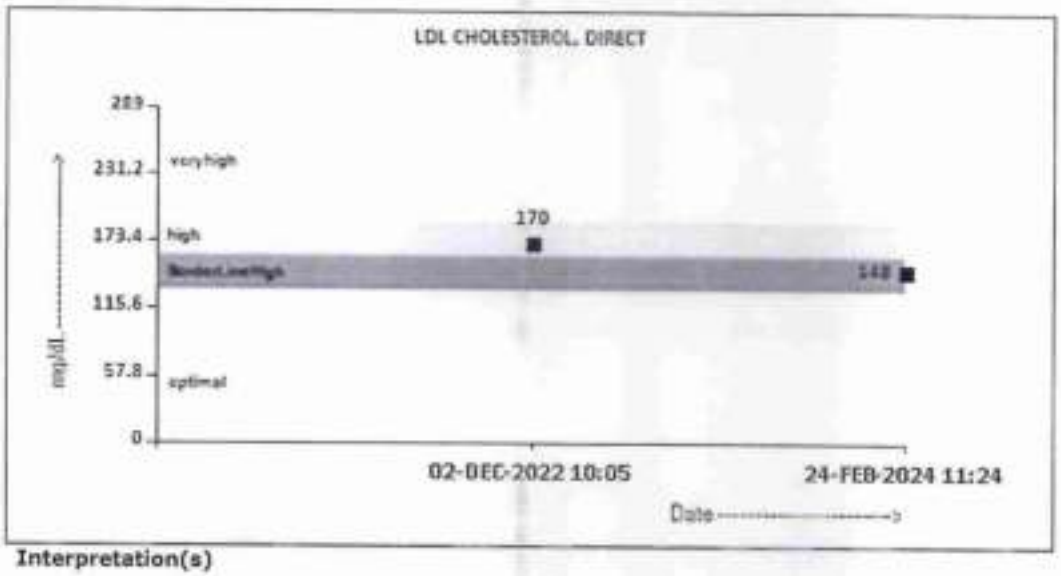

Interpretation(s)

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

CLINICAL INFORMATION :

UID:12154470 REQNO-1666896
CORP-OPD
BILLNO-150124OPCR010906
BILLNO-150124OPCR010906

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

CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE			
COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**		
CHEMICAL EXAMINATION, URINE			
PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	7.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	<=1.005	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	**DETECTED (++)**	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED	

Dr. Akshay Dhotre, MD
(Reg.no. MMC 2019/09/6377)
Consultant Pathologist

Dr. Rekha Nair, MD
(Reg No. MMC 2001/06/2354)
Microbiologist

View Details View Rep

Patient Ref. No. 2200000090476

PERFORMED AT :
Agilus Diagnostics Ltd.
Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,
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Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Diagnostics Report

Fortis

MC-5837

agilus diagnostics

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MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	5 - 7	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

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(Reg.no. MMC 2019/09/6377)
Consultant Pathologist

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Microbiologist

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Patient Ref. No. 22000000904763

Diagnostics Report

Fortis

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PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XB005166** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 09:24:00 RECEIVED : 24/02/2024 09:26:22 REPORTED :24/02/2024 14:43:51

CLINICAL INFORMATION :

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CORP-OPD
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Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	84.2	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	6.15	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	3.340	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

****End Of Report****

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

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Email : -

Patient Ref. No. 22000000904763

Diagnostics Report

Fortis

MC-1037

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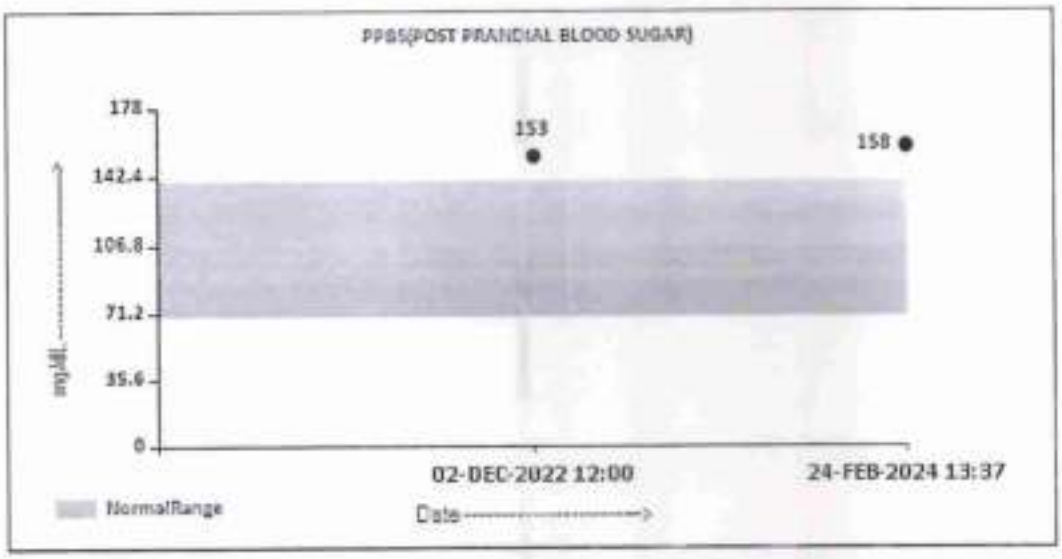
PATIENT NAME : MRS.SUNITA KUMARI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS :C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022X8005250** PATIENT ID : FH.12154470 CLIENT PATIENT ID: UID:12154470 ABHA NO :	AGE/SEX :48 Years Female DRAWN :24/02/2024 12:07:00 RECEIVED : 24/02/2024 12:09:18 REPORTED :24/02/2024 14:03:50

CLINICAL INFORMATION :

UID:12154470 REQNO-1666996
CORP-OPD
BILLNO-150124OPCR010906
BILLNO-150124OPCR010906

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**158 High**	70 - 140	mg/dL

METHOD : HEXOKINASE



Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed. Alimentary Hypoglycaemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****
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Email : -

Patient Ref. No. 220000009041847

48 Years Female 2/24/2024 10:21:01 AM

HC

Rate 92 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Baseline wander in lead(s) V2

PR 146
QRSD 88
QT 354
QTc 438

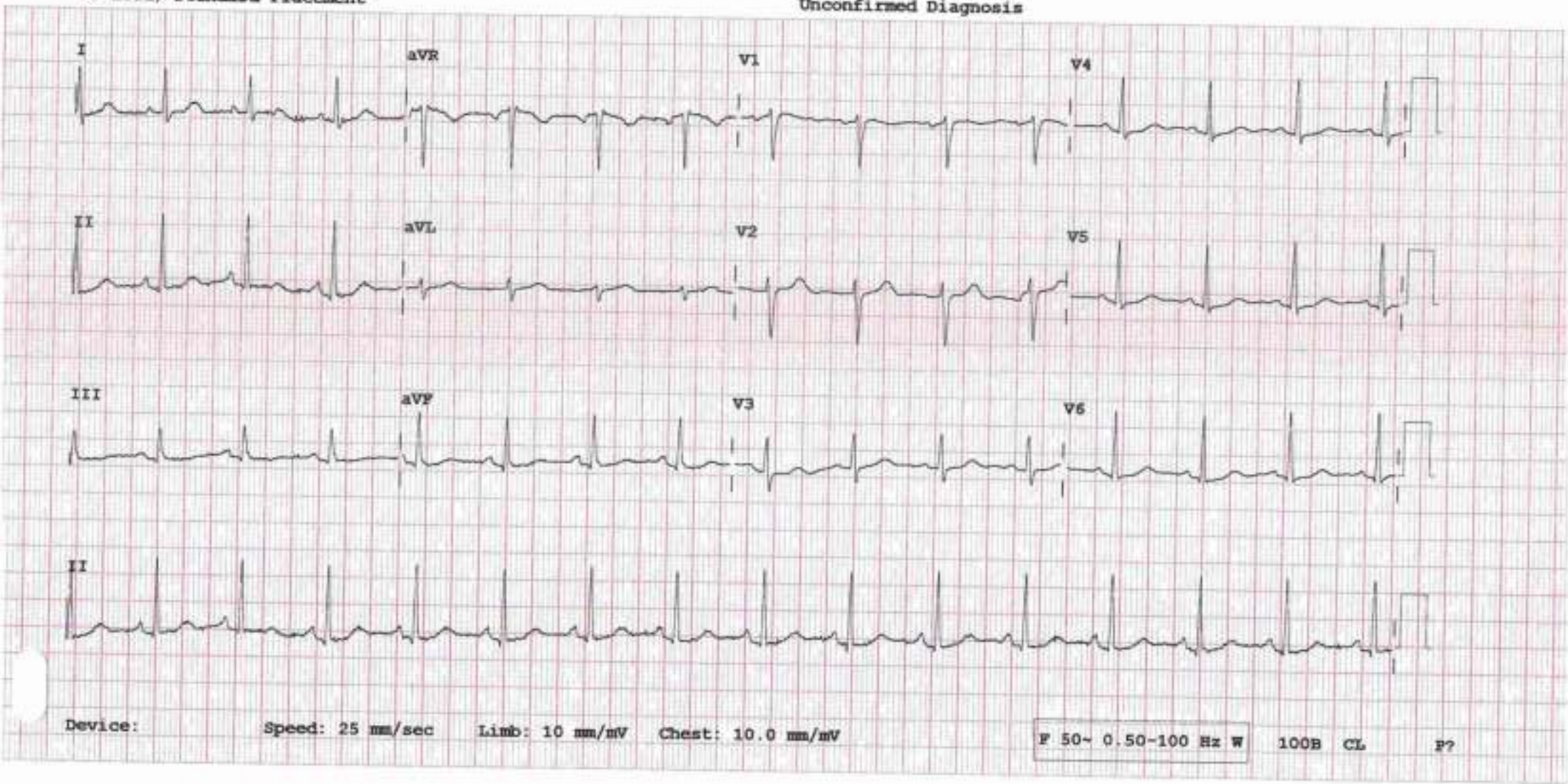
--AXIS--
P 62
QRS 62
T 23

Normal

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 26/Feb/2024

Name: Mrs. Sunita Kumari
Age | Sex: 48 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12154470 | 11169/24/1501
Order No | Order Date: 1501/PN/OP/2402/23217 | 24-Feb-2024
Admitted On | Reporting Date : 26-Feb-2024 13:21:02
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 12 mm with normal inspiratory collapse.

M-MODE MEASUREMENTS:

LA	32	mm
AO Root	18	mm
AO CUSP SEP	14	mm
LVID (s)	20	mm
LVID (d)	36	mm
IVS (d)	11	mm
LVPW (d)	11	mm
RVID (d)	30	mm
RA	29	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.5 m/sec
E/A RATIO:1.4

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

Final Impression :

- Normal 2 Dimensional and colour doppler echocardiography study.

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

DR.AMIT SINGH,
MD(MED),DM(CARD)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 24/Feb/2024

DEPARTMENT OF RADIOLOGY

(For Billing/Reports & Discharge Summary only)

Name: Mrs. Sunita Kumari
Age | Sex: 48 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12154470 | 11169/24/1501
Order No | Order Date: 1501/PN/OP/2402/23217 | 24-Feb-2024
Admitted On | Reporting Date : 24-Feb-2024 19:05:13
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. ABHIJEET BHAMBURE
DMRD, DNB (Radiologist)

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PAN NO : AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

Patient Name	:	Sunita Kumari	Patient ID	:	12154470
Sex / Age	:	F / 48Y 4M 18D	Accession No.	:	PHC.7545505
Modality	:	US	Scan DateTime	:	24-02-2024 13:23:03
IPID No	:	11169/24/1501	ReportDatetime	:	24-02-2024 13:37:53

USG – WHOLE ABDOMEN

Study limited due to decreased ultrasound penetration.

LIVER is normal in size and shows moderately raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 10.9 x 4.2 cm.Left kidney measures 10.9 x 4.2 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

UTERUS is mildly bulky, measuring 9.9 x 5.2 x 6.1 cm.
An anterior wall intramural lesion of size 2.8 x 3.9 x 2.5 cm is seen with central hyperechoic area, measuring 1.6 x 1.9 x 2.0 cm – likely fat containing area in the lesion.
Another small anterior wall intramural fibroid, measuring 1.3 x 1.0 cm.

A subcentimetric Nabothian cyst noted within cervix.

Endometrium measures 2.8 mm in thickness.

Both ovaries are normal.
Right ovary measures 3.0 x 2.5 x 1.6 cm, volume 6.8 cc.
Left ovary measures 2.5 x 2.8 x 2.1 cm, volume 7.8 cc.

No evidence of ascites.

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Modality	:	US	Scan DateTime	:	24-02-2024 13:23:03
IPID No	:	11169/24/1501	ReportDatetime	:	24-02-2024 13:37:53

Impression:

- **Grade II fatty infiltration of liver.**
- **Mildly bulky uterus.**
- **Findings area concerning for anterior wall uterine fibroid with central fat containing area as described. *Recommended MRI pelvis with contrast for further evaluation if clinically indicated.***
- **Another small uterine fibroid as described.**

DR. CHETAN KHADKE
M.D. (Radiologist)

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Admitted On | Reporting Date : 24-Feb-2024 14:06:01
Order Doctor Name : Dr.SELF .

USG - BOTH BREAST

Findings:

Bilateral breast parenchyma appears normal.

No evidence of solid or cystic lesion.

No dilated ducts are noted.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

Impression:

- **No significant abnormality detected.**

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)