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GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
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UHID	**12861296**	**Date**	**09/12/2023**		
Name	**Mrs.Asmita Shinge**	**Sex**	**Female**	**Age**	**33**
OPD	**Opthal 14**	**Health Check Up**			

Drug allergy:
Sys illness:

→ O/E → Itching, irritation (Dust allergy)

→ Specs History → 6 months.

→ NO S.H.

Auto ref → OD → plano → 6/6
OS → plano → 6/6

Aquaaid → 3-4 times a day.

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UHID	12861296	Date	09/12/2023		
Name	Mrs.Asmita Shinge	Sex	Female	Age	33
OPD	Pap	Health Check Up			

33yrs 1F, Married 11 Months

LMP- 6/12/23

O/H- Nulliparous

M/H - Regular, Moderate, painless

Med/H - Nil

S/H - Nil

F/H - Nil

Drug allergy:
Sys illness:

Adv

- HPV counselling done
- f/u for pap smear after Day 10
-

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UHID	**12861296**	**Date**	**09/12/2023**		
Name	**Mrs.Asmita Shinge**	**Sex**	**Female**	**Age**	**33**
OPD	**Dental 12**	**Health Check Up**			

Drug allergy:
Sys illness:

O/E - Stains +
Calculus +
- Caries $\frac{7}{7}$

Treatment

1) Scaling Grade I (Cleaning)
2) Filling $\frac{7}{7}$

Dr. Trupti

Diagnostics Report

Fortis

MC-5837

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PATIENT NAME : MRS. ASMITA RATAN SHINGE		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WL001428** PATIENT ID : FH.12861296 CLIENT PATIENT ID: UID:12861296 ABHA NO :	AGE/SEX :33 Years Female DRAWN :09/12/2023 10:01:00 RECEIVED : 09/12/2023 10:02:00 REPORTED :13/12/2023 10:26:12

CLINICAL INFORMATION :

UID:12861296 REQNO-1635482
CORP-OPD
BILLNO-150123OPCR069320
BILLNO-150123OPCR069320

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	12.9	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	**5.33 High**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	8.30	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	316	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	40.1	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	**75.2 Low**	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	**24.2 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	32.2	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.9	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	14.1		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	**11.1 High**	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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Consultant Pathologist

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Patient Ref. No. 22000000889348

PATIENT NAME : MRS. ASMITA RATAN SHINGE **REF. DOCTOR :** SELF

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NEUTROPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	66	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	26	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	5	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	3	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	5.48	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.16	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.42	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.25	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	2.5		

MORPHOLOGY

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

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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 cases 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.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R	03	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.2	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)	102.5	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

Comments

NOTE: RESULTS OBTAINED ON REPEAT ANALYSIS (D S -WINDOW WITH RETENTION TIME 1.63 AREA 35.7), THIS IS MOST PROBABLY DUE TO INTERFERENCE BY PRESENCE OF ABNORMAL HEMOGLOBIN VARIANTS. ADVISED HEMOGLOBIN VARIANT STUDY FOR THE SAME.

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).

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In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia 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 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 loss,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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE AB		
RH TYPE METHOD : TUBE AGGLUTINATION	POSITIVE		

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.58	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.16	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.42	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	8.0	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	4.1	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.0	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	18	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	30	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	62	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	30	5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	143	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	92	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
METHOD : HEXOKINASE			

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KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	6	6 - 20	mg/dL
CREATININE EGFR- EPI			
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	0.71	0.60 - 1.10	mg/dL
AGE	33		years
GLOMERULAR FILTRATION RATE (FEMALE) METHOD : CALCULATED PARAMETER	115.06	Refer Interpretation Below	mL/min/1.73m2
BUN/CREAT RATIO			
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	8.45	5.00 - 15.00	
URIC ACID, SERUM			
URIC ACID METHOD : URICASE UV	3.3	2.6 - 6.0	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	8.0	6.4 - 8.2	g/dL

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ALBUMIN, SERUM			
ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	4.1	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	140	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	**5.16 High**	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	106	98 - 107	mmol/L

Interpretation(s)

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 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.

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

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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000889348

Fortis

MC-5837

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PATIENT NAME : MRS. ASMITA RATAN SHINGE	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WL001428** PATIENT ID : FH.12861296 CLIENT PATIENT ID: UID:12861296 ABHA NO :	AGE/SEX :33 Years Female DRAWN :09/12/2023 10:01:00 RECEIVED : 09/12/2023 10:02:00 REPORTED :13/12/2023 10:26:12

CLINICAL INFORMATION :

UID:12861296 REQNO-1635482
CORP-OPD
BILLNO-150123OPCR069320
BILLNO-150123OPCR069320

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

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

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 diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,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 Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,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.
- 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://testguide.labmed.uw.edu/guideline/egfr
Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325
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.

Dr. Akshay Dhotre, MD
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Patient Ref. No. 22000000889348

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MC-5837

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PATIENT NAME : MRS. ASMITA RATAN SHINGE	**REF. DOCTOR :** SELF	
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CORP-OPD
BILLNO-150123OPCR069320
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Test Report Status **Final**	Results	Biological Reference Interval	Units

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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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150123OPCR069320
BILLNO-150123OPCR069320

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	**225 High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	47	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	40	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	**164 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	**185 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	9.4	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**5.6 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			

Dr. Akshay Dhotre, MD
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PATIENT NAME : MRS. ASMITA RATAN SHINGE **REF. DOCTOR :** SELF

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Test Report Status **Final**	Results	Biological Reference Interval	Units
LDL/HDL RATIO	**4.1 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

Dr. Akshay Dhotre, MD
(Reg,no. MMC 2019/09/6377)
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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

MICROSCOPIC EXAMINATION, URINE

REMARKS	TEST CANCELLED AS URINE SPECIMEN NOT RECEIVED

Interpretation(s)

Dr. Akshay Dhotre, MD
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Consultant Pathologist

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

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Patient Ref. No. 22000000889348

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PATIENT NAME : MRS. ASMITA RATAN SHINGE		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WL001428** PATIENT ID : FH.12861296 CLIENT PATIENT ID: UID:12861296 ABHA NO :	AGE/SEX :33 Years Female DRAWN :09/12/2023 10:01:00 RECEIVED : 09/12/2023 10:02:00 REPORTED :13/12/2023 10:26:12

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BILLNO-150123OPCR069320
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	151.1	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	8.33	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)	1.580	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****
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PATIENT NAME : MRS.ASMITA RATAN SHINGE	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WL001501** PATIENT ID : FH.12861296 CLIENT PATIENT ID: UID:12861296 ABHA NO :	AGE/SEX :33 Years Female DRAWN :09/12/2023 12:50:00 RECEIVED : 09/12/2023 12:53:20 REPORTED :09/12/2023 17:51:06

CLINICAL INFORMATION :

UID:12861296 REQNO-1635482
CORP-OPD
BILLNO-150123OPCR069320
BILLNO-150123OPCR069320

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	91	70 - 140	mg/dL

Comments

NOTE:- POST PRANDIAL PLASMA GLUCOSE VALUES TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

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Patient Ref. No. 22000000889421

12861296
33 Years

mrs.asmita shinge
Female

12/9/2023 1:00:58 PM

Rate 75 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 130
QRSD 78
QT 358
QTc 400

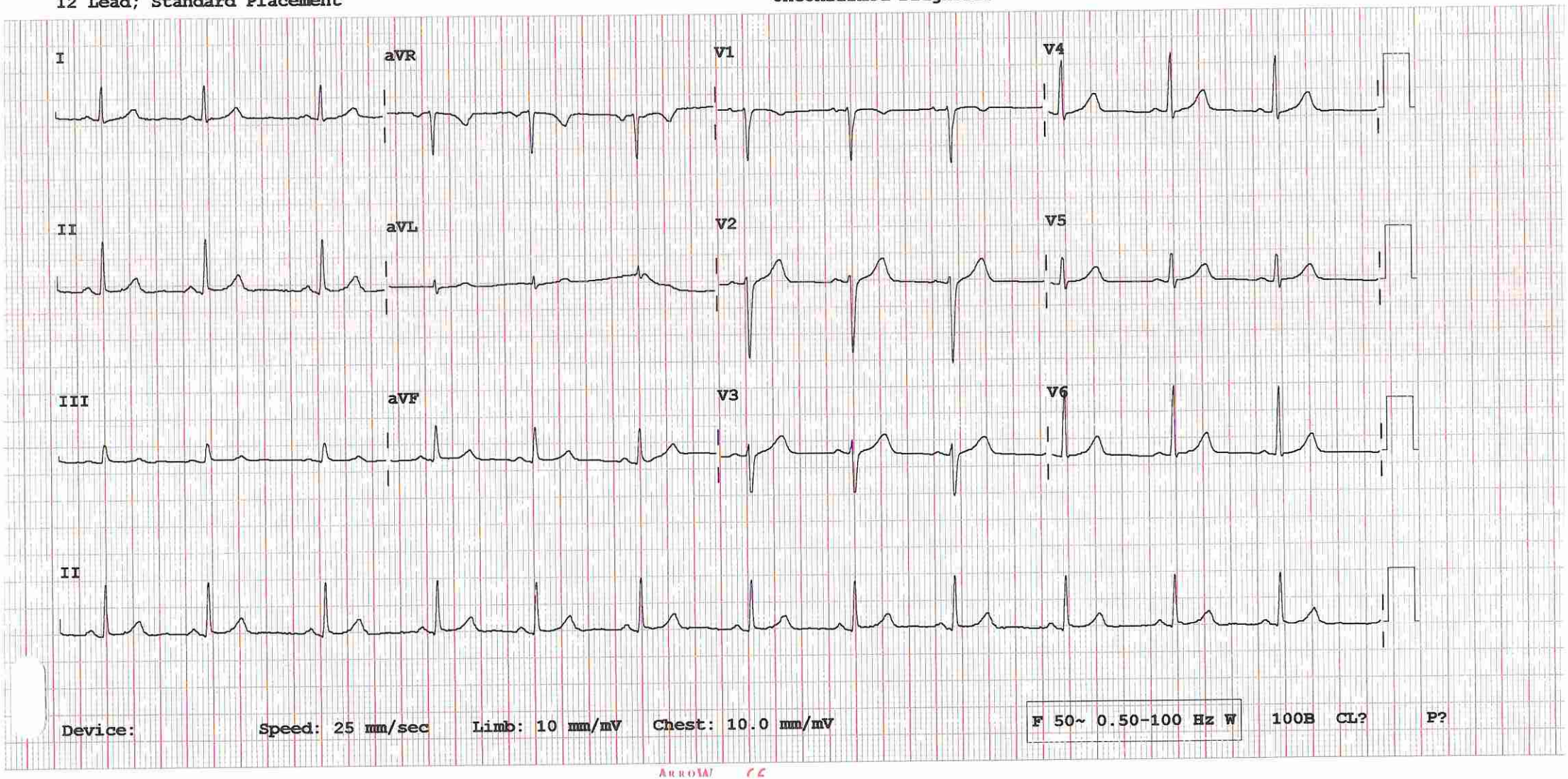
--AXIS--
P 57
QRS 61
T 47

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

HC.
Sinus rhythm
No significant ab



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

ARROW

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

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 11/Dec/2023

Name: Mrs. Asmita Ratan Shinge

Age | Sex: 33 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12861296 | 70544/23/1501

Order No | Order Date: 1501/PN/OP/2312/146437 | 09-Dec-2023

Admitted On | Reporting Date : 11-Dec-2023 09:33:47

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 e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 26 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	30	mm
AO Root	23	mm
AO CUSP SEP	18	mm
LVID (s)	25	mm
LVID (d)	42	mm
IVS (d)	10	mm
LVPW (d)	11	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 09/Dec/2023

Name: Mrs. Asmita Ratan Shinge
Age | Sex: 33 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12861296 | 70544/23/1501
Order No | Order Date: 1501/PN/OP/2312/146437 | 09-Dec-2023
Admitted On | Reporting Date : 09-Dec-2023 15:33:04
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. YOGINI SHAH
DMRD., DNB. (Radiologist)

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Patient Name	:	Asmita Ratan Shinge	Patient ID	:	12861296
Sex / Age	:	F / 33Y 10M	Accession No.	:	PHC.7078646
Modality	:	US	Scan DateTime	:	09-12-2023 11:45:03
IPID No	:	70544/23/1501	ReportDatetime	:	09-12-2023 13:00:02

US – WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein is normal.

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 9.6 x 4.1 cm.
Left kidney measures 10.2 x 5.2 cm.

PANCREAS is obscured due to excessive bowel gas.

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

UTERUS is normal in size, measuring 6.2 x 4.8 x 3.7 cm.
Endometrium measures 5.4 mm in thickness.

Right ovary measures 3.6 x 1.8 cm.
Left ovary is not seen due to excessive bowel gas.

No evidence of ascites.

IMPRESSION:

Grade I fatty infiltration of liver.

DR. KUNAL NIGAM
M.D. (Radiologist)