





**PATIENT NAME****MR. ANOOP NAIR****AGE / SEX****51YRS/MALE****REF. DOCTOR****DR. DHS DOCTOR TEAM****DATE****28/09/2024****2D ECHO CARDIOGRAPHY REPORT****Observation:**

1. Normal LV size with Normal LV systolic function. LVEF: 65%.
2. No RWMA at rest.
3. Grade I LV diastolic dysfunction.
4. Normal sized LA, RA and RV. Normal RV function.
5. All valves are normal in structure.
6. IAS and IVS are intact.
7. No PAH. RVSP = 24 mmHg.
8. No clot/vegetation / pericardial effusion.
9. Doppler: Mild MR, Mild TR, No AR, No PR.
10. IVC is normal in size and well collapse on inspiration.

**Conclusion:**

**Normal LV systolic function.  
No RWMA.  
No PAH.**

**Measurements :**

<b>LVIDD</b>	<b>39.0 mm</b>	<b>AO</b>	<b>22.0mm</b>
<b>LVIDS</b>	<b>22.0 mm</b>	<b>LA</b>	<b>28.0mm</b>
<b>LVEF</b>	<b>65%</b>		
<b>IVSD/LVPWD</b>	<b>0.09mm/08.0mm</b>		

**DOPPLER STUDY:**

<b>Valves</b>	<b>Velocity</b>	<b>Max gradient</b>	<b>Mean gradient</b>	<b>Area</b>	<b>Regurgitation</b>
<b>Aortic</b>	<b>1.1</b>	<b>5.0</b>			<b>No AR</b>
<b>Mitral</b>	<b>E:0.4 A: 0.3</b>				<b>Mild MR</b>
<b>Pulmonary</b>	<b>0.4</b>	<b>3.0</b>			<b>No PR</b>
<b>Tricuspid</b>	<b>0.3</b>	<b>1.0</b>			<b>Mild TR</b>

**DR. ANOOP NAIR**  
**DR. ANOOP NAIR**  
**G - 30352**  
**M. D.(General Medicine)**  
**DHS MULTISPECIALTY HOSPITAL**

**PATIENT NAME** NAIR ANOOP  
**AGE / SEX** 51 Y/ M  
**REF. DOCTOR** HEALTH CHECKUP  
**DATE** 28-Sep-24

**ULTRASOUND WHOLE ABDOMEN - PELVIS**

**LIVER :** Liver is normal in size and shows **grade 1 fatty changes**.

No focal lesion is seen. Intra-hepatic biliary radicals are not dilated.

**PORTAL VEIN:** appears normal in course and caliber. PV- 9 mm

**GALL BLADDER :** is distended and appears normal. No calculus or mass lesion seen.

**CBD:** appears normal, 5mm.

**PANCREAS :** Pancreas appears normal in size and echo pattern.

**SPLEEN :** Spleen is normal in size (9.5 cm) and shows normal echo pattern.

**KIDNEYS :** Both kidneys are normal in size, shape & echotexture.

No calculus or hydronephrosis seen in either kidney.

**URINARY BLADDER :** is full & normal.

**PROSTATE:** normal in size.

Bowel loops appear normal. No any inflammatory wall thickening or mass lesion is seen.

No lymphadenopathy seen.

No evidence of collection or mass lesion seen in RIF.

No free fluid.

**IMPRESSION :**

**No significant abnormality.**

  
**DR. JAY THAKKAR, MD**

Patient Name	NAIR ANOOP	Patient ID	UHID27121
Age/Gender	51 Years / M	Study Date	28-Sep-2024
Referred By	DHS DOCTOR TEAM	Reported Date	28-Sept-2024

**X – RAY CHEST PA VIEW:**

Both lung fields under vision appear normal.  
Cardiac size appears normal.  
Both costophrenic angles are clear.  
Hilar regions are normal.  
Both domes appear normal in position.  
Bony thorax under vision appears normal.



Dr.Sunny Shivlani  
MD Radiology REG-33548

Date Reported: 28-Sept-2024

This Report is done and digitally signed via Tele Radiology Done at Radiscan Diagnostic Ahmedabad. For any clinical discrepancy, please discuss with the Radiologist. This report is not valid for any medico-legal purposes

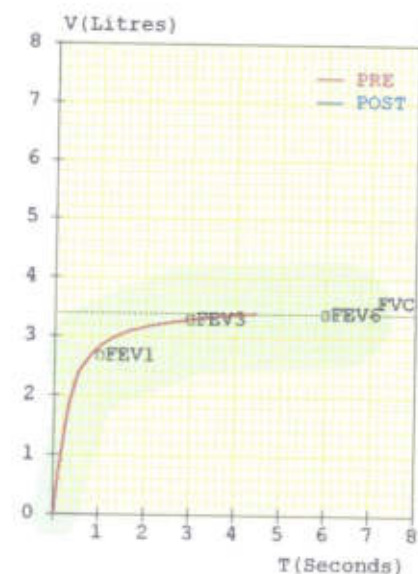
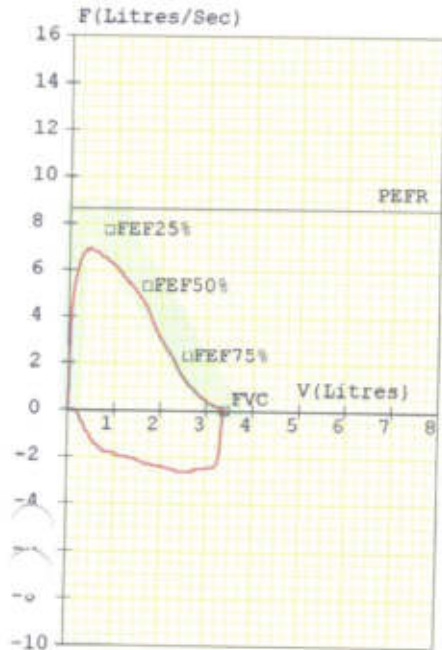
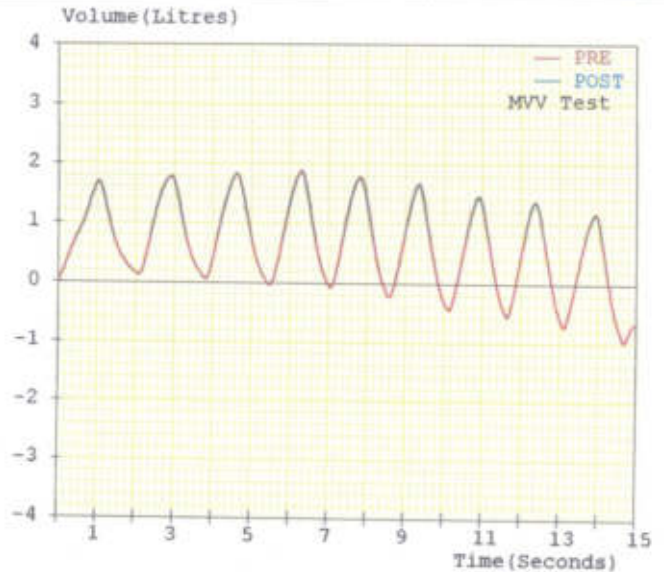
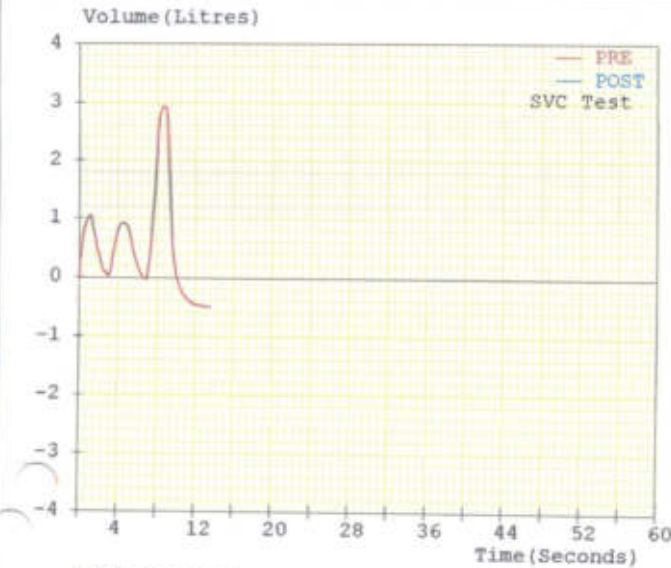


# DHS MULTISPECIALTY HOSPITAL

Vastrapur Lake-Himalaya Mall Link Road, Sunrise Park, Vastrapur, Ahmedabad-380054

Patient: MR. ANOOP NAIR  
 Refd. By: HEALTH CHECK UP  
 Pred. Eqns: RECORDERS  
 Date : 28-Sep-2024 11:41 AM

Age : 51 Years      Gender : Male  
 Height : 172 Cms      Smoker : Yes  
 Weight : 89 Kgs      Eth. Corr: 100  
 ID: 12437      Temp : 97°C



### Spirometry Results

Parameter	Pred	M.Pre	%Pred	M.Post	%Pred	%Imp
FVC (L)	03.40	03.41	100	---	---	---
FEV1 (L)	02.68	02.85	106	---	---	---
FEV1/FVC (%)	78.82	83.58	106	---	---	---
FEF25-75 (L/s)	03.48	03.20	092	---	---	---
PEFR (L/s)	08.61	06.85	080	---	---	---
FIVC (L)	---	03.26	---	---	---	---
FEV.5 (L)	---	02.32	---	---	---	---
FEV3 (L)	03.29	03.30	100	---	---	---
PIFR (L/s)	---	02.63	---	---	---	---
FEF75-85 (L/s)	---	00.78	---	---	---	---
FEF.2-1.2 (L/s)	06.24	06.33	101	---	---	---
FEF 25% (L/s)	07.73	06.32	082	---	---	---
FEF 50% (L/s)	05.34	04.25	080	---	---	---
FEF 75% (L/s)	02.30	01.19	051	---	---	---
FEV.5/FVC (%)	---	68.04	---	---	---	---
FEV3/FVC (%)	96.76	96.77	100	---	---	---
FET (Sec)	---	04.63	---	---	---	---
ExptTime (Sec)	---	00.07	---	---	---	---
Lung Age (Yrs)	051	048	094	---	---	---
FEV6 (L)	03.40	---	---	---	---	---
FIF 25% (L/s)	---	02.54	---	---	---	---
FIF 50% (L/s)	---	02.36	---	---	---	---
FIF 75% (L/s)	---	01.94	---	---	---	---
SVC (L)	---	02.97	---	---	---	---
ERV (L)	01.25	00.07	006	---	---	---
IRV (L)	---	02.02	---	---	---	---
VE (L/min)	---	15.00	---	---	---	---
Rf (l/min)	---	15.79	---	---	---	---
Ti (sec)	---	01.60	---	---	---	---
Te (sec)	---	02.20	---	---	---	---
VT (L)	---	00.95	---	---	---	---
VT/Ti	---	00.59	---	---	---	---
Ti/Ttot	---	00.42	---	---	---	---
IC (L)	---	02.97	---	---	---	---
MVV (L/min)	126	070	056	---	---	---
MRf (l/min)	---	38.06	---	---	---	---
MVT (L)	---	01.84	---	---	---	---

**Pre Medication Report Indicates**

Spirometry within normal limits as (FEV1/FVC)%Pred >95 and FVC%Pred >80.

DR. ANOOP NAIR  
 G-30352  
 M. D. General Medicine  
 DHS MULTISPECIALTY HOSPITAL  
 DR. DHS TEAM


**TEST REPORT**

<b>Reg. No :</b> 2409100627	<b>UHID :</b> UHID27121	<b>Reg. Date :</b> 28-Sep-2024
<b>Name :</b> NAIR ANOOP		<b>Collected On :</b> 28-Sep-2024 08:26
<b>Age/Sex :</b> 51 Years / Male		<b>Report Date :</b> 28-Sep-2024
<b>Ref. By :</b> MEDIWHEEL		

Parameter	Result	Unit	Reference Interval
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**COMPLETE BLOOD COUNT (CBC)**

Hemoglobin (SLS method)	14.4	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	44.1	%	40 - 54
RBC Count (Electrical Impedance)	4.67	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	6420	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	228000	/cmm	150000 - 410000
MCV (Calculated)	94.5	fL	83 - 101
MCH (Calculated)	30.9	Pg	27 - 32
MCHC (Calculated)	32.7	%	31.5 - 34.5
RDW (Calculated)	12.5	%	11.5 - 14.5

**DIFFERENTIAL WBC COUNT**

Neutrophils (%)	52	%	38 - 70
Lymphocytes (%)	39	%	20 - 45
Monocytes (%)	07	%	2 - 8
Eosinophils (%)	02	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3320	/cmm	1800 - 7700
Lymphocytes (Absolute)	2490	/cmm	1000 - 3900
Monocytes (Absolute)	460	/cmm	200 - 800
Eosinophils (Absolute)	130	/cmm	20 - 500
Basophils (Absolute)	20	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	1.33	/cmm	0.7 - 4.0

**PERIPHERAL SMEAR EXAMINATION**


RBC Morphology	RBCs are Normochromic Normocytic.
WBC Morphology	Total WBC and differential count is within normal.
Platelets	Platelets are adequate with normal morphology.
Parasites	Malarial parasite is not detected.

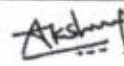
**ERYTHROCYTE SEDIMENTATION RATE**

ESR (After 1 hour)	12	mm/hr	0 - 14
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----- End Of Report -----

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**Approved by:**  Dr. Yesha H. Shah  
(MD.Pathology)

 Mr. Akshay Parmar  
M.Sc(Biochemistry)



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Parameter	Result	Unit	Reference Interval
<b>FBS</b>			
Fasting Blood Sugar (FBS) Glucose Oxidase-Peroxidase	104.3	mg/dL	70 - 110
<b>PPBS</b>			
Post Prandial Blood Sugar (PPBS) Glucose Oxidase-Peroxidase	125.3	mg/dL	110 - 140


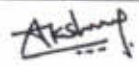
**BLOOD GROUP & RH**

SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION

ABO      'B'  
Rh (D)      Positive

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**HEMOGLOBIN A1C ESTIMATION**

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	5.7	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
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Mean Blood Glucose <i>Calculated</i>	116.89	mg/dL	
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**Criteria for the diagnosis of diabetes:**

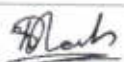
1. HbA1c  $\geq 6.5$  \*Or
  2. Fasting plasma glucose  $>126$  gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
  3. Two hour plasma glucose  $\geq 200$ mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
  4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq 200$  mg/dL.
- \*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.


**Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:**

- HbA1C, also known as glycated hemoglobin, is the most important test for the assessment of long term blood glucose control( also called glyceic control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glyceic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glycemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD ) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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Parameter	Result	Unit	Reference Interval
<b>LIVER FUNCTION TEST</b>			
SGPT <i>Optimized UV-IFCC</i>	25.1	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	20.1	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.78	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.40	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.38	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	54	U/L	53 - 128
Total Protein	6.66	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	4.52	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	<b>2.14</b>	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	<b>2.11</b>		0.8 - 2.0
GGT	45.3	U/L	1 - 55

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<b>RENAL FUNCTION TEST</b>			
Creatinine <i>Enzymatic ,IDMS Traceable</i>	1.08	mg/dL	0.7 - 1.3
Urea <i>Urease-GLDH, enzymatic UV</i>	25.3	mg/dL	18.0 - 55.0
BUN <i>Calculated</i>	11.82	mg/dL	7 - 18
Uric Acid <i>Enzymatic using TBHBA</i>	4.52	mg/dL	3.5 - 7.2
Sodium <i>Direct ISE</i>	139.6	mmol/L	137 - 145
Potassium <i>Direct ISE</i>	4.52	mmol/L	3.6 - 5.1
Chloride <i>Direct ISE</i>	95.3	mmol/L	94 - 110
Ionized Calcium <i>Direct ISE</i>	4.78	mg/dL	4.4 - 5.4

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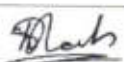
**LIPID PROFILE**


Cholesterol <i>CHOD-PAP method</i>	154	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	235.8	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	<b>47.16</b>	mg/dL	15 - 35
LDL CHOLESTEROL	70.74	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Magnetic Cholesterol Oxidase</i>	36.1	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	4.27		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	1.96		0 - 3.5
Total Lipids <i>Calculated</i>	739.60		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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**THYROID FUNCTION TEST**

T3 (Triiodothyronine) CMIA	1.13	ng/mL	0.6 - 1.81
T4 (Thyroxine) CMIA	8.18	µg/dL	4.5 - 12.5
TSH ELFA-Enzyme Linked Fluorescent Assay	1.763	µIU/ml	0.35 - 4.94

ELFA-Enzyme Linked Fluorescent Assay

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate 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.

TSH levels During Pregnancy :

First Trimester : 0.1 to 2.5 µIU/mL

Second Trimester : 0.2 to 3.0 µIU/mL


Third trimester : 0.3 to 3.0 µIU/mL

Reference : Carl A. Burtis, Edward R. Ashwood, David E. Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition.

Philadelphia: WB Saunders, 2012:2170

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**URINE ROUTINE EXAMINATION****PHYSICAL EXAMINATION**

Quantity	15 cc
Colour	Pale Yellow
Clarity	Clear

**CHEMICAL EXAMINATION (BY REFLECTANCE PHOTOMETRIC METHOD)**

pH	7.0	4.6 - 8.0
Sp. Gravity	1.015	1.002 - 1.03
Protein	Nil	
Glucose	Nil	
Ketone Bodies	Nil	
Urobilinogen	Nil	
Bilirubin	Nil	
Nitrite	Nil	
Leucocytes	Nil	
Blood	Nil	

**MICROSCOPIC EXAMINATION (MANUAL BY MICROSCOPY)**

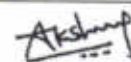
Leucocytes (Pus Cells)	1 - 5/hpf
Erythrocytes (Red Cells)	Nil
Epithelial Cells	1-2/hpf
Amorphous Material	Nil
Casts	Nil
Crystals	Nil
Bacteria	Nil
Yeast	Nil
T. Vaginalis	Nil
Spermatozoa	Nil

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PROSTATE SPECIFIC ANTIGEN 0.535                      ng/mL                      0 - 4  
(PSA)

**CHEMILUMINESCENCE**

Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-8 ng/mL.



Percentage of free PSA = free PSA/total PSA X 100

Percentage of free PSA: Patients with prostate cancer generally have a lower percentage of Free PSA than patients with benign prostatic hyperplasia. Percentage Free PSA of less than 25% is a high likelihood of prostatic cancer.

PHOSPHOROUS                      4.00                      mg/dL                      2.5 - 4.9  
*Photometric UV test*

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Name : NAIR ANOOP      Collected On : 28-Sep-2024 08:26  
Age/Sex: 51 Years / Male      Report Date : 28-Sep-2024  
Ref. By : MEDIWHEEL

<u>Parameter</u>	<u>Result</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
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**VITAMINS**

VITAMIN B12	<148	pg/mL	211 - 911
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Vitamin B12 is essential in DNA synthesis, hematopoiesis, and CNS integrity.

**Interpretation:****Increased In**

- Chronic granulocytic leukemia
- COPD and Chronic renal failure
- Leukocytosis
- Liver cell damage (hepatitis, cirrhosis)
- Obesity and Severe CHF
- Polycythemia vera
- Protein malnutrition


**Decreased In**

- Abnormalities of cobalamin transport or metabolism
- Bacterial overgrowth
- Crohn disease
- Dietary deficiency (e.g. in vegetarians)
- Diphyllobothrium (fish tapeworm) infestation
- Gastric or small intestine surgery
- Hypochlorhydria
- Inflammatory bowel diseases
- Intestinal malabsorption and Intrinsic factor deficiency

**Limitations:**

- Drugs such as chloral hydrate increase vitamin B12 levels. On the other hand ,alcohol, aminosalicic acid, anticonvulsants, ascorbic acid,cholestyramine, cimetidine, colchicines, metformin, neomycin, oral contraceptives, ranitidine, and triamterene decrease vitamin B12 levels.
- The evaluation of macrocytic anemia requires measurements of both vitamin B12 and folate levels; ideally they should be measured simultaneously.
- Specimen collection soon after blood transfusion can falsely increase vitamin B12 levels.
- Patients taking vitamin B12 supplementation may have misleading results.
- A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.

This is an electronically authenticated report.

**Approved by:**  
Dr. Yesha H. Shah  
(MD.Pathology)  
Mr. Akshay Parmar  
M.Sc(Biochemistry)

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DHS Properties and Hospitals LLP. | CIN : AAA-7816

**TEST REPORT**

Reg. No : 2409100627      UHID : UHID27121      Reg. Date : 28-Sep-2024  
Name : NAIR ANOOP      Collected On : 28-Sep-2024 08:26  
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<u>Parameter</u>	<u>Result</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
25 OH VITAMIN D TOTAL CHEMILUMINESCENCE	11.80	ng/mL	Deficiency : <10 Insufficiency : 10 - 30 Sufficiency : 30 - 100 Toxicity : >100

Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol(vitamin D3) which is synthesized in skin from 7 dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25 (OH)vitamin D in liver.

**Interpretation:**

Increased In

- Vitamin D intoxication
- Excessive exposure to sunlight

Decreased In

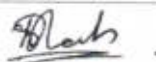
- Malabsorption
- Steatorrhea
- Dietary osteomalacia, anticonvulsant osteomalacia
- Biliary and portal cirrhosis
- Thyrotoxicosis
- Pancreatic insufficiency
- Celiac disease
- Rickets
- Alzheimer disease

**Limitations:**

More recently, it has become clear that receptors for vitamin D are present in a wide variety of cells and that this hormone has biologic effects extending beyond the control of mineral metabolism. Vitamin D deficiency is not clear. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels. In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL. A recent study states that increasing mean baseline levels from 29 to 38 ng/mL was associated with a 50% lower risk for colon cancer and levels of 52 ng/mL with a 50% reduction in the incidence of breast cancer. It is recommended to have clinical correlation with serum 25(OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.

----- End Of Report -----

This is an electronically authenticated report.

**Approved by:** Dr. Yesha H. Shah  
(MD.Pathology)Mr. Akshay Parmar  
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