

**TEST REPORT**

Reg. No : 2410100125 UHID : UHID27285 Reg. Date : 05-Oct-2024
Name : MR.BHARAT SURYAKANT PATEL Collected On : 05-Oct-2024 08:32
Age/Sex : 59 Years / Male Report Date : 05-Oct-2024
Ref. By : MEDIWHEEL

Parameter	Result	Unit	Reference Interval
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COMPLETE BLOOD COUNT (CBC)

Hemoglobin (SLS method)	13.4	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	39.0	%	40 - 54
RBC Count (Electrical Impedance)	4.24	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	5530	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	271000	/cmm	150000 - 410000
MCV (Calculated)	92.0	fL	83 - 101
MCH (Calculated)	31.5	Pg	27 - 32
MCHC (Calculated)	34.3	%	31.5 - 34.5
RDW (Calculated)	12.6	%	11.5 - 14.5

DIFFERENTIAL WBC COUNT

Neutrophils (%)	64	%	38 - 70
Lymphocytes (%)	26	%	20 - 45
Monocytes (%)	07	%	2 - 8
Eosinophils (%)	03	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3539	/cmm	1800 - 7700
Lymphocytes (Absolute)	1438	/cmm	1000 - 3900
Monocytes (Absolute)	387	/cmm	200 - 800
Eosinophils (Absolute)	166	/cmm	20 - 500
Basophils (Absolute)	0	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	2.42	/cmm	0.7 - 4.0

PERIPHERAL SMEAR EXAMINATION

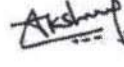
RBC Morphology	RBCs are Normochromic Normocytic.
WBC Morphology	Total WBC and differential count is within normal.
Platelets	Platelets are adequate with normal morphology.
Parasites	Malarial parasite is not detected.

ERYTHROCYTE SEDIMENTATION RATE

ESR (After 1 hour)	15	mm/hr	0 - 19
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----- End Of Report -----

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(MD.Pathology)
Mr. Akshay Parmar
M.Sc(Biochemistry)

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FBS			
Fasting Blood Sugar (FBS) Glucose Oxidase-Peroxidase	106.0	mg/dL	70 - 110
PPBS			
Post Prandial Blood Sugar (PPBS) Glucose Oxidase-Peroxidase	128.1	mg/dL	110 - 140

BLOOD GROUP & RH


SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION

ABO 'O'
Rh (D) Positive

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HEMOGLOBIN A1C ESTIMATION

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	5.6	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
Mean Blood Glucose <i>Calculated</i>	114.02	mg/dL	

Criteria for the diagnosis of diabetes:

- HbA1c ≥ 6.5 *Or
 - Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
 - Two hour plasma glucose ≥ 200 mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
 - In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 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 heamoglobin, is the most important test for the assessment of long term blood glucose control(also called glyceemic control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glyceemic 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.- Glyemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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LIVER FUNCTION TEST			
SGPT <i>Optimized UV-IFCC</i>	23.3	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	21.0	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.54	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.20	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.34	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	59	U/L	53 - 128
Total Protein	6.25	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	3.78	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	2.47	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.53		0.8 - 2.0
GGT	27.3	U/L	1 - 55
HBsAg <i>Immunochromatography</i>	Non - Reactive		

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RENAL FUNCTION TEST			
Creatinine <i>Enzymatic ,IDMS Traceable</i>	0.86	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>	4.5	mg/dL	3.5 - 7.2
Sodium <i>Direct ISE</i>	138.3	mmol/L	137 - 145
Potassium <i>Direct ISE</i>	4.56	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>	150.4	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	92.4	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	18.48	mg/dL	15 - 35
LDL CHOLESTEROL	94.22	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>	37.7	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	3.99		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	2.50		0 - 3.5
Total Lipids <i>Calculated</i>	445.60		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	0.84	ng/mL	0.6 - 1.81
T4 (Thyroxine) CMIA	7.70	µg/dL	4.5 - 12.5
TSH ELFA-Enzyme Linked Fluorescent Assay	2.072	µIU/ml	0.35 - 4.94

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

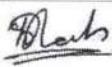
Third trimester : 0.3 to 3.0 µIU/mL

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	20 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)	Occasional/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 (PSA)	1.162	ng/mL	0 - 4
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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 <i>Photometric UV test</i>	4.20	mg/dL	2.5 - 4.9
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VITAMINS

VITAMIN B12	630.00	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

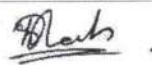
Decreased In

- 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.

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25 OH VITAMIN D TOTAL CHEMILUMINESCENCE	31.00	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

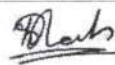
-Malabsorption
-Steatorrhea
-Dietary osteomalacia, anticonvulsant osteomalacia
-Biliary and portal cirrhosis
-Thyrotoxicosis
-Pancreatic insufficiency
-Celiac disease
-Rickets
-Alzheimer disease

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.

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**TEST REPORT**

Reg. No :	2410100135	UHID :	UHID27192	Reg. Date :	05-Oct-2024
Name :	MRS SUGANDHABEN Y PATIL			Collected On :	05-Oct-2024 12:02
Age/Sex:	69 Years / Female			Report Date :	05-Oct-2024
Ref. By :	DR.ARCHIT PARIKH				

<u>Parameter</u>	<u>Result</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
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ANTI HCV (RAPID)
Immunochromatography

Non - Reactive

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Age/Sex : 69 Years / Female		Report Date : 05-Oct-2024
Ref. By : DR.ARCHIT PARIKH		

<u>Parameter</u>	<u>Result</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
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TSH	6.530	µIU/ml	0.35 - 4.94
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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.

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HIV I & II Non - Reactive

Immunochromatography



Additional Information:

1. A NON REACTIVE result implies that no Anti HIV-1 or HIV -2 antibodies have been detected in the sample by this method. This means that either the patient has not been exposed to HIV-1 or HIV-2 infection or the sample has been tested during the "WINDOW PHASE" (before the development of detectable levels of antibodies).
2. A PROVISIONALITY REACTIVE/BORDERLINE REACTIVE result suggests possibility of HIV-1 or/and HIV-2 infection. However these results must be verified by confirmatory WESTERN BLOT/HIV PCR method before declaring the patient positive for HIV-1 or HIV-2 infection.
3. Very high levels of IgM Antibodies or Anti-HLA ABC and DR Antibodies can give false positive reaction.

**Pre & Post test counselling for HIV testing is responsibility of referring Physician.

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 Sex: Male
 Age: 59Y

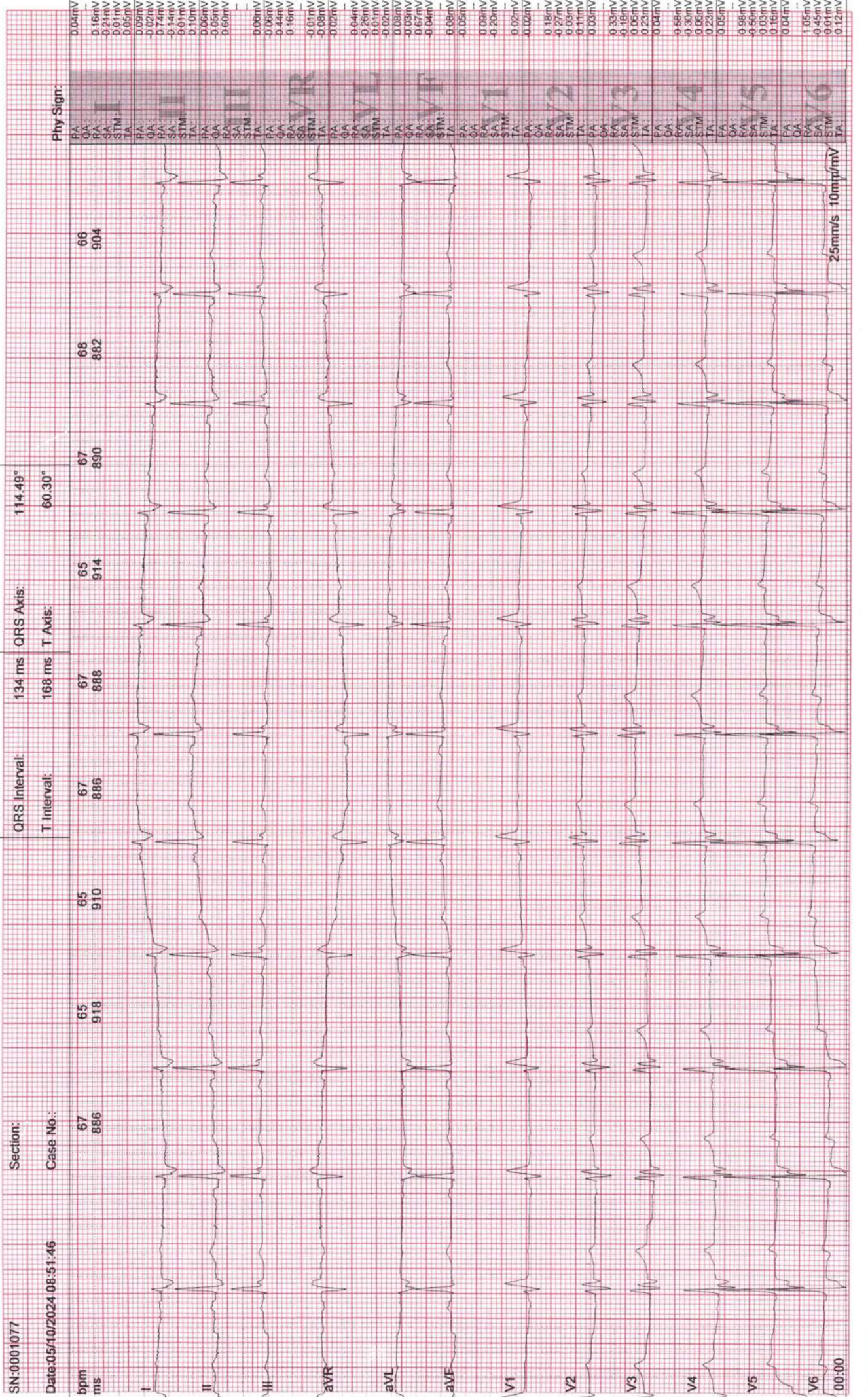
Clinic No.:
 Bed No.:

SN: 0001077
 Date: 05/10/2024 08:51:46
 Section:
 Case No.:

Frequency: 1000 Hz
 Sample Time: 13 s
 HR: 67 bpm
 P Interval: 84 ms

PR Interval: 150 ms
 QT Interval: 432 ms
 QTc Interval: 455 ms
 P Axis: 67.95°

Prompt:
 Total Beats 12 , Normal Beats 12 , SVE 0 , VE 0
 Normal Heart Rate(HR between 60 and 100 bpm):
 Light right cardiac electric axis deviation(QRS axis between 90 degree and 120 degree):



25mm/s 10mp/mV

00:00

PATIENT NAME BHARAT PATEL
AGE / SEX 59 Y/ M
REF. DOCTOR HEALTH CHECKUP
DATE 5-Oct-24

ULTRASOUND WHOLE ABDOMEN - PELVIS

LIVER : Liver is normal in size and shows normal echotexture.
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 with small 4-5mm sized soft calculi within. CBD:
appears normal, 5mm. GB wall thickness- normal.

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 :
Small soft GB calculi.


DR. JAY THAKKAR, MD

PATIENT NAME
AGE / SEX
REF. DOCTOR
DATE

MR. BHARATBHAI PATEL
59YRS/MALE
DR. DHS DOCTOR TEAM
05/10/2024

2D ECHO CARDIOGRAPHY REPORT

Observation:

1. Mild Concentric LVH.
2. Normal LV size with normal LV systolic function. LVEF: 60%.
3. Grade I LV diastolic dysfunction.
4. Reduced LV compliance.
5. Normal sized LA, RA and RV. Normal RV function.
6. All valves are normal in structure.
7. IAS and IVS are intact.
8. Mild PAH. RVSP = 36 mmHg.
9. No clot/ vegetation / pericardial effusion.
10. Doppler: Mild MR, Mild TR, No AR, No PR.
11. IVC is normal in size and well collapse on inspiration.

Conclusion: Mild Concentric LVH.
Normal LV systolic function.
No RWMA.
Mild PAH.

Measurements :

LVIDD	42.0 mm	AO	23.0mm
LVIDS	28.0 mm	LA	30.0mm
LVEF	60%		
IVSD/LVPWD	11.0mm/11.0mm		

DOPPLER STUDY:

Valves	velocity	Max gradient	Mean gradient	Area	Regurgitation
Aortic	1.1	5.4			No AR
Mitral	E:0.5 A: 0.2				Mild MR
Pulmonary	0.4	3.2			No PR
Tricuspid	0.6	1.4			Mild TR

Dr.ARCHIT PARIKH

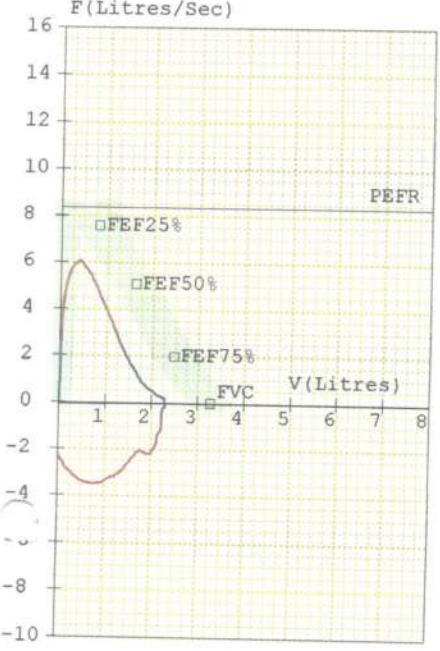
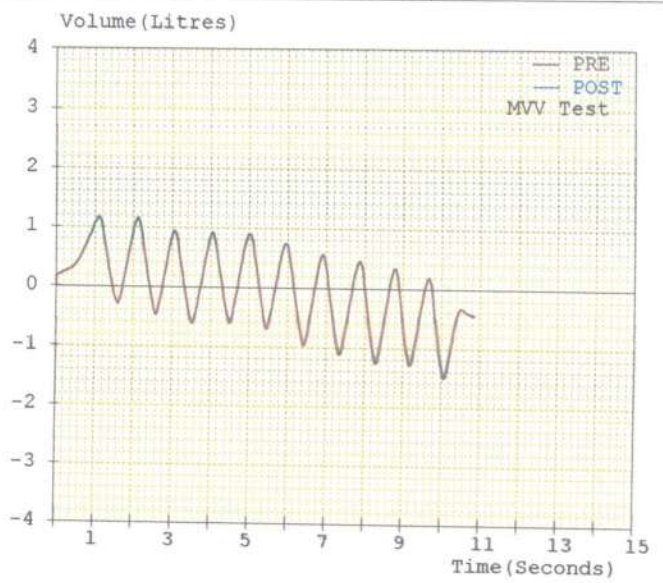
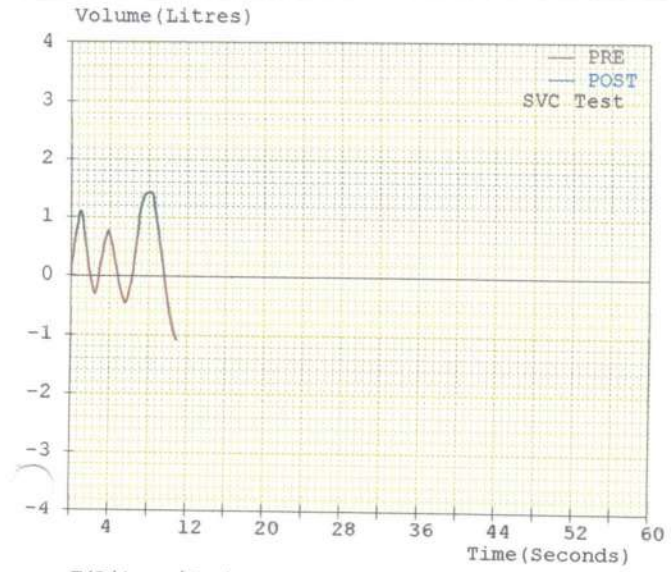
DHS MULTISPECIALTY HOSPITAL

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

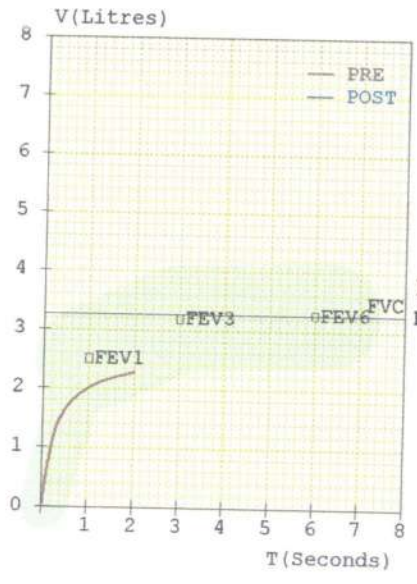


Patient: BHARAT PATEL
 Refd. By: HEALTH CHECK UP
 Pred. Eqns: RECORDERS
 Date : 05-Oct-2024 09:09 AM

Age : 59 Years Gender : Male
 Height : 172 Cms Smoker : Yes
 Weight : 61 Kgs Eth. Corr: 100
 ID: 12444 Temp : 98°C



Spirometry Results						
Parameter		Pred	M.Pre	%Pred	M.Post	%Pred
FVC	(L)	03.28	02.28	070	---	---
FEV1	(L)	02.51	02.02	080	---	---
FEV1/FVC	(%)	76.52	88.60	116	---	---
FEF25-75	(L/s)	03.12	02.56	082	---	---
PEFR	(L/s)	08.33	05.99	072	---	---
FIVC	(L)	---	02.86	---	---	---
FEV.5	(L)	---	01.67	---	---	---
FEV3	(L)	03.19	02.28	071	---	---
PIFR	(L/s)	---	03.48	---	---	---
FEF75-85	(L/s)	---	00.70	---	---	---
FEF 2-1.2	(L/s)	05.70	04.66	082	---	---
FEF 25%	(L/s)	07.57	05.62	074	---	---
FEF 50%	(L/s)	05.10	03.32	065	---	---
FEF 75%	(L/s)	01.97	01.01	051	---	---
FEV.5/FVC	(%)	---	73.25	---	---	---
FEV3/FVC	(%)	97.26	100.00	103	---	---
FET	(Sec)	---	02.05	---	---	---
ExptTime	(Sec)	---	00.07	---	---	---
Lung Age	(Yrs)	059	071	120	---	---
FEV6	(L)	03.28	---	---	---	---
FIF 25%	(L/s)	---	03.34	---	---	---
FIF 50%	(L/s)	---	02.99	---	---	---
FIF 75%	(L/s)	---	00.44	---	---	---
SVC	(L)	---	01.98	---	---	---
ERV	(L)	01.14	00.15	013	---	---
IRV	(L)	---	01.98	---	---	---
VE	(L/min)	---	25.20	---	---	---
Rf	(l/min)	---	13.33	---	---	---
Ti	(sec)	---	01.80	---	---	---
Te	(sec)	---	02.70	---	---	---
VT	(L)	---	01.89	---	---	---
VT/Ti		---	01.05	---	---	---
Ti/Ttot		---	00.40	---	---	---
IC	(L)	---	03.87	---	---	---
MVV	(L/min)	120	090	075	---	---
MRf	(l/min)	---	60.69	---	---	---
MVT	(L)	---	01.48	---	---	---



Pre Medication Report Indicates Mild Restriction as (FEV1/FVC)%Pred >95 and FVC%Pred <80

DR DHS TEAM