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Sohna Road

CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Mahender Singh Yadav on 24/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	✓
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____recommended	
• Unfit	

Dr.
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

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DATE- 23/3/24

NAME - Mahender singh yadav | PHONE - 7698007911

AGE/GENDER - 55yrs Male | ADDRESS - 136/1A/18 Laxmi Garden Gurgaon.

EMAIL - mahendrayadavgzn@gmail.com | CORPORATE NAME - Bank of Baroda

1. **Past medical history & medications**:-

NIL

2. **Any existing disease: -**

NIL

3. **Current medications :-**

NIL

4. **VITALS** - (To be filled by medical personnel)

- BLOOD PRESSURE - 124/82 mmHg
- PULSE RATE - 76 bpm
- TEMPERATURE – 97.5°F
- SPO2 – 98 %
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 177 cm
- WEIGHT – 73 kg
- BMI – 23.3

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5. **FINDINGS**: -

LAB INVESTIGATION: - All given investigations - Normal.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal
TMT - good

RADIOLOGY INVESTIGATIONS: - USG - Normal.
CXR - Prominent BVM.

6. **DOCTOR REMARKS**: - As mentioned above.

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PATIENT NAME	MR MAHENDER SINGH YADAV		REPORT DATE	3/23/2024
REF BY	P.H.M.C		AGE/SEX	55 YRS / M

ULTRASOUND WHOLE ABDOMEN

Clinical Profile-HEALTH CHECKUP.

Findings

The liver is normal in size, outline and parenchymal echotexture. No focal lesion is seen. The portal vein is normal in calibre and course.

The gall bladder shows normal contents. The intra hepatic biliary radicals and CBD are normal. The pancreas and spleen are normal.

Both the kidneys are normal in size, outline and parenchymal echopattern. No calculus, hydronephrosis or any other abnormality is seen on either side.

No free fluid is seen in the peritoneal cavity. No lymph node enlargement is seen in the para-aortic region.

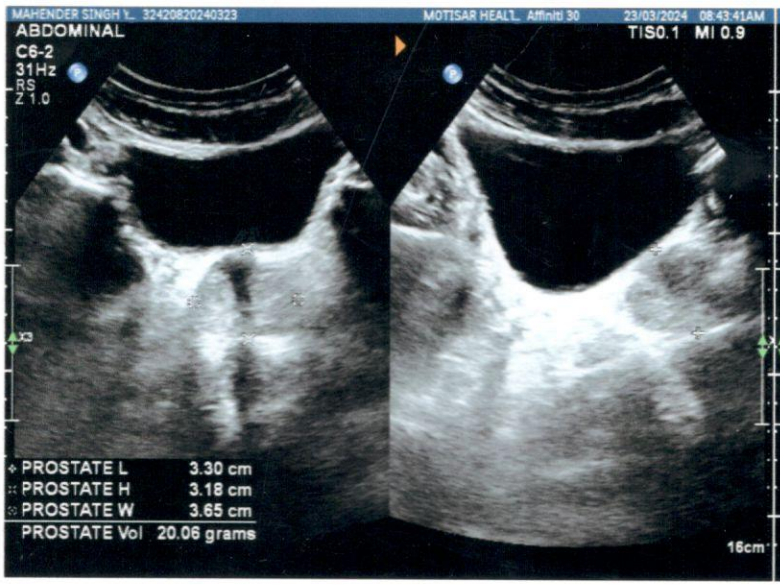
The urinary bladder is normal in outline.

The prostate and seminal vesicles are unremarkable.

IMPRESSION-
NO OBVIOUS PATHOLOGY SEEN IN THIS STUDY.

Clinical correlation is necessary.

DR. RAJNISH JUNEJA,
D.N.B (RADIO – DIAGNOSIS)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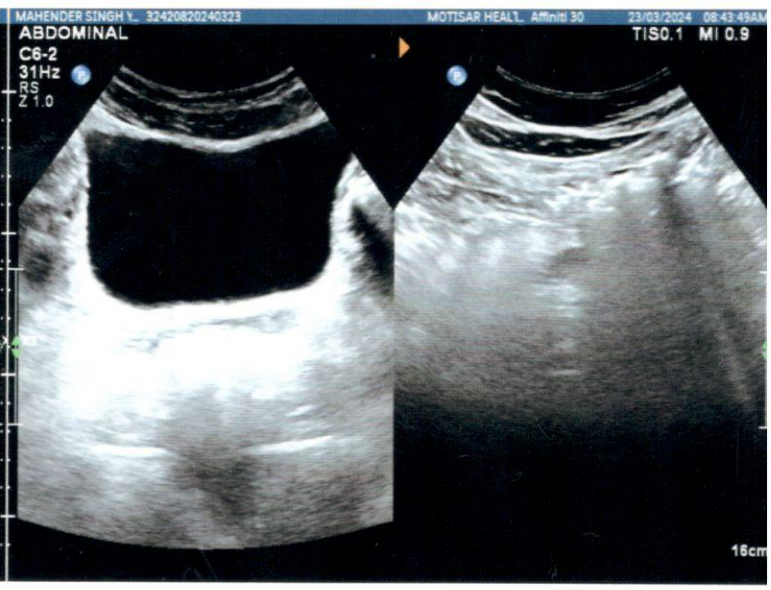
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 0.9
PROSTATE L 3.30 cm
PROSTATE H 3.18 cm
PROSTATE W 3.65 cm
PROSTATE Vol 20.06 grams
16cm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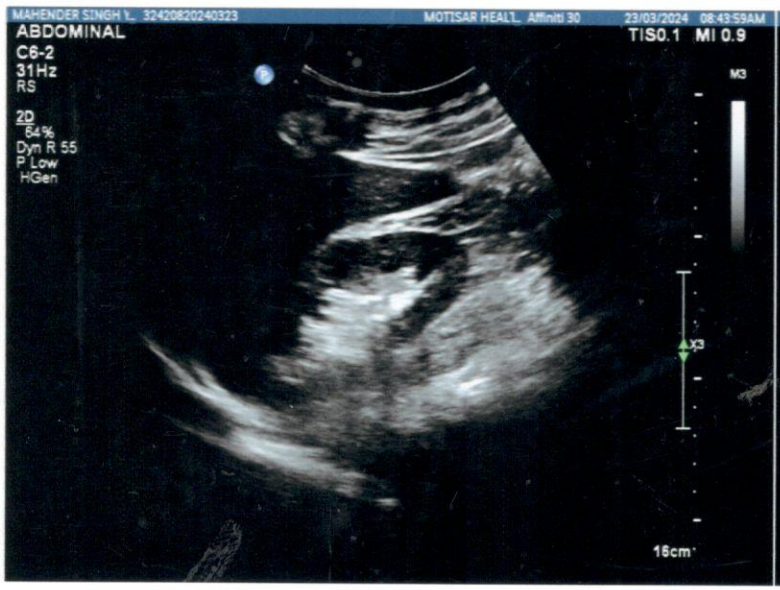
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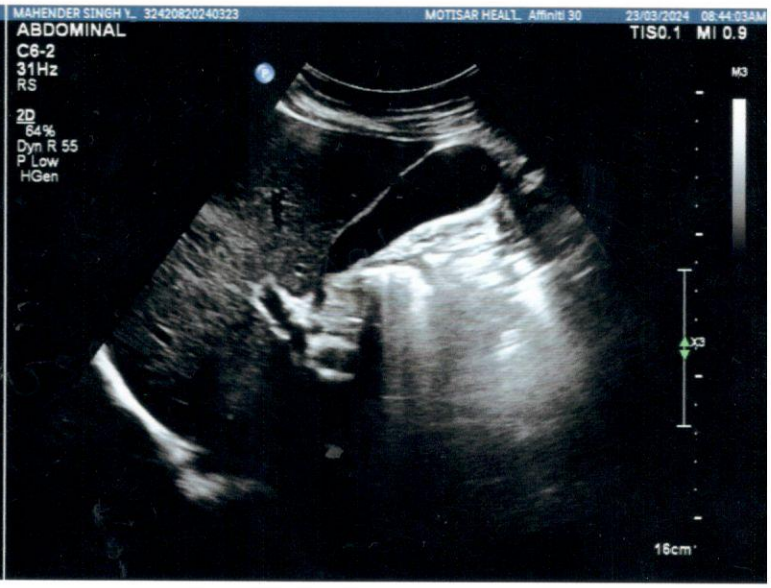
31Hz
RS
2D
64%
Dyn R 55
P Low
HGen
TIS0.1 MI 0.9
M3
16cm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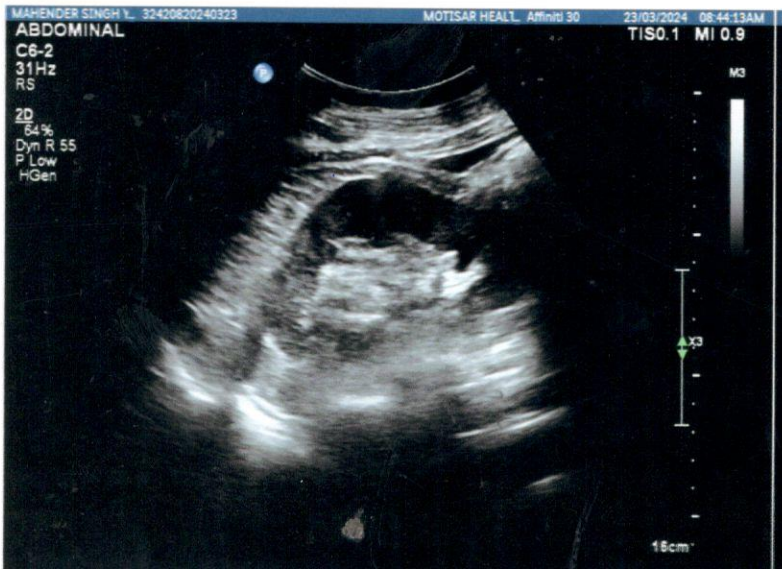
Dyn R 55
P Low
HGen
TIS0.1 MI 0.9
M3
16cm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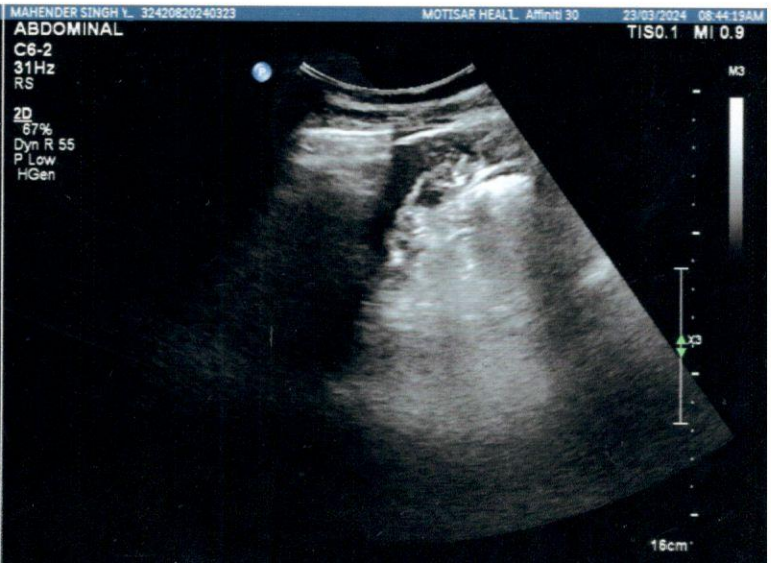
2D
64%
Dyn R 55
P Low
HGen
TIS0.1 MI 0.9
M3
16cm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C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen
TIS0.1 MI 0.9
M3
16cm

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Patient's Name:-	MR. MAHENDER SINGH YADAV	Date	:- 23/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 56Y/M

Radiograph of Chest (PA View)

Prominent broncho vascular marking are seen in bilateral lung fields.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

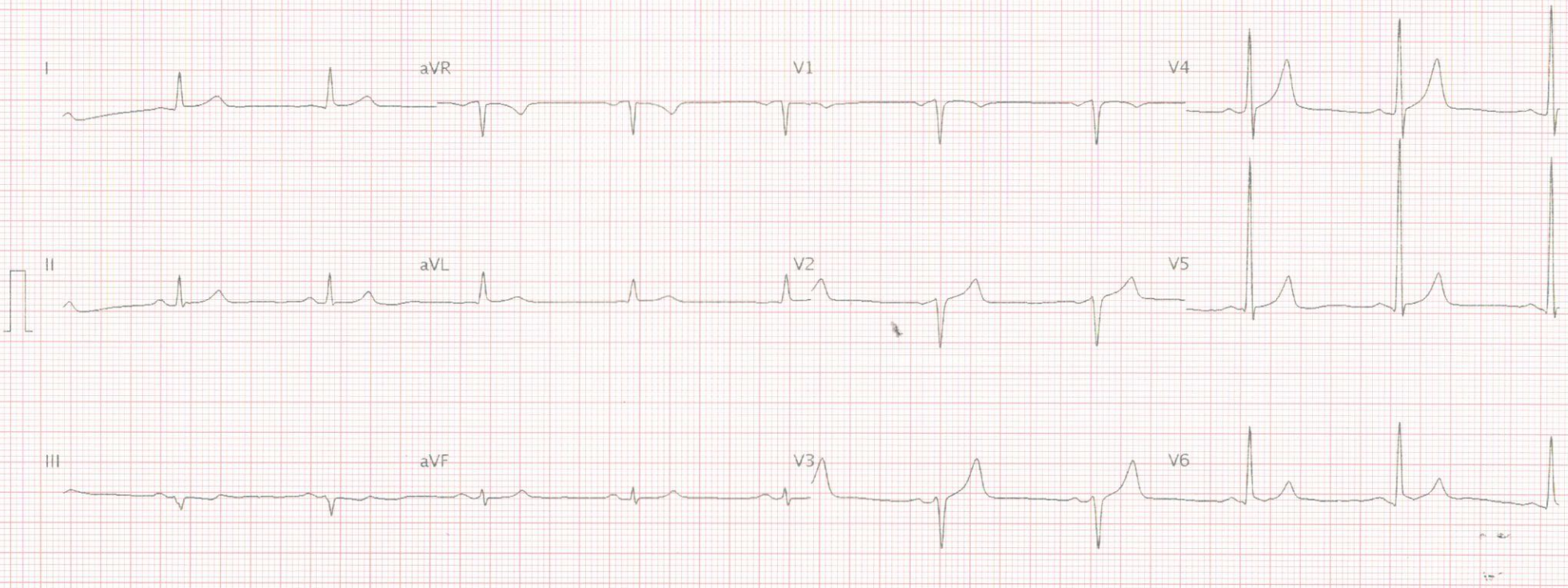
Dr Arushi Gupta
MBBS, DNB (Radio - Diagnosis)
Radiologist

Name	**Mahender Singh yadav**	23.03.2024 09:16:25	
Patient ID	**16cbd65a-82c6-46bd-9e4d-e66ae41b3c36**	**Standard 12-Lead**	

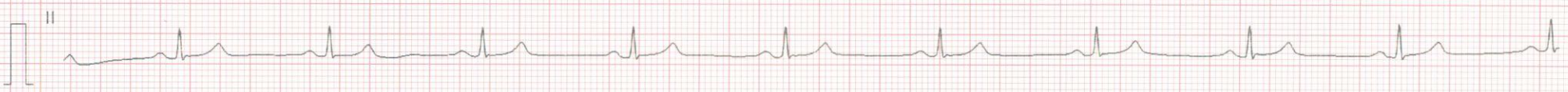
Date of birth	--	**Visit ID**	**HR**	**59 bpm**	**RR**	1017 ms	Sinus rhythm
Gender	Male	**Room**			**P**	95 ms	Normal electrical axis
Height		**Medication**			**PR**	137 ms	Nonspecific ST abnormality (elevation)
Weight		**Order ID**	**P axis**	62 °	**QRS**	85 ms	Otherwise normal ECG
Ethnicity	Undefined	**Ord. prov.**	**QRS axis**	10 °	**QT**	375 ms	
Pacemaker	Unknown	**Ord. prot.**	**T axis**	38 °	**QTcB**	372 ms	**Unconfirmed report**

Indication
Remark

Otherwise normal



25 mm/s, 10 mm/mV — Sequential — LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV — LP 25Hz, AC 60Hz

Name: MAHENDER SINGH YADAV Date: 23-03-2024 Time: 10:51

Age: 55 **Gender:** M **Height:** 177 cms **Weight:** 73 Kg **ID:** 000350

Clinical History:

Medications:

Test Details:

Protocol: Bruce **Predicted Max HR:** 165 **Target HR:** 140

Exercise Time: 0:07:12 **Achieved Max HR:** 158 (96% of Predicted MHR)

Max BP: 165/95 **Max BP x HR:** 26070 **Max Mets:** 8.1

Test Termination Criteria:

Protocol Details:

Stage Name	Stage Time	METS	Speed kmph	Grade %	Heart Rate bpm	BP mmHg	RPP	Max ST Level mm	Max ST Slope mV/s
Supine	00:11	1	0	0	89	124/82	11036	0.9 V4	0.2 V4
Standing	00:09	1	0	0	87	124/82	10788	1.1 V4	0.2 V2
HyperVentilation	00:09	1	0	0	85	124/82	10540	1.1 V4	0.2 III
PreTest	00:10	1	1.6	0	83	124/82	10292	0.9 V2	-0.2 aVR
Stage: 1	03:00	4.7	2.7	10	122	135/89	16470	0.9 II	0.4 II
Stage: 2	03:00	7	4	12	144	165/95	23760	-0.8 V6	0.5 II
Peak Exercise	01:12	8.1	5.5	14	158	165/95	26070	-2 II	0.9 V4
Recovery1	01:00	1	0	0	129	165/95	21285	1.4 V3	0.5 V4
Recovery2	01:00	1	0	0	113	165/95	18645	1 V3	0.3 II
Recovery3	01:00	1	0	0	105	165/95	17325	0.9 V4	0.2 II
Recovery4	01:00	1	0	0	102	165/95	16830	0.8 V2	0.2 V4

Interpretation

good excercise tolerance.
TMT negative for inducible ischemia

Ref. Doctor: ----

Doctor: ----

SCHILLER
The Art of Diagnostics

(Summary Report edited by User)
Spandan CS-20 Version:2.14.0

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Mahender Singh Yadav AGE/SEX: 55Y/M DATE: 23-3-24

Through health checkup

O/E — Chr. localised Periodontitis.
C Chr. Gen. Gingivitis -
Mobility grade. 3 — 21/12

T/t Advice — Scaling & polishing
— Ext^n of 21/12.

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
Age/Gender	: 55 Y 0 M 0 D /M	Registration Date	: 23/Mar/2024 02:18PM
LabNo	: DPL23742	Sample Collected Date	: 23/Mar/2024 02:18PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 05:38PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	15.20	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	5.3	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	48	%	42-52	Calculated
MCV	91.10	fL	78-100	Electrical Impedence
MCH	28.9	pg	27-31	Calculated
MCHC	**31.7**	gm/dL	32-36	Calculated
RDW-SD	**14.2**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	8020	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	58	%	40-80	VCSn Technology
LYMPHOCYTE	36	%	20-40	VCSn Technology
MONOCYTE	04	%	2-10	VCSn Technology
EOSINOPHIL	02	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	**80**	10^3/ul	150 - 450	Electrical Impedence
MPV	**12.7**	fL	7.2 - 11.7	Electrical Impedence
PCT	**0.1**	%	0.2 - 0.5	Calculated
PDW	16.2	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	4.65	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	2.89	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.32	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.16**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
Age/Gender	: 55 Y 0 M 0 D /M	Registration Date	: 23/Mar/2024 02:18PM
LabNo	: DPL23742	Sample Collected Date	: 23/Mar/2024 02:18PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 06:01PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	04	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

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Sr. Consultant (HMC.9669)

Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
Age/Gender	: 55 Y 0 M 0 D /M	Registration Date	: 23/Mar/2024 02:18PM
LabNo	: DPL23742	Sample Collected Date	: 23/Mar/2024 02:18PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 08:21PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	"AB"			Gel Columns agglutination
Rh Typing	**NEGATIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.60	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.20	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.40	mg/dL	0.1 - 1.0	Calculated
SGPT	39.50	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	37.10	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	0.94	Ratio	0.7 - 1.4	
GGT	36	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	59.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.20	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.10	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.1	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.32	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

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Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
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LabNo	: DPL23742	Sample Collected Date	: 23/Mar/2024 02:18PM
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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	187.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	79.80	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	48.30	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	122.74	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	**138.7**	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	15.96	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	3.87	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	2.54	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.39	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

Prasad

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method

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MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.MAHENDER SINGH	Barcode NO	: 20011704
Age/Gender	: 55 Y 0 M 0 D /M	Registration Date	: 23/Mar/2024 02:18PM
LabNo	: DPL23742	Sample Collected Date	: 23/Mar/2024 02:18PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:21PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.7	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	117.46	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	96.6	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	**142**	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	23.60	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	11.03	mg/dL	7 - 18	Urease
SERUM URIC ACID	6.60	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.80	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	10.40	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	136.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.10	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	102.5	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

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DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.20	ng/mL	0.79 - 1.58	CLIA
T4	9.36	µg/dl	4.9 - 11.00	CLIA
TSH	1.40	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL				
PROSTATE SPECIFIC ANTIGEN	0.5	ng/mL	0-4	CLIA

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.

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DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	25	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.00		4.5 - 7.0	
SPECIFIC GRAVITY	1.020		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	Absent		Nill	
Urine Protein	Absent		Nil	
Urine Ketones	Absent		Nil	
BLOOD	Absent		Absent	
Leukocyte esterase	Absent		Negative	
Bile pigments	Absent		Absent	
NITRITE	Absent		Negative	
UROBILINOGEN	Absent		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	1-2	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	Absent	/hpf	Absent	
CRYSTALS	Absent		Absent	
CASTS	Absent		Absent	
OTHER	Absent			
URINE SUGAR - PP				
Sample Type : Urine				
Result	Absent		Nil	Benedicts test

INTERPRETATION:

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.

***** End Of Report *****

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