

BMI CHART

Sex: M / F

Age: 48 yrs

Name: *Sushant Kumar*

BP: 110/80 mmHg Height (cms): 180 cm Weight(kgs): 93.8 kg BMI:

WEIGHT lbs 100 105 100 115 120 125 130 135 140 145 150 155 160 165 170 175 180 185 190 195 200 205 210 215

kgs 45.5 47.7 50.50 52.3 54.5 56.8 59.1 61.4 63.6 65.9 68.2 70.5 72.7 75.0 77.3 79.5 81.8 84.1 86.4 88.6 90.9 93.2 95.5 97.7

HEIGHT in/cm Underweight Healthy Overweight Obese Extremely Obese

19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40		
18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38		
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37		
15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35		
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34		
12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33		
12	13	13	14	15	16	16	17	18	18	19	19	20	20	21	21	22	22	23	23	24	24	25	
12	12	13	13	14	15	16	17	18	18	19	20	20	21	21	22	22	23	23	24	24	25	26	
64" - 193.0	63" - 190.5	62" - 187.9	61" - 185.4	60" - 182.8	511" - 180.3	510" - 177.8	59" - 176.2	58" - 172.7	57" - 170.1	56" - 167.6	55" - 165.1	54" - 162.5	53" - 160.0	52" - 157.4	51" - 154.9	50" - 152.4							

Doctors Notes:

Signature

Hiranandani Healthcare Pvt. Ltd.
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GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

UHID	13112563	Date	26/04/2024	
Name	Mr Sushant Kumar Prawin	Sex	M	Age 48
OPD	Dental	Health Check-Up		

O/E - Stains + +
 - calculus + +

Drug allergy:
Sys illness:

- Attended \bar{c} $\frac{1}{6}$

Treatment

A/d - scaling Grade II

Dr. Jeepti



UHID	13112563	Date	26/04/2024		
Name	Mr Sushant Kumar Prawin	Sex	M	Age	48
OPD	Ophthal	Health Check-Up			

Chc. Dryness

Drug allergy: → Cepluv (gmp?)
 Sys illness: → No
 Habit → tobacco

Hx NO

UR → R 6/18P
 → L 6/18P

Phu → R + 0.75 / -1.00 x 80° 6/6
 → L +0.75 / -0.75 x 80° 6/6
 Add → +1.75 → No
 → No

Fup → R 14.8
 → L 18.1

[Handwritten signature]

Soft drops

15 days



PATIENT NAME : MR. SUSHANT KUMAR PRAWIN		REF. DOCTOR : SELF
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL - VASHI, MUMBAI 440001	ACCESSION NO : 0022XD004711 PATIENT ID : FH.13112563 CLIENT PATIENT ID: UID:13112563 ABHA NO :	AGE/SEX : 48 Years Male DRAWN : 26/04/2024 10:05:00 RECEIVED : 26/04/2024 10:06:49 REPORTED : 26/04/2024 14:17:26

CLINICAL INFORMATION :
 UID:13112563 REQNO-1696125
 CORP-OPD
 BILLNO-150124OPCR022838
 BILLNO-150124OPCR022838

Test Report Status	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	13.1	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.96	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	6.29	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	200	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	41.7	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	84.1	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	26.4 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	31.4 Low	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.7	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	17.0		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	12.9 High	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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



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ULR No.22000000917252-0022

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FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL - VASHI,
MUMBAI 440001

ACCESSION NO : 0022XD004711

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NEUTROPHILS		63	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		26	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		8	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.96	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.64	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.50	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.19	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.4		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

WBC

METHOD : MICROSCOPIC EXAMINATION

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

NORMAL MORPHOLOGY

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	25 High	0 - 14	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.9 High	Non-diabetic: < 5.7	%
		Pre-diabetics: 5.7 - 6.4	
		Diabetics: > or = 6.5	
		Therapeutic goals: < 7.0	
		Action suggested : > 8.0	
		(ADA Guideline 2021)	

METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	122.6 High	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

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, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy 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: Polycythemia vera, Sickle cell anemia

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

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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 patient's metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 addition 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 platform (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	TYPE B
METHOD : TUBE AGGLUTINATION	
RH TYPE	POSITIVE
METHOD : TUBE AGGLUTINATION	

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	0.43	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.07	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.36	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.3	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.4	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	16	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	35	< 45.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	71	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	87 High	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	143	85 - 227	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA



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FBS (FASTING BLOOD SUGAR)		103 High	(Normal <100, Impaired fasting glucose: 100 to 125, Diabetes mellitus: >=126 (on more than 1 occasion) (ADA guidelines 2024))	mg/dL
METHOD : HEXOKINASE				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		10	6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE		0.97	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE		48		years
GLOMERULAR FILTRATION RATE (MALE)		96.30	Refer Interpretation Below	mL/min/1.73m ²
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO		10.31	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		6.2	3.5 - 7.2	mg/dL
METHOD : URICASE UV				

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MUMBAI 440001

ACCESSION NO : 0022XD004711

PATIENT ID : FH.13112563

CLIENT PATIENT ID: UID:13112563

ABHA NO :

AGE/SEX :48 Years Male

DRAWN :26/04/2024 10:05:00

RECEIVED :26/04/2024 10:06:49

REPORTED :26/04/2024 14:17:26

CLINICAL INFORMATION :

UID:13112563 REQNO-1696125
CORP-OPD
BILLNO-150124OPCR022838
BILLNO-150124OPCR022838

Test Report Status	Final	Results	Biological Reference Interval	Units
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TOTAL PROTEIN, SERUM

TOTAL PROTEIN
METHOD : BIURET

7.3

6.4 - 8.2

g/dL

ALBUMIN, SERUM

ALBUMIN
METHOD : BCP DYE BINDING

3.9

3.4 - 5.0

g/dL

GLOBULIN

GLOBULIN
METHOD : CALCULATED PARAMETER

3.4

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

4.00

3.50 - 5.10

mmol/L

CHLORIDE, SERUM
METHOD : ISE INDIRECT

105

98 - 107

mmol/L

Interpretation(s)



Dr. Akshay Dhotre, MD
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Consultant Pathologist

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ULR No.22000000917252-0022

PATIENT NAME : MR. SUSHANT KUMAR PRAWIN

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL - VASHI,
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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 result 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.

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 so that 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; sulfonyleureas, 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 glycaemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary 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.

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ULR No.22000000917252-0022

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CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL - VASHI, MUMBAI 440001	ACCESSION NO : 0022XD004711 PATIENT ID : FH.13112563 CLIENT PATIENT ID: UID:13112563 ABHA NO :	AGE/SEX : 48 Years Male DRAWN : 26/04/2024 10:05:00 RECEIVED : 26/04/2024 10:06:49 REPORTED : 26/04/2024 14:17:26

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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.
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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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	170	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	114	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	39 Low	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	112	< 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	131 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	22.8	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.4	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO	2.9	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
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METHOD : CALCULATED PARAMETER

Interpretation(s)

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
METHOD : PHYSICAL	
APPEARANCE	CLEAR
METHOD : VISUAL	

CHEMICAL EXAMINATION, URINE

PH	7.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.015	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

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Dr. Rekha Nair, MD
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MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	1-2	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	0-1	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	124.6	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	7.84	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.800	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	1.110	0.0 - 2.0	ng/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.

- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- 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 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.


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1. Burtis CA, Ashwood ER, Bruns DE, Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

End Of Report

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CLIENT PATIENT ID: UID:13112563

ABHA NO :

AGE/SEX : 48 Years Male

DRAWN : 26/04/2024 12:31:00

RECEIVED : 26/04/2024 12:31:20

REPORTED : 26/04/2024 14:36:32

CLINICAL INFORMATION :

UID:13112563 REQNO-1696125
CORP-OPD
BILLNO-150124OPCR022838
BILLNO-150124OPCR022838

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	106	70 - 140	mg/dL
METHOD : HEXOKINASE			


Interpretation(s)

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

End Of Report

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

Page 1 Of 1


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



View Details



View Report

PERFORMED AT :

Agilus Diagnostics Ltd
Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,
Navi Mumbai, 400703
Maharashtra, India
Tel : 022-39199222,022-49723322, Fax :
CIN - U74899PB1995PLC045956
Email : -



ULR No.22000000917287-0022

13112563

subhant prawin

Male

48 Years

4/26/2024 10:41:08 AM

He

Normal ECG

Rate 84 . Sinus rhythm.....normal P axis, V-rate 50 - 99

. Baseline wander in lead(s) V1, V2

PR 132

QRSD 94

QT 348

QTc 412

--AXIS--

P 47

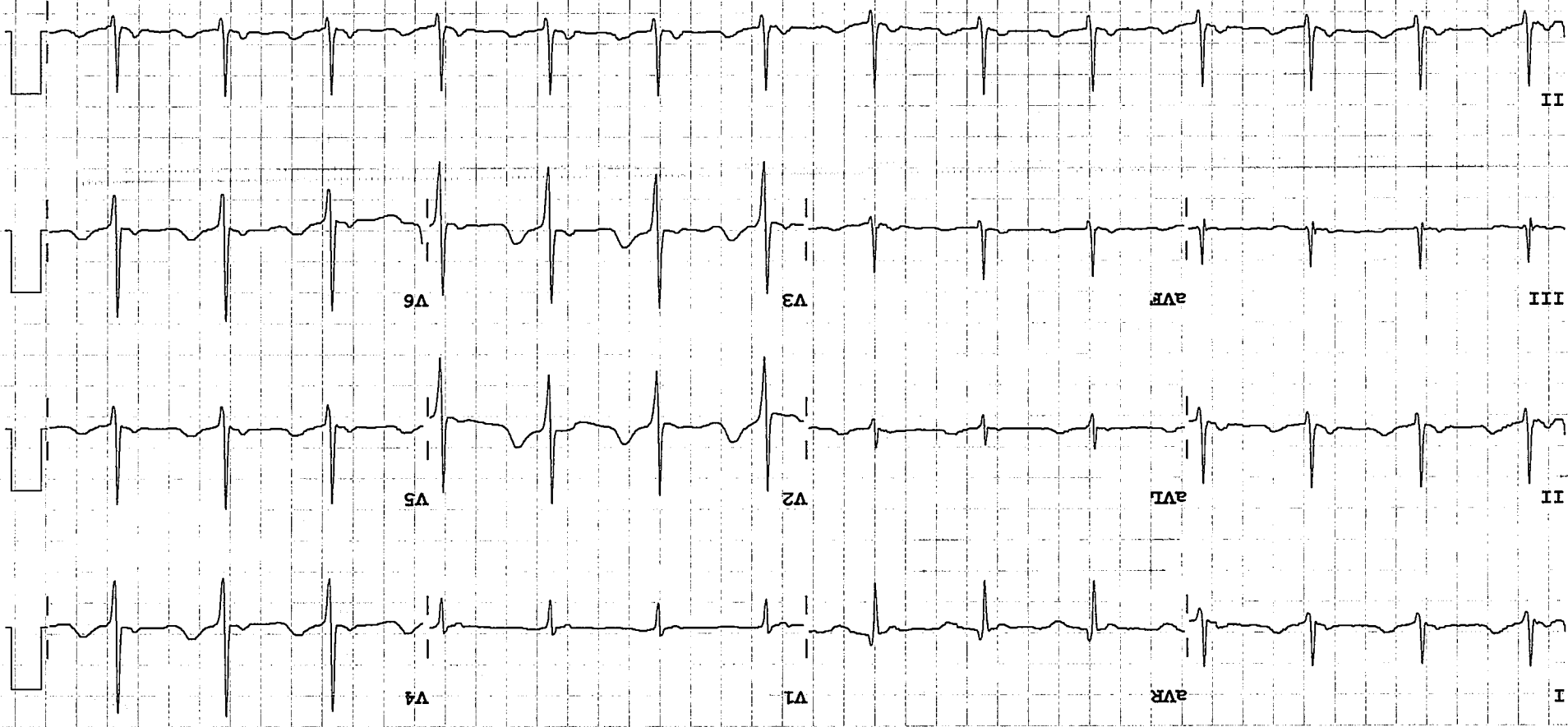
QRS 62

T 20

12 lead; standard Placement

Unconfirmed Diagnosis

- NORMAL ECG -



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~0.50-100 Hz W 100B CL P2

PHILIPS

REORDER M2242B

605

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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Emergency: 022 - 39199100 | Ambulance: 1255

For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D

**Hiranandani**
HOSPITAL

(A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 26/Apr/2024

Name: Mr. Sushant Kumar Prawin**UHID | Episode No : 13112563 | 23336/24/1501****Age | Sex: 48 YEAR(S) | Male****Order No | Order Date: 1501/PN/OP/2404/48468 | 26-Apr-2024****Order Station : FO-OPD****Admitted On | Reporting Date : 26-Apr-2024 12:03:01****Bed Name :****Order Doctor Name : Dr.SELF .****ECHOCARDIOGRAPHY TRANSTHORACIC****FINDINGS:**

- Normal chambers dimensions.
- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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= 25mmHg
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- IVC measures 15 mm with normal inspiratory collapse

M-MODE MEASUREMENTS:

LA	32	mm
AO Root	23	mm
AO CUSP SEP	18	mm
LVID (s)	27	mm
LVID (d)	42	mm
IVS (d)	11	mm
LVPW (d)	11	mm
RVID (d)	30	mm
RA	33	mm
LVEF	60	%

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CIN: U85100MH2005PTC 154823

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PAN NO : AABCH5894D



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 26/Apr/2024

Name: Mr. Sushant Kumar Prawin

UHD | Episode No : 13112563 | 23336/24/1501

Age | Sex: 48 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2404/48468 | 26-Apr-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 26-Apr-2024 12:03:01

Bed Name :

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.8 m/sec.

A WAVE VELOCITY: 0.9 m/sec

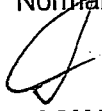
E/A RATIO: 0.9

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	08			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	04			Nil

?????

Final Impression :

- Normal chambers dimensions.
- No RWMA.
- Trivial MR , Trivial TR .No PH .
- Grade I LV diastolic dysfunction.
- Normal LV and RV systolic function.


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

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

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 26/Apr/2024

Name: Mr. Suhant Kumar Prawin

Age | Sex: 48 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13112563 | 23336/24/1501

Order No | Order Date: 1501/PN/OP/2404/48468 | 26-Apr-2024

Admitted On | Reporting Date : 26-Apr-2024 11:10:31

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.

Yogini Shah

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



Patient Name	: Suhant Kumar Prawin	Patient ID	: 13112563
Sex / Age	: M / 48Y 5M 9D	Accession No.	: PHC.7991102
Modality	: US	Scan DateTime	: 26-04-2024 12:55:14
IPID No	: 23336/24/1501	ReportDatetime	: 26-04-2024 13:04:17

USG – WHOLE ABDOMEN

LIVER is mildly enlarged in size (15.8 cm) and shows raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is partially distended, however visualised lumen appears clear.

CBD appears normal in caliber.

SPLEEN is normal in size (9.7 cm) 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 4.6 cm.

Left kidney measures 10.8 x 5.5 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 22.8 cc in volume.

No evidence of ascites.

Impression:

- Mild hepatomegaly with fatty infiltration.

DR. SIDDHESH PURUSHOTTAM

MD, DNB (Radiologist)