

ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

Patient Name	Mr. GUNJAN SHARMA	Lab No	4028379
UHID	40012084	Collection Date	23/03/2024 11:32AM
Age/Gender	36 Yrs/Male	Receiving Date	23/03/2024 11:51AM
IP/OP Location	O-OPD	Report Date	23/03/2024 5:20PM
Referred By	Dr. EHS CONSULTANT	Report Status	Final
Mobile No.	8866124833		

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Sample: FI. Plasma
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BLOOD GLUCOSE (FASTING)

BLOOD GLUCOSE (FASTING)	92.7	mg/dl	71 - 109
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Method: Hexokinase assay.

Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

BLOOD GLUCOSE (PP)

BLOOD GLUCOSE (PP)	113	mg/dl	Non – Diabetic: - < 140 mg/dl Pre – Diabetic: - 140-199 mg/dl Diabetic: - >=200 mg/dl
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Sample: PLASMA

Method: Hexokinase assay.

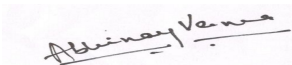
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

THYROID T3 T4 TSH

T3	1.120	ng/mL	0.970 - 1.690
T4	6.08	ug/dl	5.53 - 11.00
TSH	3.64	μIU/mL	0.40 - 4.05

Sample: Serum

RESULT ENTERED BY : Dr. ABHINAY VERMA



Dr. ABHINAY VERMA

MBBS|MD|INCHARGE PATHOLOGY

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BIOCHEMISTRY

T3:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

T4:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T4 assay employs a competitive test principle with an antibody specifically directed against T4.

TSH - THYROID STIMULATING HORMONE :- ElectroChemiLuminescenceImmunoAssay - ECLIA

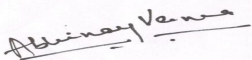
Interpretation:-The determination of TSH serves as the initial test in thyroid diagnostics. Even very slight changes in the concentrations of the free thyroid hormones bring about much greater opposite changes in the TSH levels.

LFT (LIVER FUNCTION TEST)

Sample: Serum

BILIRUBIN TOTAL	0.39	mg/dl	0.00 - 1.20
BILIRUBIN INDIRECT	0.25	mg/dl	0.20 - 1.00
BILIRUBIN DIRECT	0.14	mg/dl	0.00 - 0.30
SGOT	32.0	U/L	0.0 - 40.0
SGPT	45.5 H	U/L	0.0 - 41.0
TOTAL PROTEIN	7.4	g/dl	6.6 - 8.7
ALBUMIN	4.8	g/dl	3.5 - 5.2
GLOBULIN	2.6		1.8 - 3.6
ALKALINE PHOSPHATASE	87	U/L	40 - 129
A/G RATIO	1.9	Ratio	1.5 - 2.5
GGTP	203.0 H	U/L	10.0 - 60.0

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BIOCHEMISTRY

BILIRUBIN TOTAL :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structure.

BILIRUBIN DIRECT :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.

SGOT - AST :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT (AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.

SGPT - ALT :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT (ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.

TOTAL PROTEINS :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.

ALBUMIN :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.

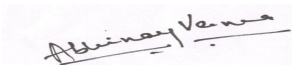
ALKALINE PHOSPHATASE :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method:

Enzymatic colorimetric assay. Interpretation:- γ -glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

LIPID PROFILE

TOTAL CHOLESTEROL	183		<200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High
HDL CHOLESTEROL	43.2		High Risk :- <40 mg/dl (Male), <40 mg/dl (Female) Low Risk :- >=60 mg/dl (Male), >=60 mg/dl (Female)
LDL CHOLESTEROL	122.9		Optimal :- <100 mg/dl Near or Above Optimal :- 100-129 mg/dl Borderline :- 130-159 mg/dl High :- 160-189 mg/dl Very High :- >190 mg/dl
CHOLESTERO VLDL	20	mg/dl	10 - 50
TRIGLYCERIDES	100		Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl
CHOLESTEROL/HDL RATIO	4	%	

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BIOCHEMISTRY

CHOLESTEROL TOTAL :- Method: CHOD-PAP enzymatic colorimetric assay.
 interpretation:-The determination of the individual total cholesterol (TC) level is used for screening purposes while for a better risk assessment it is necessary to measure additionally lipid & lipoprotein metabolic disorders.

HDL CHOLESTEROL :- Method:-Homogenous enzymetic colorimetric method.
 Interpretation:-HDL-cholesterol has a protective against coronary heart disease, while reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase the cardiovascular disease.

LDL CHOLESTEROL :- Method: Homogenous enzymatic colorimetric assay.
 Interpretation:-LDL play a key role in causing and influencing the progression of atherosclerosis and in particular coronary sclerosis. The LDL are derived form VLDL rich in TG by the action of various lipolytic enzymes and are synthesized in the liver.

CHOLESTEROL VLDL :- Method: VLDL Calculative

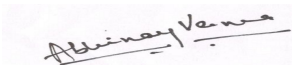
TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay.
 Interpretation:-High triglycerde levels also occur in various diseases of liver, kidneys and pancreas. DM, nephrosis, liver obstruction.

CHOLESTEROL/HDL RATIO :- Method: Cholesterol/HDL Ratio Calculative

Sample: Serum

UREA	33.0	mg/dl	16.60 - 48.50
BUN	15.4	mg/dl	6 - 20
CREATININE	0.81	mg/dl	0.70 - 1.20
SODIUM	139.9	mmol/L	136 - 145
POTASSIUM	4.19	mmol/L	3.50 - 5.50
CHLORIDE	103.3	mmol/L	98 - 107
URIC ACID	4.57	mg/dl	3.4 - 7.0
CALCIUM	10.09 H	mg/dl	8.60 - 10.00

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BIOCHEMISTRY

CREATININE - SERUM :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidney disease.

URIC ACID :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uric acid are renal diseases with decreased excretion of waste products, starvation, drug abuse and increased alcohol consume.

SODIUM:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea, diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake and kidney reabsorption.

POTASSIUM :- Method: ISE electrode. Interpretation:-Low level: Intake excessive loss from body due to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renal failure.

CHLORIDE - SERUM :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake, prolonged vomiting and reduced renal reabsorption as well as forms of acidosis and alkalosis.
Increase: dehydration, kidney failure, some form of acidosis, high dietary or parenteral chloride intake, and salicylate poisoning.

UREA:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogen concentration are seen in inadequate renal perfusion, shock, diminished blood volume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerular nephritis and UTI.

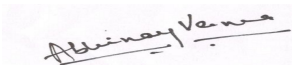
CALCIUM TOTAL :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usually associated with hypercalcemia. Increased serum calcium levels may also be observed in multiple myeloma and other neoplastic diseases. Hypocalcemia may be observed in hypoparathyroidism, nephrosis, and pancreatitis.

Sample: WHOLE BLOOD EDTA

HBA1C	5.7	%		
			< 5.7%	Nondiabetic
			5.7-6.4%	Pre-diabetic
			> 6.4%	Indicate Diabetes
			Known Diabetic Patients	
			< 7 %	Excellent Control
			7 - 8 %	Good Control
			> 8 %	Poor Control

Method : - Turbidimetric inhibition immunoassay (TINIA)
 Interpretation:-Monitoring long term glycemic control, testing every 3 to 4 months is generally sufficient.
 The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

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BLOOD BANK INVESTIGATION

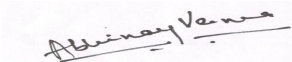
Test Name	Result	Unit	Biological Ref. Range
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BLOOD GROUPING	"A" Rh Positive		
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Note :

1. Both forward and reverse grouping performed.
2. Test conducted on EDTA whole blood.

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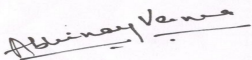
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CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Sample: Urine
<u>URINE SUGAR (POST PRANDIAL)</u>				
URINE SUGAR (POST PRANDIAL)	NEGATIVE		NEGATIVE	Sample: Urine
<u>URINE SUGAR (RANDOM)</u>				
URINE SUGAR (RANDOM)	NEGATIVE		NEGATIVE	Sample: Urine
PHYSICAL EXAMINATION				
VOLUME	20	ml		Sample: Urine
COLOUR	PALE YELLOW		P YELLOW	
APPEARANCE	CLEAR		CLEAR	
CHEMICAL EXAMINATION				
PH	6.0		5.5 - 7.0	
SPECIFIC GRAVITY	1.020		1.016-1.022	
PROTEIN	NEGATIVE		NEGATIVE	
SUGAR	NEGATIVE		NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
BLOOD	NEGATIVE			
KETONES	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
UROBILINOGEN	NEGATIVE		NEGATIVE	
LEUCOCYTE	NEGATIVE		NEGATIVE	
MICROSCOPIC EXAMINATION				
WBCS/HPF	1-2	/hpf	0 - 3	
RBCS/HPF	0-0	/hpf	0 - 2	
EPITHELIAL CELLS/HPF	1-2	/hpf	0 - 1	
CASTS	NIL		NIL	
CRYSTALS	NIL		NIL	

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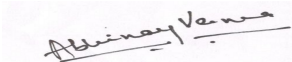
CLINICAL PATHOLOGY

BACTERIA NIL NIL
OHTERS NIL NIL

Methodology:-

Glucose: GOD-POD, Bilirubin: Diazo-Azo-coupling reaction with a diazonium, Ketone: Nitro Pruside reaction, Specific Gravity: Proton release from ions, Blood: Psuedo-Peroxidase activity oh Haem moiety, pH: Methye Red-Bromothymol Blue (Double indicator system), Protein: H+ Release by buffer, microscopic & chemical method. interpretation: Diagnosis of Kidney function, UTI, Presence of Protein, Glucoses, Blood. Vocubulary syntax: Kit insert

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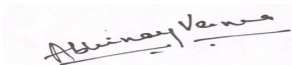
HEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range
<u>CBC (COMPLETE BLOOD COUNT)</u>			
Sample: WHOLE BLOOD EDTA			
HAEMOGLOBIN	13.6	g/dl	13.0 - 17.0
PACKED CELL VOLUME(PCV)	41.3	%	40.0 - 50.0
MCV	90.2	fl	82 - 92
MCH	29.7	pg	27 - 32
MCHC	32.9	g/dl	32 - 36
RBC COUNT	4.58	millions/cu.mm	4.50 - 5.50
TLC (TOTAL WBC COUNT)	4.99	10 ³ / uL	4 - 10
<u>DIFFERENTIAL LEUCOCYTE COUNT</u>			
NEUTROPHILS	41.7	%	40 - 80
LYMPHOCYTE	44.1 H	%	20 - 40
EOSINOPHILS	8.6 H	%	1 - 6
BASOPHIL	1.0	%	1 - 2
MONOCYTES	4.6	%	2 - 10
PLATELET COUNT	2.37	lakh/cumm	1.500 - 4.500

HAEMOGLOBIN :- Method:-SLS HemoglobinMethodology by Cell Counter.Interpretation:-Low-Anemia, High-Polycythemia.
MCV :- Method:- Calculation bysystemex.
MCH :- Method:- Calculation bysystemex.
MCHC :- Method:- Calculation bysystemex.
RBC COUNT :- Method:-Hydrodynamicfocusing.Interpretation:-Low-Anemia,High-Polycythemia.
TLC (TOTAL WBC COUNT) :- Method:-Optical Detectorblock based on Flowcytometry.Interpretation:-High-Leucocytosis, Low-Leucopenia.
NEUTROPHILS :- Method: Optical detectorblock based on Flowcytometry
LYMPHOCYTS :- Method: Optical detectorblock based on Flowcytometry
EOSINOPHILS :- Method: Optical detectorblock based on Flowcytometry
MONOCYTES :- Method: Optical detectorblock based on Flowcytometry
BASOPHIL :- Method: Optical detectorblock based on Flowcytometry
PLATELET COUNT :- Method:-Hydrodynamicfocusing method.Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

ESR (ERYTHROCYTE SEDIMENTATION RATE)	10	mm/1st hr	0 - 15
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Method:-Modified Westergrens.

Interpretation:-Increased in infections, sepsis, and malignancy.

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DEPARTMENT OF CARDIOLOGY

UHID / IP NO	40012084 (8970)	RISNo./Status :	4028379/
Patient Name :	Mr. GUNJAN SHARMA	Age/Gender :	36 Y/M
Referred By :	Dr. EHS CONSULTANT	Ward/Bed No :	OPD
Bill Date/No :	23/03/2024 11:05AM/ OPSCR23-24/16524	Scan Date :	
Report Date :	23/03/2024 1:14PM	Company Name:	Final

REFERRAL REASON: HEALTH CHECKUP

2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

M MODE DIMENSIONS: -

		Normal		Normal
IVSD	10.2	6-12mm	LVIDS	32.1
LVIDD	49.0	32-57mm	LVPWS	17.3
LVPWD	11.2	6-12mm	AO	28.6
IVSS	17.8	mm	LA	33.7
LVEF	62-64	>55%	RA	-

DOPPLER MEASUREMENTS & CALCULATIONS:

STRUCTURE	MORPHOLOGY	VELOCITY (m/s)				GRADIENT (mmHg)	REGURGITATION
		E	1.12	e'	-		
MITRAL VALVE	NORMAL	A	0.75	E/e'	-	-	NIL
		E	0.69				
TRICUSPID VALVE	NORMAL	A	0.53			-	NIL
		E	1.46				
AORTIC VALVE	NORMAL					-	NIL
PULMONARY VALVE	NORMAL					-	NIL

COMMENTS & CONCLUSION: -

- ALL CARDIAC CHAMBERS ARE NORMAL
- NO RWMA, LVEF 62-64%
- NORMAL LV SYSTOLIC FUNCTION
- NORMAL LV DIASTOLIC FUNCTION
- ALL CARDIAC VALVES ARE NORMAL
- NO EVIDENCE OF CLOT/VEGETATION/PE
- INTACT IVS/IAS

IMPRESSION: - NORMAL BI VENTRICULAR FUNCTIONS

DR SUPRIY JAIN
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INCHARGE & SR. CONSULTANT
INTERVENTIONAL CARDIOLOGY

DR ROOPAM SHARMA
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CONSULTANT & INCHARGE
EMERGENCY, PREVENTIVE CARDIOLOGY
AND WELLNESS CENTRE

DEPARTMENT OF RADIO DIAGNOSIS

UHID / IP NO	40012084 (8970)	RISNo./Status :	4028379/
Patient Name :	Mr. GUNJAN SHARMA	Age/Gender :	36 Y/M
Referred By :	Dr. EHS CONSULTANT	Ward/Bed No :	OPD
Bill Date/No :	23/03/2024 11:05AM/ OPSCR23-24/16524	Scan Date :	
Report Date :	23/03/2024 12:54PM	Company Name:	Mediwheel - Arcofemi Health Care Ltd.

ULTRASOUND STUDY OF WHOLE ABDOMEN

- Liver:** Normal in size & **shows increased parenchymal echotexture**. No obvious significant focal parenchymal mass lesion noted. Intrahepatic biliary radicals are not dilated. Portal vein is normal.
- Gall Bladder:** Lumen is clear. Wall thickness is normal. CBD is normal.
- Pancreas:** Normal in size & echotexture.
- Spleen:** Normal in size & echotexture. No focal lesion seen.
- Right Kidney:** Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.
- Left Kidney:** Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.
- Urinary Bladder:** Normal in size, shape & volume. No obvious calculus or mass lesion is seen. Wall thickness is normal.
- Prostate:** Is normal in size and echotexture.
- Others:** No significant free fluid is seen in pelvic peritoneal cavity.

IMPRESSION: USG findings are suggestive of

- **Fatty liver.**

Correlate clinically & with other related investigations.



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