

Name: MR Ramesh Chand
 UHID: 12385677 Date: 29-2-2024
 Age: 54 years Gender: male

Nursing Assessment

Profile	
Height (cm): <u>168 cm</u>	Waist Circumference (cm): <u>36 inch</u>
Weight (Kg): <u>69 kg</u>	Body Mass Index: <u>24.4 kg/m²</u>
Occupation:	Martial Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married

Vital Signs	
Pulse Rate (min): <u>62 b/min</u>	Respiratory Rate (min): <u>20 b/min</u>
Blood Pressure (mmHg): <u>130/75 mmHg</u>	Temperature (if febrile): <u>Afebrile</u>

Past History	
<input checked="" type="checkbox"/> Hypertension <u>since 2 years</u>	<input checked="" type="checkbox"/> Diabetes
<input checked="" type="checkbox"/> Heart disease	<input checked="" type="checkbox"/> Dyslipidemia
<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Tuberculosis
<input checked="" type="checkbox"/> Allergies:	
<input checked="" type="checkbox"/> Others: <u>Cholesterol since 2 years</u>	

For Women	
LMP:	Last Pap smear done in:
Menopause <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Last Mammography done in:
Consent for X-ray & Mammography	

Current Medications	
→ Tab Tazloc CT, 6.25 mg	OD
→ Tab Atchol 20 mg	1-15

Name: MR Ramesh Chand
UHID: 12385677 Date: 29-2-2024
Age: 54yrs Gender: male

Internal Medicine Consultation

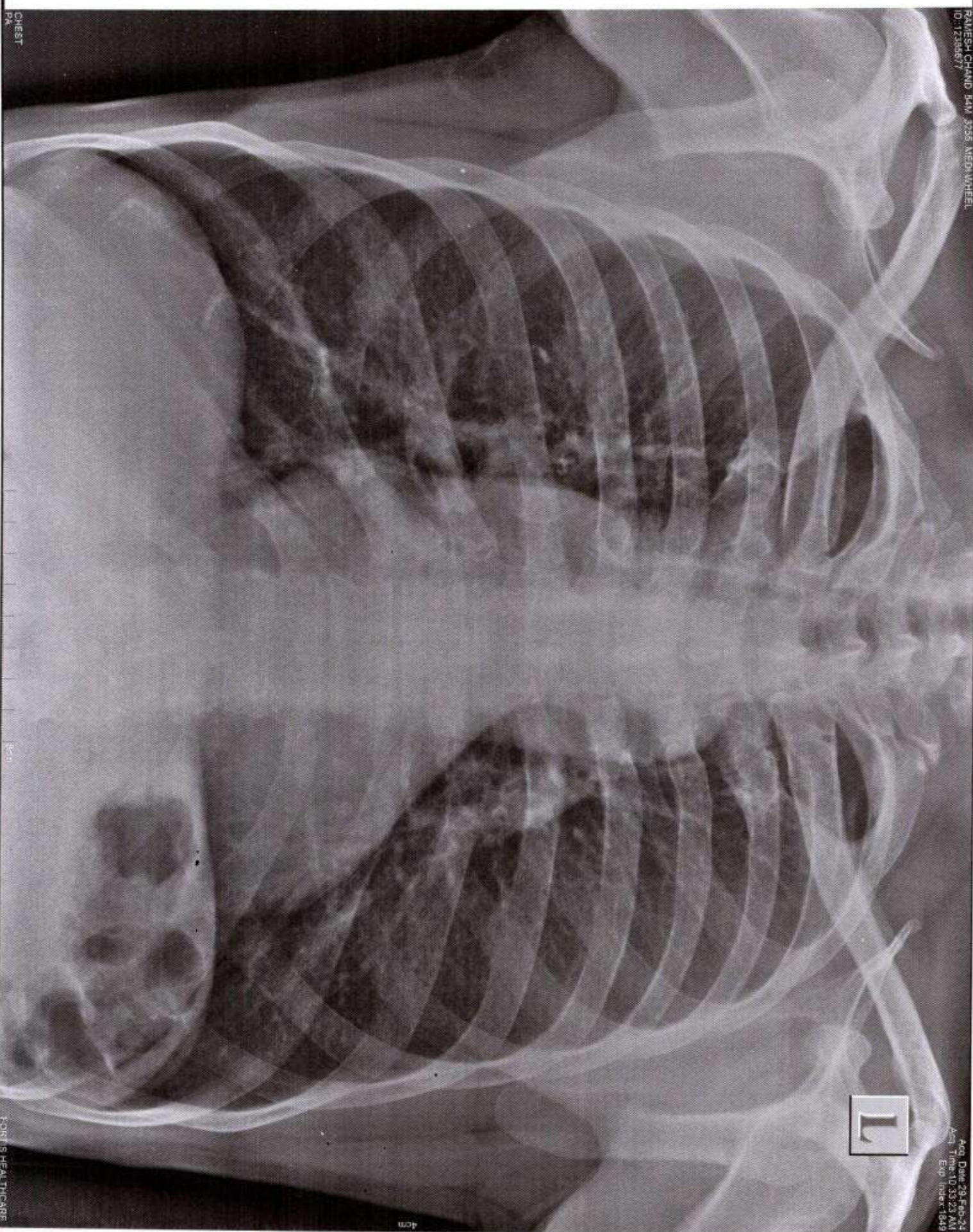
Relevant History:

Diagnosis

Investigations:

RAHESH CHAND BHV 3026 MED WHEEL
ID: 1235867

CHEST
PA



Acq Date: 29-Feb-23
Acq Time: 10:33:23 AM
Exp Index: 1849

FORTIS HEALTHCARE

43

Name: MR Ramesh Chand
 UHID: 12385677 Date: 29-2-2024
 Age: 54yr Gender: Male

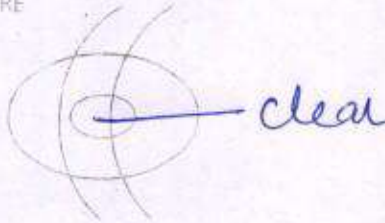
Ophthalmology Consultation

History: HT for 2yrs on Rx

Examination findings:

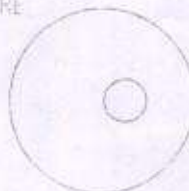
Visual acuity $\begin{cases} R \\ L \end{cases}$ 6/6 Visual acuity with glasses $\begin{cases} R \\ L \end{cases}$ 6/6 Colour Vision $\begin{cases} R \\ L \end{cases}$ WNL

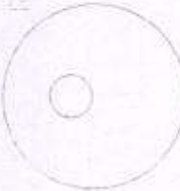
Slit Lamp Examination

RE  clear

LE  clear

Fundus Examination

RE 

LE 

Diagnosis: Presbyopia BE

Treatment:

Spectacle prescription:

Right eye

Left eye

	SPH	CYL	AXIS	VA
Distance				6/6
Near	<u>aided</u>			N/6

	SPH	CYL	AXIS	VA
Distance				6/6
Near	<u>aided</u>			N/6

Signature and stamp of the Ophthalmologist



Male

29.02.2024 10:08:07
Fortis Med Centre
sector 11
Chandigarh

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

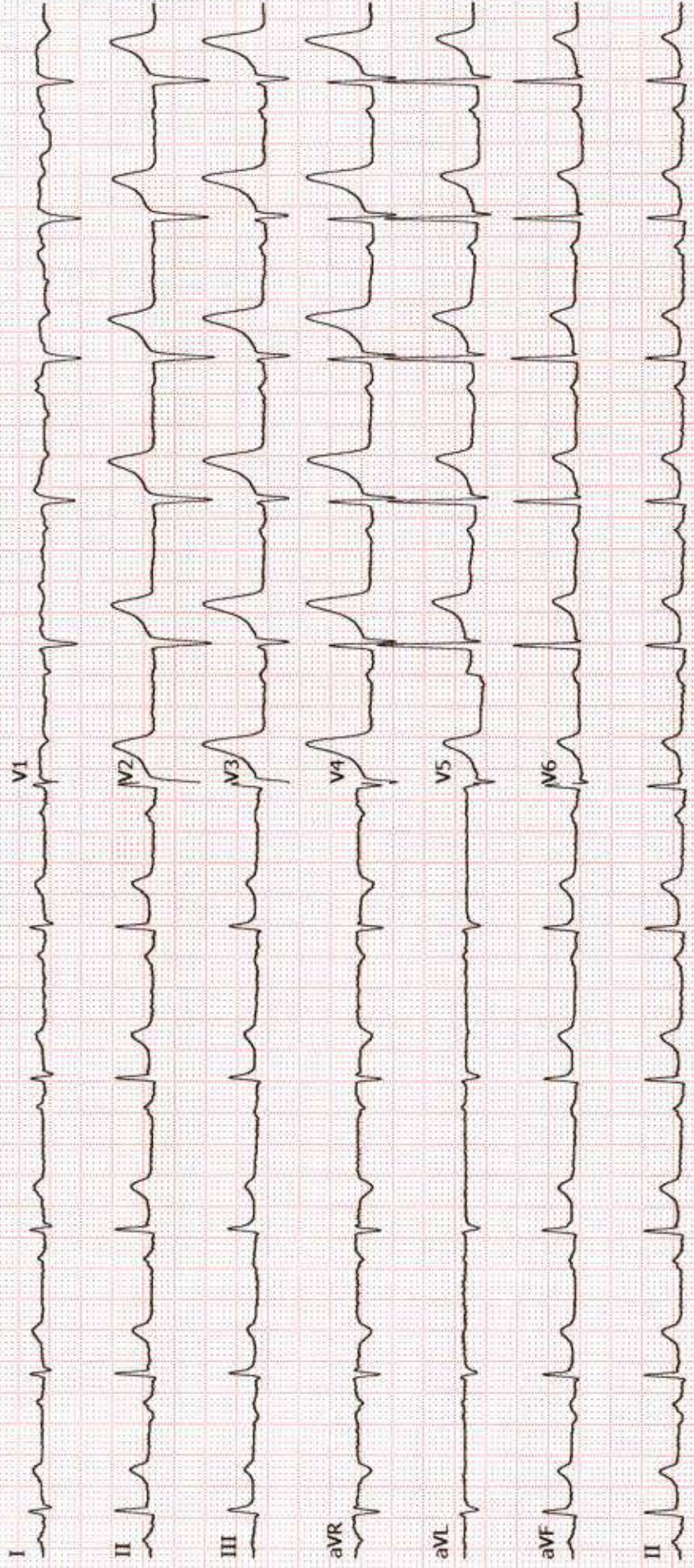
QRS : 76 ms
QT / QTcBaz : 392 / 407 ms
PR : 206 ms
P : 86 ms
RR / PP : 918 / 923 ms
P / QRS / T : 55 / 76 / 61 degrees

Normal sinus rhythm
Normal ECG

65 bpm
- / - mmHg

Location:
Order Number:
Visit:
Indication:
Medication 1:
Medication 2:
Medication 3:

Room:



DEPARTMENT OF FMC-RADIOLOGY LAB

Date: 29/Feb/2024

Name: Mr. Ramesh Chand

UHID | Episode No : 12385677 | 2630/24/10021

Age | Sex: 54 YEAR(S) | Male

Order No | Order Date: 10021/PN/OP/2402/6710 | 29-Feb-2024

Order Station : FRONTOFFICE-FMC

Admitted On | Reporting Date : 29-Feb-2024 10:46:36

Bed Name :

Order Doctor Name : Dr.SELF .

CHEST X-RAY (PA VIEW)

Unfolding arch of aorta.

Both the domes of diaphragm are normal.

Both costophrenic angles are normal.

Both lung fields are clear.

Cardiac size and silhouette are normal.

Both hila and mediastinum are normal.

Bony cage and soft tissues are normal.

Please correlate clinically and with other relevant investigations.

Dr. ADITI PANWAR

PMC - 41230

Consultant Radiologist

NAME: MR. RAMESH CHAND**AGE AND SEX: 54Y/M****UHID NO: 12385677****DATE:29/02/2024****ROI: WHOLE ABDOMEN**

Liver is normal in size, outline and echogenicity. No focal lesion seen. IHBR's are not dilated. Portal vein and hepatic veins are normal.

Gall bladder is normally distended with anechoic lumen. Wall thickness is normal. No calculus / focal lesion seen. No pericholecystic fluid / collection seen. CBD is normal.

Pancreas is visualized in region of head and proximal body and is normal in size, shape, outline and echotexture. No focal lesion seen. Distal body and tail are obscured by bowel gases.

Spleen is normal in size, outline and echotexture. No focal lesion seen.

Right kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.


Left kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Retroperitoneum is normal.

The urinary bladder is fully distended and is normal in outline and wall thickness. No calculi or growth seen. PVRU is insignificant .

Prostate is **enlarged (25.8 cc)** in size and shows normal outline and echo pattern. No focal lesion seen.

No free fluid is seen.

Opinion: Prostatomegaly Grade I**Suggested clinical correlation.****Dr. ADITI PANWAR****PMC - 41230****Consultant Radiologist**


RAMESH CHAND 54 M

Study Date: 29/02/2024

Patient ID: 12385677

Accession #:

Alt ID:

DOB:

Age:

Gender: M

Ht:

Wt:

BSA:

Institution: Fortis MEDCENTRE, Chandigarh

Referring Physician:

Physician of Record:

Performed By:

Comments:

Abdominal: Measurements and Calculations

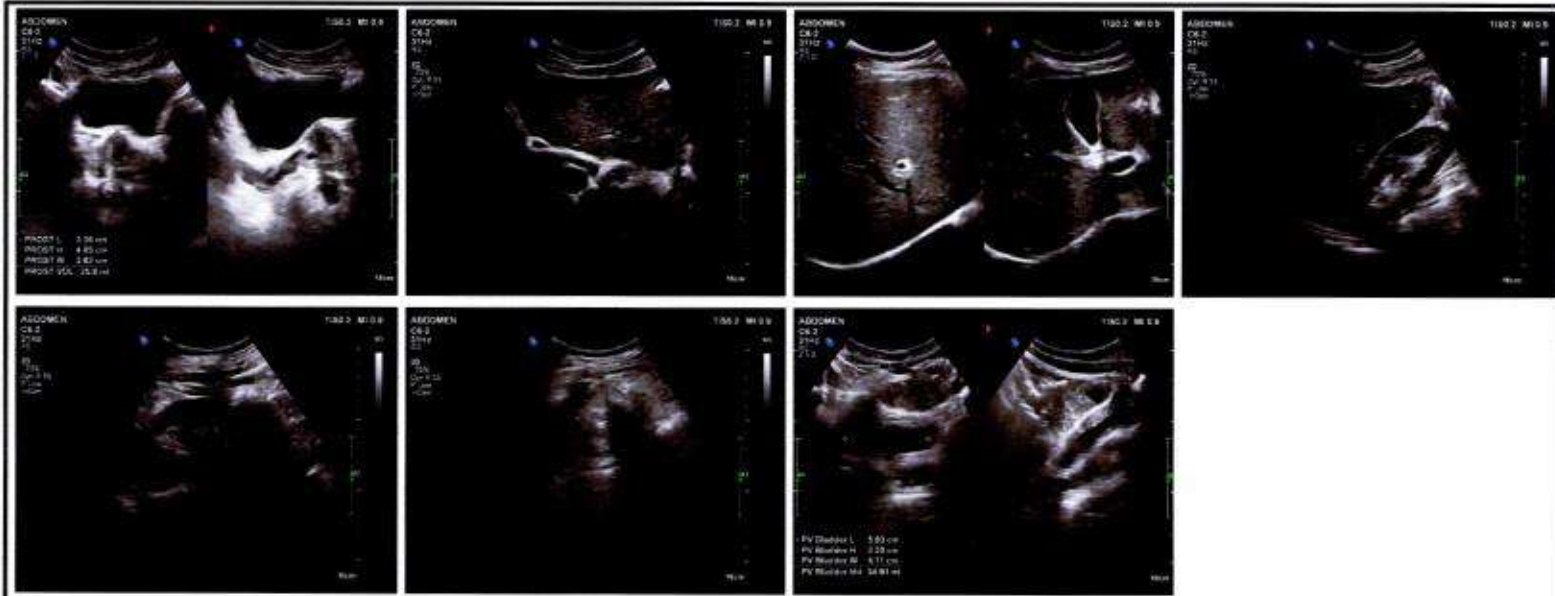
2D Abdominal Organs and Vessels

PV Bladder Vol	34.91 ml	PV Bladder H	2.20 cm
PV Bladder L	5.93 cm	PV Bladder W	5.11 cm

Other Measurements

<u>Abdomen General: Bladder Dimensions</u>	
PROST L	3.36 cm
PROST H	4.05 cm
PROST W	3.62 cm

Images



Signature

Signature:

Name(Print):

Date:

--Physician
SGO 11, Sector 11 D
Chandigarh

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Chand, Ramesh
Patient ID: 12385677
Height: 168 cm
Weight: 69 kg

DOB: 31.03.1969
Age: 54yrs
Gender: Male
Race: Indian

Study Date: 29.02.2024
Test Type: --
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR MANJEET/DR VIJAY HARJAI

Medications:
--

Medical History:
--

Reason for Exercise Test:
--

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:03	0.00	0.00	101		
	HYPERV.	00:03	0.00	0.00	101		
	WARM-UP	02:15	1.60	0.00	107	130/75	
EXERCISE	STAGE 1	03:00	2.70	10.00	105	131/75	
	STAGE 2	03:00	4.00	12.00	108	130/75	
	STAGE 3	03:00	5.50	14.00	117	140/75	
	STAGE 4	00:35	6.80	16.00	123		
RECOVERY		04:20	0.00	6.20	107	130/75	

The patient exercised according to the BRUCE for 9:34 min:s, achieving a work level of Max. METS: 12.00. The resting heart rate of 101 bpm rose to a maximal heart rate of 126 bpm. This value represents 75% of the maximal, age-predicted heart rate. The resting blood pressure of 130/75 mmHg, rose to a maximum blood pressure of 140/75 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: see 12SL interpretation.

Functional Capacity: normal.

HR Response to Exercise: attenuated secondary to medication.

BP Response to Exercise: normal resting BP - exaggerated response, normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

Conclusions

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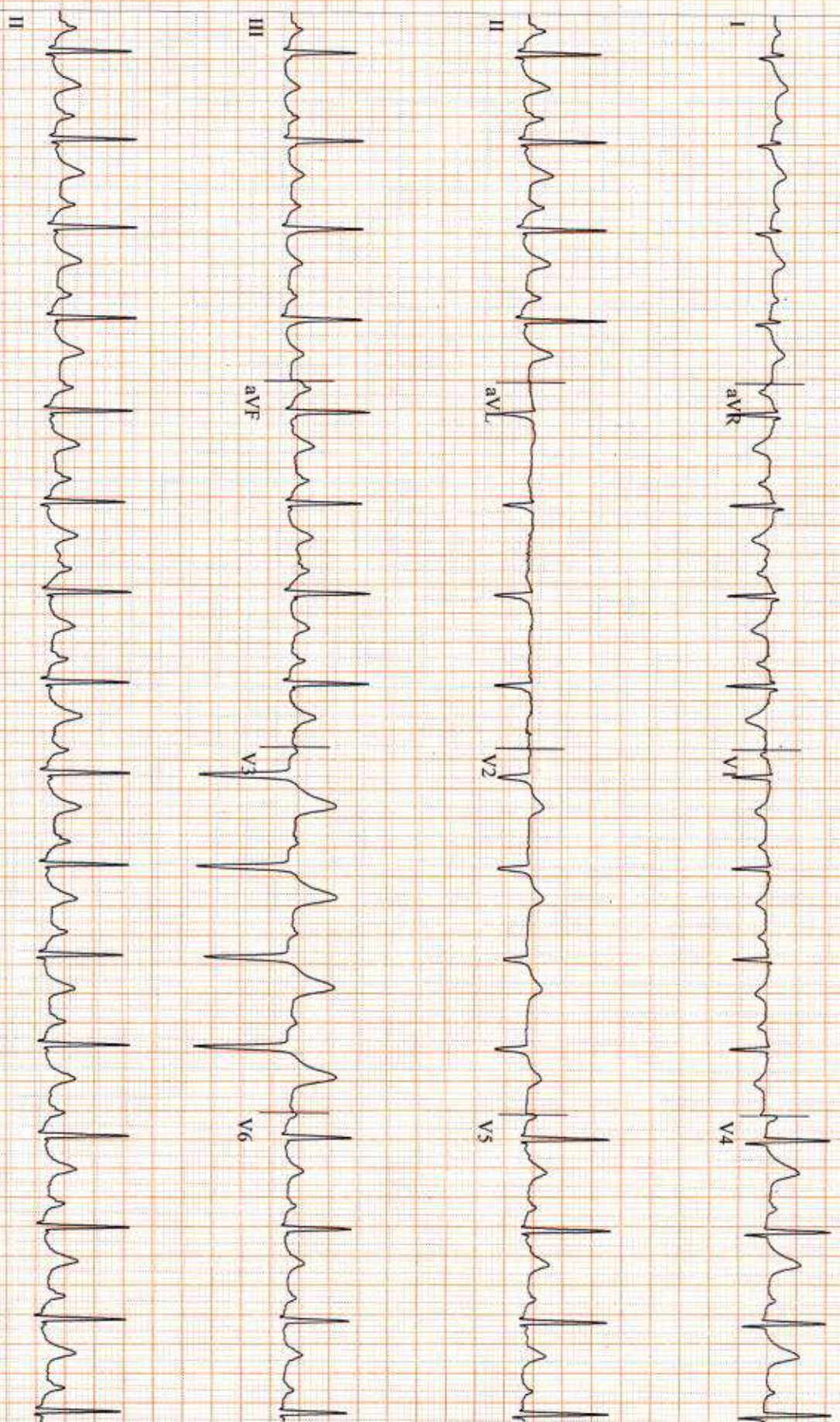
Physician _____

Chand, Ramesh
Patient ID 12385677
29.02.2024
12:22:24pm

12-Lead Report
PRETEST
WARM-UP
01:06

BRUCE
0.0 km/h
0.0 %

100 bpm



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V4,II)

Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:26:21pm

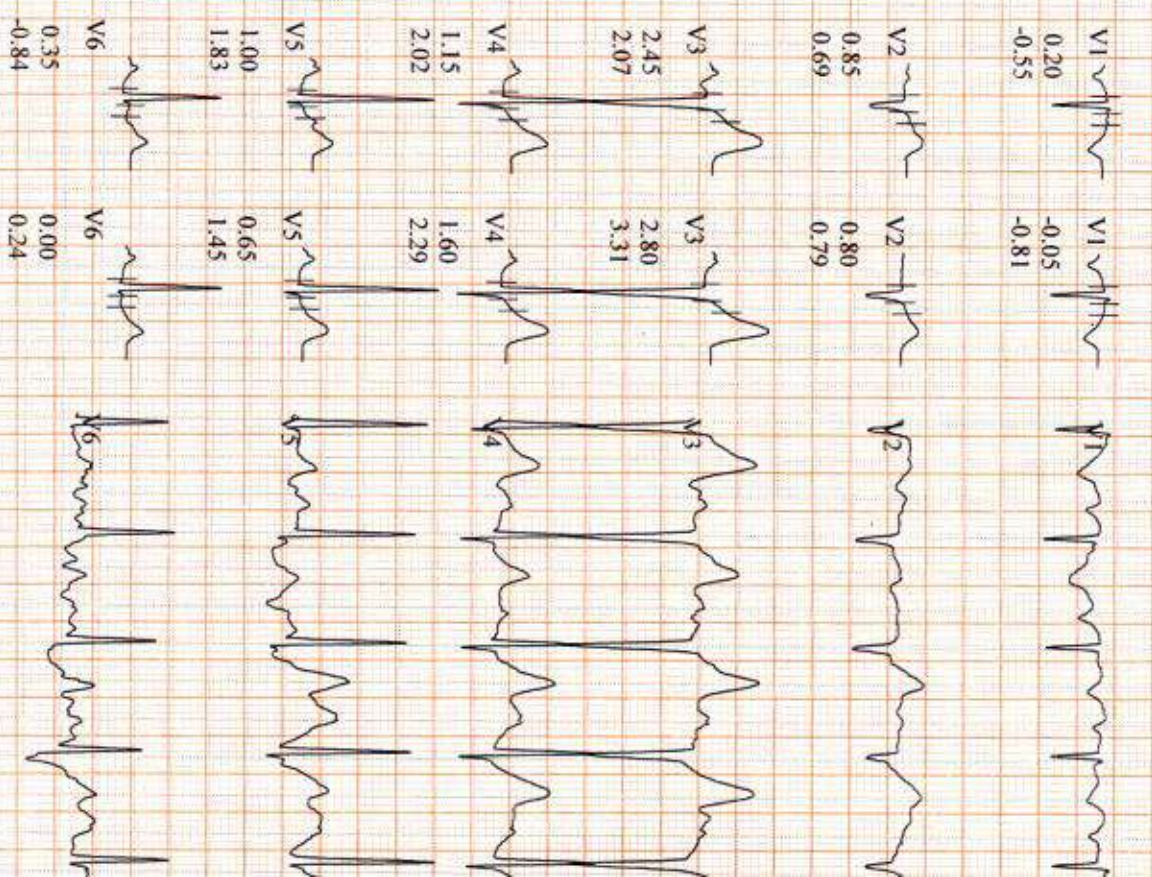
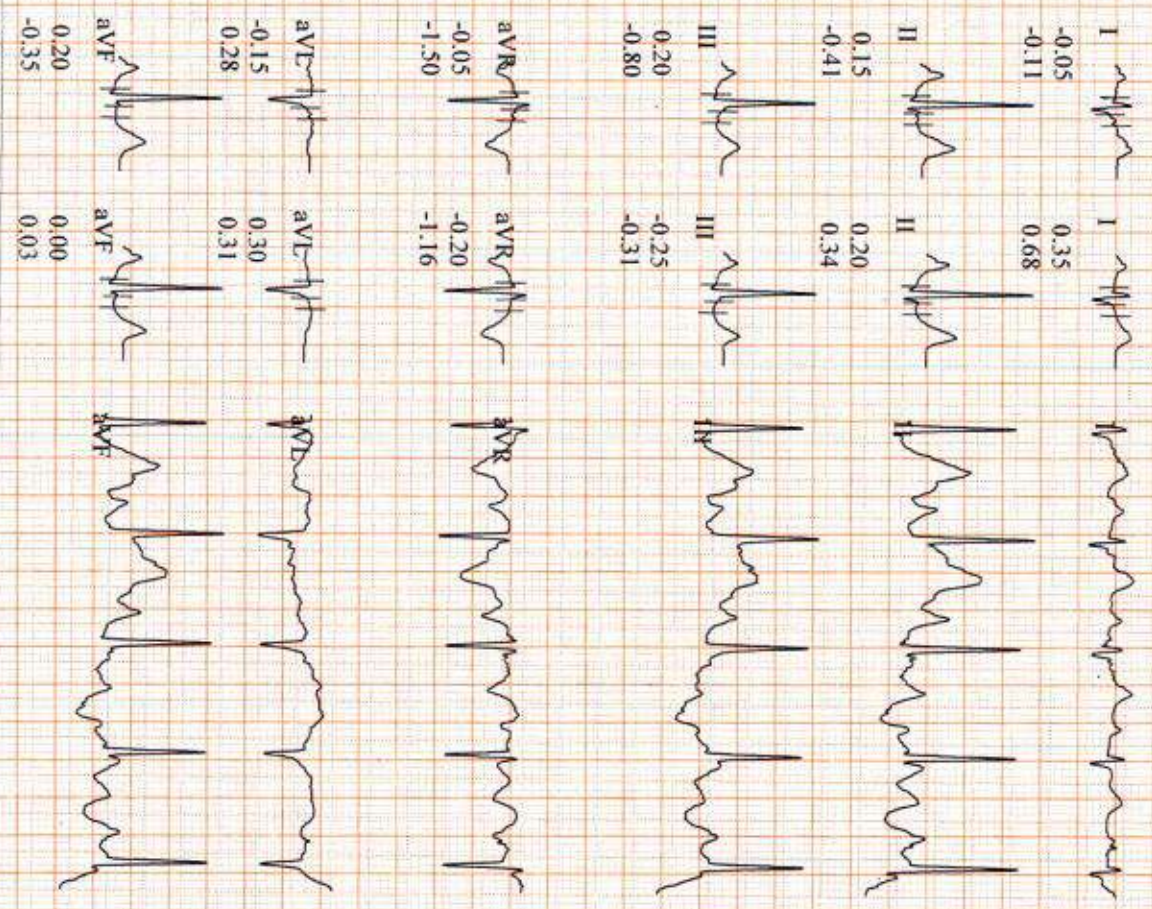
104 bpm
 131/75 mmHg

Comparative Medians Report
 EXERCISE
 STAGE 1
 02:50

BRUCE
 2.7 km/h
 10.0 %

BASELINE
 60 ms post J

CURRENT
 60 ms post J



Lead
 ST Level (mm)
 ST Slope (mV/s)

GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V4,II)

Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:29:21pm

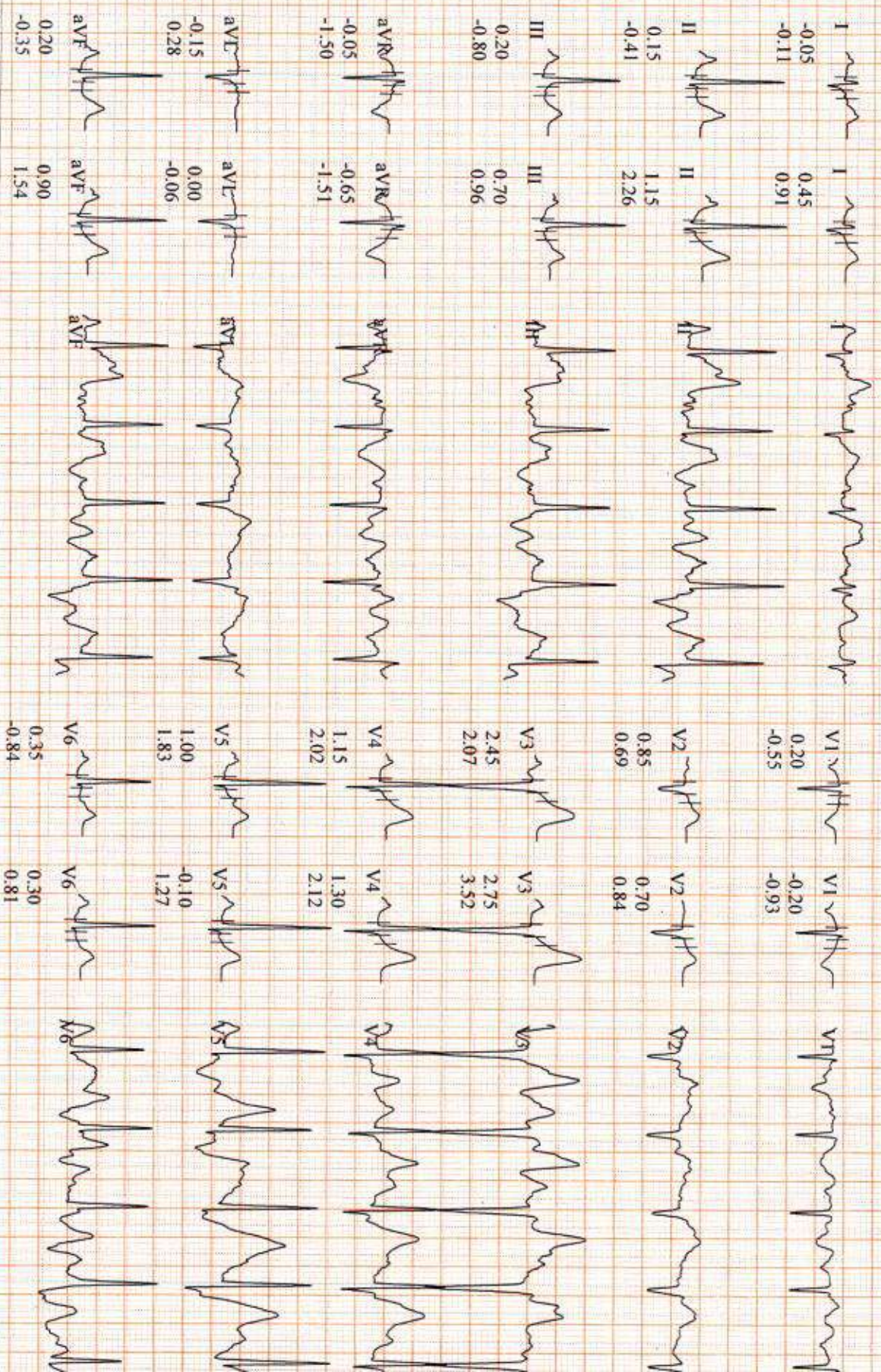
Comparative Medians Report
 EXERCISE
 STAGE 2
 05:50
 110 bpm
 130/75 mmHg

BRUCE
 4.0 km/h
 12.0%

BASELINE
 60 ms post J

CURRENT
 60 ms post J

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V4,II)

Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:32:21pm

118 bpm
 140/75 mmHg

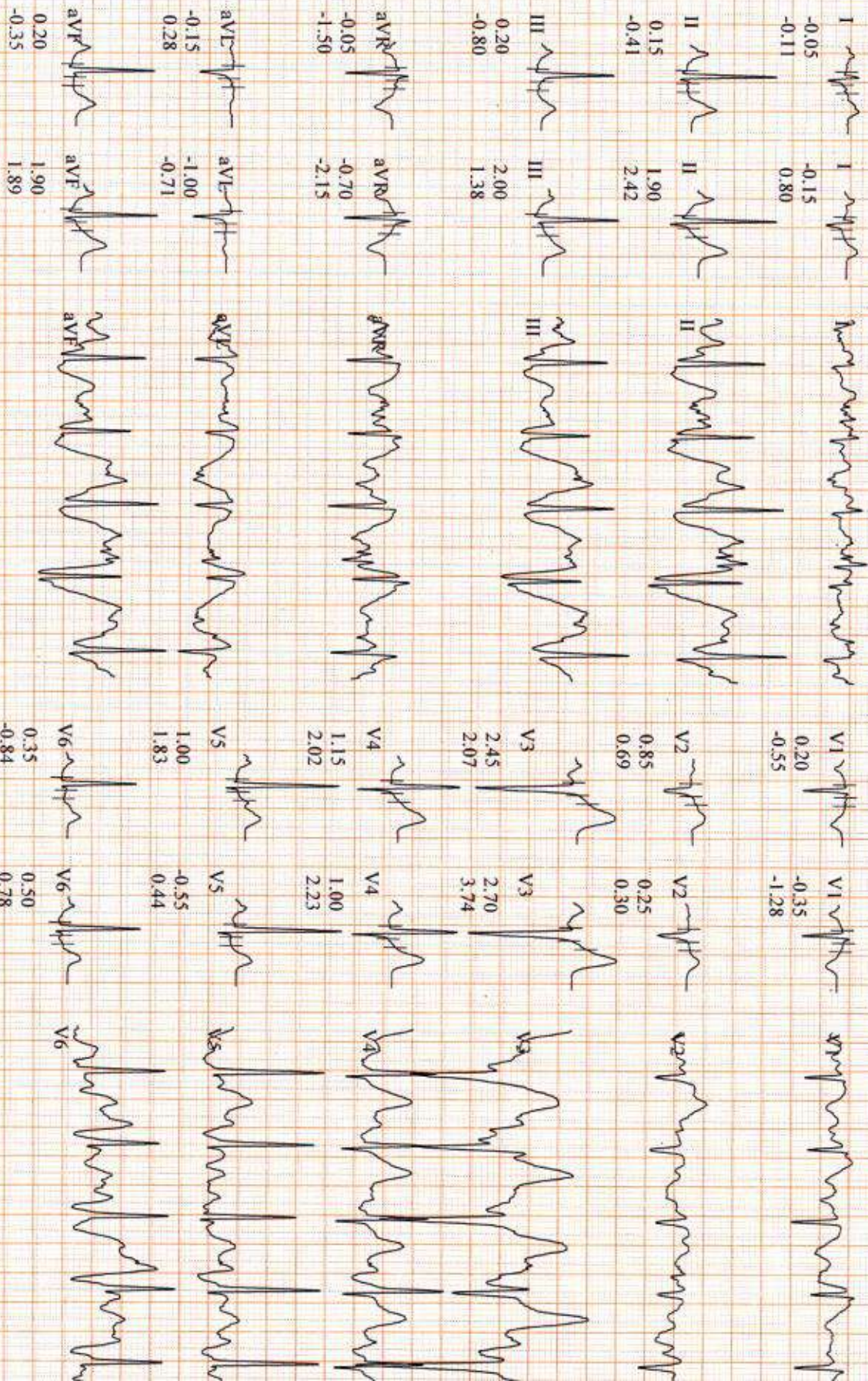
Comparative Medians Report
 EXERCISE
 STAGE 3
 08:50

BRUCE
 5.5 km/h
 14.0%

BASELINE
 60 ms post J

CURRENT
 60 ms post J

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V4,V5)

Start of Test: 12:21:13pm

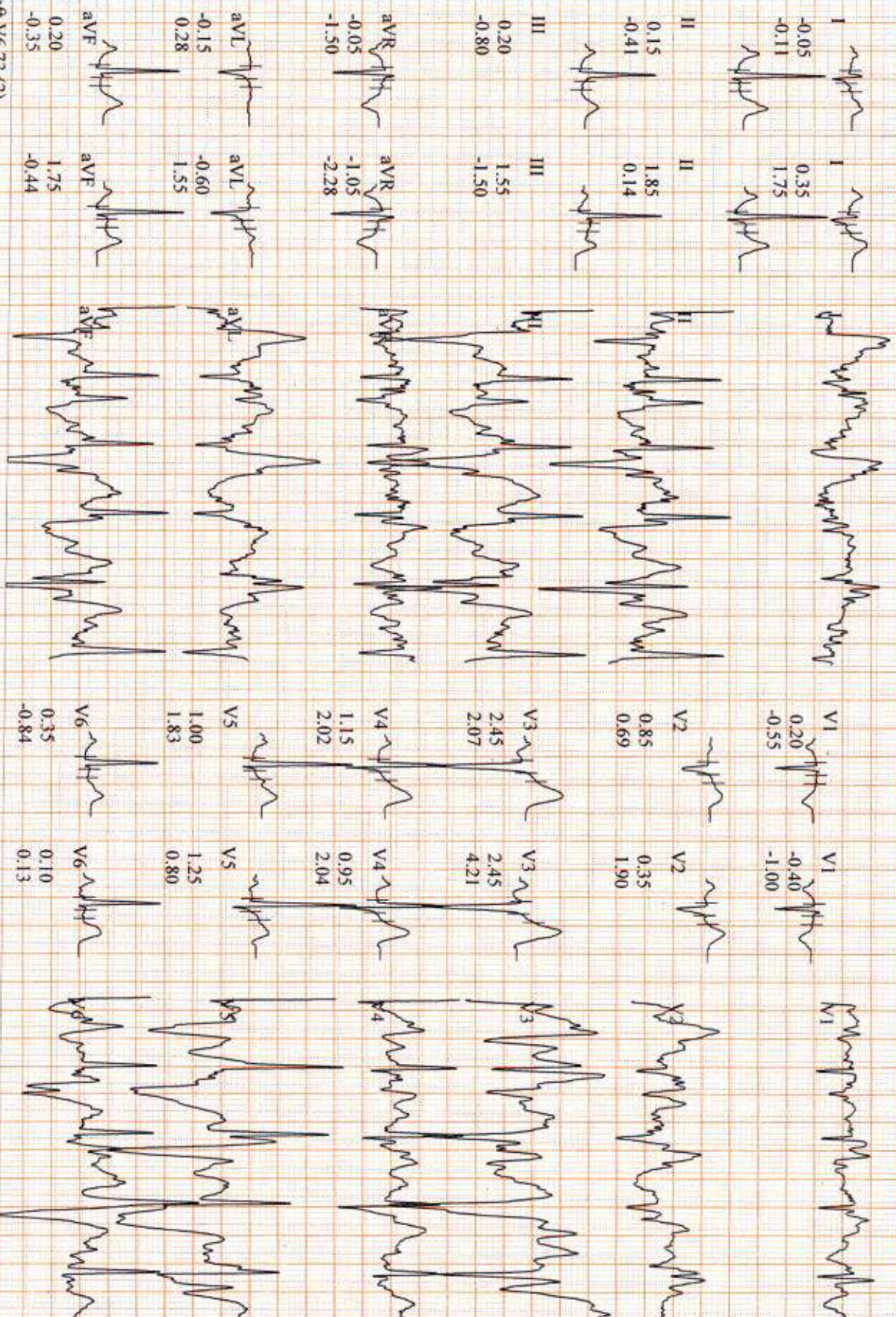
Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:33:06pm

123 bpm

Comparative Medians Report (PEAK EXERCISE)
 EXERCISE STAGE 4
 09:35
 BRUCE 6.8 km/h
 16.0 %

BASELINE 60 ms post J
 CURRENT 60 ms post J

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V4,V5)

Start of Test: 12:21:13pm

Chand, Ramesh

Patient ID 12385677

29.02.2024

12:33:55pm

Comparative Medians Report

RECOVERY #1

00:50

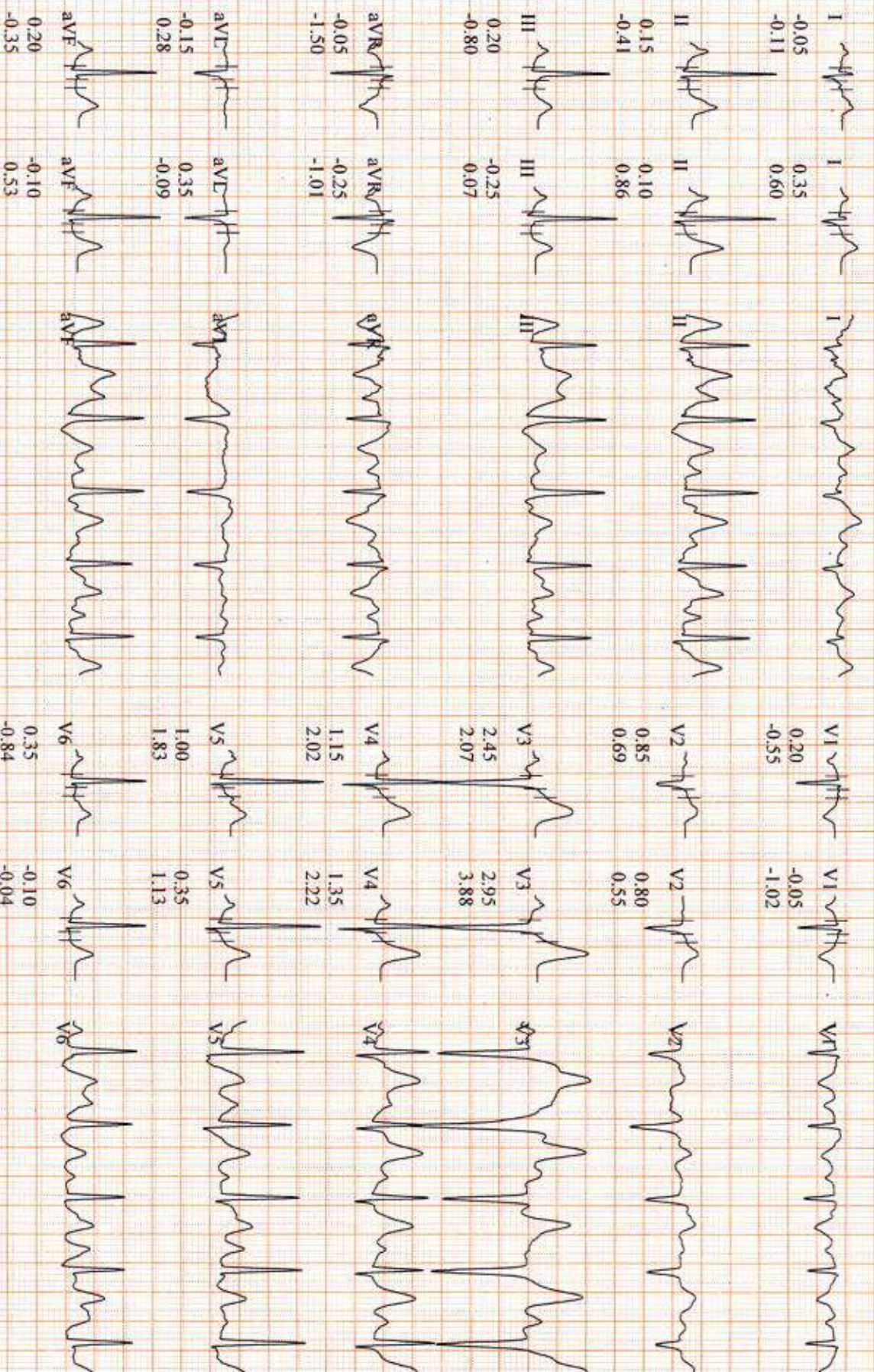
BRUCE 2.4 km/h 6.2 %

120 bpm

Lead
ST Level (mm)
ST Slope (mV/s)

BASELINE
60 ms post J

CURRENT
60 ms post J



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(V4,V5)

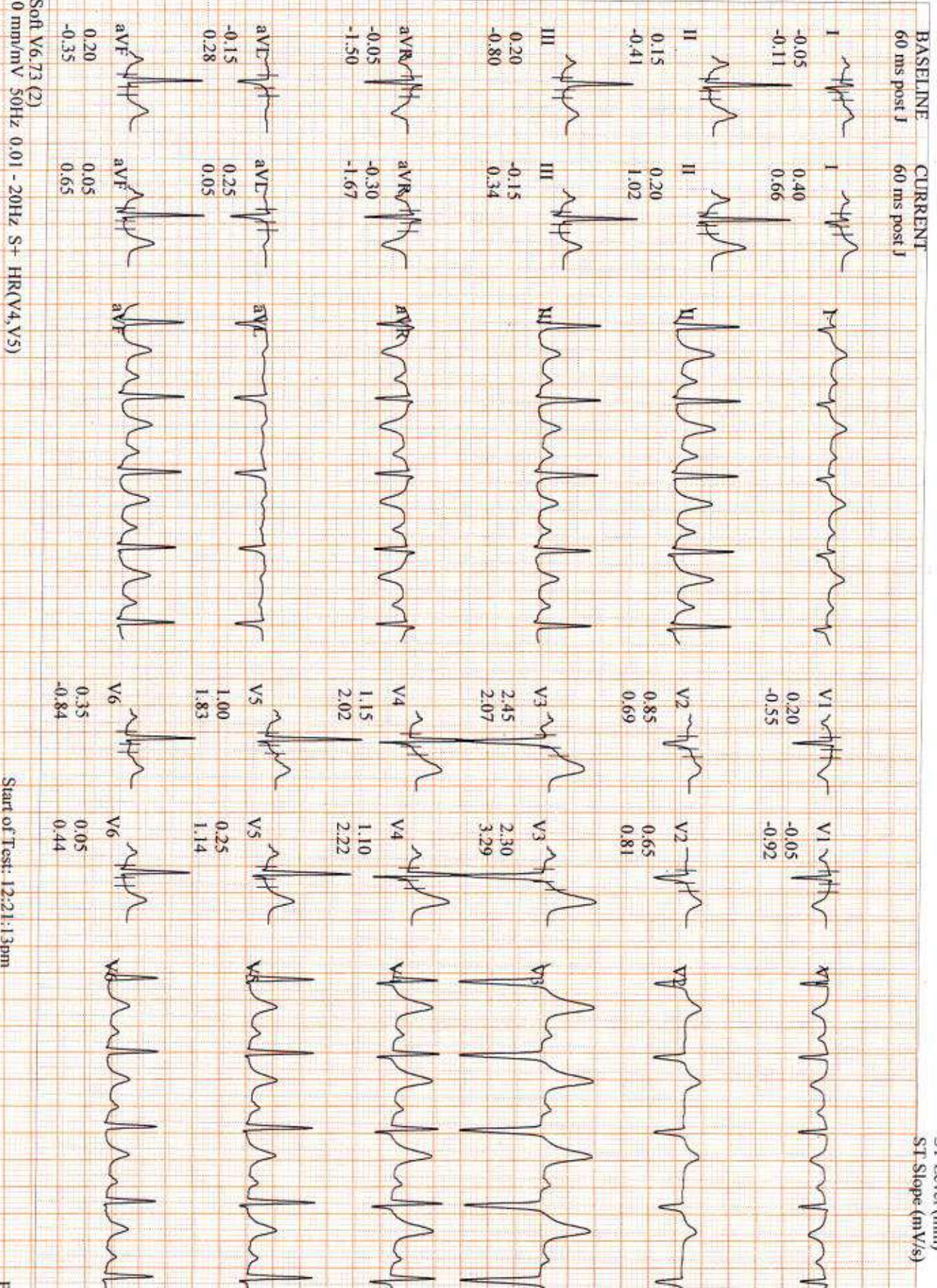
Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:34:55pm

Comparative Medians Report
 RECOVERY #1
 108 bpm
 01:50

BRUCE
 0.0 km/h
 6.1 %

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(V4,V5)

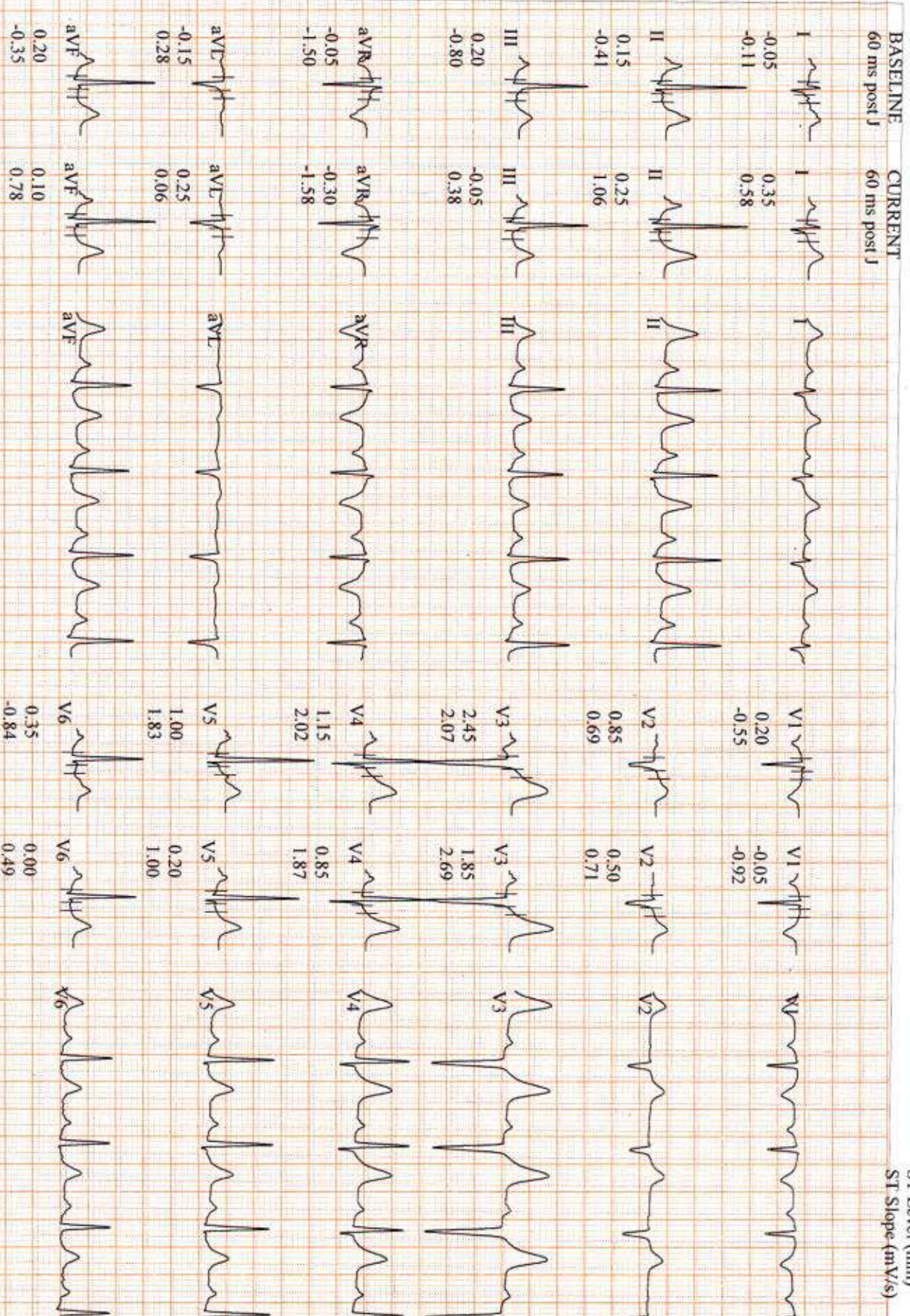
Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:35:55pm

Comparative Medians Report
 RECOVERY #1
 99 bpm
 02:50

BRUCE
 0.0 km/h
 6.2 %

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(V4,V5)

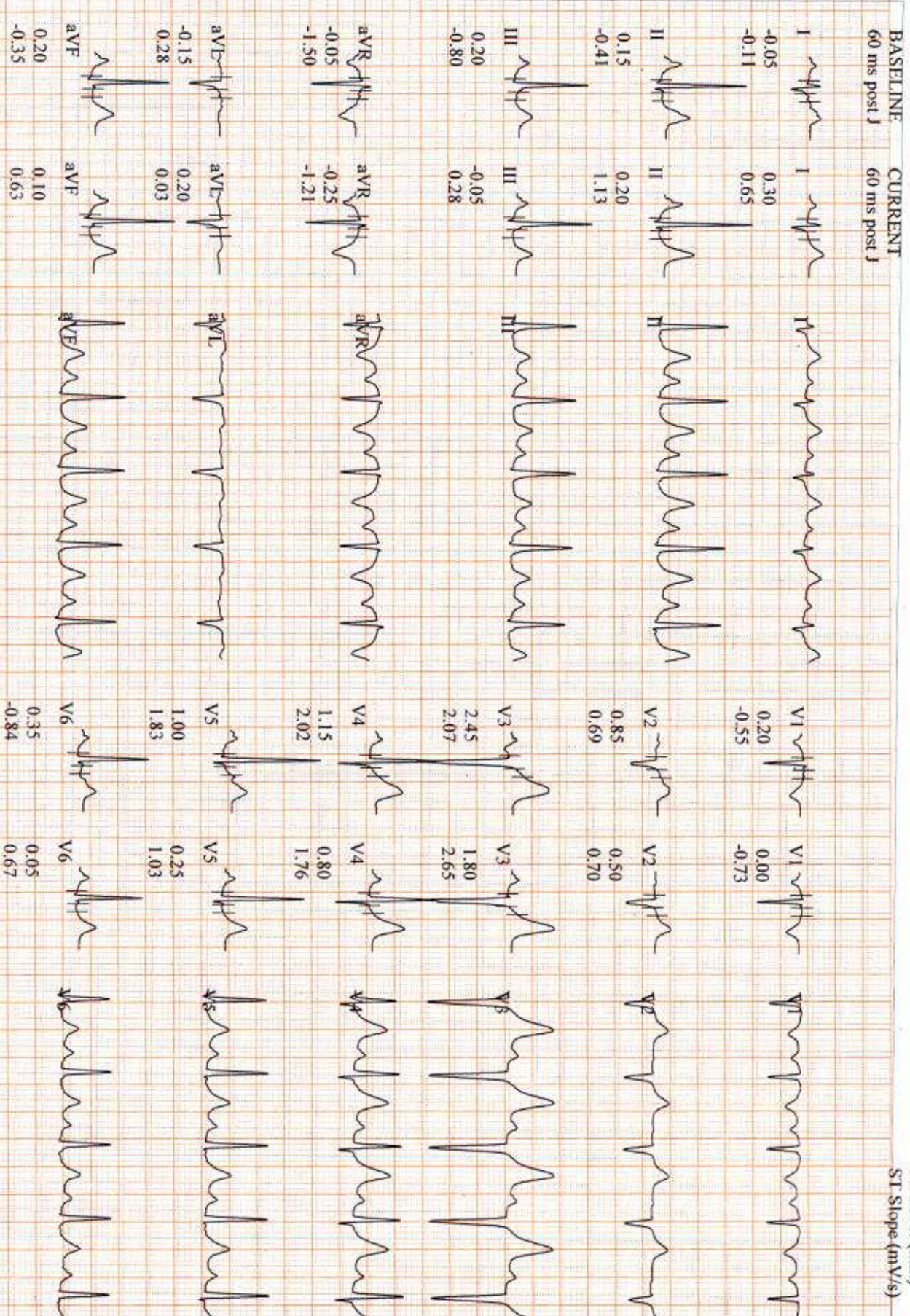
Start of Test: 12:21:13pm

Chand, Ramesh
 Patient ID 12385677
 29.02.2024
 12:36:55pm

Comparative Medians Report
 RECOVERY #1
 111 bpm
 140/75 mmHg
 03:50

BRUCE
 0.0 km/h
 6.3 %

Lead
 ST Level (mm)
 ST Slope (mV/s)



GE CardioSoft V6.73 (2)
 25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(V4, V5)

Start of Test: 12:21:13pm

PATIENT NAME : RAMESH CHAND

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS
 FORTIS MOHALI-CHC -SPLZD
 FORTIS HOSPITAL - MOHALI,
 MOHALI 160062
 7087030817

ACCESSION NO : **0006XB029400**
 PATIENT ID : FH.12385677
 CLIENT PATIENT ID: UID:12385677
 ABHA NO :

AGE/SEX : 54 Years Male
 DRAWN : 29/02/2024 10:20:00
 RECEIVED : 29/02/2024 14:37:14
 REPORTED : 04/03/2024 11:25:55

CLINICAL INFORMATION :

UID:12385677 REQNO-1669336
 CORP-OPD
 BILLNO-1002124OPCS003255
 BILLNO-1002124OPCS003255

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

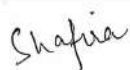
HEMOGLOBIN (HB)	15.1	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.67	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	9.31	4.0 - 10.0	thou/ μ L
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	268	150 - 410	thou/ μ L
METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	48.7	40.0 - 50.0	%
METHOD : HYDRODYNAMIC FOCUSING			
MEAN CORPUSCULAR VOLUME (MCV)	104.3 High	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	32.3 High	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	31.0 Low	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	14.3 High	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	22.3		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	10.0	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			



Dr. Subhijit kaur (MD, Pathology)
 Senior Resident, 49300



Dr. Shafira Garg (MD, Pathology)
 Attending Consultant, 47150



Dr. Irneet Mundi (MD,DNB
 Pathology)
 Associate Consultant, 34080

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View Details



View Report

PERFORMED AT :

CLINICAL LABORATORY
 Fortis Heart Institute & Multispeciality Hospital, Sector 62, Phase VIII,
 Mohali, 160062
 Punjab, India
 Tel : 0172-469-2222 Extn. 6726, 6727), Fax : 0172-469-2221 - CIN -
 L85110DL1996PLC076704
 Email : lab.mohali@fortishealthcare.com



ULR No.6000003302910-0006



PATIENT NAME : RAMESH CHAND

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL - MOHALI, MOHALI 160062 7087030817	ACCESSION NO : 0006XB029400	AGE/SEX : 54 Years Male
	PATIENT ID : FH.12385677	DRAWN : 29/02/2024 10:20:00
	CLIENT PATIENT ID: UID: 12385677	RECEIVED : 29/02/2024 14:37:14
	ABHA NO :	REPORTED : 04/03/2024 11:25:55

CLINICAL INFORMATION :

UID:12385677 REQNO-1669336
 CORP-OPD
 BILLNO-1002124OPCS003255
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Test Report Status	Final	Results	Biological Reference Interval	Units
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WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	58	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	24	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	12 High	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	6	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	00	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	5.40	2.0 - 7.0	thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.23	1.0 - 3.0	thou/ μ L
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	1.12 High	0.2 - 1.0	thou/ μ L
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.56 High	0.02 - 0.50	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	2.4		

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.

Dr. Subhijit kaur (MD, Pathology)
 Senior Resident, 49300

Dr. Shafira Garg (MD, Pathology)
 Attending Consultant,47150

Dr. Irneet Mundi (MD,DNB Pathology)
 Associate Consultant, 34080



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PERFORMED AT :

CLINICAL LABORATORY
 Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase VIII,
 Mohali, 160062
 Punjab, India
 Tel : 0172-469-2222 Extn. 6726, 6727), Fax : 0172-469-2221 - CIN -
 L85110DL1996PLC076704
 Email : lab.mohali@fortishealthcare.com



ULR No.600003302910-0006

PATIENT NAME : RAMESH CHAND

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL - MOHALI, MOHALI 160062 7087030817	ACCESSION NO : 0006XB029400 PATIENT ID : FH.12385677 CLIENT PATIENT ID: UID:12385677 ABHA NO :	AGE/SEX : 54 Years Male DRAWN : 29/02/2024 10:20:00 RECEIVED : 29/02/2024 14:37:14 REPORTED : 04/03/2024 11:25:55
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CORP-OPD
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Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	05	0 - 14	mm at 1 hr
-------	----	--------	------------

METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.7	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)	%
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	116.9 High	< 116.0	mg/dL
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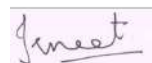
METHOD : CALCULATED PARAMETER



Dr. Subhijit kaur (MD, Pathology)
Senior Resident, 49300



Dr. Shafira Garg (MD, Pathology)
Attending Consultant, 47150



Dr. Irneet Mundi (MD,DNB
Pathology)
Associate Consultant, 34080

Page 3 Of 21



View Details



View Report

PERFORMED AT :

CLINICAL LABORATORY
Fortis Heart Institute & Multispeciality Hospital, Sector 62, Phase VIII,
Mohali, 160062
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ULR No.6000003302910-0006



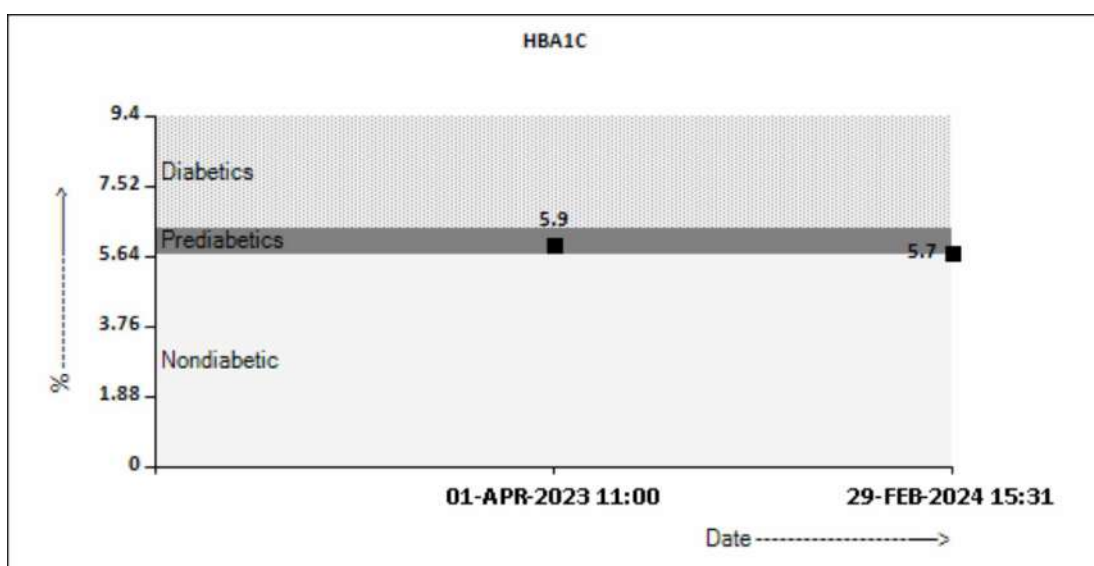
PATIENT NAME : RAMESH CHAND **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL - MOHALI, MOHALI 160062 7087030817	ACCESSION NO : 0006XB029400 PATIENT ID : FH.12385677 CLIENT PATIENT ID: UID:12385677 ABHA NO :	AGE/SEX : 54 Years Male DRAWN : 29/02/2024 10:20:00 RECEIVED : 29/02/2024 14:37:14 REPORTED : 04/03/2024 11:25:55
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CLINICAL INFORMATION :

UID:12385677 REQNO-1669336
CORP-OPD
BILLNO-1002124OPCS003255
BILLNO-1002124OPCS003255

Test Report Status	Final	Results	Biological Reference Interval	Units
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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,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

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Dr. Shafira Garg (MD, Pathology)
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Dr. Irneet Mundi (MD,DNB Pathology)
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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 $eAG \text{ (mg/dl)} = 28.7 * HbA1c - 46.7$

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

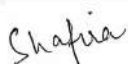
a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

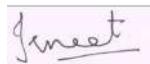
c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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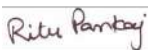
BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.75	UPTO 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.19	0.00 - 0.30	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.56	0.00 - 0.60	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.2	6.6 - 8.7	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN	4.5	3.97 - 4.94	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.7	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.7	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	22	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	14	0 - 41	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	70	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	23	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE UV	178	135 - 225	U/L

GLUCOSE FASTING, FLUORIDE PLASMA

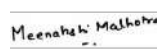
FBS (FASTING BLOOD SUGAR)	91	74 - 106	mg/dL
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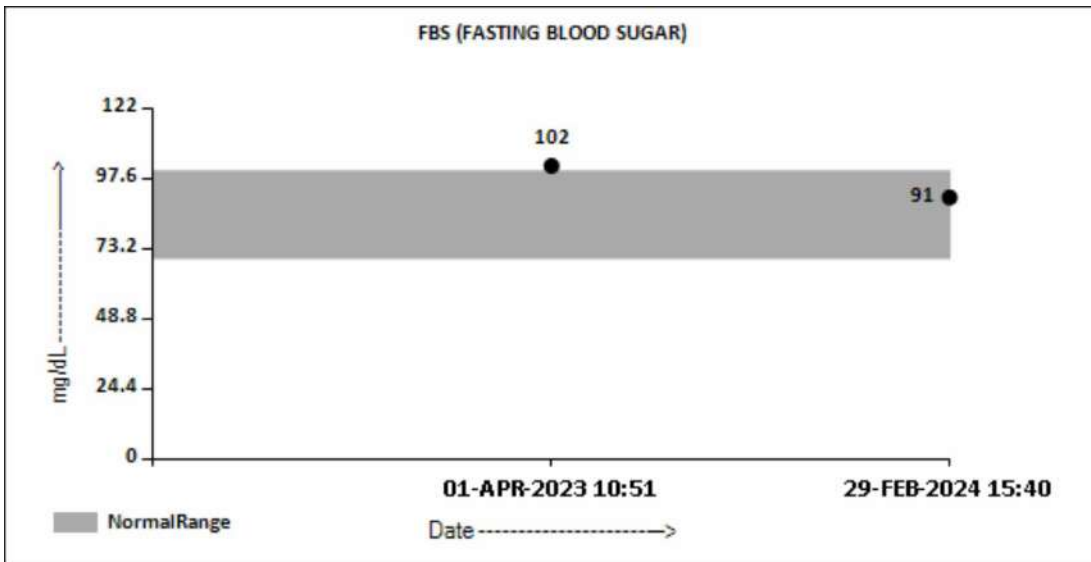
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METHOD : HEXOKINASE



BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	9	6 - 20	mg/dL
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METHOD : UREASE - UV

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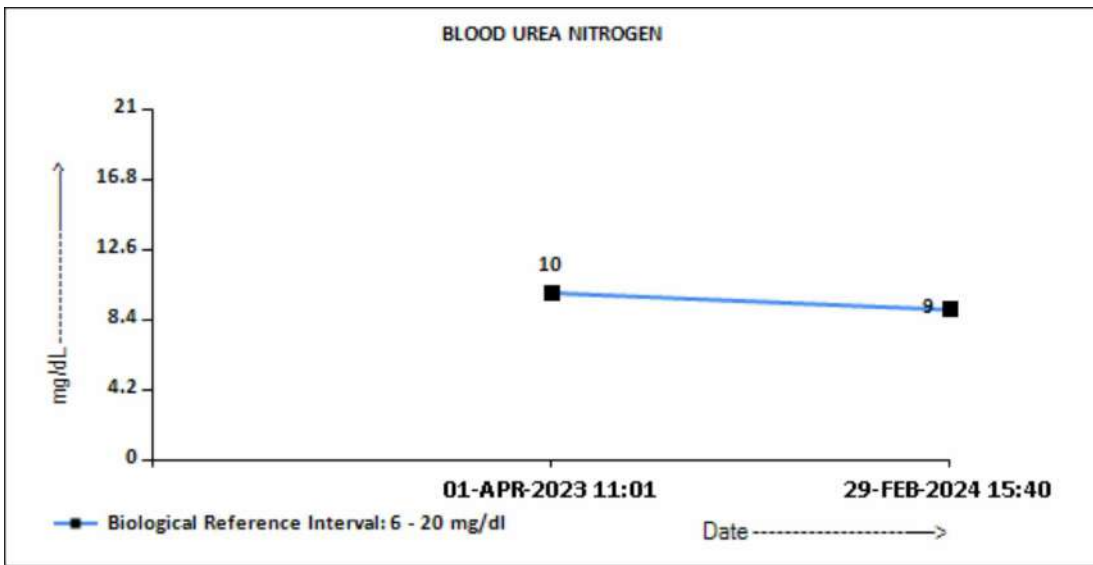
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URIC ACID, SERUM

URIC ACID	6.5	3.4 - 7.0	mg/dL
METHOD : URICASE, COLORIMETRIC			

CREATININE EGFR

CREATININE	0.70	0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC			
AGE	54		years

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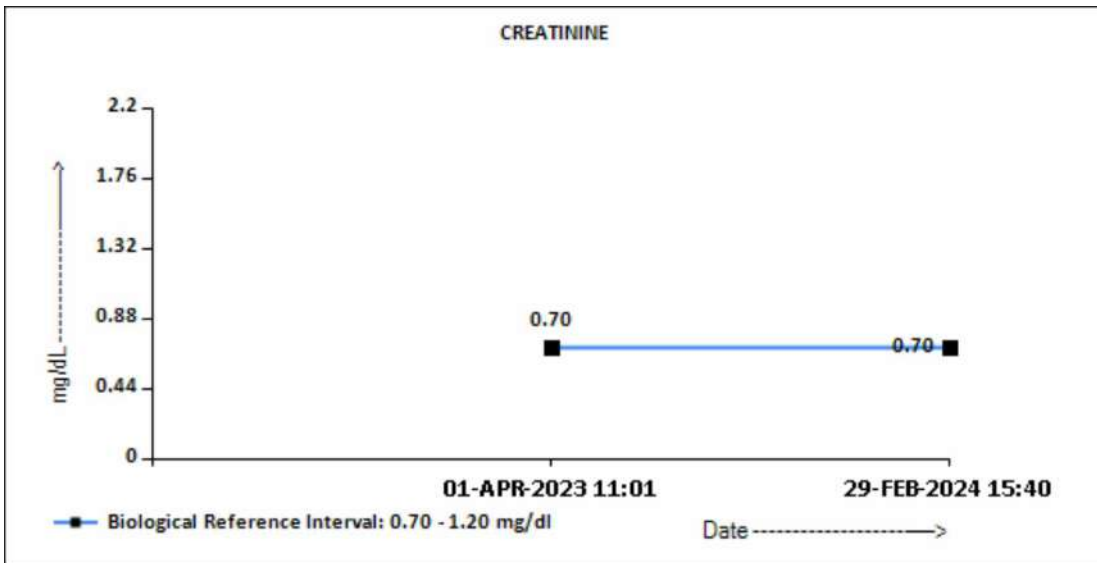
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GLOMERULAR FILTRATION RATE (MALE)	109	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)
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Interpretation(s)

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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; sulfonylureas, 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 glycemic 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.

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

GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE	215 High	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES METHOD : ENZYMATIC ASSAY	138	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
HDL CHOLESTEROL METHOD : DIRECT MEASURE - PEG	42	< 40 Low >/=60 High	mg/dL
LDL CHOLESTEROL, DIRECT METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE	168 High	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL METHOD : CALCULATED PARAMETER	173 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN METHOD : CALCULATED PARAMETER	27.6	Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	5.1 High	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

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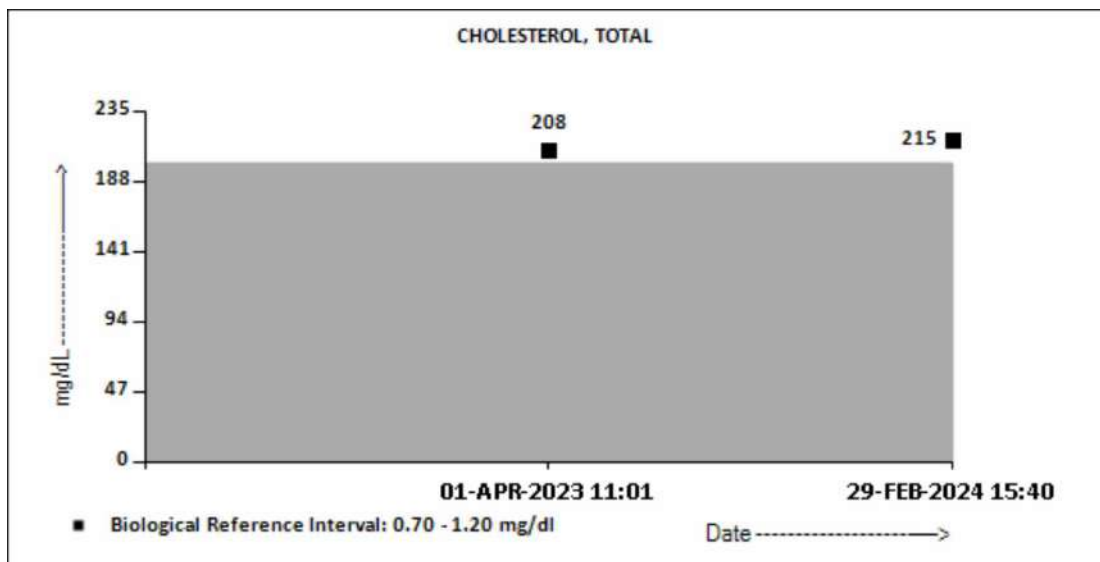
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LDL/HDL RATIO **4.0 High** 0.5 - 3.0 Desirable/Low Risk
 3.1 - 6.0 Borderline/Moderate Risk
 >6.0 High Risk

METHOD : CALCULATED PARAMETER



Hardeep Kaur
Ms. Hardeep Kaur, M.Sc.
Biochemistry

Meenakshi Malhotra
Dr. Meenakshi Malhotra (MD,
Pathology)
Senior Consultant,48159

Ritu Pankaj
Dr. Ritu Pankaj (MD,Pathology),
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Additional Director, 30897



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 Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase VIII,
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ULR No.6000003302910-0006



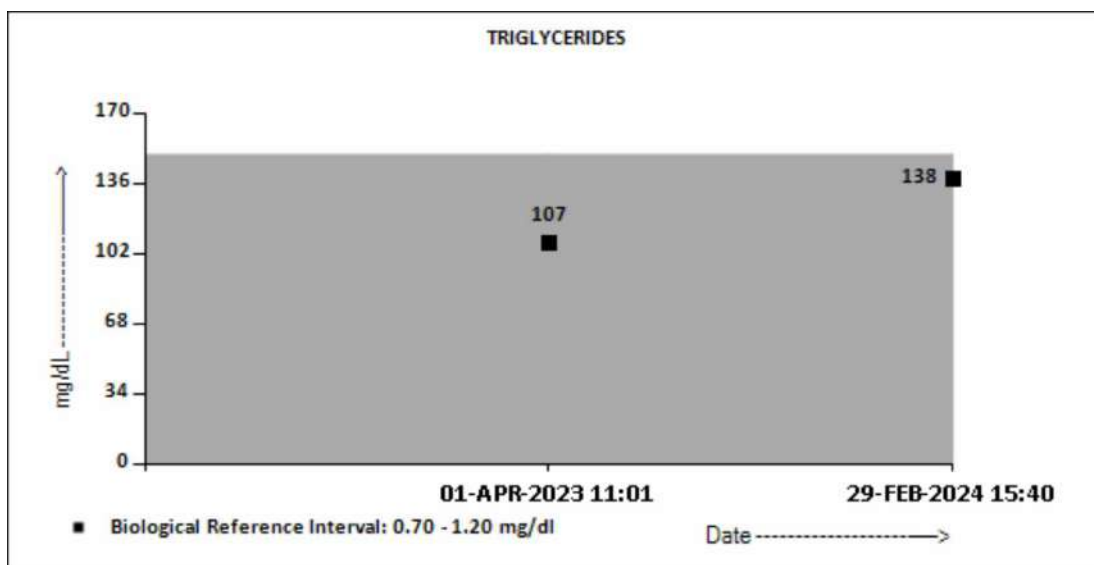
PATIENT NAME : RAMESH CHAND **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL - MOHALI, MOHALI 160062 7087030817	ACCESSION NO : 0006XB029400	AGE/SEX : 54 Years Male
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	CLIENT PATIENT ID: UID: 12385677	RECEIVED : 29/02/2024 14:37:14
	ABHA NO :	REPORTED : 04/03/2024 11:25:55

CLINICAL INFORMATION :

UID:12385677 REQNO-1669336
 CORP-OPD
 BILLNO-1002124OPCS003255
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Test Report Status	Final	Results	Biological Reference Interval	Units
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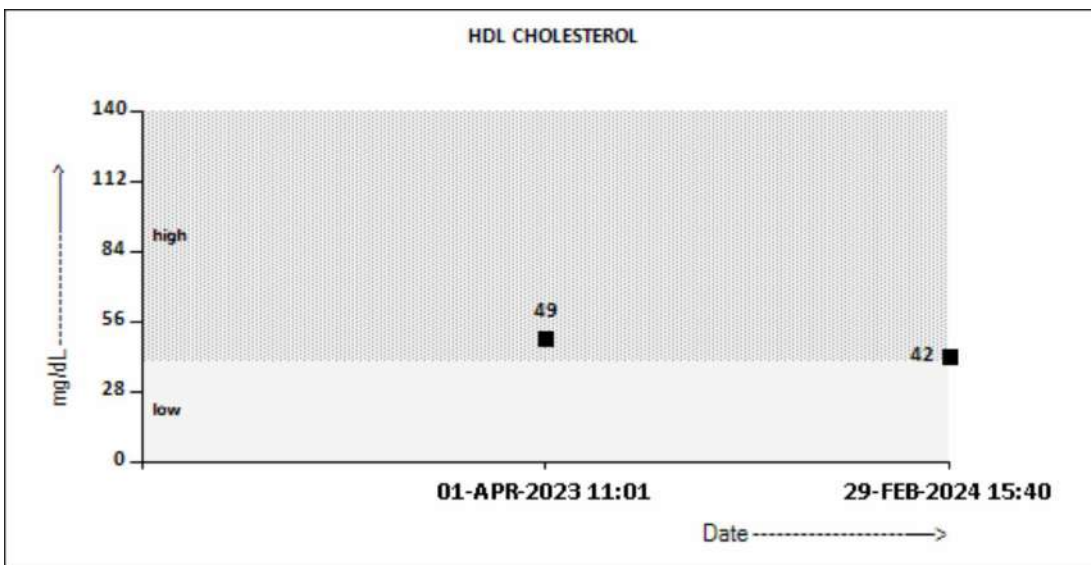
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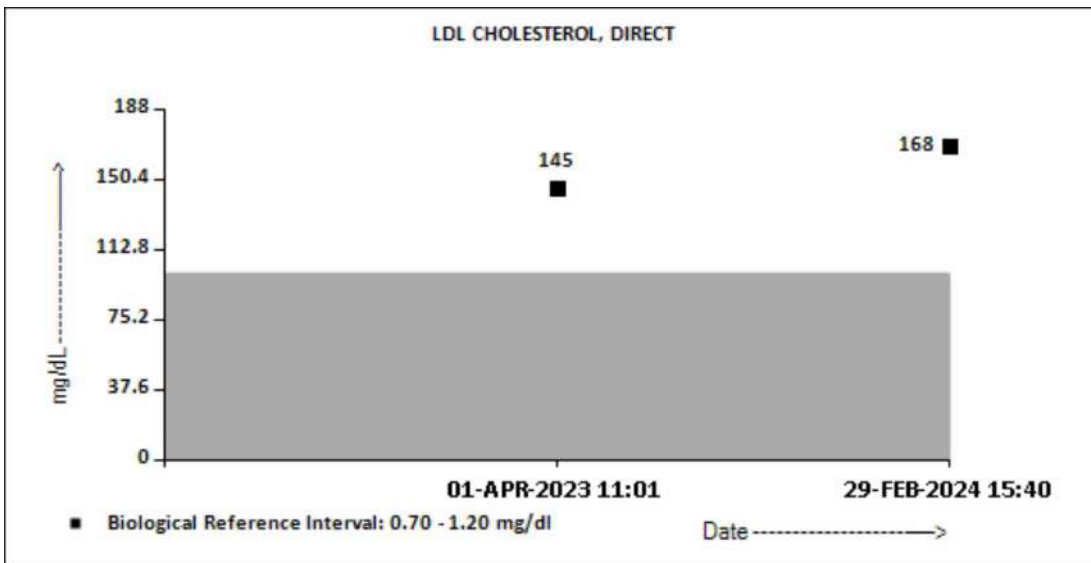
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Interpretation(s)

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	YELLOW
METHOD : MANUAL EXAMINATION	
APPEARANCE	CLEAR
METHOD : MANUAL EXAMINATION	

CHEMICAL EXAMINATION, URINE

PH	6.5	4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE		
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE PHOTOMETRY (EHRlich'S REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		

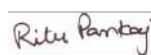
MICROSCOPIC EXAMINATION, URINE



 Dr. Shafira Garg (MD, Pathology)
 Attending Consultant, 47150



 Dr. Irneet Mundi (MD,DNB
 Pathology)
 Associate Consultant, 34080



 Dr. Ritu Pankaj (MD,Pathology),
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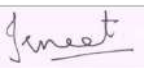
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RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)		3-5	0-5	/HPF
EPITHELIAL CELLS		NOT DETECTED	0-5	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY				
YEAST		NOT DETECTED	NOT DETECTED	

Interpretation(s)


Dr. Shafira Garg (MD, Pathology)
 Attending Consultant,47150


Dr. Irneet Mundi (MD,DNB Pathology)
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	133.2	80.00 - 200.00	ng/dL
METHOD : SANDWICH (ECLIA)			
T4	7.27	5.10 - 14.10	µg/dL
METHOD : SANDWICH (ECLIA)			
TSH (ULTRASENSITIVE)	1.050	0.270 - 4.200	µIU/mL
METHOD : SANDWICH (ECLIA)			

Interpretation(s)

Meenakshi Malhotra

Ritu Pankaj

Dr. Meenakshi Malhotra (MD, Pathology)
 Senior Consultant,48159

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.811	0.0 - 3.1	ng/mL
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METHOD : SANDWICH (ECLIA)

Interpretation(s)

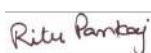
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or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

- It is 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.

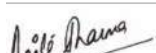
References-

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

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


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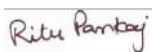
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CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
 - i. Specimen received is insufficient or inappropriate
 - ii. Specimen quality is unsatisfactory
 - iii. Incorrect specimen type
 - iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

Agilus Diagnostics Limited

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