Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 31/01/25

Name: Poonam Rani Age: 34 yrs Sex: M / F

BP: 110/70mmHg Height (cms): 151cm Weight(kgs): 59.9kg BMI: 25

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	
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

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Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
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Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	**12949688**	**Date**	**31/01/2024**		
Name	**Mrs.Poonam Rani**	**Sex**	**Female**	**Age**	**34**
OPD	**Pap Smear**	**Health Check Up**			

Drug allergy:
Sys illness:

A 34yr old female.

- $P_1 L_1 A_0$ → LSCS. → 3yr

No H/o any comorbidities

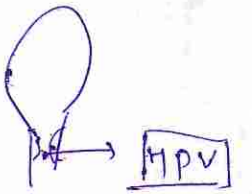
Lmp - 5/1/24, regular

5-7 day blood flow.

F/H/o - DM.

No any bleeding or any discharge

- Healthy vagina



25 – 65

Adv

- pap smear
- follow up ☐ reports
- Repeat pap smear after 3yrs.

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UHID	12949688	Date	31/01/2024		
Name	Mrs.Poonam Rani	Sex	Female	Age	34
OPD	Opthal 14	Health Check Up			

Drug allergy:→ Not known.
Sys illness: → No
Habit → No.

Glau. No.

H/O → No.

Unaided → RE 6/6
→ LE 6/6

PH → No

Pinhole → RE 6/6
→ LE 6/6

NPC → RE No
→ LE No

IOP → RE → 14.7
→ LE → 14.3

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UHID	**12949688**	**Date**	**31/01/2024**		
Name	**Mrs.Poonam Rani**	**Sex**	**Female**	**Age**	**34**
OPD	**Dental 12**	**Health Check Up**			

Drug allergy:
Sys illness:

O/E- Stains ++
- calculus ++
- caries c — 6|
- Impacted c̄ — 8|8 / 8|8

Treatment-

A/d - (1) Scaling Grade II
(2) RCT c̄ — 6|

Dr. Jyoti

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UHID	**12949688**	**Date**	**31/01/2024**		
Name	**Mrs.Poonam Rani**	**Sex**	**Female**	**Age**	**34**
OPD	**ENT 04**	**Health Check Up**			

Drug allergy:
Sys illness:

E
N | NAD
T

No significant ENT findings

Diagnostic Report

Fortis

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MC-5837

PATIENT NAME : MRS.POONAM RANI	**REF. DOCTOR :**	
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CLINICAL INFORMATION :

UID:12949688 REQNO-1656349
CORP-OPD
BILLNO-150124OPCR005893
BILLNO-150124OPCR005893

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	12.2	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.45	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	9.02	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	300	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	38.2	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	85.8	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	27.4	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	31.9	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**14.3 High**	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	19.3		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	10.3	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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

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Patient Ref. No. 22000000899488

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NEUTROPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	62	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	31	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	5	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	2	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	5.59	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.80	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.45	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.18	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0.00 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	2.0		

MORPHOLOGY

RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY
PLATELETS METHOD : MICROSCOPIC EXAMINATION	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	12	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.2	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)	102.5	< 116.0	mg/dL
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, Vasculities, 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: Polycythermia 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)

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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 patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/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 addiction 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 paltform (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 O		
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	0.79	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.19	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.60	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.9	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	4.0	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.0	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	**13 Low**	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	21	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	95	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	27	5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	151	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	81	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
METHOD : HEXOKINASE			

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Email : -

Patient Ref. No. 22000000899488

PATIENT NAME : MRS.POONAM RANI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XA005460** PATIENT ID : FH.12949688 CLIENT PATIENT ID: UID:12949688 ABHA NO :	AGE/SEX :34 Years Female DRAWN :31/01/2024 11:58:00 RECEIVED : 31/01/2024 11:59:03 REPORTED :31/01/2024 15:32:46

CLINICAL INFORMATION :

UID:12949688 REQNO-1656349
CORP-OPD
BILLNO-150124OPCR005893
BILLNO-150124OPCR005893

Test Report Status **Final**	Results	Biological Reference Interval	Units
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	12	6 - 20	mg/dL
CREATININE EGFR- EPI			
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	0.71	0.60 - 1.10	mg/dL
AGE	34		years
GLOMERULAR FILTRATION RATE (FEMALE) METHOD : CALCULATED PARAMETER	115.92	Refer Interpretation Below	mL/min/1.73m2
BUN/CREAT RATIO			
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	**16.90 High**	5.00 - 15.00	
URIC ACID, SERUM			
URIC ACID METHOD : URICASE UV	2.6	2.6 - 6.0	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	7.9	6.4 - 8.2	g/dL

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ALBUMIN, SERUM			
ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	4.0	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	138	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.47	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	104	98 - 107	mmol/L

Interpretation(s)

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** results 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.

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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 sothat 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 Glyosuria,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.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
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.

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Test Report Status **Final**	Results	Biological Reference Interval	Units

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	182	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	94	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	**65 High**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	103	< 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	117	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	18.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**2.8 Low**	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	1.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.025	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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MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	85.7	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

T4	7.02	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

TSH (ULTRASENSITIVE)	3.320	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000899488

Diagnostic Report

Fortis

agilus diagnostics

MC-5837

PATIENT NAME : MRS.POONAM RANI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XA005501** PATIENT ID : FH.12949688 CLIENT PATIENT ID: UID:12949688 ABHA NO :	AGE/SEX :34 Years Female DRAWN :31/01/2024 14:47:00 RECEIVED : 31/01/2024 14:50:07 REPORTED :31/01/2024 16:04:49

CLINICAL INFORMATION :

UID:12949688 REQNO-1656349
CORP-OPD
BILLNO-150124OPCR005893
BILLNO-150124OPCR005893

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	88	70 - 140	mg/dL

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 Glyosuria, 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

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

View Details View Report

PERFORMED AT :
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Navi Mumbai, 400703
Maharashtra, India
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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000899529

Diagnostic Report

Fortis

agilus diagnostics

MC-5837

PATIENT NAME : MRS.POONAM RANI	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022XA005506** PATIENT ID : FH.12949688 CLIENT PATIENT ID: UID:12949688 ABHA NO :	AGE/SEX :34 Years Female DRAWN :31/01/2024 15:42:00 RECEIVED : 31/01/2024 15:43:25 REPORTED :01/02/2024 10:28:55

CLINICAL INFORMATION :

UID:12949688 REQNO-1656349
CORP-OPD
BILLNO-150124OPCR005893
BILLNO-150124OPCR005893

Test Report Status **Final**	**Units**

CYTOLOGY

PAPANICOLAOU SMEAR

PAPANICOLAOU SMEAR

TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY
SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY
SPECIMEN ADEQUACY	SATISFACTORY
METHOD : MICROSCOPIC EXAMINATION	
MICROSCOPY	SMEARS STUDIED SHOW SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS, OCCASIONAL CLUSTERS OF ENDOCERVICAL CELLS IN THE BACKGROUND OF FEW POLYMORPHS.
INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

Comments

PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS, HENCE SHOULD BE INTERPRETED WITH CAUTION.

NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

****End Of Report****

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Consultant Pathologist

View Details View Report

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Email : -

Patient Ref. No. 22000000899534

34 Years Female

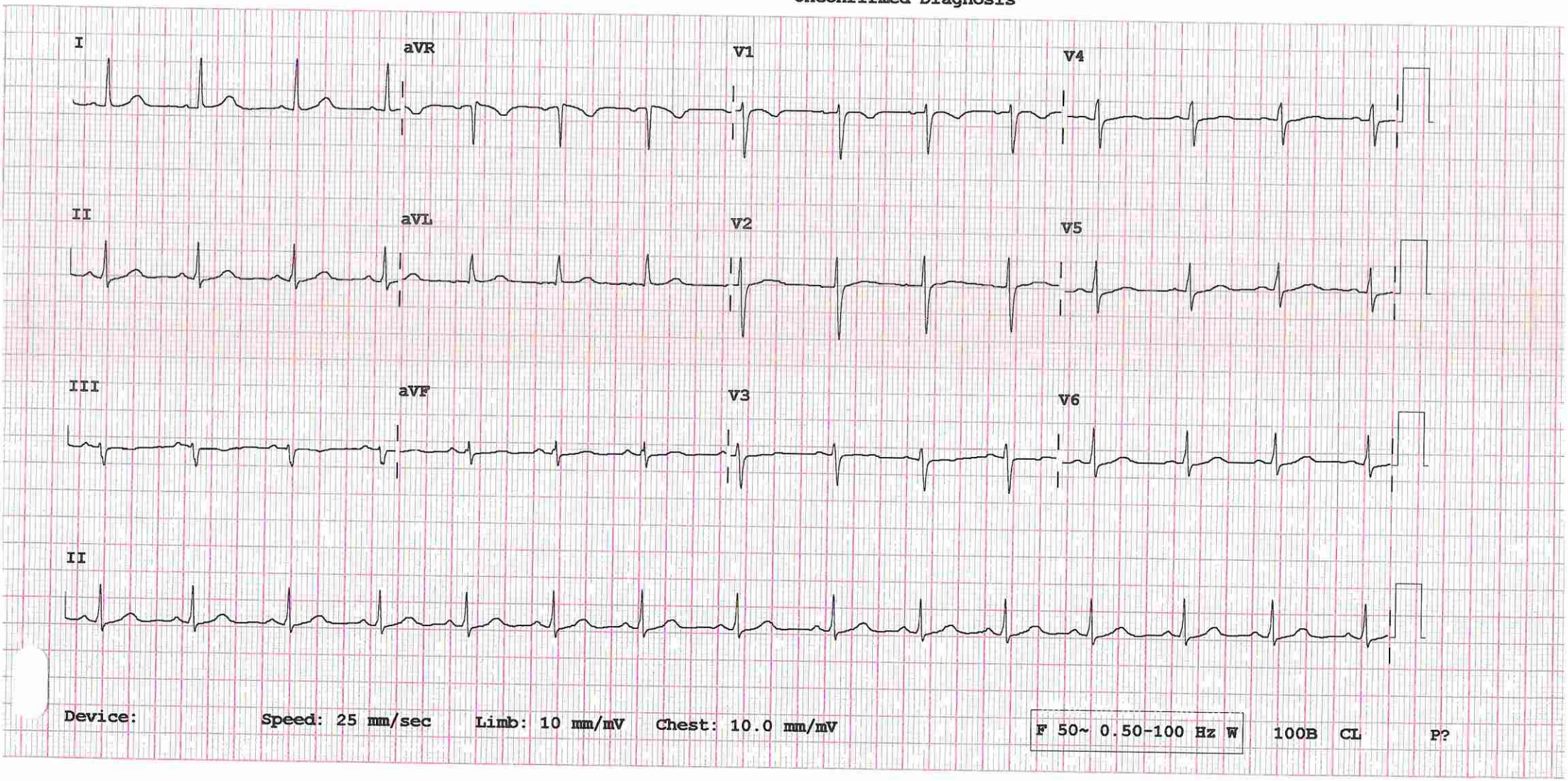
Rate 88 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 135
QRSD 86
QT 337
QTc 408

--AXIS--
P 70
QRS 4
T 18
12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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

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CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 31/Jan/2024

Name: Mrs. Poonam Rani
Age | Sex: 34 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12949688 | 6090/24/1501
Order No | Order Date: 1501/PN/OP/2401/12571 | 31-Jan-2024
Admitted On | Reporting Date : 31-Jan-2024 17:38:40
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 13 mm with normal inspiratory collapse.

M-MODE MEASUREMENTS:

LA	28	mm
AO Root	18	mm
AO CUSP SEP	15	mm
LVID (s)	24	mm
LVID (d)	36	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	24	mm
RA	22	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 1.1 m/sec.
A WAVE VELOCITY:0.7 m/sec
E/A RATIO:1.6 . E/E' 9.8

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

• Normal 2 Dimensional and colour doppler echocardiography study.

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

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

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Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 31/Jan/2024

Name: Mrs. Poonam Rani
Age | Sex: 34 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12949688 | 6090/24/1501
Order No | Order Date: 1501/PN/OP/2401/12571 | 31-Jan-2024
Admitted On | Reporting Date : 31-Jan-2024 14:59:40
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.

Bilateral cervical ribs noted.

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

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Patient Name	:	Poonam Rani	Patient ID	:	12949688
Sex / Age	:	F / 34Y 2M 9D	Accession No.	:	PHC.7391040
Modality	:	US	Scan DateTime	:	31-01-2024 12:51:17
IPID No	:	6090/24/1501	ReportDatetime	:	31-01-2024 13:42:37

USG – WHOLE ABDOMEN

LIVER is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 10.8 x 3.5 cm.
Left kidney measures 9.0 x 3.4 cm.

PANCREAS: Head and body of pancreas is visualised and appears normal. Rest of the pancreas is obscured.

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

UTERUS is retroverted and normal in size, measuring 8.0 x 6.2 x 5.6 cm.
Endometrium measures 10.8 mm in thickness.

Both ovaries are normal.
Right ovary measures 2.7 x 1.7 cm.
Left ovary measures 2.8 x 2.2 cm.

No evidence of ascites.

Impression:

- **No significant abnormality is detected.**

DR. KUNAL NIGAM
M.D. (Radiologist)

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Admitted On | Reporting Date : 31-Jan-2024 15:53:56
Order Doctor Name : Dr.SELF .

US - BOTH BREAST

Findings:

Bilateral breast parenchyma appears normal.

No evidence of solid or cystic lesion.

No dilated ducts are noted.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

Impression:

- **No significant abnormality detected.**

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