


**TEST REPORT**

<b>Reg. No :</b> 2409100336	<b>UHID :</b> UHID26867	<b>Reg. Date :</b> 16-Sep-2024
<b>Name :</b> GAJENDRA DEVRA		<b>Collected On :</b> 16-Sep-2024 08:15
<b>Age/Sex :</b> 35 Years / Male		<b>Report Date :</b> 16-Sep-2024
<b>Ref. By :</b> MEDIWHEEL		

Parameter	Result	Unit	Reference Interval
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**COMPLETE BLOOD COUNT (CBC)**

Hemoglobin (SLS method)	14.0	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	42.8	%	40 - 54
RBC Count (Electrical Impedance)	4.67	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	6110	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	<b>123000</b>	/cmm	150000 - 410000
MCV (Calculated)	91.7	fL	83 - 101
MCH (Calculated)	30.1	Pg	27 - 32
MCHC (Calculated)	32.8	%	31.5 - 34.5
RDW (Calculated)	13.7	%	11.5 - 14.5

**DIFFERENTIAL WBC COUNT**

Neutrophils (%)	60	%	38 - 70
Lymphocytes (%)	27	%	20 - 45
Monocytes (%)	06	%	2 - 8
Eosinophils (%)	<b>07</b>	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3666	/cmm	1800 - 7700
Lymphocytes (Absolute)	1650	/cmm	1000 - 3900
Monocytes (Absolute)	367	/cmm	200 - 800
Eosinophils (Absolute)	428	/cmm	20 - 500
Basophils (Absolute)	0	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	2.27	/cmm	0.7 - 4.0

**PERIPHERAL SMEAR EXAMINATION**

RBC Morphology	RBCs are Normochromic Normocytic.
WBC Morphology	Total Wbc count is normal
Platelets	Platelets are mildly reduced
Parasites	Malarial parasite is not detected.


**ERYTHROCYTE SEDIMENTATION RATE**

ESR (After 1 hour)	12	mm/hr	0 - 14
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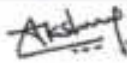
Parameter	Result	Unit	Reference Interval
<b>FBS</b>			
Fasting Blood Sugar (FBS) Glucose Oxidase-Peroxidase	106.8	mg/dL	70 - 110
<b>PPBS</b>			
Post Prandial Blood Sugar (PPBS) Glucose Oxidase-Peroxidase	126.3	mg/dL	110 - 140

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**HEMOGLOBIN A1C ESTIMATION**

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	5.5	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
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Mean Blood Glucose <i>Calculated</i>	111.15	mg/dL	
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**Criteria for the diagnosis of diabetes:**

- HbA1c  $\geq 6.5$  \*Or
  - Fasting plasma glucose  $> 126$  gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
  - Two hour plasma glucose  $\geq 200$ mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
  - In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq 200$  mg/dL.
- \*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.


**Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:**


- HbA1C, also known as glycated hemoglobin, is the most important test for the assessment of long term blood glucose control( also called glycemic control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glycemic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glycemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD ) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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<b>LIVER FUNCTION TEST</b>			
SGPT <i>Optimized UV-IFCC</i>	50.2	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	28.9	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.66	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.35	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.31	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	91	U/L	53 - 128
Total Protein	6.38	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	4.02	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	2.36	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.70		0.8 - 2.0
GGT	14.6	U/L	1 - 55
HBsAg <i>Immunochromatography</i>	Non - Reactive		

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<b>RENAL FUNCTION TEST</b>			
Creatinine <i>Enzymatic ,IDMS Traceable</i>	0.92	mg/dL	0.7 - 1.3
Urea <i>Urease-GLDH, enzymatic UV</i>	25.3	mg/dL	19.0 - 45.0
BUN <i>Calculated</i>	11.82	mg/dL	7 - 18
Uric Acid <i>Enzymatic using TBHBA</i>	6.7	mg/dL	3.5 - 7.2
Sodium <i>Direct ISE</i>	138.3	mmol/L	137 - 145
Potassium <i>Direct ISE</i>	4.52	mmol/L	3.6 - 5.1
Chloride <i>Direct ISE</i>	95.3	mmol/L	94 - 110
Ionized Calcium <i>Direct ISE</i>	4.78	mg/dL	4.4 - 5.4

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**LIPID PROFILE**


Cholesterol <i>CHOD-PAP method</i>	63	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	129.0	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	25.80	mg/dL	15 - 35
LDL CHOLESTEROL	152.1	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Magnetic Cholesterol Oxidase</i>	29.0	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	2.17		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	5.24		0 - 3.5
Total Lipids <i>Calculated</i>	344.00		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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**THYROID FUNCTION TEST**

T3 (Triiodothyronine) <i>CMA</i>	0.98	ng/mL	0.6 - 1.81
T4 (Thyroxine) <i>CMA</i>	5.53	µg/dL	4.5 - 12.5
TSH <i>ELFA-Enzyme Linked Fluorescent Assay</i>	2.984	µIU/ml	0.35 - 4.94


Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

TSH levels During Pregnancy -  
 First Trimester : 0.1 to 2.5 µIU/mL  
 Second Trimester : 0.2 to 3.0 µIU/mL  
 Third trimester : 0.3 to 3.0 µIU/mL  
 Reference : Carl A. Burtis, Edward R. Ashwood, David E. Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition. Philadelphia: WB Saunders, 2012:2170

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**URINE ROUTINE EXAMINATION**

**PHYSICAL EXAMINATION**

Quantity      15 cc  
Colour      Pale Yellow  
Clarity      Clear

**CHEMICAL EXAMINATION (BY REFLECTANCE PHOTOMETRIC METHOD)**

pH      6.0      4.6 - 8.0  
Sp. Gravity      1.025      1.002 - 1.03  
Protein      Nil  
Glucose      Nil  
Ketone Bodies      Nil  
Urobilinogen      Nil  
Bilirubin      Nil  
Nitrite      Nil  
Leucocytes      Nil  
Blood      Nil


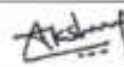
**MICROSCOPIC EXAMINATION (MANUAL BY MICROSCOPY)**

Leucocytes (Pus Cells)      1 - 5/hpf  
Erythrocytes (Red Cells)      Nil  
Epithelial Cells      1-2/hpf  
Amorphous Material      Nil  
Casts      Nil  
Crystals      Nil  
Bacteria      Nil  
Yeast      Nil  
T. Vaginalis      Nil  
Spermatozoa      Nil

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**BLOOD GROUP & RH**

SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION


ABO	'B'
Rh (D)	Positive


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**PHYSICAL EXAMINATION**


Height	172.50	cm	
Weight	76.80	kg	
BMI	25.60	kg / m <sup>2</sup>	>18.5 – underweight 18.5 and 24.9 – healthy weight 25 and 29.9 – overweight 30 and 39.9 – obese
Blood Pressure	122/70	mmHg	
Pulse Rate	74	/min	

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Parameter	Result	Unit	Biological Reference Interval
VITAMIN B12	470.00	pg/mL	211 - 911

Vitamin B12 is essential in DNA synthesis, hematopoiesis, and CNS integrity.

## Interpretation:

Increased In

- Chronic granulocytic leukemia
- COPD and Chronic renal failure
- Leukocytosis
- Liver cell damage (hepatitis, cirrhosis)
- Obesity and Severe CHF
- Polycythemia vera
- Protein malnutrition

Decreased In

- Abnormalities of cobalamin transport or metabolism
- Bacterial overgrowth
- Crohn disease
- Dietary deficiency (e.g. in vegetarians)
- Diphyllobothrium (fish tapeworm) infestation
- Gastric or small intestine surgery
- Hypochlorhydria
- Inflammatory bowel disease
- Intestinal malabsorption and Intrinsic factor deficiency


## Limitations:

- Drugs such as chloral hydrate increase vitamin B12 levels. On the other hand, alcohol, aminosalicic acid, anticonvulsants, ascorbic acid, cholestyramine, cimetidine, colchicines, metformin, neomycin, oral contraceptives, ranitidine, and triamterene decrease vitamin B12 levels.
- The evaluation of macrocytic anemia requires measurements of both vitamin B12 and folate levels; ideally they should be measured simultaneously.
- Specimen collection soon after blood transfusion can falsely increase vitamin B12 levels.
- Patients taking vitamin B12 supplementation may have misleading results.
- A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.

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DHS Properties and Hospitals LLP. | CIN : AAA-7816



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25 OH VITAMIN D TOTAL CHEMILUMINESCENCE	25.60	ng/mL	Deficiency : <10 Insufficiency : 10 - 30 Sufficiency : 30 - 100 Toxicity : >100
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Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol(vitamin D3) which is synthesized in skin from 7 dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25 (OH)vitamin D in liver.

**Interpretation:**

Increased In  
-Vitamin D intoxication  
-Excessive exposure to sunlight

**Decreased In**

-Malabsorption  
-Steatorrhea  
-Dietary osteomalacia, anticonvulsant osteomalacia  
-Biliary and portal cirrhosis  
-Thyrotoxicosis  
-Pancreatic insufficiency  
-Celiac disease  
-Rickets  
-Alzheimer disease

**Limitations:**

More recently, it has become clear that receptors for vitamin D are present in a wide variety of cells and that this hormone has biologic effects extending beyond the control of mineral metabolism. Vitamin D deficiency is not clear. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels. In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL. A recent study states that increasing mean baseline levels from 29 to 38 ng/mL was associated with a 50% lower risk for colon cancer and levels of 52 ng/mL with a 50% reduction in the incidence of breast cancer. It is recommended to have clinical correlation with serum 25(OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.

PROSTATE SPECIFIC ANTIGEN (PSA)	0.456	ng/mL	0 - 4
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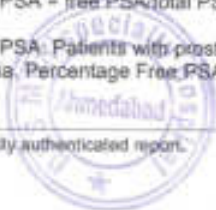
**CHEMILUMINESCENCE**


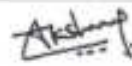
Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer. this is especially true for the total PSA values between 4-8 ng/mL.

Percentage of free PSA =  $\frac{\text{free PSA}}{\text{total PSA}} \times 100$

Percentage of free PSA: Patients with prostate cancer generally have a lower percentage of Free PSA than patients with benign prostatic hyperplasia. Percentage Free PSA of less than 25% is a high likelihood of prostatic cancer.

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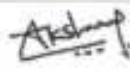
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DHS Properties and Hospitals LLP. | CIN : AAA-7816

Name: GAJENDRA DEVRA

Clinic No.:

Bed No.:

Section:

Case No.:

Date: 16/09/2024 08:59:59

bpm 67 890

ms 72 624

63 936

67 884

66 876

68 870

68 876

68 876

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Frequency:

Sample Time:

HR:

P Interval:

QRS Interval:

T Interval:

P Axis:

QRS Axis:

T Axis:

1000 Hz

13 s

68 bpm

PR Interval:

QT Interval:

QTc Interval:

154 ms

364 ms

388 ms

57.24°

25.36°

16.66°

66

876

67

890

66

876

68

870

68

876

68

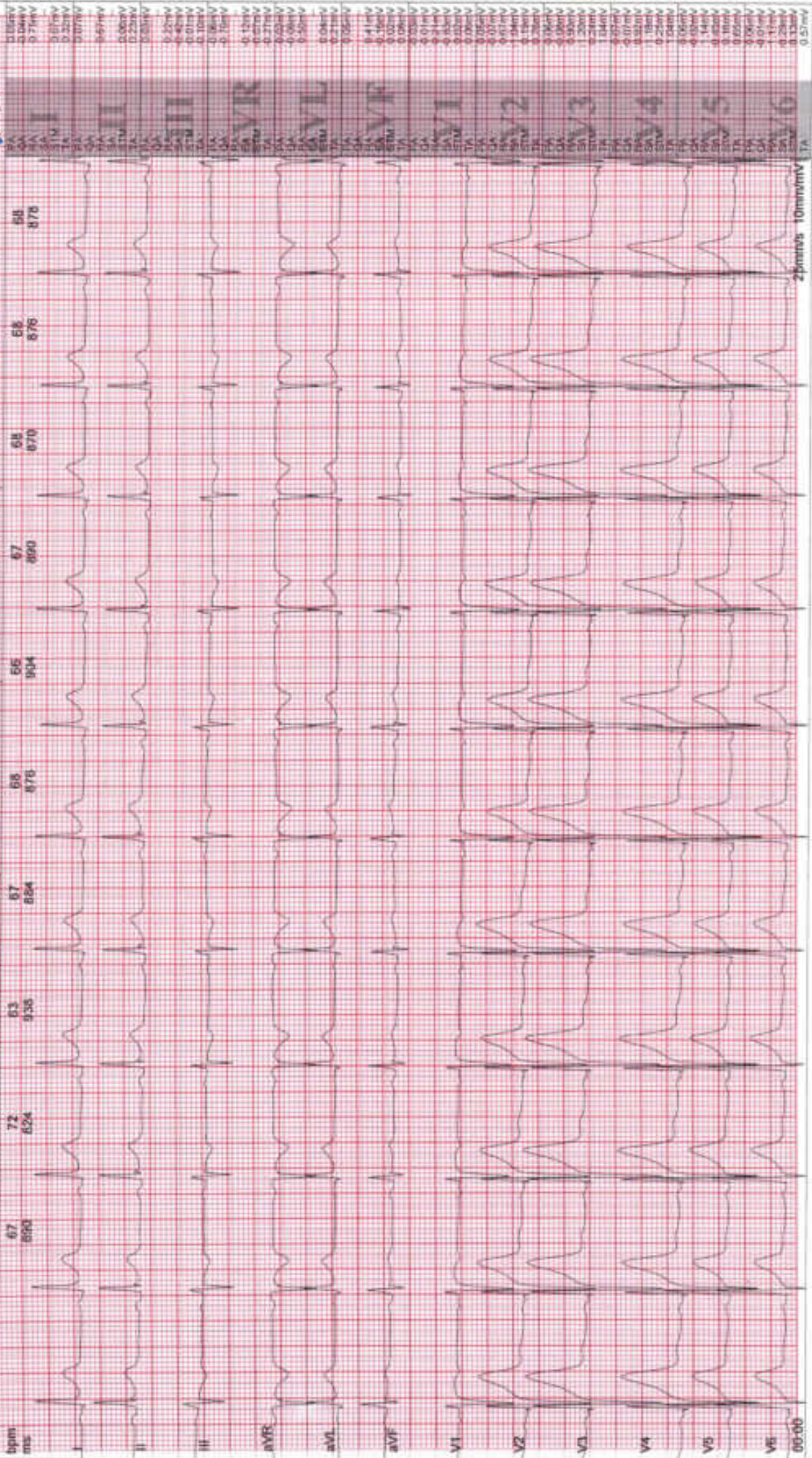
876

Prompt:

Total Beats 13, Normal Beats 13, SVE 0, VE 0.  
Normal Heart Rate(HR between 60 and 100 bpm);  
Light left cardiac electric axis deviation(QRS axis between 0 degree and 30 degree).

NORMAL ECG

Key Sign:



00:00

2mm/mv 10mm/mv

0.5mv



**PATIENT NAME** MR. GAJENDRA DEVRA  
**AGE / SEX** 35 YRS/MALE  
**REF. DOCTOR** DR. DHS DOCTOR TEAM  
**DATE** 16/09/2024

## 2D ECHO CARDIOGRAPHY REPORT

**Observation:**

1. Normal LV size with Normal LV systolic function. LVEF: 65%.
2. No RWMA at rest.
3. Reduced LV compliance.
4. Normal sized LA, RA and RV. Normal RV function.
5. All valves are normal in structure.
6. IAS and IVS are intact.
7. No PAH. RVSP = 29 mmHg.
8. No clot/ vegetation / pericardial effusion.
9. Doppler: Trivial MR, Trivial TR, No AR, No PR.
10. IVC is normal in size and well collapse on inspiration.

**Conclusion:**

Normal LV systolic function.  
No RWMA.  
No PAH.

**Measurements :**

LVIDD	38.0 mm	AO	21.0mm
LVIDS	26.0 mm	LA	28.0mm
LVEF	65%		
IVSD/LVPWD	08.0mm/09.0mm		

**DOPPLER STUDY:**

Valves	Velocity	Max gradient	Mean gradient	Area	Regurgitation
Aortic	1.1	5.1			No AR
Mitral	E:0.3 A:0.5				Trivial MR
Pulmonary	0.8	3.3			No PR
Tricuspid	0.5	1.0			Trivial TR



Dr. ARCHIT PARIKH



**PATIENT NAME** GAJENDRA DEVRA  
**AGE / SEX** 35 Y / M  
**REF. DOCTOR** HEALTH CHECKUP  
**DATE** 16-Sep-24

**ULTRASOUND WHOLE ABDOMEN - PELVIS**

**LIVER** : Liver is normal in size and shows **grade I fatty changes**. No focal lesion is seen. Intra-hepatic biliary radicals are not dilated.  
**PORTAL VEIN**: appears normal in course and caliber. PV- 9 mm  
**GALL BLADDER** : is distended and appears normal. No calculus or mass lesion seen.  
**CBD**: appears normal, 5mm.

**PANCREAS** : Pancreas appears normal in size and echo pattern.

**SPLEEN** : Spleen is normal in size (9.5 cm) and shows normal echo pattern.

**KIDNEYS** : Both kidneys are normal in size, shape & echotexture. No calculus or hydronephrosis seen in either kidney.

**URINARY BLADDER** : is full & normal.

**PROSTATE**: normal in size.

Bowel loops appear normal. No any inflammatory wall thickening or mass lesion is seen.  
No lymphadenopathy seen.  
No evidence of collection or mass lesion seen in RIF.  
No free fluid.

**IMPRESSION :**

No significant abnormality.

**DR. JAY THAKKAR, MD**





purposes

This Report is done and digitally signed via Tele Radiology Done at Radiscan Diagnostic Ahmedabad. For any clinical discrepancy, please discuss with the Radiologist. This report is not valid for any medico-legal



Date Reported: 16-Sept-2024

Dr.Sunny Shivlani  
MD Radiology REG-33548

Both lung fields under vision appear normal.  
Cardiac size appears normal.  
Both costophrenic angles are clear.  
Hilar regions are normal.  
Both domes appear normal in position.  
Bony thorax under vision appears normal.

**X - RAY CHEST PA VIEW:**

GAJENDRA DEVRA	Patient ID	UHHID26867
35 Years / M	Study Date	16-Sep-2024
Referred By	Reported Date	16-Sept-2024