HEALTHSPRING

TREADMILL STRESS TEST REPORT

DATE: 28/09/2024

NAME:	RASHI KATIYAR	**AGE**:(years)	38	**SEX**:	F

PROTOCOL USED	**BRUCE PROTOCOL**		
ANGINA SCALE (0 – None, 1 – Non-Limiting, 2 – Limiting)	0	MAXIMUM ST DEPRESSION (mm)	0
WORKLOAD: MAXIMUM METS ACHIEVED (METS)	8.07	DOUBLE PRODUCT	24336 mm of Hg/Min
DUKES SCORE (High Risk Score ≤ -11, Low Risk Score ≥ 5)	7		

CONCLUSION:

NORMAL INOTROPIC & CHRONOTROPIC RESPONSE

BASELINE ECG SHOWS NO SIGNIFICANT ST-T CHANGES

NO SYMPTOMS OR ARRHYTHMIAS WERE SEEN DURING THE EXERCISE AND RECOVERY

NO SIGNIFICANT ST-T CHANGES WERE SEEN DURING THE EXERCISE AND RECOVERY

FAIR EFFORT TOLERANCE AND FUNCTIONAL CAPACITY

TARGET HEART RATE ACHIEVED

THE STRESS TEST IS **NEGATIVE** FOR INDUCIBLE ISCHEMIA AT THE GIVEN WORKLOAD

IMPRESSION:

THE STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA AT THE GIVEN WORKLOAD

ADVISED- CLINICAL CORRELATION

DR. MUKESH JHA

MD (MEDICINE), DM (CARDIOLOGY)

REG NO- 2010/09/2935

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MC-6791

Patient Name : **Mrs. Rashi Katiyar**	**Reg.Date / Time** : 28/09/2024 / 11:16:32
Age / Gender : 38 Y / Female	**Report Date / Time** : 28/09/2024 / 20:01:03
Referred By : Dr. Rajesh Shinde	**MR No.** : **0850049**
SID No. : **40014121**	Page 1 of 13

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
CBC-Haemogram & ESR, blood				
EDTA WHOLE BLOOD				
	HAEMOGLOBIN, RED CELL COUNT & INDICES			
	HAEMOGLOBIN (Spectrophotometry)	12.1	gm%	12.0-15.0
	PCV (Electrical Impedance)	**35.7**	%	40 - 50
	MCV (Calculated)	91.9	fL	83-101
	MCH (Calculated)	31.3	pg	27.0 - 32.0
	MCHC (Calculated)	34.0	g/dl	31.5-34.5
	RDW-CV (Calculated)	14	%	11.6-14.0
	RDW-SD (Calculated)	**54**	fL	36 - 46
	TOTAL RBC COUNT (Electrical Impedance)	3.88	Million/cmm	3.8-4.8
	TOTAL WBC COUNT (Electrical Impedance)	9020	/cumm	4000-10000
	DIFFERENTIAL WBC COUNT			
	NEUTROPHILS (Flow cell)	63.6	%	40-80
	LYMPHOCYTES (Flow cell)	27.7	%	20-40
	EOSINOPHILS (Flow cell)	2.8	%	1-6
	MONOCYTES (Flow cell)	5.0	%	2-10
	BASOPHILS (Flow cell)	**0.9**	%	1-2
	ABSOLUTE WBC COUNT			
	ABSOLUTE NEUTROPHIL COUNT (Calculated)	5720	/cumm	2000-7000
	ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2500	/cumm	1000-3000

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
	ABSOLUTE WBC COUNT			
	ABSOLUTE EOSINOPHIL COUNT (Calculated)	250	/cumm	200-500
	ABSOLUTE MONOCYTE COUNT (Calculated)	450	/cumm	200-1000
	ABSOLUTE BASOPHIL COUNT (Calculated)	80	/cumm	0-220
	PLATELET COUNT (Electrical Impedance)	367000	/cumm	150000-410000
	MPV (Calculated)	9.9	fL	6.78-13.46
	PDW (Calculated)	16.2	%	11-18
	PCT (Calculated)	0.360	%	0.15-0.50
	PERIPHERAL BLOOD SMEAR			
	COMMENTS (Microscopic)	Normocytic Normochromic RBCs		

Notes : CBC plays a role in the detection of a wide range of disorders, including anaemia, thrombocytopenia, Thrombocytosis, infection, leukaemia immune system disorder. This test measures several cellular components and features of blood (Red blood cells which play a role in tissue perfusion, White cells which in host immunity and platelets which play a role in haemostasis and coagulation). This test should be interpreted carefully, correctly and in relation to the clinical history, to provide very useful information to assist
in diagnosis, drug monitoring and management of diseases.

Sample Collected at	**:**	Andheri West
Sample Collected on	**:**	28 Sep 2024 12:57
Sample Received on	**:**	28 Sep 2024 15:53
Barcode	**:**	

Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

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HAEMATOLOGY				
EDTA Blood	**ABO BLOOD GROUP***			
	BLOOD GROUP (Erythrocyte-Magnetized Technology)	O		
	Rh TYPE (Erythrocyte-Magnetized Technology)	NEGATIVE		

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	HAEMATOLOGY			
	CBC-Haemogram & ESR, blood			
	EDTA WHOLE BLOOD			
	ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	**46**	mm / 1 hr	0-20

Notes : The erythrocyte sedimentation rate (ESR) is a non-specific test. It is raised in a wide range of infectious, inflammatory, degenerative, and malignant conditions associated with changes in plasma proteins, particularly increases in fibrinogen, immunoglobulin, and C-reactive protein. The ESR is also affected by many other factors including anemia, pregnancy, haemoglobinopathies, hemoconcentration and treatment with anti-inflammatory drugs.

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE LIVER PROFILE				
SERUM				
	BILIRUBIN TOTAL (Diazotization)	0.52	mg/dl	0.2 - 1.3

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN DIRECT (Diazotization)	**0.08**	mg/dl	0.1-0.4

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN INDIRECT (Calculation)	0.44	mg/dl	0.2 - 0.7
	ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	24	U/L	<40

Notes : Elevated serum levels are found in diseases involving these tissues. Hepatobiliary diseases, such as cirrhosis, metastatic carcinoma, and viral hepatitis also increase serum AST levels.

	ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	21	U/L	<41

Notes : Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction.

	ALKALINE PHOSPHATASE (Colorimetric IFCC)	**126**	U/L	35-104

Notes : A rise in the alkaline phosphatase occurs with all forms of cholestasis, particularly with obstructive jaundice. It is also elevated in diseases of the skeletal system, such as Paget's disease, hyperparathyroidism, rickets and osteomalacia, as well as with fractures and malignant tumors.

	GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	17	U/L	<40

Notes : γ-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary diseases.Elevated GGT activities are found in the serum of patients requiring long-term medication with phenobarbital and phenytoin.

	TOTAL PROTEIN (Colorimetric)	8.20	gm/dl	6.6-8.7

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				

Notes : Hyperproteinemia can be observed in cases of severe dehydration and illnesses such as multiple myeloma.

	ALBUMIN (Bromocresol Green)	4.60	gm/dl	3.5 - 5.2

Notes : Hyperalbuminemia is of little diagnostic significance except in the case of dehydration. Hypoalbuminemia occurs during many illnesses and is caused by several factors: compromised synthesis due either to liver disease or as a consequence of reduced protein uptake; elevated catabolism due to tissue damage (severe burns) or inflammation;

	GLOBULIN (Calculation)	**3.60**	gm/dl	2.0-3.5
	A/G RATIO (Calculation)	1.3		1-2

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE RENAL PROFILE				
SERUM				
	CREATININE (Jaffe Method)	0.8	mg/dl	0.5 - 1.1

Notes : The assay of creatinine in serum or plasma is the most commonly used test
to assess renal function.

	BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	9.0	mg/dl	7-17

Notes : Elevations in blood urea nitrogen concentration are seen in inadequate renal perfusion, shock,
diminished blood volume (prerenal causes), chronic nephritis, nephrosclerosis, tubular necrosis,
glomerular nephritis (renal causes) and urinary tract obstruction (postrenal causes). Transient
elevations may also be seen during periods of high protein intake.
Unpredictable levels occur with liver diseases.

	BUN/CREATININE RATIO (Calculation)	11.2		10 - 20
	URIC ACID (Uricase Enzyme)	5.9	mg/dl	2.5 - 6.2

Notes : Uric acid measurements are used in the diagnosis and treatment of numerous renal and metabolic
disorders, including renal failure, gout, leukemia, psoriasis, starvation or other wasting conditions, and
of patients receiving cytotoxic drugs.

	CALCIUM (Bapta Method)	9.5	mg/dl	8.6-10

Notes : Increased serum calcium levels is observed in multiple myeloma and other neoplastic diseases.
Hypocalcemia may be
observed e.g. in hypoparathyroidism, nephrosis, and pancreatitis.

	PHOSPHORUS (Phosphomolybdate)	3.8	mg/dl	2.5-4.5

Notes : An increase in the level of phosphorus causes a decrease in the calcium level. The mechanism is
influenced by interactions between parathormone and vitamin D. Hypoparathyroidism, vitamin D
intoxication and renal failure with decreased glomerular phosphate filtration give rise to
hyperphosphatemia. Hypophosphatemia occurs in rickets, hyperparathyroidism and Fanconi's
syndrome

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
LIPID PROFILE				
SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	**237**	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239

Notes : Cholesterol assays are used for screening for atherosclerotic risk and in the diagnosis and treatment of disorders involving elevated cholesterol levels as well as lipid and lipoprotein metabolic disorders.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	128	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499

Notes : The determination of triglycerides is utilized in the diagnosis and treatment of patients having diabetes mellitus, nephrosis, liver obstruction, lipid metabolism disorders and numerous other endocrine diseases.

SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	45	mg/dl	Low:<40 High:>60

Notes : Elevated HDL-cholesterol concentrations protect against coronary heart disease (CHD), whereas reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase cardiovascular risk.

SERUM	LDL CHOLESTEROL (Calculation)	**166**	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	26	mg/dl	15-40
SERUM	CHOL / HDL RATIO	**5.3**		3-5
SERUM	LDL /HDL RATIO (Calculation)	**3.7**		0 - 3.5

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	93	mg/dl	70 - 110

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	102	mg/dl	70 - 140

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

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BIOCHEMISTRY				
EDTA WHOLE BLOOD	**GLYCOSYLATED HAEMOGLOBIN (HbA1C)**			
	HbA1C (High Performance Liquid Chromatography)	5.6	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
	ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	114	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.

HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
IMMUNOLOGY				
THYROID PROFILE - TOTAL				
SERUM				
	TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.34	ng/ml	0.7-2.04
	TOTAL THYROXINE (T4) (ECLIA)	6.92	ug/dl	5.5 - 11
	THYROID STIMULATING HORMONE (TSH) (ECLIA)	**45.172**	uIU/ml	0.27 - 4.20

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval

IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level.The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)
-Low TSH, Low   FT4 - Central hypothyroidism.
-Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
-Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter,Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
-Normal TSH,Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism,Medications.
-Normal TSH, High FT4-   Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbumineic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
-High TSH, Low   FT4- Primary hypothyroidism.
-High TSH, Normal FT4-   Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
-High TSH, High FT4- TSH mediated hyperthyroidism

Note:
1.   Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2.   Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3.   Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:
1.   Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2.   "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3.   Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4.   Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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MC-6791

Patient Name : **Mrs. Rashi Katiyar**

Age / Gender : 38 Y / Female

Referred By : Dr. Rajesh Shinde

SID No. : **40014121**

Reg.Date / Time : 28/09/2024 / 11:16:32

Report Date / Time : 28/09/2024 / 20:01:03

MR No. : **0850049**

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval

Sample Collected at : Andheri West

Sample Collected on : 28 Sep 2024 12:57

Sample Received on : 28 Sep 2024 15:53

Barcode :

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Consultant Pathologist

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
CBC-Haemogram & ESR, blood				
EDTA WHOLE BLOOD				
	HAEMOGLOBIN, RED CELL COUNT & INDICES			
	HAEMOGLOBIN (Spectrophotometry)	12.1	gm%	12.0-15.0
	PCV (Electrical Impedance)	**35.7**	%	40 - 50
	MCV (Calculated)	91.9	fL	83-101
	MCH (Calculated)	31.3	pg	27.0 - 32.0
	MCHC (Calculated)	34.0	g/dl	31.5-34.5
	RDW-CV (Calculated)	14	%	11.6-14.0
	RDW-SD (Calculated)	**54**	fL	36 - 46
	TOTAL RBC COUNT (Electrical Impedance)	3.88	Million/cmm	3.8-4.8
	TOTAL WBC COUNT (Electrical Impedance)	9020	/cumm	4000-10000
	DIFFERENTIAL WBC COUNT			
	NEUTROPHILS (Flow cell)	63.6	%	40-80
	LYMPHOCYTES (Flow cell)	27.7	%	20-40
	EOSINOPHILS (Flow cell)	2.8	%	1-6
	MONOCYTES (Flow cell)	5.0	%	2-10
	BASOPHILS (Flow cell)	**0.9**	%	1-2
	ABSOLUTE WBC COUNT			
	ABSOLUTE NEUTROPHIL COUNT (Calculated)	5720	/cumm	2000-7000
	ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2500	/cumm	1000-3000

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
	ABSOLUTE WBC COUNT			
	ABSOLUTE EOSINOPHIL COUNT (Calculated)	250	/cumm	200-500
	ABSOLUTE MONOCYTE COUNT (Calculated)	450	/cumm	200-1000
	ABSOLUTE BASOPHIL COUNT (Calculated)	80	/cumm	0-220
	PLATELET COUNT (Electrical Impedance)	367000	/cumm	150000-410000
	MPV (Calculated)	9.9	fL	6.78-13.46
	PDW (Calculated)	16.2	%	11-18
	PCT (Calculated)	0.360	%	0.15-0.50
	PERIPHERAL BLOOD SMEAR			
	COMMENTS (Microscopic)	Normocytic Normochromic RBCs		

Notes : CBC plays a role in the detection of a wide range of disorders, including anaemia, thrombocytopenia, Thrombocytosis, infection, leukaemia immune system disorder. This test measures several cellular components and features of blood (Red blood cells which play a role in tissue perfusion, White cells which in host immunity and platelets which play a role in haemostasis and coagulation). This test should be interpreted carefully, correctly and in relation to the clinical history, to provide very useful information to assist
in diagnosis, drug monitoring and management of diseases.

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
EDTA Blood	**ABO BLOOD GROUP***			
	BLOOD GROUP (Erythrocyte-Magnetized Technology)	O		
	Rh TYPE (Erythrocyte-Magnetized Technology)	NEGATIVE		

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
	CBC-Haemogram & ESR, blood			
EDTA WHOLE BLOOD				
	ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	**46**	mm / 1 hr	0-20

Notes : The erythrocyte sedimentation rate (ESR) is a non-specific test. It is raised in a wide range of infectious, inflammatory, degenerative, and malignant conditions associated with changes in plasma proteins, particularly increases in fibrinogen, immunoglobulin, and C-reactive protein. The ESR is also affected by many other factors including anemia, pregnancy, haemoglobinopathies, hemoconcentration and treatment with anti-inflammatory drugs.

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE LIVER PROFILE				
SERUM				
	BILIRUBIN TOTAL (Diazotization)	0.52	mg/dl	0.2 - 1.3

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN DIRECT (Diazotization)	**0.08**	mg/dl	0.1-0.4

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN INDIRECT (Calculation)	0.44	mg/dl	0.2 - 0.7
	ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	24	U/L	<40

Notes : Elevated serum levels are found in diseases involving these tissues. Hepatobiliary diseases, such as cirrhosis, metastatic carcinoma, and viral hepatitis also increase serum AST levels.

	ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	21	U/L	<41

Notes : Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction.

	ALKALINE PHOSPHATASE (Colorimetric IFCC)	**126**	U/L	35-104

Notes : A rise in the alkaline phosphatase occurs with all forms of cholestasis, particularly with obstructive jaundice. It is also elevated in diseases of the skeletal system, such as Paget's disease, hyperparathyroidism, rickets and osteomalacia, as well as with fractures and malignant tumors.

	GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	17	U/L	<40

Notes : γ-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary diseases. Elevated GGT activities are found in the serum of patients requiring long-term medication with phenobarbital and phenytoin.

	TOTAL PROTEIN (Colorimetric)	8.20	gm/dl	6.6-8.7

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval

BIOCHEMISTRY

Notes : Hyperproteinemia can be observed in cases of severe dehydration and illnesses such as multiple myeloma.

	ALBUMIN (Bromocresol Green)	4.60	gm/dl	3.5 - 5.2

Notes : Hyperalbuminemia is of little diagnostic significance except in the case of dehydration. Hypoalbuminemia occurs during many illnesses and is caused by several factors: compromised synthesis due either to liver disease or as a consequence of reduced protein uptake; elevated catabolism due to tissue damage (severe burns) or inflammation;

	GLOBULIN (Calculation)	**3.60**	gm/dl	2.0-3.5
	A/G RATIO (Calculation)	1.3		1-2

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE RENAL PROFILE				
SERUM				
	CREATININE (Jaffe Method)	0.8	mg/dl	0.5 - 1.1

Notes : The assay of creatinine in serum or plasma is the most commonly used test
to assess renal function.

	BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	9.0	mg/dl	7-17

Notes : Elevations in blood urea nitrogen concentration are seen in inadequate renal perfusion, shock,
diminished blood volume (prerenal causes), chronic nephritis, nephrosclerosis, tubular necrosis,
glomerular nephritis (renal causes) and urinary tract obstruction (postrenal causes). Transient
elevations may also be seen during periods of high protein intake.
Unpredictable levels occur with liver diseases.

	BUN/CREATININE RATIO (Calculation)	11.2		10 - 20
	URIC ACID (Uricase Enzyme)	5.9	mg/dl	2.5 - 6.2

Notes : Uric acid measurements are used in the diagnosis and treatment of numerous renal and metabolic
disorders, including renal failure, gout, leukemia, psoriasis, starvation or other wasting conditions, and
of patients receiving cytotoxic drugs.

	CALCIUM (Bapta Method)	9.5	mg/dl	8.6-10

Notes : Increased serum calcium levels is observed in multiple myeloma and other neoplastic diseases.
Hypocalcemia may be
observed e.g. in hypoparathyroidism, nephrosis, and pancreatitis.

	PHOSPHORUS (Phosphomolybdate)	3.8	mg/dl	2.5-4.5

Notes : An increase in the level of phosphorus causes a decrease in the calcium level. The mechanism is
influenced by interactions between parathormone and vitamin D. Hypoparathyroidism, vitamin D
intoxication and renal failure with decreased glomerular phosphate filtration give rise to
hyperphosphatemia. Hypophosphatemia occurs in rickets, hyperparathyroidism and Fanconi's
syndrome

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
LIPID PROFILE				
SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	**237**	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239

Notes : Cholesterol assays are used for screening for atherosclerotic risk and in the diagnosis and treatment of disorders involving elevated cholesterol levels as well as lipid and lipoprotein metabolic disorders.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	128	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499

Notes : The determination of triglycerides is utilized in the diagnosis and treatment of patients having diabetes mellitus, nephrosis, liver obstruction, lipid metabolism disorders and numerous other endocrine diseases.

SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	45	mg/dl	Low:<40 High:>60

Notes : Elevated HDL-cholesterol concentrations protect against coronary heart disease (CHD), whereas reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase cardiovascular risk.

SERUM	LDL CHOLESTEROL (Calculation)	**166**	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	26	mg/dl	15-40
SERUM	CHOL / HDL RATIO	**5.3**		3-5
SERUM	LDL /HDL RATIO (Calculation)	**3.7**		0 - 3.5

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	93	mg/dl	70 - 110

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	102	mg/dl	70 - 140

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
EDTA WHOLE BLOOD	**GLYCOSYLATED HAEMOGLOBIN (HbA1C)**			
	HbA1C (High Performance Liquid Chromatography)	5.6	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
	ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	114	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.

HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
IMMUNOLOGY				
THYROID PROFILE - TOTAL				
SERUM				
	TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.34	ng/ml	0.7-2.04
	TOTAL THYROXINE (T4) (ECLIA)	6.92	ug/dl	5.5 - 11
	THYROID STIMULATING HORMONE (TSH) (ECLIA)	**45.172**	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level.The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)
-Low TSH, Low   FT4 - Central hypothyroidism.
-Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
-Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter,Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
-Normal TSH,Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism,Medications.
-Normal TSH, High FT4-   Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbumineic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
-High TSH, Low   FT4- Primary hypothyroidism.
-High TSH, Normal FT4-   Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
-High TSH, High FT4- TSH mediated hyperthyroidism

Note:
1.   Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2.   Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3.   Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:
1.   Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2.   "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3.   Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4.   Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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Patient Name :	**Mrs. Rashi Katiyar**		**Reg.Date / Time**	:	28/09/2024 / 11:16:32
Age / Gender :	38 Y / Female		**Report Date / Time**	:	28/09/2024 / 20:01:03
Referred By :	Dr. Rajesh Shinde		**MR No.**	:	0850049
SID No. :	40014121		Page 13 of 13		

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval

Sample Collected at : Andheri West

Sample Collected on : 28 Sep 2024 12:57

Sample Received on : 28 Sep 2024 15:53

Barcode : |||||||||||||||||||||

Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

.

NAME :RASHI KATIYAR	AGE : 38YRS
GENDER : FEMALE	DATE : 28/09/2024

X-RAY CHEST PA VIEW

The bony thorax is normal.

Lung fields and pleural spaces are clear on both sides.

The silhouettes of the heart and aorta are normal in size and configuration.

Both domes of the diaphragm are normal in position, contour and outline.

IMPRESSION: NO EVIDENCE OF ANY DISEASE IS SEEN IN THE CHEST.

DR.NITISH KOTWAL
MBBS, DMRD (Bom)
Consultant Radiologist And Sonologist.
Online reporting done hence no signature

Age / Gender: 38/Female Date and Time: 28th Sep 24 10:20 AM

Patient ID: 0850049

Patient Name: Rashi Katiyar

I	aVR	V1	V4
II	aVL	V2	V5
III	aVF	V3	V6

II

25.0 mm/s 10.0 mm/mV   0-20Hz, 50Hz
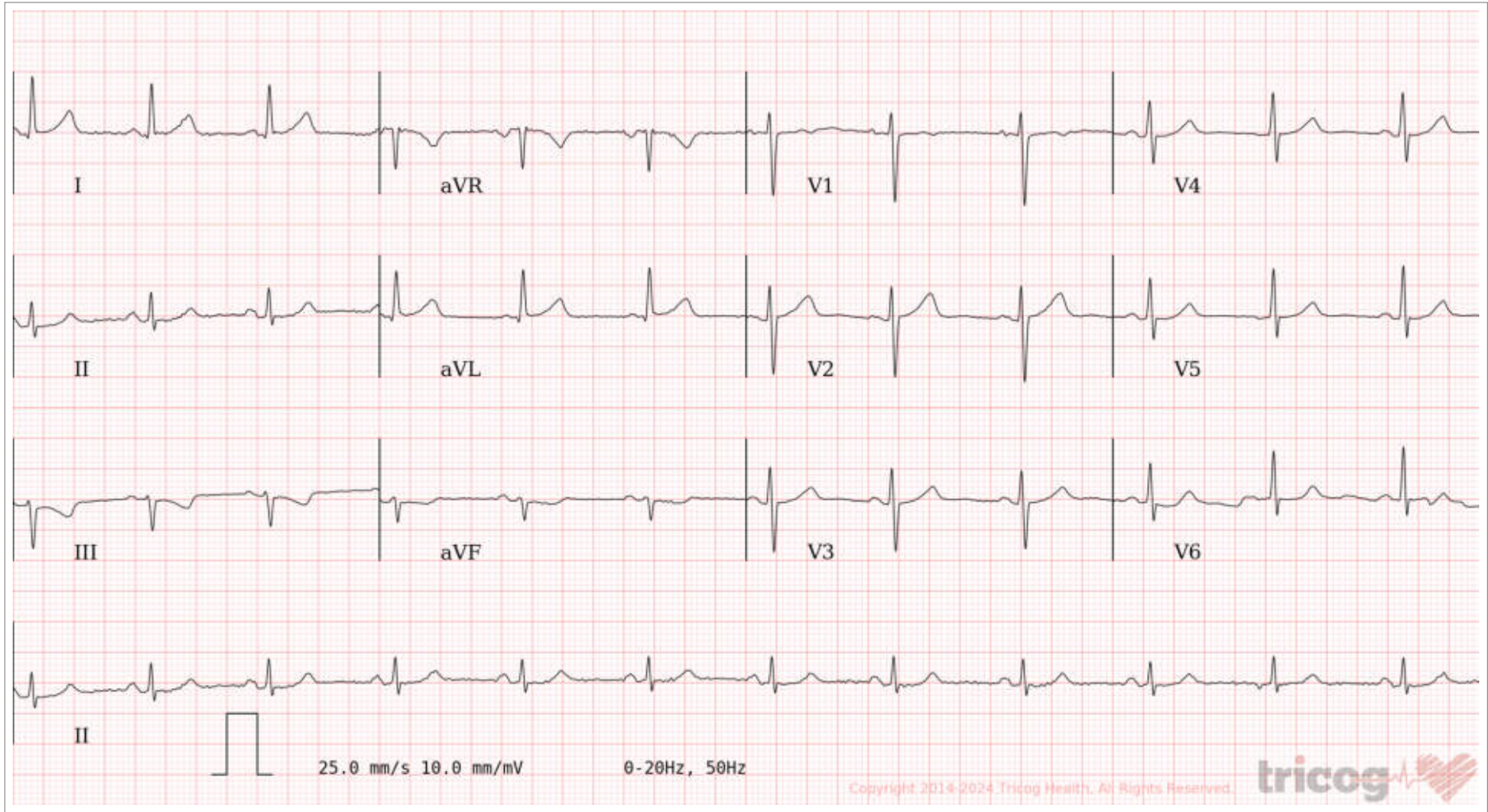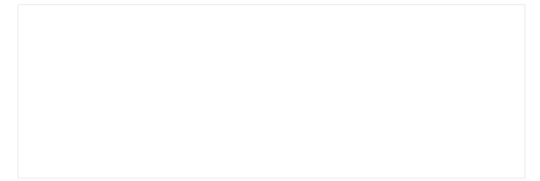
AR: NA   VR: 73bpm   QRSD: 76ms   QT: 354ms   QTcB: 390ms   PRI: 126ms   P-R-T: 53° NA -10°

Left axis deviation

Dr. K. R. SUNIL KUMAR
MBBS, D-CARD, F-DIAS
Consultant Cardiologist
Reg No. 90153

भारत सरकार

Government of India

Download Date: 08/02/2021

राशी कटियार
Rashi Katiyar
जन्म तिथि/DOB: 06/02/1986
महिला/ FEMALE

Issue Date: 05/07/2014

आधार

6590 0317 0857

VID : 9117 2559 0295 3706

मेरा **आधार**, मेरी पहचान

UNI-EM

ELECTRONICS COMPLEX
INDORE

RASHI KATIYAR   **TREADMILL TEST REPORT**

        ID   : 58
        DATE   : 28-09-2024   PROTOCOL   : Bruce
        AGE/SEX : 38 /F   HISTORY   :
        HT/WT   : 153 / 61   INDICATION :
        REF.BY : DR RAJESH SHINDE   MEDICATION :

PHASE	TOTAL TIME	STAGE TIME	SPEED Km/Hr	GRADE %	H.R. bpm	B.P. mmHg	RPP x100	ST LEVEL(MM) II	V1	V5	METS
SUPINE					90	120 / 80	108	-0.5	0	0	
STANDING					92	120 / 80	110	-0.5	0	-0.2	
HYPERVENT		0:5			96	120 / 80	115	-0.4	-0.1	0	
VALSALVA					95	120 / 80	114	-0.4	0	-0.1	
Stage 1	2:55	2:55	2.7	10	133	150 / 80	199	-0.4	0.1	-0.1	4.67
Stage 2	5:55	2:55	4	12	146	156 / 80	227	-0.5	0	-0.4	7.04
PK-EXERCISE	7:0	1:0	5.4	14	156	156 / 80	243	-0.1	0.6	-0.5	8.07
RECOVERY	8:10	0:55			126	140 / 80	176	-0.5	0.3	0.2	
RECOVERY	8:10	0:55			126	140 / 80	176	-0.5	0.3	0.2	
RECOVERY	9:10	1:55			111	120 / 80	133	-0.7	0.2	-0.2	
RECOVERY	9:10	1:55			111	120 / 80	133	-0.7	0.2	-0.2	
RECOVERY	10:10	2:55			114	110 / 80	125	-0.8	0.2	-0.7	
RECOVERY	10:10	2:55			114	110 / 80	125	-0.8	0.2	-0.7	

RESULTS

        EXERCISE DURATION   : 7:0   MAX WORK LOAD   : 8.07 METS
        MAX HEART RATE   : 156 bpm 85 % of target heart rate 182 bpm
        MAX BLOOD PRESSURE   : 156 / 80   mm Hg
        REASON OF TERMINATION : Achieved THR.

        BP RESPONSE   :
        ARRYTHMIA   :
        H.R. RESPONSE   :

IMPRESSIONS   :

Technician : 44

UNI-EM

RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 90bpm
B.P. 120/80

PRETEST
SUPINE

ST @ 10mm/mV
80ms PostJ

LINKED MEDIAN

Mag. X 2

III

I	aVR	V1	V4
0.3	0.1	0.0	0.1
0.2	-0.1	-0.1	0.4

II	aVL	V2	V5
-0.5	0.6	0.5	0.0
-0.1	0.3	0.3	0.2

III	aVF	V3	V6
-0.9	-0.7	-0.3	-0.2
-0.3	-0.2	0.2	0.2

-0.9
-0.3

II aVR aVF V2 V4 V6

I

I III aVL V1 V3 V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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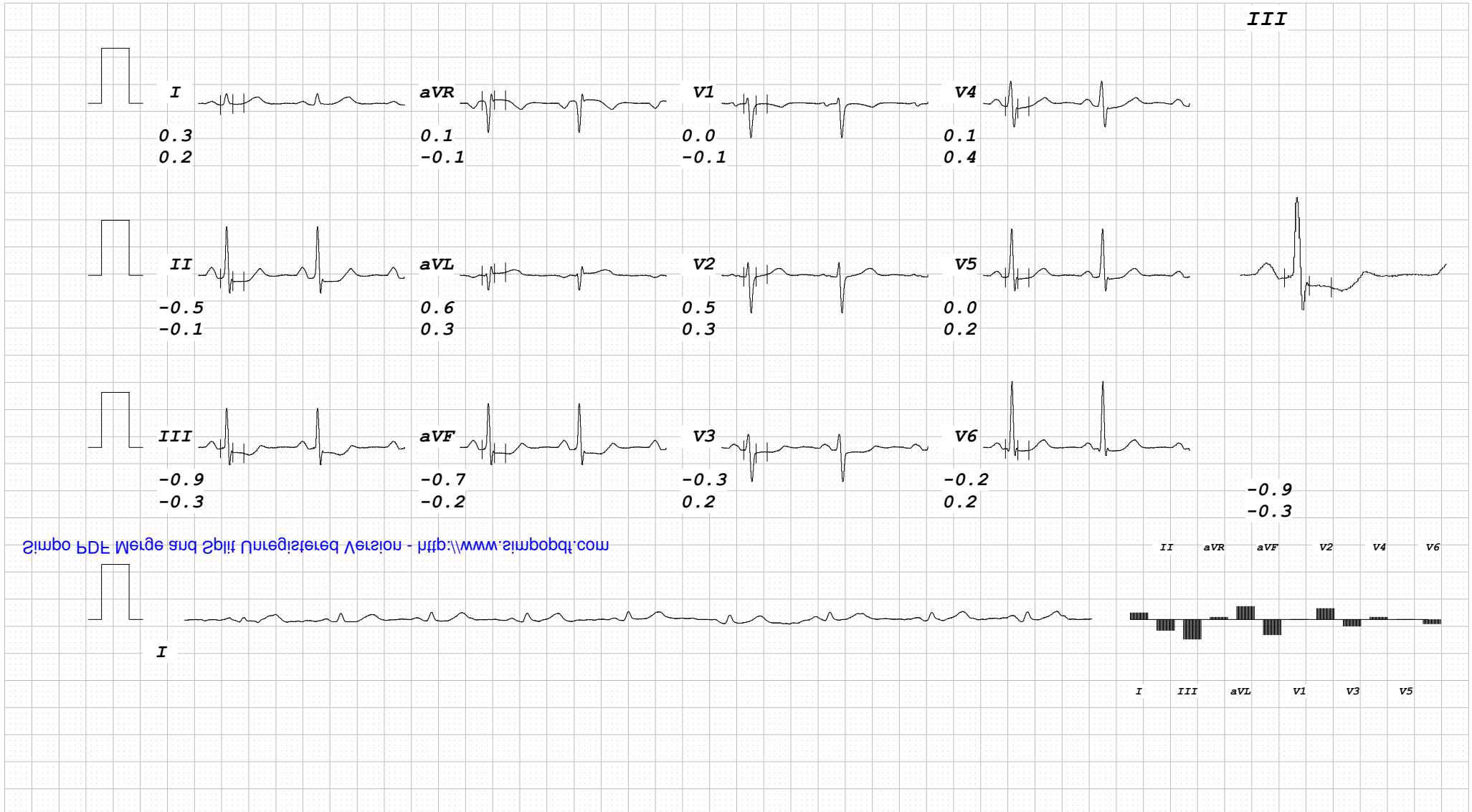
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RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 92bpm
B.P. 120/80

PRETEST
STANDING

ST @ 10mm/mV
80ms PostJ
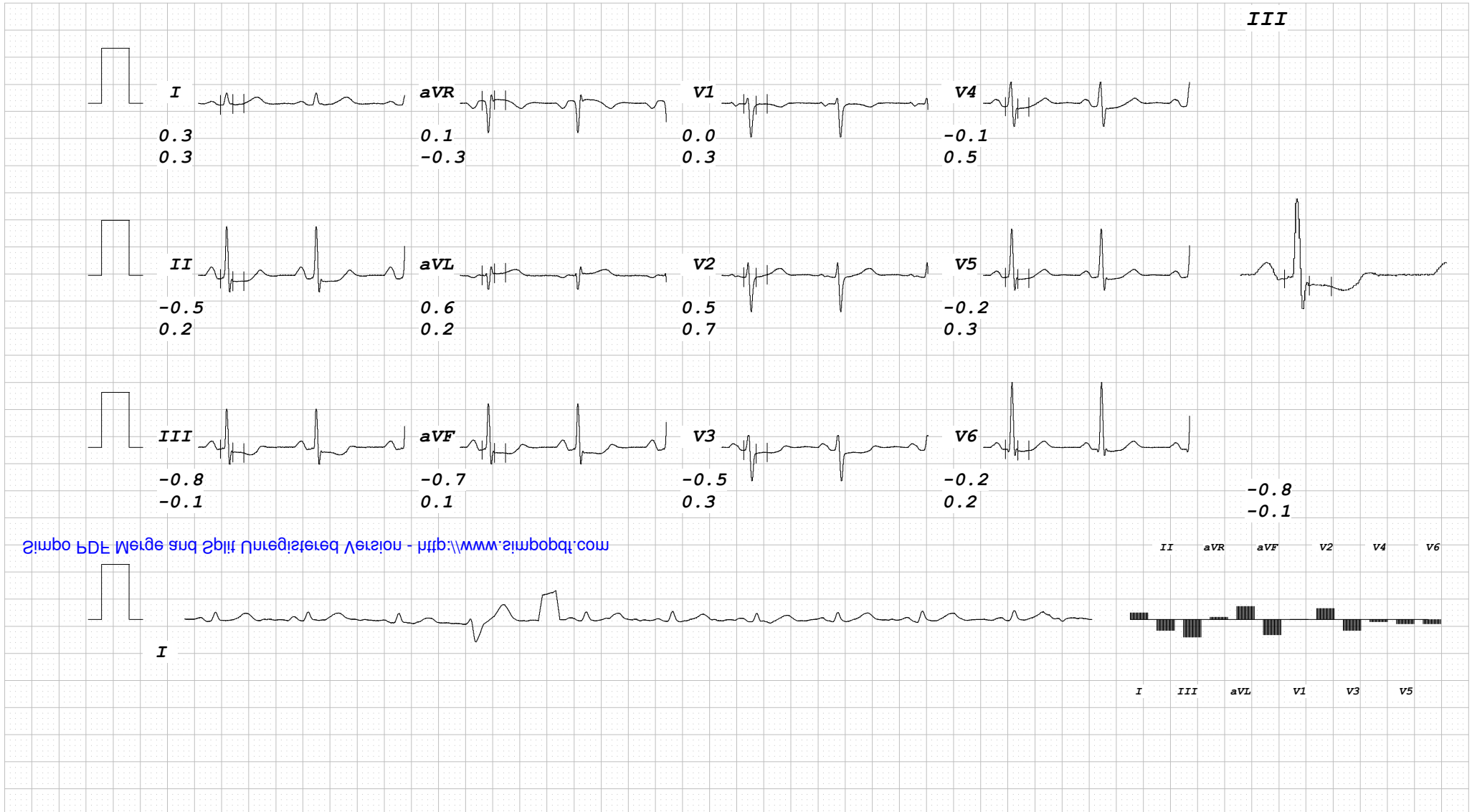
LINKED MEDIAN

Mag. X 2

III

Lead	Values
I	0.3 / 0.3
aVR	0.1 / -0.3
V1	0.0 / 0.3
V4	-0.1 / 0.5
II	-0.5 / 0.2
aVL	0.6 / 0.2
V2	0.5 / 0.7
V5	-0.2 / 0.3
III	-0.8 / -0.1
aVF	-0.7 / 0.1
V3	-0.5 / 0.3
V6	-0.2 / 0.2

III: -0.8 / -0.1

I

II   aVR   aVF   V2   V4   V6

I   III   aVL   V1   V3   V5

UNI-EM

RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 96bpm
B.P. 120/80

PRETEST
HYPERVENT
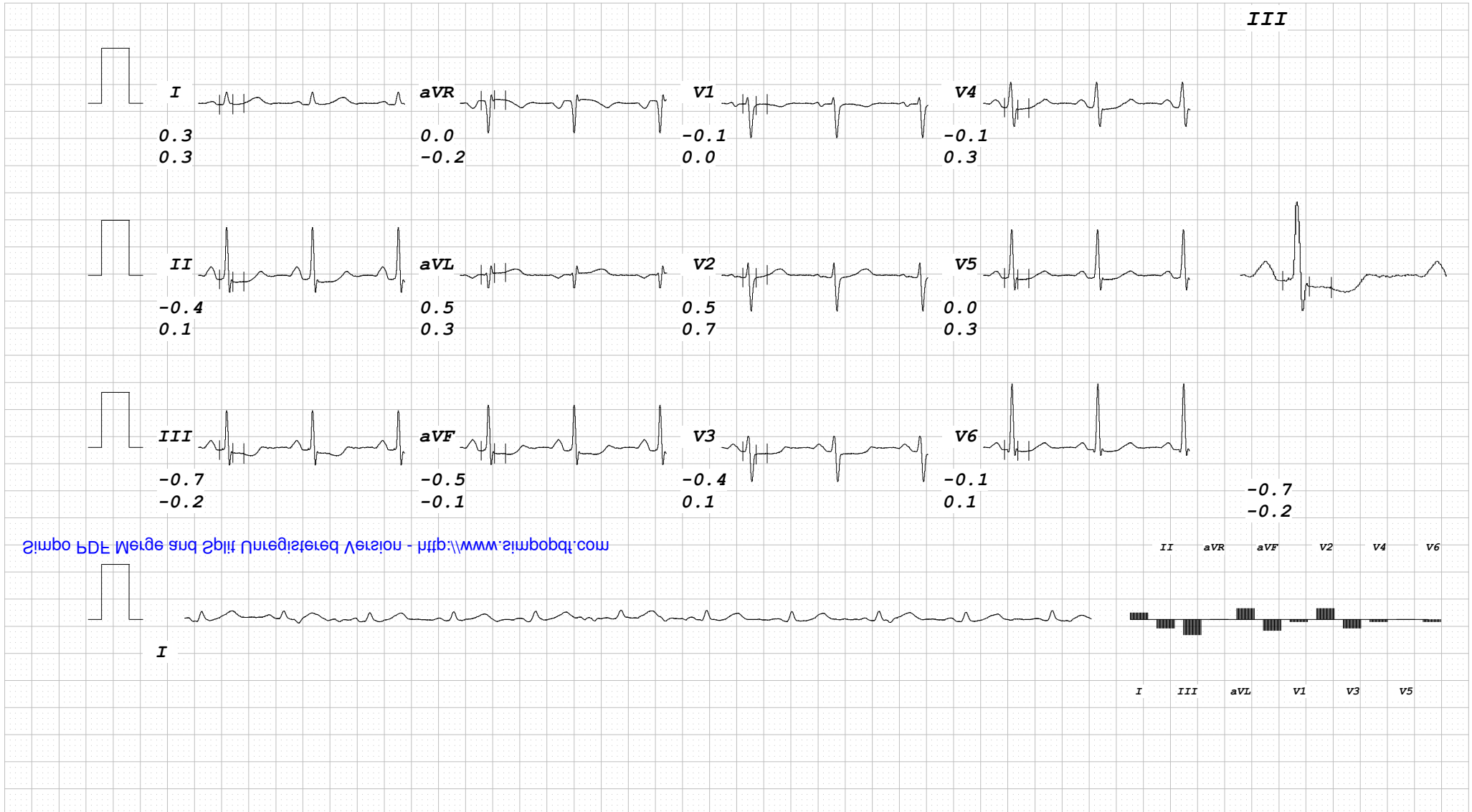
PHASE TIME 0:05

ST @ 10mm/mV
80ms PostJ

LINKED MEDIAN

Mag. X 2

III

I	aVR	V1	V4
0.3	0.0	-0.1	-0.1
0.3	-0.2	0.0	0.3

II	aVL	V2	V5
-0.4	0.5	0.5	0.0
0.1	0.3	0.7	0.3

III	aVF	V3	V6
-0.7	-0.5	-0.4	-0.1
-0.2	-0.1	0.1	0.1

| | -0.7 |
| | -0.2 |

II   aVR   aVF   V2   V4   V6

I

I   III   aVL   V1   V3   V5

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RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 95bpm
B.P. 120/80

PRETEST
VALSALVA

ST @ 10mm/mV
80ms PostJ
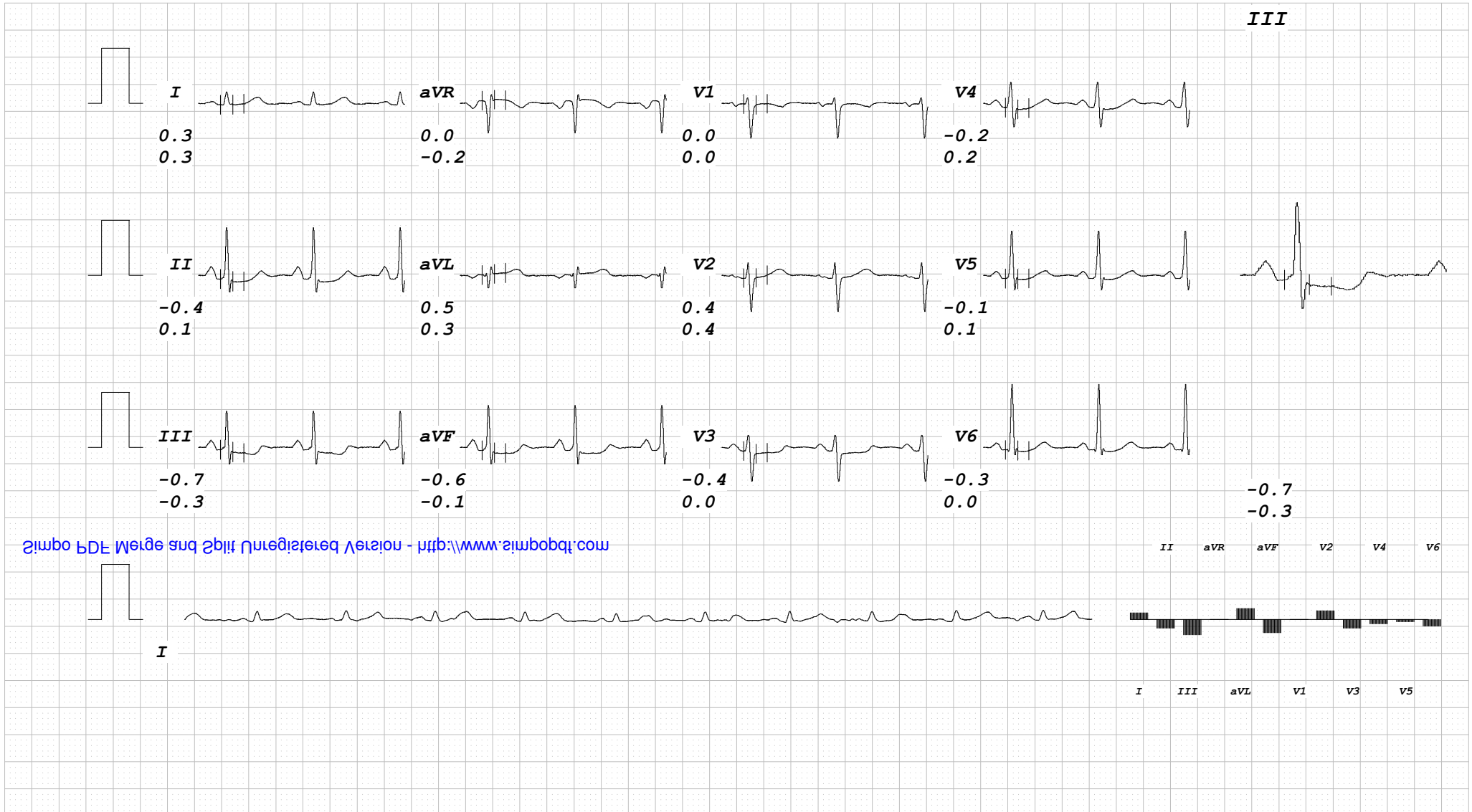
LINKED MEDIAN

Mag. X 2

III

I	aVR	V1	V4
0.3	0.0	0.0	-0.2
0.3	-0.2	0.0	0.2

II	aVL	V2	V5
-0.4	0.5	0.4	-0.1
0.1	0.3	0.4	0.1

III	aVF	V3	V6
-0.7	-0.6	-0.4	-0.3
-0.3	-0.1	0.0	0.0

-0.7
-0.3

II   aVR   aVF   V2   V4   V6

I

I   III   aVL   V1   V3   V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 133bpm
B.P. 150/80

Bruce
Stage 1
TOTAL TIME 2:55
PHASE TIME 2:55

ST @ 10mm/mV
80ms PostJ
Speed 2.7 km/hr
SLOPE 10 %

LINKED MEDIAN

Mag. X 2
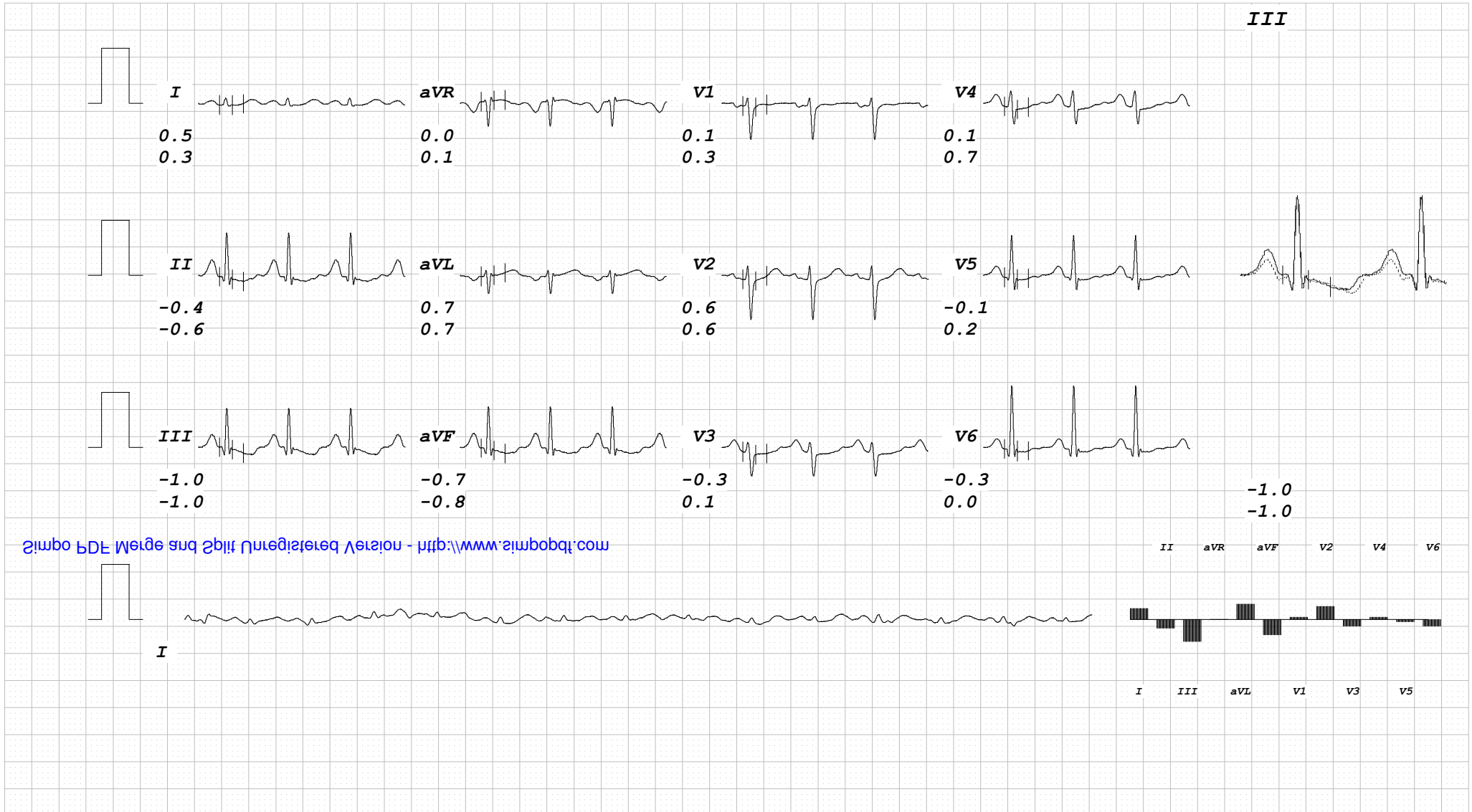
III

I	aVR	V1	V4
0.5	0.0	0.1	0.1
0.3	0.1	0.3	0.7

II	aVL	V2	V5
-0.4	0.7	0.6	-0.1
-0.6	0.7	0.6	0.2

III	aVF	V3	V6
-1.0	-0.7	-0.3	-0.3
-1.0	-0.8	0.1	0.0

-1.0
-1.0

I

II aVR aVF V2 V4 V6

I III aVL V1 V3 V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 146bpm
B.P. 156/80

Bruce
Stage 2
TOTAL TIME 5:55
PHASE TIME 2:55

ST @ 10mm/mV
80ms PostJ
Speed 4 km/hr
SLOPE 12 %

LINKED MEDIAN

Mag. X 2

V3

I
0.2
0.3

aVR
0.1
0.3

V1
0.0
0.3

V4
-0.5
0.7

II
-0.5
-0.8

aVL
0.5
0.7

V2
0.6
1.3

V5
-0.4
0.5

III
-0.7
-1.1

aVF
-0.6
-1.0

V3
-0.8
0.4

V6
-0.3
0.1

-0.8
0.4

I

II aVR aVF V2 V4 V6

I III aVL V1 V3 V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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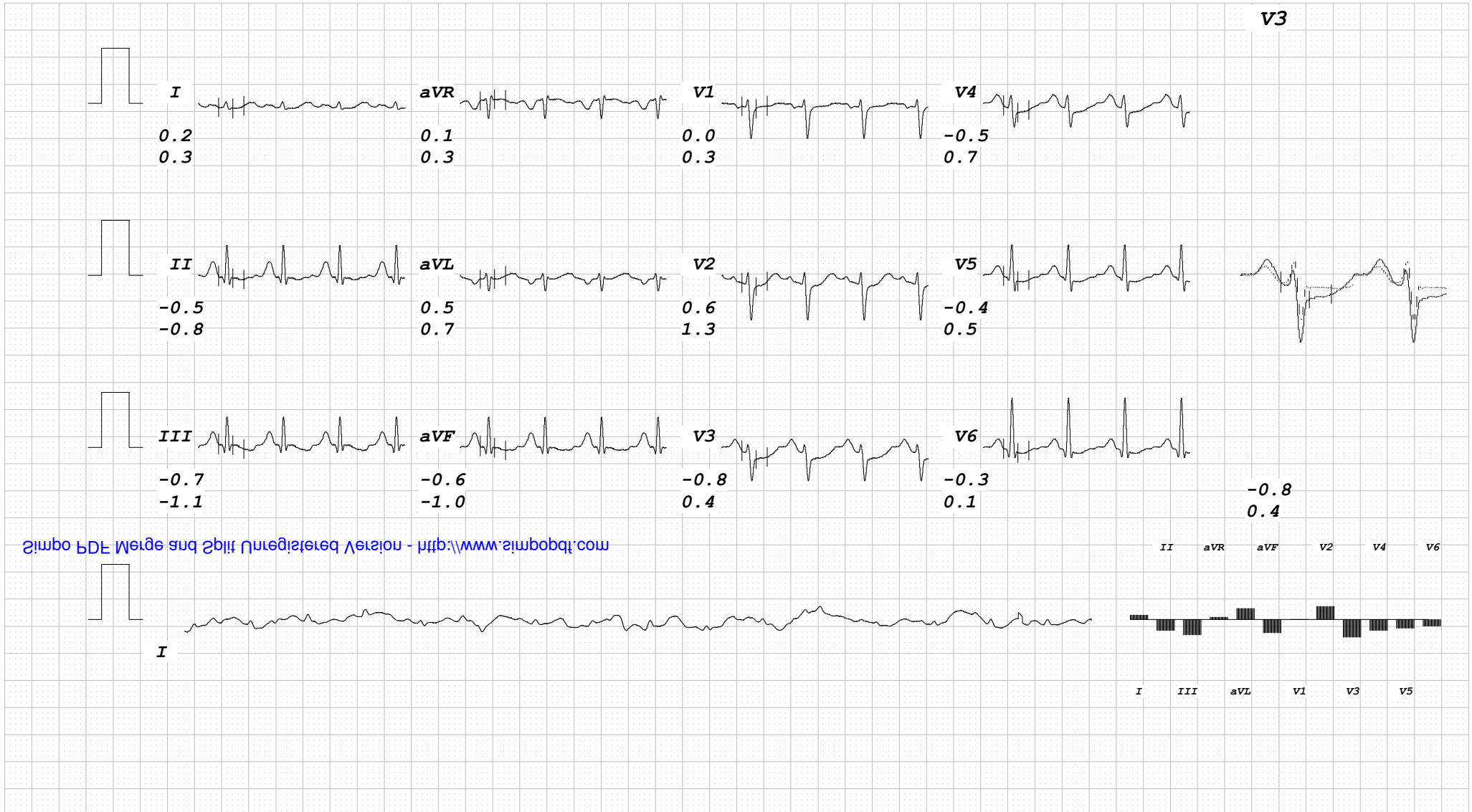
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RASHI KATIYAR
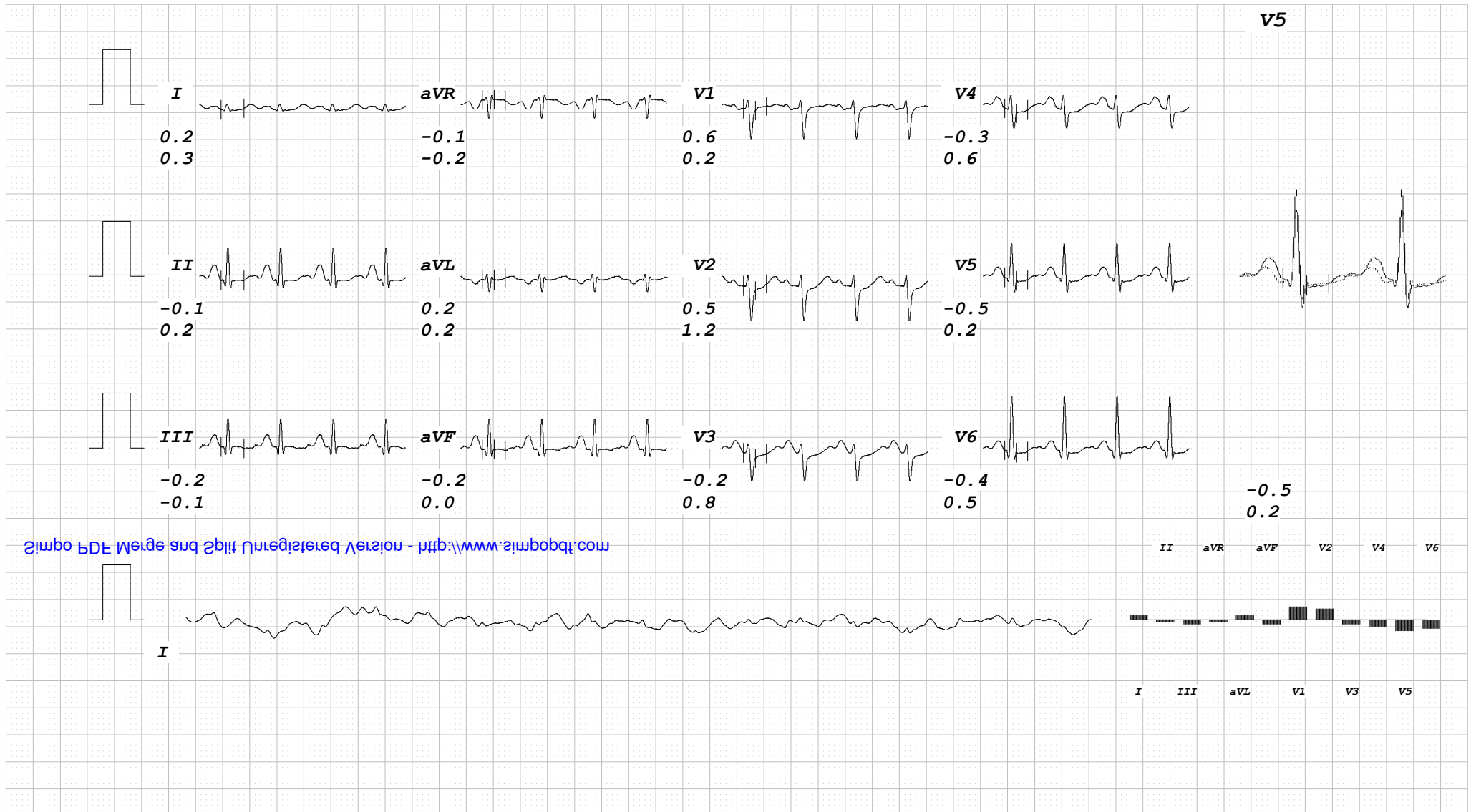I.D. 58
Age 38/F
Date 28-09-2024

RATE 156bpm
B.P. 156/80

Bruce
PK-EXERCISE
TOTAL TIME 7:00
PHASE TIME 1:00

ST @ 10mm/mV
80ms PostJ
Speed 5.4 km/hr
SLOPE 14 %

LINKED MEDIAN

Mag. X 2

V5

I	aVR	V1	V4
0.2	-0.1	0.6	-0.3
0.3	-0.2	0.2	0.6

II	aVL	V2	V5
-0.1	0.2	0.5	-0.5
0.2	0.2	1.2	0.2

III	aVF	V3	V6
-0.2	-0.2	-0.2	-0.4
-0.1	0.0	0.8	0.5

-0.5
0.2

I

II aVR aVF V2 V4 V6

I III aVL V1 V3 V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 126bpm
B.P. 140/80

Bruce
RECOVERY
TOTAL TIME 8:10
PHASE TIME 0:55

ST @ 10mm/mV
80ms PostJ
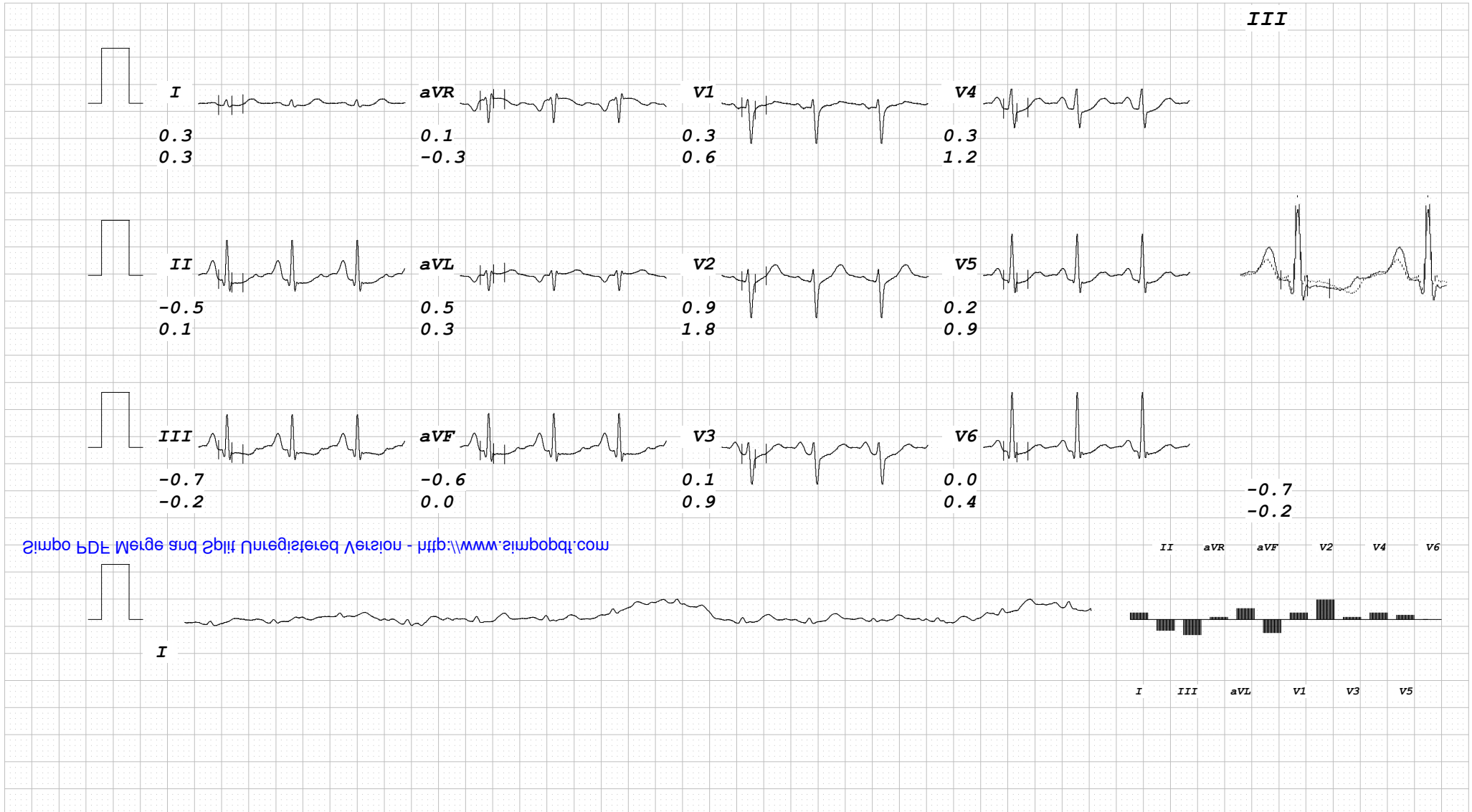
LINKED MEDIAN

Mag. X 2

III

I
0.3
0.3

aVR
0.1
-0.3

V1
0.3
0.6

V4
0.3
1.2

II
-0.5
0.1

aVL
0.5
0.3

V2
0.9
1.8

V5
0.2
0.9

III
-0.7
-0.2

aVF
-0.6
0.0

V3
0.1
0.9

V6
0.0
0.4

-0.7
-0.2

II   aVR   aVF   V2   V4   V6

I

I   III   aVL   V1   V3   V5

UNI-EM

RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 111bpm
B.P. 120/80

Bruce
RECOVERY
TOTAL TIME 9:10
PHASE TIME 1:55

ST @ 10mm/mV
80ms PostJ
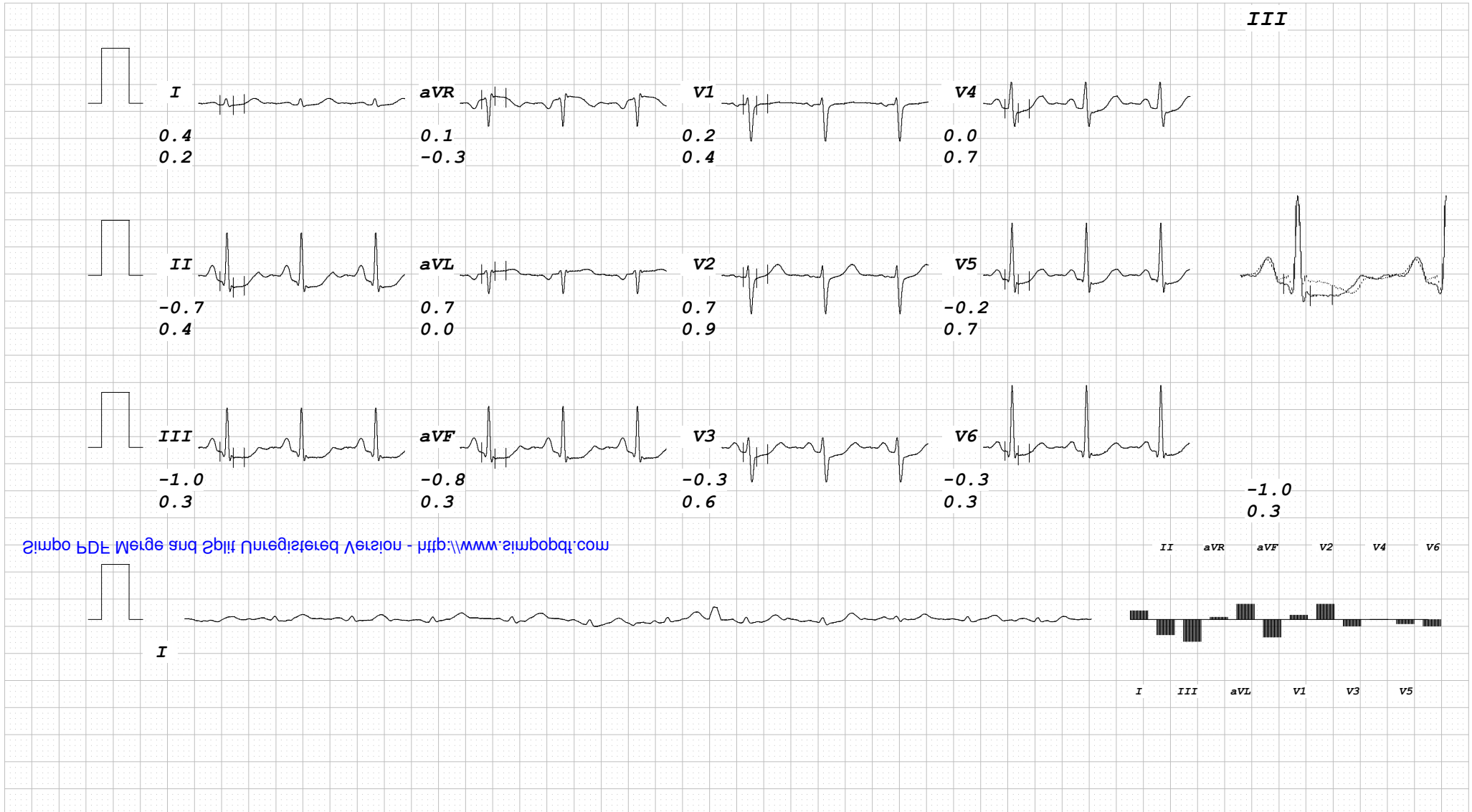
LINKED MEDIAN

Mag. X 2

III

I
0.4
0.2

aVR
0.1
-0.3

V1
0.2
0.4

V4
0.0
0.7

II
-0.7
0.4

aVL
0.7
0.0

V2
0.7
0.9

V5
-0.2
0.7

III
-1.0
0.3

aVF
-0.8
0.3

V3
-0.3
0.6

V6
-0.3
0.3

-1.0
0.3

II   aVR   aVF   V2   V4   V6

I

I   III   aVL   V1   V3   V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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UNI-EM

RASHI KATIYAR
I.D. 58
Age 38/F
Date 28-09-2024

RATE 114bpm
B.P. 110/80

Bruce
RECOVERY
TOTAL TIME 10:10
PHASE TIME 2:55

ST @ 10mm/mV
80ms PostJ

LINKED MEDIAN

Mag. X 2

III

I
0.3
0.2

aVR
0.3
0.0

V1
0.2
0.4

V4
-0.4
0.3

II
-0.8
-0.2

aVL
0.7
0.3

V2
0.4
1.0

V5
-0.7
0.4

III
-1.1
-0.4

aVF
-1.0
-0.3

V3
-0.4
0.4

V6
-0.4
0.6

-1.1
-0.4

II   aVR   aVF   V2   V4   V6

I

I   III   aVL   V1   V3   V5

Rhythm:Filtered(20 Cycle)&Base Corrected

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FAMILY HEALTH EXPER

HEALTHSPRING
FAMILY HEALTH EXPERTS

PATIENT'S NAME - Rashi Katiyar

AGE/GENDER - 38/Female

DOCTOR'S NAME - Dr. Rajesh Shinde

DATE - 28/9/24

VISION SCREENING

	RE Glasses	RE UNAIDED	LE Glasses	LE UNAIDED
DISTANT		6/9		6/9
NEAR		N/6		N/6
COLOUR		Normal.		
Recommendations				

VITALS

Pulse - 80	B.P- 120/70	SpO2 98
Height 153.	Weight - 61.5	BMI-
Waist - 99	Hip - 110.	Waist/Hip Ratio-
Chest - 103	Inspiration-	Expiration-

CENTRE NAME - HS Andheri

SIGN & STAMP-

HEALTHSPRING
FAMILY HEALTH EXPERTS
Department of Pathology
Wellspring Healthcare Pvt. Ltd.
NABL Accredited

MC-6791

Patient Name : **Mrs. Rashi Katiyar**		**Reg.Date / Time**	: 28/09/2024 / 11:16:32
Age / Gender : 38 Y / Female		**Report Date / Time**	: 28/09/2024 / 20:01:03
Referred By : Dr. Rajesh Shinde		**MR No.**	: **0850049**
SID No. : **40014121**		Page 1 of 13	

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
CBC-Haemogram & ESR, blood				
EDTA WHOLE BLOOD				
	HAEMOGLOBIN, RED CELL COUNT & INDICES			
	HAEMOGLOBIN (Spectrophotometry)	12.1	gm%	12.0-15.0
	PCV (Electrical Impedance)	**35.7**	%	40 - 50
	MCV (Calculated)	91.9	fL	83-101
	MCH (Calculated)	31.3	pg	27.0 - 32.0
	MCHC (Calculated)	34.0	g/dl	31.5-34.5
	RDW-CV (Calculated)	14	%	11.6-14.0
	RDW-SD (Calculated)	**54**	fL	36 - 46
	TOTAL RBC COUNT (Electrical Impedance)	3.88	Million/cmm	3.8-4.8
	TOTAL WBC COUNT (Electrical Impedance)	9020	/cumm	4000-10000
	DIFFERENTIAL WBC COUNT			
	NEUTROPHILS (Flow cell)	63.6	%	40-80
	LYMPHOCYTES (Flow cell)	27.7	%	20-40
	EOSINOPHILS (Flow cell)	2.8	%	1-6
	MONOCYTES (Flow cell)	5.0	%	2-10
	BASOPHILS (Flow cell)	**0.9**	%	1-2
	ABSOLUTE WBC COUNT			
	ABSOLUTE NEUTROPHIL COUNT (Calculated)	5720	/cumm	2000-7000
	ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2500	/cumm	1000-3000

Contd ...

Family Doctor   Diagnostics   Diet & Nutrition   Physiotherapy   Comprehensive Chronic Care   Home Care   Dental Service   Mental Health   Vaccination   Pharmacy   24x7 Emergency⁺

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Department of Pathology
Wellspring Healthcare Pvt. Ltd.
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MC-6791

Patient Name : **Mrs. Rashi Katiyar**		**Reg.Date / Time**	: 28/09/2024 / 11:16:32
Age / Gender : 38 Y / Female		**Report Date / Time**	: 28/09/2024 / 20:01:03
Referred By : Dr. Rajesh Shinde		**MR No.**	: **0850049**
SID No. : **40014121**		Page 2 of 13	

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
	ABSOLUTE WBC COUNT			
	ABSOLUTE EOSINOPHIL COUNT (Calculated)	250	/cumm	200-500
	ABSOLUTE MONOCYTE COUNT (Calculated)	450	/cumm	200-1000
	ABSOLUTE BASOPHIL COUNT (Calculated)	80	/cumm	0-220
	PLATELET COUNT (Electrical Impedance)	367000	/cumm	150000-410000
	MPV (Calculated)	9.9	fL	6.78-13.46
	PDW (Calculated)	16.2	%	11-18
	PCT (Calculated)	0.360	%	0.15-0.50
	PERIPHERAL BLOOD SMEAR			
	COMMENTS (Microscopic)	Normocytic Normochromic RBCs		

Notes : CBC plays a role in the detection of a wide range of disorders, including anaemia, thrombocytopenia, Thrombocytosis, infection, leukaemia immune system disorder. This test measures several cellular components and features of blood (Red blood cells which play a role in tissue perfusion, White cells which in host immunity and platelets which play a role in haemostasis and coagulation). This test should be interpreted carefully, correctly and in relation to the clinical history, to provide very useful information to assist
in diagnosis, drug monitoring and management of diseases.

Sample Collected at : Andheri West

Sample Collected on : 28 Sep 2024 12:57

Sample Received on : 28 Sep 2024 15:53

Barcode :

Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

Contd ...

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MC-6791

Patient Name : **Mrs. Rashi Katiyar**		**Reg.Date / Time**	: 28/09/2024 / 11:16:32
Age / Gender : 38 Y / Female		**Report Date / Time**	: 28/09/2024 / 20:01:03
Referred By : Dr. Rajesh Shinde		**MR No.**	: **0850049**
SID No. : **40014121**		Page 3 of 13	

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
EDTA Blood	**ABO BLOOD GROUP***			
	BLOOD GROUP (Erythrocyte-Magnetized Technology)	O		
	Rh TYPE (Erythrocyte-Magnetized Technology)	NEGATIVE		

Sample Collected at : Andheri West

Sample Collected on : 28 Sep 2024 12:57

Sample Received on : 28 Sep 2024 15:53

Barcode :

Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

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Patient Name : **Mrs. Rashi Katiyar**

Age / Gender : 38 Y / Female

Referred By : Dr. Rajesh Shinde

SID No. : **40014121**

Reg.Date / Time : 28/09/2024 / 11:16:32

Report Date / Time : 28/09/2024 / 20:01:03

MR No. : **0850049**

Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
HAEMATOLOGY				
CBC-Haemogram & ESR, blood				
EDTA WHOLE BLOOD				
	ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	**46**	mm / 1 hr	0-20

Notes : The erythrocyte sedimentation rate (ESR) is a non-specific test. It is raised in a wide range of infectious, inflammatory, degenerative, and malignant conditions associated with changes in plasma proteins, particularly increases in fibrinogen, immunoglobulin, and C-reactive protein. The ESR is also affected by many other factors including anemia, pregnancy, haemoglobinopathies, hemoconcentration and treatment with anti-inflammatory drugs.

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MD,PATHOLOGY

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE LIVER PROFILE				
SERUM				
	BILIRUBIN TOTAL (Diazotization)	0.52	mg/dl	0.2 - 1.3

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN DIRECT (Diazotization)	**0.08**	mg/dl	0.1-0.4

Notes : Bile duct obstruction or damage to hepatocellular structure causes increases in the levels of both conjugated (direct) and unconjugated (indirect) bilirubin in the circulation.

	BILIRUBIN INDIRECT (Calculation)	0.44	mg/dl	0.2 - 0.7
	ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	24	U/L	<40

Notes : Elevated serum levels are found in diseases involving these tissues. Hepatobiliary diseases, such as cirrhosis, metastatic carcinoma, and viral hepatitis also increase serum AST levels.

	ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	21	U/L	<41

Notes : Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction.

	ALKALINE PHOSPHATASE (Colorimetric IFCC)	**126**	U/L	35-104

Notes : A rise in the alkaline phosphatase occurs with all forms of cholestasis, particularly with obstructive jaundice. It is also elevated in diseases of the skeletal system, such as Paget's disease, hyperparathyroidism, rickets and osteomalacia, as well as with fractures and malignant tumors.

	GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	17	U/L	<40

Notes : γ-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary diseases.Elevated GGT activities are found in the serum of patients requiring long-term medication with phenobarbital and phenytoin.

	TOTAL PROTEIN (Colorimetric)	8.20	gm/dl	6.6-8.7

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BIOCHEMISTRY				

Notes : Hyperproteinemia can be observed in cases of severe dehydration and illnesses such as multiple myeloma.

	ALBUMIN (Bromocresol Green)	4.60	gm/dl	3.5 - 5.2

Notes : Hyperalbuminemia is of little diagnostic significance except in the case of dehydration. Hypoalbuminemia occurs during many illnesses and is caused by several factors: compromised synthesis due either to liver disease or as a consequence of reduced protein uptake; elevated catabolism due to tissue damage (severe burns) or inflammation;

	GLOBULIN (Calculation)	**3.60**	gm/dl	2.0-3.5
	A/G RATIO (Calculation)	1.3		1-2

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
COMPREHENSIVE RENAL PROFILE				
SERUM				
	CREATININE (Jaffe Method)	0.8	mg/dl	0.5 - 1.1

Notes : The assay of creatinine in serum or plasma is the most commonly used test to assess renal function.

	BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	9.0	mg/dl	7-17

Notes : Elevations in blood urea nitrogen concentration are seen in inadequate renal perfusion, shock, diminished blood volume (prerenal causes), chronic nephritis, nephrosclerosis, tubular necrosis, glomerular nephritis (renal causes) and urinary tract obstruction (postrenal causes). Transient elevations may also be seen during periods of high protein intake.
Unpredictable levels occur with liver diseases.

	BUN/CREATININE RATIO (Calculation)	11.2		10 - 20
	URIC ACID (Uricase Enzyme)	5.9	mg/dl	2.5 - 6.2

Notes : Uric acid measurements are used in the diagnosis and treatment of numerous renal and metabolic disorders, including renal failure, gout, leukemia, psoriasis, starvation or other wasting conditions, and of patients receiving cytotoxic drugs.

	CALCIUM (Bapta Method)	9.5	mg/dl	8.6-10

Notes : Increased serum calcium levels is observed in multiple myeloma and other neoplastic diseases. Hypocalcemia may be
observed e.g. in hypoparathyroidism, nephrosis, and pancreatitis.

	PHOSPHORUS (Phosphomolybdate)	3.8	mg/dl	2.5-4.5

Notes : An increase in the level of phosphorus causes a decrease in the calcium level. The mechanism is influenced by interactions between parathormone and vitamin D. Hypoparathyroidism, vitamin D intoxication and renal failure with decreased glomerular phosphate filtration give rise to hyperphosphatemia. Hypophosphatemia occurs in rickets, hyperparathyroidism and Fanconi's syndrome

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
LIPID PROFILE				
SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	**237**	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239

Notes : Cholesterol assays are used for screening for atherosclerotic risk and in the diagnosis and treatment of disorders involving elevated cholesterol levels as well as lipid and lipoprotein metabolic disorders.

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	128	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499

Notes : The determination of triglycerides is utilized in the diagnosis and treatment of patients having diabetes mellitus, nephrosis, liver obstruction, lipid metabolism disorders and numerous other endocrine diseases.

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	45	mg/dl	Low:<40 High:>60

Notes : Elevated HDL-cholesterol concentrations protect against coronary heart disease (CHD), whereas reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase cardiovascular risk.

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
SERUM	LDL CHOLESTEROL (Calculation)	**166**	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	26	mg/dl	15-40
SERUM	CHOL / HDL RATIO	**5.3**		3-5
SERUM	LDL /HDL RATIO (Calculation)	**3.7**		0 - 3.5

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval

BIOCHEMISTRY

| FLOURIDE PLASMA | BLOOD GLUCOSE FASTING (Hexokinase) | 93 | mg/dl | 70 - 110 |

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

| FLOURIDE PLASMA | BLOOD GLUCOSE POST PRANDIAL (Hexokinase) | 102 | mg/dl | 70 - 140 |

Notes : The most frequent cause of hyperglycemia is diabetes mellitus resulting from a deficiency in insulin secretion or action.
-Hypoglycemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism or insulin induced hypoglycemia.

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Specimen	Test Name / Method	Result	Units	Biological Reference Interval
BIOCHEMISTRY				
EDTA WHOLE BLOOD	**GLYCOSYLATED HAEMOGLOBIN (HbA1C)**			
	HbA1C (High Performance Liquid Chromatography)	5.6	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
	ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	114	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.

HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
IMMUNOLOGY				
THYROID PROFILE - TOTAL				
SERUM				
	TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.34	ng/ml	0.7-2.04
	TOTAL THYROXINE (T4) (ECLIA)	6.92	ug/dl	5.5 - 11
	THYROID STIMULATING HORMONE (TSH) (ECLIA)	**45.172**	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level.The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)
-Low TSH, Low   FT4 - Central hypothyroidism.
-Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
-Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter,Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
-Normal TSH,Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism,Medications.
-Normal TSH, High FT4-   Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbumineic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
-High TSH, Low   FT4- Primary hypothyroidism.
-High TSH, Normal FT4-   Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
-High TSH, High FT4- TSH mediated hyperthyroidism

Note:
1.   Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2.   Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3.   Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:
1.   Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2.   "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3.   Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4.   Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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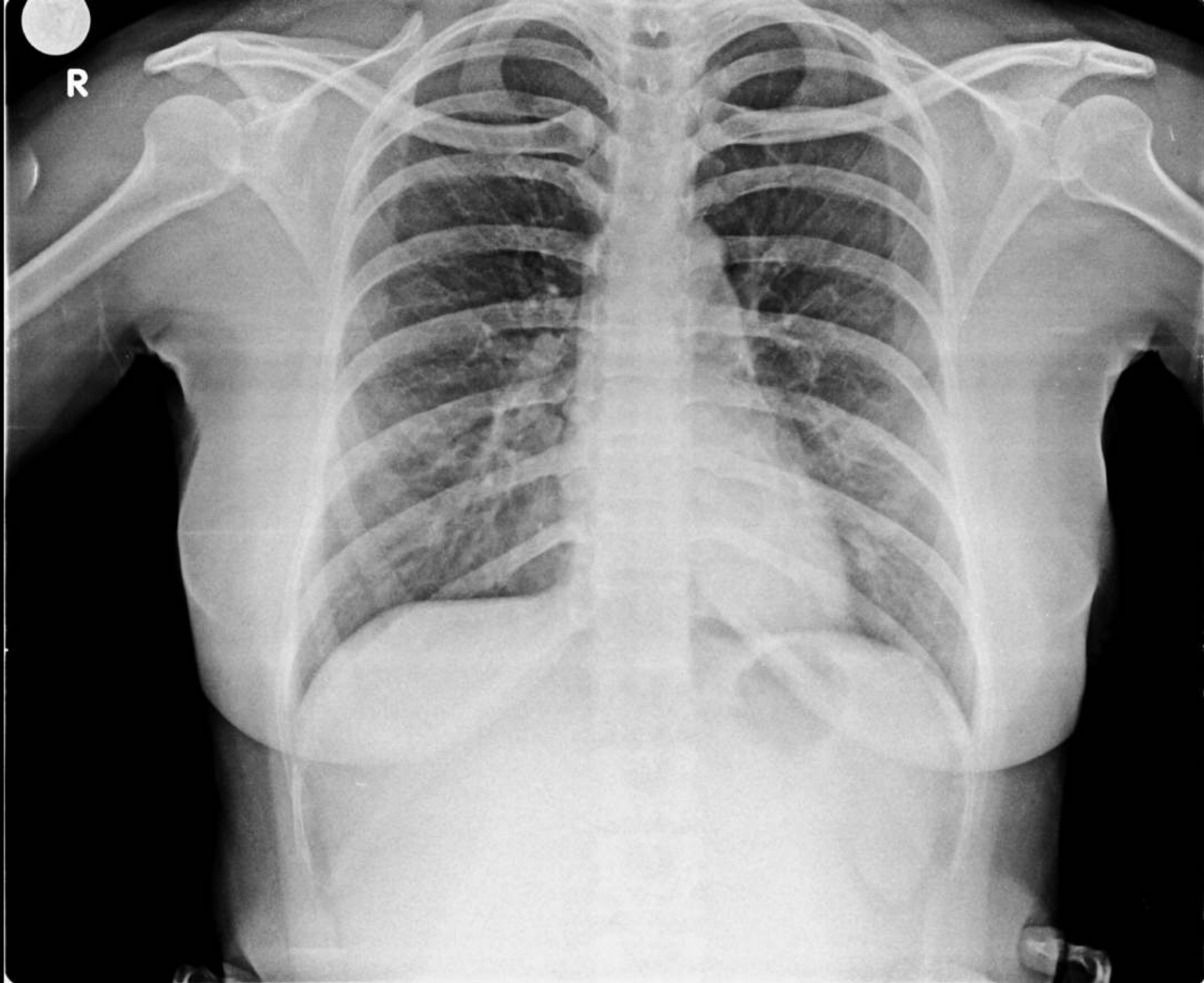| Specimen	Test Name / Method	Result	Units	Biological Reference Interval

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