
sprtsun
Bank of Baroda
INDEX
LEFT ARM
GPS Map Camera
Jaipur, Rajasthan, India
XQ8J+3RF, Sector 2, Central Spine, Vidyadhar Nagar, Jaipur, Rajasthan 302032, India
Lat 26.965465°
Long 75.782024°
25/12/23 09:43 AM GMT +05:30
Google


आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
SUBHASH CHAND KUMAWAT
MOOL CHAND KUMAWAT
17/11/1989
Permanent Account Number
DONPK9247H
Signature

Subhash.

Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041

# P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave-II, Near Axix Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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## General Physical Examination

Date of Examination: 05/12/23

Name: SUBHASH CHAND KUMAWAT Age: 34YRS DOB: 17/11/1988 Sex: Male

Referred By: BANK OF BARODA

Photo ID: PAN CARD ID #: DONPK9947H

Ht: 165 (cm) Wt: 80 (Kg)

Chest (Expiration): 90 (cm) Abdomen Circumference: 79 (cm)

Blood Pressure: 130/80 mm Hg PR: 89/ min RR: 18 / min Temp: Afebrile

BMI 29

Eye Examination: with glass
RE- G1G, N1G, NCB
LE- G1G, N1G, NCB

Other: NO

On examination he/she appears physically and mentally fit: ~~Yes~~ / No

Signature Of Examine : ---------- Name of Examinee: SUBHASH CHAND KUMAWAT

Signature Medical Examiner : ---------- Name Medical Examiner DR. PIYUSH GOYAL

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RMC No.-037041

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| **NAME :- Mr. SUBHASH CHAND KUMAWAT** | Patient ID :-12234242 | Date :- 25/12/2023 | 09:26:07 |
| Age :- 34 Yrs 1 Mon 7 Days | Ref. By Doctor:-BANK OF BARODA | | |
| Sex :- Male | Lab/Hosp :- | | |
| | Company :- Mr.MEDIWHEEL | | |

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**HAEMOGARAM**

## HAEMATOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| FULL BODY HEALTH CHECKUP BELOW 40 MALE | | | |
| **HAEMOGLOBIN (Hb)** | 13.6 | g/dL | 13.0 - 17.0 |
| **TOTAL LEUCOCYTE COUNT** | 4.30 | /cumm | 4.00 - 10.00 |
| **DIFFERENTIAL LEUCOCYTE COUNT** | | | |
| NEUTROPHIL | 50.0 | % | 40.0 - 80.0 |
| LYMPHOCYTE | **44.0** H | % | 20.0 - 40.0 |
| EOSINOPHIL | 2.0 | % | 1.0 - 6.0 |
| MONOCYTE | 4.0 | % | 2.0 - 10.0 |
| BASOPHIL | 0.0 | % | 0.0 - 2.0 |
| TOTAL RED BLOOD CELL COUNT (RBC) | **4.48** L | x10^6/uL | 4.50 - 5.50 |
| HEMATOCRIT (HCT) | 41.80 | % | 40.00 - 50.00 |
| MEAN CORP VOLUME (MCV) | 93.0 | fL | 83.0 - 101.0 |
| MEAN CORP HB (MCH) | 30.3 | pg | 27.0 - 32.0 |
| MEAN CORP HB CONC (MCHC) | 32.5 | g/dL | 31.5 - 34.5 |
| **PLATELET COUNT** | 185 | x10^3/uL | 150 - 410 |
| RDW-CV | 13.0 | % | 11.6 - 14.0 |

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## HAEMATOLOGY

| | | | |
|---|---|---|---|
| **Erythrocyte Sedimentation Rate (ESR)** | 10 | mm in 1st hr | 00 - 15 |

Methord - Westergreen

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as

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**(CBC): Methodology**: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and **MCH,MCV,MCHC,MENTZER INDEX** are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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## BIOCHEMISTRY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| FASTING BLOOD SUGAR (Plasma)<br>Methord - GOD POD | 97.3 | mg/dl | 70.0 - 115.0 |

| | |
|---|---|
| Impaired glucose tolerance (IGT) | 111 - 125 mg/dL |
| Diabetes Mellitus (DM) | > 126 mg/dL |

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm,
hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin
therapy or various liver diseases .

| | | | |
|---|---|---|---|
| BLOOD SUGAR PP (Plasma)<br>Methord:- GOD PAP | 102.0 | mg/dl | 70.0 - 140.0 |

**Instrument Name: HORIBA Interpretation:** Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

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## HAEMATOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| **GLYCOSYLATED HEMOGLOBIN (HbA1C)** | | | |
| Methord:- CAPILLARY with EDTA | 5.6 | mg% | Non-Diabetic < 6.0<br>Good Control 6.0-7.0<br>Weak Control 7.0-8.0<br>Poor control > 8.0 |
| MEAN PLASMA GLUCOSE<br>Methord:- Calculated Parameter | 110 | mg/dL | 68 - 125 |

**INTERPRETATION**

AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

**CLINICAL NOTES**

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.

Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al ]

1. Erythropoiesis
- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation
- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction
- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others
- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use,chronic renal failure
- Decreased HbA1c: hypertriglyceridemia,reticulocytosis, chronic liver disease, aspirin, vitamin C and E,splenomegaly, rheumatoid arthritis or drugs

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## HAEMATOLOGY

| | |
|---|---|
| BLOOD GROUP ABO<br>Methord - Haemagglutination reaction | "B" POSITIVE |

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## BIOCHEMISTRY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| **LIPID PROFILE** | | | |
| TOTAL CHOLESTEROL<br>Methord:- CHOD-PAP methodology | 148.00 | mg/dl | Desirable <200<br>Borderline 200-239<br>High> 240 |
| **InstrumentName**:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders. | | | |
| TRIGLYCERIDES<br>Methord:- GPO-PAP | **198.00** H | mg/dl | Normal <150<br>Borderline high 150-199<br>High 200-499<br>Very high >500 |
| **InstrumentName**:Randox Rx Imola **Interpretation** : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction. | | | |
| DIRECT HDL CHOLESTEROL<br>Methord:- Direct clearance Method | 40.20 | mg/dl | MALE- 30-70<br>FEMALE - 30-85 |
| **Instrument Name**:Rx Daytona plus **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies.Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods. | | | |
| LDL CHOLESTEROL<br>Methord:- Calculated Method | 74.80 | mg/dl | Optimal <100<br>Near Optimal/above optimal 100-129<br>Borderline High 130-159<br>High 160-189<br>Very High > 190 |
| VLDL CHOLESTEROL<br>Methord:- Calculated | 39.60 | mg/dl | 0.00 - 80.00 |
| T.CHOLESTEROL/HDL CHOLESTEROL RATIO<br>Methord:- Calculated | 3.68 | | 0.00 - 4.90 |
| LDL / HDL CHOLESTEROL RATIO<br>Methord:- Calculated | 1.86 | | 0.00 - 3.50 |
| TOTAL LIPID<br>Methord:- CALCULATED | 551.40 | mg/dl | 400.00 - 1000.00 |

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is

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## BIOCHEMISTRY

recommended

3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated fromperipheral tissues.

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## BIOCHEMISTRY

### LIVER PROFILE WITH GGT

| | | | |
|---|---|---|---|
| SERUM BILIRUBIN (TOTAL)<br>Methord:- DMSO/Diazo | 0.60 | mg/dL | Infants : 0.2-8.0 mg/dL<br>Adult - Up to - 1.2 mg/dL |
| SERUM BILIRUBIN (DIRECT)<br>Methord:- DMSO/Diazo | 0.16 | mg/dL | Up to 0.40 mg/dL |
| SERUM BILIRUBIN (INDIRECT)<br>Methord:- Calculated | 0.44 | mg/dl | 0.30-0.70 |
| SGOT<br>Methord:- IFCC | 32.7 | U/L | 0.0 - 40.0 |
| SGPT<br>Methord:- IFCC | 38.3 | U/L | 0.0 - 40.0 |
| SERUM ALKALINE PHOSPHATASE<br>Methord:- DGKC - SCE | 88.00 | U/L | 53.00 - 141.00 |
| SERUM GAMMA GT<br>Methord:- Szasz methodology<br>Instrument Name Randox Rx Imola | 29.60 | U/L | 10.00 - 45.00 |

Interpretation: Elevations in GGT levels areseen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)are observed with infectious hepatitis.

| | | | |
|---|---|---|---|
| SERUM TOTAL PROTEIN<br>Methord:- Direct Biuret Reagent | 7.25 | g/dl | 6.00 - 8.40 |
| SERUM ALBUMIN<br>Methord:- Bromocresol Green | 4.32 | g/dl | 3.50 - 5.50 |
| SERUM GLOBULIN<br>Methord:- CALCULATION | 2.93 | gm/dl | 2.20 - 3.50 |
| A/G RATIO | 1.47 | | 1.30 - 2.50 |

**Interpretation** : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e g , albumin), some with cellular integrity (e.g , transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase) Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc.Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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## BIOCHEMISTRY

### RFT / KFT WITH ELECTROLYTES

| | | | |
|---|---|---|---|
| SERUM UREA<br>Methord:- Urease/GLDH | 30.20 | mg/dl | 10.00 - 50.00 |

**InstrumentName**: HORIBA CA 60 **Interpretation** : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

| | | | |
|---|---|---|---|
| SERUM CREATININE<br>Methord:- Jaffe's Method | 1.23 | mg/dl | Males : 0.6-1.50 mg/dl<br>Females : 0.6 -1.40 mg/dl |

**Interpretation :**
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

| | | | |
|---|---|---|---|
| SERUM URIC ACID | 4.72 | mg/dl | 2.40 - 7.00 |

**InstrumentName**:HORIBA YUMIZEN CA60 Daytona plus **Interpretation**: **Elevated Urate**:High purine diet,Alcohol• Renal insufficiency,Drugs , Polycythaemia vera, Malignancies,Hypothyroidism,Rare enzyme defects ,Downs syndrome,Metabolic syndrome, Pregnancy,Gout.

| | | | |
|---|---|---|---|
| SODIUM<br>Methord:- ISE | 138.9 | mmol/L | 135.0 - 150.0 |
| POTASSIUM<br>Methord:- ISE | 4.31 | mmol/L | 3.50 - 5.50 |
| CHLORIDE<br>Methord:- ISE | 98.9 | mmol/L | 94.0 - 110.0 |
| SERUM CALCIUM<br>Methord:- Arsenazo III Method | 10.00 | mg/dL | 8.80 - 10.20 |

**InstrumentName**:MISPA PLUS **Interpretation**: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

| | | | |
|---|---|---|---|
| SERUM TOTAL PROTEIN<br>Methord:- Direct Biuret Reagent | 7.25 | g/dl | 6.00 - 8.40 |
| SERUM ALBUMIN<br>Methord:- Bromocresol Green | 4.32 | g/dl | 3.50 - 5.50 |
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## BIOCHEMISTRY

bone marrow as well as other metabolic or nutritional disorders.

**INTERPRETATION**

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare, they almost always reflect low muscle mass.

Apart from renal failure Blood Urea can increase in dehydration and GI bleed

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## CLINICAL PATHOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| **Urine Routine** | | | |
| **PHYSICAL EXAMINATION** | | | |
| COLOUR | PALE YELLOW | | PALE YELLOW |
| APPEARANCE | Clear | | Clear |
| **CHEMICAL EXAMINATION** | | | |
| REACTION(PH) | 5.5 | | 5.0 - 7.5 |
| SPECIFIC GRAVITY | 1.025 | | 1.010 - 1.030 |
| PROTEIN | NIL | | NIL |
| SUGAR | NIL | | NIL |
| BILIRUBIN | NEGATIVE | | NEGATIVE |
| UROBILINOGEN | NORMAL | | NORMAL |
| KETONES | NEGATIVE | | NEGATIVE |
| NITRITE | NEGATIVE | | NEGATIVE |
| **MICROSCOPY EXAMINATION** | | | |
| RBC/HPF | NIL | /HPF | NIL |
| WBC/HPF | 2-3 | /HPF | 2-3 |
| EPITHELIAL CELLS | 2-3 | /HPF | 2-3 |
| CRYSTALS/HPF | ABSENT | | ABSENT |
| CAST/HPF | ABSENT | | ABSENT |
| AMORPHOUS SEDIMENT | ABSENT | | ABSENT |
| BACTERIAL FLORA | ABSENT | | ABSENT |
| YEAST CELL | ABSENT | | ABSENT |
| OTHER | ABSENT | | |

**Technologist**
VIKARANT5

**DR.TANU RUNGTA**
MD (Pathology)
RMC No. 17226

# P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave-II, Near Axix Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com


| | | | |
|---|---|---|---|
| **NAME :- Mr. SUBHASH CHAND KUMAWAT** | | Patient ID :-12234242 | Date :- 25/12/2023 09:26:07 |
| Age :- | 34 Yrs 1 Mon 7 Days | Ref. By Doctor:-BANK OF BARODA | |
| Sex :- | Male | Lab/Hosp :- | |
| | | Company :- | Mr.MEDIWHEEL |

Final Authentication : 25/12/2023 16:09:20

## CLINICAL PATHOLOGY

| | | |
|---|---|---|
| URINE SUGAR (FASTING)<br>Collected Sample Received | Nil | Nil |

**Technologist**
VIKARANT5J

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## TOTAL THYROID PROFILE

### IMMUNOASSAY

| Test Name | Value | Unit | Biological Ref Interval |
|---|---|---|---|
| **THYROID-TRIIODOTHYRONINE T3**<br>Methord:- ECLIA | 0.93 | ng/mL | 0.70 - 2.04 |

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is useful in evaluating differantial diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↑ TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or↑ T3 & ↑ 10.Normal T3 & T4 along with ↑ TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & ↑ T4 along with ↑ TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

| | | | |
|---|---|---|---|
| **THYROID-THYROXINE (T4)**<br>Methord:- ECLIA | 6.89 | µIU/ml | 5.10 - 14.10 |

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is useful in evaluating differantial diagnosis

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| | | | |
|---|---|---|---|
| **TSH**<br>Methord - ECLIA | 2.561 | µIU/mL | 0.350 - 5.500 |

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result.
Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is use

**Technologist**
VIKARANTSI

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Final Authentication : 25/12/2023 16:09:20

## IMMUNOASSAY

evaluating differantial diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay

1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease
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6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
9.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis ( problem is conversion of T4 to T3)
10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,rarely they can result from TSH secreting pituitary tumours

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

1st Trimester : 0.10-2.50 uIU/mL
2nd Trimester : 0.20-3.00 uIU/mL
3rd Trimester : 0.30-3.00 uIU/mL
The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

*** End of Report ***

**Technologist**
VIKARANTJI

**DR.TANU RUNGTA**
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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com


| NAME: | MR. SUBHASH CHAND KUMAWAT | AGE | 34 YRS/M |
|---|---|---|---|
| REF.BY | BANK OF BARODA | DATE | 25/12/2023 |

## CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

**IMPRESSION: No significant abnormality is detected in lung parenchyma.**

**Dr. Mukesh Sharma**
**M.B.B.S; M.D. (Radiodiagnosis)**
**RMC No. 43418/17437**


L 2.77 cm
L 2.83 cm


L 0.87 cm
L 4.78 cm
L 0.91 cm


L 1.18 cm
L 3.21 cm
L 1.26 cm


v 0.59 m/s
p 1.41 mmHg
Frq 1.54 kHz


v 0.72 m/s
p 2.03 mmHg
Frq 1.84 kHz
v 0.56 m/s
p 1.24 mmHg
Frq 1.42 kHz


v 0.96 m/s
p 3.72 mmHg
Frq 2.42 kHz


v 2.41 m/s
p 23.15 mmHg
Frq 6.02 kHz
v 0.55 m/s
p 1.20 mmHg
Frq 1.32 kHz
v 0.31 m/s
p 0.40 mmHg
Frq 0.83 kHz

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| MR. SUBHASH CHAND KUMAWAT | 34 Y/M |
|---|---|
| Registration Date: 25/12/2023 | Ref. by: BANK OF BARODA |

## 2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARIDIOGRAPHIC WINDOW MORPHOLOGY:

| | | | |
|---|---|---|---|
| MITRAL VALVE | NORMAL | TRICUSPID VALVE | NORMAL |
| AORTIC VALVE | NORMAL | PULMONARY VALVE | NORMAL |

M.MODE EXAMITATION:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AO | 2.7 | Cm | LA | 2.8 | cm | IVS-D | 0.8 | cm |
| IVS-S | 1.1 | cm | LVID | 4.8 | cm | LVSD | 3.2 | cm |
| LVPW-D | 0.9 | cm | LVPW-S | 1.2 | cm | RV | | cm |
| RVWT | | cm | EDV | | Ml | LVVS | | ml |
| LVEF | 55-60% | | | RWMA | | ABSENT | | |

CHAMBERS:

| | | | |
|---|---|---|---|
| LA | NORMAL | RA | NORMAL |
| LV | NORMAL | RV | NORMAL |
| PERICARDIUM | | NORMAL | |

COLOUR DOPPLER:

| MITRAL VALVE | | | | | |
|---|---|---|---|---|---|
| E VELOCITY | 0.72 | m/sec | PEAK GRADIENT | | Mm/hg |
| A VELOCITY | 0.56 | m/sec | MEAN GRADJENT | | Mm/hg |
| MVA BY PHT | | Cm2 | MVA BY PLANIMETRY | | Cm2 |
| MITRAL REGURGITATION | | | ABSENT | | |
| AORTIC VALVE | | | | | |
| PEAK VELOCITY | 0.96 | m/sec | PEAK GRADIENT | | mm/hg |
| AR VMAX | | m/sec | MEAN GRADIENT | | mm/hg |
| AORTIC REGURGITATION | | | ABSENT | | |
| TRICUSPID VALVE | | | | | |
| PEAK VELOCITY | 0.55 | m/sec | PEAK GRADIENT | | mm/hg |
| MEAN VELOCITY. | 0.31 | m/sec | MEAN GRADIENT | | mm/hg |
| VMax VELOCITY | | | | | |
| | | | | | |
| TRICUSPID REGURGITATION | | | TRACE | | |
| PULMONARY VALVE | | | | | |
| PEAK VELOCITY | 0.59 | M/sec. | PEAK GRADIENT | | Mm/hg |
| MEAN VALOCITY | | | MEAN GRADIENT | | Mm/hg |
| PULMONARY REGURGITATION | | | ABSENT | | |

**Impression—**

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- TRACE TR (RVSP 23 MMHG+ RAP).
- NORMAL DIASTOLIC FUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

Dr. JYOTI AGARWAL
M.B.B.S. PGDCC (Cardiologist)
(Cardiologist)
RMC No.- 27255


LIVER
L 139.41 mm


LIVER


L 11.24 mm
d 9.04 cm
L 0.00 mm


RT KIDNEY
PANCREAS
L 97.49 mm


SPLEEN
LT KIDNEY
L 93.27 mm


d 7.12 cm
L 0.00 mm

# P3 HEALTH SOLUTIONS LLP

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| MR. SUBHASH CHAND KUMAWAT | 34 Y/M |
|---|---|
| Registration Date: 25/12/2023 | Ref. by: BANK OF BARODA |

## ULTRASOUND OF WHOLE ABDOMEN

**Liver** is of normal size (139 mm). Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

**Gall bladder** is well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

**Pancreas** is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**Spleen** is of normal size and shape. Echotexture is normal. No focal lesion is seen.

**Kidneys** are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.
**Right kidney** is measuring approx. 97 mm.
**Left kidney** is measuring approx. 93 mm.

**Urinary bladder** is well distended and does not show any calculus or mass lesion.

**Prostate** is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
No significant free fluid is seen in pelvis.

**IMPRESSION: No significant abnormality is detected.**

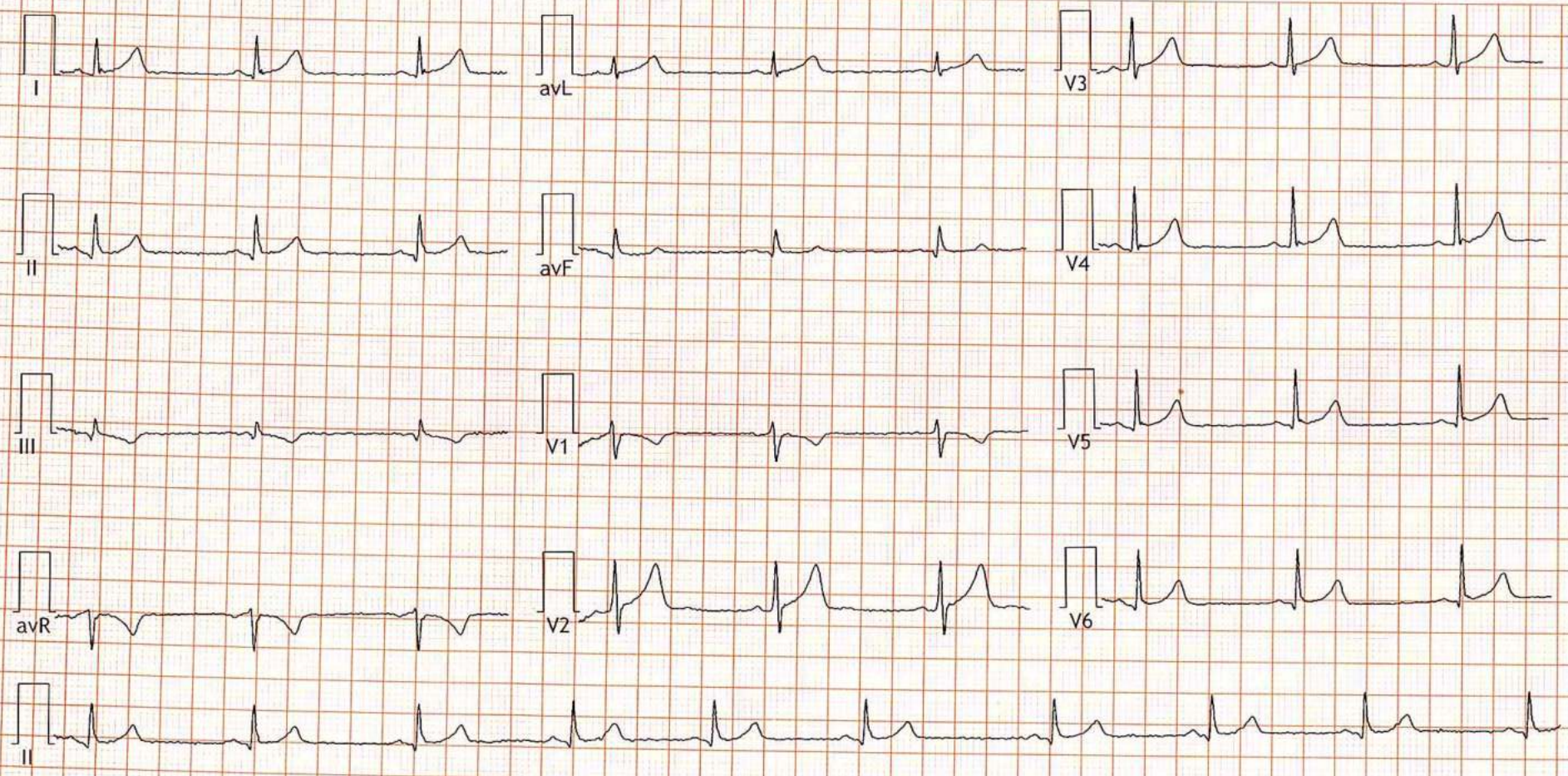
Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

Dr. MUKESH SHARMA
B.B.S., M.D.(Radiodiagnosis)
RMC No. : 43418/17437
P3 Health Solutions LLP

Tems (P) Ltd
#P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
12234242/Mr Subhash Chand Kumawat 34Yrs/Male Kgs/ Cms BP: ___/___ mmHg
Ref.: BANK OF BARODA Test Date: 25-Dec-2023(10:26:40) Notch: 50Hz 0.05Hz - 35Hz 10mm/mV 25mm/Sec

HR: 57 bpm

PR Interval: 132 ms
QRS Duration: 92 ms
QT/QTc: 386/379ms
P-QRS-T Axis: 26 - 36 - 5 (Deg)




Borderline Sinus bradycardia

FINDINGS: Abnormal ECG with Indication of Sinus Bradycardia
**Vent Rate :** 57 bpm; **PR Interval :** 132 ms; **QRS Duration:** 92 ms; **QT/QTc Int :** 386/379 ms
**P-QRS-T axis:** 26• 36• 5• (Deg)
Comments :

Subhash

Dr. Naresh Kumar Mohanka
RMC No.: 35703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)


sportstun
GPS Map Camera
Jaipur, Rajasthan, India
CANTEEN, SHANKARA EYE HOSPITAL, 6/168, Sector 2, Sector 6,
Vidyadhar Nagar, Jaipur, Rajasthan 302032, India
Lat 26.964745°
Long 75.782024°
25/12/23 09:44 AM GMT +05:30
Google


R
12234242 SUBHASH CHAND KUMAWAT 34 YRS BOB M
25.DEC.2023
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)