



BMI CHART

Date: 24/12/24

Name: mangala kamble Age: 57 yrs Sex: M/F

BP: 100/60 Height (cms): 152. Weight(kgs): 48.1 BMI: _____
mmHg cm kg

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight				Healthy				Overweight				Obese				Extremely Obese							
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature



UHID	12994072	Date	24/02/2024		
Name	Mrs Mangala Kamble	Sex	F	Age	51
OPD	PAP	Health Check-Up			

51 yr old female

Drug allergy: Nil
 Sys illness:

- Married since 28 yr

- P2 L2 A1

- P1 - 28 yr - female } FTND

- P2 - 23 yr - female }

LMP - Hysterectomy (2013).
 IIV/O cyst.

no any any Comorbidity.

FH/O → Not significant.

Adm
 - HPV (age 45)
 (0, 2, 16)

- Counselled about
 Papsmen.

pap not taken IIV/O
 Hysterectomy in (2013)

Mangala

[Signature]



7387696540

UHID	12994072	Date	24/02/2024		
Name	Mrs Mangala Kamble	Sex	F	Age	51
OPD	Optical Dental	Health Check-Up			

Drug allergy:
Sys illness:

M/H → N.R.H.

O/E →

Porcelain fracture 6/
Stain +, calculus +
Attrition (posterior)

Rs.

- Adv. RVO of 6/, crown change
- Adv Sealing

ff.
Dr Snehal Kamble
MOS Ortho,
A-29284.

PATIENT NAME : MRS.MANGALA PRASHANT KAMBLE
REF. DOCTOR :
CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022XB005189
PATIENT ID : FH.12994072
CLIENT PATIENT ID: UID:12994072
ABHA NO :
AGE/SEX : 51 Years Female
DRAWN : 24/02/2024 09:56:00
RECEIVED : 24/02/2024 09:57:41
REPORTED : 24/02/2024 12:55:23

CLINICAL INFORMATION :

 UID:12994072 REQNO-1667037
 CORP-OPD
 BILLNO-150124OPCR010939
 BILLNO-150124OPCR010939

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HAEMATOLOGY - CBC
CBC-5, EDTA WHOLE BLOOD
BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	13.3	12.0 - 15.0	g/dL
METHOD : SLS METHOD			
RED BLOOD CELL (RBC) COUNT	4.63	3.8 - 4.8	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	4.85	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	328	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	41.3	36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	89.2	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.2	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.7	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	19.3		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	9.4	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

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 Consultant Pathologist

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NEUTROPHILS		61	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		30	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		9	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		0 Low	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		2.96	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.46	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.44	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.00 Low	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.0		
METHOD : CALCULATED				

MORPHOLOGY

RBC PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
 METHOD : MICROSCOPIC EXAMINATION

WBC NORMAL MORPHOLOGY
 METHOD : MICROSCOPIC EXAMINATION

PLATELETS ADEQUATE
 METHOD : MICROSCOPIC EXAMINATION

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Interpretation(s)

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504)

This ratio element is a calculated parameter and out of NABL scope.



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CODE/NAME & ADDRESS : C000045507	ACCESSION NO : 0022XB005189	AGE/SEX : 51 Years Female
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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R **47 High** **0 - 20** **mm at 1 hr**
 METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C **5.7** **Non-diabetic: < 5.7** **%**
Pre-diabetics: 5.7 - 6.4
Diabetics: > or = 6.5
Therapeutic goals: < 7.0
Action suggested : > 8.0
(ADA Guideline 2021)

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

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-TEST DESCRIPTION :-
 Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(52 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

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REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition. GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin.
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells, Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.48	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.09	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.39	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.7	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.0	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.7	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	17	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	13	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	105	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	24	5 - 55	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	165	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	91	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
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METHOD : HEXOKINASE



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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 10 6 - 20 mg/dL
METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE 0.93 0.60 - 1.10 mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES
AGE 51 years
GLOMERULAR FILTRATION RATE (FEMALE) 74.41 Refer Interpretation Below mL/min/1.73m2
METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO 10.75 5.00 - 15.00
METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 3.6 2.6 - 6.0 mg/dL
METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.7 6.4 - 8.2 g/dL
METHOD : BIURET

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Email : -



Patient Ref. No. 22000000904786

PATIENT NAME : MRS.MANGALA PRASHANT KAMBLE

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022XB005189

PATIENT ID : FH.12994072

CLIENT PATIENT ID: UID:12994072

ABHA NO :

AGE/SEX : 51 Years Female

DRAWN : 24/02/2024 09:56:00

RECEIVED : 24/02/2024 09:57:41

REPORTED : 24/02/2024 12:55:23

CLINICAL INFORMATION :

UID:12994072 REQNO-1667037
CORP-OPD
BILLNO-150124OPCR010939
BILLNO-150124OPCR010939

Test Report Status	Final	Results	Biological Reference Interval	Units
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ALBUMIN, SERUM

ALBUMIN	4.0	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			

GLOBULIN

GLOBULIN	3.7	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	139	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.22	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	101	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. **Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.



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AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

Albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in: Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%), Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in: Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease,

malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs-insulin, ethanol, propranolol, sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons. Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m²). This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

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

Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.uw.edu/guideline/egfr>

Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325

Harrison's Principle of Internal Medicine, 21st ed. pg 62 and 334

URIC ACID, SERUM-Causes of Increased levels:-Dietary(High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic

syndrome Causes of decreased levels-Low Zinc intake, OCP, Multiple Sclerosis

TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin.

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease.

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Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	208 High	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	89	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	63 High	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	127	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	145 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	17.8	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.3	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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Final	2.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
METHOD : PHYSICAL	
APPEARANCE	HAZY
METHOD : VISUAL	

CHEMICAL EXAMINATION, URINE

PH	5.5	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD		
KETONES	DETECTED (+)	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
BLOOD	DETECTED (++) IN URINE	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	DETECTED (+)	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

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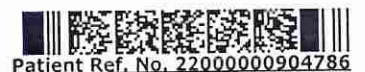
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MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	5 - 7	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	10-15	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	5-7	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
REMARKS	NOTE : AMORPHOUS DEPOSIT, URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	119.2	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	10.08	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	1.980	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

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FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022XB005266

PATIENT ID : FH.12994072

CLIENT PATIENT ID: UID:12994072

ABHA NO :

AGE/SEX : 51 Years Female

DRAWN : 24/02/2024 12:40:00

RECEIVED : 24/02/2024 12:40:20

REPORTED : 24/02/2024 14:16:38

CLINICAL INFORMATION :

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Test Report Status **Final**

Results

Biological Reference Interval Units

BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)

74

70 - 140

mg/dL

METHOD : HEXOKINASE

Comments

NOTE: POST PRANDIAL PLASMA GLUCOSE VALUES TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

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Patient Ref. No. 2200000904863

mrs mangala K
Female

12994072
51 Years

HE

Mangala K

Rate 67 . Sinus rhythm.....normal P axis, V-rate 50- 99
PR 151 . ST elev, probable normal early repol pattern.....ST elevation, age<55
QRSD 91 . Baseline wander in lead(s) V5,V6
QT 415
QTc 438

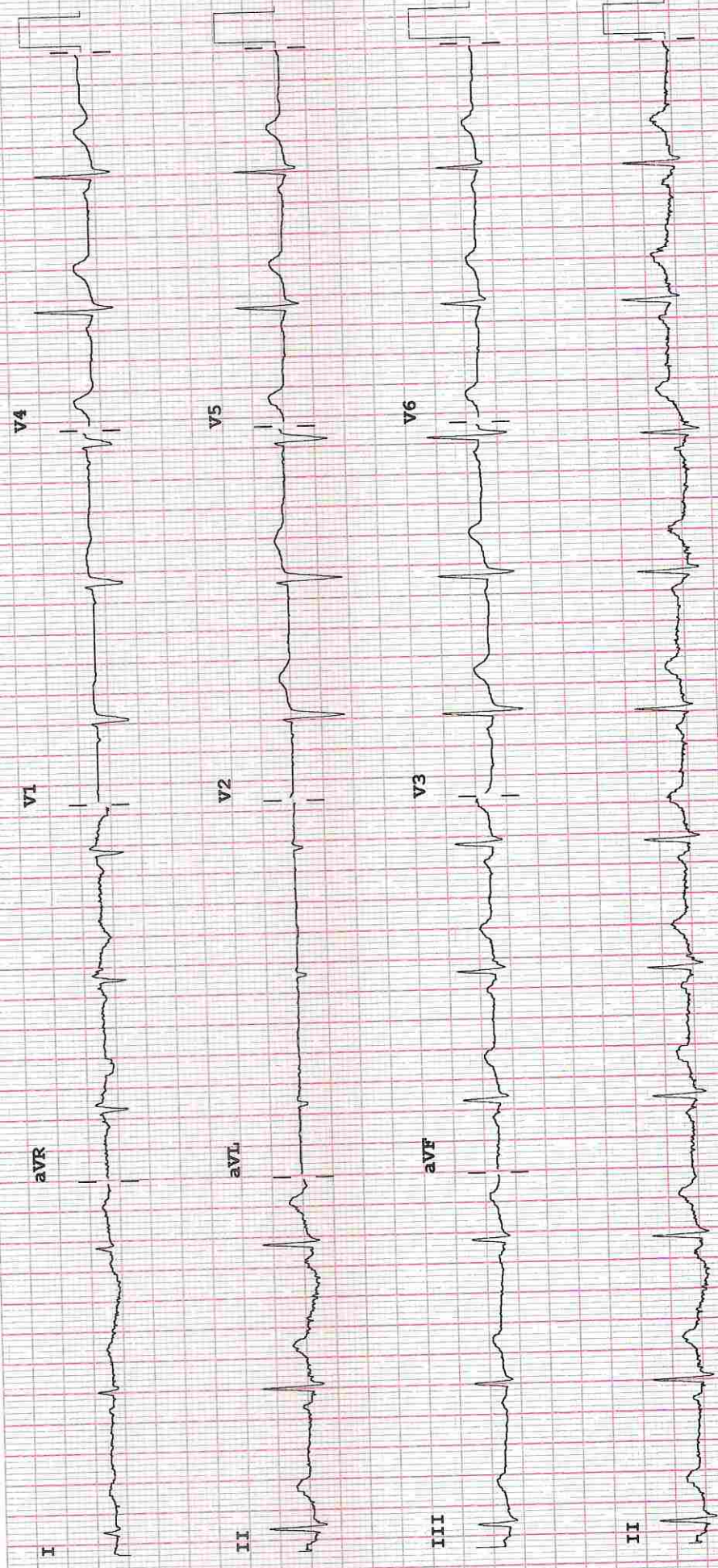
--AXIS--

P 72
QRS 77
T 66

12 Lead; Standard Placement

-- NORMAL ECG --

Unconfirmed Diagnosis



F 50~ 0.50-100 Hz W

100B CL

P?

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

Device:



DEPARTMENT OF NIC

Date: 26/Feb/2024

Name: Mrs. Mangala Prashant Kamble

UHID | Episode No : 12994072 | 11197/24/1501

Age | Sex: 51 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2402/23286 | 24-Feb-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 26-Feb-2024 13:04:30

Bed Name :

Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 30 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 14 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	21	mm
AO Root	18	mm
AO CUSP SEP	14	mm
LVID (s)	21	mm
LVID (d)	35	mm
IVS (d)	08	mm
LVPW (d)	08	mm
RVID (d)	27	mm
RA	28	mm
LVEF	60	%

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



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Date: 26/Feb/2024

DEPARTMENT OF NIC

Name: Mrs. Mangala Prashant Kamble
Age | Sex: 51 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12994072 | 11197/24/1501
Order No | Order Date: 1501/PN/OP/2402/23286 | 24-Feb-2024
Admitted On | Reporting Date : 26-Feb-2024 13:04:30
Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.
A WAVE VELOCITY: 0.6m/sec
E/A RATIO: 1.2

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	05			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

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

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

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Date: 24/Feb/2024

DEPARTMENT OF RADIOLOGY

(For Billing/Reports & Discharge Summary only)

Name: Mrs. Mangala Prashant Kamble

Age | Sex: 51 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12994072 | 11197/24/1501

Order No | Order Date: 1501/PN/OP/2402/23286 | 24-Feb-2024

Admitted On | Reporting Date : 24-Feb-2024 19:03:18

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. ABHIJEET BHAMBURE
DMRD, DNB (Radiologist)



Patient Name	:	Mangala Prashant Kamble	Patient ID	:	12994072
Sex / Age	:	F / 51Y 11M 25D	Accession No.	:	PHC.7548193
Modality	:	US	Scan DateTime	:	24-02-2024 12:26:30
IPID No	:	11197/24/1501	ReportDatetime	:	24-02-2024 12:34:06

USG – WHOLE ABDOMEN

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

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

CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 9.8 x 3.8 cm.

Left kidney measures 9.4 x 4.5 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

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

UTERUS – post hysterectomy status.

Right ovary – post salpingo-oophorectomy status.

Left ovary could not be visualised – likely atrophic.

No evidence of ascites.

Impression:

- No significant abnormality is detected.

DR. CHETAN KHADKE

M.D. (Radiologist)