Patient NAME	**: Mr Prabhakar Jha**		
DOB/Age/Gender	: 47 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 10117106/RCL9379988	Barcode NO	: HQ623815
Referred BY	: Self	Sample Type	: Whole blood EDTA
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 03:05 PM.

NABL M(EL)T LABS
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Hemogram (CBC + ESR)

Complete Blood Count (CBC)

Test Description	Value(s)	Unit(s)	Reference Range
RBC Parameters			
Hemoglobin *Cyanide free colorimetric*	15.4	g/dL	13.0 - 17.0
RBC Count *Electrical impedance*	4.8	10^6/µl	4.5 - 5.5
PCV *Calculated*	43.5	%	40 - 50
MCV *Calculated*	90.1	fl	83 - 101
MCH *Calculated*	32	pg	27 - 32
MCHC *Calculated*	**35.5**	g/dL	31.5 - 34.5
RDW (CV) * *Calculated*	12.6	%	11.6 - 14.0
RDW-SD * *Calculated*	**46.2**	fl	35.1 - 43.9
WBC Parameters			
TLC *Electrical impedance and microscopy*	6.6	10^3/µl	4 - 10
Differential Leucocyte Count			
Neutrophils *Laser based Flow-cytometry*	49	%	40-80
Lymphocytes *Laser based Flow-cytometry*	38	%	20-40
Monocytes *Laser based Flow-cytometry*	8	%	2-10
Eosinophils *Laser based Flow-cytometry*	5	%	1-6
Basophils *Laser based Flow-cytometry*	0	%	<2
Absolute Leukocyte Counts ***Calculated***			
Neutrophils. *Calculated*	3.23	10^3/µl	2 - 7
Lymphocytes. *Calculated*	2.51	10^3/µl	1 - 3
Monocytes. *Calculated*	0.53	10^3/µl	0.2 - 1.0
Eosinophils. *Calculated*	0.33	10^3/µl	0.02 - 0.5

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NABL M(EL)T LABS NABL-M(EL)T-00605

Test Description	Value(s)	Unit(s)	Reference Range
Basophils. *Calculated*	**0**	10^3/µl	0.02 - 0.5
Platelet Parameters			
Platelet Count *Electrical impedance and microscopy*	294	10^3/µl	150 - 410
Mean Platelet Volume (MPV) * *Calculated*	**8.1**	fL	9.3 - 12.1
PCT * *Calculated*	0.2	%	0.17 - 0.32
PDW * *Calculated*	11.4	fL	8.3 - 25.0
P-LCR * *Calculated*	**17**	%	18 - 50
P-LCC * *Calculated*	50	10^9/L	44 - 140
Mentzer Index * *Calculated*	18.77	%	> 13

Interpretation:
CBC provides information about red cells, white cells and platelets. Results are useful in the diagnosis of anemia, infections, leukemias, clotting disorders and many other medical conditions.

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Test Description	Value(s)	Unit(s)	Reference Range

Erythrocyte Sedimentation Rate (ESR)

ESR - Erythrocyte Sedimentation Rate *MODIFIED WESTERGREN*	5	mm/hr	0 - 10

Interpretation:
ESR is also known as Erythrocyte Sedimentation Rate. An ESR test is used to assess inflammation in the body. Many conditions can cause an abnormal ESR, so an ESR test is typically used with other tests to diagnose and monitor different diseases. An elevated ESR may occur in inflammatory conditions including infection, rheumatoid arthritis ,systemic vasculitis, anemia, multiple myeloma , etc. Low levels are typically seen in congestive heart failure, polycythemia ,sickle cell anemia, hypo fibrinogenemia , etc.

Reference- Dacie and lewis practical hematology

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Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 03:08 PM.

NABL M(EL)T LABS NABL-M(EL)T-00605

Test Description	Value(s)	Unit(s)	Reference Range

HbA1C (Glycosylated Haemoglobin)

Glycosylated Hemoglobin (HbA1c) *HPLC*	5.4	%	<5.7
Estimated Average Glucose *	108.28	mg/dL	Refer Table Below

Interpretation:

Interpretation For HbA1c% 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
Therapeutic goals for glycemic control	Age > 19 years Goal of therapy: < 7.0 Age < 19 years Goal of therapy: <7.5

Note:

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Comments :

HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations ADA criteria for correlation between HbA1c & Mean plasma glucose levels.

HbA1c(%)	Mean Plasma Glucose (mg/dL)	HbA1c(%)	Mean Plasma Glucose (mg/dL)
6	126	12	298
8	183	14	355
10	240	16	413

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Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 03:55 PM.

Test Description	Value(s)	Unit(s)	Reference Range
Blood Group ABO & Rh Typing			
Blood Group *Column Agglutination Test*	B	-	-
Rh Factor	Positive	-	-

Interpretation:
Interpreting the results of a blood group test involves understanding the ABO blood group and Rh factor results. We can interpret them as follows:

ABO Blood Grouping:
Blood Group A: Has A antigens on red blood cells and anti-B antibodies in the plasma.
Blood Group B: Has B antigens on red blood cells and anti-A antibodies in the plasma.
Blood Group AB: Has both A and B antigens on red blood cells and no anti-A or anti-B antibodies in the plasma.
Blood Group O: Has no A or B antigens on red blood cells but has both anti-A and anti-B antibodies in the plasma.

Rh Typing:
Rh-positive: Indicates the presence of the Rh antigen (D antigen) on red blood cells.
Rh-negative: Indicates the absence of the Rh antigen on red blood cells.

Interpreting your blood group involves identifying which antigens are present on your red blood cells (A, B, or both) and whether you are Rh-positive or Rh-negative. For example, if your blood group is A-positive, it means you have A antigens and Rh antigen on your red blood cells.

Knowing your blood group is important for medical purposes, such as blood transfusions, organ transplants, and during pregnancy to prevent potential complications related to blood compatibility.

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Patient ID / UHID	: 10117106/RCL9379988	Barcode NO	: ZE950954
Referred BY	: Self	Sample Type	: FLUORIDE F
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 02:39 PM.

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Test Description	Value(s)	Unit(s)	Reference Range

Glucose Fasting (BSF)

Glucose Fasting *Hexokinase*	92	mg/dL	70 - 100

Interpretation:

Status	Fasting plasma glucose in mg/dL
Normal	<100
Impaired fasting glucose	100 - 125
Diabetes	=>126

Reference : American Diabetes Association

Comment :
Blood glucose determinations in commonly used as an aid in the diagnosis and treatment of diabetes. Elevated glucose levels (hyperglycemia) may also occur with pancreatic neoplasm, hyperthyroidism, and adrenal cortical hyper function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy insulinoma, or various liver diseases.

Note
1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL or a random / 2 hour plasma glucose value of > or = 200 mg/dL with symptoms of diabetes mellitus.
2.Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis.

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Referred BY	: Self	Sample Type	: Serum
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 04:21 PM.

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Liver Function Test (LFT)

Test Description	Value(s)	Unit(s)	Reference Range
Bilirubin Total *Diazonium Salt*	0.6	mg/dL	0.2 - 1.2
Bilirubin Direct * *Diazo Reaction*	0.2	mg/dL	0.0 - 0.5
Bilirubin Indirect * *Calculated*	0.4	mg/dL	0.1 - 1.0
SGOT/AST *Enzymatic [NADH (without P-5-P)]*	30	U/L	11 - 34
SGPT/ALT *Enzymatic [NADH (without P-5-P)]*	40	U/L	< 45
SGOT/SGPT Ratio *	0.75	%	-
Alkaline Phosphatase *Para-nitrophenyl phosphate (p-NPP)*	98	U/L	50 – 116
Total Protein *Biuret*	7.6	g/dL	6.4 - 8.3
Albumin *Colorimetric BCG*	4.3	g/dL	3.5 - 5.2
Globulin * *Calculated*	3.3	g/dL	2.3 - 3.5
Albumin :Globulin Ratio * *Calculated*	1.3	-	1.3 - 2.1
Gamma Glutamyl Transferase (GGT) * *L-Gamma-Glutamyl-3-Carboxy-4-Nitroanalide*	**74**	U/L	< 55

Interpretation:

The liver filters and processes blood as it circulates through the body. It metabolizes nutrients, detoxifies harmful substances, makes blood clotting proteins, and performs many other vital functions. The cells in the liver contain proteins called enzymes that drive these chemical reactions. When liver cells are damaged or destroyed, the enzymes in the cells leak out into the blood, where they can be measured by blood tests Liver tests check the blood for two main liver enzymes. Aspartate aminotransferase (AST),SGOT: The AST enzyme is also found in muscles and many other tissues besides the liver. Alanine aminotransferase (ALT), SGPT: ALT is almost exclusively found in the liver. If ALT and AST are found together in elevated amounts in the blood, liver damage is most likely present. Alkaline Phosphatase and GGT: Another of the liver's key functions is the production of bile, which helps digest fat. Bile flows through the liver in a system of small tubes (ducts), and is eventually stored in the gallbladder, under the liver. When bile flow is slow or blocked, blood levels of certain liver enzymes rise: Alkaline phosphatase Gamma-utamyl transpeptidase (GGT) Liver tests may check for any or all of these enzymes in the blood. Alkaline phosphatase is by far the most commonly tested of the three. If alkaline phosphatase and GGT are elevated, a problem with bile flow is most likely present. Bile flow problems can be due to a problem in the liver, the gallbladder, or the tubes connecting them. Proteins are important building blocks of all cells and tissues. Proteins are necessary for your body's growth, development, and health. Blood contains two classes of protein, albumin and globulin. Albumin proteins keep fluid from leaking out of blood vessels. Globulin proteins play an important role in your immune system. Low total protein may

Indicate:

1.Bleeding
2.Liver disorder
3.Malnutrition
4.Agammaglobulinemia High Protein levels 'Hyperproteinemia: May be seen in dehydration due to inadequate water intake or to excessive water loss (eg, severe vomiting, diarrhea, Addison's disease and diabetic acidosis) or as a result of increased production of proteins Low albumin levels may be

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Referred BY	: Self	Sample Type	: Serum
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 04:21 PM.

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Test Description	Value(s)	Unit(s)	Reference Range

Caused by:
1.A poor diet (malnutrition).
2.Kidney disease.
3.Liver disease. High albumin levels may be caused by: Severe dehydration.

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Kidney Function Test (KFT)

Test Description	Value(s)	Unit(s)	Reference Range
Blood Urea *Urease*	23	mg/dL	19 - 44.1
Bun * *Calculated*	10.75	mg/dL	8.9 - 20.6
Creatinine *Kinetic Alkaline Picrate*	1.01	mg/dL	0.6 - 1.3
eGFR (CKD-EPI)	92.29	ml/min/1.73 sq m	Normal Or High: >= 90 Mild Or Decrease: 60-89 Mild To Moderate Decrease: 45-59 Mild To Severe Decrease: 30-44 Severe Decrease: 15-29 Kidney Failure: < 15
Bun/Creatinine Ratio * *Calculated*	**10.64**		12 - 20
Urea / Creatinine Ratio * *Calculated*	**22.77**		25.68- 42.8
Uric Acid *Uricase*	5.8	mg/dL	3.7 - 7.7
Calcium Serum *Arsenazo III*	8.9	mg/dL	8.4 - 10.2
Phosphorus *Phosphomolybdate*	3.1	mg/dL	2.3 - 4.7
Sodium *ISE-Indirect*	139	mmol/L	136 - 145
Potassium *ISE-Indirect*	4.5	mmol/L	3.5 - 5.1
Chloride *ISE-Indirect*	103	mmol/L	98 - 107

Interpretation:

Kidney function tests is a collective term for a variety of individual tests and proceduresthat can be done toevaluate how well the kidneys are functioning. Many conditions can affect the ability of the kidneys to carryout their vital functions. Somelead to a rapid (acute) decline in kidney functionothers lead to a gradual (chronic) declineinfunction. Both result in a buildup of toxic waste subst done on urine samples, as well as on blood samples. A number of symptoms may indicate a problem with your kidneys. These include : high blood pressure,blood in urine frequent urges to urinate,difficulty beginning urination,painful urination,swelling in the hands and feet due to a buildup of fluids in the body. A single symptom may not mean something serious. However, when occurring simultaneously, these symptoms suggest that your kidneys are not working properly. Kidney function tests can help determine the reason. Electrolytes are present in the human body and the balancing act of the electrolytes in our bodies is essential for normal function of our cells and organs. There has to be a balance.Ionized calcium this test if you have signs of kidney or parathyroid disease. The test may also be done to monitor progress and treatment of these diseases.

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Lipid Profile

Test Description	Value(s)	Unit(s)	Reference Range
Total Cholesterol *Enzymatic*	**259**	mg/dL	<200
Triglycerides *Glycerol phosphate oxidase*	**202**	mg/dL	<150
HDL Cholesterol *Accelerator Selective Detergent*	**27**	mg/dL	> 40
Non HDL Cholesterol * *Calculated*	**232**	mg/dL	<130
LDL Cholesterol * *Calculated*	**191.6**	mg/dL	<100
V.L.D.L Cholesterol * *Calculated*	**40.4**	mg/dL	<30
Chol/HDL Ratio * *Calculated*	9.59	Ratio	-
HDL/ LDL Ratio * *Calculated*	0.14	Ratio	-
LDL/HDL Ratio * *Calculated*	7.1	Ratio	-

Interpretation:

Lipid level assessments must be made following 9 to 12 hours of fasting, otherwise assay results might lead to erroneous interpretation. NCEP recommends of 3 different samples to be drawn at intervals of 1 week for harmonizing biological variables that might be encountered in single assays.

National Lipid Association Recommendations (NLA-2014)	Total Cholesterol (mg/dL)	Triglyceride (mg/dL)	LDL Cholesterol (mg/dL)	Non HDL Cholesterol (mg/dL)
Optimal	<200	<150	<100	<130
Above Optimal			100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

HDL Cholesterol	
Low	High
<40	>=60

Risk Stratification for ASCVD (Atherosclerotic Cardiovascular Disease) by Lipid Association of India.

Risk Category	A. CAD with > 1 feature of high risk group
Extreme risk group	B. CAD with >1 feature of very high risk group of recurrent ACS (within 1 year) despite LDL-C <or = 50 mg/dl or poly vascular disease
Very High Risk	1.Established ASCVD 2.Diabetes with 2 major risk factors of evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
	1. Three major ASCVD risk factors 2. Diabetes with 1 major risk factor or no evidence

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Test Description	Value(s)	Unit(s)	Reference Range

High Risk	of end organ damage 3. CHD stage 3B or 4. 4 LDL >190 mg/dl 5. Extreme of a single risk factor 6. Coronary Artery Calcium - CAC > 300 AU 7. Lipoprotein a >/= 50 mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors

1. Age >/=45 years in Males & >/= 55 years in Females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by Lipid Association of India in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal <OR = 30)	<80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	>OR = 30	>OR = 60	> 30	> 60
Very High Risk	<50	<80	>OR = 50	>OR = 80
High Risk	<70	<100	>OR = 70	>OR = 100
Moderate Risk	<100	<130	>OR = 100	>OR = 130
Low Risk	<100	<130	>OR = 130*	>OR = 160

*** After an adequate non-pharmacological intervention for at least 3 months.**

References : Management of Dyslipidaemia for the Prevention of Stroke : Clinical practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology,2022,20,134-155.

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Test Description	Value(s)	Unit(s)	Reference Range
Calcium			
Calcium Serum *Arsenazo III*	8.9	mg/dL	8.4 - 10.2

Interpretation:
Elevated calcium value are associated with hyperparathyrodism, multiple myeloma, neoplasms of bone and parathyroid & conditions of rapid demineralization, tetany & occasionally with nephrosis & pancreatitis. Severe nephritis & uremia may cause either elevated or lowered calcium values. Decreased values of calcium are noted in hypoparathyroidism, vitamin D deficiency, renal insufficiency, hypoproteinemia, malabsorption syndrome, severe pancreatitis with pancreatic necrosis and pseudo-hypoparathyroidism.

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Test Description	Value(s)	Unit(s)	Reference Range
Vitamin B12 / Cyanocobalamin			
Vitamin - B12 *CMIA*	**< 148**	pg/mL	187 - 883

Interpretation:
Low Values are a sign of a vitamin B12 deficiency. People with this deficiency are likely to have or develop symptoms.
Causes of vitamin B12 deficiency include:Not enough vitamin B12 in diet (rare except with a strict vegetarian diet), Diseases that cause malabsorption (for example, celiac disease and Crohn's disease), Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy. Increased vitamin B12 levels are uncommon. Usually excess vitamin B12 is removed in the urine. Conditions that can increase B12 levels include: Liver disease (such as cirrhosis or hepatitis), Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia).

Vitamin B12: Low Levels can cause malabsorption, Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy.High Level Liver disease, Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia).

1. Out of 140 healthy indian population, 91% of Vitamin B 12 concentrations was at lower level: 59.00 pg/ml and upper level: 700.00 pg/ml

"Patients on Biotin supplement may have interference in some immunoassays. Ref: Arch Pathol Lab Med—Vol 141, November 2017. With individuals taking high dose Biotin (more than 5 mg per day) supplements, at least 8-hour wait time before blood draw is recommended."

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Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 03:21 PM.

Test Description	Value(s)	Unit(s)	Reference Range
Vitamin D 25 Hydroxy			
Vitamin D 25 - Hydroxy *CMIA*	**16.1**	ng/mL	Deficient <20 Insufficient 21 - 29 Sufficient 30 - 100

Interpretation:
25-Hydroxy vitamin D represents the main body reservoir and transport form. Mild to moderate deficiency is associated with Osteoporosis / Secondary Hyperparathyroidism while severe deficiency causes Rickets in children and Osteomalacia in adults. Prevalence of Vitamin D deficiency is approximately >50% specially in the elderly. This assay is useful for diagnosis of vitamin D deficiency and Hypervitaminosis D. It is also used for differential diagnosis of causes of Rickets & Osteomalacia and for monitoring Vitamin D replacement therapy.

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Patient NAME	**: Mr Prabhakar Jha**		
DOB/Age/Gender	: 47 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 10117106/RCL9379988	Barcode NO	: ZE950953
Referred BY	: Self	Sample Type	: Serum
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 05:37 PM.

Test Description	Value(s)	Unit(s)	Reference Range
Thyroid Profile Total			
Triiodothyronine (T3) *CMIA*	116	ng/dL	35 - 193
Total Thyroxine (T4) *CMIA*	9.4	µg/dL	4.87 - 11.72
Thyroid Stimulating Hormone (Ultrasensitive) *CMIA*	2	mIU/L	0.35 - 4.94

Interpretation:

Pregnancy	Reference ranges TSH
1st Trimester	0.1 - 2.5
2nd Trimester	0.2 - 3.0
3rd Trimester	0.3 - 3.0

Note:
TSH levels are subject to circadian variation, reaching peak levels between 2-4 am. and at a minimum between 6-10 pm. The variation is of 50 %, hence time of the day has influence on the measured serum TSH concentrations.

Clinical Use:
- Diagnose Hypothyroidism and Hyperthyroidism
- Monitor T4 replacement or T4 suppressive therapy
- Qunatify TSH levels in the subnormal range

Increased Levels : Primary hypothyroidism, Subclinical hypothyroidis, TSH dependent Hyperthyroidism, Thyroid hormone resistance
Decreased Levels: Grace disease, Autonomous thyroid hormone secretion, TSH deficiency

Primary malfunction of the thyroid gland may result in excessive (hyper) or below normal (hypo) release of T3 or T4. In addition as TSH directly affects thyroid function, malfunction of the pituitary or the hypo - thalamus influences the thyroid gland activity. Disease in any portion of the thyroid-pitutary-hypothala- mus system may influence the levels of T3 and T4 in the blood. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels may be low. In addition, in the Euthyroid Sick Syndrome, multiple alterations in serum thyroid function test findings have been recognized in patients with a wide variety of non-thyroidal illnesses (NTI) without evidence of preexisting thyroid or hypothalami c-pitutary diseases. Thyroid Binding Globulin (TBG) concentrations remain relatively constant in healthy individuals. However, pregnancy, excess estrogen's, androgen's, antibiotic steroids and glucocorticoids are known to alter TBG levels and may cause false thyroid values for Total T3 and T4 tests.

TSH	T4	T3	INTERPRETATION
High	Normal	Normal	Mild (subclinical) hypothyroidism
High	Low	Low or Normal	Hypothyroidism
Low	Normal	Normal	Mild (subclinical) hyperthyroidism
Low	High or normal	High or normal	Hyperthyroidism
Low	Low or normal	Low or normal	Nonthyroidal illness; pituitary (secondary) hypothyroidism

(*) Parameter(s) are outside the scope of tests recognized under the NABL M(EL)T Scheme.

Pallavi

Dr. Pallavi Rath
MBBS, MD (Pathology)
Consultant Pathologist

Patient NAME	**: Mr Prabhakar Jha**		
DOB/Age/Gender	: 47 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 10117106/RCL9379988	Barcode NO	: ZE950953
Referred BY	: Self	Sample Type	: Serum
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 05:37 PM.

Test Description	Value(s)	Unit(s)	Reference Range
Normal High High	Thyroid hormone resistance syndrome (a mutation in the thyroid hormone receptor decreases thyroid hormone function)		

Prostate Specific Antigen (PSA) Total

Test Description	Value(s)	Unit(s)	Reference Range
Prostate Specific Antigen-Total (PSA-Total) *CMIA*	0.7	ng/mL	0 - 2.5

Interpretation:

1· Prostate specific antigen (PSA), a member of the human kallikrein gene family, is a serine protease with chymotrypsin-like activity.

2· The major site of PSA production is the glandular epithelium of the prostate. PSA has also been found in breast cancers, salivary gland neoplasms, periurethral and anal glands, cells of the male urethra, breast milk, blood and urine.

3· The combined use of DRE (digital rectal examination) and PSA has been shown to result in an increased detection of early stage prostate cancer.

4· PSA testing can have significant value in detecting metastatic or persistent disease in patients following surgical or medical treatment of prostate cancer.

5· Persistent elevation of PSA following treatment, or an increase in a post-treatment PSA level is indicative of recurrent or residual disease. PSA testing is widely accepted as an adjunctive test in the management of prostate cancer patients.

Increased Levels

Prostate cancer
Benign Prostatic Hyperplasia
Prostatitis
Genitourinary infections

(*) Parameter(s) are outside the scope of tests recognized under the NABL M(EL)T Scheme.

Pallavi

Dr. Pallavi Rath
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Consultant Pathologist

Patient NAME	**: Mr Prabhakar Jha**		
DOB/Age/Gender	: 47 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 10117106/RCL9379988	Barcode NO	: YB306851
Referred BY	: Self	Sample Type	: Spot Urine
Sample Collected	: Oct 17, 2024, 08:53 AM	Report Date	: Oct 17, 2024, 02:09 PM.

NABL-M(EL)T-00605

Urine Routine and Microscopic Examination

Test Description	Value(s)	Unit(s)	Reference Range
Physical Examination *			
Volume *	20	ml	-
Colour *	Pale yellow	-	Pale yellow
Transparency *	Clear	-	Clear
Deposit *	Absent	-	Absent
Chemical Examination *			
Reaction (pH) *Double Indicator*	5	-	4.5 - 8.0
Specific Gravity *Ion Exchange*	1.025	-	1.010 - 1.030
Urine Glucose (sugar) *Oxidase / Peroxidase*	Negative	-	Negative
Urine Protein (Albumin) *Acid / Base Colour Excahnge*	Negative	-	Negative
Urine Ketones (Acetone) *Legals Test*	Negative	-	Negative
Blood *Peroxidase Hemoglobin*	Negative	-	Negative
Leucocyte esterase *Enzymatic Reaction*	Negative	-	Negative
Bilirubin Urine *Coupling Reaction*	Negative	-	Negative
Nitrite *Griless Test*	Negative	-	Negative
Urobilinogen *Ehrlichs Test*	Normal	-	Normal
Microscopic Examination *			
Pus Cells (WBCs) *	1-2	/hpf	0 - 5
Epithelial Cells *	1-2	/hpf	0 - 4
Red blood Cells *	Absent	/hpf	Absent
Crystals *	Absent	-	Absent
Cast *	Absent	-	Absent
Yeast Cells *	Absent	-	Absent
Amorphous deposits *	Absent	-	Absent
Bacteria *	Absent	-	Absent
Protozoa *	Absent	-	Absent

Interpretation:
URINALYSIS- Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders.

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

(*) Parameter(s) are outside the scope of tests recognized under the NABL M(EL)T Scheme.

Pallavi

Dr. Pallavi Rath
MBBS, MD (Pathology)
Consultant Pathologist

LABORATORY REPORT

MADYOASIS DIAGNOSTICS

Patient NAME	**: Mr Prabhakar Jha**		
DOB/Age/Gender	: 47 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 10117123/RCL9379988	Barcode NO	: ZE951078
Referred BY	: Self	Sample Type	: FLUORIDE PP
Sample Collected	: Oct 17, 2024, 09:43 AM	Report Date	: Oct 17, 2024, 02:47 PM.

NABL M(EL)T LABS NABL-M(EL)T-00605

Test Description	Value(s)	Unit(s)	Reference Range

Glucose Post Prandial (BSPP)

Glucose Post Prandial *Hexokinase*	**170**	mg/dL	<140

Interpretation:

Status	PP plasma glucose in mg/dL
Normal	<140
Impaired glucose tolerance	140 - 199
Diabetes	=>200

Reference : American Diabetes Association

Comment :
Blood glucose determinations in commonly used as an aid in the diagnosis and treatment of diabetes. Elevated glucose levels (hyperglycemia) may also occur with pancreatic neoplasm, hyperthyroidism, and adrenal cortical hyper function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy insulinoma, or various liver diseases.

Note
1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL or a random / 2 hour plasma glucose value of > or = 200 mg/dL with symptoms of diabetes mellitus.
2.Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis.

*** End Of Report ***

Pallavi

Dr. Pallavi Rath
MBBS, MD (Pathology)
Consultant Pathologist

Name	:	MR. PRABHAKAR JHA	**Age/Sex**	:	47 YEARS/M
Ref By	:	Dr. MADYOASIS MEDICAL SERVICES --	**Date**	:	05 Oct 2024

2D ECHOCARDIOGRAPHY & COLOUR DOPPLER STUDY

Left Ventricle:
The left ventricle is normal in size. No e/o RWMA.
The left ventricular ejection fraction is normal .

Left Atrium:
The left atrium is normal size. No clot.

Right Ventricle:
The right ventricular is normal size. There is normal right Ventricular wall thickness.

Aorta:
The aortic root is normal.

Pulmonary Artery:
The Pulmonary artery is normal.

Pericardium:
There is no pericardial effusion. No calcification.

Aortic Valve:
The aortic valve is tri-leaflet with thin, pliable leaflets that move normally. There is no aortic Stenosis. No aortic regurgitation is present.

Mitral Valve:
The mitral valve leaflets are thin. Normal mitral gradients. There is no evidence of stenosis**,** prolapse. Diastolic flows are altered . No mitral regurgitation noted.

Tricuspid Valve:
The tricuspid valve leaflets are thin and pliable and the valve motion is normal. No tricuspid Regurgitation is noted.

Pulmonary Valve:
The pulmonary valve leaflets are thin and pliable and the valve motion is normal. No pulmonary Valvular regurgitation is noted.

Proximal Coronaries:
Not visualized.

IAS and IVS are intact.

M-MODE/2D PARAMETERS

AO	28	(23-37mm)
LA	27	(19-40mm)
RVD		(7-23mm)
LVD	40	(35-55mm)
LVS	26	(24-42mm)
IVS	12.4	(6-11mm)
LVPW	12.3	(6-11mm)
EF	55-60%	(50-70%)

Parameters in brackets indicate normal adult Values.

IMPRESSION:
Mild LVH
No e/o RWMA
Normal EF.
RA / RV not dilated.
No e/o pulmonary hypertension
Normal valves and velocities.
No clot, vegetations or effusions.

DR GANESH SANAP
MBBS, DMRD, DNB

PASSION
The Diagnostic Destination

Patient Name	:	MR. PRABHAKAR JHA	Date : 05 Oct 2024
Referred By	:	Dr. MADYOASIS MEDICAL SERVICES - -	Age : 47 YEARS Sex : M

USG ABDOMEN AND PELVIS

Liver:
The liver is normal in size and shows increased echotexture. No focal lesion is seen. The intrahepatic biliary radicles are normal. The common bile duct and the portal vein appear normal.

Gall Bladder
The gall bladder is well distended. No e/o calculus seen . The wall thickness is normal.

Pancreas
The pancreas is normal in size and shape. No focal lesion or calcifications are seen within it. The pancreatic duct is normal.

Spleen
The spleen measures 10.1cm in size and is normal in echotexture. No focal lesion is seen.

Kidneys
The right kidney measures 9.6 x 4.1cm. The left kidney measures 9.8 x 5.4 cm. Both kidneys show normal parenchymal echo texture. The cortico-medullary differentiation is maintained bilaterally. The pelvicalyceal system is normal in both the kidneys.

Aorta/IVC
The aorta and IVC appear grossly normal. No ascites or lymphadenopathy is seen.

Urinary bladder
The bladder is well distended. The wall thickness is normal. No vesical calculus is seen.

Prostate
The prostate corresponding to a weight of about 20 gms. No focal lesion or calcification is seen.

Impression

- **Diffuse fatty infiltration of liver Grade II.**
- **No other abnormality seen .**

DR GANESH SANAP
MBBS, DMRD, DNB

PASSION
The Diagnostic Destination

Patient Name: MR. PRABHAKAR JHA	Date: 05 Oct 2024
Ref. By: Dr. MADYOASIS MEDICAL SERVICES --	Age/sex :47 YEARS/M

X RAY CHEST PA VIEW

Both the lung fields are clear.

Both diaphragmatic domes have normal contours and positions.

Cardio-aortic silhouette has a normal appearance.

There is no evidence of any pleural effusion.

Bony thorax appears normal

IMPRESSION :

No obvious abnormality seen at present study.

Dr. GANESH SANAP
(MBBS,DMRD, DNB)
Consulting Radiologist