Charak dhar DIAGNOSTICS Pvt. Ltd.

292/05, Tulsidas Marg, Basement Chowk, Lucknow-226 003
Phone : 0522-4062223, 9305548277, 8400888844
9415577933, 9336154100, **Tollfree No.**: 8688360360
E-mail : charak1984@gmail.com
CMO Reg. No. RMEE 2445133
NABL Reg. No. MC-2491
Certificate No. MIS-2023-0218

Patient Name	: Mr.ANWARUN NABI	Visit No	: CHA250038625
Age/Gender	: 39 Y/M	Registration ON	: 04/Mar/2025 08:09AM
Lab No	**: 10135920**	Sample Collected ON	: 04/Mar/2025 08:12AM
Referred By	: Dr.MUFAZZAL AHMAD	Sample Received ON	: 04/Mar/2025 08:12AM
Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 04/Mar/2025 10:45AM
Doctor Advice	: URINE COM. EXMAMINATION,USG WHOLE ABDOMEN,HBSAg,UACR,ECG,PTH (Serum),PHOS,IONIC CALCIUM		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
IONIC CALCIUM				
IONIC CALCIUM	**1.08**	mmol/L	1.13 - 1.33	

INTERPRETATION:

-Calcium level is increased in patients with hyperparathyroidism, Vitamin D intoxication, metastatic bone tumor, milk-alkali syndrome, multiple myeloma, Paget's disease.
-Calcium level is decreased in patients with hemodialysis, hypoparathyroidism (primary, secondary), vitamin D deficiency, acute pancreatitis, diabetic Keto-acidosis, sepsis, acute myocardial infarction (AMI), malabsorption, osteomalacia, renal failure, rickets.

PHOSPHORUS				
Phosphorus Serum	**5.60**	mg/dl	2.68 - 4.5	Phosphomolybdate

INTERPRETATION:

-Approximately 80% of the phosphorus in the human body is found in the calcium phosphate salts which make up the inorganic substance of bone. The remainder is involved in the esterification of carbohydrate metabolism intermediaries and is also found as component of phospholipids. Phosphoproteins, nucleic acids and nucleotides.
-Hypophosphatemia can be caused by shift of phosphate from extracellular to intracellular spaces, increased renal loss (renal tubular defects, hyperparathyroidism) or gastrointestinal loss (diarrhea, vomiting) and decreased intestinal absorption.

LIMITATIONS:

-Interferences: bilirubin (up to 20 mg/dL) hemolysis (haemoglobin up to 1000 mg/dL) and lipemia (triglycerides up to 1000 mg/dL) do not interface. Other drugs and substances may interface.
-Clinical diagnosis should no be made on the findings of a single test result, but should integrate both clinical laboratory data.

URINE ALBUMIN CREATININE RATIO				
URINE FOR MICRO ALBUMIN	32	MG/L	< 20 MG/L	
URINARY CREATININE	49	mg/dL	20-320 mg/dL	
URINE ALBUMIN CREATININE RATIO	65.3	mg/g		calculated
PTH (Serum)				
PARA THYROID HORMONE	**333.90**	pg/ml	15 - 65	CLIA

[Checked By]

Print.Date/Time: 04-03-2025 13:45:18
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DR. NISHANT SHARMA
PATHOLOGIST

DR. SHADAB
PATHOLOGIST

Dr. SYED SAIF AHMAD
MD (MICROBIOLOGY)

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Test Name	Result	Unit	Bio. Ref. Range	Method
HEPATITIS B SURFACE ANTIGEN (HBsAg)				
Sample Type : Serum				
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE		<1 - Non Reactive >1 - Reactive	CMIA

Note: This is only a Screening test. Confirmation of the result (Non Reactive/Reactive)should be done by performing a PCR based test.

COMMENTS:

-HBsAg is the first serological marker after infection with Hepatitis B Virus appearing one to ten weeks after exposure and two to eight weeks before the onset of clinical symptoms. HBsAg persists during the acute phase and clears late in the convalescence phase. Failure to clear HBsAg within six months indicates a chronic HBsAg carrier state. HBsAg assays are used to identify the persons infected with HBV and to prevent transmission of the virus by blood and blood products as well as to monitor the status of infected individuals in combination with other hepatitis B serological markers.
-Borderline cases must be confirmed with confirmatory neutralizing assay.

LIMITATIONS:

-Results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infections.
-Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA) which may produce anomalous values when tested with assay kits that employs mouse monoclonal antibodies.
-Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or animal serum products can be prone to this interference and anomalous results may be observed.
-Cross reactivity for specimens from individual with medical conditions (Pregnancy, HIV etc) has been observed.
-HBsAg mutations may result in a false negative result in some HBsAg assays.
-If HBsAg results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.

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Test Name	Result	Unit	Bio. Ref. Range	Method
URINE EXAMINATION REPORT				
Colour-U	STRAW		Light Yellow	
Appearance (Urine)	CLEAR		Clear	
Specific Gravity	**1.015**		1.005 - 1.025	
pH-Urine	Acidic (6.0)		4.5 - 8.0	
PROTEIN	600 mg/dl	mg/dl	ABSENT	Dipstick
Glucose	Absent			
Ketones	Absent		Absent	
Bilirubin-U	Absent		Absent	
Blood-U	PRESENT		Absent	
Urobilinogen-U	0.20	EU/dL	0.2 - 1.0	
Leukocytes-U	Absent		Absent	
NITRITE	Absent		Absent	
MICROSCOPIC EXAMINATION				
Pus cells / hpf	1-2	/hpf	< 5/hpf	
Epithelial Cells	Occasional	/hpf	0 - 5	
RBC / hpf	Occasional		< 3/hpf	

***** End Of Report *****

[Checked By]

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DR. NISHANT SHARMA PATHOLOGIST
DR. SHADAB PATHOLOGIST
Dr. SYED SAIF AHMAD MD (MICROBIOLOGY)

Patient Name	: Mr.ANWARUN NABI	Visit No	: CHA250038625
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PR.

ECG REPORT

* RATE : 62 bpm.

* RHYTHM : Normal

* P wave : Normal

* PR interval : Normal

* QRS Axis : Normal

Duration : Normal

Configuration : Increased LV Voltages
Q in L2,L3,avF,V5,V6

* ST-T Changes : T inversion in L2,L3,avF,V6

* QT interval :

* QTc interval : Sec.

Other

OPINION: **LEFT VENTRICULAR HYPERTROPHY WITH STRAIN**
? OLD INFERIOR M.I

(Finding to be correlated clinically)

DR. PANKAJ RASTOGI ,MD.DM

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PR.

ULTRASOUND STUDY OF WHOLE ABDOMEN

- **Liver** is mildly enlarged in size (~ 158 mm) and shows increased echotexture of liver parenchyma. No intrahepatic biliary radicle dilatation is seen. No space occupying lesion is seen. Hepatic veins and IVC are seen normally.
- **Gall bladder** is normal in size and shows few calculi in lumen, size upto ~ 8 mm. No mass lesion is seen. GB walls are not thickened.
- **CBD** is normal at porta. No obstructive lesion is seen.
- **Portal vein** Portal vein is normal at porta.
- **Pancreas** is normal in size and shows homogenous echotexture of parenchyma. PD is not dilated. No parenchymal calcification is seen. No peripancreatic collection is seen.
- **Spleen** is normal in size and shows homogenous echotexture of parenchyma. No SOL is seen.
- No retroperitoneal adenopathy is seen.
- No ascites is seen.
- **Both kidneys** are normal in size and position. Bilateral renal parenchyma echogenicity is raised with attenuated cortico-medullary differentiation. No hydronephrosis is seen. No calculus or mass lesion is seen. Parenchymal thickness is normal. No scarring is seen. Right kidney measures 84 x 34 mm in size. Left kidney measures 97 x 47 mm in size.
- **Ureters** Both ureters are not dilated. UVJ are seen normally.
- **Urinary bladder** is partially distended with anechoic lumen. No calculus or mass lesion is seen. UB walls are not thickened.
- Bilateral seminal vesicles are seen normally.
- **Prostate** is normal in size, measures 34 x 37 x 30 mm with weight of 20gms and shows homogenous echotexture of parenchyma. No mass lesion is seen.
- Post void residual urine volume – Nil.

OPINION:

- **Mild hepatomegaly with fatty infiltration of liver grade-I.**
- **Cholelithiasis.**
- **Bilateral kidneys show raised renal parenchyma echogenicity with attenuated cortico-medullary differentiation -- medical renal disease (grade-I). Adv: RFT correlation.**

(Possibility of acid peptic disease could not be ruled out).

Clinical correlation is necessary.

[DR. R.K. SINGH, MD]

***** End Of Report *****