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	: Ms.LAXMI JAISWAL	Visit No	: CHA250039051
Age/Gender	: 47 Y/F	Registration ON	: 04/Mar/2025 02:34PM
Lab No	**: 10136346**	Sample Collected ON	: 04/Mar/2025 02:36PM
Referred By	: Dr.MOHD RIZWANUL HAQUE	Sample Received ON	: 04/Mar/2025 02:54PM
Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 04/Mar/2025 04:35PM
Doctor Advice	: TSH,FT4,NA+K+,HBA1C (EDTA),BUN,CREATININE,ECG,TROPONIN-I (SERUM),2D ECHO		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Glycosylated Hemoglobin (HbA1c)	**8.6**	%	4 - 5.7	HPLC (EDTA)

NOTE:-
Glycosylated Hemoglobin Test (HbA1c)is performed in this laboratoryby the Gold Standard Reference method,ie:HPLC Technology(High performance Liquid Chromatography D10) from Bio-Rad Laboratories.USA.

EXPECTED (RESULT) RANGE :

Bio system	Degree of normal
4.0 - 5.7 %	Normal Value (OR) Non Diabetic
5.8 - 6.4 %	Pre Diabetic Stage
> 6.5 %	Diabetic (or) Diabetic stage
6.5 - 7.0 %	Well Controlled Diabet
7.1 - 8.0 %	Unsatisfactory Control
> 8.0 %	Poor Control and needs treatment

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD UREA NITROGEN				
Blood Urea Nitrogen (BUN)	12.43	mg/dL	7-21	calculated

[Checked By]

Print.Date/Time: 04-03-2025 18:36:27
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DR. NISHANT SHARMA PATHOLOGIST
DR. SHADAB PATHOLOGIST
DR. ADITI D AGARWAL PATHOLOGIST

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PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
FT4				
FT4	8.21	pmol/L	7.86 - 14.42	CLIA

Note

(1) Patients having low T3 & T4 levels but high TSH levels suffer from primary hypothyroidism,cretinism,juvenile mysedema or autoimmune disorders.

(2) Patients having low T3 & T4 levels but high TSH levels suffer from grave~s disease, toxic adenoma or sub-acute thyroiditis.

(3) Patients having either low or normal T3 & T4 levels but low TSH values suffer from iodine deficiency or secondary hypothyroidism.

(4) Patients having high T3 & T4 levels but normal TSH levels may suffer from toxic multinodular goitre. This condition is mostly asymptomatic and may cause transient hyperthyroidism but no persistent symptoms.

(5) Patient with high or normal T3 & T4 levels and low or normal TSH levels suffer either from T3 toxicosis or T4 Toxicosis respectively.

(6) In patients with non thyroidal illness abnormal test results are not necessarily indicative of thyroidism but may be due to adaptation to the cacabolic state and may revert tonormal when the patient recovers.

(7) There are many drugs for eg.Glucocorticoids ,dopamine,Lithium,iodides ,oral radiographic dyes,ets.Which may affect the thyroid function tests.

(8) Generally when total T3& T4 results are indecisive then Free T3 & Free T4 test are recommended for further confirmation along with TSH levels.

(ELECTRO-CHEMILUMINISCENCE TECHINIQUE BY ELECSYSYS -2010)

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DR. SHADABKHAN
PATHOLOGIST

Dr. SYED SAIF AHMAD
MD (MICROBIOLOGY)

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Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 04/Mar/2025 05:56PM
Doctor Advice	: TSH,FT4,NA+K+,HBA1C (EDTA),BUN,CREATININE,ECG,TROPONIN-I (SERUM),2D ECHO		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
TROPONIN-I (SERUM)				
TROPONIN-I (SERUM)	0.021		cut off volue : 0.120	

NOTE: -

Troponin I (TnI) is a protein normally found in muscle tissue that, in conjunction with Troponin T and Troponin C, regulates the calcium dependent interaction of actin and myosin.1 Three isotypes of TnI have been identified: one associated with fast-twitch skeletal muscle, one with slow-twitch skeletal muscle and one with cardiac muscle.The cardiac form has an additional 31 amino acid residues at the N terminus and is the only troponin isoform present in the myocardium.Clinical studies have demonstrated that cardiac Troponin I (cTnI) is detectable in the bloodstream 4–6 hours after an acute myocardial infarct (AMI) and remains elevated for several days thereafter Thus, cTnI elevation covers the diagnostic windows of both creatine kinase-MB (CK-MB) and lactate dehydrogenase.3 Further studies have indicated that cTnI has a higher clinical specificity for myocardial injury than does CK-MB.
Done by: Vitros ECI (Johnson & Johnson)

Other conditions resulting in myocardial cell damage can contribute to elevated cTnI levels. Published studies have documented that these conditions include, but are not limited to, sepsis, congestive heart failure, hypertension with left ventricular hypertrophy, hemodynamic compromise, myocarditis, mechanical injury including cardiac surgery, defibrillation and cardiac toxins such as anthracyclines. Factors such as these should be considered when interpreting results from any cTnI test method.

[Checked By]

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Test Name	Result	Unit	Bio. Ref. Range	Method
NA+K+				
SODIUM Serum	136.0	MEq/L	135 - 155	ISE Direct
POTASSIUM Serum	4.1	MEq/L	3.5 - 5.5	ISE Direct
SERUM CREATININE				
CREATININE	0.60	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
TSH				
TSH	**5.53**	uIU/ml	0.47 - 4.52	ECLIA

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(1 Beckman DxI-600 2. ELECTRO-CHEMILUMINISCENCE TECHINIQUE BY ELECSYSYS -E411)

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

MC-2491

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PR.

ECG -REPORT

RATE : 112 bpm

* RHYTHM : Normal

* P wave : Normal

* PR interval : Normal

* QRS Axis : Normal

Duration : Normal

Configuration : Normal

* ST-T Changes : None

* QT interval :

* QTc interval : Sec.

* Other :

OPINION: **SINUS TACHYCARDIA**

(FINDING TO BE CORRELATED CLINICALLY)

[DR. RAJIV RASTOGI, MD, DM]

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PR.

2D- ECHO & COLOR DOPPLER REPORT

1. **MITRAL VALVE STUDY** : **MVOA** - Normal (perimetry) cm2 (PHT)

Anterior Mitral Leaflet:

(a) Motion: Normal **(b) Thickness** : Normal **(c) DE :2.0** cm.

(d) EF :103 mm/sec **(e) EPSS : 06** mm **(f) Vegetation : -**

(g) Calcium : -

Posterior mitral leaflet : Normal

(a). Motion : Normal **(b) Calcium: -** **(c) Vegetation : -**

Valve Score : Mobility /4 Thickness /4 SVA /4
Calcium /4 Total /16

2. **AORTIC VALVE STUDY**

(a) Aortic root :3.1cms **(b) Aortic Opening :1.6**cms **(c) Closure: Central**
(d) Calcium : - **(e) Eccentricity Index : 1** **(f) Vegetation : -**

(g) Valve Structure : Tricuspid,

3. **PULMONARY VALVE STUDY** Normal

(a) EF Slope : - **(b) A Wave : +** **(c) MSN : -**

(D) Thickness : **(e) Others :**

4. **TRICUSPID VALVE :** Normal

5. **SEPTAL AORTIC CONTINUITY** **6. AORTIC MITRAL CONTINUITY**

Left Atrium : 4.1cms **Clot : -** **Others :**
Right Atrium : Normal **Clot : -** **Others : -**

Contd…...

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VENTRICLES

RIGHT VENTRICLE : Normal

RVD (D)

RVOT

LEFT VENTRICLE :

LVIVS (D) 0.8 cm (s) 1.2 cm **Motion :** normal

LVPW (D) 0.9cm (s) 1.6cm **Motion :** Normal

LVID (D)5.6 cm (s) 4.0 cm **Ejection Fraction :55%**

Fractional Shortening : 29 %

TOMOGRAPHIC VIEWS

Parasternal Long axis view :

NORMAL LV RV DIMENSION
GOOD LV CONTRACTILITY.

Short axis view

Aortic valve level : AOV - NORMAL

PV - NORMAL

TV - NORMAL

MV - NORMAL

Mitral valve level :

Papillary Muscle Level : NO RWMA

Apical 4 chamber View : No LV CLOT
NO P E

Contd.

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PERICARDIUM

Normal

DOPPLER STUDIES

	Velocity (m/sec)	Flow pattern (/4)	Regurgitation	Gradient (mm Hg)	Valve area (cm 2)
MITRAL	**e = 0.9 a = 0.3**	**Normal**	**1**	**-**	**-**
AORTIC	**1.7**	**Normal**	**1**	**-**	**–**
TRICUSPID	**0.4**	**Normal**	**-**	**-**	**-**
PULMONARY	**1.0**	**Normal**	**-**	**-**	**-**

OTHER HAEMODYNAMIC DATA

COLOUR DOPPLER

GR I/IV MR
GR I/IV AR

CONCLUSIONS :

- **NORMAL LV RV DIMENSION**
- **GOOD LV SYSTOLIC FUNCTION**
- **LVEF = 55 %**
- **NO RWMA**
- **MILD MR**
- **MILD AR**
- **NO CLOT / VEGETATION**
- **NO PERICARDIAL EFFUSSION**

DR. RAJIV RASTOGI, MD,DM

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