PRUTHI ORTHOPAEDIC CARE CENTRE

22/1-A, Ring Road, Agra-282 004 (M) : 9627120098 e-mail : kartortho@gmail.com

Dr. (Mrs.) Kusum Pruthi
M.B.B.S. (DCH)

Dr. Kartik Pruthi
M. S. (Ortho.)
CONSULTANT ORTHOPAEDIC SURGEON

- Former Senior Resident Maulana Azad Medical College, New Delhi
- Former Clinical Associate Sir Ganga Ram Hospital, New Delhi
- A.O. Fellow Trauma Queen's Medical Center Nottinghamshire (U.K.)
- Indo - German Orthopedic Fellow for Hip & Knee Replacement Arthroplasty Krakenhaus - Bruder Regensberg (GERMANY)

To whom it may Concern Date 29/Nov/2018

DR. K.K. PRUTHI
M.S. (ORTHO)
ORTHOPAEDIC SURGEON
FORMER PROF & HEAD
DEPTT. OF ORTHOPAEDICS
S.N. MEDICAL COLLEGE AGRA

This is to certify that Mr Gyanendra Rao 53 yr Son S/o late Sri Ramesh Rao R/o A-8 Judge compound - Agra. is under my regular treatment for Sero negative Spondyloarthopathy since 29.8.17. He needs further regular treatment and physiotherapy.

[signature]

Gyanendra [signature]

Attested [signature] [signature]

DR. K.K. PRUTHI
M.S. (ORTHO)
ORTHOPAEDIC SURGEON
FORMER PROF & HEAD
DEPTT. OF ORTHOPAEDICS
S.N. MEDICAL COLLEGE, AGRA

अपातकालीन सेवा 24 घण्टे

Not Valid for Medico legal purposes

परामर्श समय · [illegible]

PRUTHI ORTHOPAEDIC CARE CENTRE

Dr. (Mrs.) Kusum Pruthi

Dr. Kartik Pruthi

continue

[illegible]

Rx [illegible]

Cap. [illegible]

दुबारा परामर्श के लिए
.....बाद आयें।

अपातकालीन सेवा 24 घण्टे

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परामर्श समय : दोपहर : 2.00 से 7.00 बजे रविवार 2.00 बजे से सायं 5.00 बजे तक

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- Indo - German Orthopedic Fellow for Hip & Knee Replacement Arthroplasty Krankenhaus - Bruder Regensburg (GERMANY)

Date [illegible]

[illegible]

C/o pain Left Shoulder

[illegible]

T. Ultracet SOS

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  Nottinghamshire (U.K.)
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  Hip & Knee Replacement Arthroplasty
  Krankenhaus - Bruder Regensburg
  (GERMANY)

Date: [illegible]

[illegible handwritten notes]

Exam.

दुबारा परामर्श के लिए [illegible] बाद आवें।

अपातकालीन सेवा 24 घण्टे

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  (GERMANY)

Date

दुबारा परामर्श के लिए .... बाद आवें।

आपातकालीन सेवा 24 घण्टे

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19.17

HB 13.5
[illegible] 02
BSR 116
SCr 1.02
CRP < 5
RA 3.2
HLA-B 27 - NEGATIVE

CT Pelvis
SIJ normal

Seronegative SpA

[illegible]

T Arcoxia MR-8 — o o

T Saaz DS o [illegible]

T HCQS 300 | [illegible]
T Deflazacort | [illegible]

Ex Ex 15 m

दुबारा परामर्श के लिए
...15 दिन...बाद आवें।

17.3.17

Improving — Continue Exercise
T Arcoxia MR o
T Saaz DS o o
T HCQS 300 | [illegible]
T Deflazacort | [illegible]
T Pantocid 40 [illegible]

दुबारा परामर्श के लिए
...2 माह...बाद आवें।

(Free)

Agra Pain Management Clinic

4/11, Lala Lajpat Rai Marg, Civil Lines, Agra
Tel. : +91 98376-64069 E-mail : apmc_pain@yahoo.in

डॉ. मणि वाहल
Dr. Maniwahal
MBBS, DA, FAAP
Regd. No. : 15413

Specialised Interventional Treatment for :

Back Pain
कमर दर्द

Disc Related Pain/Sciatica
रीढ़ की हड्डी का दर्द

Joint Pain
जोड़ों का दर्द

Neck/Cervical Pain
गरदन का दर्द

Neurological Pain
नसों का दर्द

- Cancer Pain
  कैंसर का दर्द
- Spasticity Pain
  मांसपेशी की जकड़न
- Rheumatology Pain
  गठिया बाय का दर्द

Ozone Disectomy

बिना ऑपरेशन व बिना बेहोशी के डिस्क व नस दबने का इलाज अत्याधुनिक तकनीक व ओजोन विधि द्वारा

परामर्श समय :
प्रातः 10.00 से सायं 5.00 बजे तक

Radio Frequency ablation of nerves for lowback pain, TN, Cancer Pain, Facet Pain etc.

6-10-17
BP- 110/34. Sri Gyandra Rao
SM- Rt lumbar c
PF- radiation
Rt buttock.
Wt-

Pain Relief As A Human Right

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परामर्श समय :
प्रातः 10.00 से सायं 5.00 बजे तक

17-1-18

Pt. Gyanendra

gout

Rx

1. Achrali + Fubon40 } OD.

2. Q Big + Lupimi SR } OD.

(1) 3. Tabs Alcup - sos for pain

to wear brace while walking

x 5 weeks

Radio Frequency ablation of nerves for lowback pain, TN, Cancer Pain, Facet Pain etc.

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नसों का दर्द

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  मांसपेशी की जकड़न
- Rheumatology Pain
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परामर्श समय :
प्रातः 10.00 से सायं 5.00 बजे तक

9-2-18. Mr. Gyanendra. Rao.

Rx

1. Tab Alaiht ?? Sos pain
2. Q Big + Febulat 40 } OD.
3. neurobion 100.

Local app of Dynapar 0.1% gel ?

[signature]

Radio Frequency ablation of nerves for lowback pain, TN, Cancer Pain, Facet Pain etc.

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Ozone Disectomy

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परामर्श समय :
प्रातः 10.00 से सायं 5.00 बजे तक

7-10-17 · Mr. Gyanendra Rana

✓ Pain with/into pelvis lumbar
✓ Pain Rt buttock.

C7 [illegible]
[illegible]

CRP - ve.
A[illegible] - ve
[illegible] - ve
SUA - 8.40

Adv.
MRI [illegible]
- [illegible]
- [illegible]
- [illegible]

℞
1. Febuxo 80-100
2. Q [illegible] + [illegible] } OD after [illegible]
3. [illegible] + [illegible] } OD × [illegible] day
4. [illegible] D-1 [illegible]
5. [illegible]

① Local app of [illegible]
to add [illegible]

Radio Frequency ablation of nerves for lowback pain, TN, Cancer Pain, Facet Pain etc.

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- Cancer Pain
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- Spasticity Pain
  मांसपेशी की जकड़न
- Rheumatology Pain
  गठिया बाय का दर्द

Ozone Disectomy

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परामर्श समय :
प्रातः 10.00 से सायं 5.00 बजे तक

25-10-17. Mr. Gyanendra Rao.

gout.

Rx

1. Calcispray 1 puff AIN each day.
2. OnQ 10 + Lupihuh R } OD.
   Panlongi DR - 1 BD -
3. Xykaa SD - 10D
4. Fusbin 40.
5. Stoplon RD3

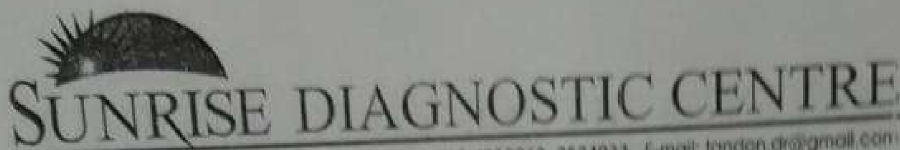
·	·	·	·

weekly for 1 month.

× 1 month.

Radio Frequency ablation of nerves for lowback pain, TN, Cancer Pain, Facet Pain etc.

Pain Relief As A Human Right



4/48, Lajpat Kunj, Bagh Farzana, Agra Tel. : +91-562-4012963, 2524033 E-mail: tandon.dr@gmail.com

Dr. Anurag Tandon
M.B.B.S., C.M.B.D., D.N.B.
CONSULTANT SONOLOGIST & RADIOLOGIST
Registrar : RUBY HALL CLINIC, PUNE

Patient Name :	MR. GYANENDRA RAO	Reg. Date :	09 Oct. 2017
Age/Sex :	40 YRS/MALE	Referred By :	Dr. MANI WAHAL (M.B.B.S.)

L3-4: Concentric disc bulge causing thecal sac compromise, bilateral moderate neural foraminal narrowing (right > left) and indentation to possible compression upon right exiting L3 nerve root. Mild ligamentum flavum hypertrophy.
L2-3 & L1-2: Mild ligamentum flavum hypertrophy.
Central canal stenosis from L1 to L4.

Intervertebral disc show normal signal intensity pattern on both T1 & T2 W images at rest of the visualized spinal levels .They show normal posterior concavity. Prethecal epidural fat is well maintained

Thecal sac shows normal appearance at rest of the levels. The conus medullaris & caudaequina appear normal. There is no focal area of cord expansion or cord edema identified. No intraspinal mass is seen

Neural foramina & exiting nerve roots appear normal at rest of the levels
Articular facet and facet joints are normal.
Pre and paraspinal soft tissues are normal.

Saggital Diameter Of Bony Spinal Canal	Size in mms	Saggital Diameter Of Spinal Canal	Size in mms
L1	11	L1-2	10
L2	11	L2-3	10
L3	09	L3-4	07
L4	10	L4-5	09
L5	11	L5-S1	11

IMPRESSION:-

- *Changes of spondylosis and syndesmophytes from C3 downwards.*
- *Desiccated all cervical discs and maintained disc space height.*
- *C3-4: Concentric mild bulge, postero-central broad based mild disc protrusion causing thecal sac indentation.*
- *C4-5: Postero-central and paracentral broad based mild disc protrusion (posterior annular tear) causing thecal sac indentation.*

DR. PRASHANT NATH GUPTA
(M.B.B.S., M.D., D.N.B.(Radiodiagnosis, BHU)
(Consultant Radiologist)

Dr. ANURAG TANDON
(Consultant Radiologist)

Detailed fetal anomalies may not always be seen due to technical inadequacy, due to fetal position, movement, amniotic fluid volume & abdominal wall thickness. Hence all anomalies may not be detected in single sonoimaging study, so there absence may not rule out fetal anomaly. Investigations have their limitations they only help in diagnosing disease in correlation to clinical symptoms.
Not valid for medico legal purposes

SUNRISE DIAGNOSTIC CENTRE

[illegible], Agra Tel.: [illegible] E-mail: [illegible]

Dr. Anurag Tandon

M.B.B.S., [illegible]

[illegible]

Patient Name :	MR. GYANENDRA RAO	Reg. Date :	09 Oct. 2017
Age/Sex :	40 YRS/MALE	Referred By :	Dr. [illegible] (M.B.B.S.)

- *C5-6: Concentric mild disc bulge, postero-central broad based mild disc protrusion causing thecal sac indentation and right sided moderate neural foraminal narrowing.*
- *C6-7: Concentric disc bulge, right far lateral and right foraminal broad based disc protrusion causing thecal sac indentation, right sided moderate neural foraminal narrowing and compression upon right exiting nerve root.*
- *Central canal stenosis from C3 to C6-7.*

- *Dorsal spine - Mild diffuse thickening of anterior longitudinal ligament at upper and mid dorsal spine.*
- *Mild marginal irregularity and multilevel schmorl's node from D5 to D12.*
- *Mild reduced all dorsal discs and maintained disc space height.*
- *Mild diffuse ligamentum flavum hypertrophy.*

- *Marginal irregularity and schmorl's node at apposing end plates of L1-2 & L5-S1.*
- *Changes of lumbar spondylosis and modic II changes at anterior corner of L2 to L4.*
- *Desiccated L3-4 disc and mild reduced disc space height.*
- *L4-5: Concentric disc bulge causing thecal sac indentation, bilateral mild to moderate neural foraminal narrowing (left > right) with possible indentation upon left exiting nerve root.*
- *L5-S1: Concentric mild disc bulge causing subtle indentation at bilateral neural foraminas.*
- *L3-4: Concentric disc bulge causing thecal sac compromise, bilateral moderate neural foraminal narrowing (right > left) and indentation to possible compression upon right exiting L3 nerve root. Mild ligamentum flavum hypertrophy.*
- *L2-3 & L1-2: Mild ligamentum flavum hypertrophy.*
- *Central canal stenosis from L1 to L4.*

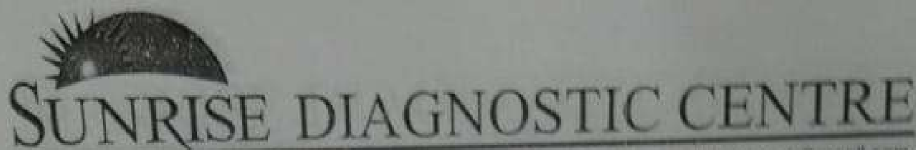
Clinical correlation is advised

DR. PRASHANT NATH GUPTA
M.B.B.S., M.D., D.N.B. [illegible]
(Consultant Radiologist)

Dr. ANURAG TANDON
(Consultant Radiologist)

[illegible] due to fetal position, movement, amniotic fluid [illegible], so their absence may [illegible] in correlation to clinical symptoms.

Not valid for medico legal purposes



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Patient Name :	MR. GYANENDRA RAO	Reg. Date :	09 Oct. 2017
Age/Sex :	40 YRS/MALE	Referred By :	Dr. MANI WAHAL (M.B.B.S.)

Neural foramina & exiting nerve roots appear normal at rest of the levels
Articular facet and facet joints are normal.
Pre and paraspinal soft tissues are normal.

LEVELS	AP (Size in mms)
C2	11
C3	09
C3-4	08
C4	09
C4-5	08
C5	10
C5-6	07
C6	09
C6-7	08
C7	10

LUMBO-SACRAL SPINE

The spine shows loss of lordosis but normal in alignment of vertebral bodies. **No abnormal hypo/hyperintense lesion is seen from within the vertebral bodies & their neural arches.**

Marginal irregularity and schmorl's node at apposing end plates of L1-2 & L5-S1.
Few marginal osteophytes from L2 downwards and modic II changes at anterior corner of L2 to L4.
Desiccated L3-4 disc and mild reduced disc space height.
L4-5: Concentric disc bulge causing thecal sac indentation, bilateral mild to moderate neural foraminal narrowing (left > right) with possible indentation upon left exiting nerve root.
L5-S1: Concentric mild disc bulge causing subtle indentation at bilateral neural foraminas.

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Patient Name :	MR. GYANENDRA RAO	Reg. Date :	09 Oct. 2017
Age/Sex :	[illegible] YRS/MALE	Referred By :	Dr. MANI WAHAL (M.B.B.S.)

MRI STUDY OF WHOLE SPINE

Whole Spine was examined in the sagittal, coronal and axial planes. Both T1 and T2 weighted images were obtained. Additionally Fat Sat saggital T2 images were also obtained.

CERVICO-DORSAL SPINE

Cervical spine shows loss of lordosis but normal alignment of vertebral bodies. No abnormal hypo/ hyperintense lesion is seen from the neural arches.

Marginal few osteophytes and syndesmophytes from C3 downwards.
Desiccated all cervical discs and maintained disc space height.
C3-4 Concentric mild bulge, postero-central broad based mild disc protrusion causing thecal sac indentation.
C4-5 Postero-central and paracentral broad based mild disc protrusion (posterior annular tear) causing thecal sac indentation.
C5-6 Concentric mild disc bulge, postero-central broad based mild disc protrusion causing thecal sac indentation and right sided moderate neural foraminal narrowing.
C6-7 Concentric disc bulge, right far lateral and right foraminal broad based disc protrusion causing thecal sac indentation, right sided moderate neural foraminal narrowing and compression upon right exiting nerve root.
Central canal stenosis from C3 to C6-7.

Dorsal spine - Mild diffuse thickening of anterior longitudinal ligament at upper and mid dorsal spine.
Mild marginal irregularity and multilevel schmorl's node noted from D5 to D12.
Mild reduced all dorsal discs and maintained disc space height.
Mild diffuse ligamentum flavum hypertrophy.

Pretheeal epidural fat is well maintained.

Thecal sac shows normal appearance at rest of the levels. Cervicomedullary junction, cervical cord and dorsal cord appears normal. There is no focal area of cord expansion or cord edema identified. No intraspinal mass is seen. Atlantoaxial joint appears normal.

DR. PRASHANT NATH GUPTA
M.B.B.S., MD, DNB (Radiodiagnosis, [illegible])
(Consultant Radiologist)

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Tele : 7088090001, 7088005500, 7088006600
Agra Branch :
Shop No. 2-3, Haji Complex, Hari Nagar, Rajpur Chungi
Agra - 282 001 Tele : 2482906

Pankaj Scanning & Pathology
Research Centre (P) Ltd.

NAME - MR.GYANENDRA RAO		38 Y/M	DATE - 30-08-2017
REF. BY - DR.K.K.PRUTHI	MS (Ortho).		

NCCT OF PELVIS FOR SACROILIAC JOINTS

NCCT pelvis done by taking contiguous thin axial sections. Thin reconstruction with coronal reformations was done.

Bilateral sacroiliac joints show normal joint space, alignment & articular surface.

Bilateral iliac blades & sacrum show normal cortical outline & density.

Pubic symphysis appear normal. Bilateral superior and inferior pubic rami show normal cortical outline & density.

Other visualized pelvic bones & myofascial planes are normally visualized.

IMPRESSION - CT FINDINGS DO NOT REVEAL ANY SIGNIFICANT ABNORMALITY.

- Please Correlate Clinically.

Dr. Vandana V. Ahluwalia	Dr. Sanjiv Sharma	Dr. Amit Singhal	Dr. Pankaj Mahinderu
M.D., DNB, MNAMS	M.D.	M.D.	M.D., MAMS
Consultant Radiologist	Consultant Radiologist	Consultant Radiologist	CAMS in Diag. Ultrasound
			University of Vienna, Austria
			Consultant Radiologist

All investigation have technical limitations. Collaborative radiology interpretation is mandatory. (In case of disparity tests may be repeated immediately)

For home collection of sample Contact No.:
(Agra) 070880 90001, 070880 05500, 070880 06600 (Mathura) 94100 38913
E-mail : drpankajlab@gmail.com, website : www.drpankajlab.com
CT - 7088610001, 8273139433 M.R.I. - 7088510001

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D. Pushpanjali Hospital & Research Centre

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Name	: MR. GYANENDRA RAO	Collected	: 23/2/2018 10:03 AM
		Received	: 23/2/2018 10:04 AM
Lab No. : 246909679	Age : 40 Yrs. Gender : Male	Reported	: 23/2/2018 01:04 PM
A/c Status :	Ref By: SELF .	Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM			
(Reflectance Photometry, Calculated)			
Cholesterol, Total	240.0	mg/dL	<200.00
Triglycerides	237.0	mg/dL	<150.00
HDL Cholesterol	39.0	mg/dL	>40.00
LDL Cholesterol	154	mg/dL	<100.00
VLDL Cholesterol	47	mg/dL	<30.00
CHOL/HDL	6.15		
LDL/HDL	3.95		

Results rechecked
Please correlate clinically

Interpretation

INTERPRETATION	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL
Optimal	< 200	< 150	< 100
Above Optimal	-	-	100 - 129
Borderline High	200 - 239	150 - 199	130 - 159
High	>= 240	200 - 499	160 - 189
Very High	-	>= 500	>= 190

Note:
1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.
3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL.

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AGRA U.P 282002

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Name	Mr. GYANENDRA RAO			Collected	[illegible]
Lab No.	246900679	Age: 40 Years	Gender: Male	Received	[illegible]
				Reported	[illegible]
A/c Status	P	Ref By : SELF		Report Status	Final

Test Name	Results	Units	Bio. Ref. Interval
TSH, SERUM (Chemiluminescent Immunoassay)	8.38	[illegible]	[illegible]

Note

TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm . The variation is of the order 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
- Quantify TSH levels in the subnormal range

Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism, Thyroid hormone resistance

Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH deficiency

Dr. Aditi Kapoor
MBBS, DCP
Chief of Lab

End of report

Dr Lal PathLabs

National Reference Lab: Sector-18, Block-E, Rohini, New Delhi - 110 085
Tel: 011 - 3040-3210, Fax: 011 - 3040-3204
E-mail: lalpathlabs@lalpathlabs.com Web: www.lalpathlabs.com

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AGRA

(Hony) Brig. Dr. Arvind Lal
M.B.B.S., D.C.P.

Dr. Vandana Lal
M.D (PATH), DNCAP

Name	: Mr. GYANENDRA RAO			Collected	: 9/10/2017 11:03:00AM
				Received	: 9/10/2017 11:07:24AM
Lab No.	: 236796469	Age: 40 Years	Gender: Male	Reported	: 9/10/2017 1:41:49PM
A/c Status	: P	Ref By :	Dr. MANI WAHAL	Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval
URIC ACID, SERUM (Uricase Colorimetric)	8.40	mg/dL	3.50 - 7.20
CALCIUM, SERUM (Arsenazo III)	9.10	mg/dL	8.80 - 10.60
TSH, SERUM (Chemiluminescent Immunoassay)	4.84	uIU/mL	0.35 - 5.50

Note

TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order 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
- Quantify TSH levels in the subnormal range

Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism, Thyroid hormone resistance

Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH deficiency

Aditi Kapoor

Dr. Aditi Kapoor
MBBS; DCP
Chief of Lab

-----End of report -----

If test results are alarming or unexpected, Client is advised to contact the laboratory immediately for possible remedial action.
@ Tests conducted at National Reference Lab, New Delhi, a CAP (7171001), ISO (FS 60411) and NABL (M-0061) accredited laboratory

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Name	: MR. GYANENDRA RAO			Collected	: 23/2/2018 10:03 AM
				Received	: 23/2/2018 10:04 AM
Lab No.	: 246909679	Age : 40 Yrs.	Gender : Male	Reported	: 23/2/2018 01:04 PM
A/c Status :		Ref By: SELF .		Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT (CBC) *(Electrical Impedence, Photometric)*			
Hemoglobin	13.8	g/dL	13.00 - 17.00
PCV (Packed Cell Volume)	42.1	%	40.00 - 50.00
Total Leucocyte Count (TLC)	8.4	thou/mm3	4.00 - 10.00
RBC Count	4.89	mill/mm3	4.50 - 5.50
MCV	86.1	fL	80.00 - 100.00
MCH	28.2	pg	27.00 - 32.00
MCHC	32.8	g/dL	32.00 - 35.00
RDW	13.4	%	11.50 - 14.50
Platelet Count	102	thou/mm3	150.00 - 450.00
Differential Leucocyte Count (DLC)			
Neutrophils	59	%	40.00 - 80.00
Lymphocytes	33.6	%	20.00 - 40.00
Monocytes	5.4	%	2.00 - 10.00
Eosinophils	1.4	%	1.00 - 6.00
Basophils	0.6	%	< 2.00
Absolute Leucocyte Count			
Neutrophils	4.96	thou/mm3	2.00 - 7.00
Lymphocytes	2.82	thou/mm3	1.00 - 3.00
Monocytes	0.45	thou/mm3	0.20 - 1.00
Eosinophils	0.12	thou/mm3	0.02 - 0.50
Basophils	0.05	thou/mm3	0.01 - 0.10

Platelets are reduced.
Urgent recheck of platelet count with a fresh E.D.T.A. sample in case the platelet count is not corelating clinically.

Note
1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are
additionally being reported as absolute numbers of each cell in per unit volume of blood.
2. Test conducted on EDTA whole blood.

Dr.Umang Bhargava

------------ End of report ------------

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[illegible]

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Name	[illegible]					Collected	11/2/2018 11:27:06AM
Lab No.	[illegible]	Age: 40 Years		Gender:	Male	Received	11/2/2018 11:29:53AM
A/c Status	[illegible]	Ref By :	SELF			Reported	12/2/2018 10:43:30AM
						Report Status	Final

Test Name	Results	Units	Bio. Ref. Interval
VITAMIN D, 25 - HYDROXY, SERUM @ (CLIA)	33.40	nmol/L	75.00 - 250.00

Interpretation

LEVEL	REFERENCE RANGE IN nmol/L	COMMENTS
Deficient	< 50	High risk for developing bone disease
Insufficient	50-74	Vitamin D concentration which normalizes Parathyroid hormone concentration
Sufficient	75-250	Optimal concentration for maximal health benefit
Potential intoxication	>250	High risk for toxic effects

Note

1. The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.
2. 25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
3. Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
4. It shows seasonal variation, with values being 40-50% lower in winter than in summer.
5. Levels vary with age and are increased in pregnancy.
6. A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available.

Comments

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels

1. Inadequate exposure to sunlight
2. Dietary deficiency
3. Vitamin D malabsorption

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Name : MR. GYANENDRA RAO OPD		Collected	: 19/11/2017 09:37 AM
		Received	: 19/11/2017 09:38 AM
Lab No. : 242282708	Age : 40 Yrs. Gender : Male	Reported	: 19/11/2017 10:31 AM
A/c Status :	Ref By: SELF .	Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM			
(Reflectance Photometry, Calculated)			
Cholesterol, Total	229.0	mg/dL	<200.00
Triglycerides	196.0	mg/dL	<150.00
HDL Cholesterol	39.0	mg/dL	>40.00
LDL Cholesterol	151	mg/dL	<100.00
VLDL Cholesterol	39	mg/dL	<30.00
CHOL/HDL	5.87		
LDL/HDL	3.87		

Results rechecked

Interpretation

INTERPRETATION	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL
Optimal	< 200	< 150	< 100
Above Optimal	-	-	100 - 129
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Rosuter Gold

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3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL

Dr. Shalini Gupta
MD (Path)

End of report