| | | | |
|---|---|---|---|
| **Patient :** | Mrs. Fathima Beevi | **Visit Date :** | 03-05-2023 |
| **Ref By :** | Dr. J. Tharik Ajees MS(Ortho) | **Age & Gender :** | 65/F |

## CT – BRAIN(PLAIN)

**TECHNIQUE:**

Serial axial sections of CT Brainwere studied.

**FINDINGS:**

**Non-haemorrhagic infarct in left anterior ganglio-capsular region / corona radiata.**

**Chronic lacunar infarcts in bilateral ganglio-capsular region.**

**Patchy periventricular hypodensities noted in bilateral supratentorial brain parenchyma suggestive of chronic small vessel ischaemic changes.**

**Age related brain parenchymal atrophy.**

**Polypoidal mucosal thickening of left sphenoethmoidal and bilateral maxillary sinuses - chronic sinusitis with inflammatory polyp formation.**

Bilateralthalami appear normal.

Brain stem and cerebellum appear normal.

No significant midline shift.

Sella and parasellar region appear normal.

No fracture in skull vault and maxilla.

Orbits and contents appear normal.

Bilateral temporal bones appear normal.

**TIRUCHY NEURO MULTI SPECIALITY CENTRE**

**D-69/2 , 8TH CROSS (EAST) ,THILLAINAGAR ,TRICHY-620018**

**DISCHARGE SUMMARY**

**IPNO : 230501**

**NAME : MRS.FATHIMA** **DOA:04 : 05 : 23**

**AGE/ SEX : 72 YRS./FEMALE** **DOD : 07 : 05 :23**

**CONSULTANT: Dr. E.ARUNRAJ DCH., MD.,DM.,(NEURO )**

**DIAGNOSIS : SHT/ DM / ACUTE CVA / RIGHT HEMIPARESIS / CHRONIC LACUNAR INFARCTS IN BILATERAL GANGLIO CAPSULAR REGION. / ACUTE NON HAEMORRHAGIC INFARCT IN LEFT ANTERIOR *GANGLIO* – CAPSULAR REGION / CORONA RADIATA .**

**COMPLAINTS : PATIENT CAME WITH COMPLAINTS OF WEAKNESS RIGHT UPPER LIMB AND LOWER LIMB SINCE FOUR DAYS .**

**H/ SLURRING OF SPEECH .**

**O/E : CONSCIOUS .**

**AFEBRILE.**

**PERL**

**EOM FULL .**

**VITALS: BP – 130 /70 MMHG**

**PR –88 / MTS**

**SPO2 –96 %**

S/E : CVS – S1 S2
RS – BAE +
P/A—SOFT.

| CNS – | R | L |
|---|---|---|
| POWER | 3 / 5 | 5 / 5 |
| | 3 / 5 | 5 / 5 |
| DTR | + | ++ |
| PLANTER | EXTENSOR | FLEXOR |

## COURSE IN HOSPITAl:

PATIENT WAS ADMITTED AND TREATED WITH ANTIPLATELETS , CEREBRAL STIMULATOR AND OTHER SUPPORTIVE MEDICINES . PATIENT WAS STABLE . PATIENT SYMPTOMATICALLY IMPROVED . HENCE DISCHARGED WITH FOLLOWING ADVICE .

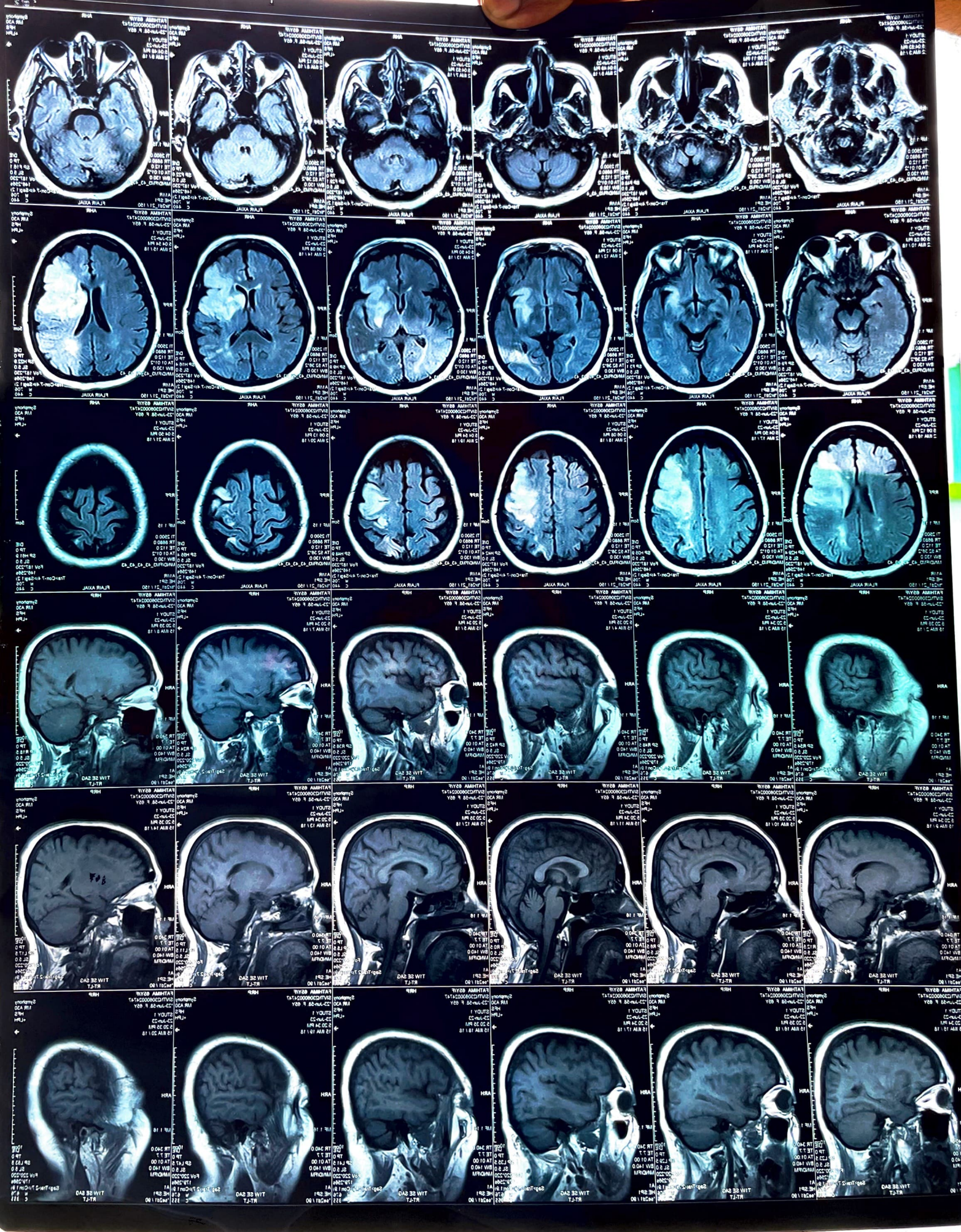
## *DISCHARGE ADVICE :*

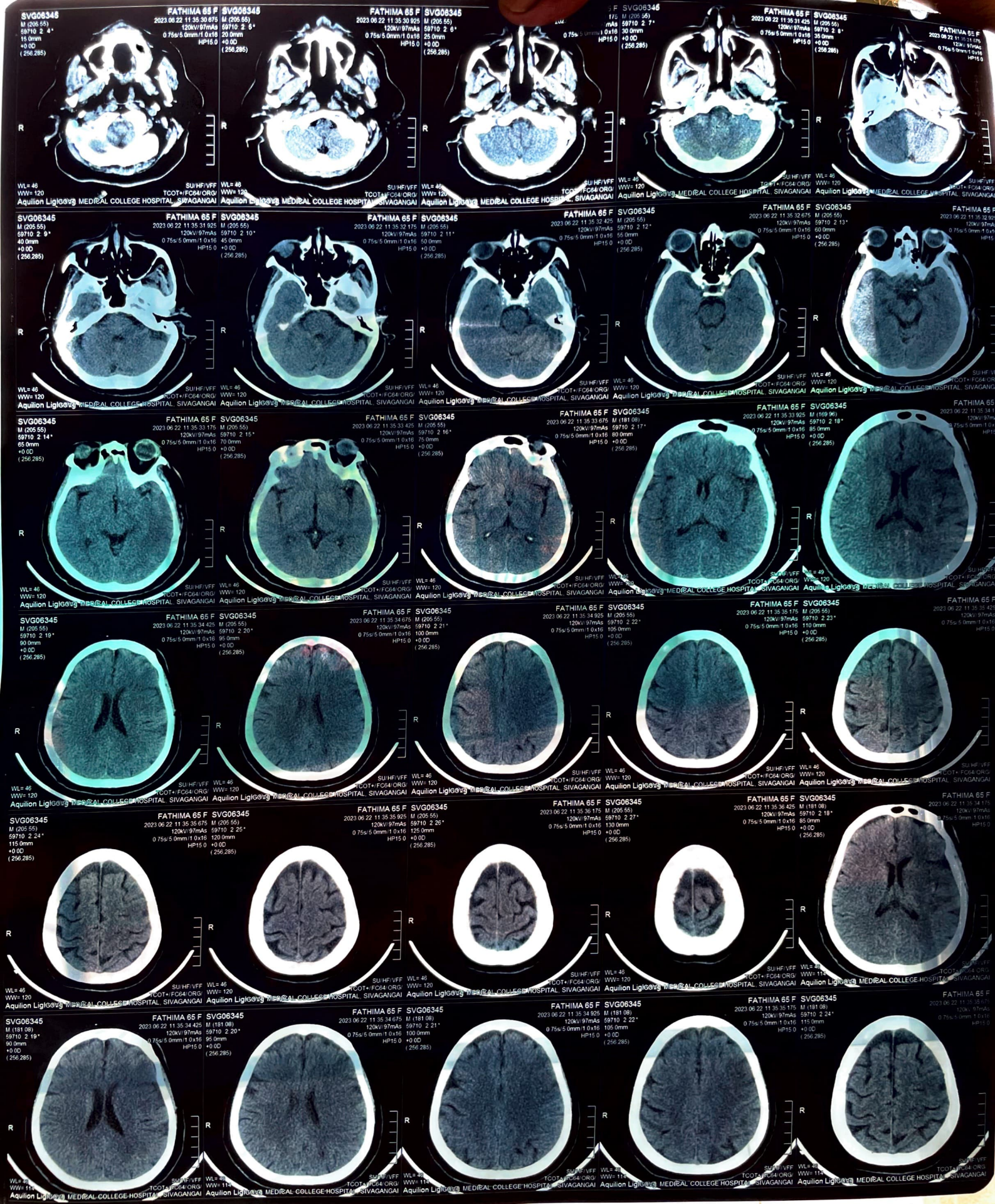
| | | |
|---|---|---|
| TAB . STOCOZ PLUS | P/O OD | 1—0--1 |
| TAB . RABEVIB DSR | P/O HS | 0—0—1 |
| TAB. CLOPILET A | P/O 0D | 0—1--0 |
| TAB . HOMIN | P/O OD | 1—0--0 |
| TAB . GLYCOMET 500 MG | P/O OD | 0—1/2--0 |
| TAB . ATOVIB 40MG | P/O HS | 0—0--1 |
| TAB. GABAWIN M25 MG | P/O HS | 0—0--1 |
| TAB. VIDANOVA 50 MG | P/O OD | 1—0--0 |
| TAB. VIGLIM 1MG | P/O OD | 1—0--0 |

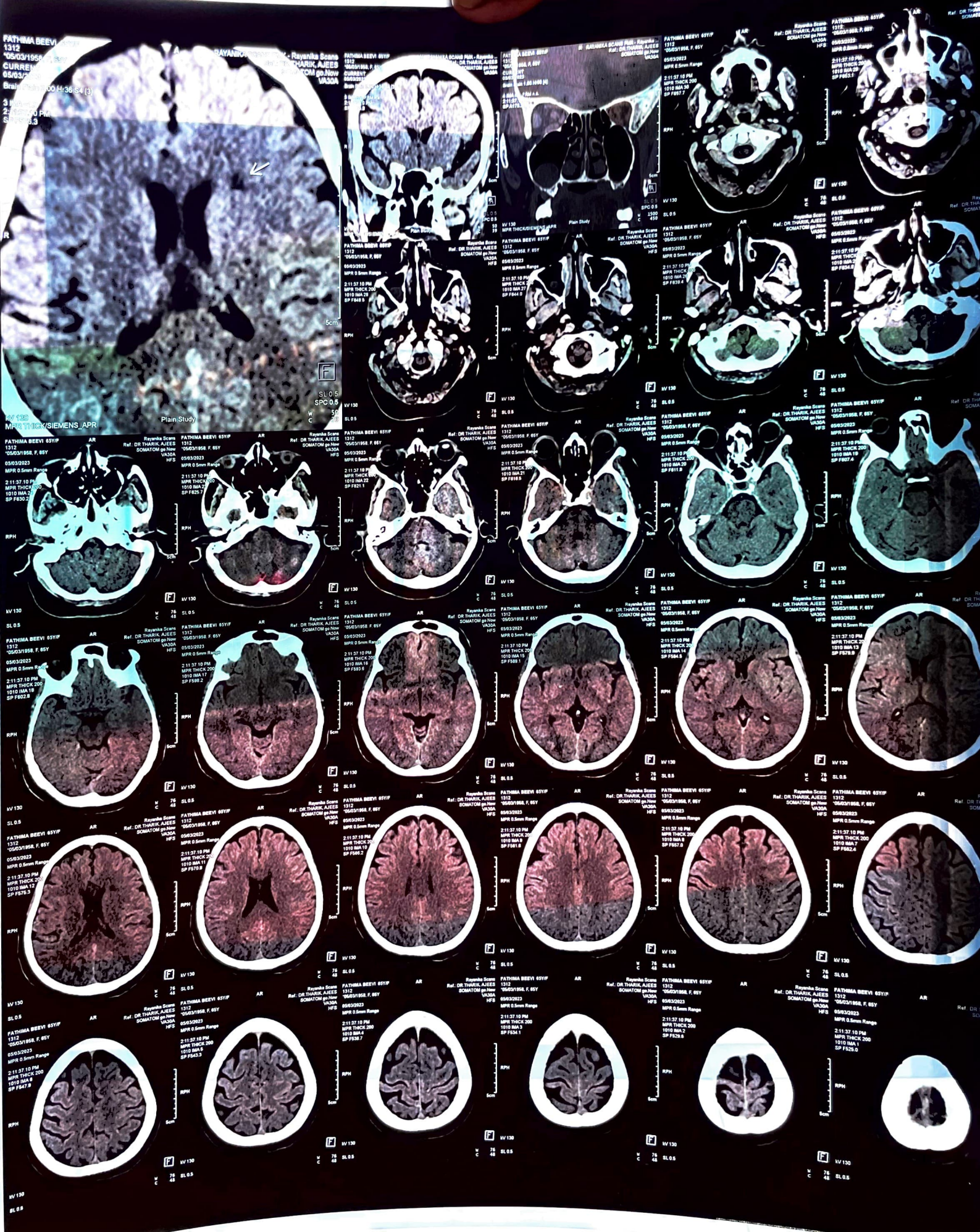
**REVIEW AFTER 15 DAYS.**

MEDICALOFFICER

Dr.E.ARUNRAJ
D.M., Neuro, D.CH., M.D.,(G.M).,FRCP(Glasgo
Consultant Neurologist
Reg. No: 56627
TRICHY NEURO & MULTI SPECIALITY CENT
D-69/2, 8th Cross East, Thillai Nagar
Trichy- 620 018




SVG06345
FATHIMA 65 F
Aquilion LightGVg MEDICAL COLLEGE HOSPITAL, SIVAGANGAI


FATHIMA BEEVI 65Y/F
1312
*05/03/1958, F, 65Y
05/03/2023
MPR 0.5mm Range
Rayanka Scans
Ref.: DR.THARIK, AJEES
SOMATOM go.Now
VA30A
HFS
Plain Study
MPR THICK/SIEMENS_APR
5cm

AGARAM DIAGNOSTICS

அகரம் டயக்னாஸ்டிக்ஸ்

| | | | |
|---|---|---|---|
| NAME | : MRS. FATHIMA | ID | : ADT-37796 |
| AGE/GENDER | : 67 years /F | RECEIVED | : 04/05/2023 21:50 |
| REFERRED BY | : ACCULIFE LAB AND DIAGNOSTICS | ANALYSED | : 04/05/2023 21:58 |
| PHONE | : 0000000000 | REPORTED | : 05/05/2023 09:08 |

**AGARAM (N) AROKIYAM**

**DEPARTMENT OF HAEMATOLOGY**

**COMPLETE BLOOD COUNT -5 P**

| Test Name | Findings | Units | Bio Ref.Interval |
|---|---|---|---|
| TOTAL RBC COUNT | 4.25 | Million/cmm | 3.90 - 5.60 Million/cmm |
| HAEMOGLOBIN-HB | *11.7* | gm% | 12.000 - 15.000 gm% |
| PCV | 37.1 | % | 36 - 46 % |
| MCV | 87.3 | fl | 83 - 101 fl |
| MCH | 27.5 | pg | 27 - 32 pg |
| MCHC | 31.5 | g/l | 31.5 - 34.5 g/l |
| RED CELL DISTRIBUTION WITH CV | 13.8 | % | 11.5 - 15 % |
| RED CELL DISTRIBUTION WITH SD | *49.0* | fl | 39 - 46 fl |
| TOTAL WBC COUNT - TC | *12610* | CELL\CUMM | 4000 - 10000 CELL\CUMM |
| DIFFERENTIAL COUNT | | | |
| NEUTROPHIL | 67.8 | % | 40 - 75 % |
| LYMPHOCYTES | 27.4 | % | 20 - 40 % |
| EOSINOPHILS | *0.1* | % | 1 - 6 % |
| MONOCYTES | 4.3 | % | 1 - 10 % |
| BASOPHILS | 0.4 | % | < 2 % |
| ABSOLUTE NEUTROPHIL COUNT | *8550* | cells/micro L | 2000 - 7000 cells/micro L |
| ABSOLUTE LYMPHOCYTE COUNT | 3460 | | 1000 - 4000 |
| ABSOLUTE EOSINOPHIL COUNT | *10* | Cells/microL | 40 - 440 Cells/microL |
| ABSOLUTE MONOCYTE COUNT | 540 | cells/micro L | 200 - 1000 cells/micro L |
| ABSOLUTE BASOPHIL COUNT | 50 | cells/micro L | < 150 cells/micro L |
| PLATELET COUNT | 382 | THOUSAND/UL | 150 - 410 THOUSAND |
| PLATELETCRIT | 34.0 | % | 19.7 - 42.4 % |
| MEAN PLATELET VOLUME - MPV | 9.0 | fL | 6.5 - 12.0 fL |
| PLATELET TO LARGE CELL RATIO - PLCR | 29.1 | % | 19.7 - 42.4 % |

Mr. GUNASEKARAN A M , M.Sc, Biochemistry
VERIFIED BY

Mr. GUNASEKARAN A M , M.Sc, Biochemistry
APPROVED BY

Disclamier :
All Laboratory test must be interpreted within the context of overall health of the patient and should be used along with other tests and clinical finding. Laboratory test results may vary depending upon age, sex, time of sample collection, diet, medication and physiological variations

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| Test Name | Findings | Units | Bio Ref.Interval |
|---|---|---|---|

***INTERPRETATION***

- *As per the recommendation of international carnal in hematology , the differential leukocyte count are additionally begging reported as absolute number in ache cell for unit volume of blood.*
- *Test concluded on whole blood EDTA.*

## DEPARTMENT OF BIOCHEMISTRY

| | | | |
|---|---|---|---|
| BLOOD GLUCOSE FASTING *(GOD-POD)* | *183.0* | mg/dl | Diabetes: > 126 and above mg/dl<br>Prediabetes: 100 - 125 mg/dl<br>Normal: Less than 100 mg/dl |

***INTERPRETATION***

***Limitations :***

*Most glucose strips and meters quantify whole blood glucose, whereas most laboratories use plasma or serum which reads 10-15% higher.*

*Blood samples in which serum is not separated from blood cells shows glucose values decreasing at rate of 3-5% per hour at room temperature*

*Strenuous exercise, strong emotions, shock, burns and infections can increase glucose physiologically.*

*Low oxygen content (e.g.venous blood, high altitudes >3000 mts) gives falsely increased values.*

HbA1c *(HPLC)*

| | | | |
|---|---|---|---|
| GLYCOSYLATED HAEMOGLOBIN - HbA1c | *8.2* | % | Below 5.6 - Non diabetic Level %<br>Impaired glucose tolerance: 5.7 - 6.4 %<br>Above 6.5 - Diabetes % |
| MEAN PLASMA GLUCOSE - MPG | *214.62* | mg/dl | |
| ESTIMATED AVERAGE GLUCOSE - eAG | *188.64* | mg/dl | |

***INTERPRETATION***

*HbA1c level reflects the mean glucose concentration over the previous period (approximately 6-8 weeks) and provides a much better indication of long term glycemic control than blood and urine glucose determinations. The American Diabetes Association recommends measurement of HbA1c every 3 months to determine whether a patient's metabolic control has remained continuously within the target range.A1C test should be performed at least 2 times a year in patients who are meeting treatment goals (and who have stable glycemic control). A1C test should be performed quarterly in patients whose therapy has changed or who are not meeting glycemic goals. Predicting development and progression of diabetic microvascular complications. This assay is not useful in determining day to day glucose control and should not be used to replace routine blood glucose testing.*

***LIPID PROFILE***

**Mr. GUNASEKARAN A M , M.Sc,**
**Biochemistry**
**VERIFIED BY**

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**Biochemistry**
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| Test Name | Findings | Units | Bio Ref.Interval |
|---|---|---|---|
| TOTAL CHOLESTEROL *(CHOD-PAP)* | *234.0* | mg/dl | Desirable blood Choesterol: < 200 mg/dl<br>Borderline high blood cholesterol: 200 - 239 mg/dl<br>High blood Cholesterol: >239 mg/dl |
| TRIGLYCERIDES *(GPO/ENZYMATIC)* | 141.0 | mg/dl | Normal: 0.1 - 160 mg/dl<br>High: 161 - 199 mg/dl<br>Hypertriglyceridemic: 200 - 499 mg/dl<br>Very High: > 499 mg/dl |
| HDL CHOLESTEROL - DIRECT *(DIRECT CLEARANCE)* | 55.0 | mg/dl | 42.0 - 88.0 mg/dl |
| LDL CHOLESTEROL - DIRECT *(DIRECT CLEARANCE)* | *150.8* | mg/dl | < 130 mg/dl |
| NON HDL CHOLESTEROL | *179.0* | | < 140 |
| VLDL | 28.2 | | < 35 |
| LDL / HDL RATIO | 2.74 | | High risk: More than - 6.0<br>Borderline: 3.0 - 4.0<br>Optimal: Less than - 3.0 |
| CHOL / HDL RATIO | 4.25 | | 3.9 - 5 |
| TGL / HDL RATIO | *2.56* | | < 2 |

***INTERPRETATION***

*The CHD risk is based on T.CHOL/ HDL ratio. Other factors affect CHD risk such as Hypertension, smoking, diabetes, severe obesity and family history of premature CHD.*

**LIVER FUNCTION TEST**

| | | | |
|---|---|---|---|
| BILIRUBIN TOTAL *(JENDRASSIK )* | 0.39 | mg/dl | < 1.2 mg/dl |
| BILIRUBIN DIRECT *(DIAZO)* | 0.14 | mg/dl | < 0.40 mg/dl |
| BILIRUBIN INDIRECT | 0.25 | mg/dl | 0.25 - 1 mg/dl |
| SGOT - AST *(IFCC / KINETIC)* | 21.0 | U/L | 0.0 - 31.0 U/L |

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| Test Name | Findings | Units | Bio Ref.Interval |
|---|---|---|---|
| SGPT - ALT *(IFCC / KINETIC)* | 14.0 | U/L | Upto - 34 U/L |
| AST/ALT RATIO | 1.5 | | |
| ALKALINE PHOSPHATASE | 104.0 | U/L | 56 - 119 U/L |
| GAMMA GT ( GAMMA GLUTAMYL TRANSPEPTIDASE ) *(KINETIC)* | 32.0 | IU/L | <38.0 IU/L |
| TOTAL PROTEIN *(BIURET)* | 6.9 | gm/dl | 6.2 - 8.0 gm/dl |
| ALBUMIN *(BROMO CRESOL GREEN)* | 3.8 | gm/dl | 3.2 - 4.6 gm/dl |
| GLOBULIN | 3.1 | gm/dl | 2.3 - 3.5 gm/dl |
| A/G RATIO | 1.23 | | 1 - 2 |

***INTERPRETATION***

*Clinical Use :*

*- High levels of GGT in the blood may be a sign of liver disease or damage to the bile ducts*

*- Bile ducts are tubes that carry bile in and out of the liver. Bile is a fluid made by the liver.*

*- It is important for digestion*

*Most causes of liver cell injury are associated with a greater increase in ALT than AST; however, an AST to ALT ratio of 2:1 or greater is suggestive of alcoholic liver disease, particularly in the setting of an elevated gamma-glutamyl transferase.*

**RENAL FUNCTION TEST**

| | | | |
|---|---|---|---|
| GLOMERULAR FILTRATION RATE - eGFR | 98.0 | ml/min/1.73 m2 | Less than 60 - is abnormal (MDRD) ml/min/1.73 m2 |
| BUN/CREATININE RATIO | *26.45* | | 10 - 20.1 |
| BLOOD UREA NITROGEN - BUN *(UREASE / GLDH)* | 15.87 | mg/dl | 05 - 20 mg/dl |
| URIC ACID *(URICASE/PEROXIDASE)* | *6.3* | mg/dl | 2.6 - 6.0 mg/dl |
| CREATININE *(ENZYMATIC)* | 0.6 | mg/dl | 0.6 - 1.1 mg/dl |
| UREA *(ENZYMATIC)* | 34.0 | mg/dl | 10 - 50 mg/dl |

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| Test Name | Findings | Units | Bio Ref.Interval |
|---|---|---|---|
| **MINERAL SCREEN** | | | |
| PHOSPHOROUS *(UV MOLYBDATE)* | 4.2 | mg/dl | Adult: 2.5 - 4.5 mg/dl<br>Child: 4.0 - 7.0 mg/dl |
| MAGNESIUM *(Xylidyl Blue)* | *2.91* | mg/dl | Serum: 1.6 - 2.6 mg/dl<br>(6 Y - 12 Y ): 1.7 - 2.1 mg/dl |
| CALCIUM *(ARSENAZO III)* | *11.5* | mg/dl | Adult: 8.6 - 10.2 mg/dl<br>Child (1 Y - 12 Y ): 8.8 - 11.0 mg/dl |
| **DEPARTMENT OF IMMUNOLOGY** | | | |
| **THYROID FUNCTION TEST** | | | |
| TOTAL TRIIODOTHYRONINE - T3 *(CLIA)* | 1.52 | ng/mL | 0.60 - 1.81 ng/mL |
| TOTAL THYROXINE - T4 *(CLIA)* | 8.6 | ug/dl | 4.50 - 10.9 ug/dl |
| THYROID STIMULATING HORMONE - TSH *(CLIA)* | 2.06 | uIU/ml | 0.55 - 4.78 uIU/ml |

***INTERPRETATION***

- *TSH Levels are subjected to circadrain variations reaching peak levels between 2-4 am and at a minimum between 6-10 pm. The variation is of order of 50% hence time of day has influence of TSH measurements.*
- *TSH values < 0.03 u/l/ml need to be clinically correlated due to presence of rare TSH variant in some individuals.*
- *Pregnancy : First trimester : 0.3 - 4.5, Second trimester: 0.5 - 4.6, Third trimester : 0.8 - 5.2*
- ***Clinical Clinical Use***
- ** Primary Hypothyroidism*
  ** Hyperthyroidism*
  ** Hypothalamic – Pituitary hypothyroidism*
  ** Inappropriate TSH secretion*
  ** Nonthyroidal illness*
  ** Autoimmune thyroid disease*
  ** Pregnancy associated thyroid disorders*
  ** Thyroid dysfunction in infancy and early childhood*

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