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Case Report

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Extreme Hyperlipasemia in Acute Pancreatitis with Rapid Clinical and Biochemical Recovery: A Case Report

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ABSTRACT

Background: Acute pancreatitis is an inflammatory condition of the pancreas characterized by severe abdominal pain and elevation of pancreatic enzymes. Management is largely supportive, and recovery in moderate to severe cases may be prolonged, with delayed normalization of biochemical markers. Rapid clinical and laboratory recovery is uncommon in cases presenting with markedly elevated enzyme levels.

Case Presentation: A 32-year-old male presented with persistent severe upper abdominal pain lasting nearly 20 days. Laboratory evaluation revealed markedly elevated pancreatic enzymes, with serum lipase at 3531 U/L and serum amylase at 1710 U/L, indicating severe acute pancreatic inflammation. A structured integrative intervention was initiated, consisting of a defined herbal formulation protocol administered in three daily doses along with a low-inflammatory, renal-supportive dietary regimen aimed at reducing digestive workload and supporting systemic metabolic balance.

Outcome: Within 72 hours of initiating treatment, the patient reported significant reduction in abdominal pain, with near-complete relief by the third day. Follow-up laboratory testing performed 10 days after treatment initiation demonstrated rapid biochemical improvement, with serum lipase decreasing to 98.8 U/L and serum amylase to 98.1 U/L, both within near-normal range. The patient resumed normal daily activities and remained symptom-free at follow-up.

Conclusion: This case demonstrates unusually rapid clinical and biochemical recovery in severe acute pancreatitis. The findings suggest that structured integrative supportive approaches may contribute to accelerated recovery and merit further systematic clinical investigation.

Keywords: Acute Pancreatitis, Hyperlipasemia, Serum Amylase, Pancreatic Inflammation, Integrative Medicine, Herbal Therapy, Dietary Intervention, Case Report

Introduction

Overview of the Disease

Acute pancreatitis is an inflammatory disorder of the pancreas characterized by sudden onset of severe upper abdominal pain and elevated pancreatic enzymes, particularly serum lipase and amylase. The condition results from premature activation of digestive enzymes within the pancreas, leading to local tissue injury and, in severe cases, systemic inflammatory responses.

Global Burden and Standard Treatment

Acute pancreatitis is one of the most common gastrointestinal emergencies worldwide and represents a significant cause of hospital admissions related to abdominal pain. The severity of the disease ranges from mild, self-limiting inflammation to severe forms associated with organ failure and systemic complications. Current standard management is primarily supportive and includes intravenous fluid resuscitation, bowel rest, pain control, nutritional management, and careful monitoring for complications. There are no universally accepted pharmacological therapies that directly reverse pancreatic inflammation.

Typical Recovery Timeline

In most cases, recovery is gradual. Clinical symptoms, particularly abdominal pain, may persist for several days to weeks, and normalization of pancreatic enzyme levels often occurs over an extended period depending on disease severity. Moderate to severe cases may require prolonged hospitalization and strict dietary modifications, and some patients experience lingering digestive disturbances or risk progression to chronic pancreatic dysfunction.

Why Rapid Recovery Is Unusual

Because treatment strategies are largely supportive rather than curative, rapid resolution of both symptoms and biochemical abnormalities is uncommon in severe presentations of acute

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pancreatitis. Markedly elevated enzyme levels are generally associated with significant pancreatic inflammation and are not typically expected to normalize within a short duration.

Purpose of Reporting This Case

This report presents a case of severe acute pancreatitis with markedly elevated serum lipase and amylase levels in which rapid symptom relief and early biochemical normalization were observed following initiation of a structured integrative herbal and dietary support protocol. The unusually fast clinical and laboratory improvement observed in this case warrants documentation and further scientific evaluation [1-5].

Case Presentation

Patient Information

A 32-year-old male presented with severe upper abdominal pain in June 2025. The patient had no previously documented history of chronic pancreatic disease, alcohol abuse, or known metabolic disorders. There was no significant prior medical or surgical history reported that could directly account for the acute presentation.

The primary presenting symptom was intense, persistent upper abdominal pain, described as severe in intensity and interfering significantly with daily activities. The pain had been present for approximately 20 days before formal evaluation and laboratory assessment were performed.

Clinical Findings

On clinical evaluation, the patient appeared distressed due to ongoing abdominal pain. The pain was localized to the upper abdomen and was continuous in nature. No signs of hemodynamic instability were reported at the time of presentation. The severity of symptoms was consistent with acute pancreatic inflammation, given the intensity and duration of pain.

Diagnostic Assessment

Laboratory investigations conducted on 13 July 2025 revealed markedly elevated pancreatic enzyme levels, strongly suggestive of acute pancreatitis.

Table 1: Initial Laboratory Findings

Parameter	Value	Reference Range
Serum Lipase	3531 U/L	<160 U/L
Serum Amylase	1710 U/L	<110 U/L

The enzyme levels were significantly higher than normal reference values, indicating severe pancreatic inflammation. No imaging findings are documented in this report. The diagnosis of acute pancreatitis was made based on the characteristic clinical presentation in combination with markedly elevated pancreatic enzyme levels.

Therapeutic Intervention

Treatment Objectives

The therapeutic approach was designed with the following primary objectives:

- To reduce pancreatic inflammation
- To stabilize abnormal digestive enzyme secretion
- To support hepatic and renal function involved in metabolic regulation and detoxification
- To reduce systemic inflammatory burden and improve overall physiological balance

Herbal Formulation Protocol

A structured herbal formulation regimen was initiated immediately after diagnosis. The protocol consisted of multiple formulations administered at specific times of the day to provide comprehensive metabolic and organ support.

Table 2: Treatment Schedule

Time of Day	Formulations Administered
Morning	S1 + S3 + S7 + EdemaEx
Afternoon	S4 + S5
Evening	S1 + S3 + S7 + EdemaEx

S1, S3, S4, S5, and S7 were administered at a dose of 15 ml each, diluted in 30 ml of warm water. EdemaEx powder was administered at ½ teaspoon (approximately 2.5 g), two to three times daily

Table 3: Formulations and Selected Key Ingredients

Formulation	Intended Support	Key Herbal Components
S1	Cellular repair and antioxidant support	Nimba, Arjuna, Bilwa, Brahmi, Gokshura, Hareetaki
S3	Cardiovascular and circulatory support	Nimba, Arjuna, Bibhitaki, Brahmi, Ashwagandha
S7	Immune and anti-inflammatory support	Guduchi, Arjuna, Hareetaki, Jambu, Nimba
S8 (EdemaEx)	Fluid balance and edema reduction	Shatavari bhed, Dalchini, Ashwagandha
S4	Hepatic metabolic support	Gokshura, Bringraj, Vibhitaki, Chirayata
S5	Renal support and metabolic clearance	Gokshura, Hareetaki, Ashwagandha, Karanja

These formulations were intended to provide antioxidant, anti-inflammatory, circulatory, hepatoprotective, and renal-supportive effects.

Dietary Protocol

A structured dietary protocol was implemented concurrently to reduce metabolic load and digestive stress on the pancreas.

Key Dietary Principles

- Strict control of dietary sodium
- Limitation of fats and processed foods
- Controlled intake of proteins and cereals
- Emphasis on cooked leafy vegetables and leached vegetable preparations
- Inclusion of flax-based functional nutrition

Foods Avoided
- Fried and processed foods
- Refined sugars and sweets
- Excess oils and heavy fats
- Alcohol and high-potassium foods

Foods Included
- Cooked leafy vegetables forming a major portion of meals
- Leached vegetable preparations to reduce mineral load
- Controlled portions of cereals such as rice or chapati
- Flax-based preparations to provide essential fatty acids

Rationale
The dietary protocol was designed to reduce digestive workload, minimize inflammatory triggers, support metabolic detoxification pathways, and create a physiological environment conducive to pancreatic recovery.

Clinical Course
Symptom Progression
Following initiation of the therapeutic intervention, the patient was monitored for symptomatic improvement. Within **72 hours,** the patient reported a marked reduction in abdominal pain. The severe, persistent pain that had affected daily activities for nearly three weeks subsided substantially, leaving only mild residual discomfort.

By the **third day of treatment,** the patient described near-complete relief from pain. Appetite and general comfort began to improve, and the patient reported increased ability to perform routine activities.

Follow-Up Laboratory Assessment
A repeat laboratory evaluation was conducted on **28 July 2025,** approximately **10 days after initiation of treatment,** to assess biochemical response.

Table 4: Trend in Pancreatic Enzyme Levels

Parameter	Baseline Value (13 July 2025)	Day 10 Value (28 July 2025)	Reference Range
Serum Lipase	3531 U/L	98.8 U/L	<160 U/L
Serum Amylase	1710 U/L	98.1 U/L	<110 U/L

Both pancreatic enzyme levels showed **dramatic reduction,** returning to near-normal ranges within ten days.

Functional Recovery
Along with biochemical improvement, the patient reported:
- Complete disappearance of severe abdominal pain
- Improved digestion and appetite
- Restoration of normal daily functioning

No new symptoms or complications were reported during the follow-up period.

Figure 1: Trend of Pancreatic Enzyme Levels During Treatment
Caption
Line graph demonstrating the rapid decline in serum lipase and serum amylase levels from baseline (Day 0) to Day 10 following initiation of integrative herbal and dietary intervention.

Outcome and Follow-Up
Following completion of the initial treatment phase, the patient demonstrated sustained clinical and biochemical recovery.

Symptom Status
By the tenth day of treatment, the patient reported complete resolution of severe abdominal pain. Only minimal transient discomfort had been noted during the early recovery period, which subsequently resolved. Appetite, digestion, and general well-being improved steadily.

Laboratory Normalization
Follow-up laboratory testing performed on Day 10 showed normalization of pancreatic enzyme levels, with serum lipase and serum amylase returning to near-reference ranges. These findings indicated marked resolution of pancreatic inflammation.

Return to Normal Activity
The patient resumed normal daily activities without restriction. Functional capacity returned to pre-illness levels, and no residual digestive disturbances were reported.

Treatment Discontinuation
In view of sustained clinical improvement and laboratory normalization, the patient discontinued the therapeutic protocol after the recovery phase under observation.

Follow-Up Status
Subsequent follow-up communication confirmed that the patient remained symptom-free and functionally well, with no recurrence of abdominal pain or related complaints reported during the follow-up period.

Discussion
Typical Course of Acute Pancreatitis
Acute pancreatitis typically follows a variable clinical course depending on severity. In mild cases, symptoms may resolve within several days; however, in moderate to severe presentations, abdominal pain can persist for a longer duration and may require extended supportive care. Biochemical normalization of pancreatic enzymes such as serum lipase and amylase generally occurs gradually and may take several weeks, particularly in patients presenting with markedly elevated baseline values. Prolonged inflammation can also lead to digestive disturbances, nutritional challenges, and, in some cases, progression toward chronic pancreatic dysfunction.

In the present context, the integrative herbal intervention was designed to support gut microbiome balance and digestive regulation. The formulations were conceptualized as having prebiotic-supportive properties that may influence microbial activity, potentially contributing to improved nutrient metabolism and systemic homeostasis. It is hypothesized that improved metabolic efficiency and reduced inflammatory stress could create a cellular environment favorable for tissue repair. Some biological pathways, including stress-protein responses (such as heat shock proteins) and mitochondrial function, may play a role in cellular recovery; however, these mechanisms remain theoretical and require further scientific validation. The observed normalization of pancreatic enzyme levels within ten

days suggests a rapid reduction in inflammatory activity, though definitive causal pathways cannot be established from this single observation.

What Makes This Case Unique

The present case is notable for both the severity at presentation and the rapidity of recovery. The patient demonstrated extremely elevated pancreatic enzyme levels, indicative of significant pancreatic inflammation. Despite this, clinical symptoms improved markedly within 72 hours, and biochemical parameters normalized within 10 days. Such early resolution of both pain and enzyme elevation is not commonly observed in cases presenting with this degree of baseline severity, making this clinical course unusual and worthy of documentation.

Possible Mechanisms

Although definitive mechanisms cannot be established from a single case, several supportive factors may have contributed to the observed recovery. The intervention strategy included components aimed at anti-inflammatory and antioxidant support, which may help mitigate pancreatic tissue injury and oxidative stress. Enhancement of circulatory and metabolic pathways may have facilitated improved nutrient delivery and removal of inflammatory byproducts. Concurrent dietary modification likely reduced digestive workload and minimized stimulation of pancreatic enzyme secretion, creating a physiological environment conducive to recovery. Additionally, support of hepatic and renal detoxification pathways may have aided systemic metabolic balance and resolution of inflammation.

Limitations

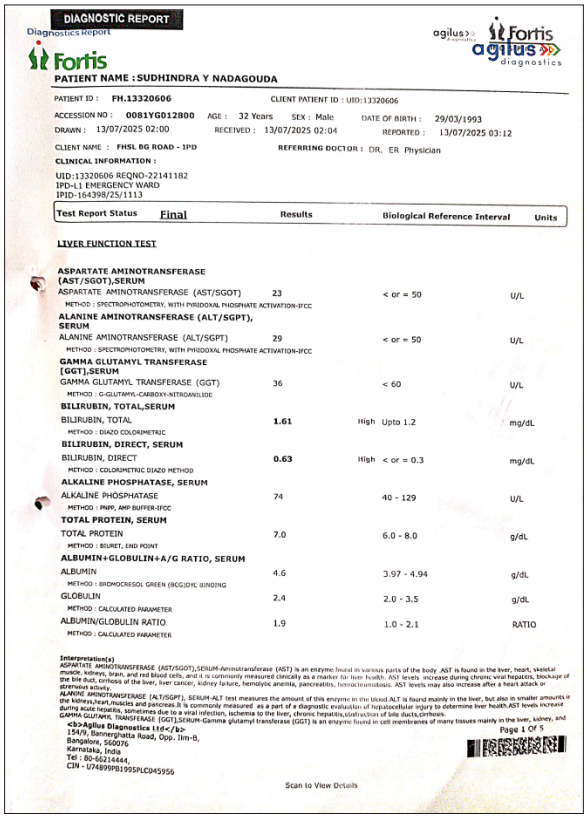
Objective imaging follow-up was not documented in this case. While the clinical and biochemical improvements were notable, controlled clinical studies are required to further evaluate the reproducibility, safety, and mechanisms of the integrative approach described.

Conclusion

This case describes a patient with severe acute pancreatitis and markedly elevated pancreatic enzyme levels who demonstrated rapid clinical improvement and early biochemical normalization following a structured integrative herbal and dietary intervention. Severe abdominal pain resolved within three days, and serum lipase and amylase levels returned to near-normal ranges within ten days, indicating prompt resolution of pancreatic inflammation.

The clinical course observed in this case differs from the more gradual recovery typically described in moderate to severe acute pancreatitis, suggesting that supportive integrative strategies may have a potential role in facilitating recovery when used alongside careful clinical monitoring.

While findings from a single case cannot establish definitive therapeutic efficacy, the rapid and sustained improvement documented here highlights the need for further systematic clinical investigation. Controlled studies are warranted to evaluate the safety, mechanisms, and reproducibility of integrative supportive approaches in the management of acute pancreatic inflammation [6-10].



DIAGNOSTIC REPORT

Diagnostics Report

Fortis

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PATIENT NAME : SUDHINDRA Y NADAGOUDA

PATIENT ID : FH.13320606 CLIENT PATIENT ID : UID:13320606

ACCESSION NO : 0081YG012800 AGE : 32 Years SEX : Male DATE OF BIRTH : 29/03/1993

DRAWN : 13/07/2025 02:00 RECEIVED : 13/07/2025 02:04 REPORTED : 13/07/2025 03:12

CLIENT NAME : FHSL BG ROAD - IPD REFERRING DOCTOR : DR. ER Physician

CLINICAL INFORMATION :

UID:13320606 REQNO-22141182
IPD-L1 EMERGENCY WARD
IPID-164398/25/1113

Test Report Status Final	Results		Biological Reference Interval	Units
LIVER FUNCTION TEST				
ASPARTATE AMINOTRANSFERASE (AST/SGOT),SERUM				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	23		< or = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT), SERUM				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	29		< or = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
GAMMA GLUTAMYL TRANSFERASE [GGT],SERUM				
GAMMA GLUTAMYL TRANSFERASE (GGT)	36		< 60	U/L
METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE				
BILIRUBIN, TOTAL,SERUM				
BILIRUBIN, TOTAL	**1.61**	High	Upto 1.2	mg/dL
METHOD : DIAZO COLORIMETRIC				
BILIRUBIN, DIRECT, SERUM				
BILIRUBIN, DIRECT	**0.63**	High	< or = 0.3	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
ALKALINE PHOSPHATASE, SERUM				
ALKALINE PHOSPHATASE	74		40 - 129	U/L
METHOD : PNPP, AMP BUFFER-IFCC				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.0		6.0 - 8.0	g/dL
METHOD : BIURET, END POINT				
ALBUMIN+GLOBULIN+A/G RATIO, SERUM				
ALBUMIN	4.6		3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN (BCG)DYE BINDING				
GLOBULIN	2.4		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.9		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				

Interpretation(s)
ASPARTATE AMINOTRANSFERASE (AST/SGOT),SERUM-Aminotransferase (AST) is an enzyme found in various parts of the body .AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.
ALANINE AMINOTRANSFERASE (ALT/SGPT), SERUM-ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury to determine liver health.AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis,obstruction of bile ducts,cirrhosis.
GAMMA GLUTAMYL TRANSFERASE (GGT),SERUM-Gamma glutamyl transferase (GGT) is an enzyme found in cell membranes of many tissues mainly in the liver, kidney, and

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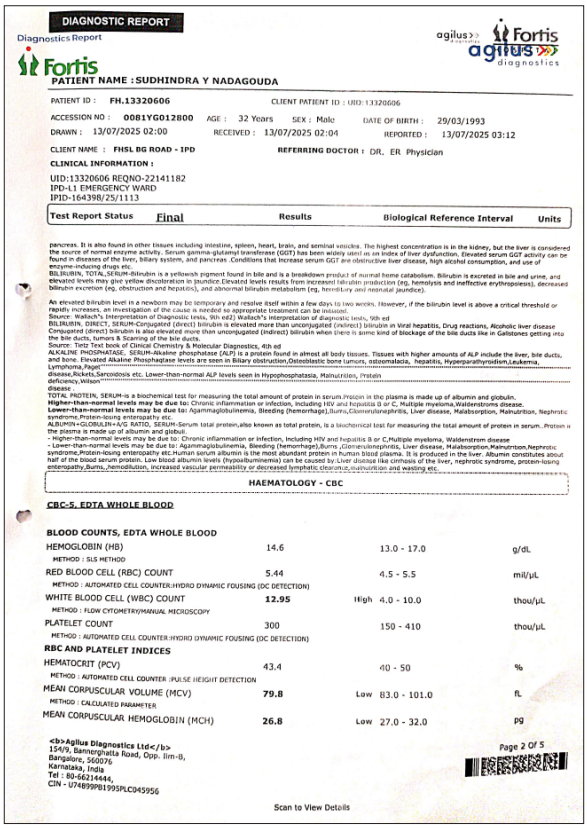

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Test Report Status Final	Results		Biological Reference Interval	Units

pancreas. It is also found in other tissues including intestine, spleen, heart, brain, and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum gamma-glutamyl transferase (GGT) has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system, and pancreas .Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption, and use of enzyme-inducing drugs etc.
BILIRUBIN, TOTAL,SERUM-Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice).

An elevated bilirubin level in a newborn may be temporary and resolve itself within a few days to two weeks. However, if the bilirubin level is above a critical threshold or rapidly increases, an investigation of the cause is needed so appropriate treatment can be initiated.
Source: Wallach's Interpretation of Diagnostic tests, 9th ed2) Wallach's interpretation of diagnostic tests, 9th ed
BILIRUBIN, DIRECT, SERUM-Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease
Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts.
Source: Tietz Text book of Clinical Chemistry & Molecular Diagnostics, 4th ed
ALKALINE PHOSPHATASE, SERUM-Alkaline phosphatase (ALP) is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts, and bone. Elevated Alkaline Phosphagtase levels are seen in Biliary obstruction,Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism,Leukemia, Lymphoma,Paget
disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein
deficiency,Wilson
disease
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN+GLOBULIN+A/G RATIO, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globuli.
- Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C,Multiple myeloma, Waldenstrom disease
- Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns ,Glomerulonephritis, Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy,Burns,hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

HAEMATOLOGY - CBC				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	14.6		13.0 - 17.0	g/dL
METHOD : SLS METHOD				
RED BLOOD CELL (RBC) COUNT	5.44		4.5 - 5.5	mil/µL
METHOD : AUTOMATED CELL COUNTER:HYDRO DYNAMIC FOUSING (DC DETECTION)				
WHITE BLOOD CELL (WBC) COUNT	**12.95**	High	4.0 - 10.0	thou/µL
METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY				
PLATELET COUNT	300		150 - 410	thou/µL
METHOD : AUTOMATED CELL COUNTER:HYDRO DYNAMIC FOUSING (DC DETECTION)				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	43.4		40 - 50	%
METHOD : AUTOMATED CELL COUNTER :PULSE HEIGHT DETECTION				
MEAN CORPUSCULAR VOLUME (MCV)	**79.8**	Low	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**26.8**	Low	27.0 - 32.0	pg

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CLINICAL INFORMATION :

UID:13320606 REQNO-22141182
IPD-L1 EMERGENCY WARD
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Test Report Status Final	Results		Biological Reference Interval	Units
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	33.6		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	12.5		11.6 - 14.0	%
MEAN PLATELET VOLUME (MPV) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	10.1		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
NEUTROPHILS METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	80		40 - 80	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	**16**	Low	20 - 40	%
MONOCYTES METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	4		2 - 10	%
EOSINOPHILS METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	**0**	Low	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	0		< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY	**10.36**	High	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY	2.07		1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY	0.52		0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY	**0.00**	Low	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY	0.00		0.0 - 0.1	thou/µL

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age < 49.5 years old and NLR > 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease. (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

BIOCHEMISTRY

LIPASE, SERUM

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PRECIISE DIAGNOSTICS

No. 18, M.K. Puttalingaiah Road,
Padmanabhanagar, Bangalore- 560 070.
Ph: 080 26792288 / 26794586
Email: preciisediagnostics@gmail.com

Name : Mr. Sudhindra Y Nada Gowda **Date : 12/07/2025**
Age : 32 years **Scan No : 2521-25**
Sex : Male **Ref By : Dr. Dileep singh**

ULTRASOUND SCANNING OF ABDOMEN AND PELVIS

Liver: Normal in shape, position and size, measures 13.1 cms and shows normal echopattern. No obvious hypo / hyperecholc focus noted within the liver. Hepatic veins and intrahepatic IVC are normal. No Intra / extrahepatic biliary dilatation. C.B.D. normal. Portal vein normal.

Gall Bladder: Well distended **& shows sludge in lumen**. No calculus. Wall thickness normal. No pericholecystic collection.

Spleen: Normal in location, echopattern and size, measures 11.8 cms.

Pancreas: **Upper limit of normal in size with probe tenderness noted - ? evolving pancreatitis.** Pancreatic duct is normal.
No ductal stones /calcification noted .No parenchymal calcification seen
Pre & Para Aortic areas : Abdominal portion of aorta and IVC normal
No evidence of pre and para aortic lymphadenopathy
Kidneys:

	Bipolar Measurements			Parenchymal thickness	
Right kidney	10.1	cms	x	1.5	cms
Left kidney	11.5	cms	x	1.7	cms

Both kidneys are normal in size, shape and location
Corticomedullary differentiation well maintained.
No evidence of renal calculi / calcification / Hydroureteronephrosis in either kidney.
No evidence of perinephric collection.
No evidence of ascites
No evidence of bowel mass.
Urinary bladder is well distended and shows echofree lumen.
No calculus /diverticulum. Wall thickness is normal.

Prostate – 11.6 gms and is of normal in size and echotexture

IMPRESSION:

- **Pancreas upper limit of normal in size with probe tenderness noted - ? evolving pancreatitis.**
- **GB sludge seen.**
- **No evidence of renal calculi / hydronephrosis in either kidney.**

Suggested correlation with serum amylase and serum lipase.

Dr. Ramesh C. S. MD RD
Consultant Radiologist

DIAGNOSTIC REPORT

Diagnostics Report

Fortis

agilus diagnostics

PATIENT NAME : SUDHINDRA Y NADAGOUDA

PATIENT ID : FH.13320606 CLIENT PATIENT ID : UID:13320606

ACCESSION NO : 0081YG012800 AGE : 32 Years SEX : Male DATE OF BIRTH : 29/03/1993

DRAWN : 13/07/2025 02:00 RECEIVED : 13/07/2025 02:04 REPORTED : 13/07/2025 03:12

CLIENT NAME : FHSL BG ROAD - IPD REFERRING DOCTOR : DR. ER Physician

CLINICAL INFORMATION :

UID:13320606 REQNO-22141182
IPD-L1 EMERGENCY WARD
IPID-164398/25/1113

Test Report Status Final	Results		Biological Reference Interval	Units
LIPASE METHOD : ENZYMATIC, COLORIMETRIC	**3531**	High	13.00 - 60.00	U/L

Comments

NOTE :LIPASE VALUE IS RECHECKED AND CONFIRMED WITH 1:50 DILUTION, PLEASE CORRELATE CLINICALLY.

AMYLASE,SERUM

AMYLASE METHOD : G7 PNP, BLOCKED	**1710**	High	28 - 100	U/L

Comments

NOTE :AMYLASE VALUE IS RECHECKED AND CONFIRMED WITH 1:10 DILUTION, PLEASE CORRELATE CLINICALLY.

Interpretation(s)
LIPASE, SERUM-Lipase is a glycoprotein enzyme. This test is useful for investigations of pancreatic disorders, usually pancreatitis however serum level of lipase is increased in both pancreatic and non-pancreatic causes like acute pancreatitis, pancreatic duct obstruction, chronic pancreatitis, perforated or penetrating peptic ulcer, acute cholecystitis, small bowel obstruction,intestinal infarction as well as in renal failure.

Values remain normal in parotitis and in macroamylasemia.

In acute pancreatitis serum lipase starts to increase within 3-6 hrs, reaches peak at 24 hrs and remains elevated for 8-14 days.Critical elevation is usually considered when the levels are three times the upper limit of normal. Since amylase levels are apt to return to normal range first, serum lipase estimation is especially helpful in patients presenting late with symptoms.
AMYLASE,SERUM-Amylase enzyme is of predominantly pancreatic or salivary gland origin. Amylase levels increase in acute pancreatitis, pseudo- cyst of pancreas, obstruction of pancreatic ducts, mumps, occasionally elevated in renal insufficiency, ruptured ectopic pregnancy, appendicitis, dissecting aortic aneurysm, cerebral trauma, diabetic acidosis and inflammation of pancreas from a perforating peptic ulcer. Rarely, combination of amylase with an immunoglobulin produces elevated serum amylase activity (macro amylasemia) because the large molecular complex is not filtered by the glomerulus.

Decrease in amylase level is seen in acute and chronic hepatitis, pancreatic insufficiency, advanced cystic fibrosis, pancreatectomy and occasionally in toxemia of pregnancy

****End Of Report****
Please visit agilusdiagnostics.com for related Test Information for this accession

Dr.Suneet Kaur Hora **DR.SHUBHIKA SACHDEVA**
LAB HEAD & Sr. CONSULTANT PATHOLOGIST **Consultant Pathologist**

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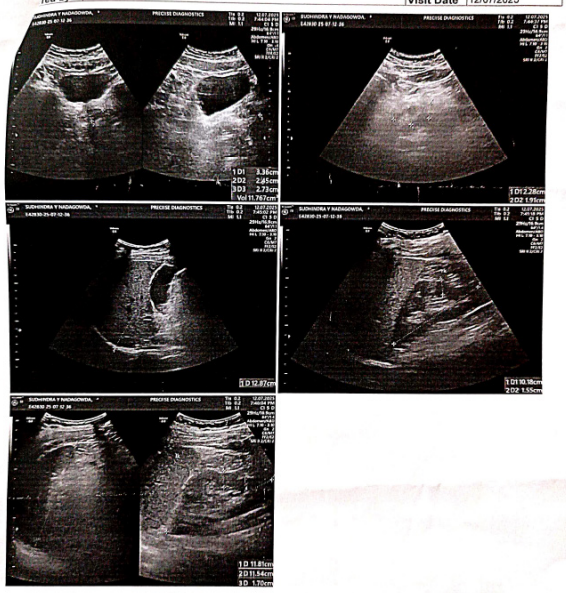
Bangalore, 560076
Karnataka, India
Tel : 80-66214444,
CIN - U74899PB1995PLC045956

Scan to View Details

name	SUDHINDRA Y NADAGOWDA	Age/Sex	
ID	E42830-25-07-12-36	Visit No	1
red by		Visit Date	12/07/2025



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MEDCIS
LABORATORY TEST REPORT

Name : MR. SUDHINDRA N
Age/ Gender : 32 years / Male
Sample Type : SERUM1
Sample ID : 244601406
Client Name : 2KABLR441
Ref. Doctor : RAVINDRA
Collected : 28/07/2025, 11:51 AM
Received : 28/07/2025, 01:24 PM
Reported : 28/07/2025, 02:06 PM

CLINICAL BIOCHEMISTRY

TEST DESCRIPTION	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
Amylase Serum			
Amylase (Method: Ethylidene-G4PNP)	98.1	U/L	28 - 100

Interpretation:

High serum amylase levels (hyperamylasemia) also occur in the inflammatory phase of chronicpancreatitis, renal failure (reduced glomerular filtration), tumors of the lungs or ovaries, pulmonary inflammation, salivary gland diseases, diabetic ketoacidosis, cerebral trauma, surgical interventions ormacroamylasemia. To confirm pancreatic specificity, an additional pancreas-specific enzyme (lipase)should also be determined.

Dr AISHWARYA S
MD PATHOLOGIST

NOTE : This sample is processed at HealthMap Diagnostics Pvt Ltd (BANGALORE) Lab.

Note: This Report is subject to the terms and conditions mentioned overleaf.
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Reported : 28/07/2025, 03:14 PM

CLINICAL BIOCHEMISTRY

TEST DESCRIPTION	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipase Serum			
Lipase (Method: 1, 2-O-dilauryl-racglycero- 3-glutaricacid (6-methyl-resorufin)ester)	98.8	U/L	13 - 60

Dr AISHWARYA S
MD PATHOLOGIST

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