DOLAGOBINDA MAHARANA

Tuberculosis

Dola Gobinda Maharana, a 37-year-old male from Odisha and staying currently in Chennai, started experiencing dry cough, weakness, and overall body heat in May 2024. Concerned about his pallid urine, he visited **Dr**. **Meeta's Homeopathy Clinic**, Chennai where he was prescribed homeopathic remedies. While he initially felt better, the symptoms returned after a month, and he noticed a significant weight loss—from 78 kg to 68 kg—along with a severe loss of appetite. He struggled with these issues from May to October 2024.

On October 14, 2024, he reached out to Dr. Biswaroop Roy Chowdhury's team, having followed Dr. BRC for five years and being a student of CCAP and CIM. So, Under Dr. Namita He began his recovery by following the DIP Diet, incorporating earthing and humming,HWI therapies, and getting daily sunlight. His condition improved remarkably; **within just 15 days, he was completely fine, with his ESR dropping from 28(19 sept) to 13 (28 oct)**. He continues to adhere to a strict DIP diet and is now leading a healthy life.

	Before (May 2024 till 14 oct 2024)	**After (14 Oct 2024 till 30 Oct 2024)**
Medical condition	**Tuberculosis**	**Completely recovered**
Hospital name	**Dr Meeta's Clinic**	**DR. BRC DIP DIET**
Medications Taken	**Homeopathy Medicines** **Belladona,tubernuclin ,phosphorous 200 , Bacillinum,Bell 200**	1. Living Water Therapy 2. DIP Diet - 100% 3. Sunlight 4. Humming Therapy 5. Earthing Therapy 6. HWI Therapy
Physical Discomforts	Dry Cough, Extreme weakness, Loss of appetite, Yellow Urine, Weight loss 10-14 Kg	Nil
Investigations	Blood Test (19 sept 2024) ESR -28 , ELISA -POSITIVE	Blood Test (28 oct 2024) ESR -13

BEFORE REPORTS

Mr. DOLAGOBINDA MAHARANA
pammal Chennai
Tel No : +918015426159
PIN No: 600075
PID NO: P40624532227437
Age: 37 Year(s) Sex: Male

Reference: DR.DR MEETA

Sample Collected At:
PAMMAL PSC
NO 12 PAMMAL MAIN ROAD

VID: 240360105815355
Registered On:
15/09/2024 07:14 AM
Collected On:
15/09/2024 7:08AM
Reported On:
16/09/2024 05:55 PM

CBC, Complete Blood Count

Investigation	Observed Value	Unit	Biological Reference Interval
Erythrocytes			
Erythrocyte (RBC) Count	5.07	mill/cu.mm	4.50-5.50
Haemoglobin (Hb)	**11.66**	gm/dL	13.0-17.0
PCV (Packed Cell Volume)	**37.5**	%	40.0-50.0
MCV (Mean Corpuscular Volume)	**73.9**	fL	78-100
MCH (Mean Corpuscular Hb)	**23.0**	pg	27-31
MCHC (Mean Corpuscular Hb Concn.)	**31.1**	g/dL	32-36
RDW (Red Cell Distribution Width)	**19.5**	%	11.5-14.0
Leucocytes			
Total Leucocytes (WBC) count	4790	cells/cu.mm	4000-11000
Absolute Neutrophils Count	3336	/c.mm	2500-7000
Absolute Lymphocyte Count	**984**	/c.mm	1550-4000
Absolute Monocyte Count	331	/c.mm	200-1000
Absolute Eosinophil Count	122	/c.mm	40-400
Absolute Basophil Count	18	/c.mm	0-100
Neutrophils	69.64	%	40.0-75.0
Lymphocytes	20.54	%	20-40
Monocytes	6.90	%	2.0-10.0
Eosinophils	2.54	%	1-6
Basophils	0.38	%	0-1.0
Platelets			
Platelet count	413.3	10^3 / µl	150-450
MPV (Mean Platelet Volume)	9.40	fL	6-9.5

EDTA Whole Blood - Tests done on Automated Five Part Cell Counter. (WBC,Platelet count by impedance method/DC detection,RBC by pulse height detection method, HB by Automated - Photometric Measurement, WBC differential by VCS technology other parameters calculated) **All Abnormal Haemograms are reviewed confirmed microscopically.** Differential count is based on approximately 10,000 cells.

Dr .Suja Ramanathan
MBBS,DNB(Pathology) Chief Of Lab Services.

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AFB SMEAR EXAMINATION BY FLUORESCENT STAIN SPUTUM-1SAMPLE

Sample : SPUTUM

Microscopy Result : Acid Fast Bacilli were not seen in the received sample.

Associated Test :

1. AFB - Xpert panel : For rapid identification of M.tuberculosis complex and detection of Rifampicin resistance.
2. AFB MDR - screen Hain's Line probe assay from all pulmonary specimen (smear positive and Negative).
3. AFB - XDR-screen Hain's Line probe assay for patients diagnosed as MDR-TB.

Tests marked with NABL symbol are accredited by NABL vide Certificate no MC-5586

Dr N.A Fairoz Banu
M.B.B.S,M.D,Consultant Microbiologist

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Investigation	Observed Value	Biological Reference Interval
Digital X- Ray- Chest - PA view (X-RAY)		
X- Ray - Chest PA view	Well defined dense opacity left base — " pneumonitis " changes. Both c p angels are free. Cardiac borders appears to be normal. Ad: check x ray after 10 days of treatment.	

DR.M.PRAKASH MAL NAHAR.,MBBS.,DMRD.,FAGE.
(Consultant Radiologist)
TNMC : 75406

NOTE: This is a plain x ray report adviced to corralate clinically with further tests.

Dr.Sockalingam
MBBS , PGD(USG) (FRCR) (UK)

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Investigation	Observed Value	Unit	Biological Reference Interval
Interferon gamma release assay (Blood,ELISA)			
Gamma Interferon,Antigen tube	1.92	IU/mL	
Gamma Interferon,Nil tube	0.31	IU/mL	
Final Result	**Positive(1.61)**	IU/mL	Negative: < 0.35 Positive: >= 0.35 Refer Interpretation

TEST DESCRIPTION :

- Interferon- gamma release assay (Quantiferon TB) is an in vitro, indirect method for documenting cell mediated immune response using a peptide cocktail of ESAT-6, CFP-10 & TB7.7 protein antigens that are associated with M. tuberculosis complex infections. The interferon-Gamma released in plasma by the stimulated white cells (effector T cells) is estimated by ELISA. The assay is thus dependent on host immune status.
- The pooled sensitivity & specificity of the test for diagnosing M. tuberculosis infection in developing countries is 78 to 83% & 98 to 100% respectively.

INTERPRETATION :

NIL (IU/mL)	TB Antigen minus NIL (IU/mL)	FINAL RESULT	INTERPRETATION
< / = 8.0	< 0.35	NEGATIVE	Mycobacterium tuberculosis infection unlikely
< / = 8.0	>/= 0.35 & <25% Of Nil tube	NEGATIVE	Mycobacterium tuberculosis infection unlikely
< / = 8.0	>/= 0.35 & >/= 25% Of Nil tube	POSITIVE	Active, latent or inapparent infection with Mycobacterium tuberculosis likely
> 8.0	Any result	INDETERMINATE	Results are indeterminate for TB antigen responsiveness

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1. A positive result favour the persons exposure to M.tuberculosis complex or certain Atypical mycobacteria (M.kansasii, M,szulgai or M.marinum) & should be followed by further medical and diagnostic evaluation for tuberculosis infection. IGRA cannot distinguish between latent tuberculosis infection versus tuberculosis disease. Latent TB infection (LTBI) is a noncommunicable, asymptomatic condition with a positive IGRA or tuberculin skin test but no clinical, radiological or bacteriological evidence of active disease & can persists for many years. LTBI has a risk to progress to tuberculosis disease, in about 5-10% of immunocompetent hosts and this risk increases with immunodeficiency. The magnitude of the measured IFN-g level does not correlate with stage of infection or likelihood for progression to active disease. IGRA is superior to the tuberculin skin test and it does not give false positive results in BCG vaccinated patients, However, booster effect leading to false positive result, due to earlier Mantoux test has been reported is some studies.
2. Management decisions for persons with a positive IGRA result should be based on Risk Assessment findings for the likelihood of M.tuberculosis infection & for progression to tuberculosis disease. IGRA test is not recommended to be used for monitoring the response to treatment.
3. IGRA test can be negative in recent contacts of TB exposure (8 - 10 week false-negative "window" may exist), co-morbid conditions impairing immune function such as HIV infection; immunosuppressive drugs (corticosteroids, TNF-alpha antagonists) ,organ transplantation; hematolymphoid malignancies, Carcinoma in head, neck, or lung; Diabetes; Silicosis and Chronic renal failure.
4. Interpretation of serial IGRA testing in health care workers with an increased LTBI risk & working in countries with low and intermediate incidences of TB have inherent challenge of significant inta-individual variability of the IFN-γ response, hence it is recommended to use a borderline zone from 0.2 to 0.7 IU/ml for the interpretation of repeat IGRA results in these cases.

REFERENCES :

- American CDC(2010) & European CDC(2011) guidelines on TB Quantiferon.
- Ringshausen et al.Journal of Occupational Medicine and Toxicology 7:6, 2012.

NOTE : Diagnostic test recommended by WHO : Xpert MTB/RIF (TB PCR Test).

MC-5586

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Investigation	Observed Value	Unit	Biological Reference Interval
Haemogram, advanced			
ESR - Erythrocyte Sedimentation Rate (EDTA Whole Blood,Automated -Capillary photometry aggregation/Manual - Westergrens method)	**28**	mm/hr	0-15

Method: Automated Westergren

Interpretation:

1. It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
2. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
3. It is also increased in pregnancy, multiple myeloma, menstruation, and hypothyroidism.

Remark : ESR Performed using capillary photometric aggregation (for automated analysis) & westergrens (for manual testing).

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Investigation	Observed Value	Unit	Biological Reference Interval
Glucose Fasting (Plasma-F,Hexokinase)	84	mg/dL	74-99

Note: An individual may show higher fasting glucose level in comparison to post prandial glucose level due to following reasons: The glycaemic index and response to food consumed, Changes in body composition, Increased insulin response and sensitivity, Alimentary hypoglycemia, Renal glycosuria, Effect of oral hypoglycaemics & Insulin treatment.

Associated Tests: HbA1c (H0018), Diabetes Profile – Maxi (D0021),HOMA Index (H0275), Insulin (I0275).

Glucose-Post Prandial(2hrs) (Plasma - P,Hexokinase)	96	mg/dL	Normal: 70-140 Impaired Tolerance: 140-199 Diabetes mellitus: >= 200 (on more than one occassion) (American diabetes association guidelines 2019)

Note: An individual may show higher fasting glucose level in comparison to post prandial glucose level due to following reasons: The glycaemic index and response to food consumed, Changes in body composition, Increased insulin response and sensitivity, Alimentary hypoglycemia, Renal glycosuria, Effect of oral hypoglycaemics & Insulin treatment.

Associated Tests: HbA1c (H0018), Diabetes Profile – Maxi (D0021),HOMA Index (H0275), Insulin (I0275).

-- End of Report --

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Dr. Meeta's Clinic

www.drmeeta.com

Dr. SUBHRAMITA PANDA
BHMS Ex-Lecturer IHMER, Chandigarh,
Ex-Physician, Raigarh (Chatisgarh)
Ex-Physician, Bakson's Allergy Clinic (New Delhi)
Ph : 044 - 4285 9282 / 98403 48971
E-mail : admin@drmeeta.com

Consultation with Appointment only

Mr Dola Govinda / 41m   wt - 63.9 kgs.

- Appetite better.   urine >> 99%.
AFB -ve.

Rx
1. Bacillinum 1m / 4-4-4 / 29/9, 30/9   X-Ray Lt. lung base - opacity Pneumonitis
2. phosphorous 200 / 4-4-4, mon-sat   Gamma interferon +ve (1.61) (+ve >0.35)
3. Tuberculinum 10m / 4-4-4, 6/10 onwards every sunday   ESR - 28.   Alers antlum?, Lt lung lower lobe ?? TB.

chel.
N.S.
— phos.
Sulph.
— Tub.

29/9/24

8/10/24 wt. 64.3 kgs.

I pray for your early recovery

- Self medication may prove dangerous. Hence always avoid it
- Do not touch homeopathic medicines by hand. It should be taken in cap of the vial.
- Do not take more than one medicine at a time. Always give suitable time interval in between.

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M- Dolo / HM

Appetite ↓, muscle catch Rt. chest.

℞

① Sulphur 10m / 4 pills 3 daily / 8/6 / 9/6 / 5 ℞.

② Bayonia 1m / 4 pills 3 daily / 10/6 onwards 1m.

8/6/24

13/7/24

- water taste/smell. wt - 71 kgs
- ↓ appetite. - thirst ↓.
- sleep disturbed.

Anorexia nervosa.

℞

① Medorrhinum 10m / 4-4-4 / Saturday.

② Nat. mur 10m / 4-4-4 / Sun Mon.

③ Kali phos 6x / 4-4-4 / Tues - Fri.

④ Lyco 10m / SOS for muscle catch / 2 doses only

13/07/24

I pray for your early recovery

- **Self medication may prove dangerous. Hence always avoid it**
- **Do not touch homeopathic medicines by hand. It should be taken in cap of the vial.**
- **Do not take more than one medicine at a time. Always give suitable time interval in between.**

met.

29/08/24 wt - 69 kgs -

- cough ends in vomitting. < 10 days.
cough < lying down.

- vomitting < it eats little heavy food.
< 4-5 pm.

- yellowish urine it water consumption is ↓

Tongue - NAD.

Rx

(1) Tuberculinum 10m / 4-4-(4) / wednesday / Thursday.

(2) Drosera 200 / 4-4-4 / ROD.

15 days.

H/o - Axilla, ringworm

7/09/24 cough > 80%.

wt - 66.5 kgs.

Rx

(1) Bacillinum 1m ~~sulphur 200~~ / 4-4-4 / 7/9 / 8/9 | 14/9 / 15/9 | ½ dr.

(2) Calc. phos 30 / 4-4-4 ~~8~~ / 8 12 4 8 | 2 dr.

(3) ~~Dasher~~ Bell 200 / 4-4-4 / 2 dr.

(4) Tuberculinum 10m / ½ dr / (SOS) cough 2 doses @ 5 min.
(NOT USED)

[signature] 7/9/24

AFTER REPORTS

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28/10/2024 12:33 PM

CBC, Complete Blood Count

Investigation	Observed Value	Unit	Biological Reference Interval
Erythrocytes			
Erythrocyte (RBC) Count	5.01	mill/cu.mm	4.50-5.50
Haemoglobin (Hb)	**11.65**	gm/dL	13.0-17.0
PCV (Packed Cell Volume)	**37.4**	%	40.0-50.0
MCV (Mean Corpuscular Volume)	**74.6**	fL	78-100
MCH (Mean Corpuscular Hb)	**23.3**	pg	27-31
MCHC (Mean Corpuscular Hb Concn.)	**31.1**	g/dL	32-36
RDW (Red Cell Distribution Width)	**16.9**	%	11.5-14.0
Leucocytes			
Total Leucocytes (WBC) count	4810	cells/cu.mm	4000-11000
Absolute Neutrophils Count	3541	/c.mm	2500-7000
Absolute Lymphocyte Count	**881**	/c.mm	1550-4000
Absolute Monocyte Count	302	/c.mm	200-1000
Absolute Eosinophil Count	68	/c.mm	40-400
Absolute Basophil Count	19	/c.mm	0-100
Neutrophils	73.61	%	40.0-75.0
Lymphocytes	**18.31**	%	20-40
Monocytes	6.27	%	2.0-10.0
Eosinophils	1.41	%	1-6
Basophils	0.40	%	0-1.0
Platelets			
Platelet count	**467.0**	10^3 / µl	150-450
MPV (Mean Platelet Volume)	9.14	fL	6-9.5

EDTA Whole Blood - Tests done on Automated Five Part Cell Counter. (WBC,Platelet count by impedance method/DC detection,RBC by pulse height detection method, HB by Automated - Photometric Measurement, WBC differential by VCS technology other parameters calculated) **All Abnormal Haemograms are reviewed confirmed microscopically.** Differential count is based on approximately 10,000 cells.

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2403601073691 81

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Method: Automated Westergren

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1. It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
2. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
3. It is also increased in pregnancy, multiple myeloma, menstruation, and hypothyroidism.

Remark : ESR Performed using capillary photometric aggregation (for automated analysis) & westergrens (for manual testing).

Reports to follow - Kindly await following pending reports :

Investigation :	Status
AFB Smear Examination by Fluorescent Stain Sputum-1sample	Pending
Interferon gamma release assay	Pending

-- End of Report --

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