Patient Name	**: MR. MANJUNATH SWAMY**	Registration	: 05/Apr/2025 08:18AM
Age/Gender	: 56 Y 0 M 0 D /M	Collected	: 05/Apr/2025 11:12AM
UHID/MR No	: KAL.0000005189	Received	: 05/Apr/2025 11:30AM
Visit ID	**: KAL5954**	Reported	: 05/Apr/2025 12:25PM
Ref Doctor	: SELF	Status	: Final Report
Barcode No	: 10215714	Client Code	: ECOTOWN
Client Name	:ECOTOWN STAFF		

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref.Interval
Complete Blood Count, CBC,WHOLE BLOOD EDTA			
***HAEMOGLOBIN (HB)** Method:Photometry	15.20	g/dl	13.0-17.0
RBC COUNT(RED BLOOD CELL COUNT) Method:Coulter principle	**5.83**	million/cmm	4.50-5.50
PCV/ Haematocrit Method:Calculated	46.6	%	40-50
Mean Cell Volume (MCV) Method:Derived from RBC Histogram	**80**	fL	83-101
Mean Cell Haemoglobin (MCH) Method:Calculated	**26**	pg	27-32
Mean Corpuscular Hb Concn. (MCHC) Method:Calculated	33	g/dl	31.5-34.5
TOTAL LEUCOCYTE COUNT (TLC) Method:Coulter principle /Manual microscopy	7,870	cells/cmm	4000-11000
DIFFERENTIAL COUNT - DC (Optical impedence /manual microscopy)			
NEUTROPHIL Method:Optical Impedence	51.00	%	33-76
LYMPHOCYTE Method:Optical Impedence	32.99	%	14-54
MONOCYTE Method:Optical Impedence	6.50	%	1-10
EOSINOPHIL Method:Optical Impedence	**9.22**	%	0-6
BASOPHIL Method:Optical Impedence	0.29	%	0-1
PLATELET COUNT Method:Optical Impedence	1.66	Lakh/cmm	1.50-4.00
Mean Platelet Volume (MPV) Method:Automated/Calculated	9	fL	7.0-11.0

Dr Syeda Sara Farheen
KMC NO- 104293
Consultant pathologist

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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref.Interval
ERYTHROCYTE SEDIMENTATION RATE, ESR,WHOLE BLOOD EDTA			
ERYTHROCYTE SEDIMENTATION RATE Method:Westergren	**24**	mm/hr	0-20
BLOOD GROUP ABO & RH,WHOLE BLOOD EDTA			
ABO Method:Slide and Tube Agglutination Method	"B"		
Rh Typing Method:Slide and Tube Agglutination Method	POSITIVE		

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

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

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref.Interval
URINE ROUTINE EXAMINATION (URE),URINE			
PHYSICAL EXAMINATION			
URINE VOLUME (R)	40	ml	
COLOUR	PALE YELLOW		Straw/ Pale Yellow
APPEARANCE(U)	CLEAR		Clear
SPECIFIC GRAVITY Method:Bromothymol blue	1.020		1.010 - 1.025
pH Method:Double indicator	6.0		5.0-7.0
CHEMICAL EXAMINATION			
PROTEIN Method:Tetrabromophenol	ABSENT		ABSENT
SUGAR Method:Strip/Benedict	ABSENT		ABSENT
BILE SALT Method: Hays Sulphur Test	ABSENT		ABSENT
BILE PIGMENTS Method:Strip /Fouchets	ABSENT		ABSENT
KETONE BODIES Method:Strip method/Rotheras	ABSENT		ABSENT
BLOOD Method:Strip/ Benzidine test	ABSENT		ABSENT
MICROSCOPIC EXAMINATION			
PUS CELLS Method:Microscopy	2-3	/HPF	0-4
Epithelial cells Method:Microscopy	1-2	/HPF	0-4
RBCs Method:Microscopy	ABSENT	/HPF	0-2
CRYSTALS Method:Microscopy	ABSENT		ABSENT

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref.Interval
CASTS Method:Microscopy	ABSENT		ABSENT
BACTERIA Method:Microscopy	ABSENT		ABSENT
OTHERS	ABSENT		

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
PLASMA GLUCOSE- FASTING (FBS),FLOURIDE PLASMA			
Plasma Glucose Fasting (FBS) Method:Hexokinase Method	98	mg/dl	70-100

INTERPRETATION(As per ADA 2022 guidelines)

Status	Fasting Plasma glucose (in mg/dl)
Normal	70-100
Pre-diabetes	101-125
Diabetes Mellitus	>126

Note: The Diagnosis of Diabetes requires a fasting plasma glucose of >or =126 mg/dl or a radom/2hour glucose value of >0r =200 mg/dl on atleast 2 occasions.

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
LIPID PROFILE,SERUM			
TOTAL CHOLESTEROL Method:CHE/CHO/POD	136	mg/dl	<200
H D L CHOLESTEROL Method:CHE/CHO/POD	**36**	mg/dl	40-60
L D L CHOLESTEROL Method:CHE/CHO/POD/CALCULATED	65	mg/dl	<100
VLDL Method:Calculated	35	mg/dl	0-40
TRIGLYCERIDES Method:GK/GPO/POD	**177**	mg/dl	<150
NON HDL CHOLESTEROL Method:Calculated	100	mg/dl	
T. CHOLESTEROL/ HDL RATIO Method:Calculated	3.78		<4.0
LDL / HDL RATIO Method:Calculated	1.81		0.5-3.0
ATHEROGENIC INDEX OF PLASMA (AIP) Method:Calculated	**0.33**		< 0.11: Low risk for CVD~ 0.11-0.24: Intermediate risk~ for CVD~ >0.24: High risk for CVD

Note: VLDL calculation is not valid when Triglyceride value is more than 400 mg/dl as other lipoproteins are usually present.

INTERPRETATION (all in mg/dl)		
TOTAL CHOLESTEROL	**LDL CHOLESTEROL**	**TRIGLYCERIDES**
Desirable: <200 Borderline: 200-239 High: >/=240	Optimal: <100 Near optimal: 100-129 Borderline high: 130-159 High: 160-189 Very high: >190	Normal: <150 Borderline high: 150-199 High: 200-499 Very high: =/>500

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
LIVER FUNCTION TEST,SERUM			
TOTAL PROTEIN Method:Biuret	7.01	g/dl	6.40-8.30
ALBUMIN Method:BCG	4.09	g/dl	3.5-5.2
GLOBULIN Method:Calculated	2.92	g/dl	2.3-3.5
A/G RATIO Method:Calculated	1.4		1.0-1.8
TOTAL BILIRUBIN Method:DPD	0.79	mg/dl	0.3-1.2
CONJUGATED/DIRECT Bilirubin Method:DPD	0.16	mg/dl	0.00-0.20
UNCONJUGATED/INDIRECT Bilirubin Method:Calculated	0.63	mg/dl	0.1-1.0
ALKALINE PHOSPHATASE Method:IFCC	68	U/L	30-120
Aspartate Transaminase (AST/ SGOT) Method:IFCC	19	U/L	<50
Alanine Aminotransferase (ALT/ SGPT) Method:IFCC	31	U/L	<50
GGT, Gamma Glutamyl transferase Method:IFCC	20	U/L	<55

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
TOTAL CALCIUM,SERUM			
SERUM TOTAL CALCIUM Method:Arsenazo III	9.2	mg/dl	8.8-10.6

INTERPRETATION:

-Calcium level is increased in patients with hyperparathyroidism, Vitamin D intoxication, metastatic bone tumor, milk-alkali syndrome, multiple myeloma, Paget's disease.
-Calcium level is decreased in patients with hemodialysis, hypoparathyroidism (primary, secondary), vitamin D deficiency, acute pancreatitis, diabetic Keto-acidosis, sepsis, acute myocardial infarction (AMI), malabsorption, osteomalacia, renal failure, rickets.

SERUM MAGNESIUM,SERUM			
SERUM MAGNESIUM Method:Xylidyl blue	1.84	mg/dl	1.8 - 2.6

COMMENTS:

-Magnesium is primarily an intracellular ion associated with gastrointestinal (GI) absorption and renal excretion. It is the fourth most abundant cation in the body and is second to potassium within cell. It is stored in bones, skeletal muscles and other cells and only a part in extracellular fluid. Mg^{2+} is a cofactor of many enzyme system concerned with cell respiration, glycolysis, transmembrane transport of other cations such as calcium and sodium. The activity of Na-K-ATPase pump depends on magnesium.
-Assessment of magnesium level is used for the diagnosis and monitoring of hypomagnesemia or hypermagnesemia.
-Magnesium deficiency leads to impairment of neuromuscular functions resulting in hyperirritability, tetany, convulsion or electrocardiographic changes. It is also associated with cardiovascular diseases such as hypertension, myocardial infarction, cardiac dysrhythmias, coronary vasopasm & premature atherosclerosis. Diabetic ketoacidosis, chronic alcoholism, malnutrition, lactation malabsorption are other conditions linked with it.
-Increased serum magnesium concentration has been observed in dehydration, Addison's disease, rhabdomyolysis or acute or chronic renal failure.

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
SERUM PHOSPHORUS,SERUM			
PHOSPHOROUS	4.00	mg/dl	2.4-4.4
Method:Molybdate-UV/ Endpoint Method			

INTERPRETATION:

-Approximately 80% of the phosphorus in the human body is found in the calcium phosphate salts which make up the inorganic substance of bone. The remainder is involved in the esterification of carbohydrate metabolism intermediaries and is also found as component of phospholipids. Phosphoproteins, nucleic acids and nucleotides.
-Hypophosphatemia can be caused by shift of phosphate from extracellular to intracellular spaces, increased renal loss (renal tubular defects, hyperparathyroidism) or gastrointestinal loss (diarrhea, vomiting) and decreased intestinal absorption.

LIMITATIONS:

-Interferences: bilirubin (up to 20 mg/dL) hemolysis (haemoglobin up to 1000 mg/dL) and lipemia (triglycerides up to 1000 mg/dL) do not interface. Other drugs and substances may interface.
-Clinical diagnosis should no be made on the findings of a single test result, but should integrate both clinical laboratory data.

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
HbA1C-Glycosylated Hemoglobin,WHOLE BLOOD EDTA			
Glycosylated Hemoglobin- HbA1C Method:HPLC	**5.80**	%	4 - 5.6
Estimated Average Glucose (eAG) Method:Calculated	120	mg/dl	

INTERPRETATION

American Diabetes Association (ADA) 2023 Criteria

	HbA1c in %
Non diabetic adults	<5.7
At risk (Prediabetes)	5.7 - 6.4
Diagnosing Diabetes	6.5 & above

1. American Diabetes Association (ADA) is recommending the use of a new term in diabetes management, estimated average glucose/eAG. The relationship between HbA1c and eAG is described by the formula 28.7 X HbA1c % - 46.7 = eAG.
2. The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.
3. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
4. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.
   Excellent control-6-7 %
   Fair to Good control – 7-8 %
   Unsatisfactory control – 8 to 10 %
   Poor Control – More than 10 %

INCREASED IN (Other than DM)

1. Chronic renal failure with or without hemodialysis.
2. Iron deficiency anemia. Increased serum triglycerides.
3. Alcohol.
4. Salicylate treatment.

DECREASED IN

1. Shortened RBC life span (hemolytic anemia, blood loss), Pregnancy.
2. Ingestion of large amounts (>1g/day) of vitamin C or E.
3. Hemoglobinopathies (e.g.: spherocytes) produce variable increase or decrease.
4. Results of %HbA1c are not reliable in patients with chronic blood loss and consequent variable erythrocyte life span.

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
RENAL FUNCTION TEST 1,SERUM			
SERUM UREA Method:Urease GLDH	21	mg/dl	17-43
BLOOD UREA NITROGEN (BUN) Method:Calculated	9.81	mg/dl	6-20
SERUM CREATININE Method:Enzymatic	1.18	mg/dl	0.70-1.18
SERUM URIC ACID Method:URICASE	6.8	mg/dl	3.5-7.2
SERUM SODIUM Method:Direct ISE	138.7	mmol/L	135-155
SERUM POTASSIUM Method:Direct ISE	3.93	mmol/L	3.5-5.0
SERUM CHLORIDE Method:Direct ISE	98.6	mmol/L	94-110

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref.Interval
SERUM IRON ,SERUM			
SERUM IRON Method:TPTZ Colorimetric	79.00	µg/dL	70-180

INTERPRETATION:

Serum iron test is used in differential diagnosis of anaemia and diagnosis of acute iron toxicity especially in children.

INCREASED IN:
-Hemosiderosis of excessive iron intake (e.g. repeated blood transfusion, iron therapy, iron containing vitamins).
-Decreased formation of RBCs (thalassemia, pyridoxal deficiency anaemia)
-Increased destruction of RBCs (hemolytic anaemia).
-Acute liver damage
-Progesteronal birth control pills & pregnancy
-Premenstrual elevation
-Acute iron toxicity

DECREASED IN:
-Iron deficiency anaemia
-Normochromic anaemia of infections & chronic diseases
-Nephrosis
-Menstruation
-Diurnal variation: Normal in mid morning, low values in mid afternoon, and very low values near midnight.

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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref.Interval
THYROID PROFILE TOTAL (T3,T4,TSH),SERUM			
T3- TRI-IODOTHYRONINE TOTAL Method:CLIA	0.95	ng/mL	0.60-1.81
T4 - THYROXINE TOTAL Method:CLIA	11.56	µg/dL	5.48-14.28
Thyroid Stimulating Hormone (TSH) Method:CLIA	4.75	µIU/mL	0.50-8.90

INTERPRETATION:

1. Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
3. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
4. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
5. Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.
7. **REFERENCE RANGE :**

PREGNANCY	TSH in uIU/mL
1st Trimester	0.10 - 2.50
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 – 3.00

Age	TSH in uIU/mL
0 – 4 Days	1.00 - 39.00
2 Weeks to 5 Months	1.70 – 9.10
5 Months to 20 Yrs.	0.70 – 6.40
21 Yrs. to 54 years	0.40 – 4.20
>55 Yrs.	0.50 - 8.90

(References range recommended by the American Thyroid Association)

Comments:

1. During pregnancy, Free thyroid profile (FT3, FT4 & Ultra-TSH) is recommended.
2. TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations.

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9036599311 / 9036599338

Working Hours : Mon - Sat 6.30 AM - 9.00 PM, Sunday : 6.30 AM - 3.00 PM enquiry@ecotowndiagnostics.com www.ecotowndiagnostics.com

Patient Name	**: MR. MANJUNATH SWAMY**	Registration	: 05/Apr/2025 08:18AM
Age/Gender	: 56 Y 0 M 0 D /M	Collected	: 05/Apr/2025 11:12AM
UHID/MR No	: KAL.0000005189	Received	: 05/Apr/2025 11:30AM
Visit ID	**: KAL5954**	Reported	: 05/Apr/2025 02:28PM
Ref Doctor	: SELF	Status	: Final Report
Barcode No	: 10215714	Client Code	: ECOTOWN
Client Name	:ECOTOWN STAFF		

DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref.Interval
25 HYDROXY VITAMIN D,SERUM			
VITAMIN D Method:CLIA	**18.73**	ng/ml	30-100

INTERPRETATION:

LEVEL	REFERENCE RANGE
Deficient	< 20 ng/ml
Insufficient	20-<30 ng/ml
Sufficient (adequate)	30-100 ng/ml
Toxicity	> 100 ng/ml

DECREASED LEVELS:
-Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany.
-Inadequate exposure to sunlight.
-Dietary deficiency.
-Vitamin D malabsorption.
-Severe Hepatocellular disease.
-Drugs like Anticonvulsants.
-Nephrotic syndrome.

COMMENTS:
-Vitamin D (Cholecalciferol) promotes absorption of calcium and phosphorus and mineralization of bones and teeth. 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 Dihydronxy vitamin D (5-8 hrs).
-The assay measures D3 (Cholecaciferol) metabolites of vitamin D.
-25 (OH) D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
-Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
-It shows seasonal variation, with values being 40-50% lower in winter than in summer.
-Levels vary with age and are increased in pregnancy.
-This is the recommended test for evaluation of vitamin D intoxication.

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Test Name	Result	Unit	Bio. Ref.Interval
PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL,SERUM			
PROSTATE SPECIFIC ANTIGEN Method:CLIA	**4.66**	ng/mL	0-4

NOTE:Rechecked.

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.

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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref.Interval
VITAMIN B12,SERUM			
VITAMIN B12 Method:CLIA	259	pg/mL	75-807

Vitamin B12, also known as cyanocobalamin, is a water soluble vitamin that is required for the maturation of erythrocytes and coenzyme form for more than 12 different enzyme systems. Groupsat risk for vitamin B12 deficiency include those (1) older than 65 years of age (2) with malabsorption (3) who are vegetarians (4) with autoimmune disorders(5) taking prescribed medication known to interfere with vitamin absorption or metabolism, including nitrous oxide, phenytoin, dihydrofolate reductase inhibitors, metformin,
and proton pump inhibitors (6) infants with suspected metabolic disorders.
The most common cause of Vitamin B12 deficiency is pernicious anemia. Deficiency of Vitamin B12 is associated with megaloblastic anemia and neuropathy. Excess Vitamin B12 is excreted in urine. No adverse effects have been associated with excess vitamin B12 intake from food or supplements in healthy people

COMMENTS:

Results may differ between laboratories due to variation in population and test method. Vitamin B12 is implicated in the formation of myelin, and along with Folate is required for DNA synthesis. The most prominent source of B12 for humans is meat while untreated fresh water can also be a source.
Megaloblastic anaemia has been found to be due to B12 deficiency, a major cause being Pernicious anemia due to poor B12 uptake resulting in below normal serum levels. Other conditions related to low B12 levels include iron deficiency anemia, pregnancy, vegetarianism, partial gastrectomy, ileal damage, oral contraceptives, parasitic infestations, pancreatic deficiency, treated epilepsy and advancing age. The correlation of serum B12 levels and Megaloblastic anemia however is not always clear - some patients with high MCV may have normal B12 levels, while some individuals with B12 deficiency may not have megaloblastic anemia. Disorders renal failure, liver diseases and myeloproliferative diseases may have elevated vitamin B12 levels.

LIMITATIONS:

For diagnostic purposes, the B12 results should be used in conjunction with other data; e.g.; symptoms results of other testing, clinical impressions, etc.
If the B12 level is inconsistent with clinical evidence, additional testing is suggested to confirm the result.

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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref.Interval
FOLIC ACID,SERUM			
FOLIC ACID Method:CMIA	3.42	ng/ml	3.1-20.5

INTERPRETATION:

Decreased levels of folic acid are seen in megaloblastic anemia, malnutrition, alcoholism, and inadequate dietary intake. Decreased levels are associated with a higher risk of fetal malformations during pregnancy.
In patients taking methotrexate therapy, antibodies formed may interfere with the assay.

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

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