SUBURBAN DIAGNOSTICS
PRECISE TESTING • HEALTHIER LIVING

Authenticity Check

Use a QR Code Scanner Application To Scan the Code

REPORT

CID	: 2412805980		
Name	: MRS.NAKSHATRA REDDY		
Age / Gender	: 77 Years / Female		
Consulting Dr.	: -	**Collected**	: 07-May-2024 / 12:06
Reg. Location	: Mapusa Goa, Ishanas Lab	**Reported**	: 07-May-2024 / 18:28

CBC (Complete Blood Count), Blood

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
RBC PARAMETERS			
Haemoglobin	**6.1**	12.0-15.0 g/dL	Spectrophotometric
RBC	**2.07**	3.8-4.8 mil/cmm	Elect. Impedance
PCV	**18.0**	36-46 %	Measured
MCV	87.2	80-100 fl	Calculated
MCH	29.7	27-32 pg	Calculated
MCHC	34.1	31.5-34.5 g/dL	Calculated
RDW	13.3	11.6-14.0 %	Calculated
WBC PARAMETERS			
WBC Total Count	**2530**	4000-10000 /cmm	Elect. Impedance
WBC DIFFERENTIAL AND ABSOLUTE COUNTS			
Lymphocytes	31.6	20-40 %	
Absolute Lymphocytes	799.5	1000-3000 /cmm	Calculated
Monocytes	9.5	2-10 %	
Absolute Monocytes	240.3	200-1000 /cmm	Calculated
Neutrophils	54.2	40-80 %	
Absolute Neutrophils	1371.3	2000-7000 /cmm	Calculated
Eosinophils	2.9	1-6 %	
Absolute Eosinophils	73.4	20-500 /cmm	Calculated
Basophils	1.8	0.1-2 %	
Absolute Basophils	45.5	20-100 /cmm	Calculated
Immature Leukocytes	-		

WBC Differential Count by Absorbance & Impedance method/Microscopy.

PLATELET PARAMETERS			
Platelet Count	**75000**	150000-400000 /cmm	Elect. Impedance
MPV	9.2	6-11 fl	Calculated
PDW	12.9	11-18 %	Calculated
RBC MORPHOLOGY			
Hypochromia	-		
Microcytosis	-		
Macrocytosis	-		

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HEALTHLINE: 022-6170-0000 | E-MAIL: customerservice@suburbandiagnostics.com | WEBSITE: www.suburbandiagnostics.com
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Anisocytosis	-
Poikilocytosis	-
Polychromasia	-
Target Cells	-
Basophilic Stippling	-
Normoblasts	-
Others	-
WBC MORPHOLOGY	-
PLATELET MORPHOLOGY	Platelets reduced on smear.
COMMENT	Leucopenia

Results rechecked.
Kindly correlate clinically and repeat estimation if required.

Specimen: EDTA Whole Blood

*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD Goa Lab, Margao

*** End Of Report ***

ilac-MRA

MC-5274

Dr.SWATI SAHAY
M.D. (PATH)
Pathologist

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KIDNEY FUNCTION TESTS

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
BLOOD UREA, Serum	40.1	17.1-49.3 mg/dl	Kinetic
BUN, Serum	18.7	8-23 mg/dl	Calculated
CREATININE, Serum	**1.29**	0.51-0.95 mg/dl	Enzymatic
eGFR, Serum	**40**	(ml/min/1.73sqm) Normal or High: Above 90 Mild decrease: 60-89 Mild to moderate decrease: 45-59 Moderate to severe decrease:30-44 Severe decrease: 15-29 Kidney failure:<15	Calculated

Note: eGFR estimation is calculated using 2021 CKD-EPI GFR equation w.e.f 16-08-2023

TOTAL PROTEINS, Serum	**5.6**	6.4-8.3 g/dL	Biuret
ALBUMIN, Serum	**3.4**	3.5-5.2 g/dL	BCG
GLOBULIN, Serum	**2.2**	2.3-3.5 g/dL	Calculated
A/G RATIO, Serum	1.5	1 - 2	Calculated
URIC ACID, Serum	**6.2**	2.4-5.7 mg/dl	Enzymatic
PHOSPHORUS, Serum	4.3	2.7-4.5 mg/dl	Molybdate UV
CALCIUM, Serum	**8.6**	8.8-10.2 mg/dl	N-BAPTA
SODIUM, Serum	135	135-148 mmol/l	ISE
POTASSIUM, Serum	4.8	3.5-5.3 mmol/l	ISE
CHLORIDE, Serum	105	98-107 mmol/l	ISE

Results rechecked

Kindly correlate clinically.
Advice : Repeat estimation with a fresh sample, if clinically indicated.

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CRP-QUANTITATIVE TEST

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
CRP-QUANTITATIVE, Serum	**0.3**	1-5 mg/l	Imm.Turbidimetry

Kindly correlate clinically.
Advice : Repeat estimation with a fresh sample, if clinically indicated.

Interpretation:
CRP elevations are nonspecific and may be useful for the detection of systemic inflammatory processes like;

- To assess treatment of bacterial infections with antibiotics
- To differentiate between active and inactive forms of disease with concurrent infection
- Postoperative monitoring & to determine the presence of postoperative complications at an early stage, such as infected wounds, thrombosis, and pneumonia.

Clinical Significance:

- C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation.
- The test measures the amount of CRP in the blood and can be valuable in detecting inflammation due to acute conditions or in monitoring disease activity in chronic conditions.
- In normal healthy individuals CRP is a trace protein, after onset of an acute phase response the serum CRP concentration rises rapidly and extensively. Alterations are detectable within 6 to 8 hours and the peak value is reached within 24 to 48 hours.
- Levels of up to thousand fold the normal value are associated with severe stimuli such as myocardial infarction, major trauma, surgery, or malignant neoplasms.
- CRP has a half-life of only a few hours, making it an ideal tool for clinical monitoring. Postoperative monitoring of CRP levels of patients indicates either the normal recovery process (decreasing levels to normal) or unexpected complications (persisting high levels).
- Persistence of a high serum CRP concentration is usually a grave prognostic sign which generally indicates the presence of an uncontrolled infection.
- CRP determination may replace the classical determination of Erythrocytes Sedimentation Rate (ESR), due to its prompt response to changes in disease activity and its good correlation to ESR.

Reflex Tests: Complement, Procalcitonin

Limitations of the test:
The CRP test is not diagnostic of any condition, but it can be used together with signs and symptoms and other tests to evaluate an individual for an acute or chronic inflammatory condition.

Reference:

- Wallach's Interpretation of Diagnostic Tests
- CRP Kit Insert

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MC-5274

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M.D. (PATH)
Pathologist

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NT-proBNP

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
NT-proBNP, Serum	308	<450 pg/ml	CLIA

Clinical Significance: Use in the quantitative determination of N-terminal pro-brain natriuretic peptide (NT-proBNP) NT-ProBNP is a marker of atrial & ventricular distension due to increased intracardiac pressure, hence it is used as an aid in the diagnosis of CHF. The diagnostic strength of NT-ProBNP is their high sensitivity for ruling out heart failure

Intended Use:

- NT-proBNP determination is used to identify patients with suspected left ventricular dysfunction. It particularly helps to differentiate between cardiac and pulmonary dyspnea.
- NT-proBNP is also a predictive marker of mortality for patients with cardiac insufficiency or coronary artery disease or for patients at risk of coronary insufficiency.
- Variations in NT-proBNP concentration may be useful to monitor the efficacy of therapy for left ventricular dysfunction.

Interpretation:

- NT pro-BNP value <125 pg/mL exclude cardiac dysfunction with a high level of certainty in patients presenting with dyspnea, As the value increases heart failure becomes more likely.
- Higher levels e than expected are seen in Increasing age, ACS ,Renal insufficiency , RV Dysfunction, Atrial fibrillation , Pulmonary hypertension, Pulmonary embolism , Anemia, Sepsis and Mitral Regurgitation ,
- Lower levels than expected are seen in Obesity, Pulomanary edema, Pericarditis/tamponade, Genetic polymorphism

Limitations:

- Patient samples may contain heterophilic antibodies that could react in immunoassays to give falsely elevated or depressed results
- NT-pro-BNP values need to be interpreted in conjunction with the medical history, clinical findings.
- Lack of NT-ProBNP elevation has been reported if Congestive Heart Failure (CHF) is very acute (first hour) or if there is Ventricular inflow obstruction

Reflex Test: hs Troponin I, CK-MB, Lipid profile, blood gas analysis

Reference: Pack insert, Tiets Textbook of clinical chemistry

*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD SDRL, Vidyavihar Lab

*** End Of Report ***

Dr.JYOT THAKKER
M.D. (PATH), DPB
Pathologist & AVP(Medical Services)

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IONISED CALCIUM

PARAMETER	RESULTS	BIOLOGICAL REF RANGE
IONISED CALCIUM, Serum	**1.02**	Adult : 1.15 - 1.35 mmol/l Neonates : 1.10 - 1.40 mmol/l

Result Rechecked

*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD Belle Vue Lab, Andheri West

*** End Of Report ***

Sonia Kher

Dr.SONIA KHER
M.D. (PATH)
Pathologist

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LIVER FUNCTION TESTS

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
BILIRUBIN (TOTAL), Serum	0.91	0.1-1.2 mg/dl	Colorimetric
BILIRUBIN (DIRECT), Serum	**0.65**	0-0.3 mg/dl	Diazo
BILIRUBIN (INDIRECT), Serum	0.26	0.1-1.0 mg/dl	Calculated
TOTAL PROTEINS, Serum	**5.6**	6.4-8.3 g/dL	Biuret
ALBUMIN, Serum	**3.4**	3.5-5.2 g/dL	BCG
GLOBULIN, Serum	**2.2**	2.3-3.5 g/dL	Calculated
A/G RATIO, Serum	1.5	1 - 2	Calculated
SGOT (AST), Serum	27.5	5-32 U/L	NADH (w/o P-5-P)
SGPT (ALT), Serum	10.0	5-33 U/L	NADH (w/o P-5-P)
GAMMA GT, Serum	39.4	3-40 U/L	Enzymatic
ALKALINE PHOSPHATASE, Serum	55.7	35-105 U/L	Colorimetric

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M.D. (PATH)
Pathologist

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Reg. Location	: Mapusa Goa, Ishanas Lab	**Reported**	: 08-May-2024 / 07:49

Iron studies

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
IRON, Serum	**218.0**	50-170 µg/dL	Colorimetric
UIBC (measured), Serum	170.9	135-392 µg/dL	Calculated
TOTAL IRON BINDING CAPACITY (TIBC), Serum	388.9	250-425 µg/dL	Colorimetric
TRANSFERRIN, Serum	302.4	250-380 mg/dl	Imm.Turbidimetry
TRANSFERRIN SATURATION, Serum	**51.1**	15-45 %	Calculated
FERRITIN, Serum	20.6	10-291 ng/ml	CLIA

Intended Use: This test is used to evaluate iron metabolism in patients when iron deficiency, overload, or poisoning is suspected.

Clinical Significance:
Abnormal levels of iron are characteristic of many diseases, including iron-deficiency anemia and hemochromatosis. As much as 70% of the iron in the body is found in the hemoglobin of the red blood cells (RBCs). The other 30% is stored in the form of ferritin and hemosiderin. Iron is supplied by the diet. About 10% of the ingested iron is absorbed in the small intestine and transported to the plasma. There the iron is bound to a globulin protein called transferrin and carried to the bone marrow for incorporation into hemoglobin. Usually about one third of the transferrin is being used to transport iron. Because of this, the blood serum has considerable extra iron-binding capacity, which is the Unsaturated Iron Binding Capacity (UIBC). The serum ferritin study is a good indicator of available iron stores in the body. Ferritin, the major iron-storage protein, is normally present in the serum in concentrations directly related to iron storage.

Test Interpretation:

- Serum iron is increased in hemosiderosis, hemolytic anemias, thalassemia, sideroblastic anemias, hepatitis, acute hepatic necrosis, hemochromatosis, inappropriate iron therapy, and iron poisoning.
- Serum iron is decreased in cases of insufficient dietary iron, chronic blood loss, inadequate absorption of iron, impaired release of iron stores (commonly observed in inflammation), infection, and chronic diseases.
- Serum TIBC is done in conjunction with serum iron levels in the evaluation and diagnosis of anemia.
- Iron deficiency anemia is characterized by a decreased serum iron, increased TIBC or transferrin, and a decreased transferrin saturation.
- Serum TIBC is increased in iron deficiency and decreased in anemia of chronic disease.

Limitations of the test

- Recent blood transfusions or recent ingestion of a meal containing high iron content may increase serum iron and ferritin levels.
- Hemolytic diseases may be associated with an artificially high iron content.
- Drugs that may cause increased iron levels include chloramphenicol, dextran, estrogens, ethanol, iron preparations, methyldopa, and oral contraceptives.
- Drugs that may cause decreased iron levels include adrenocorticotropic hormone (ACTH), cholestyramine, chloramphenicol, colchicine, deferoxamine, methicillin, and testosterone.
- Drugs that may cause increased TIBC levels include fluorides and oral contraceptives.
- Drugs that may cause decreased TIBC levels include ACTH and chloramphenicol.
- Diurnal variation is seen with iron levels low in mid afternoon and very low near mid night.
- Acute and chronic inflammatory conditions and Gaucher disease can falsely increase ferritin levels

*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD SDRL, Vidyavihar Lab

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MC-5460

Dr.JYOT THAKKER
M.D. (PATH), DPB
Pathologist & AVP(Medical Services)

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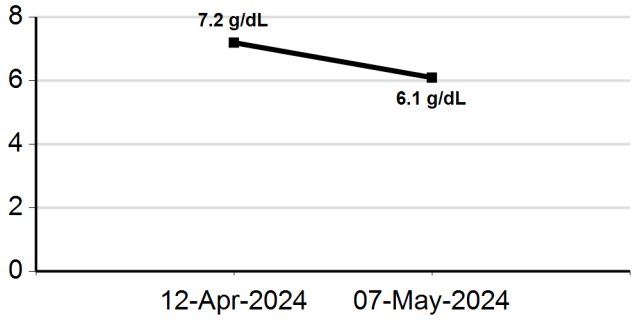
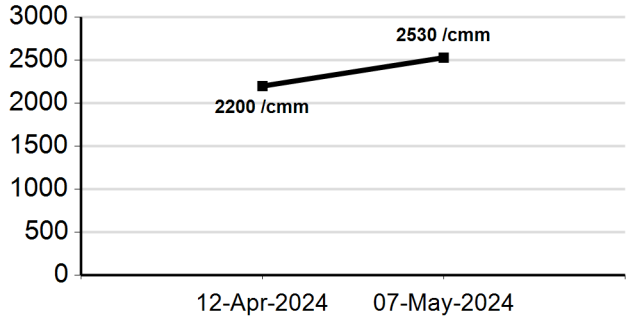
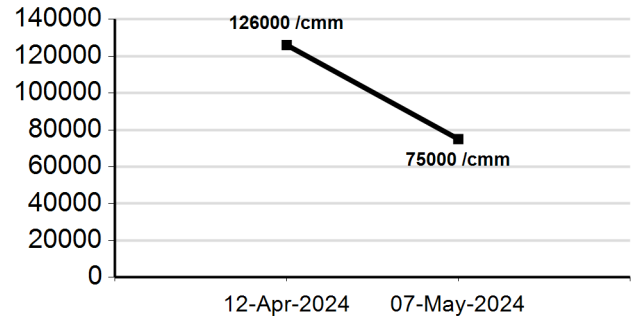
Haemoglobin



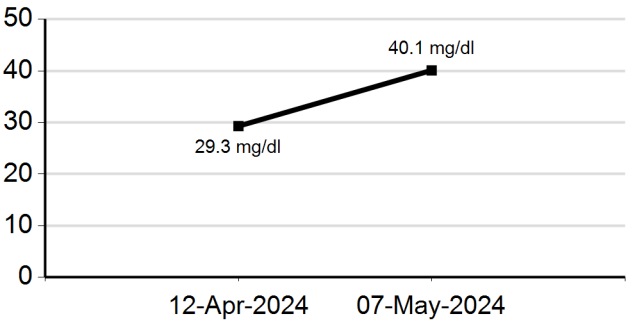
WBC Total Count



Platelet Count



BLOOD UREA



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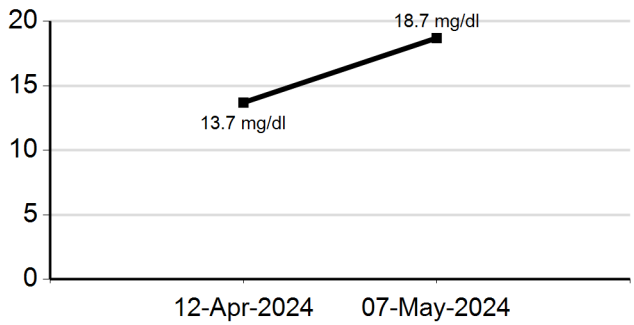
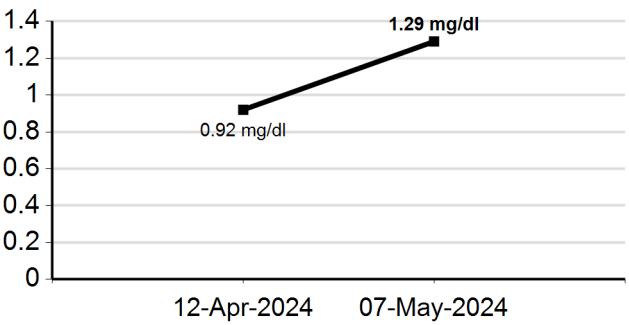


CREATININE



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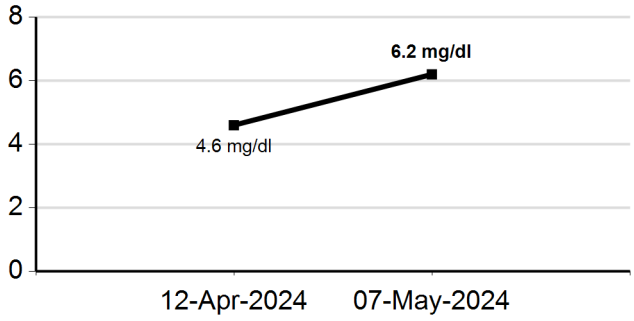
Reg. Location	: Mapusa Goa, Ishanas Lab

URIC ACID



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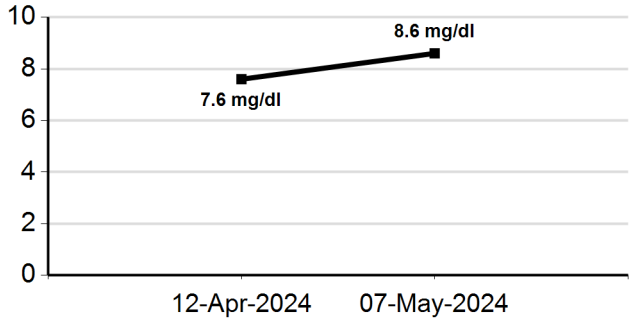

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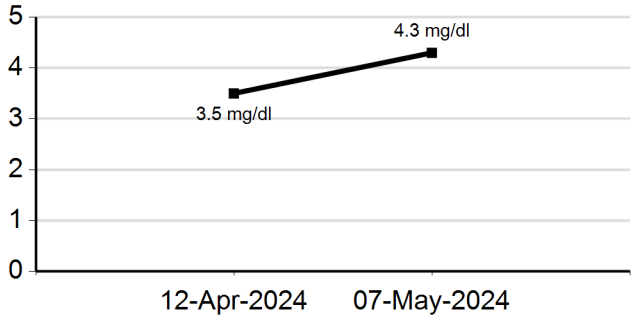
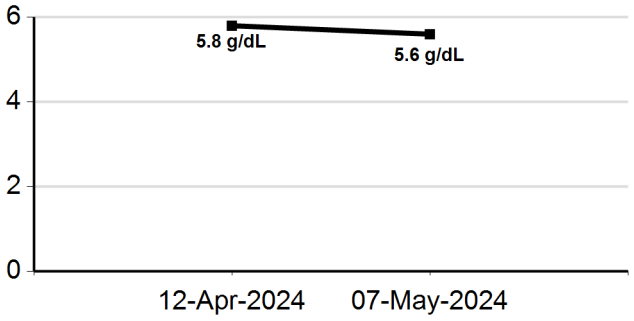


TOTAL PROTEINS



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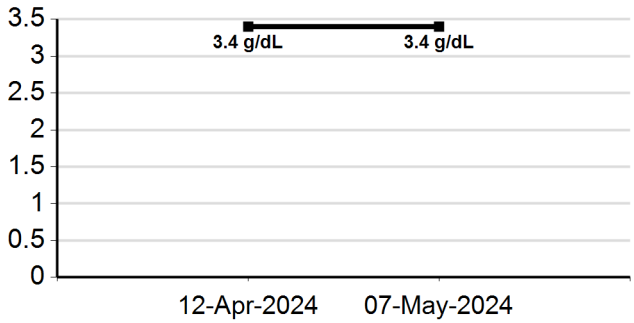

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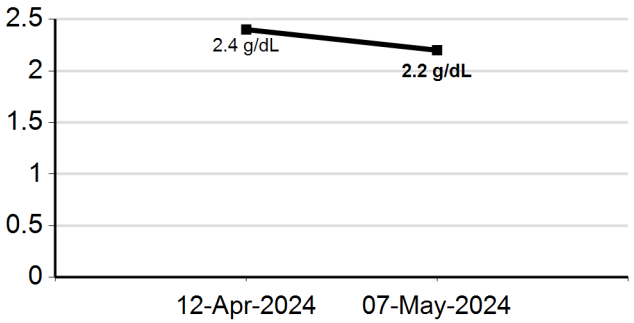

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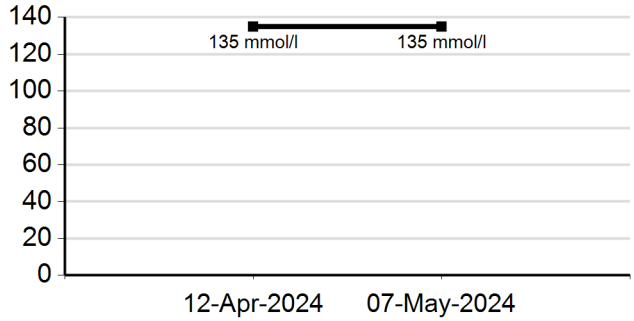
REPORT

CID	: 2412805980
Name	: MRS.NAKSHATRA REDDY
Age / Gender	: 77 Years / Female
Consulting Dr.	: -
Reg. Location	: Mapusa Goa, Ishanas Lab

SODIUM



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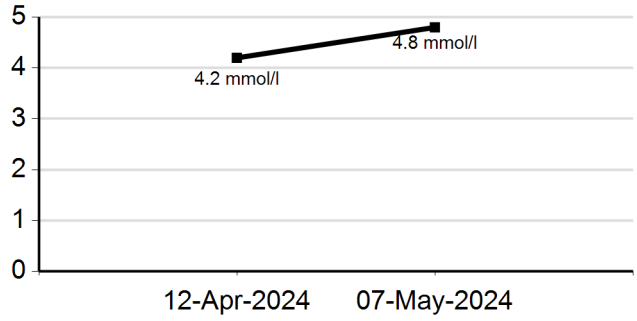

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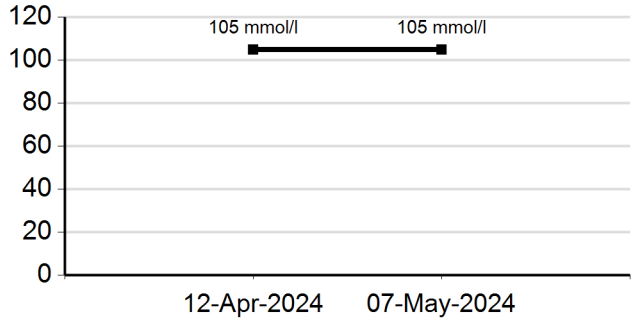

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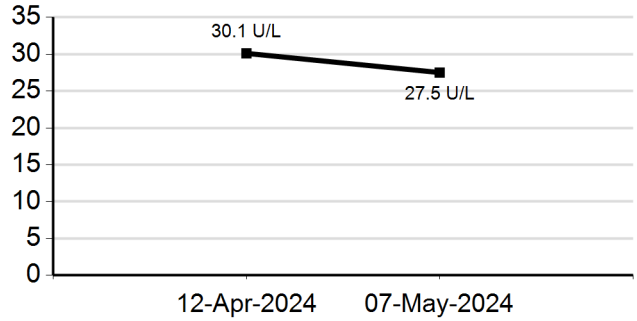

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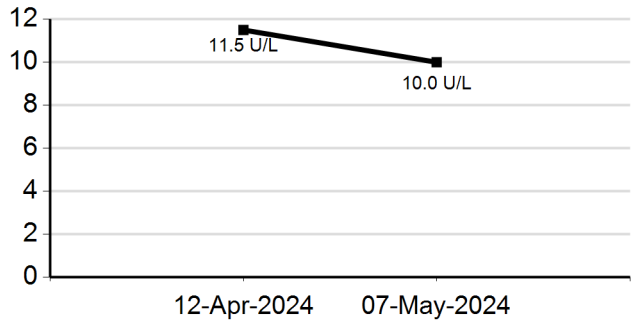

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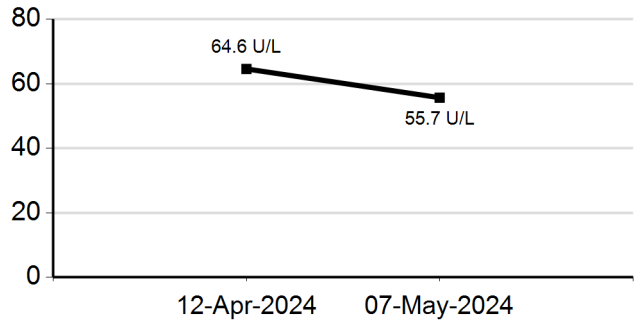

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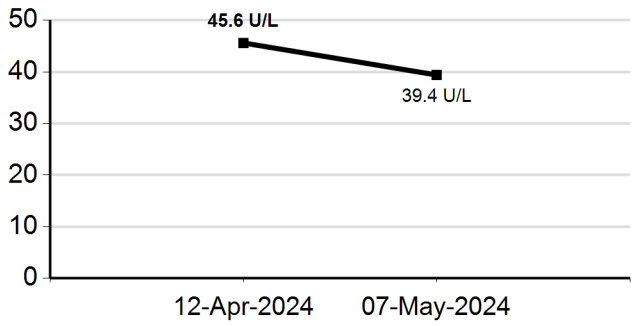
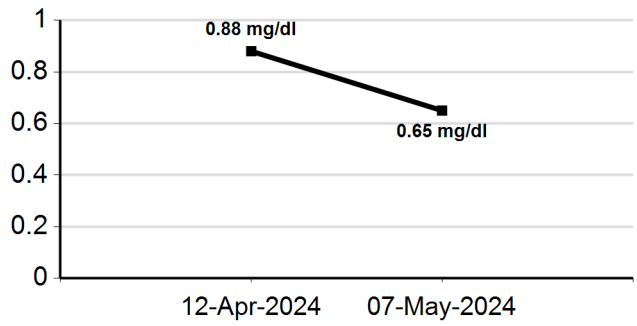
CID	: 2412805980
Name	: MRS.NAKSHATRA REDDY
Age / Gender	: 77 Years / Female
Consulting Dr.	: -
Reg. Location	: Mapusa Goa, Ishanas Lab

GAMMA GT



BILIRUBIN (DIRECT)



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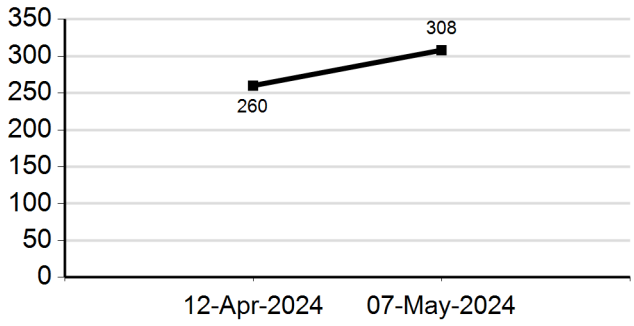

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