

Name : Mr. Mr Aman Ankur Age / Sex : 33 Year(s) / Male Collected On : 07/03/2025 08:07 AM

Ref. Doctor Patient ID : OHP46D3D1252442 : 07/03/2025 11:17 AM Received On

Visit No. : BL126133001 : Getvisit TPA : 07/03/2025 01:47 PM Client Reported On



## **CLINICAL PATHOLOGY**

## **Urine Routine Analysis**

### **PHYSICAL EXAMINATION**

Manual

Volume 50 ml

Colour Pale yellow Pale yellow

**Appearance** Clear Clear

### **CHEMICAL EXAMINATION**

Double indicator method

Protein error of pH indicator

6.0 5.0-8.0 рН

1.001-1.035 Specific gravity 1.030 Refractive Index

Nil Urine Protein Nil

Glucose Nil Nil Enzyme method GOD POD

Ketone bodies Nil Nil

Dipstick

Nil Nil Bilirubin Azo coupling method

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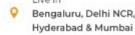
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Peroxidase activity

Griess method

Granulocyte esterase method

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Blood Negative Negative

Normal Normal

Urobilinogen Azo coupling method

Negative Negative Leucocyte Esterase

Negative Negative **Nitrites** 

-- End of Report --



Tests marked with NABL symbol are accredited by NABL vide Certificate no MC-6367

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**Dr. Sanchit Singhal** MD Pathologist















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## **BIOCHEMISTRY**



mg/dL

85

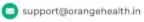
Normal Fasting Glucose: 70-99 Impaired Fasting Glucose: 100-125

Diabetes: on more than one occasion: > 126

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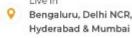
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# **LFT - LIVER FUNCTION TEST**

Serum

LDH, UV kinetic

Total Bilirubin	0.65	mg/dL	Adult: 0.2-1.3
DSA			Neonate: 1.0-10.5

Direct Bilirubin	0.33	mg/dL	Neonate: 0.0-0.6
Calculated			Adult: 0.0-0.3

3	Indirect Bilirubin	0.32	mg/dL	Adult: 0.1-1.1
	Dual wavelength			Neonate: 0.6-10.5

*	Aspartate Transaminase(AST/	26	U/L	17-49
	SGOT)			

SGOT)	
MDH, UV Kinetic	

*	Alanine Transaminase(ALT/	30	U/L	< 50
	SGPT)			

Alkaline Phosphatase	70	U/L	38-126
PNPP, AMP Buffer			

*	Gamma-Glutamyl Transferase 17	U/L	15-73
	(GGT)		
	SZAZ Carboxvlated Substrate		

Total Protein	7.2	g/dL	6.0-8.3
Biuret			

*	Albumin	4.4	g/dL	3.5-5.0
	Bromo-Cresol Green			

Globulin	2.7	g/dL	2.3-3.5
Calculated			

A/G ratio	1.6	0.8-2.0
Calculated		

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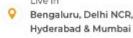
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SGOT/SGPT- RATIO

0.9

0.7 - 1.4

Calculated

Total bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.

Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver, Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis. and drug-induced hepatitis.

Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumours, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.

Alkaline phosphatase is elevated in fever and increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increased ALP activity; also increased in renal infarction and failure and in the complications of pregnancy. Low ALP activity may occasionally be seen in hypothyroidism.

Serum GGT is a sensitive indicator of hepatobiliary disease and is useful in the diagnosis of obstructive jaundice and chronic alcoholic liver disease, in the follow-up of chronic alcoholics undergoing treatment, and in the detection of hepatotoxicity. GGT is more responsive to biliary obstruction than AST, ALT, or ALP.

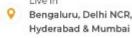
Total serum protein levels can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenström's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

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# Glycosylated Haemoglobin - (HbA1c)

Whole Blood

Glycosylated Haemoglobin 4.8 Normal: < 5.7

(HbA1c) Pre-Diabetes: 5.7-6.4

HPLC Diabetes: >= 6.5

Mean Blood Glucose mg/dL 91

Calculated

HbA1C is used to monitor fluctuations in blood glucose concentration in the past 8 to 12 week's period.

The reference interval defined as per American Diabetes Association guidelines 2016:

Less than 5.7%: Non Diabetic

b) 5.7 to 6.4%: at increased risk of developing diabetes in the future

More than 6.5%: Diabetic c)

d) Therapeutic glycemic target:

Adults: less than 7% i.

Children with Type 1 diabetes: less than 7 % ii.

Pregnant diabetic patients: less than 6.5% e)

### Note:

• Targets may be individualized based on: Age/life expectancy, Comorbid conditions, Diabetes duration, Hypoglycemia status, Individual patient considerations

Reference: American Diabetes Association. Standards of medical care in diabetes—2021.

Mean Blood Glucose is average Blood glucose which directly correlates with A1C, reported in the same units as blood sugar levels (mg/dl). Thus it reflects the average glucose concentration in the past 8 to 12 weeks period. This should not be compared with Fasting or Post prandial or random blood sugar which measures glucose concentration at that point of time of testing.

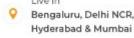
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# **Kidney Function Test Mini**

Serum

mg/dL Urea 43 19-43

Urease Newborn: 6.5-25.5

Creatinine 1.0 0.66-1.25 mg/dL

Enzymatic

Blood Urea Nitrogen (BUN) 20.1 mg/dL 6-20 Calculated

**BUN Creatinine Ratio** 20.10 Ratio 10-20 Calculated

Calcium 9.3 ma/dL 8.4-10.2

Uric Acid mg/dL 6.0 3.5-8.5 Uricase

eGFR 103 ml/min/1.73 sq Normal: >= 90

CKD EPI Mild decrease: 60-89 m

Mild moderate decrease: 45-59 Severe decrease: 15-29

End stage kidney disease: < 15

# Lipid Profile with calculated LDL

Serum

Arsenazo Method

**Total Cholesterol** 224 mg/dl < 200

CHOD-POD

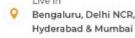
**Triglycerides** 198 mg/dL < 150 GPO-POD

**HDL** Cholesterol mg/dL > 50 34 Direct

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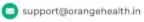
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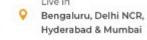
Non-HDL Cholesterol Calculated	<u>190</u>	mg/dL	< 130
LDL Cholesterol Calculated	<u>150</u>	mg/dL	< 100
VLDL Cholesterol Calculated	<u>40</u>	mg/dL	< 30
Cholesterol / HDL Ratio Calculated	<u>6.6</u>		3.30-4.40
LDL:HDL RATIO Calculated	<u>4.4</u>		0.5-3.0
HDL/LDL RATIO	<u>0.2</u>	Ratio	> 0.4

Calculated















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REMARKS	TOTAL CHOLESTEROL(mg/dL)	TRIGLYCERIDE(mg/dL)	LDL CHOLESTEROL(mg/dL)	
Optimal	<200	<150	<100	
Above Optimal	-	-	100-129	
Borderline	200-239	150-199	130-159	
High	>=240	200-499	160-189	
Very High	-	>=500	>=190	

Lipid profile is a group test consisting of various lipids. Lipid profiles are generally collected with overnight fasting. However, Recent guidelines have recommended non fasting samples for lipid profile for assessment of cardiovascular risk. The details for the study can be checked at\_ https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2733560

In certain instances measurements in the same patient can show physiological and analytical variations. In such cases three serial samples at an interval of 1 week each are recommended for Total cholesterol, TG, HDL and LDL.

Cholesterol levels are increased in primary hypercholesterolemia; secondary hyperlipoproteinemia, including nephrotic syndrome; primary biliary cirrhosis; hypothyroidism; and in some cases, diabetes mellitus. Low cholesterol levels may be found in malnutrition, malabsorption, advanced malignancy, and hyperthyroidism.

Triglyceride levels are used in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, or various endocrine disorders.

High Density Lipoprotein (HDL) cholesterol levels is used to evaluate the risk of developing coronary heart disease (CHD). The risk of CHD increases with lower HDL cholesterol concentrations.

LDL (low-density lipoprotein) cholesterol level, sometimes called "bad" cholesterol, makes up most of our body's cholesterol. High levels of LDL cholesterol raise your risk for heart disease and stroke.

Very-low-density lipoprotein (VLDL) cholesterol is produced in the liver and released into the bloodstream to supply body tissues with triglycerides. High levels of VLDL cholesterol have

been associated with the development of plaque deposits on artery walls, which narrow the passage and restrict blood flow.

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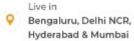
**Dr. Sanchit Singhal** MD Pathologist

















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# **IMMUNOLOGY**



Thyroid Stimulating Hormone 2.486 (TSH)

uIU/mL

0.400-4.049

Serum,CLIA

Thyroid Stimulating Hormone (TSH), also called Thyrotropin is a hormone secreted into the blood by the Pituitary gland (a gland present in the brain)). It signals the thyroid gland to make and release the thyroid hormones (T3 & T4) into the blood.

High TSH level indicates that the thyroid gland is not making enough thyroid hormone (primary hypothyroidism).

Low TSH level usually indicates that the thyroid is producing too much thyroid hormone (hyperthyroidism).

### **Factors influencing TSH levels**

Fasting: TSH level shows a significant decline after meal intake in comparison to fasting values. This may have clinical implications in the diagnosis and management of hypothyroidism, especially Subclinical hypothyroidism.1

Circadian Rhythm: TSH levels follow a circadian variation, reaching peak levels between Morning 2 – 4 am and at a minimum between Evening 6-10 pm. The variation is of the order of 50%. hence time of sample collection during a day can significantly influence on the measured serum TSH concentrations.2

Other Factors: Genetics, Poisonous substances and radiation exposure, Inflammation of the thyroid gland, Deficiency or excess of iodine in the diet, Pregnancy, Certain medications - antidepressants, cholesterol lowering drugs, chemotherapy drugs, steroids, Thyroid cancer.

### References:

- 1. Indian Journal of Endocrinology and Metabolism 18(5):p 705-707, Sep-Oct 2014.)
- 2. efaidnbmnnnibpcajpcglclefindmkaj/http://www.pnei-it.com/1/upload/thyrotropin\_secretion\_patterns\_i n\_health\_and\_disease.pdf

In pregnant females the reference range of TSH differs. Please refer the table below for the same:-

Pregnancy	TSH Reference Range (uIU/mL)
lst Trimester	0.129-3.120
2nd Trimester	0.274-2.652
3rd Trimester	0.312-2.947

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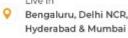
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Vitamin D (25 OH Cholecalciferol) Serum,CLIA

33.1

ng/mL

Deficient: < 20 Insufficient: 20-30 Sufficient: 30-100 Toxicity: > 100

For the diagnosis of vitamin D deficiency it is recommended to have clinical correlation with serum 25 (OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.

During the monitoring of oral vitamin D therapy - suggested testing of serum 25(OH)vitamin D is after 12 weeks or 3 months of treatment. However, the required dosage of vitamin D supplements & time to achieve sufficient vitamin D levels show significant seasonal (especially winter) & individual variability depending on age, body fat, sun exposure, physical activity, genetic factors (especially variable vitamin D receptor responses), associated liver or renal disease, malabsorption syndromes and calcium or magnesium deficiency influencing the vitamin D metabolism.

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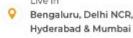
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**Dr. Sanchit Singhal** MD Pathologist













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## **HEMATOLOGY**

## **Complete Blood Count with ESR**

Whole Blood

RBC count	5 32	mill/cu.mm	4.5-5.5
NDC COUIT	J.JZ		

DC Impedance method

Haamaglahin (Hh)	15 1	am/dl	17 0 17 0
Haemoglobin (Hb)	15.1	gm/dL	13.0-17.0

Cyanide-free SLS method

Haematocrit(PCV) 46.0 % 40-50

Calculated

Mean Corpuscular Volume	86.4	fl	83-101
Micari Corpuscular Volume	00	! <b>L</b>	05 101

(MCV) Calculated

27-32 28.4 pg

Mean Corpuscular Haemoglobin(MCH)

Calculated

Mean Corpuscular 32.8

g/dL 31.5-34.5 Haemoglobin Concentration

(MCHC) Calculated

Red cell distribution width 13.5 % 11.6-14.0

(RDW) Calculated

Mentzer Index 16.2 Index Beta Thalassemia trait: < 14

Calculated Iron deficiency anaemia: >= 14

Sehgal index 1403.2 Index Beta Thalassemia trait: < 972

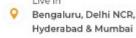
Calculated Iron deficiency anaemia: >= 972

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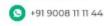


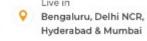
NC-0007	Total WBC count - TC DC Impedance method	6940	cells/cu.mm	4000-10000
	<u>Differential Leucocyte Count</u> Flow Cytometry	- DC		
<b>23</b>	Neutrophils	65.6	%	40-80
E - HE	Lymphocytes	24.7	%	20-40
<b>\$</b>	Monocytes	6.8	%	2-10
E CAST	Eosinophils	2.6	%	1-6
**	Basophils	0.3	%	0-2
<b>53</b>	Absolute Neutrophil Count	4553	/cu.mm	2000-7000
E-ser	Absolute Lymphocyte Count	1714	/cu.mm	1000-3000
***	Absolute Monocyte Count	472	/cu.mm	200-1000
No. of the last of	Absolute Eosinophil Count Calculated	180	/cu.mm	20-500
NC-4007	Absolute Basophil Count Calculated	21	/cu.mm	0-100
	Neutrophil Lymphocyte Ratio (NLR) Calculated	2.7	Ratio	1.0-3.0

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DC Impedance method

Quantitative Capillary Photometry

Calculated

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0.285 % 0.20-0.50 Platelet hematocrit

Calculated

Mean Platelet Volume (MPV) fL 7-13 10.1

mm/hr **Erythrocyte Sedimentation** 0-10

Rate (ESR)

1. Reference Ranges are in accordance with Dacie & Lewis Practical Hematology International Edition (12th).

2. As per International Council for Standardization in Hematology's recommendations Differential Leucocyte counts are additionally reported in Absolute numbers in each cell per unit volume of blood.

-- End of Report --



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