MC-7078

Patient Name	**: Ms. JYOTI**	Specimen Drawn ON	: 17/Mar/2025 09:00AM
Age/Gender	: 22 YRS /F	Specimen Received ON	: 17/Mar/2025 05:04PM
UHID/MR No	: ADEL.0002073209	Report Date	: 17/Mar/2025 06:19PM
Visit ID	**: MDEL2074557**	Client Code	: DL514
Ref Doctor	: Dr.SELF	Barcode No	: C1803432
Client Name	: VERITAAS HEALTHCARE DIAGN	Ref Customer	: SELF

DEPARTMENT OF HAEMATOLOGY

BLOOD PICTURE - PERIPHERAL SMEAR EXAMINATION (P/S)

RBCs	Predominantly Microcytic hypochromic Moderate Anisopoikilocytosis
WBCs	Normal in number and morphology Differential count is within normal limits
Platelets	Adequate and normal in morphology.
	No Hemoparasites or atypical cells seen in the smears studied
Impression	Microcytic hypochromic anemia
Advice	1. Serum iron studies followed by Hb HPLC if indicated. 2. Serum Ferritin 3. Clinical correlation

This report has been validated by:

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LAB HEAD
REGD NO. 21087

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QR CODE

Patient Name	**: Ms. JYOTI**	Specimen Drawn ON	: 17/Mar/2025 09:00AM
Age/Gender	: 22 YRS /F	Specimen Received ON	: 17/Mar/2025 05:04PM
UHID/MR No	: ADEL.0002073209	Report Date	: 17/Mar/2025 06:46PM
Visit ID	**: MDEL2074557**	Client Code	: DL514
Ref Doctor	: Dr.SELF	Barcode No	: C1803432
Client Name	: VERITAAS HEALTHCARE DIAGNOSTIC	Ref Customer	: SELF

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
Reticulocyte Count	**5.60**	%	0.5-2.5	Supravital Stain

Adult and children 0.5 - 2.5 %
Infants (Full term, cord blood) 2 - 5 %

Comments:

Increased percentage of reticulocyte in seen in neonatal period, pregnancy , ascent to high altitude, response to haemorrhage or haemolysis, shock or hypoxia, replacement of iron,Vit B12 or folic acid in a deficient case, recovery from bone marrow failure or suppression, bone marrow infilteration and idiopathic myelofibrosis.

Decreased percentage of reticulocytes is seen in suppression of erythropoisis eg. by infection or inflammation, pure red cell aplasia, aplastic anaemia and ineffective erythropoisis.

This report has been validated by:

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MC-7078

Patient Name	**: Ms. JYOTI**	Specimen Drawn ON	: 17/Mar/2025 09:00AM
Age/Gender	: 22 YRS /F	Specimen Received ON	: 17/Mar/2025 05:23PM
UHID/MR No	: ADEL.0002073209	Report Date	: 17/Mar/2025 06:10PM
Visit ID	**: MDEL2074557**	Client Code	: DL514
Ref Doctor	: Dr.SELF	Barcode No	: C1803433
Client Name	: VERITAAS HEALTHCARE DIAGNOSTIC	Ref Customer	: SELF

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
IRON DEFICIENCY PROFILE				
Iron, Serum	**23**	ug/dL	59-158	Colorimetric
UIBC-SERUM	326.00	ug/dL	110-370	Direct Determination with Ferrozinc
Total Iron Binding Capacity-(TIBC)	349	ug/dL	250-400	Spectro-photometry
Transferrin Saturation	**6.59**	%	16-50	Calculated
Ferritin	**3.8**	ng/mL	30-400	Chemiluminescence Immunoassay (CLIA)

Total iron-binding capacity

The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood.

Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose

Transferrin Saturation

1g of transferrin can carry 1.43g of iron. Normally, iron saturation of transferrin (transferrin saturation) is between 10% and 50%. Because of its short half-life, transferrin values decrease more quickly in protein malnutrition states and should be taken into consideration while evaluating iron-deficiency states.

Ferritin

Serum ferritin has been found to be more specific and sensitive than serum iron for differentiating iron-deficiency anemia from anemia of chronic disease. For diagnostic purposes, the Ferritin findings should always be assessed in conjunction with the patients medical history, clinical examination and other findings.

This report has been validated by:

Pawan Kumar

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Patient Name	**: Ms. JYOTI**	Specimen Drawn ON	: 17/Mar/2025 09:00AM
Age/Gender	: 22 YRS /F	Specimen Received ON	: 17/Mar/2025 04:55PM
UHID/MR No	: ADEL.0002073209	Report Date	: 17/Mar/2025 07:00PM
Visit ID	**: MDEL2074557**	Client Code	: DL514
Ref Doctor	: Dr.SELF	Barcode No	: C1803433
Client Name	: VERITAAS HEALTHCARE DIAGNOSTIC	Ref Customer	: SELF

DEPARTMENT OF SEROLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
Tissue Transglutaminase Antibody IgA	6.34	U/mL	Negative < 1.0-18~Positive > 18	Enzyme linked immunosorbent assay (ELISA)

Interpretation

Tissue Transglutaminase (tTG) test was performed by a solid phase enzyme immunoassay for the quantitative and qualitative detection of antibodies against neo-epitopes of tissue transglutaminase (tTG) in human serum.

Clinical Significance

Gluten-sensitive enteropathy or celiac disease is characterized by atrophy of the small intestinal villi leading to a so-called flat mucosa. It is caused by a pathological intolerance to gliadin, the alcohol-soluble fraction of gluten in wheat, rye and barley. As celiac disease is caused by the uptake of gluten, consequently a gluten-free diet cures the disease completely and thus has to be maintained for life-time.

Diagnosis of celiac disease is made by small intestinal biopsy (demonstrating flat mucosa) supported by serological markers. Antibodies against gliadin and anti-endomysial antibodies (EMA) are of major significance.

The diagnostic specificity of tissue transglutaminase (tTG) antibodies for Celiac disease is 95 -100%. The diagnostic sensitivity of tissue transglutaminase (tTG) antibodies for Celiac is 98 - 100%.

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

This report has been validated by:

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