

Visit ID : MSTD14542
UHID/MR No : ASTD.0000014541
Patient Name : Mrs.USHA SHARMA
Age/Gender : 75 Y O M O D /F
Ref Doctor : Dr.SELF
Client Name : CLINIC HEALTH. COM
Client Add : SHOP NO.28/834 DDA FLATS KALAL

Registration : 09/Jul/2022 11:33AM
Collected : 09/Jul/2022 02:56PM
Received : 09/Jul/2022 03:13PM
Reported : 09/Jul/2022 04:37PM
Status : Final Report
Client Code : 2690
Barcode No : A2831529

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
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LIVER FUNCTION TEST

Sample Type : SERUM

TOTAL BILIRUBIN	0.4	mg/dl	0.1-1.2	Diazotized, Sulfanilic
CONJUGATED (D. Bilirubin)	0.13	mg/dl	0.00-0.30	Jendrassik & Groff
UNCONJUGATED (I.D. Bilirubin)	0.27	mg/dl	0.1-1.0	Calculated
TOTAL PROTEINS	7.7	gm/dl	6.40-8.30	Biuret
ALBUMIN	4.3	gm/dl	3.5-5.0	BCG
GLOBULIN	3.4	gm/dl	2.0-4.1	Calculated
A/G RATIO	1.26		1.0-2.0	Calculated
SGOT	21	U/L	8.0-35.0	Enzymatic,IFFC
SGPT	29	U/L	10.0-35.0	Enzymatic,IFFC
GGT	19	U/L	8.0-55.0	Colorimetric Method
ALKALINE PHOSPHATASE	93	U/I	30-120	



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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
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TOTAL CALCIUM

Sample Type : SERUM

SERUM TOTAL CALCIUM	8.6	mg/dl	8.3-10.3	Arsenazo III
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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.



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LIPID PROFILE

Sample Type : SERUM

TOTAL CHOLESTEROL	193	mg/dl	Desirable : 80-200~Borderline: 200 – 239~High : >=240	Cholesterol oxidase/peroxidase
H D L CHOLESTEROL	37.8	mg/dl	40-60	Phosphotungstate/Mg-Cholesterol oxidase/peroxidase
L D L CHOLESTEROL	119.2	mg/dl	70-106~Above Optimal : 100-129~Borderline High : 130-159~High : 160-189~Very High : >=190	Absorption Spectrometry [Peroxidase]
TRIGLYCERIDES	180	mg/dl	40-149~BorderLine : 150-199~High : 200-499~Very High : >=500	Glycerol phosphate oxidase/peroxidase
VLDL	36.00	mg/dl	15-30	Calculated
NON HDL CHOLESTEROL	155.2	mg/dl	Desirable: <130~BorderLine : 150-199~High : 200-499~Very High : >=500	Calculated
T. CHOLESTEROL/ HDL RATIO	5.11			Calculated
LDL / HDL RATIO	3.15			Calculated



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Patient Name : Mrs.USHA SHARMA	Received : 09/Jul/2022 03:13PM
Age/Gender : 75 Y O M O D /F	Reported : 09/Jul/2022 06:03PM
Ref Doctor : Dr.SELF	Status : Final Report
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DEPARTMENT OF BIOCHEMISTRY

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PLASMA GLUCOSE - FASTING
Sample Type : FLOURIDE PLASMA

Plasma Glucose Fasting	95	mg/dl	60-110	Glucose Oxidase/Peroxidase
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INTERPRETATION:
Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapaneatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

KIDNEY FUNCTION TEST 4
Sample Type : Serum

SERUM UREA	50.95	mg/dL	15-39	Urease GLDH
SERUM CREATININE	1.39	mg/dl	0.60–1.30	Jaffes
ALKALINE PHOSPHATASE	93	U/I	30-120	
SERUM URIC ACID	11	mg/dL	3.1-7.8	URICASE
SERUM SODIUM	137.3	mmol/L	136.0-149.0	ISE
SERUM POTASSIUM	3.64	mmol/L	3.5-5.0	ISE
SERUM CHLORIDE	104.6	mmol/L	98.0-109.0	ISE



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IRON PROFILE -I
Sample Type : Serum

SERUM IRON	38.00	ugm/dl	60-170	Ferrozine
TOTAL IRON BINDING CAPACITY	292	ugm/dl	250-425	Calculations
UIBC	254.00	ugm/dL	130 - 336	Ferrozine
TRANSFERRIN SATURATION	13.01	%	16-50	

INTERPRETATION:
SERUM IRON 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
- Acute iron toxicity

SERUM IRON DECREASED IN:

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

TIBC/UIBC INCREASED IN:

- Iron deficiency anemia
- Acute & Chronic blood loss
- Acute liver damage
- Progesterone birth control pills

TIBC/UIBC DECREASED IN:

- Hemochromatosis
- Cirrhosis of the liver
- Thalassemia
- Anemia of infective & chronic disease
- Nephrosis

TRANSFERRIN SATURATION INCREASED IN:

- High Values in iron overload
- Raised transferrin saturation is an early indicator of Iron accumulation in hemochromatosis.

TRANSFERRIN SATURATION DECREASED IN:

- Low Values in iron deficiency



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Age/Gender : 75 Y O M O D /F	Reported : 09/Jul/2022 05:36PM
Ref Doctor : Dr.SELF	Status : Final Report
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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
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HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	6.4	%	Normal Glucose tolerance (non-diabetic): <5.6%-Pre-diabetic: 5.7-6.4%-Diabetic Mellitus: >6.5%	HPLC
ESTIMATED AVG. GLUCOSE	136.98	mg/dl		
INCREASED IN 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 HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
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COMPLETE HAEMOGRAM

Sample Type : WHOLE BLOOD EDTA

HAEMOGLOBIN (HB)	12.0	gm/dl	12.00-15.00	Non-Cyanmethemoglobin
PCV/HAEMATOCRIT	38.3	%	40-50	Calculated
MCV	88.5	fL	80-100	Automated/Calculated
MCH	27.7	pg	27-32	Automated/Calculated
MCHC	31.3	g/dl	32-36	Automated/Calculated
RBC COUNT (RED BLOOD CELL COUNT)	4.33	million/cmm	3.8 - 5.8	Impedance
PLATELET COUNT	2.60	lac/mm ³	1.50 - 4.50	Impedance
TOTAL LEUCOCYTE COUNT (TLC)	10,330	cell/cmm	4000-10000	Flow cytometry

DLC (by Flow cytometry/Microscopy)

NEUTROPHIL	68.0	%	40-75	
LYMPHOCYTE	22.0	%	20-40	
EOSINOPHIL	02	%	01-07	
MONOCYTE	08	%	2-10	
BASOPHIL	00	%	00-02	
RDW-CV	16.9	%	11.5-14.5	Automated/Calculated
RDW-SD	43	fL	39-46	Calculated
PDW	23.2	fL	8.30-25.00	Calculated
MPV	10.9	fL	8.60-15.50	Calculated
PCT	0.279	%	0.15-0.62	
ABSOLUTE NEUTROPHIL COUNT	7.07	x10 ³ Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	2.11	x10 ³ Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.87	x10 ³ Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	0.26	x10 ³ Cells/uL	0.2-0.5	Automated Calculated
ABSOLUTE BASOPHIL COUNT	0.00	x10 ³ Cells/uL	0.02-0.2	Automated Calculated

PERIPHERAL SMEAR

RBC series: Predominantly Normocytic Normochromic red cells are seen. No schistocytes present. No target cells are seen. No Immature RBC precursors are seen.

WBC series: Total leucocyte count within normal range. Differential cell count within normal reference range. No toxic granules seen. No blast seen.

Platelet series: Platelets are adequate in numbers and are normal in morphology.

Hemoparasite: Not seen.

Impression: Normocytic Normochromic blood picture.

ERYTHROCYTE SEDIMENTATION RATE	15	mm/1st hr	1-32	Westergren
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Age/Gender : 75 Y O M O D /F	Reported : 09/Jul/2022 03:44PM
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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref. Range	Method
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25 HYDROXY VITAMIN D

Sample Type : SERUM

VITAMIN D	10.89	ng/ml	30-100	CLIA
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INTERPRETATION:

LEVEL	REFERENCE RANGE
Deficiency (serious deficient)	< 10 ng/ml
Insufficiency (Deficient)	10-30 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.

INCREASED LEVELS:

- Vitamin D intoxication.

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 Dihydroxy vitamin D (5-8 hrs).
- The assay measures D3 (Cholecalciferol) 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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VITAMIN B12
Sample Type : SERUM

VITAMIN B12	312	pg/mL	187-883 pg/mL	CLIA
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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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THYROID PROFILE (T3,T4,ULTRASENSITIVE TSH)

Sample Type : SERUM

T3	1.15	ng/mL	0.60-1.81	CLIA
T4	9.7	ug/dl	4.5-10.9	CLIA
Ultrasensitive TSH	1.726	uIU/mL	0.55-4.78	CLIA

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. Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol and propylthiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
6. 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. Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance.
8. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.

9. REFERENCE RANGE:

PREGNANCY	Ultrasensitive TSH in uIU/mL
1st Trimester	0.100 – 2.500
2nd Trimester	0.200 – 3.000
3rd Trimester	0.300 – 3.000

Age	Ultrasensitive TSH in uIU/mL
0 – 4 Days	1.00 – 39.00
2 Weeks to 5 Months	1.70 – 9.10
6 Months to 20 Yrs.	0.70 – 6.40
>55 Yrs.	0.50 – 8.90

(Reference 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.

*** End Of Report ***

Kanika

Dr. KANIKA YADAV
MBBS ; DCP; MD Pathology
Consultant Pathologist

Aastha

Dr. Aastha Narula
MBBS; MD (Pathology)
Consultant Pathologist

Kanika

Dr. KANIKA YADAV
MBBS ; DCP; MD Pathology
Consultant Pathologist



Result Report

PatientID:

Record Date: 2022-07-09 16:10:20

Barcode: A2831529

SampleNo: 07090102

CALIB : $Y = 1.1404X + 0.7497$

NAME	%	TIME	AREA
A1A	0.7	0.24	11.04
A1B	0.7	0.31	10.38
F	0.8	0.40	13.11
LA1C+	2.2	0.48	35.35
SA1C	6.4	0.59	79.75
A0	91.4	0.88	1454.41
TOTAL AREA			1604.04

