tenet DIAGNOSTICS
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MC-2977

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Name	: **MRS.J KYATHYAINI**	TID/SID	: UMR3110365/ 29832619
Age / Gender	: 50 Years / Female	Registered on	: 30-Jun-2025 / 09:19 AM
Ref.By	: CHAITANYA DIAGNOSTICS	Collected on	: 30-Jun-2025 / 09:19 AM
Req.No	: BIL5940834	Reported on	: 30-Jun-2025 / 14:11 PM
	TEST REPORT	Reference	: Aditya Clinical Lab

DEPARTMENT OF CLINICAL CHEMISTRY II

25-Hydroxy Vitamin D

Investigation	Observed Value	Biological Reference Interval
25 Hydroxy Vitamin D Method:ECLIA	**21.3**	Deficiency: < 20 ng/mL Insufficiency: 20 - 30 ng/mL Sufficiency: 30 - 100 ng/mL Toxicity: >100 ng/mL **Note:** Biological Reference Ranges are changed due to change in method of testing.
Note	Kindly correlate clinically	

Interpretation:
1.Vitamin D is a family of compounds that is essential for the proper growth and formation of teeth and bones. This test measures the level of vitamin D in the blood.
2.Two forms of vitamin D can be measured in the blood, 25-hydroxyvitamin D and 1,25-dihydroxyvitamin D. The 25-hydroxyvitamin D is the major form found in the blood and is the relatively inactive precursor to the active hormone, 1,25-dihydroxyvitamin D. Because of its long half-life and higher concentration, 25-hydroxyvitamin D is commonly measured to assess and monitor vitamin D status in individuals.
3. The main role of vitamin D is to help regulate blood levels of calcium, phosphorus, and (to a lesser extent) magnesium.
4 Vitamin D is vital for the growth and health of bone; without it, bones will be soft, malformed, and unable to repair themselves normally, resulting in diseases called rickets in children and osteomalacia in adults.
5. Vitamin D has also been shown to influence the growth and differentiation of many other tissues and to help regulate the immune system. These other functions have implicated vitamin D in other disorders, such as autoimmunity and cancer.

* Sample processed at National Reference Laboratory,Tenet Diagnostics, Plot No.51, Kineta Towers, Journalist Colony,Road No.3, Banjarahills, Hyderabad

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Dr Afreen Anwar
Consultant Biochemist

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DEPARTMENT OF CLINICAL CHEMISTRY II

Thyroid Profile (T3,T4,TSH)

Investigation	Observed Value	Biological Reference Interval
Triiodothyronine Total (T3) Method:ECLIA	1.2	0.80-2.00 ng/mL Pregnancy: 1st Trimester: 0.81 - 1.90 ng/mL 2nd & 3rd Trimester: 1.00 - 2.60 ng/mL
Thyroxine Total (T4) Method:ECLIA	9.0	5.1-14.1 µg/dL
Thyroid Stimulating Hormone (TSH) Method:ECLIA	4.18	0.27-4.20 µIU/mL Pregnancy: 1st Trimester: 0.1 - 2.5 µIU/mL 2nd Trimester: 0.2 - 3.0 µIU/mL 3rd Trimester: 0.3 - 3.0 µIU/mL

Interpretation:

A thyroid profile is used to evaluate thyroid function and/or help diagnose hypothyroidism and hyperthyroidism due to various thyroid disorders. T4 and T3 are hormones produced by the thyroid gland. They help control the rate at which the body uses energy, and are regulated by a feedback system. TSH from the pituitary gland stimulates the production and release of T4 (primarily) and T3 by the thyroid. Most of the T4 and T3 circulate in the blood bound to protein. A small percentage is free (not bound) and is the biologically active form of the hormones.

Reference: Tietz textbook of Clinial Chemistry and Molecular Diagnostics, Nader Rifia, Andrea Ritas Horvath, Carl T. Wittwer.

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DEPARTMENT OF CLINICAL PATHOLOGY

Complete Urine Examination (CUE)

Investigation	Result	Biological Reference Intervals
Physical Examination		
Colour Method:Physical	Yellow	Straw to Yellow
Appearance Method:Physical	Clear	Clear
Chemical Examination		
Reaction and pH Method:Indicator	Alkaline (7.5)	4.6-8.0
Specific gravity Method:Refractometry	1.003	1.000-1.035
Protein Method:Protein Error of pH indicators	Negative	Negative
Glucose Method:Glucose oxidase/Peroxidase	Negative	Negative
Blood Method:Peroxidase	Negative	Negative
Ketones Method:Sodium Nitroprusside Method	Negative	Negative
Bilirubin Method:Diazonium salt	Negative	Negative
Leucocytes Method:Esterase reaction	Negative	Negative
Nitrites Method:Modified Griess reaction	Negative	Negative
Urobilinogen Method:Diazonium salt	Negative	Up to 1.0 mg/dl (Negative)
Microscopic Examination		
Pus cells (leukocytes) Method:Flow Digital Imaging/Microscopy	1-2	2 - 3 /hpf
Epithelial cells Method:Flow Digital Imaging/Microscopy	1-2	2 - 5 /hpf
RBC (erythrocytes) Method:Flow Digital Imaging/Microscopy	Absent	Absent
Casts Method:Flow Digital Imaging/Microscopy	Absent	Occasional hyaline casts may be seen

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Crystals Method:Flow Digital Imaging/Microscopy	Absent	Phosphate, oxalate, or urate crystals may be seen
Others Method:Flow Digital Imaging/Microscopy	Nil	Nil

Method: Semi Quantitative test ,For CUE

Reference: Godkar Clinical Diagnosis and Management by Laboratory Methods, First South Asia edition. Product kit literature.

Interpretation:

The complete urinalysis provides a number of measurements which look for abnormalities in the urine. Abnormal results from this test can be indicative of a number of conditions including kidney disease, urinary tract infecation or elevated levels of substances which the body is trying to remove through the urine . A urinalysis test can help identify potential health problems even when a person is asymptomatic. All the abnormal results are to be correlated clinically.

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Dr Shaikh Ayeesha
Consultant Hematopathologist
Reg.No - TSMC/FMR/00158

Name	: **MRS.J KYATHYAINI**	TID/SID	: UMR3110365/ 29832618
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Ref.By	: CHAITANYA DIAGNOSTICS	Collected on	: 30-Jun-2025 / 09:19 AM
Req.No	: BIL5940834	Reported on	: 30-Jun-2025 / 12:42 PM
		Reference	: Aditya Clinical Lab

TEST REPORT

DEPARTMENT OF HEMATOPATHOLOGY

Erythrocyte Sedimentation Rate (ESR)

Investigation	Observed Value	Biological Reference Intervals
ESR 1st Hour Method:Westergren/Vesmatic	**20**	<=12 mm/hour

Hemogram

Investigation	Observed Value	Biological Reference Interval
Hemoglobin Method:Spectrophotometry	13.3	12.0-15.0 g/dL
PCV/HCT Method:Calculated	39.2	36.0-46.0 vol%
Total RBC Count Method:Electrical Impedance	4.44	3.80-4.80 mill /cu.mm
MCV Method:Calculated	88.3	83.0-101.0 fL
MCH Method:Calculated	30.0	27.0-32.0 pg
MCHC Method:Calculated	33.9	31.5-34.5 g/dL
RDW (CV) Method:Calculated	13.3	11.6-14.0 %
MPV Method:Calculated	9.2	7.0-10.0 fL
Total WBC Count Method:Electrical Impedance	6990	4000-10000 cells/cumm
Platelet Count Method:Electrical Impedance	3.69	1.50-4.10 lakhs/cumm
Differential Count		
Neutrophils	52.2	40.0-80.0 %
Lymphocytes	37.1	20.0-40.0 %
Eosinophils	3.7	1.0-6.0 %
Monocytes	6.6	2.0-10.0 %
Basophils Method:Flow Cytometer - Microscopy	0.4	0.0-2.0 %
Absolute Neutrophil Count	3649	2000-7000 cells/cumm
Absolute Lymphocyte Count Method:Calculated	2593	1000-3000 cells/cumm

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Absolute Eosinophil Count	259	20-500 cells/cumm
Absolute Monocyte Count	461	200-1000 cells/cumm
Absolute Basophil Count Method:Calculated	28	20-100 cells/cumm
Neutrophil - Lymphocyte Ratio(NLR) Method:Calculated	1.41	0.78-3.53

Peripheral Blood Smear Examination

RBC	Normocytic normochromic
WBC	Normal in Morphology & Distribution
Platelets Method:Microscopy	Adequate

Method: Automated Hematology Cell Counter, Microscopy

Reference: Dacie and Lewis Practical Hematology,12th Edition
Wallach's interpretation of diagnostic tests, Soth Asian Edition.

Interpretation: A Complete Blood Picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

Note: These results are generated by a fully automated hematology analyzer and the differential count is computed from a total of several thousands of cells. Therefore the differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Blood Urea Nitrogen (BUN)

Investigation	Observed Value	Biological Reference Interval
Blood Urea Nitrogen. Method:Calculated	19.6	6-20 mg/dL
Urea. Method:Urease	41.9	12.8-42.8 mg/dL

Interpretation: Urea is a waste product formed in the liver when protein is metabolized. Urea is released by the liver into the blood and is carried to the kidneys, where it is filtered out of the blood and released into the urine. Since this is a continuous process, there is usually a small but stable amount of urea nitrogen in the blood. However, when the kidneys cannot filter wastes out of the blood due to disease or damage, then the level of urea in the blood will rise. The blood urea nitrogen (BUN) evaluates kidney function in a wide range of circumstances, to diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status as well.

Reference: Tietz Fundamentals of Clinical Chemistry and Molecular Diagnostics

Calcium, Serum

Investigation	Observed Value	Biological Reference Interval
Calcium Method:BAPTA	**12.9**	8.6-10.0 mg/dL
Note	Kindly correlate clinically	

Interpretation: Calcium is essential for bones, heart, nerves, kidneys, and teeth. Serum calcium levels are vital to detect hypocalcemia, hypercalcemia and associated disorders. Parathormone (PTH) and vitamin D are responsible for maintaining calcium concentrations in the blood within a narrow range of values. Serum calcium levels are diagnostic in cases of Kidney stones, Bone diseases and Neurologic disorders.

Creatinine, Serum

Investigation	Observed Value	Biological Reference Interval
Creatinine. Method:Alkaline Picrate	**1.18**	0.50-0.90 mg/dL
Note	Kindly correlate clinically	

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Interpretation:

Creatinine is a nitrogenous waste product produced by muscles from creatine. Creatinine is majorly filtered from the blood by the kidneys and released into the urine, so serum creatinine levels are usually a good indicator of kidney function. Serum creatinine is more specific and more sensitive indicator of renal function as compared to BUN because it is produced from muscle at a constant rate and its level in blood is not affected by protein catabolism or other exogenous products. It is also not reabsorbed and very little is secreted by tubules making it a reliable marker. Serum creatinine levels are increased in pre renal, renal and post renal azotemia, active acromegaly and gigantism. Decreased serum creatinine levels are seen in pregnancy and increasing age.

Glycosylated Hemoglobin (HbA1C)

Investigation	Observed Value	Biological Reference Interval
Glycosylated Hemoglobin (HbA1c) Method:High-Performance Liquid Chromatography	5.4	Non-diabetic: <= 5.6 % Pre-diabetic: 5.7 - 6.4 % Diabetic: >= 6.5 %
Estimated Average Glucose (eAG) Method:Calculated	108	mg/dL

Interpretation:

It is an index of long-term blood glucose concentrations and a measure of the risk for developing microvascular complications in patients with diabetes. Absolute risks of retinopathy and nephropathy are directly proportional to the mean HbA1c concentration. In persons without diabetes, HbA1c is directly related to risk of cardiovascular disease.

1) Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.

2) Interference of Hemoglobinopathies in HbA1c estimatiion:
A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
C. Heterozygous state detected (D10 is corrected for HbS and HbC trait).
3) In known diabetic patients, HbA1c can be considered as a tool for monitoring the glycemic control.
Excellent Control - 6 to 7 %,
Fair to Good Control - 7 to 8 %,
Unsatisfactory Control - 8 to 10 %
and Poor Control - More than 10 %.
Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022.

Vitamin B12 (Cyanocobalamin)

Investigation	Observed Value	Biological Reference Interval
Vitamin B12 (Cyanocobalamin) ,Serum Method:ECLIA	270	197-771 pg/mL **Note:** Biological Reference Ranges are changed due to change in method of testing.

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Interpretation:
1.Vitamin B12 is essential in DNA synthesis,haematopoiesis and CNS integrity.
2.Measurement of vitamin B12 is intended to identify and monitor vitamin B12 deficiency. This can arise from the following; (1) defect in the secretion of Intrinsic Factor, resulting in inadequate absorption from food (pernicious anemia); (2) gastrectomy and malabsorption due to surgical resection; and (3) a variety of bacterial or inflammatory diseases affecting the small intestine.(4) Decreased dietary intake.
3.Reduced concentrations of vitamin B12 may indicate the presence of vitamin dependent anemia.
4.Elevated concentrations of vitamin B12 have been associated with pregnancy, the use of oral contraceptives and multivitamins and in myeloproliferative diseases, such as chronic granulocytic leukemia and myelomonocytic leukemia. An elevated concentration of vitamin B12 is not known to cause clinical problems.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Electrolytes, Serum

Investigation	Observed Value	Biological Reference Interval
Sodium Method:ISE Indirect	138	136-145 mmol/L
Potassium Method:ISE Indirect	4.9	3.5-5.1 mmol/L
Chloride Method:ISE Indirect	**108**	98-107 mmol/L
Note	Kindly correlate clinically	

Interpretation: Electrolyte profile is the determination of body fluid concentrations of the four major electrolytes (sodium, potassium, chloride and bicarbonate). Serum electrolytes have a role in water homeostasis, acid –base balance, muscle function, etc. Abnormal electrolyte concentrations may be the cause or consequence of several medical disorders and require clinical correlation.

Disclaimer:
Test results released pertain to the specimen submitted. All test result are dependent on the quality of the sample received by the laboratory. Test result may show interlaboratory variations.Laboratory investigation are only a tool to faciliate in arriving at a diagnosis and should be clinically correlated by the Referring Physician.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Ferritin

Investigation	Observed Value	Biological Reference Interval
Ferritin Method:ECLIA	113.0	13-150 ng/mL **Note:** Biological Reference Ranges are changed due to change in method of testing.

Interpretation: Serum ferritin has been found to be more sensitive than serum iron for differentiating iron-deficiency anemia from anemia of chronic disease. For diagnostic purposes, the Ferritin values should always be assessed in conjuction with the patient's medical history, clinical examination and other laboratory findings.

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TEST REPORT

DEPARTMENT OF CLINICAL CHEMISTRY I

Iron with TIBC

Investigation	Observed Value	Biological Reference Interval
Iron Method:Ferrozine-no deproteinization	98	33-193 µg/dL
Total Iron Binding Capacity (TIBC) Method:Calculated	300	168-585 µg/dL

Interpretation: Iron is a nutrient essential for several functions in the body including production of RBC's and proteins .Serum Iron concentrations are decreased in Iron deficiency Anemia and chronic inflammatory disorders. Elevated serum iron levels occur in iron-loading disorders, aplastic anemia, iron poisoning, etc.
TIBC measures the blood's capacity to bind iron with transferrin. It measures the maximum amount of Iron blood can carry. TIBC is increased in iron deficiency anemia and pregnancy .TIBC is decreased in anemia of chronic inflammation.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Lipid Profile

Investigation	Observed Value	Biological Reference Interval
Total Cholesterol Method:Cholesterol Oxidase	231	Desirable: <200 mg/dL Borderline: 200-239 mg/dL High: >/=240 mg/dL
HDL Cholesterol Method:Direct Measurement	52	Low: <40 mg/dL High: >/=60 mg/dL
VLDL Cholesterol Method:Calculated	**50.00**	6.0-38.0 mg/dL
LDL Cholesterol Method:Calculated	129	Optimum: <100 mg/dL Near/above optimum: 100-129 mg/dL Borderline: 130-159 mg/dL High: 160-189 mg/dL Very high: >/=190 mg/dL
Triglycerides Method:Glycerol LPL/GK	**250**	Normal:<150 mg/dL Borderline: 150-199 mg/dL High: 200-499 mg/dL Very high: >/=500 mg/dL
Chol/HDL Ratio Method:Calculated	**4.44**	Low Risk: 3.3-4.4 Average Risk: 4.5-7.1 Moderate Risk: 7.2-11.0
LDL Cholesterol/HDL Ratio Method:Calculated	2.48	Desirable: 0.5-3.0 Borderline Risk: 3.0-6.0 High Risk: >6.0
Non HDL Cholesterol Method:Calculated	**179**	<130 mg/dL

Interpretation: Lipids are fats and fat-like substances which are important constituents of cells and are rich sources of energy. A lipid profile typically includes total cholesterol, high density lipoproteins (HDL), low density lipoprotein (LDL), chylomicrons, triglycerides, very low density lipoproteins (VLDL), Cholesterol/HDL ratio .The lipid profile is used to assess the risk of developing a heart disease and to monitor its treatment. The results of the lipid profile are evaluated along with other known risk factors associated with heart disease to plan and monitor treatment. Treatment options require clinical correlation.

Reference: Third Report of the National Cholesterol Education program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), JAMA 2001.

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Liver Function Test (LFT)

Investigation	Observed Value	Biological Reference Interval
Total Bilirubin. Method:Diazo Method	0.43	<1.2 mg/dL
Direct Bilirubin. Method:Diazo Method	0.17	<0.30 mg/dL
Indirect Bilirubin. Method:Calculated	0.26	<0.9 mg/dL
Alanine Aminotransferase ,(ALT/SGPT) Method:UV wtihout P5P	**37**	<34 U/L
Aspartate Aminotransferase,(AST/SGOT) Method:UV wtihout P5P	26	<31 U/L
ALP (Alkaline Phosphatase). Method:PNPP-AMP Buffer	**176**	35-104 U/L
Gamma GT. Method:GCNA	**70**	6-42 U/L
Total Protein. Method:Biuret	8.0	6.6-8.7 g/dL
Albumin. Method:Bromocresol Green (BCG)	4.5	3.5-5.2 g/dL
Globulin. Method:Calculated	3.50	1.8-3.8 g/dL
A/GRatio. Method:Calculated	1.29	0.8-2.0
AST/ALT Ratio Method:Calculated	0.70	<1.00
Note	Kindly correlate clinically	

Interpretation: Liver functions tests help to identify liver disease, its severity, and its type. Generally these tests are performed in combination, are abnormal in liver disease, and the pattern of abnormality is indicative of the nature of liver disease. An isolated abnormality of a single liver function test usually means a non-hepatic cause. If several liver function tests are simultaneously abnormal, then hepatic etiology is likely.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Phosphorus, Serum

Investigation	Observed Value	Biological Reference Interval
Phosphorus Method:Phosphomolybdate	2.9	2.5-4.5 mg/dL

Intepretation: Phosphorus is a vital component of bones & teeth, several lipoproteins and nucleoproteins. Phosphorus levels are important to diagnose and monitor treatment of various conditions that cause calcium and phosphorus imbalances. Phosphorus levels in urine samples are vital to monitor its elimination by the kidneys.

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	TEST REPORT	Reference	: Aditya Clinical Lab

DEPARTMENT OF CLINICAL CHEMISTRY I

Transferrin Saturation

Investigation	Observed Value	Biological Reference Interval
Transferrin Saturation Index Method:Calculated	32.7	15-50 %

Interpretation: Transferrin saturation is measured as a percentage. It is the value of serum iron divided by TIBC of the available transferrin, this value interprets how much serum iron is bound. Transferrin saturation is low in conditions like iron deficiency anemia, chronic illness, etc. It is high in hemochromatosis, hemosiderosis, hemolytic anemia, sideroblastic anemia and iron poisoning.

Reference: Tietz fundamentals of Clinical biochemistry

* Sample processed at National Reference Laboratory,Tenet Diagnostics, Plot No.51, Kineta Towers, Journalist Colony,Road No.3, Banjarahills, Hyderabad

--- End Of Report ---

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