



Name	: MRS.KAMESHWARI AVVARU	TID/SID	: UMR2599459/ 29169370
Age / Gender	: 38 Years / Female	Registered on	: 08-Mar-2025 / 08:56 AM
Ref.By	: -	Collected on	: 08-Mar-2025 / 09:34 AM
Req.No	: BIL5397039	Reported on	: 08-Mar-2025 / 18:03 PM
		Reference	: Arcofemi Health Care Ltd -

**TEST REPORT**

**DEPARTMENT OF CLINICAL PATHOLOGY**

**Complete Urine Examination (CUE)**

Investigation	Result	Biological Reference Intervals
<b>Physical Examination</b>		
Colour Method:Physical	Pale yellow	Straw to Yellow
Appearance Method:Physical	Slightly Cloudy	Clear
<b>Chemical Examination</b>		
Reaction and pH Method:Indicator	Acidic (5.5)	4.6-8.0
Specific gravity Method:Refractometry	1.008	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	<b>Positive (Trace)</b>	Negative
Nitrites Method:Modified Griess reaction	Negative	Negative
Urobilinogen Method:Diazonium salt	Negative	Up to 1.0 mg/dl (Negative)
<b>Microscopic Examination</b>		
Pus cells (leukocytes) Method:Flow Digital Imaging/Microscopy	<b>4-5</b>	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	Absent	Phosphate, oxalate, or urate crystals may be seen
Method:Flow Digital Imaging/Microscopy		
Others	Nil	Nil
Method:Flow Digital Imaging/Microscopy		

**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 infection 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.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics,Hyderabad

--- End Of Report ---



**Dr Vikas Reddy**  
Consultant Pathologist





Name	: MRS.KAMESHWARI AVVARU	TID/SID	: UMR2599459/ 29171063
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		Reference	: Arcofemi Health Care Ltd -

TEST REPORT

DEPARTMENT OF CYTOPATHOLOGY

Pap Smear, Conventional

Cytology No	<b>C-2934/25</b>
Clinical Details	For screening.
Specimen Type	Conventional smear (Pap smear)
Specimen Adequacy	Satisfactory for evaluation without evidence of endocervical/transformation zone component
Microscopic Observations:	Smear contains superficial, intermediate and parabasal cells. Mild inflammation noted.
Organisms	Not present
Interpretation	<b>Negative for intraepithelial lesion or malignancy.</b>
Note	Kindly correlate clinically

**Method** : Pap staining & microscopy

Reported as per the 2014 Bethesda System

\* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Shruiti Reddy**  
Consultant Pathologist  
Reg No.TSMC/FMR/22656





Name	: MRS.KAMESHWARI AVVARU	TID/SID	: UMR2599459/ 29169367
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Req.No	: BIL5397039	Reported on	: 08-Mar-2025 / 15:27 PM
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**TEST REPORT**

**DEPARTMENT OF HEMATOPATHOLOGY**

**Blood Grouping ABO And Rh Typing**

Parameter	Results
Blood Grouping (ABO)	O
Rh Typing (D)	Positive
Method:Hemagglutination Tube Method by Forward & Reverse Grouping	

**Method:** Hemagglutination Tube Method by Forward & Reverse Grouping

**Reference:** Tulip kit literature

**Interpretation:** The ABO grouping and Rh typing test determines blood type grouping (A,B, AB, O ) and the Rh factor (positive or negative). A person's blood type is based on the presence or absence of certain antigens on the surface of their red blood cells and certain antibodies in the plasma. ABO antigens are poorly expressed at birth, increase gradually in strength and become fully expressed around 1 year of age. In case of Rh(D) - Du(weak positive) or Weak D positive, the individual must be considered as Rh positive as donor and Rh negative as recipient.

**Note:** Records of previous blood grouping/Rh typing not available. Please verify before transfusion.

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**Dr Vikas Reddy**  
Consultant Pathologist





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**TEST REPORT**

**DEPARTMENT OF HEMATOPATHOLOGY**

**Erythrocyte Sedimentation Rate (ESR)**

Investigation	Observed Value	Biological Reference Intervals
ESR 1st Hour	<b>15</b>	<=12 mm/hour
Method:Westergren/Vesmatic		

**Complete Blood Count (CBC)**

Investigation	Observed Value	Biological Reference Intervals
Hemoglobin	13.7	12.0-15.0 g/dL
Method:Spectrophotometry		
PCV/HCT	40.1	36.0-46.0 vol%
Method:Calculated		
Total RBC Count	<b>4.95</b>	3.80-4.80 mill /cu.mm
Method:Electrical Impedance		
MCV	<b>81.0</b>	83.0-101.0 fL
Method:Calculated		
MCH	27.7	27.0-32.0 pg
Method:Calculated		
MCHC	34.2	31.5-34.5 g/dL
Method:Calculated		
RDW (CV)	<b>14.9</b>	11.6-14.0 %
Method:Calculated		
MPV	<b>6.9</b>	7.0-10.0 fL
Method:Calculated		
Total WBC Count	6250	4000-10000 cells/cumm
Method:Electrical Impedance		
Platelet Count	2.55	1.50-4.10 lakhs/cumm
Method:Electrical Impedance		
<b>Differential count</b>		
Neutrophils	58.5	40.0-80.0 %
Method:Microscopy		
Lymphocytes	30.9	20.0-40.0 %
Method:Microscopy		
Eosinophils	3.3	1.0-6.0 %
Monocytes	7.1	2.0-10.0 %
Basophils	<b>0.2</b>	< 1.0-2.0 %
Method:Flowcytometry/Electrical Impedance/Microscopy		



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**TEST REPORT**

Absolute Neutrophil Count	3656	2000-7000 cells/cumm
Method:Calculated		
Absolute Lymphocyte Count (ALC)	1931	1000-3000 cells/cumm
Absolute Eosinophil Count (AEC)	206	20-500 cells/cumm
Absolute Monocyte Count	444	200-1000 cells/cumm
Method:Calculated		
Absolute Basophil Count	<b>13</b>	20-100 cells/cumm
Method:Calculated		
Neutrophil - Lymphocyte Ratio(NLR)	1.89	0.78-3.53
Method:Calculated		

**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.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics,Hyderabad

--- End Of Report ---



**Dr Vikas Reddy**  
Consultant Pathologist



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**TEST REPORT**

**DEPARTMENT OF CLINICAL CHEMISTRY I**

**Blood Urea Nitrogen (BUN)**

Investigation	Observed Value	Biological Reference Interval
Blood Urea Nitrogen. Method:Calculated	7.9	6-20 mg/dL
Urea. Method:Urease	16.9	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

**Creatinine, Serum**

Investigation	Observed Value	Biological Reference Interval
Creatinine. Method:Alkaline Picrate	0.64	0.50-0.90 mg/dL

**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.

**Glucose Fasting (FBS)**

Investigation	Observed Value	Biological Reference Interval
Glucose Fasting Method:Hexokinase	88	Normal: <100 mg/dL Impaired FG: 100-125 mg/dL Diabetes mellitus: >=126 mg/dL

**Interpretation:** It measures the Glucose levels in the blood with a prior fasting of 9-12 hours. The test helps screen a symptomatic/ asymptomatic person who is at risk for Diabetes. It is also used for regular monitoring of glucose levels in people with Diabetes.

**Reference:** American Diabetes Association. Standards of Medical Care in Diabetes-2022



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**TEST REPORT**

**Glycosylated Hemoglobin (HbA1C)**

Investigation	Observed Value	Biological Reference Interval
Glycosylated Hemoglobin (HbA1c) Method:High-Performance Liquid Chromatography	5.1	Non-diabetic: <= 5.6 % Pre-diabetic: 5.7 - 6.4 % Diabetic: >= 6.5 %
Estimated Average Glucose (eAG) Method:Calculated	100	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 estimation:

- 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.

**Bun/Creatinine Ratio**

Investigation	Observed Value	
BUN/Creatinine Ratio Method:Calculated	10.9	10-20







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**TEST REPORT**

**Interpretation:**

The BUN/Creatinine ratio blood test is used to diagnose acute or chronic renal disease. BUN (blood urea nitrogen) and creatinine are both filtered in the kidneys and excreted in urine. The two together are used to measure overall kidney function

1. Increased ratio (>20) with normal creatinine occurs in the following conditions:

- a) Increased BUN (prerenal azotemia), heart failure, salt depletion, dehydration
- b) Catabolic states with tissue breakdown
- c) GI hemorrhage
- d) Impaired renal function plus excess protein intake, production, or tissue breakdown

2. Increased ratio (>20) with elevated creatinine occurs in the following conditions:

- a) Obstruction of urinary tract
- b) Prerenal azotemia with renal disease

3. Decreased ratio (<10) with decreased BUN occurs in the following conditions:

- a) Acute tubular necrosis
- b) Decreased urea synthesis as in severe liver disease or starvation
- c) Repeated dialysis
- d) SIADH
- e) Pregnancy

4. Decreased ratio (<10) with increased creatinine occurs in the following conditions:

- a) Phenacemide therapy (accelerates conversion of creatine to creatinine)
- b) Rhabdomyolysis (releases muscle creatinine)
- c) Muscular patients who develop renal failure

\* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr. Abdur Rehman Asif**  
Consultant Biochemist  
Reg.No - APMC/FMR/78102





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**TEST REPORT**

**DEPARTMENT OF CLINICAL CHEMISTRY I**

**Lipid Profile**

Investigation	Observed Value	Biological Reference Interval
Total Cholesterol Method:Cholesterol Oxidase	150	Desirable: <200 mg/dL Borderline: 200-239 mg/dL High: >=240 mg/dL
HDL Cholesterol Method:Direct Measurement	38	Low: <40 mg/dL High: >=60 mg/dL
VLDL Cholesterol Method:Calculated	14.80	6.0-38.0 mg/dL
<b>LDL Cholesterol</b> Method:Calculated	97.2	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	74	Normal:<150 mg/dL Borderline: 150-199 mg/dL High: 200-499 mg/dL Very high: >=500 mg/dL
Chol/HDL Ratio Method:Calculated	3.95	Low Risk: 3.3-4.4 Average Risk: 4.5-7.1 Moderate Risk: 7.2-11.0
LDL Cholesterol/HDL Ratio Method:Calculated	2.56	Desirable: 0.5-3.0 Borderline Risk: 3.0-6.0 High Risk: >6.0
<b>Non HDL Cholesterol</b> Method:Calculated	112	<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.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics,Hyderabad

--- End Of Report ---



**Dr.Abdur Rehman Asif**  
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**TEST REPORT**

**DEPARTMENT OF CLINICAL CHEMISTRY I**

**Liver Function Test (LFT)**

Investigation	Observed Value	Biological Reference Interval
Total Bilirubin. Method:Diazo Method	0.33	<1.2 mg/dL
Direct Bilirubin. Method:Diazo Method	0.16	<0.30 mg/dL
Indirect Bilirubin. Method:Calculated	0.17	<0.9 mg/dL
<b>Alanine Aminotransferase ,(ALT/SGPT)</b> Method:UV wihout P5P	16	<34 U/L
<b>Aspartate Aminotransferase,(AST/SGOT)</b> Method:UV wihout P5P	22	<31 U/L
ALP (Alkaline Phosphatase). Method:PNPP-AMP Buffer	98	35-104 U/L
Gamma GT. Method:GCNA	13	6-42 U/L
Total Protein. Method:Biuret & Bromocresol Green (BCG)	6.8	6.6-8.7 g/dL
Albumin. Method:Bromocresol Green (BCG)	4.3	3.5-5.2 g/dL
Globulin. Method:Calculated	2.50	1.8-3.8 g/dL
A/GRatio. Method:Calculated	1.72	0.8-2.0
AST/ALT Ratio Method:Calculated	<b>1.38</b>	<1.00

**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.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics,Hyderabad

--- End Of Report ---



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Consultant Biochemist  
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**TEST REPORT**

**DEPARTMENT OF CLINICAL CHEMISTRY I**

**Thyroid Profile (T3,T4,TSH)**

Investigation	Observed Value	Biological Reference Interval
Triiodothyronine Total (T3) Method:ECLIA	1.04	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	5.5	5.1-14.1 µg/dL
<b>Thyroid Stimulating Hormone (TSH)</b> Method:ECLIA	2.9	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 Clinical Chemistry and Molecular Diagnostics, Nader Rifa, Andrea Ritas Horvath, Carl T. Wittwer.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

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**DEPARTMENT OF CLINICAL CHEMISTRY I**

**Uric Acid, Serum**

Investigation	Observed Value	Biological Reference Interval
Uric Acid. Method:Uricase	3.8	2.4-5.7 mg/dL

**Interpretation**

It is the major product of purine catabolism. Hyperuricemia can result due to increased formation or decreased excretion of uric acid which can be due to several causes like metabolic disorders, psoriasis, tissue hypoxia, pre-eclampsia, alcohol, lead poisoning, acute or chronic kidney disease, etc. Hypouricemia may be seen in severe hepato cellular disease and defective renal tubular reabsorption of uric acid.

\* Sample processed at National Reference Laboratory, Tenet Diagnostics,Hyderabad

--- End Of Report ---

**Dr.Abdur Rehman Asif**  
Consultant Biochemist  
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DEPARTMENT OF ULTRASOUND  
**Ultrasound Whole Abdomen**

**LIVER** is normal shape, size (12.8 cms) and has increased echopattern.No evidence of focal lesion. No intrahepatic biliary ductal dilatation. Hepatic and portal vein radicals are normal.

**GALL BLADDER** shows normal shape and has clear contents.  
Gall bladder wall is of normal thickness. CBD is of normal calibre.

**PANCREAS** has normal shape, size and uniform echopattern.  
No evidence of ductal dilatation or calcification.

**SPLEEN** shows normal shape, size (10.1 cms) and echopattern.

**KIDNEYS** move well with respiration and have normal shape, size and echopattern. Cortico- medullary differentiations are well madeout. No evidence of calculus or hydronephrosis.  
Right kidney measures - 7.7 x 4.2 cms, Left kidney measures - 10.1 x 4.7 cms.

**URINARY BLADDER** shows normal shape and wall thickness.  
It has clear contents. No evidence of diverticula.

**UTERUS** is anteverted has normal shape and size. It has uniform myometrial echopattern.  
Endometrial echo is of normal thickness 6.8 mm. Uterus measures 7.7 x 3.3 x 4.8 cms.

**OVARIES** show multiple peripherally arranged follicles and central stromal echogenicity.  
Right ovary: 3.1 x 2.1 x 3.0 cms (Volume 10.6 cc),  
Left ovary: 2.8 x 1.6 x 3.2 cms (Volume 7.9 cc).

No evidence of free fluid in the abdomen and pelvis.

**IMPRESSION:**

\* **Grade I fatty liver.**

\* **Both ovaries show polycystic morphology.**

Suggested clinical correlation and follow up

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



**Dr Sheethal V**  
Consultant Radiologist



MC-1001

PLEASE SCAN QR CODE

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DEPARTMENT OF X-RAY  
**X-Ray Chest PA View**

Lung fields appear normal.

Cardiac size is within normal limits.

Aorta and pulmonary vasculature is normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

**IMPRESSION:**

**\* Normal study.**

Suggested clinical correlation and follow up.

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



**Dr G Priyanka**  
Consultant Radiologist