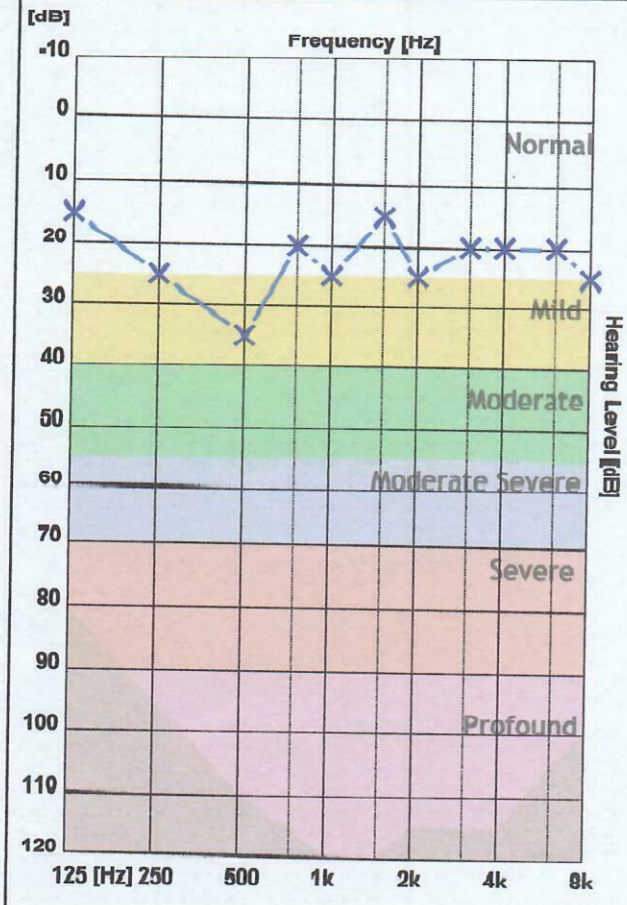
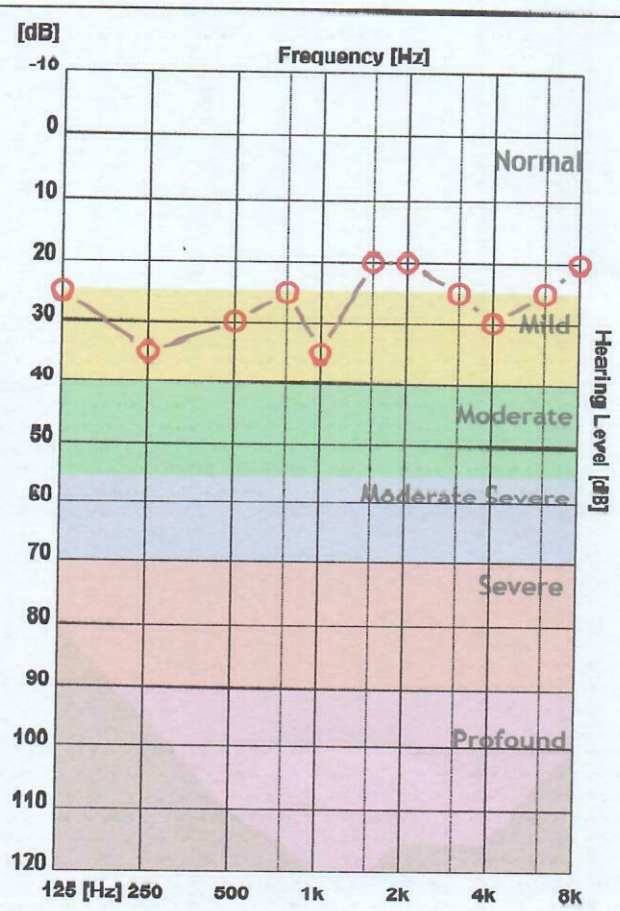
SPECTRUM DIAGNOSTICS

Bangalore

Patient ID : 0757
Name : MR KEDARNATH BEHURA
CR Number : 20241112114520
Registration Date : 12-Nov-2024

Age : 50
Gender : Male
Operator : spectrum diagnostics





	125 Hz	250 Hz	500 Hz	750 Hz	1000 H	1500 H	2000 H	3000 H	4000 H	6000 H	8000 H
X - Air Left	15	25	35	20	25	15	25	20	20	20	25
O - Air Right	25	35	30	25	35	20	20	25	30	25	20
> - Bone Left											
< - Bone Right											

	Average	High	Mid	Low
AIR Left	22.27 dB	21.25 dB	21.67 dB	23.75 dB
AIR Right	26.36 dB	25.00 dB	25.00 dB	28.75 dB

Clinical Notes :

Not Found

SPECTRUM DIAGNOSTICS AND HEARING CARE BENGALURU

SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-5722

Name	: MR. KEDARNATH BEHURA			**Bill Date**	: 12-Nov-2024 08:59 AM
Age / Gender	: 50 years / Male	**UHID**	: 1211240016	**Sample Col. Date**	: 12-Nov-2024 08:59 AM
Ref. By Dr.	: C/O APOLO CLINIC	1211240016		**Result Date**	: 12-Nov-2024 03:19 PM
Reg. No.	: 1211240016			**Report Status**	: Final
C/o	: APOLLO CLINIC				

Test Name	Result	Unit	Reference Value	Method

CHEST PA VIEW

- Visualised lungs are clear.
- Bilateral hila appears normal.
- Cardia is normal in size.
- No pleural effusion.

IMPRESSION: No significant abnormality.

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Printed On : 12 Nov, 2024 08:10 pm

DR PRAVEEN B.MBBS,DMRD,DNB Consultant
Radiologist

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SCAN FOR LOCATION

SPECTRUM
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Ref. By Dr.	: C/O APOLO CLINIC			Result Date	: 12-Nov-2024 11:29 AM
Reg. No.	: 1211240016	1211240016		Report Status	: Final
C/o	: APOLLO CLINIC				

Test Name	Result	Unit	Reference Value	Method

2D ECHO

2D ECHO CARDIOGRAHIC STUDY M-MODE

Cardiograhic Study	Size	
Aorta	33	mm
Left Atrium	40	mm
Right Ventricle	28	mm
Left ventricle (Diastole)	47	mm
Left ventricle(Systole)	29	mm
Ventricular Septum (Diastole)	10	mm
Ventricular septum (Systole)	11	mm
Posterior Wall (Diastole)	10	mm
Posterior Wall (Systole)	14	mm
Fractional Shortening	30	%
Ejection fraction	60	%

DOPPLER /COLOUR FLOW

Mitral Valve Velocity	MVE- 0.74m/s	MVA – 0.90m/s	E/A-0.92
Tissue Doppler	e' (Septal) 11cm/s	E/e'(Septal) -6	
Velocity/ Gradient across the Pulmonic valve		0.95m/s	3mmHg
Max. Velocity / Gradient across the Aortic valve		1.19m/s	4mmHg
Velocity / Gradient across the Tricuspid valve		2.70m/s	29mmHg

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2DECHO Cardiographic Study

- **SITUS SOLITUS, LEVOCARDIA**
- **SYSTEMIC VEINS**: Normal drainage. IVC-1.4>50% collapse with inspiration.
- **PULMONARY VEINS:** Normal drainage.
- **RIGHT ATRIUM:** Normal size, LEFT ATRIUM; Normal size.
- **RIGHT VENTRICLE:** Normal size & Adequate function.
- **LEFT VENTRICLE:** Normal size; No RWMA; LV Systolic function adequate.
- **IAS:** INTACT; **IVS:** INTACT.
- **MITRAL VALVE :** No stenosis; **Mild** regurgitation
- **TRICUSPID VALVE:** No stenosis; **Mild** regurgitation
- **AORTIC VALVE :** No stenosis; No regurgitation
- **PULMONIC VALVE:** No stenosis; No regurgitation
- **GREAT ARTERIES:** Normally related.
- **AORTA:** Left aortic arch. No aortic dissection
- **PULMONARY ARTERY :** Confluent branch pulmonary arteries
- **NO PDA.**
- **No pericardial effusion.**

IMPRESSION:

- **ADEQUATE LEFT VENTRICLE SYSTOLIC FUNCTION**
- **LEFT VENTRICLE DIASTOLIC DYSFUNCTION-GRADE I**
- **NO REGIONAL WALL MOTION ABNORMALITY**
- **ADEQUATE RIGHT VENTRICLE SYSTOLIC FUNCTION**
- **NO PAH**

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Printed On : 12 Nov, 2024 11:29 am

Ms.Durga V., ECHO Technician

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SCAN FOR LOCATION

SPECTRUM
DIAGNOSTICS & HEALTH CARE

NAME AND LAB NO	MR KEDARNATH BEHURA	REG-0016
AGE & SEX	50YRS	MALE
DATE AND AREA OF INTEREST	12.11.2024	
REF BY	C/O APOLO CLINIC	

USG ABDOMEN AND PELVIS

LIVER: **Normal in size with increased echogenicity**
No e/o IHBR dilatation. No evidence of focal lesion.
Portal vein appears normal. CBD appears normal.

GALL BLADDER: Partially distended .No obvious calculus in the visualised luminal portion.

SPLEEN: Normal in size and echotexture. No e/o focal lesion.

PANCREAS: Head and body appears normal . Tail obscured by bowel gas shadows .

RETROPERITONEUM: Suboptimal visualised due to bowel gas

RIGHT KIDNEY: Right kidney is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid lesions.

LEFT KIDNEY: Left kidney is normal in size & echotexture.
No evidence of calculus/ hydronephrosis.
No solid lesions.

URINARY BLADDER: Well distended. No wall thickening/ calculi.
Prevoid 400 cc , Post void 30 cc

PROSTATE: **Enlarged in size volume 28.7 cc**

- ***No evidence of ascites.***

IMPRESSION:

- ***Grade I fatty liver .***
- ***Grade I prostatomegaly with no significant post void residual urine.***
  - ***Suggested clinical / lab correlation***

DR PRAVEEN B , DMRD , DNB
CONSULTANT RADIOLOGIST

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Test Name	Result	Unit	Reference Value	Method
Complete Haemogram-Whole Blood EDTA				
Haemoglobin (HB)	16.80	g/dL	Male: 14.0 - 17.0	Spectrophotmeter
Red Blood Cell (RBC)	5.47	million/cumm	3.50 - 5.50	Volumetric Impedance
Packed Cell Volume (PCV)	49.00	%	Male: 42.0 - 51.0	Electronic Pulse
Mean corpuscular volume (MCV)	89.60	fL	78.0- 94.0	Calculated
Mean corpuscular hemoglobin (MCH)	30.70	pg	27.50-32.20	Calculated
Mean corpuscular hemoglobin concentration (MCHC)	34.20	%	33.00-35.50	Calculated
Red Blood Cell Distribution Width SD (RDW-SD)	43.40	fL	40.0-55.0	Volumetric Impedance
Red Blood Cell Distribution CV (RDW-CV)	15.40	%	Male: 11.80 - 14.50	Volumetric Impedance
Mean Platelet Volume (MPV)	10.90	fL	8.0-15.0	Volumetric Impedance
Platelet	2.78	lakh/cumm	1.50-4.50	Volumetric Impedance
Platelet Distribution Width (PDW)	12.50	%	8.30 - 56.60	Volumetric Impedance
White Blood cell Count (WBC)	7820.00	cells/cumm	Male: 4000.0 - 11000.0	Volumetric Impedance
Neutrophils	55.20	%	40.0-75.0	Light scattering/Manual
Lymphocytes	33.50	%	20.0-45.0	Light scattering/Manual
Eosinophils	6.50	%	0.0-8.0	Light scattering/Manual
Monocytes	4.50	%	0.0-10.0	Light scattering/Manual
Basophils	0.30	%	0.0-1.0	Light scattering/Manual
Absolute Neutrophil Count	4.31	10^3/uL	2.0- 7.0	Calculated

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Test Name	Result	Unit	Reference Value	Method
Absolute Lymphocyte Count	2.62	10^3/uL	1.0-3.0	Calculated
Absolute Monocyte Count	0.35	10^3/uL	0.20-1.00	Calculated
Absolute Eosinophil Count	**510.00**	cells/cumm	40-440	Calculated
Absolute Basophil Count	0.03	10^3/uL	0.0-0.10	Calculated
Erythrocyte Sedimentation Rate (ESR)	02	mm/hr	Male: 0.0 - 10.0	Westergren

Peripheral Smear Examination-Whole Blood EDTA

Method: (Microscopy-Manual)

RBC'S : Normocytic Normochromic.
WBC'S : Are normal in total number, morphology and distribution.
Platelets : Adequate in number and normal in morphology.
No abnormal cells or hemoparasites are present.
Impression : Normocytic Normochromic Blood picture.

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SCAN FOR LOCATION
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Test Name	Result	Unit	Reference Value	Method
Lipid Profile-Serum				
Cholesterol Total-Serum	168.00	mg/dL	0.0-200	Cholesterol Oxidase/Peroxidase
Triglycerides-Serum	89.00	mg/dL	0.0-150	Lipase/Glycerol Dehydrogenase
High-density lipoprotein (HDL) Cholesterol-Serum	38.00	mg/dL	40.0-60.0	Accelerator/Selective Detergent
Non-HDL cholesterol-Serum	130	mg/dL	0.0.-130	Calculated
Low-density lipoprotein (LDL) Cholesterol-Serum	112	mg/dL	0.0-100.0	Cholesterol esterase and cholesterol oxidase
Very-low-density lipoprotein (VLDL) cholesterol-Serum	18	mg/dL	0.0-40	Calculated
Cholesterol/HDL Ratio-Serum	4.42	Ratio	0.0-5.0	Calculated

Interpretation:

Parameter	Desirable	Borderline High	High	Very High
Total Cholesterol	<200	200-239	>240	
Triglycerides	<150	150-199	200-499	>500
Non-HDL cholesterol	<130	160-189	190-219	>220
Low-density lipoprotein (LDL) Cholesterol	<100	100-129	160-189	>190

Comments: As per Lipid Association of India (LAI), for routine screening, overnight fasting preferred but not mandatory. Indians are at very high risk of developing Atherosclerotic Cardiovascular (ASCVD). Among the various risk factors for ASCVD such as dyslipidemia, Diabetes Mellitus, sedentary lifestyle, Hypertension, smoking etc., dyslipidemia has the highest population attributable risk for MI both because of direct association with disease pathogenesis and very high prevalence in Indian population. Hence monitoring lipid profile regularly for effective management of dyslipidemia remains one of the most important healthcare targets for prevention of ASCVD. In addition, estimation of ASCVD risk is an essential, initial step in the management of individuals requiring primary prevention of ASCVD. In the context of lipid management, such a risk estimate forms the basis for several key therapeutic decisions, such as the need for and aggressiveness of statin therapy.

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Dr. Nithun Reddy C,MD,Consultant Pathologist

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SPECTRUM
DIAGNOSTICS & HEALTH CARE

ME-5722

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C/o	: APOLLO CLINIC				

Test Name	Result	Unit	Reference Value	Method
LFT-Liver Function Test -Serum				
Bilirubin Total-Serum	1.04	mg/dL	0.2-1.0	Caffeine Benzoate Diazotised Sulphanilic Acid
Bilirubin Direct-Serum	0.21	mg/dL	0.0-0.2	Direct Measure
Bilirubin Indirect-Serum	0.83	mg/dL	0.0-1.10	UV with Pyridoxal - 5 - Phosphate
Aspartate Aminotransferase (AST/SGOT)-Serum	19.00	U/L	15.0-37.0	UV with Pyridoxal - 5 - Phosphate
Alanine Aminotransferase (ALT/SGPT)-Serum	26.00	U/L	Male:16.0-63.0 Female:14.0-59.0	PNPP,AMP-Buffer
Alkaline Phosphatase (ALP)-Serum	74.00	U/L	Adult: 45.0-117.0 Children: 48.0-445.0 Infants: 81.90-350.30	Biuret/Endpoint-With Blank
Protein, Total-Serum	7.35	g/dL	6.40-8.20	Bromocresol Purple
Albumin-Serum	4.60	g/dL	3.40-5.00	Calculated
Globulin-Serum	2.75	g/dL	2.0-3.50	Calculated
Albumin/Globulin Ratio-Serum	1.67	Ratio	0.80-2.0	

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Test Name	Result	Unit	Reference Value	Method
Glycosylated Haemoglobin (HbA1c)-Whole Blood EDTA				
Glycosylated Haemoglobin (HbA1c)	6.20	%	Non diabetic adults :<5.7 At risk (Prediabetes) : 5.7 - 6.4 Diagnosing Diabetes :>= 6.5 Diabetes Excellent Control : 6-7 Fair to good Control : 7-8 Unsatisfactory Control :8-10 Poor Control :>10	HPLC
Estimated Average Glucose(eAG)	131.23	mg/dL		Calculated

Note: 1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.

2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Comments: HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

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Test Name	Result	Unit	Reference Value	Method
Kidney Function Test (KFT)-BUN,CREA,Uric Acid,Na,K,Cl-Serum				
Kidney Function Test (KFT)-Serum				
Blood Urea Nitrogen (BUN)	7.50	mg/dL	7.0-18.0	GLDH,Kinetic Assay
Creatinine-Serum	0.99	mg/dL	Male: 0.70-1.30 Female: 0.55-1.02	Modified kinetic Jaffe
Uric Acid-Serum	5.87	mg/dL	Male: 3.50-7.20 Female: 2.60-6.0	
Electrolytes				
Sodium (Na+)-Serum	137.8	mmol/L	135.0-145.0	ISE-Direct
Potassium (K+)-Serum	4.76	mmol/L	3.50-5.50	ISE-Direct
Chloride (Cl-)-Serum	101.00	mmol/L	96.0-108.0	ISE-Direct

Comments: Renal Function Test (RFT), also called kidney function tests, are a group of tests performed to evaluate the functions of the kidneys. The kidneys play a vital role in removing waste, toxins, and extra water from the body. They are responsible for maintaining a healthy balance of water, salts, and minerals such as calcium, sodium, potassium, and phosphorus. They are also essential for blood pressure control, maintenance of the body's pH balance, making red blood cell production hormones, and promoting bone health. Hence, keeping your kidneys healthy is essential for maintaining overall health. It helps diagnose inflammation, infection or damage in the kidneys. The test measures Uric Acid, Creatinine, BUN and electrolytes in the blood to determine the health of the kidneys. Risk factors for kidney dysfunction such as hypertension, diabetes, cardiovascular disease, obesity, elevated cholesterol or a family history of kidney disease. It may also be when has signs and symptoms of kidney disease, though in early stage often no noticeable symptoms are observed. Kidney panel is useful for general health screening; screening patients at risk of developing kidney disease; management of patients with known kidney disease. Estimated GFR is especially important in CKD patients CKD for monitoring, it helps to identify disease at early stage in those with risk factors for CKD (diabetes, hypertension, cardiovascular disease, and family history of kidney disease). Early recognition and intervention are important in slowing the progression of CKD and preventing its complications.

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Test Name	Result	Unit	Reference Value	Method
Fasting Urine Glucose-Urine	Negative		Negative	Dipstick/Benedicts (Manual)
Fasting Blood Sugar (FBS)-Plasma	111	mg/dL	60.0-110.0	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-5722

Name	: MR. KEDARNATH BEHURA			**Bill Date**	: 12-Nov-2024 08:59 AM
Age / Gender	: 50 years / Male	**UHID**	: 1211240016	**Sample Col. Date**	: 12-Nov-2024 08:59 AM
Ref. By Dr.	: C/O APOLO CLINIC	1211240016		**Result Date**	: 12-Nov-2024 11:42 AM
Reg. No.	: 1211240016			**Report Status**	: Final
C/o	: APOLLO CLINIC				

Test Name	Result	Unit	Reference Value	Method
Calcium,Total- Serum	9.70	mg/dL	8.50-10.10	Spectrophotometry (O-Cresolphthalein complexone)
Gamma-Glutamyl Transferase (GGT)-Serum	25.00	U/L	Male: 15.0-85.0 Female: 5.0-55.0	Other g-Glut-3-carboxy-4 nitro

Comments: Gamma-glutamyltransferase (GGT) is primarily present in kidney, liver, and pancreatic cells. Small amounts are present in other tissues. Even though renal tissue has the highest level of GGT, the enzyme present in the serum appears to originate primarily from the hepatobiliary system, and GGT activity is elevated in any and all forms of liver disease. It is highest in cases of intra- or posthepatic biliary obstruction, reaching levels some 5 to 30 times normal. GGT is more sensitive than alkaline phosphatase (ALP), leucine aminopeptidase, aspartate transaminase, and alanine aminotransferase in detecting obstructive jaundice, cholangitis, and cholecystitis; its rise occurs earlier than with these other enzymes and persists longer. Only modest elevations (2-5 times normal) occur in infectious hepatitis, and in this condition, GGT determinations are less useful diagnostically than are measurements of the transaminases. High elevations of GGT are also observed in patients with either primary or secondary (metastatic) neoplasms. Elevated levels of GGT are noted not only in the sera of patients with alcoholic cirrhosis but also in the majority of sera from persons who are heavy drinkers. Studies have emphasized the value of serum GGT levels in detecting alcohol-induced liver disease. Elevated serum values are also seen in patients receiving drugs such as phenytoin and phenobarbital, and this is thought to reflect induction of new enzyme activity.

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Printed On : 12 Nov, 2024 08:10 pm

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Test Name	Result	Unit	Reference Value	Method
Urine Routine Examination-Urine				
Physical Examination				
Colour	Pale Yellow		Pale Yellow	Visual
Appearance	Clear		Clear	Visual
Reaction (pH)	5.5		5.0-7.5	Dipstick
Specific Gravity	1.000		1.000-1.030	Dipstick
Biochemical Examination				
Albumin	Negative		Negative	Dipstick/Precipitation
Glucose	Negative		Negative	Dipstick/Benedicts
Bilirubin	Negative		Negative	Dipstick/Fouchets
Ketone Bodies	Negative		Negative	Dipstick/Rotheras
Urobilinogen	Normal		Normal	Dipstick/Ehrlichs
Nitrite	Negative		Negative	Dipstick
Microscopic Examination				
Pus Cells	1-2	hpf	0.0-5.0	Microscopy
Epithelial Cells	1-2	hpf	0.0-10.0	Microscopy
RBCs	Absent	hpf	Absent	Microscopy
Casts	Absent		Absent	Microscopy
Crystals	Absent		Absent	Microscopy
Others	Absent		Absent	Microscopy

Comments: The kidneys help infiltration of the blood by eliminating waste out of the body through urine.They also regulate water in the body by conserving electrolytes, proteins, and other compounds. But due to some conditions and abnormalities in kidney function, the urine may encompass some abnormal constituents, which are not normally present.A complete urine examination helps in detecting such abnormal constituents in urine. Several disorders can be detected byidentifying and measuring the levels of such substances. Blood cells, bilirubin, bacteria, pus cells, epithelial cells may be present in urine due to kidney disease or infection. Routine urine examination helps to diagnose kidney diseases, urinary tract infections, diabetes and other metabolic disorders.

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Reg. No.	: 1211240016	1211240016		**Report Status**	: Final
C/o	: APOLLO CLINIC				

Test Name	Result	Unit	Reference Value	Method
Prostate-Specific Antigen(PSA)-Serum	0.50	ng/mL	0.0-4.0	CLIA

Note: 1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding.
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with
clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, periurethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized /sedentary patients either due to supine position or suspended sexual activity.
Recommended Testing Intervals: Pre-operatively (Baseline), 2-4 days post-operatively,Prior to discharge from hospital,Monthly followup if levels are high or show a rising trend.

Clinical Use: -An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
-Followup and management of Prostate cancer patients
-Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer.
Increased Levels : Prostate cancer,Benign Prostatic Hyperplasia,Prostatitis,Genitourinary infections.

Thyroid function tests (TFT)-Serum				
Tri-Iodo Thyronine (T3)-Serum	1.38	ng/mL	0.60-1.81	Chemiluminescence Immunoassay (CLIA)
Thyroxine (T4)-Serum	11.0	µg/dL	5.50-12.10	Chemiluminescence Immunoassay (CLIA)
Thyroid Stimulating Hormone (TSH)-Serum	1.69	µIU/mL	0.35-5.50	Chemiluminescence Immunoassay (CLIA)

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Test Name	Result	Unit	Reference Value	Method

Comments: Triiodothyronine (T3) assay is a useful test for hyperthyroidism in patients with low TSH and normal T4 levels. It is also used for the diagnosis of T3 toxicosis. It is not a reliable marker for Hypothyroidism. This test is not recommended for general screening of the population without a clinical suspicion of hyperthyroidism.

Reference range: Cord: (37 Weeks): 0.5-1.41, Children:1-3 Days: 1.0-7.40,1-11 Months: 1.05-2.45,1-5 Years: 1.05-2.69,6-10 Years: 0.94-2.41,11-15 Years: 0.82-2.13,Adolescents (16-20 Years): 0.80-2.10

Reference range: Adults: 20-50 Years: 0.70-2.04, 50-90 Years: 0.40-1.81,

Reference range in Pregnancy: First Trimester : 0.81-1.90,Second Trimester : 1.0-2.60

Increased Levels: Pregnancy, Graves disease, T3 thyrotoxicosis, TSH dependent Hyperthyroidism, increased Thyroid-binding globulin (TBG).

Decreased Levels: Nonthyroidal illness, hypothyroidism , nutritional deficiency, systemic illness, decreased Thyroid-binding globulin (TBG).

Comments: Total T4 levels offer a good index of thyroid function when TBG is normal and non-thyroidal illness is not present. This assay is useful for monitoring treatment with synthetic hormones (synthetic T3 will cause low total T4).It also helps to monitor treatment of Hyperthyroidism with Thiouracil or other anti-thyroid drugs.

Reference Range: Males : 4.6-10.5,Females : 5.5-11.0,> 60 Years: 5.0-10.70,Cord :7.40-13.10,Children:1-3 Days :11.80-22.60,1-2 Weeks : 9.90-16.60,1-4 Months: 7.20-14.40,1-5 Years : 7.30-15.0,5-10 Years: 6.4-13.3

1-15 Years: 5.60-11.70,Newborn Screen:1-5 Days: >7.5,6 Days : >6.5

Increased Levels: Hyperthyroidism, increased TBG, familial dysalbuminemic hyperthyroxinemia,Increased transthyretin, estrogen therapy, pregnancy.

Decreased Levels: Primary hypothyroidism, pituitary TSH deficiency, hypothalamic TRH deficiency, non thyroidal illness, decreased TBG.

Comments: TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies. It is important to confirm any TSH abnormality in a fresh specimen drawn after ~ 3 weeks before assigning a diagnosis, as the cause of an isolated TSH abnormality.

Reference range in Pregnancy: I- trimester:0.1-2.5; II -trimester:0.2-3.0; III- trimester:0.3-3.0

Reference range in Newborns: 0-4 days: 1.0-39.0; 2-20 Weeks:1.7-9.1

Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism and Thyroid hormone resistance.

Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH deficiency.

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Test Name	Result	Unit	Reference Value	Method
Blood Group & Rh Typing-Whole Blood EDTA				
Blood Group	B			Slide/Tube agglutination
Rh Type	Positive			Slide/Tube agglutination

Note: Confirm by tube or gel method.

Comments: ABO blood group system, the classification of human blood based on the inherited properties of red blood cells (erythrocytes) as determined by the presence or absence of the antigens A and B, which are carried on the surface of the red cells. Persons may thus have type A, type B, type O, or type AB blood.

Post prandial Blood Glucose (PPBS)-Plasma	198	mg/dL	70-140	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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Test Name	Result	Unit	Reference Value	Method
Post Prandial Urine Sugar	Negative		Negative	Dipstick/Benedicts(Man

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