

Collected At : (MSK)

Name : MR. MUNISH	Age : 27 Yrs.	Registered : 23-12-2022 12:21 PM
Ref/Reg No : 12740 / TPPC/MSK-	Gender : Male	Collected : 23-12-2022 09:45 AM
Ref By : Dr. MEDI WHEEL		Received : 23-12-2022 12:21 PM
Sample : Blood, Urine		Reported : 23-12-2022 06:21 PM

Investigation	Observed Values	Units	Biological Ref. Interval
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BIOCHEMISTRY

Plasma Glucose Fasting [Method: Hexokinase]	91.0	mg/dL	70 - 110
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Plasma Glucose, PP (2 Hrs after meal) [Method: Hexokinase]	122.6	mg/dL	120-170
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Serum Bilirubin (Total)	0.9	mg/dl.	0.0 - 1.2
* Serum Bilirubin (Direct)	0.3	mg/dl.	0 - 0.4
* Serum Bilirubin (Indirect)	0.6	mg/dl.	0.2-0.7

SGPT [Method: IFCC (UV without pyridoxal-5-phosphate)]	45.9	IU/L	10 - 50
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SGOT [Method: IFCC (UV without pyridoxal-5-phosphate)]	25.5	IU/L	10 - 50
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Serum Alkaline Phosphatase [Method: 4-Nitrophenyl phosphate (pNPP)]	176.8	IU/L	108 - 306
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Serum Protein	7.1	gm/dL	6.2 - 7.8
Serum Albumin	4.5	gm/dL	3.5 - 5.2
Serum Globulin	2.6	gm/dL	2.5-5.0
A.G. Ratio	1.73 : 1		

* Gamma-Glutamyl Transferase (GGT)	15.61	IU/L	Less than 55
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BIOCHEMISTRY

KIDNEY FUNCTION TEST

Blood Urea	21.3	mg/dL	20-40
Serum Creatinine	0.80	mg/dL	0.50 - 1.40
Serum Sodium (Na ⁺)	146	mmol/L	135 - 150
Serum Potassium (K ⁺)	4.3	mmol/L	3.5 - 5.3
Serum Uric Acid	5.8	mg/dL	3.4 - 7.0

[Method for Urea: UREASE with GLDH]
 [Method for Creatinine: Jaffes/Enzymatic]
 [Method for Sodium/Potassium: Ion selective electrode direct]
 [Method for Uric Acid: Enzymatic-URICASE]

Serum Urea	21.3	mg/dL	10-45
Blood Urea Nitrogen (BUN)	9.95	mg/dL	6 - 21

CLINICAL PATHOLOGY

Urine for Sugar (F)	Absent
Urine for Sugar (PP)	Absent

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CLINICAL PATHOLOGY

URINE EXAMINATION ROUTINE

[Method: Visual, Urometer-120, Microscopy]

Physical Examination

Color	Light Yellow	
Volume	35	mL

Chemical Findings

Blood	Absent	RBC/ μ l	Absent
Bilirubin	Absent		Absent
Urobilinogen	Absent		Absent
Chyle	Absent		Absent
[Method: Ether]			
Ketones	Absent		Absent
Proteins	Absent		Absent
Nitrites	Absent		Absent
Glucose	Absent		Absent
pH	5.5		Absent
Specific Gravity	1.025		5.0 - 9.0
Leucocytes	Absent	WBC/ μ L	1.010 - 1.030

Microscopic Findings

Red Blood cells	Absent	/HPF	Absent
Pus cells	Occasional	/HPF	0-3
Epithelial Cells	Absent	/HPF	Absent/Few
Casts	Absent	/HPF	Absent
Crystals	Absent	/HPF	Absent
Amorphous deposit	Absent	/HPF	Absent
Yeast cells	Absent	/HPF	Absent
Bacteria	Absent	/HPF	Absent
Others	Absent	/HPF	Absent

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HORMONE & IMMUNOLOGY ASSAY

Serum T3	1.66	ng/dl	0.846 - 2.02
Serum T4	9.78	ug/dl	5.13 - 14.06
Serum Thyroid Stimulating Hormone (T.S.H.)	2.35	uIU/ml	0.39 - 5.60

[Method: Electro Chemiluminescence Immunoassay (ECLIA)]

SUMMARY OF THE TEST

- 1) Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
- 2) primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
- 3) Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis.
- 4) Slightly elevated T3 levels may be found in pregnancy and estrogeron therapy, while depressed levels maybe encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol and propylthiouracil.
- 5) Elevated TSH levels may also be indicative of TSH secreting pituitary tumour.

Chart of normal thyroid TSH levels during first, second and third trimester of pregnancy

Stage	Normal TSH Level
First Trimester	0.1-2.5 uIU/ml
Second Trimester	0.2-3.0 uIU/ml
Third Trimester	0.3-3.5 uIU/ml

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LIPID PROFILE (F)			
Serum Cholesterol	217.3	mg/dL	<200
Serum Triglycerides	105.3	mg/dL	<150
HDL Cholesterol	45.7	mg/dL	>55
LDL Cholesterol	151	mg/dL	<130
VLDL Cholesterol	21	mg/dL	10 - 40
CHOL/HDL	4.75		
LDL/HDL	3.3		

INTERPRETATION:

National Cholesterol Education program Expert Panel (NCEP) for Cholesterol:
 Desirable : < 200 mg/dl
 Borderline High : 200-239 mg/dl
 High : =>240 mg/dl

National Cholesterol Education program Expert Panel (NCEP) for Triglycerides:
 Desirable : < 150 mg/dl
 Borderline High : 150-199 mg/dl
 High : 200-499 mg/dl
 Very High : >500 mg/dl

National Cholesterol Education program Expert Panel (NCEP) for HDL-Cholesterol:
 <40 mg/dl : Low HDL-Cholesterol [Major risk factor for CHD]
 =>60 mg/dl : High HDL-Cholesterol [Negative risk factor for CHD]

National Cholesterol Education program Expert Panel (NCEP) for LDL-Cholesterol:
 Optimal : < 100 mg/dL
 Near optimal/above optimal : 100-129 mg/dL
 Borderline High : 130-159 mg/dl
 High : 160-189 mg/dL
 Very High : 190 mg/dL

[Method for Cholesterol Total: Enzymatic (CHOD/POD)]
 [Method for Triglycerides: Enzymatic (Lipase/GK/GPO/POD)]
 [Method for HDL Cholesterol: Homogenous Enzymatic (PEG Cholesterol esterase)]
 [Method for LDL Cholesterol: Homogenous Enzymatic (PEG Cholesterol esterase)]
 [Method for VLDL Cholesterol: Friedewald equation]
 [Method for CHOL/HDL ratio: Calculated]
 [Method for LDL/HDL ratio: Calculated]

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MSK

(A Complete Diagnostic Pathology Laboratory)

DIAGNOSTICS

RAIBARELI ROAD, TELIBAGH, LUCKNOW
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Mobile : 7565000448

NAME: - MR. MUNISH KAUSHAL

DATE: -23.12.2022

REF.BY: - MEDIWHEEL

AGE: -27Y/M

USG – WHOLE ABDOMEN

Liver appears normal in size (measures~ 132mm), shape and echopattern. No focal parenchymal lesion identified. No evidence of intra/ extrahepatic biliary tree dilatation noted. Portal vein appears to be of normal size.

Gall Bladder moderately distended. No definite calculi identified. No evidence of abnormal wall thickening noted.

Spleen appears normal in size, (measures ~ 94mm) shape and echopattern No focal parenchymal identified.

Pancreas appears normal in size, shape and echopattern. No definite calcification or ductal dilatation noted.

Right kidney measures ~ 109x43mm. Left kidney measures ~109x47mm. Both kidneys appear normal in size, shape and echopattern. Corticomedullary differentiation appears maintained. No evidence of calculus or hydronephrosis on either side.

Urinary bladder appears well distended with no calculus or mass within.

Prostate appears normal in size (vol~ 10cc) & echotexture.

No evidence of ascites or pleural effusion seen. *No significant retroperitoneal lymphadenopathy noted.*

IMPRESSION:

- *USG study of the abdomen shows no definite abnormality.*
-Suggested clinical correlation.

Dr. Sarvesh Chandra Mishra

M.D., DNB Radio-diagnosis

PDCC Neuroradiology (SGPGI, LKO)

Ex- senior Resident (SGPGI, LKO)

European Diploma in radiology EDiR, DICRI

Reports are subjected to human errors and not liable for medicolegal purpose


Dr. Sweta Kumari

MBBS, DMRD

DNB Radio Diagnosis

Ex- Senior Resident Apollo Hospital Bengaluru

Ex- Resident JIPMER, Pondicherry

Reported by: Roli Vishvakarma



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HEMATOLOGY

HEMOGRAM

Haemoglobin [Method: SLS]	15.6	g/dL	13 - 17
HCT/PCV (Hematocrit/Packed Cell Volume) [Method: Derived]	48.7	ml %	36 - 46
RBC Count [Method: Electrical Impedence]	5.12	10 ⁶ /μl	4.5 - 5.5
MCV (Mean Corpuscular Volume) [Method: Calculated]	97.2	fL	83 - 101
MCH (Mean Corpuscular Haemoglobin) [Method: Calculated]	30.5	pg	27 - 32
MCHC (Mean Corpuscular Hb Concentration) [Method: Calculated]	31.4	g/dL	31.5 - 34.5
TLC (Total Leucocyte Count) [Method: Flow Cytometry/Microscopic]	7.7	10 ³ /μl	4.0 - 10.0
DLC (Differential Leucocyte Count): [Method: Flow Cytometry/Microscopic]			
Polymorphs	57	%	40.0 - 80.0
Lymphocytes	39	%	20.0 - 40.0
Eosinophils	03	%	1.0 - 6.0
Monocytes	01	%	2.0 - 10.0
Platelet Count [Method: Electrical impedance/Microscopic]	200	10 ³ /μl	150 - 400

*Erythrocyte Sedimentation Rate (E.S.R.)

[Method: Wintrobe Method]

*Observed Reading	08	mm for 1 hr	0-10
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* ABO Typing

" B "

* Rh (Anti - D)

Positive

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BIOCHEMISTRY

*Glycosylated Hemoglobin (HbA1C)			
* Glycosylated Hemoglobin (HbA1C) (Hplc method)	5.0	%	0-6
* Mean Blood Glucose (MBG)	100.7	mg/dl	

< 6 % : Non Diabetic Level
 6-7 % : Goal
 > 8 % : Action suggested

SUMMARY

If HbA1c is >8% which causes high risk of developing long term complications like retinopathy, Nephropathy, Cardiopathy and Neuropathy. In diabetes mellitus sugar (glucose) accumulates in blood stream beyond normal level. Measurement of blood / plasma glucose level (in fasting, "after meal" i.e. PP or random condition) reflect acute changes related to immediate past condition of the patient which may be affected by factor like duration of fasting or time of intake of food before fasting, dosages of anti diabetic drugs, mental conditions like stress, anxiety etc. it does not indicate the long-term aspects of diabetic control.

Glucose combines with hemoglobin (Hb) continuously and nearly irreversibly during life span of RBC (120 days), thus glycosylated Hb is proportional to mean plasma glucose level during the previous 2-3 months. HbA1C, a glycosylated Hb comprising 3% - 6% of the total Hb in healthy may double or even triple in diabetes mellitus depending on the level of hyperglycemia (high blood glucose level), thus correlating with lack of control by monitoring diabetic patients compliance with therapeutic regimen used and long term blood glucose level control. Added advantage is its ability to predict progression of diabetic complications. HbA1c value is no way concerned with the blood sugar on the day of testing and dietary preparation of fasting is unnecessary.

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