

Lab No. : SG2/22-07-2023/SR7920941
 Patient Name : RAKHI PAUL
 Age : 30 Y 10 M 28 D
 Gender : F

Lab Add. : Sevoke Road, Siliguri 734001
 Ref Dr. : Dr. MEDICAL OFFICER
 Collection Date: 22/Jul/2023 11:13AM
 Report Date : 22/Jul/2023 06:10PM



Test Name	Result	Unit	Bio Ref. Interval	Method
*GLUCOSE, FASTING , BLOOD, NAF PLASMA				
GLUCOSE,FASTING	88	mg/dl	70 - 100 mg/dL	Hexokinase Method
UREA,BLOOD , GEL SERUM				
	15.0	mg/dl	12.8-42.8 mg/dl	UREASE-COLORIMETRIC
*CHLORIDE, BLOOD , .				
CHLORIDE,BLOOD	103	mEq/L	98 - 107 mEq/L	ISE INDIRECT
*TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .				
TOTAL PROTEIN	7.47	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN	3.7	g/dl	3.4 -5.0 g/dl	BCP
GLOBULIN	3.76	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	0.99		1.0 - 2.5	Calculated
*GLUCOSE, PP , BLOOD, NAF PLASMA				
GLUCOSE,PP	133	mg/dl	75-140	Hexokinase Method
*POTASSIUM, BLOOD , GEL SERUM				
POTASSIUM,BLOOD	4.40	mEq/L	3.1-5.5 mEq/L	ISE INDIRECT
*LIPID PROFILE , GEL SERUM				
CHOLESTEROL-TOTAL	199	mg/dl	Desirable: < 200 mg/dL Borderline high: 200-239 High: > 240 mg/dL	CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE
TRIGLYCERIDES	215	mg/dl	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	ENZYMATIC, END POINT
HDL CHOLESTEROL	47	mg/dl	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	DIRECT MEASURE-PEG
LDL CHOLESTEROL DIRECT	128	mg/dl	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	DIRECT MEASURE
VLDL	24	mg/dL	< 40 mg/dl	Calculated
CHOL HDL Ratio	4.3		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated
*SODIUM, BLOOD , GEL SERUM				
SODIUM,BLOOD	138	mEq/L	136 - 145 mEq/L	ISE INDIRECT

NOTE : Elevated Triglyceride value is to be interpreted in the light of previous 72 hrs dietary intake of lipids.Repeat estimation with 72 hrs fat restricted diet followed by 12 hrs fasting, suggested for better evaluation .

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CREATININE, BLOOD	0.58	mg/dl	0.55 - 1.02 mg/dl	ALKALINE PICRATE
*CALCIUM, BLOOD				
CALCIUM,BLOOD	8.87	mg/L	8.6-10.0 mg/dl	OCPC
*PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM				
PHOSPHORUS-INORGANIC,BLOOD	4.0	mg/dl	2.5-4.5 mg/dl	UV PHOSPHOMOLYBDATE
*URIC ACID, BLOOD , GEL SERUM				
URIC ACID,BLOOD	5.92	mg/dl	2.4 - 5.7 mg/dl	URICASE



DR. SANJAY KR. AGARWALA
MD CONSULTANT BIOCHEMIST



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[PDF Attached](#)

GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD

GLYCATED HEMOGLOBIN (HBA1C)	5.5	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***
HbA1c (IFCC)	36.0	mmol/mol	HPLC

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
 Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
 Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemc targets

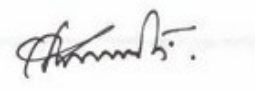
- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemc control.
- Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
- Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemc control.
- Ø If a patient changes treatment plans or does not meet his or her glycemc goals, HbA1c testing should be done quarterly.
- Ø For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.
- Ø Some patients may benefit from HbA1c goals that are stringent.

Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B₁₂/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.

Reference: Glycated hemoglobin monitoring BMJ 2006; 333:586-8

References:

1. Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.
2. Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.


Dr. SUPARBA CHAKRABARTI
 MBBS, MD(BIOCHEMISTRY)
 Consultant Biochemist

Lab No. : SR7920941 Name : RAKHI PAUL Age/G : 30 Y 10 M 28 D / F Date : 22-07-2023

***URINE ROUTINE ALL, ALL , URINE**

PHYSICAL EXAMINATION

COLOUR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION

pH	5.0	4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015	1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	ABSENT	NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	ABSENT	NOT DETECTED	Dipstick (glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	ABSENT	NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NEGATIVE	NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE	NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE	NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE	NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE	NEGATIVE	Dipstick (ester hydrolysis reaction)

MICROSCOPIC EXAMINATION

LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	6-8	/hpf	0-5	Microscopy
RED BLOOD CELLS	ABSENT	/hpf	0-2	Microscopy
CAST	ABSENT		NOT DETECTED	Microscopy
CRYSTALS	ABSENT		NOT DETECTED	Microscopy
BACTERIA	PRESENT (+)		NOT DETECTED	Microscopy
YEAST	ABSENT		NOT DETECTED	Microscopy
OTHERS	ABSENT			

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can occur due to cell lysis.
8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria and/or yeast in the urine.

***BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD**

ABO	B	Gel Card
RH	POSITIVE	Gel Card

Gel technology Dia Med ID Micro typing system is the latest technology in transfusion Medicine.

It gives more reproducible and standardized test results.

It more repaid, reliable, very sensitive and objective , and hence more consistent and comparable results are obtained. Single used cards are individualised for every patient and results can be photographed / scanned and stored for future use.

Special instruments that are used only for this technology also reduce risk of any contamination.

Ref:- WHO technical manual on transfusion medicine-Second Edition 2003

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(RESULTS ALSO VERIFIED BY : FORWARD AND REVERSE GROUPING (TUBE AND SLIDE METHOD))

TECHNOLOGY USED: GEL METHOD

ADVANTAGES :

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

Historical records check not performed.

***ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD**

1stHour	20	mm/hr	0.00 - 20.00 mm/hr	Westergren
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***CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD**


HEMOGLOBIN	13.6	g/dL	12 - 15	PHOTOMETRIC
WBC	8.4	*10 ³ /μL	4 - 10	DC detection method
RBC	4.51	*10 ⁶ /μL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE) COUNT	166	*10 ³ /μL	150 - 450*10 ³ /μL	DC detection method/Microscopy

DIFFERENTIAL COUNT

NEUTROPHILS	60	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	37	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	02	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	01	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy

CBC SUBGROUP

HEMATOCRIT / PCV	41.2	%	36 - 46 %	Calculated
MCV	91.4	fl	83 - 101 fl	Calculated
MCH	30.3	pg	27 - 32 pg	Calculated
MCHC	33.1	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	14.5	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	24.7	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	12.1		7.5 - 11.5 fl	Calculated
RBC	NORMOCYTIC			
WBC.	NORMOCHROMIC.			
PLATELET	NORMAL MORPHOLOGY.			
	ADEQUATE ON SMEAR.			


Dr. Ankush Chakraborty
MBBS, MD (Path), IFCAP
Reg. No. 65992 (WBMC)

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***THYROID PANEL (T3, T4, TSH) , GEL SERUM**

T3-TOTAL (TRI IODOTHYRONINE)	1.21	ng/ml	0.60 - 1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	5.5	microgram/dl	4.5 - 10.9 microgram/dl	CLIA
TSH (THYROID STIMULATING HORMONE)	10.33	μIU/mL	0.35-5.5μIU/mL	CLIA


BIOLOGICAL REFERENCE INTERVAL : [ONLY FOR PREGNANT MOTHERS]

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER	: 0.10 2.50 μ IU/mL
SECOND TRIMESTER	: 0.20 3.00 μ IU/mL
THIRD TRIMESTER	: 0.30 3.00 μ IU/mL

References :

1. Indian Thyroid Society guidelines for management of thyroid dysfunction during pregnancy. *Clinical Practice Guidelines*, New Delhi: Elsevier; 2012.
2. Stagnaro-Green A, Abalovich M, Alexander E, Azizi F, Mestman J, Negro R, et al. Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum. *Thyroid* 2011;21: 1081-25.
3. Dave A, Maru L, Tripathi M. Importance of Universal screening for thyroid disorders in first trimester of pregnancy. *Indian J Endocr Metab [serial online]* 2014 [cited 2014 Sep 25]; 18: 735-8. Available from: <http://www.ijem.in/text.asp?2014/18/5/735/139221>.


DR. BARNALI PAUL
MBBS, MD(PATH)

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Gender : F

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 22/Jul/2023 12:42PM



DEPARTMENT OF CARDIOLOGY

REPORT OF E.C.G.

HEART RATE : 60 /min.
RHYTHM : Regular sinus.
P-WAVE : Normal
P - R INTERVAL : 160 ms,
QRS DURATION : 80 ms
QRS CONFIGURATION : NORMAL
QRS VOLTAGE : R/S in V1 1/5 mm.
R/S in V6 10/1 mm.
QRS AXIS : +60°
Q- Waves : No significant Q-wave.
QT TIME : Normal.
ST SEGMENT : Normal.
T WAVE : NORMAL
ROTATION : Normal.
OTHER FINDINGS : Nil.
IMPRESSION : ECG WITHIN NORMAL LIMIT.


Dr. ARABINDA SAHA (MD,DM)
CONSULTANT CARDIOLOGIST

Lab No. : SG2/22-07-2023/SR7920941
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Report Date : 23/Jul/2023 12:17PM



DEPARTMENT OF RADIOLOGY
X-RAY REPORT OF CHEST (PA)

FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhouette is smoothly outlined. Shape is within normal limit.
- Lung parenchyma shows no focal lesion. No general alteration of radiographic density. Apices are clear. Bronchovascular lung markings are within normal.
- Lateral costo-phrenic angles are clear.
- Domes of diaphragm are smoothly outlined. Position is within normal limits.

IMPRESSION :

Normal study.

DR. Ziaul Mustafa
MD, Radiodiagnosis

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Lab Add. :
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Report Date : 22/Jul/2023 01:27PM



DEPARTMENT OF ULTRASONOGRAPHY

REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER

Liver is normal in size having normal shape, regular smooth outline and of homogeneous echotexture. No focal parenchymal lesion is evident. Intrahepatic biliary radicles are not dilated. Branches of portal vein are normal

PORTA

The appearance of porta is normal. Common Bile duct is normal with no intraluminal pathology (Calculi/mass) could be detected at its visualised part. Portal vein is normal at porta.

GALL BLADDER

Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected. Sonographic Murphys sign is negative.

PANCREAS

Echogenicity appears within limits, without any focal lesion. Shape, size & position appears normal. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

SPLEEN

Spleen is normal in size (98 mm). Homogenous and smooth echotexture without any focal lesion. Splenic vein at hilum appears normal. No definite collaterals could be detected.

KIDNEYS

Both kidneys are normal in shape, size (Rt. kidney 97 mm. & Lt. kidney 101 mm.) axes & position. Cortical echogenicity appears normal maintaining cortico-medullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected. Visualised part of upper ureters are not dilated.

URINARY BLADDER

Urinary bladder is distended, wall thickness appeared normal. No intraluminal pathology (calculi/mass) could be detected.

UTERUS

Uterus is anteverted, normal in size (78 mm. x 24 mm). Endometrium (collapsed wall) is in midline. Myometrium appears smooth & homogenous without any detectable/sizable focal lesion. Cervix looks normal. Pouch of Douglas is free.

OVARIES

Right ovary is normal in size, shape, position, margin and echotexture.

Left ovary is enlarged in size with similar sized non-dominant follicle arranged in periphery.

Right ovary measures 36 x 17 x 19 mm (Vol = 6 cc).

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Left Ovary measures 38 x 29 x 21 mm (Vol = 13 cc).

IMPRESSION :

Enlarged left ovary with polycystic morphology.

Please correlate clinically.

Kindly note

- Ø *Ultrasound is not the modality of choice to rule out subtle bowel lesion.*
- Ø *Please Intimate us for any typing mistakes and send the report for correction within 7 days.*
- Ø *The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.*

The report and films are not valid for medico-legal purpose.

Patient Identity not verified.

DR. Ziaul Mustafa
MD, Radiodiagnosis

Patient Data

Sample ID: D02132224982
 Patient ID: SR7920941
 Name:
 Physician:
 Sex:
 DOB:

Analysis Data

Analysis Performed: 23/JUL/2023 13:02:26
 Injection Number: 10210U
 Run Number: 253
 Rack ID: 0004
 Tube Number: 10
 Report Generated: 23/JUL/2023 13:11:55
 Operator ID: ANAMIKA

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.162	23798
A1b	---	1.3	0.228	30901
F	---	0.8	0.275	19209
LA1c	---	1.6	0.405	39426
A1c	5.5	---	0.512	115885
P3	---	3.4	0.786	82902
P4	---	1.3	0.866	32406
Ao	---	86.0	0.980	2121717

Total Area: 2,466,243

HbA1c (NGSP) = 5.5 % HbA1c (IFCC) = 36 mmol/mol

