SPECTRA DIAGNOSTIC
LABORATORY SERVICE PROVIDER

Name:	**NIKHIL JAIPRAKASH SRIVASTAVA**	Ward:	opd
Lab ID	**00000156**	Registration on:	17/03/2023 09:14:00
Age & Sex:	**40 Year | Male**	Reported on:	14:58:26
Reference:	**VELOCITY HOSPITAL**	Sample Type:	BLOOD ~ URINE

CBC ESR

Test	Observed Value		Unit	Biological Reference Interval
Haemoglobin	14.6		g/dL	13.5 - 17.5
Total RBC	4.99		mill./cm	4.50 - 5.90
Total WBC	6000		/cmm	4000 - 11000
Platelet Count	237000		/cmm	150000 - 450000
HCT	45.2		%	36.0 - 48.0
MCV	90.6		fL	80.0 - 100.0
MCH	29.3		pg	27.0 - 32.0
MCHC	32.3		g/dL	31.5 - 36.0
DIFFERENTIAL COUNT				
Neutrophils	69		%	40 - 70
Lymphocytes	27		%	20 - 40
Eosinophils	02		%	02-05
Monocytes	02		%	01-07
Basophils	00		%	00 - 02
Band Cells	00		%	0.0 - 6.0
ABSOLUTE DIFFERNTIAL COUNT				
Neutrophils	4140		/cumm	2000 - 7000
Lymphocytes	1620		/cumm	1000 - 3000
Eosinophils	120		/cumm	20 - 500
Monocytes	**120**	**L**	/cumm	200 - 1000
Basophils	0		/cumm	0 - 100
GLR / NLR (Neutrophil/Lymphocyte Ratio)	**2.6**			
M ENTZER INDEX	**18.2**			
RDW-CV	**12.9**		%	11.1 - 14.1
MPV	4.5		fl	
PCT	**0.11**		%	
PDW	17.2		%	

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PERIPHERAL SMEAR EXAMINATION

RBC Morphology	Normochromic and normocytic.		
WBC Morphology	Appear normal,Immature cells are not seen .		
Platelets in Smear	Adequate.		
Malarial Parasites	Not Detected.		
ESR			
AFTER 1 HOUR	15	mm/hr	0.0 - 15.0

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BLOOD GROUP

Test	Observed Value	Unit	Biological Reference Interval
Blood Group	"O"		
Rh Factor	POSITIVE		

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BLOOD GLUCOSE TEST

Test	Observed Value	Unit	Biological Reference Interval
Sample	FLOURIDE PLASMA		
FASTING (FBS)			
Blood Sugar-F	88.72	mg/dL	70.00-110.00

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Reference:	**VELOCITY HOSPITAL**	Sample Type:	BLOOD ~ URINE

HEMOGLOBIN A1c TEST

Test	Observed Value	Unit	Biological Reference Interval
HbA1c	5.4	%	> 8 : Action Suggested 7-8 : Good control < 7 : Goal 6.2-7 : Near Normal Glycemia < 6.2 : Non-diabetic Level
Mean Blood Glucose	108.3	mg/dL	70.0 - 140.0

Importance of HbA1c - Glycated Hb. in Diabetes Mellitus

• HbA1c, also known as Glycated Hemoglobin is the most important test for the assessment of long term blood glucose control (also called glycemic control)
• HbA1c reflects mean blood glucose concentration over past 6-8 weeks and provides amuch better indication of long term glycemic control than blood glucose determination
• HbA1c is formed by non-enzymatic reaction between glucose and Hb. , this reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
• Long term complications of diabetes such as retinopathy-eye complications, nephropathy-kidney complications and neuropathy-nerve complications, are potentially serious and can lead to blindness, kidney failure etc.
• Glycemic control monitored by HbA1c measurement using HPLC method-(Gold Standard) is considered most important. (Ref. National Glycohemoglobin Standardization Program -NGSP).

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LIPID PROFILE

Test	Observed Value	Unit	Biological Reference Interval
Sample	Fasting Blood Serum		
Cholesterol	**244.8 H**	mg/dL	<200 Desirable 200-29 Borderline >240 High
Triglyceride	109.3	mg/dL	<150 Normal 150-199 Borderline 200-499 High >=500 Very High
HDL Cholesterol	48.08	mg/dL	40-60
VLDL	21.86	mg/dL	0.00 - 30.00
LDL Cholesterol	**174.86 H**	mg/dL	< 130 : Optimal 130 - 159 : Borderline High 160 - 189 : High >= 190 : Very High
Cholesterol / HDL Chol. Ratio	**3.64 H**		0 - 3.5
Total Lipid	**5.1 L**	mg/dl	400.0 - 1000.0

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RENAL FUNCTION TEST

Test		Unit	
S. Creatinine	1.13	mg/dL	0.5-1.30
Bl. Urea	21.0	mg/dL	10.0 - 40.0
BUN	9.8	mg/dl	6.0 - 22.0
Uric Acid	3.77	mg/dL	3.5 - 7.2

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LIVER FUNCTION TEST

Test	Observed Value		Unit	Biological Reference Interval
BILIRUBIN				
Total Bilirubin	0.3		mg/dL	0.00 - 1.20
Direct Bilirubin	0.1		mg/dL	0.00 - 0.40
Indirect Bilirubin	**0.20**	**L**	mg/dL	0.30 - 1.00
SGPT(ALT)	**61.13**	**H**	U/L	0.0 - 40.0
SGOT (AST)	30.9		U/L	0.0 - 46.0
Alkaline Phosphatase	**158.6**	**H**	U/L	40-129
PROTEINS				
Total Protein	7.0		g/dL	6.0 - 8.0
Albumin	4.4		g/dL	3.50 - 5.50
Globulin	2.6		g/dL	2.0 - 4.0
A/G Ratio	1.7			

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Reference:	**VELOCITY HOSPITAL**	Sample Type:	BLOOD ~ URINE

URINE ANALYSIS

Test	Observed Value	Unit	Biological Reference Interval
Sample	Fresh Urine		
PHYSICAL EXAM INATION			
Quantity	10.0	mL	
Colour	Pale-Yellow		
Appearance	**Clear**		Clear
pH	6.0		
Specific Gravity	1.015		
Sediments	Absent		Absent
CHEM ICAL EXAM INATION			
Protein (Albumin)	Absent		Absent
Sugar	Absent		Absent
Bile Salts	Absent		Absent
Bile Pigment	Absent		Absent
Ketone	Absent		Absent
Occult Blood	**Trace**		Absent
Nitrite	Absent		Absent
Leukocyte Esterase	Absent		Absent
Urobilinogen	Normal		Normal
M ICROSCOPIC EXAM INATION			
Pus Cells	**3-4**	/hpf	Absent
Red Blood Cells	**2-3**	/hpf	Absent
Epithelial Cells	**3-4**	/hpf	Absent
Crystals	Absent		Absent
Amorphous material	Absent		Absent
Casts	Absent		Absent
Yeast	Absent		Absent
Bacteria	Few		Absent

--- End of Report ---

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Neuberg Abha
CLINICAL LABORATORIES

LABORATORY REPORT

Name	: **Mr. NIKHIL JAIPRAKASH SRIVASTAVA**	Sex/Age	: **Male** / **40 Years**	Case ID	: **30303611389**
Ref. By	:	Dis. At	:	Pt. ID	: 2620939
Bill. Loc.	: Spectra Diagnostic Laboratory Service Provider			Pt. Loc	:

Reg Date and Time	: 17-Mar-2023 10:14	Sample Type	: Serum	Mobile No.	:
Sample Date and Time	: 17-Mar-2023 10:15	Sample Coll. By	: non NACL	Ref Id1	:
Report Date and Time	: 17-Mar-2023 12:05	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Thyroid Function Test				
Triiodothyronine (T3) *CMIA*	**127.30**	ng/dL	70 - 204	
Thyroxine (T4) *CMIA*	**10.1**	µg/dL	4.6 - 10.5	
TSH *CMIA*	**1.550**	µIU/mL	0.4 - 4.94	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipent hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a supressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in Pregnacy	**Reference range (microIU/ml)**
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Interpretation Note:
Ultra sensitive-thyroid–stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone.Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.
Normal ranges of TSH & thyroid hormons vary according trimesper in pregnancy.

TSH ref range in Pregnacy	Reference range (microIU/ml)
First triemester	0.24 - 2.00
Second triemester	0.43-2.2
Third triemester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Prostate Specific Antigen *CMIA*	**1.174**	ng/mL	0.00 - 4.00	

INTERPRETATIONS:

Useful for Evaluating patients with documented prostate problems in whom multiple prostate-specific antigen tests may be necessary per year.

Monitoring patients with a history of prostate cancer as an early indicator of recurrence and response to treatment.

Prostate-specific antigen (PSA) values are reported with the 95th percentile limits by decade of age. These reference limits include men with benign prostatic hyperplasia. They exclude all cases with proven cancer.

PSA values exceeding the age-specific limits are suspicious for prostate disease, but further testing, such as prostate biopsy, is needed to diagnose prostate pathology.

Values >0.2 ng/mL are considered evidence of biochemical recurrence of cancer in men after prostatectomy

CAUTIONS:

Serum markers are not specific for malignancy, and values may vary by method.

When age is not supplied, the results cannot be flagged as high or low.

Digital rectal examination generally does not increase normal prostate-specific antigen (PSA) values. However, cystoscopy, urethral instrumentation, and prostate biopsy may increase PSA levels.

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results

- If total PSA is above cut off value (between 4 to 20 ng/ml) free PSA should be adviced to differentiate benign prostatic hyperplasia from prostatic malignancy.
- Free PSA levels above 20 to 25 % of total PSA are more likely to be associated with BPH.
- Prostate biopsy is required for the diagnosis of cancer.**Tumor marker results obtained can vary due to differences in assay methods and reagent specificity. Patient results determined by assays using different manufacturers for methods may not be comparable.**

RELATIONSHIP BETWEEN PROBABILITY OF PROSTATE MALIGNANCY & FREE PSA% TO TOTAL PSA

..... Free PSA % to total PSA	0-10%	10-15%	15-20%	20-25%	>25%.
fr Probability of malignancy	56%.	28%	20%	16%	8%

DILUTION PROTOCOL:

At our lab with kit, manual dilution protocol has been validated for PSA up to 1:20 dilution and result up to 2000 NG/ML. After above dilution, it will be done manually and because of Ag-Ab reaction curve it may be erroneous if diluted after validated dilution.

* Test results, interpretation & notes are meant for Medical Personal only.

---------- End Of Report ----------

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

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