

Garg Pathology DR. MONIKA GARG Certified by

M.D. (Path) Gold Medalist

Former Pathologist : St. Stephan's Hospital, Delhi

National Accreditation Board For Testing & Calibration Laboratories

605

Garden House Colony, Near Nai Sarak, Garh Road, Meerut Ph.: 0121-2600454, 8979608687, 9837772828

PUID C. NO: : 220320/605 **Patient Name**

: Dr. BANK OF BARODA

: Miss. SHALINI SINGH 25Y / Female

Sample By

Referred By

Organization

: 20-Mar-2022 9:40AM **Collection Time Receiving Time** ¹ 20-Mar-2022 9:43AM

Centre Name

Reporting Time : 20-Mar-2022 12:39PM : Garg Pathology Lab - TPA

Units Investigation **Biological Ref-Interval** Results

HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT			
HAEMOGLOBIN	11.4	gm/dl	12.0-15.0
(Colorimetry)			
TOTAL LEUCOCYTE COUNT	11740	*10^6/L	4000 - 11000
(Electric Impedence)			
DIFFERENTIAL LEUCOCYTE COUNT			
(Microscopy)			
Neutrophils	75	%.	40-80
Lymphocytes	20	%.	20-40
Eosinophils	03	%.	1-6
Monocytes	02	%.	2-10
Basophils	00	%.	<1-2
Band cells	00	%	0-5
Absolute neutrophil count	8.81	x 10^9/L	2.0-7.0(40-80%
Absolute lymphocyte count	2.35	x 10^9/L	1.0-3.0(20-40%)
Absolute eosinophil count	0.35	x 10^9/L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated /			
RBC Indices			
TOTAL R.B.C. COUNT	4.40	Million/Cumm	4.5 - 6.5
(Electric Impedence)			
Haematocrit Value (P.C.V.)	35.5	%	26-50
MCV	80.7	fL	80-94
(Calculated)			
MCH	25.9	pg	27-32
(Calculated)			
MCHC	32.1	g/dl	30-35
(Calculated)			



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g			
Investigation	Results	Units	Biological Ref-Interval
RDW-SD	45.2	fL	37-54
(Calculated)			
RDW-CV	13.6	%	11.5 - 14.5
(Calculated)			
Platelet Count	2.14	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	10.7	%	7.5-11.5
(Calculated)			
GENERAL BLOOD PICTURE			
NLR	3.75		1-3
6-9 Mild stres			

7-9 Pathological cause

- -NLR is a reflection of physiologic stress, perhaps tied most directly to cortisol and catecholamine levels.
- -NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
- -NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin, lactate).
- -With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP *

"B" POSITIVE

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Organization

Investigation	Results	Units	Biological Ref-Interval
GLYCATED HAEMOGLOBIN (HbA1c)*	5.0	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	96.8	mg/dl	

EXPECTED RESULTS:

Non diabetic patients & Stabilized diabetics : 4.3% to 6.30%

> Good Control of diabetes : 6.4% to 7.5% Fair Control of diabetes : 7.5% to 9.0% Poor Control of diabetes : 9.0 % and above

- -Next due date for HBA1C test: After 3 months
- -High HbF & Trig.level, iron def.anaemia result in high GHb
- -Haemolyic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control. HbA1c represents average glycemia over the past six to eight weeks. Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3) Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.

As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.

BIOCHEMISTRY (FLORIDE)

PLASMA SUGAR FASTING	88.5	mg/dl	70 - 110
(GOD/POD method)			
	BIOCHEMISTRY (SERUI	M)	
SERUM CREATININE	0.7	mg/dl	0.6-1.4
(Enzymatic)			
BLOOD UREA NITROGEN	10.40	mg/dL.	8-23



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Investigation	Results	Units	Biological Ref-Interval
LIVER FUNCTION TEST			
SERUM BILIRUBIN			
TOTAL	0.7	mg/dl	0.1-1.2
(Diazo)			
DIRECT	0.3	mg/dl	<0.3
(Diazo)			
INDIRECT	0.4	mg/dl	0.1-1.0
(Calculated)			
S.G.P.T.	50.0	U/L	8-40
(IFCC method)			
S.G.O.T.	41.0	U/L	6-37
(IFCC method)			
SERUM ALKALINE PHOSPHATASE	89.0	IU/L.	37-103
(IFCC KINETIC)			
SERUM PROTEINS			
TOTAL PROTEINS	6.8	Gm/dL.	6-8
(Biuret)			
ALBUMIN	3.6	Gm/dL.	3.5-5.0
(Bromocresol green Dye)			
GLOBULIN	3.20	Gm/dL.	2.5-3.5
(Calculated)			
A : G RATIO	1.13		1.5-2.5
(Calculated)			



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Results	Units	Biological Ref-Interval
150.0	mg/dl	150-250
75.0	mg/dl	70-150
41.8	mg/dl	30-60
15.0	mg/dl	10-30
93.2	mg/dL.	0-100
02.2	ratio	<3.55
3.6	ratio	3.8-5.9
	150.0 75.0 41.8 15.0 93.2 02.2	150.0 mg/dl 75.0 mg/dl 41.8 mg/dl 15.0 mg/dl 93.2 mg/dL. 02.2 ratio

Interpretation:

Paitient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE:

Lipid Profile Ranges As PER NCEP-ATP III:

SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated :> 240 mg/dl HDLCHOLESTEROL Desirable : > 60 Borderline : 40- 60 Decreased :< 40 mg/dl Desirable: 100 mg/dl, Borderline: 100-159 Elevated: >160 mg/dl LDL CHOLESTEROL : Desirable: 150 Borderline: 150-199 High: 200 - 499 Very High: >500 Triglycerides

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

SERUM SODIUM (Na) * 139.0 mEq/litre

(ISE method)

(ISE)



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Organization Units **Biological Ref-Interval** Investigation Results THYRIOD PROFILE* Triiodothyronine (T3) * na/dl 0.79-1.58 1.152

Thyroxine (T4) * ug/dl 4.9-11.0 10.450 (ECLIA)

THYROID STIMULATING HORMONE (TSH) * uIU/ml 0.38-5.30 0.856

(ECLIA)

(ECLIA)

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disordes such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism, serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both incresed and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness, then TSH rises to within or above the reference range with resolution of the underlying illness, and finally returns to within the reference range. The situation is complicated because drugs, including glucagon and dopamine, suppress TSH. Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) *	4.2	mEq/litre.	3.5 - 5.5
(ISE method)			
SERUM CALCIUM	10.0	mg/dl	9.2-11.0
(Arsenazo)			
	BIOCHEMICAL EXAMINATI	ON	
URIC ACID	5.0	mg/dL.	2.5-6.8



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Investigation Results	Units	Biological Ref-Interval
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URINE

PHYSICAL EXAMINATION

Volume 20 ml

Colour Pale Yellow

Clear **Appearance** Clear Specific Gravity 1.020 1.000-1.030

PH (Reaction) Acidic

BIOCHEMICAL EXAMINATION

Nil Protein Nil Nil

Sugar Nil

MICROSCOPIC EXAMINATION

Red Blood Cells /HPF Nil Nil Pus cells /HPF 0-2 2-3 /HPF **Epithilial Cells** 1-3 3-4

Crystals Nil Casts Nil

@ Special Examination

Bile Pigments Absent Blood Nil Bile Salts Absent

-----{END OF REPORT }-----



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