



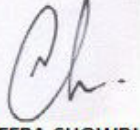
Lab No. : SRE/25-03-2023/SR7450265
Patient Name : CHIRANTAN MONDAL
Age : 33 Y 0 M 0 D
Gender : M

Lab Add. : Newtown, Kolkata-700156
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date: 25/Mar/2023 10:05AM
Report Date : 25/Mar/2023 03:37PM



Test Name	Result	Unit	Bio Ref. Interval	Method
POTASSIUM, BLOOD , GEL SERUM				
POTASSIUM,BLOOD	4.50	mEq/L	3.5-5.5 mEq/L	ISE INDIRECT
*CHLORIDE, BLOOD , .				
CHLORIDE,BLOOD	103	mEq/L	99-109 mEq/L	ISE INDIRECT
SODIUM, BLOOD , GEL SERUM				
SODIUM,BLOOD	139	mEq/L	132 - 146 mEq/L	ISE INDIRECT

□


Dr NEEPA CHOWDHURY
 MBBS MD (Biochemistry)
 Consultant Biochemist

Lab No. : SR7450265 Name : CHIRANTAN MONDAL Age/G : 33 Y 0 M 0 D / M Date : 25-03-2023

ALKALINE PHOSPHATASE , GEL SERUM

ALKALINE PHOSPHATASE 85 U/L 46-116 U/L IFCC standardization

BILIRUBIN (TOTAL) , GEL SERUM

BILIRUBIN (TOTAL) 0.90 mg/dL 0.3-1.2 mg/dL Vanadate oxidation

SGPT/ALT , GEL SERUM

SGPT/ALT **55** U/L 7-40 U/L Modified IFCC

UREA,BLOOD , GEL SERUM

UREA,BLOOD 19.3 mg/dL 19-49 mg/dL Urease with GLDH

CALCIUM, BLOOD

CALCIUM,BLOOD 9.80 mg/dL 8.7-10.4 mg/dL Arsenazo III

TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .

TOTAL PROTEIN 8.00 g/dL 5.7-8.2 g/dL BIURET METHOD

ALBUMIN 4.7 g/dL 3.2-4.8 g/dL BCG Dye Binding

GLOBULIN **3.30** g/dl 1.8-3.2 g/dl Calculated

AG Ratio 1.42 1.0 - 2.5 Calculated

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

T3-TOTAL (TRI IODOTHYRONINE) 1.02 ng/ml 0.60-1.81 ng/ml CLIA

T4-TOTAL (THYROXINE) 8.7 µg/dL 3.2-12.6 µg/dL CLIA

TSH (THYROID STIMULATING HORMONE) 3.79 µIU/mL 0.55-4.78 µIU/mL CLIA

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

References:

1. Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. *Eur J Endocrinol* 2001;145:409-13.
2. Bellantone R, Lombardi CP, Bossola M, Ferrante A, Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. *Cancer* 2001;92:2273-9.

BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL

SECOND TRIMESTER: 0.20 -3.50 µ IU/mL

THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

References:

1. Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan. *Thyroid*. Mar 2017.315-389. <http://doi.org/10.1089/thy.2016.0457>
2. Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. *Indian J Endocr Metab* 2018;22:1-4.

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SGOT/AST , GEL SERUM

SGOT/AST 30 U/L 13-40 U/L Modified IFCC

BILIRUBIN (DIRECT) , GEL SERUM

BILIRUBIN (DIRECT) 0.20 mg/dL <0.2 mg/dL Vanadate oxidation

CREATININE, BLOOD

0.96 mg/dL 0.7-1.3 mg/dL Jaffe, alkaline picrate, kinetic

LIPID PROFILE , GEL SERUM

CHOLESTEROL-TOTAL	161	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	127	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	34	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	102	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	Calculated
VLDL	25	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	4.7		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated

Reference: National Cholesterol Education Program. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III). JAMA. May 16 2001;285(19):2486-97.

URIC ACID, BLOOD , GEL SERUM

URIC ACID,BLOOD 6.20 mg/dL 3.5-7.2 mg/dL Uricase/Peroxidase

[PDF Attached](#)

GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD

GLYCATED HEMOGLOBIN (HBA1C) 4.6 % ***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***

HbA1c (IFCC) 27.0 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 glycemic targets

Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.

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Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
 Ø If a patient changes treatment plans or does not meet his or her glycemic 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.

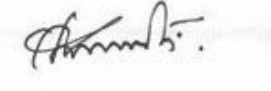
PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM

PHOSPHORUS-INORGANIC,BLOOD	3.3	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV
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URIC ACID, URINE, SPOT URINE

URIC ACID, SPOT URINE	48.00	mg/dL	37-92 mg/dL	URICASE
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Dr. SUPARBA CHAKRABARTI
 MBBS, MD(BIOCHEMISTRY)
 Consultant Biochemist



Lab No. : SR7450265 Name : CHIRANTAN MONDAL Age/G : 33 Y 0 M 0 D / M Date : 25-03-2023

CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD

HEMOGLOBIN	14.6	g/dL	13 - 17	PHOTOMETRIC
WBC	7.8	*10 ³ /μL	4 - 10	DC detection method
RBC	4.84	*10 ⁶ /μL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	165	*10 ³ /μL	150 - 450*10 ³ /μL	DC detection method/Microscopy

DIFFERENTIAL COUNT

NEUTROPHILS	59	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	30	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	07	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	03	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	01	%	0-0.9%	Flowcytometry/Microscopy

CBC SUBGROUP

HEMATOCRIT / PCV	44.6	%	40 - 50 %	Calculated
MCV	92.2	fl	83 - 101 fl	Calculated
MCH	30.1	pg	27 - 32 pg	Calculated
MCHC	32.6	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	14.4	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	37.1	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	15.5		7.5 - 11.5 fl	Calculated

ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD

1stHour	15	mm/hr	0.00 - 20.00 mm/hr	Westergren
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URINE ROUTINE ALL, ALL , URINE

PHYSICAL EXAMINATION

COLOUR	PALE YELLOW
APPEARANCE	SLIGHTLY HAZY

CHEMICAL EXAMINATION

pH	6.5		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015		1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	NOT DETECTED		NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	NOT DETECTED		NOT DETECTED	Dipstick(glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	NOT DETECTED		NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NOT DETECTED		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)

MI CROSCOPI C EXAMINATION

LEUKOCYTES (PUS CELLS)	0-1	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/hpf	0-5	Microscopy
RED BLOOD CELLS	NOT DETECTED	/hpf	0-2	Microscopy
CAST	NOT DETECTED		NOT DETECTED	Microscopy
CRYSTALS	NOT DETECTED		NOT DETECTED	Microscopy
BACTERIA	NOT DETECTED		NOT DETECTED	Microscopy
YEAST	NOT DETECTED		NOT DETECTED	Microscopy

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Lab No. : SR7450265 Name : CHIRANTAN MONDAL Age/G : 33 Y 0 M 0 D / M Date : 25-03-2023

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

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.

DR. NEHA GUPTA
MD, DNB (Pathology)
Consultant Pathologist

Lab No. : SRE/25-03-2023/SR7450265
Patient Name : CHIRANTAN MONDAL
Age : 33 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 25/Mar/2023 07:42PM



X-RAY REPORT OF CHEST (PA)

FINDINGS :

No active lung parenchymal lesion is seen.

Both the hila are normal in size, density and position.

Mediastinum is in central position. Trachea is in midline.

Domes of diaphragm are smoothly outlined. Position is within normal limits.

Lateral costo-phrenic angles are clear.

The cardio-thoracic ratio is normal.

Bony thorax reveals no definite abnormality.

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DR. BIPLAB KR. GHOSH
MD(CAL), RADIO-DIAGNOSIS

Lab No. : SRE/25-03-2023/SR7450265
Patient Name : **CHIRANTAN MONDAL**
Age : 33 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 25/Mar/2023 04:54PM



DEPARTMENT OF ULTRASONOGRAPHY
REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER

Liver is enlarged in size (15.20 cm) having grade I fatty change. 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 (0.40 cm) with no intraluminal pathology (calculi /mass) could be detected at its visualised part. Portal vein is normal (1.00 cm) at porta.

GALLBLADDER

Gallbladder is 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 (9.42 cm). 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 10.84 cm. & Lt. kidney 10.05 cm) 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.

URETERS

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.

PROSTATE

Prostate is normal in size. Echotexture appears within normal limits. No focal alteration of its echogenicity could be detectable.

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Report Date : 25/Mar/2023 04:54PM



It measures : 3.30 cm. x 3.12 cm. x 3.04 cm.

Approximate weight could be around = 16.37 gms.

RETROPERITONEUM & PERITONEUM

No ascites noted. No definite evidence of any mass lesion detected. No detectable evidence of enlarged lymph nodes noted. Visualized part of aorta & IVC are within normal limit.

IMPRESSION :

Hepatomegaly with grade I fatty change.

KINDLY NOTE

Ultrasound is not the modality of choice to rule out subtle bowel lesion.

Please Intimate us for any typing mistakes and send the report for correction within 7 days.

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.

Patient Identity not verified

DR. S. K. MONDAL
MBBS, CBET
(Sonologist)

Lab No. : SRE/25-03-2023/SR7450265
Patient Name : CHIRANTAN MONDAL
Age : 33 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 25/Mar/2023 07:03PM



DEPARTMENT OF CARDIOLOGY

E.C.G. REPORT

Heart rate - 64 / min. (average)

Rhythm - Sinus

Axis - Normal

P- Wave - Normal

PR Interval - Normal

QRS Complexes - Normal

ST Segment - Isoelectric

T Wave - Normal

QT Interval - Normal

Voltage - Normal

IMPRESSION : Normal tracing. Please correlate clinically.

Dr SANJAY SUD
MBBS (Cal), FCCP, MRI PHH(UK)
ECHO CARDIOLOGIST

Patient Data

Sample ID: C02135004703
 Patient ID: SR7450265
 Name:
 Physician:
 Sex:
 DOB:

Analysis Data

Analysis Performed: 25/MAR/2023 15:35:27
 Injection Number: 8216U
 Run Number: 190
 Rack ID: 0004
 Tube Number: 2
 Report Generated: 25/MAR/2023 15:54:19
 Operator ID: ASIT

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	0.8	0.160	12763
A1b	---	0.8	0.223	13679
F	---	0.4	0.275	7393
LA1c	---	1.5	0.402	25621
A1c	4.6	---	0.510	59302
P3	---	3.0	0.789	50195
P4	---	1.0	0.869	17429
Ao	---	88.8	0.991	1480418

Total Area: 1,666,801

HbA1c (NGSP) = 4.6 % HbA1c (IFCC) = 27 mmol/mol

