

Name : Mrs. DEEPALAKSHMI K
PID No. : MED111408920
SID No. : 222021109
Age / Sex : 48 Year(s) / Female
Type : OP
Ref. Dr : MediWheel

Register On : 10/12/2022 12:41 PM
Collection On : 10/12/2022 1:00 PM
Report On : 12/12/2022 5:00 PM
Printed On : 21/12/2022 6:18 PM



Investigation Observed Value Unit Biological Reference Interval

BLOOD GROUPING AND Rh TYPING
(EDTA Blood/Agglutination)

'B' 'Positive'

INTERPRETATION: Reconfirm the Blood group and Typing before blood transfusion

Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	12.6	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood/Derived from Impedance)	39.0	%	37 - 47
RBC Count (EDTA Blood/Impedance Variation)	4.38	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (EDTA Blood/Derived from Impedance)	88.9	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood/Derived from Impedance)	28.8	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood/Derived from Impedance)	32.4	g/dL	32 - 36
RDW-CV (EDTA Blood/Derived from Impedance)	14.9	%	11.5 - 16.0
RDW-SD (EDTA Blood/Derived from Impedance)	46.36	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood/Impedance Variation)	6520	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood/Impedance Variation & Flow Cytometry)	79.7	%	40 - 75
Lymphocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	11.9	%	20 - 45
Eosinophils (EDTA Blood/Impedance Variation & Flow Cytometry)	2.7	%	01 - 06


Dr. N.V. VARDHINI Ph.D
Consultant Geneticist

VERIFIED BY


DR GURUPRIYA J
PATHOLOGIST
Reg No : 13-48036

APPROVED BY

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Monocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	5.2	%	01 - 10
Basophils (EDTA Blood/Impedance Variation & Flow Cytometry)	0.5	%	00 - 02
INTERPRETATION: Tests done on Automated Five Part cell counter. All abnormal results are reviewed and confirmed microscopically.			
Absolute Neutrophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	5.20	10 ³ / μl	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.78	10 ³ / μl	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood/Impedance Variation & Flow Cytometry)	0.18	10 ³ / μl	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.34	10 ³ / μl	< 1.0
Absolute Basophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.03	10 ³ / μl	< 0.2
Platelet Count (EDTA Blood/Impedance Variation)	289	10 ³ / μl	150 - 450
MPV (EDTA Blood/Derived from Impedance)	9.5	fL	8.0 - 13.3
PCT (EDTA Blood/Automated Blood cell Counter)	0.27	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Blood/Automated - Westergren method)	40	mm/hr	< 20
BUN / Creatinine Ratio	16.37		6.0 - 22.0
Glucose Fasting (FBS) (Plasma - F/GOD-PAP)	103.0	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126


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The results pertain to sample tested.

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INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose Postprandial (PPBS) (Plasma - PP/GOD-PAP)	118.4	mg/dL	70 - 140
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INTERPRETATION:

Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti-diabetic medication during treatment for Diabetes.

Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
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Blood Urea Nitrogen (BUN) (Serum/Urease UV / derived)	9.5	mg/dL	7.0 - 21
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Creatinine (Serum/Modified Jaffe)	0.58	mg/dL	0.6 - 1.1
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INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin, cefazolin, ACE inhibitors, angiotensin II receptor antagonists, N-acetylcysteine, chemotherapeutic agent such as flucytosine etc.

Remark: kindly correlate clinically, suggested repeat testing with a fresh sample, if clinically indicated.

Uric Acid (Serum/Enzymatic)	2.0	mg/dL	2.6 - 6.0
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Remark: kindly correlate clinically, suggested repeat testing with a fresh sample, if clinically indicated.

Liver Function Test

Bilirubin(Total) (Serum/DCA with ATCS)	0.41	mg/dL	0.1 - 1.2
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Bilirubin(Direct) (Serum/Diazotized Sulfanilic Acid)	0.16	mg/dL	0.0 - 0.3
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Bilirubin(Indirect) (Serum/Derived)	0.25	mg/dL	0.1 - 1.0
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SGOT/AST (Aspartate Aminotransferase) (Serum/Modified IFCC)	24.2	U/L	5 - 40
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SGPT/ALT (Alanine Aminotransferase) (Serum/Modified IFCC)	17.3	U/L	5 - 41
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GGT(Gamma Glutamyl Transpeptidase) (Serum/IFCC / Kinetic)	14.4	U/L	< 38
Alkaline Phosphatase (SAP) (Serum/Modified IFCC)	81.8	U/L	42 - 98
Total Protein (Serum/Biuret)	7.03	gm/dl	6.0 - 8.0
Albumin (Serum/Bromocresol green)	3.82	gm/dl	3.5 - 5.2
Globulin (Serum/Derived)	3.21	gm/dL	2.3 - 3.6
A : G RATIO (Serum/Derived)	1.19		1.1 - 2.2

Lipid Profile

Cholesterol Total (Serum/CHOD-PAP with ATCS)	162.5	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/GPO-PAP with ATCS)	73.1	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >=500

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the `usual_ circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immuno-inhibition)	52.6	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
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LDL Cholesterol (Serum/Calculated)	95.3	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	14.6	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	109.9	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
 2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.

Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	3.1		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	1.4		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
LDL/HDL Cholesterol Ratio (Serum/Calculated)	1.8		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0

Glycosylated Haemoglobin (HbA1c)

HbA1C (Whole Blood/HPLC)	5.1	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5
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INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %


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Estimated Average Glucose (Whole Blood)	99.67	mg/dL	

INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency,

hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.

Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/Chemiluminescent Immunometric Assay (CLIA))	0.76	ng/ml	0.7 - 2.04
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INTERPRETATION:

Comment :

Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.

T4 (Tyroxine) - Total (Serum/Chemiluminescent Immunometric Assay (CLIA))	7.71	µg/dl	4.2 - 12.0
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INTERPRETATION:

Comment :

Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

TSH (Thyroid Stimulating Hormone) (Serum/Chemiluminescent Immunometric Assay (CLIA))	2.51	µIU/mL	0.35 - 5.50
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INTERPRETATION:

Reference range for cord blood - upto 20

1 st trimester: 0.1-2.5

2 nd trimester 0.2-3.0

3 rd trimester : 0.3-3.0

(Indian Thyroid Society Guidelines)

Comment :

1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.

2.TSH Levels are subject to circadian variation, reaching peak levels between 2-4am and at a minimum between 6-10PM.The variation can be of the order of 50%,hence time of the day has influence on the measured serum TSH concentrations.

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.


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<u>Urine Analysis - Routine</u>			
COLOUR (Urine)	Pale yellow		Yellow to Amber
APPEARANCE (Urine)	Clear		Clear
Protein (Urine/Protein error of indicator)	Negative		Negative
Glucose (Urine/GOD - POD)	Negative		Negative
Pus Cells (Urine/Automated ~ Flow cytometry)	Occasional	/hpf	NIL
Epithelial Cells (Urine/Automated ~ Flow cytometry)	1 - 2	/hpf	NIL
RBCs (Urine/Automated ~ Flow cytometry)	NIL	/hpf	NIL
Casts (Urine/Automated ~ Flow cytometry)	NIL	/hpf	NIL
Crystals (Urine/Automated ~ Flow cytometry)	NIL	/hpf	NIL
Others (Urine)	NIL		

INTERPRETATION:Note: Done with Automated Urine Analyser & Automated urine sedimentation analyser. All abnormal reports are reviewed and confirmed microscopically.

Stool Analysis - ROUTINE

Colour (Stool)	Brown		Brown
Blood (Stool)	Absent		Absent
Mucus (Stool)	Absent		Absent


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Reaction (Stool)	Acidic		Acidic
Consistency (Stool)	Semi Solid		Semi Solid
Ova (Stool)	NIL		NIL
Others (Stool)	NIL		NIL
Cysts (Stool)	NIL		NIL
Trophozoites (Stool)	NIL		NIL
RBCs (Stool)	NIL	/hpf	Nil
Pus Cells (Stool)	1 - 2	/hpf	NIL
Macrophages (Stool)	NIL		NIL
Epithelial Cells (Stool)	NIL	/hpf	NIL


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Consultant Geneticist

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PAP Smear by LBC(Liquid based Cytology)

SPECIMEN NO : Cy 2710/2022

MICROSCOPIC FINDINGS:

ADEQUACY : Satisfactory.

PREDOMINANT CELLS : Superficial and intermediate cells.

BACKGROUND : Clean.

ORGANISMS : No specific organisms.

IMPRESSION :

Negative for intraepithelial lesion/ malignancy.


Dr. RADHI LAWRENCE AB (Pathology)
Consultant Pathologist
Reg No : 21215

APPROVED BY

-- End of Report --

Name	Mrs.DEEPALAKSHMI K	ID	MED111408920
Age & Gender	48/FEMALE	Visit Date	10/12/2022
Ref Doctor Name	MediWheel		

SONOGRAM REPORT

BOTH BREASTS

Right breast:

All the four quadrants and subareolar region show normal echotexture.

No mass or cyst is seen. No calcification is seen.

The axillary tail of Spence is normal.

The retromammary tissues are normal.

Left breast:

All the four quadrants and subareolar region show normal echotexture.

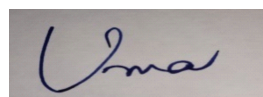
No mass or cyst is seen. No calcification is seen.

The axillary tail of Spence is normal.

The retromammary tissues are normal.

IMPRESSION :

- **Normal study.**



DR. UMALAKSHMI
SONOLOGIST

REPORT DISCLAIMER

1.This is only a radiological impression.Like other investigations, radiological investigation also have limitation. Therefore radiological reports should be interpreted in correlation with clinical and pathological findings.

2.The results reported here in are subject to interpretation by qualified medical professionals only.

3.Customer identities are accepted provided by the customer or their representative.

4.information about the customer's condition at the time of sample collection such as fasting, food consumption, medication, etc are accepted as provided by the customer or representative and shall not be investigated for its truthfulness.

5.If any specimen/sample is received from any others laboratory/hospital,its is presumed that the sample belongs to the patient identified or named.

6.Test results should be interpreted in context of clinical and other findings if any.In case of any clarification /doubt , the referring doctor/patient can contact the respective section head of the laboratory.

7.Results of the test are influenced by the various factors such as sensitivity, specificity of the procedures of the tests, quality of the samples and drug interactions etc.,

8.If the test results are found not to be correlating clinically can contact the lab in charge for clarification or retesting where practicable within 24 hours from the time of issue of results.

9.Liability is limited to the extend of amount billed.

10.Reports are subject to interpretation in their entirety.partial or selective interpretation may lead to false opinion.

11.Disputes,if any , with regard to the report findings are subject to the exclusive jurisdiction of the competent courts chennai only.