MC-2176

Suraksha DIAGNOSTICS

Lab No.	: SIL/13-03-2023/SR7399945	**Lab Add.**	: Sevoke Road,Siliguri 734001
Patient Name	: **SWAGATA DAS**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 11 M 24 D	**Collection Date:**	13/Mar/2023 03:16PM
Gender	: F	**Report Date**	: 13/Mar/2023 05:34PM

Test Name	Result	Unit	Bio Ref. Interval	Method
***SODIUM, BLOOD ,** *GEL SERUM*				
SODIUM,BLOOD	140.00	mEq/L	136 - 145 mEq/L	ISE INDIRECT
***CHLORIDE, BLOOD ,** .				
CHLORIDE,BLOOD	104.00	mEq/L	98 - 107 mEq/L	ISE INDIRECT
UREA,BLOOD , *GEL SERUM*	19.0	mg/dl	12.8-42.8 mg/dl	UREASE-COLORIMETRIC
CREATININE, BLOOD	**0.47**	mg/dl	0.55 - 1.02 mg/dl	ALKALINE PICRATE
GLUCOSE, FASTING , *BLOOD, NAF PLASMA*				
GLUCOSE,FASTING	85	mg/dl	70 - 100 mg/dL	Hexokinase Method
CALCIUM, BLOOD				
CALCIUM,BLOOD	8.70	mg/L	8.6-10.0 mg/dl	OCPC
URIC ACID, BLOOD , *GEL SERUM*				
URIC ACID,BLOOD	3.70	mg/dl	2.6 - 6.0 mg/dl	URICASE ,COLORICMETRIC
THYROID PANEL (T3, T4, TSH) , *GEL SERUM*				
T3-TOTAL (TRI IODOTHYRONINE)	1.03	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	7.6	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	1.94	µIU/mL	0.55-4.78 µIU/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.

***POTASSIUM, BLOOD ,** *GEL SERUM*				
POTASSIUM,BLOOD	3.60	mEq/L	3.1-5.5 mEq/L	ISE INDIRECT

TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .

Lab No. : SR7399945	Name : SWAGATA DAS		Age/G : 29 Y 11 M 24 D / F	Date : 13-03-2023
TOTAL PROTEIN	7.65	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN	3.8	g/dl	3.4-5.0 g/dl	BCP
GLOBULIN	**3.86**	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	**0.98**		1.0 - 2.5	Calculated
LIPID PROFILE , *GEL SERUM*				
CHOLESTEROL-TOTAL	164.65	mg/dl	Desirable: < 200 mg/dL Borderline high: 200-239 High: > or =240 mg/dL	CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE
TRIGLYCERIDES	53.51	mg/dl	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	ENZYMATIC, END POINT
HDL CHOLESTEROL	59.36	mg/dl	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	DIRECT MEASURE-PEG
LDL CHOLESTEROL DIRECT	99.0	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	6	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	**2.8**		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated
PHOSPHORUS-INORGANIC, BLOOD , *GEL SERUM*				
PHOSPHORUS-INORGANIC,BLOOD	3.4	mg/dl	2.5-4.5 mg/dl	UV PHOSPHOMOLYBDATE
***GLYCATED HAEMOGLOBIN (HBA1C) ,** *EDTA WHOLE BLOOD*				
GLYCATED HEMOGLOBIN (HBA1C)	4.8	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	29.0	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, Bio-Rad D 10
Method : HPLC Cation Exchange
HbA1C : DUAL REPORTING OF UNITS [Ref 2,3,4]
Suraksha Diagnostic Pvt. Ltd. has commenced reporting HbA1c in dual units. This is in keeping with current International recommendations to allow a transition phase from current reporting units (%) to the eventual (IFCC) units (mmol/mol). It is anticipated that only IFCC units will be used after 2 years of dual reporting. Please note that the method of analysis has not changed. Although the two results look numerically different, they are clinically equivalent. In defining HbA1C, the unit mmol /mol was determined to be the most accurate description of what is being measured. This will make the measurement more precise and allow for better comparisons of HbA1c results from different laboratories and hospitals throughout the world.

Standardization & traceability [Ref 2,3,4]
HbA1c is standardized & traceable to IFCC methods HPLC-CE & HPLC-MS. This new unit (mmol/mol) is used as part of this standardization. This change in HbA1c calibration is to conform to national & international best practice. The initiative will mean that HbA1c is measured specifically & reproducibly. It also enables the use of international reference ranges & harmonization of medical decision or target values.

Recommendations for glycemic targets [Ref 1]
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.
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 more or less 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 B_{12}/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.

Lab No. : SR7399945 **Name : SWAGATA DAS** **Age/G : 29 Y 11 M 24 D / F** **Date : 13-03-2023**

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.

3. Geistanger A, Arends S, Berding C, Hoshino T, Jeppsson J-O, Little R, Siebelder C and Weykamp C, on behalf of the IFCC Working Group on Standardization of HbA1c: Statistical Methods for Monitoring the Relationship between the IFCC Reference Measurement Procedure for Hemoglobin A1c ..Clin Chem 2008; 54(8): 1379-8.

4. International Expert Committee Report, drawn from the International Diabetes Federation (IDF), the European Association for the Study of Diabetes (EASD),American Diabetes Association (ADA), International Federation of Clinical Chemistry and Laboratory Medicine, International Society for Pediatric & Adolescent Diabetes. International Congress - IFCC, WorldLab, EuroMedLab- Berlin,2011.

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
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Method : HPLC Cation Exchange

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GLUCOSE, PP , *BLOOD, NAF PLASMA*

GLUCOSE,PP	100	mg/dl	75-140	Hexokinase Method

DR. SANJAY KR. AGARWALA
MD CONSULTANT BIOCHEMIST

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Lab No. : SR7399945 **Name : SWAGATA DAS** **Age/G : 29 Y 11 M 24 D / F** **Date : 13-03-2023**

URINE ROUTINE ALL, ALL , *URINE*

PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION				
pH	6.5		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.010		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	ABSENT		NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	ABSENT		NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	ABSENT		NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	ABSENT		NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	ABSENT		NEGATIVE	Dipstick (ester hydrolysis reaction)
MICROSCOPIC EXAMINATION				
LEUKOCYTES (PUS CELLS)	2-3	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/hpf	0-5	Microscopy
RED BLOOD CELLS	ABSENT	/hpf	0-2	Microscopy
CAST	ABSENT		NOT DETECTED	Microscopy
CRYSTALS	ABSENT		NOT DETECTED	Microscopy
BACTERIA	FEW		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.

Prabha

Dr. PRABHA ANAND , MD
CONSULTANT MICROBIOLOGISTS

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Lab No. : SR7399945 **Name : SWAGATA DAS** **Age/G : 29 Y 11 M 24 D / F** **Date : 13-03-2023**

CBC WITH PLATELET (THROMBOCYTE) COUNT , *EDTA WHOLE BLOOD*

HEMOGLOBIN	**11.3**	g/dL	12 - 15	PHOTOMETRIC
WBC	5.0	*10^3/µL	4 - 10	DC detection method
RBC	**3.70**	*10^6/µL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE) COUNT	170	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	58	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	32	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	05	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	04	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	**01**	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				
HEMATOCRIT / PCV	**34.4**	%	36 - 46 %	Calculated
MCV	93.0	fl	83 - 101 fl	Calculated
MCH	30.6	pg	27 - 32 pg	Calculated
MCHC	32.9	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	**14.4**	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	16.7	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	11.0		7.5 - 11.5 fl	Calculated
RBC	NORMOCYTIC NORMOCHROMIC.			
WBC.	NORMAL			
PLATELET	ADEQUATE ON SMEAR.			

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

1stHour	**40**	mm/hr	0.00 - 20.00 mm/hr	Westergren

Navneet

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

ABO	A	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

(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.

DEPARTMENT OF PATHOLOGY
REPORT ON EXAMINATION OF CERVICAL SMEAR FOR EXFOLIATIVE CYTOLOGY

SPECIMEN TYPE :
Conventional cervical PAP smear.

SPECIMEN ADEQUACY :
Satisfactory for evaluation. Endocervical cells seen.

GENERAL DIAGNOSTIC CATEGORIZATION :
Negative for intraepithelial lesion / malignancy [NILM].

MICROSCOPY :
Smear examined shows superficial and intermediate squamous cells. Background shows moderate acute inflammation.

IMPRESSION :
Inflammatory cervical smear.

Advice : Repeat smear after control of inflammation or if clinically indicated.

NOTE : Reported as per The 2014 Bethesda system of reporting cervical cytology.

ENCL : One (01) slide.

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Lab No. : SR7399945	Name : SWAGATA DAS	Age/G : 29 Y 11 M 24 D / F	Date : 14-03-2023

DR.BARNALI PAUL
MBBS, MD(PATH)

Suraksha DIAGNOSTICS

Lab No.	: SIL/13-03-2023/SR7399945	**Lab Add.**	:
Patient Name	: **SWAGATA DAS**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 11 M 24 D	**Collection Date:**	
Gender	: F	**Report Date**	: 13/Mar/2023 11:42AM

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

HEART RATE	:	73 /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 3/10 mm.
		R/S in V6 17/1 mm.
QRS AXIS	:	+60°
Q- Waves	:	No significant Q-wave.
QT TIME	:	352ms.
ST SEGMENT	:	Normal.
T WAVE	:	NORMAL
ROTATION	:	Normal.
OTHER FINDINGS	:	Nil.
IMPRESSION	:	**ECG WITHIN NORMAL LIMIT**.

Dr. ARABINDA SAHA (MD,DM)
CONSULTANT CARDIOLOGIST

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Lab No.	: SIL/13-03-2023/SR7399945	**Lab Add.**	:
Patient Name	: **SWAGATA DAS**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 11 M 24 D	**Collection Date:**	
Gender	: F	**Report Date**	: 13/Mar/2023 01:13PM

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 visualsed 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
Echogenecity 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. 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 105 mm. & Lt. kidney 104 mm.) axes & position. Cortical echogenecity 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 (65 mm. x 25 mm. x 35 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

Lab No.	: SIL/13-03-2023/SR7399945	**Lab Add.**	:
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Gender	: F	**Report Date**	: 13/Mar/2023 01:13PM

Ovaries are normal in size, shape, position, margin and echotexture.
Right ovary measures 30 x 17 mm.
Left Ovary measures 24 x 21 mm.

IMPRESSION :

Sonographic study of whole abdomen does not reveal any significant abnormality.

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.***

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

Patient Identity not verified.

DR. MUKTI SARKAR MD.
CONSULTANT RADIOLOGIST

Suraksha DIAGNOSTICS

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Patient Name	: **SWAGATA DAS**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 29 Y 11 M 24 D	**Collection Date:**	
Gender	: F	**Report Date**	: 13/Mar/2023 12:58PM

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

FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhoutte 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.

(Please correlate clinically & with other investigation .Follow up suggested).

DR. MUKTI SARKAR MD.
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