



**Lab No.** : BAR/14-01-2023/SR7178138  
**Patient Name** : MANISH KUMAR  
**Age** : 37 Y 1 M 12 D  
**Gender** : M

**Lab Add.** : Newtown, Kolkata-700156  
**Ref Dr.** : Dr.MEDICAL OFFICER  
**Collection Date:** 14/Jan/2023 09:14AM  
**Report Date** : 14/Jan/2023 03:33PM



Test Name	Result	Unit	Bio Ref. Interval	Method
<b>URIC ACID, URINE, SPOT URINE</b>				
URIC ACID, SPOT URINE	45.00	mg/dL	37-92 mg/dL	URICASE
<b>THYROID PANEL (T3, T4, TSH) , GEL SERUM</b>				
T3-TOTAL (TRI IODOTHYRONINE)	1.07	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.3	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	2.11	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:

- 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.
- 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:

- 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>
- Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. *Indian J Endocr Metab* 2018;22:1-4.

**Dr NEEPA CHOWDHURY**  
 MBBS MD (Biochemistry)  
 Consultant Biochemist



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**BILIRUBIN (DIRECT) , GEL SERUM**

BILIRUBIN (DIRECT)      0.10      mg/dL      <0.2 mg/dL      Vanadate oxidation

**SGOT/AST , GEL SERUM**

SGOT/AST      35.00      U/L      13-40 U/L      Modified IFCC

**POTASSIUM, BLOOD , GEL SERUM**

POTASSIUM,BLOOD      4.70      mEq/L      3.5-5.5 mEq/L      ISE INDIRECT

**UREA,BLOOD , GEL SERUM**

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

**GLUCOSE, FASTING , BLOOD, NAF PLASMA**

GLUCOSE,FASTING      84      mg/dL      Impaired Fasting-100-125  
~Diabetes- >= 126,~Fasting is defined as no caloric intake for at least 8 hours.      Gluc Oxidase Trinder

*In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.*

Reference :  
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

**URIC ACID, BLOOD , GEL SERUM**

URIC ACID,BLOOD      6.60      mg/dL      3.5-7.2 mg/dL      Uricase/Peroxidase

**ALKALINE PHOSPHATASE , GEL SERUM**

ALKALINE PHOSPHATASE      79.00      U/L      46-116 U/L      IFCC standardization

**CREATININE, BLOOD**

CREATININE,BLOOD      0.75      mg/dL      0.7-1.3 mg/dL      Jaffe, alkaline picrate, kinetic

**CHLORIDE, BLOOD , .**

CHLORIDE,BLOOD      105.00      mEq/L      99-109 mEq/L      ISE INDIRECT

**PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM**

PHOSPHORUS-INORGANIC,BLOOD      2.7      mg/dL      2.4-5.1 mg/dL      Phosphomolybdate/UV

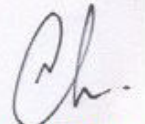
**SODIUM, BLOOD , GEL SERUM**

SODIUM,BLOOD      140.00      mEq/L      132 - 146 mEq/L      ISE INDIRECT

**BILIRUBIN (TOTAL) , GEL SERUM**

BILIRUBIN (TOTAL)      0.70      mg/dL      0.3-1.2 mg/dL      Vanadate oxidation

□

  
Dr NEEPA CHOWDHURY  
MBBS MD (Biochemistry)  
Consultant Biochemist



Lab No. : SR7178138 Name : MANISH KUMAR Age/G : 37 Y 1 M 12 D / M Date : 15-01-2023

**SGPT/ALT , GEL SERUM**

SGPT/ALT **55.00** U/L 7-40 U/L Modified IFCC

**CALCIUM, BLOOD**

CALCIUM,BLOOD 9.30 mg/dL 8.7-10.4 mg/dL Arsenazo III

[PDF Attached](#)

**GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD**

GLYCATED HEMOGLOBIN (HBA1C) 5.3 % **\*\*\*FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION \*\*\***

HbA1c (IFCC) 34.0 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.
- 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 B<sub>12</sub>/ 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.

**LIPID PROFILE , GEL SERUM**

CHOLESTEROL-TOTAL 169.00 mg/dL Desirable: < 200 mg/dL Enzymatic  
 Borderline high: 200-239 mg/dL  
 High: > or =240 mg/dL

TRIGLYCERIDES 100.00 mg/dL Normal:: < 150, GPO-Trinder  
 BorderlineHigh::150-199,  
 High:: 200-499,  
 VeryHigh::>500

HDL CHOLESTEROL 45.00 mg/dl < 40 - Low Elimination/catalase  
 40-59- Optimum  
 60 - High

LDL CHOLESTEROL DIRECT **104.0** mg/dL OPTIMAL : <100 mg/dL, Calculated  
 Near optimal/ above optimal :  
 100-129 mg/dL,

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			Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	
VLDL	20	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	3.8		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.

**TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .**

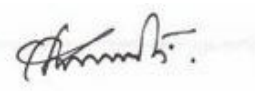
TOTAL PROTEIN	8.10	g/dL	5.7-8.2 g/dL	BIURET METHOD
ALBUMIN	4.5	g/dL	3.2-4.8 g/dL	BCG Dye Binding
GLOBULIN	<b>3.60</b>	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.25		1.0 - 2.5	Calculated

**GLUCOSE, PP , BLOOD, NAF PLASMA**

GLUCOSE,PP	94	mg/dL	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.	Gluc Oxidase Trinder
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The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :  
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.



**Dr. SUPARBA CHAKRABARTI**  
MBBS, MD(BIOCHEMISTRY)  
Consultant Biochemist



Lab No. : SR7178138 Name : MANISH KUMAR Age/G : 37 Y 1 M 12 D / M Date : 14-01-2023

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

HEMOGLOBIN	14.5	g/dL	13 - 17	PHOTOMETRIC
WBC	6.8	*10 <sup>3</sup> /μL	4 - 10	DC detection method
RBC	5.00	*10 <sup>6</sup> /μL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	174	*10 <sup>3</sup> /μL	150 - 450*10 <sup>3</sup> /μL	DC detection method/Microscopy

**DIFFERENTIAL COUNT**

NEUTROPHILS	55	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	35	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	06	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	03	%	1-6%	Flowcytometry/Microscopy
BASOPHILS	<b>01</b>	%	0-0.9%	Flowcytometry/Microscopy

**CBC SUBGROUP**

HEMATOCRIT / PCV	42.9	%	40 - 50 %	Calculated
MCV	85.9	fl	83 - 101 fl	Calculated
MCH	29.1	pg	27 - 32 pg	Calculated
MCHC	33.8	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	<b>15.5</b>	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	22.4	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	12.0		7.5 - 11.5 fl	Calculated

**URINE ROUTINE ALL, ALL , URINE**

**PHYSICAL EXAMINATION**

COLOUR	PALE YELLOW
APPEARANCE	SLIGHTLY HAZY

**CHEMICAL EXAMINATION**

pH	6.0		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)

**MICROSCOPIC EXAMINATION**

LEUKOCYTES (PUS CELLS)	0-1	/hpf	0-5	Microscopy
EPITHELIAL CELLS	2-3	/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

**Note:**

- All urine samples are checked for adequacy and suitability before examination.
- Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.

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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.

**CBC WITH PLATELET & RETICULOCYTE COUNT , EDTA WHOLE BLOOD**

HEMOGLOBIN	14.5	g/dL	13 - 17	PHOTOMETRIC
WBC	6.8	*10 <sup>3</sup> /μL	4 - 10	DC detection method
RBC	5.00	*10 <sup>6</sup> /μL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	174	*10 <sup>3</sup> /μL	150 - 450*10 <sup>3</sup> /μL	DC detection method/Microscopy

**DIFFERENTIAL COUNT**

NEUTROPHILS	55	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	35	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	06	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	03	%	1-6%	Flowcytometry/Microscopy
BASOPHILS	<b>01</b>	%	0-0.9%	Flowcytometry/Microscopy

**CBC SUBGROUP 1**

HEMATOCRIT / PCV	42.9	%	40 - 50 %	Calculated
MCV	85.9	fl	83 - 101 fl	Calculated
MCH	29.1	pg	27 - 32 pg	Calculated
MCHC	33.8	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	<b>15.5</b>	%	11.6-14%	Calculated
RETICULOCYTE COUNT-AUTOMATED,BLOOD	1.1	%	0.5-2.5%	Cell Counter/Microscopy

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

1stHour	<b>37</b>	mm/hr	0.00 - 20.00 mm/hr	Westergren
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**BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD**

ABO	AB	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. PANKTI PATEL**  
**MBBS , MD (PATHOLOGY)**  
**CONSULTANT PATHOLOGIST**

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Age : 37 Y 1 M 12 D  
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Lab Add. :  
Ref Dr. : Dr.MEDICAL OFFICER  
Collection Date:  
Report Date : 14/Jan/2023 04:46PM



### E.C.G. REPORT

DATA	
HEART RATE	72 Bpm
PR INTERVAL	170 Ms
QRS DURATION	84 Ms
QT INTERVAL	342 Ms
QTC INTERVAL	376 Ms
AXIS	
P WAVE	54 Degree
QRS WAVE	46 Degree
T WAVE	48 Degree
<b>IMPRESSION</b>	<b>: Normal sinus rhythm, within normal limits.</b>

*ACR*

Dr. A C RAY

Department of Non-invasive  
Cardiology

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**Patient Name** : **MANISH KUMAR**  
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**Gender** : M

**Lab Add.** :  
**Ref Dr.** : Dr.MEDICAL OFFICER  
**Collection Date:**  
**Report Date** : 14/Jan/2023 02:41PM



**X-RAY REPORT OF CHEST (PA)**

**FINDINGS :**

**Increased vascular marking seen in both lungs.**

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.

□

  
Dr. Anoop Sastry  
MBBS, DMRT(CAL)  
CONSULTANT RADIOLOGIST  
Registration No.: WB-36628



Lab No. : BAR/14-01-2023/SR7178138  
Patient Name : **MANISH KUMAR**  
Age : 37 Y 1 M 12 D  
Gender : M

Lab Add. :  
Ref Dr. : Dr.MEDICAL OFFICER  
Collection Date:  
Report Date : 14/Jan/2023 03:34PM



## **REPORT ON EXAMINATION OF USG WHOLE ABDOMEN**

### **LIVER**

**Liver is mildly enlarged in size ( 16.32 cm in mid clavicular line) having normal shape, with grade I fatty infiltration.** No focal parenchymal lesion is evident. Intrahepatic biliary radicles are not dilated. Branches of portal vein are normal.

### **PORTA**

CBD diameter appears normal (2.7 mm). No intraluminal obvious calculus or sizable SOL could be detected in the visualized part of the CBD.

Portal vein diameter (8.3 mm) appears normal at porta.

### **GALLBLADDER**

Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal calculus or SOL could be detected.

### **PANCREAS**

Echogenicity appears within limits, without any focal SOL. Shape, size & position appears normal on USG. Main pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

### **SPLEEN**

Spleen is normal in size (8.11 cm). No obvious focal lesion noted.

### **KIDNEYS**

Both kidneys are normal in size (Rt. Kidney 10.74 cm & Lt. kidney 11.08 cm) axes & position. Cortical echogenicity appears normal maintaining cortico-medullary differentiation. No sizeable echogenic calculus or hydronephrosis is evident in the either kidney in the present USG. However, very small non-obstructive calculus may not be visualised in USG. NCCT KUB is advised for further evaluation.

### **URETERS**

Visualised part of upper ureters are not dilated.

### **URINARY BLADDER**

Urinary bladder is distended. Wall thickness appeared normal. No intraluminal calculus or SOL noted.

### **PROSTATE**

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

It measures : 2.89 x 2.66 x 2.60 cm.

Approximate weight could be around = 10.46 gms.

### **RIGHT ILIAC FOSSA:**

No collection or mass is noted in the right iliac fossa at present.

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**IMPRESSION**

**Mild hepatomegaly with diffuse grade I fatty changes.**

*Advised clinical correlation & further necessary investigations.*

**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. Somnath Paul  
MD Radiodiagnosis

**Patient Data**

Sample ID: C02135956775  
 Patient ID: SR7178138  
 Name:  
 Physician:  
 Sex:  
 DOB:

**Analysis Data**

Analysis Performed: 14/JAN/2023 14:00:31  
 Injection Number: 8723U  
 Run Number: 251  
 Rack ID: 0007  
 Tube Number: 10  
 Report Generated: 14/JAN/2023 14:47:41  
 Operator ID: ASIT

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
Unknown	---	0.2	0.106	3665
A1a	---	0.9	0.153	20452
A1b	---	1.1	0.213	25100
F	---	0.6	0.262	14809
LA1c	---	1.7	0.390	41073
A1c	5.3	---	0.495	102524
P3	---	3.4	0.779	81252
P4	---	1.2	0.859	29248
Ao	---	86.7	0.985	2068002

Total Area: 2,386,125

**HbA1c (NGSP) = 5.3 %**      HbA1c (IFCC) = 34 mmol/mol

