Garg Pathology

Certified by :
National Accreditation Board For Testing & Calibration Laboratories
ISO 9001:2008
Garden House Colony, Near Nai Sarak, Garh Road, Meerut
Ph.: 0121-2600454, 8979608687, 9837772828

DR. MONIKA GARG
M.D. (Path) Gold Medalist
Former Pathologist :
St. Stephan's Hospital, Delhi

PUID	: 220319/602	**C. NO:**	**602**	**Collection Time**	: **19-Mar-2022 9:33AM**
Patient Name	: **Mrs. GUNJAN RANI SINGH 49Y / Female**			**Receiving Time**	: **19-Mar-2022 9:37AM**
Referred By	: **Dr. BANK OF BARODA**			**Reporting Time**	: **19-Mar-2022 12:20PM**
Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval

HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT			
HAEMOGLOBIN (Colorimetry)	13.3	gm/dl	12.0-15.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	5900	*10^6/L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	62	%.	40-80
Lymphocytes	35	%.	20-40
Eosinophils	01	%.	1-6
Monocytes	02	%.	2-10
Basophils	00	%.	<1-2
Absolute neutrophil count	3.66	x 10^9/L	2.0-7.0(40-80%
Absolute lymphocyte count	2.07	x 10^9/L	1.0-3.0(20-40%)
Absolute eosinophil count	0.06	x 10^9/L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated /			
RBC Indices			
TOTAL R.B.C. COUNT (Electric Impedence)	4.78	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	37.4	%	26-50
MCV (Calculated)	**78.2**	fL	80-94
MCH (Calculated)	27.8	pg	27-32
MCHC (Calculated)	**35.6**	g/dl	30-35
RDW-SD	41.2	fL	37-54

***THIS TEST IS NOT UNDER NABL SCOPE**

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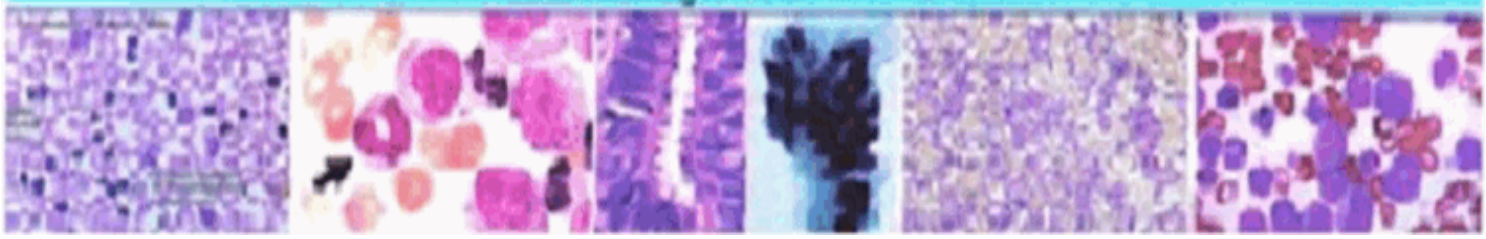
(Consultant Pathologist)



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(Calculated)			
Platelet Count	1.70	/Cumm	1.50-4.50
(Electric Impedence)			
GENERAL BLOOD PICTURE			
NLR	1.77		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 *	"AB" POSITIVE	$	$

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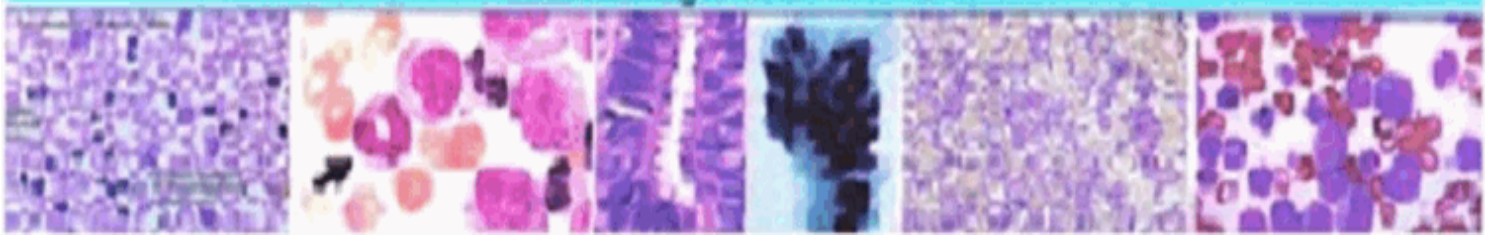

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Investigation	Results	Units	Biological Ref-Interval
GLYCATED HAEMOGLOBIN (HbA1c)*	5.4	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	108.3	mg/dl	

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 (GOD/POD method)	101.0	mg/dl	70 - 110

BIOCHEMISTRY (SERUM)

SERUM CREATININE (Enzymatic)	0.7	mg/dl	0.6-1.4
BLOOD UREA NITROGEN	13.50	mg/dL.	8-23

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Investigation	Results	Units	Biological Ref-Interval
LIVER FUNCTION TEST			
SERUM BILIRUBIN			
TOTAL (Diazo)	0.6	mg/dl	0.1-1.2
DIRECT (Diazo)	0.3	mg/dl	<0.3
INDIRECT (Calculated)	0.3	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	21.0	U/L	8-40
S.G.O.T. (IFCC method)	24.0	U/L	6-37
SERUM ALKALINE PHOSPHATASE (IFCC KINETIC)	96.0	IU/L.	37-103
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	6.8	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	3.7	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	3.10	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	**1.19**		1.5-2.5

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Investigation	Results	Units	Biological Ref-Interval
LIPID PROFILE			
SERUM CHOLESTEROL (CHOD - PAP)	**132.0**	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	**64.0**	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	41.2	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	12.8	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	78.0	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	01.9	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	**3.2**	ratio	3.8-5.9

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
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

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

SERUM SODIUM (Na) * (ISE method)	**3.8**	mEq/litre	135 - 155

(ISE)

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Investigation	Results	Units	Biological Ref-Interval
THYRIOD PROFILE*			
Triiodothyronine (T3) * (ECLIA)	1.056	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	8.346	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) * (ECLIA)	1.245	uIU/ml	0.38-5.30

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 disorders 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) * (ISE method)	**138.0**	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	9.6	mg/dl	9.2-11.0

BIOCHEMICAL EXAMINATION

URIC ACID	5.5	mg/dL.	2.5-6.8

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Referred By	: **Dr. BANK OF BARODA**			**Reporting Time**	: **20-Mar-2022 11:03AM**
Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval

CYTOLOGY EXAMINATION

SPECIMEN MG-133/22

Microscopic:

SITE OF SMEAR: ECTOCERVIX AND POSTERIOR FORNIX OF VAGINA
METHOD OF EVALUATION: BETHSEDA SYSTEM
EVALUATION OF SMEAR : SATISFACTORY
REPORT: CELLULAR SPREAD SHOWS DESQUAMATED EPITHELIAL CELLS PREDOMINANTLY SUPERFICIAL AND INTERMEDIATE CELLS. FAIR NUMBER OF PARABASAL CELLS ARE SEEN.
FEW ENDOCERVICAL CELLS SHOWING REACTIVE CHANGES ARE SEEN.
BACKROUND SHOWS MILD INFLAMMATORY REACTION. THERE IS SHIFT IN VAGINAL FLORA. LACTOBACILLI ARE REDUCED.
ANY DYSKARYOTIC CELL IS NOT SEEN. ANY BUDDING SPORES OR TROPHOZOITE IS NOT SEEN.
INFERENCE: NEGATIVE FOR INTRAEPITHELIAL CELLS OR MALIGNANCY
NOTE: This test has its own limitations. Please interpret the findings in light of clinical picture. not for medicolegal use

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
URINE			
PHYSICAL EXAMINATION			
Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.015		1.000-1.030
PH (Reaction)	Acidic		
BIOCHEMICAL EXAMINATION			
Protein	Nil		Nil
Sugar	Nil		Nil
MICROSCOPIC EXAMINATION			
Red Blood Cells	Nil	/HPF	Nil
Pus cells	2-3	/HPF	0-2
Epithilial Cells	3-4	/HPF	1-3
Crystals	Nil		
Casts	Nil		
@ Special Examination			
Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

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

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