MSK DIAGNOSTICS
(A Complete Diagnostic Pathology Laboratory)
RAIBARELI ROAD, TELIBAGH, LUCKNOW
E-mail : mskdiagnosticspvt@gmail.com, Website : mskdiagnostics.in
Mobile : 7565000448

Collected At : (MSK)

Name	: MS. RAKHI VERMA	Age	: 24 Yrs.	Registered	: 14-4-2023 04:04 PM
Ref/Reg No	: 14033 / TPPC/MSK-	Gender	: Female	Collected	: 14-4-2023 10:05 AM
Ref By	: Dr. MEDI WHEEL			Received	: 14-4-2023 04:04 PM
Sample	: Blood, Urine			Reported	: 14-4-2023 05:22 PM

BIOCHEMISTRY

Investigation	Observed Values	Units	Biological Ref. Interval
***Glycosylated Hemoglobin (HbA1C)**			
* Glycosylated Hemoglobin (HbA1C) *(Hplc method)*	5.9	%	0-6
* Mean Blood Glucose (MBG)	132.74	mg/dl	

< 6 % : Non Diebetic Level
6-7 % : Goal
> 8 % : Action suggested

SUMMARY

If HbA1c is >8% which causes high risk of developing long term complications like retinopathy,Nephropathy,Cardiopathy and Neuropathy.In diabetes mellitus sugar (glucose) accumulates in blood stream beyond normal level. Measurement of blood / plasma glucose level (in fasting,"after meal" i.e. PP or random condition) reflect acute changes related to immediate past condition of the patient which may be affected by factor like duration of fasting or time of intake of food before fasting, dosages of anti diabetic drugs, mental conditions like stress, anxiety etc. it does not indicate the long-term aspects of diabetic control.

Glucose combines with hemoglobin (Hb) continuously and nearly irreversibly during life span of RBC (120 days), thus glycosylated Hb is proportional to mean plasma glucose level during the previous 2-3 months. HBA1C, a glycosylated Hb comprising 3% - 6% of the total Hb in healthy may double of even triple in diabetes mellitus depending on the level of hyperglycemia(high blood glucose level), thus correlating with lack of control by monitoring diabetic patients compliance with therapeutic regimen used and long term blood glucose level control. Added advantage is its ability to predict progression of diabetic complications. HbA1c value is no way concerned with the blood sugar on the day of testing and dietary preparation of fasting is unnecessary.

DR. POONAM SINGH
MD (PATH)

---------- End of report ----------

(SENIOR TECHNOLOGIST)
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BIOCHEMISTRY

Investigation	Observed Values	Units	Biological Ref. Interval
Plasma Glucose Fasting [Method: Hexokinase]	88.5	mg/dL	70 - 110
Serum Bilirubin (Total)	0.6	mg/dl.	0.0 - 1.2
* Serum Bilirubin (Direct)	0.2	mg/dl.	0- 0.4
* Serum Bilirubin (Indirect)	0.4	mg/dl.	0.2-0.7
SGPT [Method: IFCC (UV without pyridoxal-5-phosphate]	48.5	IU/L	10 - 50
SGOT [Method: IFCC (UV without pyridoxal-5-phosphate]	32.7	IU/L	10 - 50
Serum Alkaline Phosphatase [Method:4-Nitrophenyl phosphate (pNPP)]	121.9	IU/L	108 - 306
Serum Protein	6.9	gm/dL	6.2 - 7.8
Serum Albumin	3.8	gm/dL.	3.5 - 5.2
Serum Globulin	3.1	gm/dL.	2.5-5.0
A.G. Ratio	1.23 : 1		
* Gamma-Glutamyl Transferase (GGT)	21.0	IU/L	Less than 38

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Investigation	Observed Values	Units	Biological Ref. Interval

BIOCHEMISTRY

KIDNEY FUNCTION TEST

Blood Urea	30.7	mg/dL.	20-40
Serum Creatinine	0.60	mg/dL.	0.50 - 1.40
Serum Sodium (Na+)	142	mmol/L	135 - 150
Serum Potassium (K+)	4.5	mmol/L	3.5 - 5.3
Serum Uric Acid	3.5	mg/dL.	2.4 - 5.7

[Method for Urea: UREASE with GLDH]
[Method for Creatinine: Jaffes/Enzymatic]
[Method for Sodium/Potassium: Ion selective electrode direct]
[Method for Uric Acid: Enzymatic-URICASE]

Serum Urea	30.7	mg/dL.	10-45
Blood Urea Nitrogen (BUN)	14.35	mg/dL.	6 - 21

CLINICAL PATHOLOGY

Urine for Sugar (F)	Absent

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HEMATOLOGY

Investigation	Observed Values	Units	Biological Ref. Interval
HEMOGRAM			
Haemoglobin [Method: SLS]	12.8	g/dL	11.5 - 15
HCT/PCV (Hematocrit/Packed Cell Volume) [Method: Derived]	38.8	ml %	36 - 46
RBC Count [Method: Electrical Impedence]	**4.94**	10^6/µl	3.8 - 4.8
MCV (Mean Corpuscular Volume) [Method: Calculated]	**76.6**	fL.	83 - 101
MCH (Mean Corpuscular Haemoglobin) [Method: Calculated]	**25.8**	pg	27 - 32
MCHC (Mean Corpuscular Hb Concentration) [Method: Calculated]	33.7	g/dL	31.5 - 34.5
TLC (Total Leucocyte Count) [Method: Flow Cytometry/Microscopic]	9.8	10^3/µl	4.0 - 10.0
DLC (Differential Leucocyte Count): [Method: Flow Cytometry/Microscopic]			
Polymorphs	76	%	40.0 - 80.0
Lymphocytes	22	%	20.0 - 40.0
Eosinophils	02	%	1.0 - 6.0
Monocytes	**00**	%	2.0 - 10.0
Platelet Count [Method: Electrical impedence/Microscopic]	208	10^3/µl	150 - 400
*Erythrocyte Sedimentation Rate (E.S.R.) [Method: Wintrobe Method]			
*Observed Reading	**32**	mm for 1 hr	0-20
* ABO Typing	" B "		
* Rh (Anti - D)	Positive		

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Investigation	Observed Values	Units	Biological Ref. Interval
LIPID PROFILE (F)			
Serum Cholesterol	**205.5**	mg/dL.	<200
Serum Triglycerides	89.3	mg/dL.	<150
HDL Cholesterol	**47.0**	mg/dL	>55
LDL Cholesterol	**141**	mg/dL.	<130
VLDL Cholesterol	18	mg/dL.	10 - 40
CHOL/HDL	4.37		
LDL/HDL	3		

INTERPRETATION:

National Cholestrol Education program Expert Panel (NCEP) for Cholestrol:
Desirable : < 200 mg/dl
Borderline High : 200-239 mg/dl
High : =>240 mg/dl

National Cholestrol Education program Expert Panel (NCEP) for Triglycerides:
Desirable : < 150 mg/dl
Borderline High : 150-199 mg/dl
High : 200-499 mg/dl
Very High : >500 mg/dl

National Cholestrol Education program Expert Panel (NCEP) for HDL-Cholestrol:
<40 mg/dl : Low HDL-Cholestrol [Major risk factor for CHD]
=>60 mg/dl : Hight HDL-Cholestrol [Negative risk factor for CHD]

National Cholestrol Education program Expert Panel (NCEP) for LDL-Cholestrol:
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

[Method for Cholestrol Total: Enzymatic (CHOD/POD)]
[Method for Triglycerides: Enzymatic (Lipase/GK/GPO/POD)]
[Method for HDL Cholestrol: Homogenous Enzymatic (PEG Cholestrol esterase)]
[Method for LDL Cholestrol: Homogenous Enzymatic (PEG Cholestrol esterase)]
[Method for VLDL Cholestrol: Friedewald equation]
[Method for CHOL/HDL ratio: Calculated]
[Method for LDL/HDL ratio: Calculated]

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HORMONE & IMMUNOLOGY ASSAY

Investigation	Observed Values	Units	Biological Ref. Interval
Serum T3	1.13	ng/dl	0.846 - 2.02
Serum T4	8.16	ug/dl	5.13 - 14.06
Serum Thyroid Stimulating Harmone (T.S.H.) [Method: Electro Chemiluminescence Immunoassay (ECLIA)]	3.36	ulU/ml	0.39 - 5.60

SUMMARY OF THE TEST

1) Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
2) primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
3) Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis.
4) Slightly elevated T3 levels may be found in pregnancy and esterogen therapy, while depressed levels maybe encountered in severe illness,malnutrition, renalfailure and during therapy with drugs like propanlol and propylthiouracil.
5) Elevated TSH levels may also be indicative of TSH secreting pituitary tumour.

Chart of normal thyroid TSH levels during first, second and third trimester of pregnancy

Stage	Normal TSH Level
First Trimester	0.1-2.5 ulU/ml
Second Trimester	0.2-3.0 ulU/ml
Third Trimester	0.3-3.5 ulU/ml

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CLINICAL PATHOLOGY

Investigation	Observed Values	Units	Biological Ref. Interval
URINE EXAMINATION ROUTINE [Method: Visual,Urometer-120, Microscopy]			
Physical Examination			
Color	Light Yellow		
Volume	30	mL	
Chemical Findings			
Blood	Absent	RBC/µl	Absent
Bilirubin	**Absent**		Absent
Urobilinogen	Absent		Absent
Ketones	**Present in traces**		Absent
Proteins	**Present in traces**		Absent
Nitrites	Absent		Absent
Glucose	Absent		Absent
pH	5.5		5.0 - 9.0
Specific Gravity	1.025		1.010 - 1.030
Leucocytes	**Absent**	WBC/µL	Absent
Microscopic Findings			
Red Blood cells	Absent	/HPF	Absent
Pus cells	**Occasional**	/HPF	0-3
Epithelial Cells	**Absent**	/HPF	Absent/Few
Casts	**Absent**	/HPF	Absent
Crystals	**Uric Acid crystal +**	/HPF	Absent
Amorphous deposit	Absent	/HPF	Absent
Yeast cells	Absent	/HPF	Absent
Bacteria	**Absent**	/HPF	Absent
Others	Absent	/HPF	Absent

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NAME:-MRS.RAKHI VERMA **DATE:-14/04/2023**

REF.BY:- MEDI WHEEL **AGE:-24Y/F**

X-RAY CHEST (P.A. View)

- Lung fields are clear.
- No focal parenchymal lesion is noted.
- Mediastinum is central.
- Cardiac size is normal.
- C.P. angles are normally visualized.
- Domes of diaphragm are normal.
- Pulmonary hila appear normal.
- Soft tissue and bones are normal.

OPINION:

- No significant abnormality detected.
  -Suggested clinical correlation.

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PDCC Neuroradiology (SGPGIMS, LKO)
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USG - ABDOMEN-PELVIS

NAME: MRS. RAKHI VERMA	**AGE/SEX: 24 Y/ F**
REFERRED BY: MEDIWHEEL	**DATE: 14.04.2023**

- Liver appears normal in shape, size (measures ~130 mm) ***& bright in echotexture without obscuration of vessel margins suggestive of grade I fatty changes.*** No evidence of focal lesion is seen. No evidence of dilated IHBR seen.
- Portal vein appears normal in caliber. CBD appears normal in caliber.
- Gall Bladder appears well distended with no calculus or changes of cholecystitis seen.
- Spleen appears normal in shape, size (measures~100 mm) &echotexture with no focal lesion within. Pancreas appears normal in size, shape &echopattern.
- Para-aortic region appears normal with no lymphadenopathy is seen.
- Right Kidney size: ~104mm; Left Kidney size: ~99mm.
- Both kidneys appear normal in position, shape, size & echotexture. CMD is normal.
- No calculus or hydronephrosis on either side.
- Urinary bladder appears well distended with no calculus or mass within.
- Uterus is normal in shape, size and echotexture.
- ***Bulky bilateral ovaries (Right ovary measures~9cc and left ovary measures ~12cc) are noted with multiple peripherally arranged subcentimetric sized follicles without dominant follicle on either side---PCOS morphology in bilateral ovaries.***
- No free fluid in peritoneal cavity. No pleural effusion on either side.
- *No abnormal bowel wall thickening or significant abdominal lymphadenopathy.*

IMPRESSION:

- ***Grade I fatty changes in liver. NO focal parenchymal lesion.***
- ***PCOS morphology in bilateral ovaries. ADV: Clinical and hormonal assay correlation.***
  Please correlate clinically.

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