



Lab No. : SRE/28-04-2023/SR7575059  
 Patient Name : PREM SHANKAR PRASAD  
 Age : 40 Y 5 M 2 D  
 Gender : M

Lab Add. : Newtown, Kolkata-700156  
 Ref Dr. : Dr.MEDICAL OFFICER  
 Collection Date: 28/Apr/2023 09:58AM  
 Report Date : 28/Apr/2023 02:24PM



Test Name	Result	Unit	Bio Ref. Interval	Method
<b>BILIRUBIN (DIRECT) , GEL SERUM</b>				
BILIRUBIN (DIRECT)	0.10	mg/dL	<0.2 mg/dL	Vanadate oxidation
<b>CREATININE, BLOOD , GEL SERUM</b>				
CREATININE, BLOOD	0.79	mg/dL	0.7-1.3 mg/dL	Jaffe, alkaline picrate, kinetic
<b>URIC ACID, BLOOD , GEL SERUM</b>				
URIC ACID, BLOOD	4.30	mg/dL	3.5-7.2 mg/dL	Uricase/Peroxidase
<b>SGOT/AST , GEL SERUM</b>				
SGOT/AST	33	U/L	13-40 U/L	Modified IFCC
<b>*CHLORIDE, BLOOD , .</b>				
CHLORIDE, BLOOD	105	mEq/L	99-109 mEq/L	ISE INDIRECT
<b>BILIRUBIN (TOTAL) , GEL SERUM</b>				
BILIRUBIN (TOTAL)	0.70	mg/dL	0.3-1.2 mg/dL	Vanadate oxidation
<b>PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM</b>				
PHOSPHORUS-INORGANIC, BLOOD	2.8	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV

□

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

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<b>SGPT/ALT , GEL SERUM</b>					
SGPT/ALT	63	U/L	7-40 U/L		Modified IFCC
<b>POTASSIUM, BLOOD , GEL SERUM</b>					
POTASSIUM,BLOOD	4.90	mEq/L	3.5-5.5 mEq/L		ISE INDIRECT
<b>UREA,BLOOD</b>					
	12.8	mg/dL	19-49 mg/dL		Urease with GLDH
<b>GLUCOSE, FASTING , BLOOD, NAF PLASMA</b>					
GLUCOSE,FASTING	92	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.

<b>CALCIUM, BLOOD</b>					
CALCIUM,BLOOD	8.80	mg/dL	8.7-10.4 mg/dL		Arsenazo III
<b>LIPID PROFILE , GEL SERUM</b>					
CHOLESTEROL-TOTAL	148	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL		Enzymatic
TRIGLYCERIDES	139	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500		GPO-Trinder
HDL CHOLESTEROL	36	mg/dl	< 40 - Low 40-59- Optimum 60 - High		Elimination/catalase
LDL CHOLESTEROL DIRECT	99	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		Elimination / Catalase
VLDL	13	mg/dl	< 40 mg/dl		Calculated
CHOL HDL Ratio	4.1		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.

<b>TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .</b>					
TOTAL PROTEIN	7.20	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	2.70	g/dl	1.8-3.2 g/dl		Calculated
AG Ratio	1.67		1.0 - 2.5		Calculated
<b>SODIUM, BLOOD , GEL SERUM</b>					
SODIUM,BLOOD	139	mEq/L	132 - 146 mEq/L		ISE INDIRECT
<b>GLUCOSE, PP , BLOOD, NAF PLASMA</b>					
GLUCOSE,PP	108	mg/dL	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.		Gluc Oxidase Trinder

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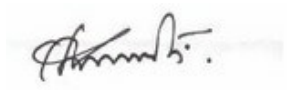
The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

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

**ALKALINE PHOSPHATASE , GEL SERUM**

ALKALINE PHOSPHATASE      **135**      U/L      46-116 U/L      IFCC standardization

□



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



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**URINE ROUTINE ALL, ALL , URINE**

**PHYSICAL EXAMINATION**

COLOUR PALE YELLOW  
 APPEARANCE SLIGHTLY HAZY

**CHEMICAL EXAMINATION**

pH	5.0	4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.020	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	0-1	/hpf	0-5	Microscopy
RED BLOOD CELLS	NOT DETECTED	/hpf	0-2	Microscopy
CAST	NOT DETECTED		NOT DETECTED	Microscopy
CRYSTALS	CALCIUM OXALATE PRESENT		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.
- The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
- Negative nitrite test does not exclude urinary tract infections.
- Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
- 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.
- 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.
- 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.

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

1stHour 11 mm/hr 0.00 - 20.00 mm/hr Westergren

**DR. NEHA GUPTA**  
**MD, DNB (Pathology)**  
**Consultant Pathologist**

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**URIC ACID, URINE, SPOT URINE**

URIC ACID, SPOT URINE      **29.00**      mg/dL      37-92 mg/dL      URICASE  
ESTIMATED TWICE



**DR. ANANNYA GHOSH**  
MBBS, MD (Biochemistry)  
Consultant Biochemist



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

ABO	B	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.**

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

HEMOGLOBIN	15.1	g/dL	13 - 17	PHOTOMETRIC
WBC	5.2	*10 <sup>3</sup> /μL	4 - 10	DC detection method
RBC	<b>5.76</b>	*10 <sup>6</sup> /μL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	<b>135</b>	*10 <sup>3</sup> /μL	150 - 450*10 <sup>3</sup> /μL	DC detection method/Microscopy

**DIFFERENTIAL COUNT**

NEUTROPHILS	50	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	39	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	07	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	03	%	1-6%	Flowcytometry/Microscopy
BASOPHILS	<b>01</b>	%	0-0.9%	Flowcytometry/Microscopy

**CBC SUBGROUP 1**

HEMATOCRIT / PCV	48.8	%	40 - 50 %	Calculated
MCV	84.7	fl	83 - 101 fl	Calculated
MCH	<b>26.2</b>	pg	27 - 32 pg	Calculated
MCHC	<b>30.9</b>	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	1.9	%	0.5-2.5%	Cell Counter/Microscopy

PLATELET  
MILD  
THROMBOCYTOPENIA  
NOTED - CONFIRMED  
BY PERIPHERAL SMEAR  
EXAMINATION. GIANT  
PLATELETS SEEN.

**DR. A. SHARMA**  
MBBS, MD (Path)  
DM (Hematopathology)  
PGIMER Chandigarh  
Consultant Hematopathologist

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**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 (0.40 cm) with no intraluminal pathology (calculi /mass) could be detected at its visualised part. Portal vein is normal (1.00 cm) at porta.

**GALLBLADDER**

Gallbladder is distended. Wall thickness appears normal. No intraluminal pathology (calculi/mass) could be detected. Sonographic Murphys sign is negative.

**PANCREAS**

Echogenicity 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 (09.51 cm). 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 10.61 cm. & Lt. kidney 10.28 cm) axes & position. Cortical echogenicity appears normal maintaining cortico-medullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected.

**URETERS**

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.

**PROSTATE**

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

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could be detectable.

It measures : 3.63 cm. x 3.17 cm. x 2.66 cm.

Approximate weight could be around = 16.05 gms.

### **RETROPERITONEUM & PERITONEUM**

No ascites noted. No definite evidence of any mass lesion detected. No detectable evidence of enlarged lymph nodes noted. Visualized part of aorta & IVC are within normal limit.

### **IMPRESSION :**

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

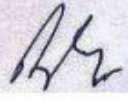
#### **KINDLY NOTE**

*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.*

**Patient Identity not verified.**

  
**DR. BIPLAB KR. GHOSH**  
MD(CAL), RADIO-DIAGNOSIS



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**DEPARTMENT OF RADIOLOGY**

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

**FINDINGS :**

**Prominent bronchovascular lung markings.**

Both the hila are normal in size, density and position.

Mediastinum is central. Trachea is in midline.

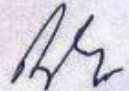
Domes of diaphragm are smoothly outlined. Position is within normal limits.

Lateral costo-phrenic angles are clear.

Cardiac size appears within normal limits. Margin is well visualised and cardiac silhouette is smoothly outlined. Shape is within normal limit.

Bony thorax reveals no definite abnormality.

□



**DR. BIPLAB KR. GHOSH**  
MD(CAL), RADIO-DIAGNOSIS

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**DEPARTMENT OF CARDIOLOGY**

**E.C.G. REPORT**

**Heart rate - 58 / min. (average)**

**Rhythm - Sinus**

**Axis - Normal**

**P- Wave - Normal**

**PR Interval - Normal**

**QRS Complexes - Normal**

**ST Segment - Isoelectric**

**T Wave - Normal**

**QT Interval - Normal**

**Voltage - Normal**

**IMPRESSION : Sinus Bradycardia. Please correlate clinically.**

Dr SANJAY SUD  
MBBS (Cal), FCCP, MRI PHH(UK)  
ECHO CARDIOLOGIST