



Name : Mr. DHEERAJ SINGH S/o UHID : 112050 PID : 24126
Age/Gender : 40 Year/Male Sample Date : 9-Mar-2024 09:20 AM
Ref. By Dr. : MEDIWHEEL Report Date : 9-Mar-2024
Address : HISAR Sample Type : Inside *24126*

Test Name	Value	Unit	Reference Range
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HEAMATOLOGY

CBC (Complete Blood Count)

Haemoglobin (Hb)	15.3	g/dl	12.0 - 17.4 g/dl
Total RBC Count	5.63	m/cumm	4.70 - 6.10
Haematocrit	45.8	%	35.0 - 50.0 %
Mean Cell Volume	81.4	fL	80.0 - 100 fL
Mean Cell Haemoglobin	27.2	pg	27.0 - 34.0 pg
Mean Cell Haemoglobin Conc	33.4	%	32.0 - 36.0
Red Cell Distribution Width (RDW) - SD	45.6	fL	35.0 - 56.0 fL
Red Cell Distribution Width (RDW) - CV	13.7	%	11.0 - 16.0 %
Total Leucocyte Count	10010	cells/cum m	4000 - 11000
Differential Leucocyte Count	.		
Neutrophils	70	%	32 - 72 %
Lymphocytes	25	%	20 - 50 %
Monocytes	3	%	2 - 11 %
Eosinophils	2	%	1 - 3 %
Basophils	0	%	0 - 2 %
Platelet Count	2,24,000	cells/cunm m	150,000 - 450,000
Platelet Distribution Width	17.5	fL	15.0 - 18.0 fL
Mean Platelet Volume	12.1	fL	7.0 - 13.0 fL

Sample Type : Whole Blood

- Spurious elevation of platelet count may be seen in patients with extensive burns, extreme microcytosis, microangiopathic hemolytic anemia, red cell fragmentation, micro-organisms like bacteria, fungi or yeast, hyperlipidemia, fragments of white blood cell (WBC) cytoplasm in patients with acute leukemia, hairy cell leukemia, lymphomas and in presence of cryoglobulins.
- Spuriously low platelet counts may be seen in cases of platelet clumping (EDTA induced), platelet cold agglutinins, multiple myeloma, platelet satellitism and in giant platelet syndromes.
- Delay in processing due to sample transport may cause a mild time dependent fall in platelet count. It is advisable to repeat the test using a citrate / heparin collection tube to avoid this pitfall.
- Automated platelet counting is subject to 10-15% variation in the result on the same as well as different analysers due to various preanalytic variables like the sampling site, skill in sample collection, anticoagulant used, sample mixing and sample transport etc.

ABO Blood Grouping

Blood Group

AB"POSITIVE

Haemaagglutination reaction

A Rh Positive, B Rh Positive, AB Rh Positive, O Rh Positive, A Rh Negative, B Rh Negative, AB Rh Negative, O Rh Negative

Sample Type : Whole Blood

HBA1C

HBA1C	5.2	%	4.27 - 6.00 %
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turbidimetric immunoassay



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HB से लेकर MRI तक एक ही छत के नीचे

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HBA1C

Average Blood Glucose	102.54	mg/dl	90.00 - 120.00 mg/dl
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turbidimetric immunoassay

Sample Type : Whole Blood

Remarks :

GLYCOSYLATED HEMOGLOBIN (HbA1c)

Reference Range : Please correlate with clinical conditions.

Bellow 6.0 % Normal value

6.0 %-7.0 % Good control

7.0 %-8.0 % Fair control

8.0 %-10 % Unsatisfactory control

Above10 % Poor control

Technology : Immunoassay and chemistry technology to measure A1C and total HB (A1C now Bayer)

AVERAGE BLOOD GLUCOSE (ABG) CALCULATED

Reference Range: Please correlate with clinical conditions.

90-120 mg/dl Excellent control

121-150 mg/d Good control

151-180 mg/dl Average control

181-210 mg/dl Action suggested

> 211 mg/dl Panic values

NOTE: Average blood glucose value is calculated from HbA1C value and it indicates average blood sugar level over past three months.

Technology: Derived from Hb A1C Values

Sample Type: Sodium heparin:

ESR

ESR	6	mmHr	0 - 15 mmHr
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Sample Type : Whole Blood

Dr. (Maj.) Guruprasad
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CLINICAL COMMENTS:

Erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that indirectly measures the degree of inflammation present in the body. Inflammation is part of the body's immune response. It can be acute, developing rapidly after trauma, injury or infection, for example, or can occur over an extended time (chronic) with conditions such as autoimmune diseases or cancer.

Moderately elevated ESR occurs with inflammation but also with anemia, infection, pregnancy, and with aging. A very high ESR usually has an obvious cause, such as a severe infection, marked by an increase in globulins, systemic vasculitis, polymyalgia rheumatica or temporal arteritis. People with multiple myeloma or Waldenstrom's macroglobulinemia (tumors that make large amounts of immunoglobulins) typically have very high ESRs even if they don't have inflammation.

Factors increasing ESR:

Advanced age

Anemia

Pregnancy

High fibrinogen

Macrocytosis

Kidney problems

Thyroid disease

Some cancers, such as multiple myeloma

Infection

Factors decreasing ESR

Microcytosis

Low fibrinogen

Polycythemia

Marked leukocytosis

CLINICAL-CHEMISTRY

URIC ACID

Uric acid	4.25	mg/dL	3.5 - 7.2
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Uricase - POD

Sample Type : SERUM

URIC ACID: Increases in case of renal failure, disseminated neoplasms, pregnancy toxemia, psoriasis, liver disease, sarcoidosis etc. Decrease is reported in Wilson's disease, Fanconi's syndrome, xanthinuria.

Glucose, Post Prandial	110.2	mg/dl	70 - 140 mg/dl
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Hexokinase / GOD - POD

Sample Type : SERUM



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Criteria for the diagnosis of diabetes (American diabetes association, 2019)

- Fasting Plasma Glucose ≥ 126 mg/dL. Fasting is defined as no caloric intake for at least 8 h.
OR
- 2-h PG ≥ 200 mg/dL during OGTT. The test should be performed using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water.*
OR
- HbA1c $\geq 6.5\%$.
OR
- Random plasma glucose ≥ 200 mg/dL in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis.

Criteria defining prediabetes (American diabetes association, 2019)

- FPG 100 mg/dL to 125 mg/dL (Impaired fasting glucose, IFG)
OR
- 2-h PG during 75-g OGTT 140 mg/dL to 199 mg/dL (Impaired glucose tolerance, IGT)
OR
- HbA1c 5.7-6.4%

Note:

All abnormal results must be confirmed with a repeat test on a different day.

Total Protein

Total Protein	7.3	gm/dl	6.0 - 8.3
BIURET			
Albumin	4.5	g/dl	2.9 - 4.5
BCG			
Globulin	2.8	gm/dl	2.0 - 3.5
Albumin-Globulin Ratio	1.7		1.2 - 2.5
Sample Type : SERUM			

CREATININE SERUM

CREATININE SERUM	1.1	mg/dL	0.5 - 1.4 mg/dL
Jaffe Kinetic			
Sample Type : SERUM			

CREATININE: Increases in any renal functional impairment (intrinsic renal lesions, decreased perfusion of the kidney, or obstruction of the lower urinary tract), acromegaly and hyperthyroidism. Decreases in pregnancy, muscle wasting.

LIVER FUNCTION TEST (LFT) (S)

Total Bilirubin-Serum	0.90	mg/dl	0.20 - 1.00 mg/dl
Bilirubin Direct Serum	0.40	mg/dl	0.10 - 0.50 mg/dl
Bilirubin Indirect-Serum	0.50	mg/dl	0.20 - 0.70 mg/dl
SGOT	32.58	IU/L	10 - 40 IU/L
IFCC with Pyridoxal Phosphate			
SGPT	72.3	IU/L	07 - 56 IU/L
IFCC with Pyridoxal Phosphate			



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LIVER FUNCTION TEST (LFT) (S)			
Alkaline Phosphatase <small>IFCC PNPP Buffer</small>	145.2	U/L	44 - 147 U/L
Total Protein <small>BIURET</small>	7.3	gm/dl	6.0 - 8.3
Albumin <small>BCG</small>	4.5	g/dl	3.5 - 5.5 g/dl
Globulin <small>AG RATIO</small>	2.8	gm/dl	2.0 - 3.5 gm/dl
	1.7		1.2 - 2.5

Sample Type : SERUM

CLINICAL COMMENT:

Liver function tests can be suggested in case of hepatitis, liver cirrhosis and monitor possible side effects of medications. A variety of diseases and infections can cause acute or chronic damage to the liver, causing inflammation (hepatitis), scarring (cirrhosis), bile duct obstructions, liver tumors, and liver dysfunction. Alcohol, drugs, some herbal supplements, and toxins can also injure the liver. A significant amount of liver damage may occur before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarrhea, and unexplained weight loss or gain appear. Early detection of liver injury is essential in order to minimize damage and preserve liver function.

Alanine aminotransferase (ALT) A very high level of ALT is frequently seen with acute hepatitis. Moderate increases may be seen with chronic hepatitis. People with blocked bile ducts, cirrhosis, and liver cancer may have ALT concentrations that are only moderately elevated or close to normal. Aspartate aminotransferase (AST) A very high level of AST is frequently seen with acute hepatitis. AST may be normal to moderately increased with chronic hepatitis. In people with blocked bile ducts, cirrhosis, and liver cancer, AST concentrations may be moderately increased or close to normal. When liver damage is due to alcohol, AST often increases much more than ALT (this is a pattern seen with few other liver diseases). AST is also increased after heart attacks and with muscle injury.

AST is a less sensitive and less specific marker of liver injury than ALT. AST is more elevated than ALT in alcohol-induced liver injury. AST could be elevated more than ALT like: (i)

Lipid Profile

Cholesterol <small>CHOD - PAP</small>	213.5	mg/dl	<200.0 mg/dl
Triglycerides <small>GPO - PAP</small>	153.4	mg/dl	< 150 mg/dl
HDL Cholesterol <small>Homogeneous Enzymatic Colorimetric test</small>	43.10	mg/dl	Adult males >45 mg/dl
LDL Cholesterol	139.72	mg/dl	<100 mg/dl
VLDL Cholesterol	30.68	mg/dl	<30.0 mg/dl
CHO/HDL Ratio	4.95	mg/dl	Low risk 3.3-4.4
Non HDL Cholesterol <small>Calculated</small>	170.4	mg/dl	<130 mg/dl

Sample Type : SERUM



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Interpretation

Note

- Measurements in the same patient can show physiological & analytical variations. 3 serial samples 1 wk apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
- Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.

CLINICAL PATHOLOGY

PHYSICAL EXAMINATION

Colour	PALE-YELLOW		
Pale-yellow, Yellowish, Colorless, YELLOW			
Quantity	30	ml	
pH	6.0		
Mucus	ABSENT		
Absent, Present			
Appearance	CLEAR		
Slightly turbid, Turbid, Clear			

Chemical Examination (Strip)

Specific Gravity	1.025		
Albumin	NEGATIVE		
Absent, Present(+), Present(2+), Present(3+)			
Sugar	NEGATIVE		
Absent, Present(+), Present(2+), Present(3+)			
Bilirubin	NEGATIVE		
Absent, Present			

Microscopic Examination (Microscopy)

Pus Cells	4-6	/HPF	
Epithelial Cells	1-2	/HPF	
RBC	NIL	/HPF	
Casts	ABSENT		
Crystals	ABSENT		
Bacteria	ABSENT		
Others			

Sample Type : Urine

Laboratory

Glucose, Fasting	87.3	mg/dl	70 - 110 mg/dl
Sample Type : SERUM			

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- OR
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Note:

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ENDOCRINE

Thyroid Hormones (T3 .T4 & TSH)

T3	0.82	ng/ml	0.60 - 1.81 ng/ml
T4	8.12	ng/dl	5.01 - 12.45 ng/dl
TSH (Thyroid stimulating hormones)	4.71	uIU/ml	0.34 - 5.50 uIU/ml

Sample Type : SERUM



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Remarks :

Note1. TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m and at a minimum between 6-10 pm. The variation is of the 50 %, hence time of the day has influence on the measured serum TSH concentrations.

2. Recommended test for T3 and T4 unbound or free level as it is metabolically active.

3. Physiological rise in Total T3 and T4 level is seen in pregnancy and in patients on steroid therapy.

Clinical Use-

- * Primary Hypothyroidism
- * Hyperthyroidism
- * Hypothalamic- Pituitary hypothyroidism
- * Inappropriate-TSH secretion
- * Nonthyroidal illness
- * Autoimmune thyroid disease
- * Pregnancy associated thyroid disorders
- * Thyroid dysfunction in infancy and early childhood

IMMUNOLOGY

Total PSA	0.78	ng/ml	0.00 - 4.0 ng/ml
Sample Type : SERUM			

Summary & Interpretation:

Elevated concentrations of PSA in serum are generally indicative of a pathologic condition of the prostate (prostatitis, benign hyperplasia or carcinoma). PSA determinations are employed for the monitoring of progress and efficiency of therapy in patients with prostate carcinoma or receiving hormonal therapy. An inflammation or trauma of the prostate (e.g. In case of urinary retention or following rectal examination, cystoscopy, coloscopy, transurethral biopsy, laser treatment or ergometry) can lead to PSA elevations of varying duration and magnitude.

--End of Report--