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MC-2977

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| | | | |
|---|---|---|---|
| Name | : **MR.NIMISH MILIND DESHMUKH** | TID/SID | : UMR1469085/ 27503472 |
| Age / Gender | : 25 Years / Male | Registered on | : 20-Apr-2024 / 10:24 AM |
| Ref.By | : SELF | Collected on | : 20-Apr-2024 / 10:36 AM |
| Req.No | : BIL4176084 | Reported on | : 20-Apr-2024 / 15:55 PM |
| | | Reference | : Arcofemi Health Care Ltd - |

TEST REPORT

## DEPARTMENT OF CLINICAL PATHOLOGY

### Complete Urine Examination (CUE), Urine

| Investigation | Result | Biological Reference Intervals |
|---|---|---|
| **Physical Examination** | | |
| Colour<br>Method:Physical | Yellow | Straw to Yellow |
| Appearance<br>Method:Physical | Clear | Clear |
| **Chemical Examination** | | |
| Reaction and pH<br>Method:Indicator | Acidic (5.0) | 4.6-8.0 |
| Specific gravity<br>Method:Refractometry | 1.020 | 1.000-1.035 |
| Protein<br>Method:Protein Error of pH indicators | Negative | Negative |
| Glucose<br>Method:Glucose oxidase/Peroxidase | Negative | Negative |
| Blood<br>Method:Peroxidase | Negative | Negative |
| Ketones<br>Method:Sodium Nitroprusside | **Positive (Trace)** | Negative |
| Bilirubin<br>Method:Diazonium salt | Negative | Negative |
| Leucocytes<br>Method:Esterase reaction | Negative | Negative |
| Nitrites<br>Method:Modified Griess reaction | Negative | Negative |
| Urobilinogen<br>Method:Diazonium salt | Negative | Up to 1.0 mg/dl<br>(Negative) |
| **Microscopic Examination** | | |
| Pus cells (leukocytes)<br>Method:Flow Digital Imaging/Microscopy | 1-2 | 2 - 3 /hpf |
| Epithelial cells<br>Method:Flow Digital Imaging/Microscopy | 1-2 | 2 - 5 /hpf |
| RBC (erythrocytes)<br>Method:Flow Digital Imaging/Microscopy | Absent | Absent |
| Casts<br>Method:Flow Digital Imaging/Microscopy | Absent | Occasional hyaline casts may be seen |

| | | | |
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|---|---|---|
| Crystals<br>Method:Flow Digital Imaging/Microscopy | Absent | Phosphate, oxalate, or urate crystals may be seen |
| Others<br>Method:Flow Digital Imaging/Microscopy | Nil | Nil |

**Method: Semi Quantitative test ,For CUE**

**Reference:** Godkar Clinical Diagnosis and Management by Laboratory Methods, First South Asia edition. Product kit literature.

**Interpretation**:

The complete urinalysis provides a number of measurements which look for abnormalities in the urine. Abnormal results from this test can be indicative of a number of conditions including kidney disease, urinary tract infecation or elevated levels of substances which the body is trying to remove through the urine . A urinalysis test can help identify potential health problems even when a person is asymptomatic. All the abnormal results are to be correlated clinically.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Shruti Reddy**
**Consultant Pathologist**
**Reg No.TSMC/FMR/22656**

| | | | |
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TEST REPORT

## DEPARTMENT OF HEMATOLOGY

### Blood Grouping ABO And Rh Typing, EDTA Whole Blood

| Parameter | Results |
|---|---|
| Blood Grouping (ABO) | A |
| Rh Typing (D) | Positive |
| Method:Hemagglutination Tube Method by Forward & Reverse Grouping | |

**Method:** Hemagglutination Tube Method by Forward & Reverse Grouping

**Reference:** Tulip kit literature

**Interpretation:** The ABO grouping and Rh typing test determines blood type grouping (A,B, AB, O ) and the Rh factor (positive or negative). A person's blood type is based on the presence or absence of certain antigens on the surface of their red blood cells and certain antibodies in the plasma. ABO antigens are poorly expresses at birth, increase gradually in strength and become fully expressed around 1 year of age.
In case of Rh(D) - Du(weak positive) or Weak D positive, the individual must be considered as Rh positive as donor and Rh negative as recipient.

**Note:** Records of previous blood grouping/Rh typing not available. Please verify before transfusion.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

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**Consultant Pathologist**
**Reg No.TSMC/FMR/22656**

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TEST REPORT

## DEPARTMENT OF HEMATOLOGY

### Erythrocyte Sedimentation Rate (ESR), Sodium Citrate Whole Blood

| Investigation | Observed Value | Biological Reference Intervals |
|---|---|---|
| ESR 1st Hour<br>Method:Westergren/Vesmatic | **14** | <=10 mm/hour |

### Complete Blood Count (CBC), EDTA Whole Blood

| Investigation | Observed Value | Biological Reference Intervals |
|---|---|---|
| Hemoglobin<br>Method:Cyanide Free Lyse Hemoglobin | 14.3 | 13.0-17.0 g/dL |
| PCV/HCT<br>Method:Calculated | 41.9 | 40.0-50.0 vol% |
| Total RBC Count<br>Method:Electrical Impedance | 4.96 | 4.50-5.50 mill /cu.mm |
| MCV<br>Method:Calculated | 84.5 | 83.0-101.0 fL |
| MCH<br>Method:Calculated | 28.8 | 27.0-32.0 pg |
| MCHC<br>Method:Calculated | 34.1 | 31.5-34.5 g/dL |
| RDW (CV)<br>Method:Calculated | **15.3** | 11.6-14.0 % |
| MPV<br>Method:Calculated | 8.6 | 7.0-10.0 fL |
| Total WBC Count<br>Method:Electrical Impedance | 6970 | 4000-10000 cells/cumm |
| Platelet Count<br>Method:Electrical Impedance | 2.54 | 1.50-4.10 lakhs/cumm |
| **Differential count** | | |
| Neutrophils<br>Method:Microscopy | 60.9 | 40.0-80.0 % |
| Lymphocytes<br>Method:Microscopy | 31.2 | 20.0-40.0 % |
| Eosinophils | 1.3 | 1.0-6.0 % |
| Monocytes | 6.4 | 2.0-10.0 % |
| Basophils<br>Method:Microscopy | **0.2** | < 1.0-2.0 % |

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**TEST REPORT**

| | | |
|---|---|---|
| Absolute Neutrophil Count<br>Method:Calculated | 4245 | 2000-7000 cells/cumm |
| Absolute Lymphocyte Count (ALC) | 2175 | 1000-3000 cells/cumm |
| Absolute Eosinophil Count (AEC) | 91 | 20-500 cells/cumm |
| Absolute Monocyte Count<br>Method:Calculated | 446 | 200-1000 cells/cumm |
| Absolute Basophil Count<br>Method:Calculated | **14** | 20-100 cells/cumm |
| Neutrophil - Lymphocyte Ratio(NLR)<br>Method:Calculated | 1.95 | 0.78-3.53 |
| RBC | Normocytic Normochromic | |
| WBC | Normal in Morphology & Distribution | |
| Platelets<br>Method:Microscopy | Adequate | |

**Method:** Automated Hematology Cell Counter, Microscopy

**Reference:** Dacie and Lewis Practical Hematology,12th Edition.
Wallach's interpretation of diagnostic tests, Soth Asian Edition.

**Interpretation:** A Complete Blood Picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

**Note:** These results are generated by a fully automated hematology analyzer and the differential count is computed from a total of several thousands of cells. Therefore the differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Shruti Reddy**
**Consultant Pathologist**
**Reg No.TSMC/FMR/22656**

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| | | Reference | : Arcofemi Health Care Ltd - |

TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Blood Urea Nitrogen (BUN), Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Blood Urea Nitrogen.<br>Method:Calculated | 10 | 6-20 mg/dL |
| Urea.<br>Method:Urease/UV | 21.3 | 12.8-42.8 mg/dL |

**Interpretation:** Urea is a waste product formed in the liver when protein is metabolized. Urea is released by the liver into the blood and is carried to the kidneys, where it is filtered out of the blood and released into the urine. Since this is a continuous process, there is usually a small but stable amount of urea nitrogen in the blood. However, when the kidneys cannot filter wastes out of the blood due to disease or damage, then the level of urea in the blood will rise. The blood urea nitrogen (BUN) evaluates kidney function in a wide range of circumstances, to diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status as well.

**Reference:** Tietz Fundamentals of Clinical Chemistry and Molecular Diagnostics

### Creatinine, Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Creatinine.<br>Method:Alkaline Picrate | 0.91 | 0.70-1.20 mg/dL |

**Interpretation:**

Creatinine is a nitrogenous waste product produced by muscles from creatine. Creatinine is majorly filtered from the blood by the kidneys and released into the urine, so serum creatinine levels are usually a good indicator of kidney function. Serum creatinine is more specific and more sensitive indicator of renal function as compared to BUN because it is produced from muscle at a constant rate and its level in blood is not affected by protein catabolism or other exogenous products. It is also not reabsorbed and very little is secreted by tubules making it a reliable marker. Serum creatinine levels are increased in pre renal, renal and post renal azotemia, active acromegaly and gigantism. Decreased serum creatinine levels are seen in pregnancy and increasing age.

### Bun/Creatinine Ratio, Serum

| Investigation | Observed Value | |
|---|---|---|
| BUN/Creatinine Ratio<br>Method:Calculated | 11 | 10-20 |

| | | | |
|---|---|---|---|
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**Interpretation:**
The BUN/Creatinine ratio blood test is used to diagnose acute or chronic renal disease. BUN (blood urea nitrogen) and creatinine are both filtered in the kidneys and excreted in urine. The two together are used to measure overall kidney function

1. Increased ratio (>20) with normal creatinine occurs in the following conditions:
a) Increased BUN (prerenal azotemia), heart failure, salt depletion, dehydration
b) Catabolic states with tissue breakdown
c) GI hemorrhage
d) Impaired renal function plus excess protein intake, production, or tissue breakdown
2. Increased ratio (>20) with elevated creatinine occurs in the following conditions:
a) Obstruction of urinary tract
b) Prerenal azotemia with renal disease

3. Decreased ratio (<10) with decreased BUN occurs in the following conditions:
a) Acute tubular necrosis
b) Decreased urea synthesis as in severe liver disease or starvation
c) Repeated dialysis
d) SIADH
e) Pregnancy

4. Decreased ratio (<10) with increased creatinine occurs in the following conditions:
a) Phenacemide therapy (accelerates conversion of creatine to creatinine)
b) Rhabdomyolysis (releases muscle creatinine)
c) Muscular patients who develop renal failure

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Afreen Anwar**
**Consultant Biochemist**

| | | | |
|---|---|---|---|
| Name | : **MR.NIMISH MILIND DESHMUKH** | TID/SID | : UMR1469085/ 27503437-F |
| Age / Gender | : 25 Years / Male | Registered on | : 20-Apr-2024 / 10:24 AM |
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| | TEST REPORT | Reference | : Arcofemi Health Care Ltd - |

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Glucose Fasting (FBS), Sodium Fluoride Plasma

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Glucose Fasting<br>Method:Hexokinase | 99 | Normal: <100 mg/dL<br>Impaired FG: 100-125 mg/dL<br>Diabetes mellitus: >/=126 mg/dL |

**Interpretation:** It measures the Glucose levels in the blood with a prior fasting of 9-12 hours. The test helps screen a symptomatic/ asymptomatic person who is at risk for Diabetes. It is also used for regular monitoring of glucose levels in people with Diabetes.

**Reference:** American Diabetes Association. Standards of Medical Care in Diabetes-2022

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Afreen Anwar**
**Consultant Biochemist**

| | | | |
|---|---|---|---|
| Name | : **MR.NIMISH MILIND DESHMUKH** | TID/SID | : UMR1469085/ 27503437-P |
| Age / Gender | : 25 Years / Male | Registered on | : 20-Apr-2024 / 10:24 AM |
| Ref.By | : SELF | Collected on | : 20-Apr-2024 / 14:03 PM |
| Req.No | : BIL4176084 | Reported on | : 20-Apr-2024 / 17:48 PM |
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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Glucose Post Prandial (PPBS), Sodium Fluoride Plasma

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Glucose Post Prandial<br>Method:Hexokinase | 116 | Normal : <140 mg/dL<br>Impaired PG: 140-199 mg/dL<br>Diabetes mellitus: >/=200 mg/dL |

**Interpretation:** This test measures the blood sugar levels 2 hours after a normal meal. Abnormally high blood sugars 2 hours after a meal reflect that the body is not producing sufficient insulin which is indicative of Diabetes.

**Reference:** American Diabetes Association. Standards of Medical Care in Diabetes-2022

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Afreen Anwar**
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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Glycosylated Hemoglobin (HbA1C), EDTA Whole Blood

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Glycosylated Hemoglobin (HbA1c)<br>Method:High-Performance Liquid Chromatography | 5.5 | Non-diabetic: <= 5.6 %<br>Pre-diabetic: 5.7 - 6.4 %<br>Diabetic: >= 6.5 % |
| Estimated Average Glucose (eAG)<br>Method:Calculated | 111 | mg/dL |

**Interpretation**:

It is an index of long-term blood glucose concentrations and a measure of the risk for developing microvascular complications in patients with diabetes. Absolute risks of retinopathy and nephropathy are directly proportional to the mean HbA1c concentration. In persons without diabetes, HbA1c is directly related to risk of cardiovascular disease.

1) Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.

2) Interference of Hemoglobinopathies in HbA1c estimatiion:
A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
C. Heterozygous state detected (D10 is corrected for HbS and HbC trait).
3) In known diabetic patients, HbA1c can be considered as a tool for monitoring the glycemic control.
Excellent Control - 6 to 7 %,
Fair to Good Control - 7 to 8 %,
Unsatisfactory Control - 8 to 10 %
and Poor Control - More than 10 %.
**Reference:** American Diabetes Association. Standards of Medical Care in Diabetes-2022.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

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**Dr Afreen Anwar**
**Consultant Biochemist**

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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Lipid Profile, Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Total Cholesterol<br>Method:Cholesterol Oxidase | 217 | Desirable: <200 mg/dL<br>Borderline: 200-239 mg/dL<br>High: >/=240 mg/dL |
| HDL Cholesterol<br>Method:Direct Measurement | **34** | Low: <40 mg/dL<br>High: >/=60 mg/dL |
| VLDL Cholesterol<br>Method:Calculated | **74.80** | 6.0-38.0 mg/dL |
| LDL Cholesterol<br>Method:Calculated | 108.2 | Optimum: <100 mg/dL<br>Near/above optimum: 100-129 mg/dL<br>Borderline: 130-159 mg/dL<br>High: 160-189 mg/dL<br>Very high: >/=190 mg/dL |
| Triglycerides<br>Method:Glycerol LPL/GK | **374** | Normal:<150 mg/dL<br>Borderline: 150-199 mg/dL<br>High: 200-499 mg/dL<br>Very high: >/=500 mg/dL |
| Chol/HDL Ratio<br>Method:Calculated | **6.38** | Low Risk: 3.3-4.4<br>Average Risk: 4.5-7.1<br>Moderate Risk: 7.2-11.0 |
| LDL Cholesterol/HDL Ratio<br>Method:Calculated | **3.18** | Desirable: 0.5-3.0<br>Borderline Risk: 3.0-6.0<br>High Risk: >6.0 |

**Interpretation:** Lipids are fats and fat-like substances which are important constituents of cells and are rich sources of energy. A lipid profile typically includes total cholesterol, high density lipoproteins (HDL), low density lipoprotein (LDL), chylomicrons, triglycerides, very low density lipoproteins (VLDL), Cholesterol/HDL ratio .The lipid profile is used to assess the risk of developing a heart disease and to monitor its treatment. The results of the lipid profile are evaluated along with other known risk factors associated with heart disease to plan and monitor treatment. Treatment options require clinical correlation.**Reference:** 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 2001.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Liver Function Test (LFT), Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Total Bilirubin.<br>Method:Diazo method | 0.67 | <1.2 mg/dL |
| Direct Bilirubin.<br>Method:Diazo method | 0.26 | <0.30 mg/dL |
| Indirect Bilirubin.<br>Method:Calculated | 0.41 | <0.9 mg/dL |
| Alanine Aminotransferase ,(ALT/SGPT)<br>Method:UV wtihout P5P | **46** | <45 U/L |
| Aspartate Aminotransferase,(AST/SGOT)<br>Method:UV wtihout P5P | 28 | <35 U/L |
| ALP (Alkaline Phosphatase).<br>Method:PNPP-AMP Buffer | 46 | 40-129 U/L |
| Gamma GT.<br>Method:Gamma-Glutamyl - 3 - Carbossi - 4 - Nitroanilide (GCNA) | 33 | 10-71 U/L |
| Total Protein.<br>Method:Biuret | 8.0 | 6.6-8.7 g/dL |
| Albumin.<br>Method:Bromocresol Green (BCG) | 4.9 | 3.5-5.2 g/dL |
| Globulin.<br>Method:Calculated | 3.1 | 1.8-3.8 g/dL |
| A/GRatio.<br>Method:Calculated | 1.58 | 0.8-2.0 |

**Interpretation:** Liver functions tests help to identify liver disease, its severity, and its type. Generally these tests are performed in combination, are abnormal in liver disease, and the pattern of abnormality is indicative of the nature of liver disease. An isolated abnormality of a single liver function test usually means a non-hepatic cause. If several liver function tests are simultaneously abnormal, then hepatic etiology is likely.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Thyroid Profile (T3,T4,TSH), Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Triiodothyronine Total (T3)<br>Method:ECLIA | 0.92 | 0.80-2.00 ng/mL |
| Thyroxine Total (T4)<br>Method:ECLIA | 6.7 | 5.1-14.1 µg/dL |
| Thyroid Stimulating Hormone (TSH)<br>Method:ECLIA | 2.5 | 0.27-4.20 µIU/mL |

**Interpretation:**

A thyroid profile is used to evaluate thyroid function and/or help diagnose hypothyroidism and hyperthyroidism due to various thyroid disorders. T4 and T3 are hormones produced by the thyroid gland. They help control the rate at which the body uses energy, and are regulated by a feedback system. TSH from the pituitary gland stimulates the production and release of T4 (primarily) and T3 by the thyroid. Most of the T4 and T3 circulate in the blood bound to protein. A small percentage is free (not bound) and is the biologically active form of the hormones.
**Reference:** Tietz textbook of Clinial Chemistry and Molecular Diagnostics, Nader Rifia, Andrea Ritas Horvath, Carl T. Wittwer.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Afreen Anwar**
**Consultant Biochemist**

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TEST REPORT

## DEPARTMENT OF CLINICAL CHEMISTRY I

### Uric Acid, Serum

| Investigation | Observed Value | Biological Reference Interval |
|---|---|---|
| Uric Acid.<br>Method:Uricase | **7.7** | 3.4-7.0 mg/dL |
| Note | Kindly correlate clinically | |

**Interpretation**

It is the major product of purine catabolism. Hyperuricemia can result due to increased formation or decreased excretion of uric acid which can be due to several causes like metabolic disorders, psoriasis, tissue hypoxia, pre-eclampsia, alcohol, lead poisoning, acute or chronic kidney disease, etc. Hypouricemia may be seen in severe hepato cellular disease and defective renal tubular reabsorption of uric acid.

* Sample processed at National Reference Laboratory, Tenet Diagnostics, Hyderabad

--- End Of Report ---

**Dr Afreen Anwar**
**Consultant Biochemist**

MR NIMISH MILIND DESHMUKH
ID: 4176084

Male
25 Years

20.04.2024 14:03:34
TENET DIAGNOSTICS
VIKRAMPURI HUB
HYDERABAD

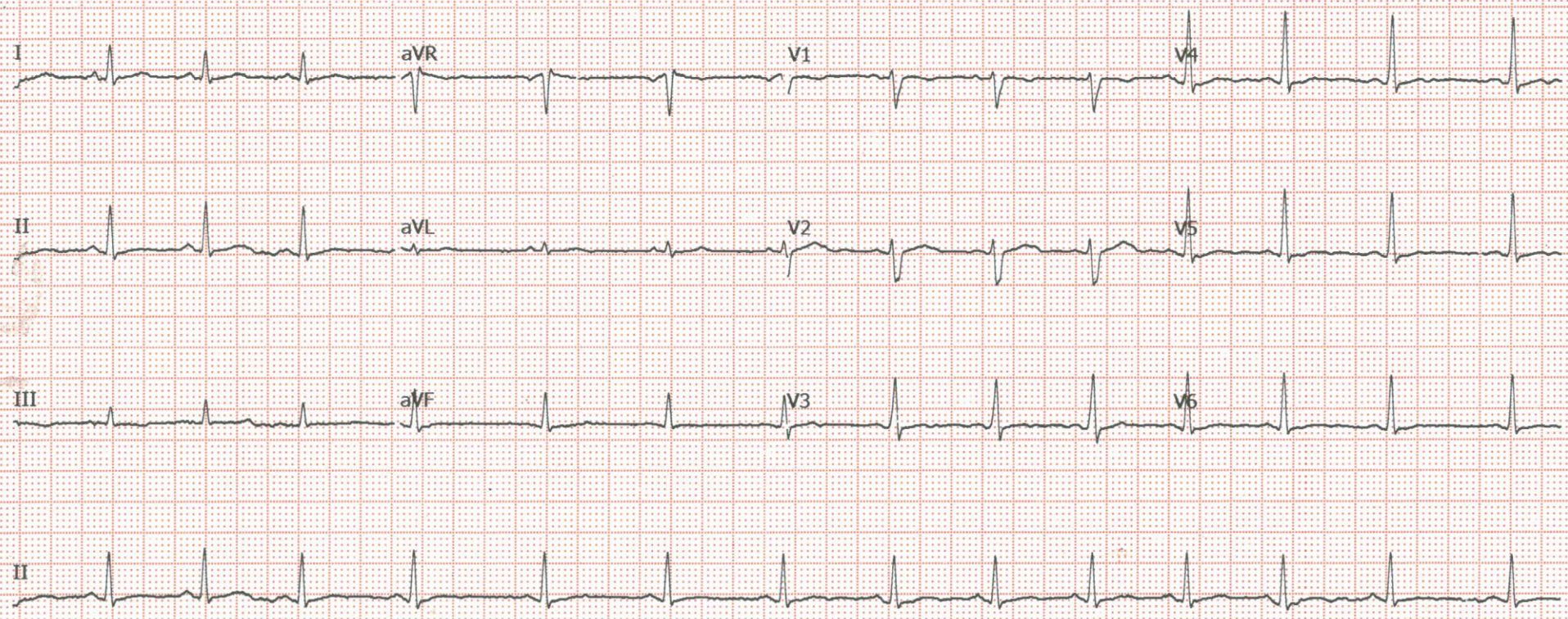
86 bpm
— / — mmHg

| | |
|---|---|
| QRS : | 80 ms |
| QT / QTcBaz : | 338 / 404 ms |
| PR : | 116 ms |
| P : | 88 ms |
| RR / PP : | 696 / 697 ms |
| P / QRS / T : | 40 / 54 / 28 degrees |

Normal sinus rhythm with sinus arrhythmia
Nonspecific T wave abnormality
Abnormal ECG

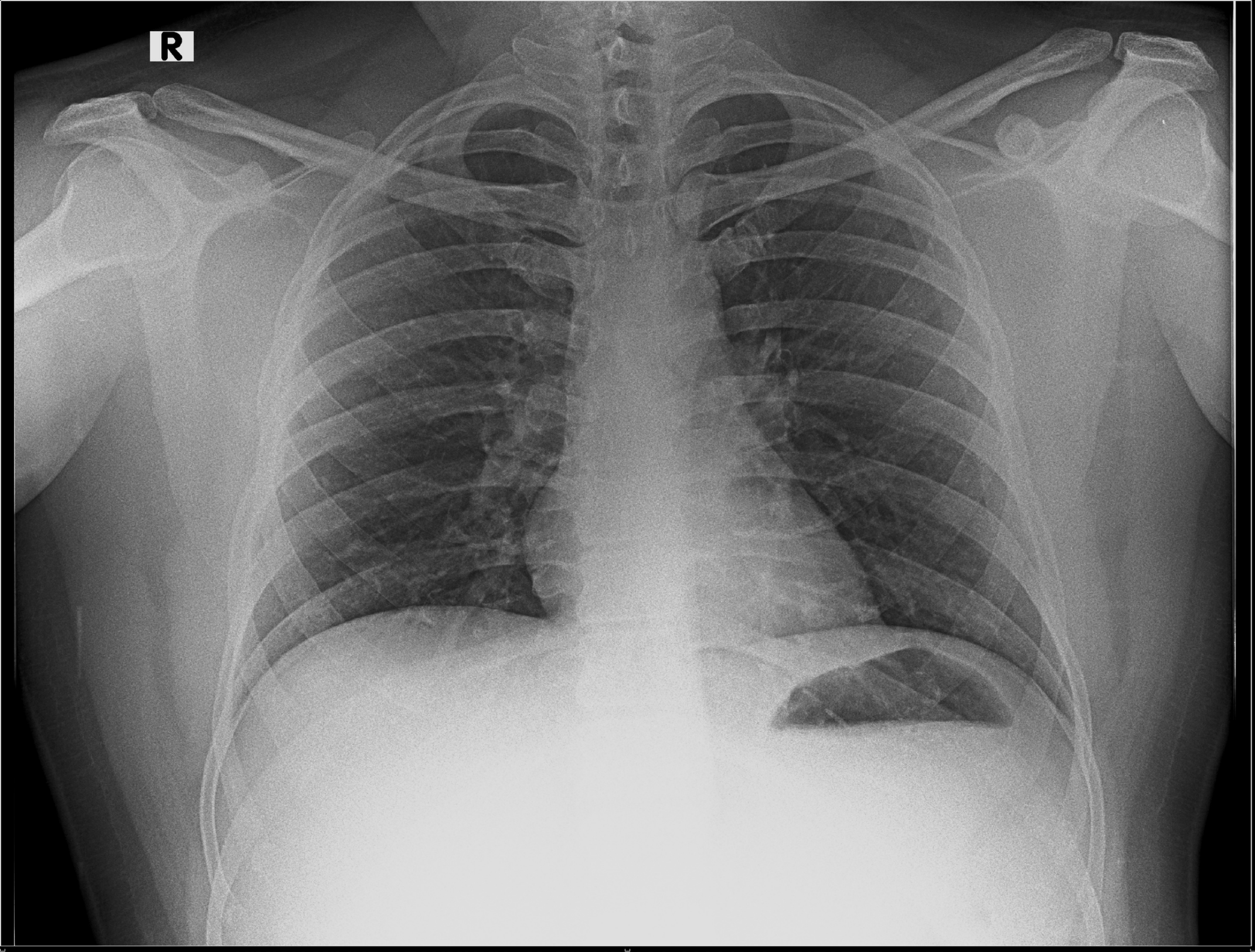
Within normal limits

Dr.RAVI SRINIVAS
MD.,DM.,
Consultant Cardiology
Regd.No:10808




Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz 4x2.5x3_25_R1 1/1

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