



MC-2178

Lab No. : SG2/10-08-2024/SR9499517	Lab Add. : Sevoke Road, Siliguri 734001
Patient Name : LAWRENCE MURMU	Ref Dr. : Dr.MEDICAL OFFICER
Age : 34 Y 11 M 8 D	Collection Date : 10/Aug/2024 10:39AM
Gender : M	Report Date : 10/Aug/2024 06:19PM

**DEPARTMENT OF BIOCHEMISTRY**

Test Name	Result	Bio Ref. Interval	Unit
SODIUM,BLOOD , GEL SERUM (Method:ISE INDIRECT)	136	136 - 145	mEq/L
GLUCOSE,PP (Method:Hexokinase Method)	140	75-140	mg/dl
SGOT/AST (Method:UV WITH P5P)	20	15 - 37	U/L
*BILIRUBIN (TOTAL) , GEL SERUM BILIRUBIN (TOTAL) (Method:DIAZONIUM ION)	1.65	0.2 - 1.2	mg/dL
SGPT/ALT (Method:UV WITH P5P)	28	16 - 63	U/L
POTASSIUM,BLOOD (Method:ISE INDIRECT)	4.4	3.5 - 5.1	mEq/L
UREA,BLOOD (Method:UREASE-COLORIMETRIC)	17	12.8-42.8	mg/dl
GLUCOSE,FASTING (Method:Hexokinase Method)	96	70 - 100	mg/dl
PHOSPHORUS-INORGANIC,BLOOD (Method:UV PHOSPHOMOLYBDATE)	3.2	2.5-4.5 mg/dl	mg/dl
*TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , . TOTAL PROTEIN (Method:BIURET METHOD)	7.97	6.6 - 8.7	g/dL
ALBUMIN (Method:BCP)	4.1	3.4 -5.0 g/dl	g/dl
GLOBULIN (Method:Calculated)	3.89	1.8-3.2	g/dl
AG Ratio (Method:Calculated)	1.05	1.0 - 2.5	
*GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD GLYCATED HEMOGLOBIN (HBA1C)	4.9	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	%
HbA1c (IFCC) (Method:HPLC)	30		mmol/mol

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
 Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
 Diabetics-HbA1c level : >= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad D 10



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**DEPARTMENT OF BIOCHEMISTRY**

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Method : HPLC Cation Exchange**Recommendations for glycemc targets**

- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemc control.
 - Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
 - Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemc control.
 - Ø If a patient changes treatment plans or does not meet his or her glycemc goals, HbA1c testing should be done quarterly.
 - Ø For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease. Action suggested >8% as it indicates poor control.
 - Ø Some patients may benefit from HbA1c goals that are stringent.
- Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B12/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.
- Reference: Glycated hemoglobin monitoring BMJ 2006; 333:586-8

References:

1. Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.
2. Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.

PDF Attached

*THYROID PANEL (T3, T4, TSH) , GEL SERUM			
T3-TOTAL (TRI IODOTHYRONINE) (Method:CLIA)	1.17	0.60 - 1.81 ng/ml	ng/ml
T4-TOTAL (THYROXINE) (Method:CLIA)	8.9	4.5 - 10.9	microgram/dl
TSH (THYROID STIMULATING HORMONE) (Method:CLIA)	5.20	0.35-5.5	µIU/mL

BIOLOGICAL REFERENCE INTERVAL : [ONLY FOR PREGNANT MOTHERS]**Trimester specific TSH LEVELS during pregnancy:**

- FIRST TRIMESTER : 0.10 - 2.50 µ IU/mL
SECOND TRIMESTER : 0.20 - 3.00 µ IU/mL
THIRD TRIMESTER : 0.30 - 3.00 µ IU/mL

References :

1. Indian Thyroid Society guidelines for management of thyroid dysfunction during pregnancy. Clinical Practice Guidelines, New Delhi: Elsevier; 2012.
2. Stagnaro-Green A, Abalovich M, Alexander E, Azizi F, Mestman J, Negro R, et al. Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum. Thyroid 2011;21: 1081-25.
3. Dave A, Maru L, Tripathi M. Importance of Universal screening for thyroid disorders in first trimester of pregnancy. Indian J Endocr Metab [serial online] 2014 [cited 2014 Sep 25]; 18: 735-8. Available from: <http://www.ijem.in/text.asp?2014/18/5/735/139221>.

BILIRUBIN (DIRECT) (Method:DIAZOTIZATION)	0.21	< 0.2	mg/dL
ALKALINE PHOSPHATASE (Method:P-NPP,AMP BUFFER)	89	46 - 116	U/L
CREATININE, BLOOD (Method: ALKALINE PICRATE)	1.25	0.70 - 1.30	mg/dl



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**DEPARTMENT OF BIOCHEMISTRY**

Test Name	Result	Bio Ref. Interval	Unit
LIPID PROFILE , GEL SERUM			
CHOLESTEROL-TOTAL (Method:CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	146	Desirable: < 200 mg/dL Borderline high: 200-239 High: > or =240 mg/dL	mg/dl
TRIGLYCERIDES (Method:ENZYMATIC, END POINT)	161	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	mg/dl
HDL CHOLESTEROL (Method:DIRECT MEASURE-PEG)	39	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	mg/dl
LDL CHOLESTEROL DIRECT (Method:DIRECT MEASURE)	94	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	mg/dl
VLDL (Method:Calculated)	14	< 40 mg/dl	mg/dL
CHOL HDL Ratio (Method:Calculated)	3.8	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	

NOTE : Elevated Triglyceride value is to be interpreted in the light of previous 72 hrs dietary intake of lipids.Repeat estimation with 72 hrs fat restricted diet followed by 12 hrs fasting, suggested for better evaluation .

URIC ACID,BLOOD (Method:URICASE ,COLORIMETRIC)	6.96	3.5 - 7.2	mg/dl
CHLORIDE,BLOOD (Method:ISE INDIRECT)	105	98 - 107	mEq/L
CALCIUM,BLOOD (Method:OCPC)	9	8.6-10.0 mg/dl	mg/L

***** End Of Report *****

Dr. Ankush Chakraborty
MBBS, MD (Path), IFCAP
Consultant Pathologist
Reg. No. 65992 (WBMC)



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Gender : M	Report Date : 10/Aug/2024 01:14PM



DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
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BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD

ABO (Method:Gel Card)	A
RH (Method:Gel Card)	POSITIVE

Gel technology Dia Med ID Micro typing system is the latest technology in transfusion Medicine.

It gives more reproducible and standardized test results.

It more repaid, reliable, very sensitive and objective , and hence more consistent and comparable results are obtained.

Single used cards are individualised for every patient and results can be photographed / scanned and stored for future use.

Special instruments that are used only for this technology also reduce risk of any contamination.

Ref:- WHO technical manual on transfusion medicine-Second Edition 2003

(RESULTS ALSO VERIFIED BY : FORWARD AND REVERSE GROUPING (TUBE AND SLIDE METHOD))

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.

ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD

1stHour (Method:Westergren)	30	0.00 - 20.00 mm/hr	mm/hr
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CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD

HEMOGLOBIN (Method:SLS haemoglobin method)	14.8	13 - 17	g/dL
WBC (Method:DC detection method)	6.9	4 - 10	*10 ³ /μL
RBC (Method:DC detection method)	5.75	4.5 - 5.5	*10 ⁶ /μL
PLATELET (THROMBOCYTE) COUNT (Method:DC detection method/Microscopy)	268	150 - 450*10 ³	*10 ³ /μL

DIFFERENTIAL COUNT

NEUTROPHILS (Method:Flowcytometry/Microscopy)	60	40 - 80 %	%
LYMPHOCYTES (Method:Flowcytometry/Microscopy)	33	20 - 40 %	%
MONOCYTES (Method:Flowcytometry/Microscopy)	03	2 - 10 %	%
EOSINOPHILS (Method:Flowcytometry/Microscopy)	04	1 - 6 %	%
BASOPHILS (Method:Flowcytometry/Microscopy)	00	0-0.9%	%

CBC SUBGROUP

HEMATOCRIT / PCV (Method:Calculated)	43.8	40 - 50 %	%
MCV	76.1	83 - 101 fl	fl

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**DEPARTMENT OF HAEMATOLOGY**

Test Name	Result	Bio Ref. Interval	Unit
(Method:Calculated) MCH	25.7	27 - 32 pg	pg
(Method:Calculated) MCHC	33.8	31.5-34.5 gm/dl	gm/dl
(Method:Calculated) RDW - RED CELL DISTRIBUTION WIDTH	16.2	11.6-14%	%
(Method:Calculated) PDW-PLATELET DISTRIBUTION WIDTH	29.8	8.3 - 25 fL	fL
(Method:Calculated) MPV-MEAN PLATELET VOLUME	13.3	7.5 - 11.5 fl	
RBC	MICROCYTIC HYPOCHROMIC		
WBC.	NORMAL MORPHOLOGY		
PLATELET	ADEQUATE ON SMEAR.		

***** End Of Report *****

Dr. Ankush Chakraborty
MBBS, MD (Path), IFCAP
Consultant Pathologist
Reg. No. 65992 (WBMC)

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Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date :
Report Date : 10/Aug/2024 02:02PM



DEPARTMENT OF X-RAY

DEPARTMENT OF RADIOLOGY
X-RAY REPORT OF CHEST (PA)

FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhouette is smoothly outlined. Shape is within normal limit.
- Lung parenchyma shows no focal lesion. No general alteration of radiographic density. Apices are clear. Bronchovascular lung markings are within normal.
- Lateral costo-phrenic angles are clear.
- Domes of diaphragm are smoothly outlined. Position is within normal limits.

IMPRESSION :

Normal study.

*** End Of Report ***

MS

DR. MUKTI SARKAR MD.
CONSULTANT RADIOLOGIST



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Gender : M	Report Date : 10/Aug/2024 07:33PM

**DEPARTMENT OF CLINICAL PATHOLOGY**

Test Name	Result	Bio Ref. Interval	Unit
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URINE ROUTINE ALL, ALL , URINE**PHYSICAL EXAMINATION**

COLOUR	STRAW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION

pH (Method:Dipstick (triple indicator method))	6.5	4.6 - 8.0
SPECIFIC GRAVITY (Method:Dipstick (ion concentration method))	1.005	1.005 - 1.030
PROTEIN (Method:Dipstick (protein error of pH indicators)/Manual)	ABSENT	NOT DETECTED
GLUCOSE (Method:Dipstick(glucose-oxidase-peroxidase method)/Manual)	ABSENT	NOT DETECTED
KETONES (ACETOACETIC ACID, ACETONE) (Method:Dipstick (Legals test)/Manual)	ABSENT	NOT DETECTED
BLOOD (Method:Dipstick (pseudoperoxidase reaction))	ABSENT	NOT DETECTED
BILIRUBIN (Method:Dipstick (azo-diazo reaction)/Manual)	ABSENT	NEGATIVE
UROBILINOGEN (Method:Dipstick (diazonium ion reaction)/Manual)	ABSENT	NEGATIVE
NITRITE (Method:Dipstick (Griess test))	ABSENT	NEGATIVE
LEUCOCYTE ESTERASE (Method:Dipstick (ester hydrolysis reaction))	ABSENT	NEGATIVE

MICROSCOPIC EXAMINATION

LEUKOCYTES (PUS CELLS) (Method:Microscopy)	0-1	0-5	/hpf
EPITHELIAL CELLS (Method:Microscopy)	0-1	0-5	/hpf
RED BLOOD CELLS (Method:Microscopy)	ABSENT	0-2	/hpf
CAST (Method:Microscopy)	ABSENT	NOT DETECTED	
CRYSTALS (Method:Microscopy)	ABSENT	NOT DETECTED	
BACTERIA (Method:Microscopy)	FEW	NOT DETECTED	
YEAST (Method:Microscopy)	ABSENT	NOT DETECTED	
OTHERS	ABSENT		

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

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DEPARTMENT OF CLINICAL PATHOLOGY

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occur due to cell lysis.

8. 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.

*** End Of Report ***

Dr. Ankush Chakraborty
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Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date :
Report Date : 10/Aug/2024 06:31PM



DEPARTMENT OF CARDIOLOGY

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

HEART RATE : 69 /min.
RHYTHM : Regular sinus.
P-WAVE : Normal
P - R INTERVAL : 160 ms,
QRS DURATION : 80 ms
QRS CONFIGURATION : NORMAL
QRS VOLTAGE : R/S in V1 2/4 mm.
R/S in V6 14/0 mm.
QRS AXIS : Normal.
Q- Waves : No significant Q-wave.
QT TIME : Normal.
ST SEGMENT : Normal.
T WAVE : NORMAL
ROTATION : Normal.
OTHER FINDINGS : Nil.
IMPRESSION : ECG WITHIN NORMAL LIMIT.

*** End Of Report ***

Dr. KAUSIK PAL
MD DM (Card)
Reg No-WBMC-56578

Lab No.	: SG2/10-08-2024/SR9499517	Lab Add.	:
Patient Name	: LAWRENCE MURMU	Ref Dr.	: Dr.MEDICAL OFFICER
Age	: 34 Y 11 M 8 D	Collection Date	:
Gender	: M	Report Date	: 10/Aug/2024 04:09PM



DEPARTMENT OF ULTRASONOGRAPHY

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 with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal at porta.

GALL BLADDER

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

PANCREAS

Echogenecity 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. 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 102 mm. & Lt. kidney 106 mm) axes & position. Cortical echogenecity appears normal maintaining corticomedullary 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.**Small cyst (6x4mm) in prostate.**

It measures : 24 mm. x 30 mm. x 34 mm.

Approximate weight could be around = 13 gms

IMPRESSION

Small cyst (6x4mm) in prostate.

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.

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DEPARTMENT OF ULTRASONOGRAPHY

The report and films are not valid for medico-legal purpose.

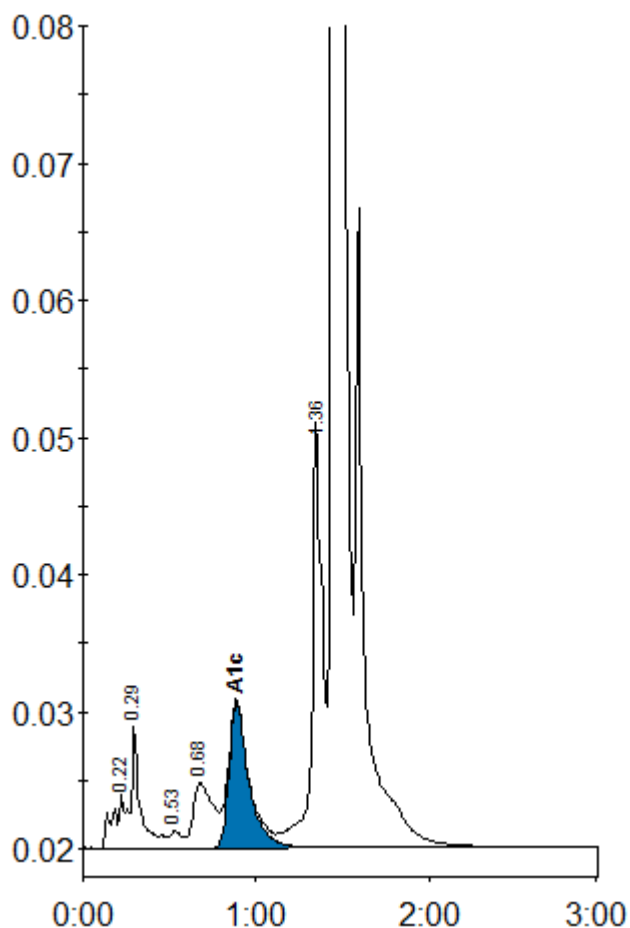
Patient Identity not verified.

MS

DR. Mukti SARKAR MD.
CONSULTANT RADIOLOGIST

Patient report

Sample ID: D02135795029
 Injection date 10/08/2024 09:11 AM
 Injection #: 3 D-10 Method: HbA1c
 Rack #: --- Rack position: 3
 Bio-Rad v: 5.00-2 S/N: #DM23F10804



Peak table - ID: D02135795029

Peak	R.time	Height	Area	Area %
A1a	0.22	3935	22326	0.9
A1b	0.29	9043	30896	1.2
F	0.53	1207	6377	0.3
LA1c/CHb-1	0.68	4772	38178	1.5
A1c	0.88	10622	84650	4.9
P3	1.36	30930	132438	5.3
A0	1.44	870218	2175192	87.4
Total Area:			2490057	

Concentration:	%	mmol/mol
A1c	4.9	30