

Name : Mrs. RUKMANI S
PID No. : MED111534792 **Register On** : 11/03/2023 9:02 AM
SID No. : 1802308913 **Collection On** : 11/03/2023 11:22 AM
Age / Sex : 42 Year(s)/ Female **Report On** : 12/03/2023 11:56 AM
Type : OP **Printed On** : 15/03/2023 7:29 PM
Ref. Dr : MediWheel

<u>Investigation</u>	<u>Observed Value</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
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BLOOD GROUPING AND Rh TYPING	'AB' 'Positive'		
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(EDTA Blood/Agglutination)

INTERPRETATION: Reconfirm the Blood group and Typing before blood transfusion

Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	12.9	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood/Derived from Impedance)	38.4	%	37 - 47
RBC Count (EDTA Blood/Impedance Variation)	4.42	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (EDTA Blood/Derived from Impedance)	86.9	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood/Derived from Impedance)	29.0	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood/Derived from Impedance)	33.4	g/dL	32 - 36
RDW-CV (EDTA Blood/Derived from Impedance)	14.0	%	11.5 - 16.0
RDW-SD (EDTA Blood/Derived from Impedance)	42.58	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood/Impedance Variation)	7600	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood/Impedance Variation & Flow Cytometry)	60.1	%	40 - 75
Lymphocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	27.9	%	20 - 45


Dr. Manjula Ramesh
 Consultant Biochemist

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DR. SUNDAR ELAYAPERUMAL MD, CIC
 CONSULTANT MICROBIOLOGIST
 REG NO. 41854

APPROVED BY

The results pertain to sample tested.

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Eosinophils (EDTA Blood/Impedance Variation & Flow Cytometry)	3.3	%	01 - 06
Monocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	8.0	%	01 - 10
Basophils (EDTA Blood/Impedance Variation & Flow Cytometry)	0.7	%	00 - 02
INTERPRETATION: Tests done on Automated Five Part cell counter. All abnormal results are reviewed and confirmed microscopically.			
Absolute Neutrophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	4.57	10 ³ / μ l	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	2.12	10 ³ / μ l	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood/Impedance Variation & Flow Cytometry)	0.25	10 ³ / μ l	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.61	10 ³ / μ l	< 1.0
Absolute Basophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.05	10 ³ / μ l	< 0.2
Platelet Count (EDTA Blood/Impedance Variation)	45 (Rechecked)	10 ³ / μ l	150 - 450
MPV (EDTA Blood/Derived from Impedance)	9.3	fL	8.0 - 13.3
PCT (EDTA Blood/Automated Blood cell Counter)	0.04	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Blood/Automated - Westergren method)	38	mm/hr	< 20


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BUN / Creatinine Ratio	9.41		6.0 - 22.0
Glucose Fasting (FBS) (Plasma - F/GOD-PAP)	98.0	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose, Fasting (Urine) (Urine - F/GOD - POD)	Negative		Negative
Glucose Postprandial (PPBS) (Plasma - PP/GOD-PAP)	116.6	mg/dL	70 - 140

INTERPRETATION:

Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti-diabetic medication during treatment for Diabetes.

Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
Blood Urea Nitrogen (BUN) (Serum/Urease UV / derived)	6.4	mg/dL	7.0 - 21
Creatinine (Serum/Modified Jaffe)	0.68	mg/dL	0.6 - 1.1

INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin, cefazolin, ACE inhibitors, angiotensin II receptor antagonists, N-acetylcysteine, chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/Enzymatic)	3.1	mg/dL	2.6 - 6.0
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Liver Function Test

Bilirubin(Total) (Serum/DCA with ATCS)	0.24	mg/dL	0.1 - 1.2
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Bilirubin(Direct) (Serum/Diazotized Sulfanilic Acid)	0.08	mg/dL	0.0 - 0.3
Bilirubin(Indirect) (Serum/Derived)	0.16	mg/dL	0.1 - 1.0
SGOT/AST (Aspartate Aminotransferase) (Serum/Modified IFCC)	15.4	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/Modified IFCC)	23.1	U/L	5 - 41
GGT(Gamma Glutamyl Transpeptidase) (Serum/IFCC / Kinetic)	14.3	U/L	< 38
Alkaline Phosphatase (SAP) (Serum/Modified IFCC)	81.0	U/L	42 - 98
Total Protein (Serum/Biuret)	7.67	gm/dL	6.0 - 8.0
Albumin (Serum/Bromocresol green)	4.25	gm/dL	3.5 - 5.2
Globulin (Serum/Derived)	3.42	gm/dL	2.3 - 3.6
A : G RATIO (Serum/Derived)	1.24		1.1 - 2.2

Lipid Profile

Cholesterol Total (Serum/CHOD-PAP with ATCS)	212.8	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/GPO-PAP with ATCS)	140.7	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500


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INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the usual circulating level of triglycerides during most part of the day.			
HDL Cholesterol (Serum/Immunoinhibition)	52.2	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/Calculated)	132.5	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	28.1	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	160.6	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
 2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.

Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	4.1		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
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Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	2.7		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
LDL/HDL Cholesterol Ratio (Serum/Calculated)	2.5		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0

Glycosylated Haemoglobin (HbA1c)

HbA1C (Whole Blood/HPLC)	6.2	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5
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INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %

Estimated Average Glucose (Whole Blood)	131.24	mg/dL
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INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycaemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.

Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/Chemiluminescent Immunometric Assay (CLIA))	0.95	ng/ml	0.7 - 2.04
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INTERPRETATION:

Comment :

Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.


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T4 (Tyroxine) - Total (Serum/Chemiluminescent Immunometric Assay (CLIA))	5.00	µg/dl	4.2 - 12.0

INTERPRETATION:

Comment :

Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

TSH (Thyroid Stimulating Hormone) (Serum/Chemiluminescent Immunometric Assay (CLIA))	8.52	µIU/mL	0.35 - 5.50
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INTERPRETATION:

Reference range for cord blood - upto 20

1 st trimester: 0.1-2.5

2 nd trimester 0.2-3.0

3 rd trimester : 0.3-3.0

(Indian Thyroid Society Guidelines)

Comment :

1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.

2.TSH Levels are subject to circadian variation, reaching peak levels between 2-4am and at a minimum between 6-10PM.The variation can be of the order of 50%,hence time of the day has influence on the measured serum TSH concentrations.

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.

Urine Analysis - Routine

COLOUR (Urine)	Pale yellow	Yellow to Amber
APPEARANCE (Urine)	Clear	Clear
Protein (Urine/Protein error of indicator)	Negative	Negative
Glucose (Urine/GOD - POD)	Negative	Negative
Pus Cells (Urine/Automated δFlow cytometry)	2 - 3 /hpf	NIL



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Epithelial Cells (Urine/Automated δ Flow cytometry)	4 - 6	/hpf	NIL
RBCs (Urine/Automated δ Flow cytometry)	NIL	/hpf	NIL
Casts (Urine/Automated δ Flow cytometry)	NIL	/hpf	NIL
Crystals (Urine/Automated δ Flow cytometry)	NIL	/hpf	NIL
Others (Urine)	Budding yeast cells present.		

INTERPRETATION:Note: Done with Automated Urine Analyser & Automated urine sedimentation analyser. All abnormal reports are reviewed and confirmed microscopically.

Stool Analysis - ROUTINE

Colour (Stool)	Brown	Brown
Blood (Stool)	Absent	Absent
Mucus (Stool)	Absent	Absent
Reaction (Stool)	Acidic	Acidic
Consistency (Stool)	Semi Solid	Semi Solid
Ova (Stool)	NIL	NIL
Others (Stool)	NIL	NIL
Cysts (Stool)	NIL	NIL


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Trophozoites (Stool)	NIL		NIL
RBCs (Stool)	NIL	/hpf	Nil
Pus Cells (Stool)	1 - 2	/hpf	NIL
Macrophages (Stool)	NIL		NIL
Epithelial Cells (Stool)	NIL	/hpf	NIL



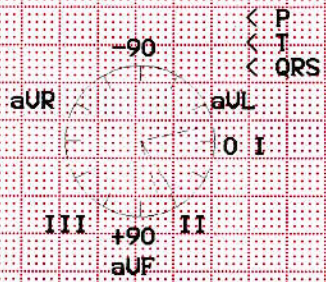
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-- End of Report --

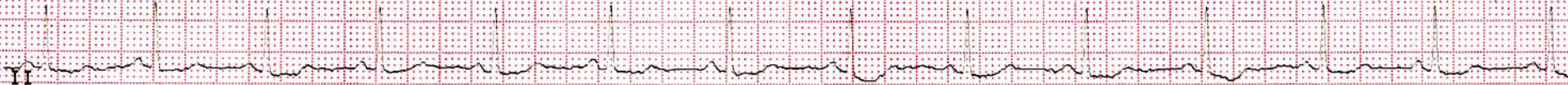
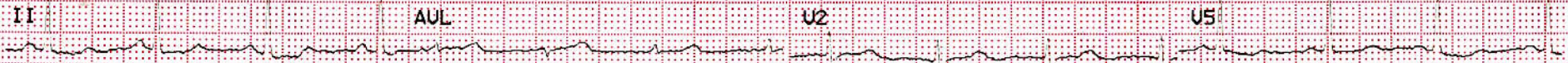
Measurement Results:
 QRS : 76 ms
 QT/QTcB : 376 / 436 ms
 PR : 122 ms
 P : 96 ms
 RR/PP : 746 / 740 ms
 P/QRS/T : 70 / 56 / -13 degrees



Interpretation:
 12SL - Interpretation:
 Normal sinus rhythm
 Nonspecific ST and T wave abnormality
 Abnormal ECG

38.4
 155.0
 24.3

Unconfirmed report.



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Age & Gender	42Y/FEMALE	Visit Date	Mar 11 2023 9:02AM
Ref Doctor Name	MediWheel		

SONOGRAM REPORT

WHOLE ABDOMEN

The liver is normal in size and shows diffuse fatty changes. No focal mass seen.

The gall bladder is normal sized and smooth walled and contains no calculus.

There is no intra or extra hepatic biliary ductal dilatation.

The pancreas shows a normal configuration and echotexture.

The pancreatic duct is normal.

The portal vein and IVC are normal.

The spleen is normal.

There is no free or loculated peritoneal fluid.

No para aortic lymphadenopathy is seen.

No abnormality is seen in the region of the adrenal glands.

The right kidney measures 9.9 x 3.3 cms.

The left kidney measures 10.1 x 4.3 cms.

Both kidneys are normal in size, shape and position. Cortical echoes are normal bilaterally.

There is no calculus or calyceal dilatation.

The ureters are not dilated.

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The bladder is smooth walled and uniformly transonic. There is no intravesical mass or calculus.

The uterus is anteverted, and measures 10.6 x 4.7 cms.

Myometrial echoes are homogeneous.

The endometrial thickness is 5.3 mm.

The right ovary measures 2.7 x 2.5 cms.

The left ovary measures 2.7 x 2.6 cms.

No significant mass or cyst is seen in the ovaries.

Parametria are free.

Iliac fossae are normal.

No mass or fluid collection is seen in the right iliac fossa. The appendix is not visualized.

IMPRESSION:

- **Fatty liver.**
- **Other organs are normal.**

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DR. S.GNANAM MBBS.,DMRD.,
CONSULTANT RADIOLOGIST

REPORT DISCLAIMER

ve limitations. 7. Results of the test are influenced by various factors such as sensitivity, specificity of the procedure, quality of the samples and drug interactions etc.,
ings. 8. If the test results are abnormal, please consult your physician for further evaluation.

SI

CONSULTANT RADIOLOGIST

DR. S.GNANAM MBBS.,DMRD.,

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ECHO CARDIOGRAPHY REPORT

Measurements:-

M Mode:

IVS d	0.9cm	IVS s	1.2cm
LVID d	3.6cm	LVID s	2.4cm
LVPW d	0.7cm	LVPW s	1.2cm
AO	2.5cm	LA	2.7cm

Doppler study:

Location	m/sec	Location	m/sec
MP A vel	0.7	MV E	0.7
PGT	2mmHg	A	0.5
AV vel	1.1	Ratio	1.4
PGT	4mmHg	TV E	0.5
EF	62%	A	0.4
FS	32%	Ratio	1.2

2D:

LA : NORMAL	RA : NORMAL
LV : NORMAL	RV : NORMAL
AV : NORMAL	PV : NORMAL
MV : NORMAL	TV : NORMAL
AO : NORMAL	PA : NORMAL

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Age & Gender	42Y/FEMALE	Visit Date	Mar 11 2023 9:02AM
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Observations:

- **Cardiac chambers dimension-normal**
- **No regional wall motion abnormality**
- **Normal LV systolic and diastolic function**
- **Valves are morphologically and functionally normal**
- **No stenosis / prolapse / regurgitation**
- **Doppler flow pattern normal**
- **No pulmonary hypertension**
- **Normal Pericardium**
- **IAS/ IVS appear Intact**
- **No mass**

CONCLUSIONS:

- ***NORMAL CARDIAC DIMENSIONS.***
- ***NO REGIONAL WALL MOTION ABNORMALITIES.***
- ***GOOD LV SYSTOLIC FUNCTION.***
- ***LVEF-62 %***
- ***NORMAL STUDY.***

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Prof. N. Subramanian MD, DM(CARD) FRCP, FACC
Consultant Cardiologist

Done By :-Ms. Binodini
Cardiac technologist

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X - RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Cardiac size is within normal limits.

Bilateral hilar regions appear normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

Impression: No significant abnormality detected.



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