

Dr. Goyal's

Path Lab & Imaging Centre

B-51, Ganesh Nagar, Opp. Janpath Corner, New Sanganer Road, Jaipur-302019
Tele: 0141-2293346, 4049787, 9887049787
Website: www.drgoyalspathlab.com | E-mail: drgoyalpiyush@gmail.com



General Physical Examination

Date of Examination: 24-12-2022

Name: JYOTI KHINCHI Age: 28 Sex: F

DOB: 15-02-1994

Referred By: BOB (Mediawheel)

Photo ID: AADHAR ID #: attached

Ht: 150 (cm)

Wt: 59 (Kg)

Chest (Expiration): 92 (cm)

Abdomen Circumference: 83 (cm)

Blood Pressure: 120/80 mm Hg PR: 78 / min RR: 16 / min Temp: Afebrile

BMI 26.2

Eye Examination: Dist vision. L.E. 6/6, R.E. 6/12, (with spec).

Near vision N/G Blue eyes, Normal Color vision.

Other: Not significant

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examinee: Jyoti Name of Examinee: _____

Signature Medical Examiner: Dr Piyush Goyal Name Medical Examiner: _____

Dr Piyush Goyal
M.B.B.S., D.M.R.D
RMC Reg No -017996

भारत सरकार
आधार



ज्योति खिंची
Jyoti Khinchi
जन्म तिथि/DOB: 05/02/1994
महिला/ FEMALE

9362 0969 5206
VID : 9150 0355 9502 7567

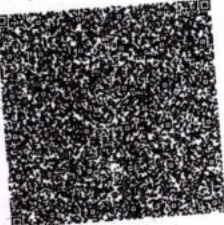
मेरा आधार, मेरी पहचान

Jyoti

भारत सरकार
आधार

पता:
द्वारा: हितेश एस खिंची, एस - 125, शांति नगर, एन बी सी
के सामने, हसनपुरा, जयपुर, जयपुर,
राजस्थान - 302006

Address:
C/O: Hitesh S Khinchi, S - 125, Shanti
Nagar, N B C Ke Samne, Hasanpura, Jaipur,
Jaipur,
Rajasthan - 302006



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1047 | help@uidai.gov.in | www.uidai.gov.in

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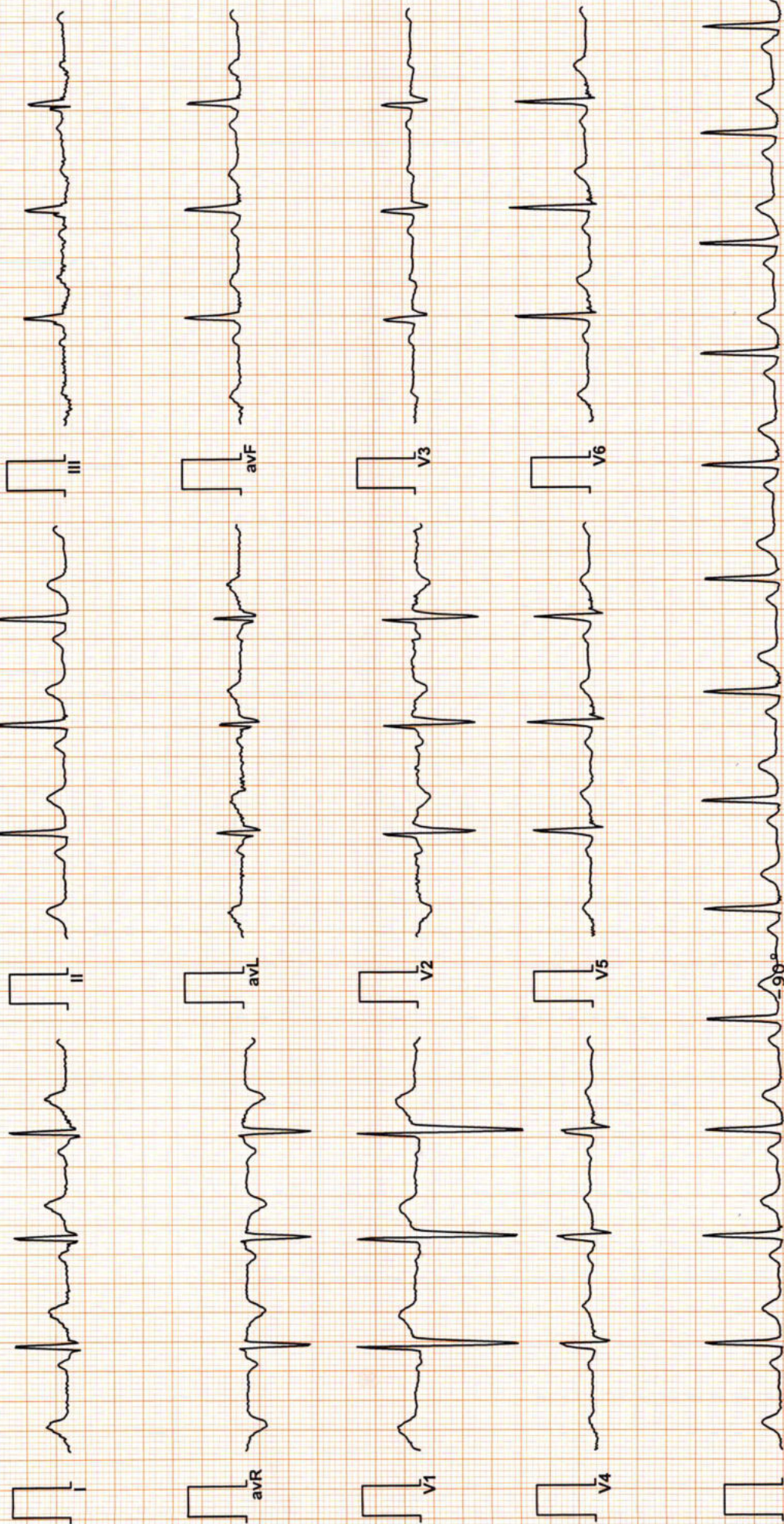
DR. GOYAL PATH LAB & IMAGING CENTER, JAIPUR

3182 / MRS. JYOTI KHINCHI / 28 Yrs / F / Non Smoker

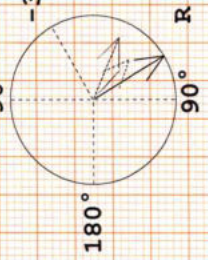
Heart Rate : 80 bpm / Tested On : 24-Dec-22 14:04:57 / HF 0.05 Hz - LF 35 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s

/ Refd By.: BOB

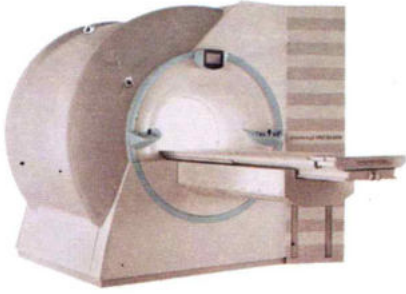
ECG



Vent Rate : 80 bpm
PR Interval : 150 ms
QRS Duration: 80 ms
QT/QTc Int : 360/395 ms
P-QRS-T axis: 43.00 • 59.00 • 23.00 •



Sinus rhythm with ϵ inversion in lead V2-V3.
Axis R 59.00° T 23.00° P 43.00°
-30°
90° 180°
Reported By: *Dr. Naresh Kumar Moflankā*
RMC No. 35703
MPBS, DIP, CARDIO (FSCORTS)
Dr. Naresh Kumar Moflankā
Reported By: *Dr. Naresh Kumar Moflankā*



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Date :- 24/12/2022 08:47:12
NAME :- Mrs. JYOTI KHINCHI
Sex / Age :- Female 28 Yrs 10 Mon 18 Days
Company :- MediWheel

Patient ID :- 122228677
Ref. By Doctor :- BOB
Lab/Hosp :-

Final Authentication : 24/12/2022 10:55:22

BOB PACKAGE FEMALE BELOW 40

ULTRA SOUND SCAN OF ABDOMEN

Liver is of normal size. Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is of normal size. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Urinary Bladder: is well distended and showing smooth wall with normal thickness. Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size and measures: 57x41x34 mm. Myometrium shows normal echo - pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is normal.

Both ovaries are visualised and are normal. No adnexal mass is seen.

No enlarged nodes are visualised. No retro-peritoneal lesion is identified. No significant free fluid is seen in pouch of Douglas.

IMPRESSION:

Normal Study.

Needs clinical correlation & further evaluation

*** End of Report ***

AHSAN

Page No: 1 of 1

Dr. Piyush Goyal
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RMC Reg No. 017996

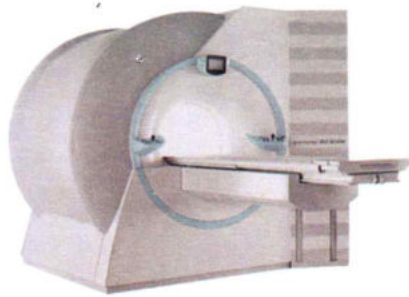
Dr. Poonam Gupta
MBBS, MD (Radio Diagnosis)
RMC No. 32495

Dr. Ashish Choudhary
MBBS, MD (Radio Diagnosis)
Fetal Medicine Consultant

FMF ID - 260517 | RMC No 22430

Dr. Abhishek Jain
MBBS, DNB, (Radio-Diagnosis)
RMC No. 21687

Transcript by.



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BOB PACKAGEFEMALE BELOW 40
 2D ECHO OPTION TMT (ADULT/CHILD)

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:
FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMINATION:

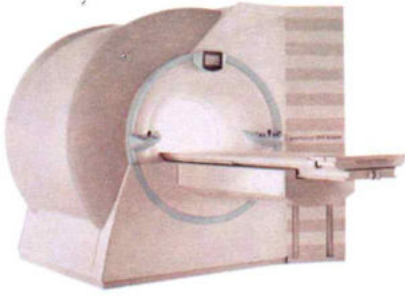
AO	19	mm	LA	29	Mm	IVS-D	7	mm
IVS-S	11	mm	LVID	35	Mm	LVSD	22	mm
LVPW-D	8	mm	LVPW-S	13	Mm	RV		mm
RVWT		mm	EDV		MI	LVVS		ml
LVEF	69%		RWMA			ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

COLOUR DOPPLER:

MITRAL VALVE			
E VELOCITY	1.0	m/sec	PEAK GRADIENT
A VELOCITY	0.60	m/sec	MEAN GRADIENT
MVA BY PHT		Cm2	MVA BY PLANIMETRY
MITRAL REGURGITATION		ABSENT	
AORTIC VALVE			
PEAK VELOCITY	1.4	m/sec	PEAK GRADIENT
AR VMAX		m/sec	MEAN GRADIENT
AORTIC REGURGITATION		ABSENT	
TRICUSPID VALVE			
PEAK VELOCITY	0.53	m/sec	PEAK GRADIENT
MEAN VELOCITY		m/sec	MEAN GRADIENT
VM _{max} VELOCITY			
TRICUSPID REGURGITATION		ABSENT	
PULMONARY VALVE			
PEAK VELOCITY	0.95	M/sec.	PEAK GRADIENT
MEAN VALOCITY			MEAN GRADIENT
PULMONARY REGURGITATION		ABSENT	



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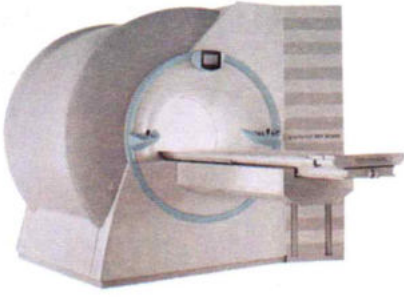
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Impression--

1. Normal LV size & contractility
2. No RWMA, LVEF 69 %.
3. Normal cardiac chamber.
4. Normal valve
5. No clot, no vegetation, no pericardial effusion. (Cardiologist)

*** End of Report ***



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Company :- MediWheel	

Final Authentication : 24/12/2022 13:21:52

BOB PACKAGEFEMALE BELOW 40

X RAY CHEST PA VIEW:

Both lung fields appears clear.

Bronchovascular markings appear normal.

Trachea is in midline.

Both the hilar shadows are normal.

Both the C.P.angles is clear.

Both the domes of diaphragm are normally placed.

Bony cage and soft tissue shadows are normal.

Heart shadows appear normal.

Impression :- Normal Study

(Please correlate clinically and with relevant further investigations)

*** End of Report ***



DR ABHISHEK JAIN
MBBS. DNB. (RADIO DIAGNOSIS)
RMC NO. 21687

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Company :- MediWheel

Patient ID :-122228677
Ref. By Dr:- BOB
Lab/Hosp :-



Sample Type :- EDTA

Sample Collected Time 24/12/2022 08:49:46

Final Authentication : 24/12/2022 13:54:22

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
BOB PACKAGE FEMALE BELOW 40			
HAEMOGARAM			
HAEMOGLOBIN (Hb)	12.7	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	6.41	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	55.4	%	40.0 - 80.0
LYMPHOCYTE	38.8	%	20.0 - 40.0
EOSINOPHIL	2.2	%	1.0 - 6.0
MONOCYTE	3.4	%	2.0 - 10.0
BASOPHIL	0.2	%	0.0 - 2.0
NEUT#	3.56	10 ³ /uL	1.50 - 7.00
LYMPH#	2.49	10 ³ /uL	1.00 - 3.70
EO#	0.14	10 ³ /uL	0.00 - 0.40
MONO#	0.21	10 ³ /uL	0.00 - 0.70
BASO#	0.01	10 ³ /uL	0.00 - 0.10
TOTAL RED BLOOD CELL COUNT (RBC)	4.64	x10 ⁶ /uL	3.80 - 4.80
HEMATOCRIT (HCT)	36.30	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	78.2 L	fL	83.0 - 101.0
MEAN CORP HB (MCH)	27.5	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	34.5	g/dL	31.5 - 34.5
PLATELET COUNT	223	x10 ³ /uL	150 - 410
RDW-CV	14.0	%	11.6 - 14.0
MENTZER INDEX	16.85		

The Mentzer index is used to differentiate iron deficiency anemia from beta thalassemia trait. If a CBC indicates microcytic anemia, these are two of the most likely causes, making it necessary to distinguish between them.

If the quotient of the mean corpuscular volume divided by the red blood cell count is less than 13, thalassemia is more likely. If the result is greater than 13, then iron-deficiency anemia is more likely.

AJAYSINGH
Technologist

Page No: 1 of 11



Dr. Chandrika Gupta
MBBS.MD (Path)
RMC NO. 21021/008037

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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Erythrocyte Sedimentation Rate (ESR)	30 H	mm/hr.	00 - 20
--------------------------------------	------	--------	---------

(ESR) Methodology : Measurement of ESR by cells aggregation.

Instrument Name : Independent form Hematocrit value by Automated Analyzer (Roller-20)

Interpretation : ESR test is a non-specific indicator of inflammatory disease and abnormal protein states.

The test is used to detect, follow course of a certain disease (e.g-tuberculosis, rheumatic fever, myocardial infarction)

Levels are higher in pregnancy due to hyperfibrinogenaemia.

The "3-figure ESR" $\times > 100$ value nearly always indicates serious disease such as a serious infection, malignant paraproteinaemia (CBC); Methodology: TLC, DLC, Fluorescent Flow cytometry, HB SLS method, TRBC, PCV, PLT Hydrodynamically focused Impedance. and

or connective tissue disease. **MCH, MCV, MCHC, MENTZER INDEX** are calculated. **Instrument Name**: Sysmex 6 part fully automatic analyzer XN-L, Japan

AJAYSINGH
Technologist

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Sample Type :- PLAIN/SERUM Sample Collected Time 24/12/2022 08:49:46 Final Authentication : 24/12/2022 15:36:10

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Method:- Enzymatic Endpoint Method	206.48	mg/dl	Desirable <200 Borderline 200-239 High > 240
TRIGLYCERIDES Method:- GPO-PAP	72.15	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
DIRECT HDL CHOLESTEROL Method:- Direct clearance Method	50.16	mg/dl	Low < 40 High > 60
DIRECT LDL CHOLESTEROL Method:- Direct clearance Method	144.29	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method:- Calculated	14.43	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	4.12		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method:- Calculated	2.88		0.00 - 3.50
TOTAL LIPID Method:- CALCULATED	558.30	mg/dl	400.00 - 1000.00
TOTAL CHOLESTEROL InstrumentName:Radox Rx Imola Interpretation: Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES InstrumentName:Radox Rx Imola Interpretation : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.			
DIRECT HDLCHOLESTERO InstrumentName:Radox Rx Imola Interpretation: An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.			
DIRECT LDL-CHOLESTEROL InstrumentName:Radox Rx Imola Interpretation: Accurate measurement of LDL-Cholesterol is of vital importance in therapies which focus on lipid reduction to prevent atherosclerosis or reduce its progress and to avoid plaque rupture.			
TOTAL LIPID AND VLDL ARE CALCULATED			

KAUSHAL

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIVER PROFILE WITH GGT			
SERUM BILIRUBIN (TOTAL) Method:- Colorimetric method	0.40	mg/dl	Up to - 1.0 Cord blood <2 Premature < 6 days <16 Full-term < 6 days= 12 1month - <12 months <2 1-19 years <1.5 Adult - Up to - 1.2 Ref-(ACCP 2020)
SERUM BILIRUBIN (DIRECT) Method:- Colorimetric Method	0.12	mg/dL	Adult - Up to 0.25 Newborn - <0.6 mg/dL >- 1 month - <0.2 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.28	mg/dl	0.30-0.70
SGOT Method:- IFCC	16.8	U/L	Men- Up to - 37.0 Women - Up to - 31.0
SGPT Method:- IFCC	21.4	U/L	Men- Up to - 40.0 Women - Up to - 31.0
SERUM ALKALINE PHOSPHATASE Method:- AMP Buffer	78.00	IU/L	30.00 - 120.00
SERUM GAMMA GT Method:- IFCC	21.60	U/L	7.00 - 32.00
SERUM TOTAL PROTEIN Method:- Biuret Reagent	7.78	g/dl	6.40 - 8.30
SERUM ALBUMIN Method:- Bromocresol Green	4.61	g/dl	3.80 - 5.00
SERUM GLOBULIN Method:- CALCULATION	3.17	gm/dl	2.20 - 3.50
A/G RATIO	1.45		1.30 - 2.50

Total Bilirubin Methodology: Colorimetric method InstrumentName: Randox Rx Imola Interpretation: An increase in bilirubin concentration in the serum occurs in toxic or infectious diseases of the liver e.g. hepatitis B or obstruction of the bile duct and in rhesus incompatible babies. High levels of unconjugated bilirubin indicate that too much haemoglobin is being destroyed or that the liver is not actively treating the haemoglobin it is receiving.

AST Aspartate Aminotransferase Methodology: IFCC InstrumentName: Randox Rx Imola Interpretation: Elevated levels of AST can signal myocardial infarction, hepatic disease, muscular dystrophy and organ damage. Although heart muscle is found to have the most activity of the enzyme, significant activity has also been seen in the brain, liver, gastric mucosa, adipose tissue and kidneys of humans.

ALT Alanine Aminotransferase Methodology: IFCC InstrumentName: Randox Rx Imola Interpretation: The enzyme ALT has been found to be in highest concentrations in the liver, with decreasing concentrations found in kidney, heart, skeletal muscle, pancreas, spleen and lung tissue respectively. Elevated levels of the transaminases can indicate myocardial infarction, hepatic disease, muscular dystrophy and organ damage.

Alkaline Phosphatase Methodology: AMP Buffer InstrumentName: Randox Rx Imola Interpretation: Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease.

TOTAL PROTEIN Methodology: Biuret Reagent InstrumentName: Randox Rx Imola Interpretation: Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

ALBUMIN (ALB) Methodology: Bromocresol Green InstrumentName: Randox Rx Imola Interpretation: Albumin measurements are used in the diagnosis and treatment of numerous diseases involving primarily the liver or kidneys. Globulin & A/G ratio is calculated.

Instrument Name Randox Rx Imola Interpretation: Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra- or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
SERUM CREATININE Method:- Colorimetric Method	0.85	mg/dl	Men - 0.6-1.30 Women - 0.5-1.20
SERUM URIC ACID Method:- Enzymatic colorimetric	4.97	mg/dl	Men - 3.4-7.0 Women - 2.4-5.7

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
BLOOD UREA NITROGEN (BUN)	8.9	mg/dl	0.0 - 23.0

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Sample Type :- EDTA

Sample Collected Time 24/12/2022 08:49:46

Final Authentication : 24/12/2022 13:54:22

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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GLYCOSYLATED HEMOGLOBIN (HbA1C)
Method:- HPLC

5.8

%

Non-diabetic: < 5.7
Pre-diabetics: 5.7-6.4
Diabetics: = 6.5 or higher
ADA Target: 7.0
Action suggested: > 6.5

Instrument name: ARKRAY's ADAMS Lite HA 8380V, JAPAN.

Test Interpretation:

HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of HbA to form an unstable schiff base. It is the major fraction, constituting approximately 80% of HbA1c. Formation of glycosylated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHb concentration represents the integrated values for glucose over the period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasma glucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values. The interpretation of GHb depends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb. High GHb have been reported in iron deficiency anemia. GHb has been firmly established as an index of long term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to the mean of HbA1C. Genetic variants (e.g. HbS trait, HbC trait), elevated HbF and chemically modified derivatives of hemoglobin can affect the accuracy of HbA1c measurements. The effects vary depending on the specific Hb variant or derivative and the specific HbA1c method.

Ref by ADA 2020

MEAN PLASMA GLUCOSE
Method:- Calculated Parameter

120

mg/dL

Non Diabetic < 100 mg/dL
Prediabetic 100- 125 mg/dL
Diabetic 126 mg/dL or Higher

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Date :- 24/12/2022 08:47:12

Patient ID :-122228677

NAME :- Mrs. JYOTI KHINCHI

Ref. By Dr:- BOB

Sex / Age :- Female 28 Yrs 10 Mon 18 Days

Lab/Hosp :-

Company :- MediWheel



Sample Type :- URINE

Sample Collected Time 24/12/2022 08:49:46

Final Authentication : 24/12/2022 17:06:31

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION(PH)	6.5		5.0 - 7.5
SPECIFIC GRAVITY	1.025		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<u>MICROSCOPY EXAMINATION</u>			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT

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Date :- 24/12/2022 08:47:12 Patient ID :-122228677
NAME :- Mrs. JYOTI KHINCHI Ref. By Dr:- BOB
Sex / Age :- Female 28 Yrs 10 Mon 18 Days Lab/Hosp :-
Company :- MediWheel



Sample Type :- PLAIN/SERUM

Sample Collected Time 24/12/2022 08:49:46

Final Authentication : 24/12/2022 12:24:50

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
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TOTAL THYROID PROFILE

SERUM TOTAL T3 1.245 ng/ml 0.970 - 1.690
Method:- Chemiluminescence(Competitive immunoassay)

SERUM TOTAL T4 9.069 ug/dl 5.500 - 11.000
Method:- Chemiluminescence(Competitive immunoassay)

SERUM TSH ULTRA 2.770 μ IU/mL 0.500 - 6.880
Method:- Enhanced Chemiluminescence Immunoassay

Interpretation: Triiodothyronine (T3) contributes to the maintenance of the euthyroid state. A decrease in T3 concentration of up to 50% occurs in a variety of clinical situations, including acute and chronic disease. Although T3 results alone cannot be used to diagnose hypothyroidism, T3 concentration may be more sensitive than thyroxine (T4) for hyperthyroidism. Consequently, the total T3 assay can be used in conjunction with other assays to aid in the differential diagnosis of thyroid disease. T3 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, Free T3 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake, or T4 uptake can be used with the total T3 result to calculate the free T3 index and estimate the concentration of free T3.

Interpretation : The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4. Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

Interpretation : TSH stimulates the production of thyroxine (T4) and triiodothyronine (T3) by the thyroid gland. The diagnosis of overt hypothyroidism by the finding of a low total T4 or free T4 concentration is readily confirmed by a raised TSH concentration. Measurement of low or undetectable TSH concentrations may assist the diagnosis of hyperthyroidism, where concentrations of T4 and T3 are elevated and TSH secretion is suppressed. These have the advantage of discriminating between the concentrations of TSH observed in thyrotoxicosis, compared with the low, but detectable, concentrations that occur in subclinical hyperthyroidism. The performance of this assay has not been established for neonatal specimens. Some drugs and some nonthyroidal patient conditions are known to alter TSH concentrations in vivo.

INTERPRETATION

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester	0.10-2.50
2nd Trimester	0.20-3.00
3rd Trimester	0.30-3.00

*** End of Report ***

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