



Dept. of Radiology
(For Report Purpose Only)



REQ. DATE : 22-MAR-2023 REP. DATE : 22-MAR-2023
NAME : MRS. RAMTEKE NILAM
PATIENT CODE : 115944 AGE/SEX : 32 YR(S) / FEMALE
REFERRAL BY : HOSPITAL PATIENT

CHEST X-RAY PA VIEW

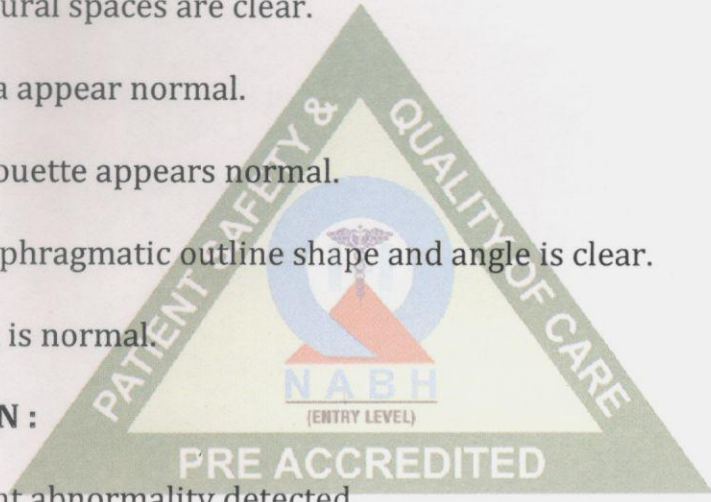
FINDINGS :

Bilateral lung fields are clear.
Trachea, carina is in central position and normal level.
Bilateral pleural spaces are clear.
Bilateral hila appear normal.
Cardiac silhouette appears normal.
Bilateral diaphragmatic outline shape and angle is clear.
Bony thorax is normal.

IMPRESSION :

No significant abnormality detected.

Advice: Clinical correlation



Dr. SAURABH PATIL
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**VITARA HEALTHCARE®**

Patient ID : 220323015
Patient Name : MRS. NILAM RAMTEKE
 Age / Gender : 32 YEARS / FEMALE
 Ref. By : AIMS HOSPITAL
 Affiliation : AIMS HOSPITAL



Registration Date : 22-Mar-2023 9:25 AM
Sample Collected on : 22-Mar-2023 9:25 AM
Sample Received on : 22-Mar-2023 12:41 PM
Report Released on : 22-Mar-2023 1:30 PM

Glycosylated Haemoglobin (HbA1c)

Investigation	Result	Unit	Bio. Ref. Range
HbA1c (HPLC)	6.2	%	Above 8% : Action Suggested Between 6-8% : Goal Below 6% : Non-Diabetic Level
Average Blood Glucose (ABG)	131	mg/dL	90 - 120 : Excellent Control 121 - 150 : Good Control 151 - 180 : Average Control 181 - 210 : Action Suggested > 211 : Panic Value

Sample Type : EDTA Whole Blood
 Method : Fully Automated H.P.L.C.

Method : Derived from HbA1c values

INTERPRETATION :

NOTE : HbA1c PARAMETER IS NGSP LEVEL 1 CERTIFIED.

- HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
- HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%
- Trends in HbA1c are a better indicator of diabetic control than a solitary test.
- Low glycosylated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & hemolytic), chronic renal failure and liver diseases, Clinic correlation is suggested.
- To estimate the eAG from the HbA1c value, the following equation is used : $eAG (mg/dl) = 28.7A1c - 46.7$
- Interference of Hemoglobinopathies in HbA1c estimation.
 - For hbF > 25%, an alternate platform (FRUCTOSAMINE) is recommended for testing of HbA1c.
 - Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
 - Heterozygous state detected (D10/Tosho G8 is corrected for HbS and HbC trait).
- In Known diabetic patients, following values 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 %

Lab Equipment

Test performed on Fully Automated Biorad D10 - HbA1c Analyzer

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BLOOD GROUP

Investigation	Result
Blood Group ABO & Rh Typing (EDTA Whole Blood)	
Blood group (ABO Typing)	"A"
RhD Factor (Rh typing)	Positive.
Method	Manual Slide Hemagglutination

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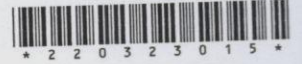
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ESR (Western)

Investigation	Result	Unit	Bio. Ref. Range
ESR (Western)	45	mm/1hr.	0-15
ESR (Western) (EDTA Whole Blood)			
Method	Western		

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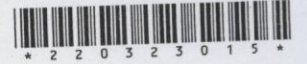
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COMPLETE BLOOD COUNT

Investigation	Result	Unit	Bio. Ref. Range
RBC PARAMETERS			
Haemoglobin (HB)	11.5	gm%	12.0-15.0
Red Blood Cells (RBC)	4.56	mill/c.mm	3.8-4.8
Packed Cell Volume (PCV/HCT)	36.8	%	36.0-46.0
Mean Corpuscular Volume (MCV)	81.0	fl	83.0-101.0
Mean Corpuscular Hemoglobin(MCH)	25.3	pg	27.0-32.0
Mean Corp. Hemo. Conc.(MCHC)	31.4	g/dl	31.5-34.5
Red Cell Distribution Width (RDW-CV)	15	%	11.6-14.0
WBC PARAMETERS			
Total Leucocytes Count(TLC)	6400	/ cumm	4000-10000
Neutrophils	43.9	%	40-80
Lymphocytes	45.6	%	20-40
Eosinophils	3.6	%	01-06
Monocytes	6.9	%	2-10
Absolute Neutrophil Count	2810	/ cumm	2000-7000
Absolute Lymphocyte Count	2918	/ cumm	1000-4000
Absolute Eosinophil Count	230	/ cumm	20-500
Absolute Monocyte Count	442	/ cumm	200-1000
PLATELET PARAMETERS			
Platelet count	459	x 10 ³ /cm	150-400
Mean Platelet Volume (MPV)	7.9	fl	9.0-13.0
Platelet Cell Distribution Width (PDW)	13	%	9-17
Platelecrit (PCT)	0.36	%	0.2-0.5

PERIPHERIAL SMEAR FINDINGS:

Morphology of W.B.C.s
Morphology of R.B.C.s
Microcytes
Macrocytes
Anisocytosis
Poikilocytosis
Hypochromia
Polychromasia
Oval Cells
Target Cells

Mild lymphocytosis.
Predominantly Normocytic Normochromic



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COMPLETE BLOOD COUNT

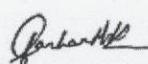
Investigation	Result	Unit	Bio. Ref. Range
Pencil Cells	-		
Platelets on Smear	Adequate		

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LIPID PROFILE

Investigation	Result	Unit	Bio. Ref. Range
Sample Type : SERUM			
Serum Triglycerides	161.0	mg/dL	Normal - Below 150 mg/dL Borderline High - 150-199 mg/dL High - 200-499 mg/dL
Method : Glycerol Phosphate Oxidase			
Serum Cholesterol -Total	168.0	mg/dL	No Risk - Below 200 mg/dL Moderate Risk - 200-239 mg/dL High Risk - Above 240 mg/dL
Method : Enzymatic			
HDL Cholesterol	35.0	mg/dL	Low - Below 40 High - Above 60
Method : Accelerator Selective Detergent			
NON - HDL Cholesterol	133.0	mg/dL	0-130
Method : Calculated			
LDL Cholesterol	100.8	mg/dL	Optimal : Below 100 mg/dL Near/Above Optimal : 100-129 mg/dL Borderline High : 130-159 mg/dL High : 160-189 mg/dL Very High : Above 180 mg/dL
Method : Liquid Selective Detergent			
VLDL Cholesterol	32.2	mg/dL	7-35
Method : Calculated			
LDL / HDL Ratio	2.9	Ratio	0-3.51
Method : Calculated			
CHOL/HDL Ratio	4.8	Ratio	3.0-5.0
Method : Calculated			

Lab Equipment : Roche Cobas-C311

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LIVER FUNCTION TEST

Investigation	Result	Unit	Bio. Ref. Range
Liver Function Test			
Bilirubin-Total	0.35	mg/dL	0.2-1.2
Bilirubin-Direct	0.16	mg/dL	0.0-0.5
Bilirubin- Indirect	0.19	mg/dL	0.1-1.0
SGOT (AST)	22.1	U/L	0-40
SGPT (ALT)	23.1	U/L	0-45
Alkaline Phosphatase	126	U/L	35-105
GAMMA GT(Gamma GT)	37	U/L	9-36
Total Protein	7.63	g/dl	6.6-8.7
Albumin	4.27	g/dl	3.5-5.0
Globulin	3.36	g/dl	1.8-3.6
A/G Ratio	1.27	Text	1.1-2.2

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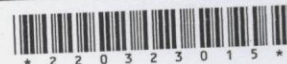
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FASTING PLASMA GLUCOSE

Investigation	Result	Unit	Bio. Ref. Range
Blood Sugar Fasting	87	mg/dL	70-110
Method	(Hexokinase/G-6-PDH)		
Note	AS PER AMERICAN DIABETES ASSOCIATION 2015 UPDATE-		

FASTING GLUCOSE LEVEL-

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

***Any positive criteria should be tested on subsequent day with same or other criteria.

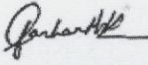
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POSTPRANDIAL PLASMA GLUCOSE

Investigation	Result	Unit	Bio. Ref. Range
Sample Type : Fluoride Plasma			
Post Prandial Plasma Glucose	130	mg/dL	70-140
Method	(2 hrs. after Lunch) (Hexokinase/G-6-PDH)		

Note

AS PER AMERICAN DIABETES ASSOCIATION 2015 UPDATE-

- POSTPRANDIAL/POST GLUCOSE (75 grams)
- Normal glucose tolerance : 70-139 mg/dl
 - Impaired glucose tolerance : 140-199 mg/dl
 - Diabetes mellitus : ≥ 200 mg/dl

***Any positive criteria should be tested on subsequent day with same or other criteria

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RENAL FUNCTION TEST - AIMS

Investigation	Result	Unit	Bio. Ref. Range
Kidney Function Test			
Blood Urea	19.9	mg/dL	16.6-48.5
Creatinine	0.59	mg/dL	0.50-0.90
Uric Acid	5.0	mg/dL	3.4-7
Sodium	138	mEq/L	136-145
Potassium	4.34	mEq/L	3.5-5
Chlorides	106.9	mEq/L	98-108

Lab Equipment
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Roche Cobas-C311

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Vitamin B12

Investigation	Result	Unit	Bio. Ref. Range
Sample Type : SERUM			
Vitamin B12 level	1212	pg/ml	197-771
Method : ECLIA			

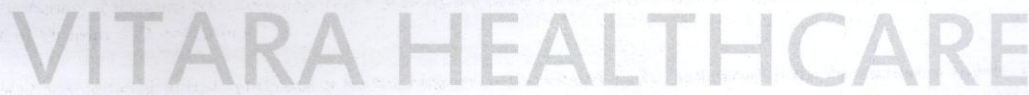
INTERPRETATION:

Note : For Values of Vitamin B12 between 203 - 338 pg/ml(Grey Zone) ,Active B12 is suggested for conclusive diagnosis of Vitamin B12 deficiency.

Vitamin B12 is a cofactor in the synthesis of methionine from homocystiene, is implicated in the formation of myelin and along with folate, is required for DNA synthesis. - There are a number of conditions that are associated with low serum B12 levels including iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ ileal damage, celiac disease, use of oral contraception, parasitic competition, pancreatic deficiency, treated epilepsy and advancing age.

Lab Equipment : Roche Cobas-E411

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THYROID FUNCTION TEST

Investigation	Result	Unit	Bio. Ref. Range
Total Triiodothyronine (T3) Method ECLIA	68.02	ng/dl	Normal : 70-204 ng/dL First Trimester : 81-190 ng/dL Second Trimester : 100-260 ng/dL Third Trimester : 100-260 ng/dL
Total Thyroxine (T4) Method ECLIA	7.04	ug/dl	5.5-11.0
Thyroid Stimulating Hormone (TSH) Method ECLIA	8.6	uIU/mL	Normal : 0.27-4.2 µIU/ml First Trimester : 0.33-4.59 µIU/ml Second Trimester : 0.35-4.1 µIU/ml Third Trimester : 0.21-3.15 µIU/ml

REFERENCE : TIETZ Fundamentals of Clinical Chemistry

INTERPRETATION :

- Decreased values of T3 (T4 and TSH normal) have minimal clinical significance and not recommended for diagnosis of hypothyroidism.
 - Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites Pregnancy, Drugs (Androgens, Estrogens, O C pills, Phenytoin), Nephrosis etc. In such cases Free T3 and Free T4 gives corrected values.
 - Total T3 may decrease by <25 percent in healthy older individuals. - In cases of primary hypothyroidism, T3 and T4 levels are low and TSH is significantly elevated. In the case of pituitary dysfunction, either due to intrinsic hypothalamic or pituitary disease i.e central hypothyroidism, normal or marginally elevated basal TSH levels are often seen despite significant reduction in T4 and T3 levels.
- Primary hyperthyroidism (eg: Grave's disease, nodular goiter) is associated with high levels of thyroid hormones and depressed or undetectable levels of TSH.

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Vitamin D3

Investigation	Result	Unit	Bio. Ref. Range
Sample Type : SERUM			
Vitamin D3	16.74	ng/ml	Deficiency : Below 10 ng/ml Insufficiency : 10-30 ng/ml Sufficiency : 30-100 ng/ml Toxicity : Above 100 ng/ml

Method : ECLIA

INTERPRETATION:

- Vitamin D is a fat-soluble steroid prohormone mainly produced photochemically in the skin from 7 dehydrocholesterol.
- Two forms of Vitamin D are biologically relevant-vitamin D3 (Cholecalciferol) & Vitamin D2 (Ergocalciferol). Both vitamins D2 & D3 can be absorbed from food, with vitamin D2 being an artificial source, but only an estimated 10-20% of vitamin D is supplied through nutritional intake. Vitamin D3 and D2 can be found in vitamin supplements.
- Vitamin D is converted to the active hormone 1,25-(OH)₂-vitamin d (Calcitriol) through two hydroxylation reactions. The first hydroxylation converts vitamin D into 25-OH vitamin D and occurs in liver. the second hydroxylation converts 25-OH vitamin d into biologically active 1,25-(OH)₂ vitamin D and occurs in the kidneys as well as in many other cells of the body.
- Vitamin D deficiency is a cause of secondary hyperparathyroidism and diseases resulting in impaired bone metabolism (like rickets, osteoporosis, osteomalacia). Reduced 25-OH vitamin D concentrations in blood (vitamin D insufficiency) have been associated with an increasing risk of many chronic diseases, including common cancers, autoimmune or infectious diseases or cardiovascular problems.

Lab Equipment : Roche Cobas-E411

----- **END OF REPORT** -----



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Patient ID : 220323015
Patient Name : MRS. NILAM RAMTEKE
Age / Gender : 32 YEARS / FEMALE
Ref. By : AIMS HOSPITAL
Affiliation : AIMS HOSPITAL



Registration Date : 22-Mar-2023 9:25 AM
Sample Collected on : 22-Mar-2023 9:25 AM
Sample Received on : 22-Mar-2023 12:41 PM
Report Released on : 22-Mar-2023 1:06 PM

Urine Routine

Investigation	Result	Unit	Bio. Ref. Range
Sample Type : URINE			
PHYSICAL EXAMINATION			
Quantity	30 ml		
Colour	Pale Yellow		
Appearance	Slightly Hazy		
pH	6.5	-	4.6-8.0
Specific Gravity	1.015	-	1.003-1.035
CHEMICAL EXAMINATION			
Protein	Present (Trace)		
Sugar	Absent		
Ketone Bodies	Present (Trace)		
Nitrite	Absent		
Blood	Absent		
Bile Salts	Absent		
Bile Pigments	Absent		
Urobilinogen	Absent		
MICROSCOPIC EXAMINATION			
Epithelial Cells	Occasional		
Pus Cells	1-2	cells/hpf	0-5 cells/hpf
Red Blood Cells	Absent		
Casts	Absent		
Crystals	Absent		
Amorphous Materials	Absent		
Bacteria	Absent		
Yeast Cells	Absent		
Trichomonas Vaginalis	Absent		
Mucus	Absent		

METHOD: Chemical Examination is done by Strip Method

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