AiMS Hospital & Research Center
Caring Redefined

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
(MBBS, MD(RADIOLOGY))

~~1728~~ 17128 OPD

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|---|---|---|---|
| Patient ID | : 220323015 | | |
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| | | **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<br>Between 6-8% : Goal<br>Below 6% : Non-Diabetic Level |

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

| | | | |
|---|---|---|---|
| Average Blood Glucose (ABG) | 131 | mg/dL | 90 - 120 : Excellent Control<br>121 - 150 : Good Control<br>151 - 180 : Average Control<br>181 - 210 : Action Suggested<br>> 211 : Panic Value |

Method : Derived from HBA1c values

**INTERPRETATION :**

NOTE : HbA1c PARAMETER IS NGSP LEVEL 1 CERTIFIED.

1. HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
2. 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%
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Low glcated haemoglobin (below 4%) in a non - diabetic indiidual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & heamolytic), chronic renal failure and live diseases, Clinic correlation is suggested.
5. To estimate the eAG from the HbA1c value, the following equation is used : eAG (mg/dl) = 28.7A1c - 46.7
6. Interference of Heamoglobipathies in HbA1c estimation.
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. Heterizygous state detected (D10/Tosho G8 is corrected for HbS and HbC trait).
7. 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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## ESR (Western)

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

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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 | Mild lymphocytosis. | | |
| Morphology of R.B.C.s | Predominantly Normocytic Normochromic | | |
| Microcytes | - | | |
| Macrocytes | - | | |
| Anisocytosis | + | | |
| Poikilocytosis | - | | |
| Hypochromia | - | | |
| Polychromasia | - | | |
| Oval Cells | - | | |
| Target Cells | - | | |



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## COMPLETE BLOOD COUNT

| Investigation | Result | Unit | Bio. Ref. Range |
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| 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<br>Borderline High - 150-199 mg/dL<br>High - 200-499 mg/dL |
| Method : Glycerol Phosphate Oxidase | | | |
| Serum Cholesterol -Total | 168.0 | mg/dL | No Risk - Below 200 mg/dL<br>Moderate Risk - 200-239 mg/dL<br>High Risk - Above 240 mg/dL |
| Method : Enzymatic | | | |
| HDL Cholesterol | **35.0** | mg/dL | Low - Below 40<br>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<br>Near/Above Optimal : 100-129 mg/dL<br>Borderline High : 130-159 mg/dL<br>High : 160-189 mg/dL<br>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 |

Lab Equipment : Roche Cobas C-311

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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 )<br>(Hexokinase/G-6-PDH) | | |
| Note | AS PER AMERICAN DIABETES ASSOCIATION 2015 UPDATE-<br><br>POSTPRANDIAL/POST GLUCOSE (75 grams)<br>- Normal glucose tolerance : 70-139 mg/dl<br>- Impaired glucose tolerance : 140-199 mg/dl<br>- Diabetes mellitus : >=200 mg/dl<br><br>***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 | 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 nearterm pregnancy, vegetarianism, partial gasterectomy/ 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) | **68.02** | ng/dl | Normal : 70-204 ng/dL<br>First Trimester : 81-190 ng/dL<br>Second Trimester : 100-260 ng/dL<br>Third Trimester : 100-260 ng/dL |
| Method ECLIA | | | |
| Total Thyroxine (T4) | 7.04 | ug/dl | 5.5-11.0 |
| Method ECLIA | | | |
| Thyroid Stimulating Hormone (TSH) | **8.6** | uIU/mL | Normal : 0.27-4.2 µIU/ml<br>First Trimester : 0.33-4.59 µIU/ml<br>Second Trimester : 0.35-4.1 µIU/ml<br>Third Trimester : 0.21-3.15 µIU/ml |
| Method ECLIA | | | |

REFERENCE : TIETZ Fundamentals of ClinicalChemistry

INTERPRETATION :
1. Decreased values of T3 (T4 and TSH normal) have minimal clinical significance and not recommended for diagnosis of hypothyroidism.
2. 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.
3. 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 pituatary dysfunction,either due to intrinsic hypothalamic or pituatary 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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**Junnar**
Phoenix Hospital, Shop No 1&2,
Junnar-Narayangaon Road,
Junnar, Dist-Pune
88 7106 7106

VITARA HEALTHCARE®

| | | | |
|---|---|---|---|
| Patient ID | : 220323015 | | |
| **Patient Name** | : **MRS. NILAM RAMTEKE** | **Registration Date** | : 22-Mar-2023 9:25 AM |
| Age / Gender | : 32 YEARS / FEMALE | **Sample Collected on** | : 22-Mar-2023 9:25 AM |
| Ref. By | : AIMS HOSPITAL | **Sample Received on** | : 22-Mar-2023 12:41 PM |
| Affiliation | : AIMS HOSPITAL | **Report Released on** | : 22-Mar-2023 1:09 PM |

## Vitamin D3

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

Method : ECLIA

INTERPRETATION:

- Vitamin D is a fat-soluble steroid prohormone mainly produced photochemiccally 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 hyperpar thyroidism 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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**Dr. Farhan Shaikh**
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Reg. No. 2013/04/0704

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| Affiliation | : AIMS HOSPITAL | **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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