Suraksha DIAGNOSTICS

Lab No.	: BOR/07-09-2024/SR9623262	**Lab Add.**	: Kamini Center, Boring Pataliputra Road, Patna 800013
Patient Name	: AMIT KUMAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 39 Y 2 M 4 D	**Collection Date**	: 07/Sep/2024 11:21AM
Gender	: M	Report Date	: 07/Sep/2024 03:02PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
URIC ACID,BLOOD , *GEL SERUM* (Method:URICASE METHOD)	5.52	3.7-9.2	mg/dL
***URIC ACID, URINE, SPOT URINE**			
URIC ACID, SPOT URINE (Method:URICASE)	58.23	37-92 mg/dL	mg/dL
***GLYCATED HAEMOGLOBIN (HBA1C) ,** *EDTA WHOLE BLOOD*			
GLYCATED HEMOGLOBIN (HBA1C)	11.3	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	%
HbA1c (IFCC) (Method:HPLC)	100		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
Method : HPLC Cation Exchange

HbA1C : DUAL REPORTING OF UNITS [Ref 2,3,4]
Suraksha Diagnostic Pvt. Ltd. has commenced reporting HbA1c in dual units. This is in keeping with current International recommendations to allow a transition phase from current reporting units (%) to the eventual (IFCC) units (mmol/mol). It is anticipated that only IFCC units will be used after 2 years of dual reporting. Please note that the method of analysis has not changed. Although the two results look numerically different, they are clinically equivalent. In defining HbA1C, the unit mmol /mol was determined to be the most accurate description of what is being measured. This will make the measurement more precise and allow for better comparisons of HbA1c results from different laboratories and hospitals throughout the world.

Standardization & traceability [Ref 2,3,4]
HbA1c is standardized & traceable to IFCC methods HPLC-CE & HPLC-MS. This new unit (mmol/mol) is used as part of this standardization. This change in HbA1c calibration is to conform to national & international best practice. The initiative will mean that HbA1c is measured specifically & reproducibly. It also enables the use of international reference ranges & harmonization of medical decision or target values.

Recommendations for glycemic targets [Ref 1]
Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic 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 glycemic control.
Ø If a patient changes treatment plans or does not meet his or her glycemic 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 more or less 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 B_{12}/ 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

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DEPARTMENT OF BIOCHEMISTRY

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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.

3. Geistanger A, Arends S, Berding C, Hoshino T, Jeppsson J-O, Little R, Siebelder C and Weykamp C, on behalf of the IFCC Working Group on Standardization of HbA1c: Statistical Methods for Monitoring the Relationship between the IFCC Reference Measurement Procedure for Hemoglobin A1c ..Clin Chem 2008; 54(8): 1379-8.

4. International Expert Committee Report, drawn from the International Diabetes Federation (IDF), the European Association for the Study of Diabetes (EASD),American Diabetes Association (ADA), International Federation of Clinical Chemistry and Laboratory Medicine, International Society for Pediatric & Adolescent Diabetes. International Congress - IFCC, WorldLab, EuroMedLab- Berlin,2011.

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Method : HPLC Cation Exchange

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PDF Attached

POTASSIUM,BLOOD (Method:ISE INDIRECT)	5.01	3.5 - 5.1	mEq/L

***THYROID PANEL (T3, T4, TSH) ,** *GEL SERUM*			
T3-TOTAL (TRI IODOTHYRONINE) (Method:CLIA)	0.78	0.60-1.81 ng/ml	ng/ml
T4-TOTAL (THYROXINE) (Method:CLIA)	8.2	3.2-12.6	µg/dL
TSH (THYROID STIMULATING HORMONE) (Method:CLIA)	1.68	0.55-4.78	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

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Gender	**:** M	Report Date	**:** 07/Sep/2024 03:02PM

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit

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.

SGPT/ALT (Method:UV P5P)	**46**	7-40 U/L	U/L
CALCIUM,BLOOD (Method:OCPC METHOD)	9.7	8.7-10.4 mg/dL	mg/dL
SGOT/AST (Method:UV P5P)	28	13-40 U/L	U/L
GLUCOSE,FASTING (Method:HEXOKINASE METHOD)	**167**	Impaired Fasting-100-125 Diabetes- >= 126 Fasting is defined as no caloric intake for at least 8 hours.	mg/dL
BILIRUBIN (DIRECT) (Method:DIAZOTIZATION METHOD)	**0.21**	<0.2 mg/dL	mg/dL
CREATININE, BLOOD (Method:ALKALINE PICRATE KINETIC)	0.9	0.7-1.3	mg/dL
***TOTAL PROTEIN [BLOOD] ALB:GLO RATIO ,** .			
TOTAL PROTEIN (Method:BIURET,SERUM BLANK, END POINT)	**8.6**	5.7-8.2	g/dL
ALBUMIN (Method:BROMO-CRESOL PURPLE)	4.6	3.2-4.8 g/dL	g/dL
GLOBULIN (Method:Calculated)	**4.02**	1.8-3.2	g/dl
AG Ratio (Method:Calculated)	1.14	1.0 - 2.5	
***LIPID PROFILE ,** *GEL SERUM*			
CHOLESTEROL-TOTAL (Method:CHOLESTEROL OXIDASE ESTERASE PEROXIDASE METHOD)	224	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	mg/dL
TRIGLYCERIDES (Method:ENZYMATIC METHOD)	**169**	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	mg/dL
HDL CHOLESTEROL (Method:DIRECT MEASURE PEG)	**68**	< 40 - Low 40-59- Optimum 60 - High	mg/dl
LDL CHOLESTEROL DIRECT (Method:DIRECT MEASURE)	**126**	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

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
VLDL (Method:Calculated)	30	< 40	mg/dL
CHOL HDL Ratio (Method:Calculated)	3.3	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	
ALKALINE PHOSPHATASE (Method:PNPP ,AMP BUFFER)	110	46-116 U/L	U/L
***BILIRUBIN (TOTAL) ,** *GEL SERUM*			
BILIRUBIN (TOTAL) (Method:JENDRASSIK GROF METHOD)	0.79	0.3-1.2 mg/dL	mg/dL
SODIUM,BLOOD (Method:ISE INDIRECT)	139	136 - 145	mEq/L
CHLORIDE,BLOOD (Method:ISE INDIRECT)	100	98 - 107	mEq/L
UREA,BLOOD (Method:UREASE)	24	19 - 49	mg/dL
PHOSPHORUS-INORGANIC,BLOOD (Method:PHOSPHOMOLYBDATE)	4.6	2.4-5.1 mg/dL	mg/dL

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

Dr S. C. Jha
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SENIOR CONSULTANT
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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
***BLOOD GROUP ABO+RH [GEL METHOD] ,** *EDTA WHOLE BLOOD*			
ABO (Method:Gel Card)	O		
RH (Method:Gel Card)	POSITIVE		

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.

***CBC WITH PLATELET (THROMBOCYTE) COUNT ,** *EDTA WHOLE BLOOD*			
HEMOGLOBIN (Method:PHOTOMETRIC)	15.6	13 - 17	g/dL
WBC (Method:DC detection method)	6.5	4 - 10	*10^3/µL
RBC (Method:DC detection method)	5.33	4.5 - 5.5	*10^6/µL
PLATELET (THROMBOCYTE) COUNT (Method:DC detection method/Microscopy)	190	150 - 450*10^3	*10^3/µL
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Flowcytometry/Microscopy)	65	40 - 80	%
LYMPHOCYTES (Method:Flowcytometry/Microscopy)	28	20 - 40	%
MONOCYTES (Method:Flowcytometry/Microscopy)	02	2 - 10	%
EOSINOPHILS (Method:Flowcytometry/Microscopy)	05	1 - 6	%
BASOPHILS (Method:Flowcytometry/Microscopy)	00	0-0.9	%
CBC SUBGROUP			
HEMATOCRIT / PCV (Method:Calculated)	48.6	40 - 50 %	%
MCV (Method:Calculated)	91.3	83 - 101 fl	fl
MCH (Method:Calculated)	29.3	27 - 32 pg	pg
MCHC (Method:Calculated)	32.1	31.5-34.5 gm/dl	gm/dl
RDW - RED CELL DISTRIBUTION WIDTH (Method:Calculated)	**15.7**	11.6-14%	%
PDW-PLATELET DISTRIBUTION WIDTH (Method:Calculated)	27.2	8.3 - 25 fL	fL
MPV-MEAN PLATELET VOLUME (Method:Calculated)	12.0	7.5 - 11.5 fl	
RBC	NORMOCYTIC NORMOCHROMIC.		
WBC.	NORMAL IN NUMBER & MORPHOLOGY		

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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
PLATELET	ADEQUATE.		
***ESR (ERYTHROCYTE SEDIMENTATION RATE) ,** *EDTA WHOLE BLOOD*			
1stHour (Method:Westergren)	**26**	0.00 - 20.00 mm/hr	mm/hr

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

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Patient Name	: AMIT KUMAR	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	**:** 39 Y 2 M 4 D	**Collection Date**	**:**
Gender	**:** M	Report Date	**:** 07/Sep/2024 04:40PM

DEPARTMENT OF X-RAY

X-RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Bilateral costophrenic angles are unremarkable.

Bilateral hila and vascular markings are unremarkable.

Domes of diaphragm are normal in morphology and contour.

Cardiac size is within normal limits.

Bony thoracic cage appears normal.

IMPRESSION:

No fracture or dislocation.

No significant abnormality detected.

Recommended clinical correlation with other investigation.

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

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Bio Ref. Interval	Unit
***URINE ROUTINE ALL, ALL ,** *URINE*			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		
APPEARANCE	SLIGHTLY HAZY		
CHEMICAL EXAMINATION			
pH (Method:Dipstick (triple indicator method))	5	4.6 - 8.0	
SPECIFIC GRAVITY (Method:Dipstick (ion concentration method))	1.015	1.005 - 1.030	
PROTEIN (Method:Dipstick (protein error of pH indicators)/Manual)	NEGATIVE	NOT DETECTED	
GLUCOSE (Method:Dipstick(glucose-oxidase-peroxidase method)/Manual)	NEGATIVE	NOT DETECTED	
KETONES (ACETOACETIC ACID, ACETONE) (Method:Dipstick (Legals test)/Manual)	NEGATIVE	NOT DETECTED	
BLOOD (Method:Dipstick (pseudoperoxidase reaction))	NEGATIVE	NOT DETECTED	
BILIRUBIN (Method:Dipstick (azo-diazo reaction)/Manual)	NEGATIVE	NEGATIVE	
UROBILINOGEN (Method:Dipstick (diazonium ion reaction)/Manual)	NEGATIVE	NEGATIVE	
NITRITE (Method:Dipstick (Griess test))	NEGATIVE	NEGATIVE	
LEUCOCYTE ESTERASE (Method:Dipstick (ester hydrolysis reaction))	NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION			
LEUKOCYTES (PUS CELLS) (Method:Microscopy)	01-02	0-5	/hpf
EPITHELIAL CELLS (Method:Microscopy)	02-03	0-5	/hpf
RED BLOOD CELLS (Method:Microscopy)	NEGATIVE	0-2	/hpf
CAST (Method:Microscopy)	NEGATIVE	NOT DETECTED	
CRYSTALS (Method:Microscopy)	NEGATIVE	NOT DETECTED	
BACTERIA (Method:Microscopy)	NEGATIVE	NOT DETECTED	
YEAST (Method:Microscopy)	NEGATIVE	NOT DETECTED	
OTHERS	NEGATIVE		

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. 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.
7. 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 *****

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DEPARTMENT OF CARDIOLOGY

E.C.G. REPORT

DATA HEART RATE	62	Bpm
PR INTERVAL	138	Ms
QRS DURATION	92	Ms
QT INTERVAL	396	Ms
QTC INTERVAL	404	Ms
AXIS P WAVE	55	Degree
QRS WAVE	-4	Degree
T WAVE	18	Degree
IMPRESSION	:	**Normal sinus rhythm.**

ACRay
Dr. A C RAY
Department of Non-invasive Cardiology