

Visit ID	: YOD610559	UHID/MR No	: YOD.0000589110
Patient Name	: Mrs. DEVARAKONDA ANITHA RANI	Client Code	: YOD-DL-0021
Age/Gender	: 39 Y 3 M 24 D /F	Barcode No	: 10899798
DOB	: 04/Oct/1984	Registration	: 27/Jan/2024 08:35AM
Ref Doctor	: SELF	Collected	: 27/Jan/2024 08:35AM
Client Name	: MEDI WHEELS	Received	:
Client Add	: F-701, Lado Sarai, Mehrauli, N	Reported	: 27/Jan/2024 11:14AM
Hospital Name	:		

DEPARTMENT OF RADIOLOGY**ULTRASOUND WHOLE ABDOMEN & PELVIS**

Clinical Details : General check-up.

LIVER : Normal in size (118mm) and echo-texture. No focal lesion is seen. Intra hepatic biliary channels are not dilated. Visualised common bile duct & portal vein appears normal.

GALL BLADDER : Contracted.

PANCREAS : Normal in size and outlines. Parenchymal texture normal. No ductal dilatation. No calcifications / calculi.

SPLEEN : Normal in size (96mm) and echotexture. No focal lesion is seen.

RIGHT KIDNEY : measures 97x43mm. Normal in size with smooth contours. Parenchymal texture normal. No focal lesion is seen. Cortico-medullary differentiation well maintained. Collecting system does not show any dilatation or calculus.

LEFT KIDNEY : measures 90x45mm. Normal in size with smooth contours. Parenchymal texture normal. No focal lesion is seen. Cortico-medullary differentiation well maintained. Collecting system does not show any dilatation or calculus.

URINARY BLADDER : Well distended. No evidence of calculi or wall thickening.

UTERUS : Anteverted, measures 61x38x25mm, normal in size. Myometrium shows normal echo-texture. No focal lesion is seen. Endometrial thickness is normal.

Right ovary measures 29x17mm. Dominant follicle noted measuring 14.4x9.2cm.

Left ovary measures 27x12mm.

Both ovaries are normal in size & echotexture. No adnexal lesion seen.

No enlarged nodes are visualised. No retro-peritoneal lesion is identified. Great vessels appear normal.

Verified By :
VIKAS REDDY



Approved By :

Dr. ANNAREDDY SIVAKALA MBBS, DNB
Reg. No.: 85185

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DEPARTMENT OF RADIOLOGY

No free fluid is seen in pelvis.

IMPRESSION:

- No significant sonographic abnormality detected with in the scope of this study.

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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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ESR (ERYTHROCYTE SEDIMENTATION RATE)

Sample Type : WHOLE BLOOD EDTA

ERYTHROCYTE SEDIMENTATION RATE	12	mm/1st hr	0 - 15	Capillary Photometry
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COMMENTS:

ESR is an acute phase reactant which indicates presence and intensity of an inflammatory process. It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders and renal diseases.


Increased levels may indicate: Chronic renal failure (e.g., nephritis, nephrosis), malignant diseases (e.g., multiple myeloma, Hodgkin disease, advanced Carcinomas), bacterial infections (e.g., abdominal infections, acute pelvic inflammatory disease, syphilis, pneumonia), inflammatory diseases (e.g. temporal arteritis, polymyalgia rheumatic, rheumatoid arthritis, rheumatic fever, systemic lupus erythematosus [SLE]), necrotic diseases (e.g., acute myocardial infarction, necrotic tumor, gangrene of an extremity), diseases associated with increased proteins (e.g., hyperfibrinogenemia, macroglobulinemia), and severe anemias (e.g., iron deficiency or B12 deficiency).

Falsely decreased levels may indicate: Sickle cell anemia, spherocytosis, hypofibrinogenemia, or polycythemia vera.

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DR. ABDUL ALEEM MOHAMMED
 MD, DNB (PATHOLOGY)
 Fellowship in Cytogenetics (USA)

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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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BLOOD GROUP ABO & RH Typing

Sample Type : WHOLE BLOOD EDTA

ABO	B			
Rh Typing	POSITIVE			

Method : Hemagglutination Tube method by forward and reverse grouping

COMMENTS:


The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings. Advsiied cross matching before transfusion

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DEPARTMENT OF HAEMATOLOGY


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CBC (COMPLETE BLOOD COUNT)
Sample Type : WHOLE BLOOD EDTA

HAEMOGLOBIN (HB)	14.7	g/dl	12.0 - 15.0	Cyanide-free SLS method
RBC COUNT (RED BLOOD CELL COUNT)	5.43	million/cmm	3.80 - 4.80	Impedance
PCV/HAEMATOCRIT	45.4	%	36.0 - 46.0	RBC pulse height detection
MCV	83.6	fL	83 - 101	Automated/Calculated
MCH	27.1	pg	27 - 32	Automated/Calculated
MCHC	32.4	g/dl	31.5 - 34.5	Automated/Calculated
RDW - CV	14	%	11.0-16.0	Automated Calculated
RDW - SD	43	fl	35.0-56.0	Calculated
MPV	11.1	fL	6.5 - 10.0	Calculated
PDW	13.5	fL	8.30-25.00	Calculated
PCT	0.44	%	0.15-0.62	Calculated
TOTAL LEUCOCYTE COUNT	8,520	cells/ml	4000 - 11000	Flow Cytometry
DLC (by Flow cytometry/Microscopy)				
NEUTROPHIL	57.9	%	40 - 80	Impedance
LYMPHOCYTE	33.6	%	20 - 40	Impedance
EOSINOPHIL	2.3	%	01 - 06	Impedance
MONOCYTE	5.8	%	02 - 10	Impedance
BASOPHIL	0.4	%	0 - 1	Impedance
PLATELET COUNT	3.91	Lakhs/cumm	1.50 - 4.10	Impedance

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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THYROID PROFILE (T3,T4,TSH)

Sample Type : SERUM

T3	1.16	ng/ml	0.60 - 1.78	CLIA
T4	13.87	ug/dl	4.82-15.65	CLIA
TSH	4.28	uIU/mL	0.30 - 5.60	CLIA

INTERPRETATION:

1. Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
3. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
4. Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol and propylthiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
6. Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.
7. Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance.
8. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.
9. **REFERENCE RANGE :**

PREGNANCY	TSH in uIU/mL
1st Trimester	0.60 - 3.40
2nd Trimester	0.37 - 3.60
3rd Trimester	0.38 - 4.04

(References range recommended by the American Thyroid Association)

Comments:

1. During pregnancy, Free thyroid profile (FT3, FT4 & TSH) is recommended.
2. TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations.

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Approved By :

Surya Deep Pratap
SURYADEEP PRATAP
 Senior Biochemist

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DEPARTMENT OF BIOCHEMISTRY

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LIVER FUNCTION TEST(LFT)

Sample Type : SERUM

TOTAL BILIRUBIN	0.59	mg/dl	0.3 - 1.2	JENDRASSIK & GROFF
CONJUGATED BILIRUBIN	0.10	mg/dl	0 - 0.2	DPD
UNCONJUGATED BILIRUBIN	0.49	mg/dl		Calculated
AST (S.G.O.T)	18	U/L	< 50	KINETIC WITHOUT P5P-IFCC
ALT (S.G.P.T)	17	U/L	< 50	KINETIC WITHOUT P5P-IFCC
ALKALINE PHOSPHATASE	104	U/L	30 - 120	IFCC-AMP BUFFER
TOTAL PROTEINS	8.1	gm/dl	6.6 - 8.3	Biuret
ALBUMIN	4.4	gm/dl	3.5 - 5.2	BCG
GLOBULIN	3.7	gm/dl	2.0 - 3.5	Calculated
A/G RATIO	1.19			Calculated

Verified By :
VIKAS REDDY



Approved By :

Suryadeep Pratap
SURYADEEP PRATAP
 Senior Biochemist

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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LIPID PROFILE
Sample Type : SERUM

TOTAL CHOLESTEROL	116	mg/dl	Refere Table Below	Cholesterol oxidase/peroxidase
H D L CHOLESTEROL	26	mg/dl	> 40	Enzymatic/ Immunoinhibiton
L D L CHOLESTEROL	76.4	mg/dl	Refere Table Below	Enzymatic Selective Protein
TRIGLYCERIDES	68	mg/dl	See Table	GPO
VLDL	13.6	mg/dl	< 35	Calculated
T. CHOLESTEROL/ HDL RATIO	4.46		Refere Table Below	Calculated
TRIGLYCEIDES/ HDL RATIO	2.62	Ratio	< 2.0	Calculated
NON HDL CHOLESTEROL	90	mg/dl	< 130	Calculated

Interpretation

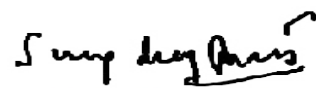
NATIONAL CHOLESTEROL EDUCATION PROGRAMME (NCEP)	TOTAL CHOLESTEROL	TRIGLYCERIDE	LDL CHOLESTEROL	NON HDL CHOLESTEROL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

REMARKS	Cholesterol : HDL Ratio
Low risk	3.3-4.4
Average risk	4.5-7.1
Moderate risk	7.2-11.0
High risk	>11.0

- Note:**
1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol
 2. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
 3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
 4. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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HBA1C

Sample Type : WHOLE BLOOD EDTA

HBA1c RESULT	7.5	%	Normal Glucose tolerance (non-diabetic): <5.7% Pre-diabetic: 5.7-6.4% Diabetic Mellitus: >6.5%	HPLC
ESTIMATED AVG. GLUCOSE	169	mg/dl		

Note:

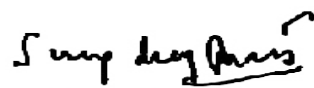
1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled .
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control .

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BLOOD UREA NITROGEN (BUN)

Sample Type : Serum

SERUM UREA	14	mg/dL	13 - 43	Urease GLDH
Blood Urea Nitrogen (BUN)	6.5	mg/dl	5 - 25	GLDH-UV

Increased In:

Impaired kidney function, Reduced renal blood flow {CHF, Salt and water depletion, (vomiting, diarrhea, diuresis, sweating), Shock}, Any obstruction of urinary tract, Increased protein catabolism, AMI, Stress

Decreased In:

Diuresis (e.g. with over hydration), Severe liver damage, Late pregnancy, Infancy, Malnutrition, Diet (e.g., low-protein and high-carbohydrate, IV feedings only), Inherited hyperammonemias (urea is virtually absent in blood)

Limitations:

Urea levels increase with age and protein content of the diet.

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DEPARTMENT OF BIOCHEMISTRY

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FBS (GLUCOSE FASTING)

Sample Type : FLOURIDE PLASMA

FASTING PLASMA GLUCOSE	180	mg/dl	70 - 100	HEXOKINASE
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INTERPRETATION:
Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)


Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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Client Name	: MEDI WHEELS	Received	: 27/Jan/2024 12:13PM
Client Add	: F-701, Lado Sarai, Mehravli, N	Reported	: 27/Jan/2024 01:04PM
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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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PPBS (POST PRANDIAL GLUCOSE)

Sample Type : FLOURIDE PLASMA

POST PRANDIAL PLASMA GLUCOSE	224	mg/dl	<140	HEXOKINASE
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INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extraprostatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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DEPARTMENT OF BIOCHEMISTRY

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SERUM CREATININE

Sample Type : SERUM

SERUM CREATININE	0.81	mg/dl	0.60 - 1.10	KINETIC-JAFFE
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Increased In:

- Diet: ingestion of creatinine (roast meat), Muscle disease: gigantism, acromegaly,
- Impaired kidney function.

Decreased In:

- Pregnancy: Normal value is 0.4-0.6 mg/dL. A value >0.8 mg/dL is abnormal and should alert the clinician to further diagnostic evaluation.
- Creatinine secretion is inhibited by certain drugs (e.g., cimetidine, trimethoprim).

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GGT (GAMMA GLUTAMYL TRANSPEPTIDASE)

Sample Type : SERUM

GGT	9	U/L	0 - 55.0	KINETIC-IFCC
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INTERPRETATION:

GGT functions in the body as a transport molecule, helping to move other molecules around the body. It plays a significant role in helping the liver metabolize drugs and other toxins. Increased GGT include overuse of alcohol, chronic viral hepatitis, lack of blood flow to the liver, liver tumor, cirrhosis, or scarred liver, overuse of certain drugs or other toxins, heart failure, diabetes, pancreatitis, fatty liver disease.

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URIC ACID -SERUM

Sample Type : SERUM

SERUM URIC ACID	4.7	mg/dl	2.6 - 6.0	URICASE - PAP
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Interpretation

Uric acid is the final product of purine metabolism in the human organism. Uric acid measurements are used in the diagnosis and treatment of numerous renal and metabolic disorders, including renal failure, gout, leukemia, psoriasis, starvation or other wasting conditions, and of patients receiving cytotoxic drugs.

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Senior Biochemist

Visit ID	: YOD610559	UHID/MR No	: YOD.0000589110
Patient Name	: Mrs. DEVARAKONDA ANITHA RANI	Client Code	: YOD-DL-0021
Age/Gender	: 39 Y 3 M 24 D /F	Barcode No	: 10899798
DOB	: 04/Oct/1984	Registration	: 27/Jan/2024 08:35AM
Ref Doctor	: SELF	Collected	: 27/Jan/2024 08:51AM
Client Name	: MEDI WHEELS	Received	: 27/Jan/2024 09:27AM
Client Add	: F-701, Lado Sarai, Mehravli, N	Reported	: 27/Jan/2024 10:37AM
Hospital Name	:		

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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BUN/CREATININE RATIO

Sample Type : SERUM				
Blood Urea Nitrogen (BUN)	6.5	mg/dl	5 - 25	GLDH-UV
SERUM CREATININE	0.81	mg/dl	0.60 - 1.10	KINETIC-JAFFE
BUN/CREATININE RATIO	8.07	Ratio	6 - 25	Calculated

Verified By :
VIKAS REDDY



Approved By :

SURYADEEP PRATAP
Senior Biochemist

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Ref Doctor	: SELF	Collected	: 27/Jan/2024 08:51AM
Client Name	: MEDI WHEELS	Received	: 27/Jan/2024 12:33PM
Client Add	: F-701, Lado Sarai, Mehravli, N	Reported	: 27/Jan/2024 02:35PM
Hospital Name	:		

DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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CUE (COMPLETE URINE EXAMINATION)

Sample Type : SPOT URINE

PHYSICAL EXAMINATION

TOTAL VOLUME	20 ML	ml		
COLOUR	PALE YELLOW			
APPEARANCE	CLEAR			
SPECIFIC GRAVITY	1.012		1.003 - 1.035	Bromothymol Blue

CHEMICAL EXAMINATION

pH	6.0		4.6 - 8.0	Double Indicator
PROTEIN	NEGATIVE		NEGATIVE	Protein - error of Indicators
GLUCOSE(U)	POSITIVE (+++)		NEGATIVE	Glucose Oxidase
UROBILINOGEN	0.1	mg/dl	< 1.0	Ehrlichs Reaction
KETONE BODIES	NEGATIVE		NEGATIVE	Nitroprasside
BILIRUBIN - TOTAL	NEGATIVE		Negative	Azocoupling Reaction
BLOOD	NEGATIVE		NEGATIVE	Tetramethylbenzidine
LEUCOCYTE	NEGATIVE		Negative	Azocoupling reaction
NITRITE	NEGATIVE		NEGATIVE	Diazotization Reaction

MICROSCOPIC EXAMINATION

PUS CELLS	1-2	cells/HPF	0-5	
EPITHELIAL CELLS	1-2	/hpf	0 - 15	
RBCs	NIL	Cells/HPF	Nil	
CRYSTALS	NIL	Nil	Nil	
CASTS	NIL	/HPF	Nil	
BUDDING YEAST	NIL		Nil	
BACTERIA	NIL		Nil	
OTHER	NIL			

Verified By :
VIKAS REDDY

Approved By :




Dr. VIKAS REDDY
Consultant Pathologist

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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***** End Of Report *****Verified By :
VIKAS REDDY

Approved By :

**Dr. VIKAS REDDY**
Consultant Pathologist