# ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

| | | | |
|---|---|---|---|
| **Patient Name** | Mrs. GUDDI MEENA | **Lab No** | 4002649 |
| **UHID** | 40001959 | **Collection Date** | 13/05/2023 11:34AM |
| **Age/Gender** | 36 Yrs/Female | **Receiving Date** | 13/05/2023 11:35AM |
| **IP/OP Location** | O-OPD | **Report Date** | 13/05/2023 5:03PM |
| **Referred By** | EHS CONSUTANT | **Report Status** | Final |
| **Mobile No.** | 9408439955 | | |

## BIOCHEMISTRY

| Test Name | Result | Unit | Biological Ref. Range |
|---|---|---|---|
| **BLOOD GLUCOSE (FASTING)** | | | Sample: Fl. Plasma |
| BLOOD GLUCOSE (FASTING) | **108.9 H** | mg/dl | 74 - 106 |

Method: Hexokinase assay.
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

| | | | |
|---|---|---|---|
| **BLOOD GLUCOSE (PP )** | | | Sample: PLASMA |
| BLOOD GLUCOSE (PP ) | 90.0 | mg/dl | Non – Diabetic: - < 140 mg/dl<br>Pre – Diabetic: - 140-199 mg/dl<br>Diabetic: - >=200 mg/dl |

Method: Hexokinase assay.
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

| | | | |
|---|---|---|---|
| **THYROID T3 T4 TSH** | | | Sample: Serum |
| T3 | 1.280 | ng/mL | 0.970 - 1.690 |
| T4 | 6.56 | ug/dl | 5.53 - 11.00 |
| TSH | 1.98 | µIU/mL | 0.40 - 4.05 |

**RESULT ENTERED BY : NEETU SHARMA**

**Dr. MUDITA SHARMA**

**MBBS|MD| PATHOLOGY**

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## BIOCHEMISTRY

**T3**:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T3 is utilized in thediagnosis of T3-hyperthyroidism the detection of early stages ofhyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

**T4**:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T4 assay employs acompetitive test principle with an antibody specifically directed against T4.

**TSH - THYROID STIMULATING HORMONE** :- ElectroChemiLuminescenceImmunoAssay - ECLIA

Interpretation:-The determination of TSH serves as theinitial test in thyroid diagnostics. Even very slight changes in theconcentrations of the free thyroid hormones bring about much greater oppositechanges in the TSH levels.

**LFT (LIVER FUNCTION TEST)** Sample: Serum

| | | | |
|---|---|---|---|
| BILIRUBIN TOTAL | 0.55 | mg/dl | 0.00 - 1.20 |
| BILIRUBIN INDIRECT | 0.38 | mg/dl | 0.20 - 1.00 |
| BILIRUBIN DIRECT | 0.17 | mg/dl | 0.00 - 0.40 |
| SGOT | 30.5 | U/L | 0.0 - 40.0 |
| SGPT | 19.2 | U/L | 0.0 - 40.0 |
| TOTAL PROTEIN | 8.1 | g/dl | 6.6 - 8.7 |
| ALBUMIN | 4.3 | g/dl | 3.5 - 5.2 |
| GLOBULIN | **3.8 H** | | 1.8 - 3.6 |
| ALKALINE PHOSPHATASE | 76.0 | U/L | 42 - 98 |
| A/G RATIO | **1.1 L** | Ratio | 1.5 - 2.5 |
| GGTP | 13.5 | U/L | 6.0 - 38.0 |

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## BIOCHEMISTRY

**BILIRUBIN TOTAL** :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structive.
**BILIRUBIN DIRECT** :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.
**SGOT – AST** :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT(AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.
**SGPT - ALT** :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT(ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.
**TOTAL PROTEINS** :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.
**ALBUMIN** :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.
**ALKALINE PHOSPHATASE** :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method: Enzymetic colorimetric assay. Interpretation:-y-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

**LIPID PROFILE**

| | | | |
|---|---|---|---|
| TOTAL CHOLESTEROL | 157 | | <200 mg/dl :- Desirable<br>200-240 mg/dl :- Borderline<br>>240 mg/dl :- High |
| HDL CHOLESTEROL | 52.7 | | High Risk :-<40 mg/dl (Male), <40 mg/dl (Female)<br>Low Risk :->=60 mg/dl (Male), >=60 mg/dl (Female) |
| LDL CHOLESTEROL | 93.3 | | Optimal :- <100 mg/dl<br>Near or Above Optimal :- 100-129 mg/dl<br>Borderline :- 130-159 mg/dl<br>High :- 160-189 mg/dl<br>Very High :- >190 mg/dl |
| CHOLESTERO VLDL | 13.36 | mg/dl | 10 - 50 |
| TRIGLYCERIDES | 66.8 | | Normal :- <150 mg/dl<br>Border Line:- 150 - 199 mg/dl<br>High :- 200 - 499 mg/dl<br>Very high :- > 500 mg/dl |
| CHOLESTEROL/HDL RATIO | 2.97 | % | |

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## BIOCHEMISTRY

CHOLESTEROL TOTAL :- Method: CHOD-PAP enzymatic colorimetric assay.
interpretation:-The determination of the individual total cholesterol (TC) level is used for screening purposes while for a better risk assessment it is necessary to measure additionally lipid & lipoprotein metabolic disorders.
HDL CHOLESTEROL :- Method:-Homogenous enzymetic colorimetric method.
Interpretation:-HDL-cholesterol has a protective against coronary heart disease, while reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase the cardiovascular disease.
LDL CHOLESTEROL :- Method: Homogenous enzymatic colorimetric assay.
Interpretation:-LDL play a key role in causing and influencing the progression of atherosclerosis and in particular coronary sclerosis. The LDL are derived form VLDL rich in TG by the action of various lipolytic enzymes and are synthesized in the liver.
CHOLESTEROL VLDL :- Method: VLDL Calculative
TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay.
Interpretation:-High triglycerde levels also occur in various diseases of liver, kidneys and pancreas.
DM, nephrosis, liver obstruction.
CHOLESTEROL/HDL RATIO :- Method: Cholesterol/HDL Ratio Calculative

**RENAL PROFILE TEST** Sample: Serum

| | | | |
|---|---|---|---|
| UREA | 23.8 | mg/dl | 16.60 - 48.50 |
| BUN | 11.1 | mg/dl | 6 - 20 |
| CREATININE | 0.88 | mg/dl | 0.50 - 0.90 |
| SODIUM | 140.7 | mmol/L | 136 - 145 |
| POTASSIUM | 4.39 | mmol/L | 3.50 - 5.50 |
| CHLORIDE | 106.3 | mmol/L | 98 - 107 |
| URIC ACID | 2.9 | mg/dl | 2.6 - 6.0 |
| CALCIUM | **8.46 L** | mg/dl | 8.60 - 10.30 |

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## BIOCHEMISTRY

**CREATININE – SERUM** :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidneydisease.
**URIC ACID** :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uricacid are renal diseases with decreased excretion of waste products, starvation,drug abuse and increased alcohol consume.
**SODIUM**:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea,diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake andkidney reabsorption.
**POTASSIUM** :- Method: ISE electrode. Intrpretation:-Low level: Intake excessive loss formbodydue to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renalfailure.
**CHLORIDE – SERUM** :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake,prolonged vomiting and reduced renal reabsorption as well as forms of acidosisand alkalosis.
Increase: dehydration, kidney failure, some form ofacidosis, high dietary or parenteral chloride intake, and salicylate poisoning.
**UREA**:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogenconcentration are seen in inadequate renal perfusion, shock, diminished bloodvolume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerularnephritis and UTI.
**CALCIUM TOTAL** :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usuallyassociated with hypercalcemia. Increased serum calcium levels may also beobserved in multiple myeloma and other neoplastic diseases. Hypocalcemia may
beobserved in hypoparathyroidism, nephrosis, and pancreatitis.

Sample: WHOLE BLOOD EDTA

| | | | |
|---|---|---|---|
| HBA1C | 5.5 | % | < 5.7% Nondiabetic<br>5.7-6.4% Pre-diabetic<br>> 6.4% Indicate Diabetes<br><br>Known Diabetic Patients<br>< 7 % Excellent Control<br>7 - 8 % Good Control<br>> 8 % Poor Control |

Method : – High - performance liquid chromatography HPLC
Interpretation:-Monitoring long term glycemic control, testing every 3 to 4 months is generally sufficient.
The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

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## BLOOD BANK INVESTIGATION

| Test Name | Result | Unit | Biological Ref. Range |
|---|---|---|---|
| BLOOD GROUPING | "O" Rh Positive | | |

Note :
1. Both forward and reverse grouping performed.
2. Test conducted on EDTA whole blood.

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## CLINICAL PATHOLOGY

| Test Name | Result | Unit | Biological Ref. Range | |
|---|---|---|---|---|
| **URINE SUGAR (POST PRANDIAL)** | | | | Sample: Urine |
| URINE SUGAR (POST PRANDIAL) | NEGATIVE | | | |
| **URINE SUGAR (RANDOM)** | | | | Sample: Urine |
| URINE SUGAR (RANDOM) | NEGATIVE | | | |
| **ROUTINE EXAMINATION - URINE** | | | | Sample: Urine |
| **PHYSICAL EXAMINATION** | | | | |
| VOLUME | 20 | ml | | |
| COLOUR | PALE YELLOW | | P YELLOW | |
| APPEARANCE | CLEAR | | CLEAR | |
| **CHEMICAL EXAMINATION** | | | | |
| PH | 6.0 | | 5.5 - 7.0 | |
| SPECIFIC GRAVITY | 1.030 | | 1.016-1.022 | |
| PROTEIN | NEGATIVE | | NEGATIVE | |
| SUGAR | NEGATIVE | | NEGATIVE | |
| BILIRUBIN | NEGATIVE | | NEGATIVE | |
| BLOOD | TRACE | | | |
| KETONES | NEGATIVE | | NEGATIVE | |
| NITRITE | NEGATIVE | | NEGATIVE | |
| UROBILINOGEN | NEGATIVE | | NEGATIVE | |
| LEUCOCYTE | TRCAE | | NEGATIVE | |
| **MICROSCOPIC EXAMINATION** | | | | |
| WBCS/HPF | 2-4 | /hpf | 0 - 3 | |
| RBCS/HPF | 0-1 | /hpf | 0 - 2 | |
| EPITHELIAL CELLS/HPF | 2-3 | /hpf | 0 - 1 | |
| CASTS | NIL | | NIL | |
| CRYSTALS | NIL | | NIL | |

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## CLINICAL PATHOLOGY

| | | |
|---|---|---|
| BACTERIA | NIL | NIL |
| OHTERS | NIL | NIL |

Methodology:-
Glucose: GOD-POD, Bilirubin: Diazo-Azo-coupling reaction with a diazonium, Ketone: Nitro Pruside reaction, Specific Gravity: Proton re;ease from ions, Blood: Psuedo-Peroxidase activity oh Haem moiety, pH: Methye Red-Bromothymol Blue (Double indicator system), Protein: H+ Release by buffer, microscopic & chemical method.
interpretation: Diagnosis of Kidney function, UTI, Presence of Protein, Glucoses, Blood. Vocubulary syntax: Kit insert

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## HEMATOLOGY

| Test Name | Result | Unit | Biological Ref. Range |
|---|---|---|---|
| **CBC (COMPLETE BLOOD COUNT)** | | | Sample: WHOLE BLOOD EDTA |
| HAEMOGLOBIN | **11.4 L** | g/dl | 12.0 - 15.0 |
| PACKED CELL VOLUME(PCV) | 36.6 | % | 36.0 - 46.0 |
| MCV | **94.1 H** | fl | 82 - 92 |
| MCH | 29.3 | pg | 27 - 32 |
| MCHC | **31.1 L** | g/dl | 32 - 36 |
| RBC COUNT | 3.89 | millions/cu.mm | 3.80 - 4.80 |
| TLC (TOTAL WBC COUNT) | 4.46 | 10^3/ uL | 4 - 10 |
| **DIFFERENTIAL LEUCOCYTE COUNT** | | | |
| NEUTROPHILS | 63.0 | % | 40 - 80 |
| LYMPHOCYTE | 28.7 | % | 20 - 40 |
| EOSINOPHILS | 1.6 | % | 1 - 6 |
| MONOCYTES | 6.3 | % | 2 - 10 |
| BASOPHIL | **0.4 L** | % | 1 - 2 |
| PLATELET COUNT | **1.32 L** | lakh/cumm | 1.500 - 4.500 |

**HAEMOGLOBIN** :- Method:-SLS HemoglobinMethodology by Cell Counter.Interpretation:-Low-Anemia, High-Polycythemia.
**MCV** :- Method:- Calculation bysysmex.
**MCH** :- Method:- Calculation bysysmex.
**MCHC** :- Method:- Calculation bysysmex.
**RBC COUNT** :- Method:-Hydrodynamicfocusing.Interpretation:-Low-Anemia,High-Polycythemia.
**TLC (TOTAL WBC COUNT)** :- Method:-Optical Detectorblock based on Flowcytometry.Interpretation:-High-Leucocytosis, Low-Leucopenia.
**NEUTROPHILS** :- Method: Optical detectorblock based on Flowcytometry
**LYMPHOCYTS** :- Method: Optical detectorblock based on Flowcytometry
**EOSINOPHILS** :- Method: Optical detectorblock based on Flowcytometry
**MONOCYTES** :- Method: Optical detectorblock based on Flowcytometry
**BASOPHIL** :- Method: Optical detectorblock based on Flowcytometry
**PLATELET COUNT** :- Method:-Hydrodynamicfocusing method.Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

| | | | |
|---|---|---|---|
| ESR (ERYTHROCYTE SEDIMENTATION RATE) | **30 H** | mm/1st hr | 0 - 15 |

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Method:-Modified Westergrens.
Interpretation:-Increased in infections, sepsis, and malignancy.

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| Test Name | Result | Unit | Biological Ref. Range |
|---|---|---|---|

## USG REPORT - ABDOMEN AND PELVIS

### LIVER:

Is normal in size (~138 mm) and uniform echo texture. No obvious focal lesion seen. No intra – Hepatic biliary radical dilatation seen.

### GALL BLADDER:

Partially distended with no obvious wall thickening/pericholecystic fat stranding/fluid. No obvious calculus/polyp/mass seen within.

### PANCREAS:

Appears normal in size and it shows uniform echotexture.

### SPLEEN:

Is normal in size (~87 mm) and shows uniform echogenicity.

### RIGHT KIDNEY:

Right kidney measures 89 x 47 mm.

The shape, size and contour of the right kidney appear normal.

Corticomedullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

### LEFT KIDNEY:

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**USG**

Left kidney measures **83 x 49 mm.**

The shape, size and contour of the left kidney appear normal.

Corticomedullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

BLADDER:

**Is partially distended (patient is not willing to hold further pressure).**

UTERUS:

**Appears normal for the age.**

**IUCD seen in situ.**

ADNEXA:

**No obvious adnexal mass lesion is seen.**

RIGHT ILIAC FOSSA:

No focal fluid collections seen.

IMPRESSION:
**No significant sonographic abnormality detected.**

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**Dr. RENU JADIYA**
**MBBS, DNB**
**RADIOLOGIST**

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**X Ray**

| Test Name | Result | Unit | Biological Ref. Range |
|---|---|---|---|

## X-RAY - CHEST PA VIEW

### OBSERVATION:

The trachea is central.

The mediastinal and cardiac silhouette are normal.

Cardiothoracic ratio is normal.

Cardiophrenic and costophrenic angles are normal.

Both hila are normal.

The lung fields are clear.

Bones of the thoracic cage are normal.

Soft tissues of the chest wall are normal.

### IMPRESSION:

**No significant abnormality seen.**

**End Of Report**

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**Dr. RENU JADIYA**
**MBBS, DNB**
**RADIOLOGIST**