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|-------------------------|--------------------------------|----------------------------|---------------------|
| Registration No. | 102395 | Mobile No. | |
| Patient Name | Mr. KASANA SANYOG KUMAR | Registration Date/Time | 02/04/2023 09:21:46 |
| Age / Sex | 45 Yrs Male | Sample Collected Date/Time | 02/04/2023 09:37:59 |
| Ref By / Hospital | Others BANK OF BARODA | Report Date/Time | 02/04/2023 14:15:34 |
| Collected At | DCKC | Printed Date/Time | 02/04/2023 15:19:04 |

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HAEMATOLOGY

Complete Blood Count (CBC)

| | | | |
|--|--------|---------------------|-----------------|
| Haemoglobin (Hb) ,EDTA <i>Method : Colorimetric</i> | 14.2 | g/dL | 13.0 - 17.0 |
| Total Leucocyte Count (TLC) ,EDTA <i>Method : Electric impedance</i> | 05.8 | 10 ⁹ /L | 04.0 - 11.0 |
| Red Blood Cell (RBC) ,EDTA <i>Method : Electric impedance</i> | 5.06 | 10 ⁶ /uL | 4.50 - 5.50 |
| Hematocrit (HCT /PCV) ,EDTA <i>Method : Pulse height detection</i> | 43.8 | % | 40.0 - 50.0 |
| Mean Corp Volume (MCV) ,EDTA <i>Method : Calculated</i> | 86.6 | fL | 83.0 - 101.0 |
| Mean Corp Hb (MCH) ,EDTA <i>Method : Calculated</i> | 28.1 | pg | 27.0 - 32.0 |
| Mean Corp Hb Conc (MCHC) ,EDTA <i>Method : Calculated</i> | 32.4 | g/dL | 31.5 - 34.5 |
| Platelet Count(PLT) ,EDTA <i>Method : Electric impedance/Microscopy</i> | 178.00 | 10 ³ /uL | 150.00 - 410.00 |
| RDW- CV% ,EDTA | 13.0 | % | 11.6 - 14.0 |
| Differential Leucocyte Count <i>Method : Microscopy</i> | | | |
| Neutrophil ,EDTA | 50.1 | % | 40.0 - 80.0 |
| Lymphocyte ,EDTA | 44.9 | % | 20.0 - 45.0 |
| Eosinophil ,EDTA | 3.0 | % | 1.0 - 6.0 |
| Monocyte ,EDTA | 2.0 | % | 2.0 - 10.0 |
| Basophil ,EDTA | 0.0 | % | 0.0 - 2.0 |
| ESR ,EDTA <i>Method : Westergreen</i> | 11 | mm/Ist hr. | 00 - 15 |

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Checked By :- POOJA



DR. NEELU CHHABRA
MD. PATHOLOGIST

At Your Home: Collection of Blood Samples, ECG, Digital X-Ray

Occupational Health Service ■ Diagnostic & Preventive ■ Health Assessment ■ Periodic Preventive Health Camps ■ Corporate Health Checks

Ultrasound | Digital X Ray | DEXA | Mammography | Path Lab | ECHO | TMT | Healthchecks | PFT | Holter | Audiometry



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Blood Group ABO ,EDTA

Method : Forward Grouping

"O"

Rh Typing ,EDTA

Method : Forward Grouping

POSITIVE

HbA1c ,EDTA

Method : Photometric method

5.3 %

INTERPRETATIONS:-

NORMAL RANGE **4.00 - 5.60** %

| | | | |
|---|------|--------|---|
| Pre Diabetic/ Higher chance of getting diabetes | 5.70 | - 6.20 | % |
| Good Diabetic Control | 6.20 | - 6.80 | % |
| Fair Diabetic Control | 6.80 | - 7.60 | % |
| Uncontrolled Diabetes -action suggested | >7.6 | | % |

Note:-

Glycosylated Haemoglobin is a specific component of HBA1C and is the blood glucose bound to it. This test is an index of carbohydrate in balance during the preceding two months. The estimation is of greater importance for specific group of patient. This result are not affected by time, meal intake exercise, diabetic drugs, emotional Stress etc. HbA1c should be routinely monitored ideally at least every 3 months.





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BIOCHEMISTRY

LIPID PROFILE

| | | | |
|--|--------------|-------|--------------|
| Total Lipids ,Serum Plain | 471 | mg/dl | 400 - 700 |
| Serum Cholesterol ,Serum Plain <i>Method : CHOD-POD</i> | 179 | mg/dl | 0 - 200 |
| Serum Triglycerides ,Serum Plain <i>Method : GOD-POD</i> | 113 | mg/dl | 60 - 165 |
| Serum HDL Cholesterol ,Serum Plain <i>Method : Direct Method</i> | 52.0 | mg/dl | 40.0 - 70.0 |
| Serum LDL Cholesterol ,Serum Plain <i>Method : Calculated</i> | 104.0 | mg/dl | 30.0 - 100.0 |
| Serum VLDL Cholesterol ,Serum Plain <i>Method : Calculated</i> | 23.0 | mg/dl | 24.0 - 45.0 |
| Total CHO/HDL Cholesterol Ratio ,Serum Plain <i>Method : Calculated</i> | 3.44 | | |
| LDL/HDL Cholesterol Ratio ,Serum Plain <i>Method : Calculated</i> | 2.00 | | |

Guidelines for Total Blood Cholesterol Levels on 11 to 12 hour fasting samples.

Desirable : Less than 200 mg/dl

Borderline High Risk : 200 to 239 mg/dl

High Risk : 240 mg/dl and over, on repeated values

Optimal Level for Cardiac Patients : Less than 200 mg/dl

HDL-C : High HDL has generally been found to be protective, decreasing the risk of coronary Artery disease (CAD) in most people. However, some recent studies have shown that in some people with high HDL, the HDL is not protective and may, in fact result in higher risk for CAD than in people with normal HDL levels. In one study it was shown that people with CAD and high HDL had underlying genetic anomalies in enzymes important in lipid turnover. Another study showed that high levels of abnormally large HDL particles were associated with increased risk of CAD. Factors that elevate HDL concentrations include chronic alcoholism, treatment with oral estrogen replacement therapy, extensive aerobic exercise, and treatment with niacin, statins, or fibrates. Smoking reduces levels of HDL cholesterol, while quitting smoking leads to a rise in the plasma HDL level.

Triglycerides
Female 40 - 140
Male 60 - 165

Adult levels:
Optimal <100 mg/dL
Near Optimal/ above optimal 100 -129 mg/dL
Borderline high 130 - 159 mg/dL
High 160 - 189 mg/dL
Verv High >=190 mg/dL

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LIVER PROFILE / LFT


| | | | |
|---|-------|-------|--|
| Serum Bilirubin (Total) ,Serum Plain <i>Method : DSA Method</i> | 0.53 | mg/dl | 0.00 - 1.20 |
| Serum Bilirubin (Direct) ,Serum Plain <i>Method : DSA Method</i> | 0.20 | mg/dl | 0.00 - 0.30 |
| Serum Bilirubin (Indirect) ,Serum Plain <i>Method : Calculated Parameter</i> | 0.33 | mg/dl | 0.00 - 0.60 |
| SGOT ,Serum Plain <i>Method : IFCC/KINETIC</i> | 15.7 | IU/l | Males : Upto 46 IU/l Females : Upto 40 IU/l |
| SGPT ,Serum Plain <i>Method : IFCC/KINETIC</i> | 13.3 | IU/l | Upto 49 IU/l |
| Serum Alkaline Phosphatase ,Serum Plain <i>Method : DEA Method</i> | 112.0 | IU/l | 30.0 - 120.0 |
| Serum Total Protein ,Serum Plain <i>Method : Biuret Method</i> | 7.43 | gm/dl | 6.00 - 8.50 |
| Serum Albumin ,Serum Plain <i>Method : BCG Method</i> | 4.47 | gm/dl | 3.20 - 5.50 |
| Globulin ,Serum Plain <i>Method : Calculated</i> | 3.00 | gm/dl | 2.00 - 4.10 |
| A/G Ratio ,Serum Plain <i>Method : Calculated</i> | 1.49 | | 1.00 - 2.10 |
| Serum GGTP ,Serum Plain <i>Method : G-Glutamyl Transferase</i> | 17.0 | U/L | 0.0 - 50.0 |



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| | | | |
|---|-------|-------|--------------|
| Blood Sugar (Fasting) ,Plasma F <i>Method : GOD POD</i> | 72.8 | mg/dl | 70.0 - 110.0 |
| Blood Sugar (PP) ,Plasma PP <i>Method : GOD POD</i> | 98.6 | mg/dl | 70.0 - 140.0 |
| Serum Creatinine ,Serum Plain <i>Method : Mosified Jaffe's</i> | 1.01 | mg/dl | 0.40 - 1.50 |
| Serum Uric Acid ,Serum Plain <i>Method : Uricase- POD</i> | 5.20 | mg/dl | 3.40 - 7.00 |
| Blood Urea Nitrogen ,Serum Plain <i>Method : Calculated</i> | 12.66 | mg/dl | 0.00 - 20.00 |





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IMMUNOASSAY

TOTAL THYROID PROFILE

| | | | |
|-----------------------|-------|--------|--------------|
| Total T3 ,Serum Plain | 1.91 | ng/mL | 0.69 - 2.15 |
| Total T4 ,Serum Plain | 10.30 | ug/dl | 5.20 - 12.70 |
| TSH | 3.86 | uIU/ml | 0.30 - 4.50 |

Comment :

| Age Group | Biological Reference Range |
|---------------------|----------------------------|
| 1-2 Days | 3.2-3.43 uIU/ml |
| 3-4 Days | 0.7-15.4 uIU/ml |
| 15 Days - 5 Months | 1.7-9.1 uIU/ml |
| 5 Months - 2 Years | 0.7-6.4 uIU/ml |
| 2 Years - 12 Years | 0.64-6.27 uIU/ml |
| 12 Years - 18 Years | 0.51-4.94 uIU/ml |
| > 18 Years | 0.35-5.50 uIU/ml |

Adults

Note: TSH levels are subject to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm to 6 am. Nadir concentrations are observed during the afternoon. Diurnal variation in TSH level approximates + 50 %, hence time of the day has influence on the measured serum TSH concentration. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, and may be seen in secondary thyrotoxicosis.

Newborn

In a very low birth weight baby (particularly premature neonates) immaturity of the hypothalamic-pituitary - thyroid axis may mask primary congenital hypothyroidism. It is recommended that the test be repeated two weeks after birth in babies 1000-1500 gm and at four weeks in those <1000 gm. Specimen collection prior to 24 hours of age, after blood transfusion and prematurity can affect this screening.

Nearly 90% of CH cases are detected by newborn screening. A small number of children may test normal on the newborn screen but later develop hypothyroidism.





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Total PSA ,Serum Plain 0.98 ng/ml 0.00 - 4.00

INTERPRETATION

Prostate-specific antigen (PSA), a glycoprotein is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels. PSA exists in serum in multiple forms: complexed to alpha-1-anti-chymotrypsin (PSA-ACT complex), unbound (free PSA), and enveloped by alpha-2-macroglobulin (not detected by immunoassays). When total PSA concentration is <2.0 ng/ml, the probability of prostate cancer in asymptomatic men is low, further testing and free PSA may provide little additional information. When total PSA concentration is >10.0 ng/mL, the probability of cancer is high and prostate biopsy is generally recommended. The total PSA range of 4.0 to 10.0 ng/ml has been described as a diagnostic "gray zone," in which the free:total PSA ratio helps to determine the relative risk of prostate cancer. Therefore, some urologists recommend using the free:total ratio to help select which men should undergo biopsy. However even a negative result of prostate biopsy does not rule-out prostate cancer. Up to 20% of men with negative biopsy results have subsequently been found to have cancer. Higher total PSA levels and lower percentages of free PSA are associated with higher risks of prostate cancer. Based on free:total PSA ratio: the percent probability of finding prostate cancer on a needle biopsy by age in years:

| Free PSA as a percent of Total PSA | Probability of carcinoma prostate when Total PSA is 4.1 - 10.0 ng / ml |
|------------------------------------|--|
| >= | 26.8 % |
| 20 - 25 | 16 % |
| 15 - 20 | 20 % |
| 10 - 15 | 28 % |
| 0 - 10 | 56 % |

Comments:-

False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy. PSA total and free levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies and nonspecific protein binding. Results obtained with different assay kits cannot be used interchangeably. All results should be correlated with





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CLINICAL PATHOLOGY

URINE ROUTINE EXAMINATION

URE PHYSICAL EXAMINATION

Colour ,URINE Pale Yellow Pale Yellow

Volume ,URINE 20 mL

Appearance ,URINE Clear Clear

URE CHEMICAL EXAMINATION

Reaction ,URINE Acidic Acidic

Ph (Strip Method) ,URINE 6.0 5.0 - 8.0

Specific Gravity ,URINE 1.010 1.001 - 1.035

Protein (Strip Method) ,URINE Nil Not-Detected

Glucose (Strip Method) ,URINE Nil Nil

URE MICROSCOPY EXAMINATION

Pus Cells ,URINE 1 - 2 /HPF 0 - 2

Epithelial Cells ,URINE 0 - 2 /HPF 0 - 2

RBC's ,URINE NIL /HPF 0 - 2

Casts ,URINE Nil

Crystals ,URINE Nil

Bacteria ,URINE Absent Absent

Mucus Thread ,URINE Nil Nil

Other ,URINE Nil



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STOOL ANALYSIS

STOOL MICROSCOPIC EXAMINATION

OTHERS ,STOOL

SNR

Nil

*** End of Report ***

