

Name : Mrs. CHANDRA KALA  
PINNINTI  
PID No. : MED121670098  
SID No. : 522302155  
Age / Sex : 35 Year(s) / Female  
Type : OP  
Ref. Dr : MediWheel

Register On : 11/02/2023 10:15 AM  
Collection On : 11/02/2023 1:20 PM  
Report On : 11/02/2023 6:42 PM  
Printed On : 21/02/2023 11:45 AM

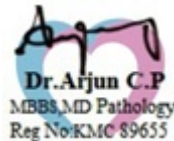


<u>Investigation</u>	<u>Observed Value</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
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## HAEMATOLOGY

### Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	12.32	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood)	38.8	%	37 - 47
RBC Count (EDTA Blood)	4.32	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (EDTA Blood)	89.7	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood)	28.5	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood)	31.8	g/dL	32 - 36
RDW-CV	15.1	%	11.5 - 16.0
RDW-SD	47.41	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood)	10520	cells/cu.mm	4000 - 11000
Neutrophils (Blood)	55.04	%	40 - 75
Lymphocytes (Blood)	21.77	%	20 - 45
Eosinophils (Blood)	17.89	%	01 - 06
Monocytes (Blood)	5.04	%	01 - 10



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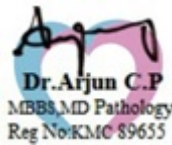
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Basophils (Blood)	0.27	%	00 - 02
<b>INTERPRETATION:</b> Tests done on Automated Five Part cell counter. All abnormal results are reviewed and confirmed microscopically.			
Absolute Neutrophil count (EDTA Blood)	5.79	10 <sup>3</sup> / $\mu$ l	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood)	2.29	10 <sup>3</sup> / $\mu$ l	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood)	1.88	10 <sup>3</sup> / $\mu$ l	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood)	0.53	10 <sup>3</sup> / $\mu$ l	< 1.0
Absolute Basophil count (EDTA Blood)	0.03	10 <sup>3</sup> / $\mu$ l	< 0.2
Platelet Count (EDTA Blood)	370.4	10 <sup>3</sup> / $\mu$ l	150 - 450
MPV (Blood)	<b>7.63</b>	fL	8.0 - 13.3
PCT (Automated Blood cell Counter)	0.28	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Citrate Blood)	14	mm/hr	< 20



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<b><u>Lipid Profile</u></b>			
Cholesterol Total (Serum/CHOD-PAP with ATCS)	157.24	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/GPO-PAP with ATCS)	130.76	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

**INTERPRETATION:** The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the usual circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immunoinhibition)	<b>41.51</b>	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/Calculated)	89.5	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	26.2	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	115.7	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

  
**DR JUSTINA WILLIAMS**  
 Senior Consultant Pathologist  
 Reg No: PNB20080000054 KTK  
**VERIFIED BY**

  
**DR SHAMIM JAVED**  
 MD PATHOLOGY  
 KMC 88902

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**INTERPRETATION:** 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.  
 2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.


Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	3.8		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
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Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	3.2		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
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LDL/HDL Cholesterol Ratio (Serum/Calculated)	2.2		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0
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<b><u>Glycosylated Haemoglobin (HbA1c)</u></b>			
HbA1C (Whole Blood/HPLC)	<b>6.3</b>	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5

**INTERPRETATION:** If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %

Estimated Average Glucose 134.11 mg/dL  
(Whole Blood)

**INTERPRETATION: Comments**

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glyceimic control as compared to blood and urinary glucose determinations.  
 Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.  
 Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.

  
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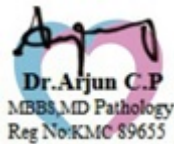
**CLINICAL PATHOLOGY**

**PHYSICAL EXAMINATION (URINE COMPLETE)**

Colour (Urine)	Pale yellow		Yellow to Amber
Appearance (Urine)	Clear		Clear
Volume(CLU) (Urine)	25		

**CHEMICAL EXAMINATION (URINE COMPLETE)**

pH (Urine)	7.0		4.5 - 8.0
Specific Gravity (Urine)	1.007		1.002 - 1.035
Ketone (Urine)	Negative		Negative
Urobilinogen (Urine)	Normal		Normal
Blood (Urine)	Negative		Negative
Nitrite (Urine)	Negative		Negative
Bilirubin (Urine)	Negative		Negative
Protein (Urine)	Negative		Negative



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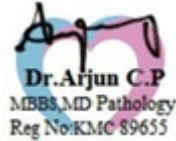
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Glucose (Urine/GOD - POD)	Negative		Negative
Leukocytes(CP) (Urine)	Negative		
<b><u>MICROSCOPIC EXAMINATION</u></b> <b><u>(URINE COMPLETE)</u></b>			
Pus Cells (Urine)	0-2	/hpf	NIL
Epithelial Cells (Urine)	2-5	/hpf	NIL
RBCs (Urine)	NIL	/hpf	NIL
Others (Urine)	NIL		

**INTERPRETATION:**Note: Done with Automated Urine Analyser & Automated urine sedimentation analyser. All abnormal reports are reviewed and confirmed microscopically.



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<b><u>PHYSICAL EXAMINATION(STOOL COMPLETE)</u></b>			
Mucus (Stool)	Absent		Absent
Consistency (Stool)	<b>Semi Solid</b>		Semi Solid to Solid
Colour (Stool)	Brown		Brown
Blood (Stool)	Absent		Absent
<b><u>MICROSCOPIC EXAMINATION(STOOL COMPLETE)</u></b>			
Ova (Stool)	NIL		NIL
Cysts (Stool)	NIL		NIL
Trophozoites (Stool)	NIL		NIL
RBCs (Stool)	NIL	/hpf	Nil
Pus Cells (Stool)	<b>1-2</b>	/hpf	NIL
<b><u>CHEMICAL EXAMINATION(STOOL ROUTINE)</u></b>			
Reaction (Stool)	<b>Acidic</b>		Alkaline

Dr. Arjun C.P  
MBBS, MD Pathology  
Reg No:KMC 89655

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**IMMUNOHAEMATOLOGY**

BLOOD GROUPING AND Rh TYPING 'B' 'Positive'  
(EDTA Blood/Agglutination)

**INTERPRETATION:**Note: Slide method is screening method. Kindly confirm with Tube method for transfusion.

A handwritten signature in black ink, appearing to read 'Ravikumar R.', is written over a circular logo with blue and pink segments.

Dr RAVIKUMAR R  
MBBS, MD BIOCHEMISTRY  
CONSULTANT BIOCHEMIST  
Reg No : 78771

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<b><u>BIOCHEMISTRY</u></b>			
BUN / Creatinine Ratio	13.5		6.0 - 22.0
Glucose Fasting (FBS) (Plasma - F/GOD-PAP)	82.13	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

**INTERPRETATION:** Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose, Fasting (Urine) (Urine - F/GOD - POD)	Negative		Negative
Glucose Postprandial (PPBS) (Plasma - PP/GOD-PAP)	99.94	mg/dL	70 - 140

**INTERPRETATION:** Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti-diabetic medication during treatment for Diabetes.


Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
Blood Urea Nitrogen (BUN) (Serum/Urease UV / derived)	6.2	mg/dL	7.0 - 21
Creatinine (Serum/Modified Jaffe)	0.46	mg/dL	0.6 - 1.1

**INTERPRETATION:** Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin ,cefazolin, ACE inhibitors ,angiotensin II receptor antagonists,N-acetylcyteine , chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/Enzymatic)	3.90	mg/dL	2.6 - 6.0
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Age & Gender	35/FEMALE	Visit Date	11/02/2023
Ref Doctor Name	MediWheel		

### ABDOMINO-PELVIC ULTRASONOGRAPHY

**LIVER** is normal in shape, size (12.9cms) and has uniform echopattern. No evidence of focal lesion or intrahepatic biliary ductal dilatation. Hepatic and portal vein radicals are normal.

**GALL BLADDER** shows normal shape and has clear contents. Wall is of normal thickness. CBD is not dilated.

**PANCREAS** Head appears normal. Rest of the pancreas is obscured by bowel gas shadows. No evidence of ductal dilatation or calcification.

**SPLEEN** shows normal shape, size and echopattern.

#### **BOTH KIDNEYS**

**Right kidney:** Normal in shape, size and echopattern. Cortico-medullary differentiation is well madeout. No evidence of calculus or hydronephrosis.

**Left kidney:** Normal in shape, size and echopattern. Cortico-medullary differentiation is well madeout. No evidence of calculus or hydronephrosis.

The kidney measures as follows:

	Bipolar length (cms)	Parenchymal thickness (cms)
Right Kidney	10.4	1.7
Left Kidney	10.1	1.3

**URINARY BLADDER** shows normal shape and wall thickness. It has clear contents. No evidence of diverticula.

**UTERUS** is anteverted and has normal shape and size. It has uniform myometrial echopattern.

Endometrial echo is of normal thickness - 4mm.

Uterus measures LS: 8.4cms      AP: 4.4cms      TS: 5.1cms.

**OVARIES** are normal in size, shape and echotexture

Right ovary measures 2.6 x 2.3cms      Left ovary measures 2.3 x 1.3cms

POD & adnexa are free.

#### REPORT DISCLAIMER

1.This is only a radiological impression.Like other investigations, radiological investigation also have limitation. Therefore radiological reports should be interpreted in correlation with clinical and pathological findings.

2.The results reported here in are subject to interpretation by qualified medical professionals only.

3.Customer identities are accepted provided by the customer or their representative.

4.information about the customer's condition at the time of sample collection such as fasting, food consumption, medication, etc are accepted as provided by the customer or representative and shall not be investigated for its truthfulness.

5.If any specimen/sample is received from any others laboratory/hospital,its is presumed that the sample belongs to the patient identified or named.

6.Test results should be interpreted in context of clinical and other findings if any.In case of any clarification /doubt , the referring doctor/patient can contact the respective section head of the laboratory.

7.Results of the test are influenced by the various factors such as sensitivity, specificity of the procedures of the tests, quality of the samples and drug interactions etc.,

8.If the test results are found not to be correlating clinically can contact the lab in charge for clarification or retesting where practicable within 24 hours from the time of issue of results.

9.Liability is limited to the extend of amount billed.

10.Reports are subject to interpretation in their entirety.partial or selective interpretation may lead to false opinion.

11.Disputes,if any , with regard to the report findings are subject to the exclusive jurisdiction of the competent courts chennai only.

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No evidence of ascites.

**IMPRESSION:**

- **No significant abnormality detected in the Abdomen & Pelvis.**

**DR.KAMESH G  
CONSULTANT RADIOLOGIST**

Kg/an

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