MC-2743

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COLLEGE of AMERICAN PATHOLOGISTS

Suraksha DIAGNOSTICS

Lab No.	: SRE/08-04-2023/SR7503500	**Lab Add.**	: Newtown, Kolkata-700156
Patient Name	: **PIPASA KOLEY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 31 Y 0 M 0 D	**Collection Date**	: 08/Apr/2023 08:21AM
Gender	: F	**Report Date**	: 08/Apr/2023 12:07PM

Test Name	Result	Unit	Bio Ref. Interval	Method
SODIUM, BLOOD , *GEL SERUM*				
SODIUM,BLOOD	143	mEq/L	132 - 146 mEq/L	ISE INDIRECT
***CHLORIDE, BLOOD ,** .				
CHLORIDE,BLOOD	107	mEq/L	99-109 mEq/L	ISE INDIRECT
UREA,BLOOD , *GEL SERUM*	23.5	mg/dL	19-49 mg/dL	Urease with GLDH
POTASSIUM, BLOOD , *GEL SERUM*				
POTASSIUM,BLOOD	4.60	mEq/L	3.5-5.5 mEq/L	ISE INDIRECT
CREATININE, BLOOD	0.65	mg/dL	0.5-1.1 mg/dL	Jaffe, alkaline picrate, kinetic

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PHOSPHORUS-INORGANIC, BLOOD , *GEL SERUM*

PHOSPHORUS-INORGANIC,BLOOD	3.8	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV

THYROID PANEL (T3, T4, TSH) , *GEL SERUM*

T3-TOTAL (TRI IODOTHYRONINE)	1.10	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.1	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	1.26	µIU/mL	0.55-4.78 µIU/mL	CLIA

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

References:

1. Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of
individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. Eur J Endocrinol 2001;145:409-13.

2. Bellantone R, Lombardi CP, Bossola M, Ferrante A,Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. Cancer 2001;92:2273-9.

BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL

SECOND TRIMESTER: 0.20 -3.50 µ IU/mL

THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

References:

1. *Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan.Thyroid.Mar 2017.315-389.http://doi.org/10.1089/thy.2016.0457*

2. *Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. Indian J Endocr Metab 2018;22:1-4.*

LIPID PROFILE , *GEL SERUM*

CHOLESTEROL-TOTAL	173	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	123	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	40	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	**108**	mg/dL	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	Calculated
VLDL	25	mg/dl	< 40 mg/dl	Calculated

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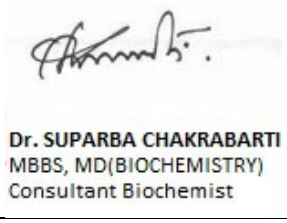
CHOL HDL Ratio	4.3	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated

Reference: *National Cholesterol Education Program. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III).* JAMA. *May 16 2001;285(19):2486-97.*



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Lab No. : SR7503500 **Name : PIPASA KOLEY** **Age/G : 31 Y 0 M 0 D / F** **Date : 08-04-2023**

CBC WITH PLATELET (THROMBOCYTE) COUNT , *EDTA WHOLE BLOOD*

HEMOGLOBIN	**11.1**	g/dL	12 - 15	PHOTOMETRIC
WBC	4.9	*10^3/µL	4 - 10	DC detection method
RBC	**3.68**	*10^6/µL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE) COUNT	170	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	56	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	37	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	05	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	02	%	1-6%	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				
HEMATOCRIT / PCV	**34.7**	%	36 - 46 %	Calculated
MCV	94.5	fl	83 - 101 fl	Calculated
MCH	30.2	pg	27 - 32 pg	Calculated
MCHC	32.0	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	**15.1**	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	28.6	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	11		7.5 - 11.5 fl	Calculated

ESR (ERYTHROCYTE SEDIMENTATION RATE) , *EDTA WHOLE BLOOD*

1stHour	**28**	mm/hr	0.00 - 20.00 mm/hr	Westergren

URINE ROUTINE ALL, ALL , *URINE*

PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	SLIGHTLY HAZY			
CHEMICAL EXAMINATION				
pH	6.0		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.020		1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	NOT DETECTED		NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	NOT DETECTED		NOT DETECTED	Dipstick(glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	NOT DETECTED		NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NOT DETECTED		NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE		NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE		NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE		NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	Dipstick (ester hydrolysis reaction)
MICROSCOPIC EXAMINATION				
LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	4-6	/hpf	0-5	Microscopy
RED BLOOD CELLS	NOT DETECTED	/hpf	0-2	Microscopy
CAST	NOT DETECTED		NOT DETECTED	Microscopy
CRYSTALS	NOT DETECTED		NOT DETECTED	Microscopy
BACTERIA	NOT DETECTED		NOT DETECTED	Microscopy
YEAST	NOT DETECTED		NOT DETECTED	Microscopy

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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 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.

BLOOD GROUP ABO+RH [GEL METHOD] , *EDTA WHOLE BLOOD*

ABO	AB	Gel Card
RH	POSITIVE	Gel Card

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.

DR. NEHA GUPTA
MD, DNB (Pathology)
Consultant Pathologist

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TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .

TOTAL PROTEIN	7.60	g/dL	5.7-8.2 g/dL	BIURET METHOD
ALBUMIN	4.7	g/dL	3.2-4.8 g/dL	BCG Dye Binding
GLOBULIN	2.90	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.62		1.0 - 2.5	Calculated

GLUCOSE, PP , *BLOOD, NAF PLASMA*

GLUCOSE,PP	112	mg/dL	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.	Gluc Oxidase Trinder

The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water.
In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

URIC ACID, BLOOD , *GEL SERUM*

URIC ACID,BLOOD	**7.10**	mg/dL	2.6-6.0 mg/dL	Uricase/Peroxidase

CALCIUM, BLOOD

CALCIUM,BLOOD	9.70	mg/dL	8.7-10.4 mg/dL	Arsenazo III

GLUCOSE, FASTING , *BLOOD, NAF PLASMA*

GLUCOSE,FASTING	91	mg/dL	Impaired Fasting-100-125 . Diabetes- >= 126. Fasting is defined as no caloric intake for at least 8 hours.	Gluc Oxidase Trinder

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

PDF Attached

GLYCATED HAEMOGLOBIN (HBA1C) , *EDTA WHOLE BLOOD*

GLYCATED HEMOGLOBIN (HBA1C)	4.7	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	28.0	mmol/mol		HPLC

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-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemic targets
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.

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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 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

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.

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Lab No. : SR7503500 **Name : PIPASA KOLEY** **Age/G : 31 Y 0 M 0 D / F** **Date : 10-04-2023**

DEPARTMENT OF CYTOPATHOLOGY

PAP SMEAR REPORT

Lab No : P -1266/23

Reporting System : The 2014 Bethesda System
Specimen : Conventional Vaginal Pap Smear.

Specimen Adequacy : Satisfactory for evaluation :
A satisfactory squamous component is present.
Obscuring elements : Absent.

General Categorization :
Negative for Intraepithelial Lesion / Malignancy (NILM).

INTERPRETATION / RESULTS : Negative for Intraepithelial Lesion / Malignancy (NILM).

Note : Pap smear cytology is a screening procedure. Findings should be correlated with colposcopic/local examination and ancillary findings.
As per current recommendation, women aged 30-65 years should be screened with both the HPV test and the Pap test, called "co-testing," as the preferred strategy. Screening with the Pap test alone every 3 years is still acceptable.

Ancillary Testing – For HPV testing using PCR from the same sample (only in case of LBC) request should come within 15 days from the reporting date.

****Report relates to the item tested only.*

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Lab No.	: SRE/08-04-2023/SR7503500	**Lab Add.**	:
Patient Name	: **PIPASA KOLEY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 31 Y 0 M 0 D	**Collection Date**	:
Gender	: F	**Report Date**	: 08/Apr/2023 12:33PM

X-RAY REPORT OF CHEST (PA)

FINDINGS :

No active lung parenchymal lesion is seen.

Both the hila are normal in size, density and position.

Mediastinum is in central position. Trachea is in midline.

Domes of diaphragm are smoothly outlined. Position is within normal limits.

Lateral costo-phrenic angles are clear.

The cardio-thoracic ratio is normal.

Bony thorax reveals no definite abnormality.

IMPRESSION :

Normal study.

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Suraksha DIAGNOSTICS

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Patient Name	: **PIPASA KOLEY**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 31 Y 0 M 0 D	**Collection Date**	:
Gender	: F	**Report Date**	: 08/Apr/2023 03:49PM

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

DATA		
HEART RATE	52	Bpm
PR INTERVAL	160	Ms
QRS DURATION	76	Ms
QT INTERVAL	398	Ms
QTC INTERVAL	372	Ms
AXIS		
P WAVE	64	Degree
QRS WAVE	20	Degree
T WAVE	22	Degree
IMPRESSION	**:**	**Sinus bradycardia.**
		Normal axis.
		No significant ischemic changes.
		Please correlate clinically.

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Reg. No: 59285(WBMC)

Lab No.	: SRE/08-04-2023/SR7503500	**Lab Add.**	:
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Age	: 31 Y 0 M 0 D	**Collection Date**	:
Gender	: F	**Report Date**	: 08/Apr/2023 12:18PM

DEPARTMENT OF ULTRASONOGRAPHY

REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER

Liver is mildly enlarged in size (14.21 cm), having normal shape, regular smooth outline and of homogeneous echotexture. No focal parenchymal lesion is evident. Intrahepatic biliary radicles are not dilated. Branches of portal vein are normal.

PORTA

The appearance of porta is normal. Common bile duct is normal (0.40 cm) with no intraluminal pathology (calculi /mass) could be detected at its visualized part. Portal vein is normal (1.00 cm) at porta.

GALLBLADDER

Gallbladder is distended. Wall thickness appears normal. No intraluminal pathology (calculi/mass) could be detected. Sonographic Murphys sign is negative.

PANCREAS

Echogenecity appears within limits, without any focal lesion. Shape, size & position appears normal. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

SPLEEN

Spleen is enlarged in size (13.73 cm). Homogenous and smooth echotexture without any focal lesion. Splenic vein at hilum appears normal. No definite collaterals could be detected.

KIDNEYS

Both kidneys are normal in shape, size (Rt. Kidney 11.05 cm. & Lt. kidney 10.16 cm.) axes & position. Cortical echogenecity appears normal maintaining cortico-medullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected.

Visualized parts of upper ureters are not dilated.

URINARY BLADDER

Urinary bladder is distended, wall thickness appeared normal. No intraluminal pathology (calculi/mass) could be detected.

UTERUS

Uterus is ante-verted, normal in size (9.57 cm x 4.60 cm x 3.27 cm). Endometrium (0.70 cm) is in midline. Myometrium appears smooth & homogenous without any detectable/sizable focal lesion.

Cervix looks normal. Pouch of Douglas is free.

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ADNEXA & OVARIES

Left ovary is bulky in size, and both ovaries are show multiple (12-15) small (3-7 mm) peripherally arranged follicles with hypertrophied echogenic central stroma.

Right ovary measures : **3.33 cm x 2.46 cm x 1.80 cm = 07.69 gms.**

Left ovary measures : **3.47 cm x 2.51 cm x 2.41 cm = 11.01 gms.**

RETROPERITONEUM & PERITONEUM

No ascites noted. No definite evidence of any mass lesion detected. No detectable evidence of enlarged lymph nodes noted. Visualized part of aorta & IVC are within normal limit.

IMPRESSION :

1) Mild hepatomegaly.

2) Splenomegaly.

3) Polycystic configuration of both ovaries.

KINDLY NOTE

Ultrasound is not the modality of choice to rule out subtle bowel lesion.

Please Intimate us for any typing mistakes and send the report for correction within 7 days.

The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.

Patient Identity not verified

DR. S. K. MONDAL
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(Sonologist)

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SURAKSHA DIAGNOSTIC, RAJARHAT, KOLKATA. **PATIENT REPORT**

BIO-RAD VARIANT TURBO CDM 5.4 **s/n 15893** **V2TURBO_A1c_2.0**

Patient Data

Sample ID:	D02135119672
Patient ID:	SR7503500
Name:	
Physician:	
Sex:	
DOB:	

Comments:

Analysis Data

Analysis Performed:	08/APR/2023 13:02:04
Injection Number:	2008U
Run Number:	47
Rack ID:	0002
Tube Number:	8
Report Generated:	08/APR/2023 13:09:58
Operator ID:	ASIT

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	0.9	0.158	23337
A1b	---	0.9	0.216	22456
F	---	1.0	0.269	24976
LA1c	---	1.7	0.395	42808
A1c	4.7	---	0.502	99853
P3	---	3.0	0.790	77947
P4	---	1.0	0.868	26731
Ao	---	87.7	0.982	2266774

Total Area: 2,584,883

HbA1c (NGSP) = 4.7 % HbA1c (IFCC) = 28 mmol/mol