



# Garg Pathology

Certified by :  
National Accreditation Board For Testing & Calibration Laboratories  
ISO 9001:2008  
Garden House Colony, Near Nai Sarak, Garh Road, Meerut  
Ph.: 0121-2600454, 8979608687, 9837772828

**DR. MONIKA GARG**  
M.D. (Path) Gold Medalist  
Former Pathologist :  
St. Stephan's Hospital, Delhi

**PUID** : 220328/604 **C. NO:** 604 **Collection Time** : 28-Mar-2022 11:33AM  
**Patient Name** : Miss. VALLARI GAUR 32Y / Female **Receiving Time** : 28-Mar-2022 12:04PM  
**Referred By** : Dr. BANK OF BARODA **Reporting Time** : 28-Mar-2022 4:20PM  
**Sample By** : **Centre Name** : Garg Pathology Lab - TPA  
**Organization** :



Investigation	Results	Units	Biological Ref-Interval
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## HAEMATOLOGY (EDTA WHOLE BLOOD)

### COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	12.1	gm/dl	12.0-15.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	7390	*10 <sup>6</sup> /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	60	%.	40-80
Lymphocytes	37	%.	20-40
Eosinophils	01	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	4.43	x 10 <sup>9</sup> /L	2.0-7.0(40-80%)
Absolute lymphocyte count	2.73	x 10 <sup>9</sup> /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.07	x 10 <sup>9</sup> /L	0.02-0.5(1-6%)

Method:- (EDTA Whole blood, Automated /

ESR (Automated Wsetergren`s) **18** mm/1st hr 0.0 - 15.0

### RBC Indices

TOTAL R.B.C. COUNT (Electric Impedence)	<b>4.29</b>	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	37.5	%	26-50
MCV (Calculated)	87.4	fL	80-94
MCH (Calculated)	28.2	pg	27-32
MCHC (Calculated)	32.3	g/dl	30-35
RDW-SD	47.3	fL	37-54



\*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

**Dr. Monika Garg**  
MBBS, MD(Path)  
(Consultant Pathologist)

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(Calculated)			
RDW-CV	13.1	%	11.5 - 14.5
(Calculated)			
Platelet Count	2.42	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	10.2	%	7.5-11.5
(Calculated)			
<b>GENERAL BLOOD PICTURE</b>			
NLR	1.62		1-3
6-9 Mild stres			
7-9 Pathological cause			

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.  
-NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).  
-NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).  
-With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

**BLOOD GROUP \***      "B" NEGATIVE      \$      \$



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<b>GLYCATED HAEMOGLOBIN (HbA1c)*</b>	5.2	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	102.5	mg/dl	

EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics	: 4.3% to 6.30%
Good Control of diabetes	: 6.4% to 7.5%
Fair Control of diabetes	: 7.5% to 9.0%
Poor Control of diabetes	: 9.0 % and above

-Next due date for HBA1C test : After 3 months

-High HbF & Trig.level, iron def.anaemia result in high GHb

-Haemolytic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control.HbA1c represents average glycemia over the past six to eight weeks.Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3 Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.

As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.

## BIOCHEMISTRY (FLORIDE)

<b>PLASMA SUGAR FASTING</b>	87.0	mg/dl	70 - 110
(GOD/POD method)			

## BIOCHEMISTRY (SERUM)

<b>SERUM CREATININE</b>	1.4	mg/dl	0.6-1.4
(Enzymatic)			
<b>BLOOD UREA NITROGEN</b>	9.98	mg/dL.	8-23



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## LIVER FUNCTION TEST

### SERUM BILIRUBIN

TOTAL 0.8 mg/dl 0.1-1.2  
(Diazo)

DIRECT 0.3 mg/dl <0.3  
(Diazo)

INDIRECT 0.5 mg/dl 0.1-1.0  
(Calculated)

S.G.P.T. 18.0 U/L 8-40  
(IFCC method)

S.G.O.T. 21.0 U/L 6-37  
(IFCC method)

SERUM ALKALINE PHOSPHATASE 101.0 IU/L 37-103  
(IFCC KINETIC)

### SERUM PROTEINS

TOTAL PROTEINS 6.2 Gm/dL 6-8  
(Biuret)

ALBUMIN 3.8 Gm/dL 3.5-5.0  
(Bromocresol green Dye)

GLOBULIN **2.40** Gm/dL 2.5-3.5  
(Calculated)

A : G RATIO 1.58 1.5-2.5  
(Calculated)



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## LIPID PROFILE

SERUM CHOLESTEROL (CHOD - PAP)	210.0	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	81.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	42.8	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	16.2	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	<b>151.0</b>	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	03.5	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	4.9	ratio	3.8-5.9

Interpretation :

\*Paitient Should be Fast overnight For Minimum 12 hours and normal diet for one week\*

NOTE :

Lipid Profile Ranges As PER NCEP-ATP III :

SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated : > 240 mg/dl  
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased : < 40 mg/dl  
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl  
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

**SERUM SODIUM (Na) \*** 139.0 mEq/litre 135 - 155  
(ISE method)  
(ISE)



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### THYROID PROFILE\*

Triiodothyronine (T3) * (ECLIA)	1.265	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	8.565	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) * (ECLIA)	3.169	uIU/ml	0.38-5.30

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disorders such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism,serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both incresed and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

<b>SERUM POTASSIUM (K) *</b> (ISE method)	4.1	mEq/litre.	3.5 - 5.5
<b>SERUM CALCIUM</b> (Arsenazo)	9.5	mg/dl	9.2-11.0

### BIOCHEMICAL EXAMINATION

URIC ACID	3.0	mg/dL.	2.5-6.8
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## CYTOLOGY EXAMINATION

### SPECIMEN

Microscopic:

MG 176/22

SITE OF SMEAR: ECTOCERVIX AND POSTERIOR FORNIX OF VAGINA

METHOD OF EVALUATION: BETHSEDA SYSTEM

EVALUATION OF SMEAR : SATISFACTORY

REPORT: CELLULAR SPREAD SHOWS DESQUAMATED EPITHELIAL CELLS PREDOMINANTLY SUPERFICIAL AND INTERMEDIATE CELLS. FEW ENDOCERVICAL CELLS SHOWING REACTIVE CHANGES ARE SEEN.

BACKGROUND SHOWS SEVERE INFLAMMATORY REACTION. THERE IS SHIFT IN VAGINAL FLORA. LACTOBACILLI ARE REDUCED.

ANY DYSKARYOTIC CELL IS NOT SEEN. ANY BUDDING SPORES OR TROPHOZOITE IS NOT SEEN.

INFERENCE: NEGATIVE FOR INTRAEPITHELIAL CELLS OR MALIGNANCY

INFLAMMATORY SMEARS

NOTE: This test has its own limitations. Please interpret the findings in light of clinical picture. not for medicolegal use



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## CLINICAL PATHOLOGY

### STOOL EXAMINATION

#### \$PHYSICAL EXAMINATION

Colour	Yellow
Mucous	Absent
Consistency	Semi Solid
PH	Acidic

Method:- Descriptive

#### \$MICROSCOPIC EXAMINATION

R.B.C.s Nil

Method:-Microscopic

Pus Cells 1-2

Method:-Microscopic

Ova Nil

Method:-Microscopic

Cysts Nil

Method:-Microscopic

#### \$SPECIAL EXAMINATION

Occult Blood Negative

Method:-Homospot Card Test



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## URINE

### PHYSICAL EXAMINATION

Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.020		1.000-1.030
PH ( Reaction )	Acidic		

### BIOCHEMICAL EXAMINATION

Protein	Nil		Nil
Sugar	Nil		Nil

### MICROSCOPIC EXAMINATION

Red Blood Cells	Nil	/HPF	Nil
Pus cells	1-2	/HPF	0-2
Epithelial Cells	1-2	/HPF	1-3
Crystals	Nil		
Casts	Nil		
@ Special Examination			
Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

-----{END OF REPORT }-----



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