Lab No.	: MRD/11-03-2023/SR7393319	**Lab Add.**	: Newtown, Kolkata-700156
Patient Name	: **Arghyadeep Ray**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 35 Y 8 M 1 D	**Collection Date**	: 11/Mar/2023 11:21AM
Gender	: M	**Report Date**	: 11/Mar/2023 05:10PM

Test Name	Result	Unit	Bio Ref. Interval	Method

PDF Attached

GLYCATED HAEMOGLOBIN (HBA1C) , *EDTA WHOLE BLOOD*

GLYCATED HEMOGLOBIN (HBA1C)	4.8	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	29.0	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.
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.*

Dr NEEPA CHOWDHURY
MBBS MD (Biochemistry)
Consultant Biochemist

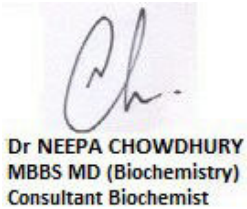
Lab No. : SR7393319	Name : Arghyadeep Ray	Age/G : 35 Y 8 M 1 D / M	Date : 11-03-2023

SGPT/ALT , *GEL SERUM*				
SGPT/ALT	37.00	U/L	7-40 U/L	Modified IFCC
BILIRUBIN (TOTAL) , *GEL SERUM*				
BILIRUBIN (TOTAL)	0.80	mg/dL	0.3-1.2 mg/dL	Vanadate oxidation
UREA,BLOOD , *GEL SERUM*	23.5	mg/dL	19-49 mg/dL	Urease with GLDH
ALKALINE PHOSPHATASE , *GEL SERUM*				
ALKALINE PHOSPHATASE	75.00	U/L	46-116 U/L	IFCC standardization
SGOT/AST , *GEL SERUM*				
SGOT/AST	25.00	U/L	13-40 U/L	Modified IFCC
SODIUM, BLOOD , *GEL SERUM*				
SODIUM,BLOOD	138.00	mEq/L	132 - 146 mEq/L	ISE INDIRECT
CREATININE, BLOOD	0.87	mg/dL	0.7-1.3 mg/dL	Jaffe, alkaline picrate, kinetic
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.

PHOSPHORUS-INORGANIC, BLOOD , *GEL SERUM*				
PHOSPHORUS-INORGANIC,BLOOD	2.9	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV
BILIRUBIN (DIRECT) , *GEL SERUM*				
BILIRUBIN (DIRECT)	0.20	mg/dL	<0.2 mg/dL	Vanadate oxidation
***CHLORIDE, BLOOD ,** .				
CHLORIDE,BLOOD	106.00	mEq/L	99-109 mEq/L	ISE INDIRECT
URIC ACID, BLOOD , *GEL SERUM*				
URIC ACID,BLOOD	6.50	mg/dL	3.5-7.2 mg/dL	Uricase/Peroxidase
POTASSIUM, BLOOD , *GEL SERUM*				
POTASSIUM,BLOOD	4.30	mEq/L	3.5-5.5 mEq/L	ISE INDIRECT



Dr NEEPA CHOWDHURY
MBBS MD (Biochemistry)
Consultant Biochemist

Lab No. : SR7393319 **Name : Arghyadeep Ray** **Age/G : 35 Y 8 M 1 D / M** **Date : 11-03-2023**

TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .

TOTAL PROTEIN	7.50	g/dL	5.7-8.2 g/dL	BIURET METHOD
ALBUMIN	4.4	g/dL	3.2-4.8 g/dL	BCG Dye Binding
GLOBULIN	3.10	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.42		1.0 - 2.5	Calculated

LIPID PROFILE , *GEL SERUM*

CHOLESTEROL-TOTAL	146.00	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	84.00	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	**39.00**	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	90.0	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	17	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	3.7		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.*

CALCIUM, BLOOD

CALCIUM,BLOOD	9.10	mg/dL	8.7-10.4 mg/dL	Arsenazo III

Dr. SUPARBA CHAKRABARTI
MBBS, MD(BIOCHEMISTRY)
Consultant Biochemist

Lab No. : SR7393319 **Name : Arghyadeep Ray** **Age/G : 35 Y 8 M 1 D / M** **Date : 11-03-2023**

URINE ROUTINE ALL, ALL , *URINE*

PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	SLIGHTLY HAZY			
CHEMICAL EXAMINATION				
pH	5.0		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)	0-1	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/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

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.

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

HEMOGLOBIN	15.0	g/dL	13 - 17	PHOTOMETRIC
WBC	6.4	*10^3/µL	4 - 10	DC detection method
RBC	4.85	*10^6/µL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	184	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	44	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	**43**	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	07	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	05	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	**01**	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				

Lab No. : SR7393319	Name : Arghyadeep Ray		Age/G : 35 Y 8 M 1 D / M	Date : 11-03-2023
HEMATOCRIT / PCV	45.3	%	40 - 50 %	Calculated
MCV	93.5	fl	83 - 101 fl	Calculated
MCH	30.9	pg	27 - 32 pg	Calculated
MCHC	33.1	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	13.4	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	23.9	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	12.3		7.5 - 11.5 fl	Calculated

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

ABO	O			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.

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

1stHour	09	mm/hr	0.00 - 20.00 mm/hr	Westergren

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

Lab No. : SR7393319 **Name : Arghyadeep Ray** **Age/G : 35 Y 8 M 1 D / M** **Date : 11-03-2023**

URIC ACID, URINE, SPOT URINE

URIC ACID, SPOT URINE	41.00	mg/dL	37-92 mg/dL	URICASE

GLUCOSE, PP , *BLOOD, NAF PLASMA*

GLUCOSE,PP	102	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.

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

T3-TOTAL (TRI IODOTHYRONINE)	1.22	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	10.2	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	**7.32**	µIU/mL	0.55-4.78 µIU/mL	CLIA

Suggested follow up with ft4 reports *and to correlate clinically*

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.*

Suraksha Diagnostic Private Limited
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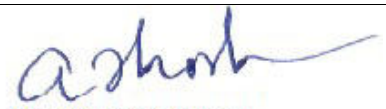
Lab No. : SR7393319 **Name : Arghyadeep Ray** **Age/G : 35 Y 8 M 1 D / M** **Date : 11-03-2023**



DR. ANANNYA GHOSH
MBBS, MD (Biochemistry)
Consultant Biochemist

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Suraksha DIAGNOSTICS

Lab No.	: MRD/11-03-2023/SR7393319	**Lab Add.**	:
Patient Name	: **Arghyadeep Ray**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 35 Y 8 M 1 D	**Collection Date:**	
Gender	: M	**Report Date**	: 11/Mar/2023 04:39PM

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

DATA

HEART RATE : 58 bpm

PR INTERVAL : 144 ms

QRS DURATION : 94 ms

QT INTERVAL : 398 ms

QTC INTERVAL : 390 ms

AXIS

P WAVE : 59 degree

QRS WAVE : 5 degree

T WAVE : 36 degree

IMPRESSION : **Sinus bradycardia.**

Otherwise normal ECG.

ACRay

Dr. A C RAY
Department of Non-invasive Cardiology

Lab No.	: MRD/11-03-2023/SR7393319	**Lab Add.**	:
Patient Name	: **Arghyadeep Ray**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 35 Y 8 M 1 D	**Collection Date:**	
Gender	: M	**Report Date**	: 12/Mar/2023 08:46AM

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.

Dr. Anoop Sastry
MBBS, DMRT(CAL)
CONSULTANT RADIOLOGIST
Registration No.: WB-36628

Lab No.	: MRD/11-03-2023/SR7393319	**Lab Add.**	:
Patient Name	: **Arghyadeep Ray**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 35 Y 8 M 1 D	**Collection Date:**	
Gender	: M	**Report Date**	: 13/Mar/2023 01:55PM

DEPARTMENT OF ULTRASONOGRAPHY
REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER
Liver is enlarged in size (156 mm) and shows increased in echogenicity. 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 (4.0 mm) with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal (10.9 mm) at porta.

GALL BLADDER
Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected. SonographicMurphys 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 normal in size (96 mm). 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 106 x 52 mm. & Lt. kidney 107 x 49 mm) axes & position. Cortical echogenecity appears normal maintaining corticomedullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected.

URETERS
Visualised part of upper ureters are not dilated.

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

PROSTATE
Prostate is normal in size. Echotexture appears within normal limits. No focal alteration of its echogenecity could be detectable.
It measures : 42 mm. x 33 mm. x 27 mm.
Approximate weight could be around = 20.3 gms.

IMPRESSION

Hepatomegaly with grade – II fatty changes.

Lab No.	: MRD/11-03-2023/SR7393319	**Lab Add.**	:
Patient Name	: **Arghyadeep Ray**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 35 Y 8 M 1 D	**Collection Date:**	
Gender	: M	**Report Date**	: 13/Mar/2023 01:55PM

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.*

The report and films are not valid for medico-legal purpose.

Patient Identity not verified.

DR. H S MOHANTY
Consultant Radiologist
MBBS , DNB (Radio-Diagnosis)

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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:	C02135015363
Patient ID:	SR7393319
Name:	
Physician:	
Sex:	
DOB:	

Comments:

Analysis Data

Analysis Performed:	11/MAR/2023 15:37:08
Injection Number:	7689U
Run Number:	176
Rack ID:	
Tube Number:	5
Report Generated:	11/MAR/2023 15:48:18
Operator ID:	ASIT

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	0.9	0.156	20327
A1b	---	0.8	0.214	18457
F	---	0.8	0.267	16965
LA1c	---	1.7	0.388	38354
A1c	4.8	---	0.491	86518
P3	---	3.3	0.779	72193
P4	---	1.1	0.857	23764
Ao	---	87.5	0.984	1930709

Total Area: 2,207,287

HbA1c (NGSP) = 4.8 % HbA1c (IFCC) = 29 mmol/mol