

<b>Patient Name :</b> MR. NEERAJ SWAMY	<b>Registration Time :</b> Nov 09, 2024, 09:12 a.m.
<b>Age / Gender :</b> 51 years / Male	<b>Receiving Time :</b> Nov 09, 2024, 10:40 a.m.
<b>MR No. / IPD No. :</b> /	<b>Reporting Time :</b> Nov 09, 2024, 04:59 p.m.
<b>Patient Type / Bed No. :</b> /	 241109036
<b>Referred By :</b> .	
<b>Client Code :</b> ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)	



Test Description	Value(s)	Unit(s)	Reference Range
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**HAEMATOLOGY**

**Complete Haemogram - Hb RBC count and indices, TLC, DLC, PLATELET, ESR.**

Hemoglobin (Hb) Method : Whole Blood, SLS-haemoglobin	13.8	g/dL	13.0 - 17.0
Erythrocyte (RBC) Count Method : Whole Blood, DC detection	5.14	x 10 <sup>6</sup> /uL	4.5 - 5.5
HCT Method : Whole Blood, RBC pulse height detection	43.0	%	42 - 52
Mean Cell Volume (MCV) Method : Whole Blood, Electrical Impedence	83.7	fL	78 - 100
Mean Cell Haemoglobin (MCH) Method : Whole Blood, Calculated	<b>26.8</b>	pg	27 - 31
Mean Corpuscular Hb Conc. (MCHC) Method : Whole Blood, Calculated	32.1	g/dL	32.0 - 35.0
Red Cell Distribution Width (RDW) CV Method : Whole Blood, Calculated	<b>14.9</b>	%	11.5 - 14.0
Total Leucocytes (WBC) Count Method : Whole Blood, Flow cytometry	6.1	x 10 <sup>3</sup> /uL	4-10
<b>DLC (Differential Leucocytes Count)</b>			
Neutrophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	72.6	%	40 - 80
Lymphocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	<b>18.6</b>	%	20 - 40
Monocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	5.7	%	2 - 10
Eosinophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	2.6	%	1 - 6
Basophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	0.5	%	0 - 2
Absolute Neutrophil Count Method : Whole Blood, Calculated	4.43	x 10 <sup>3</sup> /uL	2.0 - 7.0
Absolute Lymphocyte Count Method : Whole Blood, Calculated	1.13	x 10 <sup>3</sup> /uL	1 - 3

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241109036

**Panel :** Dr Arcofemi Health Care PVT.limited ( MediWheel )

**Client Code :** ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)

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Absolute Monocyte Count Method : Whole Blood, Calculated	0.35	x 10 <sup>3</sup> /uL	0.2-1.0
Absolute Eosinophil Count Method : Whole Blood, Calculated	0.16	x 10 <sup>3</sup> /uL	0.02 - 0.5
Absolute Basophils Count Method : Whole Blood, Calculated	0.03	x 10 <sup>3</sup> /uL	0.02 - 0.1
Platelet Count Method : Whole Blood, DC Detection	152	x 10 <sup>3</sup> /uL	150 - 450
ESR - Erythrocyte Sedimentation Rate Method : Whole blood , Modified Westergren Method	18	mm/hr	<10

**Interpretation:**

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Tests done on Automated Six Part Cell Counter.

**\*\*END OF REPORT\*\***



Dr. Ravi Gaur  
MD Pathology  
Senior Consultant Pathology  
DMC No: 49110

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Test Description	Value(s)	Unit(s)	Reference Range
<b><u>CLINICAL PATHOLOGY</u></b>			
<b><u>Urine Glucose ( Fasting &amp; PP)</u></b>			
<b>Glucose Fasting (Urine )</b> Method : Oxidase Reaction/ Manual	Negative		Negative
<b>Glucose Post Prandial (Urine)</b> Method : Oxidase Reaction/ Manual	Negative		Negative

\*\*END OF REPORT\*\*



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**IMMUNOLOGY**

**T3, T4, TSH ( Thyroid Profile Total),Serum**

<b>(Triiodothyronine) T3-Total</b> Method : ECLIA	1.27	ng/mL	0.80 - 2.00
<b>(Thyroxine) T4-Total</b> Method : ECLIA	8.37	ug/dL	5.10 - 14.10
<b>TSH-Ultrasensitive</b> Method : ECLIA	<b>5.15</b>	uIU/mL	0.27-4.20

**Interpretation**

The Biological reference interval provided is for Adults.  
 For age specific reference interval, please refer to the table given below.

TSH	T3/F13	T4/F14	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hypothyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non Thyroidal Illness/Secondary Hyperthyroidism

TSH (mU/mL)			
Children	New Born	0.7	15.2
	6 days - 3 Months	0.72	11
	4 -12 Months	0.73	8.35
	1-6 Years	0.7	5.97
	7-11 Years	0.6	4.84
	12-20 years	0.51	4.3
Adults		0.27	4.20

TSH levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentration are observed during the afternoon. diurnal variation in TSH levels is approx 50%+/-, hence time of the day can influence the measured serum concentration.

\*\*END OF REPORT\*\*

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**HAEMATOLOGY**

**Blood Group (ABO)**

Blood Group	<b>"B"</b>
Method : Forward and Reverse by Slide method	
RH Factor	<b>Positive</b>

**Methodology**

This is done by forward and reverse grouping by slide agglutination method.

**Interpretation**

Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2–4 years).

\*\*END OF REPORT\*\*



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**BIOCHEMISTRY**

**LFT (Liver Function Test,Serum)**

<b>Total Protein</b> Method : Biuret Method	6.4	g/dL	6.4-8.3
<b>Albumin</b> Method : Bromocresol Green	4.2	g/dL	3.5 - 5.2
<b>Globulin</b> Method : Calculated	2.20	g/dL	1.8 - 3.6
<b>A/G Ratio</b> Method : Calculated	1.91	ratio	1.2 - 2.2
<b>SGOT</b> Method : IFCC without Pyridoxal Phosphate	22	U/L	0 to 40
<b>SGPT</b> Method : IFCC without Pyridoxal Phosphate	20	U/L	0 to 41
<b>Alkaline Phosphatase-ALP</b> Method : PNP AMP Kinetic	87	U/L	40-129
<b>GGT-Gamma Glutamyl Transferase</b> Method : IFCC	13	U/L	0 to 60
<b>Bilirubin Total</b> Method : Colorimetric Diazo Method	0.30	mg/dL	0.0-1.20
<b>Bilirubin - Direct</b> Method : Colorimetric Diazo Method	0.10	mg/dL	Adults and Children: < 0.30
<b>Bilirubin - Indirect</b> Method : Calculated	0.20	mg/dL	0.1 - 1.0

**Interpretation :**

**SGOT/ SGPT:** Increased in Acute viral hepatitis, Biliary tract obstruction (cholangitis, choledocholithiasis), Alcoholic hepatitis and Cirrhosis, liver abscess, metastatic or primary liver cancer; non-alcoholic steatohepatitis; right heart failure. Decreased in Pyridoxine (vit B6) deficiency.

**Alkaline Phosphatase:** Increased in Obstructive hepatobiliary disease, Bone disease (physiologic bone growth, Paget disease, Osteomalacia, Osteogenic sarcoma, Bone metastases), Hyperparathyroidism, Rickets, Pregnancy (third trimester). Decreased in Hypophosphatasia.

**GGT:** Increased in Liver disease Acute viral or toxic hepatitis, Chronic or subacute hepatitis, Alcoholic hepatitis, Cirrhosis, Biliary tract obstruction.

**Protein:** Moderate-to-marked hyperproteinemia maybe due to multiple myeloma and other malignant paraproteinemias, Hypoproteinemia may be due to decreased production or increased protein loss.

**Albumin:** Increased in Dehydration, Shock, Hemoconcentration. Decreased in hepatic synthesis(Chronic liver disease, malnutrition, malabsorption, malignancy), Increased losses (Nephrotic syndrome, Burns, Trauma, Hemorrhage with fluid replacement, acute or chronic glomerulonephritis), Hemodilution (pregnancy, CHF) and Drugs (estrogens).

**Bilirubin:** A substance produced during the normal breakdown of red blood cells.Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

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Test Description	Value(s)	Unit(s)	Reference Range
<b>BIOCHEMISTRY</b>			
<b>Lipid Profile,Serum</b>			
<b>Cholesterol-Total</b> Method : Enzymatic Colorimetric,CHOD-POD	166	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.
<b>Triglycerides</b> Method : Enzymatic Colorimetric ,GOD-POD	73	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
<b>Cholesterol-HDL Direct</b> Method : CHOD-POD (Homogenous Enzymatic)	52	mg/dL	No Risk - >55 mg/dL Moderate risk - 35-55 mg/dL High risk - < 35 mg/dL
<b>LDL Cholesterol</b> Method : Calculated	99.40	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
<b>Non - HDL Cholesterol, Serum</b> Method : Calculated	114	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL
<b>VLDL Cholesterol</b> Method : Serum, Calculated	14.60	mg/dL	0 - 30
<b>CHOL/HDL RATIO</b> Method : Calculated	3.19	Ratio	3.5 - 5.0
<b>LDL/HDL RATIO</b> Method : Calculated	1.91	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
<b>HDL/LDL RATIO</b> Method : Calculated	0.52	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

**Note:** 10-12 hours fasting sample is required.

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**BIOCHEMISTRY**

**KFT (Renal Function Test,Serum)**

<b>Urea</b> Method : kinetic (urease-GLDH)	18.5	mg/dL	16.6-48.5
<b>BUN</b> Method : Calculated	8.64	mg/dL	6-20
<b>Creatinine</b> Method : Kinetic Colorimetric (Jaffe Method)	0.90	mg/dL	0.70-1.30
<b>Uric Acid</b> Method : Enzymatic Colorimetric: Uricase-POD	6.0	mg/dL	3.4-7.0
<b>Sodium</b> Method : ISE Direct	136	mmol/L	136 - 145
<b>Potassium</b> Method : ISE Direct	4.1	mmol/L	3.5 - 5.1
<b>Chloride</b> Method : ISE Direct	101	mmol/L	98 - 107

**Interpretation :**

**Urea:-** Increased in renal diseases,urinary obstructions, shock, congestive heart failure .Decreased in liver failure and pregnancy.

**Creatinine :-** Elevated in renal dysfunction, reduced renal blood flow shock, dehydration, Congestive heart failure, Diabetes Acromegaly. Decreased levels are found in Muscular Dystrophy.

**Uric acid:-** Increased in Gout, Arthritis, impaired renal functions and starvation.Decreased in Wilson's disease, Fanconis Syndrome and Yellow Atrophy of Liver.

**Sodium:-**Increased in Excessive dietary salt ,Diuretic therapy,Adrenal insufficiency,Salt-wasting nephropathy and Vomiting.Decreased levels are seen in Hyperaldsteronism ,Hyponatremia,Prerenal Azotemia,Renal Failure and Glomerulonephritis.

**Potassium:-** Low levels is common in vomiting, diarrhea, alcoholism, and folic acid deficiency. Increase level are seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid potassium infusion.

**Chloride:-** Increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis, diabetes insipidus, adrenocortical hyperfuction. Decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis.

\*\*END OF REPORT\*\*



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Test Description	Value(s)	Unit(s)	Reference Range
<b>BIOCHEMISTRY</b>			
<b>Glucose ( Fasting)</b>			
<b>Glucose Fasting</b> Method : Plasma,Enzymatic Hexokinase	96	mg/dL	Normal: 72-106 Impaired Tolerance: 100-125 Diabetes mellitus: >= 126 (on more than one occassion) (American diabetes association guidelines 2018)

**Interpretation**

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

\*\*END OF REPORT\*\*



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Test Description	Value(s)	Unit(s)	Reference Range
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**BIOCHEMISTRY**

<b>Glucose (PP)</b>			
<b>Blood Glucose-Post Prandial</b>	82	mg/dL	70 - 140
Method : Plasma, Enzymatic Hexokinase			
Interpretation			

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

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**IMMUNOLOGY**

**PSA Total (Prostate Specific Antigen),Serum**

<b>Prostate-specific antigen (Total)</b>	0.566	ng/mL	0.0-4.40
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Method : ECLIA

**INTERPRETAION**

- Prostate-specific antigen (PSA) is a glycoprotein produced by the prostate 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.
- If total prostate-specific antigen (PSA) concentration is < 2.0 ng/mL, the probability of prostate cancer in asymptomatic men is low. When total PSA concentration is > 10.0 ng/mL, the probability of cancer is high and further testing is recommended.

**Note :-**

- Normal results do not eliminate the possibility of prostate cancer.
- The test specimens should be obtained before the patients undergoing prostate manipulation procedures like biopsy/transurethral resection.

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### CLINICAL PATHOLOGY

#### Urine (RE/ME)

##### Physical Examination :

Volume	40		mL
Method : Visual Observation			
Colour	Pale Yellow		Pale Yellow
Method : Visual Observation			
Transparency (Appearance)	Clear		Clear
Method : Visual Observation			
Deposit	Absent		Absent
Method : Visual Observation			
Reaction (pH)	6.0		4.5 - 8.0
Method : Double Indicator method			
Specific Gravity	1.015		1.010 - 1.030
Method : Ionic Concentration			

##### Chemical Examination (Dipstick Method) Urine

Urine Protein	Absent		Absent
Method : Protein Ionisation/ Manual			
Urine Glucose (sugar)	Absent		Absent
Method : Oxidase Reaction/ Manual			
Blood (Urine)	Absent		Absent
Method : Peroxidase Reaction			

##### Microscopic Examination Urine

Pus Cells (WBCs)	2 - 3	/hpf	0 - 5
Method : Microscopy			
Epithelial Cells	2 - 3	/hpf	0 - 4
Method : Microscopy			
Red blood Cells	Absent	/hpf	Absent
Method : Microscopy			
Crystals	Absent		Absent
Method : Microscopy			
Cast	Absent		Absent
Method : Microscopy			
Yeast Cells	Absent		Absent
Method : Microscopy			
Amorphous Material	Absent		Absent
Method : Microscopy			

<b>Patient Name :</b> MR. NEERAJ SWAMY <b>Age / Gender :</b> 51 years / Male <b>MR No. / IPD No. :</b> / <b>Patient Type / Bed No. :</b> / <b>Referred By :</b> .		<b>Registration Time :</b> Nov 09, 2024, 09:12 a.m. <b>Receiving Time :</b> Nov 09, 2024, 10:40 a.m. <b>Reporting Time :</b> Nov 09, 2024, 07:51 p.m.  241109036 <b>Panel :</b> Dr Arcofemi Health Care PVT.limited ( MediWheel ) <b>Client Code :</b> ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)
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Test Description	Value(s)	Unit(s)	Reference Range
Bacteria	Absent		Absent
Method : Microscopy			
Others	Absent		

Remarks:-

Epithelial cells	Urolithiasis bladder carcinoma or hydronephrosis ,ureteric stents or bladdercatheters for prolonged periods of time.
Granular casts	Low intratubular pH,high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration,acute congestive heart failure, renal diseases.
Calcium Oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of VitaminC, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit( A verrhoa carambola)or its juice
Uric acid	Artharitis
Bacteria	Urinary infection when present in significant numbers and with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

**\*\*END OF REPORT\*\***



Dr.Ravi Gaur  
MD Pathology  
Senior Consultant Pathology  
DMC No: 49110





Ashutosh

Today at 2:52 pm



Neeraj swamy  
X-Ray report

