



Name : Mrs. SHREYA W/o UHID : 112918 PID : 25095  
Age/Gender : 30 Year/Female Sample Date : 23-Mar-2024 02:36 PM  
Ref. By Dr. : MEDIWHEEL Report Date : 23-Mar-2024  
Address : HISAR Sample Type : Inside \*25095\*

Test Name	Value	Unit	Reference Range
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## HEAMATOLOGY

### CBC (Complete Blood Count)

Haemoglobin (Hb)	11.7	g/dl	12.0 - 15.0 g/dl
Total RBC Count	4.48	m/cumm	4.20 - 5.40
Haematocrit	34.5	%	35.0 - 50.0 %
Mean Cell Volume	77.0	fL	80.0 - 100 fL
Mean Cell Haemoglobin	26.1	pg	27.0 - 34.0 pg
Mean Cell Haemoglobin Conc	33.9	%	32.0 - 36.0
Red Cell Distribution Width (RDW) - SD	43.2	fL	35.0 - 56.0 fL
Red Cell Distribution Width (RDW) - CV	13.8	%	11.0 - 16.0 %
Total Leucocyte Count	5030	cells/cum m	4000 - 11000
Differential Leucocyte Count	.		
Neutrophils	70	%	32 - 72 %
Lymphocytes	20	%	20 - 50 %
Monocytes	5	%	2 - 11 %
Eosinophils	3	%	1 - 3 %
Basophils	2	%	0 - 2 %
Platelet Count	1,58,000	cells/cunm m	150,000 - 450,000
Platelet Distribution Width	16.6	fL	15.0 - 18.0 fL
Mean Platelet Volume	11.7	fL	7.0 - 13.0 fL

Sample Type : Whole Blood

- Spurious elevation of platelet count may be seen in patients with extensive burns, extreme microcytosis, microangiopathic hemolytic anemia, red cell fragmentation, micro-organisms like bacteria, fungi or yeast, hyperlipidemia, fragments of white blood cell (WBC) cytoplasm in patients with acute leukemia, hairy cell leukemia, lymphomas and in presence of cryoglobulins.
- Spuriously low platelet counts may be seen in cases of platelet clumping (EDTA induced), platelet cold agglutinins, multiple myeloma, platelet satellitism and in giant platelet syndromes.
- Delay in processing due to sample transport may cause a mild time dependent fall in platelet count. It is advisable to repeat the test using a citrate / heparin collection tube to avoid this pitfall.
- Automated platelet counting is subject to 10-15% variation in the result on the same as well as different analysers due to various preanalytic variables like the sampling site, skill in sample collection, anticoagulant used, sample mixing and sample transport etc.

### ABO Blood Grouping

#### Blood Group

A<sup>+</sup> POSITIVE

Haemaagglutination reaction

A Rh Positive, B Rh Positive, AB Rh Positive, O Rh Positive, A Rh Negative, B Rh Negative, AB Rh Negative, O Rh Negative

Sample Type : Whole Blood

### HBA1C

HBA1C	5.3	%	4.27 - 6.00 %
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turbidimetric immunoassay



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Test Name	Value	Unit	Reference Range
<b>HBA1C</b>			
Average Blood Glucose	105.41	mg/dl	90.00 - 120.00 mg/dl
<small>turbidimetric immunoassay</small>			
Sample Type : Whole Blood			

### Remarks :

GLYCOSYLATED HEMOGLOBIN (HbA1c)

Reference Range : Please correlate with clinical conditions.

Bellow 6.0 % Normal value

6.0 %-7.0 % Good control

7.0 %-8.0 % Fair control

8.0 %-10 % Unsatisfactory control

Above10 % Poor control

Technology : Immunoassay and chemistry technology to measure A1C and total HB (A1C now Bayer)

AVERAGE BLOOD GLUCOSE (ABG) CALCULATED

Reference Range: Please correlate with clinical conditions.

90-120 mg/dl Excellent control

121-150 mg/d Good control

151-180 mg/dl Average control

181-210 mg/dl Action suggested

> 211 mg/dl Panic values

NOTE: Average blood glucose value is calculated from HbA1C value and it indicates average blood sugar level over past three months.

Technology: Derived from Hb A1C Values

Sample Type: Sodium heparin:

### ESR

ESR 20 mmHr 0 - 20 mmHr

Sample Type : Whole Blood

Dr. (Maj.)Guruprasad  
MBBS, DMRD, DNB  
Consultant Radiologist

Dr. Rambaksh Sharma  
MBBS, MD  
Consultant Radiologist

Dr. RAJESH REDDU  
MBBS, DMRD  
Consultant Radiologist

Dr. Amit Verma  
MBBS, MD  
Consultant Physician

Dr. Manish Varshney  
MBBS, MD  
Consultant Pathologist



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#### CLINICAL COMMENTS:

Erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that indirectly measures the degree of inflammation present in the body. Inflammation is part of the body's immune response. It can be acute, developing rapidly after trauma, injury or infection, for example, or can occur over an extended time (chronic) with conditions such as autoimmune diseases or cancer.

Moderately elevated ESR occurs with inflammation but also with anemia, infection, pregnancy, and with aging. A very high ESR usually has an obvious cause, such as a severe infection, marked by an increase in globulins, systemic vasculitis, polymyalgia rheumatica or temporal arteritis. People with multiple myeloma or Waldenstrom's macroglobulinemia (tumors that make large amounts of immunoglobulins) typically have very high ESRs even if they don't have inflammation.

#### Factors increasing ESR:

Advanced age

Anemia

Pregnancy

High fibrinogen

Macrocytosis

Kidney problems

Thyroid disease

Some cancers, such as multiple myeloma

Infection

#### Factors decreasing ESR

Microcytosis

Low fibrinogen

Polycythemia

Marked leukocytosis

### CLINICAL-CHEMISTRY

#### URIC ACID

Uric acid	5.23	mg/dL	2.5 - 6.0
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Uricase - POD

Sample Type : SERUM

URIC ACID: Increases in case of renal failure, disseminated neoplasms, pregnancy toxemia, psoriasis, liver disease, sarcoidosis etc. Decrease is reported in Wilson's disease, Fanconi's syndrome, xanthinuria.

#### Glucose.Fasting

Glucose, Fasting	90.8	mg/dl	70 - 100 mg/dl
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Hexokinase / GOD - POD

Sample Type : SERUM

#### Total Protein

Total Protein	7.86	gm/dl	6.0 - 8.3
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BIURET



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Test Name	Value	Unit	Reference Range
<b>Total Protein</b>			
Albumin	4.23	g/dl	2.9 - 4.5
BCG			
<b>Globulin</b>	<b>3.63</b>	gm/dl	2.0 - 3.5
Albumin-Globulin Ratio	0.6		1.2 - 2.5
Sample Type : SERUM			

### LIVER FUNCTION TEST (LFT) (S)

Total Bilirubin-Serum	0.90	mg/dl	0.20 - 1.00 mg/dl
Bilirubin Direct Serum	0.40	mg/dl	0.10 - 0.50 mg/dl
Bilirubin Indirect-Serum	0.50	mg/dl	0.20 - 0.70 mg/dl
SGOT	23.98	IU/L	10 - 40 IU/L
IFCC with Pyridoxal Phosphate			
SGPT	25.68	IU/L	07 - 56 IU/L
IFCC with Pyridoxal Phosphate			
Alkaline Phosphatase	129.6	U/L	44 - 147 U/L
IFCC PNPP Buffer			
Total Protein	7.98	gm/dl	6.0 - 8.3
BIURET			
Albumin	4.35	g/dl	3.5 - 5.5 g/dl
BCG			
Globulin	3.63	gm/dl	2.0 - 3.5 gm/dl
AG RATIO	2.4		1.2 - 2.5
Sample Type : SERUM			

### CLINICAL COMMENT:

Liver function tests can be suggested in case of hepatitis, liver cirrhosis and monitor possible side effects of medications. A variety of diseases and infections can cause acute or chronic damage to the liver, causing inflammation (hepatitis), scarring (cirrhosis), bile duct obstructions, liver tumors, and liver dysfunction. Alcohol, drugs, some herbal supplements, and toxins can also injure the liver. A significant amount of liver damage may occur before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarrhea, and unexplained weight loss or gain appear. Early detection of liver injury is essential in order to minimize damage and preserve liver function.

Alanine aminotransferase (ALT) A very high level of ALT is frequently seen with acute hepatitis. Moderate increases may be seen with chronic hepatitis. People with blocked bile ducts, cirrhosis, and liver cancer may have ALT concentrations that are only moderately elevated or close to normal. Aspartate aminotransferase (AST) A very high level of AST is frequently seen with acute hepatitis. AST may be normal to moderately increased with chronic hepatitis. In people with blocked bile ducts, cirrhosis, and liver cancer, AST concentrations may be moderately increased or close to normal. When liver damage is due to alcohol, AST often increases much more than ALT (this is a pattern seen with few other liver diseases). AST is also increased after heart attacks and with muscle injury. AST is a less sensitive and less specific marker of liver injury than ALT. AST is more elevated than ALT in alcohol-induced liver injury. AST could be elevated more than ALT like: (i)

### Lipid Profile

Cholesterol	128.7	mg/dl	<200.0 mg/dl
CHOD - PAP			
Triglycerides	68.2	mg/dl	< 150 mg/dl
GPO - PAP			





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Others

Sample Type : Urine

## ENDOCRINE

### Thyroid Hormones (T3 .T4 & TSH)

T3	0.98	ng/ml	0.60 - 1.81 ng/ml
T4	8.26	ng/dl	5.01 - 12.45 ng/dl
TSH Ultrasensitive	2.48	uIU/ml	0.34 - 5.50 uIU/ml

Sample Type : SERUM

Remarks :

Note1.TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m and at a minium between 6-10 pm. The variation is of the 50 %, hence time of the day has influence on the measured serum TSH concentrations.

2. Recommended test for T3 and T4 unbound or free level as it is metabolically active.

3. Physiological rise in Total T3 and T4 level is seen in pregnancy and in patients on steroid therapy.

Clinical Use-

- \* Primary Hypothyroidism
- \* Hperthyroidism
- \* Hypothalamic- Pituitary hypothyroidism
- \* Inappropriate-TSH secretion
- \* Nonthyroidal illness
- \* Autoimmune thyroid disease
- \* Pregnancy associated thyroid disorders
- \* Thyroid dysfunction in infancy and early childhood

--End of Report--



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PATIENT NAME: SHREYA  
REF BY: TPA

AGE/SEX: 30 YRS/F  
DATE: MARCH 23, 2024

## USG WHOLE ABDOMEN

**Liver:** normal in size (measures 11.6 cm). Parenchymal echotexture is normal and no focal area of altered echogenicity is seen. IHBR not dilated. CBD is normal in diameter.

**GB:** is normal, Wall thickness is normal.

**Pancreas:** head and body shows normal size and parenchymal attenuation.

**Spleen:** normal in size and normal echotexture.

**Right Kidney:** is normal in position, size and morphology. No evidence of any calculus detected. Pelvi calyceal system is normal. CMD is maintained.

**Left Kidney:** is normal in position, size and morphology. No evidence of any calculus detected. Pelvi calyceal system is normal. CMD is maintained.

**Urinary Bladder:** appears normal.

**Uterus:** is normal in size. E.T- 11.9 mm. No focal lesion seen.

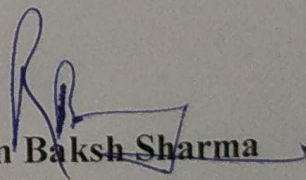
B/L ovaries are normal in size. No adnexal mass lesion seen.

No obvious abnormal bowel dilatation or wall thickening is seen in present scan.

No free fluid seen.

**IMPRESSION:** - No significant abnormality seen sonologically

Clinical correlation and further evaluation is suggested.

  
Dr. Ram Baksh Sharma  
Radiologist

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Consultant Radiologist

Dr. Anshul Jain  
Consultant Radiologist

Dr. Rajesh Reddu  
MBBS, DMRD  
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Dr. Amit Verma  
Echocardiography Specialist

Dr. Sonam Aneja  
Consultant Pathologist



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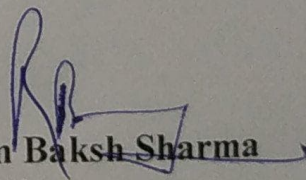
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