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*

HEAMATOLOGY

CBC (Complete Blood Count)

Test Name	Value	Unit	Reference Range
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/cumm	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/cunmm	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

1.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.
2.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.
3.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.
4. 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" POSITIVE		

Haemagglutination 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 %

turbidimetric immunoassay

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
HBA1C			
Average Blood Glucose	105.41	mg/dl	90.00 - 120.00 mg/dl
turbidimetric immunoassay			
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			

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

CLINICAL COMMENTS:
Erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specifictest 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

Uricase - POD
Sample Type : SERUM

URIC ACID: Increases in case of renal failure, disseminated neoplasms, pregnancy toxaemia, 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

Hexokinase / GOD - POD
Sample Type : SERUM

Total Protein

Total Protein	7.86	gm/dl	6.0 - 8.3

BIURET

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
Total Protein			
Albumin BCG	4.23	g/dl	2.9 - 4.5
Globulin	**3.63**	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 IFCC with Pyridoxal Phosphate	23.98	IU/L	10 - 40 IU/L
SGPT IFCC with Pyridoxal Phosphate	25.68	IU/L	07 - 56 IU/L
Alkaline Phosphatase IFCC PNPP Buffer	129.6	U/L	44 - 147 U/L
Total Protein BIURET	7.98	gm/dl	6.0 - 8.3
Albumin BCG	4.35	g/dl	3.5 - 5.5 g/dl
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 inure 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 elevated more than ALT like: (i)

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

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
Lipid Profile			
HDL Cholesterol	43.56	mg/dl	Adult females >55 mg/dl
Homogeneous Enzymatic Colorimetric test			
LDL Cholesterol	71.5	mg/dl	<100 mg/dl
VLDL Cholesterol	13.64	mg/dl	<30.0 mg/dl
CHO/HDL Ratio	2.95	mg/dl	Low risk 3.3-4.4
Non HDL Cholesterol	85.14	mg/dl	<130 mg/dl
Calculated			
Sample Type : SERUM			

Interpretation
Note
1.Measurements in the same patient can show physiological& analytical variations. 3 serial samples 1 wk apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
4. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.

CLINICAL PATHOLOGY

PHYSICAL EXAMINATION	.	
Colour	PALE-YELLOW	
Pale-yellow,Yellowish,Colorless,YELLOW		
Quantity	40	ml
pH	6.0	
Mucus	ABSENT	
Absent,Present		
Appearance	TURBID	
Slightly turbid,Turbid,Clear		
Chemical Examination (Strip)	.	
Specific Gravity	1.025	
Albumin	NEGATIVE	
Absent,Present(+),Present(2+),Present(3+)		
Sugar	NEGATIVE	
Absent,Present(+),Present(2+),Present(3+)		
Bilirubin	NEGATIVE	
Absent,Present		
Microscopic Examination (Microscopy)	.	
Pus Cells	10-12	/HPF
Epithelial Cells	6-8	/HPF
RBC	NIL	/HPF
Casts	ABSENT	
Crystals	ABSENT	
Bacteria	ABSENT	

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

Others

Sample Type : Urine

ENDOCRINE

Thvroid 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	ulU/ml	0.34 - 5.50 ulU/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 metabollically 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
* Pregnency associated thyroid disorders
* Thyroid dysfunction in infancy and early childhood

--End of Report--

Lotus Diagnostic
& Imaging Centre
A Unit of Lotus Diagnostic & Imaging Solution Pvt. Ltd.
HB से लेकर MRI तक एक ही छत के नीचे

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

Dr. Rambaksh Sharma
Consultant Radiologist

Dr. Anshul Jain
Consultant Radiologist

Dr. Rajesh Reddu
MBBS, DMRD
Consultant Radiologist

Dr. Amit Verma
Echocardiography Specialist

Dr. Sonam Aneja
Consultant Pathologist

Lotus Diagnostic
& Imaging Centre
A Unit of Lotus Diagnostic & Imaging Solution Pvt. Ltd.
HB से लेकर MRI तक एक ही छत के नीचे

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

Dr. Rambaksh Sharma
Consultant Radiologist

Dr. Anshul Jain
Consultant Radiologist

Dr. Rajesh Reddu
MBBS, DMRD
Consultant Radiologist

Dr. Amit Verma
Echocardiography Specialist

Dr. Sonam Aneja
Consultant Pathologist