SDA DIAGNOSTICS
A Quality Controlled Pathology Lab

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Branch-2: G-9, Hitech Plaza, Garh Road, Opp. Yug Hospital, Hapur Bus Stand, Meerut
Helpline No. : +91 95481 32613

Lab Ref. No.	: 234030378	C. NO:	20	Centre Name	: SDA Diagnostics
Name	: Mrs. MADARESH			Collection Time	: 23-Mar-2024 11:30AM
Age/ Gender	: 45Y / Female			Receiving Time	: 23-Mar-2024 11:30AM
Referred By	: Dr. SELF			Reporting Time	: 23-Mar-2024 12:41PM
Sample By	:				

Test Name	Results	Units	Biological Ref-Interval
	HAEMATOLOGY		
COMPLETE BLOOD COUNT			
HAEMOGLOBIN (Colorimetry)	**8.30**	g/dl	12-16.5
TOTAL LEUCOCYTE COUNT (Electric Impedence)	6000.00	/Cum m	4000-11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	50.00	%	44-68
Lymphocytes	**45.00**	%	25- 44
Eosinophils	3.00	%	0.0- 4.0
Monocytes	2.00	%	0.0-7.0
Basophils	0.00	%	0.0-1.0
Immature Cells	00	%	
Absolute Count			
Neutrophils Count (calculated)	3000.00	/cumm	2000-7000
Lymphocytes Count (calculated)	2700.00	/cumm	1000-3000
Eosinophils Count (calculated)	180.00	/cumm	40-440
Monocytes Count (calculated)	**120.00**	/cumm	200-1000
Basophils Count (calculated)l	0.00	/cumm	0-30
TOTAL R.B.C. COUNT (Electric Impedence)	4.40	10^6/uL	3.50-5.50
Haematocrit Value (P.C.V.) (Calculated)	**27.50**	%	37.0-54.0
MCV (Calculated)	**62.00**	fL	76-98
MCH	**18.90**	pg	27-32

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Test Name	Results	Units	Biological Ref-Interval
(Calculated)			
MCHC	**30.40**	g/dl	31-35
(Calculated)			
RDW-CV	**19.40**	%	11.5 - 14.5
(Calculated)			
Platelet Count	244	Thousand/cumm	150-450
(Electric Impedence)			
MPV	**10.90**	fL	11.5-14.5
(Calculated)			
PDW	10.80	fL	9.0-17.0
(Calculated)			
E.S.R	18.00	mm	00-20
(Wintrobe methrod)			
Peripheral Smear	..		
BLOOD GROUP			
Blood Group	A		
Rh Status	POSITIVE		
	.		
GLYCATED HAEMOGLOBIN (HbA1c	5.20	%	4.5-6.0
ESTIMATED AVERAGE GLUCOSE	102.54	mg/dl	

EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics : 4.5 % to 6.0 %
Good Control of diabetes : 6.1 % to 7.0 %
Fair Control of diabetes : 7.1 % to 8.0 %
Poor Control od diabetes : 8 % and above

The glycosylated hemoglobin assay has been validated as a reliable indicator of mean blood glucose levels for a period of 8-12 week period prior to HBA1C determination.ADA recommends the testing twice a year in patients with stable blood glucose, and quarterly, if treatment changes, or if blood glucose levels are unstable.

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Test Name	Results	Units	Biological Ref-Interval
	BIOCHEMISTRY		
BLOOD GLUCOSE FASTING (GOD/POD method)	97.00	mg/dl	70 - 110
BLOOD GLUCOSE P.P. (GOD/POD method) After 2.0 hrs of meal	129.00	mg/dl	70-140
BLOOD UREA NITROGEN	11.20	mg/dL	5-25

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Test Name	Results	Units	Biological Ref-Interval
LIVER PROFILE			
SERUM BILIRUBIN			
TOTAL (Diazo)	0.91	mg/dl	0.30-1.20
DIRECT (Diazo)	**0.39**	mg/dl	0.00-0.20
INDIRECT (Calculated)	0.52	mg/dl	0.20-1.00
S.G.P.T. (IFCC method)	28.00	U/L	0-45
S.G.O.T. (IFCC method)	25.00	U/L	0-45
SERUM ALKALINE PHOSPHATASE (4-nitrphenylphosphate to 2-amino-2-methyl-1propan	**155.00**	IU/L.	35-145
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	6.70	Gm/dL.	6.0-8.0
ALBUMIN (Bromocresol green Dye)	4.00	Gm/dL.	3.5-5.2
GLOBULIN (Calculated)	2.70	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	**1.48**		1.5-2.5

LIVER FUNCTION TESTS CHECK THE LEVEL OF CERTAIN ENZYMES AND PROTEINS IN BLOOD

Levels that are higher or lower than normal can indicate liver problems. Some common liver function tests include :

Alanine transaminase (ALT). ALT is an enzyme found in the liver and When the liver is damaged, ALT is released into the bloodstream and levels increase.

Aspartate transaminase (AST). AST is an enzyme that helps metabolize alanine,an amino acid. AST is normally present in blood at low levels. An increase in AST levels may indicate liver damage or disease or muscle damage.

Alkaline phosphatase (ALP). ALP is an enzyme in the liver, bile ducts and bone.

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Test Name	Results	Units	Biological Ref-Interval
RENAL PROFILE			
BLOOD UREA (Urease Glutamate dehydrogenase)	24.0	mg/dl	10-50
SERUM CREATININE (Jaffe`s)	0.80	mg/dL.	0.6-1.2
SERUM URIC ACID (Urecase method)	3.7	mg/dL.	3.5-7.5
SERUM SODIUM (Na) (ISE Direct)	138.0	mmol/l	135 - 155
SERUM POTASSIUM (K) (ISE Direct)	4.20	mmol/l	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	8.9	mg/dl	8.5-10.1
SERUM PROTEIN			
TOTAL PROTEINS (Biuret)	6.70	Gm/dL.	6.0-8.0
SERUM ALBUMIN (Bromocresol green Dye)	4.00	Gm/dL.	3.5-5.2
GLOBULIN (Calculated)	2.70	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	**1.48**	Gm/dL.	1.5-2.5

INTERPRETATION:

Urea is the end product of protein metabolism. It reflects on funcioning of the kidney in the body. Creatinine is the end product of creatine metabolism. It is a measure of renal function and eleveted levels are observed in patients typically with 50% or greater impairment of renal function. Sodium is critical in maintaining water & osmotic equilibrium in extracellular fluids. Disturbances in acid base and water balance are typically reflected in the sodium concentrations . Potassium is an essential element involved in critical cell functions. Potassium levels are influenced by electrolyte intake ,excretion and other means of elemination, exercise, hydration and medications. Calcium imbalance my cause a spectrum of disease . High concentrations are seen in Hyperparathyroidism, Malignancy & Sarcoidosis. Low levels may be due to protein deficiency, renal insufficiency and Hypoparathyroidism. Repeat measurement is recommended if the values are outside the reference range.

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Test Name	Results	Units	Biological Ref-Interval
LIPID PROFILE			
SERUM CHOLESTEROL (CHOD - PAP)	156.0	mg/dl	125-200
SERUM TRIGLYCERIDE (GPO-PAP)	98.0	mg/dl	50-150
HDL CHOLESTEROL (Direct Method)	45.0	mg/dl	30-80
VLDL CHOLESTEROL (Calculated)	19.6	mg/dl	5-35
LDL CHOLESTEROL (Calculated)	91.4	mg/dL.	70-130
LDL/HDL RATIO (Calculated)	2.0		0.0-4.9
CHOL/HDL CHOLESTROL RATIO (Calculated)	**3.5**		1.5-3.0

INTERPRETATION

TRIGLYCERIDE level > 250mg/dL is associated with an approximately 2-fold greater risk of coronary vascular disease. Elevation of triglycerides can be seen with obesity, medication, fast less than 12 hrs., alcohol intake, diabetes melitus,and pancreatitis.

CHOLESTEROL, its fractions and triglycerides are the important plasma lipids indefining cardiovascular risk factors and in the managment of cardiovascular disease.Highest acceptable and optimum values of cholesterol values of cholesterol vary with age. Values above 220 mgm/dl are associated with increased risk of CHD regardless of HDL & LDL values.

HDL-CHOLESTEROL level <35 mg/dL is associated with an increased risk of coronary vascular disease even in the face of desirable levels of cholesterol and LDL - cholesterol.

LDL - CHOLESTEROL& TOTAL CHOLESTEROL levels can be strikingly altered by thyroid, renal and liver disease as well as hereditary factors.

Based on total cholesterol, LDL- cholesterol, and total cholesterol/HDL - cholesterol ratio, patients may be divided into the three risk categories.

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Test Name	Results	Units	Biological Ref-Interval
HORMONE			
THYRIOD PROFILE			
Triiodothyronine (T3) (FIA)	0.89	ng/dl	0.52-1.85
Thyroxine (T4) (FIA)	9.13	ug/dl	4.8-11.6
THYROID STIMULATING HORMONE (TSH) (FIA)	2.57	mIU/L	0.50-5.50

Interpretation Note:
Thyroid Stimulating Hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitarythyroid axis, TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone.Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormons vary according trimesper in pregnancy.

TSH ref range in Pregnacy	**Reference range (microIU/ml)**
First triemester	0.24 - 2.00
Second triemester	0.43-2.2
Third triemester	0.8-2.5

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CLINICAL PATHOLOGY

Test Name	Results	Units	Biological Ref-Interval
URINE EXAMINATION REPORT			
PHYSICAL EXAMINATION			
VOLUME (visual)	20	ml	
COLOUR (visual)	PALE YELLOW		
APPEARENCE (visual)	CLEAR		
pH	6.00		4.6 - 8.0
SPECIFIC GRAVITY (pKa Change)	1.015		1.010-1.030
BIOCHEMICAL EXAMINATION			
UROBILINOGEN (Erlichs)	NIL		NIL
BILIRUBIN (Azo-coupling reaction)	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
SUGAR (Glucose Oxidase Peroxidase)	NIL		Nil
ALBUMIN (Protein-Error-of-Indicator))	NIL		Nil
PHOSPHATE	NIL		Nil
MICROSCOPIC EXAMINATION (Microscopy)			
RED BLOOD CELLS	NIL	/H.P.F.	0-2
PUS CELLS	1-2	/H.P.F.	0-5
EPITHELIAL CELLS	2-3	/H.P.F.	0-5
CRYSTALS	NIL	/H.P.F.	NIL
CASTS	NIL	/L.P.F.	
OTHER			

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