

REPORT

Name	: Mrs. P KRISHNAVENI	Sample ID	: 24863988
Age/Gender	: 34 Years/Female	Reg. No	: 0312404060035
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 06-Apr-2024 12:24 PM
Primary Sample	: Whole Blood	Received On	: 06-Apr-2024 01:20 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 06-Apr-2024 03:02 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

SAGEPATH CARE 1.2

Test Name	Results	Units	Ref. Range	Method
COMPLETE BLOOD COUNT (CBC)				
Haemoglobin (Hb)	10.4	g/dL	12-15	Cynmeth Method
RBC Count	4.25	10 ¹² /L	4.5-5.5	Cell Impedance
Haematocrit (HCT)	32.6	%	40-50	Calculated
MCV	77	fl	81-101	Calculated
MCH	24.4	pg	27-32	Calculated
MCHC	31.8	g/dL	32.5-34.5	Calculated
RDW-CV	15.9	%	11.6-14.0	Calculated
Platelet Count (PLT)	328	10 ⁹ /L	150-410	Cell Impedance
Total WBC Count	7.4	10 ⁹ /L	4.0-10.0	Impedance
Neutrophils	64	%	40-70	Cell Impedance
Absolute Neutrophils Count	4.74	10 ⁹ /L	2.0-7.0	Impedance
Lymphocytes	31	%	20-40	Cell Impedance
Absolute Lymphocyte Count	2.29	10 ⁹ /L	1.0-3.0	Impedance
Monocytes	03	%	2-10	Microscopy
Absolute Monocyte Count	0.22	10 ⁹ /L	0.2-1.0	Calculated
Eosinophils	02	%	1-6	Microscopy
Absolute Eosinophils Count	0.15	10 ⁹ /L	0.02-0.5	Calculated
Basophils	00	%	1-2	Microscopy
Absolute Basophil ICount	0.00	10 ⁹ /L	0.0-0.3	Calculated
Morphology				
WBC	Within Normal Limits			
RBC	Anisocytosis with Microcytic hypochromic anemia			
Platelets	Adequate.			Microscopy
Erythrocyte Sedimentation Rate (ESR)	15		10 or less	Westergren method

Comments : ESR is an acute phase reactant which indicates presence and intensity of an inflammatory process. It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders and renal diseases.



Swarnabala - M
DR. SWARNA BALA
MD PATHOLOGY

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CLINICAL BIOCHEMISTRY

SAGEPATH CARE 1.2

Test Name	Results	Units	Ref. Range	Method
Lipid Profile				
Cholesterol Total	122	mg/dL	< 200	CHOD-POD
Triglycerides-TGL	84	mg/dL	< 150	GPO-POD
Cholesterol-HDL	42	mg/dL	40-60	Direct
Cholesterol-LDL	63.2	mg/dL	< 100	Calculated
Cholesterol- VLDL	16.8	mg/dL	7-35	Calculated
Non HDL Cholesterol	80	mg/dL	< 130	Calculated
Cholesterol Total /HDL Ratio	2.9	%	0-4.0	Calculated
HDL / LDL Ratio	0.66			
LDL/HDL Ratio	1.5	%	0-3.5	Calculated

The National Cholesterol Education program's third Adult Treatment Panel (ATPIII) has issued its recommendations on evaluating and treating lipid disorders for primary and secondary.

NCEP Recommendations	Cholesterol Total in (mg/dL)	Triglycerides in (mg/dL)	HDL Cholesterol (mg/dL)	LDL Cholesterol in (mg/dL)	Non HDL Cholesterol in (mg/dL)
Optimal	Adult: < 200 Children: < 170	< 150	40-59	Adult:<100 Children: <110	<130
Above Optimal	-----	-----		100-129	130 - 159
Borderline High	Adult: 200-239 Children:171-199	150-199		Adult: 130-159 Children: 111-129	160 - 189
High	Adult:>or=240 Children:>or=200	200-499	≥ 60	Adult:160-189 Children:>or=130	190 - 219
Very High	-----	>or=500		Adult: >or=190 -----	>=220

Note: LDL cholesterol cannot be calculated if triglyceride is >400 mg/dL (Friedewald's formula). Calculated values not provided for LDL and VLDL



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Test Name	Results	Units	Ref. Range	Method
Kidney Profile-KFT				
Creatinine -Serum	0.98	mg/dL	0.60-1.10	Sarcosine oxidase
Urea-Serum	17.5	mg/dL	12.8-42.8	Glutamate dehydrogenase+Calculation
Blood Urea Nitrogen (BUN)	8.19	mg/dL	7.0-18.0	Calculated
BUN / Creatinine Ratio	8.36		6 - 22	
Uric Acid	4.4	mg/dL	2.6-6.0	Uricase
Sodium	141	mmol/L	136-145	ISE Direct
Potassium	4.0	mmol/L	3.5-5.1	ISE Direct
Chloride	105	mmol/L	98-108	ISE Direct
Liver Function Test (LFT)				
Bilirubin(Total)	0.7	mg/dL	0.3-1.2	Diazo
Bilirubin (Direct)	0.1	mg/dL	0.0 - 0.2	Diazo
Bilirubin (Indirect)	0.6	mg/dL	0.2-1.0	Calculated
Aspartate Aminotransferase (AST/SGOT)	17	U/L	5-40	IFCC with out (P-5-P)
Alanine Aminotransferase (ALT/SGPT)	8	U/L	0-55	IFCC with out (P-5-P)
Alkaline Phosphatase(ALP)	92	U/L	40-150	Kinetic PNPP-AMP
Gamma Glutamyl Transpeptidase (GGTP)	12	U/L	5-55	IFCC
Protein - Total	7.5	g/dL	6.4-8.2	Biuret
Albumin	3.7	g/dL	3.4-5.0	Bromocresol purple (BCP)
Globulin	3.8	g/dL	2.0-4.2	Calculated
A:G Ratio	0.97	%	0.8-2.0	Calculated
SGOT/SGPT Ratio	2.13			

*** End Of Report ***

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Test Name	Results	Units	Ref. Range	Method
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Thyroid Profile-I(TFT)

T3 (Triiodothyronine)	142.52	ng/dL	70-204	CLIA
T4 (Thyroxine)	9.7	µg/dL	3.2-12.6	CLIA
TSH -Thyroid Stimulating Hormone	2.55	µIU/mL	0.35-5.5	CLIA

Pregnancy & Cord Blood

T3 (Triiodothyronine):	T4 (Thyroxine)	TSH (Thyroid Stimulating Hormone)
First Trimester : 81-190 ng/dL	15 to 40 weeks:9.1-14.0 µg/dL	First Trimester : 0.24-2.99 µIU/mL
Second&Third Trimester :100-260 ng/dL		Second Trimester: 0.46-2.95 µIU/mL
		Third Trimester : 0.43-2.78 µIU/mL
Cord Blood: 30-70 ng/dL	Cord Blood: 7.4-13.0 µg/dL	Cord Blood: : 2.3-13.2 µIU/mL

Interpretation:

- Thyroid gland is a butterfly-shaped endocrine gland that is normally located in the lower front of the neck. The thyroid's job is to make thyroid hormones, which are secreted into the blood and then carried to every tissue in the body. Thyroid hormones help the body use energy, stay warm and keep the brain, heart, muscles, and other organs working as they should.
- Thyroid produces two major hormones: triiodothyronine (T3) and thyroxine (T4). If thyroid gland doesn't produce enough of these hormones, you may experience symptoms such as weight gain, lack of energy, and depression. This condition is called hypothyroidism.
- Thyroid gland produces too many hormones, you may experience weight loss, high levels of anxiety, tremors, and a sense of being on a high. This is called hyperthyroidism.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4.
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.



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Iron Profile-I				
Iron(Fe)	27	µg/dL	50-170	Ferene
Total Iron Binding Capacity (TIBC)	462	µg/dL	250-450	Ferene
Transferrin	323.08	mg/dL	250-380	Calculated
Iron Saturation((% Transferrin Saturation)	5.84	%	15-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	435	ug/dL	110-370	FerroZine

Interpretation:

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.

Correlate Clinically.

Result rechecked and verified for abnormal cases

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*** End Of Report ***



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