SagePath®
Excellence In Health Care

Sagepath Labs Pvt. Ltd.

Lab Address:- # Plot No. 564 , 1st floor , Buddhanagar , Near Sai Baba Temple Peerzadiguda Boduppal Hyderabad, Telangana.
ICMR Reg .No. SAPALAPVLHT (Covid -19)

REPORT

Name	: Mrs. M NIROSHA	Sample ID	: 24864523
Age/Gender	: 35 Years/Female	Reg. No	: 0312405070013
Referred by	: Dr. NARASIMHA REDDY	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 07-May-2024 10:06 AM
Primary Sample	: Whole Blood	Received On	: 07-May-2024 01:20 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 07-May-2024 06:04 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

Test Name	Results	Units	Ref. Range	Method
Complete Blood Picture(CBP)				
Haemoglobin (Hb)	**8.0**	g/dL	12-15	Cynmeth Method
Haematocrit (HCT)	**29.3**	%	40-50	Calculated
RBC Count	4.61	10^12/L	4.5-5.5	Cell Impedence
MCV	**64**	fl	81-101	Calculated
MCH	**17.4**	pg	27-32	Calculated
MCHC	**27.4**	g/dL	32.5-34.5	Calculated
RDW-CV	**21.2**	%	11.6-14.0	Calculated
Platelet Count (PLT)	**100**	10^9/L	150-410	Cell Impedance
Total WBC Count	7.0	10^9/L	4.0-10.0	Impedance
Differential Leucocyte Count (DC)				
Neutrophils	68	%	40-70	Cell Impedence
Lymphocytes	24	%	20-40	Cell Impedence
Monocytes	05	%	2-10	Microscopy
Eosinophils	03	%	1-6	Microscopy
Basophils	0	%	1-2	Microscopy
Absolute Neutrophils Count	4.76	10^9/L	2.0-7.0	Impedence
Absolute Lymphocyte Count	1.68	10^9/L	1.0-3.0	Impedence
Absolute Monocyte Count	0.35	10^9/L	0.2-1.0	Calculated
Absolute Eosinophils Count	0.21	10^9/L	0.02-0.5	Calculated
Absolute Basophil lCount	0.00	10^9/L	0.0-0.3	Calculated
Morphology	Severe microcytic hypochromic anemia with anisopoikilocytosis and mild thrombocytopenia with many giant platelets			PAPs Staining

NOTE- Giant platelets may affect exact estimation of platelet count

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Swarnabala.M
DR.SWARNA BALA
MD PATHOLOGY

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Primary Sample	: Whole Blood	Received On	: 07-May-2024 01:20 PM
Sample Tested In	: Serum	Reported On	: 07-May-2024 08:34 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Vitamin- B12 (cyanocobalamin)	228	pg/mL	200-911	CLIA

Interpretation:
This test is most often done when other blood tests suggest a condition called megaloblastic anemia. Pernicious anemia is a form of megaloblastic anemia caused by poor vitamin B12 absorption. This can occur when the stomach makes less of the substance the body needs to properly absorb vitamin B12.
Causes of vitamin B12 deficiency include:Diseases that cause malabsorption
1.Lack of intrinsic factor, a protein that helps the intestine absorb vitamin B12
2.Above normal heat production (for example, with hyperthyroidism)
An increased vitamin B12 level is uncommon in:
1.Liver disease (such as cirrhosis or hepatitis)
2.Myeloproliferative disorders (for example, polycythemia vera and chronic myelogenous leukemia)

Folic Acid (Vitamin B9)	18.31	ng/mL	Deficient:0.35-3.37 Indeterminate:3.38-5.38 Normal:>5.38	CLIA

Interpretation:
Folic acid is a type of B vitamin.This test is done to check for folic acid deficiency.
Folic acid helps form red blood cells and produce DNA that stores genetic codes. Taking the right amount of folic acid before and during pregnancy helps prevent neural tube defects, such as spina bifida.
Women who are pregnant or planning to become pregnant should take at least 600 micrograms (mcg) of folic acid every day. Some women may need to take more if they have a history of neural tube defects in earlier pregnancies.
Lower-than-normal folic acid levels may indicate:

- Poor diet
- Malabsorption syndrome (for example, celiac sprue)
- Malnutrition

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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Iron Profile-II				
Ferritin	**5.6**	ng/mL	10-291	CLIA
Iron(Fe)	**24**	µg/dL	50-170	Ferene
Total Iron Binding Capacity (TIBC)	**490**	µg/dL	250-450	Ferene
Transferrin	342.66	mg/dL	250-380	Calculated
Iron Saturation((% Transferrin Saturation)	**4.9**	%	15-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	**466**	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.

Result rechecked and verified for abnormal cases

*** End Of Report ***

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Sample Tested In	: Serum	Reported On	: 07-May-2024 03:47 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Thyroid Profile-I(TFT)				
T3 (Triiodothyronine)	119.65	ng/dL	70-204	CLIA
T4 (Thyroxine)	7.1	µg/dL	3.2-12.6	CLIA
TSH -Thyroid Stimulating Hormone	3.78	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.

Correlate Clinically.

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*** End Of Report ***

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