

REPORT

| | | | |
|--------------------|---------------------------------------|---------------|------------------------|
| Name | : Dr. JYOTHI | Sample ID | : A0451459 |
| Age/Gender | : 31 Years/Female | Reg. No | : 0312408220016 |
| Referred by | : Dr. VARIJA | SPP Code | : SPL-CV-172 |
| Referring Customer | : V CARE MEDICAL DIAGNOSTICS | Collected On | : 22-Aug-2024 10:03 AM |
| Primary Sample | : Whole Blood | Received On | : 22-Aug-2024 01:50 PM |
| Sample Tested In | : Citrated Plasma | Reported On | : 22-Aug-2024 06:04 PM |
| Client Address | : Kimtee colony ,Gokul Nagar, Tarnaka | Report Status | : Final Report |

HAEMATOLOGY

| Test Name | Results | Units | Ref. Range | Method |
|---|---------|---------|------------|------------------------------|
| Activated Partial Thromboplastin Time (APTT/PTTK) | | | | |
| Patient Value | 36.40 | sec | 26-40 | Photo Optical Clot Detection |
| Control Value | 33.00 | Sec | | Agglutination |
| Comments: APTT measures intrinsic and common pathways of the coagulation cascade. Prolonged APTT may be caused by heparin and other anticoagulants, factor deficiencies or inhibitors such as lupus anticoagulants | | | | |
| PROTHROMBIN TIME (P TIME) | | | | |
| PT-Patient Value | 14.4 | Secs | 10-15 | Photo Optical Clot Detection |
| PT-Mean Control Value | 13.00 | Seconds | | |
| PT Ratio | 1.11 | | | |
| PT INR | 1.20 | | 0.9-1.2 | |

Interpretation :

Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), Tissue factor and Proteins of the common pathway (Factors X, V, II & Fibrinogen). This assay is used to control long term oral anticoagulant therapy, evaluation of liver function & to evaluate coagulation disorders specially factors involved in the extrinsic pathway like Factors V, VII, X, Prothrombin & Fibrinogen.

Note

1. INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity
2. Prolonged INR suggests potential bleeding disorder / bleeding complications
3. Results should be clinically correlated
4. Test conducted on Citrated plasma

*** End Of Report ***



Swannabala - M
DR.SWARNA BALA
MD PATHOLOGY

REPORT

| | | | |
|--------------------|---------------------------------------|---------------|------------------------|
| Name | : Dr. JYOTHI | Sample ID | : A0451457 |
| Age/Gender | : 31 Years/Female | Reg. No | : 0312408220016 |
| Referred by | : Dr. VARIJA | SPP Code | : SPL-CV-172 |
| Referring Customer | : V CARE MEDICAL DIAGNOSTICS | Collected On | : 22-Aug-2024 10:03 AM |
| Primary Sample | : Whole Blood | Received On | : 22-Aug-2024 01:50 PM |
| Sample Tested In | : Whole Blood EDTA | Reported On | : 22-Aug-2024 03:42 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) | 11.7 | g/dL | 12-15 | Cynmeth Method |
| Haematocrit (HCT) | 36.3 | % | 40-50 | Calculated |
| RBC Count | 4.61 | 10 ¹² /L | 3.8-4.8 | Cell Impedence |
| MCV | 79 | fl | 81-101 | Calculated |
| MCH | 25.3 | pg | 27-32 | Calculated |
| MCHC | 32.1 | g/dL | 32.5-34.5 | Calculated |
| RDW-CV | 15.4 | % | 11.6-14.0 | Calculated |
| Platelet Count (PLT) | 185 | 10 ⁹ /L | 150-410 | Cell Impedence |
| Total WBC Count | 9.6 | 10 ⁹ /L | 4.0-10.0 | Impedence |
| Differential Leucocyte Count (DC) | | | | |
| Neutrophils | 65 | % | 40-70 | Cell Impedence |
| Lymphocytes | 27 | % | 20-40 | Cell Impedence |
| Monocytes | 06 | % | 2-10 | Microscopy |
| Eosinophils | 02 | % | 1-6 | Microscopy |
| Basophils | 00 | % | 1-2 | Microscopy |
| Absolute Neutrophils Count | 6.24 | 10 ⁹ /L | 2.0-7.0 | Impedence |
| Absolute Lymphocyte Count | 2.59 | 10 ⁹ /L | 1.0-3.0 | Impedence |
| Absolute Monocyte Count | 0.58 | 10 ⁹ /L | 0.2-1.0 | Calculated |
| Absolute Eosinophils Count | 0.19 | 10 ⁹ /L | 0.02-0.5 | Calculated |
| Absolute Basophil ICount | 0.00 | 10 ⁹ /L | 0.0-0.3 | Calculated |
| Morphology | Anisocytosis with Normocytic normochromic | | | PAPs Staining |



Swarnabala - M
DR.SWARNA BALA
MD PATHOLOGY

REPORT

| | | | |
|--------------------|--------------------------------------|---------------|------------------------|
| Name | : Dr. JYOTHI | Sample ID | : A0451458, A0451456 |
| Age/Gender | : 31 Years/Female | Reg. No | : 0312408220016 |
| Referred by | : Dr. VARIJA | SPP Code | : SPL-CV-172 |
| Referring Customer | : V CARE MEDICAL DIAGNOSTICS | Collected On | : 22-Aug-2024 10:03 AM |
| Primary Sample | : Whole Blood | Received On | : 22-Aug-2024 01:51 PM |
| Sample Tested In | : Plasma-NaF(R), Serum | Reported On | : 22-Aug-2024 03:40 PM |
| Client Address | : Kimtee colony ,Gokul Nagar,Tarnaka | Report Status | : Final Report |

CLINICAL BIOCHEMISTRY

| Test Name | Results | Units | Ref. Range | Method |
|-----------------------------|---------|-------|------------|-----------------|
| Glucose Random (RBS) | 76 | mg/dL | 70-140 | Hexokinase (HK) |

Interpretation of Plasma Glucose based on ADA guidelines 2018

| Diagnosis | Fasting Plasma Glucose(mg/dL) | 2hrs Plasma Glucose(mg/dL) | HbA1c(%) | RBS(mg/dL) |
|-------------|-------------------------------|----------------------------|----------|----------------------|
| Prediabetes | 100-125 | 140-199 | 5.7-6.4 | NA |
| Diabetes | > = 126 | > = 200 | > = 6.5 | >=200(with symptoms) |

Reference: Diabetes care 2018:41(suppl.1):S13-S27

- The random blood glucose if it is above 200 mg/dL and the patient has increased thirst, polyuria, and polyphagia, suggests diabetes mellitus.
- As a rule, two-hour glucose samples will reach the fasting level or it will be in the normal range.

TSH -Thyroid Stimulating Hormone 3.53 µIU/mL 0.35-5.5 CLIA

Pregnancy & Cord Blood

| TSH (Thyroid Stimulating Hormone (µIU/mL)) | |
|--|-------------|
| First Trimester | : 0.24-2.99 |
| Second Trimester | : 0.46-2.95 |
| Third Trimester | : 0.43-2.78 |
| Cord Blood | : 2.3-13.2 |

- TSH is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production.
- 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
- TRH stimulation differentiates secondary and tertiary hypothyroidism by observing the change in patient TSH levels. Typically, the TSH response to TRH stimulation is absent in cases of secondary hypothyroidism, and normal to exaggerated in tertiary hypothyroidism
- Historically, TRH stimulation has been used to confirm primary hyperthyroidism, indicated by elevated T3 and T4 levels and low or undetectable TSH levels. TSH assays with increased sensitivity and specificity provide a primary diagnostic tool to differentiate hyperthyroid from euthyroid patients.

Result rechecked and verified for abnormal cases

*** End Of Report ***

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Dr. Vaishnavi
DR. VAISHNAVI
MD BIOCHEMISTRY

REPORT

| | | | |
|--------------------|---------------------------------------|---------------|------------------------|
| Name | : Dr. JYOTHI | Sample ID | : A0451456 |
| Age/Gender | : 31 Years/Female | Reg. No | : 0312408220016 |
| Referred by | : Dr. VARIJA | SPP Code | : SPL-CV-172 |
| Referring Customer | : V CARE MEDICAL DIAGNOSTICS | Collected On | : 22-Aug-2024 10:03 AM |
| Primary Sample | : Whole Blood | Received On | : 22-Aug-2024 01:51 PM |
| Sample Tested In | : Serum | Reported On | : 22-Aug-2024 06:32 PM |
| Client Address | : Kimtee colony ,Gokul Nagar, Tarnaka | Report Status | : Final Report |

CLINICAL BIOCHEMISTRY

| Test Name | Results | Units | Ref. Range | Method |
|---------------------------------------|---------|-------|------------|-------------------------|
| Liver Function Test (LFT) | | | | |
| Bilirubin(Total) | 0.40 | mg/dL | 0.3-1.2 | Diazo |
| Bilirubin (Direct) | 0.13 | mg/dL | 0.0 - 0.3 | Diazo |
| Bilirubin (Indirect) | 0.27 | mg/dL | 0.2-1.0 | Calculated |
| Aspartate Aminotransferase (AST/SGOT) | 12.7 | U/L | 15-37 | IFCC UV Assay |
| Alanine Aminotransferase (ALT/SGPT) | 12.6 | U/L | 0-55 | IFCC with out (P-5-P) |
| Alkaline Phosphatase(ALP) | 126.8 | U/L | 30-120 | Kinetic PNPP-AMP |
| Gamma Glutamyl Transpeptidase (GGTP) | 17.5 | U/L | 5-55 | IFCC |
| Protein - Total | 6.71 | g/dL | 6.4-8.2 | Biuret |
| Albumin | 3.7 | g/dL | 3.4-5.0 | Bromocresol Green (BCG) |
| Globulin | 3.01 | g/dL | 2.0-4.2 | Calculated |
| A:G Ratio | 1.23 | % | 0.8-2.0 | Calculated |
| SGOT/SGPT Ratio | 1.01 | | | |

Alanine Aminotransferase(ALT) is an enzyme found in liver and kidneys cells. ALT helps create energy for liver cells. Damaged liver cells release ALT into the bloodstream, which can elevate ALT levels in the blood.

Aspartate Aminotransferase (AST) is an enzyme in the liver and muscles that helps metabolizes amino acids. Similarly to ALT, elevated AST levels may be a sign of liver damage or liver disease.

Alkaline phosphate (ALP) is an enzyme present in the blood. ALP contributes to numerous vital bodily functions, such as supplying nutrients to the liver, promoting bone growth, and metabolizing fat in the intestines.

Gamma-glutamyl Transpeptidase (GGTP) is an enzyme that occurs primarily in the liver, but it is also present in the kidneys, pancreas, gallbladder, and spleen. Higher than normal concentrations of GGTP in the blood may indicate alcohol-related liver damage. Elevated GGTP levels can also increase the risk of developing certain types of cancer.

Bilirubin is a waste product that forms when the liver breaks down red blood cells. Bilirubin exits the body as bile in stool. High levels of bilirubin can cause jaundice - a condition in which the skin and whites of the eyes turn yellow- and may indicate liver damage.

Albumin is a protein that the liver produces. The liver releases albumin into the bloodstream, where it helps fight infections and transport vitamins, hormones, and enzymes throughout the body. Liver damage can cause abnormally low albumin levels.



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| Referred by | : Dr. VARIJA | SPP Code | : SPL-CV-172 |
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CLINICAL BIOCHEMISTRY

| Test Name | Results | Units | Ref. Range | Method |
|----------------------------------|---------|--------|------------|------------|
| Electrolyte Profile-Serum | | | | |
| Sodium | 140 | mmol/L | 135-150 | ISE Direct |
| Potassium | 3.9 | mmol/L | 3.5-5.0 | ISE Direct |
| Chloride | 104 | mmol/L | 94-110 | ISE Direct |

Clinical significance:

- Prevents dehydration.
- Maintain the acid-base balance (body pH).
- Maintain the osmotic pressure.
- Body working normally.
- It regulates heart rhythm.
- Regulate muscle contractions.
- Help the brain function.
- Cells can generate energy.

Note: Separate serum or plasma from cells within 45 minutes of collection; avoid hemolysis.

Correlate Clinically.

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*** End Of Report ***



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