

Patient Name : Ms.GUNJAN RASTOGI	Visit No : CHA250033738
Age/Gender : 49 Y/F	Registration ON : 25/Feb/2025 09:54AM
Lab No : 10131034	Sample Collected ON : 25/Feb/2025 09:56AM
Referred By : Dr. T ANUSH BABU	Sample Received ON : 25/Feb/2025 10:03AM
Refer Lab/Hosp : CHARAK NA	Report Generated ON : 25/Feb/2025 11:57AM
Doctor Advice : 25 OH vit. D,VIT B12,BOTH KNEE AP LAT,ANTI CCP TITRE,CRP (Quantitative),RF FACTOR,ESR,LIPID-PROFILE,TSH,CREATININE,URINE COM. EXMAMINATION,HBA1C (EDTA),PP,FASTING	



Test Name	Result	Unit	Bio. Ref. Range	Method
ESR				
Erythrocyte Sedimentation Rate ESR	34.00		0 - 15	Westergreen

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

HBA1C				
Glycosylated Hemoglobin (HbA1c)	6.8	%	4 - 5.7	HPLC (EDTA)

NOTE:-

Glycosylated Hemoglobin Test (HbA1c)is performed in this laboratoryby the Gold Standard Reference method,ie:HPLC Technology(High performance Liquid Chromatography D10) from Bio-Rad Laboratories.USA.

EXPECTED (RESULT) RANGE :

Bio system	Degree of normal
4.0 - 5.7 %	Normal Value (OR) Non Diabetic
5.8 - 6.4 %	Pre Diabetic Stage
> 6.5 %	Diabetic (or) Diabetic stage
6.5 - 7.0 %	Well Controlled Diabet
7.1 - 8.0 %	Unsatisfactory Control
> 8.0 %	Poor Control and needs treatment



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PATHOLOGIST

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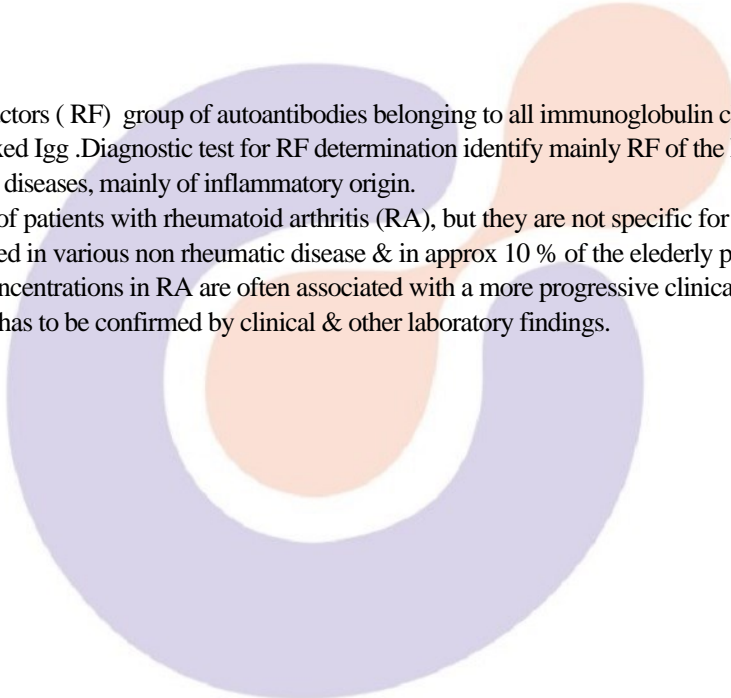
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Test Name	Result	Unit	Bio. Ref. Range	Method
RF FACTOR				
RHEUMATOID FACTOR	6.50	IU/ml	0 - 14	

SUMMARY : Rheumatoid factors (RF) group of autoantibodies belonging to all immunoglobulin classes directed against the FC fragment of altered or complexed Igg .Diagnostic test for RF determination identify mainly RF of the IgM class which are detectable in several rheumatic diseases, mainly of inflammatory origin.

RF occur in approx 70 -80 % of patients with rheumatoid arthritis (RA), but they are not specific for RA as elevated concentrations are also observed in various non rheumatic disease & in approx 10 % of the elderley population without clinical symptoms of RA. High RF concentrations in RA are often associated with a more progressive clinical course of the disease .However,a positive RF value has to be confirmed by clinical & other laboratory findings.



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Test Name	Result	Unit	Bio. Ref. Range	Method
CRP-QUANTITATIVE				
CRP-QUANTITATIVE TEST	8.3	MG/L	0.1 - 6	

Method: Immunoturbidimetric

(Method: Immunoturbidimetric on photometry system)

SUMMARY : C - reactive protien (CRP) is the best known among the acute phase protiens, a group of protien whose concentration increases in blood as a response to inflammatory disorders.CRP is normally present in low concentration in blood of healthy individuals (< 1mg/L). It is elevated up to 500 mg/L in acute inflammatory processes associated with bacterial infections, post operative conditions tissue damage already after 6 hours reaching a peak at 48 hours.. The measurement of CRP represents a useful aboratory test for detection of acute infection as well as for monitoring inflammtory proceses also in acute rheumatic & gastrointestinal disease. In recent studies it has been shows that in apparently healthy subjects there is a direct orrelation between CRP concentrations & the risk of developing oronary heart disease (CHD).

hsCRP cut off for risk assessment as per CDC/AHA Level	Risk
<1.0	Low
1.0-3.0	Average
>3.0	High

All reports to be clinically corelated

LIPID-PROFILE

Cholesterol/HDL Ratio	4.12	Ratio	Calculated
LDL / HDL RATIO	2.35	Ratio	Calculated

Desirable / low risk - 0.5 -3.0
Low/ Moderate risk - 3.0-6.0
Elevated / High risk - >6.0
Desirable / low risk - 0.5 -3.0
Low/ Moderate risk - 3.0-6.0
Elevated / High risk - > 6.0



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Test Name	Result	Unit	Bio. Ref. Range	Method
ANTI CCP TITRE				
Anti CCP TITRE	8.00	U/ML	7 - 17	

25 OH vit. D				
25 Hydroxy Vitamin D	9.23	ng/ml		ECLIA
Deficiency < 10				
Insufficiency 10 - 30				
Sufficiency 30 - 100				
Toxicity > 100				

DONE BY: ELECTROCHEMILUMINESCENCE IMMUNOASSAY(Cobas e 411,Unicel DxI600,vitros ECI)

VITAMIN B12				
VITAMIN B12	179	pg/mL		CLIA
180 - 814 Normal				
145 - 180 Intermediate				
145.0 Deficient pg/ml				

Summary :-

Nutritional & macrocytic anemias can be caused by a deficiency of vitamin B12. This deficiency can result from diets devoid of meat & bacterial products, from alcoholism or from structural / functional damage to digestive or absorptive processes. Malabsorption is the major cause of this deficiency.

URINE EXAMINATION REPORT

Colour-U	STRAW		Light Yellow	
Appearance (Urine)	CLEAR		Clear	
Specific Gravity	1.010		1.005 - 1.025	
pH-Urine	Neutral (7.0)		4.5 - 8.0	
PROTEIN	Absent	mg/dl	ABSENT	Dipstick
Glucose	0.5 gm/dl			
Ketones	Absent		Absent	
Bilirubin-U	Absent		Absent	
Blood-U	Absent		Absent	
Urobilinogen-U	0.20	EU/dL	0.2 - 1.0	
Leukocytes-U	Absent		Absent	
NITRITE	Absent		Absent	

MICROSCOPIC EXAMINATION

Pus cells / hpf	Occasional	/hpf	< 5/hpf
Epithelial Cells	Occasional	/hpf	0 - 5
RBC / hpf	Nil		< 3/hpf



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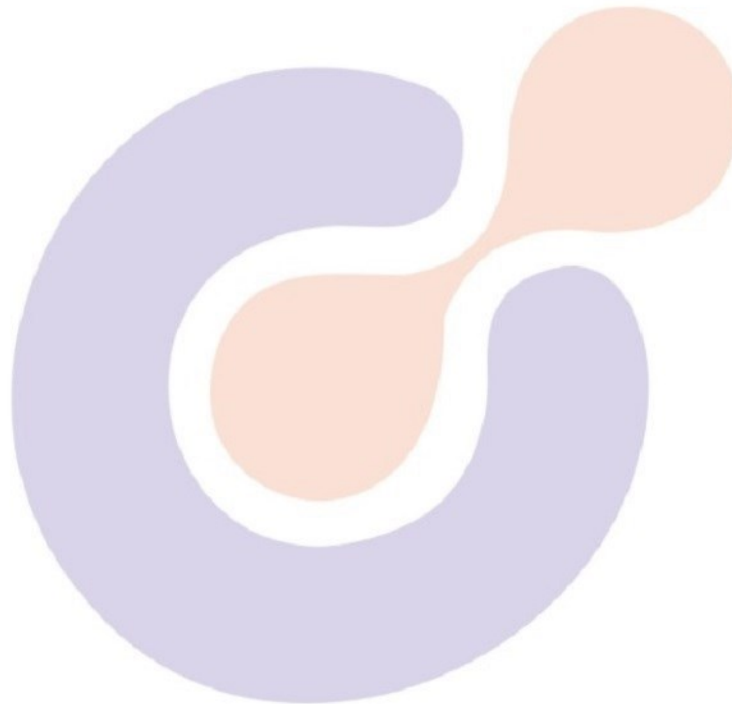
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Test Name	Result	Unit	Bio. Ref. Range	Method
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EXMAMINATION,HBA1C (EDTA),PP,FASTING



Test Name	Result	Unit	Bio. Ref. Range	Method
FASTING				
Blood Sugar Fasting	176.0	mg/dl	70 - 110	Hexokinase
PP				
Blood Sugar PP	289.5	mg/dl	up to - 170	Hexokinase
SERUM CREATININE				
CREATININE	0.60	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
LIPID-PROFILE				
TOTAL CHOLESTEROL	213.00	mg/dL	Desirable: <200 mg/dl Borderline-high: 200-239 mg/dl High:>/=240 mg/dl	CHOD-PAP
TRIGLYCERIDES	198.00	mg/dL	Normal: <150 mg/dl Borderline-high:150 - 199 mg/dl High: 200 - 499 mg/dl Very high:>/=500 mg/dl	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	51.70	mg/dL	30-70 mg/dl	CHER-CHOD-PAP
L D L CHOLESTEROL	121.70	mg/dL	Optimal:<100 mg/dl Near Optimal:100 - 129 mg/dl Borderline High: 130 - 159 mg/dl High: 160 - 189 mg/dl Very High:>/= 190 mg/dl	CO-PAP
VLDL	39.60	mg/dL	10 - 40	Calculated



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Test Name	Result	Unit	Bio. Ref. Range	Method
TSH				
TSH	2.29	uIU/ml	0.47 - 4.52	ECLIA

Note

- (1) Patients having low T3 & T4 levels but high TSH levels suffer from primary hypothyroidism,cretinism,juvenile mysedema or autoimmune disorders.
- (2) Patients having low T3 & T4 levels but high TSH levels suffer from grave~s disease, toxic adenoma or sub-acute thyroiditis.
- (3) Patients having either low or normal T3 & T4 levels but low TSH values suffer from iodine deficiency or secondary hypothyroidism.
- (4) Patients having high T3 & T4 levels but normal TSH levels may suffer from toxic multinodular goitre. This condition is mostly asymptomatic and may cause transient hyperthyroidism but no persistent symptoms.
- (5) Patient with high or normal T3 & T4 levels and low or normal TSH levels suffer either from T3 toxicosis or T4 Toxicosis respectively.
- (6) In patients with non thyroidal illness abnormal test results are not necessarily indicative of thyroidism but may be due to adaptation to the cacabolic state and may revert tonormal when the patient recovers.
- (7) There are many drugs for eg.Glucocorticoids ,dopamine,Lithium,iodides ,oral radiographic dyes,ets.Which may affect the thyroid function tests.
- (8) Generally when total T3& T4 results are indecisive then Free T3 & Free T4 test are recommended for further confirmation along with
(1 Beckman DxI-600 2. ELECTRO-CHEMILUMINISCENCE TECHINIQUE BY ELECSYSYS -E411)

*** End Of Report ***

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PATHOLOGIST PATHOLOGIST PATHOLOGIST

Signature

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SKIAGRAM BOTH KNEE AP AND LATERAL

- Bone density is reduced.
- Articular surfaces show osteophytosis.
- Joint spaces are reduced in medial tibio-femoral compartments (right >left) with sclerosis of articular surfaces.
- Tibial spines are prominent.

OPINION:

- **OSTEOARTHRITIC CHANGES BOTH KNEE JOINTS.**

Clinical correlation is necessary.

[DR. RAJESH KUMAR SHARMA, MD]

Transcribed by Gausiya

*** End Of Report ***

