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DIAGNOSTICS Pvt. Ltd.

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9415577933, 9336154100, **Tollfree No.**: 8688360360
E-mail : charak1984@gmail.com
CMO Reg. No. RMEE 2445133
NABL Reg. No. MC-2491
Certificate No. MIS-2023-0218

Patient Name	: Mr. VIRENDRA KUMAR SHARMA	Visit No	: CHA250034506
Age/Gender	: 58 Y 0 M 0 D /M	Registration ON	: 26/Feb/2025 09:26AM
Lab No	**: 10131802**	Sample Collected ON	: 26/Feb/2025 09:27AM
Referred By	: Dr.SHALINI	Sample Received ON	: 26/Feb/2025 09:42AM
Refer Lab/Hosp	: CGHS (BILLING)	Report Generated ON	: 26/Feb/2025 11:44AM
Doctor Advice	: HBA1C (EDTA),PP,FASTING,PSA-TOTAL,USG WHOLE ABDOMEN,TSH,25 OH vit. D,VIT B12,KIDNEY FUNCTION TEST - I,LFT,CBC+ESR		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
CBC+ESR (COMPLETE BLOOD COUNT)				
Erythrocyte Sedimentation Rate ESR	4.00		0 - 20	Westergreen

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DR. SHADAB
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MD (MICROBIOLOGY)

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PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Glycosylated Hemoglobin (HbA1c)	5.5	%	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

25 OH vit. D				
25 Hydroxy Vitamin D	23.56	ng/ml		ECLIA

Deficiency < 10
Insufficiency 10 - 30
Sufficiency 30 - 100
Toxicity > 100

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

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Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12				
VITAMIN B12	**115.0**	pg/mL	180 - 814 Normal 145 - 180 Intermediate 145.0 Deficient pg/ml	CLIA

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 absorpative processes. Malabsorption is the major cause of this deficiency.

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PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
CBC+ESR (COMPLETE BLOOD COUNT)				
Hb	**17.1**	g/dl	12 - 15	Non Cyanide
R.B.C. COUNT	**5.30**	mil/cmm	3.8 - 4.8	Electrical Impedence
PCV	**52.0**	%	36 - 45	Pulse hieght detection
MCV	**98.1**	fL	80 - 96	calculated
MCH	32.3	pg	27 - 33	Calculated
MCHC	32.9	g/dL	30 - 36	Calculated
RDW	13	%	11 - 15	RBC histogram derivation
RETIC	0.9 %	%	0.5 - 2.5	Microscopy
TOTAL LEUCOCYTES COUNT	6400	/cmm	4000 - 10000	Flocytrometry
DIFFERENTIAL LEUCOCYTE COUNT				
NEUTROPHIL	58	%	40 - 75	Flowcytrometry
LYMPHOCYTE	34	%	20-40	Flowcytrometry
EOSINOPHIL	4	%	1 - 6	Flowcytrometry
MONOCYTE	4	%	2 - 10	Flowcytrometry
BASOPHIL	**0**	%	00 - 01	Flowcytrometry
PLATELET COUNT	198,000	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	198000	/cmm	150000 - 450000	Microscopy .
Mentzer Index	19			
Peripheral Blood Picture	:			

Red blood cells are normocytic normochromic. Platelets are adequate. No immature cells or parasite seen.

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PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
FASTING				
Blood Sugar Fasting	109.1	mg/dl	70 - 110	Hexokinase
PP				
Blood Sugar PP	123.2	mg/dl	up to - 170	Hexokinase
LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.64	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.28	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.36	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	**130.00**	U/L	30 - 120	PNPP, AMP Buffer
SGPT	**49.9**	U/L	5 - 40	UV without P5P
SGOT	38.9	U/L	5 - 40	UV without P5P
KIDNEY FUNCTION TEST - I				
Sample Type : SERUM				
BLOOD UREA	16.20	mg/dl	15 - 45	Urease, UV, Serum
CREATININE	0.90	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
SODIUM Serum	135.0	MEq/L	135 - 155	ISE Direct
POTASSIUM Serum	5.0	MEq/L	3.5 - 5.5	ISE Direct

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Test Name	Result	Unit	Bio. Ref. Range	Method
TSH				
TSH	1.50	ulU/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)

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Test Name	Result	Unit	Bio. Ref. Range	Method
PSA-TOTAL				
PROSTATE SPECIFIC ANTIGEN	1.57	ng/mL	0.2-4.0	CLIA

COMMENT : 1. Prostate specific antigen (PSA) is useful for diagnosis of disseminated CA prostate & its equential measurement is the most sensitive measure of monitoring treatment of disseminated CA prostate with its shorter half life (half life of 2.2 days only) it is superior to prostatic acis phosphatase(PAP). PSA is elevated in nearly all patients with stage D carcinoma whereas PAP is elevated in only 45 % of patient. Mild PSA elevation are also reported in some patients of BHP.
2. Blood samples should be obtained before prostate biopsy or prostatecomy or prostatic massage or digital pre rectal examination as it may result intrasient levation of PSA value for few days.

NOTE :- PSA values obtained in different types of PSA assay methods cannot be used interchangeably as the PSA value in a given sample varies with assays from different manufactures due to difference in assay methodology and reagent specificity. If in the course of monitoring a patient the assay method used for determination is changed, additional sequential testing should be carried out to confirm baseline value.

DONE BY;
Enhanced Chemiluminescence "VITROS ECI"

***** End Of Report *****

MC-2491
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PR.

ULTRASOUND STUDY OF WHOLE ABDOMEN

- **Liver** is mildly enlarged in size, and shows homogenously increased echotexture of liver parenchyma. No intrahepatic biliary radicle dilatation is seen. No space occupying lesion is seen. Hepatic veins and IVC are seen normally.
- **Gall bladder** is normal in size. **Few tiny echogenic foci with comet tail artifacts are seen in gall bladder wall.** No calculus is seen.
- **CBD** is normal at porta. No obstructive lesion is seen.
- **Portal vein** Portal vein is normal at porta.
- **Pancreas** is normal in size and shows homogenous echotexture of parenchyma. PD is not dilated. No parenchymal calcification is seen. No peripancreatic collection is seen.
- **Spleen** is normal in size and shows homogenous echotexture of parenchyma. No SOL is seen.
- No retroperitoneal adenopathy is seen. No ascites is seen.
- **Both kidneys** are normal in size and position. No hydronephrosis is seen. A simple cortical cyst measuring 30x27mm is seen in mid pole of left kidney .No calculus is seen. Cortico-medullary differentiation is well maintained. Parenchymal thickness is normal. No scarring is seen. Right kidney measures 106 x 43 mm in size. Left kidney measures 104 x 47 mm in size.
- **Ureters** Both ureters are not dilated. UVJ are seen normally.
- **Urinary bladder** is normal in contour with anechoic lumen. No calculus or mass lesion is seen. UB walls are not thickened.
- Bilateral seminal vesicles are seen normally.
- **Prostate** is enlarged in size measures 41 x 49 x 47 mm with weight of 51 gms and shows homogenous echotexture of parenchyma. No mass lesion is seen. Median lobe is enlarged bulging into base of bladder .
- **Pre void urine volume approx. 315cc.**
- **Post void residual urine volume of approx. 100cc.**

OPINION:

- **MILD HEPATOMEGALY WITH FATTY INFILTRATION OF LIVER GRADE-I.**
- **FEW TINY ECHOGENIC FOCI WITH COMET TAIL ARTIFACTS IN GALL BLADDER WALL--? CHOLESTEROLOSIS CHANGES/ ADENOMYOMATOSIS.** *ADV: FOLLOW UP.*
- **PROSTATOMEGALY GRADE II WITH MEDIAN LOBE ENLARGEMENT …..ADV: PSA.**
- **SIGNIFICANT POST VOID RESIDUAL URINE VOLUME .**

Clinical correlation is necessary.

[DR. R.K SINGH , MD]

***** End Of Report *****