Charak dhar DIAGNOSTICS Pvt. Ltd.

292/05, Tulsidas Marg, Basement Chowk, Lucknow-226 003
Phone : 0522-4062223, 9305548277, 8400888844
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	: Ms.UQBA BUTOOL	Visit No	: CHA250042963
Age/Gender	: 17 Y/F	Registration ON	: 10/Mar/2025 12:27PM
Lab No	**: 10140258**	Sample Collected ON	: 10/Mar/2025 12:33PM
Referred By	: Dr.LOTUS HOSPITAL	Sample Received ON	: 10/Mar/2025 12:32PM
Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 10/Mar/2025 03:40PM
Doctor Advice	: USG WHOLE ABDOMEN,WIDAL,CRP (Quantitative),TSH,BLOOD GROUP,BTCT,CREATININE,DLC,GBP,HB,HBsAg (QUANTITATIVE),HCV,LFT,NA+K+,PLAT COUNT,PT/PC/INR,TLC,UREA,RANDOM,HIV		

PR.

PRE SURGICAL (RD1)

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP				
Blood Group	''AB''			
Rh (Anti -D)	**POSITIVE**			
CRP-QUANTITATIVE				
CRP-QUANTITATIVE TEST	**14.7**	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 measurment 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 apparrently 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

PT/PC/INR			
PROTHROMBIN TIME	13 Second	13 Second	Clotting Assay
Protrhromin concentration	100 %	100 %	
INR (International Normalized Ratio)	1.00	1.0	

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DR. NISHANT SHARMA PATHOLOGIST
DR. SHADAB PATHOLOGIST
DR. ADITI D AGARWAL PATHOLOGIST

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PRE SURGICAL (RD1)

Test Name	Result	Unit	Bio. Ref. Range	Method
WIDAL				
Sample Type : SERUM				
SALMONELLA TYPHI O	1/40			
SALMONELLA TYPHI H	1/40			
NOTE:	Negative			
HBsAg (HEPATITIS B SURFACE ANTIGEN)				
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE		< 1.0 : NON REACTIVE~> 1.0 : REACTIVE	(Sandwich Assay)
HIV				
HIV-SEROLOGY	NON REACTIVE		<1.0 : NON REACTIVE >1.0 : REACTIVE	
HCV				
Anti-Hepatitis C Virus Antibodies.	NON REACTIVE		< 1.0 : NON REACTIVE > 1.0 : REACTIVE	Sandwich Assay
BT/CT				
BLEEDING TIME (BT)	3 mint 15 sec	mins	2 - 8	
CLOTTING TIME (CT)	6 mint 30 sec		3 - 10 MINS.	

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PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
HAEMOGLOBIN				
Hb	**11.6**	g/dl	12 - 15	Non Cyanide

Comment:
Hemoglobin screening helps to diagnose conditions that affect RBCs such as anemia or polycythemia.

TLC				
TOTAL LEUCOCYTES COUNT	7100	/cmm	4000 - 10000	Flocytrometry
DLC				
NEUTROPHIL	63	%	40 - 75	Flowcytrometry
LYMPHOCYTE	31	%	20-40	Flowcytrometry
EOSINOPHIL	2	%	1 - 6	Flowcytrometry
MONOCYTE	4	%	2 - 10	Flowcytrometry
PLATELET COUNT				
PLATELET COUNT	**146,000**	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	160000	/cmm	150000 - 450000	Microscopy .

COMMENTS:
Platelet counts vary in various disorders; acquired, (infections-bacterial and viral), inherited, post blood transfusion, autoimmune and idiopathic disorders.

GENERAL BLOOD PICTURE (GBP)

Peripheral Blood Picture :

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

BLOOD SUGAR RANDOM				
BLOOD SUGAR RANDOM	96.6	mg/dl	70 - 170	Hexokinase
NA+K+				
SODIUM Serum	136.0	MEq/L	135 - 155	ISE Direct
POTASSIUM Serum	3.7	MEq/L	3.5 - 5.5	ISE Direct
BLOOD UREA				
BLOOD UREA	16.50	mg/dl	15 - 45	Urease, UV, Serum

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MD (MICROBIOLOGY)

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Test Name	Result	Unit	Bio. Ref. Range	Method
SERUM CREATININE				
CREATININE	0.60	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.71	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.15	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.56	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	87.20	U/L	55 - 149	PNPP, AMP Buffer
SGPT	34.0	U/L	5 - 40	UV without P5P
SGOT	32.0	U/L	5 - 40	UV without P5P
TSH				
TSH	1.80	ulU/ml	0.7 - 6.4	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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PR.

ULTRASOUND STUDY OF WHOLE ABDOMEN

- **Liver** is **mildly enlarged in size (~163mm)** and shows homogenous 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 and shows anechoic lumen. No calculus / mass lesion is seen. GB walls are not thickened.
- **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.
- **Few subcentimeteric mesenteric lymphnodes are seen measuring upto approx 9.8 x 8.2mm (non specific)**.
- No ascites is seen.
- **Both kidneys** are normal in size and position. No hydronephrosis is seen. **A tiny concretion is seen at mid pole of left kidney measuring approx 2.3mm.** No mass lesion is seen. Cortico-medullary differentiation is well maintained. Parenchymal thickness is normal. No scarring is seen. Right kidney measures 92 x 36 mm in size. Left kidney measures 93 x 43 mm in size.
- **Ureters** Both ureters are not dilated. UVJ are seen normally.
- **Urinary bladder** is *partially distended* with anechoic lumen. No calculus or mass lesion is seen. UB walls are not thickened.
- **Uterus** is normal in size, measures 63 x 34 x 27 mm and shows homogenous myometrial echotexture. Endometrial thickness measures 6.3 mm. No endometrial collection is seen. No mass lesion is seen.
- **Cervix** is normal.
- **Both ovaries** are normal in size and echotexture.
- No adnexal mass lesion is seen.
- No free fluid is seen in Cul-de-Sac.

OPINION:

- **MILD HEPATOMEGALY.**
- **TINY LEFT RENAL CONCRETION.**
- **FEW SUBCENTIMETERIC MESENTERIC LYMPHNODES (NON SPECIFIC)**.

Clinical correlation is necessary.

[DR. R. K. SINGH, MD]

Transcribed by Gausiya

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