DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : B MANJHI	**REF. DOCTOR :** DR. SADAR HOSPITAL	
B MANJHI	ACCESSION NO : **0707XG000001**	AGE/SEX : 69 Years Male
	PATIENT ID : BMANM310155707	DRAWN : 01/07/2024 08:48:58
	CLIENT PATIENT ID:	RECEIVED : 01/07/2024 08:51:45
	ABHA NO :	REPORTED : 01/07/2024 17:37:34

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	**7.8 Low**	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	**4.01 Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	6.10	4.0 - 10.0	thou/µl
PLATELET COUNT	234	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	**25.7 Low**	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV)	**64.0 Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**19.5 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	**30.4 Low**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**18.0 High**	11.6 - 14.0	%
MENTZER INDEX	16.0		
MEAN PLATELET VOLUME (MPV)	10.2	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	64	40 - 80	%
LYMPHOCYTES	28	20 - 40	%
MONOCYTES	05	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	3.90	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.71	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.30	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.18	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.3		

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ULR No.775000008214370-0707

DIAGNOSTIC REPORT

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B MANJHI	ACCESSION NO : **0707XG000001** PATIENT ID : BMANM310155707 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :69 Years Male DRAWN :01/07/2024 08:48:58 RECEIVED :01/07/2024 08:51:15 REPORTED :01/07/2024 17:37:34

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HAEMATOLOGY

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	**86 High**	0 - 14	mm at 1 hr

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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DIAGNOSTIC REPORT

MC-6746

agilus diagnostics

PATIENT NAME : B MANJHI		**REF. DOCTOR : SELF**
CODE/NAME & ADDRESS : CR00000048 - KIT DOWN KIT DOWN SADAR HOSPITAL, BOKORO SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY, BOKARO 827001 7260813496	ACCESSION NO : **0031XG004836** PATIENT ID : BMANM06075531 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :69 Years Male DRAWN :01/07/2024 08:07:00 RECEIVED :06/07/2024 12:56:38 REPORTED :06/07/2024 14:36:49

CLINICAL INFORMATION :

0707XG000001

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.40	0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT			
BILIRUBIN, DIRECT	0.14	0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION			
BILIRUBIN, INDIRECT	0.26	0.1 - 1.0	mg/dL
METHOD : CALCULATED			
TOTAL PROTEIN	7.5	5.80 - 8.10	g/dL
METHOD : BIURET			
ALBUMIN	3.7	3.2 - 4.6	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)			
GLOBULIN	**3.8 High**	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.0	1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	13	5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	6	0 - 55	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)			
ALKALINE PHOSPHATASE	**277 High**	40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE			
GAMMA GLUTAMYL TRANSFERASE (GGT)	32	11 - 59	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD			
LACTATE DEHYDROGENASE	199	125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE			

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.A

A Chatterjee

Dr.Anwesha Chatterjee
Pathologist

Dr. Chaitali Ray, PHD
Biochemist

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CIN - U74899PB1995PLC045956

ULR No.31000005054074-0031

DIAGNOSTIC REPORT

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PATIENT NAME : B MANJHI	REF. DOCTOR : DR. SADAR HOSPITAL	
B MANJHI	ACCESSION NO : 0707XG000001	AGE/SEX : 69 Years Male
	PATIENT ID : BMANM310155707	DRAWN : 01/07/2024 08:48:58
	CLIENT PATIENT ID:	RECEIVED : 01/07/2024 08:51:15
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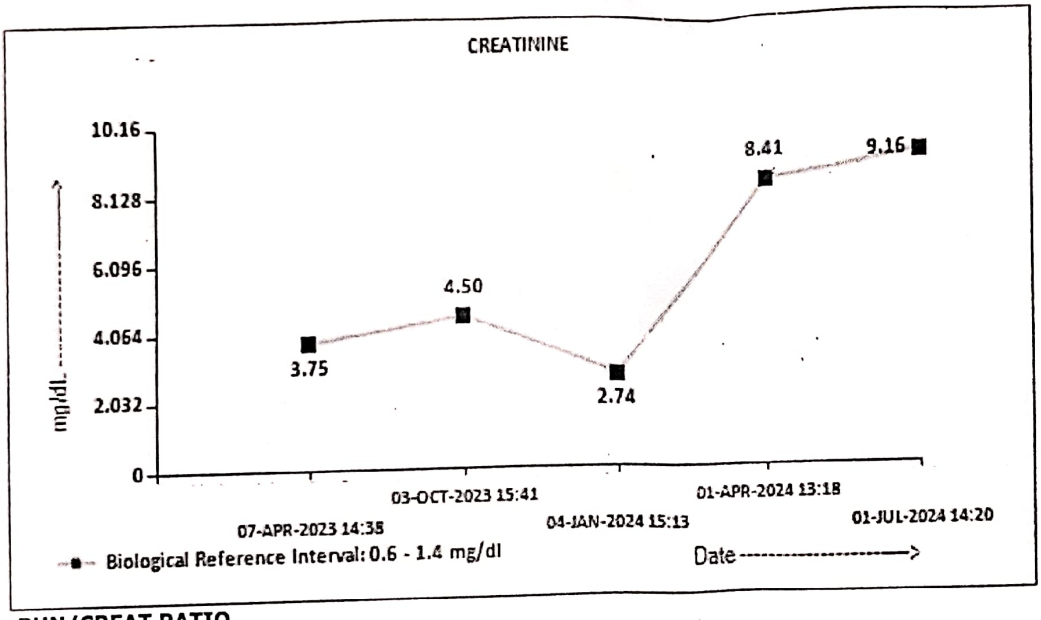
Test Report Status Final	Results	Biological Reference Interval	Units

BIOCHEMISTRY

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	**44 High**	6 - 22	mg/dL
CREATININE, SERUM			
CREATININE	**9.16 High**	0.6 - 1.4	mg/dL



BUN/CREAT RATIO			
BUN/CREAT RATIO	**4.80 Low**	5.0 - 15.0	
CALCIUM, SERUM			
CALCIUM	**7.3 Low**	8.4 - 10.4	mg/dL

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ULR No.775000008214370-0707

DIAGNOSTIC REPORT

MC-5746

agilus diagnostics

PATIENT NAME : B. MANJHI		**REF. DOCTOR : SELF**
CODE/NAME & ADDRESS : CR00000044 - AGILUS AGILUS PATHLABS REACH LIMITED OPD PATIENTS SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY, BOKARO 827001 7260813496	ACCESSION NO : **0031XG001170** PATIENT ID : BMANM02075531 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :69 Years Male DRAWN :01/07/2024 08:07:00 RECEIVED :02/07/2024 12:04:43 REPORTED :02/07/2024 13:50:57

CLINICAL INFORMATION :

0707XG000001

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
URIC ACID, SERUM			
URIC ACID METHOD : URICASE	6.7	3.5 - 7.2	mg/dL

Interpretation(s)
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis

****End Of Report****
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CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

Agilus Diagnostics Limited
Fortis Hospital, Sector 62, Phase VIII,
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AChatterjee

Dr.Anwesha Chatterjee
Pathologist

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Dr. Chaitali Ray, PHD
Biochemist

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ULR No.31000005050401-0051

DIAGNOSTIC REPORT

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PATIENT NAME : B MANJHI		**REF. DOCTOR :** DR, SADAR HOSPITAL
B MANJHI	ACCESSION NO : 0707XG000001 PATIENT ID : BMANM310155707 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 69 Years Male DRAWN : 01/07/2024 08:48:58 RECEIVED : 01/07/2024 08:51:15 REPORTED : 01/07/2024 17:37:34

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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	**131.1 Low**	135.0 - 148.0	mmol/l
POTASSIUM, SERUM	4.31	3.5 - 5.3	mmol/L
CHLORIDE, SERUM	104.7	98.0 - 107.0	mmol/l

Interpretation(s)

Sodium	Potassium	Chloride
Decreased In: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), antipsychotics.	**Decreased In:** Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	**Decreased In:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased In: Dehydration (excessivesweating, severe vomiting or diarrhea), diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	**Increased In:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	**Increased In:** Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	**Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	**Interferences:** Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-**Higher than normal level may be due to:**
• Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)
Lower than normal level may be due to:• Myasthenia Gravis, Muscuophy
CALCIUM, SERUM-**Common causes of decreased value of calcium (hypocalcemia)** are chronic renal failure, hypomagnesemia and hypoalbuminemia.
Hypercalcemia (increased value of calcium) can be caused by Increased intestinal absorption (vitamin D intoxication), increased skeletal reabsorption (immobilization) or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95% of all cases of hypercalcemia.
Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels. The following regression equation may be helpful.

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ULR No.775000008214370-070

DIAGNOSTIC REPORT

agilus diagnostics

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EIA - INFECTIOUS SECTION

HEPATITIS B SURFACE ANTIGEN, SERUM

HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	NON REACTIVE	

HEPATITIS C ANTIBODIES, SERUM

HEPATITIS C ANTIBODIES	NON REACTIVE	NON REACTIVE	

Interpretation(s)

HEPATITIS B SURFACE ANTIGEN, SERUM-**Hepatitis B** is caused by infection with HBV, a enveloped DNA agent that is classified as hepadnavirus. This test detects the presence of viral surface antigen i.e HBsAg also known as "Australia antigen" in serum sample and is indicative of HBV infection, either acute or chronic.

Test Utility: HBsAg is the first serologic marker appearing in the serum 6-16 weeks following hepatitis B viral infection. In typical HBV infection, HBsAg will be detected weeks before the liver enzyme levels (ALT) become abnormal and 3-5 weeks before patient develops jaundice. In acute cases HBsAg usually disappears 1-2 months after the onset of symptoms. Persistence of HBsAg for more than 6 months indicates development of either a chronic carrier state or chronic liver disease.The presence of HBsAg is frequently associated with infectivity. HBsAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.

Limitations: For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection. If the antibody results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.HBsAg detection will only indicate the presence of surface antigens in the serum and should not be used as the sole criteria for diagnosis, staging or monitoring of HBV infection. This test may be negative during "window period" after disappearance of anti-HBsAg antibody.The current assay being a highly sensitive test may yield a small percentage of false positive reports. Hence all HBsAg positive specimens should be confirmed with an assay based upon Neutralisation of Human anti Hepatitis B Surface antibody.

HEPATITIS C ANTIBODIES, SERUM-**Hepatitis C Virus (HCV)** is a blood borne flavivirus. It is one of the most important causes of post-blood transfusion as well as community acquired non-A non-B hepatitis and chronic liver failure. Although the majority of infected individuals may be asymptomatic, HCV infection may develop into chronic hepatitis, cirrhosis and/or increased risk of hepatocellular carcinoma.

Notes & Limitations: HCV antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance of the first biochemical marker of illness) and is almost always detectable by the late convalescent stage of infection. A negative result may also be observed due to loss of HCV antigen, years following resolution of infection. Infants born to hepatitis C infected mothers may have delayed seroconversion to anti-HCV. Hence a negative result should be evaluated cautiously with respect to clinical findings. It is to be noted that absence of HCV antibodies after 14 weeks of exposure is strong evidence against HCV infection.Presence of HCV antibodies does not imply an active Hepatitis C infection but is indicative of both past and/or recent infection .It has been reported that as many as 90% of individuals receiving intravenous commercial immunoglobulin test falsely positive for HCV antibody. Also,patients with autoimmune liver disease may show a false positive HCV antibody result. Hence it is advisable to confirm a positive antibody result with a supplemental test. A positive result when followed by a positive supplemental test (i.e HCV-RNA-PCR) suggests active hepatitis C infection.

****End Of Report****

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EIA - INFECTIOUS SECTION

HEPATITIS B SURFACE ANTIGEN, SERUM

HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	NON REACTIVE

HEPATITIS C ANTIBODIES, SERUM

HEPATITIS C ANTIBODIES	NON REACTIVE	NON REACTIVE

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ULR No.775000008214370-070

Reg. No. 2035500207

Mob. : 7856066080, 9304967550

MICRO DIAGNOSTIC CENTRE

PLOT NO. - 15, CO-OPERATIVE COLONY
BOKARO STEEL CITY-827001

INVESTIGATION REPORT

Name Mr Bagbrai Manjhi ..... Age 65 Y. Sex M.

Ref. by Dr. ..... Date 5.7.2024

HAEMATOLOGY

TEST	RESULT	Normal Range
Haemoglobin		14.5 gms/b 1 (M)
Total WBC Count		4,000-11,000 cumm
Total RBC Count		4.5-6.5 mill/cumm
Platelate Count		1.5-3.5 lakh/cumm
P.C.V.		

W.B.C. DIFFRENTIAL

Neutrophil	55-70%
Lymphocyte	20-35%
Eosinophil	1-4%
Monocyte	2-5%
Basophil	0-1%
Nucleated RBC	
ESR- 1st hr.	up to 15 mm (M)
ESR - 2nd hr.	
M.P.	M.F.

B.T.	Mts	Sec.	1 min - 6 min
C.T.	Mts	Sec.	2 min - 10 min

SEROLOGY

(ABO) Blood Group	R.H.
V,.D.R.L. (H)	K.T.
V.D.R.L. (W)	K.T.
R.A. Factor	
C.R. Protein	
A.S.O. Titer	
(Below 200 IU/Ml)	
Aust. Antigen	

MANTOUX TEST

[Negative<5mm, Doubt Full 5-9 mm, Positive>9mm]

P.P.D. TU

WIDAL	1/20	1/40	1/80	1/160	1/320
TO					
TH					
AH					
BH					

BIOCHEMISTRY

Test	Result	Normal Range
Blood Sugar (Fasting)	mg%	(60-110 mg%)
Blood Suger (P.P.)	mg%	(80-150 mg%)
Blood Suger (Random)	mg%	(80-140 mg%)
Blood Urea	mg%	(14 - 40 mg%)
Serum creatinine	mg%	(0.6 - 1.6 mg%)
Serum Uric Acid	mg%	(2-5-7.0 mg%)
Serum Cholesterol	mg%	(150 - 250 mg%)
Triglyceride	mg%	(70 - 180 mg%)
H.D.L.	mg%	(35 - 60 mg%)
L.D.L.	mg%	(<150 mg%)
Serum Billirubin Total	mg%	(0.3 - 0.9 mg%)
Direct	mg%	(0.2-0.6 mg%)
Indirect	mg%	
Serumalkaline phosphate	U/L	(40-210 U/L)
SGPT	U/L	(5-40 U/L)
SGOT	U/L	(5 - 35 U/L)
Total Protein	gm%	(6.0 - 7.5 gm%)
Albumin	gm%	(3.8-5.1 gm%)
Globulin	gm%	(1.8 - 3.8 gm%)
A.G. Ratio	gm%	(1.2-2.1:2)
Serum Calcium	mg%	(9.0-11.0 mg%)
Inorganic Phosphours	mg%	(2.0 - 6.0 mg%)
Sodium	meq/L	(136-140meq/L)
Potassium	meq/L	(3.8-5.0 meq/L)
Chloride	meq/L	(95-103 meq/L)
Bicarbonate	meq/L	(21-28 meq/L)
CPK	U/L	(50-170 U/L)
Sr. Amylase	U/L	(40-110 U/L)

P.B.S.

HIV Test— NEGATIVE.

1) If the Report is alarming or unexpected please contact The Lab Immedietly for revial to Result
2) Not For Medico - Legal Purposes.
3) Please correlate with clinical condition.

P.T.O.

Sr. Technologist

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : B MANJHI	REF. DOCTOR : DR. SADAR HOSPITAL	
B MANJHI	ACCESSION NO : 0707XG000001	AGE/SEX : 69 Years Male
	PATIENT ID : BMANM310155707	DRAWN : 01/07/2024 08:48:58
	CLIENT PATIENT ID :	RECEIVED : 01/07/2024 08:51:15
	ABHA NO :	REPORTED : 02/07/2024 13:56:42

Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - ANEMIA

SERUM IRON AND TIBC STUDIES			
IRON	36 Low	65 - 175	µg/dL
METHOD : FERENE			
TOTAL IRON BINDING CAPACITY	285	250 - 450	µg/dL
METHOD : CALCULATED PARAMETER			
% SATURATION	13	13 - 45	%

Interpretation(s)
SERUM IRON AND TIBC STUDIES-Total iron binding capacity (TIBC) measures the blood's capacity to bind iron with transferrin and thus is an indirect way of assessing transferrin level.
Taken together with serum iron and percent transferrin saturation this test is performed when they is a concern about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, alterations in liver function (such as cirrhosis, hepatitis, or liver failure) must be considered when performing this test.
Increased in:
- iron deficiency
- acute and chronic blood loss
- acute liver damage
- progesterone birth control pills

Decreased in:
- hemochromatosis
- cirrhosis of the liver
- thalassemia
- anemias of infection and chronic diseases
- nephrosis
- hyperthyroidism

The percent Transferrin saturation = Serum Iron/TIBC x 100
Unsaturated Binding Capacity (UIBC)=TIBC - Serum Iron.
Limitations: Estrogens and oral contraceptives increase TIBC and Asparaginase, chloramphenicol, corticotropin, cortisone and testosterone decrease the TIBC level.

Reference:
1.Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 563, 1314-1315.
2. Wallach's Interpretation of Diagnostic tests, 9th Edition, Ed Mary A Williamson and L Michael Snyder, Pub Lippincott Williams and Wilkins, 2011, 234-235.

****End Of Report****
Please visit www.agilusdiagnostics.com for related Test Information for this accession

Dr. Chaitali Ray, PHD
Chief Biochemist cum MRQA

Dr.Anwesha Chatterjee,MD,DipRCPath
(Histopathology)
Pathologist

View Details View Report

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West Bengal, India
Tel : 9111591115, Fax : 30203412
CIN : U74899PB1995PLC045956

ULR No.77500000821437O-0031

OPD SLIP

मुस्कान हॉस्पीटल
एण्ड रिसर्च सेन्टर

Dr. S. C. Munshi
MBBS, DCH, MD (Paeds)
Consultant Paediatrician & Neonatologist
Time : 9:30 am to 01:30 pm
(Sunday Off)

Dr. Irfan Ansari
MBBS, MS (Gen. Surgery)
Consultant Laparoscopic & Cancer Surgeon
Time : 10:30 am to 02:30 pm
(Friday Evening Off)

Dr. Md. Shahnawaj Anwar
MBBS, MD (Med.)
Consultant Physician
Cardiologist & Diabetologist
Time : 11:00 am to 02:30 pm
07:00 pm to 08:00 pm
(Sunday Evening Off)

Dr. Manoj Kr. Srivastava
MBBS, AFMC (PUNE)
Child Specialist, General Physician & Surgeon
Time : 11:30 am to 02:00 pm

Muskan Ruganalya (P) Ltd.
Undertaking
Muskan SUPERSPECIALITY Centre
Plot No. : S-3, City Centre,
Beside M-Bazar, Sector - IV,
Bokaro Steel City (Jharkhand)
[Near Samarjit Gas Agency]
Ph. : 06542-231335, 08877080738

Facilities Available :

Gastroenterology Department :
- Upper GI Endoscopy
- Variceal Band Ligation.
- Sclerotherapy
- Colonoscopy
- ERCP.

Eye Department :
- Phaco Surgery & OCT etc.
- Ben Franklin Optical Point

Neuro Surgery Deparment :
- OPD.

Name : Bagni Manjhi
Age/Sex: 70/m
Weight

MUSKAN Hospital &Research Centre

Date : 08 JUL 2024

CKD on
MHD
Hypothyroidism

C/o
F/U case

O/E
BP 140/80 mmHg
HR 83/m
SPO₂ - 93%
Chest
CVS / NAD

MHD thrice/week

Inj EPO. 4000 unit SC
3/week
Livogen syp.
Eltroxin 50 mcg
Amlodipine 5 mg.
F/A 5 mg.
Calcium acetate TDS
Calcium carbonate 60K / wk.
Torsemide 40
AD

Vit. D

Report दिखाने का समय
1 : 15 PM to 1 : 45 PM
EXCEPT FRI & SUN

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Not for medico legal purpose