DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : BIJALI RANI DEVI	**REF. DOCTOR :** DR. SADAR HOSPITAL	
	ACCESSION NO : **0707XG000948**	AGE/SEX : 50 Years Female
	PATIENT ID : BIJAF090474707	DRAWN : 17/07/2024 11:59:04
	CLIENT PATIENT ID:	RECEIVED : 17/07/2024 12:02:03
	ABHA NO :	REPORTED : 17/07/2024 18:33:07

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)	**8.7 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	**3.27 Low**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	4.60	4.0 - 10.0	thou/µL
PLATELET COUNT	**94 Low**	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	**26.3 Low**	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	**80.0 Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**26.5 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.0	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**15.7 High**	11.6 - 14.0	%
MENTZER INDEX	24.5		
MEAN PLATELET VOLUME (MPV)	10.5	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	52	40 - 80	%
LYMPHOCYTES	40	20 - 40	%
MONOCYTES	03	2 - 10	%
EOSINOPHILS	05	1 - 6	%
BASOPHILS	0	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.39	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.84	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	**0.14 Low**	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.23	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3		

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

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ULR No.775000008440577-0707

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HAEMATOLOGY

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

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	**80 High**	0 - 20	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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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
TOTAL PROTEIN	7.3	6.0 - 8.3	g/dL
ALBUMIN	3.7	3.2 - 5.0	g/dL
GLOBULIN	3.6	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.0	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	31	0 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	19	0 - 45	U/L
ALKALINE PHOSPHATASE	**190 High**	39 - 118	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	29	0 - 50	U/L
LACTATE DEHYDROGENASE	**579 High**	200 - 450	U/L
KIDNEY FUNCTION TEST			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	**29.40 High**	6 - 22	mg/dL
CREATININE, SERUM			
CREATININE	**4.83 High**	0.6 - 1.2	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	6.09	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	4.8	2.5 - 6.8	mg/dL

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Test Report Status **Final**	Results	Biological Reference Interval	Units
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.3	6.0 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	3.7	3.2 - 5.0	g/dL
GLOBULIN			
GLOBULIN	3.6	2.0 - 4.1	g/dL
CALCIUM, SERUM			
CALCIUM	9.2	8.4 - 10.4	mg/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**131.8 Low**	137 - 145	mmol/L
POTASSIUM, SERUM	**3.40 Low**	3.6 - 5.0	mmol/L
CHLORIDE, SERUM	104.0	98 - 107	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride

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ULR No.775000008440577-0707

1346

SADAR HOSPITAL BOKARO
CAMP 2 BOKARO

Registration No : 20240044201
Visit No : 1 / Token No : 76
Room No : Main Building A,OPD Block,Ground,G.Medicine OPD 9

Dr. Saurabh
Medicine OPD

Name : **Mrs. Bijli Rani Devi**
Sex/Age : **50Y / F**
Department : Medicine

Registration Amount : **Rs. 5**
Mobile No : **9162162790**
Address :BHANDRO(JHARKHAND)
Date of Registration : 11/07/2024 11.47 AM
MLC Patient : NO

Patient Type : General
Guardian Name : MAHAVIR MAHTO(Husband)

A case of MHD

HIV-I
Anti-HCV
HBsAg
KFT
LFT
CBC,
S. Iron
S. electrolytes (Na+, K+, Ca++),

Report for Blood Examn.

HIV-Non-Reactive

CBS-186
22/7/24.

22/7/24

Prepared By: Ms. Kumari Priti

Date Time: 11/07/2024 11.47 AM

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : BIJALI RANI DEVI	**REF. DOCTOR : DR. SADAR HOSPITAL**	
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Test Report Status **Final**	Results	Biological Reference Interval	Units
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 2-4 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" i.e. 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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ULR No.775000008440577-0707

DIAGNOSTIC REPORT

MC-5746

agilus diagnostics

PATIENT NAME : BIJALI RANI DEVI		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : CR00000048 -	ACCESSION NO : **0031XG014961** PATIENT ID : BIJAF18077431 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :50 Years Female DRAWN :17/07/2024 11:07:00 RECEIVED :18/07/2024 13:35:18 REPORTED :18/07/2024 14:41:09

CLINICAL INFORMATION :

0707XG000948

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
BILIRUBIN (TOTAL, DIRECT, INDIRECT), SERUM			
BILIRUBIN, TOTAL	0.30	0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT			
BILIRUBIN, DIRECT	0.13	0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION			
BILIRUBIN, INDIRECT	0.17	0.1 - 1.0	mg/dL
METHOD : CALCULATED			

Interpretation(s)
BILIRUBIN (TOTAL, DIRECT, INDIRECT), 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.

Total Bili- Source: Wallach"s Interpretation of Diagnostic tests, 9th ed
Direct Bili - Source: Tietz Text book of Clinical Chemistry & Molecular Diagnostics, 4th ed

****End Of Report****
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CIN - U74899PB1995PLC045956

ULR No.31000005064205-0031

DIAGNOSTIC REPORT

MC-5746

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Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - ANEMIA			
SERUM IRON AND TIBC STUDIES			
IRON	**42 Low**	50 - 170	µg/dL
METHOD : FERENE			
TOTAL IRON BINDING CAPACITY	**158 Low**	250 - 450	µg/dL
METHOD : CALCULATED PARAMETER			
% SATURATION	27	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, jron 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.

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ULR No.775000008440577-0031

R.N.B HOSPITAL & PAL EYE RESEARCH CENTER

Dr. Mukteshwar Rajak
M.B.B.S., M.D (MEDICINE)
D.M. (NEPHROLOGY)
EX. H.O.D (NEPHROLOGY)
JOINT DIRECTOR (BGH)
Life Member API, Life Member ISN
Sr. CONSULTANT NEPHROLOGIST
TRANSPLANT PHYSICIAN

BP 120/66 mm/Hg
Pulse 69 b/min
SPO₂ 98%

Date: 21/06/24

Patient Name: Bijli Rani Devi Age: 50y Sex: F

BHORRA

A. HTN
• CKD ? On MHD > 5 mo
• 2° Anemia

• Urine for C/S
• CBC
• CXR
• Urine for C/S
• HBA1C
• Kapiwatky
• CXR

Rx

1. Tab CALCIGARD (R) 20 — 1-1 — 60
2. Tab PRAZOPRESS XL — 30
3. Tab Dytor 10 — 30
4. Tab Nirova — 60
5. Tab SEBINIX — 30 — 1/2 — 1
6. Paracetamol — 10
7. Tab Augmentin 625 — 10
8. Inj Zyrop — 4K IU — Twice / WK
9. H.D Twice / WK

27/6/24

Proper UF. Try to achieve dry wt.