

DIAGNOSTIC REPORT

PATIENT NAME : NANDESHWAR YADAV

REF. DOCTOR : DR. SADAR HOSPITAL

ACCESSION NO : **0707XG000653**
 PATIENT ID : **NANDM240377707**
 CLIENT PATIENT ID:
 ABHA NO :

AGE/SEX : 47 Years Male
 DRAWN : 11/07/2024 11:02:09
 RECEIVED : 11/07/2024 11:04:31
 REPORTED : 11/07/2024 17:26:49

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

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

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	6.7 Low	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	2.56 Low	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT	4.60	4.0 - 10.0	thou/ μ L
PLATELET COUNT	142 Low	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	20.5 Low	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV)	80.0 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	26.1 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.6	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	16.8 High	11.6 - 14.0	%
MENTZER INDEX	31.3		
MEAN PLATELET VOLUME (MPV)	8.8	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	70	40 - 80	%
LYMPHOCYTES	22	20 - 40	%
MONOCYTES	05	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	0	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	3.22	2.0 - 7.0	thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT	1.01	1.0 - 3.0	thou/ μ L
ABSOLUTE MONOCYTE COUNT	0.23	0.2 - 1.0	thou/ μ L
ABSOLUTE EOSINOPHIL COUNT	0.14	0.02 - 0.50	thou/ μ L
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.2		

Sanjeev

Dr. Sanjeev Kumar
 Consultant - Pathologist &
 Laboratory Head

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Agilus Pathlabs Reach Limited
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ULR No. 775000008355646-0707

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Test Report Status Final

Results

Biological Reference Interval Units

HAEMATOLOGY

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

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R **42 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, Vasculitides, 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: Polycythemia 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.

Sanjeew

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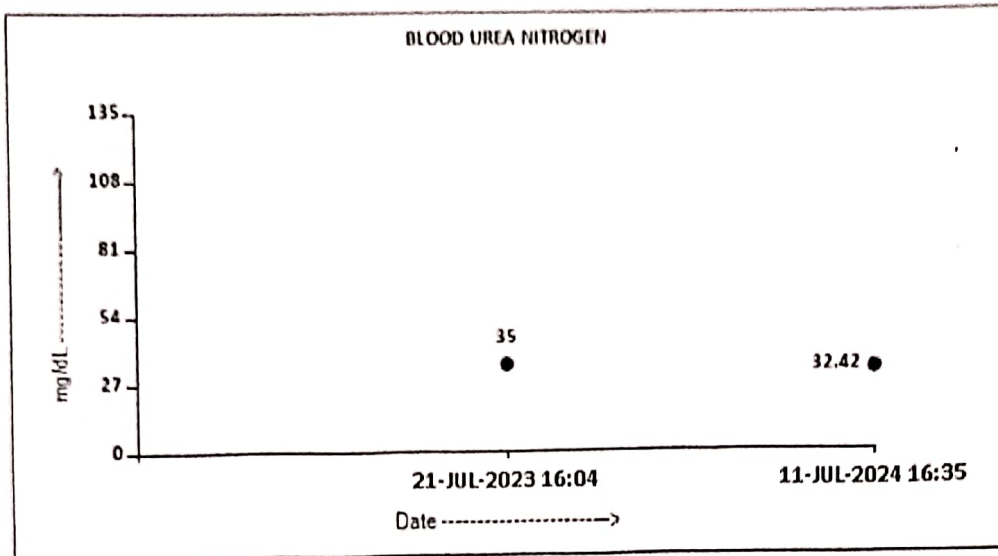
ADHA NO :

REPORTED : 11/07/2024 17:26:49

Test Report Status **Final**

Results

Biological Reference Interval Units



CREATININE, SERUM

CREATININE

4.33 High

0.6 - 1.4

mg/dL

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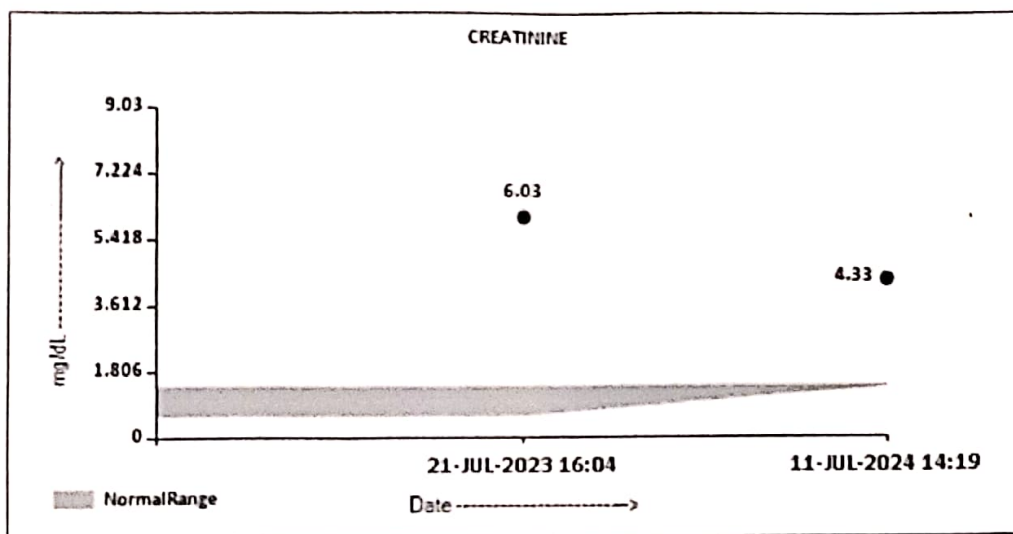
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BUN/CREAT RATIO			
BUN/CREAT RATIO	7.49	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	3.6	3.6 - 7.2	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.1	6.0 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	4.5	3.2 - 5.0	g/dL
GLOBULIN			
GLOBULIN	2.6	2.0 - 4.1	g/dL

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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

TOTAL PROTEIN	7.1	6.0 - 8.3	g/dL
ALBUMIN	4.5	3.2 - 5.0	g/dL
GLOBULIN	2.6	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.7	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	29	0 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	14	0 - 45	U/L
ALKALINE PHOSPHATASE	186 High	41 - 137	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	116 High	0 - 50	U/L
LACTATE DEHYDROGENASE	634 High	200 - 450	U/L

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	32.42 High	6 - 22	mg/dL
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CALCIUM, SERUM

CALCIUM	10.2	8.4 - 10.4	mg/dL
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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	142.5	137 - 145	mmol/L
POTASSIUM, SERUM	4.70	3.6 - 5.0	mmol/L
CHLORIDE, SERUM	105.5	98 - 107	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, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, 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 HCO ₃ ⁻), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemia, 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)

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,

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ULR No. 775000008355646-0707

DIAGNOSTIC REPORT



PATIENT NAME : NANDESHWAR YADAV		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 : 0031XG009590	AGE/SEX : 47 Years Male	DRAWN : 11/07/2024 11:07:00
	PATIENT ID : NANDM12077731	RECEIVED : 12/07/2024 13:42:17	REPORTED : 12/07/2024 15:42:56
	CLIENT PATIENT ID:		
	ABHA NO :		

CLINICAL INFORMATION :

0707XG000653

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

BILIRUBIN (TOTAL, DIRECT, INDIRECT), SERUM				
BILIRUBIN, TOTAL	1.40 High	0.2 - 1.2		mg/dL
METHOD : DIAZONIUM SALT				
BILIRUBIN, DIRECT	0.66 High	0.0 - 0.5		mg/dL
METHOD : DIAZO REACTION				
BILIRUBIN, INDIRECT	0.74	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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Chaitali

Dr. Anwesha Chatterjee
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Dr. Chaitali Ray, PHD
Biochemist



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 CIN - U74899PB1995PLC045956



ULR No. 31000005058830-0031



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SPECIALISED CHEMISTRY - ANEMIA

SERUM IRON AND TIBC STUDIES

IRON	68	65 - 175	µg/dL
METHOD : FERENE			
TOTAL IRON BINDING CAPACITY	343	250 - 450	µg/dL
METHOD : CALCULATED PARAMETER			
% SATURATION	20	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 there 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 (UBC)=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****

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ULR No.775000008355646-0031

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Test Report Status**Final****Results****Biological Reference Interval****Units****SPECIALISED CHEMISTRY - ANEMIA****FERRITIN, SERUM****FERRITIN**

149.4

30 - 400

ng/mL

METHOD : ELECTROCHEMILUMINESCENCE

Interpretation(s)

FERRITIN, SERUM-Ferritin is a high-molecular-weight protein that contains approximately 20% iron. It occurs normally in almost all tissues of the body but especially in hepatocytes and reticuloendothelial cells, where it serves as an iron reserve. When needed, the iron molecules are released from the apoferritin shell and bind to transferrin, the circulating plasma protein that transports iron to the erythropoietic cells.

A low serum ferritin value is thought to be the best laboratory indicator of iron depletion. Virtually all patients with low serum iron and low ferritin have iron deficiency. Serum ferritin concentration, when considered with other factors such as serum iron, iron-binding capacity and tissue iron stores is valuable in the diagnosis of iron deficiency anemia, anemia of chronic infection and conditions such as thalassemia and hemochromatosis that are associated with iron overload. It is particularly useful in distinguishing between iron-deficiency anemia (serum ferritin levels diminished) and "anemia of chronic disease" (serum ferritin levels usually normal or elevated).

Ferritin is an acute phase reactant. It can be found to be elevated in the following conditions and do not reflect actual body iron stores: 1.Inflammation 2.Significant tissue destruction 3.Liver diseases 4.Malignancies such as acute leukemia and Hodgkin's disease 5.Therapy with iron supplements.

Interferences:

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed.

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

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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

65.4 Kg

Refered 02/10/2024
0064
12/12

BP 150/100 mm/hg
Pulse 90/min
SPO2 91%

Date: 15/07/24

Patient Name: Nandeshwar Yadav Age: 48y Sex: M

Ht: 6'7"

TAT - 207

P/C F. HTN
• CKD Stage III
• 20 Anem.

- 1. Tab Bisphosphonate 30
2. ORSINOL 2x 30
3. Keto add 60
4. SODASIS 1x2 60
5. Milipressin 30
6. Cilastin 30
7. TRORAB 30
8. 4-zyvon-4K (50) 100
9. H.D. 100

0064
15/7/24

Fees Valid Up to 15 days

दवा मिलने का स्थान :

Shubh Vinayak Medicine

Plot No.-180, Coperative Colony

R.N.B HOSPITAL Help line No.

06542 255060, 9153899691