DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : SUDHA DEVI | **REF. DOCTOR :** DR. SADAR HOSPITAL

ACCESSION NO : **0707XG000007**	AGE/SEX : 36 Years Female
PATIENT ID : SUDHF230188707	DRAWN : 01/07/2024 09:43:15
CLIENT PATIENT ID:	RECEIVED : 01/07/2024 09:45:41
ABHA NO :	REPORTED : 01/07/2024 17:37:54

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)	**9.3 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	**3.01 Low**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	5.90	4.0 - 10.0	thou/µL
PLATELET COUNT	**135 Low**	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	**28.3 Low**	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	94.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	31.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.9	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**15.1 High**	11.6 - 14.0	%
MENTZER INDEX	31.2		
MEAN PLATELET VOLUME (MPV)	10.2	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	50	40 - 80	%
LYMPHOCYTES	**42 High**	20 - 40	%
MONOCYTES	05	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.95	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	2.48	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)	1.2		

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ULR No.775000008215005-0707

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HAEMATOLOGY

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

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R	**50 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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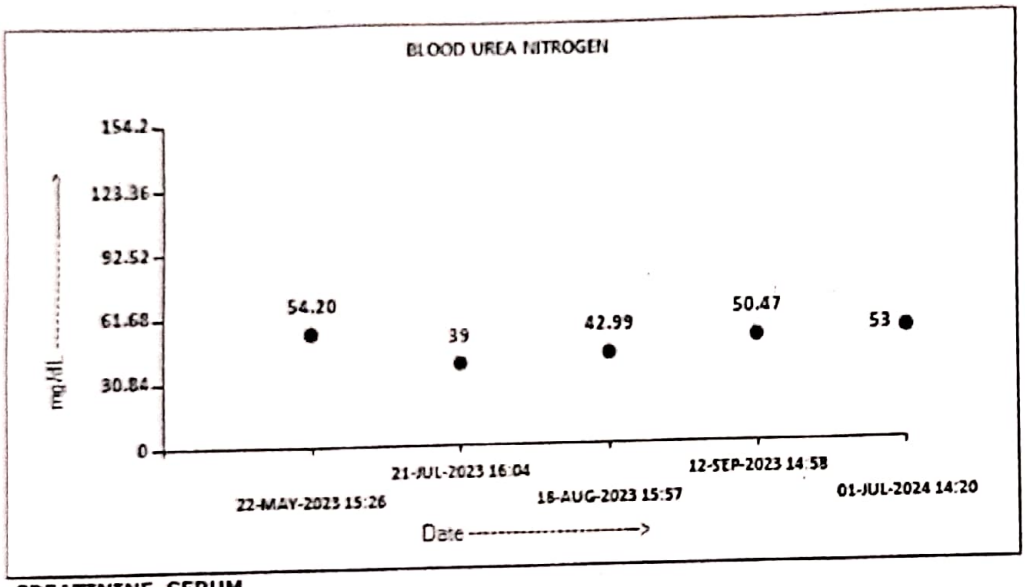
BIOCHEMISTRY

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	**53 High**	6 - 22	mg/dL



CREATININE, SERUM

CREATININE	**4.55 High**	0.6 - 1.2	mg/dL

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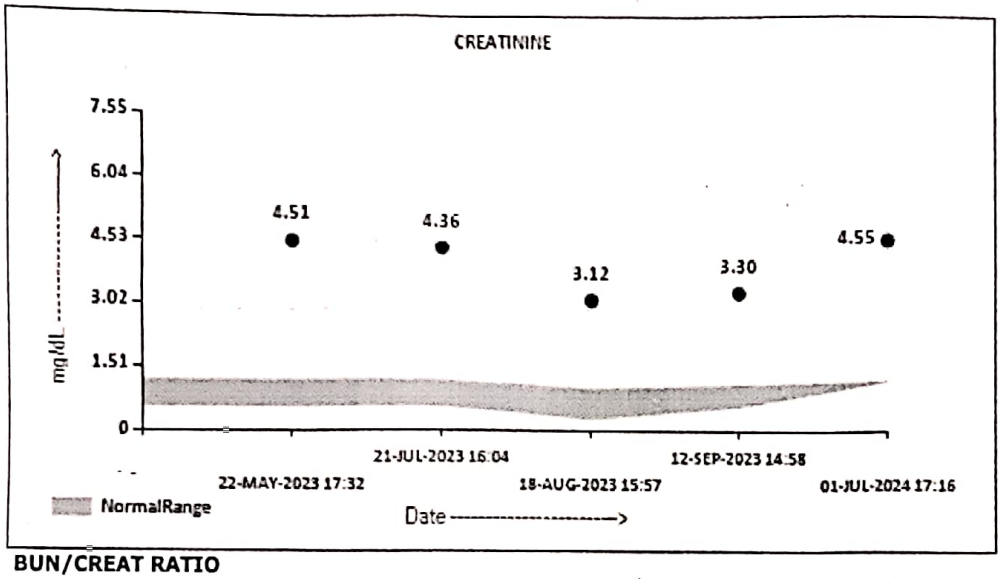

BUN/CREAT RATIO

BUN/CREAT RATIO	11.65	5.0 - 15.0	

CALCIUM, SERUM

CALCIUM	8.7	8.4 - 10.4	mg/dL

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	138.0	135.0 - 148.0	mmol/L
POTASSIUM, SERUM	4.43	3.5 - 5.3	mmol/L
CHLORIDE, SERUM	**107.5 High**	98.0 - 107.0	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride

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DIAGNOSTIC REPORT

MC-5746

agilus diagnostics

PATIENT NAME : SUDHA DEVI

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 : **0031XG001174** PATIENT ID : SUDHF02078831 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :36 Years Female DRAWN :01/07/2024 09:07:00 RECEIVED :02/07/2024 12:06:53 REPORTED :02/07/2024 13:48:10

CLINICAL INFORMATION :

0707XG000007

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
URIC ACID, SERUM			
URIC ACID METHOD : URICASE	5.8	2.6 - 6.0	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.

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ULR No.31000005050405-0031

DIAGNOSTIC REPORT

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SPECIALISED CHEMISTRY - ANEMIA

SERUM IRON AND TIBC STUDIES

IRON METHOD : FERENE	98	50 - 170	µg/dL
TOTAL IRON BINDING CAPACITY METHOD : CALCULATED PARAMETER	252	250 - 450	µg/dL
% SATURATION	39	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, 561, 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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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.77500000821500S-0707

CKD 5D/CAKUT
(L) Solitary kidney
c VUR
(L) PC NUR (+).

आई. जी. आई. एम. एस. पटना

21,25(431)
12/7/24

c/o Headache
Muscle cramps } c̄ during HD.

No other complaint at Present

BP during HD - (130-160 / 78) mmHg

Adv:-

- MHD - 2/wk at centre of choice
- Inj. Camisure 1 amp. iv after HD
- Rest to continue same Rx
- F/up x 1 month. c̄ reports.