REPORT

PATIENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL	
TARA DUBEY	ACCESSION NO : 0707XG000313	AGE/SEX : 73 Years
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 17
	ABHA NO :	REPORTED : 05/07/2024 19

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)	12.0	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	3.90	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	7.00	4.0 - 10.0	thou/µl
PLATELET COUNT	**134 Low**	150 - 410	thou/µl
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	36.2	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	93.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	30.8	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.1	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**14.8 High**	11.6 - 14.0	%
MENTZER INDEX	23.8		
MEAN PLATELET VOLUME (MPV)	10.7	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	60	40 - 80	%
LYMPHOCYTES	34	20 - 40	%
MONOCYTES	03	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	4.2	2.0 - 7.0	thou/µl
ABSOLUTE LYMPHOCYTE COUNT	2.38	1.0 - 3.0	thou/µl
ABSOLUTE MONOCYTE COUNT	0.21	0.2 - 1.0	thou/µl
ABSOLUTE EOSINOPHIL COUNT	0.21	0.02 - 0.50	thou/µl
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1.	thou/µl
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.8		

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Sadar Hospital,Sector 1, Bokaro Steel City
Bokaro, 827001
Jharkhand, India
Tel : 7260813496

UCR No. 7750000004

REPORT

agi

PATIENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL	
TARA DUBEY	ACCESSION NO : 0707XG000313	AGE/SEX : 73 Years Female
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 12
	ABHA NO :	REPORTED : 05/07/2024 19

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
TOTAL PROTEIN	**5.7 Low**	6.0 - 8.3	g/dL
ALBUMIN	3.8	3.2 - 5.0	g/dL
GLOBULIN	**1.9 Low**	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	2.0	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	21	0 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	9	0 - 45	U/L
ALKALINE PHOSPHATASE	**1138 High**	39 - 118	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	**74 High**	0 - 50	U/L
LACTATE DEHYDROGENASE	218	200 - 450	U/L
KIDNEY FUNCTION TEST			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	**67.53 High**	6 - 22	mg/dL

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Jharkhand, India
Tel : 7260813496

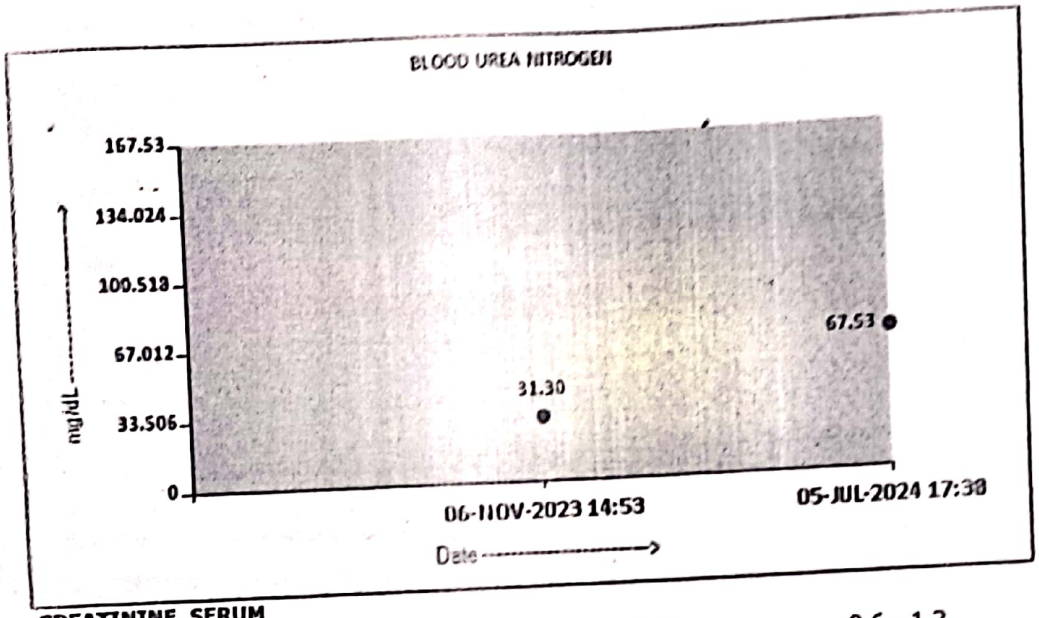
ULR No.77500000827623

REPORT

agi

IENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL	
TARA DUBEY	ACCESSION NO : 0707XG000313	AGE/SEX : 73 Years
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 12
	ABHA NO :	REPORTED : 05/07/2024 19

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



CREATININE, SERUM			
CREATININE	**8.77 High**	**0.6 - 1.2**	mg/dl

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Tel : 7260813496

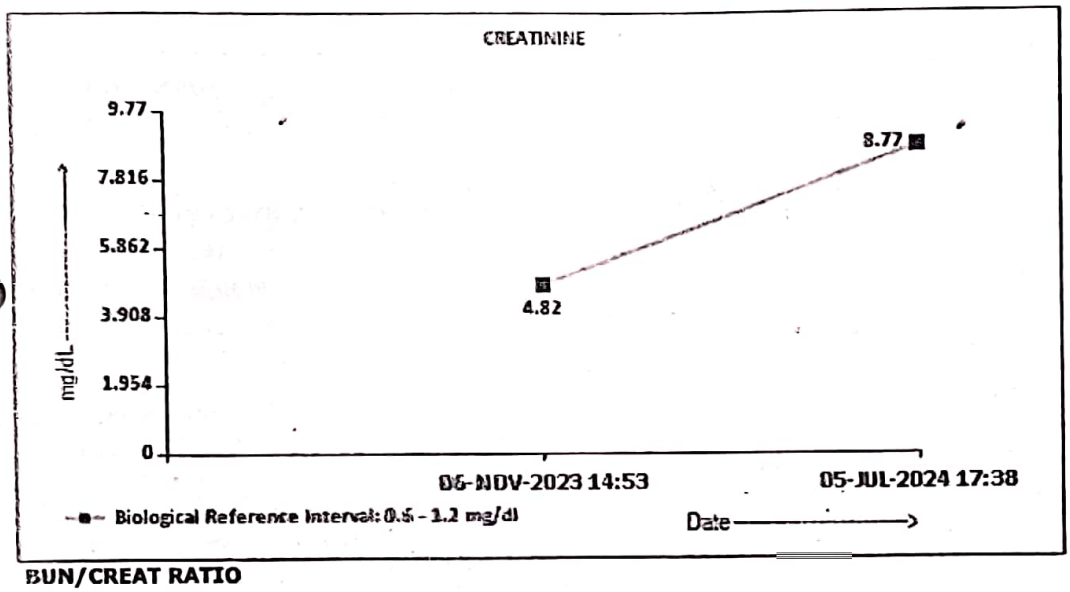
ULR No.77500000827

REPORT

agi

IENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL	
TARA DUBEY	ACCESSION NO : 0707XG000313	AGE/SEX : 73 Years Female
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 12
	ABHA NO :	REPORTED : 05/07/2024 19

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



BUN/CREAT RATIO			
BUN/CREAT RATIO	7.70	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	6.7	2.5 - 6.8	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	5.7 Low	6.0 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	3.8	3.2 - 5.0	g/dL
GLOBULIN			
GLOBULIN	1.9 Low	2.0 - 4.1	g/dL

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ULR No.77500000827625

REPORT

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IENT NAME : TARA DUBEY	**REF. DOCTOR :** DR. SADAR HOSPITAL	
ARA DUBEY	ACCESSION NO : **0707XG000313**	AGE/SEX : 73 Years Female
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 12 16
	ABHA NO :	REPORTED : 05/07/2024 19 09

Test Report Status **Final**	Results	Biological Reference Interval	Units
CALCIUM, SERUM			
CALCIUM	9.2	8.4 - 10.4	mg/dl
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	137.9	135.0 - 148.0	mmol/l
POTASSIUM, SERUM	4.78	3.5 - 5.3	mmol/L
CHLORIDE, SERUM	106.4	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)
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 (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

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Jharkhand, India

ULR No.77500000827072

REPORT

MC-5746

ENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL
RA DUBEY	ACCESSION NO : 0707XG000313 PATIENT ID : TARAM061150707 CLIENT PATIENT ID: ABHA NO :
	AGE/SEX : 73 Years DRAWN : 05/07/2024 12 RECEIVED : 05/07/2024 12 REPORTED : 06/07/2024 14

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - ANEMIA			
SERUM IRON AND TIBC STUDIES			
IRON	122	50 - 170	µg/dL
METHOD : FERENE TOTAL IRON BINDING CAPACITY	161 Low	250 - 450	µg/dL
METHOD : CALCULATED PARAMETER % SATURATION	76 High	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, 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

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ULR No.77500000827623

REPORT

agi

IENT NAME : TARA DUBEY	REF. DOCTOR : DR. SADAR HOSPITAL	
ARA DUBEY	ACCESSION NO : 0707XG000313	AGE/SEX : 23 Years
	PATIENT ID : TARAM061150707	DRAWN : 05/07/2024 12
	CLIENT PATIENT ID:	RECEIVED : 05/07/2024 12
	ABHA NO :	REPORTED : 05/07/2024 19

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

EIA - INFECTIOUS SECTION

HEPATITIS B SURFACE ANTIGEN, SERUM		
HEPATITIS B SURFACE ANTIGEN	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. 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 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 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 carefully 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 (HCV-RNA-PCR) suggests active hepatitis C infection.

****End Of Report****

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Jharkhand, India
Tel : 7260813496

ULR No.77500030827

SADAR HOSPITAL BOKARO
CAMP 2 BOKARO

Registration No : 20240044004
Visit No : 1 / Token No : 52
Room No : Main Building A,OPD Block,Ground,G.Medicine OPD 9

Dr. Nazma Khatoon
Medicine OPD

Name : **Mrs. Tara Dubey**
Sex/Age : **70Y / F**
Department : Medicine

Registration Amount : Rs. 5
Mobile No : 9431734621
Address :SEC- 4/G 2086(JHARKHAND)
Date of Registration : 10/07/2024 01.19 PM

Patient Type : General
Guardian Name : P DUBEY(Husband)

MLC Patient : NO

CBS - 65
08/7/24

Report for Blood Examn.

HIV - Non-Reactive

10/7/24

Prepared By: Mr.
Narendra Kumar Sinha

Date Time: 10/07/2024 01.19 PM

DIAGNOSTIC REPORT

MC-5718

PATIENT NAME : TARA DUBEY		**REF. DOCTOR :** DR. SADAR HOSPITAL
TARA DUBEY	ACCESSION NO : **0707XG000313** PATIENT ID : TARAM061150707 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :73 Years Female DRAWN :05/07/2024 12:13:27 RECEIVED :05/07/2024 12:16:00 REPORTED :09/07/2024 10:46:38

Test Report Status **Final**	Results	Units

MOLECULAR BIOLOGY

HEPATITIS B VIRUS DNA QUANTITATIVE

HBV VIRAL LOAD	24	IU/ML

Comments

TEST PERFORMED ON EDTA PLASMA
Abbott - Limited of Detection < 10 IU/ml
Coversion Factor - 1 IU = 3.41 copies/ml
***** KINDLY NOTE: THE HBV VIRAL LOAD CAN BE EXPRESSED AS LOG 1.38 AND THE CALCULATED VALUE IS 82 CPS/ML (CONVERSION FACTOR: 1 IU/ML=3.41 CPS/ML).

Interpretation(s)
HEPATITIS B VIRUS DNA QUANTITATIVE-Clinical Utility: The viral load provides the direct and reliable estimate of the level of HBV replication. Quantitation of HBV DNA level is important as it serves to be a prognostic marker of HBV infection. It is used for establishing baseline levels in patients before initiation of the therapy and for monitoring therapeutic response and disease progression. A sudden rise in the viral load may indicate emergence of resistant strains during the therapy.

Method: Real Time PCR

Interpretation: HBV viral load is expressed as IU/ml. For conversion to WHO International Units (IU): 1 IU corresponds to approximately 5.8 copies/ml The lower limit of detection of this assay is 20.0 IU/mL. Values below 20.0 IU/ml does not exclude the possibility of an infection. It may reflect a viral load below the detection limit of the assay. An increase or decrease of more than threefold may be considered clinically significant. Follow up viral load values below the detectable limit may indicate resolution of the infection after therapy. Reappearance or increasing viral load may indicate relapse or resistance to the therapy. All viral load results should be interpreted in conjunction with the clinical history, clinical status of the patient and other diagnostic parameters.

Recommendations: Viral load is a monitoring test and hence should not be used for screening or diagnostic purpose. Wide variations in viral load have been observed due to following reasons:
a) Use of different technologies/ platforms for follow up testing. Hence, it is recommended to monitor patients using same technology.
b) Nonadherence to specimen collection protocol. Hence, it is recommended to immediately freeze the serum/EDTA plasma after collection and separation.
Limitations: PCR is a highly sensitive technique common reasons for paradoxical results are contamination during specimen collection, selection of inappropriate specimen and inherent PCR inhibitors in the specimen.

References

1. Hepatology (1989) 10: 198202
2. New England Journal of Medicine (1990) 323:295301.
3. Hepatology (1997) 25: 241244.
4. Antiviral Res (1997) 35: 65 82.
5. WHO: Blood Safety & Clinical Technology (2002) 19.

Note: The performance of this test has been evaluated at Agilus Diagnostics Limited.

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

Dr. Rashmi Khadapkar
Senior Research Scientist

Dr. Deepak Sanghavi
Chief Of Lab - Mumbai Reference Lab

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CAP ACCREDITED

ULR No.77500000S270