DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : U K MALIK

REF. DOCTOR : DR. SADAR HOSPITAL

ACCESSION NO : 0707XG000764
PATIENT ID : UKMAM051080707
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX :43 Years Male
DRAWN :13/07/2024 09:12:37
RECEIVED :13/07/2024 09:14:58
REPORTED :13/07/2024 17:48:08

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)	**8.2 Low**	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	**2.59 Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	4.60	4.0 - 10.0	thou/µL
PLATELET COUNT	**107 Low**	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	**24.0 Low**	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV)	93.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	31.8	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	34.4	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**16.5 High**	11.6 - 14.0	%
MENTZER INDEX	35.9		
MEAN PLATELET VOLUME (MPV)	9.2	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	54	40 - 80	%
LYMPHOCYTES	39	20 - 40	%
MONOCYTES	04	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	0	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.48	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.79	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	**0.18 Low**	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.14	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.4		

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

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ULR No.77500000838188 4-0707

DIAGNOSTIC REPORT

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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 - 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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ULR No.77500000838188S4-0707

DIAGNOSTIC REPORT

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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

TOTAL PROTEIN	7.8	6.0 - 8.3	g/dL
ALBUMIN	5.0	3.2 - 5.0	g/dL
GLOBULIN	2.8	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	8	0 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	9	0 - 45	U/L
ALKALINE PHOSPHATASE	114	41 - 137	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	30	0 - 50	U/L
LACTATE DEHYDROGENASE	386	200 - 450	U/L

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	**56 High**	6 - 22	mg/dL

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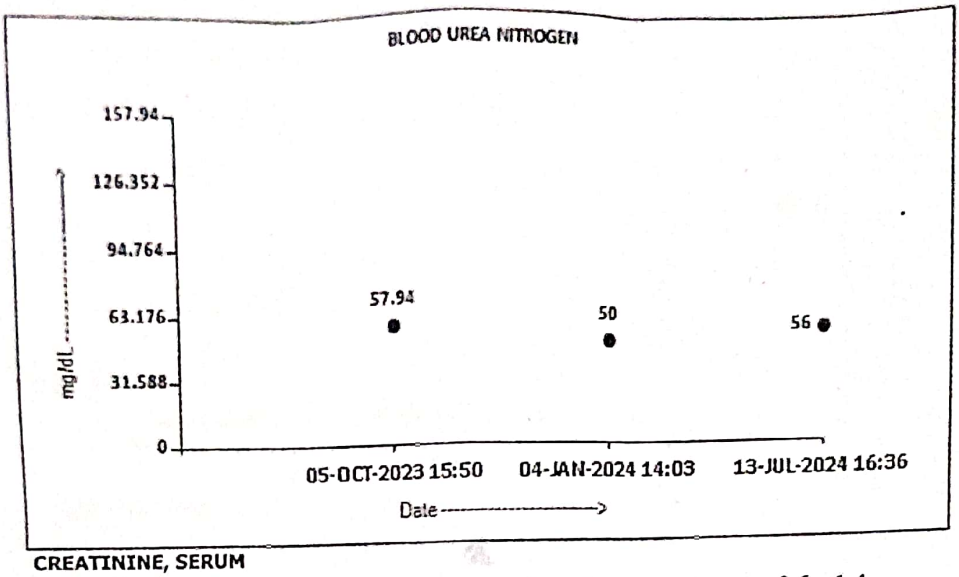

CREATININE, SERUM

CREATININE	**8.60 High**	0.6 - 1.4	mg/dL

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ACCESSION NO : **0707XG000764**		AGE/SEX	:43 Years Male
PATIENT ID	: UKMAM051080707	DRAWN	:13/07/2024 09:12:37
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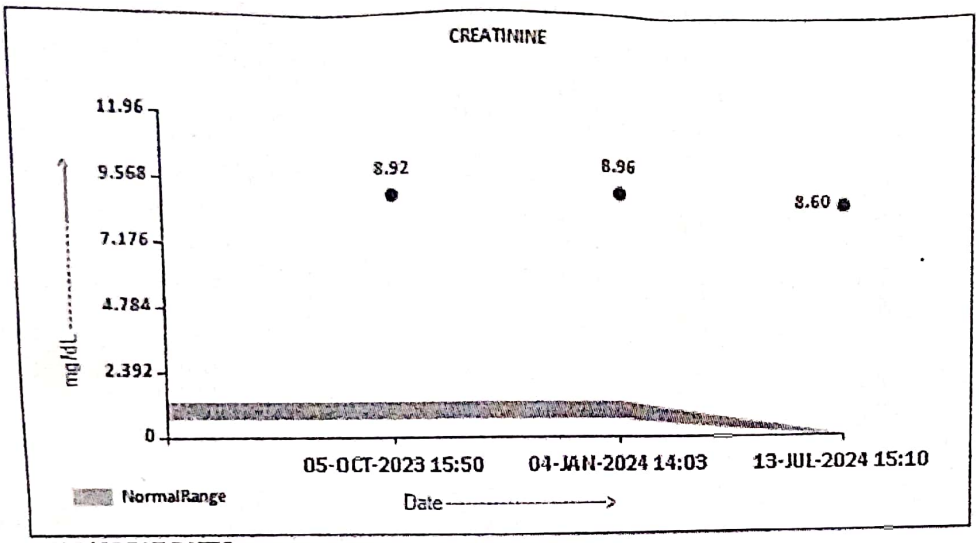
Test Report Status **Final**	Results	Biological Reference Interval	Units



BUN/CREAT RATIO

BUN/CREAT RATIO	6.51	5.0 - 15.0	

URIC ACID, SERUM

URIC ACID	3.9	3.6 - 7.2	mg/dL

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.8	6.0 - 8.3	g/dL

ALBUMIN, SERUM

ALBUMIN	5.0	3.2 - 5.0	g/dL

GLOBULIN

GLOBULIN	2.8	2.0 - 4.1	g/dL

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CALCIUM, SERUM			
CALCIUM	9.7	8.4 - 10.4	mg/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	139.6	137 - 145	mmol/L
POTASSIUM, SERUM	4.02	3.6 - 5.0	mmol/L
CHLORIDE, SERUM	105.1	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, 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 (eg,

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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.77500000S3S1884-0707

SADAR HOSPITAL BOKARO
CAMP 2 BOKARO

Registration No : 20240003084
Visit No : 3/ Last Visit Date : 04/04/2024 12.00 AM / Token No : 25
Room No : Main Building A,OPD Block,Ground,G.Medicine OPD 9

Dr. Madan Prakash
Medicine OPD

Name : **Mr. Utpal Kumar Mallik**
Sex/Age : **43Y 6M / M**
Department : Medicine

Registration Amount : **Rs. 5**
Mobile No : **6207191417**
Address :SATANPUR(JHARKHAND)
Date of Registration : 16/07/2024 09.38 AM
MLC Patient : NO

Patient Type : General
Guardian Name : AWANIKANT MALLIK(Father)

Last Complete Collection Date/Amount : 16/01/2024 09.33 AM/Rs. 5

CBS - 92
12.7.24

Report for Blood Exam -
HIV - Non-Reactive
12/7/24

Prepared By: Mrs. Preeti Kumari

Date Time: 16/07/2024 09.38 AM

DIAGNOSTIC REPORT

MC-5746

agilus diagnostics

PATIENT NAME : U K MALIK | **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : CR00000044 SRL REACH LTD OPD PATIENTS SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY, BOKARO 827001 7260813496	ACCESSION NO : **0031XG011166** PATIENT ID : UKMAM14078131 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :43 Years Male DRAWN :13/07/2024 09:07:00 RECEIVED :14/07/2024 12:25:32 REPORTED :14/07/2024 15:04:04

CLINICAL INFORMATION :

0707XG000764

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
IRON, SERUM			
IRON	**58 Low**	65 - 175	µg/dL
METHOD : FERENE			

Interpretation(s)
IRON, SERUM-Serum iron test is useful for etio- morphological diagnosis of anemias, in hemochromatosis, in hemosiderosis and in acute iron toxicity. Serum iron is recommended to be correlated with Total Iron Binding Capacity (TIBC) for evaluation of iron deficiency.

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

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 Ltd
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

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

Dr. Chaitali Ray, PHD
Chief Biochemist cum MRQA

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ULR No.3100000506040 9-0031

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

45.1 kg

BP 110/70 mm/Hg
Pulse 80 /min
SPO_2 96.1%

Date: 17/7/24

Patient Name : Utpal Kr Mallick Age: 43y Sex: M

- Hb% 8.2gr/dl
- Sr. creatinine 8.6 mg/dl

- HIV
- HCV
- HBsAg } 3 way

Δ
- HTN
- CKD 2° to MHD
- 2° anemia c.

℞

1. Sorbistis INJ — (60)
2. Tab. Rantac — (30)
3. Tab/Cap. Shelcal CT — (60) 1-1
4. Tab. Cvotra — (60) 1-1
5. Tab. Folic acid — (30)
6. B. complex — (30)
7. H.O. Tablet/Water.

17/7/24