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REFERENCE LABORATORIES

LABORATORY REPORT

Name	: **Mr BAPPA DITYA MUKHIRJEE**	Sex/Age	: **Male / 51 Years**	Case ID	: **50605804133**
Ref. By	: NIMBA NATURE CURE	Dis. At	:	Pt. ID	: 6117975
Bill. Loc.	:			Pt. Loc	:
Reg Date and Time	: 16-Jun-2025 08:55	Sample Type	: Whole Blood EDTA,Plasma Fluoride F	Mobile No.	: 6207015048
Sample Date and Time	: 16-Jun-2025 08:55	Sample Coll. By	: NSML	Ref Id1	:
Report Date and Time	: 16-Jun-2025 09:44	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
HAEMATOLOGY INVESTIGATIONS				
HB AND INDICES				
Haemoglobin *Colorimetric*	14.1	g/dL	13.00 - 17.00	
RBC (Electrical Impedance) *Electrical Impedance*	5.03	millions/cumm	4.50 - 5.50	
PCV(Calc) *Calculated*	44.47	%	40.00 - 50.00	
MCV (RBC histogram) *Calculated*	88.4	fL	83.00 - 101.00	
MCH (Calc) *Calculated*	28.1	pg	27.00 - 32.00	
MCHC (Calc) *Calculated*	31.8	g/dL	31.50 - 34.50	
RDW (RBC histogram)	13.60	%	11.00 - 16.00	
TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)				
Total WBC Count *Flowcytometry*	4880	/µL	4000 - 10000	
Neutrophil	60.8	%	40.00 - 70.00	
Lymphocyte	28.6	%	20.00 - 40.00	
Eosinophil	2.7	%	1.00 - 6.00	
Monocytes	7.3	%	2.00 - 10.00	
Basophil	0.6	%	0.00 - 2.00	
Neutrophil *Calculated*	2967	/µL	2000.00 - 7000.00	
Lymphocyte *Calculated*	1396	/µL	1000.00 - 3000.00	
Eosinophil *Calculated*	132	/µL	20.00 - 500.00	
Monocyte *Calculated*	356	/µL	200.00 - 1000.00	
Basophil *Calculated*	29	/µL	0.00 - 100.00	
PLATELET COUNT(Optical)				
Platelet Count *Electrical Impedance*	261000	/µL	150000.00 - 410000.00	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Neut/Lympho Ratio (NLR) *CALC*		2.13		0.78 - 3.53

SMEAR STUDY

RBC Morphology		Normocytic Normochromic RBCs.		
WBC Morphology		Total WBC count within normal limits.		
Platelet		Platelets are adequate in number.		
Parasite		Malarial Parasite not seen on smear.		
ESR		14	mm/hr	03 - 15

BIOCHEMICAL INVESTIGATIONS

Plasma Glucose - F *Photometric,Hexokinase*	H	**286.60**	mg/dL	70.0 - 100

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
25 OH Cholecalciferol (D2+D3) *CMIA*	29.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 160 Toxicity	

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g, due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

INTERPRETATION
Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.
Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.
Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH- VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D. Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients.CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
VITAMIN B - 12 *CMIA*	501.0	pg/mL	187 - 883	

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C *HPLC*	13.10	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) *Calculated*	329.27	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy,comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
Urea *Urease/GLDH*	32.00	mg/dL	14.98 - 38.52	
Creatinine *Jaffe, alkaline picrate, kinetic with blank rate correction*	0.78	mg/dL	0.70 - 1.30	
Uric Acid *Uricase*	3.97	mg/dL	3.5 - 7.2	
Sodium *Direct ISE*	139.30	mmol/L	136 - 145	
Potassium *Direct ISE*	4.39	mmol/L	3.5 - 5.1	
Chloride *Direct ISE*	98.60	mmol/L	98 - 107	
Calcium *OCPC*	8.87	mg/dL	8.5 - 10.1	
Proteins (Total) *Colorimetric, Biuret*	6.68	gm/dL	6.4 - 8.2	
Albumin *Bromocresol purple*	3.60	gm/dL	3.4 - 5.0	
Globulin *CALC*	3.08	gm/dL	2.0 - 4.1	
A/G Ratio *Calculated*	1.17		1.0 - 2.1	
Skeletal Profile				
Calcium *OCPC*	8.87	mg/dL	8.5 - 10.1	
Phosphorus Inorganic *Phosphomolybdate*	3.40	mg/dL	2.5 - 4.9	

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Report Date and Time	: 16-Jun-2025 10:08	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
S.G.P.T. *IFCC without pyriodoxal phosphate*	24.80	U/L	00 - 45.00	
S.G.O.T. *UV with P5P*	25.87	U/L	15 - 37	
Alkaline Phosphatase *Enzymatic, PNPP-AMP*	95.63	U/L	50 - 136	
Proteins (Total) *Colorimetric, Biuret*	6.68	gm/dL	6.4 - 8.2	
Albumin *Bromocresol purple*	3.60	gm/dL	3.4 - 5.0	
Globulin *CALC*	3.08	gm/dL	2.0 - 4.1	
A/G Ratio *Calculated*	1.17		1.0 - 2.1	
Bilirubin Total *JENDRASSIK GROF*	0.54	mg/dL	0.2 - 1.00	
Bilirubin Conjugated *JENDRASSIK GROF*	0.10	mg/dL	0 - 0.20	
Bilirubin Unconjugated *Calculated*	0.44	mg/dL	0 - 0.8	
Gamma Glutamyl Transferase *L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate*	35.71	U/L	15 - 85	

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Triiodothyronine (T3) *CMIA*	0.77	ng/mL	0.70 - 2.04	
Thyroxine (T4) *CMIA*	8.58	µg/dL	4.87 - 11.72	
TSH *CMIA*	1.59	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

• Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.

• Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipent hypothyroidism (subclinical hypothyroidism).

• Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.

• Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a supressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy Reference range (microIU/ml)

First trimester 0.24 - 2.00

Second trimester 0.43-2.2

Third trimester 0.8-2.5

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Interpretation Note:
Ultra sensitive-thyroid–stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone.Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.
Normal ranges of TSH & thyroid hormons vary according trimesper in pregnancy.

TSH ref range in Pregnacy	Reference range (microIU/ml)
First triemester	0.24 - 2.00
Second triemester	0.43-2.2
Third triemester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

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TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS					
Lipid Profile					
Cholesterol *Colorimetric: cholesterol esterase and cholesterol oxidase conversion followed by a Trinder endpoint*	H	**287.4**	mg/dL	00 - 200	
HDL Cholesterol *Homogenous Assay*		46.1	mg/dL	40 - 60	
Triglyceride *Glycerol Phosphate Oxidase*	H	**241.20**	mg/dL	00 - 149	
VLDL *Calculated*	H	**48.24**	mg/dL	10 - 40	
Chol/HDL *Calculated*	H	**6.23**		0 - 4.1	
LDL Cholesterol *Calculated*	H	**193.06**	mg/dL	0.00 - 100.00	

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal<100	Desirable<200	Low<40	Normal<150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-189	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment
- For LDL Cholesterol level Please consider direct LDL value
  Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Detail test interpreation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Prostate Specific Antigen (PSA)				
Prostate Specific Antigen *CMIA*	0.228	ng/mL	0.00 - 4.00	

	0 - 0.5 *(ng/mL)	>0.5 - 2.5 (ng/mL)	>2.5 - 5.0 (ng/mL)	>5.0 - 10 (ng/mL)	>10 (ng/mL)
Healthy Males	87.2	12.8	0.0	0.0	0.0
BPH	51.9	42.9	4.2	0.5	0.5
Stage A Prostate Cancer	38.5	42.3	11.5	3.8	3.8
Stage B Prostate Cancer	23.9	68.7	7.5	0.0	0.0

*% of population

Use

The total PSA test and digital rectal exam (DRE) are used together to help determine the need for a prostate biopsy. The goal of screening is to minimize unnecessary biopsies and to detect clinically significant prostate cancer while it is still confined to the prostate.

Clinical Significance of elevated levels of PSA are associated with prostate cancer, but they may also be seen with prostatitis and benign prostatic hyperplasia (BPH). Mild to moderately increased concentrations of PSA may be seen in those of African American heritage, and levels tend to increase in all men as they age.

Prostate biopsy is required for the diagnosis of cancer.

FREE PSA:TOTAL PSA

Males:

When Total PSA concentration is in the range of 4.0-10.0 ng/mL:

Probability of cancer			
Free PSA/total PSA ratio	50-59 years	60-69 years	> or =70 years
< or =0.10	49%	58%	65%
0.11-0.18	27%	34%	41%
0.19-0.25	18%	24%	30%
>0.25	9%	12%	16%

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT

Name	: **Mr BAPPA DITYA MUKHIRJEE**	Sex/Age	: **Male / 51 Years**	Case ID	: **50605804133**
Ref. By	: NIMBA NATURE CURE	Dis. At	:	Pt. ID	: 6117975
Bill. Loc.	:			Pt. Loc	:

Reg Date and Time	: 16-Jun-2025 08:55	Sample Type	: Spot Urine	Mobile No.	: 6207015048
Sample Date and Time	: 16-Jun-2025 08:55	Sample Coll. By	: NSML	Ref Id1	:
Report Date and Time	: 16-Jun-2025 09:44	Acc. Remarks	:	Ref Id2	:

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
URINE EXAMINATION (STRIP METHOD AND MICROSCOPY)				
Physical examination				
Colour	Pale yellow			
Appearance	Clear			
Chemical Examination				
Sp.Gravity *Dip Stick, Polyelectrolyte based reaction*	1.020		1.003 - 1.035	
pH *Dip Stick, Double indicator*	6.00		4.6 - 8	
Leucocytes (ESTERASE) *Dip Stick, Esterase reaction*	Negative		Negative	
Protein *Dip Stick, Protein error of indicators*	Negative		Negative	
Glucose *Dip Stick, GOD-POD*	**Present (+++)**		Negative	
Ketone Bodies Urine *Dip Stick, Nitroprusside reaction*	**Present (+)**		Negative	
Urobilinogen *Dip Stick, Modified Ehrlich reaction*	Negative			
Bilirubin *Azo Coupling Method*	Negative		Negative	
Blood *Dip Stick, Peroxidase like reaction*	Negative		Negative	
Nitrite *Diazotization reaction*	Negative		Negative	
Microscopic examination				
Leucocyte	**00-01**	/HPF	Nil	
Red Blood Cell	Nil	/HPF	Nil	
Epithelial Cell	Present +	/HPF	Present(+)	
Bacteria	Nil	/µL	Nil	
Yeast	Nil	/µL	Nil	
Cast	Nil	/HPF	Nil	

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Crystals Nil /HPF Nil

Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Result/Notifications				
			Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Pus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

---------- End Of Report ----------

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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