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Excellence In Health Care

Sagepath Labs Pvt. Ltd.

Lab Address:- # Plot No. 564 , 1st floor , Buddhanagar , Near Sai Baba Temple Peerzadiguda Boduppal Hyderabad, Telangana.
ICMR Reg .No. SAPALAPVLHT (Covid -19)

LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451526		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	:	Received On	: 28-Sep-2024 03:13 PM
Sample Tested In	: Urine	Reported On	: 28-Sep-2024 07:50 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

GLUCOSE FASTING

Test Name	Results	Units	Biological Reference Interval
Fasting Urine Glucose *(Method: Automated Strip Test)*	(+)		Negative

*** End Of Report ***

DR.VAISHNAVI
MD BIOCHEMISTRY

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LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451533		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	: Whole Blood	Received On	: 28-Sep-2024 12:50 PM
Sample Tested In	: Serum	Reported On	: 28-Sep-2024 07:28 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

IMMUNOLOGY & SEROLOGY

Test Name	Results	Units	Biological Reference Interval
Testosterone Free *(Method: ELISA)*	1.20	pg/mL	0-2.85

Interpretation : .

- Most circulating testosterone is bound to sex hormone-binding globulin (SHBG), a lesser fraction is albumin bound and a small proportion exists as free hormone. Testosterone is weakly bound to serum albumin and dissociates freely in the capillary bed, and is readily available for tissue uptake.
- All non-SHBG-bound testosterone is considered bioavailable.
- During childhood, increase production of testosterone causes premature puberty in boys and masculinization in girls. In adult women, excess testosterone production can cause virilization, including hirsutism, acne, oligo-amenorrhea, or infertility.
- Common causes of pronounced elevations of testosterone include genetic conditions (eg, congenital adrenal hyperplasia); adrenal, testicular, and ovarian tumors etc.
- Decreased testosterone in females causes mild symptoms like some decline in libido and nonspecific mood changes. In males, it results in partial or complete degrees of hypogonadism.
- Measurement of total testosterone may not be sufficient for diagnosis but is helpful if it is combined with measurements of LH and follicle-stimulating hormone. However, these tests may be insufficient for diagnosis of mild abnormalities of testosterone homeostasis, particularly if abnormalities in function and levels of SHBG are present.
- Additional measurements of free testosterone or bioavailable testosterone are recommended in this situation.
- .

*** End Of Report ***

DR. RUTURAJ MANIKLAL KOLHAPURE
MD, MICROBIOLOGIST

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LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451536		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	: Whole Blood	Received On	: 28-Sep-2024 12:50 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 28-Sep-2024 03:31 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

Test Name	Results	Units	Biological Reference Interval
Complete Blood Picture(CBP)			
Haemoglobin (Hb) *(Method: Cynmeth Method)*	**11.5**	g/dL	12-15
Haematocrit (HCT) *(Method: Calculated)*	**38.4**	%	40-50
RBC Count *(Method: Cell Impedence)*	4.65	10^12/L	3.8-4.8
MCV *(Method: Calculated)*	83	fl	81-101
MCH *(Method: Calculated)*	**24.7**	pg	27-32
MCHC *(Method: Calculated)*	**29.9**	g/dL	32.5-34.5
RDW-CV *(Method: Calculated)*	13.8	%	11.6-14.0
Platelet Count (PLT) *(Method: Cell Impedance)*	233	10^9/L	150-410
Total WBC Count *(Method: Impedance)*	5.2	10^9/L	4.0-10.0
Differential Leucocyte Count (DC)			
Neutrophils *(Method: Cell Impedence)*	54	%	40-70
Lymphocytes *(Method: Cell Impedence)*	40	%	20-40
Monocytes *(Method: Microscopy)*	04	%	2-10
Eosinophils *(Method: Microscopy)*	02	%	1-6
Basophils *(Method: Microscopy)*	0	%	1-2
Absolute Neutrophils Count *(Method: Impedence)*	2.81	10^9/L	2.0-7.0
Absolute Lymphocyte Count *(Method: Impedence)*	2.08	10^9/L	1.0-3.0
Absolute Monocyte Count *(Method: Calculated)*	0.21	10^9/L	0.2-1.0
Absolute Eosinophils Count *(Method: Calculated)*	0.1	10^9/L	0.02-0.5
Absolute Basophil lCount *(Method: Calculated)*	0.00	10^9/L	0.0-0.3
Morphology *(Method: PAPs Staining)*	Normocytic normochromic		

MC 3633

Swarnabala - M
DR.SWARNA BALA
MD PATHOLOGY

LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451526		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	:	Received On	: 28-Sep-2024 12:40 PM
Sample Tested In	: Urine	Reported On	: 28-Sep-2024 04:10 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL PATHOLOGY

Test Name	Results	Units	Biological Reference Interval
Complete Urine Analysis (CUE)			
Physical Examination			
Colour	Pale Yellow		Straw to light amber
Appearance	Clear		Clear
Chemical Examination			
Glucose *(Method: Strip Reflectance)*	(+)		Negative
Protein *(Method: Strip Reflectance)*	Absent		Negative
Bilirubin (Bile) *(Method: Strip Reflectance)*	Negative		Negative
Urobilinogen *(Method: Ehrlichs reagent)*	Negative		Negative
Ketone Bodies *(Method: Strip Reflectance)*	Negative		Negative
Specific Gravity *(Method: Strip Reflectance)*	1.015		1.000 - 1.030
Blood *(Method: Strip Reflectance)*	Negative		Negative
Reaction (pH) *(Method: Reagent Strip Reflectance)*	5.5		5.0 - 8.5
Nitrites *(Method: Strip Reflectance)*	Negative		Negative
Leukocyte esterase *(Method: Reagent Strip Reflectance)*	Negative		Negative
Microscopic Examination (Microscopy)			
PUS(WBC) Cells *(Method: Microscopy)*	02-03	/hpf	00-05
R.B.C. *(Method: Microscopic)*	Nil	/hpf	Nil
Epithelial Cells *(Method: Microscopic)*	01-02	/hpf	00-05
Casts *(Method: Microscopic)*	Absent		Absent
Crystals *(Method: Microscopic)*	Absent		Absent
Bacteria	Nil		Nil
Budding Yeast Cells *(Method: Microscopy)*	Nil		Absent

Comments : Urine analysis is one of the most useful laboratory tests as it identifies a wide range of medical conditions including renal damage, urinary tract infections,diabetes, hypertension and drug toxicity.

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Swarnabala - M
DR.SWARNA BALA
MD PATHOLOGY

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LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451534, A0451539		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	: Whole Blood	Received On	: 28-Sep-2024 03:13 PM
Sample Tested In	: Plasma-NaF(F), Plasma-NaF(PP)	Reported On	: 28-Sep-2024 05:54 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

GLUCOSE POST PRANDIAL (PP)

Test Name	Results	Units	Biological Reference Interval
Glucose Fasting (F) *(Method: Hexokinase)*	**164**	mg/dL	70-100

Interpretation of Plasma Glucose based on ADA guidelines 2018

Diagnosis	FastingPlasma Glucose(mg/dL)	2hrsPlasma Glucose(mg/dL)	HbA1c(%)	RBS(mg/dL)
Prediabetes	100-125	140-199	5.7-6.4	NA
Diabetes	> = 126	> = 200	> = 6.5	>=200(with symptoms)

Reference: Diabetes care 2018:41(suppl.1):S13-S27

Glucose Post Prandial (PP) *(Method: Hexokinase (HK))*	**244**	mg/dL	70-140

Interpretation of Plasma Glucose based on ADA guidelines 2018

Diagnosis	FastingPlasma Glucose(mg/dL)	2hrsPlasma Glucose(mg/dL)	HbA1c(%)	RBS(mg/dL)
Prediabetes	100-125	140-199	5.7-6.4	NA
Diabetes	> = 126	> = 200	> = 6.5	>=200(with symptoms)

Reference: Diabetes care 2018:41(suppl.1):S13-S27

- Postprandial glucose level is a screening test for Diabetes Mellitus
- If glucose level is >140 mg/dL and <200 mg/dL, then GTT (glucose tolerance test) is advised.
- If level after 2 hours = >200 mg/dL diabetes mellitus is confirmed.
- Advise HbA1c for further evaluation.

*** End Of Report ***

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LABORATORY TEST REPORT

Name	: Mrs. AKSHATA		
Sample ID	: A0451536, A0451533		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	: Whole Blood	Received On	: 28-Sep-2024 12:50 PM
Sample Tested In	: Whole Blood EDTA, Serum	Reported On	: 28-Sep-2024 05:29 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval
Glycated Hemoglobin (HbA1c) (Method: HPLC)	**8.7**	%	Non Diabetic:< 5.7 Pre diabetic: 5.7-6.4 Diabetic:>= 6.5
Mean Plasma Glucose (Method: Calculated)	202.99	mg/dL	

Glycated hemoglobins (GHb), also called glycohemoglobins, are substances formed when glucose binds to hemoglobin, and occur in amounts proportional to the concentration of serum glucose. Since red blood cells survive an average of 120 days, the measurement of GHb provides an index of a person's average blood glucose concentration (glycemia) during the preceding 2-3 months. Normally, only 4% to 6% of hemoglobin is bound to glucose, while elevated glycohemoglobin levels are seen in diabetes and other hyperglycemic states Mean Plasma Glucose(MPG):This Is Mathematical Calculations Where Glycated Hb Can Be Correlated With Daily Mean Plasma Glucose Level

***NOTE:** The above Given Risk Level Interpretation is not age specific and is an information resource only and is not to be used or relied on for any diagnostic or treatment purposes and should not be used as a substitute for professional diagnosis and treatment. Kindly Correlate clinically.*

INTERPRETATION

Method: Analyzer Fully automated **HPLC** platform.

Average Blood Glucose(eAG) (mg/dL)	Level of Control	Hemoglobin A1c (%)
421	ALERT	14%
386		13%
350		12%
314		11%
279		10%
243		9%
208		8%
172	POOR	7%
136	GOOD	6%
101	EXCELLENT	5%

HbA1c values of 5.0- 6.5 percent indicate good control or an increased risk for developing diabetes mellitus. HbA1c values greater than 6.5 percent are diagnostic of diabetes mellitus. Diagnosis should be confirmed by repeating the HbA1c test.

NOTE: Hb F higher than 10 percent of total Hb may yield falsely low results. Conditions that shorten red cell survival, such as the presence of unstable hemoglobins like Hb SS, Hb CC, and Hb SC, or other causes of hemolytic anemia may yield falsely low results. Iron deficiency anemia may yield falsely high results.

Insulin - Fasting (Method: CLIA)	18.33	mIU/L	Random Insulin:2.6-37.6 Fasting Insulin :3.0-25.0 PP Insulin: 5.0-55.0

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Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval
PRL(Prolactin) (Method: CLIA)	20.14	ng/mL	Refer Table

Interpretation:

Age	Reference Range: Male (ng/mL)	Reference Range: Female(ng/mL)
Puberty Tanner Stage		
1	< 10.0	3.6-12.0
2-3	< 6.1	2.6-18.0
4-5	2.8-11.0	3.2-20.0
Adult	2.1-17.7	Nonpregnant :2.8–29.2 Pregnant :9.7–208.5 Postmenopausal :1.8–20.3

- Prolactin is a 23kD sized hormone produced by the lactotroph cells of the pituitary gland, a grape-sized organ found at the base of the brain. Normally present in low amounts in men and non-pregnant women, prolactin's main role is to promote lactation (breast milk production).
- Breast milk production that is not related to childbirth (galactorrhea)
- Erection problems in men
- Irregular or no menstrual periods (amenorrhea)

Anti Mullerian Hormone (AMH) (Method: CLIA)	1.91	ng/mL	Refer Table

Age Ranges in Females:		Fertility Ranges:
18-25 Years: 0.96-13.34 ng/mL	26-30 Years: 0.17-7.37 ng/mL	Optimal Fertility: 4.0-6.8 ng/mL
31-35 Years: 0.07-7.35 ng/mL	36-40 Years: 0.03-7.15 ng/mL	Satisfactory Fertility: 2.2-4.0 ng/mL
41-45 Years: < 3.27 ng/mL	> 46 Years: < 1.15 ng/mL	Low Fertility: 0.3-2.2 ng/mL
Male Reference Range: 0.73-16.05 ng/mL		

OVER VIEW:

Antimullerian hormone (AMH), also called müllerian inhibiting substance, is a glycoprotein that regulates reproductive duct development. Its presence in the fetal male causes regression of the müllerian (female) ducts which then allows for the wolffian (male) ducts to develop. AMH is produced by the Sertoli cells of the testis beginning around 6 weeks gestation; levels remain elevated until puberty. In the female fetus, the absence of AMH allows the müllerian ducts to develop into the fallopian tubes, uterus, and upper 2/3 of the vagina. The hormone is secreted by the granulosa cells of preantral and small antral follicles of the ovaries and begins to be detected around 36 weeks gestational age. AMH levels are low in female children until puberty. They typically remain constant during the reproductive years and then decline steadily with age as the number of follicles decrease. AMH is undetectable at menopause.

Clinical Significance:

- Assess gonadal function in children
- Evaluation of infants with ambiguous genitalia and other intersex conditions.
- Evaluating testicular function in infants and children including cryptorchidism and anorchidism.
- Aid in the assessment of infrequent or absent menses, including premature ovarian insufficiency, polycystic ovarian syndrome and menopause.
- Assessing ovarian status including follicle development, ovarian reserve, and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization (IVF).
- Assessing ovarian function prior to, during, and following gonadotoxic cancer treatment in premenopausal women.
- Diagnosing and monitoring patients with AMH-secreting ovarian granulosa cell tumors.

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Name	: Mrs. AKSHATA		
Sample ID	: A0451536, A0451533		
Age/Gender	: 33 Years/Female	Reg. No	: 0312409280018
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 28-Sep-2024 09:06 AM
Primary Sample	: Whole Blood	Received On	: 28-Sep-2024 12:50 PM
Sample Tested In	: Whole Blood EDTA, Serum	Reported On	: 28-Sep-2024 05:29 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval
TSH -Thyroid Stimulating Hormone (Method: CLIA)	1.72	µIU/mL	0.35-5.5

Pregnancy & Cord Blood

TSH (Thyroid Stimulating Hormone (µIU/mL)	
First Trimester	: 0.24-2.99
Second Trimester	: 0.46-2.95
Third Trimester	: 0.43-2.78
Cord Blood	: 2.3-13.2

- TSH is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low
- TRH stimulation differentiates secondary and tertiary hypothyroidism by observing the change in patient TSH levels. Typically, the TSH response to TRH stimulation is absent in cases of secondary hypothyroidism, and normal to exaggerated in tertiary hypothyroidism
- Historically, TRH stimulation has been used to confirm primary hyperthyroidism, indicated by elevated T3 and T4 levels and low or undetectable TSH levels. TSH assays with increased sensitivity and specificity provide a primary diagnostic tool to differentiate hyperthyroid from euthyroid patients.

*** End Of Report ***

DR.VAISHNAVI
MD BIOCHEMISTRY

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