

Dr. Vinay Chopra
 MD (Pathology & Microbiology)
 Chairman & Consultant Pathologist

Dr. Yugam Chopra
 MD (Pathology)
 CEO & Consultant Pathologist

NAME	: Mrs. SONAM	PATIENT ID	: 1648501
AGE/ GENDER	: 37 YRS/FEMALE	REG. NO./LAB NO.	: 012410200011
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 20/Oct/2024 09:24 AM
REFERRED BY	:	COLLECTION DATE	: 20/Oct/2024 09:41AM
BARCODE NO.	: 01519222	REPORTING DATE	: 20/Oct/2024 04:46PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c):	6.5 ^H	%	4.0 - 6.4
WHOLE BLOOD			
<i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>			
ESTIMATED AVERAGE PLASMA GLUCOSE	139.85	mg/dL	60.00 - 140.00
<i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>			

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):	
REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HBA1C) in %
Non diabetic Adults >= 18 years	<5.7
At Risk (Prediabetes)	5.7 – 6.4
Diagnosing Diabetes	>= 6.5
Therapeutic goals for glycemic control	Age > 19 Years
	Goals of Therapy: < 7.0
	Actions Suggested: >8.0
	Age < 19 Years
	Goal of therapy: <7.5

COMMENTS:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0% may not be appropriate.
- High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shortens RBC life span like acute blood loss, hemolytic anemia falsely lowers HbA1c results.
- HbA1c results from patients with HbSS, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.




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BARCODE NO.	: 01519222	REPORTING DATE	: 20/Oct/2024 12:28PM
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Test Name	Value	Unit	Biological Reference interval
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ENDOCRINOLOGY

BETA HCG - TOTAL (QUANTITATIVE): MATERNAL

BETA HCG TOTAL, PREGNANCY MATERNAL: 30106.42^H mIU/mL < 5.0

SERUM

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:

MEN:	mIU/ml	< 2.0
NON PREGNANT PRE-MENOPAUSAL WOMEN:	mIU/ml	< 5.0
MENOPAUSAL WOMEN:	mIU/ml	< 7.0
BETA HCG EXPECTED VALUES IN ACCORDANCE TO WEEKS OF GESTATIONAL AGE		
WEEKS OF GESTATION	Unit	Value
4-5	mIU/ml	1500 - 23000
5-6	mIU/ml	3400 - 135300
6-7	mIU/ml	10500 - 161000
7-8	mIU/ml	18000 - 209000
8-9	mIU/ml	37500 - 219000
9-10	mIU/ml	42800 - 218000
10-11	mIU/ml	33700 - 218700
11-12	mIU/ml	21800 - 193200
12-13	mIU/ml	20300 - 166100
13-14	mIU/ml	15400 - 190000
2nd TRIMESTER	mIU/ml	2800 - 176100
3rd TRIMESTER	mIU/ml	2800 - 144400




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1.hCG is a Glycoprotein with alpha and beta chains. Beta subunit is specific to hCG.

2.It is largely secreted by trophoblastic tissue. Small amounts may be secreted by fetal tissues and by the adult ant pituitary.

INCREASED :

1.Pregnancy

2.Gestationalsite & Non gestational trophoblastic neoplasia.

3.In mixed germ cell tumors.

SIGNIFICANTLY HIGHER THAN EXPECTED LEVEL:

1.Multiple pregnancies & High risk molar pregnancies are usually associated with levels in excess of one lac mIU/ml.

2.Erythroblastosis fetalis & Downs syndrome.

DECREASED:

1.Ectopic pregnancy.

2.Intra-uterine fetal death.

NOTE:

1.The test becomes positive 7-9 days after the midcycle surge that precedes ovulation (time of blastocyst implantation). Blood levels rise rapidly after this and double every 1.4 - 2 days.

2.Peak values are usually seen at 60-80 days of LMP. The levels then begin to taper and ebb out around the 20th week. These low levels are then maintained throughout pregnancy.

3.Doubling time: In intra-uterine pregnancy, serum hCG levels increase by approximately 66% every 48 hrs.Inappropriately rising serum hCG levels are suggestive of dying or ectopic pregnancy.

CAUTION:

Spuriously high levels (Phantom hCG) may be seen in presence of heterophilic antibodies (found in some normal people). If persistently raised levels are seen in a non-pregnant patient with no evidence of other obvious causes for such an increase a urine hCG assay may help confirm presence of the heterophile antibodies.

*** End Of Report ***




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