

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

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

NAME	: Mrs. SAMRITI	PATIENT ID	: 1319539
AGE/ GENDER	: 30 YRS/FEMALE	REG. NO./LAB NO.	: 012412110005
COLLECTED BY	:	REGISTRATION DATE	: 11/Dec/2024 08:42 AM
REFERRED BY	:	COLLECTION DATE	: 11/Dec/2024 11:42AM
BARCODE NO.	: 01522285	REPORTING DATE	: 11/Dec/2024 12:47PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	79.71	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
GLUCOSE POST PRANDIAL (PP): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	130.11	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0

INTERPRETATION:

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose below 100 mg/dL and post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl and post-prandial plasma glucose level between 140 – 200 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A fasting plasma glucose level of above 125 mg/dL and post-prandial plasma glucose level above 200 mg/dL is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.




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BARCODE NO.	: 01522285	REPORTING DATE	: 11/Dec/2024 11:40AM
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SGOT/SGPT PROFILE

SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	30.3	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	18.8	U/L	0.00 - 49.00
SGOT/SGPT RATIO <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.61		

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference Range.

USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:-

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)

DECREASED:-

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).

PROGNOSTIC SIGNIFICANCE:-

NORMAL	< 0.65
GOOD PROGNOSTIC SIGN	0.3 - 0.6
POOR PROGNOSTIC SIGN	1.2 - 1.6




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ENDOCRINOLOGY

THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 2.605 μ IU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

AGE	REFERENCE RANGE (μ IU/mL)
0 – 5 DAYS	0.70 – 15.20
6 Days – 2 Months	0.70 – 11.00
3 – 11 Months	0.70 – 8.40
1 – 5 Years	0.70 – 7.00
6 – 10 Years	0.60 – 5.50
11 - 15	0.50 – 5.50
> 20 Years (Adults)	0.27 – 5.50
PREGNANCY	
1st Trimester	0.10 - 3.00
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 - 4.10

NOTE:- TSH levels are subjected to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50 %. Hence time of the day has influence on the measured serum TSH concentration.

USE:- TSH controls biosynthesis and release of thyroid hormones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

INCREASED LEVELS:

- 1.Primary or untreated hypothyroidism, may vary from 3 times to more than 100 times normal depending on degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis.
- 4.DRUGS: Amphetamines, Iodine containing agents and dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge.

DECREASED LEVELS:

- 1.Toxic multi-nodular goitre & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.





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8.Pregnancy: 1st and 2nd Trimester


LIMITATIONS:

- 1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.
- 2.Autoimmune disorders may produce spurious results.

*** End Of Report ***




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