Diagnoedge LABS

Diagnostic Report

Name : MS. RIYA	Lab ID : 30	Sample Collection : 06/02/2026 11:05:36
Age/Sex : 32 Yrs. / F	Ref.By : Self	Sample Received : 06/02/2026 11:27:35
Sent By : Dr Path Care	Printed : 08/02/2026 18:53:21	Report Released : 06/02/2026 15:12:41

Blood Sugar Fasting (BSF)

Test		Result	Unit	Reference Range	Method
Blood Sugar , Fasting (F) , Plasma	:	88.37	mg/dl	74-120 mg/dl	GOD-POD

Interpretation:

The American Diabetes Association (ADA) recommends the following criteria for the diagnosis of diabetes:

1. Symptoms of diabetes and a random glucose > 200 mg/dl.

2. Fasting glucose ≥ 126 mg/dL..

Impaired fasting glucose (IFG), fasting glucose between 100 and 125 mg/dl, is defined by the ADA as a category at risk for future diabetes and cardiovascular disease.

Glycosylated Haemoglobin (HbA1c)

Test		Result	Unit	Reference Range	Method
HbA1C	:	5.10	%		HPLC
Estimated average glucose (eAG)	:	99.67	mg/dl		Calculated

Interpretation:

Reference Group	HbA1c %
Non diabetic adults =18 years	< 5.7
At risk (Prediabetes)	5.7 - 6.4
Therapeutic goals for glycemic control	Age > 19 years Goal of therapy: < 7.0 Action suggested: > 8.0 Age < 19 years Goal of therapy: < 7.5

HbA1c %	Mean Plasma Glucose (mg/dL)
4	68
5	97
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Note:

1. Since HbAlc reflects long-term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbAlc. Converse is true for a diabetic previously under good control but now poorly controlled.

2. 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.

Comments: HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

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Complete Blood Count (CBC)

Test		Result	Unit	Biological Ref. Range
Haemoglobin	:	12.30	g/dL	12.0 - 15.0 g/dL
Method: Photometric Light Absorbance				
RBC Count	:	5.11 [H]	mill/cumm	3.8-4.8 mill/cumm
Method: DC sheath flow detection				
Haematocrit (PCV/HCT)	:	39.50	%	36.0-46.0 %
Method: Pulse height detection				
Red Blood Cell Indices				
Mean Corpuscular Volume (MCV)	:	77.30 [L]	fl	83.0 - 101.0 fl
Method: Calculated				
Mean Corpuscular Haemoglobin (MCH)	:	24.00	pg	27 - 32 pg
Method: Calculated				
Mean Corpuscular Haem. Conc. (MCHC)	:	31.10 [L]	g/dl	31.5 - 34.5 g/dl
Method:Calculated				
RDW-CV	:	12.10	%	11.6 - 14.0 %
Method: Calculated				
RDW-SD	:	33.30 [L]	fL	39 - 46 fL
Method: Calculated				
White Blood Cells				
Total Leukocyte Count	:	5200.00	cells/cumm	4000 - 10000 cells/cumm
Method: Flow cytometry				
Differential Leucocyte Count				
Neutrophils	:	53.00	%	40-80 %
Method:Flowcytometry / Microscopy				
Eosinophils	:	2.10	%	01-06 %
Method:Flowcytometry / Microscopy				
Lymphocytes	:	40.10 [H]	%	20-40 %
Method:Flowcytometry / Microscopy				
Basophils	:	0.50	%	0-02 %
Method:Flowcytometry / Microscopy				
Monocytes	:	4.30	%	2-10 %
Method:Flowcytometry / Microscopy				
Absolute Neutrophil Count (ANC)	:	2.76	10^3/µL	2 - 7 10^3/µL
Method:Calculated				
Absolute Eosinophil Count (AEC)	:	0.11	10^3/µL	0.02 - 0.5 10^3/µL
Method:Calculated				
Absolute Lymphocyte Count (ALC)	:	2.09	10^3/µL	1 - 3 10^3/µL

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Method:Calculated

Absolute Monocyte Count (AMC)	:	0.22	10^3/µL	0.2 - 1.0 10^3/µL

Method:Calculated

Platelets

Platelet Count	:	111.00 [L]	10^3/µL	150 - 410 10^3/µL

Method: Electrical impedance /Microscopy

PCT	:	15.20 [H]	%	0.20-0.36 %

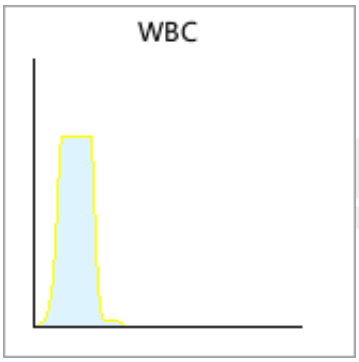
Method- Calculated

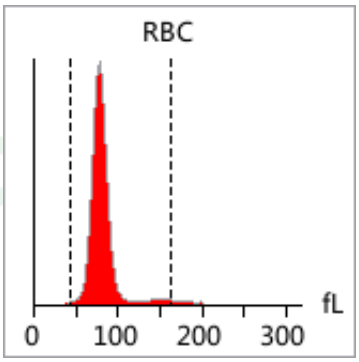
MPV	:	13.70 [H]	fL	7.5 - 10.5 fL

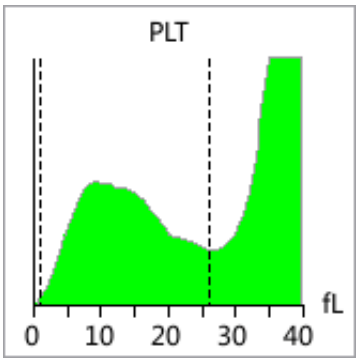
Method- Calculated

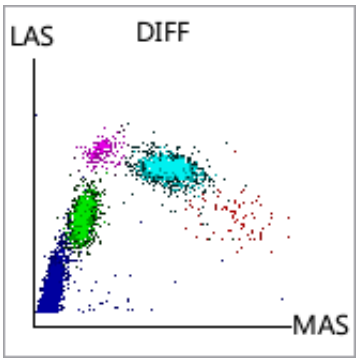
PDW	:	16.00 [H]	fL	10-14 fL

Method-Calculated









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Erythrocyte Sedimentation Rate (ESR)

Test	Result	Unit	Reference Range	Method
Erythrocyte Sedimentation Rate (ESR) :	18	mm / hour	0-20 mm / hour	Wintrobe Method

Interpretation:

The erythrocyte sedimentation rate measures the rate at which the red cells in sample of blood placed in a thin tube, fall to the bottom. It is generally regarded a non-specific measure of inflammation; and is increased in infections, arthritis, some cancers like Multiple Myeloma, pregnancy and in some anemias. A decrease in ESR is noted in polycythemia and liver disease.

Liver Function Test (LFT) With GGT

Test		Result	Unit	Reference Range	Method
Bilirubin (Total),Serum	:	0.46	mg/dl	0.0-2.0 mg/dl	Diazotization
Bilirubin (Direct),Serum	:	0.13	mg/dl	0.10-0.40 mg/dl	Diazotization
Bilirubin (Indirect)Serum	:	0.33	mg/dl	0.00-1.60 mg/dl	Calculated
Aspartate Aminotransferase (AST/SGOT),Serum	:	21	U/L	0.0-31.0 U/L	UV;IFCC without Pyridoxal Phosphate
Alanine Aminotransferase (ALT/SGPT)Serum	:	19	U/L	0.00-34.0 U/L	UV;IFCC without Pyridoxal Phosphate
Alkaline Phosphatase-ALP,Serum	:	47.09	U/L	30-120 U/L	ALP-AMP
Total Protein - Serum	:	7.01	g/dl	6.6-8.3 g/dl	Biuret
Albumin ,Serum	:	4.23	g/dl	3.50-5.30 g/dl	Bromo Cresol Green
Globulin	:	2.78	g/dl	2-3.9 g/dl	Calculated
A/G Ratio	:	1.52		1.1-2.5	Calculated
Gamma Glutamyl Transferase	:	13	U/L	<38 U/L	UV Assay - Szasz

Interpretation:

The liver panel includes investigating a group of parameters to determine how well the liver is performing its various excretory, metabolic and synthetic functions. These tests also help the health provider to determine the cause of liver damage, and monitor the progression of the disease.

ALT/SGPT (Alanine aminotransferase) and **AST/SGOT (Aspartate Aminotransferase)** are enzymes produced by liver cells. Increased levels indicate acute and chronic liver cell injury, as seen in viral hepatitis, alcoholic liver disease, toxins and sepsis.

The levels of the enzyme **Gamma glutamyl transferase(GGT)** are elevated in case of injury to the liver by alcohol, or due to bile duct obstruction.

The enzyme **Alkaline Phosphatase** is raised in obstruction of the bile duct due to stones, tumors, etc.

Bilirubin is a yellowish pigment made by breakdown of red blood cells. Total bilirubin is a sum of direct (conjugated) and indirect (unconjugated) bilirubin. Indirect bilirubin is converted into direct bilirubin in the liver and excreted through the bile, into the intestine. Direct bilirubin levels may be raised in viral hepatitis, gall stones and alcoholic liver disease. and indirect bilirubin may be raised in hemolytic anemias like thalassemia, sickle cell anemia and hereditary spherocytosis. A liver panel also includes measurement of **Total proteins, mainly Albumin and Globulin.** Lower than normal levels of albumin and globulins are noted in malnutrition, burns and nephrotic syndrome. Increased albumin levels may be noted in dehydration. Higher than normal levels of globulins may be seen in chronic infections and multiple myeloma.

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Lipid Profile

Test		Result	Unit	Reference Range	Method
Total Cholesterol , Serum	:	207	mg/dl	<239 mg/dl	CHOD-PAP
Triglyceride,Serum	:	96	mg/dl	<200 mg/dl	GPO-POD
HDL Cholesterol , Serum	:	46	mg/dl	>45 mg/dl	PVS /PEGME
LDL Cholesterol , Serum	:	141.80	mg/dl	<159 mg/dl	Calculated
VLDL Cholesterol ,Serum	:	19.20	mg/dl	<30 mg/dl	Calculated
Non - HDL Cholesterol	:	161.00	mg/dl	0-189 mg/dl	Calculated
Total Cholesterol / HDL Ratio,Serum	:	4.50 [H]		Refer to Table	Calculated
LDL/HDL Ratio	:	3.08 [H]		<=3.0 is ideal	Calculated
Triglycerides/HDL Ratio	:	2.09 [H]		<=2.0 is ideal	Calculated

Interpretation

National Lipid Association Recommendations (NLA-2014)	Total Cholesterol in mg/dL	Triglyceride in mg/dL	LDL Cholesterol in mg/dL	Non- HDL Cholesterol in mg/dL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130-159
Borderline High	200-239	150-199	130-159	160-189
High	≥ 240	200-499	160-189	190-219
Very	-	≥ 500	≥ 190	≥ 220

Note:

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.

2. Lipid Association of India (LAI) recommends screening of all adults above the age of 20 years for Atherosclerotic Cardiovascular Disease (ASCVD) risk factors especially lipid profile. This should be done earlier if there is family history of premature heart disease, dyslipidemia, obesity or other risk factors

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Renal Function Test with Electrolyte (RFT)

Test		Result	Unit	Reference Range	Method
Blood Urea Nitrogen (BUN) ,Serum	:	12.79	mg/dl	6.0-19.0 mg/dl	Calculated
Urea ,Serum	:	27.38	mg/dl	13- 40 mg/dl	Urease -GLDH
Creatinine Serum	:	0.59	mg/dl	0.5-0.9 mg/dl	Sarcosine Oxidase
Uric Acid, Serum	:	4.1	mg/dl	2.3-6.1 mg/dl	Uricase POD
Bun/Creatinine Ratio	:	21.68		12-20	Calculated
Urea/Creatinine Ratio	:	46.41			Calculated
Electrolytes, Serum					
Potassium	:	4.76	mmol/L	3.5-5.3 mmol/L	Flame photometry
Chloride	:	107	mmol/L	98-107 mmol/L	Flame photometry
Sodium	:	139	mmol/L	135-148 mmol/L	Flame photometry

Interpretation:

Renal function tests assess kidney performance.

- **Creatinine & Urea (BUN)**: Key markers of kidney function. Increased in dehydration, kidney disease, and urinary obstruction; decreased in low-protein diet and severe liver disease.
- **Uric Acid:** Elevated in kidney disease, gout, high-purine diet (red meat, seafood, beer, lentils), or genetic disorders. Can cause kidney stones and damage.
- **Electrolytes (Na, K, Cl):** Essential for fluid balance, muscle/heart function, and pH regulation.
  - **Hyponatremia:** Diuretics, heart failure, cirrhosis.
  - **Hypernatremia:** Dehydration, excess salt.
  - **Hypokalemia:** Diarrhea, ketoacidosis.
  - **Hyperkalemia:** Renal failure, Addison's disease, K-sparing diuretics.
  - **Hypochloremia:** Heart failure, alkalosis, diuretics.
  - **Hyperchloremia:** Dehydration, salt excess, renal failure.

Calcium

Test		Result	Unit	Reference Range	Method
Calcium ,Serum	:	9.77	mg/dl	8.6-10.2 mg/dl	Arsenazo

Interpretation:

Common causes of decreased value of calcium (hypocalcemia) are chronic renal failure, hypomagnesemia and hypoalbuminemia. Hypercalcemia (increased value of calcium) can be caused by increased intestinal absorption (vitamin d intoxication), increased skeletal reabsorption (immobilization),or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95 % of all cases of hypercalcemia. Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels important source of preanalytical error in the measurement of calcium is prolonged torniquet application during sampling. Thus, this along with fist clenching should be avoided before phlebotomy.

Critical value of Calcium established as per laboratory policy: Adult : < 6.0 or > 13.0 Such critical value if obtained needs urgent medical attention

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Iron Studies

Test		Result	Unit	Reference Range	Method
Iron , Serum	:	88.4	ug/dL	50-170 ug/dL	Colorimetric assay (Ferrozine)
UIBC (Unsaturated Iron binding Capacity)	:	173.62	ug/dL	110-370 ug/dL	Colorimetric assay
Iron Binding Capacity Total (TIBC)	:	262.02	ug/dl	228-428 ug/dl	Calculated
Transferrin Saturation	:	33.74	%	15.0-50.0 %	Calculated

Interpretation:

Anemias are the most common hematological disorder in both adult and pediatric populations. An iron panel helps the health care provider to find about the cause of anemia, so that appropriate treatment can be provided to the patient. Tests on the iron panel include; fasting serum iron, TIBC, and percentage transferrin saturation.

Serum iron is a measure of circulating iron, most of which is bound to transferrin. Iron is an essential nutrient that, among other functions, is required for the production of Hemoglobin in the red blood cells.

Transferrin is the main iron transport protein; its synthesis is inversely proportional to body iron stores.

The total iron binding capacity (TIBC) reflects the available iron binding sites on transferrin. Normally, serum iron occupies about one-third of the binding sites on transferrin. The measurement of the maximum concentration of iron that transferrin can bind is called the total iron-binding capacity (TIBC).

The transferrin saturation is the ratio of serum iron to the TIBC, expressed as a percentage. Transferrin saturations of less than 20% indicate iron deficiency, while transferrin saturations of more than 50% suggest iron overload.

A summary of changes in the various parameters of the iron profile in different diseases is given in the table below.

DISEASE	SERUM IRON	TIBC	% TRANSFERRIN SAT.
Iron Deficiency	Decreased	Increased	Decreased
Anemia of chronic disease	Decreased	Decreased	Decreased
Iron overload states	Increased	Normal to decreased	Increased

Phosphorus

Test		Result	Unit	Reference Range	Method
Phosphorus	:	3.3	mg/dl	2.6-4.7 mg/dl	UV-phosphomolybdate

Interpretation:

Hypophosphatemia is relatively common in hospitalized patients. Levels below 1.5 mg/dL may result in muscle weakness, hemolysis of red cells, coma, and bone deformity and impaired growth. Rapid elevations of serum phosphate levels is hypocalcemia with tetany, seizures, and hypotension.

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Vitamin - B12

Test		Result	Unit	Reference Range	Method
Vitamin B12	:	578	pg/ml	180-916 pg/ml	CLIA

Interpretation:

Vitamin b12 deficiency leads to Megaloblastic anemia and demyelination of large nerve fibers of the spinal cord. Normal body stores are sufficient to last for 3-6 years. Sources of Vitamin B12 are liver, shellfish, meat, eggs, milk, cheese & yogurt.

Causes of Decreased levels

1. Lack of Intrinsic Factor: Total or Partial gastrectomy, Atrophic gastritis, Intrinsic factor antibodies.
2. Malabsorption: Regional ileitis, Resected bowel, Tropical sprue, celiac disease, pancreatic insufficiency, bacterial overgrowth & achlorhydria.
3. Loss of Ingested Vitamin B12: fish tapeworm.
4. Congenital disorders: Osmotic aciduria & transcobalamin deficiency.
5. Increased demand: Pregnancy especially last trimester.

Causes of Increased Levels

Chronic renal failure, Congestive heart failure, Acute & Chromic Myeloid Leukemia, Polycythemia Vera, Liver disease, Drug induced cholestasis & Protein malnutrition.

25-Hydroxy-Vitamin D Total

Test		Result	Unit	Reference Range	Method
Vitamin-D 25 Hydroxy	:	22.40	ng/ml	Refer to table ng/ml	CLIA

Reference Interval:

Vitamin D Status	Range, Adult ng/mL	Range, Pediatric ng/mL
Deficiency	<20	<15
Insufficiency	20-30	15-20
Sufficiency	30-100	20-100

Interpretation:

Vitamin D is a fat- soluble Vitamin found in animal products like milk, eggs and fish. It is also produced in the skin by exposure to the sun. It helps to maintain adequate serum calcium and phosphate concentrations to enable normal bone density. Some studies have linked it to better immunity and cardiac health. Vitamin D deficiency may cause muscular and bony pain, Rickets in children and Osteomalacia in adults. Vitamin D toxicity can lead to hypercalcemia and renal failure.

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THYROID FUNCTION TEST (TFT)

Test		Result	Unit	Reference Range	Method
T3 (Triiodothyronine)	:	0.96	ng/ml	0.75-2.10 ng/ml	CLIA
T4 (Thyroxine)	:	6.50	µg/dl	5.0-13.0 µg/dl	CLIA
TSH (Thyroid Stimulating Hormone)	:	1.137	µlU/ml	0.30-4.5 µlU/ml	CLIA

TSH-Ultra (Thyroid Stimulating Hormone			
For Pregnant Female (uIU/mL)		**Pediatric Age Group (uIU/mL)**	
First Trimester	0.10 - 2.50	Infants (1-23 months)	0.87 - 6.15
Second Trimester	0.20 - 3.00	Children (2-12 Years)	0.67 - 4.16
Third Trimester	0.30 - 3.00	Adolescents (13-20 Years)	0.48 - 4.17

Interpretation:

Thyroid function tests (TSH, T3, T4) help assess thyroid activity. They are useful in diagnosing hypo- or hyperthyroidism, and in monitoring therapy.

Hypothyroidism (low function): Symptoms include weight gain, lethargy, hair loss, dry skin, depression, heavy menses. Causes: autoimmune thyroiditis, iodine deficiency, thyroid surgery/radiation, certain drugs (e.g., amiodarone), pituitary tumors, thyroid dysgenesis. **Hyperthyroidism** (overactive): Symptoms include palpitations, weight loss, increased appetite, tremors, sweating. Causes: Graves' disease, toxic multinodular goiter, functioning adenomas.

CONDITION	T3	T4	TSH		CONDITION	T3	T4	TSH
Primary hypothyroidism	LOW	LOW	HIGH		Subclinical hypothyroidism	NORMAL	NORMAL	HIGH
Primary hyperthyroidism	HIGH	HIGH	LOW		Subclinical hyperthyroidism	NORMAL	NORMAL	LOW

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Urine Routine Examination

Test		Result	Unit	Reference Range	Method
PHYSICAL EXAMINATION					
Quantity	:	30	ml		Manual
Colour	:	Yellow			Manual
Appearance	:	Clear			Manual
CHEMICAL EXAMINATION					
Specific Gravity	:	1.020		1.010-1.030	Automated dipstick
pH	:	6.0		5.5-7.0	Automated dipstick
Protein	:	Negative		Negative	Automated dipstick
Blood	:	Negative		Absent	Automated dipstick
Glucose	:	Negative		Negative	Automated dipstick
Ketones Bodies	:	Negative		Negative	Automated dipstick
Bilirubin	:	Negative		Negative	Automated dipstick
Urobilinogen	:	Normal		Normal	Automated dipstick
Leucocytes	:	Negative		Negative	Automated dipstick
Nitrite	:	Negative		Negative	Automated dipstick
MICROSCOPIC EXAMINATION					
Pus Cells	:	1-3	/HPF	0-5 /HPF	Microscopy
RBCs	:	Not seen	/HPF	Not Seen /HPF	Microscopy
Epithelial cells	:	5-7 [H]	/HPF	0-5 /HPF	Microscopy
Crystals	:	Not seen	/HPF	Not seen /HPF	Microscopy
Casts	:	Not seen	/HPF	Not seen /HPF	Microscopy
Bacteria	:	Present [H]	/HPF	Absent /HPF	Microscopy
Other	:	Amorphous Debris present [H]			Microscopy

Interpretation:

Urine examination (physical, chemical, microscopic) helps screen for kidney, liver, and urinary tract disorders.

Physical: Color/appearance – yellow (bile pigments), red (blood), cloudy (protein/pus).

Chemical:

- pH : dehydration, DKA; pH : UTI, alkalosis.
- Specific gravity : dehydration, diabetes; : renal failure, excess fluids.
- Glucose: diabetes, pregnancy.
- Protein: illness, diabetes, glomerulonephritis.
- Bilirubin: hepatitis, obstructive liver disease.
- Urobilinogen : hemolysis; absent: bile duct obstruction.
- Nitrite +: UTI.

Microscopic:

- RBCs: UTI, stones, glomerulonephritis, trauma.
- WBCs: UTI/inflammation.
- Epithelial cells: normally few; in inflammation.

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