Registration.Date	:	03/04/2025	Permanent ID No.	:	270389
Patient Name	:	**MR. SIVARAMAKRISHNAN B.A.**	Patient ID No.	:	1200205
Age / Gender	:	77 Yrs / Male	Reg Date/Time	:	03-04-2025 10:45am
Reference (Dr.)	:	Mulay Atul ; MD,DNB (Nephro)	Sample Coll.Date/Time	:	03-04-2025 00:00
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HAEMOGRAM (CBC)

Investigation		Result	Units	Reference Range
Haemoglobin *(SLS haemoglobin photometry)*	: L	**9.40**	gm/dL	13.0 - 17.0
RBC Count *(Hydrodynamically focusing DC detection)*	: L	**2.88**	mill/cu mm	4.5 - 6.5
Haematocrit (PCV) *(Cumulative pulse height detection method)*	: L	**28.00**	%	40 - 52
MCV (Mean Corpuscular Volume) *(Derived from RBC histogram)*	:	97.20	fL	83 - 101
MCH (Mean Corpuscular Hb) *(Calculated)*	: H	**32.60**	pg	27 - 32
MCHC (Mean Corpuscular Hb Conc.) *(Calculated)*	:	33.60	gm/dL	32 - 36
RDW (Red cell Distribution Width)	: H	**14.8**	%	11.6 - 14.0
RBC Morphology	:	Predominantly Normocytic Normochromic.		
Total WBC (Leucocyte) Count *(Fluroscent Flow cytometry)*	:	6400	/cu mm	4,000 - 11,000
Neutrophils	:	70	%	40 - 75
Lymphocytes	:	23	%	20 - 40
Eosinophils	:	03	%	1 - 6
Monocytes	:	04	%	1 - 10
Basophils	:	00	%	0 - 2
Neutrophil/Lymphocyte ratio(N/L ratio) *(Calculated)*	: H	**3.04**	Ratio	1.05 - 2.67
Absolute Neutrophil Count	:	4480	/cu mm	2000 - 7000
Absolute Lymphocyte Count	:	1472	/cu mm	1000 - 3000
Absolute Eosinophil Count	:	192	/cu mm	20 - 500
Absolute Monocyte Count	:	256	/cu mm	200 - 1000
Absolute Basophil Count	:	0	/cu mm	0 - 100
Platelet Count *(Hydrodynamically focussing DC detection)*	:	207000	/cu mm	1,50,000 - 4,50,000
MPV (Mean Platelet Volume) *(Calculated)*	:	8.9	fL	7.8 - 12.0
Platelet Remarks	:	Adequate		
PBS For Parasites	:	Malarial parasites not seen		

EDTA Whole Blood - [Tests done on fully automated five part Haematology analyzers - XN1000, (Sysmex)/ BC-6800 Plus (Mindray). WBC Differential by Fluorescent Flowcytometry and Absolute counts are calulated. All abnormal Haemograms are reviewed and confirmed microscopically.

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94030 85417, 80802 44202, 90492 34055
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CRP (C REACTIVE PROTEIN)

Investigation		Result	Units	Reference Range
C-Reactive Protein, Serum *(Serum, Immuno-turbidimetric method)*	: H	**10.24**	mg/L	0 to 5

COMMENTS:

1. C Reactive Protein (CRP) is the most sensitive acute phase reactant for inflammation.
2. The levels increase dramatically after severe trauma, bacterial infection, surgery & neoplastic proliferation.
3. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury or necrosis.
4. It is used in inflammatory disorders for monitoring course and effect of therapy. It assesses response to antibiotic treatment and differentiates between active and inactive disease forms with concurrent infection.
5. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.

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BIOCHEMICAL TEST

Investigation		Result	Units	Reference Range
Blood Urea *(Serum, Method: Urease)*	:	36.6	mg/dL	17 - 49
Creatinine *(Serum, Method: Modified Jaffe)*	:	1.25	mg/dL	0.60 - 1.30
Uric Acid, Serum *(Method: Uricase UV)*	: H	**8.4**	mg/dL	2.5 - 8.0
Calcium *(Serum, Method: Arsenanzo)*	:	8.9	mg/dL	8.7 - 10.7

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PROTEINS (Serum)

Investigation		Result	Units	Reference Range
Total Proteins, Serum *(Biuret Method)*	:	6.8	gms/dL	6.4 - 8.3
Albumin, Serum *Bromocresol Green (BCP)*	:	3.5	gms/dL	3.5 - 5.2
Globulin, Serum *(Calculated parameter)*	:	3.30	gms/dL	1.8 - 3.9
A/G (Ratio) *(Calculated parameter)*	:	1.06		0.9 - 2.0

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ALBUMIN/CREATININE RATIO (ACR) (Urine)

Investigation		Result	Units	Reference Range
Urinary Microalbumin *(Method: Immunoturbidimetry)*	:	4126.00	mcg/dL	<2000
Spot urinary Creatinine(mg/dL)	:	70.22	mg/dL	Normal human urine: >20 Diluted urine sample:6-20 Substituted Urine sample: <6
Urinary Albumin Creatinine Ratio *(Method: Calculated)*	:	58.76	mcg/mg	<30: Normal 30 - 299: Microalbuminuria >300: Overt albuminuria

NOTE:
It is recommended that at least two out of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.

CLINICAL USE:
1. Early detection of Diabetic nephropathy.
2. Therapeutic monitoring of patients with Nephropathy.
3. Routine management of patients with Diabetes.

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ELECTROLYTES

Investigation		Result	Units	Reference Range
Sodium *(Serum, Method: ISE Indirect)*	:	141	mmol/L	135 - 145
Potassium *(Serum, Method: ISE Indirect)*	:	3.6	mmol/L	3.5 - 5.3
Chloride *(Serum, Method: ISE Indirect)*	:	105	mmol/L	97 - 110

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HBA1c by HPLC

Investigation		Result	Units	Reference Range
HbA1c by HPLC *(EDTA, HPLC by Variant II Turbo, Biorad)*	:	5.6	%	Non-Diabetic : <= 5.6 Pre-Diabetic : 5.7 - 6.4 Diabetic : >=6.5 (American Diabetes Association 2023 guidelines) Refer interpretation for monitoring ranges.
Estimated Average Glucose (eAG) (Calculated)	:	114.02	mg/dL	Refer interpretation for monitoring ranges.

Interpretation and Remark :

1.HbA1c is used for monitoring diabetic control. It reflects the estimated Average Glucose(eAG).

2.HbA1c has been endorsed by ADA (American Diabetes Association) 2023, for diagnosis of diabetes using a cut-off point of 6.5%.

3.Trends in HbA1c are a better indicator of diabetic control than a solitary test.

4.In known diabetic patients, following values can be considered as a tool for monitoring glycemic control:

6.0 to 7.0 % - Excellent control
7.0 to 8.0 % - Fair to Good control
8.0 to 10.0 % - Unsatisfactory control
Above 10.0 % - Poor control.

5.Interpretation of Estimated Average Glucose in known diabetic patients:

90 to 120 - Excellent control
121 to 150 - Good control
151 to 180 - Average control
181 to 210 - Poor control.
>211 - Panic value

6.To estimate the eAG from the HbA1C value, following equation is used: eAG (mg/dl) = 28.7 x A1c - 46.7.

7. Falsely low glycated haemoglobin is often associated with systemic inflammatory diseases, haemolytic anaemia, certain haemoglobinopathies, recent blood transfusion, acute blood loss, hypertriglyceridemia, CRF and liver diseases and certain drugs causing increased erythrocyte destruction (Dapsone, Ribavirin, Antiretrovirals, Trimethoprim, Sulfamethoxazole etc), altered Hb (Hydroxyurea) or altered glycation (Vit E, Vit C, Aspirin in small doses). Clinical correlation suggested.

8.Interference of Haemoglobinopathies in HbA1c estimation - If HbF > 25% or other Homozygous or Heterozygous haemoglobinopathy is detected, HbA1c can be reported faulsely low or falsely high, an alternate platform (Fructosamine) is recommended for testing of HbA1c.

9.Inappropriately high HbA1c is caused by severe iron deficiency, Vit B12 deficiency, alcoholism, uraemia, hyperbiliruninaemia, certain drugs like Aspirin (large doses), chronic opiate use and presence of haemoglobinopathy.

Note: Hemoglobin electrophoresis (HPLC method) is recommended for detecting hemoglobinopathy.

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BIOCHEMICAL TEST

Investigation		Result	Units	Reference Range
Bicarbonate, Serum *(PEP-PEPC method)*	:	24.90	mmol/L	22 - 29

--End Of Report--

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Patient Data

Sample ID:	1200205
Patient ID:	1200205
Name:	-
Physician:	
Sex:	
DOB:	

Comments:

Analysis Data

Analysis Performed:	03/04/2025 12:49:21
Injection Number:	8856
Run Number:	132
Rack ID:	0001
Tube Number:	4
Report Generated:	03/04/2025 12:52:04
Operator ID:	

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.3	0.170	26029
A1b	---	0.7	0.229	12938
F	---	2.3	0.278	45495
LA1c	---	2.3	0.399	44565
A1c	5.6	---	0.502	89595
P3	---	4.4	0.791	86620
P4	---	1.0	0.858	19909
Ao	---	83.5	0.995	1644608

Total Area: 1,969,759

HbA1c (NGSP) = 5.6 %