Centre for Oncopathology

Supported by Tata Trusts

Surgical / Molecular Pathology Report

Name: Mrs. NOOR BANO

Path No: 25H-235

Age: 41 years **Gender:** Female

Referred by: Dr. Deepak Kumar Shukla

Accessioned on: 09 Jan 2025 11:15 AM

Reported on: 14 Jan 2025 04:21 PM

Nature of material: 1 paraffin block (39380-24) of liver lesion

MICROSCOPIC APPEARANCE

The biopsy is severely depleted in the paraffin block, however, shows a tumor arranged in tubular and organoid patterns.

The tumor cells reveal round to oval nuclei with stippled chromatin and scanty to moderate eosinophilic cytoplasm.

On immunohistochemistry, the tumor cells express CK7, synaptophysin, chromogranin A & HNF1β.

The Mib1 labelling index is 5%.

Rb1 is retained.

The tumor cells are negative for HSA, arginase & CK20.

IMPRESSION

Liver lesion:-

Well differentiated neuroendocine tumor WHO grade II.

There is no adenocarcinoma component seen in this biopsy.

Report typed by: Smita Gosavi.

End of Report

Dr. Vinita Pandey

MD, DNB, FRCPath

Dr. Anita Borges | Dr. Vinita Pant | Dr. Shilpa Prabhudesai | Dr. Vinita Pandey | Dr. Rakesh Demde | Dr. Ashish Shah

Centre for Oncopathology (A unit of Tata Cancer Care Foundation)

3rd Floor, Mahalaxmi Engineering Estate, Plot No. 571, Lady Jamshedji Cross Road No. 1.

Next to K.J.Khilnani School, Mahim (W), Mumbai - 400 016.

Call: 022-66496649 | Email id- infocop@tatacancercare.org | Website: www.oncopath.org

Regd.Off.:Adjacent to 33 KVA Substation, Alipiri to SV Zoo Park Road,

Tirupati, Chittoor, Tirupati (urban), Andhra Pradesh, India - 517501

Tata Cancer Care Foundation was formerly known as Alamelu Charitable Foundation

Patient ID:	**MH014310373**	Date	08.01.2025
Name	**Noor Bano**	Age/ Sex	51yr/F
Study Name	Whole Body NOTA PET-CT	Referring physician	Dr. Deepak Shukla
Clinical history and NOTA PET Indication	C/o liver SOL. Biopsy and IHC liver lesion 17.04.2022 s/o metastatic adenocarcinoma (pancreatico-billiary origin). PET- CT scan done on 22.04.2022 s/o liver lesions with abdominal nodes. On alternative treatment. PET- CT scan done on 25.11.2024 s/o liver lesions and abdominal nodes. AFP 2.22; CEA - 1.76; CA 19.9 - 5.1 (27.11.2024). Biopsy & IHC from liver 17.12.2024 s/o MiNEN with NET & well differentiated adenocarcinoma of pancreatico-billiary / GIT origin. NOTA-NOC PET-CT for further evaluation.		

18 F NOTA-NOC whole body PET/CT

Procedure details-

Whole body images (Head to midthigh) were acquired in 3-D mode after I.V. injection of F18-NOTA-octreotide (somatostatin receptor analogue) using a dedicated PET-CT scanner. IV contrast was given. Reconstruction of the acquired data was performed so as to obtain fused PET-CT images in transaxial, coronal and sagittal views.

Findings-

Brain –

No abnormal focal tracer uptake or lesion is noted in the brain parenchyma.

Head and Neck region

Non tracer avid hypodense lesion is seen in the left lobe of the thyroid gland - **suggested USG correlation**

There is no significant abnormal tracer uptake seen in the nodes, soft tissues and glandular structures of the neck, which appear normal on CT.

Thorax

Few non to faintly tracer avid subcentimetric mediastinal nodes are seen.

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Few non tracer avid subcentimetric anterior diaphragmatic nodes are seen.

No significant abnormal tracer uptake or anatomical abnormality is seen in the mediastinum and bilateral lung fields.

Abdomen and pelvis

Multiple intensely tracer avid irregular hypodense soft tissue density lesions (~8.3x8.8cm; SUV max 15.5 in segment VIII; another ~6.1x5.2cm; SUV max 14.8, in segment II; in segment V & VI ~9.0x6.4cm, SUV max 19.9) with areas of necrosis within, are seen in both the lobes of the liver.

Tracer avid portal (~11mm; SUV max 10.5) node is seen.

Tracer avid soft tissue density mass lesion (~2.2x2.9x1.8cm; SUV max 25.9) is seen in relation to the inferior aspect of segment VI of the liver, having loss of fat planes with adjacent bowel loops and indistinct fat planes at places with the right lower anterior abdominal wall.

Tracer avid irregular soft tissue density mass lesion (~2.5x3.2x3.5cm; SUV max 16.3) is seen along the small bowel loops in the left iliac region of the abdomen.

There is normal distribution of the radiotracer within the gastrointestinal and genitourinary system without focal areas of abnormal tracer accumulation.

There is NO abnormal radiotracer uptake or significant anatomical abnormality seen elsewhere in the abdomen.

MH014310373

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Musculoskeletal-

NO abnormal significant tracer uptake / significant anatomic abnormality is seen in the visualized bones in this study.

Impression-

Scan evidence of intensely tracer avid mass lesions in the left iliac region of the abdomen (in relation to the small bowel loops), in both the lobes of the liver and in the sub hepatic region along with abdominal node (portal) as described - likely primary (? GI origin) & metastatic (? liver lesions) neoplastic disease with somatostatin receptor expression along with regional nodal metastases

No definite scan evidence of any abnormal lesion with somatostatin receptor expression elsewhere in the body in the present study.

Suggested clinical correlation and corroboration with other investigational report

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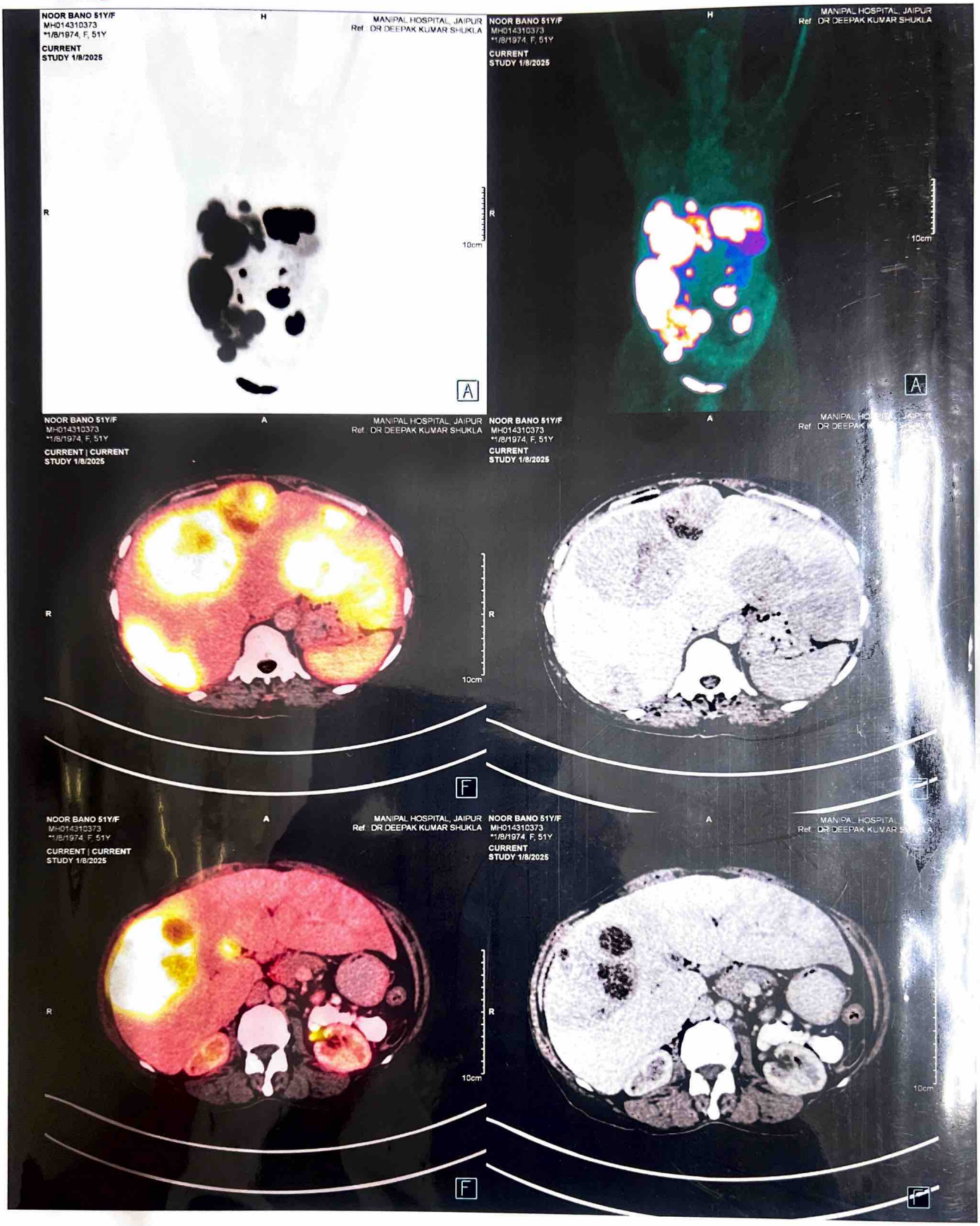

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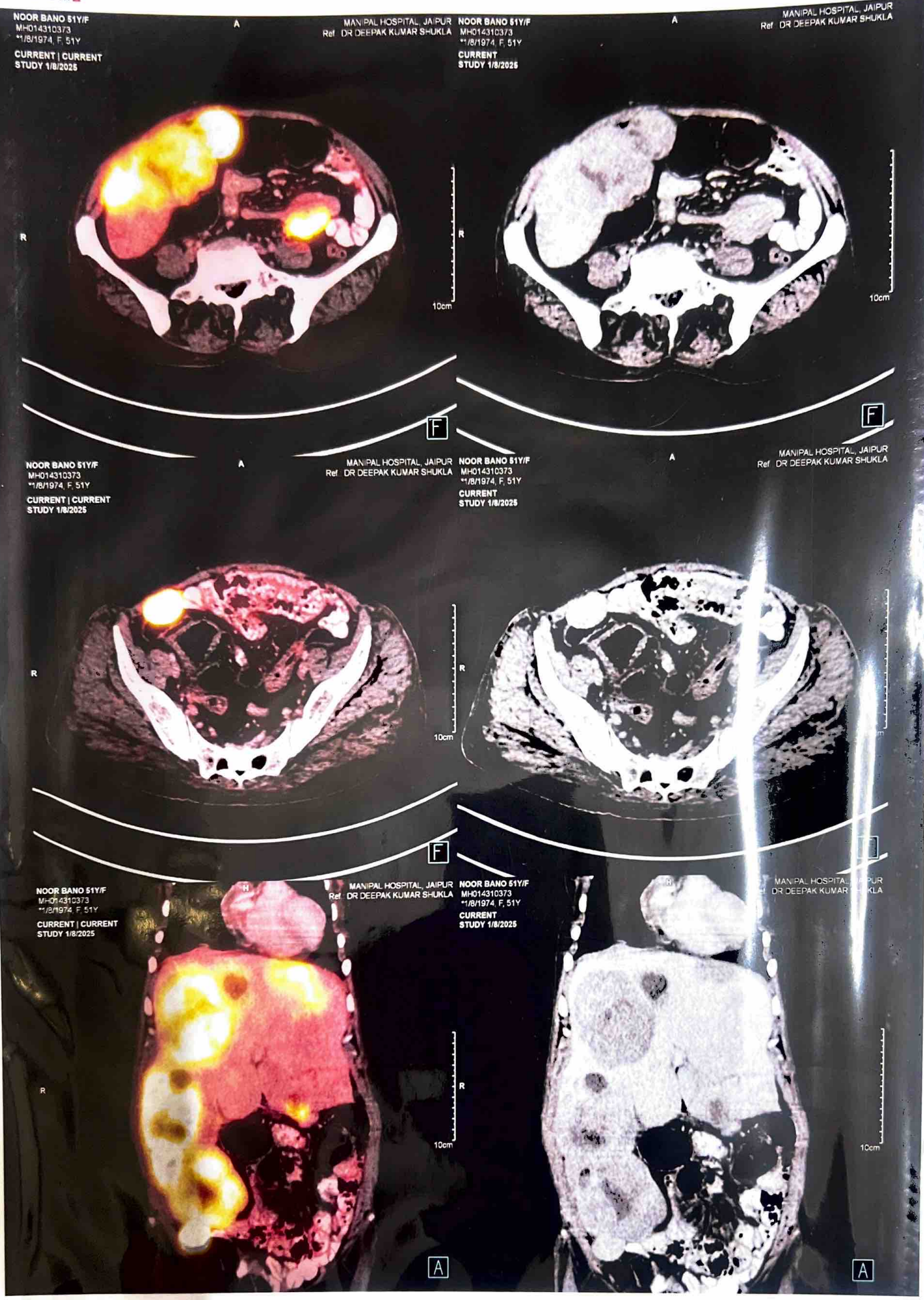

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CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **KWC3822**	SIN No., Date	:**KWC003594** 17-Dec-24 04:46 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:17-Dec-24 04:52 PM
Age	: 51 Y 7 M 15 D Gender: F	Received Date	:18-Dec-24 10:17 AM
Referred By	: **DR. DR. RAGHUNATH**	Report Date	:25-Dec-24 03:01 PM
Source By	: KALWAR ROAD CENTER	Collected at	:Kalwar Road Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF Immunohistochemistry (IHC)

IHC (ANY 8 AND ABOVE MARKER)
IMMUNOHISTOCHEMISTRY REPORT

IHC No. BIH/176 /24
BIOPSY SITE :- Liver Biopsy.

IHC performed on the block (outside block) bearing accession number - **BL/12699/24**.

IHC Findings

Tumor cells are **diffusely immunopositive** for CK7, CK19, Synaptophysin, Chromogranin, NSE, CDX2, MUC1 (100% tumor cells are positive for all markers) and **diffusely immunonegative** for CK20, CEA, SATB2, Glypican-3, Hepar 1 & PAX8.

Ki67 index is 8- 10%.

IMPRESSION – IHC profile is in favour of MiNEN (Mixed Neuroendocrine – Non Neuroendocrine neoplasm) with NET (grade II) and Well Differentiated Adenocarcinoma of Pancreato biliary / GIT origin (not lower GIT).

Note:

1 – As well differentiated NET has less sensitivity for FDG PET CT, Advised G68 DOTATATE PET / CT to rule out metastatic lesion.

2 – Endoscopic evaluation of upper GIT / Pancreato biliary tract to rule out possible primary site.

Processing : IHC carried out on Formalin fixed paraffin block Detection system Polyexcel HRP Polymer DAB Detection detection Kit.
Quality Assurance :• The external and internal control (wherever applicable) show appropriate reactivity.

***** End Of Report *****

Dr. Anjali Sharma
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RMC No.- 1 7041

Dr. Chandrika Gupta
MD Pathology
RMC No.- 21021 008037

Dr Neelam Goyal
MD Pathology
RMC No.- 45151

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CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **KWC3814**	SIN No., Date	:**KWC003587** 17-Dec-24 09:59 AM
Name	: **Mrs.NOOR BANO**	Collection Date	:17-Dec-24 10:04 AM
Age	: 51 Y 7 M 15 D Gender: F	Received Date	:17-Dec-24 12:12 PM
Referred By	: **Dr.DR. RAGHUNATH**	Report Date	:17-Dec-24 04:22 PM
Source By	: KALWAR ROAD CENTER	Collected at	:Kalwar Road Center
Report Status	: Final Report	DOC No	:

HISTOPATHOLOGY REPORT

BIOPSY NO:	BL/12699/24
SPECIMEN:	LIVER BIOPSY
GROSS:	Received single one block for review bearing histopath number 39380/24. (Previous report not provided to tally the biopsy number).
MICROSCOPY:	Biopsy show several fragments of neoplastic tissue. The cells are arranged in papillae, back to back thick trabeculae with thin sinusoids in between, and tubular fashion. Individual cells exhibit mild pleomorphism, are columnar to polyhedral, with abundant granular to whispy cytoplasm, enlarged nuclei, granular chromatin & invisible nucleoli. Some of the cells have nuclear grooving and intranuclear inclusions. An occasional cell show intra cytoplasmic brown pigment. An occasional atypical mitosis is seen.
IMPRESSION/ DIAGNOSIS:	**Findings are suggestive of Low Grade Epithelial Neoplasm.** **Possibility suggested are :** **1 – Low grade Hepatocellular Carcinoma.** **2 – Metastatic Carcinoma.** **Advice – IHC marker studies & Serum AFP, CEA, CA19.9 for confirmation of primary V/s metastatic nature of tumor.** **(IHC marker study is available at Dr. B Lal Clinical Laboratory).**

Note :
Histopathology report is opinion. In case the report is not correlating clinically kindly contact to laboratory for review or take a second opinion
Gross specimen will retained for 1 Month from Date of receiving of the sample.
H& E stained slides and Paraffin Block Will be retained for 10 years.
Interpretation with " Suggestive findings" need additional test or clinical correlation for final diagnosis.
Slides and blocks will be issued only after prior request of atleast 02 days

***** End Of Report *****

* NOTE – This sample has been processed at our reference lab. For any query, write us to

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RMC No. - 21021

Dr. Chandrika Gupta
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RMC No.- 21021 008037

Dr Neelam Goyal
MD Pathology
RMC No - 45151

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LIFE'S ON

Name	: MRS NOOR BANO	**Age**	: 41 Yr(s) Sex :Female
Registration No	: MH014310373	**Lab No**	: 44241200267
Patient Episode	: O02000712613	**Collection Date :**	14 Dec 2024 14:33
Referred By	: DR. RAGHUNATH ANANT NAGAVEKAR	**Reporting Date :**	16 Dec 2024 15:41
Receiving Date	: 14 Dec 2024 15:20		

Clinical Laboratory Report

HISTOPATHOLOGY

BIOPSY NO: HP 39380-24

SPECIMEN:
Liver lesion(USG guided trucut biopsy).

CLINICAL DETAILS :
follow up case of metastatic adenocarcinoma , Multiple Liver SOL

GROSS:
Specimen consists of 2 linear cores of tissue measuring 1.5x1 cm.
Entire tissue processed in one block.

MICROSCOPIC:
Section shows diffuse sheets of atypical epithelial cells showing nuclear atypia and pleomorphism arranged in tubulopapillary pattern.

Liver parenchyma not identified.

IMPRESSION:
*Liver lesion shows presence of Adenocarcinoma.

ADVISE:Immunohistochemistry for exact histogenesis.

----------END OF REPORT----------

Dr. Kirti Pandia
Consultant Pathologist

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Patient ID:	**MH014310373**	Date	25.11.2024
Name	**Noor Bano**	Age/ Sex	41yr/F
Study Name	Whole Body FDG PET-CT	Referring physician	Dr. Harish K C
Clinical history and PET/CT Indication	C/o liver SOL. Biopsy and IHC liver lesion 17.04.2022 s/o metastatic adenocarcinoma (pancreatico-billiary origin). PET- CT scan done on 22.04.2022 s/o liver lesions with abdominal nodes. On alternative treatment. PET- CT for further evaluation.		

18 F FDG whole body PET/CT

Procedure details-

Whole body images (Head to Mid-thigh) were acquired in 3-D mode after I.V. injection of F18-FDG using a dedicated PET-CT scanner. IV contrast was given. Reconstruction of the acquired data was performed so as to obtain fused PET-CT images in transaxial, coronal and sagittal views.

Findings-

Brain –

No abnormal focal FDG uptake or lesion is noted in the brain parenchyma.

Note:- Brain lesions may not be apparent on the PET- CT study and additional investigation may be performed if clinically indicated.

Head and Neck region

Low grade FDG avid hypodense lesion is seen in the left lobe of the thyroid gland (SUV max 3.8) - **suggested USG / FNAC correlation**

There is no significant abnormal tracer uptake seen in rest of the nodes, soft tissues and glandular structures of the neck, which appear normal on CT

Thorax

Few faintly to low grade FDG avid mediastinal nodes are seen (some calcified) (largest right hilar ~10mm; SUV max 3.3) - **? inflammatory**

Few non to faintly FDG avid small subcentimetric anterior diaphragmatic nodes are seen.

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There is NO significant abnormal 18FDG uptake or anatomical abnormality is seen in rest of the mediastinum and bilateral lung fields.

Abdomen and pelvis

Both the lobes of the liver are noted to be enlarged (CC span ~25.0cm). Few FDG avid large irregular soft tissue density mass lesions (largest ~8.8x8.6x8.7cm; SUV max 7.5, in segment VIII; another in segment II & III ~5.2x5.8cm; SUV max 5.0) are seen in both the lobes of the liver, showing early enhancement and relative washout in the delayed phase. The lesion has loss of fat planes with the right branch of the portal vein. There is no involvement of the hepatic artery or the main portal vein. Few non FDG avid hypodense lesions (areas of necrosis) are seen within the above mentioned lesions.

Few faintly to low grade FDG avid abdominal nodes are seen - portal (~7mm; SUV max 2.9), peripancreatic, mesenteric, retroperitoneal {paraaortic (~6mm; SUV max 3.3), aortocaval} nodes

There is normal distribution of the radiotracer within rest of the gastrointestinal and genitourinary system without focal areas of abnormal tracer accumulation.

There is NO abnormal radiotracer uptake or significant anatomical abnormality seen elsewhere in the abdomen.

Musculoskeletal-

NO abnormal significant FDG uptake / significant anatomic abnormality is seen in the visualized bones in this study.

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Impression-

Scan evidence of few FDG avid large irregular soft tissue density mass lesions in both the lobes of the liver (showing early enhancement and relative washout in the delayed phase) as described - ? primary neoplastic disease (favouring HCC)

Scan evidence of few faintly to low grade FDG avid abdominal nodes as described - suspicious for metastases

No definite scan evidence of any abnormal hyper metabolic lesion elsewhere in the body in the present study.

Suggested clinical correlation and corroboration with other investigational report

Compared to previous PET-CT scan done on 22.04.2022 at JNIC Jaipur - increase in the size of the liver lesions in the present study.

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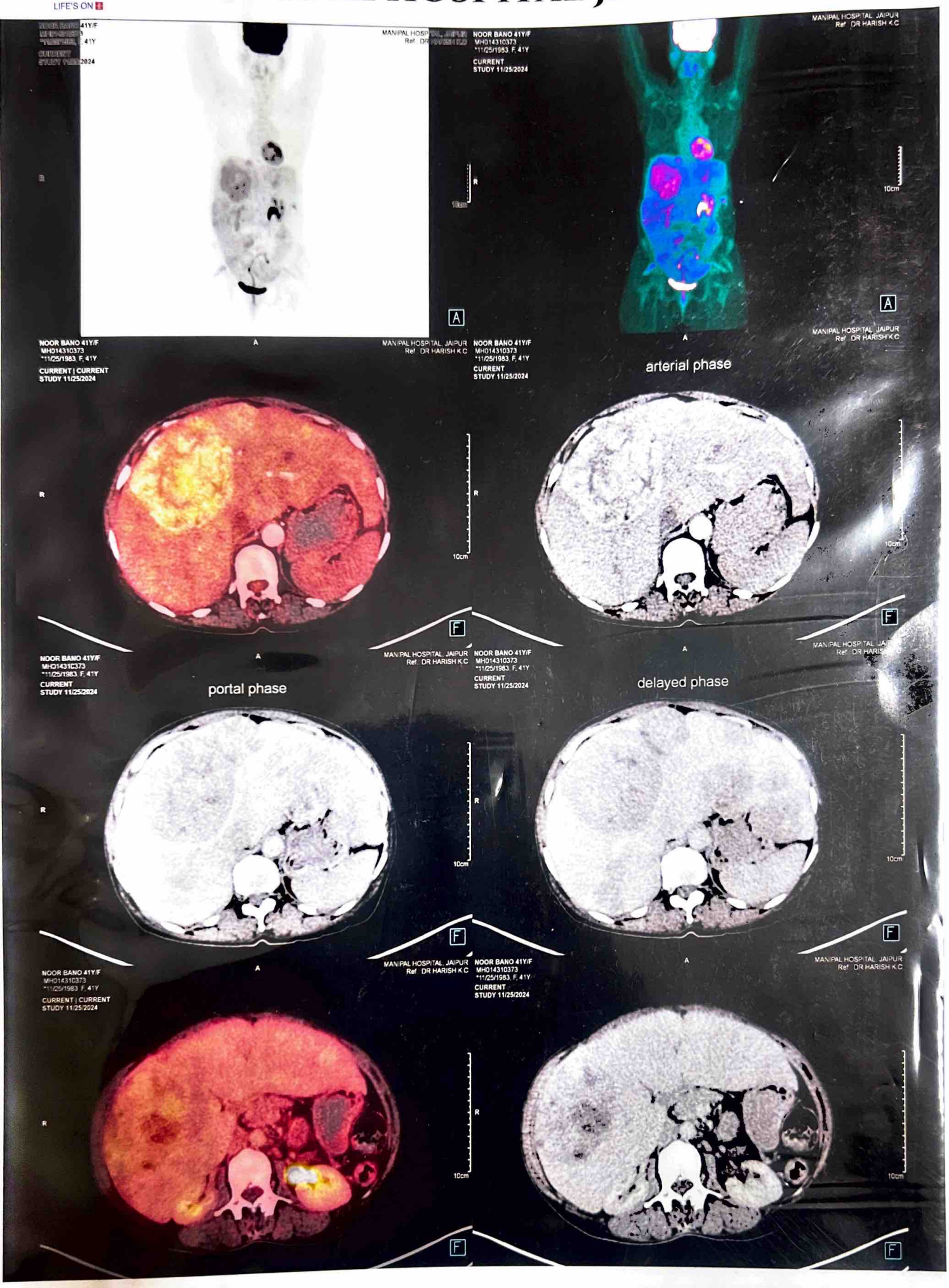

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LIFE'S ON

Name	: MRS NOOR BANO	**Age**	: 41 Yr(s) Sex :Female
Registration No	: MH014310373	**Lab No**	: 43241203878
Patient Episode	: O02000712613	**Collection Date**	: 14 Dec 2024 14:07
Referred By	: DR. RAGHUNATH ANANT NAGAVEKAR	**Reporting Date**	: 14 Dec 2024 15:51
Receiving Date	: 14 Dec 2024 14:55		

Clinical Laboratory Report

HAEMATOLOGY

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
PROTHROMBIN TIME (Automated/Clotting Assay)	**Specimen-Citrate Plasma**		
Prothrombin Time Test			
MNPT	11.6	sec	[10.0-15.0]
ISI Value	11.7	sec	
INR	1.03		
	1.02		

Note:

- PT evaluates coagulation factors in extrinsic and common pathways of coagulation.INR is a calculation that adjusts for changes in PT reagents.
- PT is increased in liver diseases, Vit K deficiency,defective or decreased factor 7,10,5 prothrombin; DIC, and oral anti-coagulant (warfarin) therapy.
- INR -People taking oral anti coagulant warfarin should have an INR of 2-3 for basic blood needs.For those who have a high risk of blood clot,the INR needs to be higher about 2.5to 3.5

----------END OF REPORT----------

Dr. Kirti Pandia
Consultant Pathologist

This report is based on the specimen's received. The report may need to be correlated clinically as laboratory investigations are dependent on multiple variables. These results should not be reproduced in part.

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CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:27-Nov-24 06:57 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:27-Nov-24 07:49 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF COAGULATION

Test Name	Observations	Unit	Biological Ref.Interval
PROTHROMBIN TIME(SODIUM CITRATE PLASMA)			
Patient Plasma *by (Optical Nephelometry)*	**13.20**	Seconds	9.1 - 12.1
Mean Normal Prothrombin Time (MNPT)	14.2	Seconds	
Prothrombin Ratio (PR)	1.00		
International Normalized Ratio (INR)	1.00		<1.0

INR Interpretation:-

- Recommended INR range for Patient on oral anticoagulants therapy : 2.0 - 3.0
- Recommended INR range for Patient with mechanical heart valves: 2.5 - 3.5

Comments

- Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), Tissue factor and Proteins of the common pathway (Factors X, V, II & Fibrinogen).
- This assay is used to control long term oral anticoagulant therapy, evaluation of liver function & to evaluate coagulation disorders specially factors involved in the extrinsic pathway like Factors V, VII, X, Prothrombin & Fibrinogen.
- INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity
- Results should be interpretated with clinical and other laboratory findings.

Reference:
Kit insert

Kindly note: Please check the change in biological reference range of prothrombin time

Dr Shivam Puri
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RMC No -28386

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TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:27-Nov-24 06:57 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:27-Nov-24 07:45 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF CLINICAL-BIOCHEMISTRY

Test Name	Observations	Unit	Biological Ref.Interval
LFT-LIVER FUNCTION TEST(Serum)			
SGOT/ AST *by (UV (With-P-5-P))*	18.0	U/L	<35
SGPT/ ALT *by (UV (With-P-5-P))*	19.0	U/L	14 - 36
Alkaline Phosphatase *by (Para- nitrophenyl phosphate)*	102.00	U/L	38 - 126
Billirubin Total *by (Diazonium Salt)*	0.43	mg/dL	0.2 - 1.3
Billirubin Direct *by (Diazo Reaction)*	0.19	mg/dL	0.0 - 0.4
Indirect Bilirubin *by (Calculated)*	0.24	mg/dL	
Total Protein *by (Biuret Method)*	**5.70**	g/dL	6.0 - 8.0
Albumin *by (Bromocresol Green Assay)*	3.79	g/dL	3.5 - 4.8
Globulin *by (Calculated)*	1.91	gm/dL	
A/G Ratio *by (Calculated)*	1.98		
Gamma Glutamyl Tranferase *by (G-glutamyl-p-nitroanilide)*	**61.0**	U/L	12 - 43

Kindly note: Please check the changes in biological reference range of GGT (Gamma glutamyl Transferase), Alkaline phosphatase, Total bilirubin, SGOT and SGPT.

Dr Shivam Pun
MD Pathology
RMC No -28386

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This test has been performed at **Dr.B.Lal Clinical Laboratory - Sikar, Rathi Hospital, Near Pandit Ji Ki Kothi,**

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Mail Id: customercare@blallab.com
CIN: U33125RJ1994PTC009129

NABL Accredited
ilac-MRA
MC-2866

TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:28-Nov-24 02:25 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:28-Nov-24 02:45 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF SEROLOGY

Test Name	Observations	Unit	Biological Ref.Interval
HBsAg / HEPATITIS-B SURFACE ANTIGEN / AUSTRALIA ANTIGEN(Serum)			
Hepatitis B Surface Antigen (HBsAg) *by (CMIA)*	0.24(Non-Reactive)	S/co	Non-Reactive:< 1.0 Reactive:> 1.0 or 1.0

Remarks:-

- This assay is a chemiluminescent microparticle immunoassay (CMIA) for the qualitative detection of hepatitis B surface antigen (HBsAg) in human serum and plasma.
- HBsAg is frist serologic marker to appear and used as an aid in the diagnosis of suspected hepatitis B viral (HBV) infection.
- HBsAg persists during acute phase and clears in the convalescence period. Failure to clear HBsAg within six months indicates a chronic HBsAg carrier state.
- HBsAg assays also monitors the status of infected individuals (infection resolved or chronic carrier state).
- For diagnosis, a confirmatory test and clinical history of the patient should be correlated.
- This is only a screening test. All samples detected reactive must be confirmed by using HBsAg confirmatory test.
- If the HBsAg Quantitative results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.
- For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection.
- Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed. Additional information may be required for diagnosis.
- Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA) which may produce anomalous values when tested with assay kits that employ mouse monoclonal antibodies.

Dr. B. Lal Gupta
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RMC 9236 11112

Dr Monika Agrawal
MD Microbiology
RMC No 20861

Ramjas Nagar
Technologist

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Website: www.blallab.com, Customer care: Ph.+91-91661 25555
Mail Id: customercare@blallab.com
CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:28-Nov-24 02:25 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:28-Nov-24 02:45 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF SEROLOGY

Test Name	Observations	Unit	Biological Ref.Interval
ANTI HCV ANTIBODY / TOTAL ANTIBODY TO HEPATITIS C(Serum)			
Hepatitis C Virus Antibodies *by (CMIA)*	0.11(Non-Reactive)	S/Co	Non-Reactive : < 1.0 Reactive : > 1.0 or 1.0

Remarks:-

- This is a chemiluminescent microparticle immunoassay (CMIA) for the qualitative detection of antibody to hepatitis C virus (anti-HCV) in human serum and palsma.
- HCV is a bloodborne virus which causes infection that remains either asymptomatic or may develop into chronic hepatitis, cirrhosis and/or increased risk of hepatocellular carcinoma.
- The presence of anti HCV Ab indicates either recent or past infection with hepatitis C virus.
- Anti HCV positive samples should be confirmed by confirmatory test HCV RNA PCR and correlatedwith the clinical history of the patient.

***** End Of Report *****

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TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:28-Nov-24 01:56 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:28-Nov-24 02:52 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF CLINICAL-BIOCHEMISTRY

Test Name	Observations	Unit	Biological Ref.Interval
CA 19-9(Serum)			
CA 19-9 *by (CMIA)*	5.10	U/mL	<37

Remarks:

CA 19-9 assay value is frequently elevated in various gastrointestinal conditions such as pancreatic, colorectal gastric and hepatic carcinomas.CA 19-9 is used as an adjunct with other diagnostic information in the management of patients with pancreatic cancer.Increased serum CA 19-9 assay values are observed in patients with metastases and in nonmalignant conditions such as hepatitis, cirrhosis panceratitis, and other gastrointestinal disease Elevated levels are also seen in cystic fibrosis. Persistent elevation in CA 19-9 assay value following treatment may be indicative of occult metastatic and/ or residual disease. A presistently rising CA 19-9 assay value may be associated with progressive malignant disease and poor therapeutic response. A declining CA 19-9 assay value may be indicative of a favorable prognosis and a good response to treatment. CA 19-9 cannot be used as cancer screening test.

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Dr Neelam Goyal
MD Pathology
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CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:27-Nov-24 06:57 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:27-Nov-24 08:03 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF CLINICAL-BIOCHEMISTRY

Test Name	Observations	Unit	Biological Ref.Interval
ALPHA FETO PROTEIN (AFP)(Serum)			
Alpha Feto Protein (AFP)	2.22	IU/mL	0.73 - 7.25

Remarks:-

- AFP cannot be recommended as a screening procedure to detect cancer in the general population.
- AFP appears in the fetus as major serum protein but its concentration decreases rapidly towards birth.
- Reappearance of elevated AFP concentration in adult serum is observed only during pregnancy or in several benign and malignant diseases.
- Elevated concentration of serum AFP has been observed not only in patients with nonseminomatous testicular cancer but also in malignant conditions such as hepatocellular carcinoma, ovarian cancer, gastro intestinal and pulmonary cancer.
- Benign hepatic conditions such as acute viral hepatitis,chronic active hepatitis and cirrhosis may present with elevated concentrations of serum AFP.
- For diagnostic purposes, the results obtained from this assay should always be used in combination with the clinical examination, medical history and other findings of the patient.

CEA-CARCINO EMBRYONIC ANTIGEN(Serum)			
CEA *by (CMIA)*	1.76	ng/mL	<=5.0

Remarks:-

- Elevated CEA levels are frequently observed in smokers, in cancer patients and in patients with a variety of non-malignant diseases and inflammatory conditions. Therefore, a serum CEA level, regardless of its value, should not be interpreted as absolute evidence for the presence or absence of malignant disease.
- The CEA value should be used in conjunction with information available from clinical evaluation & other diagnostic procedures.
- CEA assay should not be used as a cancer screening test but can be used in predicting prognosis and management of cancer patient.

Dr Shivani Puri
MD Pathology
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CIN: U33125RJ1994PTC009129

TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:28-Nov-24 02:11 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:28-Nov-24 02:11 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:29-Nov-24 04:40 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF CLINICAL-BIOCHEMISTRY

DCP-DECARBOXY PROTHROMBIN (PIVKA-II) O.S.(SERUM)

Test Name	Observed Value	Unit	Biological Reference Interval
DCP- Decarboxy Prothrombin PIVKA II (Serum,CMIA)	13.70	mAU/ml	17.36 - 50.90

Test Description

- Des-gamma-carboxy prothrombin (DCP), also known as the protein induced by vitamin K absence or antagonist II (PIVKAII), is an abnormal form of the coagulation protein, prothrombin. DCP is a nonfunctional prothrombin resulting from a lack of carboxylation of 10 glutamic acid residues in the N-terminal portion of the molecule.
- DCP can be elevated in other conditions besides HCC. Conditions such as obstructive jaundice, intrahepatic cholestasis causing chronic decrease in vitamin K, and ingestion of drugs such as warfarin or wide-spectrum antibiotics can result in high concentrations of DCP.
- DCP is considered a complementary biomarker to alpha fetoprotein (AFP) and AFP-L3% for assessing the risk of developing HCC. Based on prospective studies for establishing HCC diagnosis, the sensitivities for AFP, AFP-L3%, and DCP were 68%, 62%, and 73%, respectively, when used independently, however, when the 3 markers were combined, the sensitivity was 86%. In some studies, DCP levels were shown to correlate with tumor size and metastatic HCC.
- In addition, some studies have also shown that 25% to 50% of patients with HCC can have DCP values within the reference range, hence a normal DCP value does not rule out HCC.

References:

1. Des-gamma-carboxy prothrombin as an important prognostic indicator in patients with small hepatocellular carcinoma. World J Gastroenterol 2008 March 7; 14(9): 1370-1377
2. Nakamura, S. et al., Sensitivity and specificity of des-gamma-carboxy prothrombin for diagnosis of patients with hepatocellular carcinoma varies according to tumor size, American Journal of Gastroenterology, 2006, 101:2038-2043
3. Clinical Significance of AFP and PIVKA-II Responses for Monitoring Treatment Outcomes an Predicting Prognosis in Patients with Hepatocellular Carcinoma. BioMed Research International Volume 2013, 6 pages ,Article ID 310427.

The test has been processed at Metropolis Health Service (I) Ltd., Mumbai (NABL & CAP Accredited).

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TEST REPORT

Lab ID	: **RRC1935**	SIN No., Date	:**RRC001900** 27-Nov-24 06:41 PM
Name	: **Mrs.NOOR BANO**	Collection Date	:27-Nov-24 06:50 PM
Age	: 56 Y 5 M 0 D Gender: F	Received Date	:27-Nov-24 06:57 PM
Referred By	: **DR. SANDEEP SATSANGI**	Report Date	:27-Nov-24 07:45 PM
Source By	: Dr. B Lal Clinical Laboratory-	Collected at	:Royal Residency Center
Report Status	: Final Report	DOC No	:

DEPARTMENT OF CLINICAL-PATHOLOGY

Test Name	Observations	Unit	Biological Ref.Interval
URINE COMPLETE EXAMINATION			
Physical Examination			
Appearance	Slightly Hazy		Clear
Color	Pale Yellow		Pale Yellow /Yellow
Specific Gravity	1.030		1.003 - 1.035
pH	5.0		4.6 - 8.0
Chemical Examination			
Protein	Negative	mg/dL	Negative
Glucose	Negative	mg/dL	Negative
Ketone	Negative	mg/dl	Negative
Urobilinogen	Normal	mg/dL	Normal
Bilirubin	Negative	mg/dL	Negative
Occult Blood	Negative	Ery/µL	Negative
Microscopic Examination			
Red Blood Cells	0-0	/HPF	0.0 - 2.0
White Blood Cells (Pus Cells)	5-7	/HPF	0.0 - 5.0
Epithelial Cells	5-7	/HPF	0 - 5
Casts	Absent	/HPF	Absent
Crystals	Absent	/HPF	Absent
Bacteria	Absent	/HPF	Absent
Others	Absent		Absent

Methodology: - Automated Dipstick Method & Microscopy.

Dr Shivam Puri
MD Pathology
RMC No.-28386

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LIFE'S ON

Name	: MRS NOOR BANO	**Age** :	41 Yr(s) Sex :Female
Registration No	: MH014310373	**Lab No** :	42241109372
Patient Episode	: O02000702513	**Collection Date :**	23 Nov 2024 08:36
Referred By	: REFERRAL DOCTOR	**Reporting Date :**	23 Nov 2024 10:17
Receiving Date	: 23 Nov 2024 09:28		

BIOCHEMISTRY — Clinical Laboratory Report

SERUM CREATININE(Kinetic mod.Jaffe)	1.08	mg/dl	[0.60-1.40]
*eGFR (Calculated)	63.9	ml/min/1.73sq.m	[>60.0]

Disclaimer :

eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis / Icterus / Lipemia.

----------END OF REPORT----------

Dr Suresh Kumar Meena
MD, Biochemistry

This report is based on the specimen's received. The report may need to be correlated clinically as laboratory investigations are dependent on multiple variables. These results should not be reproduced in part.

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CIN: U85110KA2010PTC052540

NABH H-0115 | NABL M-0399

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LIFE'S ON

Name	: MRS NOOR BANO	**Age**	: 41 Yr(s) Sex :Female
Registration No	: MH014310373	**Lab No**	: 43241106760
Patient Episode	: O02000702513	**Collection Date :**	23 Nov 2024 08:36
Referred By	: REFERRAL DOCTOR	**Reporting Date :**	23 Nov 2024 09:55
Receiving Date	: 23 Nov 2024 09:29		

HAEMATOLOGY

Clinical Laboratory Report

COMPLETE BLOOD COUNT (Automated) Specimen-EDTA Blood

WBC Count (TC)	14030 #	/cu.mm	[4400-11000]
RBC Count	3.99	million/cu.mm	[3.80-4.80]
Haemoglobin	9.4 #	g/dl	[12.0-15.0]
Haematocrit [PCV]	33.4 #	%	[36.0-46.0]
MCV	83.7	fl	[83.0-101.0]
MCH	23.6 #	pg	[27.0-32.0]
MCHC	28.1 #	g/dl	[31.5-34.5]
Platelet Count	578000 #	/ cu.mm	[150000-400000]
RDW (CV)	22.6 #	%	[11.6-14.0]
MPV	9.80	fL	
DIFFERENTIAL COUNT			
Neutrophils	67.9	%	[40.0-75.0]
Lymphocytes	28.4	%	[20.0-45.0]
Monocytes	2.8	%	[2.0-10.0]
Eosinophils	0.6	%	[0.0-7.0]
Basophils	0.3	%	[0.0-1.0]
IG	0.10	%	
Neutrophil Absolute	9530.0 #	/cu mm	[2000.0-7000.0]
Lymphocyte Absolute	3980.0 #	/cu mm	[1000.0-3000.0]
Monocyte Absolute	390.0	/cu mm	[200.0-1000.0]
Eosinophil Absolute	90.0	/cu mm	[20.0-500.0]
Basophil Absolute	40.0	/cu mm	[20.0-100.0]
IG Absolute	20.0	/cu mm	

----------END OF REPORT----------

Dr. Kirti Pandia
Consultant Pathologist

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CIN: U85110KA2010PTC052540

NABH H-0115 NABL M-0399
MH-F-401 BR 2

LABORATORY TEST REPORT

Patient ID:	**102439950**	**Booking. Date & Time:**	**15/09/2024 17:03:03**
Name:	**Mrs NOOR BANO**	**Sample Collection:**	**15/09/2024 17:03:31**
Age:	**54 Yrs** **Sex:** **Female**	**Sample Received :**	**15/09/2024 17:03:31**
Ref. By:		**Report Date& Time:**	**16/09/2024 12:36:02**
Company :	**AL SAYED HOSPITAL FATEHPUR**	**Sample Type:**	**Serum**
		Report Status:	**Final**

Test Name	Value	Unit	Ref Range

IMMUNOLOGY

CA 19.9; PANCREATIC CANCER MARKER Chemiluminescence	15.4	U/mL	0.0 - 37.0

COMMENT :

Carbohydrate antigen 19-9 (CA 19-9) is a modified Lewis(a) blood group antigen. CA 19-9 may be elevated in patients with gastrointestinal malignancies such as cholangiocarcinoma, pancreatic cancer, or colon cancer. Benign conditions such as cirrhosis, cholestasis, and pancreatitis also result in elevated serum CA 19-9 concentrations.

Serial monitoring of carbohydrate antigen 19-9 (CA 19-9) should begin prior to therapy to verify post-therapy decreases in CA 19 -9 and to establish a baseline for evaluating possible recurrence. Single values of CA 19-9 are less informative. Elevated values may be caused by a variety of malignant and nonmalignant conditions including cholangiocarcinoma, pancreatic cancer, and colon cancer. Carbohydrate antigen 19-9 (CA 19-9) is neither specific nor sensitive enough to be used as a cancer screen. Do not interpret serum CA 19-9 levels as absolute evidence of the presence or the absence of malignant disease. Use serum CA 19-9 in conjunction with information from the clinical evaluation of the patient and other diagnostic procedures.

Clinical Use

An aid in the management of Pancreatic cancer patients
Monitor the course of disease and predict recurrence in patients with Pancreatic carcinoma

DISEASE	PERCENTAGE POSITIVITY OF CA 19.9
Pancreatic Cancer	80
Hepatobilliary Cancer	67
Gastric Cancer	40-50
Hepatocellular Cancer	30-50
Colorectal Cancer	30
Breast Cancer	15
Pancreatitis	10-20
Benign Gastrointestinal diseases	10-20

*** End of Report ***

DR. POOJA AGARWAL
M.D.(PATHOLOGY)
Reg.No. 16727

Dr. D.C KOTHARI
MD, Pathology
RMC. 30184, 13983

LABORATORY TEST REPORT

Patient ID:	**102439950**	**Booking. Date & Time:**	**15/09/2024 17:03:03**
Name:	**Mrs NOOR BANO**	**Sample Collection:**	**15/09/2024 17:03:31**
Age:	**54 Yrs** **Sex:** **Female**	**Sample Received :**	**15/09/2024 17:03:31**
Ref. By:		**Report Date& Time:**	**15/09/2024 17:54:04**
Company :	**AL SAYED HOSPITAL FATEHPUR**	**Sample Type:**	**Serum**
		Report Status:	**Final**

Test Name	Value	Unit	Ref Range
IMMUNOLOGY			
CA 125 OVARIAN CANCER MARKER Chemilumenescence	8.4	U/ml	0.0 - 35.0

Note:

1. This test is not recommended to screen ovarian cancer in the general population.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for or therapy
3. Patients with confirmed Ovarian cancer may show normal pre-treatment
4. CA 125 levels. Hence this assay, regardless of level, should not be interpreted as absolute evidence for the presence or absence of malignant disease. The assay value should be used in conjunction with findings from clinical evaluation and other diagnostic procedures.

Clinical Use

- An aid in the management of Ovarian cancer patients. Preoperative CA 125 level or < 65 U /mL is associated with a significantly greater 5 year survival rate.
- Monitor the course of disease in patients with Invasive epithelial ovarian cancer
- Detection of residual tumor in patients with Primary epithelial ovarian cancer who have undergone first line therapy. Persistent elevation of CA125 levels after 3 cycles of therapy indicates a poor prognosis.

STAGE OF OVARIAN CANCER	PERCENTAGE POSITIVITY OF CA 125
Stage I	50
Stage II	90
Stage III & IV	>90

Increased Levels

- Primary epithelial ovarian carcinoma
- Healthy individuals (1-2 %)
- First trimester of pregnancy
- Follicular phase of menstrual cycle
- Non malignant conditions – Cirrhosis, Hepatitis, Endometriosis, Ovarian cysts, Pelvic Inflammatory disease
- Non Ovarian malignancies - Endometrial, Pancreatic, Lung, Breast, Colorectal & other Gastrointestinal tumors.

*** End of Report ***

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