Lab Address:- # Plot No. 564 , 1st floor , Buddhanagar , Near Sai Baba Temple Peerzadiguda Boduppal Hyderabad, Telangana.
ICMR Reg .No. SAPALAPVLHT (Covid -19)

Name	: Mrs. SAMREEN W/O AKIL AHMAD		
Sample ID	: A1961688		
Age/Gender	: 35 Years 2 Months 5 Days/Female	Reg. No	: 0772508280075
Referred by	: Dr. ARCHANA MASSEY MS (OBS AND GYN)	SPP Code	: SPL-UP-098
Referring Customer	: UNIQUE PATH	Collected On	: 26-Aug-2025 01:10 PM
Primary Sample	: Whole Blood	Received On	: 29-Aug-2025 02:36 PM
Sample Tested In	: Serum	Reported On	: 30-Aug-2025 07:33 AM
Client Address	: HAAFIZPUR, AZAMGARH	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval

PDF Attached

Double Marker

Free -Beta -HCG *(Method: CLIA)*	49.83	ng/mL	< 2 :Non-Pregnant 5.4 - 393.4 : Pregnant
PAPP-A *(Method: CLIA)*	0.47	mIU/mL	< 0.1 : Non-Pregnant 0.1-19.5 : Pregnant

Risk analysis for Trisomy 21 is >1:50 is positive. PAPP-A value low. Adv: NIPT, FISH and karyotyping

Interpretation:

DISORDER	SCREEN POSITIVE/HIGH RISK CUT OFF
Trisomy 21 (Down)	< 1:250
Trisomy 18/13	< 1:100

DISORDER	SCREEN NEGATIVE/LOW RISK CUT OFF
Trisomy 21 (Down)	> 1:250
Trisomy 18/13	> 1:100

Note: Statistical evaluation has been done using CE marked PRISCA 5 software. · Screening tests are based on statistical analysis of patient demographic and biochemical data. They simply indicate a high or low risk category. Confirmation of screen positives is recommended by Chorionic Villus Sampling (CVS). · The interpretive unit is MoM (Multiples of Median) which takes into account variables such as gestational age (ultrasound), maternal weight, race, insulin dependent Diabetes, multiple gestation, IVF (Date of Birth of Donor, if applicable), smoking & previous history of Down syndrome. Accurate availability of this data for Risk Calculation is critical. · Ideally all pregnant women should be screened for Prenatal disorders irrespective of maternal age. The test is valid between 9-13.6 weeks of gestation, but ideal sampling time is between 10-13 weeks gestation. · First trimester detection rate of Down syndrome is 60% with a false positive rate of 5%. A combination of Nuchal translucency, Nasal bone visualization and biochemical tests (Combined test) increases the detection rate of Down syndrome to 85% at the same false positive rate.

Comments: First trimester screening for Prenatal disorders (Trisomy 21, 18 & 13) is essential to identify those women at sufficient risk for a congenital anomaly in the fetus to warrant further evaluation and followup. For Open neural tube defects, second trimester screening before 20 weeks is recommended. These are screening procedures which cannot discriminate all affected pregnancies from all unaffected pregnancies. Screening cutoffs are established by using MoM values that maximize the detection rate and minimize false positives.

DR. LAVANYA LAGISETTY
MD BIOCHEMISTRY

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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval
Ultra Sensitive -TSH			
TSH (Ultra Sensitive) *(Method: Chemiluminescence Immunoassay)*	1.520	uIU/mL	0.35-4.94

Pregnancy & Cord Blood

TSH (Thyroid Stimulating Hormone (µIU/mL)	
First Trimester	: 0.24-2.99
Second Trimester	: 0.46-2.95
Third Trimester	: 0.43-2.78
Cord Blood	: 2.3-13.2

- TSH is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low
- TRH stimulation differentiates secondary and tertiary hypothyroidism by observing the change in patient TSH levels. Typically, the TSH response to TRH stimulation is absent in cases of secondary hypothyroidism, and normal to exaggerated in tertiary hypothyroidism
- Historically, TRH stimulation has been used to confirm primary hyperthyroidism, indicated by elevated T3 and T4 levels and low or undetectable TSH levels. TSH assays with increased sensitivity and specificity provide a primary diagnostic tool to differentiate hyperthyroid from euthyroid patients.

*** End Of Report ***

DR. LAVANYA LAGISETTY
MD BIOCHEMISTRY

Prisca 5.1.0.17

Date of report: 30-08-2025

NA

Patient data			
Name	Mrs. SAMREEN W/O AKIL AHMAD	Patient ID	0772508280075
Birthday	25-06-1990	Sample ID	A1961688
Age at sample date	35.2	Sample Date	26-08-2025
Gestational age	11 + 3		

Correction factors					
Fetuses	1	IVF	no	Previous trisomy 21 pregnancies	unknown
Weight	69.1	diabetes	no		
Smoker	no	Origin	Asian		

Biochemical data

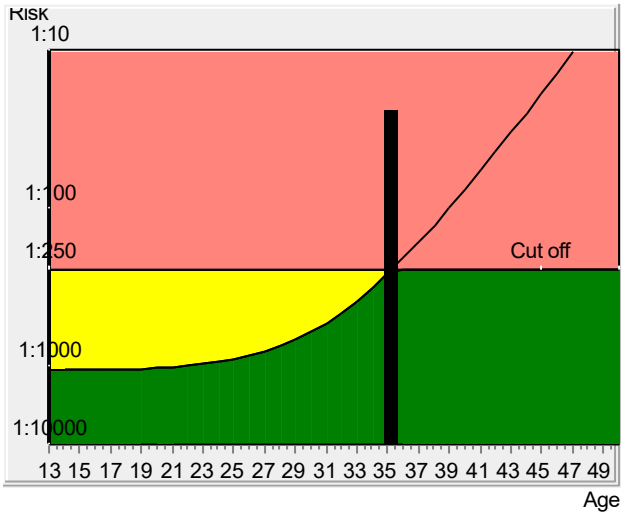
Parameter	Value	Corr. MoM
PAPP-A	0.47 mIU/mL	0.21
fb-hCG	49.83 ng/ml	1.04

Risks at sampling date

Age risk	1:250
Biochemical T21 risk	>1:50
Combined trisomy 21 risk	>1:50
Trisomy 13/18 + NT	1:80

Ultrasound data

Gestational age	11 + 2
Method	CRL Robinson
Scan date	25-08-2025
Crown rump length in mm	47.4
Nuchal translucency MoM	1.39
Nasal bone	present
Sonographer	NA
Qualifications in measuring NT	MD



Trisomy 13/18 + NT

The calculated risk for Trisomy 13/18 test (with nuchal translucency) is 1:80, which represents an increased risk.

Trisomy 21

The calculated risk for Trisomy 21 (with nuchal translucency) is above the cut off, which indicates an increased risk.

After the result of the Trisomy 21 Test (with nuchal translucency), it is expected that among less than 50 pregnancies with the same data, there is one trisomy 21 pregnancy.

The PAPP-A level is low.

The calculated risk by PRISCA depends on the accuracy of the information provided by the referring physician.

Please note that risk calculations are statistical approaches and have no diagnostic value!

The patient combined risk presumes the NT measurement was done according to accepted guidelines (Prenat Diagn 18: 511-523 (1998)).

The laboratory can not be hold responsible for their impact on the risk assessment ! Calculated risks have no diagnostic value!

Sign of Physician

below cut off | Below Cut Off, but above Age Risk | above cut off