Marengo Asia Hospitals

4127213

NABH
OUR ACCREDITATIONS

DEPARTMENT OF LABORATORY SERVICES

Patient	Mr. ANOOP SINGH	**Lab No/ManualNo**	4127213/
UHIDNo/IPNO	400221221	**CollectionDate**	15/11/2024 9:10AM
Age/Gender	37 Years/Male	**Receiving Date**	15/11/2024 10:09AM
Bed No/Ward	OPD	**Report Date**	15/11/2024 2:52PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry					
MediWheel Full Body Plus Comprehensive With Vitamin Male					
***SERUM CREATININE**					Serum
Serum - Creatinine	0.8	mg/dL	0.8 - 1.2	Enzymatic (Creatinine Amidohydrolase)	

Interpretation:-
Serum creatinine and urinary creatinine excretion is a function of lean body mass in normal persons and shows little or no response to dietary changes. The serum creatinine concentration is higher in men than in women. Since urinary creatinine is excreted mainly by glomerular filtration, with only small amounts due to tubular secretion, serum creatinine and a 24-hour urine creatinine excretion can be used to estimate the glomerular filtration rate.Serum creatinine is increased in acute or chronic renal failure, urinary tract obstruction, reduced renal blood flow, shock,dehydration, and rhabdomyolysis. Causes of low serum creatinine concentration include debilitation and decreased muscle mass. common in the elderly, in the bedridden, and in patients with advanced malignancy.

***URIC ACID (SERUM)**					Serum
Serum Uric Acid	4.4	mg/dL	4.0 - 8.6	Uricase	

Interpretation:-
Uric acid is the end product of purine metabolism. Elevationsof uric acid occur in renal failure, prerenal azotemia, gout, lead poisoning,excessive cell destruction (e.g., following chemotherapy), hemolytic anemia,and congestive heart failure and after myocardial infarction. Uric acid is alsoincreased in some endocrine disorders, acidosis, toxemia of pregnancy,hereditary gout, and glycogen storage disease type I. A low uric acidconcentration may be found following treatment by some drugs (e.g., low-doseaspirin), with low dietary intake of purines, in the presence of renal tubulardefects, and in xanthinuria.

***PHOSPHORUS (SERUM)** Serum

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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Dr. Nutan Sood
MD (Pathology)
Senior Consultant,Laboratory Services,
Regd No: HN 012481

Prepared By MAH002502

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L-Low H-High CH - Critical High CL - Critical Low

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Serum - Phosphorus	**H** **4.6**	mg/dL	2.7 - 4.5	Phosphomolybdate Reduction

Interpretation:-
Phosphorus, as phosphate, is distributed throughout the body. Causes of high serum phosphorus include dehydration,hypoparathyroidism, hypervitaminosis D, metastases to bone, sarcoidosis, pulmonary embolism, renal failure, and diabetes mellitus with ketosis. Low serum phosphorus is found in primary hyperparathyroidism and other causes of serum calcium elevation, sepsis, vitamin D deficiency, renal tubular disorders, chronic hemodialysis, vomiting, and occasionally with decreased dietary phosphate intake.

***GLUCOSE (PP)** PLASMA(FLUORIDE)

Glucose - Post Prandial (PPBS)	122	mg/dL	70 - 140	Glucose oxidase ,hydrogen Peroxidase

Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

***LIPID PROFILE SERUM** Serum

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Cholesterol		200	mg/dL	Method :Cholesterol oxidase, esterase, peroxidase Adults (>=20 Years) Desirable <200 mg/dL, Borderline200-239 mg/dL High>240 mg/dL	Cholesterol oxidase, esterase,peroxidase
HDL Cholesterol	**H**	**82**	mg/dL	40 - 60	Direct measure, PTA/MgCl2
Triglycerides		85	mg/dL	Method : Enzymatic Normal < 150 mg/dl, Borderline High 150-199 mg/dl, High 200-499 mg/dl, Very High>=500 mg/dl	Enzymatic method
Cholesterol VLDL		17	mg/dL	0 - 40	Calculated
Cholesterol / HDL Ratio		2.44			Calculated
LDL	**H**	**101**	mg/dL	0 - 100	Calculated
LDL/HDL Ratio		1.23			Calculated

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NCEP Guidelines:

Lipid	Desirable	Borderline High	High	Very High
Total Cholesterol	< 200	200-239	> 240	
LDL Cholesterol	< 100	130-159	160-189	> 190
HDL Cholesterol	> 60	< 40 (Risk factor)		
Triglycerides	< 150	150-199	200-499	> 500

***PROSTATIC SPECIFIC ANTIGEN(PSA)** — Serum

PSA - TOTAL		0.4	ng/mL	0.0 - 4.0	Chemiluminescence

COMMENTS
Prostate-specific antigen (PSA) is a glycoprotein that is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels.
PSA exists in serum in multiple forms: complexed to alpha-1-anti-chymotrypsin (PSA-ACT complex), unbound (free PSA), and enveloped by alpha-2-macroglobulin (not detected by immunoassays).
Higher total PSA levels and lower percentages of free PSA are associated with higher risks of prostate cancer

***BLOOD UREA** — Serum

Serum - Urea	**L**	**18**	mg/dL	19 - 43	Urease with indicator dye

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Interpretation:-

The major pathway of nitrogen excretion is in the form of urea that is synthesized in the liver, released into the blood, and cleared by the kidneys. A high serum urea nitrogen occurs in glomerulonephritis, shock, urinary tract obstruction, pyelonephritis, and other causes of acute and chronic renal failure. Severe congestive heart failure, hyperalimentation, diabetic ketoacidosis, dehydration, and bleeding from the gastrointestinal tract elevate urea nitrogen. Low urea nitrogen often occurs in normal pregnancy, with decreased protein intake, in acute liver failure, and with intravenous fluid administration.

***B12 VITAMIN** — Serum

Vit-B12	**L**	**191**	pg/mL	200 - 835	Chemiluminescence

Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function. In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption. The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted. Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases). Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia. Pernicious anemia is a macrocytic anemia caused by vitamin B12 deficiency that is due to a lack of IF secretion by gastric mucosa. Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.

Interpretation :

A serum vitamin B12 level less than 180 pg/ml may cause megaloblastic anemia and peripheral neuropathies , Vitamin B12 levels less than 150 pg/ml is considered evidence of vitamin B12 deficiency.

***VITAMIN D 25- HYDROXY** — Serum

Vitamin D 25 Hydroxy (Total)	**L**	**11.0**	ng/mL	30 - 100	Chemiluminescence

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Reference Range

Status	**25- (OH) Vitamin D**
Deficient	< 20 ng/mL
Insufficient	20 - 30 ng/mL
Sufficient	30 - 100 ng/mL
Potential Toxicity	>100 ng/mL

Vitamin D is a critical nutrient to maintain strong bones. It is produced by the body in response to sunlight and occurs naturally in some foods. However, for some adults, factors such as restricted diet, frequent use of sunscreen and a sedentary lifestyle can lead to vitamin D deficiencies.

Comments

*Decreased Levels
· Inadequate exposure to sunlight
· Dietary deficiency
· Vitamin D malabsorption
· Severe Hepatocellular disease
· Drugs like Anticonvulsants
· Nephrotic syndrome

* Increased levels
· Vitamin D intoxication

***GLUCOSE (FASTING).** PLASMA(FLUORIDE)

Glucose F	81.00	mg/dL	70.00 - 100.00	Glucose oxidase ,hydrogen Peroxidase

Interpretation:-
Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

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Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry					
MediWheel Full Body Plus Comprehensive With Vitamin Male					
***GLYCOCYLATED HEMOGLOBIN (HBA1C)**					EDTA Blood
HbA1C -(Glycosylated Hemoglobin)	5.5	%		HPLC	

Biological Ref. Range:

Hb A1c (%) - Degree of Glucose control
<5.6% - Normal
5.7% to 6.4% - Prediabetes
>=6.5% - Diabetes
<7% - ADA Target
>8% - Action Suggested

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Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
Biochemistry						
MediWheel Full Body Plus Comprehensive With Vitamin Male						
***LIVER FUNCTION TEST (LFT) SERUM**						Serum
Serum -Total Protein	**H**	**8.5**	g/dL	6.3 - 8.2	Biuret Method	
Serum - Albumin		4.7	g/dL	3.5 - 5.0	BCG	
Globulin		3.8	g/dL	2 - 5	Calculated	
AG Ratio		1.24		1 - 2	Calculated	
Serum - SGOT / AST (Aspartate Amino Transferase)		50	U/L	17 - 59	Kinetic(leuco dye) with pyridoxal 5 phosphate	
Serum - SGPT / ALTV (Alanine Amino Transferase)	**H**	**74**	U/L	10 - 40	Reflectance spectrophotometry/ kinetic with pyridoxal -5-phosphate	
Serum- GGT	**H**	**116**	U/L	15 - 73	L-G-glutamyl-p-nitroanilide	
Serum - Alkaline Phosphatase		88	U/L	38 - 126	P-nitrophenyl phosphate	
Bilirubin Total		0.6	mg/dL	0.2 - 1.3	Diphylline,Diazonium Salt	
Bilirubin Direct		0.4	mg/dL		Calculated	
				Calculated Neonate Ref. Range. 0 - 30 Days - (0.0 -0.6) mg/dL Adult Ref. Range. >30 Days - (0.0-0.3) mg/dL		
Bilirubin Indirect		0.2	mg/dL	0.0 - 1.1	Dual wavelength	

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Interpretation:-
Total bilirubin in serum and plasma is the sum of unconjugated bilirubin (Bu), mono- and di-glucuronide conjugated bilirubin (Bc)?, and delta bilirubin (DELB), a bilirubin fraction covalently bound to albumin. With the exception of anicteric jaundice, total serum bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.
Jaundice has been classified as unconjugated and conjugated hyperbilirubinemia. Increased plasma-unconjugated bilirubin is commonly seen in hemolytic disorders, Gilbert's syndrome, Crigler-Najjar syndrome, neonatal jaundice, and ineffective erythropoiesis and in the presence of drugs competing for glucuronide. Increased plasma-conjugated bilirubin occurs with hepatobiliary disorders, including intrahepatic and extrahepatic biliary tree obstruction, liver cell damage, Dubin-Johnson syndrome, and Rotor syndrome.Neonatal bilirubin, the sum of Bu and Bc, is increased in erythroblastosis fetalis (hemolytic disease of the newborn), which causes jaundice in the first two days of life. Other causes of neonatal jaundice include physiologic jaundice, hematoma/hemorrhage, hypothyroidism, and obstructive jaundice.
Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver. Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, and drug-induced hepatitis.
Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumors, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.
Alkaline phosphatase is present mainly in bone, liver, kidney, intestine, placenta, and lung. Serum alkaline phosphatase may be elevated in increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increase alkaline phosphatase activity; alkaline phosphatase activity may be increased in renal infarction and failure and in the complications of pregnancy. Low alkaline phosphatase activity may occasionally be seen in hypothyroidism.

Serum proteins transport drugs and metabolites and maintain plasma osmotic pressure. Most serum proteins are synthesized in the liver, with the exception of gamma globulins. One of the most important serum proteins produced in the liver is albumin. Total serum protein concentration can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenstrom's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Total protein concentration is occasionally increased in collagen diseases, lupus erythematosus, and other instances of chronic infection or inflammation. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

End Of Report

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Test Name	Result	Unit	Bio. Ref. Range	Method	Sample
Clinical Pathology					
MediWheel Full Body Plus Comprehensive With Vitamin Male					
***URINE ROUTINE EXAMINATION**					Urine
Physical Examination:					
Volume	50	mL		Physical Examination	
Colour	Pale Yellow		Pale Yellow	Physical Examination	
Appearence:	Clear			Physical Examination	
Chemical Examination:					
pH	5.5		4.6 - 8.0	Indicator Test	
Specific Gravity	1.005		1.000 - 1.035	Ion Exchange	
Protein	Nil			Protein Error of Indicator/ Sulphosalicylic Acid	
Glucose	Nil			Glucose Oxidase - Peroxidase/ Benedict's Method	
Ketone	Nil			Nitroprusside Reaction / Rothera's Method	
Bilirubin	Absent			Diazonium Method/ Fouchet's Method	
Urobilinogen	Normal			Ehrlich's Reaction/ Ehrlich's Reagent	
Nitrite:	Negative		Negative	Diazotization Reaction	
Blood :	Nil			Peroxidase Reaction	
Microscopic Examination:					
Casts	Nil		Nil	Microscopy	
Epithelial cells	0-2	/HPF	0 - 1	Microscopy	
Pus Cells	0-2	/HPF	0 - 5	Microscopy	
RBC	00	/HPF	0 - 2	Microscopy	
Crystals	Nil		Nil	Microscopy	

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Dr. Kriti Ganguly
MD,Microbiology,Consultant(Lab Services)
DMC Regd No: 63478

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Age/Gender	37 Years/Male	**Receiving Date**	15/11/2024 12:46PM
Bed No/Ward	OPD	**Report Date**	15/11/2024 1:56PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Interpretation:-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders.
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever. Protein reported in urine as Negative(<15 mg/dl), 1+(>=30 mg/dl), 2+(>=100 mg/dl) & 3+(>=500 mg/dl).
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications. Glucose reported in urine as Negative (<25 mg/dl), 1+(>=50 mg/dl), 2+(>=100 mg/dl), 3+(>=300 mg/dl), 4+(>=1000 mg/dl).
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or hemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high.Positive nitrite test suggestive of 105 or more organism in 1 ml of urine specimen.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetis insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia.

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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DMC Regd No: 63478

L-Low H-High CH - Critical High CL - Critical Low

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DEPARTMENT OF LABORATORY SERVICES

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UHIDNo/IPNO	400221221	**CollectionDate**	15/11/2024 9:10AM
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Bed No/Ward	OPD	**Report Date**	15/11/2024 12:49PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
Haematology						
MediWheel Full Body Plus Comprehensive With Vitamin Male						
***ERYTHROCYTE SEDIMENTATION RATE (ESR)**						EDTA Blood
Erythrocyte Sedimentation Rate (ESR)	**H**	**18**	mm/hr	0 - 15	Modified westergren Method	

Interpretation:-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post-partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

COMPLETE BLOOD COUNT(CBC) EDTA WHOLE BLOOD						EDTA Blood
Haemoglobin		15.3	g/dL	13.5 - 18.0	Spectrophotometry (Cyanide free method)	
Hematocrit/PCV		43.5	%	42.0 - 52.0	Derived from RBC pulse hieght detection	
RBC COUNT	**L**	**4.55**	10^6/µL	4.70 - 6.00	Electrical Impedance	
MCV		95.6	fl	78.0 - 100.0	Calculated	
MCH	**H**	**33.7**	pg	27.0 - 31.0	Calculated	
MCHC	**H**	**35.3**	g/dL	31.5 - 34.5	Calculated	
RDW-CV		13.4	%	11.5 - 14.0	Calculated	
Platelet count		345	10^3/µL	150 - 450	Electrical Impedance	
Total Leucocyte Count (TLC)		6.81	10^3/µL	4.00 - 10.50	Double Hydrodynamic Sequential System (DHSS)	

Differential Leucocyte Count

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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		Sample Quality	

Neutrophils	58.7	%	40 - 80	Flow Cytometry
Lymphocytes	31.9	%	20 - 40	Flow Cytometry
Monocytes	8.1	%	2 - 10	Flow Cytometry
Eosinophils	1.3	%	1 - 6	Flow Cytometry
Basophils	0	%	0 - 1	Flow Cytometry
Absolute Leucocyte Count				
Absolute Neutrophil Count	4.00	10^3/µL	1.50 - 6.60	Calculated
Absolute Lymphocyte Count	2.17	10^3/µL	1.50 - 3.50	Calculated
Absolute Monocyte Count	0.55	10^3/µL	0.00 - 1.00	Calculated
Absolute Eosinophil Count	0.09	10^3/µL	0.00 - 0.70	Calculated
Absolute Basophil Count	0.00	10^3/µL	0.00 - 1.00	Calculated

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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Prepared By MAH002502

Printed at 21/11/2024 10:55

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Bed No/Ward	OPD	**Report Date**	15/11/2024 12:42PM
Referred By	PHC Department	**Report Status**	Final
		Sample Quality	

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample

Immuno-Haematology

MediWheel Full Body Plus Comprehensive With Vitamin Male

***BLOOD GROUPING** — EDTA Blood

ABO GROUP	'AB'	Tube Agglutination Method
RH Type	POSITIVE	

Interpretation:-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.
Disclaimer: Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same.
The test is performed by both forward as well as reverse grouping methods.

End Of Report

Note-:This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

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Prepared By MAH002502 **Printed at 21/11/2024 10:55** **Page: 15 Of 15**

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