**DIAGNOSTIC REPORT**

agilus diagnostics

**PATIENT NAME : SANJAY KUMAR NIGAM (UBOIE3359)** **REF. DOCTOR :** DR. UNIONBANK - MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

| | | |
|---|---|---|
| **CODE/NAME & ADDRESS :** C000138355<br>ARCOFEMI HEALTHCARE LTD (MEDIWHEEL<br>F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI<br>NEW DELHI 110030<br>8800465156 | ACCESSION NO : **0290XB000942**<br>PATIENT ID : SANJM200871290<br>CLIENT PATIENT ID: UBOIE3359<br>ABHA NO : | AGE/SEX : 52 Years Male<br>DRAWN :<br>RECEIVED : 06/02/2024 09:24:40<br>REPORTED : 08/02/2024 16:13:18 |

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**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**XRAY-CHEST**

| | |
|---|---|
| »» | BOTH THE LUNG FIELDS ARE CLEAR |
| »» | BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR |
| »» | BOTH THE HILA ARE NORMAL |
| »» | CARDIAC AND AORTIC SHADOWS APPEAR NORMAL |
| »» | BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL |
| »» | VISUALIZED BONY THORAX IS NORMAL |
| IMPRESSION | NO ABNORMALITY DETECTED |

DR. G.S. SALUJA MBBS,DMRD
(CONSULTANT RADIOLOGIST)

**ECG**

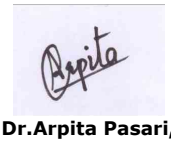
| | |
|---|---|
| ECG | SINUS RHYTHM, NORMAL ECG |

**MEDICAL HISTORY**

| | |
|---|---|
| RELEVANT PRESENT HISTORY | NOT SIGNIFICANT |
| RELEVANT PAST HISTORY | SURGICAL H/O CATARACT. |
| RELEVANT PERSONAL HISTORY | NOT SIGNIFICANT |
| RELEVANT FAMILY HISTORY | F/H/O HYPOTHYROID , RA - MOTHER. |
| OCCUPATIONAL HISTORY | NOT SIGNIFICANT |
| HISTORY OF MEDICATIONS | NOT SIGNIFICANT |

**ANTHROPOMETRIC DATA & BMI**

| | | | |
|---|---|---|---|
| HEIGHT IN METERS | 1.69 | | mts |
| WEIGHT IN KGS. | 79 | | Kgs |
| BMI | 28 | BMI & Weight Status as follows:<br>Below 18.5: Underweight | kg/sqmts |



**Dr.Arpita Pasari, MD**
**Consultant Pathologist**



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Agilus Diagnostics Ltd.
Gate No 2, Residency Area, Opp. St. Raphaels School,
Indore, 452001
Madhya Pradesh, India
Tel : 0731 2490008

**Patient Ref. No. 775000006319740**

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| | | 18.5 - 24.9: Normal<br>25.0 - 29.9: Overweight<br>30.0 and Above: Obese | |

**GENERAL EXAMINATION**

| | | | |
|---|---|---|---|
| MENTAL / EMOTIONAL STATE | NORMAL | | |
| PHYSICAL ATTITUDE | NORMAL | | |
| GENERAL APPEARANCE / NUTRITIONAL STATUS | OVERWEIGHT | | |
| BUILT / SKELETAL FRAMEWORK | AVERAGE | | |
| FACIAL APPEARANCE | NORMAL | | |
| SKIN | NORMAL | | |
| UPPER LIMB | NORMAL | | |
| LOWER LIMB | NORMAL | | |
| NECK | NORMAL | | |
| NECK LYMPHATICS / SALIVARY GLANDS | NOT ENLARGED OR TENDER | | |
| THYROID GLAND | NOT ENLARGED | | |
| CAROTID PULSATION | NORMAL | | |
| TEMPERATURE | AFEBRILE | | |
| PULSE | 78/MIN, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT | | |
| RESPIRATORY RATE | NORMAL | | |

**CARDIOVASCULAR SYSTEM**

| | | | |
|---|---|---|---|
| BP | 150/100 MM HG (SUPINE) | | mm/Hg |
| PERICARDIUM | NORMAL | | |
| APEX BEAT | NORMAL | | |
| HEART SOUNDS | NORMAL | | |
| MURMURS | ABSENT | | |

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**RESPIRATORY SYSTEM**

| | |
|---|---|
| SIZE AND SHAPE OF CHEST | NORMAL |
| MOVEMENTS OF CHEST | SYMMETRICAL |
| BREATH SOUNDS INTENSITY | NORMAL |
| BREATH SOUNDS QUALITY | VESICULAR (NORMAL) |
| ADDED SOUNDS | ABSENT |

**PER ABDOMEN**

| | |
|---|---|
| APPEARANCE | NORMAL |
| VENOUS PROMINENCE | ABSENT |
| LIVER | NOT PALPABLE |
| SPLEEN | NOT PALPABLE |
| HERNIA | NORMAL |

**CENTRAL NERVOUS SYSTEM**

| | |
|---|---|
| HIGHER FUNCTIONS | NORMAL |
| CRANIAL NERVES | NORMAL |
| CEREBELLAR FUNCTIONS | NORMAL |
| SENSORY SYSTEM | NORMAL |
| MOTOR SYSTEM | NORMAL |
| REFLEXES | NORMAL |

**MUSCULOSKELETAL SYSTEM**

| | |
|---|---|
| SPINE | NORMAL |
| JOINTS | NORMAL |

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**BASIC EYE EXAMINATION**

| | |
|---|---|
| CONJUNCTIVA | NORMAL |
| EYELIDS | NORMAL |
| EYE MOVEMENTS | NORMAL |
| CORNEA | NORMAL |
| DISTANT VISION RIGHT EYE WITHOUT GLASSES | 6/6, WITHIN NORMAL LIMIT |
| DISTANT VISION LEFT EYE WITHOUT GLASSES | 6/6, WITHIN NORMAL LIMIT |
| NEAR VISION RIGHT EYE WITHOUT GLASSES | N/6, WITHIN NORMAL LIMIT |
| NEAR VISION LEFT EYE WITHOUT GLASSES | N/6, WITHIN NORMAL LIMIT |
| COLOUR VISION | NORMAL |

**BASIC ENT EXAMINATION**

| | |
|---|---|
| EXTERNAL EAR CANAL | NORMAL |
| TYMPANIC MEMBRANE | NORMAL |
| NOSE | NO ABNORMALITY DETECTED |
| SINUSES | NORMAL |
| THROAT | NO ABNORMALITY DETECTED |
| TONSILS | NOT ENLARGED |

**BASIC DENTAL EXAMINATION**

| | |
|---|---|
| TEETH | DENTAL CHECK-UP DONE |
| GUMS | HEALTHY |

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**SUMMARY**

| | |
|---|---|
| RELEVANT HISTORY | NOT SIGNIFICANT |
| RELEVANT GP EXAMINATION FINDINGS | OVERWEIGHT |
| REMARKS / RECOMMENDATIONS | NONE |

**FITNESS STATUS**

| | |
|---|---|
| FITNESS STATUS | FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS) |

**Comments**

CLINICAL FINDINGS:-

LOW HB.

AISED TSH.

DYSLIPIDEMIA.

OVER WEIGHT STATUS.

FITNESS STATUS :-

FITNESS STATUS : FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)

ADVICE: WEIGHT REDUCTION, LOW FAT& CARBOHYDRATE DIET AND REGULAR PHYSICAL EXERCISE FOR OVERWEIGHT STATUS AND DYSLIPIDEMIA.
ADD TAKE FOOD STUFFS RICH IN IRON i.e. BEATROOT & SPINACH WITH IRON SUPPLEMENTS IN DIET. (NEEDS PHYSICIAN CONSULTATION IF HB < 8 gms%.)

NEED PHYSICIAN CONSULTATION FOR LIFE STYLE MODIFICATION.

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**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

**Liver** is normal in size, shape with smooth outline. Parenchymal echotexture is homogeneous. Intra & Extra hepatic biliary radicals are normal. Portal vein and C.B.D are normal in caliber.

**Gall Bladder** is normal, thin walled & its lumen is echo free.

**Spleen** is normal in size, shape & echotexture.

**Pancreas** is normal in size, shape & echotexture.

**Both Kidneys** are normal in size, shape and echotexture. Central pelvicalyceal system is normal. Corticomedullary differentiation is maintained.

**IVC** and **AO** is normal in caliber.No lymphadenopathy.

**Urinary Bladder** is normal thin walled,there is no calculus.

**Prostate** is normal in size & echotexture.

There is small defect 4 mm seen in umbilical region with reducible content- hernia.

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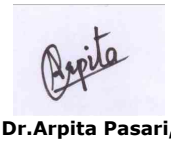
**TMT OR ECHO**

**CLINICAL PROFILE**

ECHO DONE



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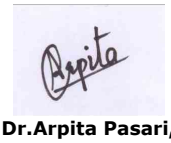
IMPRESSION- NO RWMA AT REST
- DIASTOLIC DYSFUNCTION
- LVEF 64 %

Interpretation(s)
MEDICAL HISTORY-
**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

**********
FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, Agilus diagnostic classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – AGILUS Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician'''''''s consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by Agilus diagnostic Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.



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## HAEMATOLOGY - CBC

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**BLOOD COUNTS,EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| HEMOGLOBIN (HB) | **11.3 Low** | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT | 5.48 | 4.5 - 5.5 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT | 4.89 | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT | 150 | 150 - 410 | thou/µL |

**RBC AND PLATELET INDICES**

| | | | |
|---|---|---|---|
| HEMATOCRIT (PCV) | **35.2 Low** | 40 - 50 | % |
| MEAN CORPUSCULAR VOLUME (MCV) | **64.2 Low** | 83 - 101 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | **20.7 Low** | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 32.2 | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW) | **21.2 High** | 11.6 - 14.0 | % |
| MENTZER INDEX | 11.7 | | |
| MEAN PLATELET VOLUME (MPV) | 9.1 | 6.8 - 10.9 | fL |

**WBC DIFFERENTIAL COUNT**

| | | | |
|---|---|---|---|
| NEUTROPHILS | 73 | 40 - 80 | % |
| LYMPHOCYTES | 21 | 20 - 40 | % |
| MONOCYTES | 04 | 2 - 10 | % |
| EOSINOPHILS | 02 | 1 - 6 | % |
| BASOPHILS | 00 | 0 - 2 | % |
| ABSOLUTE NEUTROPHIL COUNT | 3.57 | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT | 1.03 | 1 - 3 | thou/µL |
| ABSOLUTE MONOCYTE COUNT | 0.20 | 0.20 - 1.00 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT | 0.10 | 0.02 - 0.50 | thou/µL |

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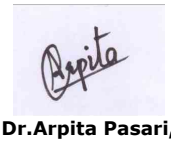
Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.



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## HAEMATOLOGY

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

| | | | |
|---|---|---|---|
| **ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD** | | | |
| E.S.R | 04 | 0 - 14 | mm at 1 hr |
| METHOD : MODIFIED WESTERGREN | | | |
| **GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD** | | | |
| HBA1C | 5.2 | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>Therapeutic goals: < 7.0<br>Action suggested : > 8.0<br>(ADA Guideline 2021) | % |
| METHOD : HPLC TECHNOLOGY | | | |
| ESTIMATED AVERAGE GLUCOSE(EAG) | 102.5 | < 116.0 | mg/dL |

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-TEST DESCRIPTION :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

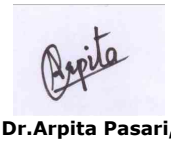
ESR is not diagnostic it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine,

salicylates)



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**Consultant Pathologist**



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Madhya Pradesh, India
Tel : 0731 2490008

Patient Ref. No. 775000006319740

**PATIENT NAME : SANJAY KUMAR NIGAM (UBOIE3359)** **REF. DOCTOR :** DR. UNIONBANK - MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

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| **CODE/NAME & ADDRESS :** C000138355<br>ARCOFEMI HEALTHCARE LTD (MEDIWHEEL<br>F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI<br>NEW DELHI 110030<br>8800465156 | ACCESSION NO : **0290XB000942**<br>PATIENT ID : SANJM200871290<br>CLIENT PATIENT ID: UBOIE3359<br>ABHA NO : | AGE/SEX : 52 Years Male<br>DRAWN :<br>RECEIVED : 06/02/2024 09:24:40<br>REPORTED : 08/02/2024 16:13:18 |

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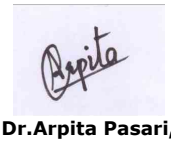
|---|---|---|---|

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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DIAGNOSTIC REPORT

agilus diagnostics

**PATIENT NAME : SANJAY KUMAR NIGAM (UBOIE3359)** **REF. DOCTOR :** DR. UNIONBANK - MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

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**IMMUNOHAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

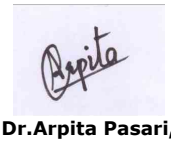
**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| ABO GROUP | TYPE B | | |
| METHOD : TUBE AGGLUTINATION | | | |
| RH TYPE | POSITIVE | | |
| METHOD : TUBE AGGLUTINATION | | | |

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-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.



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## BIOCHEMISTRY

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

| | | | |
|---|---|---|---|
| FBS (FASTING BLOOD SUGAR)<br>METHOD : HEXOKINASE | 90 | 74 - 99 | mg/dL |

**GLUCOSE, POST-PRANDIAL, PLASMA**

| | | | |
|---|---|---|---|
| PPBS(POST PRANDIAL BLOOD SUGAR)<br>METHOD : HEXOKINASE | 137 | Normal: < 140,<br>Impaired Glucose Tolerance:140-199<br>Diabetic > or = 200 | mg/dL |

**LIPID PROFILE WITH CALCULATED LDL**

| | | | |
|---|---|---|---|
| CHOLESTEROL, TOTAL<br>METHOD : OXIDASE, ESTERASE, PEROXIDASE | 173 | Desirable: <200<br>BorderlineHigh : 200-239<br>High : > or = 240 | mg/dL |
| TRIGLYCERIDES<br>METHOD : ENZYMATIC ASSAY | 128 | Desirable: < 150<br>Borderline High: 150 - 199<br>High: 200 - 499<br>Very High : > or = 500 | mg/dL |
| HDL CHOLESTEROL<br>METHOD : DIRECT- NON IMMUNOLOGICAL | **37 Low** | < 40 Low<br>> or = 60 High | mg/dL |
| CHOLESTEROL LDL | **110 High** | Adult levels:<br>Optimal < 100<br>Near optimal/above optimal: 100-129<br>Borderline high : 130-159<br>High : 160-189<br>Very high : = 190 | mg/dL |
| NON HDL CHOLESTEROL | **136 High** | Desirable: Less than 130<br>Above Desirable: 130 - 159 | mg/dL |

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| | | Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | |
| METHOD : CALCULATED<br>VERY LOW DENSITY LIPOPROTEIN | 25.6 | < or = 30 | mg/dL |
| METHOD : CALCULATED<br>CHOL/HDL RATIO | **4.7 High** | 3.3 - 4.4 | |
| LDL/HDL RATIO | 3.0 | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |

**Interpretation(s)**

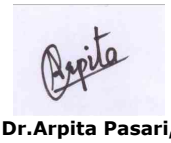
Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

**Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India**

| **Risk Category** | |
|---|---|
| Extreme risk group | A.CAD with > 1 feature of high risk group |
| | B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease |
| Very High Risk | 1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia |
| High Risk | 1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque |
| Moderate Risk | 2 major ASCVD risk factors |
| Low Risk | 0-1 major ASCVD risk factors |
| **Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors** | |
| 1. Age > or = 45 years in males and > or = 55 years in females | 3. Current Cigarette smoking or tobacco use |
| 2. Family history of premature ASCVD | 4. High blood pressure |
| 5. Low HDL | |

**Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.**

| **Risk Group** | **Treatment Goals** | | **Consider Drug Therapy** | |
|---|---|---|---|---|
| | **LDL-C (mg/dl)** | **Non-HDL (mg/dl)** | **LDL-C (mg/dl)** | **Non-HDL (mg/dl)** |
| Extreme Risk Group Category A | <50 (Optional goal < OR = 30 ) | < 80 (Optional goal <OR = 60) | >OR = 50 | >OR = 80 |
| Extreme Risk Group Category B | <OR = 30 | <OR = 60 | > 30 | >60 |
| Very High Risk | <50 | <80 | >OR= 50 | >OR= 80 |



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| | | | | |
|---|---|---|---|---|
| High Risk | <70 | <100 | >OR= 70 | >OR= 100 |
| Moderate Risk | <100 | <130 | >OR= 100 | >OR= 130 |
| Low Risk | <100 | <130 | >OR= 130* | >OR= 160 |

*After an adequate non-pharmacological intervention for at least 3 months.

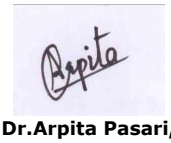
**References:** Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

**LIVER FUNCTION PROFILE, SERUM**

| | | | |
|---|---|---|---|
| BILIRUBIN, TOTAL<br>METHOD : JENDRASSIK AND GROFF | 1.09 | 0.0 - 1.2 | mg/dL |
| BILIRUBIN, DIRECT<br>METHOD : DIAZOTIZATION | **0.42 High** | 0.0 - 0.2 | mg/dL |
| BILIRUBIN, INDIRECT<br>METHOD : CALCULATED | 0.67 | 0.00 - 1.00 | mg/dL |
| TOTAL PROTEIN<br>METHOD : BIURET | 6.8 | 6.4 - 8.3 | g/dL |
| ALBUMIN<br>METHOD : BROMOCRESOL GREEN | 4.4 | 3.50 - 5.20 | g/dL |
| GLOBULIN<br>METHOD : CALCULATED | 2.4 | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO<br>METHOD : CALCULATED | 1.8 | 1.0 - 2.0 | RATIO |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT)<br>METHOD : UV WITH P5P | 20 | UPTO 40 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT)<br>METHOD : UV WITH P5P | 20 | UP TO 45 | U/L |
| ALKALINE PHOSPHATASE<br>METHOD : PNPP | 54 | 40 - 129 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT)<br>METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE | 15 | 8 - 61 | U/L |
| LACTATE DEHYDROGENASE<br>METHOD : ENZYMATIC LACTATE - PYRUVATE(IFCC) | 223 | 135 - 225 | U/L |

**BLOOD UREA NITROGEN (BUN), SERUM**

| | | | |
|---|---|---|---|
| BLOOD UREA NITROGEN<br>METHOD : UREASE KINETIC | 12 | 6 - 20 | mg/dL |



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| **CREATININE, SERUM** | | | |
| CREATININE | 1.04 | 0.70 - 1.20 | mg/dL |
| METHOD : ALKALINE PICRATE KINETIC JAFFES | | | |
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO | 11.54 | 5.0 - 15.0 | |
| METHOD : CALCULATED | | | |
| **URIC ACID, SERUM** | | | |
| URIC ACID | 6.9 | 3.5 - 7.2 | mg/dL |
| METHOD : URICASE/CATALASE UV | | | |
| **TOTAL PROTEIN, SERUM** | | | |
| TOTAL PROTEIN | 6.8 | 6.4 - 8.3 | g/dL |
| METHOD : BIURET | | | |
| **ALBUMIN, SERUM** | | | |
| ALBUMIN | 4.4 | 3.5 - 5.2 | g/dL |
| METHOD : BROMOCRESOL GREEN | | | |
| **GLOBULIN** | | | |
| GLOBULIN | 2.4 | 2.0 - 4.1 | g/dL |

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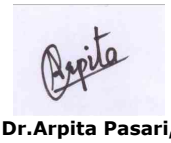
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM, SERUM | 144.1 | 136.0 - 146.0 | mmol/L |
| METHOD : DIRECT ION SELECTIVE ELECTRODE | | | |
| POTASSIUM, SERUM | 3.87 | 3.50 - 5.10 | mmol/L |
| METHOD : DIRECT ION SELECTIVE ELECTRODE | | | |
| CHLORIDE, SERUM | 103.5 | 98.0 - 106.0 | mmol/L |
| METHOD : DIRECT ION SELECTIVE ELECTRODE | | | |

**Interpretation(s)**

| Sodium | Potassium | Chloride |
|---|---|---|
| **Decreased in:**CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants (SSRI), antipsychotics. | **Decreased in:** Low potassium intake,prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome,osmotic diuresis (e.g., hyperglycemia),alkalosis, familial periodic paralysis,trauma (transient).Drugs: Adrenergic agents, diuretics. | **Decreased in:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics. |
| **Increased in:** Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives. | **Increased in:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration,renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics,NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole. | **Increased in:** Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates. |
| **Interferences:** Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose. | **Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal. | **Interferences:**Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride) |

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-TEST DESCRIPTION
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy (adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol



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Patient Ref. No. 775000006319740

**PATIENT NAME : SANJAY KUMAR NIGAM (UBOIE3359)** **REF. DOCTOR :** DR. UNIONBANK - MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

| | | |
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| **CODE/NAME & ADDRESS :** C000138355<br>ARCOFEMI HEALTHCARE LTD (MEDIWHEEL<br>F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI<br>NEW DELHI 110030<br>8800465156 | ACCESSION NO : **0290XB000942**<br>PATIENT ID : SANJM200871290<br>CLIENT PATIENT ID: UBOIE3359<br>ABHA NO : | AGE/SEX : 52 Years Male<br>DRAWN :<br>RECEIVED : 06/02/2024 09:24:40<br>REPORTED : 08/02/2024 16:13:18 |

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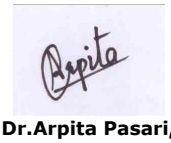
sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
• Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)
Lower than normal level may be due to:• Myasthenia Gravis, Muscuophy
URIC ACID, SERUM-Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.



**Dr.Arpita Pasari, MD**
**Consultant Pathologist**



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## CLINICAL PATH - URINALYSIS

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**PHYSICAL EXAMINATION, URINE**

| | |
|---|---|
| COLOR | PALE YELLOW |
| APPEARANCE | CLEAR |

**CHEMICAL EXAMINATION, URINE**

| | | | |
|---|---|---|---|
| PH | 5.5 | 4.7 - 7.5 | |
| SPECIFIC GRAVITY | 1.020 | 1.003 - 1.035 | |
| PROTEIN | NOT DETECTED | NOT DETECTED | |
| GLUCOSE | NOT DETECTED | NOT DETECTED | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| BLOOD | NOT DETECTED | NOT DETECTED | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| UROBILINOGEN | NORMAL | NORMAL | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| LEUKOCYTE ESTERASE | NOT DETECTED | NOT DETECTED | |

**MICROSCOPIC EXAMINATION, URINE**

| | | | |
|---|---|---|---|
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| PUS CELL (WBC'S) | 2-3 | 0-5 | /HPF |
| EPITHELIAL CELLS | 2-3 | 0-5 | /HPF |
| CASTS | NOT DETECTED | | |
| CRYSTALS | NOT DETECTED | | |
| BACTERIA | NOT DETECTED | NOT DETECTED | |
| YEAST | NOT DETECTED | NOT DETECTED | |
| REMARKS | Please note that all the urinary findings are confirmed manually as well. | | |

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**Interpretation(s)**

The following table describes the probable conditions, in which the analytes are present in urine

| Presence of | Conditions |
|---|---|
| Proteins | Inflammation or immune illnesses |
| Pus (White Blood Cells) | Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment |
| Glucose | Diabetes or kidney disease |
| Ketones | Diabetic ketoacidosis (DKA), starvation or thirst |
| Urobilinogen | Liver disease such as hepatitis or cirrhosis |
| Blood | Renal or genital disorders/trauma |
| Bilirubin | Liver disease |
| Erythrocytes | Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases |
| Leukocytes | Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions |
| Epithelial cells | Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time |
| | |
| Granular Casts | Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein |
| Hyaline casts | Physical stress, fever, dehydration, acute congestive heart failure, renal diseases |
| Calcium oxalate | Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice |
| Uric acid | arthritis |
| Bacteria | Urinary infectionwhen present in significant numbers & with pus cells. |
| Trichomonas vaginalis | Vaginitis, cervicitis or salpingitis |

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**SPECIALISED CHEMISTRY - HORMONE**

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**THYROID PANEL, SERUM**

| | | | |
|---|---|---|---|
| T3 | 117.10 | 80.0 - 200.0 | ng/dL |
| METHOD : CHEMILUMINESCENCE TECHNOLOGY | | | |
| T4 | 6.57 | 5.10 - 14.10 | µg/dL |
| METHOD : CHEMILUMINESCENCE TECHNOLOGY | | | |
| TSH (ULTRASENSITIVE) | **15.750 High** | 0.270 - 4.200 | µIU/mL |
| METHOD : CHEMILUMINESCENCE TECHNOLOGY | | | |

**Interpretation(s)**

**Triiodothyronine T3** , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4**.**

| Sr. No. | TSH | Total T4 | FT4 | Total T3 | Possible Conditions |
|---|---|---|---|---|---|
| 1 | High | Low | Low | Low | (1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment |
| 2 | High | Normal | Normal | Normal | (1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons. |
| 3 | Normal/Low | Low | Low | Low | (1) Secondary and Tertiary Hypothyroidism |
| 4 | Low | High | High | High | (1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy |
| 5 | Low | Normal | Normal | Normal | (1) Subclinical Hyperthyroidism |

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|---|---|---|---|---|---|
| 6 | High | High | High | High | (1) TSH secreting pituitary adenoma (2) TRH secreting tumor |
| 7 | Low | Low | Low | Low | (1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism |
| 8 | Normal/Low | Normal | Normal | High | (1) T3 thyrotoxicosis (2) Non-Thyroidal illness |
| 9 | Low | High | High | Normal | (1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies |

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
**NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.**TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

****End Of Report****
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2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
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   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
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7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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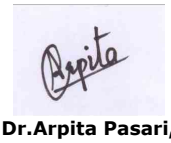

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