

PATIENT NAME : PUNAM

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000138376

ARCOFEMI HEALTHCARE LTD (MEDIWHEEL  
F-703, LADO SARAI, MEHRAULISOUTH WEST  
DELHI  
NEW DELHI 110030  
8800465156

ACCESSION NO : 0062WJ004220

PATIENT ID : PUNAF08018562

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 38 Years Female

DRAWN :

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REPORTED : 31/10/2023 15:28:51

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****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 NORMAL

**ECG**

ECG WITHIN NORMAL LIMITS

**MEDICAL HISTORY**

RELEVANT PRESENT HISTORY NOT SIGNIFICANT  
 RELEVANT PAST HISTORY NOT SIGNIFICANT  
 RELEVANT PERSONAL HISTORY MARRIED, 2 CHILDREN, VEG  
 MENSTRUAL HISTORY (FOR FEMALES) NOT SIGNIFICANT  
 LMP (FOR FEMALES) 3/10/2023  
 OBSTETRIC HISTORY (FOR FEMALES) P2A1L2, FTNVD  
 LCB (FOR FEMALES) 12 YRS BACK  
 RELEVANT FAMILY HISTORY FATHER- HIGH BLOOD PRESSURE  
 OCCUPATIONAL HISTORY HOME MAKER  
 HISTORY OF MEDICATIONS NOT SIGNIFICANT

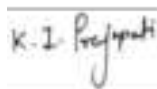
**ANTHROPOMETRIC DATA & BMI**

HEIGHT IN METERS	1.62	mts
WEIGHT IN KGS.	66.25	Kgs
BMI	25	kg/sqmts

BMI & Weight Status as follows  
 Below 18.5: Underweight  
 18.5 - 24.9: Normal  
 25.0 - 29.9: Overweight  
 30.0 and Above: Obese

**GENERAL EXAMINATION**

MENTAL / EMOTIONAL STATE NORMAL  
 PHYSICAL ATTITUDE NORMAL



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 Consultant Pathologist

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New Delhi, 110085  
 New Delhi, India  
 Tel : 9111591115, Fax :  
 CIN - U74899PB1995PLC045956



Patient Ref. No. 775000005249528

PATIENT NAME : PUNAM

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000138376

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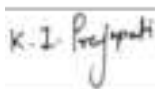
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GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
BREAST (FOR FEMALES)	NORMAL		
TEMPERATURE	NORMAL		
PULSE	60/MINUTE REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
<b>CARDIOVASCULAR SYSTEM</b>			
BP	96/67 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
<b>RESPIRATORY SYSTEM</b>			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
<b>PER ABDOMEN</b>			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		



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HERNIA ABSENT  
 ANY OTHER COMMENTS NIL

**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

**BASIC EYE EXAMINATION**

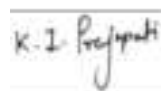
CONJUNCTIVA NORMAL  
 EYELIDS NORMAL  
 EYE MOVEMENTS NORMAL  
 CORNEA NORMAL  
 DISTANT VISION RIGHT EYE WITHOUT GLASSES 6/12  
 DISTANT VISION LEFT EYE WITHOUT GLASSES 6/12  
 NEAR VISION RIGHT EYE WITHOUT GLASSES N/12  
 NEAR VISION LEFT EYE WITHOUT GLASSES N/12  
 COLOUR VISION NORMAL

**BASIC ENT EXAMINATION**

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

**BASIC DENTAL EXAMINATION**

TEETH CARIES



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GUMS

HEALTHY

ANY OTHER COMMENTS

NIL

**SUMMARY**

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

WITHIN NORMAL LIMITS

RELEVANT NON PATHOLOGY DIAGNOSTICS

NO ABNORMALITIES DETECTED

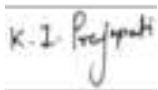
REMARKS / RECOMMENDATIONS

OPHTHALMOLOGIST FUP DENTAL TREATMENT

**FITNESS STATUS**

FITNESS STATUS

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



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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

**REPORT ENCLOSED**

**TMT OR ECHO**

**CLINICAL PROFILE**

**NEGATIVE**

**Interpretation(s)**

MEDICAL HISTORY.....  
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE 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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**Consultant Pathologist**



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MC-5733



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**HAEMATOLOGY - CBC**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN (HB) METHOD : CYANMETHEMOGLOBIN METHOD	<b>11.6 Low</b>	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : IMPEDANCE	3.98	3.8 - 4.8	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT METHOD : IMPEDANCE	4.60	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT METHOD : IMPEDANCE	204	150 - 410	thou/ $\mu$ L

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV) METHOD : CALCULATED	37.4	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CELL COUNTER	94.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	29.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	<b>31.0 Low</b>	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED	<b>14.4 High</b>	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	23.6		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	10.7	6.8 - 10.9	fL

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS METHOD : IMPEDANCE / MICROSCOPY	58	40 - 80	%
LYMPHOCYTES METHOD : IMPEDANCE / MICROSCOPY	33	20 - 40	%
MONOCYTES METHOD : IMPEDANCE / MICROSCOPY	7	2 - 10	%
EOSINOPHILS	2	1 - 6	%

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METHOD : IMPEDANCE / MICROSCOPY				
BASOPHILS		0	0 - 2	%
METHOD : MICROSCOPIC EXAMINATION				
ABSOLUTE NEUTROPHIL COUNT		2.67	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.52	1 - 3	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.32	0.20 - 1.00	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.09	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.8		
METHOD : CALCULATED PARAMETER				

**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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Consultant Pathologist



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## HAEMATOLOGY

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	22 High	0 - 20	mm at 1 hr
-------	---------	--------	------------

METHOD : WESTERGREN METHOD

## GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.8	Non-diabetic: < 5.7	%
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Pre-diabetics: 5.7 - 6.4  
Diabetics: > or = 6.5  
Therapeutic goals: < 7.0  
Action suggested : > 8.0  
(ADA Guideline 2021)

METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	91.1	< 116.0	mg/dL
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## 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, Vasculitides, 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: Polycythemia 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)

## REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACCC 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:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
- Diagnosing diabetes.
- Identifying patients at increased risk for diabetes (prediabetes).

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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 addition 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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<b>PATIENT NAME : PUNAM</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS</b> : C000138376 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO</b> : <b>0062WJ004220</b>	<b>AGE/SEX</b> : 38 Years	Female
	<b>PATIENT ID</b> : PUNAF08018562	<b>DRAWN</b> :	
	<b>CLIENT PATIENT ID</b> :	<b>RECEIVED</b> : 28/10/2023 09:18:31	
	<b>ABHA NO</b> :	<b>REPORTED</b> : 31/10/2023 15:28:51	

Test Report Status	Final	Results	Biological Reference Interval	Units
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**IMMUNOHAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

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

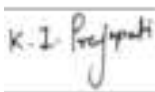
<b>ABO GROUP</b>	TYPE O
METHOD : TUBE AGGLUTINATION	
<b>RH TYPE</b>	POSITIVE
METHOD : TUBE AGGLUTINATION	

**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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Consultant Pathologist



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**Patient Ref. No. 775000005249528**



MC-5733



**PATIENT NAME : PUNAM**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS :** C000138376

ARCOFEMI HEALTHCARE LTD (MEDIWHEEL  
F-703, LADO SARAI, MEHRAULISOUTH WEST  
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NEW DELHI 110030  
8800465156

**ACCESSION NO :** 0062WJ004220

**PATIENT ID :** PUNAF08018562

**CLIENT PATIENT ID:**

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**AGE/SEX :** 38 Years Female

**DRAWN :**

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**BIOCHEMISTRY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR)	85	Normal <100 Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021)	mg/dL
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METHOD : HEXOKINASE

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR)	93	70 - 140	mg/dL
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**LIPID PROFILE WITH CALCULATED LDL**

CHOLESTEROL, TOTAL	157	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
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METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

TRIGLYCERIDES	78	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
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METHOD : ENZYMATIC, END POINT

HDL CHOLESTEROL	<b>37 Low</b>	< 40 Low >/=60 High	mg/dL
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METHOD : DIRECT MEASURE POLYMER-POLYANION

CHOLESTEROL LDL	<b>104 High</b>	< 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
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NON HDL CHOLESTEROL	120	Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	mg/dL
---------------------	-----	--	-------

METHOD : CALCULATED

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VERY LOW DENSITY LIPOPROTEIN		15.6		mg/dL
CHOL/HDL RATIO		4.2	3.3 - 4.4: Low Risk 4.5 - 7.0: Average Risk 7.1 - 11.0: Moderate Risk >11.0: High Risk	
LDL/HDL RATIO		2.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >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
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.

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MC-5733

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**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	1.03	Upto 1.2	mg/dL
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METHOD : DIAZONIUM ION, BLANKED (ROCHE)

BILIRUBIN, DIRECT	0.33 High	Upto 0.2	mg/dL
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METHOD : DIAZONIUM ION, BLANKED (ROCHE)

BILIRUBIN, INDIRECT	0.70	0.00 - 0.90	mg/dL
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METHOD : CALCULATED PARAMETER

TOTAL PROTEIN	6.6	6.4 - 8.3	g/dL
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ALBUMIN	4.2	3.97 - 4.94	g/dL
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METHOD : BROMOCRESOL PURPLE

GLOBULIN	2.4	2.0 - 4.0	g/dL
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METHOD : CALCULATED PARAMETER

ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
------------------------	-----	-----------	-------

METHOD : CALCULATED PARAMETER

ASPARTATE AMINOTRANSFERASE(AST/SGOT)	27	0 - 32	U/L
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METHOD : IFCC WITH PYRIDOXAL 5 PHOSPHATE

ALANINE AMINOTRANSFERASE (ALT/SGPT)	40 High	0 - 33	U/L
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METHOD : UV WITH P5P-IFCC

ALKALINE PHOSPHATASE	92	35 - 104	U/L
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METHOD : PNPP, AMP BUFFER-IFCC

GAMMA GLUTAMYL TRANSFERASE (GGT)	22	5 - 36	U/L
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METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC

LACTATE DEHYDROGENASE	151	135 - 214	U/L
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METHOD : L TO P, IFCC

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

BLOOD UREA NITROGEN	7	6 - 20	mg/dL
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METHOD : UREASE - UV

**CREATININE, SERUM**

CREATININE	0.53	0.5 - 0.9	mg/dL
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METHOD : ALKALINE PICRATE

**BUN/CREAT RATIO**

BUN/CREAT RATIO	13.21	5.00 - 15.00	
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**URIC ACID, SERUM**

URIC ACID	3.8	2.4 - 5.7	mg/dL
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METHOD : URICASE, COLORIMETRIC

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**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN 6.6 6.4 - 8.3 g/dL  
METHOD : BIURET

**ALBUMIN, SERUM**

ALBUMIN 4.2 3.97 - 4.94 g/dL  
METHOD : BROMOCRESOL PURPLE (BCP) DYE-BINDING

**GLOBULIN**

GLOBULIN 2.4 2.0 - 4.0 g/dL  
METHOD : CALCULATED PARAMETER

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM 138 136 - 145 mmol/L  
METHOD : ISE INDIRECT

POTASSIUM, SERUM **5.42 High** 3.3 - 5.1 mmol/L  
METHOD : ISE DIRECT

CHLORIDE, SERUM 105 98 - 106 mmol/L  
METHOD : ISE INDIRECT

**Interpretation(s)**

Sodium	Potassium	Chloride
<b>Decreased in:</b> CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. <b>Drugs:</b> thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), antipsychotics.	<b>Decreased in:</b> 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). <b>Drugs:</b> Adrenergic agents, diuretics.	<b>Decreased in:</b> 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, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. <b>Drugs:</b> chronic laxative, corticosteroids, diuretics.
<b>Increased in:</b> Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. <b>Drugs:</b> steroids, licorice, oral contraceptives.	<b>Increased in:</b> Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. <b>Drugs:</b> potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	<b>Increased in:</b> Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO <sub>3</sub> <sup>-</sup> ), respiratory alkalosis, hyperadrenocorticism. <b>Drugs:</b> acetazolamide, androgens, hydrochlorothiazide, salicylates.

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**Patient Ref. No. 775000005249528**



MC-5733



**PATIENT NAME : PUNAM** **REF. DOCTOR : SELF**  
**CODE/NAME & ADDRESS : C000138376** **ACCESSION NO : 0062WJ004220** **AGE/SEX : 38 Years Female**  
 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL **PATIENT ID : PUNAF08018562** **DRAWN :**  
 F-703, LADO SARAI, MEHRAULISOUTH WEST **CLIENT PATIENT ID:** **RECEIVED : 28/10/2023 09:18:31**  
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<p><b>Interferences:</b> Severe lipemia or hyperproteinemia, 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.</p>	<p><b>Interferences:</b> 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.</p>	<p><b>Interferences:</b> 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)</p>
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**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 so that 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, 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 Glycosuria, 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 Glycosuria, 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.

*K. I. Prajapati*

**Dr. Kamlesh I Prajapati**  
**Consultant Pathologist**



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MC-5733



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**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.

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**Consultant Pathologist**

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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION, URINE**

COLOR PALE YELLOW  
APPEARANCE CLEAR

**CHEMICAL EXAMINATION, URINE**

PH	6.0	4.5 - 7.5
SPECIFIC GRAVITY	1.005	1.005 - 1.030
PROTEIN	NOT DETECTED	NEGATIVE
GLUCOSE	NOT DETECTED	NEGATIVE
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NEGATIVE
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)	0-1	0-5	/HPF
EPITHELIAL CELLS	<b>5-7</b>	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

REMARKS NOTE:- MICROSCOPIC EXAMINATION OF URINE IS PERFORMED BY CENTRIFUGE URINARY SEDIMENT.

**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

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Agilus Diagnostics Ltd.  
Plot No.160,Pocket D-11 Sector 8, Rohini



**Patient Ref. No. 775000005249528**



PATIENT NAME : PUNAM

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000138376

ARCOFEMI HEALTHCARE LTD (MEDIWHEEL  
F-703, LADO SARAI, MEHRAULISOUTH WEST  
DELHINEW DELHI 110030  
8800465156

ACCESSION NO : 0062WJ004220

PATIENT ID : PUNAF08018562

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 38 Years Female

DRAWN :

RECEIVED : 28/10/2023 09:18:31

REPORTED : 31/10/2023 15:28:51

Test Report Status	Final	Results	Biological Reference Interval	Units
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## CYTOLOGY

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## PAPANICOLAOU SMEAR

TEST METHOD

PAP stain

Specimen Type : Conventional PAP smear  
Received two unstained slides fixed in Alcohol.Reporting system:- 2014 The Bethesda system of reporting cervical  
cytology.

Specimen Adequacy : Satisfactory for evaluation

Endocervical component/ Transformation zone - Endocervical cells  
present in small clumps

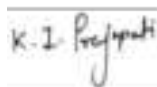
Microscopy :

Smears examined show superficial and intermediate squamous epithelial  
cells.

Scattered RBCs present in the background.

Interpretation : Negative for intraepithelial lesion or malignancy (NILM).

Comment : Pap smear cytology is a screening procedure.

Corroboration of cytopathologic findings with  
colposcopic/local examination and ancillary findings is recommended.  
Test was done by manual method

Dr. Kamlesh I Prajapati  
Consultant Pathologist

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Plot No.160,Pocket D-11 Sector 8, RohiniNew Delhi, 110085  
New Delhi, India  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956

Patient Ref. No. 775000005249528



MC-5733



<b>PATIENT NAME : PUNAM</b>	<b>REF. DOCTOR : SELF</b>
<b>CODE/NAME &amp; ADDRESS : C000138376</b> ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO : 0062WJ004220</b> <b>PATIENT ID : PUNAF08018562</b> <b>CLIENT PATIENT ID:</b> <b>ABHA NO :</b>
	<b>AGE/SEX : 38 Years Female</b> <b>DRAWN :</b> <b>RECEIVED : 28/10/2023 09:18:31</b> <b>REPORTED : 31/10/2023 15:28:51</b>

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**CLINICAL PATH - STOOL ANALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION,STOOL**

COLOUR	BROWN	
CONSISTENCY	SEMI FORMED	
MUCUS	ABSENT	NOT DETECTED
VISIBLE BLOOD	ABSENT	ABSENT
ADULT PARASITE	NOT DETECTED	

**MICROSCOPIC EXAMINATION,STOOL**

PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	

**Interpretation(s)**

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc.The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
<b>Pus cells</b>	Pus in the stool is an indication of infection
<b>Red Blood cells</b>	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
<b>Parasites</b>	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days.Stool specimens for parasitic examination should be collected before initiation of antidiarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
<b>Mucus</b>	Mucus is a protective layer that lubricates, protects& reduces damage due to bacteria or viruses.
<b>Charcot-Leyden crystal</b>	Parasitic diseases.

**Dr. Kamlesh I Prajapati**  
Consultant Pathologist



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Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

## ADDITIONAL STOOL TESTS :

- Stool Culture**: - This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT)**: This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL**: In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
- Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomiting & abdominal cramps. Adults are also affected. It is highly contagious in nature.

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**SPECIALISED CHEMISTRY - HORMONE**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**THYROID PANEL, SERUM**

T3	104.90	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
T4	7.97	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)	1.460	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL

**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

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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
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 during 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\*\***

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

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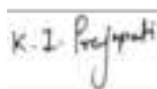
### CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
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:
  - i. Specimen received is insufficient or inappropriate
  - ii. Specimen quality is unsatisfactory
  - iii. Incorrect specimen type
  - iv. Discrepancy between identification on specimen container label and test requisition form

5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
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.

#### Agilus Diagnostics Ltd

Fortis Hospital, Sector 62, Phase VIII,  
Mohali 160062



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