

PATIENT NAME : MUKESH KUMAR

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138361  
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
F-703, LADO SARAI, MEHRAULISOUTH WEST  
DELHI  
NEW DELHI 110030  
8800465156

ACCESSION NO : **0028WD000361**  
PATIENT ID : MUKEM15028828  
CLIENT PATIENT ID:  
ABHA NO :

AGE/SEX : 35 Years Male  
DRAWN :  
RECEIVED : 12/04/2023 08:50:13  
REPORTED : 13/04/2023 10:49:08

Test Report Status	Final	Results	Biological Reference Interval	Units
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## HAEMATOLOGY - CBC

## MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

## BLOOD COUNTS, EDTA WHOLE BLOOD

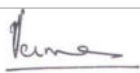
HEMOGLOBIN (HB)	14.8	13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.88	4.5 - 5.5	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	6.80	4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	185	150 - 410	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	45.0	40.0 - 50.0	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	92.2	83.0 - 101.0	fL
METHOD : DERIVED/COULTER PRINCIPLE			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	30.3	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.9	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	<b>15.3 High</b>	11.6 - 14.0	%
METHOD : DERIVED/COULTER PRINCIPLE			
MENTZER INDEX	18.9		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	10.7	6.8 - 10.9	fL
METHOD : DERIVED/COULTER PRINCIPLE			

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	51	40 - 80	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
LYMPHOCYTES	38	20 - 40	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
MONOCYTES	9	2.0 - 10.0	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
EOSINOPHILS	2	1.0 - 6.0	%



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Email : customercare.noida@srl.in



Patient Ref. No. 775000002884651

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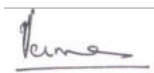
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METHOD : VCS TECHNOLOGY/ MICROSCOPY				
<b>BASOPHILS</b>		0	0 - 1	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
<b>ABSOLUTE NEUTROPHIL COUNT</b>		3.50	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>ABSOLUTE LYMPHOCYTE COUNT</b>		2.60	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>ABSOLUTE MONOCYTE COUNT</b>		0.60	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>ABSOLUTE EOSINOPHIL COUNT</b>		0.14	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>ABSOLUTE BASOPHIL COUNT</b>		<b>0.00 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>NEUTROPHIL LYMPHOCYTE RATIO (NLR)</b>		1.4		
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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Test Report Status **Final**

Results

Biological Reference Interval Units

## HAEMATOLOGY

## MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R 2 &lt; 15 mm at 1 hr

METHOD : MODIFIED WESTERGREIN METHOD BY AUTOMATED ANALYSER

## Interpretation(s)

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE 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

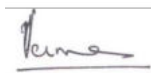
## LIMITATIONS

**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. 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.



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### IMMUNOHAEMATOLOGY

#### MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

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

ABO GROUP	TYPE O
METHOD : COLUMN AGGLUTINATION TECHNOLOGY	
RH TYPE	POSITIVE
METHOD : COLUMN AGGLUTINATION TECHNOLOGY	

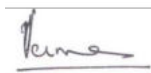
#### Interpretation(s)

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 BELOW 40 MALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR)	93	74 - 106	mg/dL
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METHOD : HEXOKINASE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	5.0	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	96.8	< 116.0	mg/dL
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**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR)	70	Non-Diabetes 70 - 140	mg/dL
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METHOD : HEXOKINASE

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	<b>203 High</b>	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
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METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

**TRIGLYCERIDES**

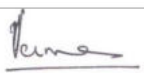
	<b>177 High</b>	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
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METHOD : ENZYMATIC, END POINT

**HDL CHOLESTEROL**

	<b>38 Low</b>	< 40 Low >/=60 High	mg/dL
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METHOD : DIRECT MEASURE POLYMER-POLYANION



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CHOLESTEROL LDL	<b>130 High</b>	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	<b>165 High</b>	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

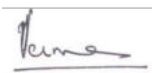
METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN	<b>35.4 High</b>	Desirable value :	mg/dL
CHOL/HDL RATIO	<b>5.3 High</b>	10 - 35 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	<b>3.4 High</b>	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

**Interpretation(s)**

**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.64	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED ( ROCHE )			
BILIRUBIN, DIRECT	0.21	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	0.43	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT			
ALBUMIN	<b>5.0 High</b>	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			



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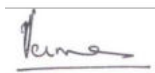
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GLOBULIN		2.5	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO		2.0	1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE(AST/SGOT)		24	0 - 40	U/L
METHOD : UV WITHOUT P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		29	0 - 41	U/L
METHOD : UV WITHOUT P5P				
ALKALINE PHOSPHATASE		116	40 - 129	U/L
METHOD : PNPP, AMP BUFFER-IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		30	8 - 61	U/L
METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC				
LACTATE DEHYDROGENASE		183	135 - 225	U/L
METHOD : L TO P, IFCC				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		12	6 - 20	mg/dL
METHOD : UREASE - UV				
<b>CREATININE, SERUM</b>				
CREATININE		0.96	0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		12.50	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
<b>URIC ACID, SERUM</b>				
URIC ACID		5.9	3.4 - 7.0	mg/dL
METHOD : URICASE, COLORIMETRIC				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		7.5	6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT				
<b>ALBUMIN, SERUM</b>				
ALBUMIN		<b>5.0 High</b>	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN				
<b>GLOBULIN</b>				



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GLOBULIN	2.5	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
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METHOD : CALCULATED PARAMETER

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

SODIUM, SERUM	<b>135 Low</b>	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.31	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	<b>96 Low</b>	98 - 107	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. Drugs: 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).Drugs: 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, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.
<b>Increased in:</b> Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: 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. Drugs: potassium salts, 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 HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates.
<b>Interferences:</b> 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.	<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.	<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)

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 Tel : 0120-2403338, Fax :  
 CIN - U74899PB1995PLC045956  
 Email : customercare.noida@srl.in



**Patient Ref. No. 775000002884651**



**PATIENT NAME : MUKESH KUMAR**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000138361**

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

**ACCESSION NO : 0028WD000361**

**PATIENT ID : MUKEM15028828**

**CLIENT PATIENT ID:**

**ABHA NO :**

**AGE/SEX : 35 Years Male**

**DRAWN :**

**RECEIVED : 12/04/2023 08:50:13**

**REPORTED : 13/04/2023 10:49:08**

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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.

**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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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

**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.

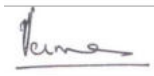
**AST** is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis 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



**Dr. Neena Verma**  
Senior Pathologist



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**ACCESSION NO : 0028WD000361**

**PATIENT ID : MUKEM15028828**

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**AGE/SEX : 35 Years Male**

**DRAWN :**

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(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

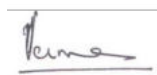
**TOTAL PROTEIN, SERUM-** is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin.

**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. Neena Verma**  
**Senior Pathologist**



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**CLINICAL PATH - URINALYSIS**

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

**PHYSICAL EXAMINATION, URINE**

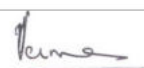
**COLOR** PALE YELLOW  
METHOD : VISUAL  
**APPEARANCE** CLEAR  
METHOD : VISUAL

**CHEMICAL EXAMINATION, URINE**

<b>PH</b> <small>METHOD : DOUBLE INDICATOR PRINCIPLE</small>	6.0	4.7 - 7.5	
<b>SPECIFIC GRAVITY</b> <small>METHOD : PKA CHANGE OF PRETREATED POLYELECTROLYTES</small>	<=1.005	1.003 - 1.035	
<b>PROTEIN</b> <small>METHOD : PROTEIN- ERROR INDICATOR</small>	NOT DETECTED	NOT DETECTED	
<b>GLUCOSE</b> <small>METHOD : OXIDASE-PEROXIDASE REACTION</small>	NOT DETECTED	NOT DETECTED	
<b>KETONES</b> <small>METHOD : ACETOACETIC REACTION WITH NITROPRUSSIDE</small>	NOT DETECTED	NOT DETECTED	
<b>BLOOD</b> <small>METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN</small>	NOT DETECTED	NOT DETECTED	
<b>BILIRUBIN</b> <small>METHOD : DIAZOTIZATION</small>	NOT DETECTED	NOT DETECTED	
<b>UROBILINOGEN</b> <small>METHOD : MODIFIED EHRlich REACTION</small>	NORMAL	NORMAL	
<b>NITRITE</b> <small>METHOD : CONVERSION OF NITRATE TO NITRITE</small>	NOT DETECTED	NOT DETECTED	
<b>LEUKOCYTE ESTERASE</b> <small>METHOD : ESTERASE HYDROLYSIS ACTIVITY</small>	NOT DETECTED	NOT DETECTED	

**MICROSCOPIC EXAMINATION, URINE**

<b>RED BLOOD CELLS</b> <small>METHOD : MICROSCOPIC EXAMINATION</small>	NOT DETECTED	NOT DETECTED	/HPF
<b>PUS CELL (WBC'S)</b> <small>METHOD : MICROSCOPIC EXAMINATION</small>	1-2	0-5	/HPF
<b>EPITHELIAL CELLS</b> <small>METHOD : MICROSCOPIC EXAMINATION</small>	1-2	0-5	/HPF



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 Senior Pathologist



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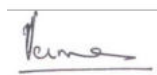
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CASTS METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	

**Interpretation(s)**



**Dr. Neena Verma**  
**Senior Pathologist**



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**SPECIALISED CHEMISTRY - HORMONE**

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

**THYROID PANEL, SERUM**

T3 METHOD : ECLIA	129.3	80.00 - 200.00	ng/dL
T4 METHOD : ECLIA	10.36	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : ECLIA	3.110	0.270 - 4.200	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
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

**Dr. Shyla Goel, M.B.B.S ,DCP**  
**Sr.Pathologist**



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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.



**Dr. Shyla Goel, M.B.B.S ,DCP**  
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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 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**

NORMAL

**TMT OR ECHO**

TMT OR ECHO

2D ECHO DONE

**ECG**

ECG

WITHIN NORMAL LIMITS

**MEDICAL HISTORY**

RELEVANT PRESENT HISTORY NOT SIGNIFICANT  
 RELEVANT PAST HISTORY NOT SIGNIFICANT  
 RELEVANT PERSONAL HISTORY MARRIED 1CHILD NON VEG  
 RELEVANT FAMILY HISTORY MOTHER DIABETES  
 OCCUPATIONAL HISTORY JOB  
 HISTORY OF MEDICATIONS NOT SIGNIFICANT

**ANTHROPOMETRIC DATA & BMI**

HEIGHT IN METERS 1.72 mts  
 WEIGHT IN KGS. 62.3 Kgs  
 BMI 21

BMI & Weight Status as follows/sqmts  
 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  
 GENERAL APPEARANCE / NUTRITIONAL STATUS HEALTHY  
 BUILT / SKELETAL FRAMEWORK AVERAGE



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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		NORMAL		
PULSE		82/MINUTE, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
<b>CARDIOVASCULAR SYSTEM</b>				
BP		122/82		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		NORMAL		
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		
<b>CENTRAL NERVOUS SYSTEM</b>				
HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		
CEREBELLAR FUNCTIONS		NORMAL		



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**PERFORMED AT :**

SRL Ltd  
E-368, LGF, Nirman Vihar, Near Nirman Vihar Metro  
NEW DELHI, 110092  
NEW DELHI, INDIA  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956  
Email : wellness.eastdelhi@srl.in



**Patient Ref. No. 775000002884651**



<b>PATIENT NAME : MUKESH KUMAR</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000138361</b>		<b>ACCESSION NO : 0028WD000361</b>	<b>AGE/SEX : 35 Years Male</b>
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )		<b>PATIENT ID : MUKEM15028828</b>	<b>DRAWN :</b>
F-703, LADO SARAI, MEHRAULISOUTH WEST		<b>CLIENT PATIENT ID:</b>	<b>RECEIVED : 12/04/2023 08:50:13</b>
DELHI		<b>ABHA NO :</b>	<b>REPORTED : 13/04/2023 10:49:08</b>
NEW DELHI 110030			
8800465156			

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

**NORMAL SCAN**

**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.

\*\*\*\*\*

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

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

**CONDITIONS OF LABORATORY TESTING & REPORTING**

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.</li> <li>2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.</li> <li>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.</li> <li>4. A requested test might not be performed if:                     <ol style="list-style-type: none"> <li>i. Specimen received is insufficient or inappropriate</li> <li>ii. Specimen quality is unsatisfactory</li> <li>iii. Incorrect specimen type</li> <li>iv. Discrepancy between identification on specimen container label and test requisition form</li> </ol> </li> </ol> | <ol style="list-style-type: none"> <li>5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety &amp; technical integrity.</li> <li>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.</li> <li>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.</li> <li>8. Test results cannot be used for Medico legal purposes.</li> <li>9. In case of queries please call customer care (91115 91115) within 48 hours of the report.</li> </ol> |
|---|---|

**SRL Limited**  
 Fortis Hospital, Sector 62, Phase VIII,  
 Mohali 160062



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 E-368, LGF, Nirman Vihar, Near Nirman Vihar Metro  
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